NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 28 March 2025, 9:15 AM — 1:15 PM GMT
Venue	Sudbury Community Health Centre, Church Field Road, Sudbury, CO10 2DZ
Description	A meeting of the Board of Directors in the Public domain on Friday 28th March 2025
Organiser	Gemma Wixley

Agenda

AGENDA
Presented by Jude Chin

0. WSFT Public Board Agenda - 28 Mar 2025.docx

9:15 AM — 1. GENERAL BUSINESS
Presented by Jude Chin

10:10 AM — 1.1. Welcome and apologies for absence - Richard Jones, David Weaver, Roger Petter
To Note - Presented by Jude Chin

1.2. Declaration of interests for items on the agenda
To Assure - Presented by Jude Chin

10:10 AM — 1.3. Minutes of the previous meeting - 31st January 2025 (ATTACHED)
To Approve - Presented by Jude Chin

Item 1.3 - 2025 01 31 January - WSFT Public Board Minutes Draft.docx

1.4. Action log and matters arising (ATTACHED)
To Review - Presented by Jude Chin

Item 1.4 - Board Actions - Complete.pdf

Item 1.4 - Board Actions - Active.pdf

10:10 AM	1.5.	Questions from Governors and the Public relating to items on the agenda To Note - Presented by Jude Chin
	1.6.	Patient story - presentation To Review - Presented by Susan Wilkinson
10:10 AM	1.7.	Chief Executive's report (ATTACHED) To inform - Presented by Ewen Cameron Item 1.7 - CEO Board report - March 2025 FINAL.docx
10:10 AM	2.	STRATEGY
	2.1.	WSFT Strategy (ATTACHED) Presented by Sam Tappenden Item 2.1 - Strategy Update to Board Final March 2025.docx
10:45 AM	2.2.	Future System board report (ATTACHED) To Assure - Presented by Ewen Cameron Item 2.2 - Future System Board Report.docx
	2.3.	Suffolk System Update Report - SNEE Integrated Care Board (ICB); Wider System Collaboration (ATTACHED) To Assure - Presented by Peter Wightman and Clement Mawoyo Item 2.3 - West Suffolk Alliance Update Mar 25 report.docx Item 2.3.1 Position paper VW stepup March 2025 final action log#3120.docx
	2.4.	Digital Board Report (ATTACHED) To Assure - Presented by Nicola Cottington Item 2.4 - Trust Board digital report Mar 2025.docx
10:45 AM	Comfort Break	

	2.5.	Collaborative Oversight Group (ATTACHED) To Assure - Presented by Sam Tappenden Item 2.5 - Provider Collaborative Update Open Board March 2025.docx
10:55 AM	3.	ASSURANCE
	3.1.	IQPR Report (ATTACHED) To Review - Presented by Nicola Cottington Item 3.1 - IQPR Cover Sheet.docx
11:10 AM	3.2.	Finance Report To Review - Presented by Jonathan Rowell Item 3.2 - Board Report - Month 11 Finance Report Cover Sheet.docx Item 3.2 - M11 Finance Report for Board.pptx
	3.3.	Operational Planning Guidance (ATTACHED) To Review - Presented by Matt Keeling Item 3.3 - 25-26 Operational Planning for Board_.docx
	3.4.	Budgets and capital programme 2025/26 (ATTACHED) To Review - Presented by Jonathan Rowell Item 3.4 - Capital Planning_Trust Board_20250328.docx Item 3.4 - 2526_20250312.pdf
11:35 AM	Comfort Break	
11:50 AM	4.	PEOPLE, CULTURE AND ORGANISATIONAL DEVLEOPMENT

	4.1. Involvement Committee Report - Chair's Key Issues from the meeting (ATTACHED) To Assure - Presented by Tracy Dowling and Jeremy Over Item 4.1 - Involvement CKI Feb 2025 - final.doc
	4.1.1. Putting You First Awards (ATTACHED) Presented by Jeremy Over Item 4.1.1 - PYF awards Mar25.pptx
12:15 PM	5. OPERATIONS, FINANCE AND CORPORATE RISK
12:25 PM	5.1. Insight Committee Report - Chairs key issues from the meetings (ATTACHED) To Assure - Presented by Antoinette Jackson and Nicola Cottington Item 5.1 - Insight CKI 2025.01.15 FINAL.docx Item 5.1 - Insight CKI 2025.02.19 FINAL.docx
12:25 PM	6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT
	6.1. Improvement Committee Report - Chairs key issues (ATTACHED) To Assure - Presented by Susan Wilkinson Item 6.1 - Improvement Cttee CKIs 15 01 25 RP, SW.docx Item 6.1 - Improvement Cttee CKIs 19 02 25 RP, SW.docx
	6.2. Quality & Nurse Staffing Report (ATTACHED) To Assure - Presented by Susan Wilkinson Item 6.2 - Nurse Staffing Jan. Feb 2025 FINAL.docx
	6.3. Maternity services report (ATTACHED) For Approval - Presented by Susan Wilkinson and Karen Newbury Item 6.3 - March 2025 Maternity and Neonatal quality safety and performance Board report BOARD COPY.docx

NHS
West Suffolk
NHS Foundation Trust

12:50 PM **7. GOVERNANCE**

7.1. Audit CKI Committee report (ATTACHED)
For Approval - Presented by Michael Parsons and Jonathan Rowell

Item 7.1 - AUDIT CKI report 18 Mar 2025 PS mp.docx

7.2. Board Assurance Framework (ATTACHED)
To Note - Presented by Pooja Sharma

Item 7.2 - BAF report to Board March 25.docx

7.3. Governance Report (ATTACHED)
For Approval - Presented by Pooja Sharma

Item 7.3 - Governance report 28 March 2025.docx

Item 7.3 Annex A PP(24)093 Risk Management Policy and Strategy 21 Mar 2025 Approved via Chair's action.docx

Item 7.3 Annex B Modern-slavery-statement 2025.docx

Item 7.3 Annex C Draft Board meeting May 2025 agenda DRAFT.docx

---

8. OTHER ITEMS
Presented by Jude Chin

1:10 PM **8.1. Any other business**
To Note - Presented by Jude Chin

8.2. Reflections on meeting
For Discussion - Presented by Jude Chin

8.3. Date of next meeting - 23 May 2025
To Note - Presented by Jude Chin

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

9. SUPPORTING APPENDICES
To inform - Presented by Jude Chin

Item 3.1 IQPR Full Report
To Note - Presented by Nicola Cottington

Item 3.1 - Board Report January 2025.pptx

Item 7.1 Audit CKI Appendices

Item 7.1 - APPENDIX Scheme of reservation and delegation March 25 AC draft for Trust Board 28 Mar 2025.docx

Item 7.1 - APPENDIX SFIs AC draft for Trust Board 28 Mar 2025.docx

Item 7.1 - APPENDIX WSFT Policy on the engagement for non-audit services AC 18 Mar 2025 DRAFT v2.docx

Item 7.3 Governance Appendices

Item 7.3 APPENDIX Involvement Committee Terms of Reference Dec 2024.docx

Item 7.3 APPENDIX Improvement Committee Terms of Reference Jan 2025 v1.docx

Item 7.3 APPENDIX Audit Committee Terms of Reference Mar 2025 DRAFT v1.docx

AGENDA

Presented by Jude Chin

WSFT Board of Directors – meeting in public

Date and Time	Friday, 28 March 2025 9:15 -13:15
Venue	Sudbury Community Health Centre, Church Field Road, Sudbury, CO10 2DZ

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence –** Richard Jones, David Weaver, Roger Petter	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** – 31 January 2025	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
	1.5	**Questions from Governors and the public relating to items on the agenda**	Chair	Note	Verbal
	1.6	**Patient Story**	Chief Nurse	Review	Verbal/ Video
	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10.10	2.1	**WSFT Strategy**	Director of strategy and transformation		Report
	2.2	**Future system board report**	Chief Executive	Assure	Report
	2.3	**System update/Alliance report** - SNEE Integrated Care Board (ICB) - Wider system collaboration - Virtual Ward: position re step up admissions (action log#3120)	West Suffolk Alliance Director and Director of Integrated Adult Health and Social Care	Assure	Report
	2.4	**Digital Board report**	Chief Operating Officer	Assure	Report
10:30 Comfort Break					
10:40	2.5	**Collaborative oversight group**	Director of strategy and	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
			transformation		
3.0 ASSURANCE					
10:50	3.1	**IQPR report** To consider areas for escalation *(linked to CKI reports from assurance committees)*	Executive leads	Review	Report
	3.2	**Finance report**	Interim CFO	Review	Report
	3.3	**Operational planning guidance**	Interim CFO / Chief Operating Officer Matt Keeling to present	Review	Report
	3.4	**Capital planning 2025-26**	Interim CFO	Review	Report
11:35 Comfort Break					
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT					
11.50	4.1	**Involvement Committee report –** Chair's key issues from the meetings **People and OD Highlight Report** - Putting you First award	NED Chair Dir of workforce & Comms	Assure Inform	Report
5.0 OPERATIONS, FINANCE AND CORPORATE RISK					
12.15	5.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT					
12.25	6.1	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	6.2	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	6.3	**Maternity services report** - Maternity services quality and performance report	Chief Nurse Karen Newbury Kate Croissant Simon Taylor	Approval	Report
7.0 GOVERNANCE					
12:50	7.1	**Audit Committee report** – Chair's key issues from the meetings	NED Chair	Inform	Report
	7.2	**Board assurance framework**	Trust Secretary	Approval	Report

Time	Item	Subject	Lead	Purpose	Format
	7.3	**Governance Report**	Trust Secretary	Inform	Report
8.0 OTHER ITEMS					
13.10	8.1	**Any Other Business**	All	Note	Verbal
	8.2	**Reflections on meeting**	All	Discuss	Verbal
	8.3	**Date of next meeting** Board meeting on 23 May 2025	Chair	Note	Verbal
	Resolution The Trust Board is invited to adopt the following resolution: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960				

Supporting Annexes

Agenda item	Description
3.1	IQPR
7.1	Audit committee CKI Appendices
7.3	Maternity papers Annexes

Guidance notes

Trust Board Purpose
The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Our Vision and Strategic Objectives			
Vision Deliver the best quality and safest care for our local community			
Ambition	First for Patients	First for Staff	First for the Future
Strategic Objectives	• Collaborate to provide seamless care at the right time and in the right place • Use feedback, learning, research and innovation to improve care and outcomes	• Build a positive, inclusive culture that fosters open and honest communication • Enhance staff wellbeing • Invest in education, training and workforce development	• Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities • Invest in infrastructure, buildings and technology

Our Trust Values	
Fair	We value fairness and treat each other appropriately and justly.
Inclusivity	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respectful	We respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safe	We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.
Teamwork	We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Richard Jones, David Weaver, Roger Petter

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

1.3. Minutes of the previous meeting - 31st January 2025 (ATTACHED)

To Approve

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 31 January, 2025, 09:15 – 13:30
Newmarket Community Hospital

Members:		
Name	**Job Title**	
Jude Chin	Trust Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Nicola Cottington	Executive Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Richard Goodwin	Executive Medical Director/Board Level Maternity and Neonatal Safety Champion	RG
Jonathan Rowell	Interim Chief Finance Officer	JR
Sam Tappenden	Director of Strategy & Transformation	ST
Antoinette Jackson	Non-Executive Director/SID	AJ
Michael Parsons	Non-Executive Director	MP
Tracy Dowling	Non-Executive Director	TD
Roger Petter	Non-Executive Director/ Board Level Maternity and Neonatal Safety Champion	RP
Richard Flatman	Non-Executive Director	RF
Heather Hancock	Non-Executive Director	HH
Alison Wigg	Non-Executive Director	AW
David Weaver	Associate Non-Executive Director	DW
Clement Mawoyo	Director of Integrated Adult Health & Social Care West Suffolk	CM
Peter Wightman	West Suffolk Alliance Director	PW
In attendance:		
Dan Spooner	Deputy Chief Nurse	DS
Pooja Sharma	Deputy Trust Secretary	PS
Anna Hollis	Acting Head of Communications	AH
Karen Newbury	Director of Midwifery (Item 4.3 only)	KN
Kate Croissant	Clinical Director for Women & Children (Item 4.3 only)	KC
Simon Taylor	Associate Director of Operations, Women & Children Services & Clinical Support Services (Item 4.3 only)	ST
Carol Steed	Deputy Director of Workforce	CS
Jane Sharland	Freedom to Speak up Guardian	JS
Apologies: Jeremy Over, Executive Director of Workforce & Communications, Paul Zollinger-Read, Associate Non-Executive Director, Richard Jones, Trust Secretary.		
Governors observing: Jane Skinner		
Staff:		
Members of the public: -		

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed all to the meeting and apologies for absence, detailed above, were noted.	
1.2	**Declarations of interest**	
	There were no declarations of interest for items on the agenda.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting on 29 November, 2024, were accepted as a true and accurate reflection, subject to the following amendment: **Attendance:** inclusion of Tracy Dowling, non-executive director. Ravi Ayyamuthu, amendment of job title to **Deputy** (~~Interim~~) Medical Director.	
1.4	**Action Log and matters arising**	
	Action Ref. 3112 – Patient Story – Locality Groups Connection to MyWish – meeting to discuss being held on 4 February, 2025. Update to be provided at March Board Meeting. ***Action Ref 3116 – People & OD Highlight Report – Guardian of Safe Working Annual Report – AI*** – Conversation on going. Update to be provided at March Board Meeting.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	The Trust is in the lower quartile for Care Hours Per Patient Day (CHPPD). Are its quality indicators benchmarked against trusts who might have greater CHPPD? This has been considered at the Involvement Committee, in context with the CQC inpatient survey results, which were amongst the best in the country. This has provided comfort that despite having a lower proportion of care hours per patient day, patients were receiving good care. **Do we know our number of falls?** Falls are mapped against the national falls database. Pressure ulcers are measured locally. Any incidents of harm go through the Patient Safety Incident Response framework (PSIRF). **What is the clinical staff uptake of flu and COVID vaccines this year, compared to last?** This year was lower in terms of nursing staff. Previous vaccination team visits to wards for those staff unable to leave clinical areas were reduced due to resource constraints. However, these visits have increased in January and numbers are improving. Further, due to a high level of sickness, staff were unable to be vaccinated due to being unwell. The Trust is ahead of the national rate for flu revaccination, which has fallen significantly. The post-pandemic period has had an	

	effect on people's willingness to be vaccinated both staff and the general population.	
1.6	**Patient Story**	
	The Board received a video recording from a patient's wife regarding her and her husband's experience of end-of-life care whilst the husband was a patient of the hospital. The recording was made following a face-to-face meeting to listen to her concerns and receive feedback. Work with Quality Improvement is to be undertaken to assist in identifying those patients at end of life and with palliative care in order to reduce the number of patient moves. Whilst accepting the need for staff to move away from the computer screen when having sensitive conversations with patients and relatives, it was also a matter of confidence and work is being undertaken with ward managers in this regard. Roger Petter (RP) highlighted that the wife had asked why she was continually asked questions, when detail was contained within the notes. He advised that most clinicians want to do this, in order to avoid making assumptions from the notes alone. In asking questions, the clinician can pick up on nuances. Alison Wigg (AW) asked if there was any learning on palliative care to be taken to the new hospital? Sue Wilkinson (SW) advised that palliative care was a part of coproduction for the new hospital. Palliative Care is a small team which provides specialist advice and guidance to ward staff. End of life care is not solely their responsibility. All nurses and doctors should know how to have a conversation about end of life and how to care for these patients. Intentional rounding, whereby a patient receives a visit every two hours from nursing staff to ask if they are in pain, want to go to the toilet, or if there was anything else that could be done for them is still being carried out and tracked on e-Care. However, an assessment is being carried out to ensure this remains impactful. There is insufficient resource at present to allow for longer conversations with patients. Staff need to be upskilled to be able to multitask and have good communication with patients whilst delivering care. Nicola Cottington (NC) advised that there were ways that digital innovation could be used to enable more face-to-face conversations and the Trust was in discussion with providers regarding applications. The need not to overburden e-Care was stressed. RP stated that in primary care the computer screen set up was side by side, enabling better conversations. Could the Trust do the same? SW advised that computers on the ward were on wheels. Many junior doctors scribed for the more senior and therefore the senior should step away and go to the patient. It was also a matter of clinician confidence. Having an end-of-life conversation with a	

	patient is very difficult and requires training to be able to do well. These conversations are not purely a factual transmission of information; the clinician is judging how best to communicate. JC asked how the Trust could effect change and share this message? SW advised that this video was to be presented at the Experience of Care Committee. It should be noted that most of the time staff got it right. JC enquired if there were any potential gaps in the palliative care pathway? SW advised she was the lead on end-of-life care at the ICB. Work from the "Die Well" meetings was taken to the West Suffolk Alliance and a deep dive in this regard had been carried out. Consideration should be given to how all the domains were brought back in to focus, including "Age Well" and "Being Well." It was a matter of proactive management. Peter Wightman (PW) advised that in terms of the system approach to end-of-life care, North East Essex have had a very successful programme with these guided conversations. Suffolk is looking to replicate.	
1.7	**CEO Report**	
	Ewen Cameron (EC), CEO, presented the report and highlights were noted: ***Sustainability Review*** – noted this review is being undertaken and it is hoped will provide some new solutions for implementation across the system to deal with future clinical sustainability challenges. ***Planning Guidance*** – noted an increase in funding for health. However, this will be taken up by pay awards, inflation and National Insurance and in real terms will mean a cut. Systems have been given much greater flexibility on use of their budget in order to gain from the best use of resources. SW highlighted the need to be conscious of co-production with colleagues and service users. There were stresses on acute and community staff from service delivery expectations from the local population. Any potential de-prioritisation must be carried out in collaboration, in order to ensure people's understanding of the rationale. Carol Steed (CS) highlighted the need to retain focus on the workforce and how to support them through the process. Richard Flatman (RF) asked, in terms of percentage cuts in costs and required increase in productivity, how this compared with the assumptions already made in the Trust's planning? Did it increase the challenge? Jonathan Rowell (JR) advised that for this year, the headline number of 5% included funding payables and the NI increase, together with all the inflationary uplifts anticipated. However, the guidance also requests a 2% efficiency factor on top.	

	The Trust has assumed 1.1% therefore the headline number is 2.0%. NC reported that in order to achieve this the Trust will rely on system flexibility and relationships and will feature some tough conversations and decisions at that level. Given the context of the Trust's financial position and sustainability review this will be difficult. Further, given this flexibility there was the risk of in-equitability across borders. NC asked how this would be messaged out to all staff? Those not delivering hands on care were also integral. Divisions had been making logical decisions to take tasks away from clinical staff and allocate to non-clinical colleagues, resulting in cost effectiveness and improving the skills of those staff, as part of the pathway. To only prioritise clinical staff could be counterintuitive and make people feel less valued.	
2.0 STRATEGY		
2.1	**Future System Board Report**	
	Ewen Cameron, CEO presented the report. Noted RIBA 2 designs were complete with a 10% increase in area drawn to be addressed in the next stage(s). Good progress is being made. Antoinette Jackson (AJ) asked how the work carried out by the Operational Readiness Board, (ORB) was to be tied in with the other meetings discussing this workstream? NC advised that the ORB performed a different function to the other meetings. Its aim was to ensure that on day one of opening, everything was in place to deliver a service. Sam Tappenden (ST) stated the requirement for a portfolio delivery plan for the next few years to include CIP delivery and transformation which was being worked on. Tracy Dowling (TD) asked how the Trust was engaging with clinical staff on transformation and change in order to ensure they owned the change and building? ST advised there was much coproduction. Deliverables were to shortly be reviewed in order to provide high impact. JC asked if an assurance structure was in place? ST advised that there were some structures in place, but more could be done. This would form part of the work being undertaken on governance and the strategy refresh.	
2.2	**Anchor Programme – Update Report**	
	Ewen Cameron, CEO, presented the 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. The Trust is in receipt of two impact reports in this regard. NC asked if all staff were aware of the content, as there was much to be celebrated contained within? She noted in terms of ESNEFT's contributions, work had been targeted on addressing inequalities, whilst this Trust's were more generic, could WSFT be more targeted? JC advised that ESNEFT has put greater resource in to managing this programme and it was a discussion for the Board as to where this sat in terms of priorities and level of resource. Alison Wigg (AW) asked whether the use of suppliers to benefit the local community has been embedded within the Future System Programme? It was unsure at this stage in the process. AJ highlighted that the report undertook a thematic approach of different organisations. Did the Trust have a sense of the totality in order to ascertain which elements were to be undertaken? EC advised that this was a system report rather than the Trust's. JC stated that it was not a linked process, but examples of what had been done. It was not part of an integrated plan. AJ queried if this was not an integrated plan why was it being done? What is the decision making on resources? EC advised that the only resource at present was CEO attendance at meetings, to increase this resource would have an impact on other areas within the Trust. AJ asked where the Trust was taking the strategic view? EC responded that this was being carried out at a corporate level rather than part of an Anchor programme. CS advised that there was an opportunity within the Trust's strategy refresh to provide a steer regarding its participation in the Anchor programme. **Action: Anchor ambition to be incorporated in to the strategy refresh.**	**ST**
2.3	**System Update Report**	
	Peter Wightman, West Suffolk Alliance Director, presented the report. ***Suffolk Enhanced Bus Partnership*** - there has been high utilisation of new bus routes introduced in 2024/5 to include stops at WSFT Main hospital site. 2025/6 funding announced and ideas on use requested from Alliance members. ***Evaluation of Physical Activity Pilot – Abbeycroft Leisure*** – Positive outcomes noted. Physical Activity Strategy Group to determine the way forward, including potential partner financial contributions and commissioning requirements. ***Virtual Ward*** – noted the service is in the process of being integrated within the WSFT community Integrated Nursing Teams (INTs) and Early Intervention Team (EIT).	

	TD referred to the metrics on falls and utilisation of the virtual ward, which did not include information on how much related to step-up admission prevention rather than step down from hospital. She expressed concern that the virtual ward was to expand from March, whilst not fully utilised. She stated a need in next year's planning to test how much the Trust was optimising admission prevention and what it would take to get to the level of those organisations benchmarking the best. EC advised that the expansion in capacity had been created by the integration of the team into the INTs; this was not an expansion of funding. Further investment in expansion could not be made until such time as activity increased. JC asked what models others were using in terms of stepping up or down? CM advised that the Alliance had been looking at a step-up pathway that had been tested with care homes and was to be scaled up. They have also focused on a COPD pathway, for admission avoidance which is well used. TD stated the need to do more particularly around frailty. The Trust should look at best practices and how quickly it could achieve these. Those who did not need to be in hospital should not be. Acceleration and focus were required. **Action: Future reports to include detail of Level 1 Falls and outcomes from ICB commissioned Suffolk Falls Service and how these triangulate with the Trust.** JC enquired as to GP confidence in stepping up? CM advised that good progress had been made. The aim was to ensure all INTs support virtual ward and have taken a phased approach to ensure safety and quality of service. It is anticipated that by February this will have been fully rolled out to all INTs and primary care networks supporting referrals. NC advised that step up referrals were able to be taken from the Emergency Department to Virtual Ward and work on socialising this with staff was being undertaken. **Action: Update on Virtual Ward to come to March Board Meeting.**	**PW** **CM**
2.4	**Collaborative Oversight Group**	
	Sam Tappenden, Director of Strategy & Transformation presented the report. ***Essex & Suffolk Elective Orthopaedic Centre (ESEOC)*** – opportunities being investigated in the corporate space for joint working. JC asked whether there was any work being undertaken on sharing of patient data between the two Electronic Patient Record (EPR) systems? NC advised that there is a health information exchange that can feed in to this. The transfer of information to ESEOC has been complex due to a lack of a digital electronic portal at ESNEFT.	

	JC asked if the flow of information would be two-way? EC advised this was technically possible, as there was a two-way link between this Trust and Addenbrookes, however this had not been funded by WSFT.	
3.0 ASSURANCE		
3.1	**IQPR Report**	
	Nicola Cottington, Chief Operating Officer presented the report. She highlighted the need for information to provide assurance rather than operational detail in terms of Urgent and Emergency Care (UEC), a key area of performance. She referred to planning for a different service offer for people living with frailty, rather than the need to access multiple services. This cohort, whilst needing care and treatment, may not require emergency medicine. CS suggested a link with voluntary organisations in the community for this group would be useful. Discussion on transformational change has been undertaken by the executive team. **Action: Comprehensive report on UEC to come to March Board Meeting. AJ and NC to agree on template to be used.** Heather Hancock (HH) asked if work on the frailty initiative would provide a template for transformative care going forward, not only on how, but what and why? ST advised that this could be used as a future template. NC advised that Ultrasound is an area of vulnerability. Recruitment of sonographers is a national issue. The introduction of financial controls in the Autumn has had an impact on recruitment. If vacancies are filled, recovery will be back on track. TD referred to the innovative pathways within dermatology. Was the same being done in terms of pathways for 65 week and cancer waits, or were these still traditional consultant led resulting in long waits for areas of high demand? NC responded that the Trust had been using technology in the last couple of years, which has helped in managing demand. Confidence in its use by GPs and Consultants has been encouraged.	**NC/AJ**
3.2	**Finance Report**	
	Jonathan Rowell (JR), Interim Chief Finance Officer, presented the report. The deficit at Month 9 of £471k has been discussed at Insight. A strong performance in December has resulted in a forecast for overachievement on the year end saving targeted from £19.2m to £21.2m. Noted the Trust has agreed a revised control total with the ICB of 23.9m.	

	Michael Parsons (MP) asked what more would be required to reduce the run rate and what actions were in place? He also enquired as to the effectiveness of the work carried out by PA Consulting. JR advised that in terms of the run rate, it was critical for the Trust to focus on substantive controls on pay, with a target in mind. Achieving this target is predicated on any requirement to use bank staff. PA Consulting have been engaged to assess the financial recovery plan, provide assurance on same and assistance with the governance process to drive this. They have also been requested to identify further opportunities and assess this year's plan. This has added value, i.e. substantive staffing, understanding the pipeline and focus on estates. It has been noted there are now diminishing returns for 2025 and will now refocus on 2026. TD referred to much discussion on pay controls. Was there more the Trust could be doing in terms of non-pay? JR advised that much of the non-pay overspend was in relation to community equipment and wheelchairs, but this was heading in the right direction. The reductions through the non-pay panel or catalogue masking were not as great as anticipated. ST advised that as part of the corporate workstream review, PA had been asked to look at non-pay and have provided recommendations as part of their proposal to strengthen controls. Whilst not massive opportunities there was the potential to go further. NC queried what assurance the Board would receive regarding the impact on quality and safety of the financial decisions taken? SW advised that the QIA process is not solely a performance indicator; it helps sort through decisions to ensure there is no specific quality impact. Decisions that may impact on quality she, as Chief Nurse and Richard Goodwin, Medical Director, take a measured approach to monitoring. There is an opportunity to review what indicators the Trust thinks, in the current climate, will demonstrate impact. Most indicators hold steady for 3-6 months. After that time, any deterioration will show and will need to be mapped. NC advised that the QIA process is reported to the Insight Committee. She asked, in terms of making difficult decisions, how did the Board ensure it is explicitly informed of any impact on patients? Incremental impact was a difficult thing to measure and not every single decision went through the QIA process. Board oversight was required in addition to that of the executive team. JC suggested that a discussion take place at the Management Executive Meeting on how this process was reported to the Board. He queried whether there were other leading indicators that would provide forewarning of any potential impact to patients on decisions to be made? **ACTION: Management Executive Group to consider process of reporting to Board impact of financial decisions made.**	**NC**

	David Weaver (DW) asked if the Trust's funding partners were in agreement with the math in terms of run rate? JR advised that they were and it was clearly set out in the Trust's Financial Recovery Plan. In February, the Board would need to look at a plan for next year and choices to be made. In calls with NHS England, it has been made clear that the Trust has to do everything it can to be as productive as possible. The executive team will need to present to the Board the intricacies of decisions required to be made. He expressed concern at the pressure on the Trust to achieve a certain figure and the affect this will have on staff due to their perception of the future in the organisation.	
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT		
4.1	**Improvement Committee Report**	
	Reports were noted. It was agreed that future reports would include the outcome of any accreditations detailed.	
4.2	**Quality and Nurse Staffing Report**	
	Dan Spooner (DS), Deputy Chief Nurse presented the report. Noted a challenging period for nursing, predominantly due to large increase in flu related absences; a 2% rise compared to September. This, coupled with consistent staffing of escalation areas and staff moves, has been challenging, witnessed in staff fill rates and Care Hours per Patient Day, (CHPPD). NC highlighted the over achievement of the reduced fill rate and stated this was not a situation that could be sustained. DS responded that due to levels of sickness in October and November this ambition had been paused in December. This is being reviewed as the flu season comes to a close. SW advised that fill rates could be mitigated during the day by other peripatetic staff. Of concern was the resilience of staff, particularly at night. Staff are working to mitigate this. It was noted that the peripatetic staff are not on health rosters and therefore not reflected in fill rates. However, they are documented in the daily Matron's Log. JC asked if low fill rates at night was one of the reasons CHPPD had dropped? DS advised that this was more pertinent to the day. CHPPD was noted across a 24-hour period. Fill rates at night have been maintained at over 90%.	
4.3	**Maternity Services Report**	
	Karen Newbury, (KN), Director of Midwifery, Kate Croissant, (KC), Clinical Director for Women & Children Services and Simon Taylor ADO, Women & Children& Clinical Support Services in attendance. The report was taken as read. NC queried the low number of survey responses received on discharge from the labour suite. KN advised that this information	

	was not provided by the directorate, but came via the Patient Advice and Liaison Service (PALS). Many of those discharged from the Labour Suite will proceed to Ward F11. Additional detail can be requested to demonstrate this. AJ highlighted the number of midwives leaving the profession and asked if there were any themes from this the Board should be aware of? KN reported that the number of resignations has significantly reduced. The primary reason given has been people's mental health, not necessarily related to work, but life in general and difficulties in working some particular shift patterns. Ward Managers are aware and are looking at how to tailor ways of working in order to support people. They are also working with occupational health in terms of work life balance. SW asked what impact the appointment of an EDI midwife has had on the directorate? KN advised the reason for this appointment was due to the potential for those from a black and Asian background to have a higher chance of an adverse incident within their maternity journey. Reflective of the national picture for staff, i.e. those internationally educated or of different ethnicities, (Trust and community) the directorate is looking at how to be a service without racism and with progression for everybody. Perinatal culture work, involving the GMC and NMC, on what constitutes acceptable behaviours, is also being carried out, together with other training and support from the regional team. CS reported questions about the Trust's maternity service posted on local social media, where comments had been varied. She queried how the service linked in with the community to assure them that the service to be received will be a good one? KN advised that negative comments were historical. The service now had a positive social media presence, undertaken by a member of the team, in their own time. She advised that in most instances, if a member of the public wished to ascertain the safety of a maternity service, they would look at the organisation's CQC results for the Maternity Incentive Scheme. WSFT has not had an inspection since 2021 and therefore still showed as requiring improvement. Richard Goodwin (RG) suggested that for most people in this geography it will be their first interaction with the service that will be key. ***Compliance with Year 6 of the Maternity Incentive Scheme Safety Actions 2025/2025*** – **following evidence received through this Committee, Improvement and via the relevant safety champions, the Board confirmed their assurance that all possible steps have been taken to provide safe care and services within the Maternity and Neonatal care settings.**	
5.0 OPERATIONS, FINANCE AND CORPORATE RISK		
5.1	**Insight Committee Report**	
	The report was taken as read.	

	AJ advised that following a joint review by the ICB and regional finance teams, the CEO had received a formal request to re-set WSFT's 2024/25 control total to £23.9m for the year, from the original plan of £15.3m. The letter also outlined a number of further mitigations/conditions to the offer which the Board were asked to accept in order to reach agreement on the re-set. Due to issues of timing of the ICB and Trust Board meetings, it was agreed that the matter be discussed at the Insight Committee, attended by the Chair and other Board members for the particular item. Given the improved performance in Month 9 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.	
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT		
6.1	**Involvement Committee Report**	
	The report was taken as read. TD highlighted, under Item 7.1 of the CKI, First for Staff, Pulse Staff Survey Results 2021-2024 that results were currently dipping. The results of the Annual Staff Survey are awaited. Results received so far will be taken to the next meeting of the Involvement Committee for discussion. **Action: An overview of results and summary actions for addressing any issues identified from Annual Staff Survey to be included with final report to the Board.**	**JMO/CS**
	Freedom to Speak Up	
	Jane Sharland, Freedom to Speak Up Guardian, presented the report. Noted the Speak Up Month in October 2024 to raise awareness had been very successful. Anonymous concerns remain low, but numbers have risen in the last quarter. Job security, financial constraints, poor communication and lack of civility reported. Ongoing stress and pressures cited as a potential reason for incivility and the launch of the Health and Wellbeing Employee Assistance Programme has been timely. Some staff's perception that the worst of the financial difficulties were over was reported. EC advised that initial communications to staff had detailed that this would be a three-year challenge and nothing less had been intimated. Noted issues regarding discharge planning, including communication between acute and community and inadequate feedback to community on discharge incidents reported on RADAR. Noted further work being undertaken with wellbeing and EDI leads to increase representation in FTSU.	

	RP referred to the concerns via a professional group, with the majority from nursing and midwifery, the largest staff group. He expressed an interest in seeing this data presented as a proportion of the total workforce to help identify any areas of concern. **Action: JS to consider presentation of data to reflect reported concern results as a percentage of total workforce.** JC asked if there was any data available regarding the use and benefit of the employee assistance programme? CS advised that the Trust was looking to develop a health and wellbeing dashboard to gain metrics on utilisation and impact. JC enquired if the Trust had been able to recruit the number of champions required and in the areas currently without representation? JS advised more champions were always required and some departments remained without. Recruitment continued. JC asked if there was any assistance the Board could offer to aid in recruitment, particularly in those areas unrepresented? JS agreed to give the matter some thought and advise. AJ asked if there was anything the Board could be doing differently? JS advised greater interaction with staff, providing an opportunity for concerns to be raised.	**JS**
	Putting You First Awards	
	The awards were noted and congratulations offered to the recipients.	
7.0 GOVERNANCE		
7.1	**Audit Committee Report**	
	MP presented the report. The backloading of numerous audits to end of the financial year, for a variety of reasons was noted, together with the importance of keeping to timelines wherever possible. In light of the Trust's financial position, it is planned for the 2025/2026 audit plan to give greater prominence to financial control.	
7.2	**Charitable Funds Committee**	
	MP presented the report. Noted new Head of Fundraising to commence employment in February, 2025. RF referred to the minutes from the recent Charitable Funds Committee that intimated a clear commitment by the Trust to fund any potential shortfall in the fundraising efforts for the robot appeal from the capital programme. Was this correct? JR advised the understanding was that in the event of any shortfall the Trust would look at the capital funding, but was not committed to underwriting. The focus was on fundraising to ensure no shortfall. Whilst the	

	supplier was keen for an order to be placed, this would not be done until the results of the fundraising efforts were known.	
7.3	**Board Assurance Framework (BAF)**	
	Pooja Sharma (PS), Deputy Trust Secretary presented the report. Next steps actions were noted. Action 4 "Schedule **review of risks to the agreed strategic** when the strategy refresh has been undertaken. This will also include review and assessment of the risk appetite for each risk (Q1)" **Action: wording to be amended to read strategy and not strategic.** **Subject to the amendment requested, the Board gave its approval to the next step actions.** RF highlighted BAF Risk 3 "*The Trust fails to work effectively with our partners to ensure the greatest possible contribution to preventing ill health, increasing wellbeing and reducing health inequalities"* and change in the appetite status to "hungry", from "open" when last reported at the September Board Meeting. He advised that the appetite should be that of the Board. Given recent changes, he suggested appetites of the current membership should be sought. Noted further work is to do be done in this regard. **Action: BAF 3 appetite to revert to "open".** JC referred to the number of risks within the red zone and queried whether the Trust was being objective enough given the mitigating actions being taken. He asked if these should be revisited? NC suggested this might affect the environment the Trust was operating in. She believed BAFs 2 (*The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities*) and 5 (*Fail to ensure the Trust implements secure, cost effective and innovative approaches that advance our digital and technological capabilities to better support the health and wellbeing of our communities*) should remain red in light of the financial and capacity situation and the environment and sustainability review for BAF 5. AJ advised the Trust was still evolving its approach and learning how to use the framework. Internal audit will be looking at the Trust's risks and mitigations.	**PS** **PS**
7.4	**Governance Report**	
	PS, Deputy Trust Secretary, presented the report. Noted the organogram of corporate governance has recently been reviewed and summarises the key management and assurance committees. The Remuneration Committee has met to consider recruitment of a new Chief Nurse and substantive Chief Finance Officer. The	

	committee also agreed that the Chief Information Officer be a regular attendee at public and private Board meetings. AW highlighted a lack of change in the digital board structure. Work in this regard is ongoing.	
8.0 OTHER ITEMS		
8.1	**Any Other Business**	
	None noted.	
8.2	**Reflections on meeting**	
	• Valuable and deep discussions, also balanced and rounded. Not just transactional. Challenge given. • Undertake high level review of annexes around NHS providers effective approvals and compare. • Include names within minutes to provide evidence of challenge.	
8.3	**Date of next meeting** 28 March, 2025.	

1.4. Action log and matters arising (ATTACHED)

To Review

Presented by Jude Chin

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3112	Open	29/11/24	1.6	**Patient Story - locality groups connection to MyWish.** Consideration to be given to structure and connection to voluntary sector. Update to be provided to January Board.	Meeting to discuss, being held on 4 February, 2025. Update to be provided at March Board Meeting**. Discussed with My Wish team and processes agreed.**	PW/CM	~~31/01/2025~~ 28/03/2025	Complete	28/03/2025
3116	Open	29/11/24	4.2	**People and OD Highlight Report - Guardian of Safe Working Annual Report** - Director of Workforce to speak to Francesca Crawley and Troy Pask re concerns expressed over staffing pressures. Interim report to be produced for return to January Board, with a verbal update to Involvement.	Meetings with the Medical Director have taken place, and it has been agreed that further data/monitoring is needed to fully understand the issues. This is being undertaken. Outcomes of this work are being discussed at TNC. **Update to be provided at March Board Meeting.** **Discussed at February's meetings of Involvement Committee and Trust Negotiating Council, informed by discussions between the medical director and junior doctor representatives. Data is being gathered to support further understanding and action. There continues to be no increase in exception reporting. Concern to be monitored by Involvement Committee.**	JMO	28/03/25	Complete	28/03/2025
3119	Open	31/1/25	2.3	**System Update Report -** Future reports to include detail of Level 1 Falls and outcomes from ICB commissioned Suffolk Falls Service and how these triangulate with the Trust.	**To be monitored at alliance committee and included in WSFT system report when further data available.**	PW	28/03/25	Complete	28/03/2025
3120	Open	31/1/25	2.3	**System Update Report -** update on virtual ward to come to March Board Meeting.	**Today's (28.3.25) report Item 2.3 refers.**	PW	28/03/25	Complete	28/03/2025
3125	Open	31/1/25	7.3	**Board Assurance Framework** - BAF 4 to amend strategic to **strategy**.	**Actioned.**	PS	28/03/25	Complete	10/03/2025
3126	Open	31/1/25	7.3	**Board Assurance Framework** - BAF 3 appetite to be amended to "open"	**BAF amended.**	PS	28/03/25	Complete	18/03/2025

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3118	Open	31/1/25	2.2	**Anchor Programme** - Anchor ambition to be incorporated in to the strategy refresh.		ST	25/07/25	Green	
3121	Open	31/1/25	3.1	**IQPR Report** - Comprehensive report on UEC to come to March Board Meeting. AJ and NC to agree on template to be used.	**Insight Committee in March is focusing on the Trust's Planning Guidance submissions which need to be made before the March Board meeting. Urgent and Emergency Care is scheduled for a deep dive at the May meeting.**	NC/AJ	28/03/25	Green	
3122	Open	31/1/25	3.2	**Finance Report -** Management Executive Group to consider process of reporting to Board impact of financial decisions made.	**There have been ongoing discussions at Insight Committee about the QIA process, with assurance provided that a process is in place. This will be discussed further at MEG 26th March.**	NC	28/03/25	Green	
3123	Open	31/1/25	6.1	**Involvement Committee** - Plan detailing actions for addressing any issues identified from Annual Staff Survey to be included with final report to the Board.		JMO/CS	23/05/25	Green	
3124	Open	31/1/25	6.1	**Freedom to Speak Up** - Consider presentation of data to reflect reported concern results as a percentage of total workforce.	**Detail to be contained within May FTSU report.**	JS	23/05/25	Green	

1.5. Questions from Governors and the Public relating to items on the agenda

To Note

Presented by Jude Chin

1.6. Patient story - presentation

To Review

Presented by Susan Wilkinson

1.7. Chief Executive’s report (ATTACHED)

To inform

Presented by Ewen Cameron

WSFT Board of Directors (Open)	
Report title:	**CEO report**
Agenda item:	1.7
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Dr Ewen Cameron, chief executive
Report prepared by:	Dr Ewen Cameron, chief executive Sam Green, communications manager (acting) Anna Hollis, deputy head of communications

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.	☒	☒	☒

There is no doubt February was a challenging period for the Trust. This was in part due to operational pressures and high service demand, including an increased prevalence of flu, and norovirus, which resulted in the closure of wards and limited our ability to admit patients who attended our emergency department.
However, despite this, I want to thank the many staff in hospital and community services who have worked to significantly improve the 4-hour performance in our emergency department over the first 17 days in March. Whilst we often think of this standard as being an operational one, it is probably the one that impacts more on the safety and quality of care than any of the others. To be running at 87.5% performance and best performing across the Midlands and East regions, and fourth nationally in the month to date in March is a fantastic achievement and will be significantly improving the outcomes and experience for patients coming through our urgent and emergency care (UEC) pathways.
In terms of our ongoing financial recovery programme, positive but tough progress is being made to live within our means. I stress again that it is vitally important and necessary that we return to a financially sustainable position and as we reach a new financial year there is lots more to be done. Substantial planning is ongoing for cost improvement programmes in 2025/26 that will oversee £20m of savings.

While our financial position has required the single biggest increase in attention this last year, our finances are not the only thing that matters. We will be focusing on developing our overall strategy for the years ahead and implementing change and transformation that will also help us provide better quality care to our patients and reduce pressure on our busy teams.

Performance

Finance

At the end of January, our reported position in-year was a £23.3 million deficit, which is £9.0 million worse than planned.

We are working at pace to support the Trust's financial recovery plan; and are on track to deliver within our revised year end deficit target expected at £26.5m. Our underlying deficit is reducing due to a lot of hard work and the measures in place to reduce spend. Some of these controls will remain in place due to the constrained and challenging environment we are working in, but we are in a better position.

The challenge for next year remains and we are working through plans; we are identifying opportunities to improve this 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 made progress in our elective recovery generally; at the end of February 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 clearing our 65 week waits.

Urgent and emergency care

As I have shared, I am very pleased to say that ahead of the end of March, our teams have worked incredibly hard to not just deliver against the 76% target on the 4-hour standard but exceed it. While our performance was 62.1% in December, 63.4% in January and 67.1% in February, in March up until the 17th, we averaged 87.5%, with a one-day peak of 95.9%. This is an incredible achievement and is a key indicator that we use to show how we are delivering high quality and safe care for our patients who need our urgent and emergency care services.

Being the best performing Trust across the Midlands and East regions, and fourth nationally in the month to date in March is testament to the hard work of our UEC teams, which comes despite ongoing pressure in these services, as well as a period of increased prevalence of flu, and norovirus, which resulted in the closure of wards.

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 January 2025, the position is:

- 70.7% of patients had cancer ruled out or confirmed within 28 days, this is behind the national standard and slightly behind our internal Trust trajectory.
- 63.7% of patients were treated within 62 days, which is behind the national standard for 2024/25.

The 28-day target has improved 12% since December 2024, while the 62-day target dropped by almost 8% on the previous month. We are working very hard to deliver our

services against the national targets so that our patients receive the care they need as quickly as possible, and we expect these figures to improve for February and March.

Diagnostics

On 16 December 2024, our brand new Community Diagnostic Centre at the Newmarket Community Hospital began seeing its first patients. This facility provides a wide range of diagnostic services, including MRI, CT, X-ray and ultrasound scans, as well as heart and lung scans. Now fully online, this expansion of our services is showing a marked improvement in our performance.

Against the 6-week standard, the CDC is having an early impact with 99.82% of patients having their CT scan within 6 weeks in January 2025, which has been recovered from a low of 51.5% in June last year. Additionally, with the additional MRI scanner, there was a 12.5% improvement against this 6-week target in January, which we expect to continue growing as time goes on and we move to longer opening hours and weekend working.

Quality

As many will know, our West Suffolk Hospital has undergone a significant programme of works to mitigate the risks associated with reinforced autoclaved aerated concrete – also known as RAAC – which was used extensively in the construction of the main hospital and other buildings on the site. Since we learned of additional risks associated with RAAC in 2019, we have completed the installation of numerous safety features, such as fail-safe roof supports, and continue to conduct regular checks to ensure our patients, staff, and visitors are safe. This has been a huge task for colleagues across the organisation and I thank both those involved in the complex project management as well as those on the ground who have helped to manage the disruption and relocation of their services around the site.

Over the past year, we have been running ‘Super Saturdays’ – offering specialist services on the weekend to dramatically reduce waiting times for particular patients needing treatment. This has been conducted across numerous specialties, including ophthalmology, orthopaedics, plastic and general surgery. On 22 February, we conducted a Super Saturday for patients waiting for carpal tunnel surgery, which alleviates pain and aching in the hands, wrists, and arms. Thanks to our dedicated surgeons, nurses, theatre practitioners, porters, and the waiting list team, we were able to complete 47 procedures in one day. This required a monumental effort, and I am pleased to say that another carpal tunnel Super Saturday is taking place in March. This means 65% of patients on the Trust’s waiting list for this procedure will receive the care and treatment they need more quickly.

Workforce

Getting out and about seeing the amazing work our teams do is something I relish.

I had the privilege of presenting a Putting You First award to John, one of our porters. John had been nominated for the compassionate care he provided to a patient with dementia who was distressed during their time in the emergency department. He helped to settle them during a transfer to CT. It’s really easy to forget the enormous impact non-clinical staff can have on the experience of patients as they undergo treatment.

I was also able to spend some time with the community midwifery team based at the Newmarket Community Hospital, where I heard about the really important role they play in the lives of our community through and after pregnancy. They provide vital and often lifesaving advice, which provides new and soon-to-be parents with the skills they need to

care for their newborn, and impact on pregnancy outcomes by reducing smoking in families during pregnancy. It was a real pleasure to hear the team talking about their service with such pride and joy.

Additionally, on 13 February I was honoured to present one of our cardiac rehabilitation sisters, Kate Turner, with a trophy to commemorate her 50 years of working in the NHS. Kate started at the former West Suffolk Hospital as a cadet nurse, moving on to a post in gynaecology once she gained her registration, and then into coronary care in the intensive treatment unit in 1980. Kate has remained in this specialty ever since - a shining example of someone that followed their calling and dedicated their working life to helping care for some of our sickest patients. While Kate is still working at our Trust, she will be retiring in April. I would like to sincerely thank her for her 50 years of service and wish her all the best as she moves into the next chapter of her life.

Future

In recent weeks the Government have announced that over the next two years it will be integrating NHS England into the Department of Health and Social Care (DHSC). This will have far-reaching implications, which we will work with our DHSC and NHS England colleagues to understand and help in any way we can to ensure this transition benefits the Trust and our patients as much as possible.

While there is significant change across the health and social care sector, there is also lots we are doing to improve the care we provide for our patients.

Part of this is our ongoing project to deliver a new, state-of-the-art hospital on the Hardwick Manor site in Bury St Edmunds. In January, following the completion of the Government's review of the New Hospital Programme, we received confirmation construction would begin between 2027-2028 and a broad capital budget of £1-1.5bn. We continue to work with the New Hospital Programme team to deliver a modern facility that supports the best care for west Suffolk.

We are continuing to work with our DHSC New Hospital Programme colleagues and local, regional and national stakeholders to ensure that we get this once in a generation opportunity right, which is what our communities absolutely deserve.

Since 16 December 2024, our Newmarket Community Diagnostic Centre has been going from strength to strength. This includes hiring graduates from our West Suffolk Community Diagnostic Academy, which gave those without a background in health or social care access to a rewarding NHS career, to expanding our opening hours from 8am to 8pm, and opening our lung function and echocardiogram services.

Additionally, in the time since the CDC has been operational up until 11 March, I was pleased to learn that it has conducted almost 6,400 examinations – including more than 1,000 MRI scans – on more than 5,000 patients. This expansion in our diagnostic capacity will help us to continue seeing our patients even more quickly and help us tackle health inequalities in the region.

We continue to work with partners in the system to establish ways of delivering services that will be more clinically and financially sustainable and hope to be able to report on any changes over the coming months.

2. STRATEGY

2.1. WSFT Strategy (ATTACHED)

Presented by Sam Tappenden

WSFT Board of Directors (Open)	
Report title:	**Strategy update to Board**
Agenda item:	2.1
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Sam Tappenden, Executive Director of Strategy and Transformation
Report prepared by:	Stephanie Rose, Programme Director

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 purpose of this report is to provide the Board with an update regarding the refresh of the Trust's strategy 'First for the Future'.

This report will set out updated timescales for the strategy refresh, outline the proposed approach, and highlight the key dependencies.

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

Context

1.1. The Trust's strategy, 'First for our patients, staff, and the future', was published in January 2022. The strategy articulates a vision, three ambitions, and five values as follows:
- **Vision:** 'To deliver the best quality and safest care for our community'.
- **Ambitions:** (1) first for patients; (2) first for staff and (3) first for the future.
- **Values:** Fairness, Inclusivity, Respect, Safety, and Teamwork.

1.2. The strategy was intended to cover the period 2021 – 2026, with annual reviews to oversee the strategy's delivery success.

1.3. As well as the corporate strategy, the Trust has several enabling strategies, including digital, quality, estates, and clinical and care.

1.4. The Trust has several gaps in its departmental-level strategies, which will be addressed through the strategy refresh process.

Figure 1: 'First for the Future' strategy visual

2. External environment

2.1. There are several material changes taking place in the Trust's external environment which will have a significant impact on the Trust's strategy:

- The highly anticipated NHS 10-Year Health Plan which is due to be published in Spring 2025.
- The government's focus on the 'three shifts' of hospital to community, 'analogue to digital', and 'treatment to prevention'.
- The sharp focus on planning guidance on financial sustainability, waiting list recovery, and productivity.
- The Suffolk and North East Essex (SNEE) Sustainability Review, which is due to be completed in April.
- Accelerated local government devolution in Suffolk.
- The abolition of NHS England (NHSE), and considerable workforce reductions in Integrated Care Boards (ICBs).
- On-going discussions with the National Hospital Programme (NHP), regarding the development of a new West Suffolk Hospital.

3. Strategic refresh

3.1. In October 2024 the Board agreed to a 'refresh' of the Trust's strategy to take account significant changes, challenges, and opportunities.

3.2. Significant engagement has since taken place with the Trust's Board and Senior Leadership Team (SLT), with plans to engage much more widely.

3.3. It was planned that a refreshed strategy be delivered by April 2025. However, since then, the Trust has had a major organisational focus on financial sustainability, the sustainability review, and managing winter pressures, which has delayed the refresh work.

4. Communications and engagement

4.1. Engagement will take the form of surveys, focus groups, and feedback from patients/staff, and 1:1s with senior leaders in partner organisations.

4.2. As well as some basic standard information requests, proposed community and staff survey questions could include:

- What matters most to you about health and care services provided by the West Suffolk NHS Foundation Trust?
- What do we do well?

- What could we be doing better?
- In five years' time, what change(s) would you like to see in health and care services provided by the Trust?
- What would you like the Trust to be known for in 2030?

4.3. The survey will be issued via internal channels (e.g. staff briefing), and regular meetings accessed for focus groups (e.g. medical staffing committee, non-medical clinical council, Trust council, all staff update) as well as some in person events and online events set up.

4.4. Likewise, the Trust's social media channels will be used to share the survey with our community, and we will look to access focus group opportunities via our patient VOICE group and other patient forums in the healthcare system.

4.5. Structured interviews will be carried out with key stakeholders and relevant stakeholder forums accessed where possible.

5. Updated timescales

5.1. We are now planning to have a refreshed strategy for Board sign-off in July 2025. This will provide sufficient time to incorporate outputs of work (e.g. sustainability review), updates in government policy (e.g. the 10-Year Health Plan), and other factors.

5.2. It is proposed that both internal and external engagement commences from mid-April until the end of May to ensure the Trust has sufficient opportunities to receive the feedback of patients, staff, and our partners.

5.3. Analysis, drafting, and message testing will take place in June/July.

5.4. The strategy can then be refreshed, refined, and presented to Board on the 25th July for final approval and then implementation.

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

- Finalise plans with our corporate teams (e.g. communications, strategy, and transformation).

- Provide updates to Management Executive Group (MEG) to enable executives to track progress.

Action Required

The WSFT Board is asked to note:

- For strategy engagement to commence from the end of April.
- For a refreshed strategy to be presented to Board on 25th July.

Risk and assurance:	Risk of failure to define the strategy, priorities, and role of the Trust in the West Suffolk Alliance.
Equality, Diversity and Inclusion:	
Sustainability:	
Legal and regulatory context	

2.2. Future System board report (ATTACHED)

To Assure

Presented by Ewen Cameron

WSFT Board of Directors (Open)	
Report title:	Future System Board Report
Agenda item:	2.2
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Ewen Cameron, chief executive
Report prepared by:	Gary Norgate, programme director

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

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

Scheme Status

As reported last month, the project to build a new West Suffolk Hospital is within the first wave of schemes to be built with an expected commencement date in 2027/28 and a capital budget of between £1 and £1.5bn.

It is expected that a more precise allocation of capital budget will be provided at the end of March, providing our scheme with the basis for finalising design choices.

Royal Institute of British Architects Stage 2 Design:

Stage 2 designs see our new hospital drawn to the 1:200 scale and provide detail on how services will be positioned within the new hospital as well as how they interact with utilities and the fabric / grid of the building.

Having completed our stage 2 designs, we are currently going through a control point review with our national team colleagues.

This review involves national subject matter experts assessing our designs for efficiency and completeness and in the first draft of their report (received 14/2/25) it is reported:

We note that the West Suffolk Hospital Trust have, in agreement with NHP, developed a design that to date sits outside of full Hospital 2.0 (H2.0)[1] compliance, with regards to the development of the clinical layouts and adjacencies. In turn the development of the architectural massing and form has also deviated away from H2.0.

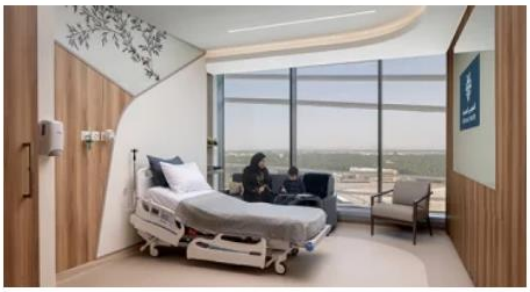
This review focuses on key design elements and compliance issues that require resolution prior to commencement of RIBA Stage 3. The objective of this technical assurance review is to ensure that the proposed design aligns with the latest H2.0 principles, while mitigating potential risks related to planning constraints, technical standards, and service integration.

The submission had the level of detail as expected for RIBA 2, albeit not fully aligned to the H2.0

Following our review the top three technical assurance recommendations are as follows:

1. Full design co-ordination between all disciplines, with the current architectural layout being more advanced in areas, than all other design disciplines. All architectural drawings to follow the same base layout alongside forming 1:500 and 1:200 packages of drawings.
2. West Suffolk Hospital Trust and NHP to agree on mutually suitable inpatient ward layout as the current architectural design does not align with latest H2.0 template. Where deviations exist and are agreed with the clinical directorate a clinical review shall be undertaken including travel times.
3. Departmental layouts outside of the inpatient wards to be updated to integrate NHP baseline designs.

In essence these three recommendations refer to some relatively straightforward and expected adjustments (e.g. given the timing of our report, we knowingly used a previous H2.0 ward design that included external pod bathrooms, these will now be corrected to reflect the latest designs).
That said, recommendation 3 is being conducted by HDR Architects[2] and aims to establish the extent to which their optimised layouts can be encompassed within the constraints of our site without adversely impacting our timelines whilst reducing our capital costs. We expect this work to conclude before the end of May. HDR's website explains their credentials.



Health & Life Sciences

Our architecture and engineering teams create innovative, flexible and adaptable healthcare and research facilities that challenge traditional models and introduce transformative design ideas. Our many healthcare and laboratory planning experts bring a deep understanding of diverse patient care and research environment requirements.

[1] Hospital 2.0 is the name given to describe the standard designs and layouts being produced as the means of providing a common standard to all new hospitals. This central approach ensures best practice and reduces the costs and time that would be required if each new hospital project designed its own solution independently.
[2] HDR are the architects employed by the New Hospital Programme to design the Hospital 2.0 standard new hospital design.

In parallel with our work with HDR, we are also using the activity forecasts from our demand modelling to determine whether the Hospital 2.0 schedule of accommodation would provide the basis for design, cost and space efficiencies.

Right Sized Hospital

In my last report, I explained that we had held a series of roundtables and workshops to test, challenge and determine a collective view of "the right sized hospital". Since these workshops, we have programmed the national demand model with our refreshed and collectively agreed "mitigators" (i.e. those actions that we will undertake to improve efficiency, productivity and, therefore mitigate the effects of a growth in demand) and derived an agreed scope and scale for the new hospital.

The outcomes from these discussions have now been formally documented within a final report prepared by the NHP modelling team. The outcomes remain unchanged from those previously discussed; however, this formal documentation will now allow us (Trust, NHP, NHSE and ICB) to collectively agree the "right sized hospital".

Challenges

As scale (right sized hospital), design (Hospital 2.0) and capital budget become clearer, it is likely that our progress will suffer a slight hiatus as we work to ensure we have an optimised and affordable design before committing ourselves to the next level of detail. This is an expected step, however, whilst pressuring an already challenging schedule, it should allow us to "get things right first time" and thus save time from the real potential of conducting abortive work.

Commercial Progress

Since my last report, the national programme has made two significant strides:

1) **Announcement of a Programme Delivery Partner**. This decision follows a highly robust procurement exercise that has resulted in the appointment of a consortium led by Mace and Turner and Townsend as the providers of professional services aimed at supporting the development and successful execution of "40 new hospitals." This announcement ends a period of uncertainty and provides the basis for consistent advice and support to all schemes throughout their journeys to the realisation of their new facilities.

2) **Launch of the Hospital 2.0 Alliance** (formally known as the Main Works Framework). This signifies the commencement of a procurement exercise aimed at securing the commitment of the major construction companies to the realisation of the New Hospital Programme. The "Alliance" sets out the terms and conditions under which construction partners will build each hospital. The size and complexity of the New Hospital Programme has made it necessary to create these bespoke conditions as a means of maximising partner participation, optimising risk apportionment and ensuring consistency.

In terms of West Suffolk, the timely launch of the Alliance means that we will no longer need to conduct a bespoke procurement exercise using traditional terms. This reduces effort, reduces cost and reduces commercial risk. That said, our project plan remains very tight and as such any significant delay to the completion of the Alliance tender could re-open the need for us to progress independently. Both NHP and I will remain in close contact to ensure we understand progress and the consequence of delay.

Both of these announcements represent significant progress and demonstrate the support of the Government following its review of the Programme.

Finance

The Programme is progressing within its NHP allocated budget and is fully funded to deliver RIBA stages 2 and 3 as well as its Outline Business Case.

Capital budget is expected to be confirmed in March 25. We are highly likely to have to challenge our designs to meet the allocation. To this end (as discussed above) we are working with HDR Architects and NHP to optimise our RIBA2 layouts and maximise use of H2.0 Standards.

As mentioned last month, part of our preferred design would include establishing a remote endoscopy hub, co-located with our community diagnostic hub in Newmarket. The funding of this new building was to have been provided as part of our wider NHP scheme, however, there was an opportunity to seek alternative funding from a new national initiative. A business case for these funds was submitted and we have we received news of a positive outcome. Consequently, designs for this element of our future infrastructure will progress independently from The NHP.

Outside of capital affordability, the Trust continues to work with its ICB colleagues to assess and understand the sustainability of its current and future operational costs. Given the fact that any new hospital will increase capacity the Future System Team are working to ensure the implications and benefits of a new hospital are fully understood and reflective of any changes to our established clinical model.

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

- Complete the NHP Control Point 2 Gateway and reflect the three main recommendations of the design guardian report.
- Conclude plans aimed at ensuring the sustainable affordability of our project (in light of a known capital envelope).
- Transformation – continue plans for the delivery of the Clinical and Care Strategy and draft an operational readiness plan.
- Continue to work with co-production teams on the refinement of scale and layout of individual departments.

Action Required

The Board of directors is asked to note the content of this report.

2.3. Suffolk System Update Report - SNEE Integrated Care Board (ICB); Wider System Collaboration (ATTACHED)

To Assure

Presented by Peter Wightman and Clement Mawoyo

WSFT Board of Directors (Open)	
Report title:	**West Suffolk Alliance Update**
Agenda item:	2.3
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Peter Wightman – Director West Suffolk Alliance
Report prepared by:	C King/M Shorter/P Wightman

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

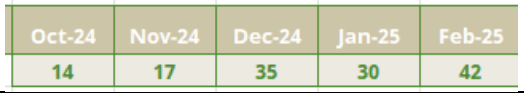
Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
The attached paper provides a summary of the key items of business for West Suffolk Alliance for Committee meetings held February and March 2025.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
Board members are asked to note progress identified
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed up (evidence impact of action)*
Actions are managed through the Alliance Committee process
Action Required
Note the report

Risk and assurance:	Risks to continuation of work in the Start Well domain – First 1001 days – due to changes in leadership and pull-back of funding. Higher levels of rising demand in Neurodiversity assessment are well above the ability to respond effectively across Children and Young Peoples work Challenges around managing a block contract for Community Services requires a better understanding of resource allocation and service delivery with strategic ambitions focusing on further shift and frailty integration with the need for a single vision in alignment with SNEE ICB work needed.

Equality, Diversity and Inclusion:	
Sustainability:	
Legal and regulatory context	NHSE Integrated Care Boards

West Suffolk Alliance Committee reports

1.	**Introduction**
1.1	**West Suffolk Alliance Update including Committee meetings held 11 February and 11 March 2025**
	Key themes
2	**Age Well**
2.1	**Community services contracting update** Noted Suffolk Community health service contract is due to reach the end of its 10-year term in October 2027. The ICB is beginning a review process to ensure readiness to determine its approach by Autumn 2025 to the contract. The key issues were described to the committee including: a) Current operational challenges of recruitment in shortage professional areas, high caseloads for nursing teams, and increased demand for equipment b) The strategic ambition of "future shift" to manage frailty in the community as effectively as possible to prevent avoidable hospital bed days. This includes defining the place and capacity of these services as part of a whole system approach. Importance of integration with primary care, social care and VCFSE. c) The update focussed primarily on adult services; similar work is needed for CYP services. Next Steps: - continue collaboration with Ipswich and East Suffolk colleagues, refining the community services strategy, and aligning with the sustainability review and frailty work. - Involving members of the committee in this process - An update to the Committee within three months is required to include a CYP response/report. - Learning from how resources have been used in the past will add clarity on priorities and outline how to best address growing demand and prevent hospital bed days. The aim is to have a view by Autumn 2025 given the long lead-time in contract completion which will feed into the wider ICB on contract renewal
2.2	**Care Homes support team update -** The Committee noted the WSFT decision to stop the service given the lack of evidence it was having a positive impact. Assurance was given that this support is best provided as a part of the integrated neighbourhood team. INTs will continue higher support/monitoring for homes where there is greatest challenge.
2.3	**Home First Reablement** Committee received an update on the Home First reablement service, which has received additional funding from the discharge allocation. The service supports individuals' post-hospital discharge to regain functions. It has demonstrated a significant reduction in care hours with 55% of individuals fully reabled and not requiring ongoing care. A decrease in Accident & Emergency (A&E) is noted with a further 23% of patients partially reabled with reduced care. Noted - Increased GP capacity has been required to support this extra capacity - Failure of reablement services would require an additional 240 hours /week procurement. - Providers face cost pressures from a combination of National insurance costs, living wage increase and more patients with complex needs. The service is seen a key contributor to the strong discharge performance in West Suffolk.
2.4	**Better Care Fund – Discharge funding** The Committee received a report on forecast outturn for schemes for 2024/25 and plans for 2025/26. Underspends arising from delays in delivery have been used to support spot purchasing of community beds at peak times and to support SNEE ICS financial position.

	The committee agreed the proposed schemes for 2025/26 which are primarily a continuation of services commissioned in 2024/25 based on evaluation. Evaluation is due in April/May for those schemes started late in the year e.g. additional hospice capacity. A return to Committee for update is scheduled for April 2025 and will outline the full year plan for Better Care Fund (BCF) funding
2.5	**Level 1 falls service** The service has seen a steady increase in referrals. There is further scope for growth (2 per day). Improvements have been made with out of hours calls and at weekends. Response times are in line with expected rates of return, provide a quicker response and help alleviate pressure on other emergency response services.  Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 14 | 17 | 35 | 30 | 42
3.	**Die Well Domain update**
3.1	a. The virtual ward for palliative and EoL care is now successfully integrated and is part of business as usual operations for all six integrated neighbourhood teams. b. The Compassionate Communities Initiative (CCI) is being developed across Suffolk with workshops planned in Haverhill and Forest Heath Primary Care Networks (PCN's). It is referenced that Waveney is to be included to ensure a single charter for all of Suffolk. c. The ICB is considering a business case, supported by a social finance loan from MacMillan to improve the identification and advance care planning for people expected to be in their last year of life. This includes "My Care choices" system to record and make the plans for widely available through digital change project.
4	**Be Well and Health Inequalities updates**
4.1	**Physical activity** a. **Active Suffolk - Place based project in Lakenheath** Committee received update that the Sport England project in Lakenheath was progressing well. The process includes wide engagement of partners and blending this with evidence to inform an outcome by September 2025 to release the final part of funding to leave lasting legacy in Lakenheath. **b. Commissioning Abbeycroft:** Non-recurring NHS funding for two extra physical activity services ends in March 2025. The Committee has previously received evidence of the impact of these services for older people and the wider community targeted by the schemes. All statutory bodies are asked to decide how much funding they can contribute to the service in 2025/26, and the scope will be discussed at a workshop in April and reported to the committee for decision in May.
5.	**Health Equity update**
5.1	a. Committee were asked to extend the programme timeframe in light of restrictions in 24/25. It was noted that the successful implementation of blood pressure monitoring, through libraries, and targeted smoking cessation initiatives with Feel Good Suffolk (FGS) have shown positive engagement and outcomes in the community. b. Phlebotomy is scheduled to take place at the Newbury Centre - Bury St Edmunds – (BSE) following an ask from the Howard Estate Community who are keen to engage with health. Outputs are anticipated in March/April 2025 following stage 1 engagement on the estate and in Haverhill. **c.** The Committee agreed to continue this work into 25/26, subject to funding availability, to include expansion of blood pressure monitoring and smoking cessation programmes alongside other issues. There remains some flexibility in the remaining budget and further conversations are underway with FGS around the potential to use a Clinical Pharmacist in (BSE) to support the use of Champix for smoking cessation.
6.	**Start Well**
6.1	**First 1001 days.** 1. Committee noted that many of the original objectives have not been achieved due to a reduction in resource in the team. A reset of objectives for 2025 – 2026 is required to align with the Children and Young Peoples's (CYP) Committees discussion on Governance and priorities

	2. The Public Health management (PHM) dashboard had been paused due to GP collective action; however, this has now been restarted (excepting 3 practices in West Suffolk). This will provide a comprehensive data set for new parents and Children and Young people (CYP)
6.2	**Children and Young People services** 3. The service has seen a significant rise in Neurodiversity referrals which are well above the ability of the service to respond effectively. A better process is required to ensure those with the greatest need get support in a timely way. This is not just in West Suffolk but across SNEE and nationally. The team are developing a new model which is more needs-led that manages parental and carer expectations. **4.** The Committee agreed to seek clear ICB policy and priorities for specialist provision support.
7.	**Localities**
7.1	The Committee received an update from Mildenhall and Brandon locality. They updated the specific challenges of a very dispersed locality and the work done to date to identify priorities and action to achieve the specific health inequalities identified by data and qualitative information.
8.	**Next steps**
	WSFT specific actions include: • Continuation of jointly developing frailty strategy as part of WSA • Notification of financial input into the Physical Strategy required by March 31 2025
9.	**Conclusion**
	WSFT remains an active part of multi-partner working focussed on specific improvement goals through the live well domains.
10.	**Recommendations**
	Note the report

WSFT Board of Directors (Open)	
Report title:	Virtual Ward: position re step up admissions
Agenda item:	2.3 (action log # 3120)
Date of the meeting:	28 March 2025
Lead:	Clement Mawoyo, Director of Integrated Adult Health & Social Care West Suffolk
Report prepared by:	Caroline Millard, Senior Ops Manager, Virtual Ward

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 provides an update on admission avoidance ("step up") admissions to Virtual Ward ("VW") and summarises plans in place to increase this activity in 2025.

The following table summarises VW capacity and occupancy for the last quarter:

	Dec 2024	Jan 2025	Feb 2025
VW capacity (incl paeds)	46	50	54
Average no of patients	33	37	36
Average occupancy	73%	74%	67%
Proportion of step up admissions	c.20%	c.20%	c.20%

Ongoing integration work under the Shared Service Delivery (SSD) programme enabled a further increase in capacity to 59 from 1 March 2025 in line with agreed trajectory. Capacity will remain at this level until such time as consistent performance of 80% occupancy is achieved. At this point the case for further investment (and/or decommissioning of underutilised pathways to redirect and optimise current investment) will be presented to WSFT Investment Panel.

WSFT has maintained its commitment to ensuring that VW provides additional inpatient capacity and that performance reporting meets national definitions (please see latest guidance in Virtual Wards operational framework, NHS England, August 2024). It is recognised that some other trusts include outpatient OPAT activity in VW performance reporting. To date WSFT has not done so, although will do so (in line with national guidance) from July 2025 when the OPAT service becomes integrated into wider community services under the SSD programme.

Although there is ongoing work to expand patient cohorts on key pathways, the available evidence (taskforce implementation 2025) indicates that VW and acute teams effectively identify all appropriate stepdown patients from the Emergency Department, Acute Assessment Unit and on the medical, surgical and paediatric wards at West Suffolk Hospital. To date the majority of admissions to VW have been early discharges from hospital ("stepdown") with c.80% of admissions to virtual care currently identified via this route.

Plans are in place to ensure that VW occupancy is maximised by enabling stepup admissions from a range of referral sources as outlined in this paper.

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

Development of stepup activity

There are a range of community based services in which practitioners are well placed to identify acutely unwell patients who require hospital level care and can safely and effectively be cared for in their home setting, thereby avoiding presentation in the Emergency Department.

Pathway criteria, referral processes, onboarding provision and governance arrangements need to be developed and agreed to facilitate this.

Key milestones for 2025 are outlined in the table below.

Milestone	Start date	Notes	Status
Development, testing and evaluation of stepup model for nursing homes	31.06.2024	Pilot with local partners Stowhealth Care. Now operational as BAU in four nursing homes.	Completed Oct 2024
Development, testing and evaluation of stepup model for primary care	01.04.2025	Pilot with (i) Unity Healthcare Haverhill, Long Melford & Lavenham (ii) Haverhill Family Practice (iii) Guildhall & Barrow (iii) Forest Surgery (iv) Brandon Medical Practice (v) Swan Surgery	On track
Commence stepups by EIT team	07.04.2025	EIT to carry remote monitoring kit to enable instant onboarding to VW	On track
Commence stepups by Community Matrons	06.05.2025	Mildenhall, Sudbury, Newmarket & Haverhill	On track
Commence stepups by Community Matrons	01.07.2025	Bury Town & Bury Rural	On track
Rollout primary care stepup model to all West Suffolk practices	01.10.2025	Dependency on implementation of integrated workforce model (SSD programme)	On track
Rollout nursing home stepup model to all West Suffolk nursing homes (prioritising	01.11.2025	Dependency on implementation of integrated workforce model (SSD programme)	On track

homes who most frequently convey to ED)			

Enablers

Maximisation of stepup admissions to virtual care is dependent upon:

- Delivery of **integrated workforce model** under SSD programme providing efficiencies, service resilience, and staff in the right place at the right time to enable timely onboarding in the community.
- Investment in **point of care testing** to diagnose and care for acutely unwell patients in community settings. Business case prepared and appropriate capital bids underway (initial application made for UEC capital funding).
- Delivery of **first dose antibiotics** in community settings to reduce ED conveyances. Working group established to progress this.
- **Community geriatrician resource** in the community to enable stepups and develop acuity profile. It is essential this resource is maintained within community to enhance clinical risk taking for the patient portfolio.
- Funding for existing **trainee ACPs in adult community teams** (to make permanent on qualification).

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

Plans are in place to ensure that VW occupancy is maximised by enabling stepup admissions from a range of referral sources as outlined in this paper.

It is anticipated that these measures will contribute to increased occupancy of the virtual ward with an ambition of achieving the following targets:

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
VW capacity	59	59	59	59	59	59	59	59
Ave no pts	39	43	45	47	49	51	53	59
Ave occupancy	66%	73%	76%	80%	83%	86%	90%	100%
% of stepups	20%	25%	25%	30%	30%	35%	40%	50%

NB: capacity figures assume no further investment.

Recommendation / action required

Board members are requested to note the contents of this paper and support the direction of travel.

Previously considered by:	N/A
Risk and assurance:	If we do not plan to fully mitigate risks from unplanned increases in demand, surges in infectious disease, industrial action and delivery of the RAAC remediation plan, this may undermine our ability to deliver all NHS objectives set out in national and local strategic plans and operational planning guidance.
Equality, diversity and inclusion:	Equality & diversity is a key component in the development of the virtual care service. Selection of the current remote monitoring platform has been informed by the aim to include all groups in the offer of virtual care and negate the effects of digital poverty.
Sustainability:	Minimisation of waste by recycling of digital equipment. Ongoing work to reduce staff mileage. Leads working with ICB to quantify 'green benefits' across SNEE. Financial assessment indicates that virtual care is more cost efficient than care on physical wards.
Legal and regulatory context:	Evaluation of VW performance is assessed against the CQC key lines of enquiry via regular review of feedback from patients and team colleagues. Incidents and risks are reviewed at monthly governance meeting. Leadership development plan in place.

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?

2.4. Digital Board Report (ATTACHED)

To Assure

Presented by Nicola Cottington

WSFT Board of Directors (Open)	
Report title:	Digital programme board report
Agenda item:	2.4
Date of the meeting:	28 March 2025
Lead:	Nicola Cottington, Chief Operating Officer
Report prepared by:	Liam McLaughlin, Chief Information Officer (CIO)

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 digital programme covers a wide range of projects and initiatives and the key deliverables are described. It is governed through a revised steering group structure aligned to the Trust and digital strategy reporting to the Digital board.

The report provides evidence and assurance that the digital programme is in line with Trust plans

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

The people, financial and technical resources are constrained and so it is essential to ensure that the digital initiatives support the Trust strategy, ambitions and plans, and deliver the expected benefits and organisational transformation.

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

The digital programme will continue to support and closely align with the Trust strategy.
The following action is planned and will be monitored through the Digital Board:

- Implementation of new Digital governance structure, including prioritisation and decision-making
- Review of Digital programme in light of financial recovery
- Since the last Digital board, as part of Corporate services review, resources to support digital are being considered

Recommendation / action required

The Board is asked to note the report and assurance that the digital programme is in line with Trust plans.

Previously considered by:	This is based on a summary of the last Digital Board meeting held on 23rd October 2024
Risk and assurance:	Risks are managed through the Pillar governance and through the Trust risk register
Equality, diversity and inclusion:	The Trust approach is considered to be “digital first but not digital only” ensuring that access to service is not limited by or to digital technologies
Sustainability:	Many digital initiatives support the sustainability agenda including tools to support remote working, reductions in the power and heat consumption of current technologies and cloud based services delivered from highly energy efficient data centres
Legal and regulatory context:	n/a

Digital Programme report

1.	**Introduction**
1.1	The digital programme and the digital services department support the Trust in providing a wide range of technical infrastructure, clinical systems and digital solutions to support the operation and transformation of the organisation
2.	**Background**
2.1	The digital programme now consists of 5 main groups of work: • Patient focus particularly the patient portal and related patient facing digital solutions • Clinical systems – primarily e-Care, the main hospital patient record • Community digital initiatives • Digital infrastructure and foundations • Optimisation
2.2	Additionally, the Future System Programme has a digital workstream which is considering and defining work requirements to support a smart hospital and outlines the developments that can be carried out in advance of the new hospital. This also includes initiatives to assess the digital capabilities and preparedness of both of staff and patient/carer communities.
2.3	Overall, resources to deliver the programme remain fully committed. There are a number of initiatives, mainly driven from a financial perspective, to explore projects and ongoing work that may be paused or stopped. But the impact of not being able to replace staff from posts that have become vacant is being felt. Following challenge at the digital board, a subsequent review is underway of all projects to clarify which are required, which are nearing completion, those that can be stopped or paused and those requiring further clarification of benefits. Consideration is being given to ensure better alignment of digital work with the key priorities and ambitions of the Trust to maximise the use of constrained resources and to deliver improved efficiency and productivity

3.	**Detailed sections and key issues**
3.1	**Patient portal** The new patient portal is now live and has had significant uptake in a very short space of time. It offers improved experience for patients with a simpler registration process which uses the same login credentials as the NHS App. We now have over 44,000 patients registered far exceeding the registrations on the previous offering. The portal shows a wide range of clinical details to patients and offers improved features for patients to complete questionnaires and to gather updated information that will support their clinical care. It is integrated with the NHS App so that appointments at the hospital can be seen in the app and associated notifications sent. Integration of other patient feedback processes (eg Amplitude for feedback on orthopaedic outcomes) is planned
3.2	**Clinical systems** The digital board considered the preparations for forthcoming e-Care Phase 5 implementation which has subsequently been completed successfully. This major development brings the remaining medicines that were previously prescribed on paper into e-Care to be managed digitally. It also moves the systems used to support ITU patients into e-Care simplifying the integration with wider hospital processes. A number of projects have been implemented since the last report with projects underway and a number of projects stopped or on hold. The main work can be summarised: *Completed projects:* • Upgrade to a cloud based system for the mortuary and bereavement department • Implementation in ED of the automated medicines dispensing cabinets • Enhancements to the system used to manage referrals *In progress:* • Revisions to the processes for managing Transfer of Care and associated discharge summaries • Continued roll out of the e-Consent/Shared decision making approach by department *Stopped/on hold:* • Oncology MDT solution stopped due to the difficulty of viable integration options • Integration between Pharmacy stock control system and e-Care • Results management awaiting definition of required workflows • Extension of the Endoscopy Management Systems to include Bronchoscopy
3.3	**Community digital initiatives** The WSFT digital team that support the Community teams continues to work with the proposed supplier to deliver a replacement Virtual Wards solution. The incumbent supplier, although withdrawing from the market, has indicated they will extend support for their solution which gives some further contingency to manage any risks. Virtual ward is seen as a strategic direction nationally and for the Trust to help manage demand for inpatient beds.
3.4	**Digital foundations and futures**

	Work is continuing on the final stages on the major infrastructure refresh to network equipment and firewalls which is progressing with minimal interruption to services. Resources remain stretched due to continued demand driven by the cyber security imperative. This involves patching servers and workstations, responding to critical alerts, applying security updates, investigating possible threats and providing evidence to support assurance processes. The cyber hygiene report, considered through the Information Governance Steering group, was presented for the first time to the Digital board. This highlights seven of the KPIs used to give assurance on cyber security and feeds into the Cyber Assurance Framework assessment (previously known as the Data Security and Protection Toolkit - DSPT) which is due to come into effect in June 2025. The Trust has been confirmed as "Standards Met" against the 23/24 DSPT assessment and has been reaccredited by NHS England as a secure e-mail system (DCB1596).
3.4	**Optimisation** Last year we completed 360 out of 400 change requests and have a well defined process for managing these to completion. They are the smaller developments that may involve collecting additional data through new forms, refinements to existing workflows or changes to improve processes. They are important to maintain engagement with a wide range of staff who make extensive use of digital systems and who want to have say in and influence over how the systems, workflows and processes operate in practice. For many of the requests, a relatively limited amount of work can have a significant effect. However, we are exploring ways to better manage the change control process through improved prioritisation and alignment of the change and clearer definition and realisation of the expected benefits.
3.6	**Oracle Health roadmap** As previously reported, Oracle Health as a key partner of the Trust, offered a road mapping session which resulted in key outcomes including: • OH provided insight into new capabilities following the merger between Oracle and Cerner, covering both clinical systems and additional solutions beyond core clinical e-Care offerings. • A demonstration of new solutions related to community care and clinical digital AI agents. • Utilising Oracle's new OH toolkits to explore how to integrate these technologies into the new hospital program. Further actions will follow to widen the engagement with the possibilities that the full range of services and technologies that Oracle can offer.
3.7	**AI Strategy** The Trust already makes use of a number of AI tools, in particular to support the dermatology and stroke pathways. The AI works to triage, confirm or re-enforce diagnosis based on images taken and this is one of the most frequently cited use case in clinical practice and one that, given the necessary assurance, is likely to return the greatest benefits. We are proposing some interim AI assurance steps whilst we develop a more formal AI strategy and policy. Work is already underway on a SNEE ICS AI Strategy and ESNEFT will sharing the work they have done on this. Regional policies are also being developed and all these will need to feed into the way we deal with these initiatives from a Digital Clinical Safety point of view. Further benefits are likely from AI to support many administrative processes and this will be explored further over the coming months.

3.8	**Cyber Security Strategy** The Cyber Security Strategy has been developed with and is aligned to both ESNEFT and SNEE ICB. It emphasises the importance of considering not just products, but also the people involved in cyber security. WSFT has a strong cyber security awareness across the Trust but there is always more work to be done in this area as new threats emerge in an increasingly volatile world. The cyber security strategy is built around the principle of security by design, aiming to make the organisation more aware of cyber security risks and actions and deal with them up front before they become blockers. The strategy is intended to improve staff awareness and ensure security is considered early in all that we do and embedded within the organisation's culture. Wider staff communication of the strategy is planned.
4.	**Next steps**
4.1	The digital programme will continue to support and closely align with the Trust strategy.
5.	**Conclusion**
5.1	The digital programme covers a wide range of projects and initiatives, and these are managed effectively through the revised governance structure of steering groups reporting to the digital board
6.	**Recommendations**
	The report provides evidence and assurance that the digital programme is in line with Trust plans

Comfort Break

2.5. Collaborative Oversight Group (ATTACHED)

To Assure

Presented by Sam Tappenden

WSFT Board of Directors (Open)	
Report title:	**Collaborative Oversight Group update March 2025**
Agenda item:	2.5
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Sam Tappenden, Executive Director of Strategy and Transformation
Report prepared by:	Stephanie Rose, Programme Director

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 East Suffolk & North Essex NHS Foundation Trust (ESNEFT) and the West Suffolk NHS Foundation Trust (WSFT) have been developing a provider collaborative approach over the past three years as part of the 'Suffolk and North Essex Provider Collaborative (SNEE PC)'. A governance structure has been established which includes the formation of a Collaborative Oversight Group (COG) to provide assurance and scrutiny. This paper serves as a report on progress of the Collaborative Oversight Group.

SO WHAT?

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

This report serves to assure WSFT Board that the trust is working collaboratively with partners within the SNEE footprint to ensure we maximise efficiencies and drive better health outcomes for the patients of Suffolk and North East Essex.

WHAT NEXT?

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

The Trust will continue to prioritise the delivery of the Provider Collaborative work plan and provide update reports to the WSFT Board regarding progress.

Action Required

The WSFT Board is asked to:

1. Note the development progress of the SNEE PC under the Collaborative Oversight Group (COG)
2. To continue to support the development of the SNEE PC

Risk and assurance:	
Equality, Diversity and Inclusion:	*As per individual reports.*
Sustainability:	*As per individual reports.*
Legal and regulatory context	

Collaborative Oversight Group update March 2025

1.	**Introduction**
1.1	The Suffolk and North Essex Provider Collaborative has an embedded governance structure which includes a Collaborative Oversight Group to provide assurance and scrutiny to the SNEE PC. The Collaborative Oversight Group has met four times since inception, most recently on 4th February 2025. Five priority programmes of work have been agreed by the Collaborative Oversight Group for the SNEE PC.
2.	**Background**
2.1	The 2019 NHS Long Term Plan sets out a "duty to collaborate" which was further developed in Working Together at Scale (2021), which requires NHS Providers to be part of one or more Provider Collaboratives. With finite resources, increasing demand, and the shift towards greater collaboration, the Trust has real opportunities to collaborate with partners for patient benefit.
2.2	A workplan consisting of five priority programmes has been agreed for the SNEE PC for 2024-25; clinical services, development, digital, efficiencies at scale and elective care.
3.	**Detailed sections and key issues**
3.1	Governance arrangements and the establishment of governance structures is now in place for the SNEE PC, and the beginning of 2025 saw the employment of a second joint post across WSFT and ESNEFT, a project management officer (PMO). Alongside the Programme Director, the PMO has commenced work looking to ensure all collaborative activity is aligned to trust transformation teams, business planning and that where appropriate, reporting is combined to drive further efficiencies.
3.2	<u>Clinical Services Programme</u> This programme resource has been drafted with supporting the ICB sustainability review and informing the needs of the Providers in this piece of work. A recent presentation was delivered to the Collaborative Oversight Group in February highlighting the joint working between ESNEFT and WSFT for paediatric urology patients.
3.3	<u>Development programme</u> The Collaborative Oversight Group agreed on 4 June 2024 that it would be helpful to develop a memorandum of understanding (MoU) through their development programme, to act as a framework to ensure that the vision and shared principles are aligned to for all collaborative activity. The MoU is not a legal document, and it is not intended to be legally binding, and no legal obligations or legal rights shall arise between parties from this memorandum. It is a shared understanding and commitment to a way of working between both parties who have each entered it intending to honour all their obligations within it. This MoU is at final approval stage and upon sign-off will form part of the governance arrangements for the SNEE PC.
3.4	<u>Digital Programme</u>

	The digital collaborative delivery group formed in 2024 and meets on a monthly basis. The digital teams at WSFT and ESNEFT are mature in terms of collaborative working and have just submitted their first case study on the Xerox Xen project to NHS Providers, to be included in their next publication. Two work planning sessions took place on 12th February and 5th March which will inform the work programme for 2025-26.
3.5	Efficiencies at Scale Programme The largest of the five programmes of the SNEE PC has seen extensive work take place, particularly within the estates and facilities space which includes: - The transition of mattress decontamination services for ESENFT from a private supplier to WSFT - The commencement of a procurement process for a joint car parking service - Analysis and Reconciliation services to multiple divisions of WSFT - The management of medical devices across WSFT and ESNEFT and identification of potential joint contracts and in-sourcing of services
3.6	Elective Care Programme This programme has focused on the mobilisation of the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) which opened on 11th November 2024 successfully bringing clinical teams from three sites (within WSFT and ESNEFT) operating in a single location under system wide pathways. Key outcomes include: • Over 600 patients have had their surgery completed • Zero-day discharge for arthroplasty achieved • Completed first weekend operating list with further weekend being planned to end of March • Semi-elective ambulatory trauma has commenced • A range of cases completed above and beyond what was expected in the first weeks • Completed our first High Volume low complexity list by a WSFT surgeon • Extended Recovery opened on the 13th of January 2025 to support our most complex patients
4.	**Next steps**
4.1	Work has commenced on 2025-26 work planning, and we look forward to agreement of priorities for the next financial year. The appointment of a PMO lead has enabled continued development of the reporting aspects of this programme, support to programmes in delivery of projects, benefits realisation, and wider programme support with comms which we look forward to reporting on in due course.
5.	**Conclusion**
5.1	To conclude, the SNEE PC nears financial year end in a good position. The digital programme has established a digital collaborative delivery group which is working at pace to identify opportunities within the digital space. The efficiencies at scale programme now includes a breadth of projects which feature a wide range of large-scale projects including car parking services, corporate services, and mattress decontamination services which will deliver not only financial benefit to WSFT through CIP delivery but an opportunity to work within the SNEE PC to share expertise and to develop our staff. Governance within the SNEE PC will be further strengthened by an MoU. Work planning has commenced for 2025-26 and we anticipate the findings of the ICB sustainability review which will help to inform this process and drive the future direction of the SNEE PC. The

	SNEE PC is well placed to serve as a vehicle for which WSFT can deliver upon the large-scale reform that is required to sustain future services within WSFT and the system.
6.	**Recommendations**
	The WSFT Board is asked to: 1. Note this update on the Collaborative Oversight Group that is overseeing the progress of the SNEE PC 2. Continue with support to the SNEE PC

3. ASSURANCE

3.1. IQPR Report (ATTACHED)

To Review

Presented by Nicola Cottington

NHS West Suffolk NHS Foundation Trust

WSFT Board of Directors (Open)	
Report title:	**Integrated Quality and Performance Report**
Agenda item:	3.1
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Sue Wilkinson, chief nurse Nicola Cottington, chief operating officer
Report prepared by:	Andrew Pollard, information analyst. Narrative provided by clinical and operational leads.

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

Executive summary:	The Integrated Quality and Performance Report (IQPR) uses the Making Data Count methodology to report on the following aspects of key indicators: 1. The ability to reliably meet targets and standards (pass/fail) 2. Statistically significant improvement or worsening of performance over time. Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?). Please note the IQPR will be refreshed in line with the NHS 2025/6 priorities and

Executive summary:	operational planning guidance, published 30th January 2025. This provides an opportunity to review the structure and format of the IQPR and board feedback is welcomed. Following feedback from the national Making Data Count team, it is planned that the narrative for the metrics will be more concise going forwards, so that the key points stand out. Consideration is also being given about how to present the information to demonstrate inter-related metrics. It is planned to include a productivity section of the IQPR. A Trust Performance and Accountability framework is also in development which will set out how performance against the key metrics is managed within the organisation. Please refer to the assurance grid for an executive summary of performance. The following areas of performance are highlighted below for the board's attention: • Ambulance handovers within 30 minutes is not showing significant improvement and is linked to the overall Urgent and Emergency Care (UEC) performance challenges. 4-hour performance in the Emergency Department (ED) is not meeting trajectory or target (64% against the trajectory of 70% and target of 78% by March 2025), however the gap between performance and trajectory has narrowed. The action plan is summarised and it is recognised that sustainable improvement requires transformational change to the model of delivery. • Virtual Ward occupancy was 74% against a target of 80% and numbers of patients being cared for by the Virtual ward continue to increase. • Performance against the 28-day Faster Diagnosis Standard (FDS) improved to 72.9% in January and this improvement is forecast to continue, including meeting the 77% target by March. • 6-week diagnostic performance has continued to underperform; this is due to a number of factors including the delay in the Community Diagnostic Centre (CDC) opening, staffing issues, reduction in additional sessions for endoscopy and the change in DEXA provision. The areas of focus are Dexa, endoscopy and ultrasound. Whilst additional staffing resources have been approved, there is insufficient take up currently. • There has been a significant improvement in the total volume of patients over 65 weeks, and the Trust is confident in ensuring there are no patients waiting over 65 weeks at the end of March, excluding patient choice and those unfit for surgery.

NHS West Suffolk NHS Foundation Trust

	• Timely and accurate nutritional assessments continue to be a focus of quality improvement. The introduction of the new shortened assessment for the emergency department will be monitored for effectiveness. • On going quality improvement will continue within the maternity services regarding post partum haemorrhage and will be monitored through the maternity improvement board, performance review meetings and externally through the local maternity and neonatal system strategic meetings. • We continue to monitor the threshold combination of HOHA and COHA cases of C-Difficile infections and work with community colleagues to support appropriate stewardship of anti-microbial usage. We have enhanced support for the QI programme and this continues to report into Improvement committee. • We will monitor the impact the current staffing within the PALS and patient complaints team has on performance. • Appraisal participation rates are below target although improved slightly in month to 87.5%. • Mandatory training completion rates are better than the 90% target, maintained at 90.3%. • Staff retention is strong with a turnover rate (7.6%) better than the target threshold of 10%. This is also now the case for each division and corporate services, with the exception of estates and facilities, where sickness rates are also significantly adrift from the 4.6% target, sitting at 8.11%.
Action required / Recommendation:	To receive and approve the report

Previously considered by:	**Component metrics are considered by Patient Safety and Quality Group and Patient Access Governance Group.**
Risk and assurance:	BAF risk: Capacity (Ref: 02): The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities

Equality, diversity and inclusion:	Monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level. From June 2024, health inequalities metrics will be included in the IQPR.
Sustainability:	N/A
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

3.2. Finance Report

To Review

Presented by Jonathan Rowell

WSFT Board of Directors (Open)	
Report title:	Finance Report – as at February 2025 (M11)
Agenda item:	3.2
Date of the meeting:	28 March 2025
Lead:	Jonathan Rowell, interim chief finance officer
Report prepared by:	Nick Macdonald, deputy director of finance

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

Executive Summary

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

The attached Finance Board Report details the financial position for Month 11 (February 2025).

Income and Expenditure position
The Trust continues to make progress on its recovery trajectory and is on track for the revised control total of £23.8m. In particular, workforce savings are being seen, with the trust reporting 187.7 fewer WTE in February than in April 2024. The controls put in place as part of the financial recovery plan remain, and the underlying run-rate is expected to reduce further by March. This exit rate for 24/25 is important in determining the start position for the 25/26 plan.

Efficiencies
The combined revised CIP and FRP schemes planned to deliver £16.0m YTD, with actual delivery of £18.7m YTD, a favourable variance of £1.7m YTD

Cash
The cash position remains critical and the Trust has received a further £2.9m of revenue (deficit) support for March.

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

The underlying recurring run rate of around £1.7m is in excess of the finance recovery plan (at £1.3m deficit per month). This exit rate for 24/25 impacts on the planned deficit for 25/26.

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

The FRP has significantly improved our recurring run rate and the full year effect of savings made will contribute to our 25/26 planning and cost improvement programme. Our 25/26 plan is currently being discussed and will be finalised shortly.

Recommendation / action required
Review and approve this report

Previously considered by:	n/a
Risk and assurance:	Financial risk
Equality, diversity and inclusion:	n/a
Sustainability:	Financial sustainability
Legal and regulatory context:	Financial reporting

	[Insert report title]
1.	**Introduction**
1.1	
2.	**Background**
2.1	
2.2	
2.3	
3.	**Detailed sections and key issues**
3.1	
3.2	
4.	**Next steps**
4.1	
4.2	
5.	**Conclusion**
5.1	
6.	**Recommendations**
	[Insert same wording you have on your cover sheet]

Guidance notes

The practice of scrutiny and assurance

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

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

WSFT Monthly Finance Report

2024-25 – February 2025 (M11)
for Board
28th March 2025

Putting you first

Executive Summary as at February 2025

NHS West Suffolk NHS Foundation Trust

Summary
The Trust continues to make progress on its recovery trajectory and is on track for the revised control total of £23.8m. In particular workforce savings are being seen, with the trust reporting 3.7% fewer WTE in February (4,932.8 WTEs) than in April 2024 (5,120.52 WTEs), a reduction of 187.72 WTEs. The controls put in place as part of the financial recovery plan remain, and the underlying run-rate is expected to reduce further by March. This exit rate for 24/25 is important in determining the start position for the 25/26 plan.

The cash position remains critical, and revenue support will continue to be required into 2025/26.

Revenue
The reported I&E for the year to February is a deficit of £24.9m against an external planned deficit of £15.6m. This results in an adverse variance of £9.3m YTD. The in-month position is a deficit of £1.6m which includes non-recurring benefits of £0.1m, largely associated with ERF. The recurring deficit in February is £1.73m. In February, the trust is £133k behind the anticipated FRP trajectory.

The ERF over performance within the year-to-date position amounts to £2.97m (net of final 23/24 performance), which is 4.77% above target

Efficiencies
For ease of monitoring and reporting we now aggregate the efficiencies from the revised CIP and FRP programmes. These combined revised CIP and FRP schemes planned to deliver £16.0m YTD, with actual delivery of £18.7m YTD, a favourable variance of £2.7m YTD. The current overperformance is due to FRP schemes delivering earlier than anticipated in the FRP. M11 totals £2.5m against a plan of £3.0m, an unfavourable variance of £0.5m. The Trust is on plan to deliver the efficiencies required for the financial recovery plan.

Temporary pay controls have had a sustained impact, with monthly agency expenditure reduced from £471k to £118k (a 75% reduction) and bank expenditure reduced from £2.345m to £1.532m (a 35% reduction) compared to April-24.

Capital
YTD capital spend at month 11 is £31m. This is slightly behind plan, but the Trust is on track to achieve the plan for 2024/25. At month 9 the Capital Programme was reforecast to take in to account a rephasing of capital spend on the New Hospital Programme in to 2025/26 and the anticipated underspend (against internally funded projects) of £1m that has been agreed by the Trust Board. The Programme has been further reduced in month 11 due to additional rephasing of spend on the New Hospital Programme into 2025/26. Forecast capital spend for 2024/25 is £33.4m.

Cash
The Trust's cash balance as at 28 February 2025 was £13m compared to a plan of £1.1m. Cash continues to be rigorously monitored and managed to ensure that we have adequate cash reserves to match our expenditure. However, as the Trust continues to report a deficit, our cash position continues to deteriorate. To date, the Trust has received £21m in revenue (deficit) support and £2.1m of working capital revenue support. The Trust has been awarded a further £2.9m of revenue deficit support for March. The cash position remains critical and cash support will continue to be required in to 2025/26.

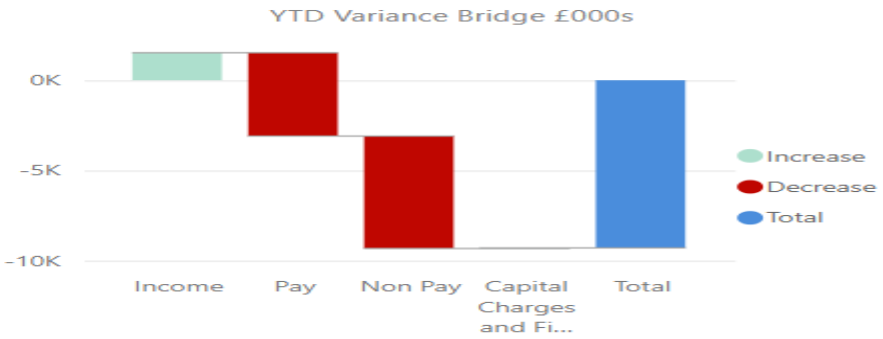
M11 position and forecast

Our formal forecast remains as per our initial plan at £15.2m deficit.

Whilst our financial recovery plan forecast a deficit of £28.5m we are now anticipating that we can improve this to £26.5m due to additional ERF.

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)	Annual Budget £m
EBITDA							
Income							
NHS Contract Income	30.3	30.8	0.6	334.5	337.1	2.6	364.8
Other Income	3.3	3.6	0.3	36.2	35.2	-1.0	39.5
Total	**33.5**	**34.4**	**0.9**	**370.7**	**372.3**	**1.5**	**404.3**
Expenditure							
Pay Costs	23.9	24.2	-0.3	263.4	268.0	-4.6	286.2
Non-pay Costs	9.0	10.1	-1.0	102.9	109.1	-6.2	111.5
Total	**32.9**	**34.3**	**-1.4**	**366.2**	**377.1**	**-10.9**	**397.7**
EBITDA Position	**0.6**	**0.1**	**-0.5**	**4.5**	**4.8**	**-9.3**	**6.7**
Depreciation	**1.4**	**1.4**	**0.0**	**15.3**	**15.2**	**0.0**	**16.6**
Finance Costs	**0.4**	**0.4**	**0.0**	**4.8**	**4.6**	**0.1**	**5.2**
Impairments	**0.0**	**0.0**	**0.0**	**0.0**	**0.1**	**-0.1**	**0.0**
Deficit/(Surplus)	**1.2**	**1.6**	**-0.4**	**15.6**	**24.9**	**-9.3**	**15.2**

Deficit YTD £	**24.9M**	
Variance against plan YTD £	**-9.3M**	**Adverse**
Movement in month against plan £	**-0.4M**	**Adverse**
EBITDA Postion YTD £	**-4.8M**	**Adverse**
EBITDA margin YTD	**-1%**	**Adverse**
Cash at bank	**£13.2M**	



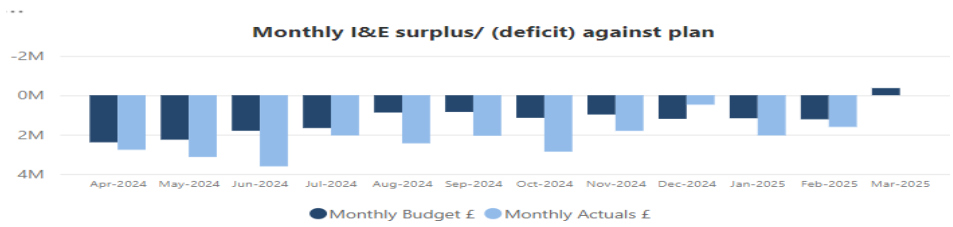
Income and Expenditure Summary – February 2025

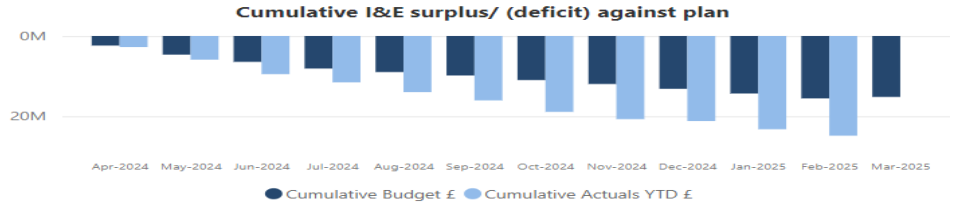
West Suffolk NHS Foundation Trust

The adverse variance was £0.4m in February, which includes a shortfall of £553k against our monthly CIP target.

Our recurring run rate in February was around £40k better than in January.

Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-1,222	-1,609	-388	↓
YTD surplus/ (deficit)	-15,562	-24,861	-9,299	↓
Clinical Income YTD	334,504	337,066	2,563	↑
Non-Clinical Income YTD	36,226	35,188	-1,038	↓
Pay YTD	263,371	267,991	-4,620	↓
Non-Pay YTD	102,866	109,100	-6,234	↓
EBITDA YTD	4,492	-4,837	-9,330	↓
EBITDA %	1.2	-1.3	-2.5	↓





High level reasons for variance from plan to February 2025	Monthly Variance											
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Total YTD
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non - Recurring												
ED expenditure relating to UEC improvement in 2324	150	0	0	0	0	0	0	0	0	0	0	150
Escalation ward unfunded (April and May)	155	115	0	0	0	0	0	0	0	0	0	270
Endoscopy Maintenance	0	0	90	0	0	0	0	0	0	0	0	90
Industrial action	0	0	130	0	0	(311)	0	0	0	0	0	(181)
Drug underspends (Exclude Medicine)	0	0	0	(72)	(13)	60	0	0	0	0	0	(25)
Rates Credit	0	0	0	(554)	0	0	0	0	0	0	0	(554)
Other non Clinical Income	0	0	0	0	197	0	0	0	0	0	0	197
ERF income	0	0	0	0	0	0	(409)	0	(1,468)	(154)	0	(2,031)
Pay award backdated	0	0	0	0	0	0	904	(214)	0	0	95	785
Bad debts written off							143	4	0	0	12	159
Redundancies								190	29	100	31	350
Impairment of Fixed asset								196	0	0	(42)	154
Transformation Costs								100	100	127	0	327
Back dated APA claims and salary arrears from 2324								(199)	0	31		(168)
CSS Equipment										170	0	170
VAT refund											(216)	(216)
Blood bottles rebate								(130)	0	0	0	(130)
Energy bills	(97)	(97)	78	(58)	(43)	0	47	(116)	0	0	0	(286)
	208	18	298	(684)	141	(251)	685	(169)	(1,339)	274	(120)	(939)
Recurring, but outside of our control												
Inflationary pressures	60	65	70	75	80	85	90	95	100	105	110	935
Pay award M7 onwards	0	0	0	0	0	0	151	120	120	120	120	631
Private patient income	0	0	0	(152)	86	35	40	168	(98)	(40)	0	39
	60	65	70	(77)	166	120	281	383	122	185	230	1,605
Recurring, but we can improve												
Community Income shortfall	64	64	64	64	44	46	28	4	0	0	0	378
Community Equipment and Wheelchairs	0	160	80	0	119	42	87	54	27	0	0	569
CIP behind original plan	0	0	360	921	631	773	627	666	548	456	553	5,535
ECW above plan	271	207	359	263	252	181	148	126	123	156	197	2,283
Back dated APA claims and salary arrears	126	200	145	100	34	0	25	0	0	0	0	630
Drugs within Medicine	100	100	100	(65)	(84)	240	65	50	108	43	0	657
Various mitigating (underspends) / overspends	(450)	225	169	(146)	262	57	(227)	(305)	(126)	(132)	(172)	(845)
ERF income	0	(160)	160	0	0	0	0	0	(184)	(90)	(300)	(574)
Winter	0	0	0	0	0	0	0	0	0	0	0	0
Total recurring variance	**171**	**861**	**1,507**	**1,060**	**1,424**	**1,459**	**1,034**	**978**	**618**	**618**	**508**	**10,238**
Total Variance	**379**	**879**	**1,805**	**376**	**1,565**	**1,208**	**1,719**	**809**	**(721)**	**892**	**388**	**9,299**
Actual deficit	**2,769**	**3,136**	**3,611**	**2,042**	**2,442**	**2,056**	**2,866**	**1,811**	**478**	**2,040**	**1,609**	
Planned deficit	**2,390**	**2,257**	**1,806**	**1,666**	**877**	**848**	**1,147**	**1,002**	**1,199**	**1,169**	**1,199**	
Recurring actuals	**2,561**	**3,118**	**3,313**	**2,726**	**2,301**	**2,307**	**2,181**	**1,980**	**1,817**	**1,766**	**1,729**	

Actions, Finance Recovery Plan and Run Rate

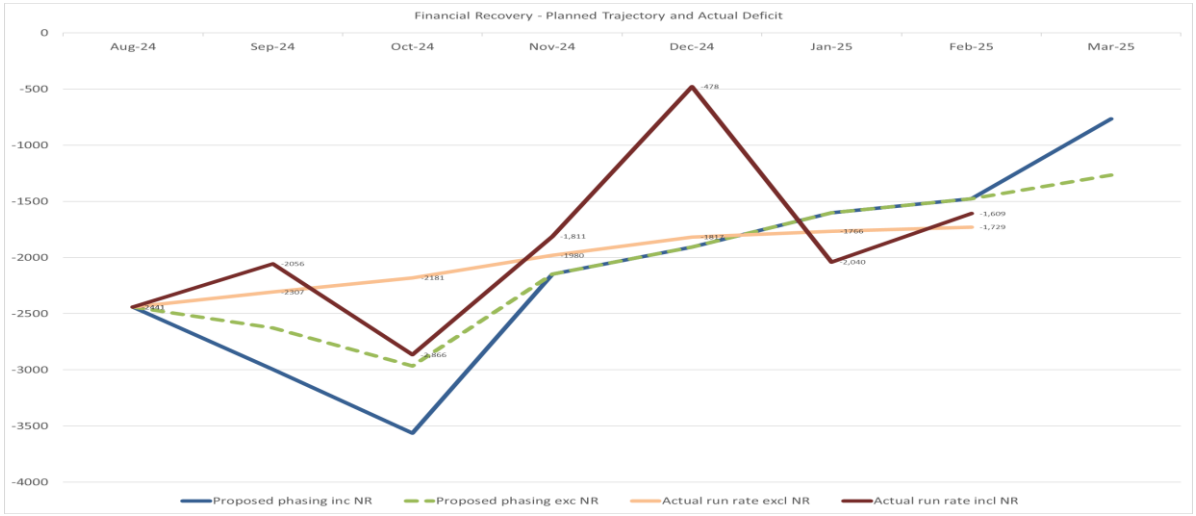
West Suffolk NHS Foundation Trust

Progress against recovery plan

Good progress is being made against the FRP trajectory – with savings of £2.7m more than planned and the overall financial position being £2.8m better, which is largely due to ERF being better than the FRP anticipated.

The recurring trajectory for pay spend is decreasing. There has been material reductions in substantive staff, bank, agency and locum spend, with further savings expected. However, substantive pay suffered a non-recurring cost of £0.2m during M11 due to clarification over honorary GP payments (although this did not impact on WTEs).

Savings in many areas are being seen earlier than were phased in the FRP, but this means they are not all being delivered to the depth of the FRP. As a result, our recurring position appears to be falling short of the planned £1.3m recurring monthly deficit in the FRP. We reviewed this forecast during M10 and now anticipate this figure to be around £1.7m



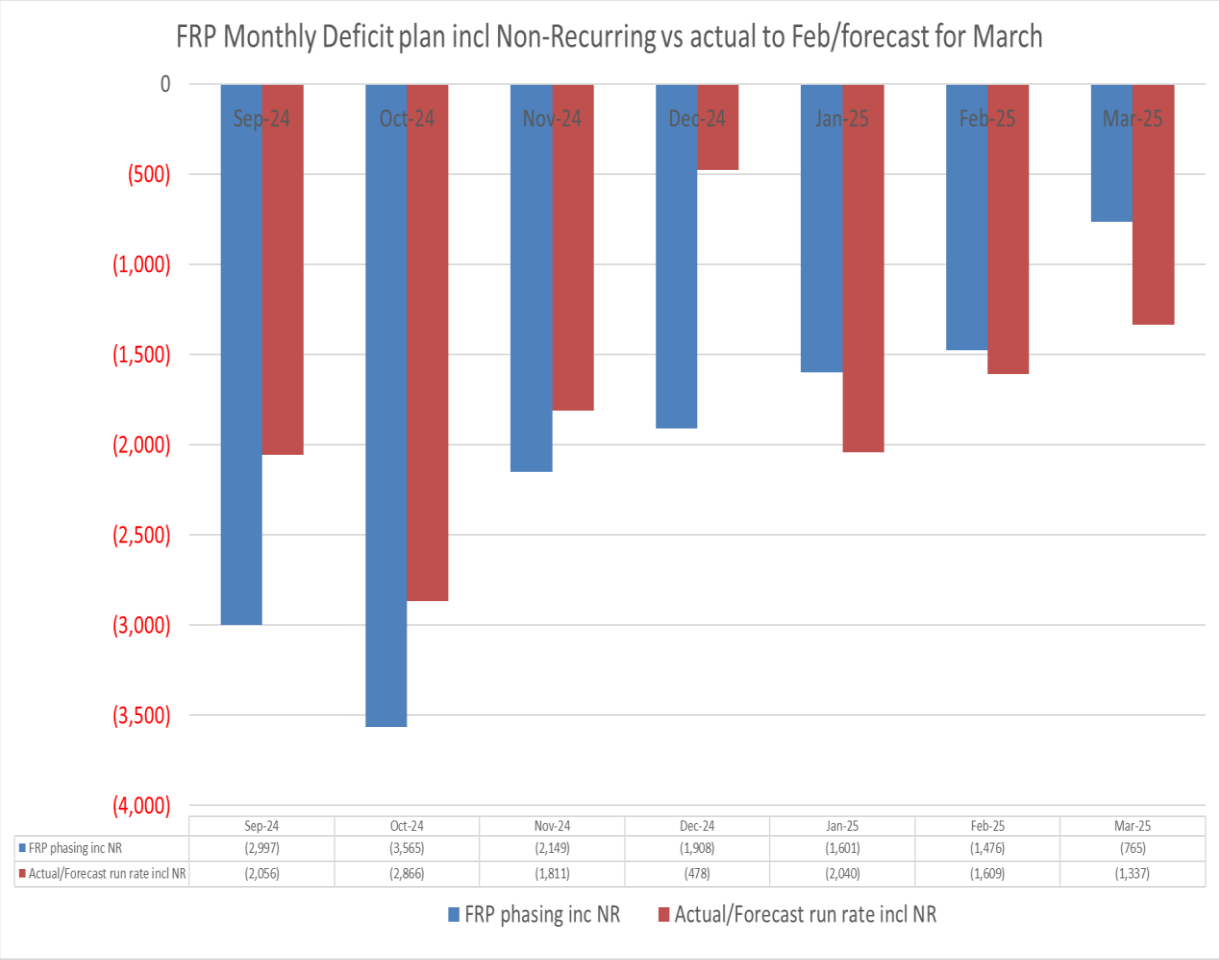
Run rate

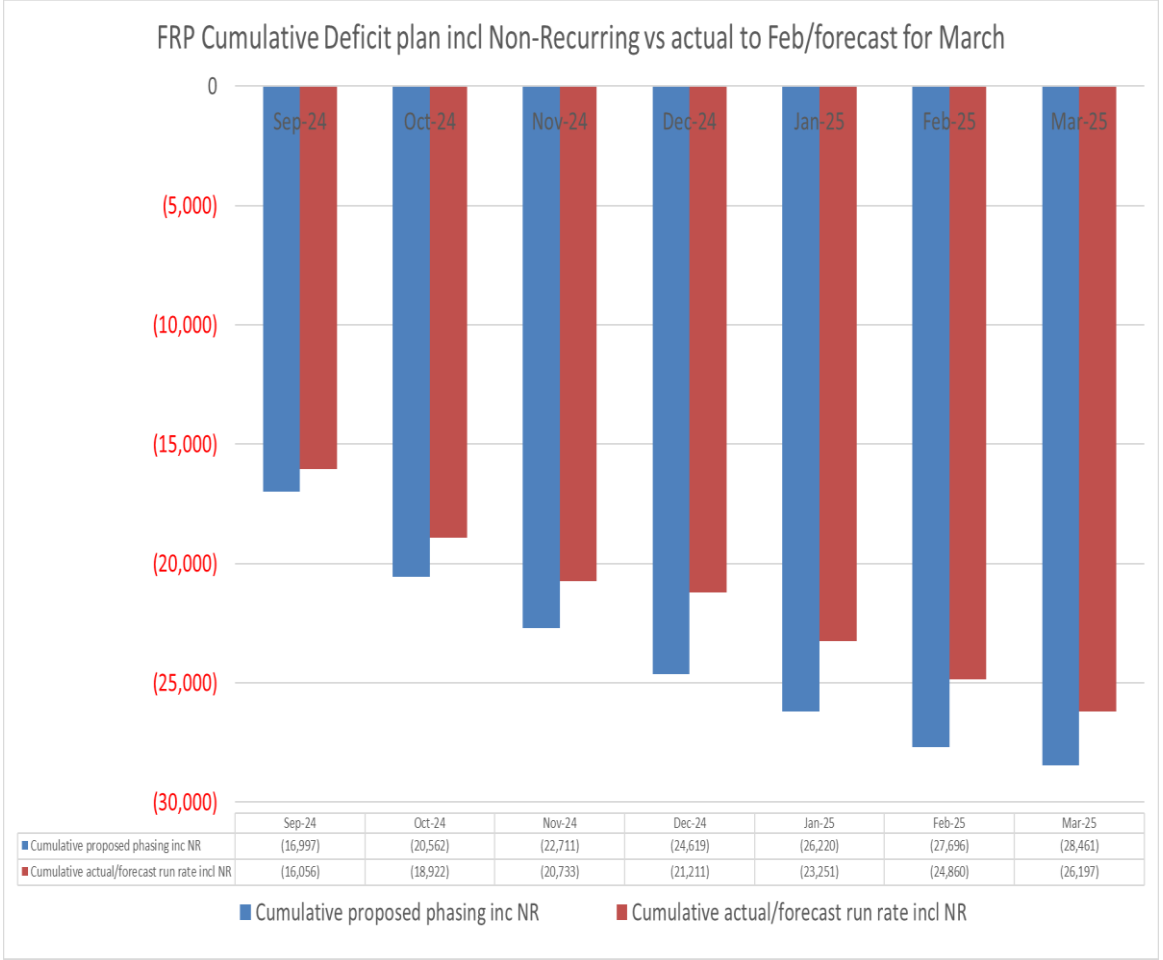
Our rate of expenditure over income (run rate) is as below:

- April £2.8m (£2.3m recurring)
- May £3.1m (£2.9m recurring)
- June £3.6m (£3.1m recurring)
- July £2.1m (£2.4m recurring)
- August £2.4m (£2.4m recurring)
- September £2.1m (£2.3m recurring)
- October £2.9m (£2.18m recurring, £2.0m recurring without pay awards)
- November £1.8m (£1.98m recurring, £1.9m recurring without pay awards)
- December £0.5m (£1.82m recurring, £1.7m recurring without pay awards)
- January £2.0m (£1.77m recurring, £1.6m recurring without pay awards)
- February £1.6m (£1.73m recurring, £1.6m recurring without pay awards)

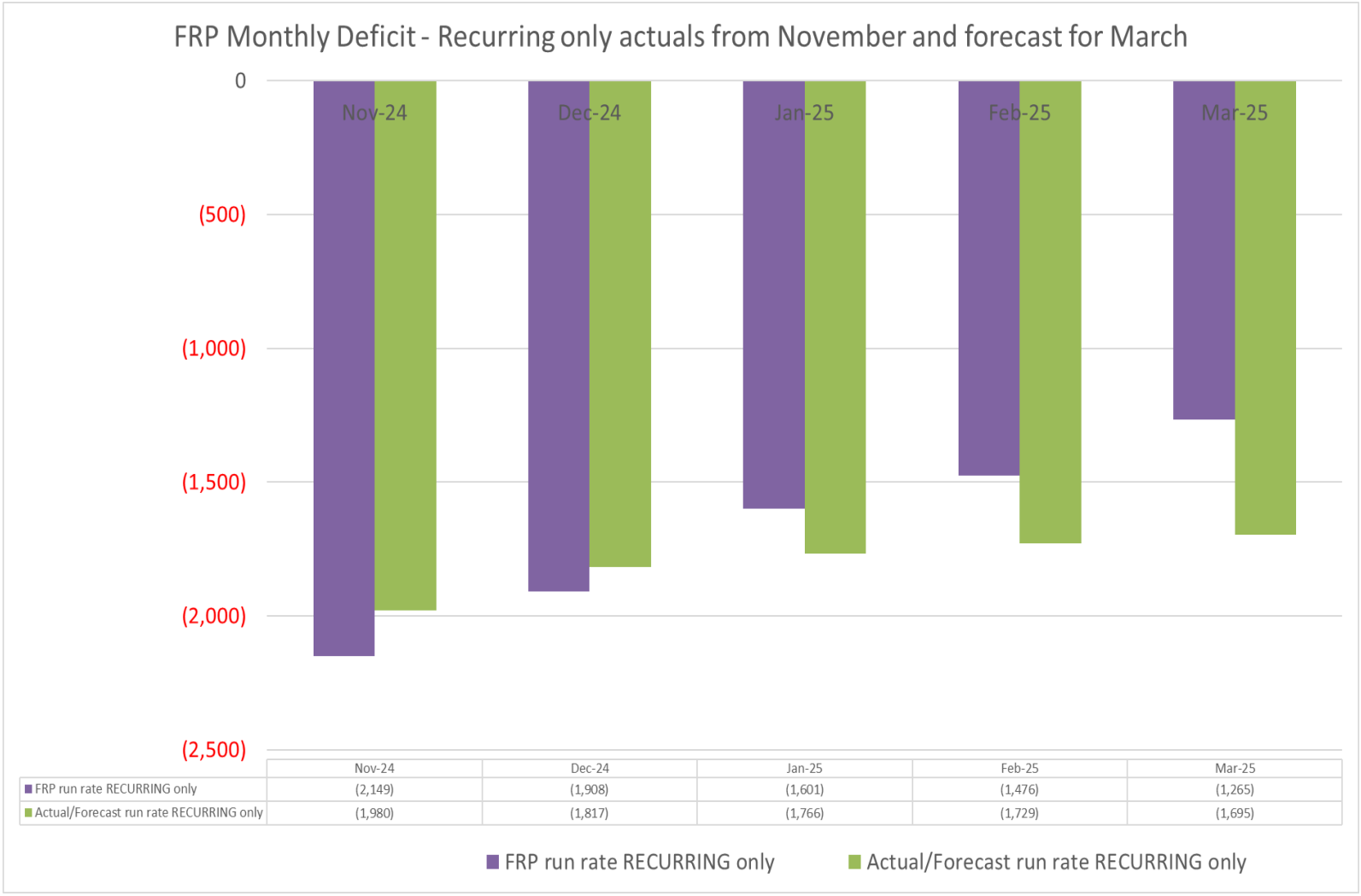
Reconcile M11 actual to FRP trajectory	£'000
FRP planned deficit for February	(1,476)
Actual deficit	1,609
Revised CIP behind FRP	(42)
FRP actions behind plan	(343)
10 actions behind FRP (excl ERF)	(168)
Redundancies	(31)
Pay arrears	(95)
Sale of asset	42
Support to go home (backdated)	82
VAT refund	216
Backdated ERF	300
Other	39
	1,609

Actual expenditure/forecast against our initial trajectory as presented in the FRP, as at M10





Recurring deficit forecast as at M11 against FRP



	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
FRP run rate RECURRING only	(2,149)	(1,908)	(1,601)	(1,476)	(1,265)
Actual/Forecast run rate RECURRING only	(1,980)	(1,817)	(1,766)	(1,729)	(1,695)

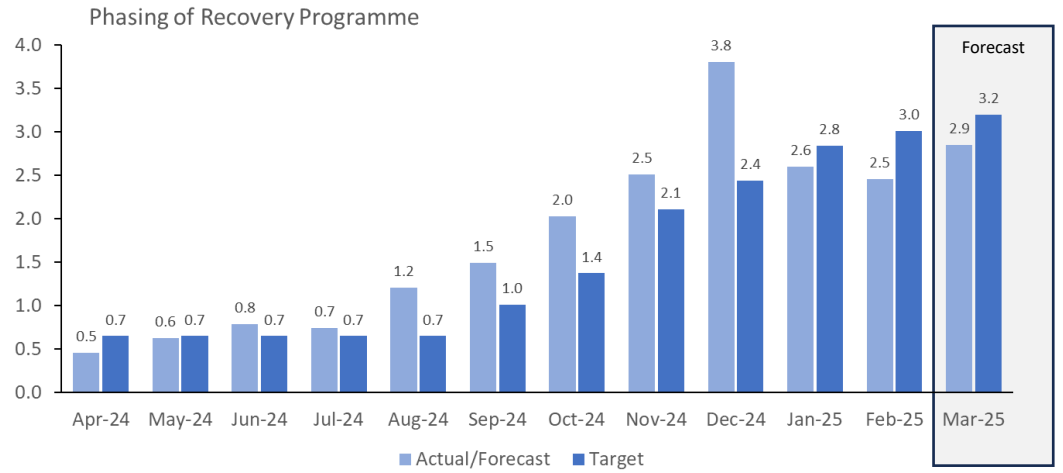
Efficiencies as per Finance Recovery Plan

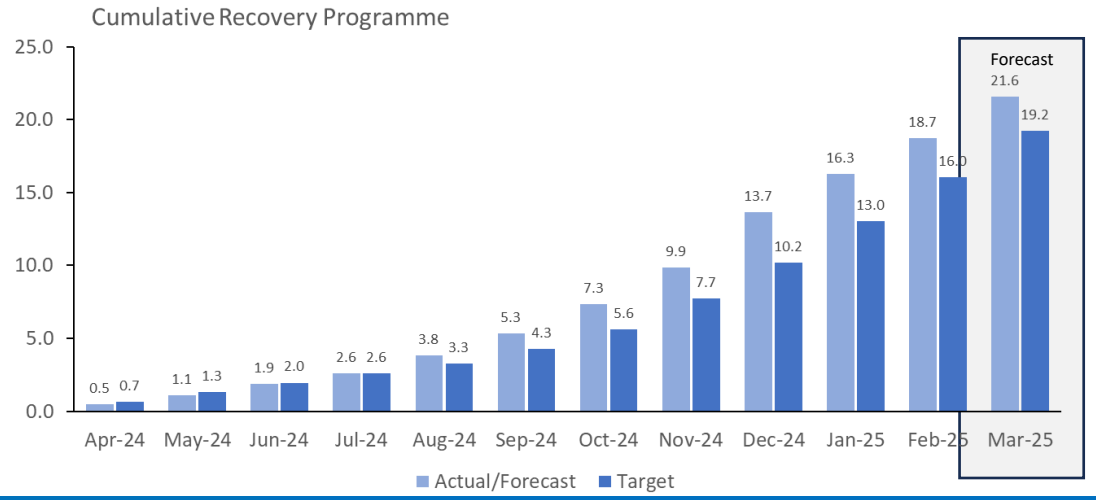
The combined revised CIP and FRP schemes planned to deliver £16.0m YTD, with actual delivery of £18.7m YTD, a favourable variance of £2.7m YTD.

The current overperformance is due to FRP schemes delivering earlier than anticipated in the FRP. The forecast is to deliver the planned total efficiencies (£21. 6m).

M11 totals £2.5m against a plan of £3.0m, an unfavourable variance of £0.5m.

Division	Year to Date			Full Year			In Month		
	Target YTD	Actuals YTD	Variance	Annual Target	Actuals/ Forecast 2024-2025	Variance	Target	Actuals	Variance
CIP									
Community	781	1,163	381	865	1,296	431	83	196	113
Corporate	2,344	3,397	1,053	2,595	3,726	1,130	248	305	57
CSS	455	711	256	504	793	289	48	84	36
Estates & Facilities	453	1,029	576	502	1,087	585	48	56	8
Medicine	977	695	(282)	1,099	1,046	(52)	120	78	(42)
Surgery	1,270	1,150	(120)	1,406	1,184	(222)	135	33	(101)
Women & Children	313	346	33	327	385	58	14	41	27
Trust Wide (not division specific)	1,357	442	(915)	1,502	442	(1,060)	144	4	(139)
CIP Target Adjustment (per FRP)		0	0		0	0		0	0
Total CIP	7,950	8,931	982	8,800	9,959	1,159	840	797	(42)
FRPs									
Community	704	759	55	881	955	74	176	199	23
Corporate	129	147	18	200	184	(16)	54	37	(17)
CSS	380	732	352	600	864	264	170	108	(62)
Estates & Facilities	230	262	32	300	317	17	70	55	(15)
Medicine	1,032	1,134	102	1,348	1,284	(64)	315	172	(144)
Surgery	407	506	99	524	600	76	117	96	(21)
Women & Children	567	732	165	835	927	92	217	110	(107)
Total FRPs	3,449	4,272	822	4,688	5,131	443	1,119	777	(343)
Ten Actions									
01 - Non-Pay Control Panel	420	255	(165)	490	320	(170)	70	0	(70)
02 - Non-Pay Procurement Catalogue Masking	250	70	(180)	300	85	(215)	50	16	(35)
03 - Temporary Medical Staffing Spend	120	175	55	140	195	55	20	20	0
04 - Temporary Nursing Staffing Spend	400	433	33	500	516	16	100	83	(17)
05 - Interim and Contract staff Spend	50	60	10	60	70	10	10	10	0
06 - Vacancy Control Panel Pause during August-24	1,360	702	(658)	1,760	946	(814)	360	248	(112)
07 - Other temporary spend (non-medical, non-nursing)	180	164	(16)	210	188	(22)	30	1	(29)
08 - Review of Trust Contracts (SLA, maintenance contracts)	100	0	(100)	150	0	(150)	50	0	(50)
09 - Income and ERF review	712	2,612	1,900	870	2,897	2,027	141	285	144
10 - Review of 24/25 planned 'investments'	1,046	1,046	0	1,269	1,269	0	223	223	0
Total Ten Actions	4,638	5,517	879	5,749	6,486	738	1,054	886	(168)
	16,037	18,721	2,684	19,237	21,576	2,340	3,013	2,460	(553)

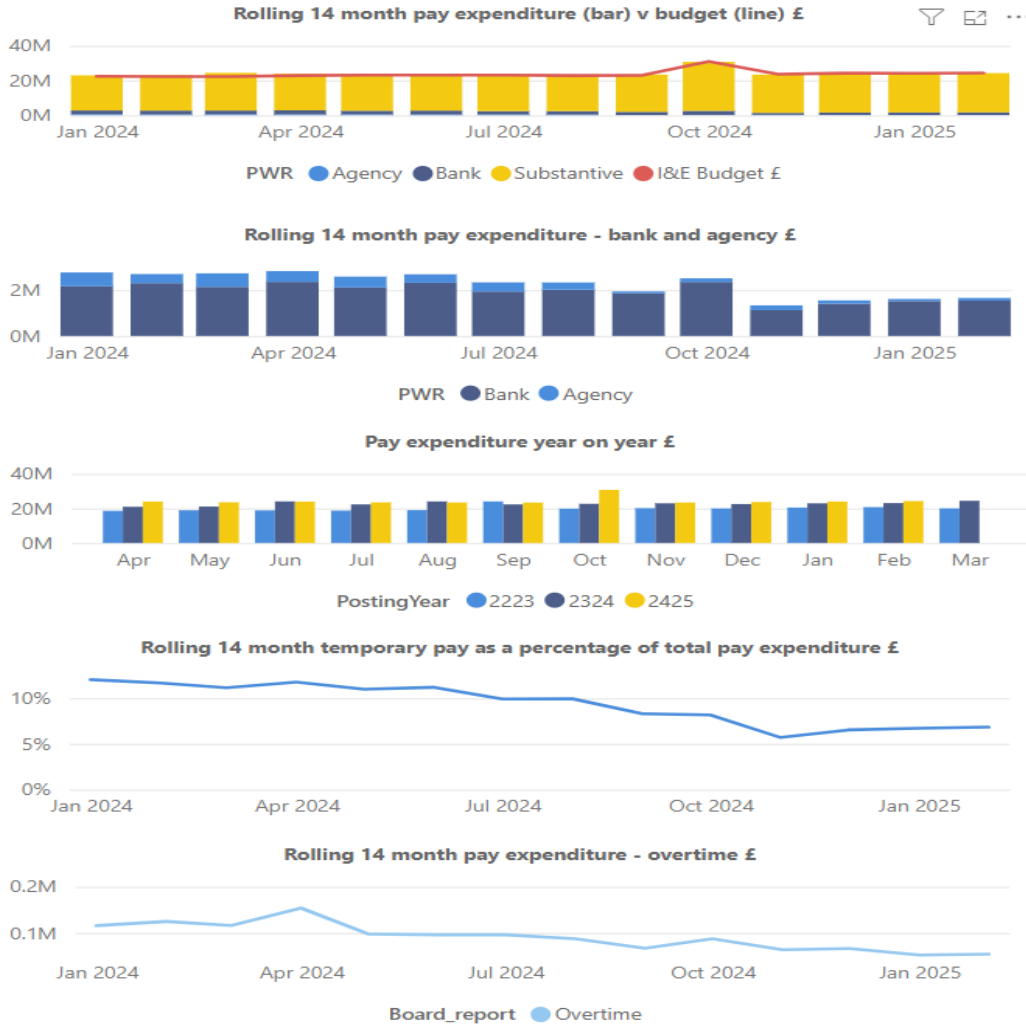




Pay Costs by Staff Type

During February the Trust overspent by £0.3m on pay due to an adjustment relating to funding of GP trainees (£0.2m) and backdated payments (£0.1m).

		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Substantive	Medical Staff	5,748	6,162	6,090	-72	63,566	66,682	3,116
	Nursing	8,076	7,952	8,787	835	87,367	96,449	9,081
	Sci & Professional	1,114	1,084	1,178	94	12,199	13,051	853
	A&C	3,552	3,555	3,821	266	39,261	41,536	2,275
	AHP	2,367	2,343	2,561	219	25,665	27,735	2,070
	Prof & Tech	240	235	244	8	2,520	2,734	214
	Support Staff	827	809	884	75	9,080	10,002	922
	Other	541	437	405	-31	5,061	4,745	-317
	Unallocated CIP	0	0	-490	-490	0	-4,536	-4,536
	Total	22,465	22,577	23,481	904	244,719	258,399	13,680
Additional Medical Sessions	Medical Staff	255	291	95	-197	3,403	1,122	-2,281
	Total	255	291	95	-197	3,403	1,122	-2,281
Bank & Locum Staff	Medical Staff	381	350	147	-203	5,185	1,402	-3,784
	Nursing	546	569	19	-550	6,874	195	-6,679
	Sci & Professional	30	33	4	-29	344	42	-302
	A&C	50	56	-21	-77	800	145	-655
	AHP	19	16	0	-15	201	4	-197
	Prof & Tech	1	0	0	0	7	0	-7
	Support Staff	177	163	78	-85	2,709	950	-1,759
	Other	1	0	0	0	6	0	-6
	Total	1,205	1,187	228	-959	16,125	2,737	-13,389
Agency	Medical Staff	74	54	32	-23	1,221	347	-874
	Nursing	-26	16	17	0	414	184	-230
	Sci & Professional	14	5	10	5	180	113	-67
	A&C	20	23	18	-5	503	196	-306
	Prof & Tech	12	20	17	-3	504	189	-315
	Support Staff	0	4E-5	0	-4E-5	1	0	-1
	Total	93	118	93	-24	2,822	1,028	-1,794
Overtime	Nursing	15	16	2	-13	261	27	-234
	Sci & Professional	9	11	5	-6	131	53	-79
	A&C	10	9	0	-9	222	5	-216
	AHP	9	11	0	-11	133	0	-133
	Prof & Tech	10	8	0	-8	174	0	-174
	Total	52	54	8	-46	922	85	-836
Total		**24,070**	**24,227**	**23,904**	**-323**	**267,991**	**263,371**	**-4,620**

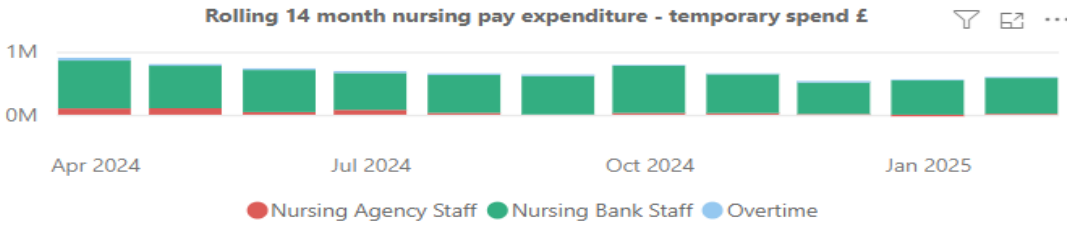


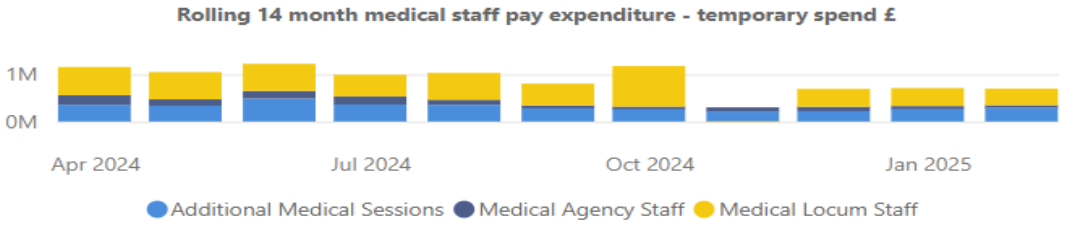
Pay Costs (by Staff Group)

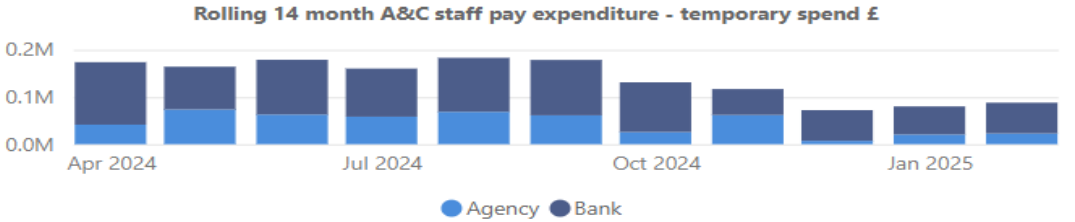
Medical Staffing, and in particular Extra Contracted Work (ECW) are the staff group with the most significant adverse variance. ECW increased by £36k in February compared with January.

Overall pay costs increased in month due to an adjustment relating to funding of GP trainees (£0.2m) and backdated payments (£0.1m).

		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Medical Staff	Substantive	5,748	6,162	6,090	-72	63,566	66,682	3,116
	Additional Medical Sessions	255	291	95	-197	3,403	1,122	-2,281
	Bank & Locum Staff	381	350	147	-203	5,185	1,402	-3,784
	Agency	74	54	32	-23	1,221	347	-874
	Total	6,458	6,858	6,364	-494	73,375	69,553	-3,822
Nursing	Substantive	8,076	7,952	8,787	835	87,367	96,449	9,081
	Bank & Locum Staff	546	569	19	-550	6,874	195	-6,679
	Agency	-26	16	17	0	414	184	-230
	Overtime	15	16	2	-13	261	27	-234
	Total	8,610	8,553	8,825	273	94,917	96,855	1,938
Sci & Professional	Substantive	1,114	1,084	1,178	94	12,199	13,051	853
	Bank & Locum Staff	30	33	4	-29	344	42	-302
	Agency	14	5	10	5	180	113	-67
	Overtime	9	11	5	-6	131	53	-79
	Total	1,167	1,132	1,197	65	12,853	13,259	405
A&C	Substantive	3,552	3,555	3,821	266	39,261	41,536	2,275
	Bank & Locum Staff	50	56	-21	-77	800	145	-655
	Agency	20	23	18	-5	503	196	-306
	Overtime	10	9	0	-9	222	5	-216
	Total	3,632	3,643	3,819	176	40,786	41,883	1,097
AHP	Substantive	2,367	2,343	2,561	219	25,665	27,735	2,070
	Bank & Locum Staff	19	16	0	-15	201	4	-197
	Overtime	9	11	0	-11	133	0	-133
	Total	2,394	2,369	2,562	192	25,998	27,738	1,740
Prof & Tech	Substantive	240	235	244	8	2,520	2,734	214
	Bank & Locum Staff	1	0	0	0	7	0	-7
	Agency	12	20	17	-3	504	189	-315
	Overtime	10	8	0	-8	174	0	-174
	Total	263	263	261	-3	3,205	2,923	-282
Support Staff	Substantive	827	809	884	75	9,080	10,002	922
	Bank & Locum Staff	177	163	78	-85	2,709	950	-1,759
	Agency	0	4E-5	0	-4E-5	1	0	-1
	Total	1,004	972	962	-10	11,789	10,952	-838
Other	Substantive	541	437	405	-31	5,061	4,745	-317
	Total	541	437	405	-31	5,061	4,745	-317
Other	Bank & Locum Staff	1	0	0	0	6	0	-6
	Total	1	0	0	0	6	0	-6
Unallocated CIP	Substantive	0	0	-490	-490	0	-4,536	-4,536
	Total	0	0	-490	-490	0	-4,536	-4,536
Total		24,070	24,227	23,904	-323	267,991	263,371	-4,620







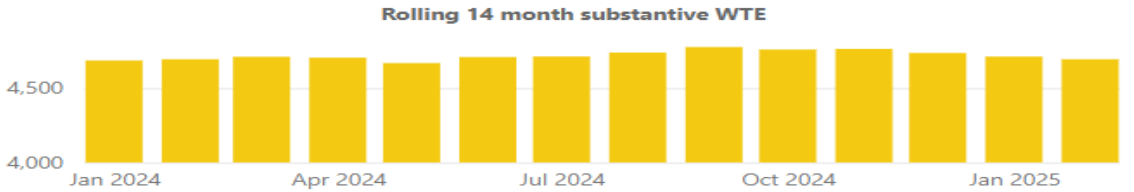
Workforce – WTEs by Staff Type

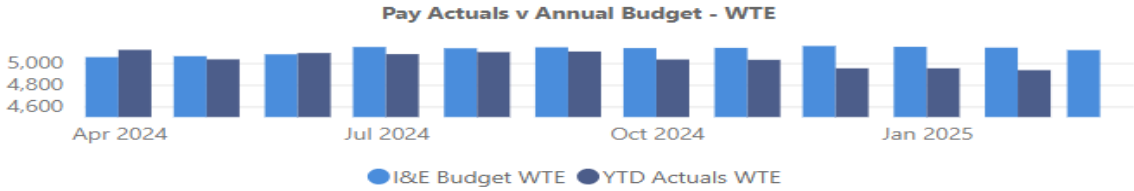
The table below reports a decrease of 19.6 WTEs in February compared with January.

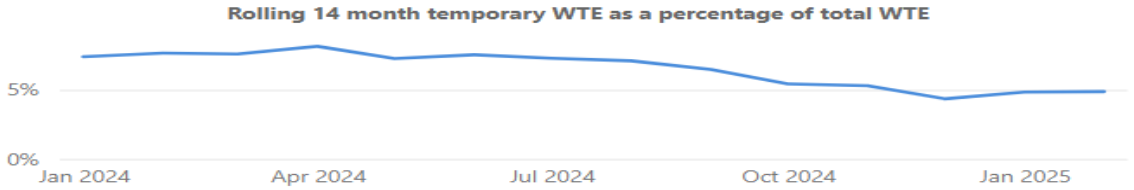
Substantive staff have decreased by 20.7 WTEs in month.

In total we are reporting a reduction of 187.72 WTEs since April 2024 (5,120.52 WTEs).

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Substantive	Nursing	1,941.7	1,921.4	1,938.9	2,143.5	204.6	1,940.5	2,137.0	196.4
	A&C	961.3	976.3	961.8	1,039.1	77.3	975.8	1,031.1	55.3
	Medical Staff	587.0	563.2	581.7	626.8	45.1	583.0	623.0	40.0
	Support Staff	281.1	282.5	275.7	313.4	37.7	284.1	318.9	34.9
	AHP	554.3	561.3	552.9	590.5	37.6	550.3	595.2	44.9
	Sci & Professional	271.4	271.1	267.9	296.3	28.4	273.4	297.5	24.1
	Other	66.1	72.7	62.5	83.0	20.6	67.6	66.1	-1.5
	Prof & Tech	50.5	44.3	51.4	55.4	4.0	49.6	54.8	5.2
	Unallocated CIP	0.0	0.0	0.0	-26.9	-26.9	0.0	-24.5	-24.5
	Total	4,713.4	4,692.8	4,692.7	5,121.2	428.5	4,724.4	5,099.2	374.8
Agency	Medical Staff	4.2	6.9	1.6	1.9	0.3	6.8	1.9	-4.9
	A&C	1.7	3.1	0.0	0.0	0.0	5.4	0.0	-5.4
	Support Staff	0.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0
	Sci & Professional	2.1	5.7	1.0	0.0	-1.0	3.6	0.0	-3.6
	Prof & Tech	2.0	16.4	3.0	0.0	-3.0	9.7	0.0	-9.7
	Nursing	4.4	19.9	4.0	0.0	-3.9	6.2	0.0	-6.2
	Total	14.4	54.4	9.5	1.9	-7.6	31.7	1.9	-29.8
Additional Medical Sessions	Medical Staff	13.9	11.7	12.8	4.3	-8.5	14.5	6.8	-7.8
	Total	13.9	11.7	12.8	4.3	-8.5	14.5	6.8	-7.8
Overtime	A&C	1.7	6.1	1.6	0.0	-1.6	4.1	0.0	-4.1
	Sci & Professional	1.5	2.8	1.7	0.0	-1.7	2.2	0.0	-2.2
	AHP	1.7	1.4	2.1	0.0	-2.1	2.6	0.0	-2.6
	Prof & Tech	2.7	5.6	2.3	0.0	-2.3	4.4	0.0	-4.4
	Nursing	3.5	11.2	3.7	0.0	-3.7	5.1	0.0	-5.1
	Total	11.0	27.1	11.4	0.0	-11.4	18.4	0.0	-18.4
Bank & Locum Staff	Other	0.3		0.0	0.0	0.0	0.2	0.0	-0.2
	Prof & Tech	0.2	0.3	0.2	0.0	-0.2	0.2	0.0	-0.2
	AHP	3.8	5.2	3.3	0.0	-3.3	4.2	0.0	-4.2
	Sci & Professional	8.9	11.6	8.7	0.0	-8.7	8.4	0.0	-8.4
	Support Staff	16.0	32.4	18.0	3.3	-14.7	28.2	3.3	-24.9
	A&C	16.3	30.4	18.6	1.5	-17.1	24.1	2.4	-21.7
	Medical Staff	28.9	46.7	25.5	8.1	-17.4	36.9	7.8	-29.1
	Nursing	125.3	168.7	132.1	0.3	-131.8	147.6	0.3	-147.3
	Total	199.8	295.2	206.4	13.2	-193.3	249.7	13.8	-236.0
Total		4,952.4	5,081.3	4,932.8	5,140.6	207.8	5,038.8	5,121.6	82.8



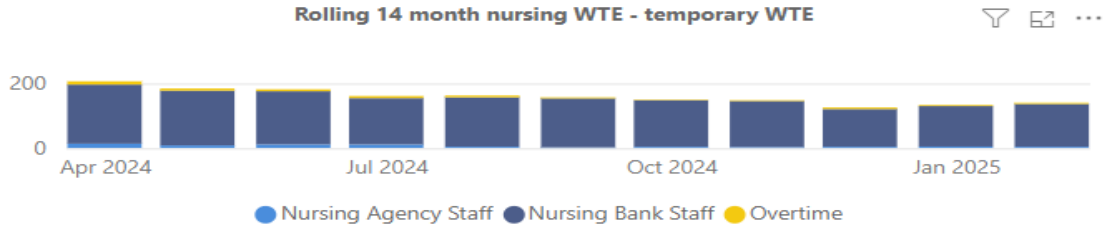


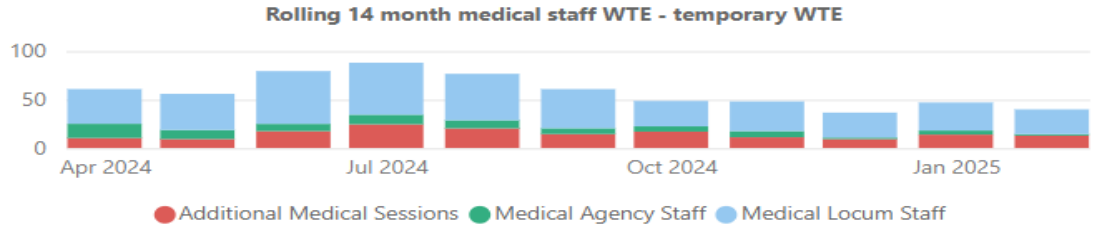


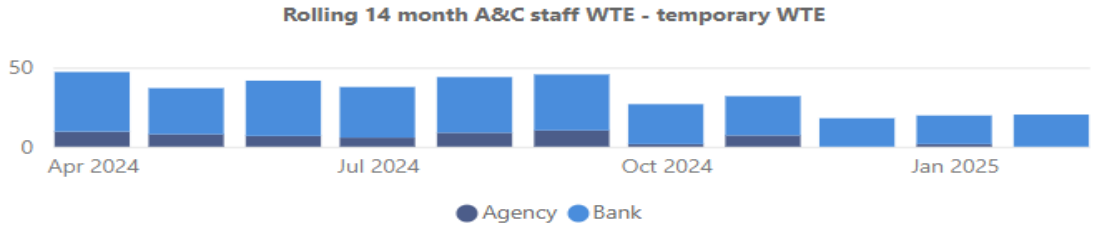
Workforce - WTE (by Staff Group)

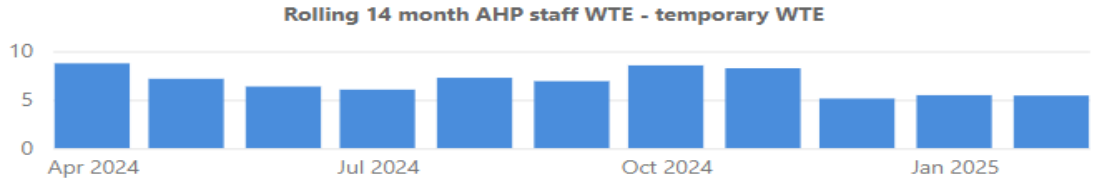
There appear to be 18.5 WTE more Substantive Medical Staff than in February 2024, with a reduction in the use of temporary medical staff (Extra Contracted Work, locums and agency staff) of 25.5 WTE. Total decrease of 7.0 WTE (1.1%).

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Medical Staff	Substantive	587.0	563.2	581.7	626.8	45.1	583.0	623.0	40.0
	Additional Medical Sessions	13.9	11.7	12.8	4.3	-8.5	14.5	6.8	-7.8
	Bank & Locum Staff	28.9	46.7	25.5	8.1	-17.4	36.9	7.8	-29.1
	Agency	4.2	6.9	1.6	1.9	0.3	6.8	1.9	-4.9
	Total	634.0	628.5	621.5	641.1	19.6	641.3	639.4	-1.8
Nursing	Substantive	1,941.7	1,921.4	1,938.9	2,143.5	204.6	1,940.5	2,137.0	196.4
	Bank & Locum Staff	125.3	168.7	132.1	0.3	-131.8	147.6	0.3	-147.3
	Agency	4.4	19.9	4.0	0.0	-3.9	6.2	0.0	-6.2
	Overtime	3.5	11.2	3.7	0.0	-3.7	5.1	0.0	-5.1
	Total	2,075.0	2,121.2	2,078.7	2,143.8	65.1	2,099.4	2,137.2	37.9
Sci & Professional	Substantive	271.4	271.1	267.9	296.3	28.4	273.4	297.5	24.1
	Bank & Locum Staff	8.9	11.6	8.7	0.0	-8.7	8.4	0.0	-8.4
	Agency	2.1	5.7	1.0	0.0	-1.0	3.6	0.0	-3.6
	Overtime	1.5	2.8	1.7	0.0	-1.7	2.2	0.0	-2.2
	Total	283.9	291.1	279.3	296.3	17.0	287.6	297.5	9.9
A&C	Substantive	961.3	976.3	961.8	1,039.1	77.3	975.8	1,031.1	55.3
	Bank & Locum Staff	16.3	30.4	18.6	1.5	-17.1	24.1	2.4	-21.7
	Agency	1.7	3.1	0.0	0.0	0.0	5.4	0.0	-5.4
	Overtime	1.7	6.1	1.6	0.0	-1.6	4.1	0.0	-4.1
	Total	980.9	1,015.9	982.0	1,040.6	58.6	1,009.3	1,033.5	24.2
AHP	Substantive	554.3	561.3	552.9	590.5	37.6	550.3	595.2	44.9
	Bank & Locum Staff	3.8	5.2	3.3	0.0	-3.3	4.2	0.0	-4.2
	Overtime	1.7	1.4	2.1	0.0	-2.1	2.6	0.0	-2.6
	Total	559.8	567.9	558.4	590.5	32.2	557.1	595.2	38.1
Prof & Tech	Substantive	50.5	44.3	51.4	55.4	4.0	49.6	54.8	5.2
	Bank & Locum Staff	0.2	0.3	0.2	0.0	-0.2	0.2	0.0	-0.2
	Agency	2.0	16.4	3.0	0.0	-3.0	9.7	0.0	-9.7
	Overtime	2.7	5.6	2.3	0.0	-2.3	4.4	0.0	-4.4
	Total	55.4	66.5	56.8	55.4	-1.4	63.9	54.8	-9.1
Support Staff	Substantive	281.1	282.5	275.7	313.4	37.7	284.1	318.9	34.9
	Bank & Locum Staff	16.0	32.4	18.0	3.3	-14.7	28.2	3.3	-24.9
	Agency	0.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0
	Total	297.1	317.4	293.7	316.7	23.1	312.3	322.3	9.9
Other	Substantive	66.1	72.7	62.5	83.0	20.6	67.6	66.1	-1.5
	Total	66.1	72.7	62.5	83.0	20.6	67.6	66.1	-1.5
Other	Bank & Locum Staff	0.3		0.0	0.0	0.0	0.2	0.0	-0.2
	Total	0.3		0.0	0.0	0.0	0.2	0.0	-0.2
Unallocated CIP		0.0	0.0	0.0	-26.9	-26.9	0.0	-24.5	-24.5
Total		4,952.3	5,081.3	4,932.8	5,140.6	207.8	5,038.8	5,121.6	82.8









Statement of Financial Position – 28 February 2025

West Suffolk NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2024	Plan 31 March 2025	Plan YTD 28 February 2025	Actual at 28 February 2025	Variance YTD 28 February 2025
	£000	£000	£000	£000	£000
Intangible assets	57,724	51,078	51,632	52,445	813
Property, plant and equipment	130,806	159,588	159,040	153,399	(5,641)
Right of use assets	11,624	9,512	9,688	9,968	280
Trade and other receivables	7,158	7,158	7,158	7,158	0
Total non-current assets	**207,312**	**227,336**	**227,518**	**222,970**	**(4,548)**
Inventories	4,640	4,600	4,600	5,139	539
Trade and other receivables	20,378	18,378	18,378	23,347	4,969
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	9,315	1,107	1,142	13,171	12,029
Total current assets	**34,823**	**24,575**	**24,610**	**42,147**	**17,537**
Trade and other payables	(41,934)	(28,587)	(28,457)	(40,990)	(12,533)
Borrowing repayable within 1 year	(4,732)	(4,722)	(4,722)	(4,529)	193
Current Provisions	(58)	(58)	(58)	(58)	0
Other liabilities	(1,776)	(2,685)	(2,685)	(10,952)	(8,267)
Total current liabilities	**(48,500)**	**(36,052)**	**(35,922)**	**(56,529)**	**(20,607)**
Total assets less current liabilities	**193,635**	**215,859**	**216,206**	**208,588**	**(7,617)**
Borrowings	(44,048)	(39,160)	(39,718)	(40,327)	(609)
Provisions	(407)	(407)	(407)	(396)	11
Total non-current liabilities	**(44,455)**	**(39,567)**	**(40,125)**	**(40,723)**	**(598)**
Total assets employed	**149,180**	**176,292**	**176,081**	**167,865**	**(8,216)**
Financed by					
Public dividend capital	277,694	320,343	319,244	321,236	1,992
Revaluation reserve	11,941	11,941	11,941	11,941	0
Income and expenditure reserve	(140,455)	(155,992)	(155,104)	(165,312)	(10,208)
Total taxpayers' and others' equity	**149,180**	**176,292**	**176,081**	**167,865**	**(8,216)**

The table shows the year-to-date Statement of Financial Position as at 28 February 2025.

The variance to plan of property, plant and equipment is due to the reduction in the capital programme as noted in the capital progress section below.

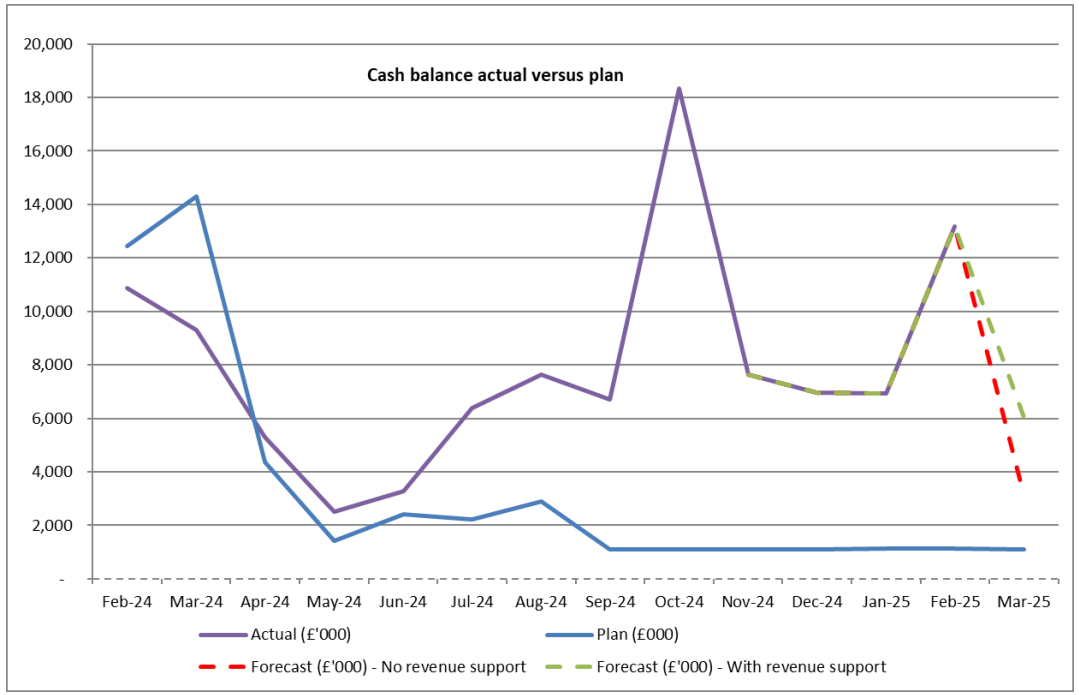
Trade and other receivables are higher than plan and this is due in the main to the timing of trade debtor invoices being raised but not paid by the end of February.

Trade and other payables have increased due to aged trade creditors which we are currently unable to pay within expected timescales due to our difficult cash position. A reduction should be seen in month 12 as we have been able to pay aged creditors due to our higher than planned cash balance.

Deferred income (other liabilities) is higher than plan, mostly due to £8.1m of income received in advance from the ICB in relation to depreciation tariff funding, pay award funding and income received in advance for funding for Newmarket CDC.

Cash balance for the year

The graph below illustrates the cash trajectory since February 2024. The Trust is required to keep a minimum balance of £1.1m.



The Trust's cash balance as at 28 February 2025 was £13m compared to a plan of £1.1m. The cash position is still being masked by advanced cash received from the ICB, including pay award expenditure received in advance, and revenue support received to reflect the change in the Trust's control total for 2024/25. The influx in cash has meant that we have been able to clear a large amount of aged creditors during March.

Our cash continues to be rigorously monitored to ensure that we have adequate cash reserves to match our expenditure. However, as the Trust continues to report a deficit, our cash position continues to deteriorate. This will continue into 2025/26.

To date, the Trust has received £21m in revenue (deficit) support and £2.1m in working capital revenue support. The Trust received a further £2.9m in revenue deficit support in March, which means that revenue deficit support matches the Trust's forecast deficit for 2024/25 of £23.9m. The need for revenue support is under constant review as the cash position moves daily. Cash support will be required in to 2025/26 as the Trust continues to report a deficit. Discussions are being held with the ICB and NHSE national and regional teams on what support would be most viable for the Trust during 2025/26.

Better Payment Practice Code (BPPC) – Month 11

West Suffolk NHS Foundation Trust

February 2025		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	9,222	106,484
Total bills paid within target	5,935	89,651
Percentage of bills paid within target	***64%***	***84%***
NHS		
Total bills paid in the year	657	6,749
Total bills paid within target	248	3,264
Percentage of bills paid within target	***38%***	***48%***
Total		
Total bills paid in the year	9,879	113,233
Total bills paid within target	6,183	92,915
Percentage of bills paid within target	**63%**	**82%**
Previous month performance	**61%**	**82%**

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

The performance is measured over the year and the table shows the Trust's performance at month 11. There continues to be a slight improvement in our BPPC performance as we have been able to pay some more invoices quicker due to the injection of cash from the ICB and continued revenue support.

Capital progress report

Capital Spend - 28th Feb 2025	Year to Date - Month 11			Full Year		
Capital Scheme	YTD Forecast £000's	**YTD Actual £000's**	Variance to Forecast	Full year Forecast £000's	*Funding Split* *Internal £000's*	*PDC Available £000's*
RAAC Programme	5,833	**5,090**	743	6,118		***6,118***
Newmarket CDC	10,583	**11,386**	- 803	10,583		***7,860***
New Hospital Programme* **	5,973	**5,943**	31	6,834		***6,834***
Digital Pathology	-	**19**	- 19	86		***86***
Image Sharing	-	**- 2**	2	345		***345***
CT Scanner*	1,104	**1,104**	-	1,104		***1,104***
Estates	4,022	**2,826**	1,196	3,743	***3,902***	
IM&T	1,953	**2,456**	- 503	2,112	***2,375***	***30***
Medical Equipment**	677	**409**	269	694	***822***	
Imaging Equipment	1,757	**1,786**	- 29	1,757	***1,900***	
UEC Capital	-	**-**	-		***2,000***	
Total Capital Schemes	31,903	**31,015**	887	33,376	***10,999***	***22,377***
Overspent vs Plan					***33,376***	
Underspent vs Plan						

* Late addition to Capital Plan - included in resubmission in June 2024
** This includes all equipment being purchased across the Trust
*** NHP budget is subject to change throughout the year and is fully funded by PDC

The Capital Plan for 2024/25 was agreed at £44m. £11.99m as internally funded, with the remaining £32m being funded by PDC.

At month 9 the forecast reduced to £34.8m due to the rephasing of PDC for the New Hospital Programme and a reduction in internally funded projects of £1m.

The forecast has further reduced in month 11 due to additional rephasing of the New Hospital Programme, moving £1.5m of PDC into 2025/26. The Total forecast capital spend for 2024/25 is now £33.4m

The year-to-date capital spend at month 11 is £31m. This is slightly behind plan, but it is expected that the full year plan will be achieved by the end of March for 2024/25.

Given concerns over cash and the impact of our capital expenditure on our future I&E position (depreciation and PDC), we are continually reviewing our Capital Programme.

3.3. Operational Planning Guidance (ATTACHED)

To Review

Presented by Matt Keeling

WSFT Board of Directors (Open)	
Report title:	NHS 2025/26 priorities and operational planning guidance response
Agenda item:	3.3
Date of the meeting:	28 March 2025
Lead:	Nicola Cottington, Executive Chief Operating Officer
Report prepared by:	Matt Keeling, Deputy Chief Operating Officer Hannah Knights, Head of Operations – Elective Access Stephen Day, Senior Contracts Manager

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

Executive Summary

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

Each year, NHS England publishes the NHS priorities and operational planning guidance, setting out key objectives against operational performance standards, alongside finance and quality expectations. This paper sets out the requirements for 2025/26 and the Trust's response to these, as part of the Suffolk and North East Essex (SNEE) submission.

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

For elective care, the Trust is committing to delivering the 5% Referral To Treatment (RTT) improvement to 63.6% through reducing first outpatient wait times and increasing activity to increase the 18-week compliance. Seven specialties have been identified as those where the impact will be greatest having high volumes but low RTT performance, these will form the focus for outpatient transformation with the aim of increasing first appointment activity. This commitment assumes that maximum outpatient and theatre utilisation is delivered and maintained, i.e., delivering more activity within the same resource, to which any 'cost out' schemes as part of the clinical productivity cost improvement plan, must be delivered in addition, not instead of. Achievement of the RTT trajectory at annex A is heavily dependent on outpatient transformation, profiled to make most impact from Q3-4.

The Trust has committed to achieving the 62-day standard (75%) and Faster Diagnosis Standard (FDS) (80%) for 2025/26. Gynaecology, skin and lower gastrointestinal (LGI) are the areas of focus for transformation to support this and central funding has been made available to support Trusts to attain improvements in cancer performance.

For urgent and emergency care, the Trust is forecasting delivery of the requirement to meet the 4-hour standard to 78% in March 2026. Performance has been modelled on the seasonal pattern observed since reporting recommenced in May 2023, with similar growth in attendances and improvement in performance modelled to that which was observed between 2023/24 and 2024/25. Given WSFT's exceptional performance against the 4-hour standard in March 2025 the trajectory has been recently updated, and developed further since Insight Committee on 19th March. The Trust has also committed to a reduction in 12 hour waits and has accepted the fair shares allocation of ambulance handover delays.

Maintenance of urgent and emergency care performance will require transformational change, particularly ahead of winter 2025/26, including the development of sub-acute frailty services.

No separate planning trajectory is required for the expectation to improve access to general practice, applicable to WSFT's Glemsford Surgery, and achievement of this ambition will be monitored through the national GP patient survey.

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

The final draft system submission will be made by the ICB to NHSE region by 20th March, with the final submission due 27th March.

Performance against trajectories will be monitored at the Patient Access Governance Group and Insight Committee. A revised Integrated Quality and Performance Report (IQPR) is being developed to reflect the update standards. Productivity improvements underpinning delivery are monitored through the clinical productivity workstream.

Recommendation / action required

It is recommended that the Board support the commitments to the expectations in the 25/26 planning guidance, understanding the risks presented particularly in relation to productivity improvement assumptions and the transformation of urgent and emergency care pathways.

Previously considered by:	Key assumptions and commitments have been developed and shared through the ICB Elective Planning Task and Finish Group, chaired by the ICB Director of Operations. This paper was considered by Insight Committee on 19th March 2025 and recommendations supported.
Risk and assurance:	BAF Risk Capacity (Ref: 02): The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities. BAF 2 is monitored through Insight Committee. There is a risk relating to financial recovery and productivity gains. There is a 2% productivity assumption in the operational planning commitments, which covers the 2% growth assumption. In addition, the Trust has a clinical productivity Cost Improvement Plan, currently factored in at £9.4m. This is before the challenge to improve the financial forecast further for 25/26, through additional productivity gains.
Equality, diversity and inclusion:	It is possible that focussing on the reduced number of priorities in the planning guidance, plus narrowing this focus further to seven high-volume, high-risk specialities, could create longer waits for certain sections of the population. This could increase health inequalities. Access and waiting times for a broader range if services are monitored at department level and Performance Review Meetings.

Sustainability:	Increasing virtual consultations as part of improving outpatient productivity reduces patient journeys and can reduce carbon emissions in line with the Trust's Net Zero ambition.
Legal and regulatory context:	NHS 2025/26 priorities and operational planning guidance

	NHS 2025/26 priorities and operational planning guidance response
1.	**Introduction**
1.1	Each year, NHS England publishes the NHS priorities and operational planning guidance, setting out key objectives against operational performance standards, alongside finance and quality expectations. The incoming government has set a mandate to reduce the number of essential objectives for the NHS, reducing the number of national priorities for 2025/26 with the intention of giving local systems greater control and flexibility over how local funding is deployed to best meet the needs of their local population. Systems are encouraged to shift their focus from inputs to outcomes for patients and local communities, supported by changes to the financial framework.
2.	**Background**
2.1	The priorities for operational performance for WSFT in 2025/26 are: • Reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for elective treatment a minimum 5% - for WSFT compared to a November 2024 baseline the target is 63.6%. Providers are also expected to deliver continued reductions in long waits, with no more than 1% of the total waiting list waiting more than 52 weeks by March 2026. For WSFT this equates to a target of 338 patients, using the November 2024 waiting list size baseline and assuming the total waiting list size remains unchanged. • Continue to improve performance against the cancer 62-day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026. • Improve A&E waiting times and ambulance response times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26 – to support this, WSFT will need to deliver timely ambulance handovers within the 'lost hours' fair shares quota. Providers should also deliver a reduction in the percentage of patients spending more than 12 hours in an emergency department. • Improve access to general practice, evidenced through improved patient experience of access to general practice as measured by the ONS Health Insights Survey.
2.2	There is a clear expectation that organisations live within the budget allocated, reducing waste, and improving productivity. Integrated Care Boards (ICBs), trusts, and primary care providers must work together to plan and deliver a balanced net system financial position in collaboration with other integrated care system (ICS) partners. The Suffolk and North East Essex (SNEE) ICB has adopted a planning principle of "the money is the money".
2.3	SNEE ICB have facilitated a series of task and finish groups for urgent and emergency care and elective care to produce a co-ordinated system response using the same principles, assumptions, and modelling across providers prior to submission to the NHS England East of England regional team. These groups will also make decisions on how plans should be modified following feedback on draft submissions from the regional team on 10 March 2025.

3.	Detailed sections and key issues
3.1	Elective Care The first draft submissions for both WSFT and ESNEFT modelled the Referral to Treatment (RTT) activity and performance that could be achieved within the defined funding envelope for 2025/26, which is just slightly below 2024/25 allocations (approx. 0.5%). As set out in Annex A, this did not meet the requirement to deliver a 5% improvement in the number of patients waiting less than 18 weeks by March 2026 compared to a November 2024 baseline. A revised trajectory, factoring in 2% growth and assuming top quartile productivity in theatres and outpatients leading to a 2% gain largely cancel one another out, improving the March 2026 performance projection by only 0.05%. Divisional analysis modelled the costs of delivering additional activity to meet the 5% improvement requirement at £2.1 - £2.9 million, this is heavily weighted towards elective inpatient and day case activity and assumes a similar waiting list profile and pathways to 2024/25. Feedback from the NHS England East of England regional team to SNEE ICB and provider CEOs on 10 March 2025 set a clear expectation that the 5% improvement must be delivered without relying on additional activity costs. To do this, we must ensure that the focus shifts away from delivery of RTT pathways in theatres towards outpatients, in particular reducing the waiting times for first appointments to within 18 weeks. The suggested RTT performance improvement trajectory for providers in the SNEE system is as follows (noting the WSFT baseline and target need to be corrected to 58.6% and 63.6% respectively):

	EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION	WEST SUFFOLK NHS FOUNDATION TRUST
Nov 24 Baseline	55.4%	58.4%
Apr-25	55.8%	58.8%
May-25	56.3%	59.2%
Jun-25	56.7%	59.6%
Jul-25	57.1%	60.0%
Aug-25	57.5%	60.4%
Sep-25	57.9%	60.9%
Oct-25	58.3%	61.3%
Nov-25	58.8%	61.7%
Dec-25	59.2%	62.1%
Jan-26	59.6%	62.5%
Feb-26	60.0%	62.9%
Mar-26	60.4%	63.4%
Minimum Target by March 2026	60.4%	63.4%
% Improvement needed	5.0%	5.0%
Improvement per month (over 12M)	0.4%	0.4%

Providers and systems have been directed towards resources highlighting opportunities to increase RTT performance without delivering additional activity beyond that which has been funded. However, it is not possible to definitively quantify the impact of each potential intervention on overall RTT % performance. We must also assume that maximised theatre and outpatient productivity is

	delivered and maintained, i.e. delivering more activity within the same resource, to which any 'cost out' schemes must be delivered in addition, not instead of. The assumptions behind the plan at annex A are: • Advice & Guidance increases by 200% and leads to a 45% reduction in referrals for this increase in usage. • 2% demand growth (SNEE wide position) • 2% clock stops productivity increase (OP and EL) – SNEE position • Additional 2% productivity for outpatient first appointments, this is created by reducing follow ups by 6% (assuming 4% is used for the 2% increase in first attendances (2:1 ratio) and the other 2% is released to deal with the increase in A&G. Assumes that 70% of the clock stops this creates goes towards patients waiting under 18wks and 30% over) • 5.8% clock stop rate for validating patients over 18wks during the validation sprints Acknowledging that the highest volume of clock stops occurs from a non-admitted activity, the primary improvement approach for delivering the 5% RTT improvement will be on reducing first outpatient wait times and increasing activity to increase the 18-week compliance. 7 specialties have been identified as those where the impact will be greatest having high volumes but low RTT performance, these will form the focus for outpatient transformation with the aim of increasing first appointment activity: • Urology - 64.4% • Gynaecology Service - 62% • Ear Nose and Throat - 59.5% • General Surgery - 59.3% • Ophthalmology - 59.2% • Dermatology - 53.5% • Trauma and Orthopaedics - 47.2% Within these specialties, it will be necessary to divert activity towards first outpatient attendances, potentially requiring a corresponding reduction in outpatient follow-up, day case or elective inpatient activity. However, this may increase the risk of not delivering the planning guidance requirement to have no more than 1% of the waiting list over 52 weeks. Alongside reducing first outpatient waiting times, RTT validation will need to be a key focus, recognising that currently only patients over 37 weeks are being validated, without the resource to currently validate those patients between 18-37 weeks, the current volume of patients in this category is 9360 as of 11 March 2025. Whilst the resource to validate is limited due to the loss of some of the data quality team earlier in the year, there are plans to test and utilise MBI Health's Rova tool, which can be embedded in our Luna PTL. The Rova tool scans letters for words, such as discharge, PIFU (Patient Initiated Follow Up) etc. which could indicate a clock stop to allow more targeted validation. This is planned to be implemented from April 2025. Knowing there will be a tariff associated with validation patients against the baseline during 'sprint' periods, we may need to look at the option of bringing in resource during these times to increase the validation activity to attract the maximum tariff possible, whilst also increasing the overall RTT compliance.

	In addition, moving from Dr Doctor to PPUK (Patient Portal UK) for our text message validation campaign, will support the increase in messages to reach 100% compliance against the requirement for all patients over 12 weeks to receive contact due to the way in which the responses are able to come in via PPUK with less options. However, there is risk with this, in that the Dr Doctor contract ends on 31 March 2025 and the PPUK contract has not yet been signed. Existing outpatient transformation work to reduce Did Not Attend (DNA) rates, increase the number of Specialist Advice (Advice & Guidance) requests to reduce referrals and increasing Patient Initiated Follow Up rates to reduce face to face follow up activity will need to be expedited and have greater delivery ambitions in 2025/26. Although these will not be the primary means by which the 5% RTT improvement is delivered, they will support delivery of the overall aim of 92% of patients waiting less than 18 weeks by March 2029.
3.2	<u>Cancer Waiting Times</u> As set out in Annex B, WSFT have committed to achieving the 62-day standard and Faster Diagnosis Standard (FDS) for 2025/26. For the FDS to improve to the required 80%, the development of the skin pathway with a community teledermatology solution will be key, however this is currently dependent on the Cancer Service Development Funding bids, awaiting approval by the East of England Cancer Alliance In gynaecology, implementation of the unscheduled bleeding on HRT pathway should reduce the increase in cancer referrals and allow faster diagnosis standards to improve. Implementation of nurse led biopsies, and a revised bladder pathway will be the central focus for improvement for urology throughout 2025/26. To deliver the 62-day standard to 75%, lower gastrointestinal (GI) and skin are the central focus for improvements, with lower GI revising the allocation of cases through the multidisciplinary team (MDT) meetings to surgery, and skin cancer front end pathway developments as the key actions. Schemes have been submitted to support the operational performance via the cancer System Development Fund (SDF).
3.3	<u>Urgent and Emergency Care</u> As set out in Annex C, WSFT is forecasting delivery of the requirement to meet the 4-hour standard to 78% in March 2026. Performance has been modelled on the seasonal pattern observed since reporting recommenced in May 2023, with similar growth in attendances and improvement in performance modelled to that which was observed between 2023/24 and 2024/25. Given WSFT's exceptional performance against the 4-hour standard in March 2025 the trajectory has been recently updated, and there is further work to model the impact and timing of transformational changes, including within the frailty model, as these plans are developed. There is a requirement to reduce the number of patients spending >12 hours in Emergency Departments. The magnitude of this reduction has not been specified, so WSFT has submitted a very conservative reduction which we will aim to significantly over-deliver on once the actions to achieve this are developed and in place. WSFT have taken the same modelling approach for ambulance handover delays – outperforming the 'fair shares' allocation in the first months of the year, with a

	reduced (compared to 2024/25) but still significant risk of delays above the allocation in winter months. Although this is not a performance standard measured separately, all three acute hospital sites in SNEE have been asked to develop a trajectory to support the headline indicator of ambulance Category 2 response times within a 30-minute average. Maintenance of urgent and emergency care performance will require transformational change, particularly ahead of winter 2025/26, including the development of sub-acute frailty services
3.4	Primary Care No separate planning trajectory is required for the expectation to improve access to general practice, applicable to WSFT's Glemsford Surgery. Currently, GP appointments within 2 weeks are at a consistent performance around 78%, which may require an improvement to deliver a corresponding increase in patient experience of access. Local work will need to be undertaken to calibrate these two indicators and develop a performance improvement plan.
4.	**Next steps**
4.1	The final draft system submission will be made by the ICB to NHSE region by 20th March, with the final submission due 27th March. Performance against trajectories will be monitored at the Patient Access Governance Group and Insight Committee. A revised Integrated Quality and Performance Report (IQPR) is being developed to reflect the update standards. Productivity improvements underpinning delivery are monitored through the clinical productivity workstream.
5.	**Recommendations**
	It is recommended that the Board support the commitments to the expectations in the 25/26 planning guidance, understanding the risks presented particularly in relation to productivity improvement assumptions and the transformation of urgent and emergency care pathways.

ANNEX A - ELECTIVE RTT PLANNING TRAJECTORIES

RTT - Incomplete pathways

Provider Level			Nov-24	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
E.B.18	Count	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 52 weeks or more	1,393	1,044	1,045	1,037	1,013	980	970	964	950	958	949	944	938
E.B.	Count	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 18 weeks or less	19,796	19,731	19,732	19,643	19,338	18,969	18,799	18,641	18,427	18,413	18,224	18,035	17,571
E.B.3a	Count	The number of incomplete Referral to Treatment (RTT) pathways	33,801	34,483	34,470	34,088	33,079	31,808	31,212	30,673	29,899	30,079	29,666	29,252	27,618
E.B.18/E.B.3a	Percentage	% patients waiting 52 weeks or more	4.1%	3.0%	3.0%	3.0%	3.1%	3.1%	3.1%	3.1%	3.2%	3.2%	3.2%	3.2%	3.4%
E.B.40/E.B.3a	Percentage	% patients waiting 18 weeks or less	58.6%	57.2%	57.2%	57.6%	58.5%	59.6%	60.2%	60.8%	61.6%	61.2%	61.4%	61.7%	63.6%

ANNEX B – CANCER WAITING TIMES PLANNING TRAJECTORIES

CANCER 62-DAY STANDARD

	November 2024 baseline	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Mar-26 Target
Number of patients seen within 62 days	110.5	103	111	104	132	108	106	135	139	104	113	120	123	
Total number of patients seen	153.0	154	153	139	177	143	139	176	181	136	150	157	160	
Percentage of patients seen within 62 days	72.2%	66.9%	72.5%	74.8%	74.6%	75.5%	76.3%	76.7%	76.8%	76.5%	75.3%	76.4%	76.9%	**75.0%**

CANCER FASTER DIAGNOSIS STANDARD

	November 2024 baseline	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Mar-26 Target
Number of patients receiving communication of diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis, within 28-days	818.0	1,016	1,053	1,108	1,233	1,051	1,087	1,283	1,230	1,077	1,131	1,178	1,179	
Total number of patients receiving communication of diagnosis for cancer or ruling out of cancer, or a decision to treat if made before a communication of diagnosis	1,386.0	1,368	1,397	1,449	1,587	1,374	1,398	1,618	1,559	1,355	1,415	1,463	1,452	
Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days	59.0%	74.3%	75.4%	76.5%	77.7%	76.5%	77.8%	79.3%	78.9%	79.5%	79.9%	80.5%	81.2%	**80.0%**

ANNEX C – URGENT AND EMERGENCY CARE PLANNING TRAJECTORIES

4-hour standard trajectory (updated since Insight 19.3.25 with 5% improved performance Sep-Feb)

	Nov-24	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Mar-26 Target
Total # of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	5,422	6,950	7,384	6,723	6,885	6,276	6,764	6,676	6,552	6,431	6,254	6,239	7,757	
Total # of attendances at Type 1, 2, 3 A&E departments	8,738	8,747	9,570	8,966	9,289	8,819	9,021	9,251	9,108	9,291	8,722	8,584	9,948	
% of attendances at Type 1, 2, 3 A&E departments, departing in less than 4 hours	62.1%	79.5%	77.2%	75.0%	74.1%	71.2%	75.0%	72.2%	71.9%	69.2%	71.7%	72.7%	78.0%	78.0%
Number of attendance at type 1 A&E department over 12 hours	1,120	984	759	923	593	587	772	961	917	1,177	1,149	1,002	963	
Number of attendances at type 1 A&E departments	7,953	7,902	8,669	8,208	8,504	8,020	8,229	8,482	8,422	8,589	8,079	7,708	9,175	
Percentage of attendance at type 1 A&E department over 12 hours	14.1%	12.5%	8.8%	11.2%	7.0%	7.3%	9.4%	11.3%	10.9%	13.7%	14.2%	13.0%	10.5%	

Ambulance handover 'lost hours' trajectory

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
24/25	1,245	362	318	451	314	533	317	198	402	938	627	1,524	1,200		
25/26 Target				420	434	420	434	434	420	434	420	434	434	392	434
25/26 Plan				400	300	300	300	300	350	500	600	800	600	450	434

Last 12 months	7,184
25/26 Target	5,110
25/26 Plan	5,334

3.4. Budgets and capital programme 2025/26 (ATTACHED)

To Review

Presented by Jonathan Rowell

WSFT Board of Directors (Open)	
Report title:	**Capital planning - Proposed Capital Programme – 2025/26**
Agenda item:	**3.4**
Date of the meeting:	**28 March 2025**
Lead:	**Jonathan Rowell, Interim Chief Finance Officer**
Report prepared by:	**Chris Todd, Associate Director of Estates and Facilities** **Liam McLaughlin, Chief Information Officer**

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

Within Suffolk and North East Essex (SNEE) Integrated Care System (ICS), WSFT has a defined allocation of £10.478m Capital Resource Limit (CRL). In addition, WSFT has the Public Dividend Capital (PDC) funded RAAC Programme that is also identified in the attached table.

This paper demonstrates the prioritisation process for a risk and business-continuity focused 2025/26 plan as part of a rolling 3-year Capital Programme and the rolled-back pressure on 2026/27 as a result of the reduction to Capital expenditure in 2024/25.

The investments in each scheme have to be taken in the context of the remaining life of the Reinforced Aeriated Autoclaved Concrete (RAAC) structure.

In-line with previous annual reviews of the Capital Programme, the Associate Director of Estates and Facilities and Chief Information Officer met with the divisions to establish the 2025/26 programme as part of a 3-year programme. We held two meetings, one for initial review and the second for final confirmation, the latter meeting was attended by;

- Emma Bray, Capital Accountant
- Liam McLaughlin, Chief Information Officer
- Simon Taylor, ADO – Women's, Children and Clinical Support
- Chris Todd, Associate Director of Estates and Facilities
- Sarah Watson – ADO Medicine
- Nic Smith Howell – ADO ICYPS
- Moira Welham, ADO – Surgery

The funding is built-up as follows;

- £10.478m CRL allocation at SNEE ICB System Level.
- £1.340m Public Dividend Capital (PDC) to support the RAAC programme (yet to be confirmed by NHSE)

The following principles support the plan:

- Commence developing this into a programme in the context of Future System (i.e. make the best out of investment made in the WSH to be demolished by front-end funding any schemes)

- The programme is based on an overcommitment of the CRL. Typically, capital schemes do not spend as quickly as planned or are not delivered for a variety of reasons; expenditure can be slowed down if required, for example, should an unforeseen expenditure hit capital and to remain within the CRL. Retaining a contingency element to the programme typically ends up with this being spent late in the year and decisions being made based on delivery by 31/3 rather than risk/ business-based need.

- There is a £400K allocation specifically against Transformation, the scope is to be confirmed.

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

Attached (2526_20250312.pdf) is the draft Capital Programme for 2025/26, each scheme falls into three priorities:

- Pre-commitments – these are schemes approved in a previous financial year that have a commitment in the 2025/26 programme

- Backlog – these are schemes identified either through the 6-facet survey and reviewed by the EFM Team, Equip Medical Device asset register or the IT Asset register

- ADO – these are schemes identified within the divisions for investment to support organisational needs a number in themselves are transformative.

A number of schemes cross between divisions, but this is a reference for where each scheme is driven from.

The single line under 'Equipment' **(£0.4m)** will develop into multiple schemes prioritised by the Medical Devices Group.

The 'Priority' column relates to '1' (2025-26), '2' (2026-27) and 3 (2027-28 onwards). A number of schemes have a recurring annual investment need so appear across multiple years.

The 'Plan' column identifies the anticipated cost of each scheme – if each scheme was fully delivered, this would be a **£26.597m** Capital Programme.

The prioritisation having been completed, the Trust is showing an overcommitment of **£1.001m**, **8**% over-allocated.

We have a smaller than usual pre-commitment of **£0.5m** showing for schemes planned for 2024/25 that end up taking place in 2025/26 (as noted previously, slowing projects to make the financial year-end), this

figure will only be confirmed shortly after 1/04/2025; this is smaller than previous years due to the slow-down of expenditure to match the Financial Recovery Plan.

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

Insight Committee have approved the proposed programme.

Each scheme will require a Business Case (Statement of Need for approval by Capital Strategy Group, Business Case if required for Board) to be completed by the relevant ADO, EFM or IM&T lead.

Should in-year changes be required, if these cannot be managed by CSG through slippage in other schemes, Executive Directors will be updated on the proposed change to the plan and approval will be required if CSG cannot manage the change under delegated authority.

We await confirmation of the RAAC funding **(£1.34m)**

Recommendation / action required

The Trust Board is asked to note that Insight Committee approved and reviewed the programme and agreed with the recommendation to approve the backlog and prioritised schemes and note further review will take place once the carry-over from 2024/25 is confirmed.

Previously considered by:	• ADO Peer Review • Capital Strategy Group 20/02/2025 • Financial Accountability Committee 05/03/2025 • Insight Committee 19/03/2025
Risk and assurance:	Effective Use of Resources within West Suffolk NHS Foundation Trust Oversight of the management of risk and business planning being aligned to the Capital Investment Programme Recognition in the reduced life of the Fixed Asset at West Suffolk Hospital
Equality, diversity and inclusion:	Capital schemes will be subject to Equality Impact Assessments, there is an element on the programme specifically supporting the improvements required under the Equality Act (formerly Disability Discrimination Act)
Sustainability:	Each scheme is developed to minimise our use of resources and therefore the impact on the environment. Schemes use local suppliers wherever possible.
Legal and regulatory context:	Fundamental Standard 15 International Accounting Standards

CAPITAL PLAN FOR 2025/26 - West Suffolk NHS Foundation Trust

Priorities	Division	Description	Plan	Prioritised 25/26	Prioritised 26/27	Prioritised 27/28
Pre-Commitments		Carry forward from 2024/25		500,000	1,000,000	1,000,000
Pre-Commitments	Estate	EFM Capitalisation (Exc. RAAC)	700,000	700,000	700,000	700,000
Pre-Commitments	IT Hardware	IT Capitalisation	500,000	0	0	0
Pre-Commitments	Estate	installation of Nurse Call	60,000	60,000	60,000	0
Pre-Commitments	IT Software	Interoperability backfill	126,000	0	126,000	0
Pre-Commitments	Estate	CL3 Room	250,000	250,000	0	0
Pre-Commitments	Estate	RAAC	1,340,000	600,000	1,340,000	1,340,000
Backlog	Estate	Works to Heating and Domestic System, Legionella, balancing etc.	150,000	150,000	100,000	100,000
Backlog	Estate	Ventilation - Priority repairs following Verifications	100,000	100,000	30,000	30,000
Backlog	Estate	Sluice Room Refurbishment x 2	96,000	96,000	96,000	96,000
Backlog	Estate	Programme to upgrade Public WC's - Phase 2 of 3	91,000	91,000	91,000	91,000
Backlog	Estate	Compartmentation fire protection works	220,000	220,000	220,000	220,000
Backlog	Estate	Roads Repair and relining - Rolling required	40,000	40,000	40,000	40,000
Backlog	Estate	Drainage Internal - Rolling required	40,000	40,000	40,000	40,000
Backlog	Estate	Drainage External - Rolling required	40,000	40,000	40,000	40,000
Backlog	Estate	Ward Kitchen Refurbishment	120,000	120,000	120,000	120,000
Backlog	Estate	Equality and Diversity Works	150,000	150,000	50,000	50,000
Backlog	Imaging	Sudbury Ultrasound (Sherlock)	100,000	0	100,000	0
Backlog	Imaging	Phillips Bucky (Sudbury)	250,000	250,000	0	0
Backlog	Estate	Electrical Safety - Priority repairs to Fixed Wire Testing	50,000	50,000	50,000	50,000
Backlog	Estate	Flooring across site to meet slips, trips, falls + IPC Priorities	70,000	70,000	35,000	35,000
Backlog	Estate	DSU 1+2	500,000	500,000	0	0
Backlog	Estate	Hardwick Manor Backlog	150,000	150,000	0	0
Backlog	Estate	CHP Replacement	250,000	250,000	0	0
Backlog	Equipment	Olympus Stack	255,000	255,000	0	0
Backlog	Equipment	Lubron RO	130,000	130,000	0	0
Backlog	Equipment	Theatre Lights	250,000	125,000	0	0
Backlog	Equipment	Anaerobic Incubator	30,000	30,000	0	0
Backlog	Equipment	Cellpath Specimen Storage Cabinet	18,000	18,000	0	0
Backlog	Equipment	Cellpath Fume Hood x 2	15,000	15,000	0	0
Backlog	Equipment	Microbiology Fridge	6,000	6,000	0	0
Backlog	Equipment	Medical Device Programme	400,000	400,000	400,000	400,000
Backlog	Equipment	Anaesthetic Machine Replacement (yr1)	450,000	0	450,000	450,000
Backlog	Imaging	Interventional Radiology Room 1	900,000	0	0	0
Backlog	Imaging	MRI 2 Aera	1,000,000	0	1,000,000	0
Backlog	Imaging	Phillips Bucky (Thetford)	250,000	0	250,000	0
Backlog	Imaging	Obs Ultrasound (Lewis)	100,000	100,000	0	100,000
Backlog	Imaging	Obs Ultrasound (Morse)	100,000	0	100,000	0
Backlog	Imaging	Obs Ultrasound (Frost)	100,000	100,000	0	0
Backlog	Imaging	AN Ultrasound (Cagney)	100,000	0	100,000	0
Backlog	Imaging	Room 2 Builders Work	200,000	200,000	0	0
Backlog	IT Hardware	Rolling hardware replacement programme	450,000	1,290,000	1,500,000	0
Backlog	IT Software	Windows 11	243,000	243,000	0	0
Backlog	IT Software	Windows 11 (Wow)	594,000	94,000	0	0
Backlog	IT Hardware	Server Replacements	350,000	70,000	70,000	0
Backlog	IT Hardware	Mobile devices for Closed Loop Bloods	150,000	0	0	0
Backlog	IT Hardware	ToughPad Replacements (Opthalmology/ ICU)	15,000	0	0	0
Backlog	IT Hardware	Kiosk Hardware	30,000	0	0	0
Backlog	IT Hardware	Network Monitoring	50,000	0	0	0
Backlog	IT Software	e-Care upgrade for enhanced device integration	85,000.00	85,000	0	0
Backlog	IT Hardware	Self check in kiosk extension to CDC	95,000.00	95,000	0	0
Backlog	IT Hardware	Upgrade to portering handheld devices for compliance	84,000.00	84,000	0	0
Backlog	IT Software	Compliance upgrade for Order Comms (ICE)	75,000.00	75,000	0	0
Backlog	IT Hardware	Server backup capacity	852,000.00	852,000	0	0
Backlog	IT Hardware	Network edge equipment replacement (out of support)	250,000.00	250,000	0	0
Backlog	IT Hardware	IT (Other)	800,000	0	1,200,000	1,200,000
ADO/SLT		ADO Schemes	3,000,000	0	1,535,000	3,000,000
ADO/SLT		Transformation (Rowan Plus Others?)	400,000	400,000	0	0
ADO/SLT	Equipment	EV Charging Upgrades NCH	30,000	0	0	0
ADO/SLT	Surgery	Additional Lamina Flow Hood in DTU + LIFT	1,500,000	0	0	0
ADO/SLT	Surgery	Finishes, ceiling, lights, AHU Alterations - T2	190,000	190,000	0	0
ADO/SLT	Surgery	Finishes, ceiling, lights, AHU Alterations - T3	190,000	0	0	0
ADO/SLT	Surgery	Finishes, ceiling, lights, AHU Alterations - T4	190,000	190,000	0	0
ADO/SLT	Surgery	Finishes, ceiling, lights, AHU Alterations - T5	190,000	0	0	0
ADO/SLT	Surgery	Finishes, ceiling, lights, AHU Alterations - T6	190,000	0	0	0
ADO/SLT	Surgery	Finishes, ceiling, lights, AHU Alterations - T7	190,000	0	0	0
ADO/SLT	Surgery	Finishes, ceiling, lights, AHU Alterations - T8	190,000	0	0	0
ADO/SLT	Surgery	Finishes, ceiling, lights, AHU Alterations - T9	190,000	0	0	0
ADO/SLT	Clinical Support	Temperature Monitoring	60,000	60,000	0	0
ADO/SLT	Surgery	Mohs Scope	90,000	90,000	0	0
ADO/SLT	Clinical Support	Mortuary Bereavement Space	100,000	100,000	0	0
ADO/SLT	Medicine	ED Reception	70,000	70,000	0	0
ADO/SLT	IT Software	GS1 Barcode compliance	150,000	0	0	0
ADO/SLT	Community	Newmarket Office Space	122,000	0	0	0
ADO/SLT	IT Software	Lung Function Test Integration	30,000	0	0	0
ADO/SLT	Estate	Maple House	160,000	0	0	0
Backlog	Endoscopy	11 Scopes	565,000	565,000	565,000	0
ADO/SLT	Equipment	C-Arm for T&O	120,000	0	0	0
ADO/SLT	Equipment	ED Additional Capacity	120,000	0	0	0
ADO/SLT	Equipment	Expansion of JFDU	200,000	0	0	0
ADO/SLT	Equipment	Theatre Robot (possible Charity)	1,200,000	0	1,200,000	0
ADO/SLT	Equipment	Audiology Booths (Location TBC)	130,000	0	0	0
ADO/SLT	Equipment	CYPS Development (BSE/ BSE Rural)	1,000,000	550,000	450,000	0
ADO/SLT	Equipment	KTP Laser and Micro Laryngoscopy	200,000	200,000	0	0
ADO/SLT	Estate	G3 Refurbishment/ DOSA Project	1,000,000	1,000,000	0	0
ADO/SLT	Estate	Robot Estates Works	150,000	0	0	0
ADO/SLT	Estate	Education Centre Investment - Ramp, flooring	200,000	200,000	0	0
ADO/SLT	Equipment	Fibroscanner - Medicine	110,000	110,000	0	0
ADO/SLT	Equipment	Audiology Equipment - St Helens, BSE CDC	150,000	150,000	0	0
ADO/SLT	Estate	Glemsford Offices	60,000	0	0	0
ADO/SLT	Estate	Pre-Op Assessment	100,000	0	0	0
			26,357,000	**12,819,000**	**13,058,000**	**9,102,000**
		CRL Available (inc. PDC)	**10,175,000.00**	**11,818,000.00**	**11,153,000.00**	**9,250,000.00**
		Undercommittment/ Overcommitment		**-1,001,000.00**	**-1,905,000.00**	**148,000.00**
					-0.08	-0.17	0.02

Comfort Break

4. PEOPLE, CULTURE AND ORGANISATIONAL DEVLEOPMENT

4.1. Involvement Committee Report - Chair's Key Issues from the meeting (ATTACHED)

To Assure

Presented by Tracy Dowling and Jeremy Over

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

Originating Committee: Involvement Committee			Date of meeting: 19th February 2025		
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
4.3	Actions from previous meeting: Guardian of Safe Working Hours	2. Reasonable	Issue raised at Board by resident doctors raising concerns about being asked to move to work in areas different to their rota	To continue to be monitored to assess frequency and concerns regarding continuity of care and impact on staff morale, including at Trust Negotiating Committee with medical staff representatives	1. No escalation
6.0	Education and Training Report	1. Substantial	Evidence of strong multi-professional access to education and training across the organisation with clarity about areas requiring attention and areas of future innovation.	Maintain focus on paediatrics and surgical foundation training. Maintain focus on locally employed doctors as vital for clinical sustainability. Consider how to measure the output and impact of our investment in education and training. Ensure that the development of our strategic workforce plan includes full consideration of associate and extended scope of practice clinical roles; developing sustainable career pathways for these vital roles.	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 19th February 2025		
Chaired by: Tracy Dowling - Non executive Director			Lead Executive Directors: Jeremy Over and Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
6.2	Staff Psychology Service Specification	2. Reasonable	It was agreed that the service is valued by staff and the draft revised service specification was noted. The next step is to re-launch the service and the Tier 1 level support available to staff.	Undertake further work to define outcome metrics and other measures of success to ensure value added from the investment in this service. Ensure clarity on complaints management for the service. Ensure clarity on patient records as through this service our staff become patients of the Trust. These areas need to accompany the service specification as an internal SLA, to be approved by MEG.	1. No escalation
6.3	National Staff Survey 2024	2. Reasonable	The initial results of the Autumn 2024 Staff Survey show a decrease in scores across most categories compared to 2023. Whilst this is regrettable, it is not surprising given the impacts of the financial recovery actions during the period of the survey. There is variance in results across the divisions with Community and Corporate	A more detailed analysis will be completed once the full report and benchmarking is released in March. However, it is clear from the interim results where actions, communications and learning need to focus. The results show what a shock the financial position and resultant actions have been to the staff of WSFT;	1. No escalation; however response to the full report will come to Trust Board for assurance

Originating Committee: Involvement Committee			Date of meeting: 19th February 2025		
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
			Divisions scoring most highly, and Medicine Division and Estates and Facilities scoring generally lower.	however, living within our means and delivering high quality care through productive service models are core requirements. There is therefore organisational development work to do to navigate the cultural change needed across large parts of the Trust.	
7.0	Equality, Diversity and Inclusion Update	1. Substantial	Jamais Webb-Small presented the EDI workforce annual report and the WRES and WDES reports. The reports identified EDI activities, priorities, achievements and challenges from 2024; and key areas of focus for 2025. It was agreed that these comprehensive reports give robust assurance of activities in progress, and clarity on future priorities whilst recognising that the data shows that disparity and discrimination are still prevalent as it is in wider	The reports have been approved for publishing internally and externally. It was agreed that we would like to see more evidence of trends over time to know that the activity in place is having positive impact. We want to see further action to address the inequity between shortlisting and appointment between white and BME applicants. We want to see improvement in disability status disclosure rates; reduction in harassment, bullying or	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 19th February 2025		
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
			society. A Board level EDI development session was fully supported as a priority action.	abuse from colleagues towards those with disabilities, and improvement in the extent to which the organisation values the work of staff with disabilities.	
8.2	Quality Priorities Review and 2025/6 proposed priorities	1. Substantial	Good assurance was provided of progress made on the 2024-5 quality priorities. The quality priorities for 2025-6 were agreed.	Progress delivering the quality priorities will be reported to the Involvement Committee every 4 months. The proposed quality priorities for 2025-6 will be subject to on-going engagement with various stakeholders including VOICE to ensure they are meeting the communities needs. The priorities may be subject to change as a result of this engagement (by April 25)	1. No escalation
8.3	EDS Report Summary and EDS Reporting Submission	1. Substantial	The EDS is a system which allows NHS organisations to review and improve their performance for people with protected characteristics.	The action plan for radiology services was agreed. It was confirmed that feedback has been shared with radiology staff members.	1. No escalation

Originating Committee: Involvement Committee			**Date of meeting: 19th February 2025**		
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
			The Trust EDS Reporting Submission was approved. The EDS report into radiology services was considered.		
9.1	People and Culture Committee	1.Substantial	The revised terms of reference were agreed.		1. No escalation
9.2	Experience of Care and Engagement Committee Report	1. Substantial	The report was received for information.		1. No escalation
10	IQPR extract for Involvement Committee	1. Substantial	Metrics reviewed and both patient experience and human resource metrics show good performance.		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.

4.1.1. Putting You First Awards (ATTACHED)

Presented by Jeremy Over

NHS
West Suffolk
NHS Foundation Trust

Putting You First awards

February / March 2024/5 winners

Board of Directors: 28 March 2025

Putting you first

Stefan Hughes, rehabilitation engineer, wheelchair services
Nominated by Riya Chauhan, clinical engineering trainee

As a rehabilitation engineer, Stefan always goes the extra mile for patients and staff. He is dedicated, incredibly knowledgeable, and an incredible team member. His commitment to improving the lives of patients is extraordinary, and his impact on both our team and those we serve is nothing short of inspiring.

Stefan is patient, and is a skilled communicator for both verbal and non-verbal individuals. He has mastered the art of finetuning a prescription to ensure his patients' needs are met. His decades of experience and unique technical expertise make him an indispensable resource, not only for patients but for the entire team. We rely on his knowledge daily, and he is always willing to answer questions, share insights, and guide our learning.

What truly sets Stefan apart is his ability to connect with patients on a personal level. He takes the time to explain why a specific solution is prescribed, ensuring patients understand the reasoning behind recommended changes. This approach empowers them, fostering trust and making them active participants in their recovery journey. His ability to communicate complex ideas in a way that is clear and relatable is a testament to his skill and empathy.

Beyond his technical abilities, Stefan is a kind and supportive core member of our team. With a big heart and a positive attitude, he consistently uplifts team morale, creating a collaborative and encouraging work environment. His unwavering dedication to both patients and colleagues makes him an exceptional candidate for the Putting You First Award.

Ellie Stewart, matron, women's and children's services

Nominated by Jo Rayner and Lizzie Mappleback, associate director of strategic change (ICB)

Ellie's passion for improving women's health has shone through in her role as part of the Insight and Oversight Group (I&O Group) delivering improvements to women's health services across Suffolk and North East Essex.

Not only has Ellie given her time to support the I&O Group to coproduce the outcomes for women but she has also offered her specialist knowledge and skills in the delivery. One example is that Ellie has been actively involved in developing content for the ground-breaking women's health app, designed and commissioned by the women's health group. Ellie has offered her specialist knowledge to ensure that the content is accurate and relevant to support women to understand their conditions, self-manage where appropriate and seek help where required.

A second example is that Ellie is delivering a specialist training session on long-acting reversible contraception (LARC) to 100 professional colleagues to enable services to be more widely available to women in a primary care setting. Not only will this reduce the demand for this service in an acute setting, but it should also reduce waiting times for women to receive this treatment which will have a tangible positive outcome on their quality of life.

Ellie's passion and enthusiasm for her specialism and supporting women is unparalleled and we are very lucky in the west Suffolk system to have Ellie championing women's health. Ellie, you are a superstar!

Rachel Cooper, home enteral feeding dietitian
Nominated by Lisa Penfold, service lead for nutrition and dietetics

Rachel has stepped up and worked beyond her current role as a home enteral feeding dietitian to help manage the nutrition nursing service to ensure patient safety and maintain the high quality of the service provided to patients in the community.

Due to unforeseen circumstances, the nutrition nursing team was reduced to one third of the team within one month. A delay in the new team lead starting in post meant that there was not an opportunity to provide training to the new recruit. Rachel has temporarily taken over the main tasks of the role, including; analysing reports; ordering ancillaries and equipment; triaging and troubleshooting when patients contact the service in order to prevent admission. This is in addition to her own clinical role and organising the induction and training for the new nutrition nurse and recruiting to the other vacant post. The number of patients being managed in the community has also increased by about 15%.

Rachel has remained calm and positive over the past few months. She has shown true leadership, flexibility, teamwork and professionalism. I am very grateful to have Rachel working within Nutrition and Dietetic Department.

5. OPERATIONS, FINANCE AND CORPORATE RISK

5.1. Insight Committee Report - Chairs key issues from the meetings (ATTACHED)

To Assure

Presented by Antoinette Jackson and Nicola Cottington

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

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*

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

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

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

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 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.	**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

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

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.	

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

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

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

Assurance level

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

Originating Committee: Insight Committee			***Date of meeting: 19 February 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*
Finance Accountability Committee	**Month 10 Reporting** The Trust continues to make progress on its recovery trajectory and is on track for the revised control total of £23.8m. Workforce savings are being seen, with the trust reporting 168.1 fewer WTE in January than in April 2024. The controls put in place as part of the financial recovery plan remain. This exit rate for 24/25 is important in determining the start position for the 25/26 plan. The recurring deficit in January is £1.77m £165k behind the anticipated FRP trajectory. ERF remains on trajectory, although there is some risk of	**3 Partial**	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 £23.8m. This revised forecast remains challenging and has some risks. It is unlikely that the exit monthly run rate for the year will be 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.	Work continues on the development of the Financial Recovery Plan for 2025/26 in the context of the new Planning Guidance and indicative financial allocations, see Operational Planning Guidance item below.	3.Escalate to Board

Originating Committee: Insight Committee			***Date of meeting: 19 February 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*
	interruption with winter pressures and norovirus impacting on elective capacity. The combined revised CIP and FRP schemes planned to deliver £13.0m YTD, with actual delivery of £16.2m YTD, a favourable variance of £3.2m YTD. The cash position remains critical and the Trust has put in an application for a further £7.9m of revenue (deficit) support for quarter 4 to match the deficit forecast.				

Originating Committee: Insight Committee			Date of meeting: 19 February 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*
Quality Impact Panel Reviews	The scope of the QIA Panel is to ascertain the quality or sustainability impact of the cost improvement programmes schemes. Two schemes were reviewed by the panel in January 1. A restructure of the mortuary staffing model 2. A review of staffing in The Support To Go Home (STGH) scheme which previously received non-recurrent funding for additional reablement capacity and a responsive coordinator. As funding for these posts has now ceased the workforce is being realigned with the budget.	**1. Substantial**	The Panel's remit is to solely to focus on the quality impacts of each scheme, on patients, their families, staff and the Trust more widely based on assessment criteria. Insight Committee concluded it can give assurance that there is a robust process in place for assessing the risk of an adverse impact on quality. The actual quality outcomes of the schemes over time will be considered by the other assurance committees as part of their role in the ongoing monitoring of services	The Panel will meet fortnightly, as required, as new schemes come forward.	1 No escalation

Originating Committee: Insight Committee			Date of meeting: 19 February 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*
Operational Planning Guidance	The operational planning guidance was published on the 30th January 2025, with the expectation of planning submissions to be completed by 20th February 2025. The Trust has also been notified of its indicative financial allocations for the year. This very much remains a dynamic planning environment where regular changes are being made and so the figures presented to Insight were not final. However, they suggest there is additional risk of c£16m in the Trust's financial position for 2025/26 which would give a of c£31m for the year.	**3. Partial**	The guidance outlines the performance the Trust will be expected to achieve in 2025/26. Key targets are highlighted in the operational sections below. A full summary of the targets is included in the Committee report. Given the uncertainty of the financial position the Committee agreed that all risks should be reflected in full in our submission and that a high-level deficit plan of £31m be submitted at this stage.	The financial figures will continue to be refined during March and it is likely that the final submission will improve; albeit many of the factors moving against the financial position are not likely to materially change. The ICB are aware of our risks and the uncertainty around our position. Discussions are also underway with the ICB around the assumptions and associated costs of achieving the operational standards. The Trust will need to decide what targets we want to realistically commit to and what resources will be required.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 February 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 December month end position was 120 patients over 65 weeks, with a provisional January month end position of 92 patients, 68 of which are capacity breaches and a forecast position of zero over 65 weeks by the end of March 2025.	**2 Reasonable**	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 improved elective position and commitment to reduce the 65 week waits by March 2025, we have been removed from 'Tier 2' for Elective Recovery.	3. Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 February 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	**Diagnostics** Diagnostic performance against the 6-week standard is forecast to be c.50% in March 2025, against an expectation of 95% compliance. Although the opening of the Newmarket CDC in late 2024 has seen the modelled step change increase in imaging performance delivered, delays to the DEXA service relocation, non-obstetric ultrasound and endoscopy activity not increasing will need to be addressed to regain compliance.	**4 Minimal**	Longer waiting times for diagnosis and treatment have a detrimental effect on patients.	As a result of our worsening Cancer and Diagnostic performance we have now been placed in 'Tier 1' 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 Cancer FDS and diagnostic modalities that are driving underperformance.	3.Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 19 February 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*
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 November, projected to improve in December through recovery in both Skin and Breast services. insourcing and sickness within the photography team for the teledermatology service provided as part of the pathway.	**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. The November performance has been largely 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 less take up of shifts from external bank staff owing to this being temporarily paused. The skin pathway has not met increases in demand across the summer, because insourcing has ceased and sickness within the photography team for the teledermatology service provided as part of the pathway.	As a result of our worsening Cancer and Diagnostic performance we have now been placed in 'Tier 1' 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 Cancer FDS and diagnostic modalities that are driving underperformance. Improving radiological support to 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	3. Escalate to Board

Originating Committee: Insight Committee			***Date of meeting: 19 February 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*
			Planning guidance requires improved performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026 and improvement against performance against the 62-day cancer standard to 75% by March 2026.	one-stop breast clinics being booked within 28 days once more.	

Originating Committee: Insight Committee			Date of meeting: 19 February 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	**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 December with variance worsening – 62.1% against a plan of 75%.	**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. Planning guidance shows the 4-hour target is once again 78% by March 2026. Modelling the same trajectory of performance improvement seen from 23/24 to 24/25 for 25/26 gets us to 78%, with no additional expenditure. Guidance is less precise on 12-hour waits other than we must demonstrate a reduction, as a % of overall attendances. We have included an indicative reduction of -0.5%in our submission.	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

Originating Committee: Insight Committee			Date of meeting: 19 February 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*
Update on Community Equipment and Wheelchair services	The Community Equipment Service (CES) and Wheelchair Service (WCS) presented a report to Insight Committee in October 2024 due to significant budget pressures within the services. Unfunded elements included no uplifts for demographic pressures and growth, inflationary pressures and changes in VAT treatment By December 2024, these unfunded pressures resulted in a £499k overspend for the 'Community' element of CES .This position significantly exceeds the growth and inflation funding provided through the Community Contract (4.2% in 23/24 and 3.9% in 24/25. Proactive financial management measures achieved £220k in cost avoidance for CES and £240k for WCS through enhanced controls and monitoring.	**1** **Substantial**	The paper set out, actions which are being taken as part of the service recovery plan. The service acts as a key enabler for the wider system in terms of discharges and admission avoidance, and any projects or changes to patient flow could further increase the cost to CES and this needs to be recognised in relevant business cases/decision making. Without additional funding support, there is a risk that service capacity may not continue to meet the growing system demands, potentially affecting patient flow and care quality.	The management Executive Group have agreed a series of actions to support the services and discussions continue with system partners on funding issues and risk sharing.	1. No escalation

Originating Committee: Insight Committee			Date of meeting: 19 February 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*
	A recent Internal Audit report provided substantial assurance that robust governance and control mechanisms are in place, using the contract mechanism to maintain performance, avoid additional cost pressures and provide value for money. The service is gatekeeping effectively and looking for all opportunities to reduce costs.				

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.*

6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT

6.1. Improvement Committee Report - Chairs key issues (ATTACHED)

To Assure

Presented by Susan Wilkinson

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**	**Nutrition Steering Group** Must Risk Assessment <24 hrs Insufficient staff able to operate Cortrak machine for placement of enteral feed tubes Patients requiring parenteral nutrition cared for on designated wards (eg gastro and surgical)	3 2 2	Improvements seen, moving from special cause concern to common cause variation. This allows timely intervention / referral. Equipment uses electromagnetic sensing so fewer Xrays and more effective placement. Issue when nutrition nurse unavailable. Small audit suggests that safety & monitoring is much improved	Impact of early assessment in ED being reviewed. Ongoing 'food as medicine' QI programme. Ward managers monitoring performance. Gastro registrars may be trained, but with their turnover this may not be justified. ITU staff have been trained. Continued audits will be performed. ECare recording of PN should help compliance.	1
5.1 **PQSGG**	**Trauma Group** 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

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
	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**		
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**	**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

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
	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	

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
			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	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

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
			phototherapy monitoring devices		
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	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	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	1

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
		2	continues to identify highest risk. <u>Post-partum Haemorrhage</u> (>1500 ml) - ongoing quality improvement. Nov data shows 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	'Food as Medicine" workshop is in progress. 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.	
		1			
7.1	**<u>Deep Dive: Shared Decision Making</u>**	2	Very helpful presentation on the process by which patient, family, doctors and nurses make	Guidelines for CYP and adults without capacity are nearing completion. Future work on	1

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
			shared decisions. Required by GMC, LMC, NHSE, CQC. Mandatory training in place. Roll out to ACPs, nurses and midwives due April 2025. Trust's guidelines for adults with capacity are in place.	guidelines for EOLC, with anticipated benefits for patients and the Trust. Outcomes will 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	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	3

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
			in order to improve our CQC rating. We need to demonstrate the improvements made, eg to corridor care and safety issues.	patient safety culture – a practical guide", taking part in an ICB CQC leads meeting, and application to be part of CQC national work. 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

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
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 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.	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 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.	1
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	The situation will continue to be monitored, particularly in relation to Ockenden recommendations.	1

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
			vacancies for consultant obstetric anaesthetists.		
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.	1
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	Standardised templates (with some flexibility) will improve accountability and reporting, and the documentation of Divisional Board meetings. Process still in	1

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
			and based on different models. Strong governance is vital for the Trust and for CQC.	development, but the plan is to move to a governance framework. Completion aimed for summer 2025.	

**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: 19 February 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**	**Thrombosis Group** Consistent compliance with VTE assessments	1	This ensures that correct prophylaxis is given to reduce the risk of hospital-acquired VTEs	We have good assurance and will look at how this relates to outcomes and prophylaxis, using audit and other methods.	1
5.1 **PQSGG**	**Deteriorating Patient / Resus Group** Sepsis: improvement in taking of blood cultures; lactate results achieving target; administration of antibiotics and iv fluids in common cause variation.	2	Early sepsis recognition and treatment improves patient outcomes and shortens length of stay.	NICE sepsis guidelines have been updated and give more emphasis on high-risk patients. Internal monitoring will change (Spring 2025) due to e-Care provision. This should give more consistent assurance.	1
	BLS: Current compliance levels 80% for trust overall (88% nursing staff, 58% medical staff). We need to improve our assurance.	2	Prompt BLS is key for survival to discharge. NCAA data suggests WSFT is performing well against national average despite low compliance	Additional training starting Jan 2025 to support 90% ambition. BLS has been introduced to all inductions, and F2F training at	

Originating Committee: Improvement Committee			Date of meeting: 19 February 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
	Call for Concern (C4C): 78 calls since launch, 31% calls appropriate use of service	2	Increase in calls in Dec, possibly following cease of Clinical Helpline. Jan calls have reduced to expected levels. Use of service now being assessed, and better communication is a recurrent theme.	the place of work should improve medical compliance. C4C team working with patient experience team. If inappropriate calls remain high, this will be looked at further.	
5.1 **PQSGG**	**<u>Dementia / Delirium and Frailty Steering Group</u>** Dementia pathway in development following successful implementation of delirium pathway. Restrictive practice: panel planned for Q4 to review restrictive interventions and the legal frameworks in place.	2 2	A clear pathway will help continuity of care and also ensure that ward-based interventions are in place before specialist advice is sought. Initial focus on physical restraint but may expand to chemical restraint after pilot. Restrictive practice should be proportionate to the risk of harm.	Working group to be set up and implementation to be monitored. We have a duty to protect our staff as well as our patients. Pilot areas G5 and G10.	1

Originating Committee: Improvement Committee			Date of meeting: 19 February 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
	Delirium Discharge Nurse activity: High numbers of referrals in this quarter. Concerns regarding cessation of external funding of the role.	1	Supporting discharge of patients admitted with an associated delirium helps patient experience and also patient flow through the organisation.	Review shows a potential cost saving of 142 bed days per quarter and a positive impact on patient flow. Submission made to ICB and funding tbc.	
5.1 **PQSGG**	**<u>Mortality Oversight Group</u>** SHIMI data shows lower than expected deaths (0.85)	1	Indicative of good safe care. We are performing best in the East of England.	Good assurance. Continue monthly monitoring and reporting.	1
5.1 **PQSGG**	**<u>Human Tissue Authority / Mortuary</u>** No reportable HTA incidents in last quarter. Eden Software live since Dec 2024. Used by mortuary, bereavement and medical examiner services. Fuller Report: Pre-emptive action already taken by mortuary	1 1 1	These are serious incidents or near-misses in licensed mortuaries that may affect the dignity of the deceased. This gives better management of deceased patients' records and helps to minimise risks. Fuller Report published 2023 following unauthorised access to mortuary at Maidstone and Tunbridge Wells NHS Trust by a	Continue to monitor. Continue use. Swipe card access and CCTV installed on mortuary door.	1

Originating Committee: Improvement Committee			Date of meeting: 19 February 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
	services following phase 1 recommendations.		member of staff and subsequent criminal acts.	Working with ICB to arrange supportive peer review visits.	
5.2 **CEGG**	**<u>Accreditation – Point of Care Testing</u>** (POCT)	3	POCT are working through accreditation device by device, currently looking at blood gas analysers.	Expanding virtual ward is one of the challenges. Accreditation not yet applied for but believed to be achievable.	1
5.2 **CEGG**	**<u>Accreditation - Endoscopy</u>**	2	Accreditation looks particularly at clinical quality, patient experience, workforce and training. No outstanding action plans. Challenges include expansion of endoscopy to Newmarket in 2025/26, and endoscopy is one of the last departments to go live for Concentric.	Accreditation renewal due May 2025 and believed to be achievable. .	1

Originating Committee: Improvement Committee			**Date of meeting: 19 February 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
5.2 **CEGG**	**Life Cycle of a Clinical Audit** MBRRACE (mothers and babies: reducing risk through audit and confidential enquiries)	1	National reporting and audit mechanism for analysing results. BAME over-representation in reports is recognised and analysed. JADE team and other initiatives to help.	Regularly discussed at MatNeo Safety meetings	1
5.2 **CEGG**	**Life Cycle of a Clinical Audit** SSNAP (Sentinel Stroke National Audit Programme)	3	National QI programme covering whole patient journey. WSFT has always scored very highly with an ongoing 'A' rating.	Significant update to SSNAP due to advancements in treatments and updated guidelines. Many changes will be hard to achieve with resource constraints and it is anticipated that we will score a 'C'. Meetings planned with ICB and integrated stroke delivery network to discuss.	1
5.2 **CEGG**	**Clinical Audit Programme Update** A local project in Surgical Division to increase engagement in audit	1	This is in line with the ConsultOne Well-led report regarding benefit and learning from audit.	Ongoing Trust initiatives to improve audit learning and outcomes.	1

Originating Committee: Improvement Committee			**Date of meeting: 19 February 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
5.2 **CEGG**	**Getting it Right First Time** (GIRFT). A national programme to improve patient care using data-driven evidence. CEGG receives quarterly updates.	3	GIRFT has a structure in place for preparation of reviews, but no structure for coordinating the response to reviews, and no governance framework. We have limited assurance about implementing GIRFT recommendations.	Development and agreement of a governance framework.	1
6.1 Including 6.2	**Integrated Quality and Performance Report (IQPR)** **Performance Review Meetings (PRM Packs)**	2	IQPR will be refreshed in line with NHS 2025/26 priorities and operational planning guidance. C diff remains in common cause variation and continues as a key priority. HCAIs pose a serious risk to patients, staff and visitors, and can increase length of stay. The new strain remains a significant threat nationally.	The narrative for metrics will be more concise in the future so that key points stand out. QI Programme ongoing, will run to at least Oct 2025. Ongoing work with community colleagues regarding anti-microbial stewardship. C diff deep dive postponed to next month.	

Originating Committee: Improvement Committee			Date of meeting: 19 February 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
			PPH – ongoing QI Programme which is monitored through various regulatory mechanisms. PPH following vaginal delivery showed special cause concern, and following LSCS showed uncontrolled variation. Nutritional Assessments within 24 hours reduced in December, partly due to patients who remained in ED over 24 hours. The MUST score was completed on admission to the ward. Patient Safety Incidents and Reportable Occurrences remain stable and within expected limits.	QI 3rd cycle launched. Ongoing work to deep dive into causes of PPH. The effectiveness of the ED short assessment will be assessed next month once more data is available. Improvements in UEC performance will enable earlier nutritional assessments. 'Food as medicine' workstreams continue.	
7.1	**Quality Priorities 2025/26: UEC Care Pressures** Under our Quality Accounts, we are required to provide a description of future areas for improvement, and describe	2	Priorities for 2024/25: -To deliver measurable improvements in safe care through implementation of our patient safety strategy. This will be measured through the quality	Progress reports for 2024/25 priorities will be provided to March meeting.	1

Originating Committee: Improvement Committee			Date of meeting: 19 February 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
	achievements against the previous year's priorities.	3	of discharge summaries, and also through the rates of HCAI C. diff infections. -To reduce inequalities in experience of care. This will be measured through various measures, including recording of information on e-Care, accessibility improvements, completion of the Equality Delivery System by March 2025. **<u>Proposed quality priorities for 2025/26</u>**: -<u>Temporary Escalation Spaces</u> Important for patient safety and experience, ability of staff to deliver care, and staff morale. Measured through audit and various data, looking at harm, incidents, experience & risk.	Improvement Committee will receive final draft of the annual report in the April meeting, following sub-group meetings to discuss this. Both proposals agreed by the committee. Progress reported to PSQGG, and quarterly updates will be provided to Improvement Committee. A TES quality group has been created to develop reporting metrics and support improvement of flow alongside operational performance.	

Originating Committee: Improvement Committee			**Date of meeting: 19 February 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
			-Getting it Right for Patients and Staff: place, service, pathway. This was chosen at a trust-wide safety summit. Aim is to improve communication about the placement of patients, handovers, minimise ward moves, follow correct referral processes, and ensure the right patient is cared for in the right place	A multi-professional project group will be formed, and a programme of improvements developed using QI methodology. We need to ensure the right information is captured. This will be reported to Improvement Committee quarterly.	
7.2	**Transfer of Care Group: Update on Discharge Summaries** Need to improve quality of information as well as the %. Various workstreams in place. Improvement Cttee metrics:	2	Target for getting the letter to the GP within 24 hours is 95% and we currently achieve about 80%. Delays risk safety incidents, complaints and poor patient experience. Governance: clinical guidelines approved; performance data shared at departmental meetings.	Improvement work has been initiated to help achieve the objectives. In-patients and ED need particular efforts. Communication to be delivered throughout March via Staff Bulletin, MD bulletin, Intranet page, Resident doctors' WhatsApp group, All Staff Update.	1

Originating Committee: Improvement Committee			Date of meeting: 19 February 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
		2	Staff engagement & training: plan agreed and scheduled for promotion March 2025 e-Care: latest Oracle model provides an improved method for creating the ToC documentation. New ways of working are being explored, eg protected time for completion. Long-term opportunities: AI and Computer Assisted Design (CAD) are being explored by other organisations	Revised workflow to be demonstrable by April, and training May / June. Future possibilities	
7.3	**Response to RCN Corridor Care Priorities** RCN report is sobering reading and a carefully considered response is important, respecting the impact on both patients and staff.	2	Temporary Escalation Spaces (TES) impact patient care and safety, and also the ability of staff to deliver care and affect staff morale. RCN survey found that 67% of nursing staff respondents had delivered care in TES; >90% felt patient safety is compromised in these spaces;	WSFT regularly uses TES and we do not consider this appropriate or best practice. We have clear governance around TES use, and our SOPs and escalation plans aim to ensure that our most vulnerable patients are not nursed in TES. We	1

Originating Committee: Improvement Committee			Date of meeting: 19 February 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
			many patients have their privacy and dignity compromised. WSFT TES spaces are 3 corridor spaces in ED (regularly used over winter period); 4 spaces in AAU external corridor (used 14 times since recording commenced in Q3); and 'Arrive by 9' spaces on most inpatient wards (regularly used and important for patient flow). We discussed that >12-hour ED stays are equivalent to a TES.	addressed these issues in a deep dive in August 2024. PALS have surprisingly little data relating to TES and will add a flag so that data is more easily captured. TES Oversight Group established to audit and monitor TES use and outcomes. Mandatory reporting will occur via this group. For review in 3 months.	
7.4	**Maternity Report:** 60 Safer Steps	1	This was a regional assessment of safety and care provision. The feedback was very positive, and we were complemented on communications, governance structures, staff feedback, and student integration.	Some recommendations were made but none of them was considered a major issue.	1

Originating Committee: Improvement Committee			**Date of meeting: 19 February 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
7.4	**Maternity Report:** Claims and Incident Quarterly Review	2	In the last 10 years claims for WSFT are about £32.3 million with the average claim about £1 million (30 claims). This represents 49% of the total value of claims against the Trust (a lower % than national average). Most claims are as expected and benchmarked. Cerebral palsy remains the biggest claim by value. Themes from incidents, complaints and mortalities were described in detail. How to support staff affected by these remains a high priority.	Ongoing monitoring to identify and mitigate risks. Learning points were identified from some of the events, eg the correct call cascade was an issue in multiple PPH reviews. High levels of pre-term births continue to be a problem: Trust rate is 7.8% against a national ambition of 6%. Securing testing equipment for predicting prem births has been an issue, and this will be followed up outside Improvement Committee.	1

Originating Committee: Improvement Committee			Date of meeting: 19 February 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

**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.

6.2. Quality & Nurse Staffing Report (ATTACHED)

To Assure

Presented by Susan Wilkinson

WSFT Board of Directors (Open)	
Report title:	Nursing, safe staffing report: **January and February 2025**
Agenda item:	6.2
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Susan Wilkinson, chief nurse
Report prepared by:	Daniel Spooner, deputy chief nurse

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 reports on safe staffing, fill rate, contributory factors, and quality indicators for inpatient areas for the months of January and February 2025. It complies with national quality board (NQB) recommendations to demonstrate effective deployment and utilisation of nursing and midwifery staff.

The paper identifies planned staffing levels and where unable to achieve, actions taken to mitigate where possible. The paper also demonstrates the potential resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives within the sphere of nursing resource management. This paper also demonstrates how nursing directorate is supporting the Trust's financial recovery ambitions, through the nursing and midwifery deployment group.

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

- High sickness levels in continued in M10 across both registered and unregistered workforce, signs of improvement in M11.
- Overall fill rate at 90% for all shifts and areas in M11
- CHPPD in special cause for concern
- Turnover saw small increase but consistently under 10% ambition.
- Highest number of compliments received in M10.
- Inpatient vacancy rate moved out of improvement trend to common cause variation

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

To continue to embed and monitor temporary spend and achievement of CIP whilst monitoring any potential safety implications.

Continued focus on recruitment and retention on nursing assistants

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

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

Nurse Staffing Report – January and February 2025

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the months of January and February 2025 (M10 and M11). It evidences how planned staffing has been successfully achieved and how this is supported by nursing and midwifery recruitment and deployment. This paper also presents the impact of achieved staffing levels including nurse and midwifery sensitive indicators such as falls, pressure ulcers, complaints and compliance with nationally mandated staffing such as CNST provision in midwifery. The paper will also demonstrate initiatives underway to review staffing establishments and activities to ensure nursing and midwifery workforce is deployed in the most cost-efficient way.

2. Background

2.1 The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly. This paper will identify safe staffing and actions taken in January and February 2025. The following sections identify the processes in place to demonstrate that the Trust proactively monitors and manages nurse staffing to support patient safety.

3. Key issues

3.1 **Nursing Fill Rates**

The Trust's safer staffing submission has been submitted to NHS Digital for January and February 2025. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, the previous four months. Appendix 1a and 1b illustrates a ward-by-ward breakdown for these periods.

	Day		Night	
Average fill rate (planned Vs actual)	Registered	Care Staff	Registered	Care staff
Sept 2024	90%	87%	96%	95%
October 2024	87%	85%	93%	93%
November 2024	87%	85%	95%	94%
December 2024	87%	87%	94%	93%
January 2025	85%	86%	91%	94%
February 2025	86%	84%	94%	95%

Table 1

Total average 'planned versus actual' staffing fill rates has moved to special cause for concern after falling below expected average for the past 5 months. Average fill across all shifts and disciplines are consistent at 90%. Night shifts are consistently above 90%.

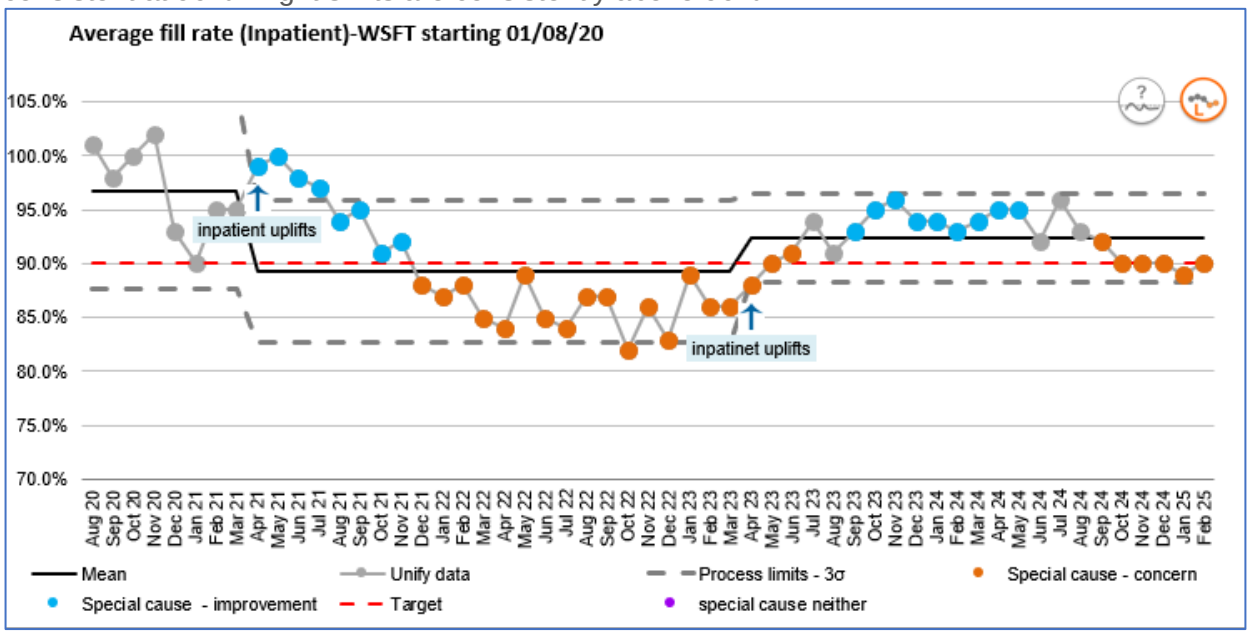


Chart 2

3.2 **Care hours per patient day**

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1a/b). CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care). CHPPD can be affected adversely by opening additional beds either planned or emergency escalation, as the number of available nurses to occupied beds is reduced. Periods of high bed occupancy can also reduce CHPPD.

Model hospital data suggests that WSFT is in the lowest quartile nationally, when bench marking against all other organisations with inpatients beds (Appendix 2 for full data set). This suggests that WSFT provides less care hours per patient than many organisations. When compared to our peer organisations [those of a similar size and service provision] we also rank in the lowest quartile and our position has deteriorated from last reporting period. This is likely to be linked to a number of drivers including escalating sickness rates, reduced bank fill and consistent staffing of escalation areas in M10 and 11.

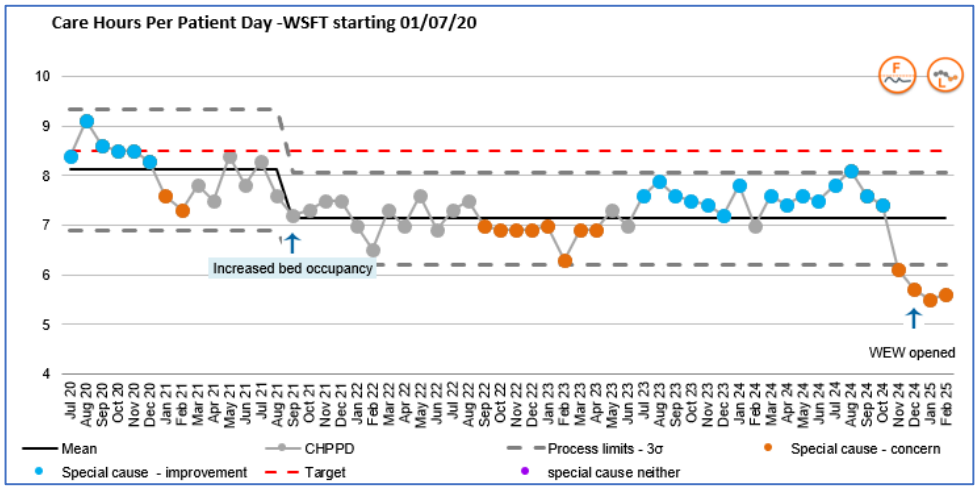


Chart 3

3.3 **Sickness**

January 2025 saw continued high levels of sickness in both staff groups, however as we have emerged from seasonal influenza, there is an improvement in sickness, correlated with reduced inpatient activity [of influenza A] in February 2025 (chart 4)

	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
Unregistered staff (HCSW)	7.95%	7.83%	6.94%	7.25%	6.55%	6.61%	7.76%	6.35%
Registered Nurse/Midwives	3.41%	3.37%	3.70%	4.79%	4.90%	5.54%	5.78%	5.14%
Combined Registered/Unregistered	**4.87%**	**4.78%**	**4.71%**	**5.55%**	**5.42%**	**5.87%**	**6.41%**	**5.52%**

Table 4

Chart 4

3.4.1 **Recruitment and Retention**

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

Table 5 demonstrates the total RN/RM establishment for the inpatient areas in whole time equivalents (WTE). The total number of substantive RNs has seen an improving trend, however inpatient vacancy rate has now moved into common cause variation. Full list of SPC related to vacancies and WTE can be found in appendix 2. Areas of concern remain within the non-registered staff group where vacancy percentage is higher. Vacancy rates compared with last reporting period are as follows.

- Inpatient RN/RM vacancy percentage has increased by 1.3% to **9.5%** at M11.
- Total RN/RM vacancy rate has also increased by 0.8% to **8.1%** in M11.
- Inpatient NA vacancy rate reduced by 0.6% to **11.8** in M11.
- Total NA vacancy has reduced by 0.6% to **11.6%** in M11.

Despite some small increases in vacancy rate inpatient WTE and vacancy percentage are in special cause improvement.

While NA WTE is in special cause concern, vacancy rates in both inpatient and overall have remained in common cause variation, suggesting budgetary changes have kept vacancy rate static.

	Sum of Month 6	Sum of Month 7	Sum of Month 8	Sum of Month 9	Sum of Month 10	Sum of Month 11	WTE vacancy at 11
RN	727.5	729.6	727.2	724.7	715.4	714.0	74.9
NA	388	380.3	384.3	383.3	384.3	386.0	51.7

Table 5 Inpatient actual substantive staff WTE.

3.4.2 **New Starters**

Table 6 demonstrates registered and non-registered staff commencing induction within the WSFT. Induction attendance for registered nurses has declined in the last 3 months.

	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25
RN/RM	19	24	17	5	4	6
NA	11	16	16	11	15	17

Table 6: Data from HR and attendance to WSH induction program.

- In January 4 registrants attended induction; of these; 1 RN was for the acute, 1 RN for community and 2 RMs for midwifery.
- In January, 15 NAs attended induction; of these; 9 NAs were for the acute Trust and 2 for bank staff and 4 for community services.

- In February 6 registrants attended induction; of these; 2 RNs were for the acute, 2 RN bank staff, 1 RN for community teams and 1 RM for maternity services.
- In February 17 NAs attended induction; of these; 11 NAs were for the acute Trust, 2 bank staff, 4 for community.

3.4.3 **Turnover**

On a retrospective review of the last rolling twelve months, turnover for RNs continues to positively be under the ambition of 10%. Small increases in both groups have been seen with RN turnover increasing to 5.6%. NA turnover saw an increase to 9.6%.

	Turnover	01/03/2024	-	28/02/2025			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,508.50	1,323.2814	74	63.4733	91	74.1200	6.0325%	5.6012%
Additional Clinical Services	617.00	522.0653	118	109.2133	62	50.4800	10.0486%	9.6693%

Table 7. (Data from workforce information)

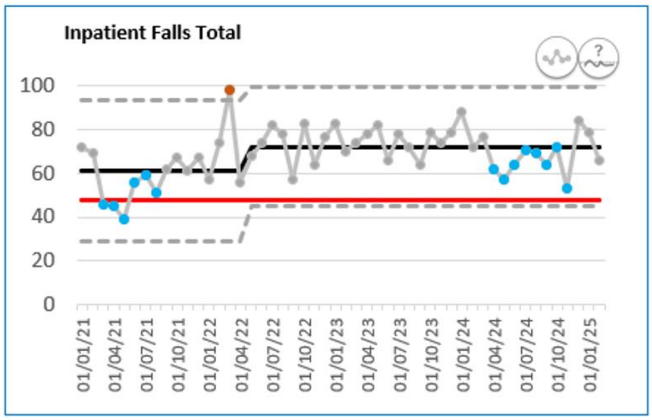
3.5 **Quality Indicators**

Falls and acquired pressure ulcers.

Improvement projects and oversight of these quality indicators are reviewed through the patient quality and safety governance group (PQASG).

Over the last six months, falls per 1000 bed days and overall falls entered special cause improvement in M8 however a spike in falls was seen in M9. Falsl per 1000 bed days has returned to levels similar to the previous improvement period and below average for this period (M10 and M11).

Pressure ulcers remain in common cause variation and incidents have been below expected average for four out of the past five months within the acute site. A spike in incidents occurred in January, however this was not sustained. A deep dive into community incidents has occurred for January and contributing factors are not consistent or indicative of a theme. Reason for incidents are multiple including concordance, patient choice, end of life and deterioration post inpatient stay and deferred visits. This will be explored further at PQSGG in March.



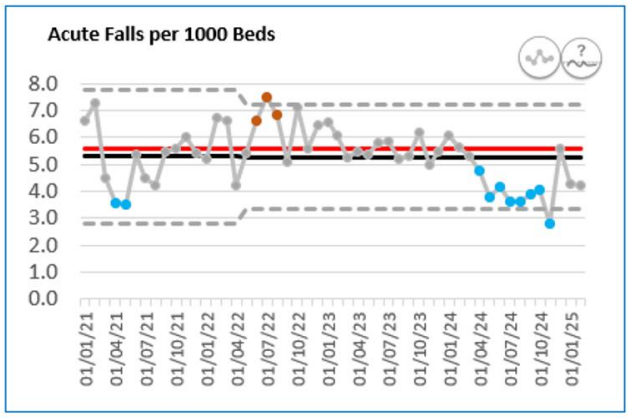
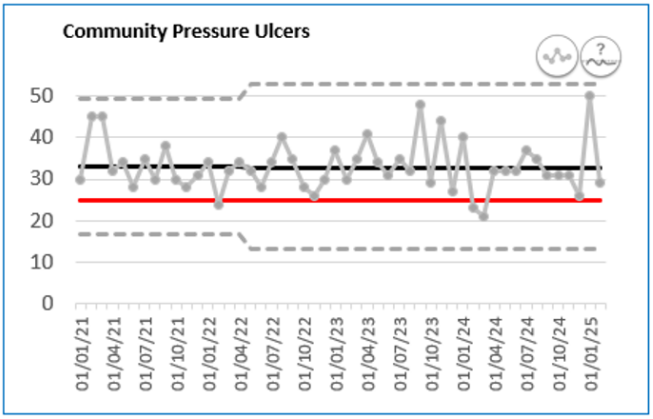


Chart 8 inpatient falls



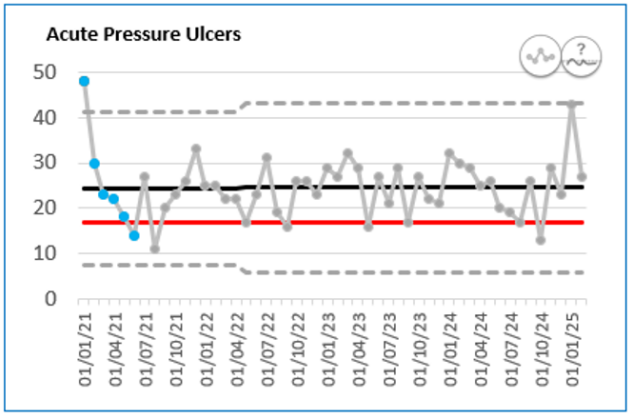


Chart 9 Pressure ulcers acquired in care.

3.6 **Compliments and complaints**

13 formal complaints were received in January. The most consistent theme this month was patient care, with a total of 6 formal complaints being listed under this subject. F8 and G10 each received 2 formal complaints making these the highest areas for the month.

19 formal complaints were received in February. The emergency department received the highest number of complaints this month with a total of 3 formal complaints. Orthopaedics received 2 formal complaints. The most common theme this month was clinical treatment with 7 complaints being listed under this heading. 3 complaints were listed under the subject communications.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period. The number of complaints for this period remains in common cause variation. Compliments is consistently improving in special cause and saw the highest number of compliments received in January.

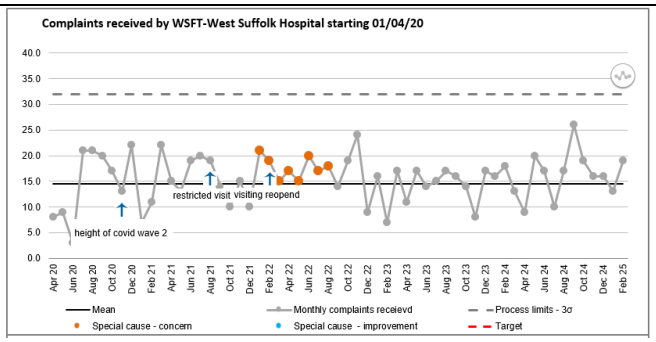


Chart 10a (complaints)

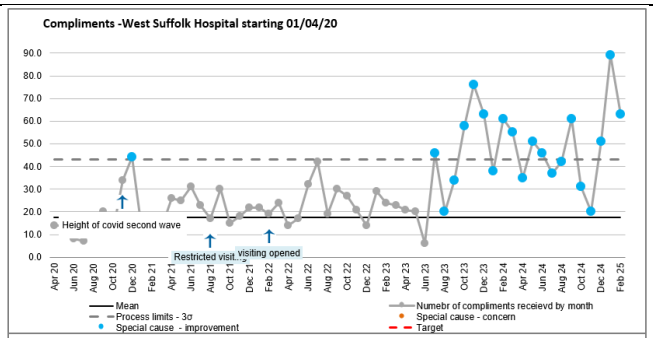


Chart 10b (compliments)

3.7 **Adverse staffing incidents**

January (M10) saw the largest number of incidents in the last year (chart 11). This coincides with the grip and control of 90% fill rate ambition, reduced bank fill and escalating sickness rates since September. This suggests that during this time, the resilience of staffing was reduced.

Red flags as per NQB (Appendix 4) are now able to be reported through RADAR from M9 and are demonstrated in chart 11.1. The most common red flag event for appears to be the inability to conduct regular intentional rounding at times of shortfall.

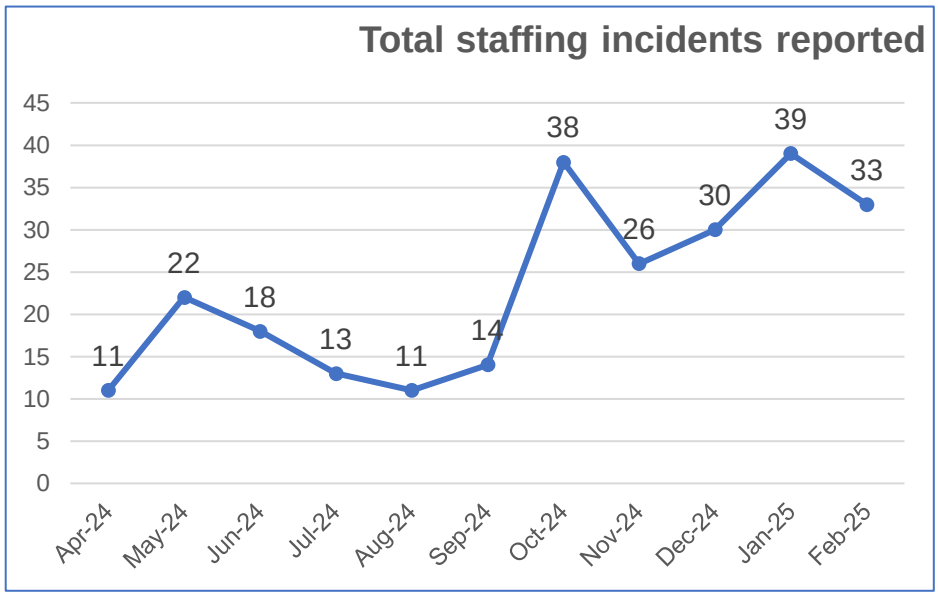


Chart 11

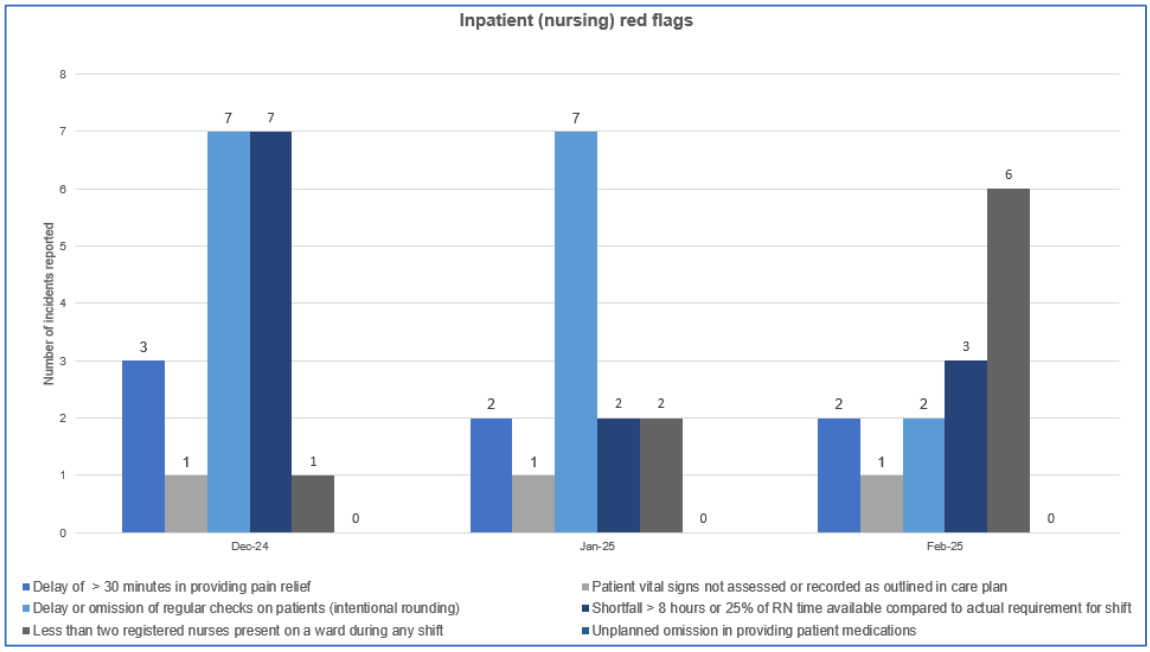


Chart 11.1

3.8 **Maternity services**

A full maternity staffing report will be attached to the maternity paper as per CNST requirements.

1:1 Care in Labour

The recommendation comes from NICE's second guideline on safe staffing in the NHS, which gives advice on midwifery safe staffing levels for women and their babies on whatever setting they choose. This recommendation is also 1 of the 10 safety actions published as part of the Maternity Incentive Scheme Year 6. Maternity services should have the capacity to provide women in established labour with supportive one-to-one care. This is because birth can be associated with serious safety issues and can help ensure that a woman has a safe experience of giving birth. Escalation plans have been developed to respond to unexpected changes in demand. In both January and February 2025 compliance against this standard was 100%.

Red Flag events

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as events that are immediate signs that something is wrong, and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Red Flags were previously captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle. In April 2024 the Trust introduced a new reporting system RADAR. In January 2025 two red flag event were reported, due to delay in induction of labour process. In February 2025 two red flag events were recorded due to delay in induction of labour process. No adverse outcome resulted from the occurrence.

Midwife to Birth ratio

The latest BirthRate plus review was undertaken in March 2023 and illustrated that Midwife to Birth ratio at West Suffolk NHS Foundation Trust should reduce to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services, total number of women having community care irrespective of place of birth and primarily the configuration of maternity services

- January 2025 Midwife to birth ratio was 1:21
- December 2024 midwife to birth ratio was 1:18.4

Supernumerary status of the labour suite co-ordinator (LSC)

This is one of the Maternity Incentive Scheme Year 6 safety actions requirements and was also highlighted as a 'should' from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice. 100% compliance against this standard was achieved in both January and February 2025.

	Standard	August	September	October	November	December	January	February
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:24	1:23	1:19	1:18.3	1:20.6	1:21	1:18.4
No. Red Flags reported	NA	3	2	0	0	2	2	2

Table 12

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

Sickness & Turnover

Special cause improvement in both turnover (chart 13a) and sickness (chart 13b are under trust target ambition. Some areas observed high sickness in January, however overall sickness is at 4.75%in January and 4.81% in February

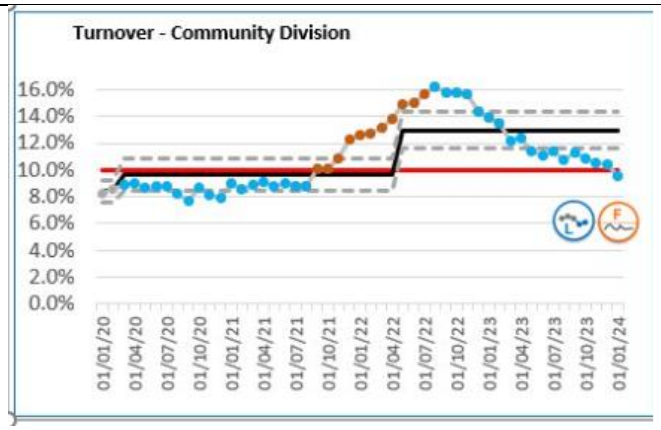


Chart 13a

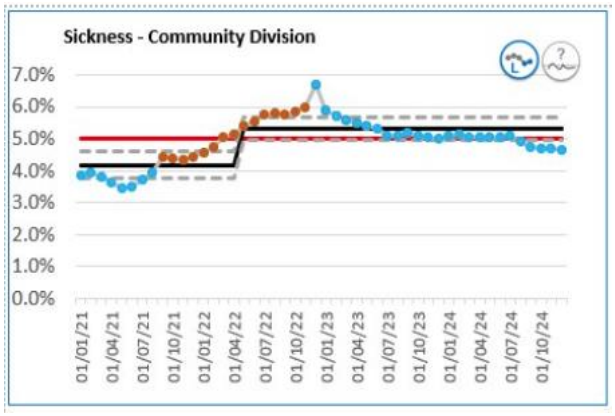


Chart 13b

Demand

The demand for community nursing services continues to increase (chart 14), this has been an increasing trend for the past 18 months.

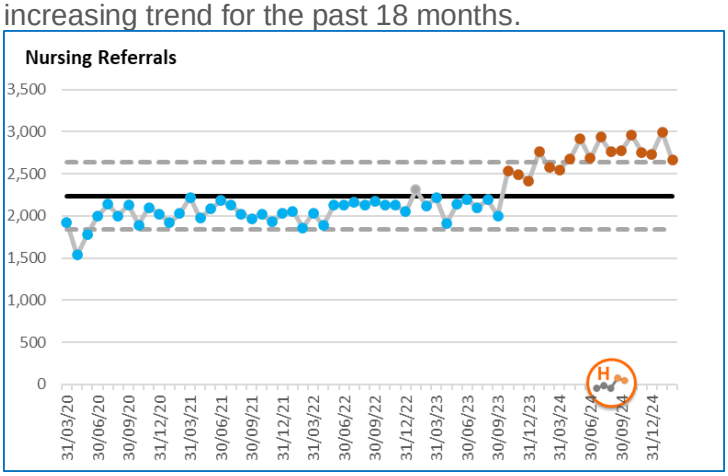


Chart 14

The division has begun to review the clinical impact of the increase in demand by measuring the number of cancelled care plan hours per week, as the clinical team's triage, defer and manage their visits (chart 15). This often involves deferring visits to the following day if the visit has been triaged as a lower priority. The harm this causes is difficult to monitor, senior matrons are completing a manual audit of some of the deferred, or cancelled care. The audit results show that 2 patients came to minor harm because of their care being deferred. This is being monitored and staff are supported to complete RADARs if a delayed visit is perceived to have contributed to any patient harm.

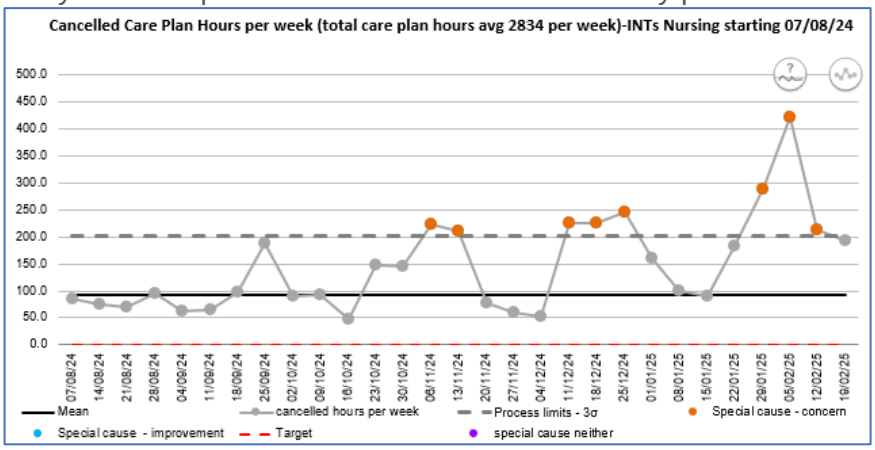


Chart 15

Community based actions

- Senior matrons to continue monthly audit, checking sample of patients with deferred care to see if harm has occurred and if radar is completed. Provide feedback loop to DNs for assurance of prioritisation.

- The Community Nursing Safer Staffing Tool (CNSST)has been re-launched. The trust is signed up to this and will be planning to take part in the audit which measures dependency of demand and recommends nursing establishment.
- CNSST will provide opportunity to carry out in depth review of skill mix, to see if correct to meet the dependency and acuity of patients.
- THE INTS , EIT and Virtual ward are involved in a shared services integration projects, this has shown an improved capacity in the virtual ward in January. There are 4 out of the 6 INTS supporting virtual ward work.
- INT teams continue to utilise the daily capacity dashboard use to support any staff moves and reviewed on weekly basis to review rosters for the 2 weeks ahead and to manage daily escalations for urgent issues relating to capacity.

4. Next steps/Challenges

4.1 **Nursing Resource oversight Group**

The Nursing Deployment Group continue to meet monthly to review best practice methods of deploying staff and to reduce the temporary nursing spend. Interventions include the commencement of a better rostering subgroup to fully utilise eRostering modules, stringent control over agency and overtime spend and reducing high-cost temporary nursing shifts. The reduction in temporary spend is demonstrated in the chart 11 below. M11 illustrates a move from special cause improvement to common cause variation. The uptick in temp spend will be explored at the next NMDG [at the time of writing] to understand drivers for this.

Regular agency use has been all but eliminated in all areas, and sourcing high cost is managed by exception only.

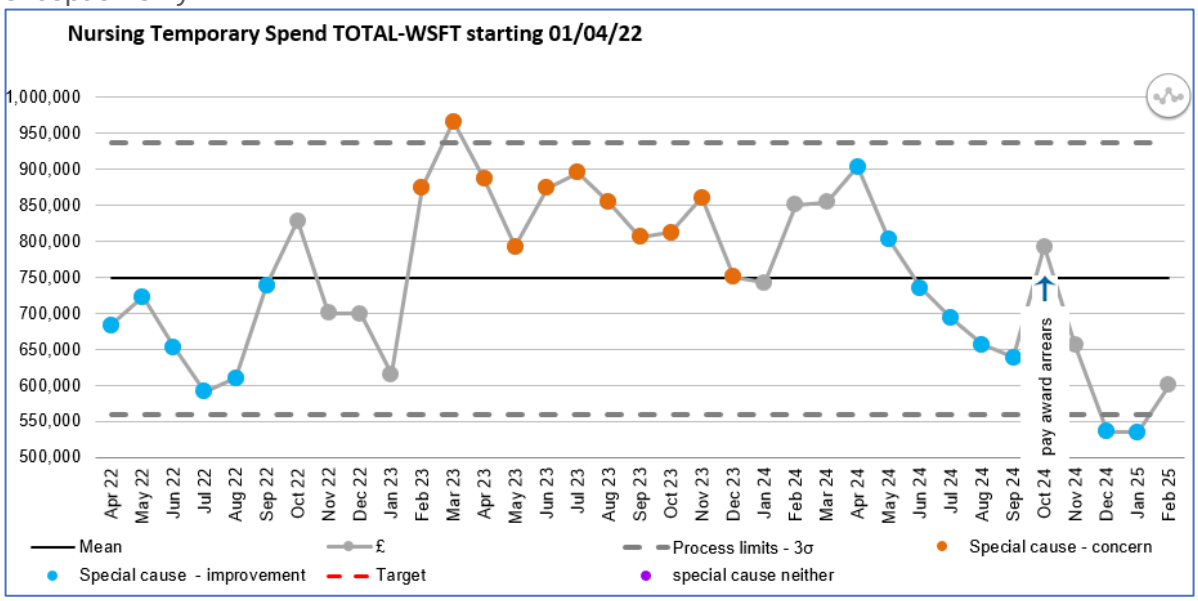


Chart 12

Nursing spend came in underbudget in M11 and is currently forecast to end this financial year under budget (table 12.) in the region of 1.4 million. While this is encouraging, continued focus on reducing run rate is required to achieve final ambitions.

Pay Category	In Month Budget	In Month Actual	In Month Variance	YTD Budget	YTD Actual	YTD Variance	FY Budget	FY Forecast	FY Variance	WTE Bgt	WTE Act	WTE Var
Agency	16,737	16,433	305	184,107	414,414	(230,307)	200,844	430,293	(229,449)	0.01	3.95	(3.94)
Bank	21,329	584,078	(562,749)	222,090	7,135,264	(6,913,173)	244,607	7,857,854	(7,613,247)	0.27	135.85	(135.58)
Substantive	8,787,376	7,952,093	835,283	96,448,647	87,367,436	9,081,210	104,624,466	95,344,599	9,279,867	2,143.53	1,938.92	204.61
Grand Total	**8,825,442**	**8,552,603**	**272,838**	**96,854,844**	**94,917,114**	**1,937,730**	**105,069,917**	**103,632,747**	**1,437,170**	**2,143.81**	**2,078.72**	**65.09**

Table 12.

5. Conclusion

5.1 Registered nurse recruitment continues positively and the trust vacancy rate for both inpatient and total nurses and midwives is consistently under 10%. Nursing assistant recruitment has remained static.

	Average fill rate for inpatient planned staffing is consistent at 90%, but day shifts for RNs has been below 90% for the last five months, this has been driven by escalating sickness rates that have meant that the 90% fill rate ambition was negatively overachieved. High levels of sickness have impacted on nursing shift fill rates, however early signs in M11 suggests that this may be improving. The focus on temporary spend continues and nursing and midwifery pay is on track to be underbudget at year end. Continued focus on the impact of robust nursing and midwifery deployment controls will continue monitoring both activity and quality impact.
6.	**Recommendations**
	For the board to take assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments,

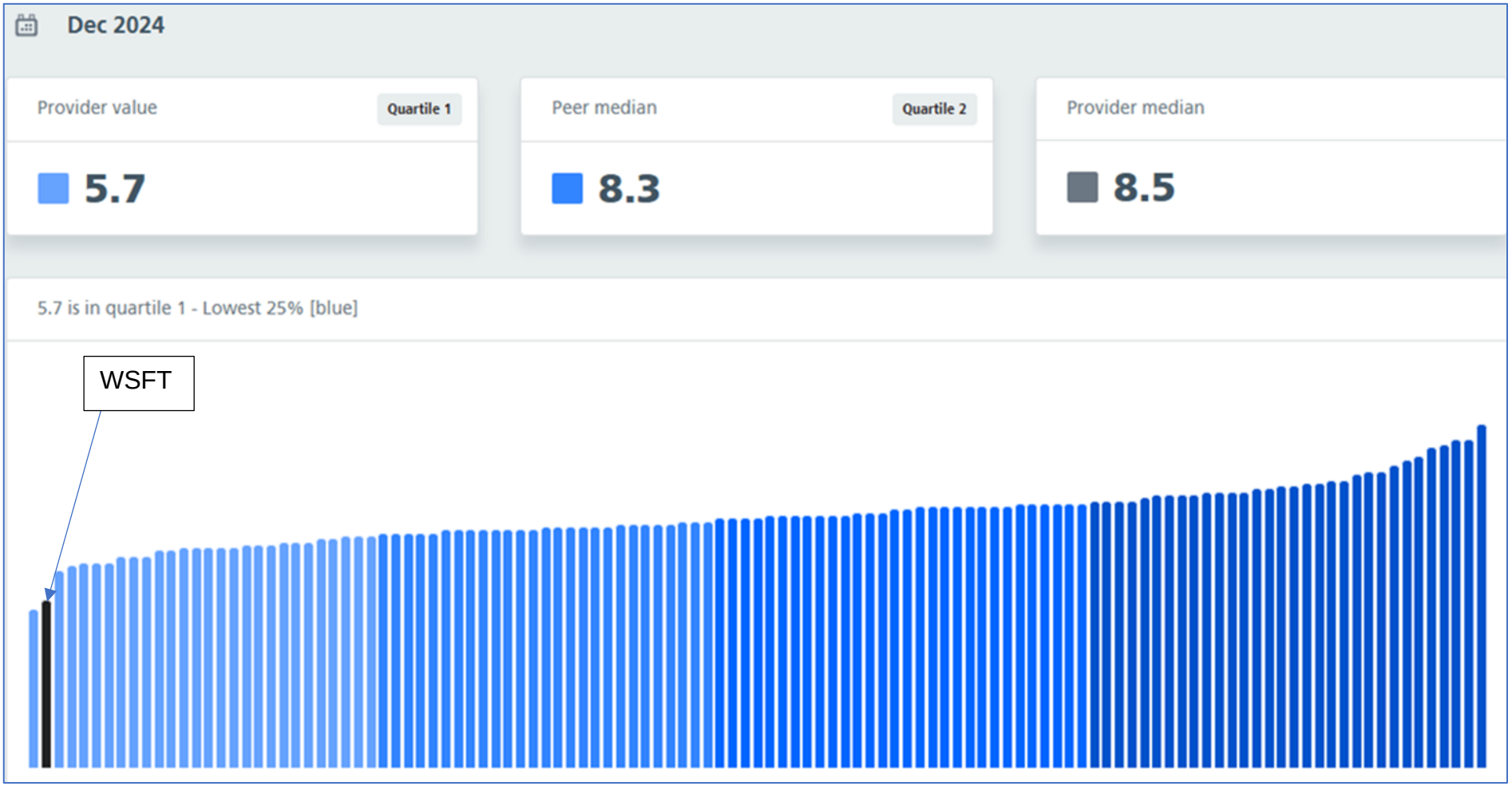
Appendix 1a. Fill rates for inpatient areas (January 2025) Data adapted from NHSE Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1430	1387.5	1775.75	1541.25	1069.5	1066.5	1426	1362	97%	87%	100%	96%	986	2.5	2.9	5.7
Glastonbury Court	719	721.5	1069	1053	713	713	536	531	100%	99%	100%	99%	590	2.4	2.7	5.2
Acute Assessment Unit	2313.5	2165.6667	1911.75	1719.5	1736.5	1641.25	1368.5	1320.75	94%	90%	95%	97%	1078	3.5	2.8	6.8
Cardiac Centre	1776.5	1539.5	1064	738.5	1782.5	1552.75	713	634	87%	69%	87%	89%	845	3.7	1.6	5.5
G10	1778	1403.25	1773.5	1509.25	1069.5	867	1782.5	1677.5	79%	85%	81%	94%	1322	1.7	2.4	4.1
G9	1748	1493	1417	1261.5	1403	1368.5	1069.5	1012	85%	89%	98%	95%	1072	2.7	2.1	4.9
F12	563.5	619	352	282.25	713	444	356.5	357.5	110%	80%	62%	100%	363	2.9	1.8	4.9
F7	1775	1396	1773.5	1470.75	1426	1128.75	1782.5	1464	79%	83%	79%	82%	1583	1.6	1.9	3.7
G1	1425.5	971.5	345	232.5	713	713	356.5	322	68%	67%	100%	90%	456	3.7	1.2	5.5
G3	1752	1365.75	1777	1599.5	1069.5	1003.25	1426	1452.5	78%	90%	94%	102%	1083	2.2	2.8	4.9
G4	1801	1484.5	1780	1513.25	1069.5	897	1426	1381	82%	85%	84%	97%	1156	2.1	2.5	8.8
G5	1633	1345.1667	1761.75	1567.5833	1058	970.5	1426	1406.5	82%	89%	92%	99%	217	10.7	13.7	24.2
G8	2364	1821.1667	1767.25	1411.75	1621.5	1575.25	1069.5	1037	77%	80%	97%	97%	1203	2.8	2.0	5.0
F8	1777.5	1421.3333	1716	1335.3333	1069.5	779	1426	1389.75	80%	78%	73%	97%	1032	2.1	2.6	4.9
Critical Care	2821	2353.5	150	132.25	2496	2293.25	0	0	83%	88%	92%	*	218	21.3	0.6	20.4
F3	1674.5	1380	1745	1578.5	1069.5	1022	1414.5	1390.75	82%	90%	96%	98%	1187	2.0	2.5	4.8
F4	885.5	747.5	604.75	416.5	690	478.5	471.5	392	84%	69%	69%	83%	274	4.5	3.0	8.9
F5	1706	1402.75	1372	1198	1035	1012.666667	1069.5	1016	82%	87%	98%	95%	614	3.9	3.6	7.6
F6	1478.5	1328.75	1642	1432	1058	1055.5	1384	1270.5	90%	87%	100%	92%	1474	1.6	1.8	3.6
Neonatal Unit	1907.5	1432.5	372	498	1116	996	744	576	75%	134%	89%	77%	147	16.5	7.3	19.7
F1	1827	2028.5	713	644	1437.25	1415.25	0	0	111%	90%	98%	*	247	13.9	2.6	14.5
F14	372	372	372	372	744	732	0	0	100%	100%	98%	*	290	3.8	1.3	5.1
F10 (WEW)	1315	1214	1419	1047.1167	885.5	770.5	1403	1276	92%	74%	87%	91%	1234	1.6	1.9	0.8
Total	36,843.50	31,394.33	28,673.25	24,554.28	27,045.25	24,495.42	22,651.00	21,268.75	**85%**	**86%**	**91%**	**94%**	**18671**	**3.0**	**2.5**	**5.5**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

Appendix 1b. Fill rates for inpatient areas (February 2025) Data adapted from Unify submission.

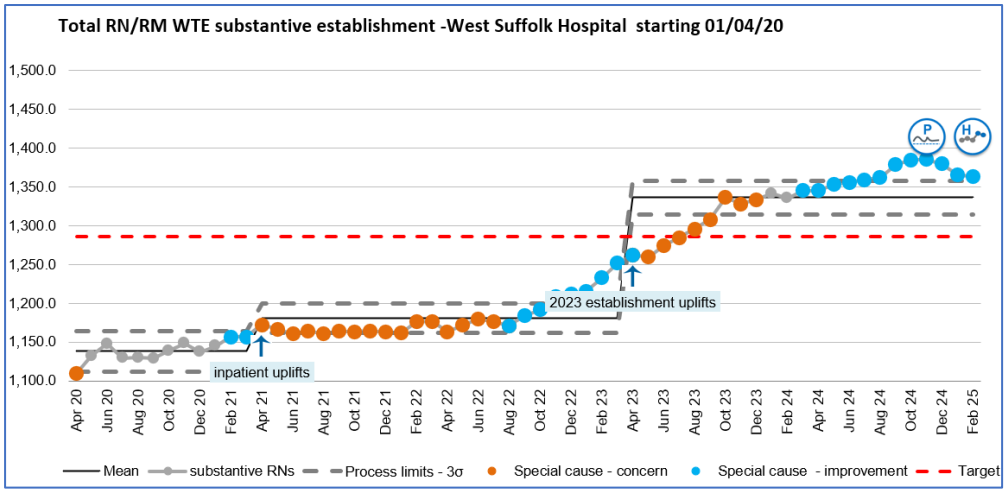
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1289.75	1240.75	1609.75	1510.5	966	958.5	1288	1277.5	96%	94%	99%	99%	949	2.3	2.9	5.3
Glastonbury Court	644.5	644.5	965.5	932.5	644	644	488	484	100%	97%	100%	99%	613	2.1	2.3	4.4
Acute Assessment Unit	2089	2015	1849	1715.9167	1598.5	1553	1265	1206.75	96%	93%	97%	95%	940	3.8	3.1	6.9
Cardiac Centre	1600.5	1389.75	947.16667	677.21667	1610	1455.5	644	543.5	87%	71%	90%	84%	755	3.8	1.6	5.4
G10	1604.5	1288.25	1606	1456.5833	965	877.75	1608	1522	80%	91%	91%	95%	1215	1.8	2.5	4.2
G9	1587	1426	1288	1089.75	1288	1288	966	956.25	90%	85%	100%	99%	942	2.9	2.2	5.1
F12	609.5	558.5	317.5	207	644	513.5	322	286.583333	92%	65%	80%	89%	332	3.2	1.5	4.7
F7	1607.5	1183.75	1610	1258.5	1288	1013.5	1610	1435.5	74%	78%	79%	89%	1345	1.6	2.0	3.7
G1	1233	876	321	240	644	644	322	299	71%	75%	100%	93%	423	3.6	1.3	4.9
G3	1594	1291.25	1600	1378.25	966	924	1288	1311	81%	86%	96%	102%	917	2.4	2.9	5.3
G4	1597	1317	1602.25	1382.75	966	828.5	1288	1303	82%	86%	86%	101%	981	2.2	2.7	4.9
G5	1525	1241.25	1588.75	1238.5833	965.5	942	1288	1295.5	81%	78%	98%	101%	229	9.5	11.1	21.1
G8	1940.75	1664.1833	1371.9167	1369.9167	1598.5	1498.666667	966	965.5	86%	100%	94%	100%	1087	2.9	2.1	5.1
F8	1610	1279.0333	1594.25	1168.3333	957.5	752	1288	1276	79%	73%	79%	99%	944	2.2	2.6	4.7
Critical Care	2319.5	2107.1667	105	98.75	2199.16667	2095.25	0	0	91%	94%	95%	*	198	21.2	0.5	21.7
F3	1571	1405.5	1568.75	1309.5	966	964.5	1288	1308.5	89%	83%	100%	102%	1054	2.2	2.5	4.7
F4	828	773	551.25	357.83333	609.5	483	414	317.333333	93%	65%	79%	77%	183	6.9	3.7	10.6
F5	1552.5	1297.0833	1241.25	975.41667	966	989	966	875	84%	79%	102%	91%	479	4.8	3.9	8.6
F6	1489	1236.75	1535.3333	1195.7833	918.5	916.5	1270.5	1198.5	83%	78%	100%	94%	1324	1.6	1.8	3.6
Neonatal Unit	1707	1296.75	336	396	1008	844.5	672	468	76%	118%	84%	70%	119	18.0	7.3	25.3
F1	1640	1524.25	644	561.25	1288	1276.5	0	0	93%	87%	99%	*	222	12.6	2.5	15.1
F14	327.5	315.5	332.25	325.75	672	672	0	0	96%	100%	100%	*	312	3.2	1.0	4.2
F10 (WEW)	1180	1127	1257.5	863	701	712.5	1288	1229	96%	69%	102%	95%	1101	1.7	1.9	3.6
Total	33,146.50	28,498.22	25,842.42	21,709.08	24,429.17	22,846.67	20,529.50	19,558.42	**86%**	**84%**	**94%**	**95%**	**16664**	**3.0**	**2.5**	**5.6**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

Appendix 2. CHPPD Model Hospital data (December data most recent accessed 18.3.25)

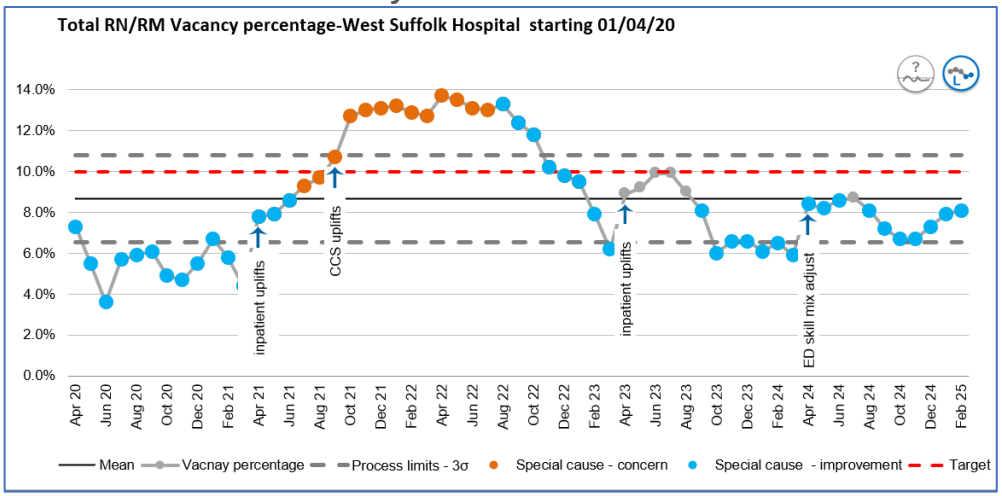


Appendix 3 WTE and Vacancy rates.

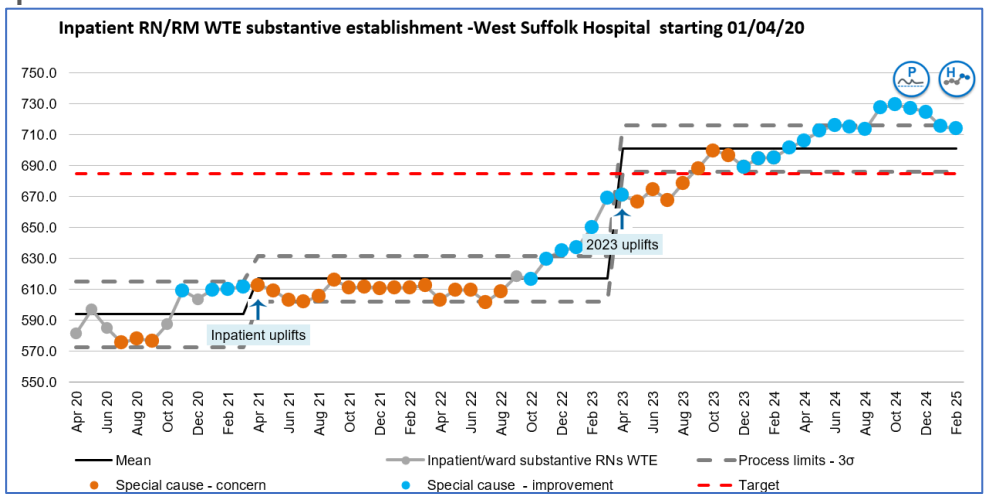
Trust Total RN/RM WTE



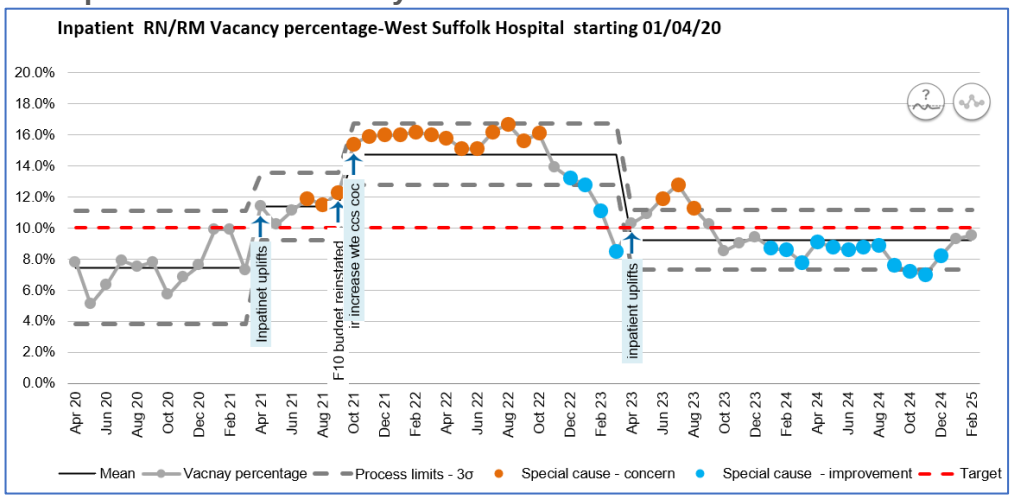
Trust Total RN/RM vacancy %



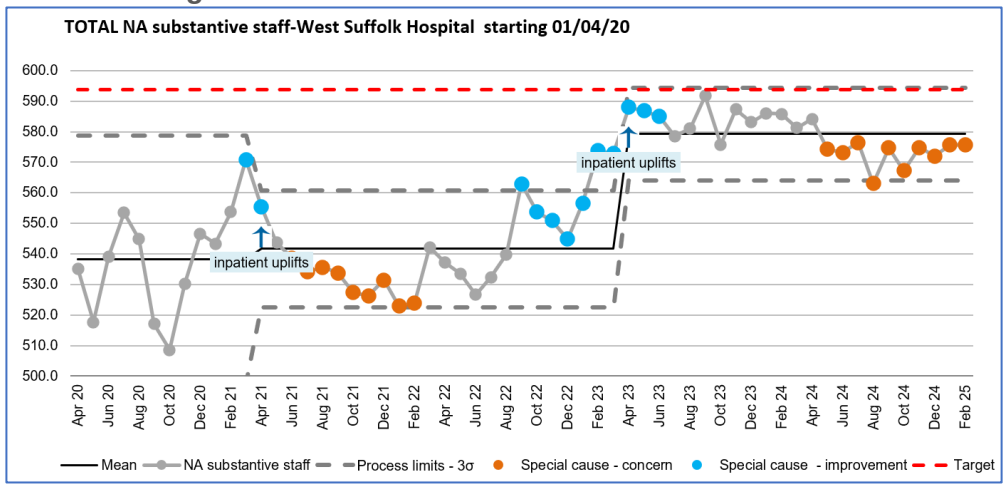
Inpatient RN/RM WTE



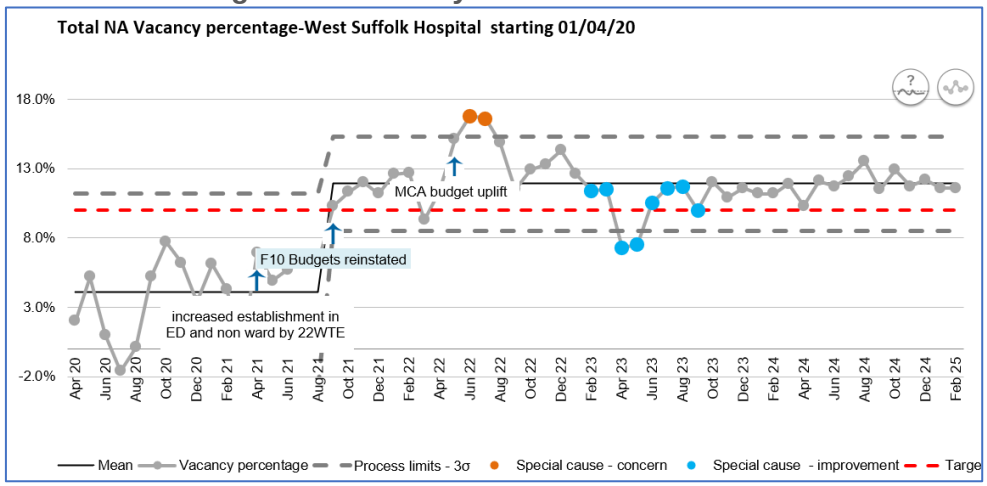
Inpatient RN/RM vacancy %



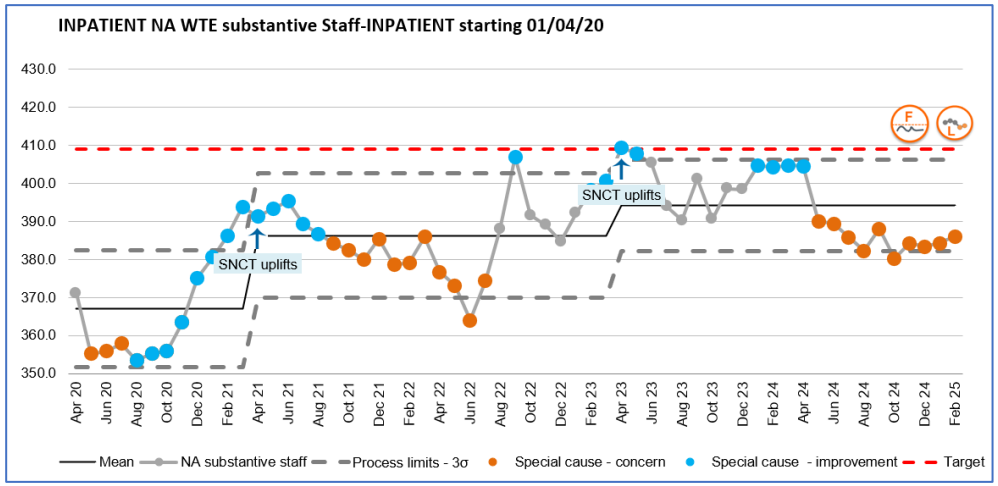
Total NA/unregistered WTE.



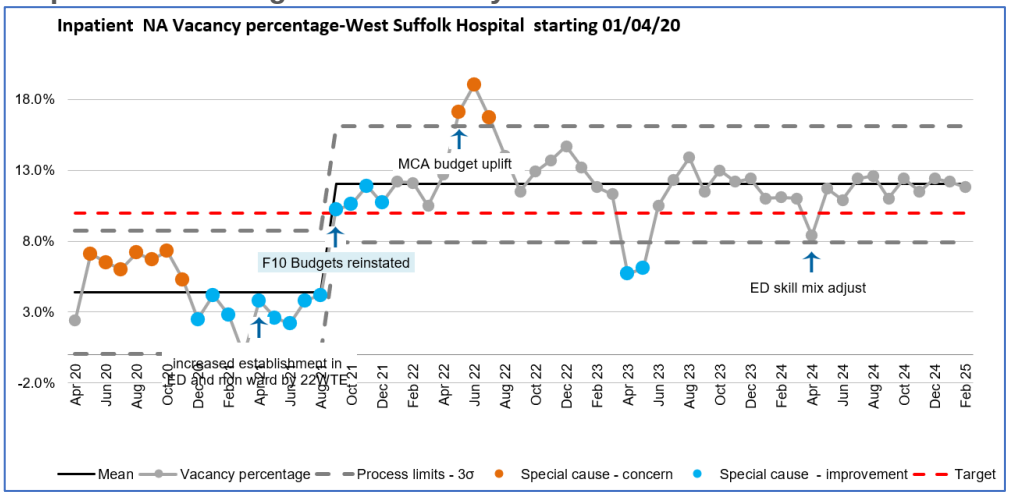
Total NA/Unregistered vacancy %



Inpatient NA/unregistered WTE



Inpatient NA/unregistered vacancy %



Appendix 4. Red Flag Events

Maternity Services

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per MEOWS
1:1 care in established labour not provided to a woman

Acute Inpatient Services

Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: • pain: asking patients to describe their level of pain level using the local pain assessment tool. • personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration. • placement: making sure that the items a patient needs are within easy reach. • positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift.
Fewer than two registered nurses present on a ward during any shift.
Unable to make home visits.

6.3. Maternity services report (ATTACHED)

For Approval

Presented by Susan Wilkinson and Karen Newbury

WSFT Board of Directors (Open)	
Report title:	Maternity & Neonatal quality, safety, and performance report
Agenda item:	Maternity and Neonatal services
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Richard Goodwin Medical Director & Executive Mat/Neo Safety Champion
Report prepared by:	Karen Newbury, Director of Midwifery Justyna Skonieczny Head of Midwifery

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

Executive Summary

WHAT?

This report presents a document to enable board scrutiny of Maternity and Neonatal services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives in line with the NHS Perinatal quality surveillance Model (Dec 2020).

This report contains:

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Training compliance for all staff groups in maternity related to the core competency framework.
- Reports approved by the Improvement Committee
- Closed Board reports, nil due this month
- Next steps

SO WHAT?

The report meets NHSE standard of perinatal surveillance by providing the Trust board a methodical review of maternity and neonatal safety and quality.

WHAT NEXT?

Action plans will be monitored and any areas of non-completion will be escalated as appropriate.
Quarterly, bi-annual and annual reports will evidence the updates.
As applicable, reports will be shared with external stakeholders as required.

Action Required

For assurance and information.

Risk and assurance:	As below
Equality, Diversity and Inclusion:	This paper has been written with due consideration to equality, diversity, and inclusion.
Sustainability:	As per individual reports
Legal and regulatory context	The information contained within this report has been obtained through due diligence.

Maternity quality, safety, and performance report

1.	**Detailed sections and key issues**
1.1	**Maternity and Neonatal improvement plan** The Maternity and Neonatal Improvement Board (MNIB) receives the updated Maternity improvement plan monthly. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, Maternity and Newborn Safety Investigations, external site visits and self-assessment against other national best practice (e.g., MBRRACE, SBLCBv3, UKOSS). It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) in October 2022, that NHSE regional team and ICS (Integrated Care System) will be invited to attend the MNIB monthly for additional assurance and scrutiny. NHSE regional team, Local Maternity and Neonatal System ICB members and the Lead for the Neonatal Operational Delivery Network, undertook a 60 Supportive Steps visit on the 31st January 2025, to provide a systematic review of the Trust's maternity and neonatal service. The day's feedback was overwhelmingly positive. Having now received the final report this is mirrored by all the good practices identified along with areas for consideration and /or further action. Due to the number of the latter (32) an action plan is under way and will be presented at April's Improvement Board. The impact of all changes is being closely monitored through various channels such as the Maternity and Neonatal Improvement Board, training trackers, dashboards, clinical auditing, and analysis of clinical outcomes for specific pathways. The Trust remains dedicated to making sustained improvements in quality and safety for women and pregnant people, babies, their families, and the staff working within the teams.
1.2	**Safety Champion feedback** The Board-level safety champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff can raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'. Roger Petter our Non-Executive Maternity and Neonatal Safety Champion visited maternity Triage on 21st January 2025 Due to high acuity on the unit, Roger had less opportunity to speak to staff than he would have liked. However, it was a good opportunity to see it operating smoothly when under pressure. The atmosphere was calm and controlled, with an impression of a well organised and well-run unit, with effective teamwork. No specific safety issues were raised affecting service users or staff. The only concern raised was that the clinical space available is rather cramped. This lack of space can impact on a patient's experience and could affect the ability to maintain confidentiality. However, if required, rooms are

	available for use elsewhere in the unit to overcome this.The staff spoken to felt well supported and no other concerns were raised. Roger visited obstetric theatres on 12th February 2025 where he spoke to a number of staff and gained the impression of a well-run team with good leadership and organisation. Generally, things are working very well, and much of the discussions related to communication Communication between the obstetric theatres and the maternity unit has improved since commencing joint QI projects and subsequent meetings. Occasionally a patient will arrive in theatres before the huddle has been completed, especially in emergency situations however key information needs to be shared in a structured way to ensure optimal safety. This will be captured in the 'transfer to theatre' QI work. Communication between theatre staff and members of the multidisciplinary team is also crucial, and the theatre staff are understandably keen that they feel listened to by all staff. An example was given whereby some staff felt that they were not adequately heard. Thankfully this case had a good outcome for the patient, but further work needs to take place to empower staff to be heard. The theatre team is very keen to continue improving relationships between theatres and the maternity unit and would welcome visits from midwives who are not familiar with attending theatre an initiative is starting to help with this to ensure that theatres are seen as a welcoming environment and that the theatre team seen as part of the wider maternity team which in turn will help to improve the experience for patients. The obstetric emergency study days are seen as an important training programme to help patient safety and outcomes. Unfortunately, not all staff are able to do this due to staffing pressures, and sometimes staff will be called back to theatres. Whilst solutions are found, theatre staff are keen that this continues to be prioritised.
1.3	**Listening to Staff** The maternity and neonatal service continues to promote all staff accessing the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery/Nursing Advocates, Unit Meetings and 'Safe Space'. In addition to this there are maternity and neonatal staff focus groups, and specific care assistant and support worker forum, which all provide an opportunity to listen to staff. On the back of retention data from the national and regional teams, it is recognised that the majority of midwives are leaving the profession 2-5 years after qualification. Our recruitment and retention lead has offered all band 6's a 'stay conversation' and continues to update line mangers and the senior leadership team of any themes identified so that solutions can be sought. The 2025 National Staff Satisfaction Survey results have just been published and in response the quadrumvirate and HR Business Partner are reviewing the findings and developing an action plan. In addition, the quadrumvirate are continuing to focus on the SCORE Culture Survey results which provided in-depth information regarding our workforce, specific to roles, teams and work settings. SCORE Culture Survey is the final component of the Perinatal Culture & Leadership Programme with the aim of nurturing a positive safety culture, enabling psychologically safe working environments, and building compassionate leadership to make work a better place to be and is included in the requirements for NHS Resolutions Maternity Incentive Scheme. All staff across Women's & Children were invited to participate in the survey with a response rate of 49%. An external culture coach then met with targeted groups to gain further understanding of the survey results. This feedback has been reviewed and the following aspirations identified. 1. Develop a strong and effective communication ethos, 2. Create a strong sense of belonging for all, across the service 3. Culture is embedded and prioritised as how we do things here.

The perinatal quadrumvirate and in-house culture coaches are continuing the work regarding our safety culture and aspirations. This month, maternity and neonatal staff were invited to professional behaviours and patient safety sessions run jointly by the General Medical Council and Nursing & Midwifery Council. The sessions were positively received by those attending. Two further sessions are planned for May, to capture as many staff as possible of all grades who work in maternity and neonates. Our HR Business Partner and Freedom to Speak up Guardian were also in attendance, to action any immediate issues without impacting confidentiality.

1.4 **Service User feedback**

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment.

Ward/Dept	January Survey returns	% of discharged people provided feedback *	January Very good and good %	February Survey returns	February Very good and good %	% of discharged people provided feedback *
F11	24	7%	96%	5	100%	2%
Antenatal	23	NA	91%	31	100%	NA
Postnatal Community	31	NA	77%	22	73%	NA
Labour Suite	5	26%	100%	1	100%	1%
Birthing Unit	6	46%	100%	5	100%	36%
NNU	3	8%	100%	3	100%	8%
Transitional Care	6	NA	100%	5	100%	NA

*Target of ≥30%

Due to the low number of responses the maternity and neonatal team are working closely with the Patient Engagement team and the Parent Education and Patient Experience Lead Midwife to increase the number of responses. In line with the results above, postnatal care was also an area identified for further focus via the CQC 2024 maternity survey results, in response we are currently engaging with our service users to understand fully where improvements need to be made.

In addition to the FFT, feedback is gained via our PALS, CQC Maternity survey and Healthwatch surveys. The maternity service has also noted increased volume of feedback received via social media. The Parent Education and Patient Experience Lead Midwife works closely with the Maternity and Neonatal Voice Partnership (MNVP) Local Maternity and Neonatal System (LMNS) Lead to ensure co-production of action plans in response to any form of feedback.

In January 2025, the patient experience team at WSFT received two compliments regarding the maternity and neonatal services, specifically highlighting the care provided in the Antenatal Clinic and the community. In February 2025, an additional two compliments were noted, focusing on the care received in the Labour Suite and the Antenatal Clinic.

During January 2025, the Trust recorded a total of seven PALS inquiries related to the Antenatal Clinic, ward F11, the Neonatal Unit, and community services, focusing on issues related to clinical treatment, access to treatment, communication, and administrative matters. In February 2025, another seven PALS inquiries were logged, primarily concerning the Antenatal Clinic, ward F11, and the Labour Suite, with the predominant topics being access to treatment or medications and communication.

In January and February 2025, no formal complaints were submitted.

1.5 **Reporting and learning from incidents**

During January and February 2025 there was 0 cases that met the referral criteria to the Maternity and Newborn Safety Investigations (MNSI).

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

Quarterly reports are shared with the Trust Board to give an overview of any cases, with the learning and assurance that reporting standards have been met to MNSI/Early Notification Scheme and the Perinatal Mortality Reporting Tool (PMRT).

1.6 **Training compliance for all staff groups in maternity related to the core competency framework.**

Jan 2025 Staff Group	Saving Babies Lives 1,2,5,6	GAP/GROW	Maternity Emergencies / PROMPT	Skills and Drills	Personalised Care	Safeguarding	Care in labour & Immediate Postnatal	Neonatal Life Support	Fetal Heart Surveillance	Newborn Feeding update
Midwives	95.88%	94.7%	98.21%	98.21%	95.81%	95.91%	97.06%	98.21%	96%	95.91%
MCA/MSW	NA	NA	95.24%	95.24%	NA	100%	95.02%	95.24%	NA	100%
Consultant Obstetrician	81.25%	86%	100%	100%	87.5%	100%	91.66%	NA	100%	NA
Obstetric Registrar	81.82%	83.3%	75%	75%	50%	100%	44.44%	NA	100%	NA
SHO/Core trainees	N/A	100%	100%	100%	N/A	100%	N/A	NA	NA	NA
Sonographer	NA	79%	NA	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	82.35%	82.35%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	93.75%	93.75%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	75%	NA	82%	NA	87.5%	NA	No Data
Neonatal Nurses	NA	NA	NA	95%	NA	95%	NA	97%	NA	95%
Neonatal Doctors	NA	NA	NA	No Data	NA	73%	NA	100%	NA	No Data
ANNP/PA	NA	NA	NA	No Data	NA	100%	NA	100%	NA	No Data

Feb 2025 Staff Group	Saving Babies Lives 1,2,5,6	GAP/GROW	Maternity Emergencies / PROMPT	Skills and Drills	Personalised Care	Safeguarding	Care in labour & Immediate Postnatal	Neonatal Life Support	Fetal Heart Surveillance	Newborn Feeding update
Midwives	95.38%	93.5%	95.88%	95.88%	95.81%	95.88%	95.86%	95.88%	93%	95.88%
MCA/MSW	NA	NA	97.67%	97.67%	NA	96%	95.24%	97.67%	NA	96%
Consultant Obstetrician	87.5%	86.7%	100%	100%	87.5%	95%	75%	NA	100%	NA
Obstetric Registrar	81.82%	83.3%	75%	75%	50%	100%	50%	NA	100%	NA
SHO/Core trainees	N/A	100%	100%	100%	N/A	100%	N/A	NA	NA	NA
Sonographer	NA	79%	NA	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	76.5%	76.5%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	93.75%	93.75%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	75%	NA	89%	NA	94.2%	NA	No Data
Neonatal Nurses	NA	NA	100%	100%	NA	100%	NA	100%	NA	100%
Neonatal Doctors	NA	NA	NA	No Data	NA	87%	NA	100%	NA	No Data
ANNP/PA	NA	NA	NA	No Data	NA	100%	NA	100%	NA	No Data

Key

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

	The consultant obstetric anaesthetist reduction is due to them being required to forego the training to facilitate additional theatre lists. They will be prioritised to attend the next session. The Neonatal consultants and trainee doctors attending safeguarding equates to two people in each group. The Named Nurse for Safeguarding Children is working with the team to address this. Additional training sessions were introduced at the beginning of 2024 in response to the launch of the Six Core Competency Framework version 2, and although compliance in these areas is improving, it is increasingly difficult to release all staff groups for this training. A full review of the current training requirements is underway to identify more efficient ways of delivering the training. Data collection regarding compliance is not yet robust, but processes have now been put into place to try and resolve this, however for some training elements this is reliant on individuals providing evidence of training compliance in their previous Trust.
2.	**Reports**
2.1	**Reports approved by the Improvement Committee** Year 6 of the NHS Resolution Maternity Incentive Scheme was launched in April 2024 with ten key Safety Actions to be achieved and maintained by the Maternity and Neonatal Services provided by West Suffolk NHS Foundation Trust. Whilst there have been some minor changes to the safety requirements for this year in some of the Safety Actions, one of the key changes has been to the processes and pathways for Trust committee and Board oversight. This has afforded the Trust the opportunity to optimise the reporting structures and assurance processes to ensure that each report has appropriate oversight and approval during this time. Reports to provide assurance in each Safety Action can be monthly, quarterly, six-monthly, annually or as a one-off oversight report at the end of the reporting period for sign-off prior to submission. Many of the reporting processes are embedded into business as usual for the services so are continued out with the Maternity Incentive Scheme (MIS). The updated process was agreed at the Board Meeting on the 24th May 2024, whereby some reports will be presented and approved by the Board sub-committee, the Improvement Committee. The Improvement Committee will provide an overview and assurances to the Trust Board that reports have been approved and any concerns with safety and quality of care or issues that need escalating. Following reports were presented and approved at the Improvement Committee held on the 19th February 2025: • Maternity claims scorecard review – Quarter 3 24/25 No reports were due to be presented to the Improvement Committee held on the 19th March 2025.
3.	**Reports for CLOSED BOARD** There are no reports due for closed board.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly.

7. GOVERNANCE

7.1. Audit CKI Committee report (ATTACHED)

For Approval

Presented by Michael Parsons and Jonathan Rowell

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			**Date of meeting: 18 March 2025**		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
Annual Governance Statement (AGS)	Review of AGS including internal control issues.	Substantial	The Committee agreed that the (1) building structure, (2) performance and patient access, and (3) financial control and sustainability remain relevant as significant internal control matters for this year's AGS. In addition, MEG should consider including in the AGS any other significant issues from internal audits with negative assurance opinions.	Consideration while drafting the AGS.	2. To MEG to finalise AGS
Code of Governance 2022	Self-assessment was undertaken to evaluate the Trust's compliance with the expectations set out in the new Code.	Substantial	The internal review demonstrates that the Trust is largely compliant with the Code of Governance, with the one area for improvement identified being progressed.	The gap identified is being addressed through the development of a new policy for Board approval on 'purchase of non-audit services from its external auditor'.	3 -> Board approval where required **SEE SEPARATE PAPER REQUESTING APPROVAL**

Originating Committee: Audit Committee			**Date of meeting: 18 March 2025**		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
Matters relating to Year-end 2024/25	Updates to governance documents (standing financial instructions, standing orders, scheme of delegation).	Substantial	Proposed amendments (SFIs and SoD) were approved by the Committee noting no amendments needed to Standing Orders.		3 -> Board approval where required **SEE SEPARATE PAPER REQUESTING APPROVAL**
Terms of reference	Annual review of the terms of reference was undertaken.	Substantial	Minor amendments were approved by the Committee.		3 -> Board approval where required **SEE SEPARATE PAPER REQUESTING APPROVAL**
Internal Audit (RSM)	Approval of Internal Audit Plan for 2025/26. Update on delivery of internal audit plan 2024/25 and implementation of recommendations.	Reasonable	The Committee approved the Internal Audit Plan for 2025/26, subject to further consideration by Executive in relation to coverage of productivity issues. Discussed progress with delivering the 2024/25 audit plan, and expressed concern at	Executive to consider the approach to productivity issues within the audit plan (and other assurance activity). Executive to review protocol and escalation approach to ensure 2025/26 IA plan is not backloaded.	2 -> Management Executive Group

Originating Committee: Audit Committee			Date of meeting: 18 March 2025		
Chaired by: Michael Parsons			Lead Executive Director: Jonathan Rowell		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
			delays in concluding audits, resulting in a significant back-loading of the plan. Three audits awaited sign-off and a further two audits are still in progress: Governance - Well Led and Future Systems Programme - Clinical and Care Strategy. The draft Head of Internal Audit Opinion was discussed – noting that it may change in light of the assurance opinions in the final audits and any further information supplied by the Trust in response to audit recommendations. The Committee also reviewed progress with implementation of outstanding management actions.	Executive to continue to address overdue audit actions.	

Originating Committee: Audit Committee			**Date of meeting: 18 March 2025**		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
Counter Fraud (RSM)	Approval of workplan for 2025/26. Update on counter-fraud activity.	Substantial	The Committee approved the workplan for 2025/26 and noted actions on awareness and training. Case studies on fraud were noted with information on prevention measures. Discussed RSM analysis emerging areas of risk, including increasing levels of regulation, technology resilience, access to markets, technology fraud, shifts in business culture and potential for an epidemic.	Benchmarking data will be considered at a future meeting.	1. No escalation
External Audit (KPMG)	Approval of audit plan and planning for upcoming audit.	Substantial	The Committee approved the audit plan and noted key points. The good working relationship between the external auditors and the trust finance team was welcomed; timeliness of		1. No escalation

Originating Committee: Audit Committee			**Date of meeting: 18 March 2025**		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / MEG 3. Escalate to Board
			information provision and responsiveness to queries during the audit will be essential to achieve timelines.		
Fit & Proper Persons Annual Report	Review of Fit and Proper Persons annual report.	Substantial	The Fit and Proper Persons annual report was noted and approved, with minor amendments.		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.

7.2. Board Assurance Framework (ATTACHED)

To Note

Presented by Pooja Sharma

WSFT Board of Directors (Open)	
Report title:	**Board Assurance Framework**
Agenda item:	7.2
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Mike Dixon, Head of Health, Safety and Risk

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 provides an update on development of the board assurance framework (BAF). The BAF remains structured around the agreed **10 strategic risks:**

1. Capability and skills
2. Capacity
3. Collaboration
4. Continuous improvement & Innovation
5. Digital
6. Estates
7. Finance
8. Governance
9. Patient Engagement
10. Staff Wellbeing

The assessment of each BAF risk continues to be developed in line with the approach approved at by Board, including review by the agreed governance group and Board assurance committee.

Annex A of this report **maps movement for each of the BAF risk** according to the risk score for 'current' (with existing controls in place) and 'future' (with identified additional controls in place).

All of the BAF risk assessments have been reviewed and updated. The Management Executive Group (MEG) now undertake scheduled reviews of the individual risks within the BAF, this supports reporting into the Board assurance committees.

The following **summarises changes since the last report**:

- **BAF 1 Capability and Skills** – reviewed and updated by the Executive Director of Workforce and Communications and presented to MEG in January and Involvement in February
- **BAF 4 Continuous improvement & innovation** – reviewed and updated by the Executive Director of Strategy and Transformation and presented to MEG in February and Improvement Committee in March
- **BAF 6 Estates** - reviewed and updated by the Associate Director of Estates and Facilities and presented to MEG in February
- **BAF 7 Finance** – reviewed and updated by the Finance Director and presented to MEG in January and Insight in February. This review is ongoing to reflect the current risk and assurance ratings
- **BAF 8 Governance** – reviewed and updated by the Executive Chief Nurse and presented to MEG in December and the Improvement Committee in January
- **BAF 10 Staff Wellbeing** – reviewed and updated by the Executive Director of Workforce and Communications and presented to MEG in January and Involvement in February

Based on the current assessments **four risks will achieve the risk appetite** rating approved by the Board based on the identified additional mitigations and future risk score (Annex B). This position will form part of the review and challenge by the relevant assurance committee of the Board for all of the risks – testing the risk rating, additional controls and risk appetite.

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

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

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

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

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

- Following discussion at the Insight Committee a matrix will be developed to **map the interdependencies** between individual BAF risks. An example is the strategy refresh described within the improvement risk (BAF 4) directly links with the additional controls for capacity. The next iteration of this report will include this update to provide greater visibilities of interdependencies (Q4)
- Schedule **review of risks to the agreed strategy** when the strategy refresh has been undertaken. This will also include review and assessment of the risk appetite for each risk (Q1)
- Develop **longer term assessment** of the mitigation and risk for each of the BAF risks to achieve the agreed risk appetite (Q1).

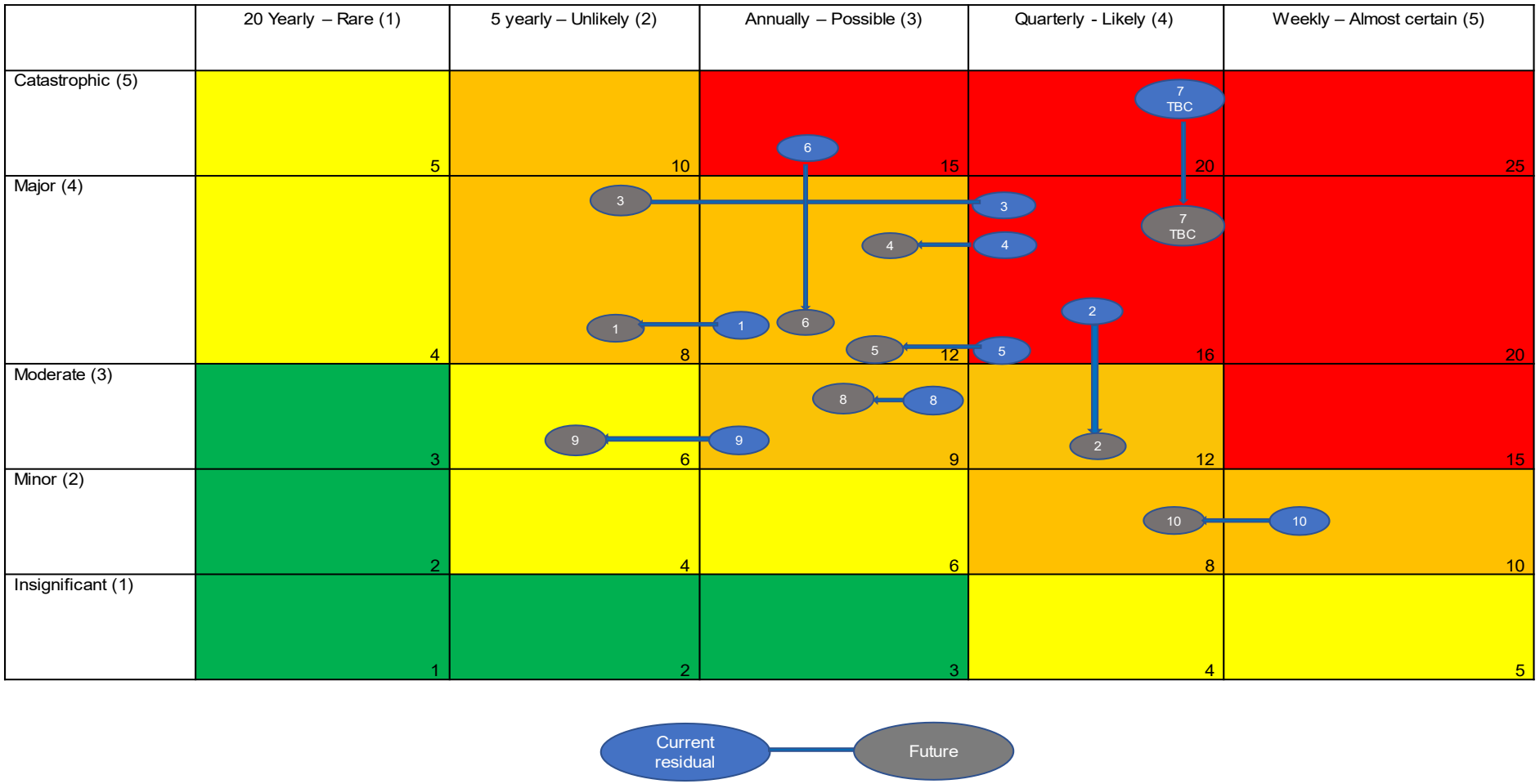
Action Required

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

Previously considered by:	The Board of Directors

Risk and assurance:	Failure to effectively manage risks to the Trust's strategic objectives. Agreed structure for Board Assurance Framework (BAF) review with oversight by the Audit Committee. Internal Audit review and testing of the BAF.
Equality, diversity and inclusion:	Decisions should not disadvantage individuals or groups with protected characteristics
Sustainability:	Decisions should not add environmental impact
Legal and regulatory context:	NHS Act 2006, Code of Governance. Well-led framework

Annex A: BAF risk movement



1. Capability and skills
2. Capacity
3. Collaboration
4. Continuous improvement & Innovation
5. Digital
6. Estates
7. Finance
8. Governance
9. Patient Engagement
10. Staff Wellbeing

Annex B: Risk themes – summary table

Risk Descriptions	Exec lead	Board comm.	Board committee review (MEG review)	Appetite Level and score	Current risk score	Future risk score (target date)	Future risk with appetite?	Assur. level
BAF 1 Fail to ensure the Trust has the capability and skills to deliver the highest quality, safe and effective services that provide the best possible outcomes and experience (Inc developing our current and future staff)	HR&C	Involvement	Feb 25 (Jan '25)	Cautious (9)	12	8 (Mar 25)	Yes	Reasonable
BAF 2 The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities	COO	Insight	Planned for Apr '25 (Mar '25)	Cautious (9)	16	12 (Mar 25)	No	Partial
BAF 3 The Trust fails to work effectively with our partners to ensure the greatest possible contribution to preventing ill health, increasing wellbeing and reducing health inequalities	DST	Involvement	Planned for Apr '25 (Mar '25)	Hungry (20)	16	8 (2026)	No	Partial
BAF 4 There is a risk that the Trust does not have the capacity, capability, or commitment to change the way it provides health and care services, which could lead to a failure to respond to changing demand pressures, unsustainable services, and/or not delivering major projects, which would worsen operational pressures, quality of care, and financial viability.	DST	Improvement	Mar '25 (Feb '25)	Open (12)	16	12 (July 25)	Yes	Partial
BAF 5 Fail to ensure the Trust implements secure, cost effective and innovative approaches that advance our digital and technological capabilities to better support the health and wellbeing of our communities	COO	Digital Board	Planned for Apr '25	Cautious (9)	16	12 (Dec 24)	No	Partial
BAF 6 [1] Fail to ensure the Trust estates are safe, fit for purpose while maintained to the best possible standard so that everyone has a comfortable environment to be cared for and work in today and for the future	DoR	Future Systems Board	Planned for Mar '25 (Feb '25)	Open (12)	15	12 (Dec 24)	Yes	Partial
BAF 7 Fail to ensure we manage our finances effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions, and values	DoR	Insight	Feb '25 (Jan '25)	Cautious (9)	TBC	TBC	TBC	TBC

Risk Descriptions	Exec lead	Board comm.	Board committee review (MEG review)	Appetite Level and score	Current risk score	Future risk score (target date)	Future risk with appetite?	Assur. level
BAF 8 Fail to ensure the Trust has the appropriate governance structures, principles and behaviours to help us safely deliver the best quality and safest care for our local population (our vision) and ambitions (for patients, staff and the future) in the right way	ECN	Improvement	Jan '25 (Dec '24)	Minimal (6)	9	9	No	Reasonable
BAF 9 [1] Fail to effectively engage and communicate with our patients and the public, reducing inequality and responding to the needs of our communities	ECN	Involvement	Planned for Apr '25 (Mar '25)	Cautious (9)	9	6 (Dec 24)	Yes	Reasonable
BAF 10 [1] Fail to ensure the Trust can effectively support, protect and improve the health, wellbeing and safety of our staff	HR&C	Involvement	Feb '25 (Jan '25)	Cautious (9)	10	8 (Mar 25)	No	Reasonable

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

7.3. Governance Report (ATTACHED)

For Approval

Presented by Pooja Sharma

WSFT Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	7.3
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
This report summarises the main governance headlines for March 2025, as follows: • Senior Leadership Team • Management Executive Group - Risk Management Policy and Strategy • Council of Governors • Terms of reference – Involvement, Improvement and Audit Committee • Modern Slavery Statement • Register of interests • NHS Code of Governance • Policy on the engagement for non-audit services, updates to the standing orders, standing financial instructions and scheme of reservation and delegation (reported via the audit committee) • Board development session – summary • Urgent decisions by the Board • Use of Trust's seal • Agenda items for next meeting
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
This report supports the Board in maintaining oversight of key activities and developments relating to organisational governance.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The items reported through this report will be actioned through the appropriate routes.
ACTION REQUIRED

The Board is asked to note the report and:

- **Approve** the Risk Management Policy and Strategy
- **Approve** the terms of reference of the board committees - improvement, involvement and audit committees
- **Approve** the updated modern slavery statement
- Note and approve changes reported via the audit committee

Legal and regulatory context	NHS Act 2006, Health and Social Care Act 2013

Governance Report

1. Senior Leadership Team report

The Senior Leadership Team met on 17 March 2025.

The March session featured a presentation on Equality Impact Assessment (EIA) aimed at providing an understanding of the assessment process, how to complete it and reviewing how activities, decisions, and policies impact individuals with specific characteristics.

2. Management Executive Group (FOR APPROVAL)

The Management Executive Group is established as the most senior executive forum within the Trust. Meeting takes place at least three times in a month, including corporate performance review meetings.

The MEG reviewed and approved the revised Risk Management Policy and Strategy via Chair's action and presented to the Board for approval. (see Annex A).

3. Council of Governors report

The Council of Governors met on 26 Feb 2025.

The Council of Governors received an update on **transformational programmes** outlining the different aspects that drive transformation with a focus on transforming frailty services and an overview and scope of SNEE ICB commissioned **sustainability review** by the executive director of strategy and transformation.

The Council of Governors received the **feedback reports from chairs of the board assurance committees** and governor observers. A summary of the agenda items was received with the committee's key issues and respective governor observers' reports providing highlight updates for the Council. The Council of Governors also received the audit committee's key issues report.

The Governors noted the report from **Nomination Committee** which highlighted NED composition of Board. The governors noted the size, structure and composition of the present Board and ongoing review of the board skills mix. The Council of Governors also approved the NEDs appraisal process.

The Council of Governors received a report from the **membership and engagement committee** to draw attention to VOICE meetings and initiatives around patient engagement and governor activities. An update was also provided on the membership and engagement strategy development plan which is evolving and steps being taken to deliver the priorities as set out in the foundation trust membership and engagement strategy.

The Council of Governors noted the **governance report** and identified Governor readers for the draft annual report (including quality accounts). The Governors also approved the approach to drafting Governors' commentary for inclusion in the quality accounts. The Governors' 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.

4. Board Committees - terms of reference (ToR) (FOR APPROVAL)

The following Board sub-committee ToRs are presented as part of annual review and approval. The committees have approved their terms of reference either in the committee meetings or via committee chair's action as indicated.

Involvement committee (reviewed in committee meeting - 20 December 2024)

Improvement Committee (reviewed in committee meeting - 15 January 2025)
Audit committee (reviewed in committee meeting - 18 March 2025)

Full copies of the terms of reference are provided as an addendum to the Board pack.

The Board is asked to approve the terms of reference of Involvement, Improvement and Audit committees.

5. Modern slavery statement (FOR APPROVAL)

The West Suffolk NHS Foundation Trust (WSFT) Board supports the government's objectives to eradicate modern slavery and human trafficking. The Board is asked to approve the updated modern slavery statement (Annex B) which will be included on the Trust website.

6. Register of interests

It is a Constitutional requirement that appointed Board of Directors have a duty to avoid conflicts of interest with the Trust. To ensure full openness and transparency, the register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.

For accuracy and completeness of our register of interests, we will be sending out the declaration of interest forms to all board members to capture any relevant interests or relationships. Updates from Board members will be requested in April to allow these to incorporated into the annual report for submission to the external auditors. The updated register of interests will be presented to the Board in May.

7. NHS Code of Governance (2022)

An updated NHS code of governance for NHS provider trusts was published at the end of 2022. The code sets out an overarching framework for the corporate governance of trusts, supporting delivery of effective corporate governance, understanding of statutory requirements where compliance is mandatory and provisions with which trusts must comply, or explain how the principles have been met in other ways.

The Trust is committed to sustaining the highest standards of governance in accordance with the Code of Governance. In line with our commitment, we have undertaken an internal review of compliance with the new code which assessed our practices, policies and procedures against the expectations of the Code. The overall assessment demonstrates compliance.

The external auditor's review of the Trust's annual report will provide further evidence for our internal review. The assessment was presented to the Audit Committee in March for oversight and assurance highlighting any areas for development.

8. Implementation of Policy on the engagement for non-audit services, updates to the standing orders, standing financial instructions and scheme of reservation and delegation (For Approval via the audit committee report)

The Board is asked to note amendments and approve the standing financial instructions and scheme of reservation and delegation. No changes were noted to standing orders.

Policy on the engagement for non-audit services is also presented to the Board for approval.

More details are reported via the audit committee report.

9. Board development session

On 28 February, the Board held a development session covering three key areas: Sustainability review, Future Shift – Transforming Frailty Services, and Financial Planning

Update for 2025-26. The session was well-received, with valuable discussions and contributions.

- Sustainability Review: The Board received an update from McKinsey on the aims and progress of the sustainability review. Discussions focused on the emerging case for change narrative, preliminary analyses and data insights, next steps in the review process

- Future Shift - Transforming Frailty Services: A session was held on transforming frailty care, with key discussions on population health data and service breadth for frail individuals, the rationale for a Trust-wide focus on frailty care transformation, strategic approaches and tactical implementation plans and board decisions on progressing this initiative. Breakout discussions explored whether frail individuals should be the primary focus for prioritization, how to best mobilise the Trust and system around this priority and tactical steps for successful implementation

- Financial Planning update 2025-26: The Board received an update on the Trust's financial plan for 2025-26, including a proposed deficit plan and additional cost improvement programme (CIP), the impact of newly published planning guidance and funding allocations, ongoing efforts to refine the plan and explore further deficit reduction measures, acknowledgement of financial challenges but commitment to improving operational and clinical productivity.

There was consensus that the session had been valuable with good contributions and the Trust will continue to develop and refine plans in the coming weeks to align with financial targets and service improvement goals.

10. Urgent decisions by the Board

None to report.

11. Use of Trust Seal

None to report.

12. Agenda Items for the Next Meeting (Annex C)

The annex provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points. The final agenda will be drawn-up and approved by the Chair.

Document ref. no: PP(25)093

Strategy and Policy for Risk Management

For use in:	All areas of WSFT
For use by:	All trust staff
For use for:	Management of all areas of risk to the Trust
Document owner:	Trust Secretary and Head of Governance
Status:	Under Review

Summary

This document provides guidance on the Trust's risk management responsibilities and procedures to ensure risks are effectively identified, monitored and managed (controlled). Staff must ensure that risks are appropriately reported to managers. Managers must ensure that risks are properly assessed and as necessary escalated.

The Trust's risk register is used to capture Divisional and Corporate risks. Risks are rated as Red (high), Amber (Significant), Yellow (Moderate) and Green (low) based on an assessment of the likelihood and consequence (harm) of a risk materialising. This risk rating informs the escalation requirements. Monitoring arrangements are in place to ensure that risks are appropriately reviewed and agreed action taken. These arrangements ensure that staff, patients and others (others include visitors and contractors) are protected through the delivery of high quality and safe services.

Contents

1. Introduction

The Trust is committed to ensuring the safety of staff, patients and others through an integrated approach to managing risk, regardless of whether the risk relates to the delivery of patient care or achievement of business objectives. Good arrangements for risk management underpin the Trust's ability to identify and manage its risks in a robust manner.

Healthcare is a hazardous environment; it brings together sick and vulnerable patients with medical services often using complex technology and requires the effective coordination of many people. Complex systems in any industry are prone to human error. No matter how committed, skilled and hard working the staff, the complexity of modern NHS care and the nature of human behaviour means that incidents do happen and errors are made. Very few errors are due to a lack of care or commitment from healthcare professionals or from a desire to deliberately harm patients.

Therefore, the Trust operates effective risk management systems and a positive learning environment that supports improvements in patient care and safety which will reduce the level of risk. The Trust's objective is to manage risk as part of normal line management responsibilities which are monitored by the Trust's committee structure with risk escalated in an appropriate and timely fashion. Funding must be appropriately prioritised to mitigate/address 'risk' as part of the management and business planning processes.

To support this the Trust has appropriate policies and procedures in place to eliminate or minimise risk and these should be followed by staff who will be provided with the necessary training.

The Trust captures all risk assessments on radar healthcare using the event module. This process has been put in place so that risk assessments can be managed at a local level. Please refer to the risk assessment policy (PP132).

The Trust has a separate risk register module within radar healthcare to capture Divisional risks and Corporate level risks

2. Background

Effective risk management is vital to the provision of high-quality services and ensuing the success and sustainability of the Trust. Therefore identification, control and management of risk is fundamental. To achieve effective risk management the Trust requires a systematic approach to clinical and non-clinical risk management by maintaining and improving the quality of staff and patient care and ensuring that other types of risk are identified and managed appropriately.

Under the Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999 the Trust has a legal duty to identify risks to health, safety and welfare and to ensure so far as is reasonably practicable that these risks are eliminated, mitigated and managed appropriately to safeguard the health, safety and welfare of staff, patients, and others on Trust premises who could be affected by its undertakings.

NHS organisations also need to consider the standards and requirements issued by the Department of Health and other regulatory bodies (such as NHSE and the Care Quality Commission (CQC)).

3. Aims

- To support the delivery of high-quality services and protect staff, patients and others through an integrated approach to risk management (whether the risk relates to patient care, health, safety and welfare, environmental, information governance, business continuity and finance)
- To support achievement of the Trust's strategic objectives as set out in the assurance framework.
- To clearly define roles and responsibilities for the management of risk.
- To ensure that risk management methods are clearly understood and systematically applied throughout the Trust.

- To ensure that risks are identified, evaluated and prioritised for action.
- To establish clear and effective communication that enables information sharing.
- To foster an open culture that supports organisational risk identification and learning, including incident reporting.

4. Objectives and implementation

All Trust policies and procedures (including Health, Safety and Welfare, Nursing, Financial and Personnel) are relevant to risk management. Following appropriate standards, national and statutory guidance and best practice identified in policies and procedures will so far as is reasonably practicable minimise risk.

The implementation of the risk management strategy will be achieved through:

1. Developing robust arrangements in all divisions for managing and escalating risk.
2. Undertaking effective monitoring of these risk management arrangements.
3. Providing training and support to managers to enable them to manage risk as part of normal line management responsibilities.
4. Capturing Divisional and Corporate risks on the Trust's Risk Register. Ensuring that any decision to accept risk is taken appropriately and that prioritisation of funding, where required to manage identified risks, takes place as part of the management process and business planning arrangements.
5. Through business continuity arrangements ensure that procedures exist for establishing contingency plans.
6. Ensure that all staff groups within the Trust systematically report incidents on radar healthcare.
7. Use information from risk assessments, incidents, complaints, audit (clinical and non-clinical), claims and other relevant internal and external sources to capture risks on the risk register which will be used to improve safety and facilitate Trust learning.
8. Ensuring that there are appropriate policies and procedures in place that are communicated to and followed by staff to identify, eliminate or mitigate risk.
9. Improve compliance with risk management assessment frameworks and benchmark performance with other organisations:
   a) Supporting registration with the Care Quality Commission for the delivery of healthcare
   b) Supporting licensing by NHSE for the delivery of healthcare
10. Foster cross-organisational learning through appropriate information sharing and representation on local forums.
11. Mitigate the adverse financial consequence of a risk through the appropriate use of "insurance" arrangements.
12. Utilise internal and external audit, and other external regulatory and assessment bodies to provide assurance of the implementation and effectiveness of controls to eliminate or minimise risk.

5. Risk Management procedures

5.1 Risk identification

Risks can be identified from many different sources. Effective risk management allows these various sources to drive a single co-ordinated approach to the identification, assessment, elimination or the reduction of risk. Some of the potential sources are described below.

- Local risk assessments
- Clinical and non-clinical incident reporting (including near misses), accidents, fire and security
- Concerns identified through complaints, litigation, inquests and internal whistle-blowing
- Feedback from patients and stakeholders, including patient and staff surveys
- Clinical audit findings
- National recommendations and guidance, including confidential enquiry recommendations safety alerts and NICE guidance

- Benchmarking, clinical indicators and performance assessments
- External and strategic risks through PEST and SWOT analysis of the annual plan
- External and Internal Audit reports
- Assessment against Care Quality Commission's standards
- The Care Quality Commission inspections, improvement review reports and benchmark analysis
- Compliance with performance targets and regulatory requirements, including NHSE and the CQC
- Results of information governance assessments (e.g. data confidentiality, quality and security).
- Information from disciplinary procedures, grievances and harassment cases
- External regulatory and assessment body inspections and reviews, including Royal Colleges, Post Graduate dean reports; accreditation inspections and Health and Safety Executive (HSE) reports

Aggregated data from each of these sources informs risk management priorities. For example, aggregated information from incidents, complaints and claims would inform a programme to add an entry into the risk register.

5.2 Management options

Risk transfer
Where the level of risk is unacceptably high and the Trust cannot, for whatever reason, put adequate control measures in place to eliminate or reduce the risk the Board will consider whether the activity should continue in the Trust. An example of such a risk avoidance measure would be the decision that patients requiring certain high-risk surgical procedures for which the required level of surgical expertise or equipment is not available in the Trust will be referred to a tertiary centre for their treatment. In this case a balance of risk must be considered – the risk from transferring the patient must be less than the risk of operating in the Trust environment.

Risk reduction
Where a risk is identified that cannot be eliminated or avoided the Trust must consider whether there are suitable and sufficient control measures in place. If there are not, then the Trust must consider how better control measures may be applied in order to reduce the risk. Making and carrying out risk reduction action plans is the responsibility of the risk owner or the Division.

Risk acceptance
When all reasonable control mechanisms have been put in place, some residual risk will inevitably remain in many Trust processes. This level of risk must be accepted. Risk acceptance by the Trust will be systematic, explicit and transparent. The financial consequences of risk acceptance will be managed through participation in NHS Resolution insurance schemes.

5.3 Risk assessment

The Trust has an agreed Risk Assessment Policy and Procedure (PP132), which sets out:

- how all risks are assessed
- how risk assessments are conducted consistently
- authority levels for managing different levels of risk within the organisation
- how risks are escalated through the organisation
- how the organisation monitors compliance with all of the above

All risk assessments must be captured and maintained on radar.

Risk Rating:
To assist in prioritising risks the following formula is used:-
Likelihood x Consequence (severity) = **Risk Rating (RR)** - as seen in the matrix below:

Scoring Matrix

	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
20 Yearly – Rare (1)	1	2	3	4	5
5 yearly - Unlikely (2)	2	4	6	8	10
Annually – Possible (3)	3	6	9	12	15
Quarterly - Likely (4)	4	8	12	16	20
Weekly - Almost certain (5)	5	10	15	20	25

Risk review frequency

Green (low)	• Review progress as appropriate, including the implementation of any additional controls (minimum every 12 months)
Yellow (moderate)	• Review progress as appropriate, including the implementation of any additional controls (minimum every 12 months)
Amber (medium)	• Review progress as appropriate, including the implementation of any additional controls (minimum every six months)
Red (high)	• Review progress as appropriate, including the implementation of any additional controls (minimum every three months).

5.4 Risk Register and Board Assurance Framework

Risk Register
The risk register will be used and reviewed at a divisional level, including: divisional boards Committee (or equivalent), relevant management groups and board assurance committees (see Appendix C).

As such, the risk register allows risks to be systematically recorded, managed and escalated. This intelligence is incorporated into the Trust's strategic and business planning processes at division and corporate levels.

Reporting from the risk register ensures appropriate escalation of risk according to the risk rating as set out in section 5.3. This will include reports to Divisional Board and reporting to Divisional Performance Review Meetings (PRM).

In addition to the reporting requirements above a quarterly review of the risk register is presented by the Health, Safety and Risk Manager to the Corporate Risk Governance Group to identifying trends, as well as review performance in risk identification, escalation and mitigation.

Risks to the Trust's strategic objectives are managed through the **Board Assurance Framework (BAF)**. The Board and its assurance committees review these assessments and mitigate plans.

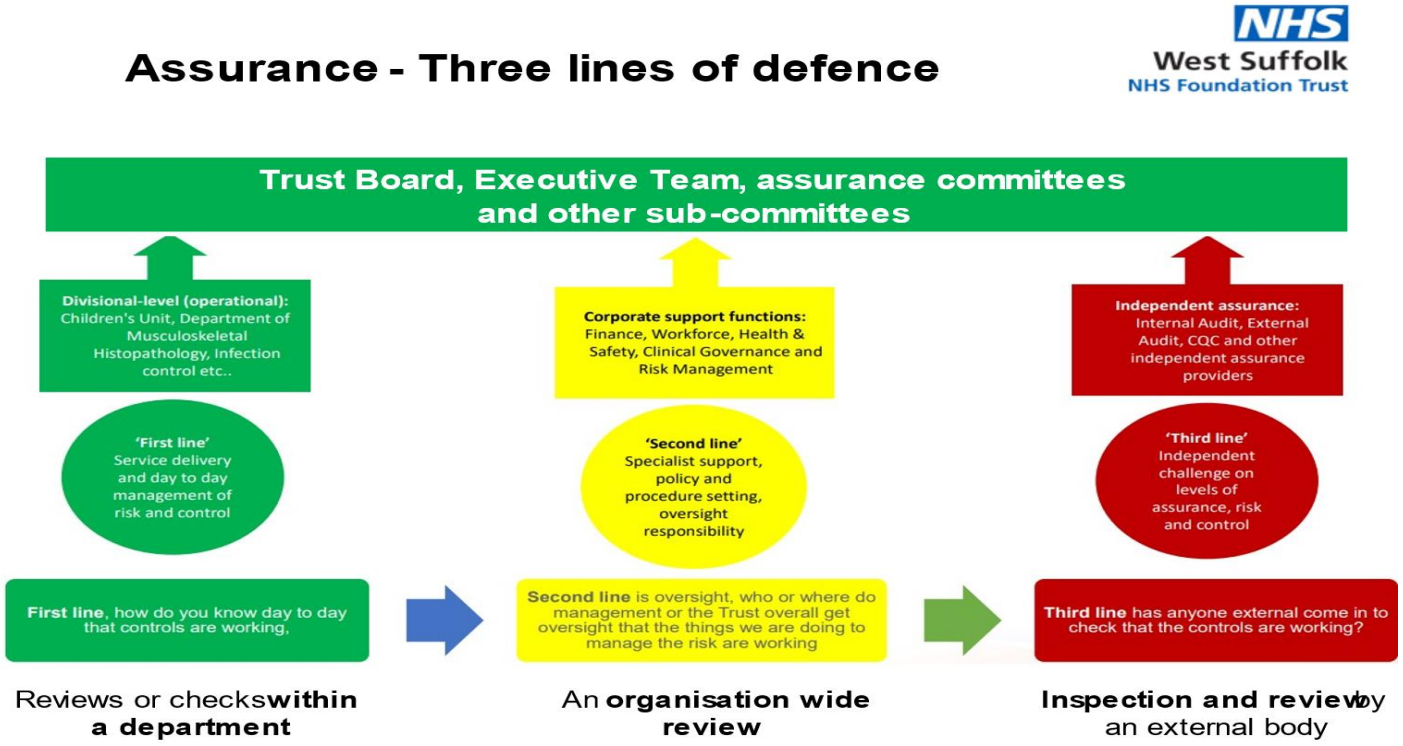
The Board assurance committee's will receive their allocated risks from the BAF to ensure that reporting arrangements are effectively capturing, managing and escalating risks.

5.5 Assurance

As part of the process for managing risk, consideration must be given to the level of independent assurance for the effectiveness of identified controls. The level of assurance expected will be influenced by the nature of the risk e.g. risks at the strategic or corporate level will require greater assurance.

The Trust will seek assurance that hazards are being appropriately identified and managed through the following:

- Receipt by relevant committees of reports for activities detailed in the Risk Management Strategy
- Receipt by the Board assurance committees of reports from governance and specialist groups
- Findings of Internal and External Audit reviews informing the Audit Committee, priorities for these reviews informed by the assurance framework and risk register
- The annual governance statement (AGS), supported by external audit and internal audit work programmes
- Compliance with regulatory requirements, including the Care Quality Commission and NHSE
- Findings of external reviews and reports regarding the Trust's practices and procedures
- Achievement of the Trust's strategic objectives as set out in the assurance framework
- Review of the risk register and board assurance framework demonstrating progress with additional controls to eliminate or minimise risk.
- Using the three lines of defence approach as per below



6. Roles and responsibilities

The Trust's governance committee structure for managing risk is outlined in the chart at **Appendix B**. The following section outlines key roles and responsibilities of individuals and committees to ensure the systematic implementation of the processes for the management of risk at all levels of the organisation. Critical to any governance system is the ability to identify and escalate and manage risk in a timely and effective way.

6.1 Corporate responsibilities

Chief Executive, Executive Chief Finance Officer, and Executive Chief Nurse

The overall responsibility for effective risk management in the Trust, meeting all statutory requirements and adhering to guidance issued in respect of risk lies with the Chief Executive. At an operational level, the Executive Chief Nurse is the Director designated with responsibility for governance and risk management. Accountability for management of financial (business) risk including the correct application of Standing Financial Instructions and Standing Orders lies with the Chief Finance Officer.

The Executive Chief Nurse will liaise with the Executive Medical Director for medical issues relating to clinical risk management, patient safety and staff concerns regarding service delivery.

Trust Board
The Board is collectively responsible for promoting the success of the Trust by directing and supervising the organisations affairs. This responsibility is achieved through:

- providing active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed.
- setting the organisation's strategic aims, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance
- setting the organisation's values and standards and ensuring that its obligations to patients, the local community and the Secretary of State are understood and met.

The Board has delegated some of its powers to formally constituted committees. These committees have a remit and decision making powers defined by the Board and report back to it at agreed intervals. The Board remains responsible for considering and accepting high (red) risks escalated through the risk management procedures.

Risk Appetite Statement

Risk appetite is a way of expressing WSFT's attitude to different types of risk and the nature of the risks it is prepared to take. WSFT's appetite for risk can vary dependent on the nature of the risk and the prevailing operating conditions or circumstances.

WSFT has developed an approach to defining its risk appetite. The risk appetite is not absolutely prescriptive but instead provides a number of underlying component parts that encourage structured thinking. The aim of the risk appetite is to allow WSFT to reach an informed conclusion as to whether the risk can be accepted and to what extent.

All risks should be considered in the context of WSFT's risk appetite. To assist this further the Board have identified a number of risk appetite themes against which they have assigned a risk appetite. Therefore, in the instances where risks are associated with the theme and dependent on the risk score assigned, WSFT will be more easily able to determine how to respond and so make best use of mitigation resources

Risk Theme	Appetite Level	Maximum Risk Score
Capability and skills	**Cautious**	9
Capacity	**Cautious**	9
Collaboration	**Open**	12
Continuous improvement & Innovation	**Open**	12
Digital	**Cautious**	9
Engagement	**Cautious**	9
Estates	**Open**	12
Finance	**Cautious**	9
Governance, Compliance and Professionalism	**Minimal**	6
Staff Wellbeing	**Cautious**	9

The Trust will continue to keep under review its risk appetite, fully recognising that this may be subject to change due to various factors both internal and external that could shape the nature and extent of the risks we are prepared to take.

A cycle of reporting by risk appetite will be introduced so that WSFT can understand its risk exposure in connection with the risk appetite themes and ensure an effective response.

Board Assurance Committees:

- **Insight Committee** with an assurance on operations, finance and corporate risk
- **Involvement Committee** with an assurance on people and organisational development
- **Improvement Committee** with an assurance on quality, patient safety and quality improvement.

Audit Committee
The committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.

Remuneration Committee
Sets remuneration for Executive Directors and considers organisational remuneration issues.

Charitable Funds Committee
Ensure appropriate management and control of charitable funds in accordance with the requirements of Charitable Commission guidance.

Governance groups
1. Review information to
   - identify deteriorating trends and/or areas where the Trust is a potential outlier or underperformer
   - gain assurance on effective and/or improving systems
   - seek to understand the rationale for any improvement or deterioration in performance

2. Identify and prioritise scope for improvement opportunities
3. Ensure the best utilisation of resources (staffing/financial/information/training) and cooperative working to support clinical effectiveness (involvement).

Management Executive Group
Is corporately responsible for formulation and delivery of the Trust's strategy, service aims and objectives as approved by the Board of Directors.

Senior Leadership Team
Provides strategic leadership to the Trust and has been established to:

- be the key forum for sharing contemporaneous intelligence concerning the health and care system and other strategic matters
- bring senior leaders together creating the opportunity to collectively tackle cross cutting and culture changing topics and issues.

Specialist advisory committees
The Trust has established a number of specialist committees/groups. Each committee provides a forum for discussing quality, risk and other issues where expert opinion can be sought. Issues that individual committees are unable to resolve can be escalated to the responsible committee.

Health and Safety Committee
The function of this committee is to maintain effective joint consultation across the Trust, monitoring (with the aid of the incident reporting system) the health, safety, welfare and environment within the workplace for staff, patients and others to the site in line with statute legislation. The accountability for the committee is to the Corporate Risk Governance Group.

6.2 Divisional responsibilities

ADOs/Deputy Directors and Clinical Directors
ADOs/Deputy Directors and Clinical Directors are responsible for ensuring that hazards are controlled appropriately in their area of responsibility. These responsibilities will in the main be discharged through the implementation of good risk management practices to identify hazards and manage risk (see section 5.1 for sources of risk identification). These approaches will be implemented in the services, departments and specialities in their management responsibility.

Key responsibilities include:

- Taking action on hazards identified within their area that cannot be eliminated by the Lead Clinician, Head of Department, Service Manager or Matron. This includes the development of continuity plans for key business risks (see Business Continuity Policy PP256).
- Investigate and manage serious incidents (graded as red) using the Trust's approved Incident reporting and management procedure. Ensuring that lessons are learnt and changes in practice implemented, including appropriately sharing across the Trust.
- Coordinate inquest preparation relevant to their area of responsibility.
- Review compliance with NICE and other national guidelines or standards.
- Consider and addressed issues identified through clinical benchmarking indicators and performance assessments.
- Act on risk issues escalated by Lead Clinicians, Heads of Department, Service Managers and Matrons
- To decide who will have access to the risk register based on two profiles:
    - **Add/ View and Approve**-ADO/Senior Operations Manager or equivalent.
    - **Editor and View**- Service manager or equivalent
- To ensure all of the agreed Divisional risks have been added to the risk register and approved.

Escalating any significant concerns to the appropriate Director and reporting via Divisional Performance Meetings to the relevant Board Assurance Committee and/or Board.

Lead Clinicians, Heads of Department, Service Managers and Matrons
Lead Clinicians*, Heads of Department, Service Managers and Matrons are responsible for ensuring that risk is managed appropriately in their area(s) of responsibility.

Key responsibilities include:

- Reviewing risks on the risk register
- Reviewing incidents, complaints and claims within their area and identifying lessons learnt
- Identifying lessons and changes in practice arising from incidents, complaints and claims that should be shared across the Trust
- Acting on the results of audit reports and their recommendations
- Reviewing training provision and uptake (including: induction (Trust and local), mandatory training, competencies, skills and equipment)

Escalating any significant concerns to the appropriate ADOs and/or Clinical Director.

* For specialities in which a Lead Clinical has not been identified responsibilities remain with the Clinical Director.

Managers (including Ward Managers and Area Managers)
All managers are responsible for:

- Must take immediate action to eliminate or reduce risks rated as high (red) or more.
- Recommend, implement and monitor the effectiveness of those appropriate control measures to eliminate or minimise the risks within their areas of responsibility.
- Ensuring that all staff and others in their areas affected by the organisation's operations are made aware of all the hazards within their working environment and of their personal responsibilities, and that they receive appropriate information, instruction, training and supervision to enable them to work safely.
- Ensuring that staff within their area are aware of the Trust's strategy for managing risk, and their individual responsibilities in delivering this strategy.
- Ensuring that staff within their area are appropriately trained (see section 7).
- Escalating any significant concerns to their Head of Department, Service Manager or Matron.

All staff
All staff are expected to:

- Report incidents and near misses using the Trust's incident reporting system (radar healthcare) and in accordance with the Trust's Incident reporting and management policy and procedure PP105
- Support safe clinical practice in diagnosis and treatment.
- Be familiar with the Trust's risk management strategy and departmental risk issues.
- Adhere to all relevant Trust policy and procedures.
- Be aware of emergency procedures relevant to their area of work.
- Attend mandatory training or seek additional training to carry out the duties of their role.

Divisional Performance Review Meetings
Responsible for reviewing quality, finance, risk and operational delivery/performance within the Division. This includes:

- Receiving performance reports for the key areas, including defined metrics and KPIs
- Receiving Divisional reports detailing areas of good practice and concerns with appropriate remedial action plans

- Accountable to the Management Executive Group and escalating areas of concern as appropriate to the relevant Board Assurance Committee and/or Board.

Divisional Board
Provides a single line of accountability for all aspects of quality and performance including patient safety, risk management, patient experience, quality improvement, operational standards, financial performance and staff engagement relating to the Division.

- Approve the division's **strategies, policies, plans and business cases** and allocation of management, financial and physical resources in line with the Trust's strategic framework, ambitions and operational plan
- Monitor the division's **quality, operational and financial performance**, agreeing actions and responsibilities to address shortcomings to ensure delivery of:
    - quality and performance metrics, statutory duties, national and local standards and targets and other obligations
    - quality priorities and quality improvements, including CQC self-assessment
    - activity and income plan
    - capacity and workforce plans
    - cost improvement plan to achieve the Trust plan for the division and monitor its delivery and receive assurances on project quality assurance scores
- Review divisional **business plans**, including consideration of all underpinning strategies e.g. information, estates, education, and workforce etc.
- Develop and deliver **transformation schemes** for the division
- Review **capacity and demand** within the division and approve changes to use of resources in line with identified need
- Prioritise and implement capital and revenue **business cases** gathering relevant evidence of benefits realisation. Approval of business case will be made in accordance with the approved scheme of delegation
- Ensure that **risks** to patients, staff or performance are effectively identified, assessed and managed and as appropriate escalated
- Reviewing identified hazards and associated risk assessments within the division and to consider what should be added to the risk register.
- ensure effective preparation for the Divisional Performance Review Meeting **escalating** issues as appropriate and reporting business case decisions taken within delegated authority.

Operational, specialty & business unit meetings
To work in collaboration with colleagues within the triumvirate in achieving divisional & strategic objectives. The triumvirate is responsible for the performance of their business unit for all national and local targets and other metrics monitored and reported by the Trust. This includes the monitoring and management of:

- All quality metrics collected including all those included in the quality dashboard such as patient falls and pressure ulcers
- Patient experience performance including all patient surveys, Friends and Family testing, patient complaints and compliments
- Quality improvement framework and delivery, including audit and effectiveness
- Health and safety management including management of the risk assessments, risk register, incidents and trends
- Management of budgets, capital spends and monitoring of project ROI
- Adherence to national and local targets e.g. 18-week RTT, Rapid Access and the 4 hour emergency attendance target
- Achievement of relevant CQUIN requirements
- Workforce metrics including sickness absence, efficiency of rostering, recruitment and retention and use of bank and agency staff
- Service reviews including skill mix and production of business cases
- Business planning, short and long term in line with the Trust's strategic framework

- Populate & analyse the business unit dashboard in liaison with the triumvirate colleagues at monthly business unit meetings
- Any business cases or plans requiring approval for the business unit, including the production and monitoring of benefits
- Implement decisions of the Divisional Board
- Report and escalate issues as appropriate to the Divisional Board.

Ward/Department Governance Groups
Have responsibility to consider quality and risk management issues within the ward/department. This includes:

- Monitor and when necessary take action to improve performance against agreed ward/department quality priorities in relation to safety, effectiveness and patient experience
- Provide a systematic approach to encourage learning and promote improvements in practice based on individual and aggregated analysis of incidents, complaints and claims, through:
    - Monthly review of incidents, complaints and PALS enquiries, including monitoring of action plans for amber incidents.
    - Regular analysis of incident and complaint data
- Reviewing identified hazards and associated risk assessments within the division and to consider what should be added to the risk register.
- Ensure effective implementation of best practice locally through audit, clinical benchmark analysis and implementation of national best practice (e.g. NICE and Royal College reports).
- Escalating any significant concerns or recommendations of any risks which need to be added to the risk register to Service Manager/Matron and/or the Divisional Board.

6.3 Nursing and Governance Department

Within the Governance Department, the following key posts support the management of quality and risk in the Trust: Trust Secretary & Head of Governance, Head of Patient Safety and Quality, Head of Health, Safety and Risk, Head of Patient Experience, Head of Information Governance and Legal Services, Trust Solicitor, Patient Safety & Quality Managers , Head of Compliance and Effectiveness. Together these posts are responsible for:

- Communicating and co-ordinating the process of risk management throughout the Trust.
- Supporting Divisional Boards to identify and manage risks at a local level.
- Acting as a central reference point for all risk management issues and co-ordinating the management of risk activities throughout the Trust.
- Managing the Trust's system (radar) for reporting incidents and near misses and encouraging prompt reporting of all incidents.
- Liaising with statutory and other official bodies, for example the Health and Safety Executive, Care Quality Commission, Audit Commission, NHSE&I.
- Supporting the review of incident trends and feeding back information and learning to relevant committees, i.e. Clinical Effectiveness Governance Group and Divisional Boards.
- Co-ordinating the investigation of serious incidents in line with the Trust's Incident Reporting and Management Policy PP105.
- Reporting of Serious Incidents Requiring Investigation (SIRIs) to the Integrated Care Board ICB and providing progress reports regarding investigation and learning.
- Managing claims (clinical negligence, employers and public liability, property losses) quickly, economically and effectively to minimise the financial and other potential negative consequences e.g. distress to the claimant and negative publicity etc.
- Supporting the clinical audit process by promoting, supporting and facilitating this across the Trust so that that all patient care wherever possible should be evidence based.
- Ensuring that appropriate audit processes are in place and that results and recommendations coming from clinical audit are incorporated into the clinical governance agenda of divisions and are their implementation monitored.

- Co-ordinating the implementation of NICE guidance, National Service frameworks (NSFs) and confidential enquiries.
- Ensuring that the Trust has appropriate and adequate 'insurance' arrangements with NHS Resolution in respect of clinical negligence and third party and professional liability and where appropriate commercial insurers.
- Acting as a central source of information on risk and statutory safety issues, distributing this information as necessary using the Trust's risk register and assurance framework.
- Ensuring that the Trust has appropriate policies and procedures relating to risk/health and safety issues to comply with statutory requirements and Approved Code Of Practices.
- Ensuring effective liaison with other organisations with whom there is a shared responsibility for risk management such as the ICB.

6.4 Other specialist support

Specialist support and advice is also available, including Occupational Health, Estates, Local Security Specialist, Emergency Planning, Infection Control Team, Named Nurse for Safeguarding Children, Blood Transfusion Team and Clinical skills trainers.

7. Education and training

7.1 Board members and senior managers

The Board of Directors will receive specific risk management training on a two-yearly basis. This will be arranged by the Trust secretary and reflect specific learning needs of board members and issues included within the annual risk management plan and quality improvement plan. This training will be considered mandatory and where individuals miss training alternative opportunities will be arranged.

It is essential for senior staff to have a high level of awareness of the duties placed upon them by the Health and Safety at Work etc Act 1974 and other relevant legislation.

All Managers within The Trust are required to complete the relevant mandatory training. Any change in policy / practice / legislation etc. will be addressed through targeted update training to all relevant staff.

7.2 All staff groups (including volunteers)

The policy and procedure for delivery of mandatory training to all other staff groups is set out in trust policy PP244 mandatory training.

8. Monitoring

- Two-yearly review of the committees' terms of reference to ensure they have fulfilled their responsibilities.
- The Board receives information on key performance indicators as part of the integrated quality and performance report (IQPR)
- The Trust rolling programme of workplace assessments will identify whether appropriate risk management processes are in place at local level (e.g. local risk assessments).
- The Board assurance committees will receive information on its high (red) risks.
- Risk register reports to Corporate Risk Governance Group, includes thematic analysis of the risk register

9. Development of strategy and policy

9.1 Other relevant documents

- Incident reporting and management PP105;

- Handling of Clinical Negligence and Personal Injury Claims PP061;
- Health, Safety and Welfare Policy PP018
- Inquest policy and procedure PP135
- Local resolution of complaints PP002
- Maternity, Obstetric and Gynaecological Risk Management Strategy PP137
- Occupational Health Policies PP046
- Staff Concerns about Patient Care PP056
- Risk assessment policy and procedure PP132
- PP244 Mandatory training
- Business Continuity Policy PP256
- NICE policy PP218
- Responding to nationally issued best clinical practice publications PP205

9.2 Changes compared to previous document

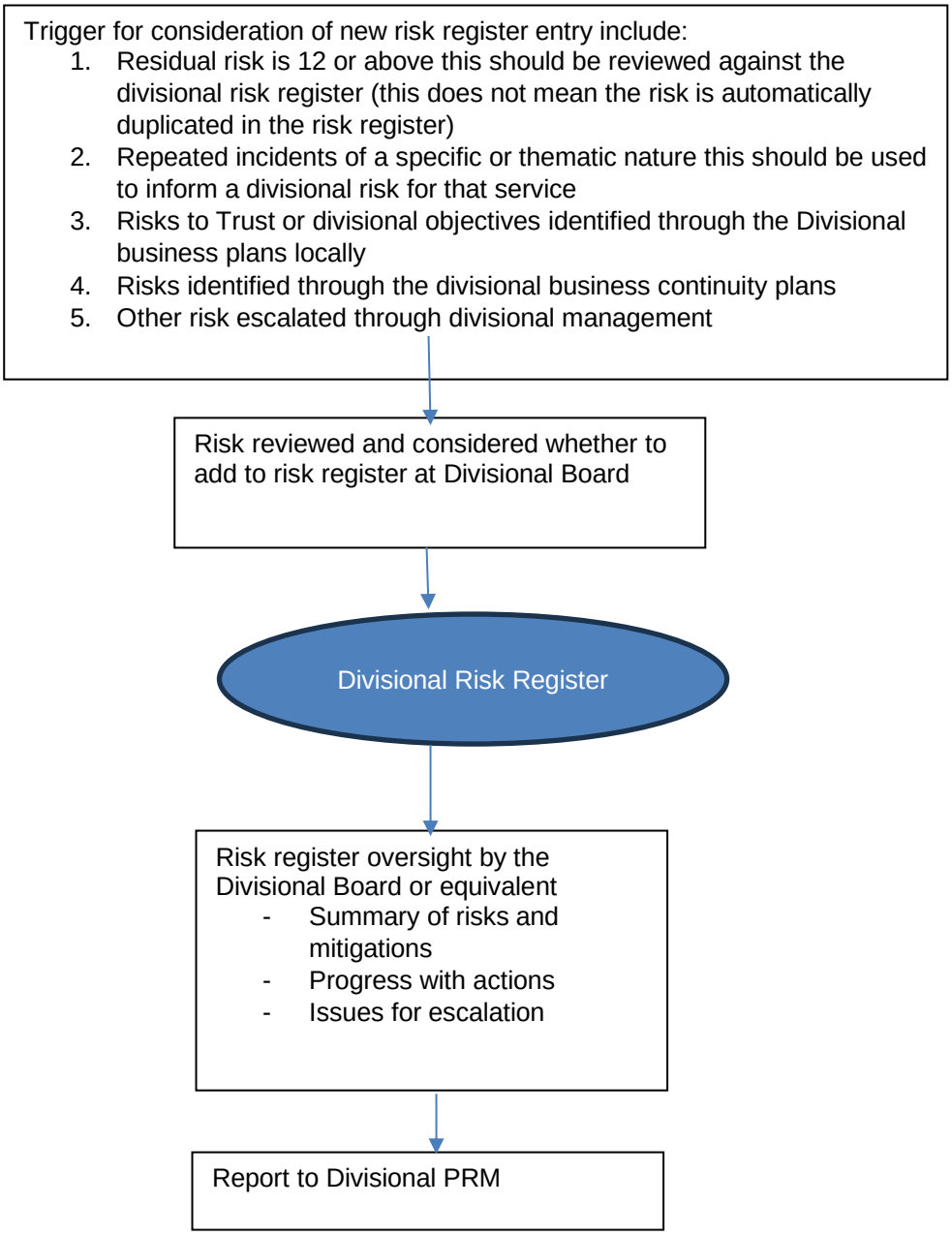
This document replaced the Trust's previous Risk Management Strategy PP(23)093. Changes to the document include:

- Updated to reflect introduction of new risk management system radar healthcare
- Updated details of specialist committees
- Updated Risk Appetite
- Added new risk matrix

Document configuration information

Author(s):	Trust Secretary and Head of Health, Safety and Risk
Other contributors:	Executive Chief Nurse
Approvals and endorsements:	CRGG, MEG and Trust Board
Consultation:	
Issue no:	16
File name:	S:\RISK OFFICE\Policies and Procedures\PP(24)093 Risk Management Policy and Strategy.docx
Supersedes:	PP(23)093
Equality Assessed	Yes
Implementation	This document will be widely circulated within the Trust, including all heads of department and ward managers and will be made availability on the Trust's Intranet and Internet sites. Relevant changes will be brought to the attention of staff during circulation. Comprehensive training programmes exist including mandatory training and relevant modules as detailed in the Trust's training prospectus. Specialist training will also be targeted at those with responsibility for managing hazards with a high risk rating.
Monitoring:	See section 8. The Corporate Risk Governance Group has the responsibility for monitoring compliance to this policy and strategy.
Other relevant policies/documents & references:	See section 9.1 and 9.3

Appendix A **Divisional Risk Register**

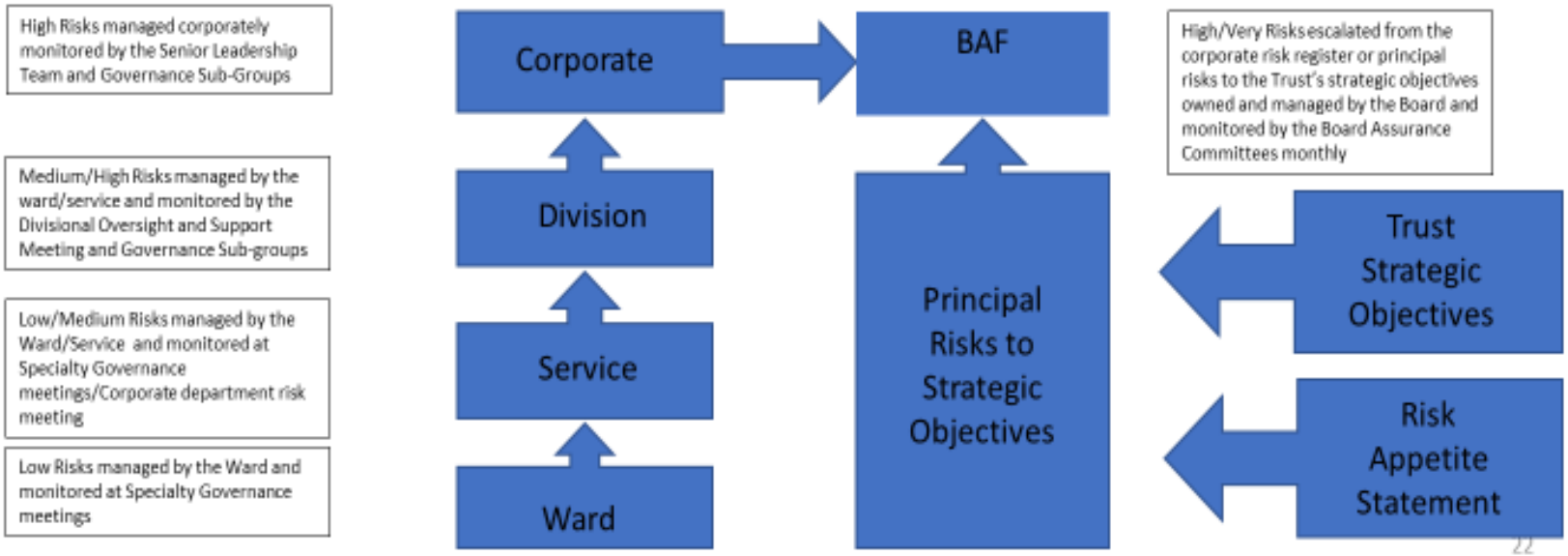


Risk Management

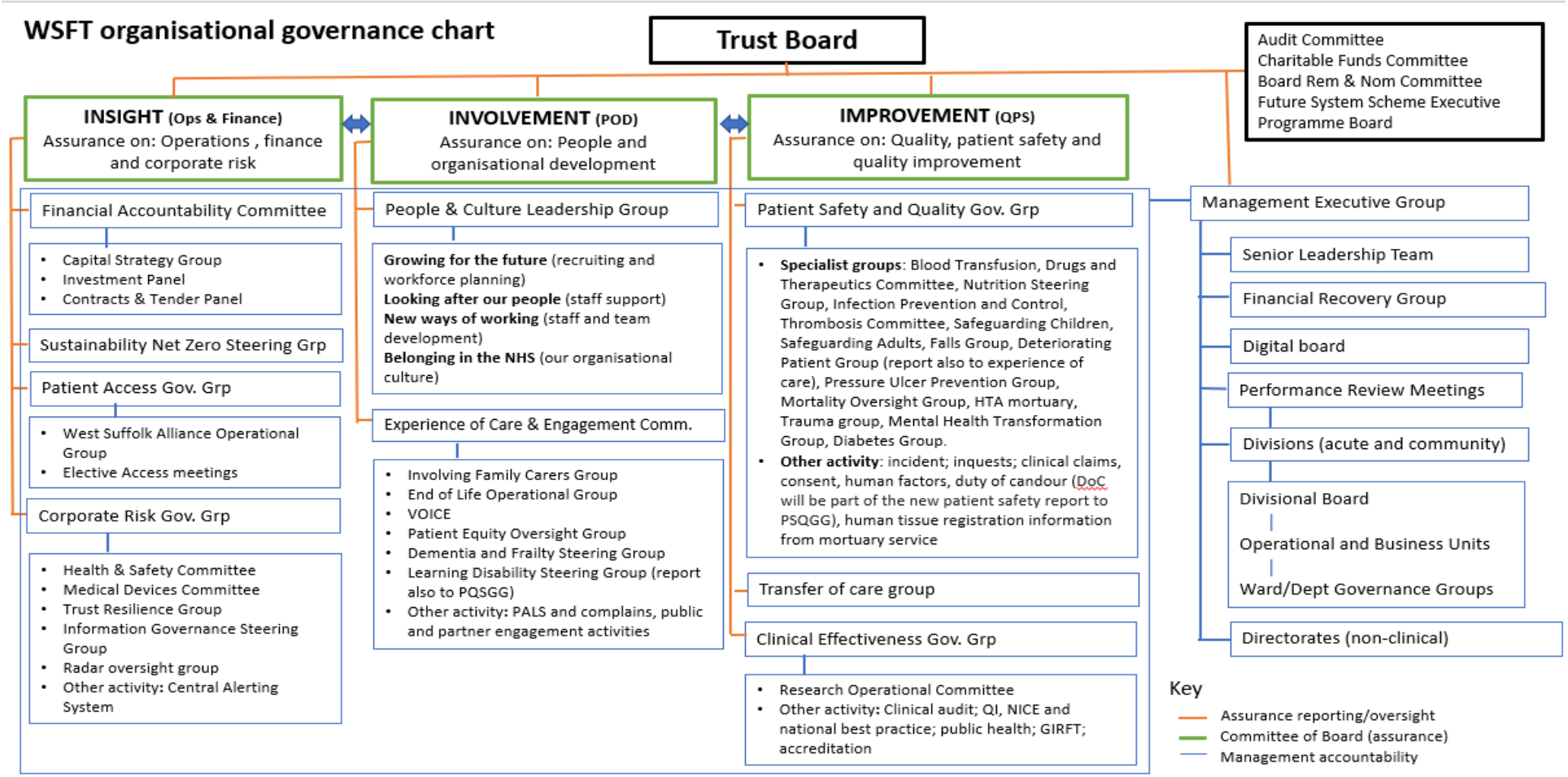
The board is responsible for ensuring that the organisation has appropriate risk identification and risk management processes in place to deliver strategic plans and comply with the registration and licensing requirements of key regulators. This includes systematically assessing and managing risks at all levels from ward to board.

Risk Management is the process of identifying, assessing, analysing and managing all potential risks. Decisions made within an organisation should take into account potential risks that could directly or indirectly affect patient care.

Board Assurance Framework: This is a document that sets out strategic objectives, identifies risks in relation to each strategic objective along with controls in place and assurances available on their operation.



Appendix C: Organisational governance chart



Modern Slavery Act Statement

Our organisation

The West Suffolk NHS Foundation Trust (WSFT) provides acute and community healthcare services in West Suffolk, as well as running the West Suffolk Hospital, West Suffolk NHS Foundation Trust is joining up NHS care across the area providing many of the community services in West Suffolk.

The West Suffolk NHS Foundation Trust is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain.

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same values.

We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management will act upon them in accordance with our policies and procedures.

The West Suffolk NHS Foundation Trust supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it and supporting victims. We are committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to mitigate the risk of modern slavery are outlined in the sections below.

Arrangements to prevent slavery and human trafficking

We are committed to ensuring there is no modern slavery or human trafficking in our supply chains or any part of our business activity.

Our commitment to social and environmental responsibility is covered by our approach to modern slavery and human trafficking, which is part of our safeguarding arrangements.

People

- Appropriate pre-employment checks on directly employed staff and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff
- A range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair Terms and Conditions of employment and access to training and development opportunities
- Consultation and negotiation with Trade Unions on proposed changes to employment, work organisation and contractual relations
- Appropriate adult and children's safeguarding policies are in place to ensure staff are alert to, and report any concerns about patients who may be subject to human trafficking or modern slavery

Speaking up at the Trust

- The Trust believes that every member of staff has a duty to raise concerns at the earliest reasonable opportunity about the provision of care or any other malpractice within the trust where care and/or behaviour/conduct is believed to be inadequate or unacceptable. In addition, staff have duties imposed upon them to raise such concerns through their respective professional regulatory bodies, such as the GMC, NMC, ACCA etc.

Safeguarding/Training

The following arrangements are in place within our safeguarding policies and procedures, training and operations:

- Trafficking is highlighted as a possible risk for unaccompanied asylum seeking children within our safeguarding children policy and there is a link to the Suffolk safeguarding children board's quick guidance on the safeguarding microsite. Any concerns where a child may be considered at risk of abuse follows the same pathway of referral.
- The Trust's domestic abuse and women at risk of social exclusion policies address the risk of modern slavery. The Trust safeguarding specialist midwife would be informed and a multi-agency referral completed. The role of safeguarding specialist midwife is to have concern for the safety and wellbeing of a child or unborn in these circumstances.
- The modern slavery and trafficking statement and information related to the NHS Safeguarding App is part of the WSFT trust induction for adult and children safeguarding training resource.

Supplies and tenders

The Trust complies with the Procurement Act 2023 and uses the mandatory Pre-Qualification Questionnaire on procurements which exceed the prescribed threshold. Bidders are required to confirm their compliance with the modern slavery act.

Sub-contractors

Our procurement and contracting team is qualified and experienced in managing healthcare contracts and have received appropriate briefings on the requirements of the Modern Slavery Act 2015, which includes:

- Requesting evidence of their plans and arrangements to prevent slavery in their activities and supply chain
- Using our routine contract management meetings with our providers to address any issues around modern slavery
- Implementing any relevant clauses contained within the standard NHS contract

Board Approval

This statement has been approved by the Trust Board, who will review and update it on an annual basis.

Approval date: 28 March 2025 (subject to approval by the Board)

Annex C: Scheduled draft agenda items for next meeting – 23 May 2025

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient/staff story	✓	✓	Verbal	Matrix	SW / JMO
Chief Executive's report	✓		Written	Matrix	EC
System update: - West Suffolk Alliance and SNEE Integrated Care Board (ICB) - Wider system collaboration - Collaborative oversight group	✓		Written	Matrix	 PW / CM ST ST
Future System Board Report	✓		Written	Matrix	EC
Digital Board report	✓		Written	Matrix	NC
Insight Committee - committee key issues (CKI) report - Finance report	✓		Written	Matrix	AJ / NC / JR
Involvement Committee – committee key issues (CKI) report - People and OD Highlight Report o Putting you First award	✓		Written	Matrix	TD / JMO
Improvement Committee – committee key issues (CKI) report - Maternity services quality and performance report - Nurse staffing report - Quality and learning report, including mortality and quality priorities - AuditOne recommendation – progress report	✓		Written	Matrix	RP / SW
Audit committee – committee key issues (CKI) report	✓		Written	Matrix	MP
Charitable funds committee report (27 Mar CFC meeting)	✓		Written	Matrix	RF
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Governance report, including - Senior Leadership Team report - Management executive group report - Council of governors - Use of Trust's seal - Register of interests (Board of Directors) - Agenda items for next meeting	✓		Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Board assurance framework report	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)	✓	✓	Verbal	Matrix	JC

Description	Open	Closed	Type	Source	Director
Annexes to Board pack: - Integrated quality & performance report (IQPR) – annex to Board pack - Others as required					

8. OTHER ITEMS

Presented by Jude Chin

8.1. Any other business

To Note

Presented by Jude Chin

8.2. Reflections on meeting

For Discussion

Presented by Jude Chin

8.3. Date of next meeting - 23 May 2025

To Note

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

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

9. SUPPORTING APPENDICES

To inform

Presented by Jude Chin

Item 3.1 IQPR Full Report

To Note

Presented by Nicola Cottington

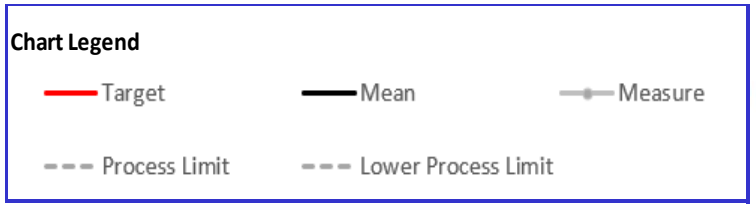
Assurance Grid

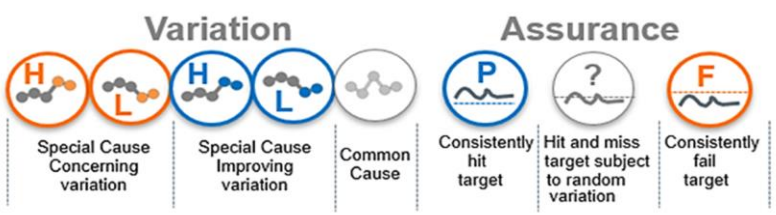
Performance in January 2025		ASSURANCE: Will we reliably meet the target based?		Not Met	
		Pass (P)	Hit and Miss (?)	Fail (F)	No Target
VARIANCE: Variation from the mean The colours indicate the trend- positive (blue), Negative (orange), or neither (grey)	Special Cause Improvement (H / L)		**INSIGHT** Virtual Beds Trajectory **INVOLVEMENT** Staff Sickness – Rolling 12months Staff Sickness Mandatory Training Turnover	**INSIGHT** Virtual Ward Total average occupancy number RTT 78+ Weeks Waits **INVOLVEMENT** Appraisal	**INSIGHT** Virtual Ward Total bed days RTT 65+ Week Waits RTT NDD Only Waiting List RTT NDD Only 65 Weeks Wait **IMPROVEMENT** SHMI **INVOLVEMENT** % resolved in one week Total PALS resolved Count
	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 – Acute Virtual Ward Total average occupancy percentage 28 Day Faster Diagnosis Cancer 62 Day Performance Community Paediatrics RTT Overall 78 Waiting List Community Paediatrics RTT Overall 104 Waiting List **IMPROVEMENT** C-diff Hospital & Community onset, Healthcare Associated	**INSIGHT** 4 hour performance 12 hour breaches as a percentage of attendances	**INSIGHT** Criteria to reside – Acute Criteria to reside – Community Potential 65+ ww at end of Jan 2025 Community Paediatrics RTT Overall Waiting List Community Paediatrics RTT Overall 65 Waiting List RTT NDD Only 78 Weeks Wait RTT NDD Only 104 Weeks Wait **IMPROVEMENT** % of patients with Measured Weight Post Partum Haemorrhage Inpatient Deaths **INVOLVEMENT** Active complaints Closed complaints % extended Count extended % Complaints responded to late Count responded to late
Deteriorating	Special Cause Concern (H / L)			**INSIGHT** 12 Hour Breaches Incomplete 104 Day Waits Diagnostic Performance- % within 6 weeks Total	**INSIGHT** RTT Waiting List Community Paediatrics RTT Overall 52 Waiting List RTT NDD Only 52 Weeks Wait **IMPROVEMENT** % of patients with a MUST/PYMS assessment completed within 34 hours of admission

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 6 weeks Total, RTT 78+ Weeks Waits
INVOLVEMENT – Well Led: Appraisal

INSIGHT COMMITTEE METRICS

Urgent & Emergency Care summary

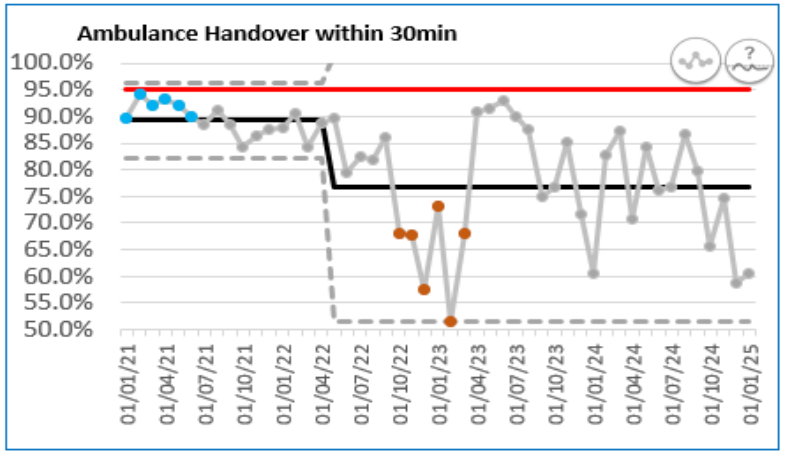


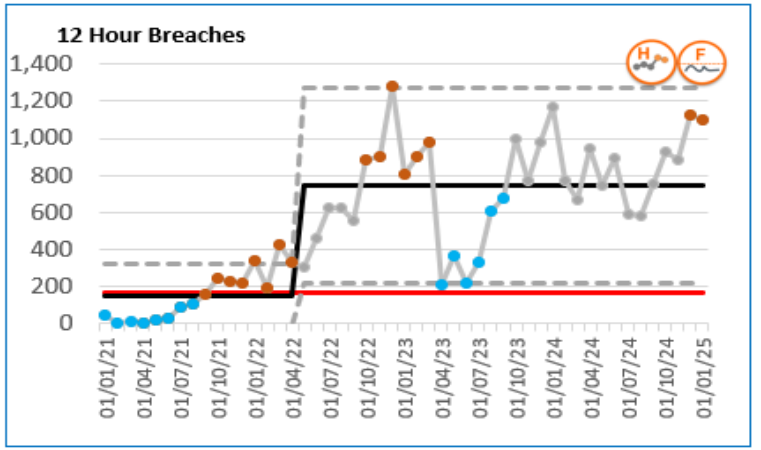


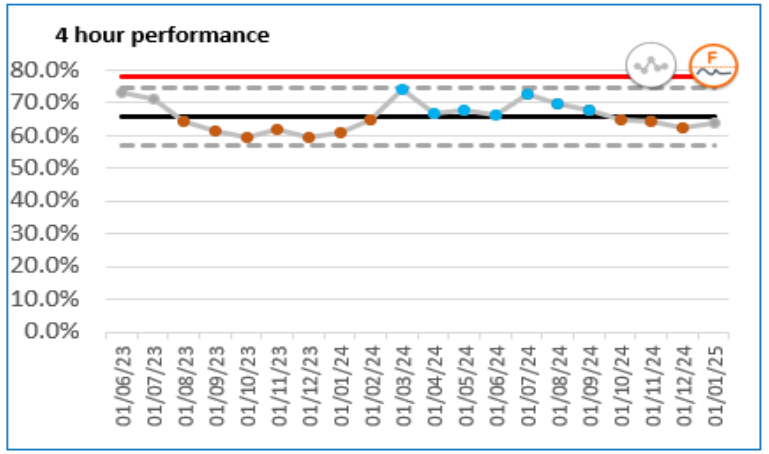
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Jan 25	60.5%	95.0%			76.7%	51.6%	101.8%
12 Hour Breaches	Jan 25	1101	167	H	F	747	223	1272
4 hour performance	Jan 25	63.7%	78.0%		F	65.7%	56.9%	74.6%
Non-admitted 4 hour performance	Jan 25	76.3%	85.0%			75.9%	65.4%	86.3%
12 hour breaches as a percentage of attendances	Jan 25	14.0%	2.0%		F	9.5%	3.0%	16.0%
Urgent 2 hour response - EIT	Jan 25	95.0%	70.0%		P	90.7%	83.1%	98.4%
Criteria to reside (Average without reason to reside) Acute	Jan 25	54				55	40	70
**Criteria to reside (Average without reason to reside) Community	Jan 25	32				35	23	47
% patients with no criteria to reside (acute)	Jan 25	12.3%	10.0%			12.7%	8.7%	16.7%
Virtual Beds Trajectory	Jan 25	50	40	H		42	39	45
Virtual Ward Total average occupancy number	Jan 25	37.1	47.2	H	F	23.3	14.7	31.9
Virtual Ward Total average occupancy percentage	Jan 25	74%	80%			68%	43%	93%
Virtual Ward Total bed days	Jan 25	1625		H		718	325	1112
Virtual Ward Total average LOS per patient	Jan 25	8.1	14.0		P	9.0	5.0	13.0

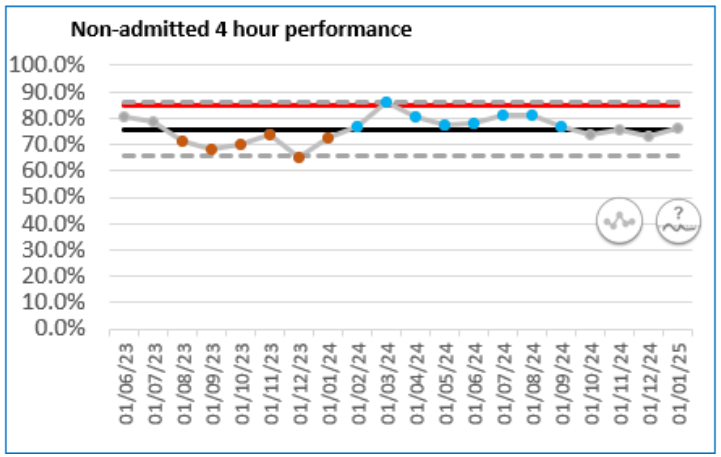
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

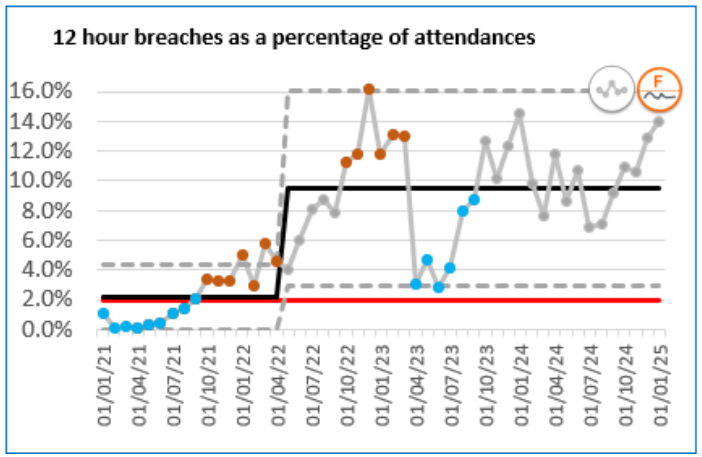
Urgent & Emergency Care: ED 4 Hour Performance

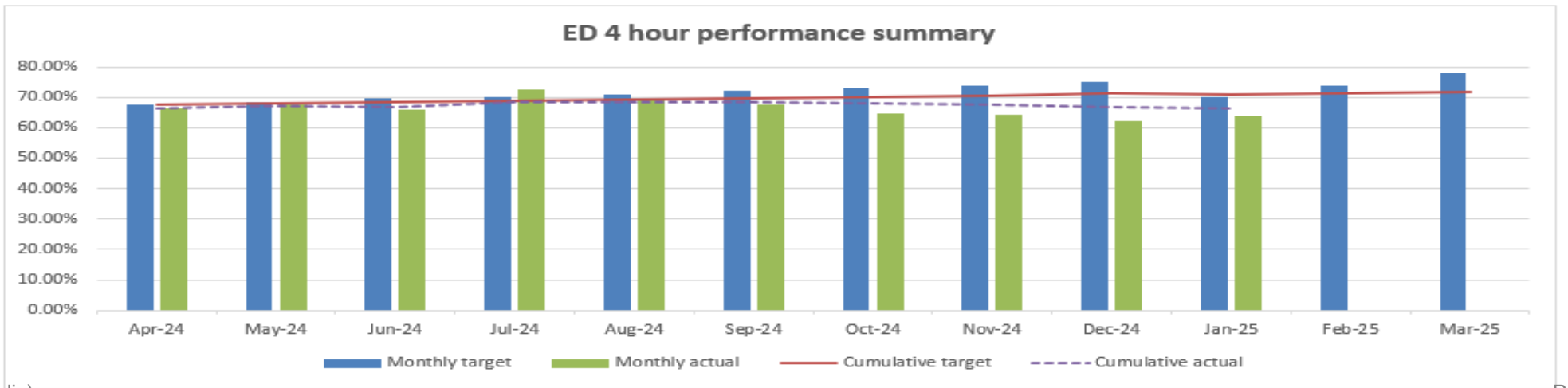












Urgent & Emergency Care

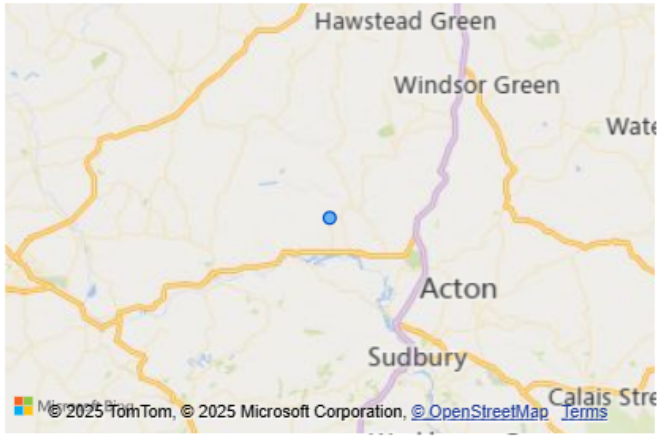
What	So What?	What Next?
30 minute ambulance handover metric, demonstrates no significant change. The main cause being high numbers of patients waiting a bed in the Emergency Department, resulting in the need to use additional cohorting areas. 12 hour length of stay breaches in January continue to show a failing picture. Numbers of 12 hour breaches as a percentage of attendances remains high and a cause for concern. Non-admitted performance shows no significant change with 76.79% achieved for January. The Emergency Department 4 hour performance for January was 63.69%, which was below the in-month trajectory of 70%.	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 national targets. Achieving the monthly trajectory will keep us on track to achieve 78% by March for the 4 hour standard. 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., continuing to working through a condensed action plan in order to achieve 78% 4hr Emergency Department target by March '25. Weekly performance meetings with the Emergency Department and Medical Division Senior Leaders/Executives continues. **Plans/Projects in February/March'25** • March Focus Action Plan developed, key areas include: Increased senior manager presence supporting performance at weekends and 5-9pm as an extension of current daily rota. Additional porter during key times to ensure smooth transfer of patients. Extended hours of MECU until midnight to support the minor injury/illness patients. Increased presence of surgical registrars in the Emergency department, Working to increase the number of patients taken to ambulatory areas such as Same Day Emergency Care/ ambulatory units. Emergency Intervention Team (EIT) based in ED in March. • The business case to continue the Minor Emergency Care Unit (MECU) was unable to be funded. Current work is underway to relocate the unit within the Organization, potentially in Outpatients with the aim of transferring there as soon as the current contract ends on April 10th , ensuring the service continues to function. • Pre booked next day returner Emergency Nurse Practitioner slots to support minor injuries attending after 10pm continues. • Ambulance service conducting a February Focus, their senior managers/clinicians working with crews to look at alternative pathways rather than the Emergency Department for suitable patients. • Acute Ward Taskforce commences 3rd March for one week. Longer term – Focus of the division in 2025 is Frailty transformation with an emphasis on Frailty being embedded within the community, this will include exploring a Frailty Hub being located away from the acute side to release UEC pressure.

Community Access Glemsford Surgery

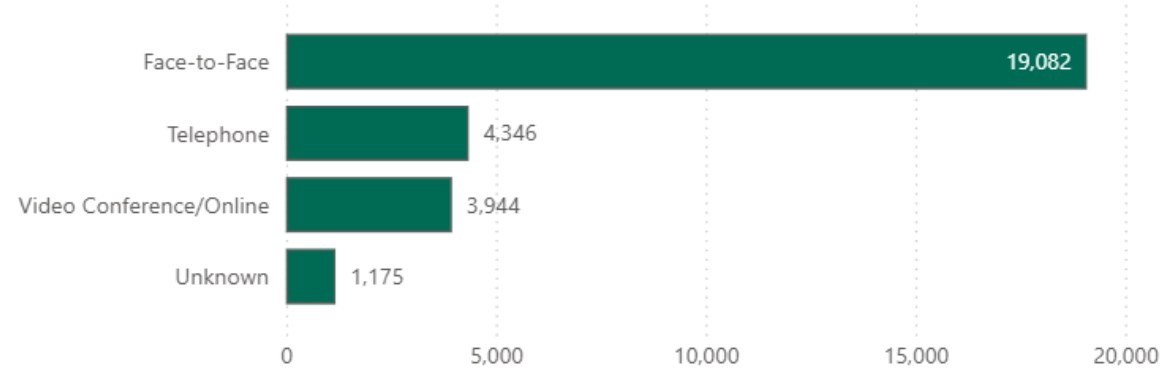
Practice Appointments

Refreshed on 15/01/2025, Data coverage up to 01/11/2024

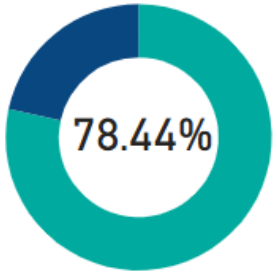
Alliance: All | PCN: All | Practice: Glemsford



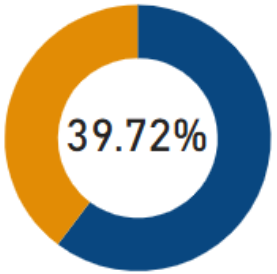
Practice appointments by contact mode



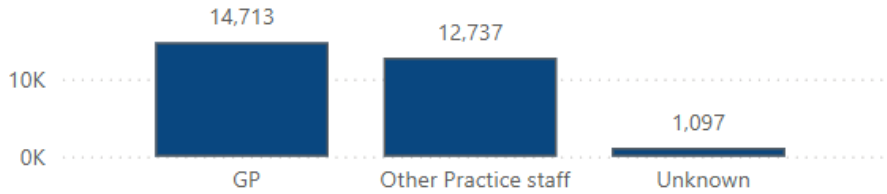
Seen within 2 weeks



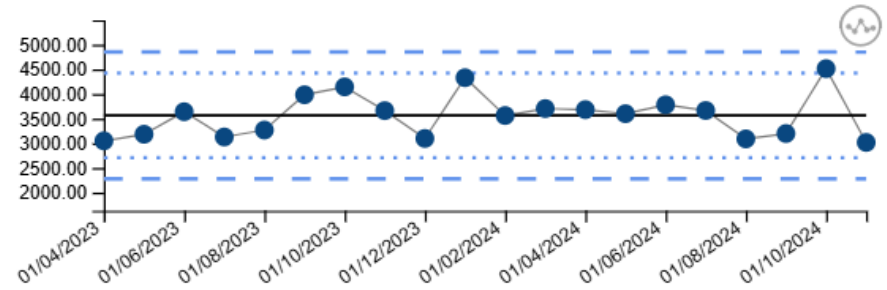
Seen within 48 hours



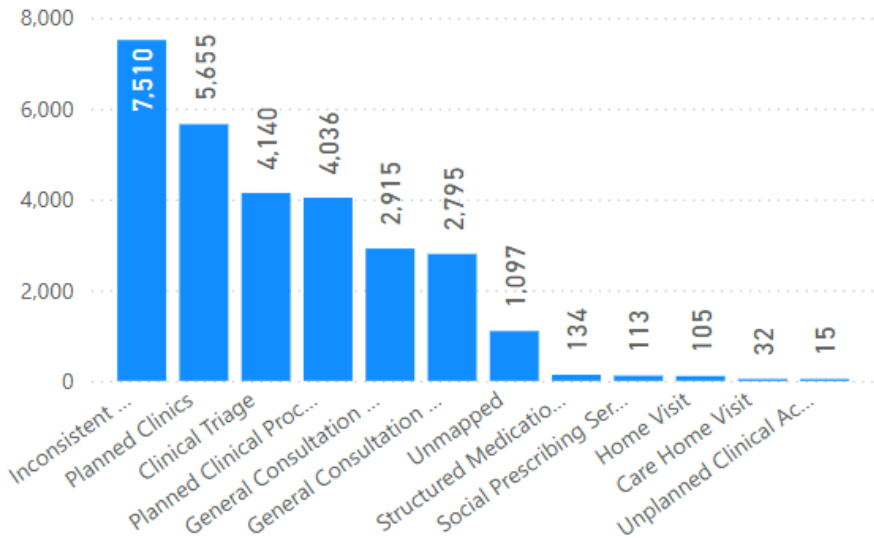
Practice appointments by health care professional type



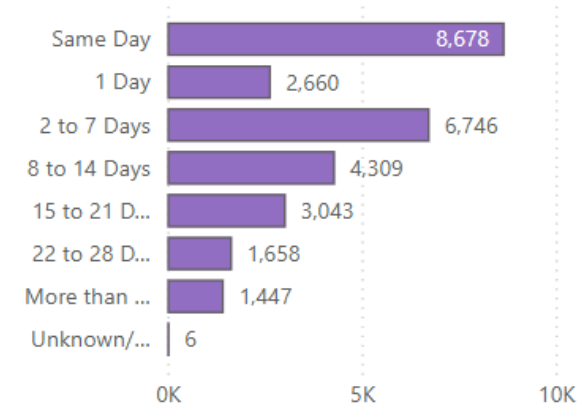
Total appointments by month



Sum of Total Appointments by National Category

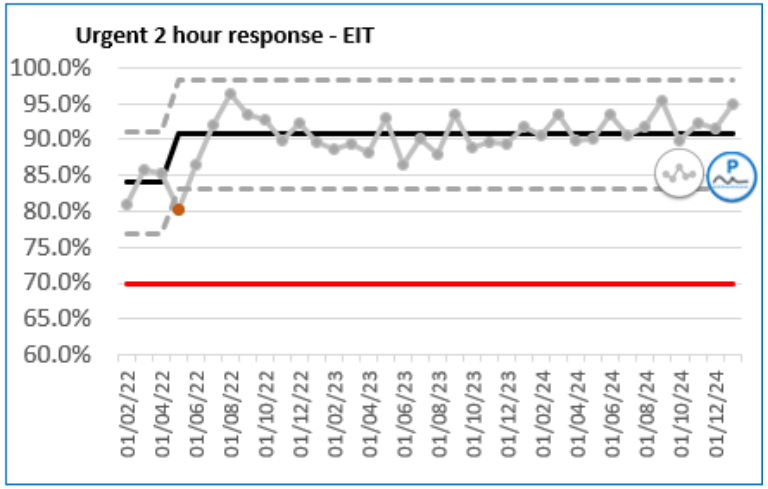


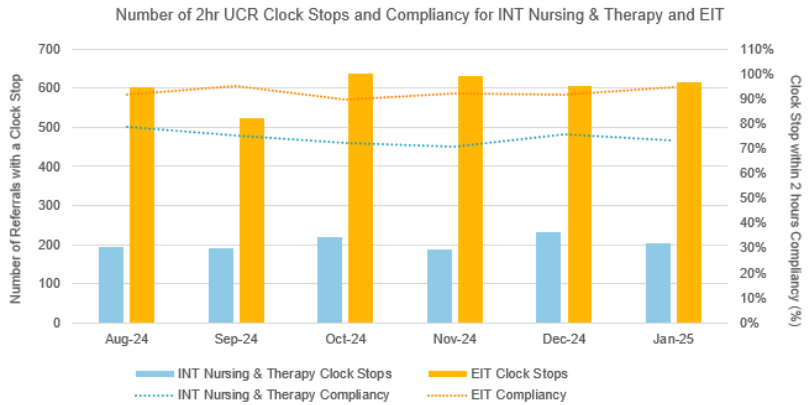
Appointments by wait time

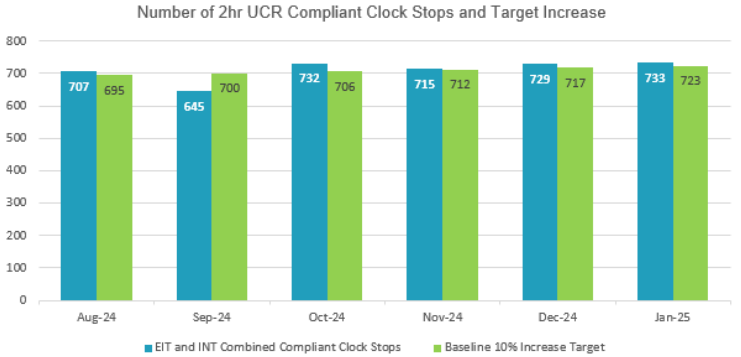


Produced by ICB

Urgent & Emergency Care: UCR







Team	Aug-24				Sep-24				Oct-24				Nov-24				Dec-24				Jan-25			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant
Total INT Nursing & Therapy	194	153	41	79%	191	144	47	75%	220	159	61	72%	186	132	54	71%	231	175	56	76%	203	149	54	73%
Total EIT*	604	554	50	91.72%	525	501	24	95.43%	637	573	64	89.95%	632	583	49	92.25%	605	554	51	91.57%	615	584	31	94.96%
Combined Total	798	707	91	88.60%	716	645	71	90.08%	857	732	125	85.41%	818	715	103	87.41%	836	729	107	87.20%	818	733	85	89.61%

What

- Remains well above 70% target for 2 hour response.
- The number of referrals & clock stops for urgent Care Response is increasing month on month, and exceeding the 10% baseline increase target.

So What?

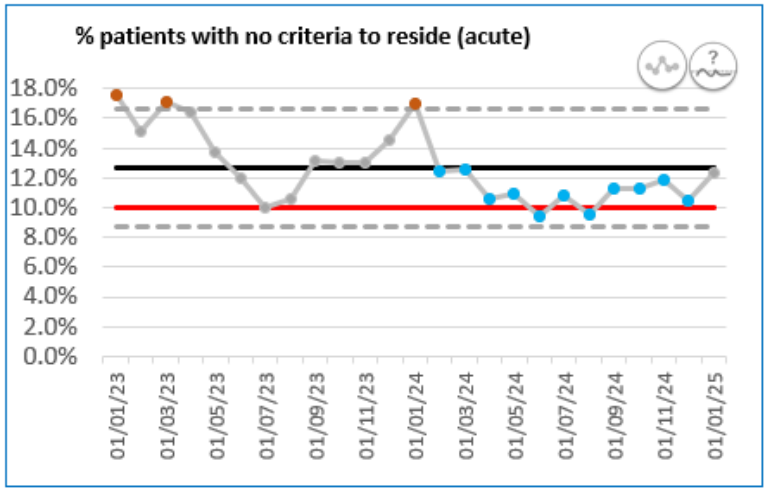
Excellent performance to meet the 2 hour response target

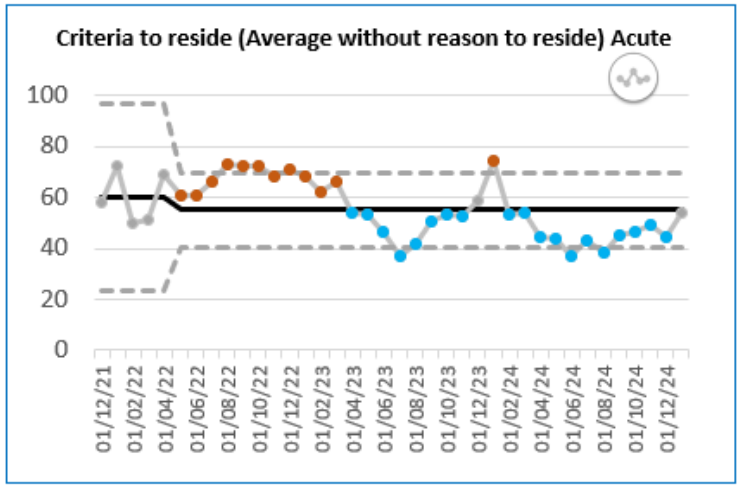
What Next?

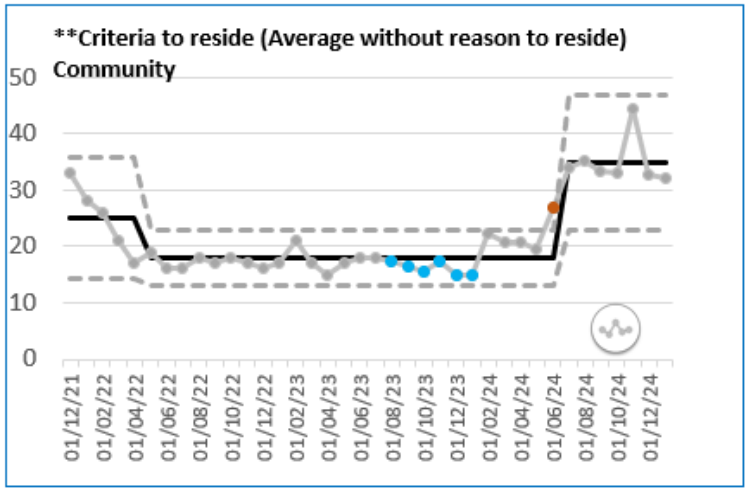
To maintain compliance with urgent 2 hour response INT teams will have to continue to cancel or defer less urgent work. All performance and quality metrics are being monitored , this is limited by capacity to streamline data collection to smartly identify cases for review. Cancelled visit clinical audit due, undetermined where this will fit in and scope of harm review at present.

Community taskforce focus on increasing therapy presence in Emergency Department (ED) for March. Plan to test impact and identify where we can work pre-presentation to avoid patients journey to ED.

Urgent & Emergency Care: Criteria to reside

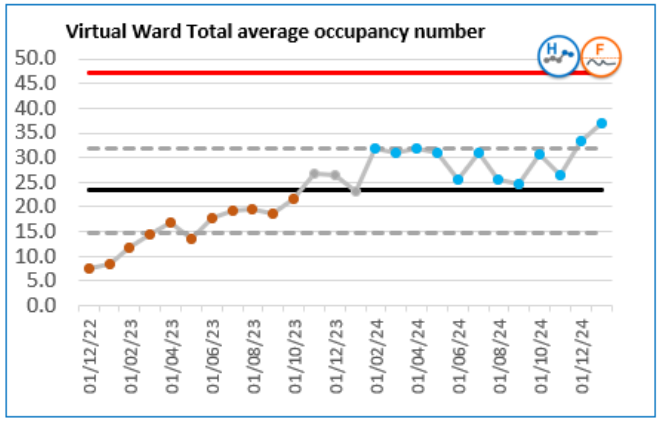


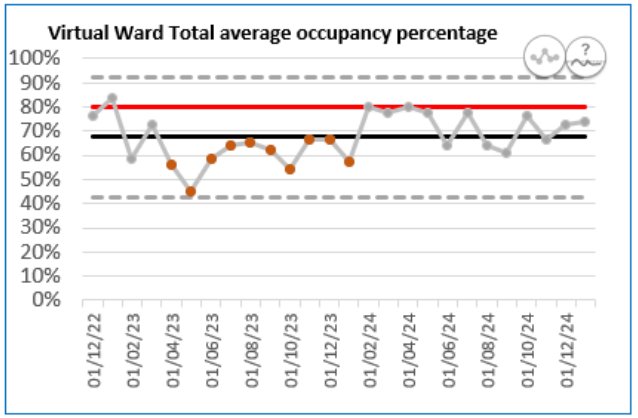


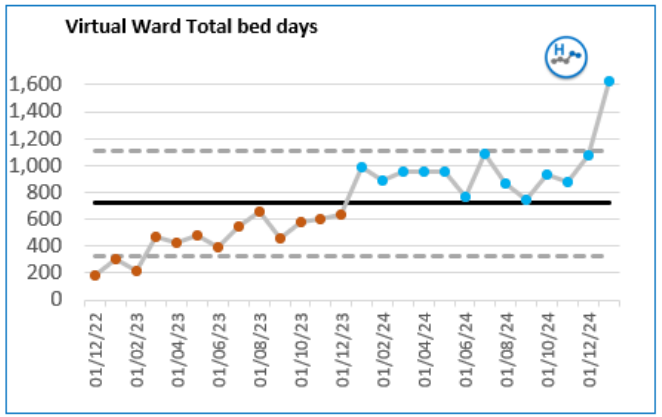


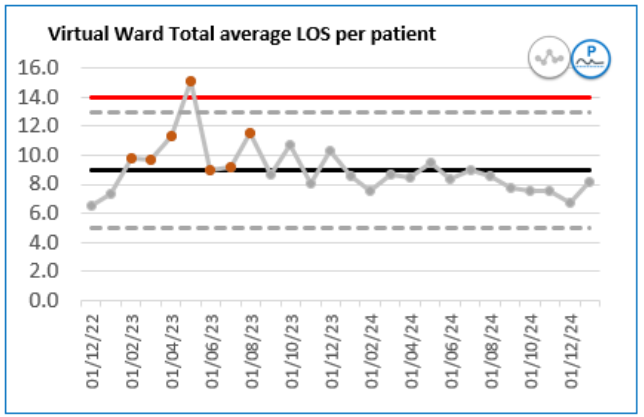
What	So What?	What Next?
No significant change in criteria to reside data this month for acute or community.	Patients remaining in hospital longer without criteria to reside directly impacts on bed capacity and patient flow within the Trust. Longer length of stay leads to greater deconditioning and loss of independence.	The Community Taskforce team have produced a detailed action plan aimed at improving flow through Transfer Of Care Hub and CAB : working groups already underway and priority actions to be implemented and taking effect throughout March.

Urgent & Emergency Care (TRUST – Virtual Ward)

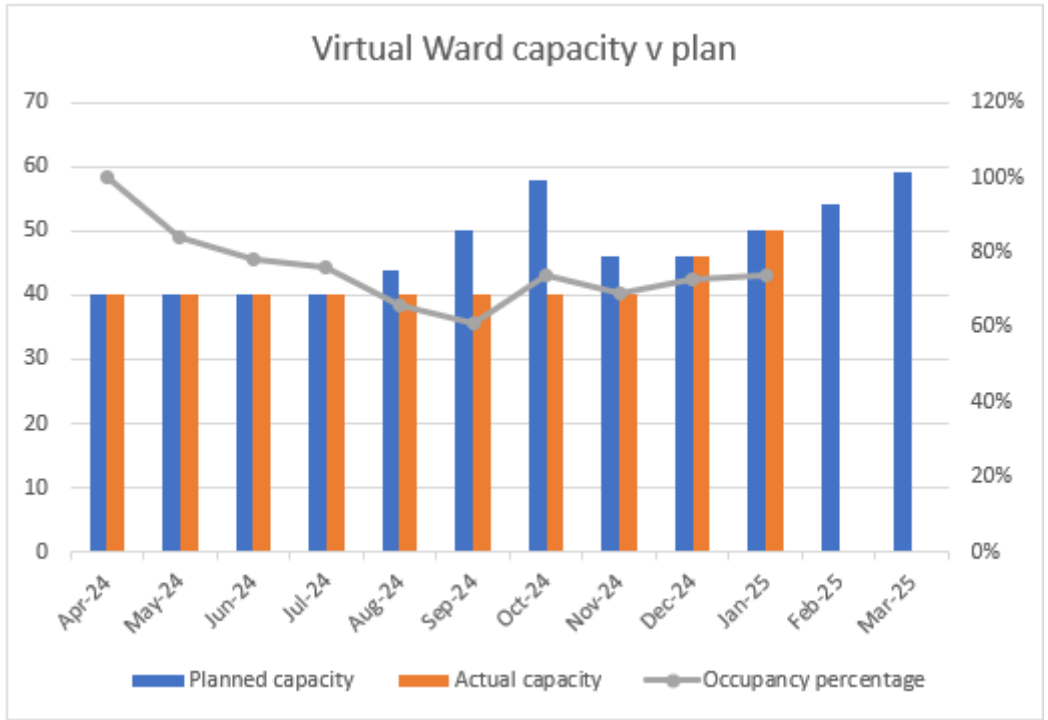






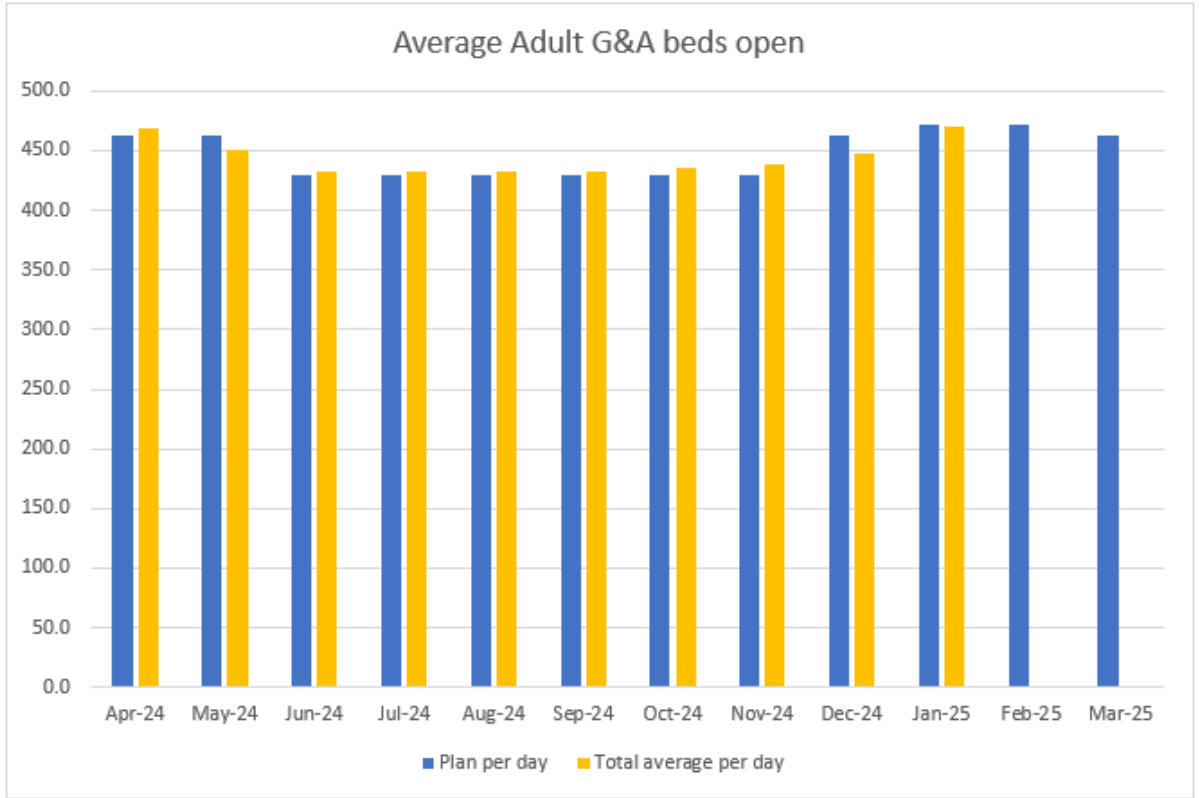


What	So What?	What Next?
Capacity within virtual ward in on an improvement trend and in line with the revised trajectory agreed at Management Executive Group on 13/11/24. The increase in capacity is enabled by efficiencies achieved via enhanced integration across the INTs, EIT and virtual ward (via Shared Services Delivery programme). Occupancy is also on improvement trend. Length of stay consistently remains significantly below the national target of 10 days whilst maintaining appropriate acuity.	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow across the Trust and strategic ambition of caring for patients at or near wherever possible. Length of stay is important to facilitate effective flow.	Further integration with virtual ward core nursing and therapy team aligned into INTs and development of fully integrated staffing model. Plan to increase proportion of step up referrals in place to further develop occupancy rate. Virtual ward has developed specific actions plans as part of the UEC taskforce to be completed by end of March.



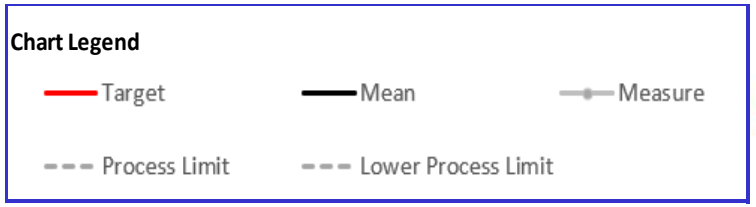
What	So What?	What Next?
Capacity to care for patients on our virtual ward in in line with the agreed trajectory. Health watch Suffolk presented an excellent investigation into carers experience of virtual ward on 6/2/25. The results were very positive and reinforce the impact of virtual ward for the right patients.	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.	Recruitment is underway for a joint VW Consultant/Community Geriatrician to provide clinical leadership and support further integration along with increase in step up activity. Healthwatch investigation provided rich data which will give a focus for areas of improvements, which is focused on the use of the digital platform.

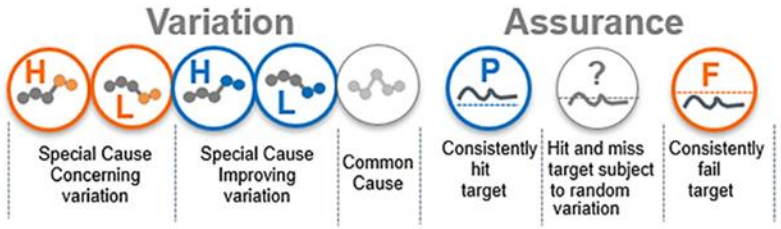
Urgent & Emergency Care: Beds



What	So What?	What Next?
January 2025 saw an increase in the average core beds open by 24.6 – this corresponds with the full opening of the winter escalation ward and use throughout January. Use of escalation beds decreased compared to December, though are above the annual average given their increased in response to operational pressures alongside other escalation spaces in line with our Tactical Patient Flow Escalation Plan.	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 all escalation area is monitored through the daily capacity meetings in conjunction with divisional leadership teams 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 increase in bed capacity through the winter escalation ward will be required through February 2025. A taskforce led by Medicine and Community and Integrated Therapies is reviewing ward processes in March to expedite discharge, reduce length of stay and enable the winter escalation ward to safely close.

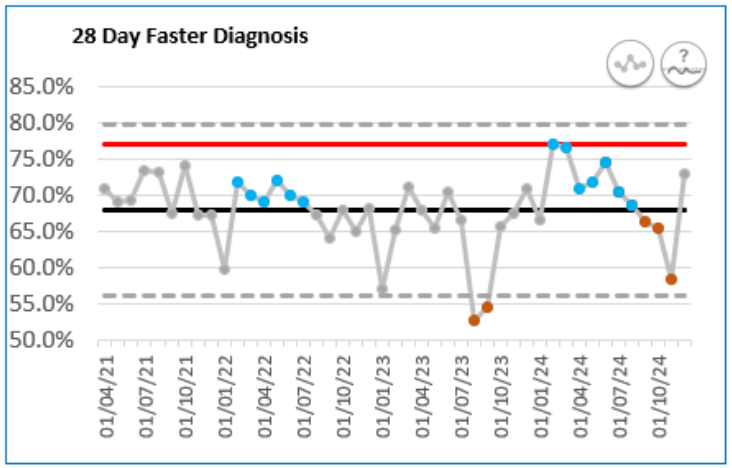
Cancer Access Summary

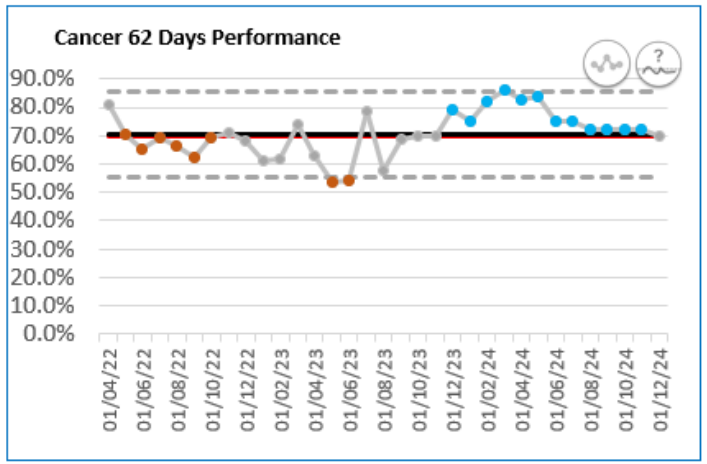


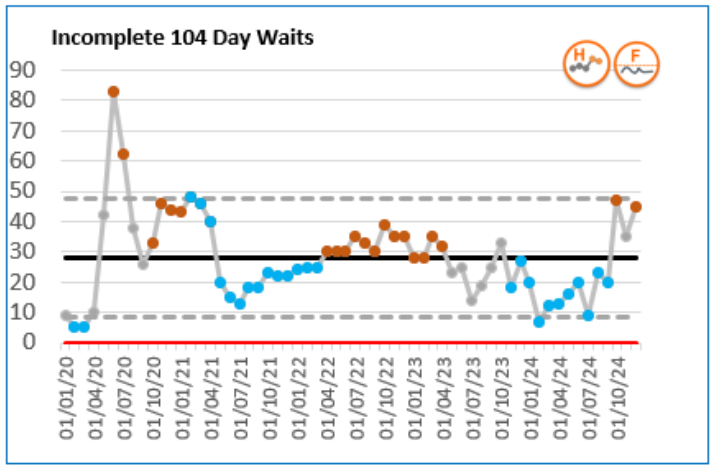


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Dec 24	72.9%	77.0%			68.0%	56.2%	79.8%
Cancer 62 Days Performance	Dec 24	70.1%	70.0%			70.7%	55.6%	85.8%
Incomplete 104 Day Waits	Dec 24	45	0			28	8	48

Cancer Access (Month Behind)

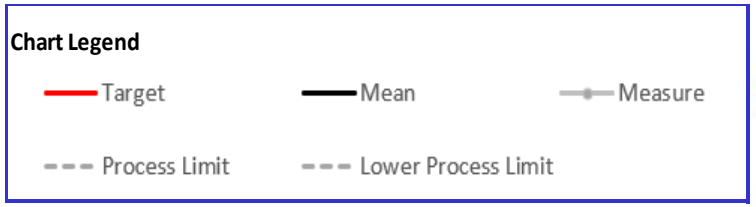


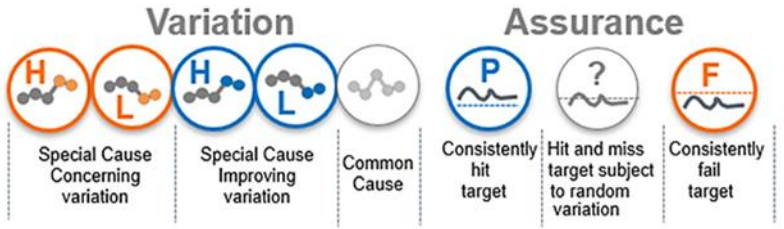




What	So What?	What Next?
Significant performance increase in overall FDS compliance from 58.5% to 72.9% with the biggest increases in Skin to 78.8% and Breast at 79.3%. Whilst this is still below the trajectory position, it is still expected that we recover to 77% by March 2025. For Skin this is due to the reduction in the waiting time for photography and the additional sessions throughout the month for both clinical review and face to face clinics. 62 Day performance is currently above the national requirement of 70% by the end of March 2025, largely due to good performance in Breast, Lung and Urology, with Skin performance still significantly low at 30%, however the overall backlog of patients in the Skin pathway has reduced indicating the recovery of 62 day performance will commence.	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.	Task and finish group established for Skin pathway including community teledermatology provision, with a view for revised pathway to be in place by Q3. Additional substantive radiographer for Breast surgery out to advert. 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.

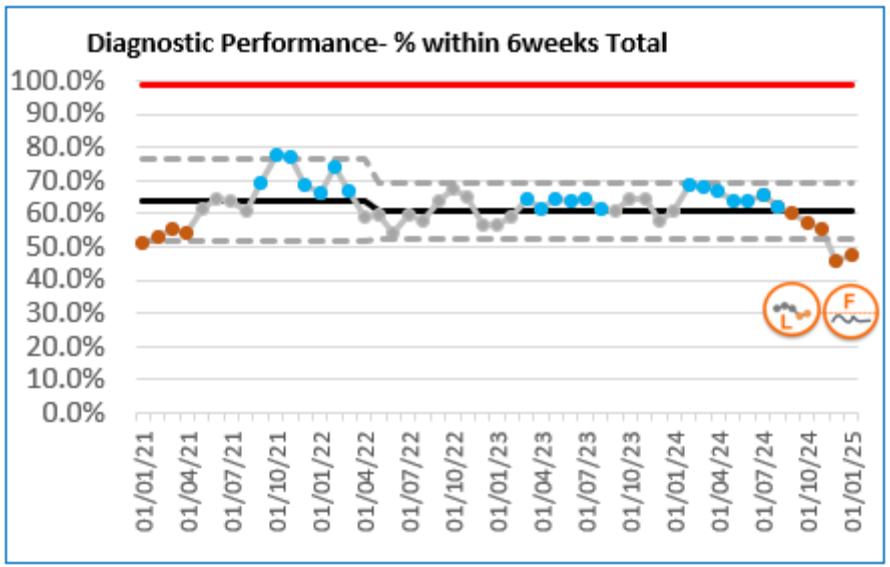
Elective Access: Summary





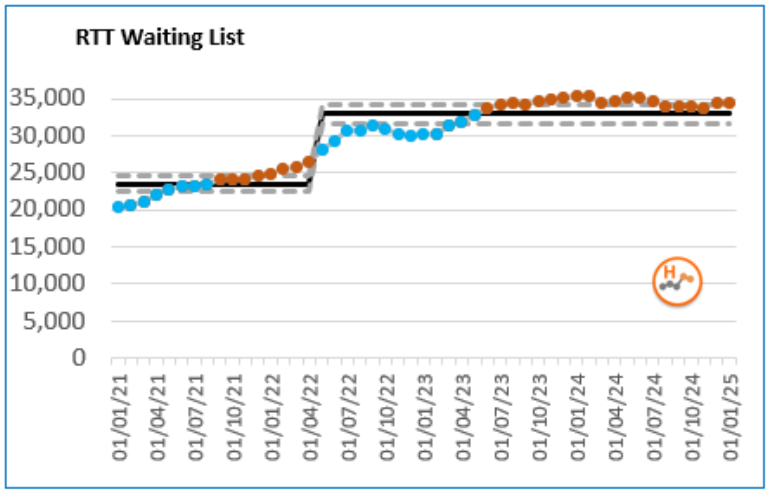
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Jan 25	47.7%	99.0%			61.0%	52.6%	69.4%
RTT Waiting List	Jan 25	34423	-			32992	31730	34255
RTT 65+ Week Waits	Jan 25	92	-			434	252	616
RTT 78+ Week Waits	Jan 25	10	0			137	75	199
Potential 65+ ww at end of Jan 2025	Jan 25	92	-			654	-433	1741
Community Paediatrics RTT Overall Waiting List	Jan 25	502	-			504	447	561
Community Paediatrics RTT Overall 52 Weeks Wait	Jan 25	5	-			1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	Jan 25	0	-			0	0	0
Community Paediatrics RTT Overall 78 Weeks Wait	Jan 25	0	0			0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Jan 25	0	0			0	0	0
RTT NDD Only Waiting List	Jan 25	7	-			51	19	83
RTT NDD Only 52 Weeks Wait	Jan 25	3	-			1	0	2
RTT NDD Only 65 Weeks Wait	Jan 25	0	-			0	0	1
RTT NDD Only 78 Weeks Wait	Jan 25	0	-			0	0	1
RTT NDD Only 104 Weeks Wait	Jan 25	0	-			0	0	0

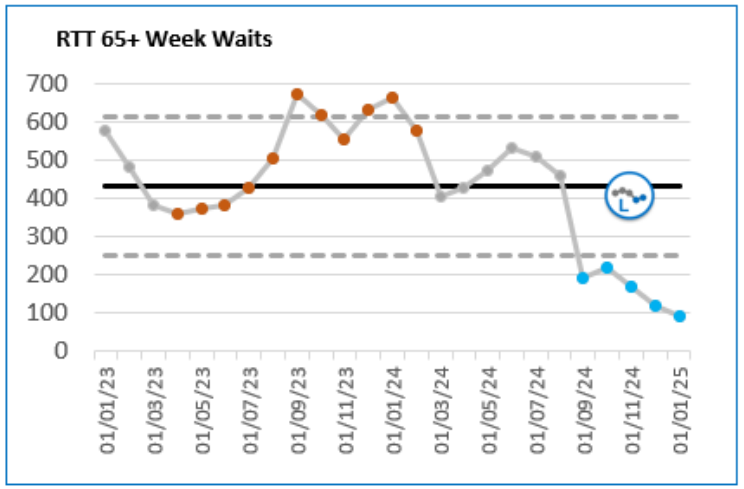
Elective Access

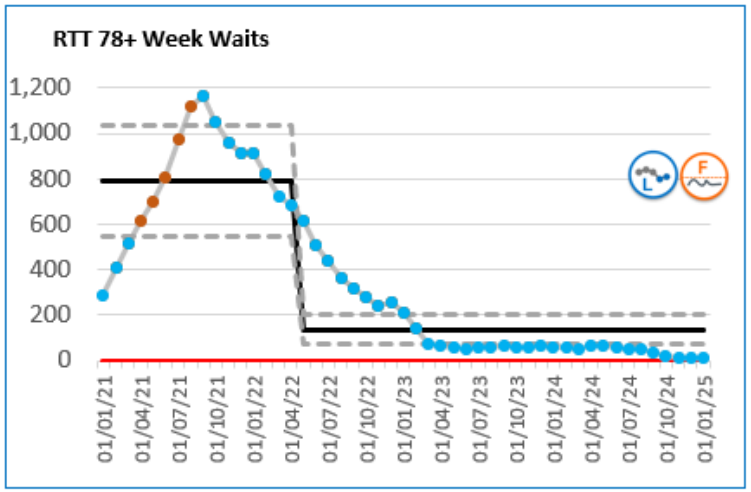


Diagnostics

What	So What?	What Next?
Overall performance continues to be significantly lower than national standard of 95%. CT and Echo's both compliant at 99%, with Cystoscopy on track at 86%. MRI performance increased to 51%, and is on track for full recovery by the end of March 2025, with the benefit of CDC activity. The main areas of challenge for recovery are Ultrasound, DEXA, Endoscopy and Audiology. Within Ultrasound, the inability to recruit to vacant sonography posts is restricting recovery, whilst agency has been approved, there had been minimal uptake to the end of January. Recovery is unlikely to be achieved before the end of 2025, with the current trajectories. Within DEXA, delays with the implementation of the permanent site means we are reliant on the mobile scanner provision, which is only 3 days a month, with the permanent site provision being 3 days week once open. There has been some additional days provided but this is not making an impact on the overall backlog. Within Endoscopy focus has been on sustaining the wait times for patients on a cancer pathway, with limited capacity to make improvements on the overall DM01 performance. Agency was approved, however there has been no success to date in filling the vacant sessions. Additional sessions from internal staff have been on-going. However, with the current capacity it is not possible to forecast a date for recovery. The capacity constraints in Audiology are specifically within community paediatric audiology, locums were approved but have been unsuccessful. A DM01 recovery paper was presented to MEG on the 11/12/2024 and 22/01/2025, and the NHSE/ICB tier 1 meetings. Resources are being deployed in line with his plan where available and in line with current financial recovery governance processes on temporary staffing.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards.	Ultrasound: • Continue to request agency staff via appropriate governance. • Engagement with NHS England for international recruitment. DEXA: • To confirm mobile scanner availability from April onwards. • To review options for sending patients to ESNEFT via mutual aid. • To present back to MEG options for recovery taking into account the above and cost. Endoscopy: • Continue with ECW requests • SDF funding requested via Cancer Alliance A DM01 recovery paper was presented to MEG on the 11/12/2024 and 22/01/2025, and the NHSE/ICB tier 1 meetings. Resources are being deployed in line with his plan and in line with current financial recovery governance processes on temporary staffing.

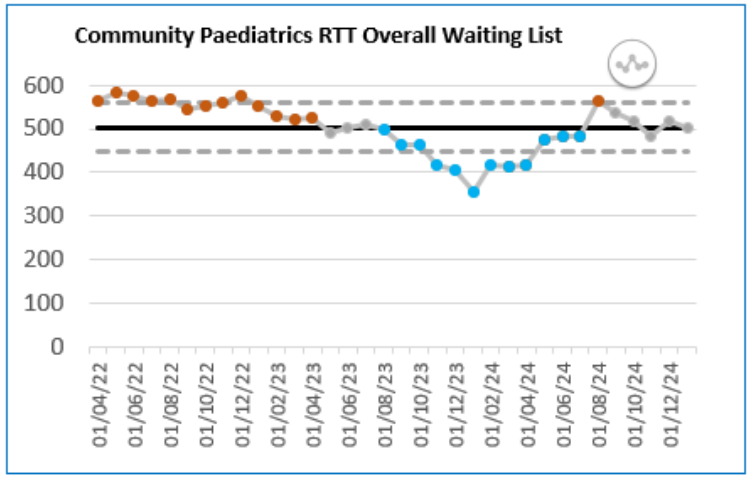


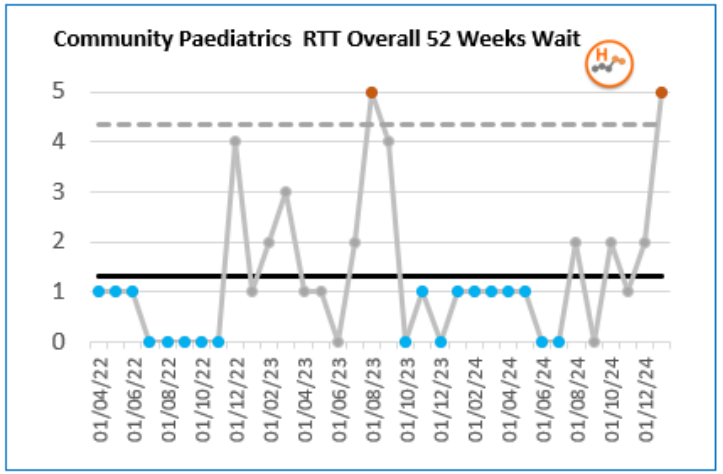


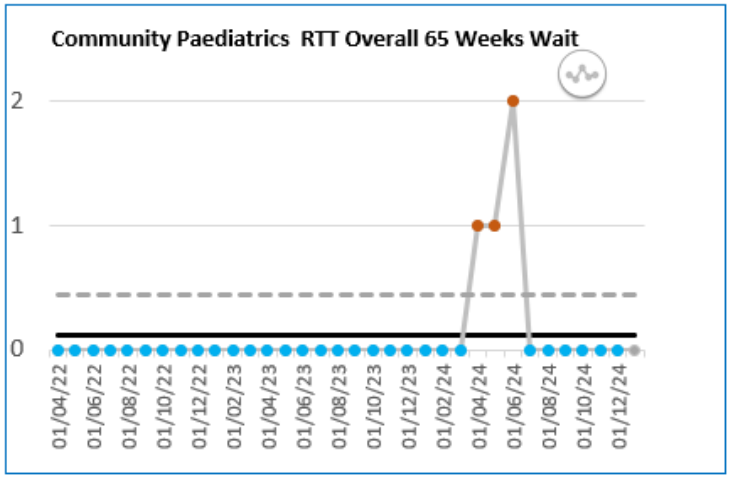


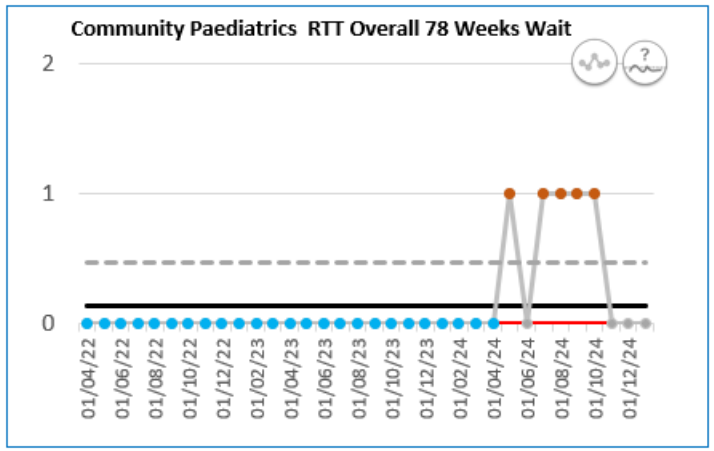
What	So What?	What Next?
The 78 week wait position for the end of January was 10 patients, which is a further reduction. The number of patients in both the actual 65ww and 65ww cohort are continuing to decrease, with the January 65ww position at 92 patients. It is forecast that this will now continue to reduce and expected to clear 65 weeks by the end of March 2025, excluding choice, unfit and grafts.	Delivering the objective of no patients waiting over 65 weeks by March 2025 is a 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 re-allocate theatre lists appropriately to increase Gynaecology theatre capacity to reach a sustained position. Additional sessions to continue for Dermatology.

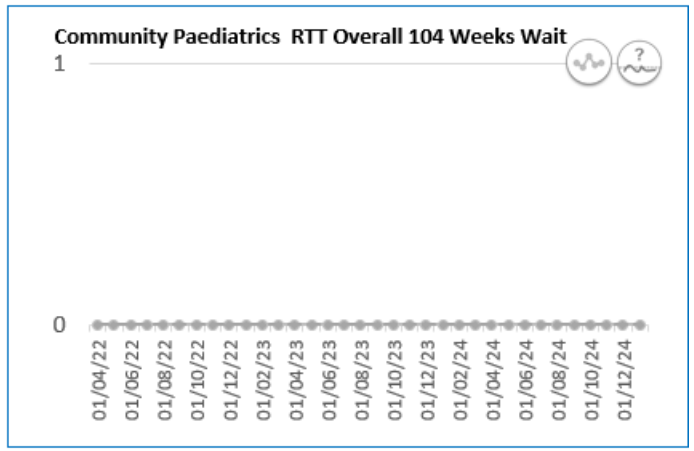
Elective Access (Community Paediatrics)











What	So What?	What Next?
There is an increase in the number of children waiting over 52weeks for initial assessment. This impacts primarily on school age children waiting for socio-communication assessment (possible autism) up to the age of 11yrs. The reduction in performance relates to sustained high level of referral demand and high service caseload numbers.	Level of current demand is above the available clinical capacity within the paediatric medical team. Capacity will reduce further at the end of March as a result of clinician retirements. The team is prioritising response to preschool referrals and to support children with complex medical needs to minimise clinical risk. The team is also maintaining service response to vulnerable children (safeguarding and children in care assessments). Waiting times impacts on children accessing diagnosis but should be supported by the wider system (education etc)	In view of further staff reductions, the focus is on maintaining capacity to manage clinical risk. Recruitment to substantive posts is underway. Securing agency locum cover is being prioritised (1wte secured for March). Support for additional funding from the ICB is being considered to aid service recovery/response to school age autism assessment demand.

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	10,669	(5.7%)
Nov	9,891	10,708	10,174	(5.0%)
Dec	8,744	9,466	8,833	(6.7%)
Jan	10,345	11,200	10,877	(2.9%)
Feb	9,206	9,966		
Mar	9,365	10,138		
Total (YTD)	96,405	104,364	100,824	(3.4%)

January 2025

23/24	10,345
ERF	11,200
24/25	10,877
Var	(323)
Var %	(2.9%)

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	2,423	(0.3%)
Oct	2,459	2,663	2,515	(5.6%)
Nov	2,408	2,608	2,510	(3.8%)
Dec	2,056	2,227	2,100	(5.7%)
Jan	2,420	2,621	2,518	(3.9%)
Feb	2,219	2,404		
Mar	2,241	2,428		
Total (YTD)	22,579	24,456	24,276	(0.7%)

January 2025

23/24	2,420
ERF	2,621
24/25	2,518
Var	(103)
Var %	(3.9%)

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	27,992	(5.5%)
Nov	26,273	28,028	27,208	(2.9%)
Dec	23,225	24,777	23,683	(4.4%)
Jan	27,480	29,316	26,140	(10.8%)
Feb	24,452	26,086		
Mar	24,876	26,537		
Total (YTD)	256,07	273,182	267,922	(1.9%)

January 2025

23/24	27,480
ERF	29,316
24/25	26,140
Var	(3,176)
Var %	(10.8%)

Elective

Mon	23/24	ERF	24/25	Var %
Apr	256	277	270	(2.5%)
May	267	289	293	1.5%
Jun	247	267	233	(12.8%)
Jul	280	303	275	(9.3%)
Aug	256	277	277	0.0%
Sep	256	277	286	3.3%
Oct	284	307	337	9.9%
Nov	268	290	286	(1.5%)
Dec	249	269	254	(5.5%)
Jan	234	253	252	(0.5%)
Feb	244	264		
Mar	244	264		
Total (YTD)	2,597	2,808	2,763	(0.5%)

January 2025

23/24	234
ERF	253
24/25	252
Var	(1)
Var %	(0.5%)

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

All

All

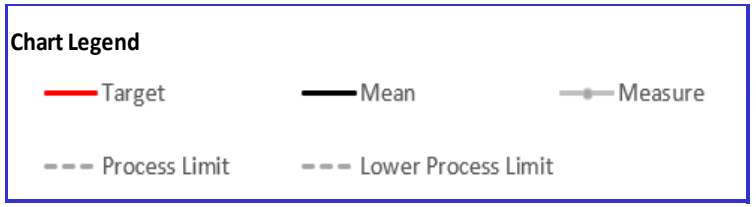
Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	38.2%	37.2%	37.0%	38.2%	38.5%	38.5%	36.6%	35.7%	37.4%	36.6%	38.2%	38.6%	**37.5%**
24/25	40.2%	39.3%	39.8%	40.8%	42.5%	39.7%	39.8%	39.3%					**40.1%**

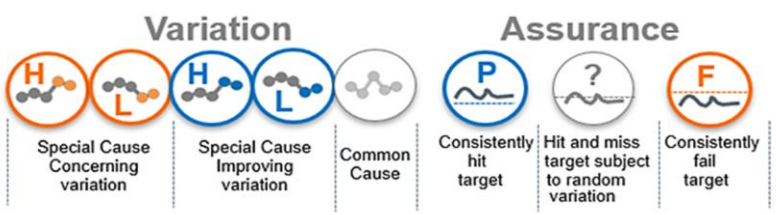
Target	46.0%
Month	40.8%
YTD	40.1%

Elective Access: Activity

What	So What?	What Next?
None of the activity across day cases, electives and first outpatient appointments is meeting the 2024/25 target of 108.09% of 2019/20 activity year to date or in month, although shows in month improvements from December 2024 to January 2025. Outpatient follow-ups, which should be reducing compared to 2019/20 levels showed their biggest negative variance in January at -10.8%, -1.9% year to date. Outpatient attendances that are a first attendance or with a procedure have increased by 2.6% year on year, although are not meeting the 46.0% target.	Increasing activity eligible for Elective Recovery Fund income is required 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.	All divisions to focus on delivery of activity in Q4 in line with financial recovery plans and to meet operational performance expectations for cancer Faster Diagnosis Standard and zero 65 week elective waits. Activity plans being developed in response to the 2026/26 NHS planning guidance and financial model, to be finalised in March 2025.

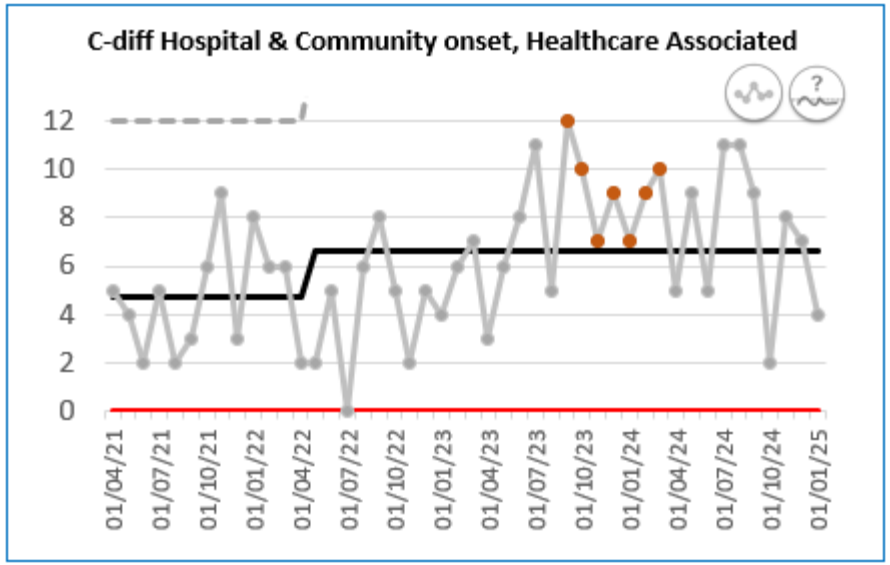
IMPROVEMENT COMMITTEE METRICS





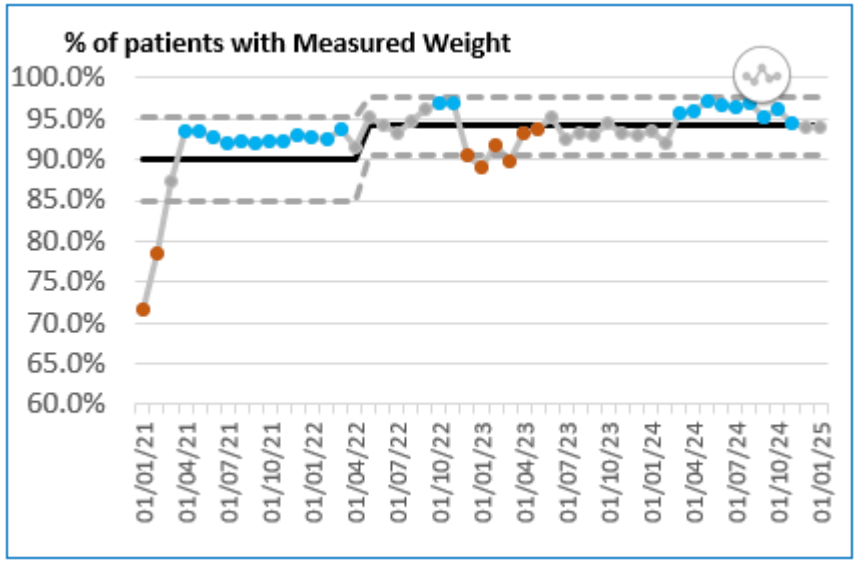
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-diff Hospital & Community onset, Healthcare Associated	Jan 25	4	0			7	-2	15
% of patients with Measured Weight	Jan 25	94.1%				94.2%	90.6%	97.8%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Jan 25	71.4%				85.3%	75.9%	94.8%
Post Partum Haemorrhage	Jan 25	4				7	-1	15

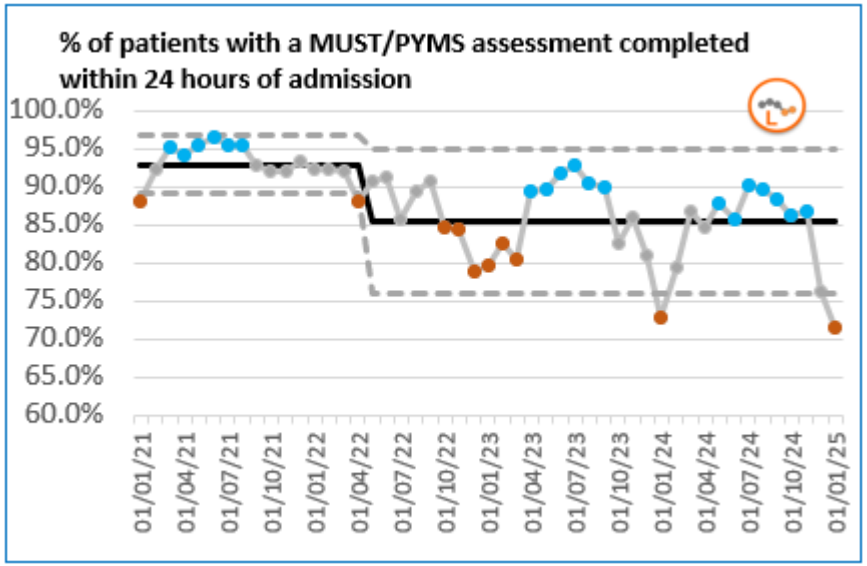
Safe



What	So What?	What Next?
Whilst there is a reduction in *Clostridioides difficile* infection cases for the last two consecutive months, the data illustrates common cause variation, suggesting limited assurance of sustained improvement at this point. The threshold set combines hospital onset & community onset, healthcare associated cases (HOHA/COHA) which provides the organisations measure for national/regional data and better demonstrates the impact on our patient group. *Clostridioides difficile* are bacteria found in the bowel, usually causing no harm. This bacteria can cause diarrhoea, especially in older persons, those who have been in contact with a contaminated environment, have undergone bowel procedures or in people who have been or are being treated with certain antibiotics. Data suggests that West Suffolk has a higher-than-average age population. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years.	Infection prevention and control is a key priority for all NHS providers. 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. A new strain of *Clostridioides difficile* has been identified which has been linked with extensive outbreak scenarios within the UK. The NHS Standard Contract 2024/25: Minimising *Clostridioides difficile* sets a threshold for WSH of 91 HOHA/COHA cases 2024-25.	The situation remains complex, multifaceted and has 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 and will run for at least 12 months – 18 months, October 2025. Full update to be provided at March 2025 improvement board QI update: • Review of isolation signage and Trust roll out; Feb-March 2025 • Audit of isolation room compliance – signage, cleaning, door closure; Jan - March 2025. • Hand hygiene tool review, observation of missed opportunities; Feb – March 2025. • IPC audit proposal to be presented at IPCC Feb 2025 • Review of investigation process when a C.diff case is identified – including review of RADAR completion, accountability and actions after a case, review has commenced Jan-March 2025. • Life QI update March 2025. • Initial review of chemical used to clean the floors – Feb 2025.

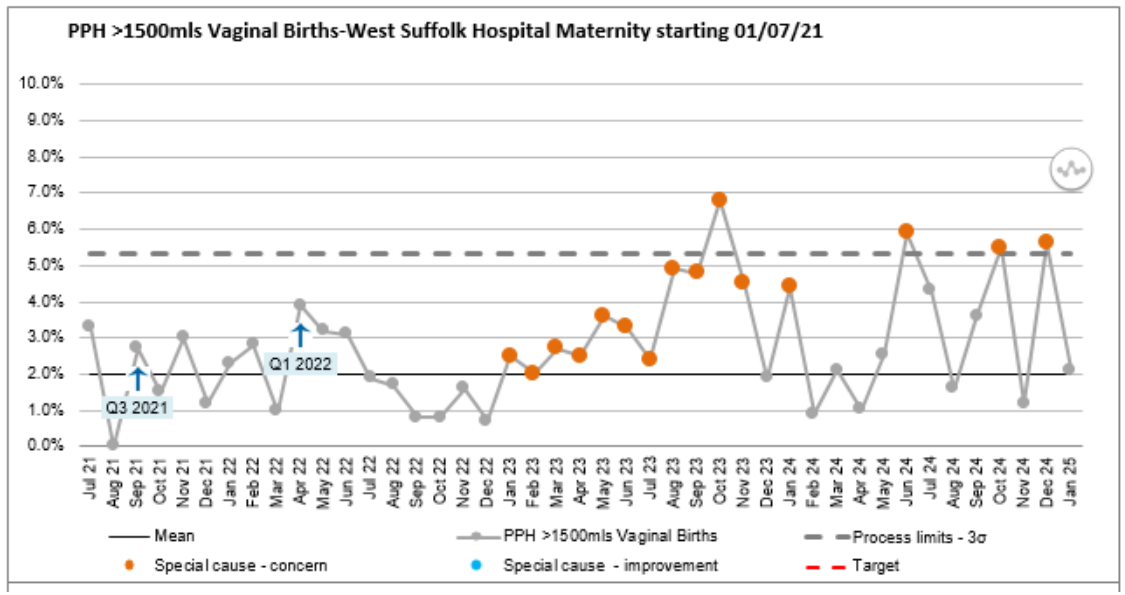
Safe

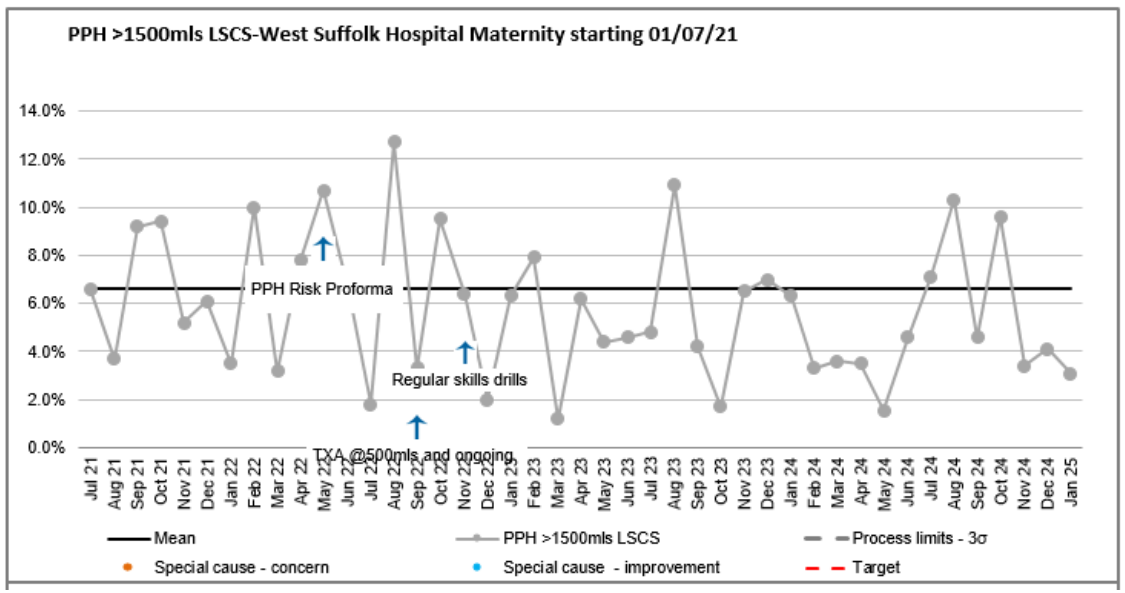




What	So What?	What Next?
Again, this month we have seen a decrease in nutritional screening associated with MUST, after seeking further guidance from the information team it has shown that we had an increase in patients awaiting beds following a decision to admit, this has increased this month to 251 from 211 in December. Additional assurance can be taken from the patient safety report that indicates that 98.92% have a MUST score completed during admission. The short rapid assessment in ED continues to be embedded, Data regarding completion and impact will be available next month, local feedback suggest this is working well, however we have no reportable data currently. Percentage of patients weighed is static for this month, this remains a focus for all teams	Good nutrition is an integral component of patient care. Not only does eating correctly provide substantial physical benefits, but it also ensures psychological comfort though a patient's admission. The world health organisation agrees and from 2016 -2025 they have collectively acknowledged the concept of 'food as medicine' which is something the trust is actively supporting with food as medicine workshops. This matrix is something that is fully supported by the senior team with an awareness of where the improvements need to be focused.	• Improvement with the UEC performance will result in patients getting to the wards earlier and having assessment carried out in a timely manner, it is hoped that we see improvement in February and March. • Monitor and review any complaints regarding nutritional aspects and make sure shared learning is fed back to all patient facing staff. This is also discussed at the monthly nutritional steering group. • The food as medicine work streams continue. With the second meeting held on the 3rd February. • Monitor patients to make sure that they are re weighed at 7 days This is reviewed using the documentation Radar audit which is completed in ward areas weekly, and any changes are escalated as required.

Safe

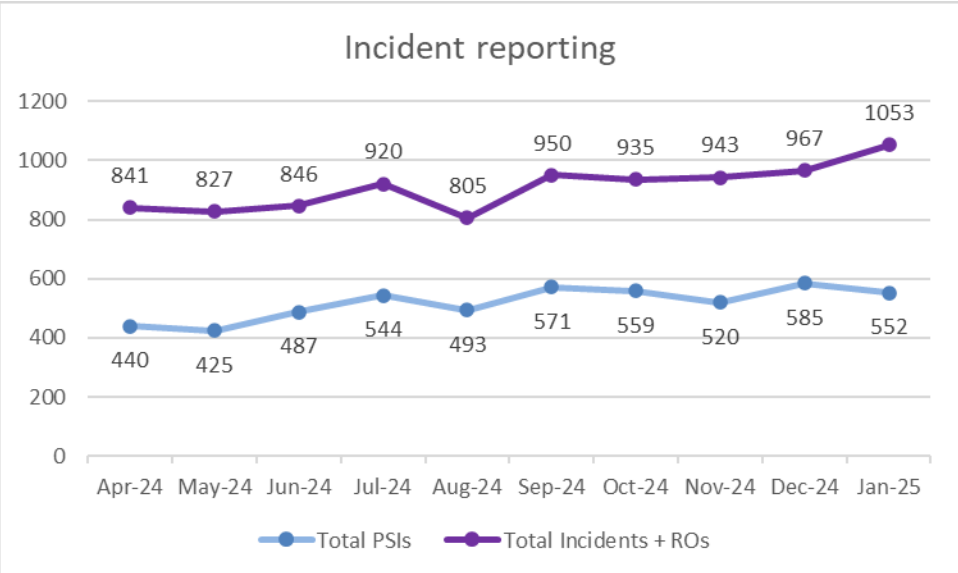

PPH >1500mls Vaginal Births-West Suffolk Hospital Maternity starting 01/07/21
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Q3 2021
Q1 2022
Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25
Mean
PPH >1500mls Vaginal Births
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

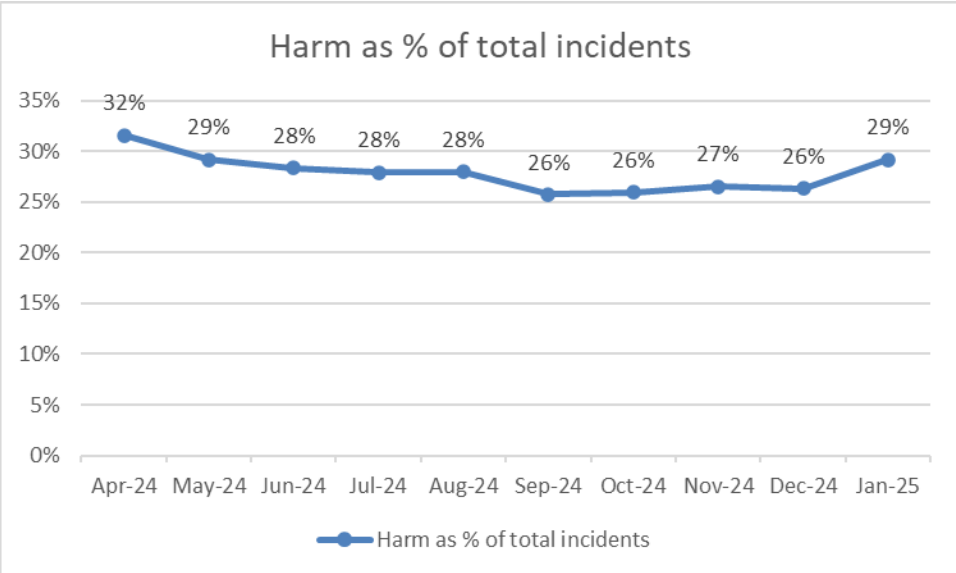

PPH >1500mls LSCS-West Suffolk Hospital Maternity starting 01/07/21
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
PPH Risk Proforma
Regular skills drills
TXA @500mls and ongoing
Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23 Sep 23 Oct 23 Nov 23 Dec 23 Jan 24 Feb 24 Mar 24 Apr 24 May 24 Jun 24 Jul 24 Aug 24 Sep 24 Oct 24 Nov 24 Dec 24 Jan 25
Mean
PPH >1500mls LSCS
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Safe

What	So What?	What Next?
This month data of Post-partum Haemorrhages (PPH) exceeding 1500 mls for Vaginal and lower section caesarean sections (LSCS) births shows common cause variation. A comprehensive review of all cases was conducted in line with the internal governance procedures. In January 2025, there were four reported cases of PPH over 1500 mls, with two 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.	Following a PPH there is the potential increase of length of stay, additional treatment and financial implications for the organisation and family. 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. 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)	Quality Improvement 3rd cycle launched 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. Ongoing reviews of all PPH and thematic reviews are required to continue, to truly understand the factors causing the variation and subsequent solutions to be found.

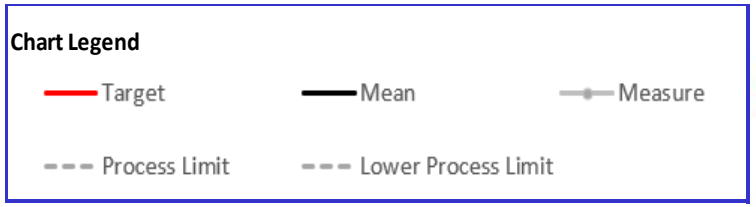
Safe

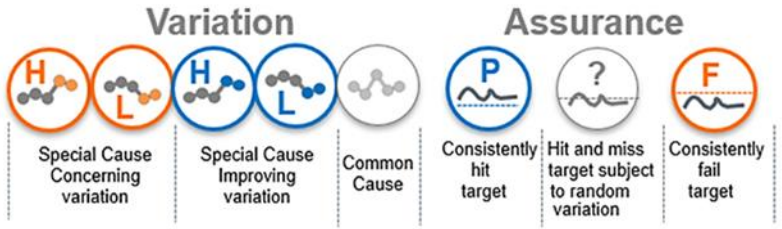




What	So What?	What Next?
There has been an increase in the reported numbers of pressure ulcers and RPI events which have contributed to the overall rise in total patient safety incidents and reportable occurrences (RO). This month there has also been a reduction in the amount of pathology incidents and bed capacity incidents. Overall the amount of PSI's reported remains within mean limits whilst reported RO's has risen. This is due to a sharp rise in the amount of RPI events recorded. Harm as a % of total incidents has risen can be contributed to a rise in the number of reported PSI's for clinical care and treatment.	We want to encourage reporting of all incidents, including low harm and near miss to enable improvement work to take place without patients coming to harm. This is key safety insight. The committees which oversee safety data including incidents and RO's use reporting data to monitor trends over time which prioritises improvement work.	Safety and quality committees report to patient safety and quality governance group (PSQGG) and improvement work is monitored as part of the reporting schedule. An analysis of the incidents which are submitted under clinical care and treatment as part of our quarterly analysis report, which reports to PSQGG to ascertain if a focus of improvement needs to be changed or introduced. Introduction of the least restrictive review pilot to use learning from RPI events to drive improvements. Due to commence in March.

Mortality Summary

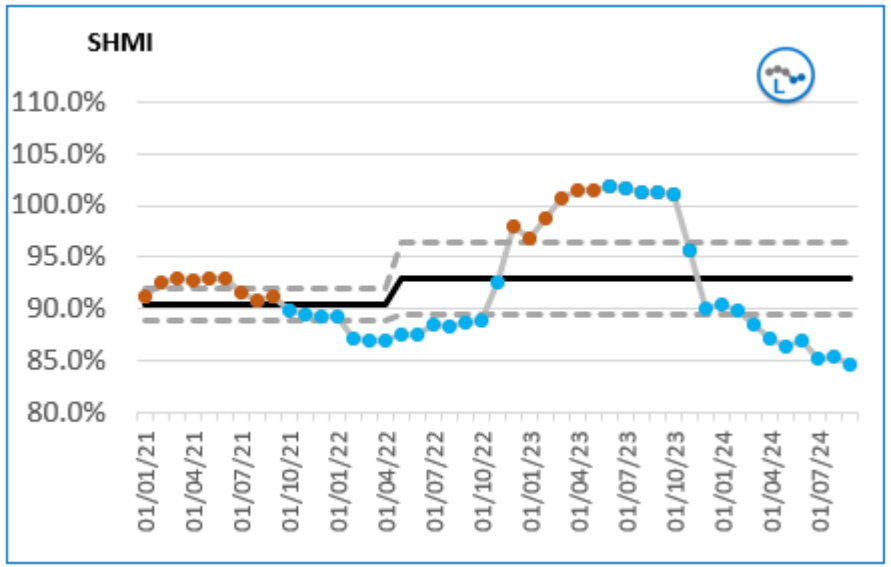


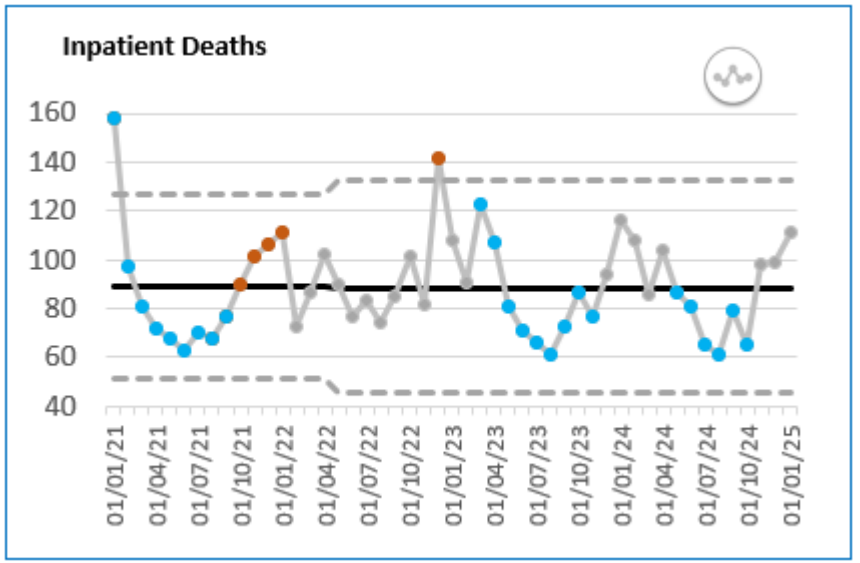


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Sep 24	84.6%				93.0%	89.5%	96.4%
Inpatient Deaths	Jan 25	111				89	45	132

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

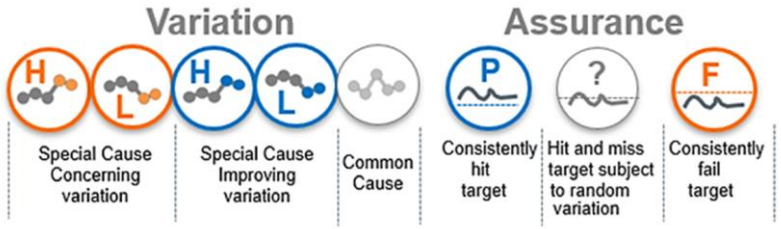
Mortality





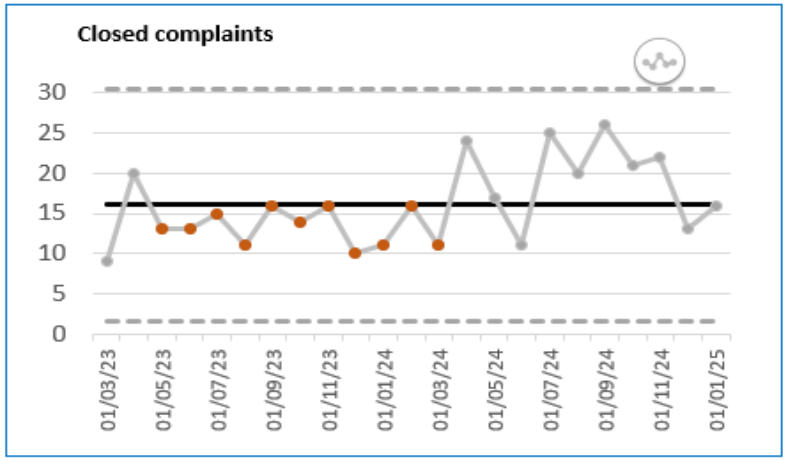
What	So What?	What Next?
The SHMI data shows that we continue to have lower than expected deaths when analysed by demographic and disease coding Our inpatient deaths are as expected during the winter months Closer scrutiny of these deaths through the Mortality Oversight Group has revealed no unusual trends in location or cause of death on MCCD	This provides reassurance that the care we are providing is delivering better than expected outcomes Patients can be reassured that in comparison with other healthcare providers WSH has lower mortality for inpatients. Staff can observe that the care they deliver is reducing mortality	Looking forward we expect our SHMI to remain below the national average. We continue to scrutinise deaths through the Learning From Deaths programme which feeds into the Mortality Oversight Group that regularly review SHMI data

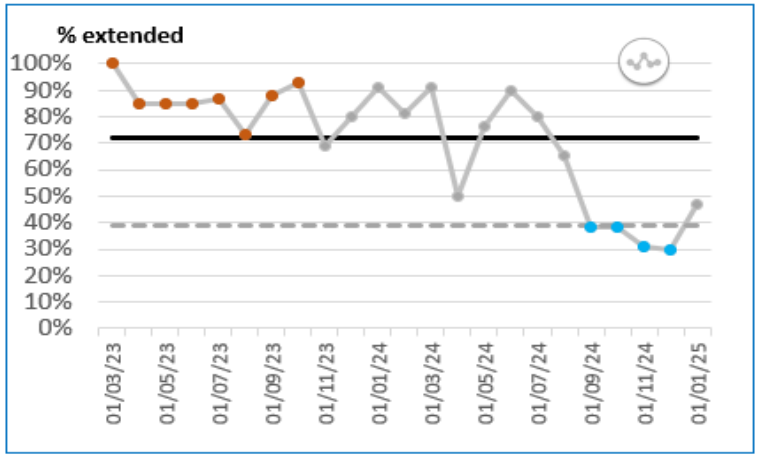
INVOLVEMENT COMMITTEE METRICS

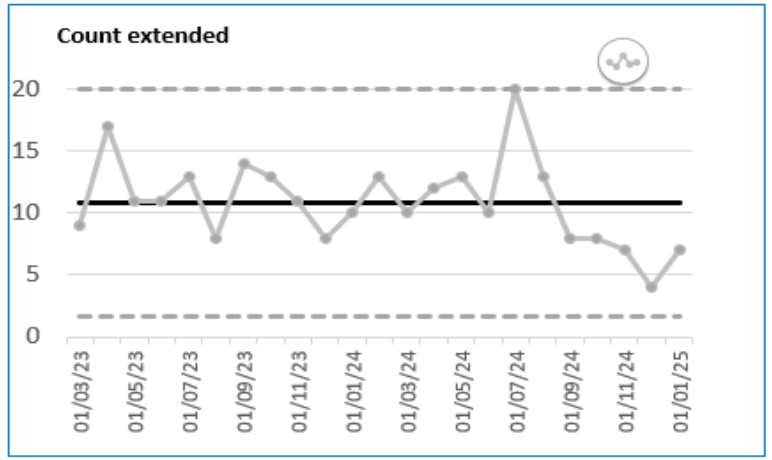


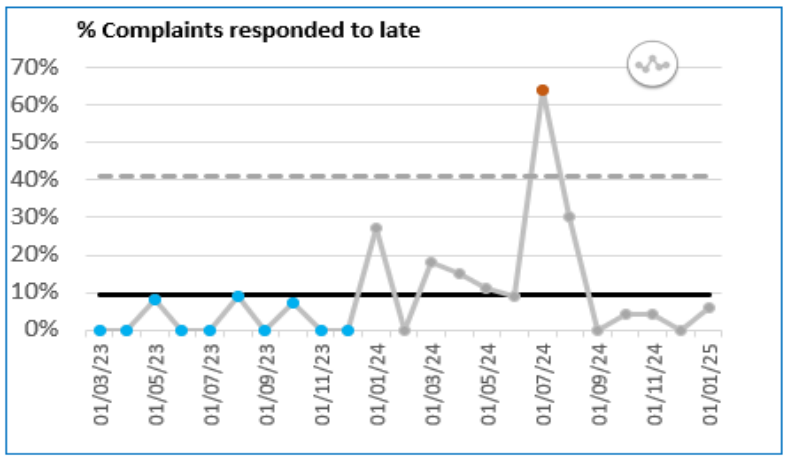
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Active complaints	Jan 25	22	-			29	15	42
Closed complaints	Jan 25	16	-			16	2	30
% extended	Jan 25	47%	-			72%	39%	105%
Count extended	Jan 25	7	-			11	2	20
% Complaints responded to late	Jan 25	6%	-			9%	-22%	41%
Count responded to late	Jan 25	1	-			2	-4	8
% resolved in one week	Jan 25	79%	-	H		58%	28%	88%
Total PALS resolved Count	Jan 25	332	-	H		170	52	288

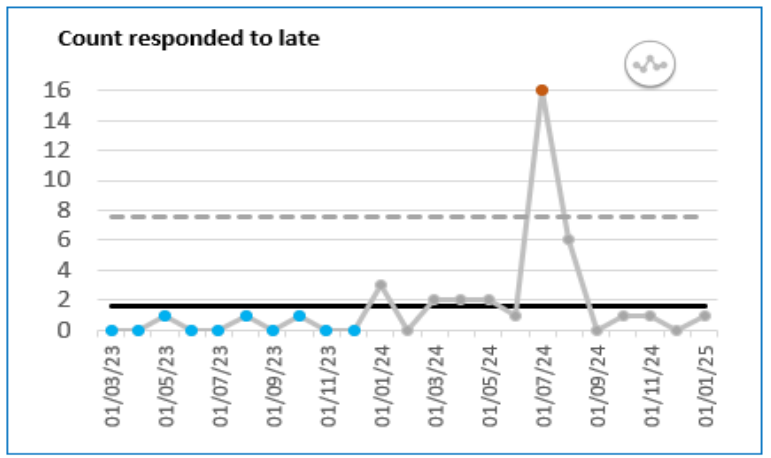
Safe

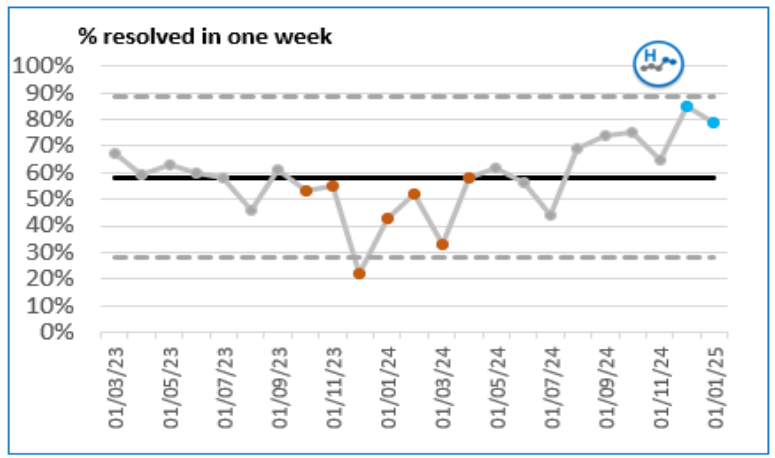

Closed complaints
30
25
20
15
10
5
0
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25

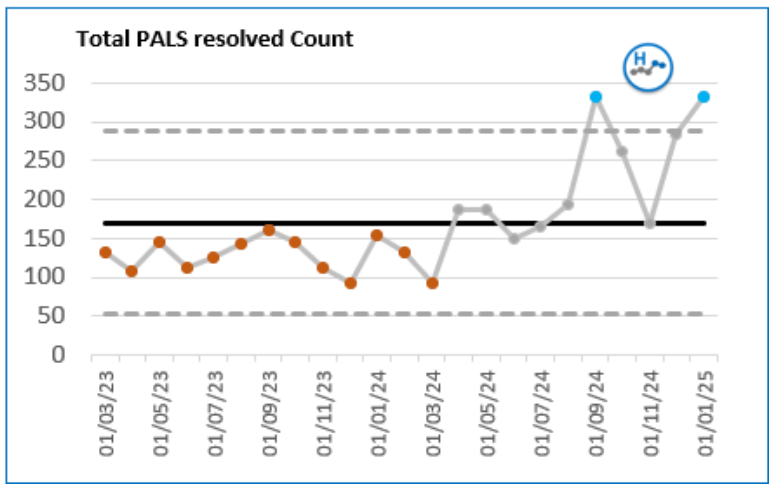

% extended
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25


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


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

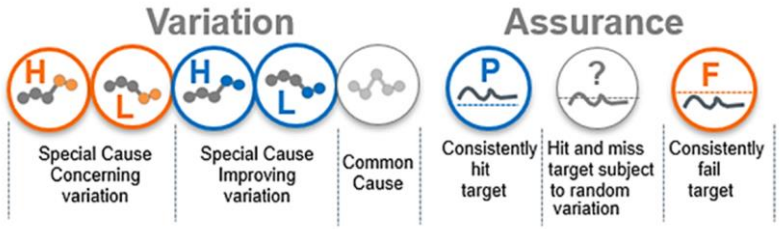

Count responded to late
16
14
12
10
8
6
4
2
0
01/03/23
01/05/23
01/07/23
01/09/23
01/11/23
01/01/24
01/03/24
01/05/24
01/07/24
01/09/24
01/11/24
01/01/25


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


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

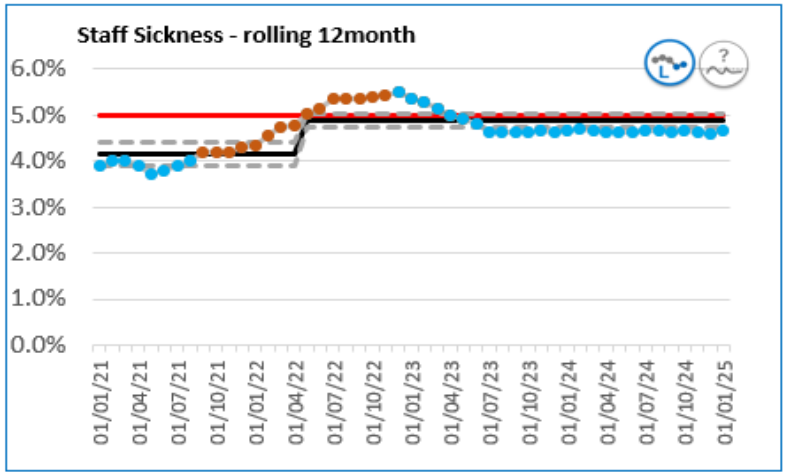
Safe

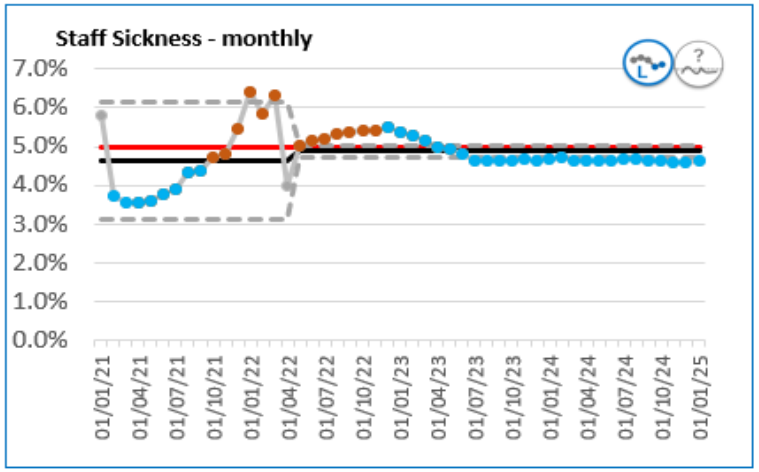
What	So What?	What Next?
16 formal complaints were responded to in January. 7 of these complaints were extended from its original timeframe which is an increase from 31% to 47%. This was an expected increase due the follow on from the festive period and staff within the team and across the Trust on annual leave. Out of the 16 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 which in turn has had a positive effect on the total open complaints, which has reduced to 22 which is an all-time low. 332 PALS cases resolved within January with 79% closed within one week. The volume of cases logged has increased and on an upward trajectory. Whilst a slight reduction in cases resolved within 1 week compared to December, the data set remains within the controlled limits and meets the set KPI metrics of 75%	Whilst contingency plans have been put in place to cover for unexpected or annual leave within the PALS/Complaints team, there were delays in obtaining staff responses from clinical colleagues due to the festive period. All complainants were kept up to date with extensions and reasons for delays. The data reflects that the PALS team are handling more concerns and enquiries that come in to the patient experience team, which is promoting early resolution and minimal numbers are being escalated to a formal complaint. 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 PALS team have recently improved its short form to ensure themes are being captured for thematical analysis opportunities.	The target remains for the PALS team to reach a minimum of 75% of cases resolved within one week. There has been a change in direct line management for PALS and support is being given to PALS to ensure this metric reaches the target and is maintained. 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. A benchmarking exercise is being conducted across the regional Trusts for complaints and PALS performance including WTE/structure, resolution times and volume of complaints. Following this we will review processes and triaging if required.

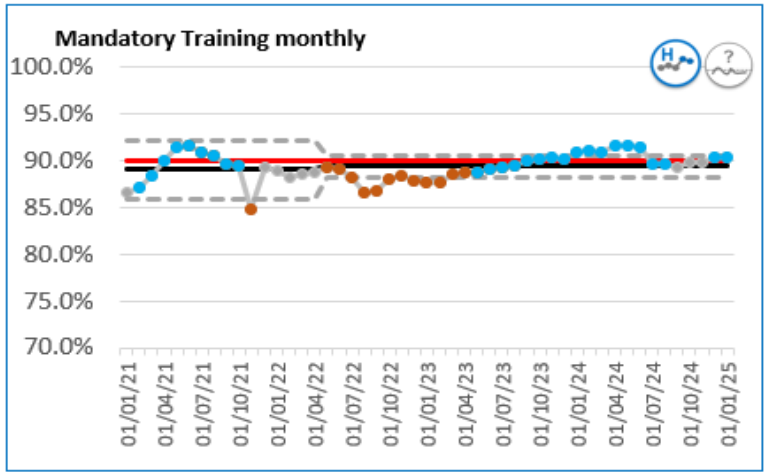


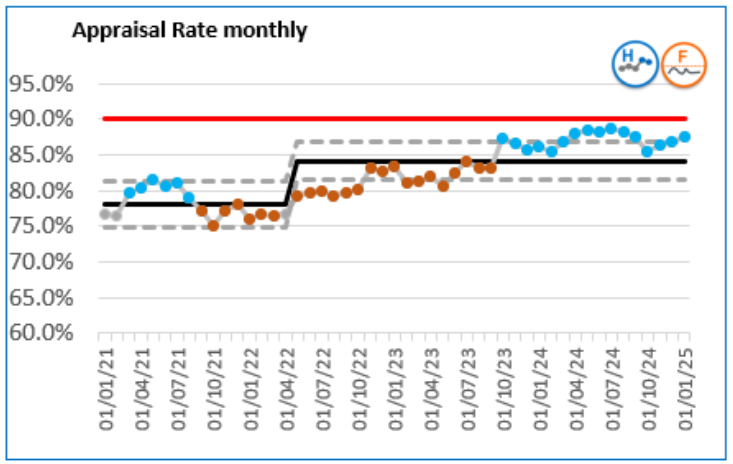
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jan 25	4.7%	5.0%	L	?	4.9%	4.7%	5.0%
Staff Sickness - monthly	Jan 25	4.7%	5.0%	L	?	4.9%	4.7%	5.0%
Mandatory Training monthly	Jan 25	90.3%	90.0%	H	?	89.4%	88.2%	90.5%
Appraisal Rate monthly	Jan 25	87.5%	90.0%	H	F	84.2%	81.6%	86.8%
Turnover rate monthly	Jan 25	7.6%	10.0%	L	?	10.3%	9.4%	11.2%

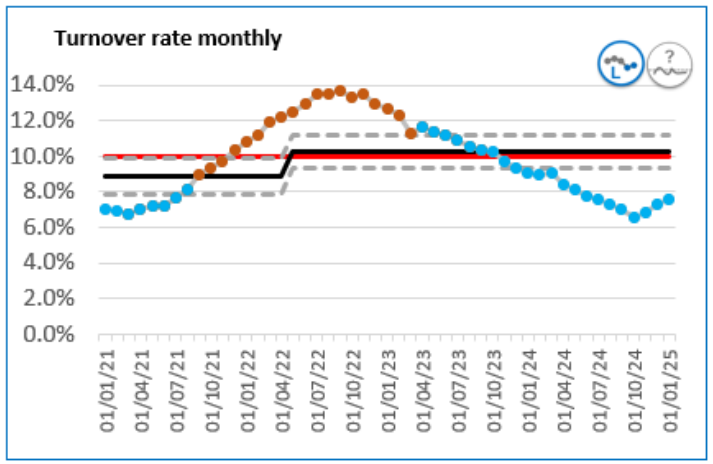
Well Led











What	So What?	What Next?
All four of our key performance indicators continue to record an improving variation, with three out of four achieving target. Sickness – achieving target at 4.7% versus 5% target. Mandatory training – achieving target at 90.3%. Appraisal – consistently failing target, 87.5% 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. Maintain 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.

Item 7.1 Audit CKI Appendices

Trust Policy and Procedure **Document Ref. No: PP366**

Scheme of reservation and delegation of powers

For use in:	All areas of the Trust
For use by:	All Trust staff
For use for:	Financial Governance matters
Document owner:	Assistant Director of Finance
Status:	Final

Contents **Page**

1. Introduction

1.1 Under the Standing Order relating to the Arrangements for the Exercise of Functions by Delegation (Standing Order 5) the Trust is given powers to:

> Make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit. [SO para 5.1]

1.2 Furthermore The Code of Accountability for NHS Boards requires the Board of Directors to demonstrate the existence of comprehensive governance arrangements, which may be delegated, and draw up a schedule of decisions reserved to it. The schedule must also ensure that management arrangements are in place to enable the clear delegation of other responsibilities.

1.3 This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation, including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.4 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board of Directors Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

2. Scope

2.1. All Trust staff (including permanent, locum, secondee, students, agency, bank and voluntary) must follow the policies agreed by the Trust. Breaches of adherence to Trust policy may have potential consequences for the employee, including in some cases, formal action.

2.2. The Scheme of Delegation covers only matters delegated by the Board of Directors. This should be used in conjunction with specific matters referred to in the Standing Financial Instructions (SFIs) and Standing Orders (SOs) and other established procedures within the Trust.

2.3. The Chief Executive shall exercise all powers of the Trust, which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee, on behalf of the Board of Directors. The Chief Executive shall prepare a Scheme of Delegation identifying which functions him/her shall perform personally and which functions have been delegated to other Directors and Officers.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer the Chief Executive is accountable to NHS England (NHSE) for the funds entrusted to the Trust.

2.4. Powers are delegated to Directors and officers on the understanding that they would not exercise delegated powers in a matter that in their judgment was likely to be a cause for public concern.

2.5. In the absence of a Director or Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Deputy Chief Executive.

2.6. The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors from time to time taking into account where necessary, the requirements of regulators e.g. NHSE and the Charity Commissioners. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with Standing Orders, committees may not delegate executive powers to sub committees unless expressly authorised by the Board of Directors.

3. Scheme of reservation and delegation – decisions reserved to the Board

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
1. Regulation and Control	1.1	Approve this Scheme of Reservation and Delegation	✓		Ratified by the Audit Committee.
	1.2	Approve Standing Orders and Standing Financial Instructions	✓		Ratified by the Audit Committee.
	1.3	Suspend, vary or amend SOs	✓		Ratified by the Audit Committee.
	1.4	Ratify any urgent decisions taken by the Chair and Chief Executive outside of Board meetings.	✓		
	1.5	Receive the Register of Interests and determine the extent to which any member may remain involved in the matter under consideration.	✓		
	1.6	Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.	✓		
	1.7	Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and on which to take appropriate action.	✓		
	1.8	Confirm the recommendations of the Trust's committees where the committees do not have executive powers.	✓		
	1.9	Approve arrangements relating to the discharge of the Trust's responsibilities as a Corporate Trustee for funds held on trust.	✓		

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	1.10	Establish terms of reference and reporting arrangements for all committees and sub-committees that are established by the Board	✓		
	1.11	Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.	✓		**Should this be delegated?**
	1.12	Authorise the use of the Trust seal.	✓		
	1.13	Ratify, or otherwise, instances of failure to comply with Standing Orders brought to the Chief Executive's attention.	✓		
	1.14	Consider the action, formal or informal, for members of the Board or employees who are in breach of statutory requirements or Standing Orders.	✓		
	1.15	Prepare the Trust's overarching scheme of reservation and delegation which sets out those decisions of the Trust reserved to the Board and those delegated to the: - Trust Board committees and sub-committees - Members of the Trust Board - An individual who is an employee of the Trust but not a member of the Trust Board		Trust Secretary	
	1.16	Prepare Standing Orders (SOs) and Standing Financial Instructions (SFIs)		SOs - Trust Secretary SFIs - Executive Chief Finance Officer	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	1.17	Prepare detailed financial policies that underpin the Trust's prime financial policies.		Executive Chief Finance Officer	
	1.18	Approve detailed financial policies.		Insight Committee	Dependent upon the policy being approved.
	1.19	Final authority in interpretation of Standing Orders.		Chair	Advised by the Chief Executive and Trust Secretary
	1.20	Review decisions to suspend Standing Orders.		Audit Committee	
	1.21	Execute Powers reserved to the Board outside of Board meetings.		Chair and Chief Executive	At least two non-executive directors must be consulted.
	1.22	Maintain the Register of Interests		Trust Secretary	
	1.23	Maintain an effective system of financial control.		Executive Chief Finance Officer	
	1.24	Approve proposed prepayment arrangements.		Executive Chief Finance Officer	
2. Meetings of the Trust	2.1	Call Meetings.		Chair	
	2.2	Chair all Board meetings and associated responsibilities.		Chair	
	2.3	Give final ruling in questions of order, relevancy and regularity of meetings.		Chair	
3. Annual Reports, Accounts and Audit	3.1	Receive and approve the Trust's Annual Report and Annual Accounts.	✓		Advised by the Audit Committee
	3.2	Receive and approve the Annual Report and Accounts for Charitable Funds (delegated authority from the Trust Board)		Audit Committee	Advised by members of the Charitable Funds Committee.

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	3.3	Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate.		Audit Committee	
	3.4	Agree the make-up of the Audit Panel (responsible for the appointment and dismissal of the External Auditors).		Audit Committee	Appointment of External Auditors is by the Council of Governors
	3.5	Approval of external auditors' arrangements for the separate audit of funds held on trust.		Audit Committee	Advised by members of the Charitable Funds Committee.
	3.6	Review the Auditors Annual Report received from the External Auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee.	✓		
	3.7	Review the Trust's annual accounts prior to submission to NHS England/Department of Health & Social Care		Audit Committee	
	3.8	Ensure an adequate internal audit service is provided.		Audit Committee	
	3.9	Approve the annual internal audit plan.		Audit Committee	
	3.10	Receive and approve the Trust's Quality Account.	✓		Advised by the Audit Committee
4. Workforce	4.1	Appoint the Deputy Chair of the Board.		Council of Governors	
	4.2	Appoint, appraise, discipline and dismiss Executive Directors.		Remuneration Committee	
	4.3	Determine the broad remuneration policy and performance management framework and to set individual remuneration arrangements for the Trust's Executive Directors.		Remuneration Committee	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	4.4	Make recommendations to the Board on any termination arrangements for executive directors.		Remuneration Committee	
	4.5	Make recommendations to the Board on special/exceptional payments covering any individual member of staff or staff group.		Remuneration Committee	
	4.6	Approve variation to funded establishment of any department including temporary staffing, appointments and re-grading, in line with the Budget Setting Policy.		Workforce Committee	
5. Strategy, Plans and Budgets	5.1	Define the strategic aims and objectives of the Trust.	✓		
	5.2	Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.	✓		Advised by the Improvement Committee
	5.3	Approve annual financial plan, including the capital programme.	✓		Advised by the Insight Committee
	5.4	Approve annually Trust's proposed organisational development proposals.	✓		Advised by the Involvement Committee
	5.5	Ratify proposals for acquisition, disposal or change of use of land and/or buildings.	✓		
	5.6	Approve private finance initiative (PFI) proposals.	✓		
	5.7	Approve the opening and closing of bank accounts.	✓		
	5.8	Approve Business Cases for revenue over £500k.	✓		

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	5.9	Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £2m (revenue) or £1m (capital) for the life of the contract. Initial review to be undertaken by Contracts & Procurement Panel and / or Capital Strategy Group.	✓		Advised by Finance Accountability Committee
	5.10	Approval or extension of revenue contracts subject to tender, awarded via framework agreements, extension under applicable Procurement Regulations 2024 or as part of a joint capital / revenue arrangement. De minimis amount for singular or multi year agreements will be £25,000.	✓	Contracts & Procurement Panel	Report to Finance & Accountability Committee
	5.11	Grant new substantial interest of land owned by the Trust to third parties.	✓		
	5.12	Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Executive Chief Finance Officer (for losses and special payments) previously approved by the Board.		Audit Committee	Advised by Finance Accountability Committee
	5.13	Approve individual compensation payments over £50k.	✓		
	5.14	Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST).	✓		
	5.15	Approve a list of employees authorised to make short term borrowings on behalf of the Trust (this must include the Chief Executive and the Executive Chief Finance Officer)	✓		
6. Quality and Safety	6.1	Approve the Trust's arrangements for handling complaints.	✓		Advised by Involvement Committee

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	6.2	Propose arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		Improvement Committee	
	6.3	Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.		Improvement Committee	
7. Operational and Risk Management	7.1	Approve the Trust's policies and procedures for the management of risk.	✓		Advised by Insight Committee
	7.2	Approve arrangements for risk sharing and/or risk pooling with other organisations.	✓		
	7.3	Approve the Trust's counter fraud and security management arrangements.		Audit Committee	
8. Communications	8.1	Approve arrangements for the handling of Freedom of Information requests.		Corporate Risk Governance Group	
9. Monitoring	9.1	Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated.	✓		
	9.2	Continually appraise the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements.	✓		
	9.3	Receive reports from Executive Chief Finance Officer on financial performance against budget and annual business plan.	✓		Advised by Insight Committee

Further details of delegation can be found in the NHS foundation trust accounting officer memorandum (April 2015)

4. Detailed scheme of delegation for standing financial instructions (SFIs)

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. ***The delegation shown below is the lowest level to which authority is delegated.*** *Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.*

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1. Management of Budgets Responsibility for keeping expenditure within budgets: **a)** At specialty/department level **b)** For the totality of a Division **c)** Corporate Function **Revenue Budget Virement** • All virements between pay and non-pay • All other virements within single cost centre • All other virements between cost centres	 Designated Budget Holder Divisional Director/Divisional Associate Director of Operations Relevant Executive Director Executive Chief Finance Officer Designated Budget Holder Designated Budget Holder of all affected areas	SFIs Section 3
2. Expenditure process & Business Cases Each officer who commits the Trust to expenditure must do so in line with the Standing Financial Instructions and this Scheme of Reservation and Delegation. Before expenditure is committed, consideration needs to be considered as to whether this is within the budget set or whether a business case is required. Business cases are required for any new requests for funds that is over and above existing resources and must be submitted to the Investment Panel for approval. Further approval is required as follows:		Business Case Requirements - West Suffolk NHS Intranet

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• **Gross annual revenue costs <= £10,000 per annum**		
- and/or one-off capital costs <= £10,000	Divisional Board	
- Capital costs >£10,000 up to £50,000	Chief Operating Officer or Executive Chief Finance Officer	
- Capital costs >£50,000	Chief Operating Officer or Executive Chief Finance Officer and Capital Strategy Group	
• **Gross annual revenue >£10,000 up to £50,000 per annum**		
- and/or one-off capital costs <= £10,000	Divisional Board with recommendation to the Chief Operating Officer or Executive Chief Finance Officer	
- Capital costs >£10,000 up to £50,000	Chief Operating Officer or Executive Chief Finance Officer	
- Capital costs >£50,000	Chief Operating Officer or Executive Chief Finance Officer and Capital Strategy Group	
• **Gross annual revenue >£50,000 up to £250,000 per annum**		
- and/or one-off capital costs <= £10,000	Management Executive Group	
- Capital costs >£10,000 up to £50,000	Management Executive Group	
- Capital costs >£50,000	Management Executive Group and Capital Strategy Group	
• **Gross annual revenue >£250,000 per annum**		
- and/or one-off capital costs <= £10,000	Trust Board	
- Capital costs >£10,000 up to £50,000	Trust Board	
- Capital costs >£50,000	Trust Board and Capital Strategy Group	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• **Any spend (revenue or capital) > £10m for length of contract*** *Note that this does not apply where the contract is NHS to NHS or for spend on the New Hospital Project. This does apply to any spend in collaboration with another NHS body that is greater than £10m in aggregate e.g. a contract with one supplier for NHS bodies across the region. The Trust introduced a policy of 'no purchase order, no pay' in 2015. All items of expenditure must have a purchase order raised before a commitment to expenditure is made. The purchase order number must be quoted on the invoice from the supplier. Once items are received, they must be receipted on the purchase ordering system immediately to ensure the prompt payment of the invoice to the supplier. There are exceptions to this process e.g., for services provided by other NHS Organisations, and some agency expenditure payments where a separate approval route is in place. Points of clarity: - All financial limits within this document should be treated as VAT inclusive regardless of whether the VAT can be reclaimed or not except for contracts that may require Trust Board approval. - For those contracts which may need Trust Board approval the amount net of reclaimable VAT should be the value used to determine the level of authorisation required. Finance must confirm the correct VAT treatment before this decision can be made.	Cabinet Office	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
- NB items must not be split across multiple requisitions. All 'call off orders' must have an indicative level of activity and therefore an indicative value for which the following limits should be applied. - When considering the delegated matters determined by the 'annual value' or 'life of contract' which drives the most senior decision must be used. The 'annual value' should be based on the average value for the contract life.		
3. Non Pay Revenue Expenditure **(a) Pharmacy Orders**		
• <= £500,000 within agreed contracts	Chief Pharmacist	SFIs Section 11
• > £500,000 up to £1,000,000 within agreed contracts	Chief Executive or Executive Chief Finance Officer	
• > £1,000,000	Trust Board	
(b) All other revenue requisitions, orders and invoices (based on total contract value)*		SFIs Section 11
• <= £10,000 – requires up to 3 written quotations at the discretion of procurement for items over £5,000 - informal	Budget Holder per authorised signatory list **	
• > £10,000 up to £50,000 – requires 3 written quotations - formal	Associate Director of Operations or Associate Director of service area **	
• >£50,000 up to £100,000 – requires 3 written quotations - formal	Executive Director**	
• >£100,000 up to £500,000 – requires 5 written tenders or maximum suppliers in the market if less than 5	Chief Executive and Executive Chief Finance Officer	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• >£500,000 up to £2m – requires 5 written tenders or maximum suppliers in the market if less than 5 • >£2m – requires 5 written tenders or maximum suppliers in the market if less than 5 Where a contract includes the option to extend, the above values apply to the full term of the contract including any possible extensions. In addition to the above, the following approvals are in place: • All non-critical non-pay expenditure over £500 • All non-critical non-pay expenditure over £15,000 In order to define exceptions that are critical, the Non Pay Control Panel will define clinical and critical non-clinical products in line with their Terms of Reference and the NPCP decision tree. *All requisitions must have the highest level of Divisional Sign off as well as the relevant Committee sign off.	Chief Executive and Executive Chief Finance Officer (in consultation with the Management Executive Group) Chief Executive or Executive Chief Finance Officer (on the instruction of the Trust Board) ** within their authorised budget areas only Non-Pay Control Panel (NPCP) Suffolk and North East Essex Integrated Care Board (SNEE ICB)	
4. Pay Costs *Note that this applies to all staff groups, including medical staff.* **<u>Substantive posts</u>** • All recruitment and pay adjustment requests, excluding Corporate areas (for review). • All recruitment and pay adjustment requests (for approval).	Divisional Recruitment Control Panels (DRCP) Trust Recruitment Control Panel (TRCP) SNEE ICB	SFIs section 10

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• New posts that are non-clinical (after approval by TRCP). All recruitment requests will be submitted to the DRCPs in the first instance for review and, if approved, will then be reviewed at the TRCP. Corporate functions will be submitted directly to the TRCP. The recruitment system Trac will be used to facilitate the requests. The system has an authorisation function for requests and all managers have access to the system. **<u>Temporary Staff and Extra Contractual Work (ECWs)</u>** • ECW requests and use of temporary staff, including bank, agency and interim roles, excluding Corporate Areas (for review). • ECW requests and use of temporary staff, including bank, agency and interim roles (for approval). • Temporary staff within Corporate areas (after approval by ECWTSCP). Requests for ECWs and temporary, bank and agency staff will be submitted to ECWTSCP once they have been reviewed at a divisional level. Requests for temporary staff for any corporate functions will be submitted directly to ECWTSCP and also require approval from the ICB. The recruitment system Trac will be used to facilitate all of the requests for both substantive and temporary staff. The system	Divisional Recruitment Control Panels (DRCP) Extra Contractual Work and Temporary Staff Control Panel (ECWTSCP) SNEE ICB	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
has an authorisation function for requests and all managers have access to the system.		
5. Capital Purchases & Schemes **a)** All capital schemes or capital purchases must be listed in the Trust Board approved Capital Programme and must be agreed with the Executive Chief Finance Officer prior to implementation or purchase. Note that this also includes all expenditure in relation to leases (new and extensions) and right of use assets. Note that the below values are for the life of the contract.		SFIs section 14
• <= £500,000	Executive Director (on instruction from the Capital Strategy Group)	
• £500,000 - £1,000,000 (for scheme's included in the approved capital programme)	Chief Executive or Executive Chief Finance Officer (in consultation with the Capital Strategy Group and the Finance Accountability Committee)	
• £500,000 - £1,000,000 (for scheme's not included in the approved capital programme)	Chief Executive or Executive Chief Finance Officer (in consultation with the Trust Board and the Capital Strategy Group)	
• £1,000,000 - £15,000,000	Trust Board	
• £15,000,000 to £50,000,000*	NHS England and The Department of Health and Social Care	
• Over £50,000,000*	NHS England, The Department of Health and Social Care and HM Treasury	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
* may be reduced to £15,000,000 by NHS England if the Trust is in financial distress		
b) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Associate Director of Estates and Facilities	
c) Granting and termination of equipment leases within the Trust's delegated limit	Chief Executive or Executive Chief Finance Officer	
d) Transfers between Revenue/Capital	Executive Chief Finance Officer	
6. Waiving of Competition and Contract Signature		SFIs section 7.5.3
a) Waiving of Competition		
• Waiving of quotations irrespective of value	Head of Procurement	
• Waiving of quotations <=£10,000	Assistant Director of Finance or Deputy Director of Finance	
• Waiving of quotations >£10,000 <=£100,000	Executive Chief Finance Officer or Chief Executive	
• Waiving of quotations >£100,000 <=£500,000	Chief Executive or Executive Chief Finance Officer, with ratification from the Financial Accountability Committee.	
• Waiving of quotations >£500,000	Chief Executive or Executive Chief Finance Officer, with ratification from the Trust Board.	
b) Healthcare Service Level Agreements	Chief Executive or Executive Chief Finance Officer	
c) Signing of contracts with suppliers following approval of expenditure in line with the Scheme of Delegation	Chief Executive or Executive Chief Finance Officer	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
7. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	Executive Chief Finance Officer or Nominated Deputy	SFIs Section 6
b) Price of NHS Contracts/Service Agreements	Executive Chief Finance Officer	SFIs Section 7 and 8
8. Petty Cash Disbursements		
a) Expenditure up to £100 per item	Petty Cash Holder	
b) Expenditure >£100	Financial Accountant	
c) Reimbursement of patient's monies up to £100	Patient Affairs Officer	
d) Reimbursement of patient's monies in excess of £100	Executive Chief Finance Officer or Assistant Director of Finance	
9. Expenditure on Charitable Funds		Charitable Funds Policy
• Up to £5,000 per request	Head of Fundraising and Fund Holder	
• >£5,000 up to £25,000	2 of either Executive Chief Operating Officer, Executive Chief Finance Officer or Director of Workforce	
• >£25,000 up to £100,000	Charitable Funds Committee	
• >£100,000	Trust Board	
The Head of Fundraising must approve all expenditure to ensure that it is in line with the charitable objective. All expenditure must be spent and approved in line with the Charitable Funds Policy. Retrospective approvals will not be given. Where expenditure is		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
over £5,000 then a 2nd competitive quote should be obtained as a minimum, or a waiver completed in line with section 6 of this Scheme of Reservation and Delegation.		
10. Maintenance / Operation of Bank Accounts		
• CHAPS and 'Faster' Payments	Executive Chief Finance Officer/Authorised Signatory for Bank Account	SFIs Section 6.4.6
11. Estates Agreements/ Leases/ Licences and Service Level Agreements (SLAs) For acquiring use of Trust property		
a) Preparation and signature of all tenancy agreements/leases/licences and SLAs for all staff subject to Trust Policy on accommodation for staff	Director of Workforce & Communications or nominated Deputy in consultation with Associate Director of Estates and Facilities	SFIs section 12.3
a) New or extensions to existing property leases, licences or SLAs in line with delegated limits taking into consideration the total value of the Term known or in the case of a licence the estimated value being not less than 3 years.	Executive Chief Finance Officer and Associate Director of Estates and Facilities	
b) Letting of existing premises to outside organisations.	Executive Chief Finance Officer and Associate Director of Estates and Facilities	
c) Approval of rent based on professional assessment	Executive Chief Finance Officer and Associate Director of Estates and Facilities	
d) Agreement of lease, Licence or property SLA dilapidations in excess of £5,000.	Executive Chief Finance Officer and Associate Director of Estates and Facilities	
e) High value property agreements whether income related or in terms of consolidated expenditure as a lease, licence or SLA should be reported to the Trust Board if the total value is in excess of £1 million.	Executive Chief Finance Officer and Associate Director of Estates and Facilities to advise the Trust Board	
12. Condemning & Disposal of Assets and Supplies		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
a) Condemning		SFIs section 16
• Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively and where the value exceeds £5,000.	Head of Procurement or Head of EBME or Capital Accountant	
b) Disposal		
• Where the item being disposed of has a net book value of over £5,000 and less than £50,000.	Capital Accountant	
• Where the net book value is greater than £50,000.	Executive Chief Finance Officer	
13. Losses, Write-off & Compensation		SFIs section 16
a) Losses in relation to: - Cash - Fruitless payments (including abandoned projects) - Patients, staff and visitors for loss of personal effects - Bad debt write offs and claims abandoned (including salary overpayments) - Damage or loss to buildings, fittings, furniture, equipment, property, stores		
• Up to £5k	Executive Chief Finance Officer	
• Between £5k up to £25k	Executive Chief Finance Officer and Chief Executive	
• £25k up to £250k	Audit Committee	
• Over £250k	Trust Board	
b) For clinical negligence		
• Up to £10,000	Legal Services Manager	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• >=£10,000 **c)** For personal injury • Up to £10,000 staff • Up to £3,000 public Liability • Greater than above limits Note that all losses and special payments are to be reported to the Audit Committee on an annual basis.	NHS Resolution Legal Services Manager having taken legal advice and consulted with the Trust insurers Legal Services Manager having taken legal advice and consulted with the Trust insurers NHS Resolution or relevant body	
14. Special Payments The following items require approval from HM Treasury before being committed to and therefore the Executive Director of Workforce and the Executive Chief Finance Officer must be alerted to any such instances (note that a value does not apply unless specifically stated): **Special Payments** • Extra contractual payments to contractors • Compensation payments (e.g. for personal injury outside of the Injury Benefit Scheme, traffic accidents and damage to property) • Extra statutory and extra regulatory payments • Ex-gratia payments beyond statutory cover or legal liability (e.g. payments for hardship or out of court settlements)	Executive Chief Finance Officer and HM Treasury The Trust Board should also be aware.	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
Special Severance Payments • Any severance payments (contractual and non-contractual) made to any Director of Chief Executive. • Non-contractual severance payments to staff (e,g, gardening/special leave, compensation payments, settlement agreements outside of the normal contract arrangement). • Contractual payments to staff over £100,000. • Any payment in lieu of notice (PILON). • Any payment that is considered to be novel, contentious or could cause repercussions elsewhere in the public sector.	Executive Director of Workforce and Executive Chief Finance Officer and HM Treasury The Trust Board should also be aware.	
15. Credit Notes Where a credit note is required to be issued against an invoice raised by the Trust which will result in income being credited, it must be authorised as follows: • Up to £1,000 • £1,000 up to £10,000 • Over £10,000	Accounts Receivable Manager and Financial Controller Financial Controller and Assistant Director of Finance Assistant Director of Finance and Executive Chief Finance Officer	
16. Reporting of Incidents to the Police • Where a criminal offence other than fraud is suspected • Where a fraud against the Trust is suspected	In line with Trust Policy Executive Chief Finance Officer	SFIs Section 2 & 16

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
17. Receiving Hospitality Gifts and hospitality should be declined where possible. If not, any items valued over £25 must be declared and recorded on the Gifts and Hospitality Register. Approving the acceptance of hospitality by employees except for trivial gifts as defined in the NHS England guidance: 'Managing Conflicts of Interest in the NHS' (Publications Gateway Reference 06419)	Trust Secretary	Standards of Business Conduct
18. Maintenance & Update of Trust Financial Procedures	Executive Chief Finance Officer	
19. Implementation of Internal and External Audit Recommendations	Executive Chief Finance Officer	SFIs Section 2
20. Investment of Funds • Trust Funds • Charitable Funds (Investment advisors).	 Executive Chief Finance Officer Charitable Funds Committee	 SFIs Sections 12, 19
21. Workforce • Authority to complete requests using the TRAC system for adjustments to pay, new starters and variations. • Authority and responsibility to complete relevant forms to notify of a member of staff leaving the Trust • Authority to authorise overtime • Authority to authorise travel & subsistence expenses • Authority to waive contractual notice period	 Line Manager Line Manager Line Manager Line Manager Budget Holder in consultation with HR	
22. Authorisation of New Drugs		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• Annual cost < £25,000 • Annual cost > £25,000	Drugs & Therapeutics Committee Drugs & Therapeutics Committee and Executive Chief Finance Officer	
23. Authorisation of Sponsorship deals	Chief Executive	
24. Authorisation of Research Projects	Chief Executive or Medical Director and Research Committee	
25. Authorisation of Clinical Trials	Research Operational Committee	
26. Insurance Policies and Risk Management	Chief Executive	SFIs section 23
27. Patients & Relatives Complaints • Overall responsibility for ensuring that all complaints are dealt with effectively • Responsibility for ensuring complaints relating to a care group are investigated thoroughly.	 Executive Chief Nurse Executive Chief Nurse	
28. Relationships with Press **a)** Non-Emergency General Enquiries • Within Hours • Outside Hours **b)** Emergency • Within Hours • Outside Hours	 Associate Director of Communications Tactical Manager on call Chief Executive or Associate Director of Communications Tactical Manager on call	Media Policy (PP119)
29. Infectious Diseases & Notifiable Outbreaks	Tactical Manager on Call or Control of Infection Doctor	
30. Extended Role Activities	Executive Chief Nurse	Nurse/Midwives/Health Visitors Act Midwives

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.		Rules/Code of Practice UKCC Code of Professional Conduct
31. Patient Services Variation of operating and clinic sessions within existing numbers and all proposed changes in bed allocation and use.	Executive Chief Operating Officer	
32. Facilities for staff not employed by the Trust to gain practical experience Professional Recognition & Insurance of Medical Staff, honorary contracts, work experience students	Director of Workforce and Communications	Honorary Contracts (Protocols for Issue) PP107
33. Review of all statutory compliance legislation Health and Safety requirements including control of Substances Hazardous to Health Regulations Employment Law	 Trust Secretary Executive Director of Workforce & Communications	
34. Review of Medicines Inspectorate Regulations	Chief Pharmacist	
35. Review of Trust's compliance with the Data Protection Act	Data Protection Officer	
36. Review the Trust's compliance with the Access to Records Act	Health Records Manager	Health Records Policy (PP136)
37. Review the Trust's compliance with the Confidentiality Code of Practice, NCRS Acceptable Use Policy and Caldicott Principles for information sharing with other Authorities and Third Party Contractors.	Data Protection Officer	Safe haven policy (PP126)
38. The keeping of a Declaration of Interests Register	Trust Secretary	SOs Section 7
39. Attestation of sealings in accordance with Standing Orders	Two Board Directors or a Board Director and the Trust Secretary	SOs Section 8
40. The keeping of the Gifts and Hospitality Register	Trust Secretary	Standards of business conduct (PP)54)
41. Ensuring compliance with regulations in respect of the retention of records	Managers and Heads of Department in accordance with referenced policy	Retention, storage and disposal policy (PP192)

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
42. Clinical Audit	Medical Director and Improvement Committee	
43. Patients Property Release of patients property where: • Value of deceased patients property <=£5,000 - forms of indemnity required. • Value of deceased patients property >£5,000 production of Probate or Letters of Administration	 Executive Chief Finance Officer or Delegated Officer Executive Chief Finance Officer or Delegated Officer	Patient Property (PP042)

5. Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

References to statutory provisions shall be deemed to include references to any provision amending, re-enacting or replacing them and to such provisions as amended from time to time.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

44. **the 2006 Act** is the National Health Service Act 2006.

45. **the 2012 Act** is the Health and Social Care Act 2012.

46. **Accountable Officer** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

47. **Adviser** means a person formally appointed by resolution of the Council of Governors to advise the Council of Governors at meetings of the Council of Governors in an advisory and non-voting capacity.

48. **Annual Members Meeting** is defined in paragraph 9 of the constitution.

49. **Audit Committee** means a committee whose functions are concerned with the arrangements for providing the Board with an independent and objective review on its financial and risk systems, financial information and compliance with laws, guidance, and regulations governing the NHS and with the arrangements for the monitoring and improving the quality of healthcare for which the Trust has responsibility.

50. **Board of Directors ("the Board")** means the Executive and Non-Executive Directors including the Chairman as constituted in accordance with the Constitution as the Board of Directors.

51. **Chair** means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "Chair" shall be deemed to include the Deputy Chair if the Chair is absent or otherwise unavailable.

52. **Chief Executive** means the Accountable Officer of the Trust , to ensure that the Trust meets its statutory requirements and service obligations as set out in its Provider License.

53. **Committee Members** means in the context of a Committee persons formally appointed by the Council of Governors or Board of Directors to be members of the Committee.

54. **Corporate Trustee** means the Trustee of the My Wish Charity. The Directors of West Suffolk NHS Foundation Trust act on behalf of the Corporate Trustee in exercising their duty with regards to the Charity Commission's public benefit guidance when exercising any powers or duties to which this guidance is relevant.

55. **Council of Governors** means the elected and appointed Governors of the Trust collectively as a body, as constituted in accordance with the Constitution.

56. **Constitution** means this constitution and all annexes to it.

57. **Deputy Chair** means the Non Executive Director appointed by the Council of Governors to take on the Chair duties if the Chair is absent for any reason.

58. **Director** means a Member of the Board.

59. **Executive Director** means a Member of the Board who holds an executive office of the Trust.

60. **Executive Chief Finance Officer** means the Chief Financial Officer of the Trust.

61. **Governor** means a person who is a member of the Council of Governors.

62. **Licence** , originally issued by Monitor, the Licence sets out a range of conditions that the Trust must meet.

63. **Member** means any person registered as a member of the Trust, and authorised to vote in elections to select Governors.

64. **Monitor** is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act. Monitor were part of NHS Improvement who were subsequently dissolved to become part of NHS England in June 2022.

65. **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

66. **Non Executive Director** means a member of the Board of Directors who is not an Executive Director of the Trust.

67. **Officer** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

68. **Secretary** means a person who may be appointed to act independently of the Council of Governors to provide advice on corporate governance issues to the Council of Governors, and the Chair and monitor the Trust's compliance with the law, Standing Orders and relevant guidance.

69. **SFIs** means Standing Financial Instructions.

70. **SOs** mean Standing Orders.

71. **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried on for profit.

Author(s):	Trust Secretary Assistant Director of Finance
Other contributors:	Executive Chief Finance Head of Procurement, Deputy Director of Workforce Executive Director of Workforce and Communications
Approvals and endorsements:	Audit Committee and Trust Board
Consultation:	
Issue no:	
File name:	
Supercedes:	Reservation and delegation of powers PP(17)222
Equality Assessed	Yes
Implementation	Policy is a standard reference document for Trusts
Monitoring: (give brief details how this will be done)	Policy monitored through financial systems and procedures
Other relevant policies/documents & references:	Standing Financial Instructions Standing Orders
Additional Information:	

West Suffolk NHS
NHS Foundation Trust

Trust Policy and Procedure **Document Ref. No: PP364**

Standing Financial Instructions (SFIs)

For use in:	All areas of the Trust
For use by:	All Trust staff
For use for:	Financial Governance matters
Document owner:	Assistant Director of Finance
Status:	Final

Contents **Page**

Contents **Page**

Contents **Page**

Contents **Page**

1. INTRODUCTION

These SFIs are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree SFIs for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the SOs.

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of SFIs and SOs (on which they should be advised by the Chief Executive).

1.1 PURPOSE

These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They also act to protect individuals against accusations of impropriety, fraud or failure to ensure value for money. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust. Use of the Trust in this context implies the Foundation Trust and the My Wish Charity

1.2 SCOPE

These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Executive Chief Finance Officer, the Deputy Director of Finance or the Assistant Director of Finance.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Executive Chief Finance Officer or their nominated representative must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

The failure to comply with SFIs and SOs can in certain circumstances result in potential consequences for the employee, including in some cases, formal action. Where a breach constitutes a criminal offence, the matter may be subject to criminal investigation and will be handled in accordance with the Trust's Anti-Fraud, Financial Irregularities and Anti-Bribery Policy.

Overriding SFIs – If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Executive Chief Finance Officer as soon as possible.

This document must be read in conjunction with:

- Standing Orders
- Scheme of Reservation and Delegation
- Financial Procedures
- Procurement Procedural documents

1.3 DEFINITIONS

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

References to statutory provisions shall be deemed to include references to any provision amending, re-enacting or replacing them and to such provisions as amended from time to time.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

- **the 2006 Act** is the National Health Service Act 2006.

- **the 2012 Act** is the Health and Social Care Act 2012.

- **Accountable Officer** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

- **Adviser** means a person formally appointed by resolution of the Council of Governors to advise the Council of Governors at meetings of the Council of Governors in an advisory and non-voting capacity.

- **Annual Members Meeting** is defined in paragraph 9 of the constitution.

- **Audit Committee** means a committee whose functions are concerned with the arrangements for providing the Board with an independent and objective review on its financial and risk systems, financial information and compliance with laws, guidance, and regulations governing the NHS and with the arrangements for the monitoring and improving the quality of healthcare for which the Trust has responsibility.

- **Board of Directors ("the Board")** means the Executive and Non-Executive Directors including the Chairman as constituted in accordance with the Constitution as the Board of Directors.

- **Chair** means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "Chair" shall be deemed to include the Deputy Chair if the Chair is absent or otherwise unavailable.

- **Chief Executive** means the Accountable Officer of the Trust , to ensure that the Trust meets its statutory requirements and service obligations as set out in its Provider License.

- **Committee Members** means in the context of a Committee persons formally appointed by the Council of Governors or Board of Directors to be members of the Committee.

- **Corporate Trustee** means the Trustee of the My Wish Charity. The Directors of West Suffolk NHS Foundation Trust act on behalf of the Corporate Trustee in exercising their duty with regards to the Charity Commission's public benefit guidance when exercising any powers or duties to which this guidance is relevant.

- **Council of Governors** means the elected and appointed Governors of the Trust collectively as a body, as constituted in accordance with the Constitution.

- **Constitution** means this constitution and all annexes to it.

- **Deputy Chair** means the Non Executive Director appointed by the Council of Governors to take on the Chair duties if the Chair is absent for any reason.

- **Director** means a Member of the Board.

- **Executive Director** means a Member of the Board who holds an executive office of the Trust.

- **Executive Chief Finance Officer** means the Chief Financial Officer of the Trust.

- **Governor** means a person who is a member of the Council of Governors.

- **Licence**, originally issued by Monitor, the Licence sets out a range of conditions that the Trust must meet.

- **Member** means any person registered as a member of the Trust, and authorised to vote in elections to select Governors.

- **Monitor** is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act. Monitor were part of NHS Improvement who were subsequently dissolved to become part of NHS England in June 2022.

- **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

- **Non Executive Director** means a member of the Board of Directors who is not an Executive Director of the Trust.

- **Officer** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

- **Secretary** means a person who may be appointed to act independently of the Council of Governors to provide advice on corporate governance issues to the

Council of Governors, and the Chair and monitor the Trust's compliance with the law, Standing Orders and relevant guidance.

- **SFIs** means Standing Financial Instructions.
- **SOs** mean Standing Orders.
- **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried on for profit.

Amounts referred to include VAT regardless of whether or not the VAT is reclaimable.

1.4 Responsibilities and delegation

1.4.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Reservation and Delegation document.

(e) Approval of monitoring information received by the Board.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the '"Scheme of Reservation and Delegation" document. All other powers have been delegated to such other committees as the Trust has established.

1.4.2 The Chief Executive and Executive Chief Finance Officer

The Chief Executive and Executive Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's

activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of these instructions in way they can understand their responsibilities within these Instructions.

1.4.3 **The Executive Chief Finance Officer**

The Executive Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Executive Chief Finance Officer include:

(d) the provision of financial advice to other members of the Board and employees, excluding personal financial advice which prohibited;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.4.4 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of SOs, SFIs, Financial Procedures and the Scheme of Delegation.

1.4.5 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Executive Chief Finance Officer.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with SOs, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following relevant guidance which will support the Board in advising on key risks and provide an independent and objective view of internal control. The Committee shall:

(a) monitor and review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(b) ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Trust Board;

(c) ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Trust Board;

(d) review the work and findings of the External Auditor, appointed by the Governors, and consider the implications and management's responses to their work;

(e) review the Annual Report and Financial Statements of the Trust before submission to the Board, to determine their completeness, objectivity integrity and accuracy;

(f) review and approve the Annual Report and Financial Statements of the Charitable Funds before submission to the Charity Commission (delegated authority from the Trust Board);

(g) review proposed changes to SOs, SFIs, Scheme of Reservation and Delegation of Powers for approval by the Board. To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension; and

(h) review the SOs, SFIs, Scheme of Reservation and Delegation on at least a two yearly basis for approval by the Board.

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care (DHSC).

2.1.3 It is the responsibility of the Executive Chief Finance Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when an Internal Audit service provider is changed.

2.1.4 The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.2 Executive Chief Finance Officer

2.2.1 The Executive Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS Internal Audit Standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption and in conjunction with the Local Counter Fraud Specialist (LCFS) and NHS Counter Fraud Authority (NHSCFA) in instances of fraud, bribery or corruption;

(d) ensuring that an Internal Audit Annual Report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.2.2 The Executive Chief Finance Officer, designated auditors or LCFS are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit should fulfil its terms of reference by systematic review and evaluation of risk management, control and governance which comprises the policies, procedures and operations in place to:

(a) establish, and monitor the achievement of, the organisation's objectives;

(b) identify, assess and manage the risks to achieving the organisation's objectives;

(c) ensure the economical, effective and efficient use of resources;

(d) ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations;

(e) safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption;

(f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

2.3.2 Internal Audit should devote particular attention to any aspects of the risk management, control and governance affected by material changes to the organisation's risk environment.

2.3.3 Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from DHSC.

2.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Executive Chief Finance Officer must be notified immediately, and the matter referred to the LCFS.

2.3.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.3.6 The Head of Internal Audit shall be accountable to the Executive Chief Finance Officer. The reporting system for Internal Audit shall be agreed between the Executive Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of

normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the Head of Internal Audit shall have access to report to the Chief Executive, Chair or any non-executive Director of the Trust.

2.3.7 If the Head of Internal Audit or the Audit Committee considers that the level of audit resources or the terms of reference in any way limit the scope of Internal Audit, or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they should advise the Board accordingly.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

2.4.2 External audit responsibilities (in compliance with the requirements of the Independent Regulator) are:

a) To be satisfied that the accounts comply with the directions provided, i.e. that the accounts comply with the Annual Reporting Manual issued by NHS England and the Group Accounting Manual issued by DHSC;

b) To be satisfied that the accounts comply with the requirements of all other provisions, contained in, or having effect under, any enactment which is applicable to the accounts;

c) To be satisfied that proper practices have been observed in compiling the accounts;

d) To be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources;

e) To comply with any directions given by the National Audit Office as to the standards, procedures and techniques to be adopted, i.e. to comply with the Audit Code;

f) to consider the issue of public interest report;

g) to certify the completion of the audit;

h) to express an opinion on the accounts; and

i) to refer the matter to the Independent Regulator if the Trust, or any officer or director of the Trust, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

2.4.3 External Auditors will ensure that there is a minimum of duplication of effort between themselves and other agencies. The auditors will discharge this responsibility by:

a) reviewing the statement made by the Chief Executive in the Annual Governance Statement and making a negative statement within the audit opinion if the Annual Governance Statement is not consistent with their knowledge of the Trust;

b) reviewing the results of the work of relevant assurers, for example the Care Quality Commission and Internal Audit, to determine if the results of the work have an impact on their responsibilities; and

c) Undertaking any other work that they feel necessary to discharge their responsibilities.

2.4.4 Any non-audit services performed by the External Auditor must be in accordance with the Trust's policy on non-audit services, which states that any such engagement for non-audit services must be approved by the Executive Chief Finance Officer and the Audit Committee.

2.5 Fraud, Bribery and Corruption

2.5.1 The Trust Chief Executive and Executive Chief Finance Officer have overall responsibility for ensuring that there are sound systems of internal control (e.g. procedures, guidance notes and effective supervision) to minimise the opportunities for fraud, bribery and corruption within the day-to-day business of the Trust and its contractors. This responsibility extends to ensuring that policies and procedures for all work related to fraud and bribery is implemented and the findings from investigations and proactive counter fraud work are acted upon accordingly.

In line with their responsibilities, the Chief Executive and the Executive Chief Finance Officer will monitor and ensure compliance with the NHS Standard Contract and the NHSCFA Standards for Providers.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the LCFS as specified by NHSCFA guidance;

2.5.3. The LCFS shall report to the Executive Chief Finance Officer and shall work with staff in the NHSCFA in accordance with the NHSCFA Standards.

2.5.4. **Fraud:** any person who dishonestly makes a false representation to make a gain for themselves or another, or who dishonestly fails to disclose to another person, information which he is under a legal duty to disclose or commits fraud by abuse of position including any offence as defined in the Fraud Act 2006.

Bribery: giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.

Where the organisation is engaged in commercial activity it could be considered guilty of a corporate bribery offence if an employee, agent, subsidiary or any other person acting on its behalf bribes another person, intending to obtain or retain business or an advantage in the conduct of business for the organisation and it cannot demonstrate that it has adequate procedures in place to prevent such.

2.5.5 The LCFS will provide a written report, and attend the Audit Committee to present, at least annually, on counter fraud work within the Trust.

2.5.6 The Trust will complete a Self-Review Tool, inclusive of a summary of the counter fraud, bribery and corruption work conducted over the previous twelve months, for submission to the NHSCFA.

2.5.7 The Executive Chief Finance Officer must prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

2.5.8 All suspected incidents of potential fraud, bribery or corruption should be reported to the Trusts' LCFS, either directly (contact details can be found on the Trusts' intranet pages) or by contacting the National Fraud and Corruption reporting line by telephoning 0800 028 40 60. Your call will be treated in confidence and you can remain anonymous. You may also report your concerns on-line at www.cfa.nhs.uk/reportfraud.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management, through representation on the Corporate Risk Committee.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Associate Director of Estates and Facilities .

3. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board a Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Executive Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in any planning guidance issued from the Department of Health and Social Care and relevant regulatory bodies;

(b) accord with workload and workforce plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds or be clear about the funding strategies for any planned deficit; and

(e) identify potential risks.

3.1.3 The Executive Chief Finance Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Executive Chief Finance Officer to enable budgets to be compiled.

3.1.5 Budget holders at an appropriate level will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Executive Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board without prior authority.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Chief Finance Officer.

3.3 Budgetary Control and Reporting

3.3.1 The Executive Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) summary balance sheet;

(iii) movements in working capital;

(iv) Movements in cash and capital;

(v) capital project spend and projected outturn against plan;

(vi) explanations of any material variances from plan;

(vii) details of any corrective action where necessary and the Chief Executive's and/or Executive Chief Finance Officer' view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and workforce budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board. Cost containment plans will be prepared and presented to Board within 1 month of the overspend being reported;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) permanent employees are appointed in line with the SoD.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust Plan and a balanced budget over time.

3.3.4 All employees of the Trust, especially those involved with the budgetary processes, have a responsibility to the Board for identifying all possible opportunities to make savings or to use resources more effectively. All such opportunities should be brought to the attention of the appropriate Executive Director.

3.3.5 The budgetary process requires adherence to particular timescales for the performance of routines and duties. These timescales change periodically and will

be issued by the Finance Department annually. The Executive Chief Finance Officer is responsible for issuing and reviewing guidance on budgetary timetables. It is the responsibility of all Executive Directors to adhere to such timetables and to inform the Executive Chief Finance Officer of any reasons preventing the achievement of a specific deadline.

3.3.6 The Executive Chief Finance Officer reserves the right to have access to all Budget Holders and has the authority to require explanations on performance, spending and income trends within the remit of the Budget Holder.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 14).

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the returns are submitted to DHSC and regulatory bodies as required.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Executive Chief Finance Officer, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by relevant regulatory bodies, the Trust's accounting policies, and other relevant accounting requirements;

(b) prepare and submit annual financial reports to the relevant regulatory body certified in accordance with current guidelines;

(c) submit financial returns to the relevant regulatory body for each financial year in accordance with the timetable prescribed.

4.2 The Trust's Annual Accounts must be audited by an Auditor appointed by the Trust's Council of Governors. The Trust's audited Annual Accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an Annual Report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the relevant guidance and timetable.

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 The Executive Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by DHSC. In line with 'Cash Management in the NHS' Trusts should

minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and GBS Accounts

5.2.1 The Executive Chief Finance Officer is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's charitable funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with guidance from DHSC and the relevant regulatory body on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Executive Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Executive Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 No Trust monies or donated funds can be held in any personal bank accounts. Any accounts linked to the Trust; either by name or address should be managed and controlled by Finance, individual accounts held by departments is strictly forbidden and can lead to identified personnel being referred to counter fraud or HR which may in turn result in an investigation and / or dismissal.

5.3.4 The Executive Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Executive Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Executive Chief Finance Officer is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow DHSC and other relevant regulatory guidance in setting prices for NHS and non NHS contracts.

6.2.2 The Executive Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by DHSC or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in DHSC's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.2.3 All employees must inform the Executive Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Invoices for income due to the Trust must be raised in a controlled manner and must only be done so by the Finance Department.

6.3 Debt Recovery

6.3.1 The Executive Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments by the Trust should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Executive Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Chief Finance Officer.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with losses procedures.

6.4.6 All payments made on behalf of the Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS) or by Faster Payments and drawn in accordance with these instructions, except with the agreement of the Executive Chief Finance Officer, as appropriate, who shall be satisfied about security arrangements.

6.4.7 To comply with money laundering legislation, under no circumstances will the Trust accept cash payments in excess of £10,000 in respect of any single transaction. Any attempts by an individual to effect payment above this amount shall be notified immediately to the Executive Chief Finance Officer.

7. TENDERING AND CONTRACTING PROCEDURE

7.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and SFIs (except where Standing Order No. 3.13 Suspension of SOs is applied).

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union (EU) promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SOs and SFIs. The Trust is governed to follow the Procurement Act 2023 for all tendering and contracting procedures, including the awarding of contracts.

7.3 Capital

The Trust shall comply as far as is practicable with the requirements of the DHSC Group Accounting Manual and NHSE Capital Guidance in respect of capital investment and estate and property transactions.

7.4 Formal Competitive Tendering

7.4.1 General Applicability

The Trust shall ensure that competitive quotes/ tenders are invited for:

- the supply of goods, materials and manufactured articles;

- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

7.4.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these SOs and SFIs shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with SFI No. 8 and No. 9.

7.4.3 **Exceptions and instances where formal tendering need not be applied**

All amounts referred to are inclusive of VAT regardless of whether the VAT is reclaimable or not.

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income for the contract period does not, or is not reasonably expected to, exceed **£100,000**;

(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI No. 16;

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where National Framework agreements are in place. Use can be approved by the Board in line with the SoD;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

(m) where the Provider Selection Regime (PSR) allows direct award under route A, B & C

The Executive Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Financial Accountability Committee quarterly and the Audit Committee annually.

7.4.4 **Fair and Adequate Competition**

Due consideration is required of 7.5.3 above and the exceptions in SFI 17apply. The Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate. In most cases there should be no less than two firms/individuals, having regard to their capacity supply the goods, materials, services or works required, invited to bid for work. It is noted that where computer software and hardware are involved, compatibility issues may reduce choice.

7.5 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits

shall be reported to the Chief Executive, and be recorded in an appropriate Trust record. Such cases should be reported to the Audit Committee at the earliest opportunity.

7.6 Contracting/Tendering Procedure

7.6.1 Invitation to tender

(i) all invitations to tender shall state the date and time as being the latest time for the receipt of tenders. The invitation to tender shall state that no tender will be considered unless it is received by the date and time stipulated in the invitation to tender.

(ii) all invitations to tender shall state that no tender will be accepted unless:

(a) the prescribed electronic submission process is followed if coordinated by Procurement; or

(b) the following:

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(ii) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with DHSC guidance and, in minor respects, to cover special features of individual projects.

7.6.2 Receipt and safe custody of tenders

The Chief Executive or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

7.6.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be either:

(a) Opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(b) Unlocked in the e-tendering portal

(ii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £100,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's SoD.*

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Executive Chief Finance Officer' staff in the preparation of a tender proposal will not preclude the Executive Chief Finance Officer or any approved Senior Manager from the Executive Chief Finance Officer directorate from serving as one of the two senior managers to open tenders.

(v) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Trust Secretary will count as a Director for the purposes of opening tenders.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (SO No. 17.6.5 below).

*Note that point (iii) to (viii) does not apply to tenders made via the e-tendering portal.

7.6.4 **Admissibility**

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Executive Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

7.6.6 **Acceptance of formal tenders (See overlap with SFI No. 7.7)**

(i) Seeking clarification of a Tender whether in writing or by way of a meeting is permitted to clarify technical aspects of the tender. However, the Head of Procurement or Legal advisor must be consulted and a written record of the clarification sought and resolution should be kept.

(ii) The lowest tender shall be accepted based on price or published scoring method for Most Advantageous Method (MAT), if payment is to be made by the Trust. Or, accepted if the highest payment is to be received by the Trust. Exception: There are good and sufficient reasons to the contrary. Such reasons

shall be set out in either the contract file, or other appropriate record and held with the tender documentation in accordance with statutory records retention management requirements.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection in accordance with statutory records retention and management requirements.

7.6.7 **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only. However, a Tender report summary, normally generated by a sub-committee, will be brought to Finance Accountability Committee for information.

7.6.8 **List of approved firms for Estates and Facilities**

(a) **Responsibility for maintaining list**

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms for Estates and Facilities from who tenders and quotations may be invited. The approved list shall be kept under frequent review with no company or individual retained for longer than three years without financial or qualitative assessment. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust

is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and will comply with the provisions of the Equality Act 2010, Modern Slavery Act 2015 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Executive Chief Finance Officer may make or institute any enquiries they deem appropriate concerning the financial standing, financial suitability or economic stress of approved contractors through new business or supply chain partners. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

7.6.9 **Exceptions to using approved contractors**

After consultation with the Associate Director of Estates and Facilities, if in the opinion of the Chief Executive and the Executive Chief Finance Officer or the Director with lead responsibility for clinical governance, it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been kept up to date, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of alternatives. This may be through an existing external framework, Constructionline or through open market quotation / tender.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.7 Quotations: Competitive and non-competitive

7.7.1 **General Position on quotations**

Written quotations are required where formal tendering procedures are not adopted where the intended expenditure or income is reasonably expected to exceed £5,000 but not expected to exceed £100,000. For orders below £5,000 2 verbal quotes should be sought and recorded by the authoriser.

7.7.2 **Competitive Quotations**

(i) Quotations should be obtained from at least 2 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust for contracts up to £10,000. 3 formal quotes should be obtained for contracts in excess of £10,000 but less than £100,000.

(ii) Quotations should be in writing for all orders over £5,000 unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations over £5,000 should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

7.7.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Executive Chief Finance Officer.

7.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Designated budget holders	up to	£10,000
Associate Director of Operations	up to	£50,000
Executive Director	up to	£100,000
Chief Executive and Executive Chief Finance Officer	up to	£500,000
Management Executive Group	Up to	£2m
Trust Board	over	£2m
Cabinet Office	over	£10m

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's SoD.

In accordance with the Quotation procedures tenders are not required under £10,000.

At the time of approval the Trust Board may delegate the responsibility for signing of orders / requisitions to the Chief Executive and the Executive Chief Finance Officer.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

7.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Executive Chief Finance Officer.

7.10 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust must assess the most competitive funding source for capital projects. This may include borrowing from DHSC (or delegated departments), borrowing commercially or PFI/ PPP schemes. The selection of the most competitive funding sources will be from a combination of business case shortlisting and competitive tendering. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and for PFI/ PPP genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to NHS England and DHSC for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) The Procurement Act 2023;

(c) any relevant directions including Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities and guidance on the Procurement and Management of Consultants;

(d) NHS Standard Contract Conditions or NHS Supply of Goods & Services Contacts, Service Level agreements or other structured agreements as are required to deliver services;

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited; and

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. See SoD section 4 item 4.

7.13 Health and care Services Agreements

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Body Corporate (PBC), is a legal document and is enforceable in law.

7.14 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DHSC or NHS England guidance has been issued but subject to compliance with such guidance, or One Public Estate requirements.

7.15 In-house Services

7.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) stakeholder group, comprising the Chief Executive or nominated officer/s and specialist;

(b) in-house tender group, comprising a nominee of the Chief Executive and technical support; and

(c) evaluation team, comprising normally of a sector or Market Specialist, a procurement Specialist and a representative of the Executive Chief Finance Officer. For services having a likely annual expenditure exceeding £250,000, a non-Executive Director should be a member of the evaluation team. Additional Consultancy support can also be sought from external organisations.

7.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.15.4 The evaluation team shall make recommendations to the Board.

7.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.16 Applicability of SFIs on Tendering and Contracting to funds held in trust

These Instructions also apply to works, services and goods purchased from the Trust's charitable funds and private resources.

8. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 7.13)

8.1 Service Level Agreements (SLAs)

8.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within any planning guidance and priorities issued by DHSC and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the provision of reliable information on cost and volume of services;
- the NHS Outcomes Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways;
- the priorities and operational planning guidance for the ICB.

8.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals, wider Trust management, other public sector partners in the ICB and the voluntary sector. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA, including information on costing arrangements.

9. COMMISSIONING

Not applicable to NHS Foundation Trusts.

10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF DIRECTORS, EMPLOYEES, VOLUNTEERS, OFF-PAYROLL WORKERS AND OFFICERS

10.1 Remuneration and Terms of Service (see overlap with SO No. 4)

10.1.1 In accordance with SOs the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

10.1.2 The Board's Remuneration and Nominations Committee will decide on appropriate remuneration and terms of service of the Chief Executive and other Executive Directors (and other very senior Officers) including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms and will advise the Board of Directors of any decisions made;

10.1.3 Regular reviews of the remuneration and terms of service of the Chief Executive and other Executive Directors (and other senior Officers) will be carried out to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate. To decide the appropriate remuneration of the Chief Executive and other Executive Directors and advise the Board of Directors of any decisions made. Any decisions made by the Remuneration Committee shall be recorded in the minutes of the meetings.

10.1.4 The Remuneration Committee shall monitor and evaluate the performance of individual Executive Directors (and other senior Officers).

10.1.5 The Committee shall also advise on and oversee appropriate contractual arrangements for all Directors and Officers, including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate (including approval required for special payments).

10.1.6 The Board of Directors will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those Officers and Officers not covered by the Committee.

10.1.7 The Trust will pay allowances to the Chair and other Non- Executive Directors in accordance with the decision of the Council of Governors in accordance with the Constitution.

10.2 Funded Establishment

10.2.1 The Workforce plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive, those with the delegated authority or as determined by the workforce plan taking into account management of changes and business cases.

10.3 Staff Appointments

10.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or those with the delegated authority;

(b) it is within the limit of their approved budget and funded establishment; and

(c) it is in accordance with any local or Trust-wide controls placed on recruitment to vacant positions.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service etc. for employees.

10.3.3

10.4 Processing Payroll

10.4.1 The Executive Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment; and

(e) performance managing the outsourced payroll provision to ensure it is in line with the contract and service continuity is maintained and where necessary

reporting any variations to the contract or significant areas of risk in relation to the service to the Board.

10.4.2 The Executive Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Executive Chief Finance Officer's instructions and in the form prescribed by the Executive Chief Finance Officer;

(c) submitting termination forms via HR in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Executive Chief Finance Officer and Executive Director of Workforce must be informed immediately.

10.4.4 Regardless of the arrangements for providing the payroll service, the Executive Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

10.6 Consultant staff appointments

10.6.1 Appointment of Consultant Staff follows the same process as for agenda for change staff, including anyExtra Contractual work (ECWs).

10.6.2

11. NON-PAY EXPENDITURE

11.1 Delegation of Authority

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

11.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

11.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

11.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Team shall be sought. Where this advice is not acceptable to the requisitioner, the Executive Chief Finance Officer (and/or the Chief Executive) shall be consulted.

11.2.2 **Under no circumstances should a requisition be split in such a way to circumvent particular spending limits attached as per the Scheme of Delegation.**

11.2.2 System of Payment and Payment Verification

The Executive Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Methods of payment can include use of commercial bank accounts, Government banking Services accounts, Government Procurement cards and Trust authorised credit cards.

11.2.3 The Executive Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct; and

- the account is in order for payment.

(iii) A timetable and system for submission to the Executive Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are where it is normal industry practice to pay in advance such as travel tickets, hotel bookings, course bookings and maintenance contracts.

(f) Be responsible for ensuring payments to suppliers are supported by an order that has been receipted unless the service supplied has been approved as an exception.

11.2.4 **Prepayments**

In accordance with HM Treasury guidance, prepayments are a risk and only permitted where the industry norm requires payment in advance such that it is impossible to negotiate alternative terms e.g. software licences and maintenance contracts. The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11.2.5 Official orders

Official purchase orders must be raised in advance of any commitment of expenditure on the Trust procurement system and:

(a) be consecutively numbered;

(b) be in a form approved by the Executive Chief Finance Officer;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Executive Chief Finance Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Chief Finance Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement or relevant legislation after leaving the EU;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by DHSC;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6, the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" and the principles set out in the Bribery Act 2010);

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity [(1).] These must be confirmed by an official order and clearly marked "Confirmation Order" as soon as practicably possible but not more than 60 days;

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Executive Chief Finance Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Chief Finance Officer; and

(l) petty cash records are maintained in a form as determined by the Executive Chief Finance Officer.

(m) All goods, services or works received are promptly checked and receipted to ensure prompt payment of invoices.

(1) Any procurement or work contracted in response to an event that is classified as a Major Incident will be deemed to be compliant if it is line with the powers of the Emergency Planning Officer or business continuity responsible officer.

11.2.7 The Chief Executive and Executive Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice guidance and Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities. The technical audit of these contracts shall be the responsibility of the relevant Director.

11.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

11.3.1 Payments to local authorities and voluntary organisations must comply with the powers of section 28A of the NHS Act 1977 as Amended whereby there are conditions on any payments made under section 76 and 256/257 of the NHS Act 2006. (See overlap with Standing Order No. 9.1)

12. FINANCING

12.1 External Borrowing

12.1.1 The Executive Chief Finance Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by DHSC. The Executive Chief Finance Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

12.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and the Executive Chief Finance Officer.

12.1.3 The Executive Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts, which are in line with guidance issued by NHS England and DHSC.

12.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from DHSC.

12.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Executive Chief Finance Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

12.1.6 All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Trust Board.

12.2 Investments

12.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

12.2.2 The Executive Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

12.2.3 The Executive Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12.3 Leases and right of use assets

12.3.1 The Executive Chief Finance Officer, or their Deputy, must be consulted on any lease arrangement (including managed service arrangements) that the Trust is considering entering in to. A full options appraisal must be completed on whether a lease arrangement is appropriate, the best value for money and that funding options allow.

12.3.2 Only the Executive Chief Finance Officer, or their Deputy, in conjunction with the Associate Director of Estates and Facilities has the authority to authorise a lease in the Trust's name.

13. FINANCIAL FRAMEWORK

13. 1 The Executive Chief Finance Officer should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to NHS England regarding resource and capital allocation and funding to Trust's. The Executive Chief Finance Officer should also ensure that the direction and guidance in the framework is followed by the Trust.

14. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

14.1 Capital Investment

14.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s), support and the availability of resources to finance all revenue consequences, including capital charges. Any resource required outside of agreed budgets will be taken through the required authorisation process.

(d) That the Capital Plan is produced on an annual basis and is submitted and approved by the Board prior to the start of the financial year.

14.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a statement of need is produced setting out:

(i) an option appraisal of potential benefits for all capital purchases (including proposals to lease, hire or rent asses) and their impact on the Trust's ability to achieve its financial targets;

(ii) the involvement of appropriate Trust personnel and external agencies (e.g. legal advice);

(ii) appropriate project management and control arrangements;

(b) that the Executive Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case.

14.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities" as well as Trust SOs and SFIs and in accordance with relevant HM Treasury and DHSC guidance.

14.1.4 The Executive Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

14.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with best practice guidance and the Trust's Standing Orders. Contracts will be constructed using an accepted format such as Joint Contracts Tribunal (JCT) and legal advice will be sought where appropriate.

14.1.6 The Executive Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes set by NHS England and DHSC.

14.2 Asset Registers

14.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

14.2.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers is determined by International Accounting Standard (IAS) 16 which requires each asset component to be treated separately for depreciation purposes.

14.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) contract agreements in respect of assets held under a lease or managed service arrangement.

14.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

14.2.5 The Executive Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.2.6 The value of each class of asset will be determined by the Executive Chief Finance Officer with reference to IAS 16 which states that revaluations should be carried out with sufficient regularity that the carrying amount does not differ materially from that which would be determined using fair value at the balance sheet date.

14.2.7 The value of each asset shall be depreciated as determined by the Chief Financial Officer to comply with the requirements of IAS 16.

14.2.8 The Executive Chief Finance Officer of the Trust shall calculate and pay capital charges (depreciation and public dividend capital (PDC)) as specified by the Group Accounting Manual, issued by DHSC.

14.3 Security of Assets

14.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

14.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Executive Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.3.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Executive Chief Finance Officer.

14.3.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

14.3.6 Where practical, assets should be marked as Trust property.

15. STORES AND RECEIPT OF GOODS

15.1 General position

15.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

15.2 Control of Stores, Stocktaking, condemnations and disposal

15.2.1 Subject to the responsibility of the Executive Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Executive Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of a designated

Pharmacy Manager; the control of any fuel oil and coal of a designated Estates Manager.

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as health service property.

15.2.3 The Executive Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Executive Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Chief Finance Officer.

15.2.6 The designated manager shall be responsible for a system approved by the Executive Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated manager shall report to the Executive Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 16 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by NHS Supply Chain

15.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and retain evidence for 2 years before accepting the charge.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 Disposals and Condemnations

16.1.1 **Procedures**

The Executive Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Executive Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Executive Chief Finance Officer;

(b) recorded by the Condemning Officer in a form approved by the Executive Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Executive Chief Finance Officer.

16.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Executive Chief Finance Officer who will take the appropriate action.

16.2 Losses and Special Payments

16.2.1 **Procedures**

The Executive Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

16.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Executive Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Executive Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Executive Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Executive Chief Finance Officer must inform the LCFS in accordance with NHSCFA Standards for Providers.

All fraud investigations will be reported to the NHSCFA, the External Auditor and the Audit Committee.

16.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Chief Finance Officer must immediately notify:

(a) the Board,

(b) the External Auditor.

16.2.4 Within limits delegated to it by DHSC and as noted in the SoD, the Board shall approve the writing-off of losses.

16.2.5 The Executive Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.6 For any loss, the Executive Chief Finance Officer should consider whether any insurance claim can be made.

15.2.7 The Executive Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.8 No special payments exceeding delegated limits shall be made without the prior approval of DHSC and HM Treasury.

16.2.9 All losses and special payments must be reported to the Financial Accountability Committee quarterly and to the Audit Committee annually.

17. INFORMATION TECHNOLOGY – FINANCIAL DATA

17.1 Responsibilities and duties of the Executive Chief Finance Officer

17.1.1 The Executive Chief Finance Officer, who is responsible for the accuracy and security of the computerised **financial** data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.2 The Executive Chief Finance Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

17.1.3

17.2 Responsibilities and duties of other Directors and Officers in relation to computer systems/digital services of a general application

17.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Executive Chief Operating Officer

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational

requirement.

17.3 Contracts for Financial Computer Services with other health bodies or outside agencies

The Executive Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Executive Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

17.4 Risk Assessment

The Executive Chief Operating Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Executive Chief Finance Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Executive Chief Finance Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;

- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Executive Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19. FUNDS HELD ON TRUST

19.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, which defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for trust funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Executive Chief Finance Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

19.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Scheme of Reservation and Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

19.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately for trust funds.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Executive Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. The Standards of Business Conduct policy follows the guidance contained in the NHS England 'Managing Conflicts of Interest in the NHS, June 2017. This is also deemed to be an integral part of these SOs and SFIs (see overlap with SO No. 6).

21. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Foundation Trusts.

22. RETENTION OF RECORDS

22.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with NHS England and DHSC.

22.2 The records held in archives shall be capable of retrieval by authorised persons.

22.3 Records held in accordance with latest NHS England and DHSC guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

23. RISK MANAGEMENT AND INSURANCE

23.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current NHS England DHSC assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement- within the Annual Report and Accounts as required by the current DHSC guidance.

23.2 Insurance: Risk Pooling Schemes administered by NHS Resolution (NHSR)

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHSR self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

23.3 Insurance arrangements with commercial insurers

23.3.1 The Board must assess the overall adequacy of insurance in place and where risks are not covered by NHSR commercial insurance must be considered and reviewed annually.

23.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by the NHSR the Executive Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Executive Chief Finance Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHSR for one or other of the risks covered by the schemes, the Executive Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Executive Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Executive Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

24. **Freedom of Information (FOI)**

24.1 The Head of Governance is responsible for maintaining a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

Author(s):	Trust Secretary and Head of Governance Assistant Director of Finance
Other contributors:	
Approvals and endorsements:	Audit Committee and Trust Board
Consultation:	
Issue no:	
File name:	
Supercedes:	Standing orders, reservation and delegation of powers and standing financial instructions PP(17)346
Equality Assessed	Yes
Implementation	Policy is a standard reference document for Trusts
Monitoring: (give brief details how this will be done)	Policy monitored through financial systems and procedures
Other relevant policies/documents & references:	Scheme of Delegation Standing Orders
Additional Information:	

WSFT Board of Directors (Open)	
Report title:	Policy on the engagement of the external auditor to supply non-audit services
Agenda item:	5.5
Date of the meeting:	28 March 2025
Sponsor/executive lead:	Michael Parsons, Chair of the Committee
Report prepared by:	Liana Nicholson, Assistant Director of Finance 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 policy is developed in response to the recommendations contained in the Code of Governance for provider trusts (2022):
Section D, 2.5 Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.

Draft Policy on the use of external auditors for non-audit services **(Annex A)**

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

The Audit Committee reviewed and agreed to make a recommendation to the Board of Directors for implement and approve the draft policy at the meeting in March 2025.

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

The policy will take effect as soon as it receives the approval of the Board.

Action required / Recommendation:

The Board of Directors is asked to approve the Policy on the engagement of the external auditor to supply non-audit services.

Previously considered by:	Audit Committee
Risk and assurance:	Board of Directors and Council of Governors unable to undertake its statutory duties.

Equality, diversity and inclusion:	NA
Sustainability:	NA
Legal and regulatory context:	Trust Constitution FT Code of Governance

Annex A

West Suffolk NHS Foundation Trust

Policy on the engagement of the external auditor to supply non-audit services

For use by:	All Staff considering commissioning additional services from the External Auditors Audit Committee in considering proposals for additional services to be provided by the external Auditors.
Approved by:	Audit Committee
Approval date:	
Implementation date:	
Review date:	
In case of queries contact Responsible Officer:	Trust Secretary and Head of Corporate Governance
Division and Department	Corporate Governance, Corporate

Table of Contents

Policy on the engagement of the external auditor to supply non-audit services

1. INTRODUCTION

1.1 This policy has been created in response to the recommendations contained in the code of governance for provider trusts (2022):

Code of Governance for provider trusts (2022) section D, 2.5 *Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.*

1.2 This policy shall be applied whenever the Trust is considering the possibility of using its external auditor for the provision of non-audit services.

1.3 This policy has been developed by the Trust's Audit Committee and was approved by the Trust Board on ……..…….

1.4 The principal purpose of the policy is to ensure that non-audit services provided by the external auditor do not impair, or appear to impair, the external auditor's independence or objectivity.

NHS Foundation Trust's must follow the NHS Foundation Trust Code of Governance in appointing an external auditor, including the appointment for non-audit services.

In taking decisions on non-audit services that might be provided by the audit firm, regard must be had to:

- The requirements of national and international standards (including ethical standards) for auditors;
- The requirements set out by NHS England in *Audit and assurance: a guide to governance for providers and commissioners*

To ensure compliance with ISA (UK&I) 260, the auditors may require that approval is also obtained from the Council of Governors.

1.5 The Audit Committee is responsible for ensuring there is a clear policy in place for the engagement of external auditors to supply additional services, in order to ensure that their independence and objectivity is not compromised.

In principle, the Trust should avoid the involvement of its external auditors in additional services in order to avoid any potential risk to audit objectivity and the public interest responsibilities.

There are limited circumstances where it may be appropriate to procure additional work from the external auditors. If so, the safeguards in this policy must apply.

2. PURPOSE

2.1 To advise and inform Trust staff of the process when considering procuring work from the Trust's External Auditors that is outside the contract for external audit. To set out the process for Audit Committee approval of any additional services beyond audit services

3. NON-AUDIT SERVICES WHICH THE EXTERNAL AUDITOR IS PROHIBITED FROM SUPPLYING TO THE TRUST

3.1 There may be occasions when the external auditor is best placed to undertake particular accountancy, advisory and consultancy work on behalf of the Trust. However, the following services are specifically prohibited:

- work related to accountancy records and financial statements that will ultimately be subject to external audit;
- management of, or significant involvement in, internal audit services;
- work that involves making judgements and taking decisions which are the responsibility of the Trust's management;
- any work where a mutuality of interest is created that could compromise the independence of the external auditor, or might give rise to a reasonable perception that their independence could be impaired, including any work that involves acting as advocate for the Trust;
- any other work which is prohibited by UK ethical guidance.

A full list can be seen in **appendix A**.

4. PROCESS - PROVISION OF NON-AUDIT SERVICES TO THE TRUST BY THE EXTERNAL AUDITOR

4.1 Under no circumstances can any commitment be made to obtain non-audit services from the external auditors prior to obtaining the approvals required by this policy.

4.2 The procurement of non-audit services to the Trust by the external auditor shall at all times comply with the Trust's Standing Orders, and in particular the tendering and contracting procedures set out in those Standing Orders and otherwise in the Trust's Standing Financial Instructions.

4.3 The Chief Finance Officer shall first be consulted in writing and provided with full details of the proposal by officers of the Trust whenever the possibility of using the external auditor for the provision of non-audit services is under consideration. The Chief Finance Officer shall evaluate and be authorised to decide upon each such request that the Trust consider the possibility of using the external auditor for the provision of the non-audit services. The Chief Finance Officer shall apply this policy in evaluating and reaching decisions upon such requests.

4.4 The approval of the Audit Committee is required before any commitment to utilise the external audit firm for non-audit services can be entered into. The following steps must be followed-

a. At the earliest stage, and well before the preparation of a paper for consideration by the Committee, the Chief Finance Officer must be consulted and provided with full details of the proposal.

b. A full paper must be prepared for the consideration of the Committee, including:

- Confirmation that the external auditors have performed their internal independence checks and no issues have been raised;
- A justification as to why, exceptionally, the use of the external audit firm for the proposed work is appropriate and will not impact on the independence of the audit process;
- The cost of the proposed use of the external audit firm;
- The cumulative amount of non-audit fees incurred and committed to for the year to date, together with that proposed; and that amount as a percentage of the audit fee for the year;

c. The proposal will be presented to the Audit Committee by the individual leading on the project where it is proposed to use non-audit services, who will make themselves available to answer queries from the Committee.

The appointment of external auditor has been reserved by Parliament to the Council of Governors. Accordingly, the Audit Committee may require that the question of approval is referred to the Council for decision. In this event, no commitment can be entered into without the prior approval of the Council.

5 REPORTING

5.1 Where any approvals have been granted under this policy within a financial year, the Council of Governors should receive a report at least annually of non-audit services that have been approved for the auditors to provide under the policy (on the basis of services approved, regardless of whether they have started or finished) and the expected fee for each service.

The Council of Governors is entitled to take this information into account in considering any question of the appointment or removal of an audit firm, in accordance with its statutory responsibilities.

Appendix A: Prohibited non-audit services

The following services cannot be provided by the organisation's current or proposed external auditor:

a) Tax services relating to:

   i. preparation of tax forms
   ii. payroll tax
   iii. customs duties
   iv. identification of public subsidies and tax incentives unless support from the
   v. auditor in respect of such services is required by law
   vi. support regarding tax inspections by tax authorities unless support from the
   vii. auditor in respect of such inspections is required by law
   viii. calculation of direct and indirect tax and deferred tax or
   ix. provision of tax advice

b) Services that involve playing any part in the management or decision making of the audited body.

c) Bookkeeping and preparing accounting records and financial statements.

d) Payroll services.

e) Designing and implementing internal control or risk management procedures related to the preparation and/or control of financial information or designing and implementing financial information technology systems.

f) Valuation services, including valuations performed in connection with actuarial services or litigation support services

g) legal services, with respect to:
   i. the provision of general counsel
   ii. negotiating on behalf of the audited body or
   iii. acting in an advocacy role in the resolution of litigation.

h) Services relating to the audited body's internal audit function

i) Services linked to the financing, capital structure and allocation, and investment strategy of the audited body, except providing assurance services in relation to the financial statements, such as the issuing of comfort letters in connection with prospectuses issued by the audited body.

j) Promoting, dealing in, or underwriting shares in an entity controlled by the audited body.

k) Human Resources services, with respect to
   i. Management in a position to exert significant influence over the preparation of the accounting records or financial statements which are the subject of the statutory audit where such services involve searching for or seeking out candidates for such positions or undertaking reference checks for such positions.
   ii. Structuring the organisation design and
   iii. Cost control.

However, the services referred to in points (a)(i), (a)(iv) to (a)(vii) and (f), may be provided (but would be included for the purposes of applying the 70% cap) if the following requirements are complied with:

a) They have an inconsequential effect, separately or in aggregate, on the financial statements or on the organisation's arrangements to secure value for money.

b) The estimation of the effect on the financial statements, or on the organisation's arrangements to secure value for money, is comprehensively documented and explained to those charged with governance.

c) The principles of independence laid down in section 1 of the FRC's Ethical Standard are complied with; and

d) For the purposes of giving an opinion on the financial statements and/or, where appropriate, reaching a conclusion on arrangements to secure value for money, the auditor would not place significant reliance on the work performed in carrying out these services.

   Where there are doubts about whether a service would have an inconsequential effect on the financial statements or arrangements to secure value for money in the view of an objective, reasonable and informed third party, then the effect is not regarded as inconsequential

Item 7.3 Governance Appendices

INVOLVEMENT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Involvement Committee (the Committee). The Committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on people and organisational development.

1.2. In line with the In line with the CQC single assessment framework (SAF) and NHS Impact, the Committee is authorised to provide the board with assurance that the Trust is engaging and involving people who use the services, the public, the staff and external partners to support high quality sustainable services.

1.3. The Committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

1.4. Real learning comes from developing insights and understanding across the entire breadth of the committee's remit, and this understanding will drive change and improvement.

2. Level of Authority

2.1. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The Committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

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

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to provide assurance to the board in relation to the Trust's strategies, plans and the management of risks, pertaining to:

- 3.1.1. patient and service user experience and engagement;
- 3.1.2. staff experience and engagement;
- 3.1.3. relationships and partnerships with external representative groups;

3.1.4. and the ongoing nurturing and development of the organisation's leadership and culture.

3.2. These themes are cross-cutting and work in one area will likely have impact and benefits across the entirety of the committee's breadth of scope. That being said, there are distinct areas of inquiry and focus, aligned with the Trust's three strategic ambitions, as follows:

(a) First for staff
- Organisational values, leadership & cultural development (inc. speak up culture)
- Staff engagement & feedback (inc. staff survey/s)
- Support for staff health and wellbeing
- Education, training & workforce development
- HR & employment practice

(b) First for patients
- Patient and carer engagement & feedback (inc. patient survey/s)
- Co-production of improvements to quality & service provision
- Sharing and adoption of learning from complaints & incidents

(c) First for the future
- A culture of diversity and inclusion, focusing on outcomes: for patients, services users and staff
- The approach to and development of partnership working with our Alliance and ICS
- Our responsibilities and contribution as an anchor institution
- Meeting statutory duties for public and patient involvement in relation to the planning and provision of services
- Member and governor engagement activities, and their alignment with the Trust's strategic priorities

4. Membership

4.1. Membership of the Committee will comprise:

Executive Leads
- Executive director of workforce and communications
- Executive chief nurse

Other Members
- At least two non-executive directors, one of whom will chair the meeting
- Executive medical director
- Executive chief operating officer
- Executive Chief Finance Officer
- Executive director of strategy and transformation

The Chair, other Non-executive directors and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance by invitation would be:
- Head of patient experience
- Associate director of communications
- Deputy director/s of workforce & OD
- Trust secretary

- Governor observers

**Board assurance committees are not public meetings and, occasionally, matters discussed may be confidential within the Trust. Governor observers and other regular attendees must maintain confidentiality about what is discussed.*

4.2. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The Committee may ask any other officials of the organisation or representatives of external partners to attend and to assist it with its discussions on any matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of matters.

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be three members of whom at least one must be a non-executive director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the Committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The Committee shall operate as follows:

- The Committee will meet every other month until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the Committee and ultimately the board.

7. Sub Committees

7.1. The Committee shall receive regular reports from the sub-groups and speciality committees / functions in place such as:

- Experience of Care & Engagement Committee
- People and Culture Leadership Group

7.2. Other groups may be invited to report into or attend the meeting on an ad hoc basis to report on various themes, topics and initiatives taken by the organisation.

7.3. The Terms of Reference of the above groups annually and their effectiveness will be reviewed by the Committee every two years.

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

8.1. The Committee shall be supported by Trust office.

8.2. Minutes will be prepared after each meeting of the Committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the Committee. Once the Committee has approved the full minutes, a copy will be available, for information, to the Board at its next meeting.

9. Accountability and reporting arrangements

9.1. The Committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the Committee will be included in the Board of Directors' agenda and papers.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. We will focus on values and behaviours to develop our culture and to model this through the organisation. This will include 'setting the scene' at the beginning of the meeting; we will take time to reflect at the end of the meeting using open questions to seek response. We will ensure that colleagues and partners invited to the meeting are always briefed and supported to be comfortable to contribute fully.

10.2. We will consider our membership to ensure we reflect the partners we want to involve and the diversity of leadership we need to see to gain the multiple perspectives we need to achieve our goals.

10.3. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness every two years and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

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

Date approved by the Involvement Committee: 20 December 2024
Date approved by the Board of Directors:
Next review date: March 2026

IMPROVEMENT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Improvement Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on quality, patient safety and change management.

1.2. In line with the CQC single assessment framework (SAF) and the NHS Impact, the committee is authorised to provide the board with assurance that there is a culture of high quality, sustainable care and robust systems for learning, continuous improvement and innovation.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executives to consider.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The committee may establish sub-groups/committees reporting to it. The committee shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to provide assurance to the board in relation to:

- The effectiveness of the Trust's systems and processes for ensuring clinical governance, quality governance and patient safety is embedded from ward to board
- The Trust's compliance with statutory and regulatory standards, particularly in relation to the Care Quality Commission, Clinical Negligence Scheme for Trusts and the well-led framework
- Oversight of the delivery of statutory and mandatory requirements relating to Quality and Safety of care

- The provision of a platform and forum for the sharing of best practice and improvement learning throughout the Trust
- Trust performance in relation to patient safety outcomes and effectiveness with particular focus on providing assurance to the Board on actions taken to address any major performance variations
- Reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address them
- The systems and processes in place in the Trust in relation to infection control and to review progress against identified risks to reducing hospital acquired infections
- Reports on actions to address trends relating to adverse events (including serious incidents), claims and litigation.
- Key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate
- Ensuring that lessons are learnt and implemented across the Trust from patient feedback, including patient safety data and trends, compliments, complaints, patient surveys, national audits/confidential enquiries and learning from the wider NHS community
- Systems within the Trust for obtaining and maintaining licences and accreditations relevant to clinical activity, receiving such reports as required
- Review significant risks including those in the BAF and are relevant to the scope of the committee as allocated by the Board.

4. Membership

4.1. Membership of the committee will comprise:

Executive Leads:

- Executive Chief Nurse
- Executive Medical Director

Other Members

- At least two non-executive directors, one of whom will chair the meeting
- Director of strategy and transformation
- Chief Operating Officer
- Executive Director of Workforce and Communications

The Chair, other Non-executive directors and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance by invitation would be:

- Head of Patient Safety
- Head of Compliance and Effectiveness
- Chair of Patient Quality and Safety Governance Group
- Chair of Clinical Effectiveness governance group
- Clinical directors as required
- Associate Medical Directors
- Trust Secretary
- Governor observers.

**Board assurance committees are not public meetings and, occasionally, matters discussed may be confidential within the Trust. Governor observers and other regular attendees must maintain confidentiality about what is discussed.*

4.2. The committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be four members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. Virtual attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

7. Sub Committees

7.1. The committee shall receive regular reports from the Patient Quality and Safety Governance Group, Transfer of Care Group and Clinical Effectiveness Governance Group.

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

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

8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors' meeting agenda and papers.

9.4.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness every two years and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

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

Date approved by the Improvement Committee: January 2025
Date approved by the Board of Directors: To be presented in March Board for approval
Next review date: March 2026

AUDIT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive Committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2. The Committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.

1.3. The Committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The Committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

2. Level of Authority

2.1. The Committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The Committee is responsible for providing an opinion as the adequacy of the integrated governance arrangements and Board Assurance Framework.

2.2. The Board of Directors authorises the Committee to investigate any activity within its duties (as detailed below) and grants to the Committee complete freedom of access to the Trust's records, documentation and employees. This authority does not extend, other than in exceptional circumstances, to confidential patient information.

2.3. The Committee may seek any information (excluding confidential patient information, other than in exceptional circumstances) or explanation it requires from the Trust's employees who are directed to co-operate with any request made by the Committee.

2.4. The Trust Board authorises the Committee to obtain external professional advice or expertise if the Committee considers this necessary.

2.5. The Committee has a statutory role in respect of assurance, controls, compliance, data and probity. The aim is to ensure complete coverage while avoiding duplication by close liaison and cross-representation between the board assurance committees.

2.6. The Committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

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

3. Duties and responsibilities

The key duties and responsibilities of the Committee are as follows:

3.1 Governance and Assurance

3.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Trust's other Board Assurance Committees for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

In particular, the Committee shall independently monitor and review:

3.1.1.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors in order to advise (when requested by the Board or as the Committee deems appropriate) on whether such disclosures taken as a whole are fair, balanced and understandable.

3.1.1.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.

3.1.1.3 the effectiveness of systems for ensuring the optimum collection of income.

3.1.1.4 the effectiveness of risk management systems.

3.1.1.5 the effectiveness of the Board Assurance Framework (BAF).

3.1.1.6 The Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors.

3.1.1.7 the Quality Report assurance and review alongside the annual report and accounts.

3.1.1.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance.

3.1.1.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

3.1.1.10 the adequacy and security of arrangements by which staff or contractors may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

3.1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.1.4 The Committee will receive the minutes from the Trust's other Board Assurance Committees for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

3.1.5 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, NHS England, any reviews by The Department of Health and Social Care or arm's length bodies, regulators/inspectors (CQC, NHS Resolution etc) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.)

3.1.6 In addition, the Committee will review the work of other Board Assurance Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include items in relation to quality, risk, governance and assurance. The conclusion of this review should be referred to specifically in the Committee's self-effectiveness report to the Board of Directors.

3.1.7 The Committee will consider how its work integrates with wider performance management and standards compliance and include this within the report to the Board of Directors.

3.1.8 In reviewing the work of other Board Assurance Committees and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that these Board Assurance Committees gain from the clinical audit function.

3.1.9 The Audit Committee will receive assurance on the arrangements for clinical audit within the Trust, including the process by which clinical audits are selected and agreed actions implemented.

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. This will be achieved by:

3.2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

3.2.2 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

3.2.3 consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

This will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions.

3.2.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

3.2.5 assessing the quality of internal audit work on an annual basis.

3.2.6 Ensuring any material objection to the completion of an assignment which has not been resolved through negotiation is brought to the Committee by the Chief Executive Officer or Chief Finance Officer with a proposed solution for a decision.

3.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

3.3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.

3.3.2 consideration of the major findings of counter fraud work (and management's response).

3.3.3 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation.

3.3.4 receiving an annual review of the work undertaken by the counter fraud function.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work.

3.4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit.

3.4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

3.4.3 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit.

3.4.4 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

3.4.5 To review External Audit reports, including value for money reports and management letters, together with the management response.

3.4.6 Ensuring that there is in place a clear policy for the engagement of External Auditors to supply non-audit services, including the pre-approval by the Committee of any non-audit work to be provided by the Trust's External Auditors.

3.4.7 To assess the quality of External Audit work on an annual basis.

3.5 Financial Reporting

3.5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to:

- the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the Terms of Reference of the Committee;

- changes in, and compliance with, accounting policies and practices;
- explanation of estimates and provisions having material effect;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- the schedule of losses and special payments; and
- significant adjustments resulting from the audit.

3.6 Key Trust Documents

3.6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors.

3.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

3.7 Other

3.7.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers.

3.7.2 Review schedules of losses and compensations.

3.7.3 Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.

3.7.4 Entries recorded in the gifts and hospitality register would be considered on an exception basis as reported by the panel considering the entries made.

3.7.5 The Committee shall at its discretion request and review reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control.

4. Membership

Membership of the Committee will comprise:

4.1. The Committee shall be appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust and shall consist of no fewer than three members, one of whom has recent and relevant finance experience. One of the members will be appointed Chair of the Committee by the Board of Directors.

4.2. At least one member will have a formally recognised professional accountancy qualification and/or a level of relevant financial experience assessed as being appropriate to the role by the Nominations Committee, on behalf of the Board of Directors.

4.3. The Trust Chair will ensure that there is cross-representation by non-executive directors on the Audit Committee and any of the Trust's other Board Assurance Committees.

4.4. The Chair of the Trust shall not be a member of the Committee.

4.5. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.6. The Committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

4.7. The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee.

In attendance:

4.8. The Chief Executive, Chief Finance Officer and the Trust Secretary will normally attend all Committee meetings.

4.9. The Head of Internal Audit, the Counter Fraud Specialist and a representative of the Trust's External Auditors will attend as necessary.

4.10. Other members of the Board of Directors to attend the Audit Committee by invitation.

4.11. All other attendances will be at the specific invitation of the Committee.

4.12. The Committee will have the over-riding authority to restrict attendance under specific circumstances.

4.13. The Committee will meet with the External and Internal Auditors, without any other Board Director present at least once a year.

4.14. Attendance at meetings will be recorded as part of the normal process of the meeting. A record of attendance will be reported as part of the Committee's self-effectiveness report.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The Committee shall operate as follows:

- Meetings will normally be held at least three times a year

- Special meetings may be convened by the Board of Directors or the Chair of the Committee

- The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary

7. Sub Committees

7.1. The Committee shall receive regular reports as appropriate from the sub-groups and speciality committees in place.

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

8.1. The Minutes of Audit Committee meetings shall be formally recorded and a summary of the discussions, which includes a report of the Committee's activities and key issues, is submitted to the Board of Directors no less often than three times a year. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

8.2. The Committee shall be supported by the Trust office.

9. Accountability and reporting arrangements

9.1. The Committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The Chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the Committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9.4. The key issues of the Committee will be included in the Board of Directors' agenda and papers.

9.5. A separate section of the Trust's Annual Report will describe the work of the Committee in discharging its responsibilities.

9.6. The Committee will report to the Board planned future workload and priorities for approval.

9.7. The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference. This determines standing items for the agenda and items for regular reporting.

9.8. Maintain and monitor performance against the agreed reporting framework.

9.9. Follow-up agreed actions to ensure these are implemented in a timely and effective manner.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, the Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The terms of reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Audit Committee: 18 March 2025
Date approved by the Board of Directors:
Next review date: March 2026