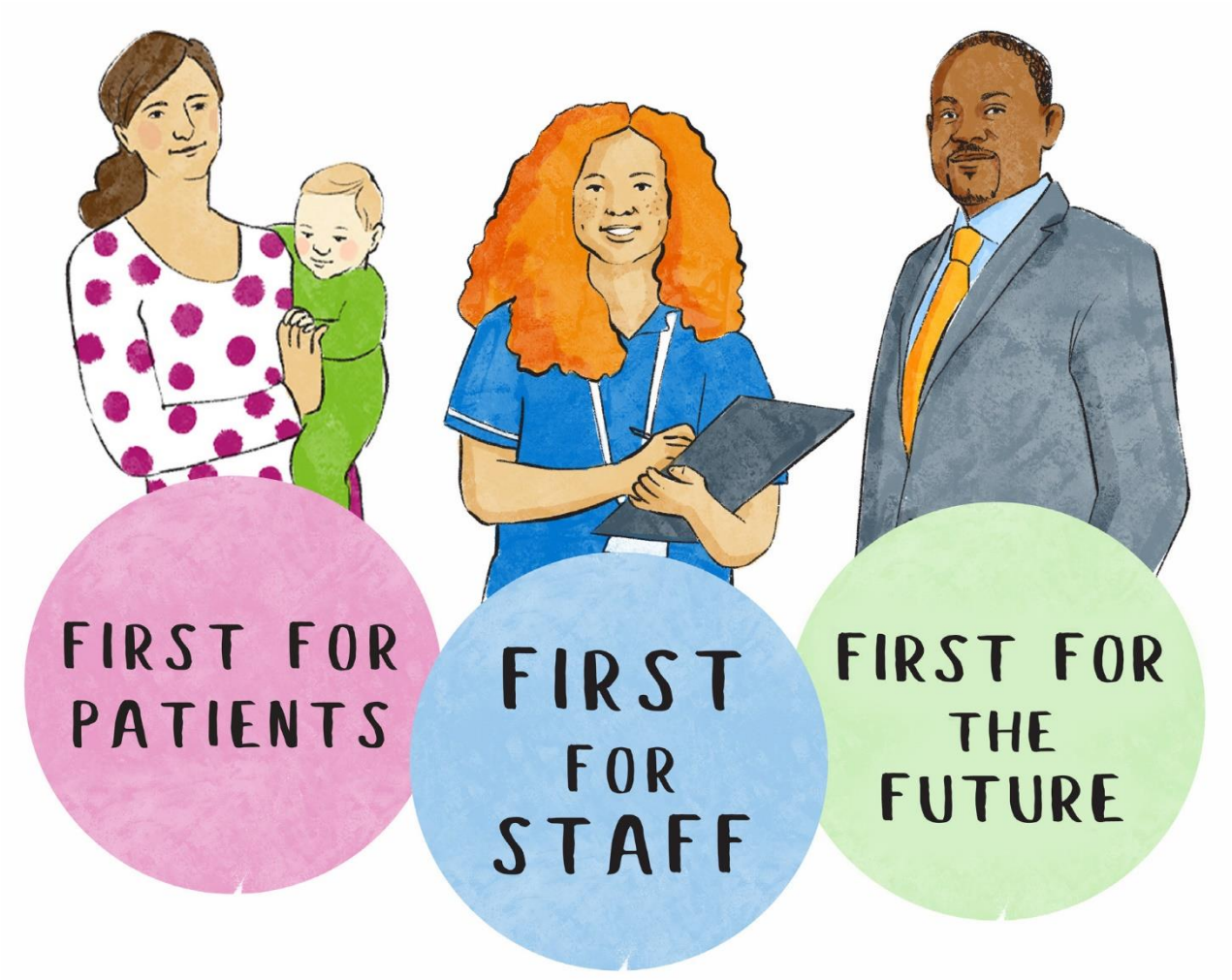
NHS
West Suffolk
NHS Foundation Trust

Quality accounts 2024-25



June 2025

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Throughout this document the organisation West Suffolk NHS Foundation Trust is referred to as WSFT and West Suffolk Hospital as WSH.

Chief executive's statement

This year has seen us mount a robust response to our financial challenges while providing safe, timely and quality care for our patients. Our programme of React, Recover, Renew is under way to reduce the significant deficit in our finances, and means we have had to take difficult - but necessary - decisions.

We have worked as a team to tackle our current deficit and plan for our financial future, and we are on track to deliver within our revised year end deficit target expected at £26.5m. Measures in place to cut spending - for example, reducing agency and bank costs - mean our underlying deficit continues to reduce. Substantial planning is ongoing for new cost improvement programmes in 2025-26 that will oversee £26.6m of savings. This has been developed with support and ideas from colleagues across the Trust, and we are grateful to them for their cooperation and commitment.

At the same time, we have been reviewing how we operate as a healthcare provider now, and how we can transform our strategy to ensure our services meet the needs of our present and future population.

We have redoubled our efforts to drive down waiting lists and improve the waiting times for diagnosis and treatment; and for people attending our emergency department (ED).

Industrial action in the summer - along with winter pressures, including an increased prevalence of flu, norovirus and other seasonal illness - resulted in the closure of wards and limited our ability to admit patients who attended our ED.

This Quality Account includes further information about our progress on tackling waiting times, but the work of our staff to support these measures deserves to be highlighted here.

Sustained efforts by our teams have led to significantly improved waiting times in our ED in March, when we achieved 88% performance against the national 4-hour standard, the best performing Trust across the Midlands and East region, fourth in the nation as a whole, and ahead of the 78% target.

We have continued to make progress on our elective recovery and are working hard on caring for patients who have been waiting for more than 65 weeks. The opening of the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) at Colchester Hospital has allowed our whole system to reduce waiting times for people who need orthopaedic surgery, in a state of the art facility.

We have also made significant progress on the early detection of cancer and reducing waiting times for patients with cancer. At the end of March 2025, 83.2% of patients were treated within 62 days, this is above the national requirement of 70% for 2024/25 and 79.1% of patients had cancer ruled out or confirmed within 28 days, also above the national requirement of 77% for 2024-25.

Earlier this year we were moved into tier one of NHS England's framework for cancer. This was the result of some high-volume pathways within cancer services being unable to deliver the planned level of activity primarily due to sickness and vacancies. We have maintained pathway-specific best practice and moved out of tier one during the first quarter of 2025-26.

We have had successes in meeting the national priority to move services into community and, more importantly, ensure our patients across West Suffolk have access to joined-up care closer to home.

In December we opened our Community Diagnostic Centre at Newmarket Community Hospital, which is having an early impact in helping us improve on our performance against the six-week target for patients to receive a diagnostic scan. This will continue to grow as we move to longer opening hours and weekend working.

The challenges of the past year were reflected in our NHS Staff Survey 2024 results. We saw a fall across all nine key scores and are now below the national average in each area. In the coming months all our leaders will be working to identify priority areas where we can take action to improve.

Our staff have shown great resilience, camaraderie and innovation. Despite both local and national pressures, they continue to deliver outstanding treatment and care to our patients, help for visitors, and unparalleled support to their colleagues across the Trust. Those efforts have been recognised at a national level, and this Quality Account details some of the achievements of our teams.

It will also detail our progress on the priorities we set last year, and focus on the aims we have set ourselves for the coming 12 months:

Patient safety priorities:

- **To deliver safe care for patients being cared for in temporary escalation spaces**
- **Getting it right for patients and staff; place, service, pathway.**

Experience of care priorities:

- **To reduce inequalities in healthcare for service users**
- **To utilise feedback and engagement activity to drive changes that matter to our patients and the public.**

In January, the Government confirmed that the building of a new hospital for West Suffolk would be in the first wave of projects that are expected to start building in 2027/28. We continue to plan for this vital new facility, including engaging with stakeholders and our community to ensure it will meet the needs of our future population.

Meanwhile, we have continued our programme of work to monitor and safely maintain the existing hospital, built from reinforced autoclaved aerated concrete (RAAC) planks. We completed the work on the final phase of roof refurbishment in the spring, the first of the affected hospitals to do so.
In March 2025, the Government announced the abolition of NHS England, alongside other policies that will have a profound impact on how healthcare is planned, managed and delivered across the country.

At the same time, we supported the system-wide sustainability review being undertaken by Suffolk and North East Essex Integrated Care Board (SNEE ICB), with external support from McKinsey. The review commenced in January 2025 and the final report was received in May.

This means the coming year will bring further change for our Trust, and further challenges for our colleagues. Our Trust has shown that its strength lies in what can be achieved by working together, for our community, our staff and for the future.

I can confirm that to the best of my knowledge the information contained in the quality report 2024-25 is accurate and has received the full approval of the Trust Board.

Dr Ewen Cameron
Chief Executive Officer
20 June 2025

Quality structure and accountabilities

Our strategic vision for quality

This quality report highlights the actions West Suffolk NHS Foundation Trust WSFT is taking to improve the quality of services we provide. We put quality at the heart of everything we do and recognise that a focus on quality is key to transforming care and maintaining sustainability for the population of West Suffolk.

Our vision and priorities align with our alliance partners, including:

- our NHS partner provider organisations: the Norfolk and Suffolk NHS Foundation Trust (NSFT), East of England Ambulance Service NHS Trust (EEAST) and East Suffolk and North Essex NHS Foundation Trust (ESNEFT) through a commitment to work collaboratively to reduce variation in the services available to our communities and to improve the wider determinants of health
- Suffolk and North-East Essex Integrated Care Board (SNEE ICB), whose vision is to deliver the best possible outcomes for every one of the million people in Suffolk and North East Essex within six 'Live well' domains. These have a focus on improving health and wellbeing, reducing health inequalities, and working collaboratively. More information is available through the SNEE-ICB joint forward plan found here Joint Forward Plan - NHS Suffolk and North East Essex ICB.
- at system level working within the West Suffolk Alliance with our Suffolk & North East Essex Integrated Care Partners across the NHS, local government, social care and the voluntary, community, faith and social enterprise (VCFSE) sector towards a 'Future Shift' in local health and care. More information about this can be found on the SNEE-ICS website here sneeics.org.uk)
- our patients, both formally via our Council of Governors and through our 2025/26 experience of care quality priority (see page X)

Our quality structure

The Board monitors quality through its monthly performance management arrangements at Trust level (with an integrated quality and performance report using 'making data count' methodology). At divisional level, performance management meetings (PRMs) take place monthly and enable a focus on each division's progress against trust-wide priorities such as training, appraisal or staff turnover. Also considered are division specific issues such as elective surgical waits, diagnostics, time in the emergency department and community audiology assessments.

The Board receives assurance regarding quality across the organisation through the three assurance committees of the Board, which ensure quality is delivered in a coordinated way to support safe, effective and patient-focused healthcare. Our '3i' assurance committees provide a focus on finance, operations, culture, patient and staff safety and quality:

- **Insight Committee** with a focus on operations, finance and organisational risk
- **Involvement Committee** focussing on people (both patients and staff), organisational development, patient experience and engagement
- **Improvement Committee** with a focus on quality, patient safety, risk management and quality improvement.

At organisation level, the Improvement Committee receives updates from specialist groups focussing on quality, safety and effectiveness at topic level with examples such as falls, pressure ulcers, nutrition, medicines management, infection prevention and safeguarding though the 'patient safety and quality governance group' (PSQGG). It also has oversight of clinical audit, public health, research and development, accreditation and the work of the quality improvement team through the 'clinical

effectiveness governance group' (CEGG).

Our future plans - continuous quality improvement (CQI) approach

In 2025, we are taking the opportunity to refresh our Trust's strategy to reflect national changes, planning guidance and the anticipated launch in June of the Department of Health & Social Care's new 10 year Health Plan with its 'three shifts'

- moving care from hospitals to communities
- from sickness to prevention
- from analogue to digital

Embedding our CQI approach will be supported through the development of Quality Management System (QMS) bringing together all aspects of quality (safety, effectiveness and patient experience). We will ensure that quality is embedded within operational 'business as usual', cost effectiveness, performance efficiency and service transformation.

Quality priorities for 2025-26

Our quality priorities have been developed to support our ambition to deliver high quality services and the best possible experience for all our patients who are receiving care at one of our hospitals or within the community. The quality priorities programme has been informed by listening to what our partners, community and staff tell us.

Patient safety priority:	To deliver safe care for patients being cared for in temporary escalation spaces
Patient safety priority:	Getting it right for patients and staff: place, service, pathway
Experience of care priority:	To reduce inequalities in healthcare for service users
Experience of care priority:	To use feedback and engagement to drive changes that matter to our patients and the public

Our quality priorities set out key improvements we aim to deliver and the measures that we will use to understand progress and success. These measures will be reviewed and developed as we progress.

Patient safety priority: To deliver safe care for patients being cared for in temporary escalation spaces

Why is this a priority?
Temporary escalation spaces (TES) is a term used to describe the practice of providing medical attention to patients who are being cared for in non-designated clinical spaces such as corridors, due to limited capacity and increasing demand on our resources. This is a phenomenon which has been highlighted nationally due to the implications for patient safety, dignity, experience and the ability of staff to deliver fundamental standards of care.

The impact on staff morale should also be considered because of the compromises staff are making in the delivery of healthcare. This is a priority for WSFT as it is nationally, because we want to ensure we are delivering the safest and high-quality care to our patients when we do need to open temporary escalation spaces.

What is our target?
Our overarching aim is to reduce or eliminate the use of TES. However, when these areas are in use, we need to be assured that we are delivering safe care. This will be measured through quantitative and qualitative metrics that support patient flow across our organisation.

What will we do to improve our performance?
We will create a TES quality group to develop reporting metrics to measure and ultimately support the improvement of flow alongside operational performance. We will look at services across our system to understand barriers to flow and a proactive approach to measuring ourselves on the quality of service we provide and review if patient outcomes are impacted.

This will be undertaken by reviewing incident data, assessing patient harm by conducting clinical harm reviews and completing regular audits to measure our performance against the fundamental standards as set out by NHS England (NHSE). We will use data to understand how and when we need to open temporary escalation spaces, working with system partners to understand contributory factors.

How will we measure and monitor our performance?
It will be measured through a programme of safety insight, including audit, incident, harm reviews, experience data and risk, which we will align with improvement opportunities.

How and where will progress be reported?
Through the Patient Safety and Quality Governance group and the Improvement committee (four-monthly).

Patient safety priority: Getting it right for patients and staff: place, service, pathway

Why is this a priority?
As part of our Patient Safety Incident Response Framework (PSIRF) (see page X on Incident reporting and learning) we consider the complex and dynamic systems in which we deliver healthcare and produce safety actions and areas for improvement. Safety actions allow us to mitigate risk, often in the locality or service in which the incident occurred and are often completed during the investigation.

Areas for improvement are insights which have been gleaned during the investigation and allow us to think much more broadly about how we can implement system changes. These are often complex and have no obvious boundary, but they allow us to think differently about change and look at by working collaboratively across the organisation, we have the ambition to deliver sustainable,

improvements in safety across the Trust.

We undertook a thematic analysis of all areas for improvement following our first two years of operating PSIRF and presented three overarching areas of improvement at a Trust-wide safety summit. Colleagues chose 'Getting it right for patients and staff: place, service, pathway' as the safety improvement idea they would like to take forward.

What is our target?
To develop a programme of improvement which will help us improve communication about the placement of patients, including safe handover, minimising ward moves, following correct referral processes and ensuring we are caring for the right patient, in the right place at the right time. We will use the principles of NHS England » NHS IMPACT to support the development of our Quality Improvement (QI) programme.

What will we do to improve our performance?
We will establish a multi-professional project group and use QI methodology to plan a programme of improvement. We will draw on relevant safety insight to help us prioritise individual work streams.

How will we measure and monitor our performance?
We will use QI methodology and map our programme of improvement on our digital improvement platform LifeQI.

How and where will progress be reported?
This will be shared at the Trusts Improvement committee which convenes three times a year.

Experience of care priority:
To reduce inequalities in healthcare for service users
To use feedback and engagement to drive changes that matter to our patients and the public

Why are these a priority?
The two proposed priorities have been determined based on assessment that there is further work to do to reduce inequalities in healthcare for service users, in line with NHS England's approach (NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities) and from recommendations from the internal 'well-led' audit findings. Continuing and extending some of last year's priorities, which were broad and ambitious, will ensure strategies and objectives are truly embedded and help to form part of the culture and ethos of the organisation.

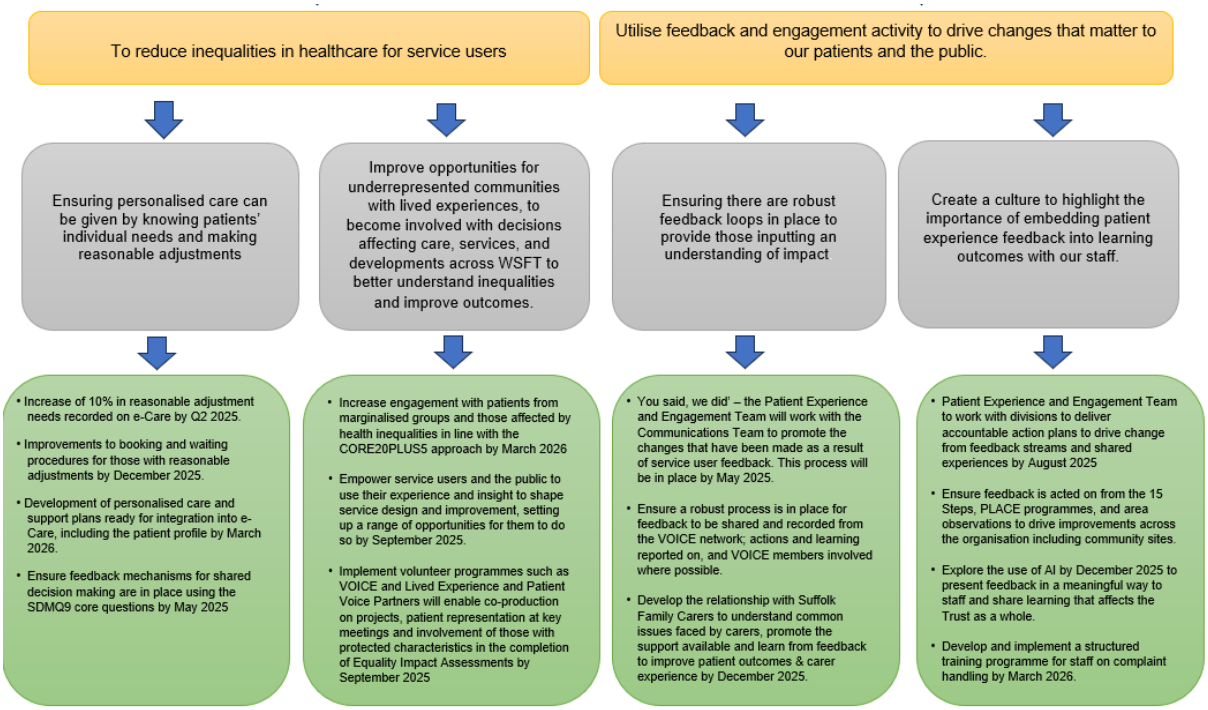
What are our targets?
- to ensure personalised care can be provided because we know patients' individual needs and can make reasonable adjustments

- to improve opportunities for underrepresented communities with lived experience to become involved with decisions affecting care, services, and developments across WSFT, so we can better understand inequalities and improve outcomes

- to ensure people sharing feedback can see where their input is having an impact

- to create a culture where our staff understand the importance of embedding the feedback our patients share about their experience.

What will we do to improve our performance?



How will we measure and monitor our performance?

Individual actions will be tracked monthly to understand progress and success. The approach reflects the triangulation between the Trust's vision, our Experience of Care strategy, and our statutory requirements under the Public Sector Equality Duty (Equality Act, 2010).

All our engagement activity is in line with NHS England's 10 key principles for working with people and communities.

How and where will progress be reported?

Through the Experience of Care and Engagement group and the Involvement committee.

Statements of assurance from the Board

This section of the quality report is prescribed by regulation. It provides a series of mandated statements from the Board which directly relate to the drive for quality improvement. These statements provide assurance in three key areas:

- our performance against essential standards and delivery of high-quality care, for example our registration status with the Care Quality Commission (CQC)
- measuring our clinical processes and performance, such as participation in national clinical audit
- providing a wider perspective of how we improve quality, for instance through participation in clinical trials.

Review of services

During 2024-25, WSFT provided and/or was sub-contracted to provide **89 relevant health services**. WSFT has reviewed all the data available to it on the quality of care in all these relevant health services.

The income generated by the relevant health services reviewed in 2024-25 was **£393.9m**, which represents **92.0% of the total income** generated by WSFT for 2024-25.

Information about the quality of these services is obtained from a range of sources, which address the three quality domains described earlier (safety, effectiveness and experience). Key sources of intelligence are summarised below. Many of these sources of information provide an indication of quality across more than one domain.

Sources of quality assurance

- compliance monitoring through our automated audit platform RadarAudit. This was introduced in 2024-25 and replaces the previous system Tendable (previously Perfect Ward)
- monitoring of key safety measures through our integrated quality and performance report (IQPR) including falls, pressure ulcers, nutrition, infection prevention, mortality, post-partum haemorrhage and incident reporting
- incident and outcome reporting through our Radar incident and event reporting platform including the topics previously listed above as well as safeguarding, restrictive physical interventions and use of our temporary escalation spaces
- patient experience measured through feedback from complaints, compliments and the Patient Advice and Liaison Service (PALS) as well as local and national patient surveys, patient forums, feedback from our Foundation Trust members, governors and community engagement conversations
- staff feedback including national surveys, Freedom to Speak Up (FTSU) contacts and the feedback and participation of our staff governors
- benchmarking through participation in the national clinical audit and outcome programme and quality assurance through local clinical audits see (see below).

Participation in clinical audits and confidential enquiries

During 2024-25, 69 national clinical audits including national confidential enquiries covered NHS services that WSFT provides.

During 2024-25, WSFT participated in 100% of national clinical audits and 100% of national

confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries in which WSFT participated, and for which the data was completed during 2024-25, are listed alongside the number of the cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry listed in Annex A.

Research and development

344 patients receiving relevant health services provided or sub-contracted by WSFT, were recruited during 2024-25 to participate in National Institute for Health Research (NIHR) portfolio or commercially adopted research studies approved by the research operational committee.

Seven-day services

The Trust has maintained progress with the work of the seven-day services group which led the original seven-day service development and improvement plan. The Trust operates a full seven-day service for both the emergency department (ED) and inpatients across a wide range of clinical areas to manage weekend admissions and discharges. In the community most of our services are seven-day and some are 24-hour. Our continued focus on improving urgent and emergency care patient flows will support the priority standards of:

- standard 2: time to consultant review, with particular focus on the internal professional standards.
- standard 8: ongoing review – 95% of patients who require a once-daily consultant directed review receive such a review.
- we already achieve standards 5 (access to diagnostics) and 6 (access to consultant-directed interventions), where there is access to diagnostics and interventions on-site or through formal agreement with neighbouring trusts.

These priority standards link to the national standards B1230-seven-day-services-clinical-standards-08-feb-2022.pdf (england.nhs.uk)

Consolidating vacancies and rota issues

The human resources department aims to fill staffing gaps through new appointments. There can be a delay in this process due to waiting for confirmation of training gaps from NHS East of England. Locally employed doctors (LEDs), have been employed specifically for service developments, including the emergency department, general surgery and general medicine. These appointments support the work to ensure that we can safely fill our rotas and staff the wards as well as ensuring safer working hours for all doctors.

Staff who speak up (including whistleblowers)

In line with The National Guardian's Office, we aim to make speaking up business as usual within the Trust. In the first instance we encourage all colleagues to seek the support of their line manager, and specialist departments (e.g. health, safety and risk office, postgraduate medical education team and governance support). However, there are many alternative routes available to colleagues. Ways of speaking up are actively promoted throughout the organisation. Our Freedom to Speak Up policy outlines the internal and external routes available to raise concerns, should this be more appropriate.

The Trust's FTSU Policy reflects the national standard policy produced by the National Guardian's Office. Its aim is to ensure all matters raised are captured and considered appropriately. This policy is available to all staff on the intranet and on the public facing internet (www.wsh.nhs.uk).

Internal routes for staff to speak up

- **Freedom to Speak Up Guardian** - responsible for helping to nurture a culture of openness, by acting as an independent and impartial source of advice to colleagues at any stage of raising a concern
- **designated executives, specified non–executive director and other senior staff** - the Trust policy outlines specific individuals who have a role to support any member of staff who wishes to speak up
- **Speaking up Champions** - are here to listen to colleagues and refer to the appropriate services, and where necessary, escalate to the FTSU Guardian. They will support the Trust and the Freedom to Speak Up Guardian in promoting and nurturing a positive speaking up culture.
- **chaplaincy service** - the chaplaincy team provides a listening ear in times of difficulty or crisis, whether personal or work-related, a space to talk about life, the purpose or the meaning of things, and pastoral counselling, regardless of faith or belief. For staff who have a faith, the chaplaincy service can also provide support with: practising a faith or spiritual tradition, making contact with representatives of other faith communities and prayer support
- **anonymous reporting** - colleagues who wish to speak to the FTSU Guardian anonymously can complete the anonymous reporting form on the intranet or by writing a letter to the Freedom To Speak Up Guardian c/o the Drummond Education Centre at the West Suffolk Hospital. Alternatively, colleagues can leave a message on an anonymous reporting phone-line
- **staff support and wellbeing service** – this clinical psychologist-led service offers one-off and ongoing support to individuals and teams. Staff can raise any issues of concern with the team
- **staff networks** - have been developed and relaunched and provide a forum for colleagues to speak up and share concerns. There are currently four networks including Pride, REACH (race, equality and cultural heritage), parent and carer and a disability network. Working with these networks there is proactive effort to increase diversity within the network of champions with a view to reducing barriers to speaking up.
- **human resources team** - provide support, guidance and advice to managers, employees, and workers in line with the FTSU policy for any concerns raised, as well as to individuals considering raising a concern under the FTSU policy
- **other support mechanisms** - as part of our approach to partnership working with staff-side organisations we actively promote trade unions as a source of support for staff for health and safety advice, education support and member support for disciplinary issues.

Addressing barriers to Speaking Up

Staff can access support through our intranet's Culture and Wellbeing pages. Posters are displayed throughout the Trust giving contact details of the FTSU Guardian. The network of champions promote speaking up within their teams and networks and support and signpost staff wishing to speak up. Services are regularly advertised in regular internal communications including the Green Sheet internal staff newsletter and the weekly staff briefing email. A face to face introduction to speaking up and how to access support are given at induction, preceptorship and leadership training programmes as well as team meetings. Every October, Speak Up Month activities raise awareness of speaking up channels.

All staff are required to undertake mandatory training which encourages staff to access the FTSU policy to identify routes to speaking up. Managers at band 7 or above are also required to undertake Listen Up training. Follow Up training for Senior Leaders is available via ESR (NHS electronic staff record).

An equality, diversity and inclusion (EDI) survey has been implemented to understand the demographic of colleagues speaking up, identifying if/where there may be groups of staff who are not speaking up so steps can be taken to address these barriers.

How we provide feedback to staff who speak up

Feedback depends on the mechanism used to report the concern and may be written or verbal taking

into consideration the preference of the person raising the concern. The individual who raised the concern will be provided with direct feedback. Where concerns are reported anonymously, feedback can be provided through general Trust communication routes.

The Board receives quarterly reports from the FTSU Guardian so it can track themes that are being raised by staff and ensure there is an effective organisational response to them.

How we ensure staff who speak up do not suffer detriment

Our Freedom to Speak Up policy emphasises that staff raising concerns should not suffer any detriment and the mandatory training and policy supports this. A questionnaire is provided to all staff who have raised concerns via the FTSU Guardian. Included in this is an option for individuals to report if they feel they have suffered detriment and a clear statement indicating that detriment as a result of speaking up will not be tolerated at the Trust.

Goals agreed with commissioners

WSFT income in 2024/25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because NHSE has continued the national pause for CQUINS.

What others say about us

The Trust has unconditional registration with the Care Quality Commission (CQC) with no enforcement action. The Trust's overall rating is 'requires improvement'. The acute services are rated 'requires improvement' and the community services (adults, children and young people and inpatient services) are all rated as 'good'.

Although we have not had a formal trust-wide inspection since 2019, we have maintained a relationship with the CQC though proactive communication of emerging risks and responsive feedback to any direct queries raised with them.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓↓ Jan 2020
Community	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall trust	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020

Core areas were inspected last in inspections in 2016, 2018, 2019, 2021 and 2022 (see charts).

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency care	Requires improvement → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020
Medical care (including older people's care)	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Good → ← Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020
Surgery	Requires improvement ↓ Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020
Critical care	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Outstanding Aug 2016	Good Aug 2016
Services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Good Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018
Outpatients	Requires improvement ↓ Jan 2018	Not rated	Good → ← Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018

In the most recent comprehensive inspection report published in January 2020, inspectors said staff: “treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions they worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care”.

The Trust’s maternity services were inspected in April 2021, and while the score for “well-led” did improve, it did not affect the overall rating of the service. The report noted that: “leaders ran services well and supported staff to develop their skills. Staff understood the service’s vision and values, and how to apply them in their work. Staff were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.”

Last inspection: 13 April 2021 **Report published: 22 June 2021**

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

In 2022 we received a “Good” CQC rating for the Glemsford GP practice that is part of the WSFT, with the staff’s kindness and respect for patients highlighted.

Last inspection: 20 August 2022 **Report published: 14 September 2022**

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

The WSFT recognises that the CQC introduced a changed assessment framework since our last inspection. The Trust anticipates a future inspection within this new regime and welcomes the opportunities this will bring to demonstrate how the organisation is working towards achieving a 'Good' rating.

Awards and accolades

First for Patients

Stroke care: Our stroke service has been rated as providing patients with the highest quality stroke care, putting it first among acute admitting trusts in the eastern region and second in England. According to the most recent set of figures, from July to September 2024, the service received a consistent "A" rating for the previous 26 quarters, more than six years. The team achieved an overall score of 94, its highest ever.

Hip fracture care: Data from the National Hip Fracture Database (NHFD) confirmed our patients were receiving some of the best hip fracture care in England and Wales, with the Trust rated top in the country for meeting best practice criteria for patients treated for a hip fracture. It also recorded its highest ever best practice score of 96.4 percent of patients meeting all eight criteria of delivering care, compared to a national average of 50.1 percent. This is an excellent example of multidisciplinary team working with ward, theatre and anaesthetic colleagues all contributing to enhanced patient care.

Our trauma and orthopaedic team were shortlisted for an award in this year's *Nursing Times* Awards. Colleagues entered the **Theatre and Surgical Nursing Award** category to showcase their work to support and improve patients' recovery from hip fracture surgery by providing targeted nutritional supplementation.

Experience of patients with cancer: Our Trust scored highly in the 2023 National Cancer Patient Experience Survey, with patients rating their cancer care nine out of 10.

The survey aims to understand the experiences of patients that have received cancer care across England, capturing their perspectives, and monitoring how services are progressing at the local, regional, and national level. This latest set of results highlights that the Trust scored in the upper end of the expected range for the majority of survey questions, with none scoring below the expected range compared to other trusts.

Experience of our inpatients: People we have cared for as inpatients have rated their overall experience as being in the top five of the acute and combined trusts in England, and among the best in the region.

In the NHS Adult Inpatient Survey for 2023, the Trust was rated at 8.5 out of 10 for overall experience, placing it fifth in England and second in the eastern region. The Trust also scored in the

top two or top five in the region on most other criteria including admission and leaving the hospital, the hospital and ward, doctors, nurses, care and treatment, kindness, compassion, respect and dignity.

Services closer to home: This year saw the completion of the Newmarket Community Diagnostic Centre (CDC) which started to see patients in December 2024. In its first 100 days it had seen more than 6,000 patients and carried out more than 8,800 scans.

The facility is based at Newmarket Community Hospital and provides patients living in the west of the region with faster access to diagnostic tests, reducing the length of time between being referred for tests, having appointments, getting results, and beginning any treatment.

Closer working in the community: We know that for most people and if appropriate, being able to be cared for at home, rather than in hospital, will bring better outcomes and faster recovery. While joined-up working with services across the system is business as usual for our integrated neighbourhood teams (INTs), this year has seen further integration with Trust teams focused on providing holistic care to people where they live. The early intervention and virtual ward teams are now working even more closely with the INTs, keeping people at home and preventing admission or re-admission to hospital.

Improving quality and safety - Call 4 Concern: We have introduced Call 4 Concern (C4C) at the West Suffolk Hospital, a public patient safety initiative which allows inpatients and their loved ones to call for immediate help if they are worried about their condition deteriorating.

If patients and carers are concerned about their condition, or simply feel that something 'isn't quite right', they can contact the critical care outreach team CCOT which will triage and prioritise the referral, review and assess the patient, suggest potential treatments, and liaise with ward staff about any points of concern.

Radar: Launched in April 2024, this is the Trust's new system for recording incidents, logging risk assessments, undertaking compliance audits and sharing praise for peers. A comprehensive programme of support was undertaken to introduce staff to Radar, with feedback informed updates and further advice for users.

Patient Portal: The new patient portal introduced in 2024 offers patients a better experience in managing their health online, making it easier to access medical information such as test results or appointments.

NHS 15 Steps: Trust Chair, Jude Chin, governors and non-executive directors (NEDs) are following the 15 steps challenge, a national NHS initiative to improve quality, by visiting a variety of areas, speaking to staff and patients. These are an opportunity to recognise good work, and suggest where improvements might be made for the future.

Improving waiting times: Super Saturdays are part of a 12-month programme to reduce waiting times, where the Trust's multi-disciplinary teams of clerks, porters, nurses, theatre practitioners, support workers and doctors ensure patients are seen as quickly as possible. 15 Super Saturdays have been held since July 2024, with 465 procedures completed. For example, colleagues in the Day Surgery Unit at the West Suffolk Hospital completed 47 carpal tunnel surgeries in one 'Super Saturday' on 22 February 2025.

Progress on elective recovery: As well as Super Saturdays, our colleagues have been making progress generally to reduce waiting times for elective surgery. At the end of March 2025:

- 31 patients were waiting over 65 weeks: 10 of these were due to insufficient capacity (appointment or treatment slots) available to avoid the patient waiting 65 weeks.
- 4 patients over 78 weeks: this reduced month on month throughout 2024/25.
- The focus is now on reducing our 52 week waits to less than 1% of the total waiting list size.

Thirty years of our Day Surgery Unit: In April 2024 our Day Surgery Unit marked 30 years since it opened on the West Suffolk Hospital site. Patients benefit from innovative and high-quality care, and the unit has continued to adapt and transform, carrying out a wide variety of procedures on patients with often complex conditions.

Waiting times in our Emergency Department: Since May 2023, the Trust has been reporting on the national four-hour standard for the percentage of people attending our emergency department (ED) who are admitted, transferred, or discharged within four hours of arrival. While we have not always achieved this target, especially in winter months when the ED was under significant pressure, data for the end of March 2025, shows that our teams have not just delivered against the 76% target, but significantly exceeded it.

Cancer care: This year, we have focused on the early detection of cancer and reducing waiting times for patients with cancer, 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 March 2025, the position was:

- 83.2% of patients were treated within 62 days, this is above the national requirement of 70% for 2024/25
- 79.1% of patients had cancer ruled out or confirmed within 28 days, also above the national requirement of 77% for 2024/25.

Digital innovation: The Trust, in collaboration with Virtual Bones, was a winner in the *HSJ* Digital Awards 2024, recognising excellence in digitising, connecting, and transforming health and care. The initiative won in the category: **Improving urgent and emergency care through digital:** enhancing efficiency in musculoskeletal injuries management and referral pathway.

Awards for sustainability: In the Awards for Excellence in Waste Management for the NHS in England, our waste management team were awarded silver in two categories: **Best reduction in clinical waste**; and **Best reduction in carbon emissions.**

Regional recognition: Teams and colleagues were well represented at the CanDo Health and Care Awards, presented by Suffolk and North East Essex Integrated Care System. The Trust was recognised in a variety of categories, showcasing innovative, compassionate, joined-up and imaginative care.

Reaching out to our community: Our Annual Members' Meeting in September celebrated the 50th anniversary of the West Suffolk Hospital, and the well-attended event emphasised its importance to our community and local people. It was also a chance to share plans for the new healthcare facility to be built at Hardwick Manor in Bury St Edmunds, and the Community Diagnostic Centre in Newmarket.

Baby life support sessions: More than 2,000 people across West Suffolk have now benefited from an initiative run by our colleagues that provides free basic life support and advice sessions for people looking after small babies and children.

Leg health advice: Looking after your legs – preventing ulcers and venous disease, was the focus of both a popular public event in Newmarket, and an online event to allow as many people as possible to benefit from the advice and support of our clinicians.

Cancer forum: Our annual cancer forum was held in October and aimed to support cancer patients we have cared for by giving them an opportunity to reflect on their treatments and improve the experience for others in the future.

First for Staff

Workplace adjustments: In a move set to transform the workplace environment for our colleagues, our organisational development team introduced a comprehensive workplace adjustment package. Designed to support colleagues with health conditions to flourish in their roles, this initiative underscores our commitment to fostering an inclusive and supportive workplace for all team members. This was supported by our disability staff network, one of four networks that supports the Trust in listening to staff and being more inclusive.

Recognition and reward: The Radar incident-recording system also introduced a method to put colleagues forward for a STAR (Special Thanks and Recognition), which has proved popular. We continue to present Putting You First awards to colleagues who go above and beyond for our patients or their peers.

The Trust is fortunate in having many staff who have been with the NHS for decades, often their whole working life, and we are delighted to recognise them with long service awards. This year midwife Diane Hele, and cardiac rehabilitation specialist nurse Kate Turner, have each received trophies to mark an incredible 50 years' service to the NHS.

Supporting our staff to achieve their potential: Leadership and management programmes, mentoring and coaching are just some of the ways we continue to ensure our colleagues, whatever their role, can progress in their careers. These initiatives have been well-received, with many colleagues taking part.

Meanwhile, our apprenticeships programme has grown, and seen dozens of our colleagues enabled to achieve a variety of qualifications in a broad sphere of roles and professions.

Awards for our team: In the regional national apprenticeship and skills awards organised by the Department of Education, our clinical education team was named T level Employer of the Year. Meanwhile, the preceptorship team was shortlisted in the category of Preceptorship Programme of the Year in the **Nursing Times** Workforce Awards.

Health and wellbeing: We continue to offer access to a wide range of physical and mental health support: our staff psychology team; reduced membership fee for Abbeycroft Leisure facilities; a staff physiotherapist; and a new employee assistance programme offering confidential advice on a broad range of topics.

We are in partnership with our integrated care board to offer the Nature at Work programme, introduced earlier this year and already proving popular with staff keen to get the benefits of being closer to nature. Our in-house vaccination team once again offered Covid-19, seasonal influenza and respiratory syncytial virus (RSV) vaccinations to staff, with a flexible programme of clinics and visits to teams and bases.

First for the Future

A new healthcare facility: At the start of 2025, the Government reaffirmed its commitment to replacing West Suffolk Hospital. Our plans for a new, state-of-the-art hospital on the Hardwick Manor site in Bury St Edmunds are moving forward, and we are working with our community and with system partners to ensure we meet current and future needs.

New facilities in the west of the county: The Community Diagnostic Centre will continue to grow and develop, and the Newmarket Community Hospital site is also set to have a new DEXA bone density scanning service; and an endoscopy unit.

ESEOC: The Essex and Suffolk Elective Orthopaedic Centre (ESEOC) opened on Monday, 11 November 2024 at Colchester Hospital. On the opening day of the centre, a team of West Suffolk Hospital-based colleagues delivered the first list of Trust patients, part of five operating lists running

that day, alongside East Suffolk and North Essex Foundation Trust clinicians.

The ESEOC provides state of the art facilities for patients needing orthopaedic surgery across our region and will see a significant number of elective procedures moving from West Suffolk Hospital to ESEOC each year, reducing waiting times. Our Trust supported a programme of engagement about the move of these services, with clinicians, system partners and the public in the summer of 2024.

Research and healthcare science: In the past year our research team has enrolled people in a range of trials, supporting a vital area of work for the NHS in improving healthcare outcomes.

Meanwhile, healthcare scientists are a key part of the NHS workforce nationwide, and at our Trust we have people working in audiology, pathology, clinical engineering, rehabilitation engineers, diagnostic cardiology, research and development and respiratory disciplines. All these colleagues are part of a drive to ensure the NHS can access best practice and innovations that will improve patient diagnosis and care.

Developing our future workforce: 2024 saw the second year of the Trust offering work placements to health and care students from the West Suffolk College. As well as winning a prestigious award, and with the support of clinical teams across the Trust, the T Level programme has given young people the opportunity to explore careers in the NHS and received excellent feedback.

Our volunteer team organises opportunities for young volunteers at the hospital, while also working with our health and care academies, programmes for college students, and clinical shadowing. The health and care academy, run by the clinical education team, is a regular programme offering varied teaching sessions, advice on interviews and applications, professionalism, and the chance to meet people who work across the Trust.

Sustainability: In 2024 the Trust recruited Green Champions, colleagues who will help us meet the NHS net zero ambitions, implement sustainability changes and promote initiatives within their teams and departments.

A new Green Plan is being developed to ensure we meet our commitment to work within available resources, to protect and improve health, now and for future generations.

The Community Diagnostic Centre (CDC) was designed and built using sustainable methods of construction. Both at the CDC and across the Newmarket Community Hospital site, more than 120 solar panels have been installed. The CDC was built to achieve a 10% target of on-site energy generation, this target has been exceeded and the CDC now produces a minimum of 46% of on-site energy generation. This is also supported by heat pumps that will provide heating and cooling to the building year-round.

Plans for the new hospital are being developed to ensure that it will have a net zero carbon impact.

Data quality

WSFT submits data every week to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patients' valid NHS number was:

Valid NHS number	WSFT	East of England	National
Admitted patient care	**99.7%**	99.8%	99.7%
Outpatient care	**99.9%**	99.9%	99.7%
Accident and emergency care	**97.7%**	-	98.2%

(The above figures cover April 2024 to January 2025 inclusive – taken from NHS Digital)

The percentage of records in the published data which included the patients' valid general medical practice code was:

Valid general medical practice code	WSFT	National
Admitted patient care	**100%**	99.4%
Outpatient care	**99.9%**	99.3%
Accident and emergency care	**100%**	99.1%

(The above figures cover April 2024 to January 2025 inclusive – taken from NHS Digital)

WSFT's **Data Protection and Security Toolkit** overall score for 2023-24 was 'Standards Not Met' at publication in June 2024. An improvement plan was submitted to NHS Digital and this was accepted. The improvement plan was completed and the Trust's status changed to 'Standards Met' in January 2025. The assessment for 2024-25 will not be submitted until after publication of the Quality Accounts.

WSFT was not subject to the **payment by results (PbR) clinical coding external audit** during the reporting period 2024-25. A local audit was undertaken, and the error rates reported in the latest published audit for that period for diagnosis and treatments coding (clinical coding) were:

Data field - inpatients	Error rate
Primary diagnosis	6.0%
Secondary diagnosis	5.1%
Primary procedure	3.9%
Secondary procedure	2.8%

The audit sample was 200 finished consultant episodes (FCEs) from medical, surgical and women and children's health services. The results of this audit should not be extrapolated further than the actual sample audited.

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Performance against 2024-25 priorities

The quality priorities agreed for the year 2024-25 were driven by our strategy and set out key improvements we aimed to deliver and the measures that we used to understand progress and success. Recognising that the strategy is a long-term plan, the expectation is to demonstrate progress on the priorities as described in this section.

Delivering our strategy

Use feedback, learning, research and innovation to improve our care and outcomes:

- we will give everyone the tools and support they need to put quality and safety first by ensuring staff have the confidence to raise concerns and to make changes when things go wrong
- we will ensure patients and families can share their experiences, positive and negative, to help us improve.

Priorities for 2024-25

Quality priority 1 - to improve the **quality** and **timeliness** of discharge summaries to ensure appropriate communication at the point of transfer of care (EFFECTIVE)

Quality priority 2 - reduction of rates of hospital and community onset healthcare associated Clostridium difficile infection (SAFE)

Quality priority 3 - To reduce **inequalities in experience** for service users through our 'Experience of care' workplan (EXPERIENCE)

Discharge summaries quality and timeliness (EFFECTIVE)

The following describes progress against our agreed delivery measures.

Why was this a priority?

Effective communication is critical across all patient pathways and especially so when a patient's care and treatment is being handed over to other care providers. After hospital admission, completion of a transfer of care summary letter is mandated by the NHS contract. The primary purpose of this document is to ensure that ongoing treatment and care needs are met by other healthcare providers following discharge and usually by the patient's GP. In addition, the document serves as a comprehensive record of the patient's inpatient admission which can be used by referrers (GPs).

Like many trusts, the WSFT strives to meet the **95% target of getting the letter to the GP within 24 hours** but has found this difficult to achieve.

Incident analysis, complaints received, and anecdotal evidence suggested that our Trust should actively aim to improve the quality of communication at this point in the patient's journey.

What was our target?

To improve the quality and timeliness of discharge summaries to ensure appropriate communication at the point of transfer of care

Timeliness measures

- percentage of elective summaries sent to GPs within 24 hours of discharge
- percentage of non-elective summaries sent to GPs within 24 hours of discharge
- percentage of emergency department summaries sent to GPs within 24 hours of discharge.

Quality

- incident data and PALS/clinical helpline information review
- consultation survey with GP colleagues to better understand quality issues.

What did we do to improve our performance?

- new clinical guidelines approved which set expectations and standardise best practice
- performance data shared at departmental clinical governance meetings which inspires ownership and leadership
- medical staff worked with digital (eCare) team and Human Factors colleagues to explore new ways of working including protecting time for completion, senior clinical leadership to ensure timely completion and early document preparation in the days before discharge using existing documentation.
- Work is underway to provide a more streamlined approach to producing the GP summary. This will be achieved using the latest tools now available to the Trust in the e-Care electronic patient record. This change is expected to improve productivity and efficiency reducing the time required to complete and send the summary.
- Once negotiated with the local integrated care board, the Trust intends to adopt a new approach to managing summaries for same day emergency care patients. This approach will ensure that national standards are met, and compliance data can be measured specifically for this group of patients against the same 95% standard.

How did we measure and monitor our performance, and did we meet our target?

Timeliness

Initial reporting against the 95% requirement showed below-target compliance, however, analysis during the year has demonstrated that the exclusion criteria needed to be more clearly defined for departments that issue a standard clinic letter as a substitute for a GP discharge letter.

Following clarification of the data-set criteria, validated data is now being produced (from September 2024 onwards) and this will enable ongoing monitoring in 2025. Data is only available two to three months in arrears, as it requires completion of clinical coding to produce department level data.

While the data can now be measured against the target, there has not been a sufficient reporting time to be able confidently to assure the target is being met. This will continue to be monitored at Trust and divisional level to ensure continued progress.

Monthly review of metrics has revealed improvements in a small number of clinical areas and members of the steering group are identifying lessons learned from these areas that can be extended more widely.

The practice of issuing clinic letters has typically been adopted as a productivity gain by departments that offer a short stay episode of care. The care is started as an inpatient admission, rapidly followed and completed, by an outpatient follow-up. This includes same day emergency care activity and some elective procedures that are completed in the outpatients department.

Quality

A detailed analysis of incident data was undertaken by the patient safety team as part of a wider thematic review of discharge, transfer and follow-up arrangements, forming part of a patient safety incident investigation (PSII). This was wider than the focus of the quality and timeliness of discharge letters but was able to provide some useful qualitative learning points.

A consultation survey with GP colleagues to better understand quality issues is planned for 2025, and is currently being tested with our partners at Glemsford Surgery.

How and where was progress reported?

Following the creation of the Transfer of Care Group (TOCG), the Transfer of Care Summary Group was established as a sub-group. Its aims to ensure that WSFT monitors the quality of the transfer of care communications shared with other providers at the point of discharge from acute inpatient care; learnings from incidents that may occur as part of the process; and supports quality improvement initiatives to improve the process.

The TOCG reports quarterly to the Improvement committee, the Trust Board assurance sub-committee with responsibility for quality and safety. This includes updates on the progress of this quality priority.

Updates on the individual metrics have also been shared at departmental clinical governance meetings and there is discussion about the regular presentation of the metrics at a divisional level.

What next for 2025?

A communications plan has been agreed which uses staff bulletins including the medical director's bulletin, resident doctors' group messaging app, a new intranet page and the bimonthly All Staff Update on Microsoft Teams.

Resident doctor training is to be revised to reflect new workflows and qualitative feedback.

It is planned to promote the use of the Patient Portal to view transfer of care summaries. An "instructions

for patient" document using data recorded by the discharging clinician will be presented in an easier-to read document. Currently, patients are provided with a printed copy of the GP letter.

A project to oversee adoption of the latest Oracle (Cerner) "module" is planned A revised workflow would provide an improved method for creating the transfer of care documentation in the patient record.

A GP survey is being tested by our partners in Glemsford Surgery before a wider rollout.

Reduction of rates of hospital and community onset healthcare associated C. difficile infection (SAFE)

Why was this a priority?

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or contact in a healthcare setting.

Clostridioides difficile (C. difficile) are bacteria found in the bowel, usually causing no harm. These bacteria can cause diarrhoea, especially in older persons (data suggests that West Suffolk has an older population age than the national average); those who have been in contact with a contaminated environment; have undergone bowel procedures; or have been or are being treated with certain antibiotics.

HCAIs such as C. difficile pose a serious risk to patients, staff and visitors. They may have significant adverse health impacts and incur considerable costs for the NHS. Infection prevention and control processes are a key priority for all NHS providers.

It is recognised nationally that the rates of C. difficile have increased significantly over the last two reporting years. WSFT was identified as being the third lowest performing Trust (i.e. higher rates of C. difficile) nationally (NHSE May 2024) and the lowest performing Trust regionally for CDI rates (UKHSA September 2024).

What was our target?

The NHS Standard Contract 2024-25 (June 2024) states that trusts are required to minimise rates of C. difficile (and Gram-negative bloodstream infections) so that they are no higher than the threshold levels set by NHS England.

Table 1: C. difficile and Gram-negative bloodstream infections

Org Code	Name	Case thresholds for 2024-25			
		C. difficile	E. coli	P. aeruginosa	Klebsiella spp.
RGR	WSFT	91	56	9	21

What did we do to improve our performance?

- antimicrobial hard stop automatically sets a reminder to clinicians that the antimicrobial treatment will be stopped on day seven if no further action is taken, addressing the course length challenge
- reducing the overall use of the antibiotic Meropenem usage across the Trust
- monitoring using specialist software
- peer auditing of clinical areas
- dirty utility audit embedded on regular ward audit programme
- emergency department matron working with eCare and housekeeping team to support improved cleaning in the department between patients
- new hand hygiene training and presentation.
- improving audit data on the five moments of hand hygiene
- daily review of side room usage by infection prevention and control team
- stool specimen collection form browser report now available to support decision making on

sample collection
- dedicated governance support from the Trust patient safety and quality team.

What are the challenges that impact upon this topic?

C. difficile specific:
- capacity of pharmacy team to continue to carry out antimicrobial audits
- clinical awareness and engagement in principles of prescribing and managing antimicrobials
- duplication of sampling, leading to potential extended use of isolation facilities
- new emerging Ribotype (955) suspected to have an increased transmissibility and greater impact on patients.

Wider infection prevention agenda:
- continued challenges due to capacity across the ED footprint
- no designated decant ward and limited ability to carry out rolling deep cleans due to capacity challenges
- time for staff to engage and deliver audits and understand the implications and results
- staff engagement across various professions and varied compliance
- training all staff in accordance with Trust policy, and management of non-compliance
- capacity, patient flow and limited number of isolation facilities that do not meet required standards, e.g. ensuite bathrooms

How did we measure and monitor our performance?

Number of C. difficile infections are reported in our integrated quality and performance report (IQPR) overseen by the Improvement committee (one of our 3i Board assurance committees).

Chart 1: Cumulative healthcare associated C. difficile cases

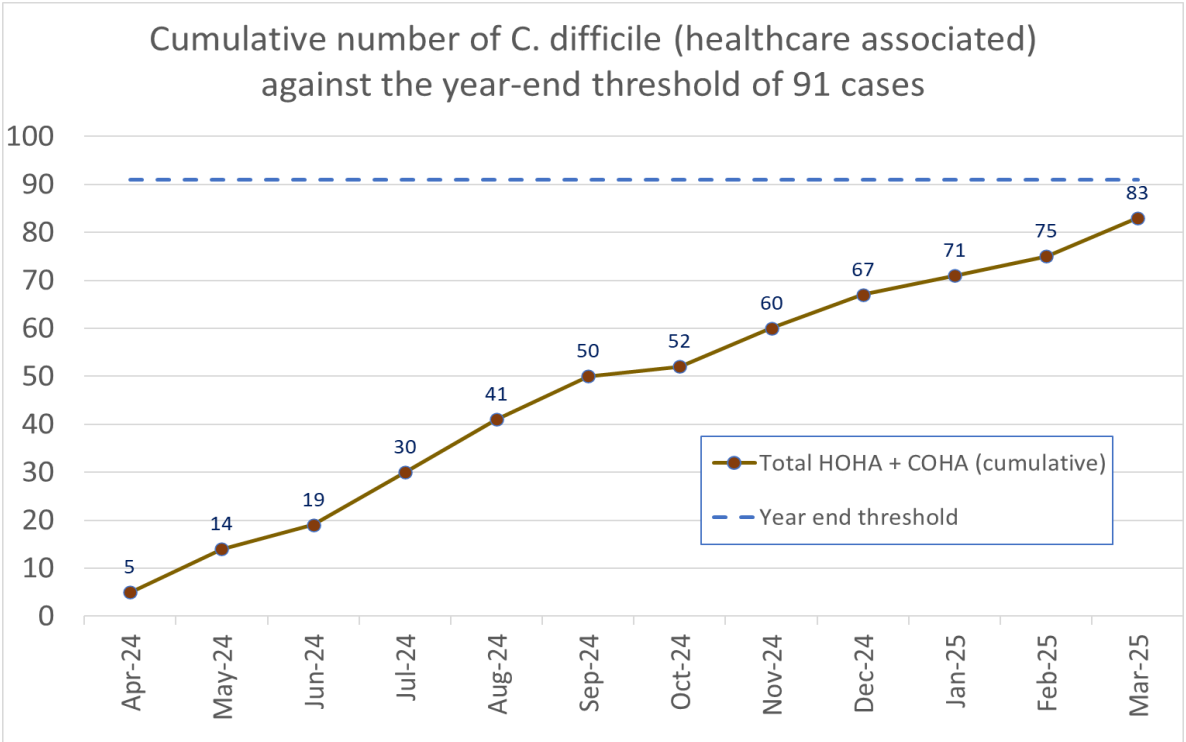


Table 2: Our data, year to date

Class	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Hospital Onset Healthcare Associated (HOHA)	4	7	2	6	6	6	2	5	5	4	3	6
Community Onset Healthcare Associated (COHA)	1	2	3	5	5	3	0	3	2	0	1	2
Community Onset Community Associated (COCA)	4	0	2	4	2	6	1	2	2	2	1	1
Community Onset Indeterminate Association (COIA)	1	1	1	2	1	0	1	2	0	1	1	0

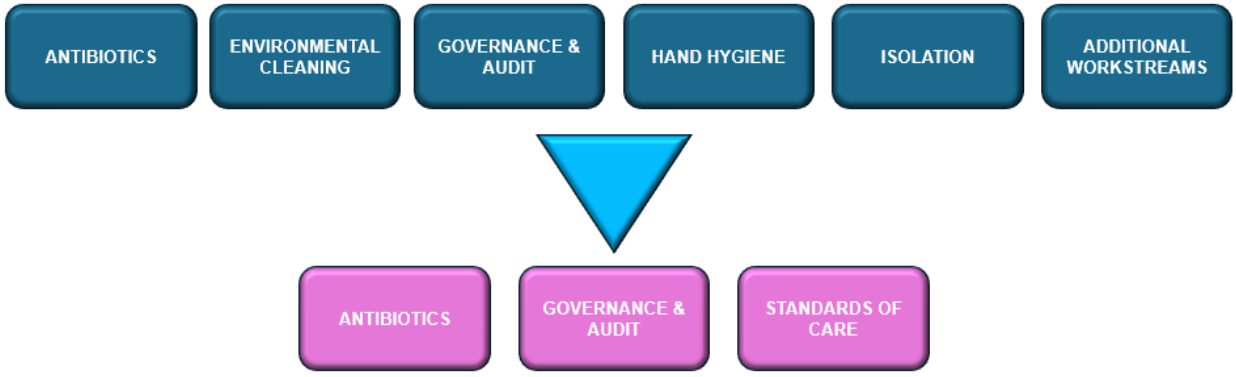
Did we meet our target?

The year-end cumulative total for Hospital Onset Healthcare Associated and Community Onset Healthcare Associated was 83. This met the requirement to be below a maximum threshold of 91 cases

How and where was progress reported?

A Quality Improvement Programme (QIP) began in March 2024 with a plan to run for at least 12 months. An initial programme of six sub-groups were later aggregated into three with oversight by a programme board (chaired by the deputy chief nurse) from September 2024.

Fig 1 – Programme board sub-groups



What next for 2025?

The Trust introduced a new risk management and compliance software system (Radar) in 2024-25. The RadarAudit module contains a programme of infection prevention and control compliance audits. These are in the process of being streamlined and focussed to ensure that they:

- allow a focus on hand hygiene
- provide Trust-wide (inpatient[1]) standards to enable analysis
- model standards against the national infection prevention and control manual (NIPCM) for England: Standard infection control precautions (SIPC)

In addition to the RadarAudit module the quality priority work includes

- review of single side room isolation signage
- quarterly information bulletins on relevant infection prevention hot topics and seasonal illness
- developing a Trust cleaning poster
- review of cleaning processes to include chemicals and equipment methods and modes
- review of reporting process for C. difficile and other HCAI cases.

[1] Separate toolkit allows focus on community IPC standards and processes

Reduce inequalities in experience for service users (EXPERIENCE)

Why was this a priority?

Our engagement activity is in line with NHS England's 10 key principles for working with people and communities and our statutory requirements under the Public Sector Equality Duty (Equality Act, 2010).

What was our target?

To reduce inequalities in experience for service users through our Experience of care workplan.

Experience of care measures

- development of personalised care and support plan datasets into e-Care, including integration of the patient profile by March 2025
- increase of 10% in recording protected characteristics on patient records
- implementation of a reasonable adjustment policy to support service access by March 2025
- increase of 10% in reasonable adjustment needs recorded on e-Care by December 2024
- improvements to booking and waiting procedures for those needing reasonable adjustments by March 2025
- accessibility improvements to web content and software by March 2025
- assessment/completion of the Equality Delivery System to provide better working practices and environments by March 2025
- accessible guides and improvement plans for all Trust sites by September 2024.

What did we do to improve our performance?

See Table below for a progress update for each item.

How did we measure and monitor our performance, and did we meet our target?

Of our eight measures of success, we completed one, two are on track for completion in early 2025, three will progress towards completion in 2025-26 and two will require a longer-term framework which is scheduled in the Trust's workplan.

How and where was progress reported?

To the Experience of care and engagement committee (ECEC) and its parent committee the Involvement (Board assurance) committee.

What next for 2025?

See Table below for a future status update for each item.

Progress update

Measures of success	Activities/progress
Development of personalised care and support plan datasets into e-Care, including integration of the patient profile	29 patient profiles have been completed since April 2024, designed for vulnerable patients or those lacking capacity. We are now looking to incorporate communication passports into patient profiles for patients who have acquired disabilities due to a stroke or neurological condition. The generic patient profile template incorporates elements of the personalised care and support plan datasets. This is subject to review to ensure usability for maximum impact by ascertaining what information is most useful for patients. This longer term project has a final timescale for implementation of the datasets in December 2026.

Measures of success	Activities/progress
Increase of 10% in recording of protected characteristics on patient records	An audit of ethnicity recording in the emergency department and outpatients in October and November 2024 showed 91.5% ethnicity coding. This compares to a baseline of ethnicity coding of 75.3% in all eCare records. The outpatient audit highlighted that the deficit in ethnicity coding was due to patient choice (not wishing to disclose their ethnicity) and some posters to encourage sharing this information have been developed. Other protected characteristics require further work and a task and finish group is being set up to look at how the Trust can better record these, including how patients might be able to do this themselves through the Patient Portal or possibly the digital outpatient check-ins.
Implement a reasonable adjustment policy	The reasonable adjustment policy has been drafted and is anticipated to be published in early 2025/26.
Increase of 10% in reasonable adjustment needs recorded on e-Care	The ability to record reasonable adjustments on our electronic patient record has been delayed but should be available in the second quarter of 2025-26. Training and education for staff on how to complete these assessments is part of the implementation plan.
Improvements to booking and waiting procedures for those needing reasonable adjustments	This is part of the 2025-26 work plan for the Patient Equity Group.
Accessibility improvements to web content and software	There is a three-year implementation plan to develop a fully accessible website. Transferring patient leaflets from PDF to HTML format will ensure they are accessible and easy to navigate. This transition will bring us into full compliance with government regulations.
Assessment/completion of the Equality Delivery System	The Equality Delivery System assessment has been finalised and submitted.
Accessible guides and improvement plans for all Trust sites	All accessibility guides for West Suffolk NHS Foundation Trust sites (West Suffolk Hospital, Newmarket Community Hospital and King Suite at Glastonbury Court) have been completed and published.

Other quality indicators

WSFT has a comprehensive quality reporting framework that includes an array of quality indicators that are monitored and reported on a monthly basis. These include priorities identified by patients and staff, issues arising from national guidance and research, and other stakeholders such as SNEE ICB. Performance against agreed indicators is monitored by the Board on a regular basis. A range of nationally-mandated quality indicators is reported in Annex B.

National standards

	2024-25 Target	2024-25 Actual	2023-24 Actual	2022-23 Actual	2021-22 Actual
C. *difficile* - health care associated[1]	91	83	67	52	37
Ambulance handover within 30 minutes	95.0%	95.7%			
Maximum waiting time of four hours in ED from arrival to admission, transfer or discharge2	76% (Mar 25)	88.4%	73.95%	-	-
62-day combined referral-to-treatment wait for first treatment - all cancers	70% (Mar 25)	83.2%	76.2%	65.3%	71.5%
28-day faster diagnosis standard (cancer)	77% (Mar 25)	79.07%	66.4%	67.3%	69.4%
Maximum six-week wait for diagnostic procedures	95% (Mar 25)	53.2%	68.2%	60.1%	67.1%
Referral to treatment – no patient waiting longer that 65 weeks as at 31 March 2025	0	31			

Positions are at March 2025 unless otherwise stated

1 From 2022-23 target and performance includes both hospital and community onset healthcare associated cases, prior data only includes hospital associated cases

2 WSFT piloted new emergency department reporting standards between 2018-19 and 2022-23 and therefore did not report performance against this standard during this period.

We recognise the underperformance in a number of areas, and this will continue to be the subject of scrutiny at Board, assurance committees and governance groups. Plans to achieve the agreed standards for 2025-26 are monitored and reviewed through our specialist committees and governance structures, in line with the organisational governance framework.

Elective access, including referral to treatment (RTT), diagnostics and cancer

There has been significant progress in reducing the elective waiting times for patients over 2024-25. Following positive progress throughout the year, the number 65-week waits did not reach the ambition of zero but achieved the lowest reported at 31.

Eliminating and maintaining a zero position of 65 week waits, remains a significant focus with the national requirement to reduce to zero by the end of Q1. We will also focus on reducing of the 52 week waits to 1% of our total waiting list size.

The two-year objective of 95% of diagnostic tests delivered within six weeks by March 2025 was not achieved, with capacity constraints specifically in ultrasound, DEXA (dual x-ray absorptiometry), endoscopy and community audiology. The Community Diagnostic Centre (CDC) at Newmarket, opening in December 2024 has provided a significant improvement in performance within in magnetic resonance imaging (MRI) and computed tomography (CT), however recruitment challenges in ultrasound have impacted the ability to recover this position as forecast. DEXA is expected to improve throughout 2025/26 in line with the implementation of a new service from the end of May 2025 and options for increased activity in Endoscopy will need to be reviewed.

Performance remains strong in echocardiography, cystoscopy and urodynamics. While there is no national standard for diagnostics in 2025-26, reducing the wait times and improving the diagnostic waiting times and activity (DM01) performance will be key to delivery of the elective and cancer performance standards.

Cancer performance standards were met in March 2025, and overachieved for both the 28-day faster diagnosis and 62-day referral to treatment standards. This followed large drops in performance

throughout the year, owing to challenged pathways in both breast and skin, with skin making significant recovery throughout Q4.

With the national standards increasing in both these areas for 2025-26 sustained improvements will need to be made to respond to increases in demand across high volume pathways in breast, skin and gynaecology cancers, with working groups already in place to build on improvements and transformation work.

Urgent and emergency care

Having reintroduced the 4-hour standard for the emergency department (ED) in May 2023, WSFT has demonstrated improved performance throughout 2024/25 with significant progress again in March, ending the year at 88.4% against the standard of 78%.

The headline metric for urgent and emergency care (UEC) will continue to be the 4-hour standard, which will remain at 78% to March 2026. Additional indicators of average ambulance handover times will need to be maintained below 30 minutes and the number of patients waiting 12 hours or more in the Emergency Department (ED will need to be reduced from current levels towards an ambition of fewer than 2% of attendances.

Key to delivery and further improvement will be consolidating and continuing workstreams from 2024/25 plans, building on the work undertaken to reduce delays and improve flow by dedicated taskforces in ED, the transfer of care hub, community assessment beds and inpatient acute wards. successful improvement initiatives from last year have already been made substantive, such as the Minor Emergency Care Unit (MECU), and within the department, lessons learned from the additional senior operational and clinical leadership support in March 2025 will be captured and evolved into further initiatives owned and delivered by the clinical and operational team. This additional support may need to be deployed again should performance significantly deviate from trajectory.

Stroke services

The focus nationally and within WSFT has been on performance against the Sentinel Stroke National Audit Programme (SSNAP). SSNAP is a major national quality improvement programme and is the source of stroke data for the NHS assessing stroke care against 43 key indicators. It reviews the whole patient journey from admission to hospital, across the whole inpatient stay, including rehabilitation at home or in the community, and outcomes at six months after stroke.

At the end of September 2024 our stroke team successfully continued to retain its top-grade A ranking, something that has been achieved for more than five years, with the team being ranked 2nd nationally during the reporting period July to September 2024.

In October 2024 SSNAP underwent a significant update with new metrics and targets to measure performance against. These targets have been designed to be challenging in order to drive further improvement for stroke patients nationally. For the first reporting quarter of the new dataset, October to December 2024, trusts did not receive an A-E rating. WSFT are measuring above national average in most key areas, however we are expecting that all teams nationally will drop their ratings and that we will be unable to achieve an A rating moving forward. An action plan is in place to improve performance in line with the new targets. The results for the final quarter of 2024-25 are not yet available.

We have a contract in place to deliver an early supported discharge service (ESD) for stroke patients across Suffolk. This provides up to six weeks of intensive stroke rehabilitation in patients' own homes following their discharge from hospital, helping them to regain their mobility and independence. The service is provided by the Suffolk Alliance, which is a partnership of WSFT, East Suffolk and North Essex NHS Foundation Trust, and Suffolk County Council, and is supported by a variety of third sector partners.

Community and primary care

Adult community services have consistently met the 2-hour urgent community response standard. However, demand for Integrated Neighbourhood Team (INT) nursing continues to rise month on month. Compliance with the 2-hour response activity has been maintained by the nursing teams cancelling and/or deferring less urgent planned care. The impact of postponing home visits on the delivery of community patient care is being monitored. Regarding primary care access, the percentage of patients seen within two weeks at Glemsford Surgery is reported to be significantly improved from 78% to 99%.

An AI triage and booking system has been introduced at Glemsford Surgery – initially some concerns were raised regarding access to appointments through the AI platform and some changes have been made to improve this along with communication to patients and offers of support and training on how to utilise the AI booking system.

Integrated community paediatric services (ICPS)

The eight core services in our integrated community paediatric services continue to support a rising number of referrals in response to growing needs of children with special educational needs and disabilities (SEND). Caseloads are also high in the community paediatric medical team and paediatric speech and language therapy service.

Over the last year the paediatric teams have received a large backlog of referrals for autism assessments in school age children up to the age of 11 years which was held in the previously commissioned coordination function for the neurodevelopmental pathway. Using funding from the Integrated Care Board (ICB), 850 referrals were triaged and over 500 children received their assessment from an external provider. This was completed by November 2024, bringing an end to a period of extended wait for assessment for these families. The paediatric team is receiving unprecedented levels of referrals for autism assessments in the school age pathway and is working with the ICB and mental health trust to consider the model for neurodevelopmental assessment in the future.

In December 2024 the community paediatric audiology team supported an external review of the service by NHS England and the ICB. This review was part of a national programme focusing on paediatric audiology standards after concerns arose from some services elsewhere in the country. The review report highlighted that the community team was a high assurance service with no risks identified. This was a pleasing outcome and reinforced the great work of the team which has also been supporting a high referral demand and had capacity challenges in the clinical team. Waiting times for initial assessments in the audiology team for initial assessments are not meeting the required standard of first appointment within six weeks but the team are focusing on recovery of this position and working with colleagues in the acute hospital audiology team to improve levels of compliance.

Incident reporting and learning

The Trust introduced a new cloud-based risk management system (Radar) in 2024-25. This enables multidisciplinary reporting of patient, staff and organisational incidents. By reviewing investigations and thematic learning, key learning can be identified, and actions put into place to prevent recurrence.

The Trust transitioned to the national Learn from Patient Safety Events (LFPSE) system alongside the change to Radar. This includes a national structured question-set template for patient safety incidents which differs from the one used in the previous system (Datix).

More information about LFPSE can be found on the NHS England website at
Learning from patient safety events.

WSFT uses the national Patient Safety Incident Response Framework (PSIRF) to manage its incident reporting, investigation and learning programmes. PSIRF is a national initiative designed to further improve safety through learning from patient safety incidents and forms part of the wider national patient safety strategy.

More information about PSIRF can be found on the NHS England website at Patient safety incident response framework.

During 2024-25 the total number of patient safety incidents reported was 6,229. From that total number, two patient safety incident investigations (PSIIs) were commissioned.

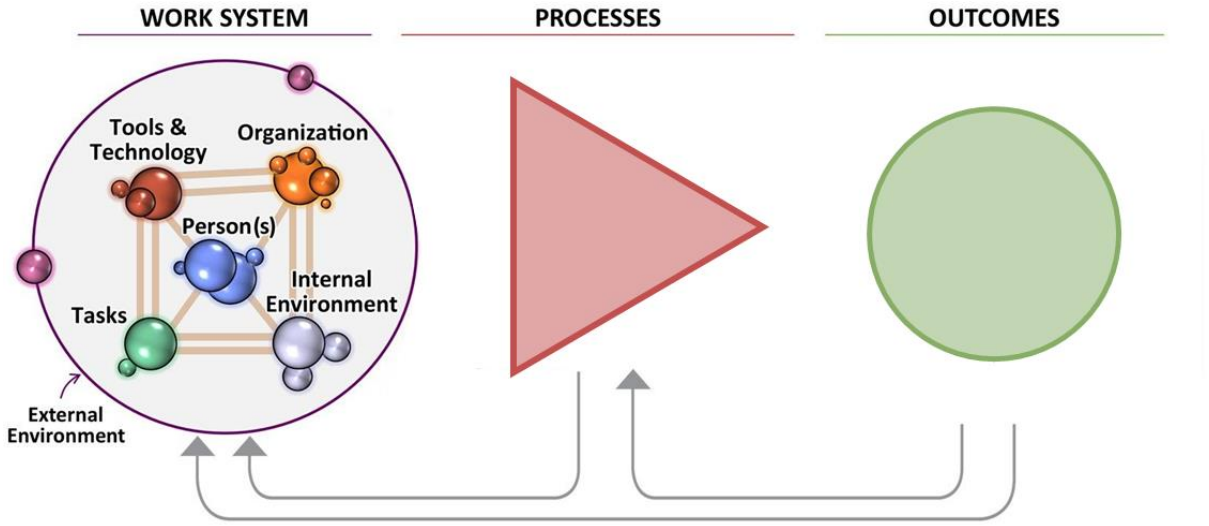
PSIIs are conducted for systems improvement. They are not inquiries into the cause of death, nor to apportion blame or hold individuals or organisations to account. Recommendations and improvement plans are designed to effectively and sustainably address any system factors and help deliver safer care for our patients.

The two PSIIs were commissioned in 2024-25 according to the following (local and national) categories from our Patient Safety Incident Response Plan (PSIRP).

Local	1C. Barriers to effective discharge due to issues in coordination of system	0
	2C. Diabetes, problems with the clinical care/management of diabetic patients when diabetes is not the primary reason for admission to service/hospital	0
	4C. Barriers to effective inclusivity	0
	6C. Identified increase in incidence of subject of theme which has potential for harm	0
National	7C. Never Event [1]	1
	8C. Deaths more likely than not due to problems in care [2]	1

1 - 7C Never Event – Piece of equipment retained in patient following a procedure (no adverse impact)
2 - 8C Deaths more likely than not due to problems in care - Late/missed diagnosis

All other patient safety incidents were subject to another method of review. This could be through our risk management system Radar, or other centrally coordinated learning responses such as after action review, patient safety audit or structured judgement review. This is part of the overall principles of PSIRF to focus on improvement following system-based learning to improve patient safety for the future. WSFT uses Systems Engineering Initiative for Patient Safety (SEIPS) as a model for understanding the dynamic system factors of a given situation.

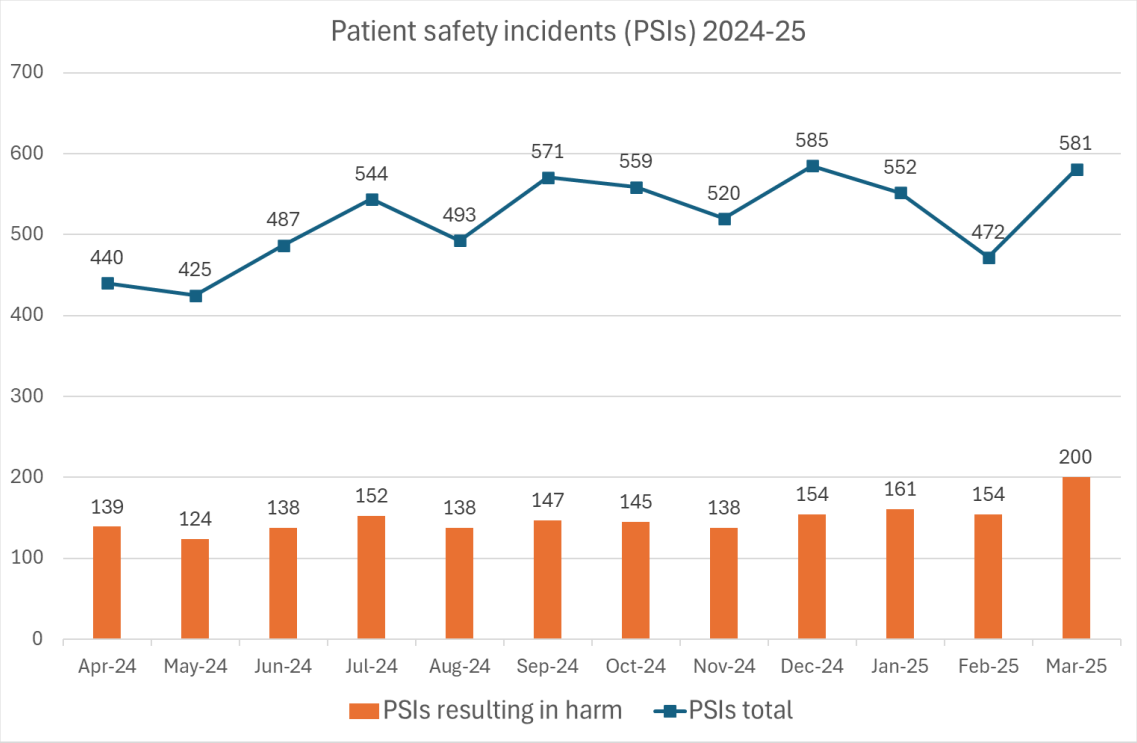


Overview of the SEIPS model, taken from Holden et al (2013), and Holden and Carayon (2021)

Patient safety incidents reported

The chart below shows how many patient safety incidents were reported in 2024-25. The organisation reviews these data monthly and recognises a high reporting rate as a positive reflection of an open culture within the organisation which supports learning from incidents.

Patient safety incidents (PSIs) 2024-25



Source: Radar

Learning and identification of safety actions and areas for improvement from patient safety incidents

All patient safety incidents produce learning outcomes. These can be divided into safety actions and areas for improvement. Where incident investigation is not timely and the quality of learning has been diminished due to time, review of the incident will be undertaken by the central patient safety team and closed.

Safety actions are formally assigned to a divisional representative and tracked following an investigation pathway using Radar. Overdue safety actions will be flagged to staff responsible and their manager at regular intervals by an automated email and reported through appropriate governance processes (in development). Capture of safety actions is reported through the patient safety report to the Improvement committee (via the Patient Safety and Quality governance group).

The Trust has adopted the term Area for Improvement (AFI) instead of recommendations to reduce the likelihood of identifying solutions at an early stage of the incident process. This follows the NHS England ‘safety action development guide’ (August 2022). The patient safety team has undertaken a thematic review of areas for improvement which were identified following the first two cycles of PSIRF. These areas for improvement were themed as opportunities for the Trust to improve care and presented at the Patient Safety Summit in September 2024.

The total number of safety actions assigned to staff in 2024-25 in relation to incidents was 1,816. These are managed locally with divisional and specialist lead accountability. 1,634 of these safety actions have been completed. AFIs identified from the two PSII reports completed in 2024-25 are currently being finalised.

Wider learning can be gained from thematic review of events such as pressure ulcers and falls, which feed into quality improvement programmes overseen by the specialist teams.

Patient Safety Incident Response Plan (PSIRP)

We are on our third iteration of our PSIRP and have been following this plan since 1 June 2023. During 2025-26 we will refresh our plan for the fourth time to ensure we are investigating topics of risk for patient safety for our Trust.

In September 2024 we held our second Patient Safety Summit; an opportunity to review areas for improvement highlighted through patient safety investigation and showcase examples of safety improvements taking place across the Trust. This work was linked to our first two years of PSIRF. At the summit colleagues were asked to vote for the organisational theme they would like to see taken forward as a safety improvement project.

An organisational quality improvement programme has been launched for “Getting it right for patients and staff - place, service, pathway”. Colleagues have been asked to join a project group to establish programmes of work and measurable outcomes. Initial focus will be on appropriate referral and service provision. This has been accepted as a quality priority and will be monitored through the Improvement committee.

Areas for improvement which are not adopted will be risk assessed and added to the corporate risk register if deemed to be a clinical risk for patient care. The patient safety team will review areas for improvement before the next safety summit in September 2025.

Duty of candour (DoC)

DoC applies to notifiable patient safety incidents. A notifiable patient safety incident is an incident which is unintended or unexpected and in the reasonable opinion of a healthcare professional, already has, or might result in death or severe or moderate harm to the person receiving care. This is a legal requirement requiring NHS organisations to:

- have a face-to-face discussion and offer an apology to the patient or relevant person following a safety incident resulting in moderate harm or more
- provide written communication following the face-to-face discussion with the patient, to include: an account of the known facts about the incident, details of any enquiries to be undertaken, the results of any enquiries into the incident and an apology.

The aim is to ensure health service bodies are open and transparent when an incident happens. DoC can make an important contribution to creating a culture of openness and honesty which always places the safety and the needs of the patient and family above the reputation of the organisation.

In 2023-24 WSFT introduced a new DoC audit which enabled a greater focus on the quality of the DoC process, rather than a simple proxy measure of 10 working day timeliness (the national target is “as soon as reasonably practicable”).

In 2024-25, the average time to complete the verbal duty of candour was six working days, while the average for the written of duty candour was 11 days. The largest incident category requiring duty of candour was pressure ulcers.

The patient safety team will meet the integrated care board in the coming year to have a system discussion about approaches to duty of candour. This is to gauge how individual organisations are approaching timescales across the region, in view of the 10-day requirement no longer being included in CQC guidance.

Learning from deaths

During 2024-25, 1,048 of WSFT's patients died, including deaths in the emergency department at the West Suffolk Hospital and community hospitals.
This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 278 in the first quarter, of which 275 were adults, three were people with learning disabilities and three had a severe mental illness; one was a neonatal death and two were stillbirths
- 205 in the second quarter, of which 205 were adults, one was a person people with learning disabilities. There were no deaths for people with a severe mental illness, and no neonatal deaths or stillbirths.
- 264 in the third quarter, 262 of which were adults, five were people with learning disabilities and one had a severe mental illness; there were two neonatal deaths and no stillbirths.
- 301 in the fourth quarter, of which 299 were adults, one was a person with learning disabilities and three were people with severe mental illness; there no neonatal deaths and two stillbirths.

By March 2025, 80 case record reviews and nine investigations had been carried out in relation to the deaths included above. In two cases, a death was subjected to both a case record review and an investigation.

Four (0.38%) of the 1,048 patient deaths during the reporting period are judged to more likely than not have been due to problems in the care provided to the patient. These are all subject to a detailed incident review to ensure all aspects of learning are captured and addressed.

The number of deaths in each quarter for which a case record review or an investigation was carried out was as follows:

	Patient deaths			
Quarter	Total	Case Record Review	Investigation	Judged Preventable
Q1 (Apr-Jun24)	278	25	3	0
Q2 (Jul-Sept24)	205	32	4	3 (1.46% of total deaths)
Q3 (Oct-Dec24)	264	17	2	0
Q4 (Jan-Mar25	301	4	2	1 (0.33% of total deaths)

- *case record review: Royal College of Physicians' Structured Judgement Review (SJR)*
- *investigation: incident investigation/reviews as per PSIRF (see below)*
- *judged preventable: using the Hogan preventability scoring >50% likelihood and/or PMRT led criteria D (likely to have made a difference)*

Collation of mortality data and case review methodology

All inpatient deaths excluding neonatal death and stillbirths are collated via the Trust's electronic patient record and recorded on a bespoke mortality database. Neonatal deaths and stillbirths are collated via the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK perinatal mortality surveillance system. Deaths of patients with a learning disability are recorded on the Trust mortality database but also reported to the national learning disabilities mortality review programme (LeDeR).

Any maternal deaths are also reported to the Maternity and Newborn Safety Investigations (MNSI) for external review. There were no deaths of women during or immediately following delivery in 2024-25. Feedback from local MNSI reviews and wider learning from the national MNSI maternity reporting programme are included in the maternity programme of improvement.

For adult deaths, the case record review is undertaken using the Royal College of Physicians' structured judgement review (SJR) method. The objective of the SJR method is to review the quality of the care provided, to provide information about what can be learned about the hospital systems where care goes well, and to identify points where there may be omissions or errors in the care

process.

Stillbirths and neonatal deaths are reviewed locally using the perinatal mortality toolkit (PMRT) or through external review by the MNSI for cases meeting the notification and reporting requirement definitions of MBRRACE.

WSFT uses a local patient safety review template and the national patient safety incident investigation (PSII) toolkit for a small number of deaths where an incident investigation is warranted, including for those judged preventable in line with the national patient safety incident response framework (PSIRF). More details on PSIRF can be found in section 20.

Bereaved families are invited to give feedback on the care their relative received, this can be via the medical examiner, the learning from deaths reviewer, the patient safety incident investigator or MNSI. The Trust records and reviews deaths of patients with a learning disability and patients with a severe mental illness. Feedback from these reviews to enhance wider learning is included as scheduled agenda items in the monthly mortality oversight group meetings. This includes feedback from external reviews to incorporate wider national learning.

Our learning themes

Case record reviews and investigations conducted in relation to the deaths have highlighted the following themes:

- the early involvement and input of the critical care outreach team for patients identified as being at higher risk of deterioration
- Delays in timely Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) conversations and form completion
- the importance of quality ReSPECT form conversations and transcription of this into the health record. Where ReSPECT wishes have not been explicitly clear with a concise plan of escalation, this has at times resulted in end of life wishes not being met.
- communication between healthcare staff and patients and relatives or carers/loved ones continues to be an area that requires improvement. Some mortality reviews have highlighted that family members have been shocked when their relative has died so quickly, despite the patient following a poor trajectory. Clinical staff are being encouraged to use phrases such as “your relative is sick enough to die” and to convey a clear message when having difficult conversations.
- recognition of end of life remains a local priority to review. Although more recent reviews demonstrate some improvement in this area over the past year, there are still reviews that highlight some areas may require more support to make end of life decision-making. If end of life is recognised at an appropriate time, it opens the lines for communication and planning to proceed.
- fluid balance monitoring being infrequent or incomplete continues to be a theme noted in structured judgement reviews SJRs
- extended wait times in the emergency department continues to be a national and organisational concern. This results in more patients dying in the department itself rather than on a ward. This may include those that are identified as being at the end of life early on in their presentation. The improvement of care for these patients has been a local drive with good palliative care team input in the emergency department. However, this is not the ideal environment for the end of life care the Trust aims to deliver.
- three of the reported deaths in the maternity unit were at an extreme premature gestation (less than 22 weeks). There was no overarching theme identified among these cases.

Actions and improvement programmes

- In 2024 the implementation of the ReSPECT tool went live across the organisation. It continues to be formally monitored for quantitative compliance and has a quality audit for

qualitative data, with a task and finish steering group.

- refinement for the pain management of patients with chest wall injuries was highlighted for service improvement work. A new guideline is being written to improve the care given and outcomes for this cohort of patients.
- fluid balance monitoring. the deteriorating patient group is undertaking a project considering potential solutions to overcome the barriers preventing teams completing this care requirement.
- relatives' commented that a side room or quieter area would have improved the care they felt their relative received at the end of their life. This has been focus at the local end of life steering group for quality improvement, such as a "quiet bay" bed space.
- we have used the "Grand Round" resident doctors' education session to review examples of cases that clearly demonstrate the importance of early recognition that someone is at the end of life. This can affect the ability to offer supportive, comfortable care for patients for whom invasive procedures, such as blood tests, are not beneficial.
- automatic referral to the preterm birth clinic will be facilitated for patients where information regarding previous caesarean sections is unavailable or cannot be retrieved, such as births that occurred at another trust.
- improvement in the safe storage and record keeping of placenta to enable diagnostics following pregnancy loss is in place to ensure appropriate investigations are facilitated in qualifying cases. The criteria for histological examination have also been reinforced among the broader team.

Complaints management

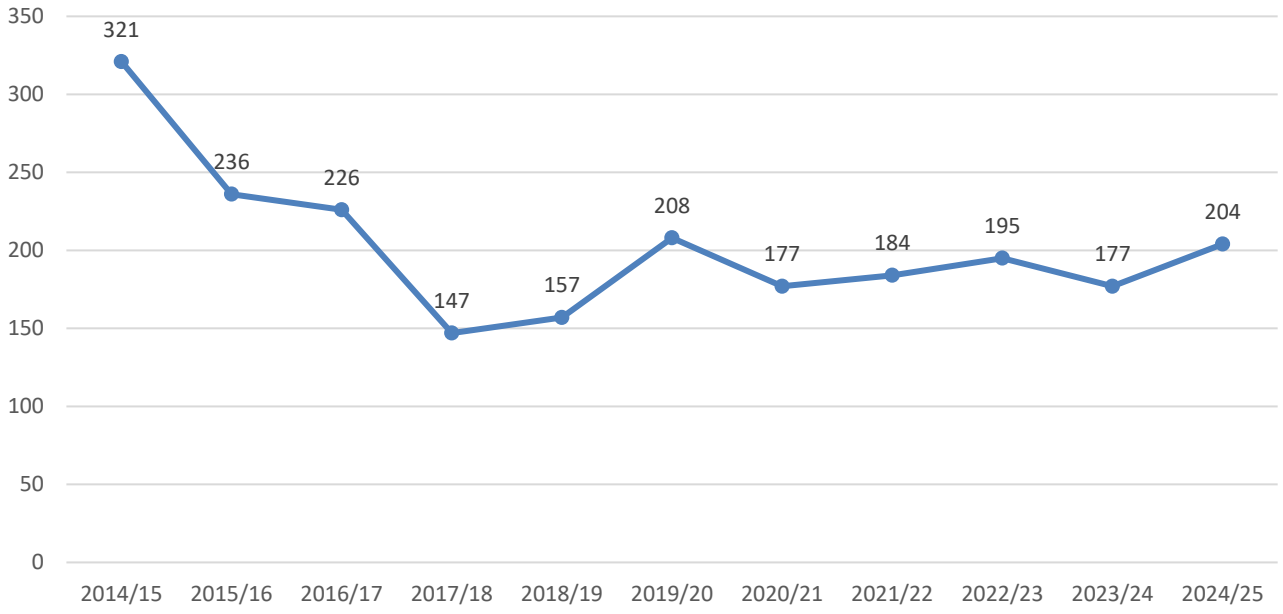
WSFT is committed to providing an accessible, fair and effective means of communication for anyone who wishes to express concerns about the care, treatment or service provided by the Trust. In responding to and reviewing complaints, WSFT adheres to the NHS Complaints Standards published in December 2022 by the Parliamentary and Health Service Ombudsman (PHSO).

Complaints are reviewed with service managers, associate directors, clinical directors and the senior nursing team to ensure that issues are addressed, learning takes place and trends identified.

Examples of learning are detailed below. Themes and lessons learned are also reviewed at the Experience of care and engagement committee and the Involvement committee.

WSFT received 204 formal complaints during 2024-25. The Board monitors complaints and learning each month as part of the quality reporting arrangements.

Number of formal complaints received



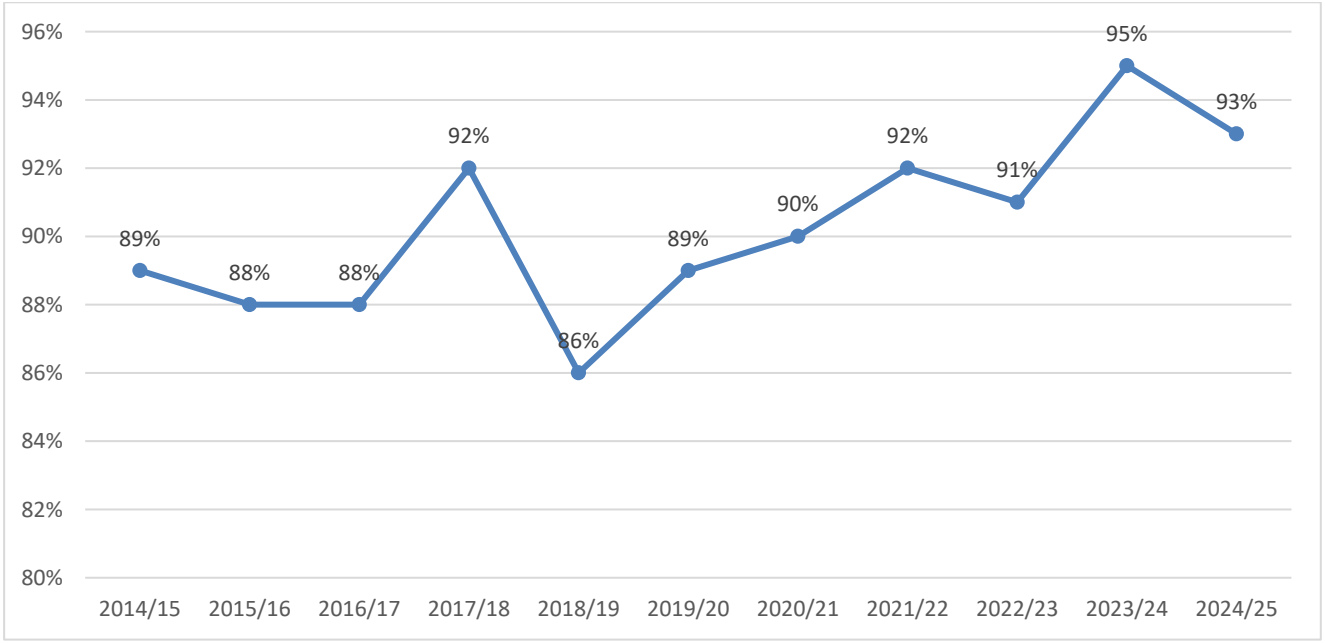
Source: Datix and Radar

As a Trust we aim to resolve complaints at the first stage, resolving a person's concerns upon receipt of their first contact. On occasion, people are dissatisfied with the outcome of our investigations and request a review, at this stage we would consider this to have gone beyond the first stage.

In 2024-25 the Trust successfully resolved 193 complaints at the first stage, with 15 investigations escalating to second stage throughout the year, reflecting a 93% first-time resolution rate.

The consistently high number of complaints resolved at first stage demonstrates quality investigations at local level. New complaints management processes were implemented to improve the complainants' experience, with the aim of ensuring complaints are resolved at the first stage.

Complaints closed at first stage



Source: Datix and Radar

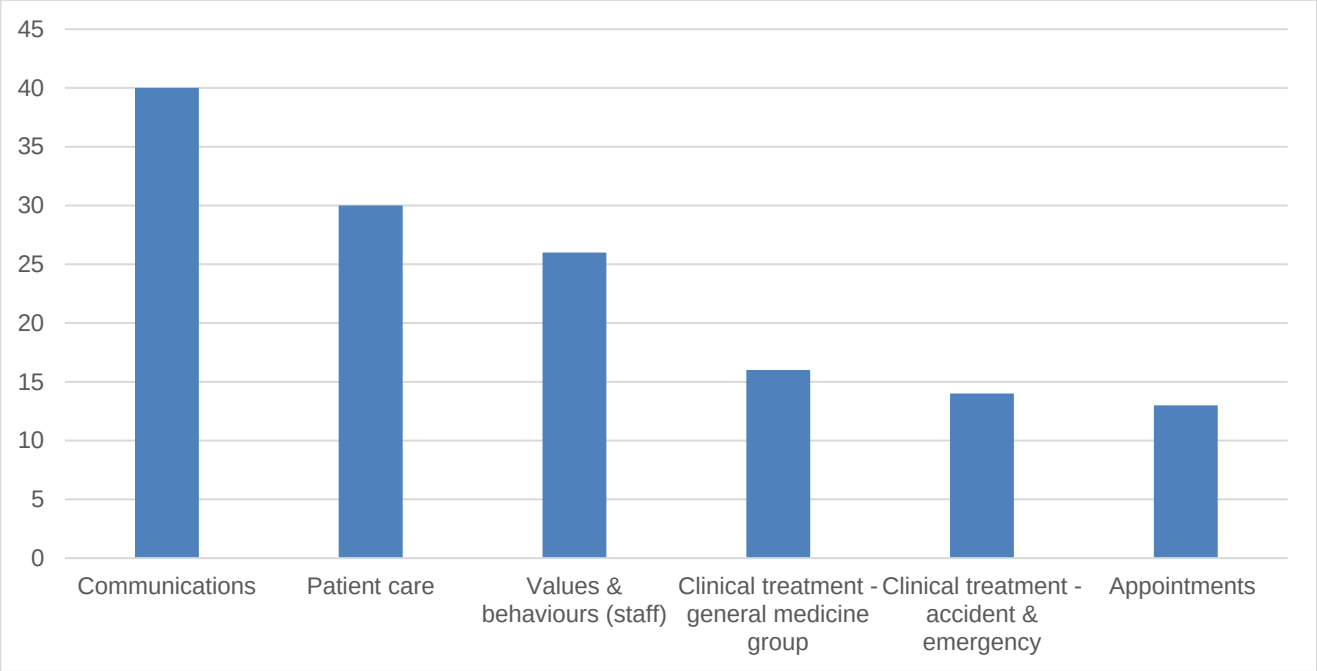
Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the

PHSO or the Local Government and Social Care Ombudsman (LGSCO) for an independent review. During 2024-25, one complaint was referred to the PHSO and following investigation this was found to not be upheld.

Of the two cases referred to the PHSO in 2023-24, the investigations were concluded in 2024-25 and one was not upheld. The other investigation was referred to both the PHSO and LGSCO. The LGSCO concluded that the complaint was not upheld, however, the PHSO partially upheld the complaint. The recommendations made by the PHSO for this case have been completed.

There are currently no ongoing PHSO or LGSCO investigations and with only one complaint being referred in 2024-25. This further demonstrates the thorough investigations completed at local level.

Top six primary subjects of complaints



Source: Radar

The numbers identified in the chart above list only primary concerns; many complaints have multiple categories. Four out of the six top categories have remained the same since the previous financial year, however, clinical treatment in the emergency department, and appointments, have become among the highest subjects for formal complaints in 2024-25.

Communication remains the top category of concern and the number of complaints have increased from 28 in 2023-24 to 40 in 2024-25. Patient care complaints have increased from 23 in 2023-24 to 30 in 2024-25. Values and behaviours of our staff has also increased from 19 in 2023-24 to 26 in 2024-25. Clinical treatment – general medicine group has decreased from 20 in 2023-24 to 16 in 2024-25.

As well as responding to and learning from individual complaints, WSFT identifies themes and trends from local complaints and national publications such as the PHSO. We have provided a sample of the learning outcome from complaints, which has support WSFT's quality priorities and other service improvements:

- actions have been completed to improve communications between staff, patients and relatives
- Oliver McGowan training recommended for staff
- gastroenterologist of the week introduced to aid with communication and continuity (same named person) for patients

- visiting times for birthing partners changed to allow them to stay on the ward overnight
- additional training for midwives on tongue tie assessments to increase number of staff able to complete this
- timing of breakfast on ward F11 changed to first delivery of the day, to better accommodate patients who need to control blood sugars
- adrenal pathway established between radiology and endocrinology to ensure appropriate referrals if adrenal lesions incidentally found during scans
- nutritional values to be added to patient menus to assist with diabetes management
- additional safeguarding training given to staff for both adults and paediatric patients
- catheter passports and additional training for these being rolled out Trust-wide.
- additional equipment provided to ward staff to improve pressure area care.

There were some complaints that were also investigated simultaneously with serious incident investigations and the actions identified through these investigations are being progressed and reported via this route.

Managing compliments

A total of 666 compliments have been formally received by WSFT. This figure only includes “thank you” correspondence shared with the patient experience team.

National CQC patient surveys

The Care Quality Commission (CQC) carries out a variety of patient surveys, the most frequent of which occurs annually. Feedback from national as well as local surveys is used to monitor service performance and focus on quality improvement. WSFT was involved in the following CQC surveys which have been reported on during 2024-25:

- 2023 Adult Inpatient Survey (published August 2024)
- 2024 Urgent and Emergency Care Survey (published November 2024)
- 2024 Maternity Survey (published November 2024).

Interpreting our data

These reports show how the Trust scored for each evaluative question in the surveys, compared with other trusts that took part.

It uses an analysis technique called the “expected range” to determine if the Trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement.

2023 Adult Inpatient Survey (published August 2024)

Respondents and response rate

- 559 WSFT patients responded to the survey
- The response rate was 48.95%.

Banding

Much better than most trusts on 0 questions

Better than most trusts on these three questions:

- did you have confidence and trust in the nurses treating you?
- do you think the hospital staff did everything they could to help control your pain?
- did hospital staff discuss with you whether you would need any additional equipment in your

home, or any changes to your home, after leaving the hospital?

Somewhat better than most trusts on these three questions:

- how would you rate the hospital food?
- when you asked nurses questions, did you get answers you could understand?
- before you left hospital, did you know what would happen next with your care?

Worse than most trusts on 0 questions

About the same as other trusts on 43 questions

2024 Urgent and Emergency Care Survey (published November 2024)

Respondents and response rate

443 WSFT patients responded to the survey

- the response rate was 37%.

Banding

Much better than expected on one question

- Q38. From the information you were given by hospital staff, did you feel able to care for your condition at home?

Better than expected on seven questions

- Q12. After your first assessment, did the nurse or doctor tell you what would happen next?
- Q17. Did you have enough time to discuss your condition and treatment with the doctor or nurse?
- Q18. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?
- Q27. Were you involved as much as you wanted to be in decisions about your care and treatment?
- Q35. Thinking about any new medication you were to take at home, were you given any of the following? (*list given in questionnaire*)
- Q41. If you contacted any health or social care services after leaving A&E, was the care and support available when you needed it?
- Q43. Overall, how was your experience while you were in A&E?

Somewhat better than expected on seven questions

- Q21. Did you have confidence and trust in the doctors and nurses examining and treating you?
- Q22. If a family member, friend or carer wanted to talk to a doctor or nurse, did they have enough opportunity to do so?
- Q28. If you had any tests, did a member of staff explain why you needed them in a way you could understand?
- Q29. Before you left A&E, did a member of staff explain the results of the tests in a way you could understand?
- Q30. Do you think the hospital staff helped you to control your pain?
- Q36. Before you left A&E, did hospital staff give you information on how to care for your condition at home?
- Q42. Overall, did you feel you were treated with respect and dignity while you were in A&E?

Somewhat worse than expected on 0 questions
Worse than expected on 0 question
About the same on 15 questions

2024 Maternity Survey (published November 2024)

Respondents and response rate
126 WSFT patients responded to the survey

- the response rate was 42%.

Banding

Much better than expected on one question

- C4. Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?

Better than expected on two questions

- B12. Thinking about your antenatal care, were you spoken to in a way you could understand?
- E2. Were your decisions about how you wanted to feed your baby respected by midwives?

Somewhat better than expected on four questions

- B11. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?
- B14. During your pregnancy did midwives provide relevant information about feeding your baby?
- B17. If you raised a concern during your antenatal care, did you feel that it was taken seriously?
- F10. Did a midwife ask you about your mental health?

Somewhat worse than expected on one question

- D2. On the day you left hospital, was your discharge delayed for any reason?

Worse than expected on 0 questions

About the same as other trusts on 49 questions

Action plan

Results are reviewed by relevant groups and reported to the Experience of care and engagement committee. Action plans are established with the support of the patient experience and engagement team alongside any existing work in our workstreams. Actions from the CQC survey results have included:

- the creation of focus groups in particular areas
- in-depth local surveys to determine support patients feel they need
- working closely with the Transfer of Care group
- development of personalised care plans
- a week focusing on time-critical medications
- improved communication with patients waiting in an ambulance
- review of “what to do at home” leaflets.

National staff survey

The Trust performs a full census of staff and has seen a decrease in the response rate of 2%, now at 44%, which is 4% below the national average for acute and community trusts.

There has been a significant reduction in 58% of scores when compared to the Trust’s scores from the previous year, and significant increase in 1% of scores. When comparing the Trust scores against the average of other similar organisations, the Trust has seen a significant reduction in 62% of scores, and a significant increase in 9% of scores. The Trust’s scores are either average or above in 28% of the questions.

The Trust is in line with the average for the recommender questions and has seen a significant decrease in the question of staff being happy with the standard of treatment provided by the organisation if friends or family needed treatment from 70% to 61% (national average of 61%); there has also been a significant decrease in recommending the organisation as a place to work from 65% to 49%, the Trust is below the national average of 59%.

The Trusts most declined scores are the organisation takes positive action on health and well-being declined from 61% to 41% (national average 55%) and is one of the Trusts bottom scores vs organisation average, would recommend organisation as place to work declined from 65% to 49% (national average 59%), have adequate materials, supplies and equipment to do my work declined from 61% to 47% (national average 57%) and is one of the Trusts bottom scores vs organisation average, care of patients/service users is organisation's top priority declined from 76% to 63% (national average 72%) and organisation acts on concerns raised by patients/service users declined from 69% to 57% (national average 69%) and one of the Trusts bottom scores vs organisation average.

There are two further bottom scores vs organisation average. Feedback given on changes made following errors/near misses/incidents is 49% and national average is 60%, and there are opportunities for me to develop my career in this organisation is 43% and national average is 54%.

The Trust most improved scores are, don't work any additional paid hours per week for this organisation, over and above contracted hours has improved from 63% to 74% (national average 64%) and is one of the Trusts top scores vs organisation average, last experience of physical violence reported improved from 67% to 70% (national average 71%), not felt pressure from manager to come to work when not feeling well enough improved from 78% to 80% (national average 78%), received appraisal in the past 12 months improved from 86% to 88% (national average 84%) and is one of the Trusts top scores vs organisation average, satisfied with level of pay improved from 33% to 34% (national average 32%) and is one of the Trusts top scores vs organisation average.

There are two further top scores vs organisation average. I can eat nutritious and affordable food at work is 62% the national average is 56% and in the last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities is 73% the national average is 70%.

Workforce Race Equality Standard (WRES)

The scores presented below are the scores for indicators 5, 6, 7 and 8 split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard. Data for indicators 5 to 8 come from the NHS Staff Survey.

Indicator		**WSFT 2024**	Average (median) for acute Trusts	**WSFT 2023**	**WSFT 2022**
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (indicator 5)	White	**22%**	23%	**21%**	**25%**
	BME	**32%**	28%	**31%**	**31%**
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (indicator 6)	White	**23%**	22%	**23%**	**23%**
	BME	**30%**	25%	**25%**	**28%**
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (indicator 7)	White	**54%**	59%	**59%**	**56%**
	BME	**46%**	50%	**52%**	**50%**
In the last 12 months have you	White	**7%**	7%	**7%**	**7%**

Indicator		**WSFT 2024**	Average (median) for acute Trusts	**WSFT 2023**	**WSFT 2022**
personally experienced discrimination at work from any of the following – manager/team leader or other colleagues? (indicator 8)	BME	**16%**	16%	**16%**	**18%**

Actions relating to the WRES are included and identified in the Trust's inclusion workplan. Our inclusion workplan brings together actions and priority areas arising from several of our EDI commitments, including: WRES, Workforce Disability Equality Standard (WDES), Unison's Anti-Racism Charter, NHS EDI Improvement plan, data from staff survey and other statutory reports.

It includes actions relating to: becoming an anti-racist organisation, upholding our commitments to ensure sexual safety within our healthcare settings, improving the EDI disclosure rates of protected characteristics amongst our staff, supporting our four staff networks and, following the launch of our new Equality Impact Assessment (EIA) process, providing additional resources to empower and educate colleagues on how to complete EIAs efficiently for all change activities that impact colleagues and/or patients. All of our actions in place are aligned to, and contribute towards the progress of, the six high impact actions set out within the NHS EDI improvement plan.

A brief example of actions in place for each of the high impact areas is as followed:

High impact action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
Example of an action we are doing: Board members are to schedule annual EDI development sessions. In addition to regularly scheduled EDI reports that generate discussion, engagement and progression of our EDI agenda, these development sessions serve as protected and focussed time for our board members to reflect upon key trends in our data and commit to further actions regarding what else they can do as our senior leaders to accelerate progress within our Trust.

High impact action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
Example of an action we are doing: design and implement a chief executive officer (CEO) mentoring programme focussed on supporting colleagues (both clinical and non-clinical) at Band 7 and above who are keen to develop their career. This positive action initiative should be available for colleagues from our BME and LGBTQ+ communities as well as colleagues who have a disability or are underrepresented within their professional fields for reasons of their gender, because of the underrepresentation of these colleagues in senior roles within our organisation.

High impact action 3: Develop and implement an improvement plan to eliminate pay gaps.
Example of an action we are doing: Alongside the statutory annual gender pay gap report and the ethnicity pay gap report that the Trust conducted for the first time in 2024, we will commit to producing a report on the disability pay gap by September 2025.

High impact action 4: Develop and implement an improvement plan to address health inequalities within the workforce.
Example of an action we are doing: Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. We have initiated this by seeking guidance from the East of England EDI team to learn and be informed by best practice.

High impact action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.
Example of an action we are doing: continue the roll out the safe space initiative. Work with the integrated clinical education team to begin to collect data regarding who is attending these sessions and the main themes arising from them so additional organisational support can be implemented if

required.

High impact action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.
Example of an action we are doing: Review the Respect for Others policy, which is due to be reviewed by April 2025. As a part of this review, we must ensure that the definitions of harassment, discrimination and bullying are clear. We must include definitions and examples of sexual harassment, racism, ableism, misogyny and/or any other types of discrimination and/or abuse in the workplace, where appropriate, to ensure that there is a clear understanding across the organisation. We must also ensure there is information about intersectionality within the policy, to raise awareness and highlight the compounding impact that can be felt by individuals who are experiencing harassment, discrimination and abuse on the grounds of more than one of their protected characteristics. Ensure the policy signposts to clear processes of action, intervention and support.

Development of the quality report

In preparing the quality report, we also sought the views of SNEE ICB, Suffolk Health Scrutiny Committee, Healthwatch Suffolk and our governors.

Commentary from these parties is detailed in Annex C. As a result of the feedback received, changes were made to simplify the language used in the document and provide appropriate explanation of abbreviations or phrases.

Annex A: Participation in clinical audit

This annex provides detailed information to support the clinical audit section of the quality report.

Table A: National clinical audits, including clinical outcome review programmes participation

National clinical audit	Host organisation	Eligible	Participated	%
Rehabilitation Following Critical Illness - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100%
Blood Sodium Study - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Yes	Ongoing2
Emergency Surgery in Children and Young People - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Yes	Ongoing2
Acute Limb Ischaemia - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Yes	Ongoing2
Juvenile Idiopathic Arthritis - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Yes	100%
End of Life Care - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing1
British Hernia Society Registry	British Hernia Society	No	N/A	-
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	No	N/A	-
National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology	Yes	Yes	Ongoing1
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	No	N/A	-
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	Ongoing1
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	Ongoing1
National Cardiac Arrest Audit (NCAA) - National Cardiac Audit Programme (NCAP)	Intensive Care National Audit & Research Centre	Yes	Yes	Ongoing1
Sentinel Stroke National Audit Programme (SSNAP)	King's College London	Yes	Yes	Ongoing1
National Audit of Metastatic Breast Cancer (NAoMe)	National Cancer Audit Collaborating Centre (NATCAN)	Yes	Yes	Ongoing1
National Audit of Primary Breast Cancer (NAoPri)	National Cancer Audit Collaborating Centre	Yes	Yes	Ongoing1
National Bowel Cancer Audit (NBOCA)	National Cancer Audit Collaborating Centre	Yes	Yes	Ongoing1

National clinical audit	Host organisation	Eligible	Participated	%
National Kidney Cancer Audit (NKCA)	National Cancer Audit Collaborating Centre	Yes	Yes	Ongoing1
National Lung Cancer Audit (NLCA)	National Cancer Audit Collaborating Centre	Yes	Yes	Ongoing1
National Non-Hodgkin Lymphoma Audit (NNHLA)	National Cancer Audit Collaborating Centre	Yes	Yes	Ongoing1
National Oesophago-Gastric Cancer Audit (NOGCA)	National Cancer Audit Collaborating Centre	Yes	Yes	Ongoing1
National Pancreatic Cancer Audit (NPaCA)	National Cancer Audit Collaborating Centre	Yes	Yes	Ongoing1
National Prostate Cancer Audit (NPCA)	National Cancer Audit Collaborating Centre	Yes	Yes	Ongoing1
National Heart Failure Audit - National Cardiac Audit Programme (NCAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing1
National Adult Cardiac Surgery Audit - National Cardiac Audit Programme (NCAP)	National Institute for Cardiovascular Outcomes Research	No	N/A	-
Left Atrial Appendage Occlusion (LAAO) Registry	National Institute for Cardiovascular Outcomes Research	No	N/A	-
The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	National Institute for Cardiovascular Outcomes Research	No	N/A	-
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	National Institute for Cardiovascular Outcomes Research	No	N/A	-
National Audit of Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research)	Yes	Yes	Ongoing1
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) - National Cardiac Audit Programme)	National Institute for Cardiovascular Outcomes Research	No	N/A	-
National Congenital Heart Disease (CHD) - National Cardiac Audit Programme	National Institute for Cardiovascular Outcomes Research	No	N/A	-
Patent Foramen Ovale Closure (PFOC) Registry	National Institute for Cardiovascular Outcomes Research	No	N/A	-
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	NHS Benchmarking Network	Yes	Yes	Ongoing1
National Comparative Audit of NICE Quality Standard QS138	NHS Blood and Transplant	Yes	Yes	100%
National Comparative Audit of Bedside Transfusion Practice	NHS Blood and Transplant	Yes	Yes	100%
Breast and Cosmetic Implant Registry (BCIR)	NHS Digital	Yes	Yes	Ongoing1
National Audit of Cardiac Rehabilitation - (NACR)	NHS Digital	Yes	Yes	Ongoing1
National Core Diabetes Audit - National Diabetes Audit (NDA)	NHS Digital	Yes	Yes	Ongoing1
National Diabetes Footcare Audit (NDFA) - National Diabetes Audit (NDA)	NHS Digital	Yes	Yes	Ongoing1

National clinical audit	Host organisation	Eligible	Participated	%
National Diabetes Inpatient Safety Audit (NDISA) Previously NaDIA-Harms - National Diabetes Audit	NHS Digital	Yes	Yes	Ongoing1
National Obesity Audit	NHS Digital	No	N/A	-
National Pregnancy in Diabetes Audit (NPID) - National Diabetes Audit	NHS Digital	Yes	Yes	Ongoing1
National Audit of Pulmonary Hypertension	NHS Digital	No	N/A	-
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	NHS England	Yes	Yes	Ongoing1
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	Yes	Yes	Ongoing1
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Yes	Yes	Ongoing1
Time Critical Medications QIP	Royal College of Emergency Medicine	Yes	Yes	Ongoing1
Care of Older People QIP	Royal College of Emergency Medicine	Yes	Yes	Ongoing1
Mental Health (Self-Harm) QIP	Royal College of Emergency Medicine	Yes	Yes	Ongoing1
National Maternity & Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	Ongoing1
Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing1
Maternal mortality confidential enquiries	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing1
Maternal mortality surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing1
Perinatal mortality and serious morbidity confidential enquiry	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing1
Perinatal Mortality Surveillance	MBRRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	Yes	Yes	Ongoing1
Adolescent Mental Health	Royal College of Emergency Medicine	Yes	Yes	Ongoing1
Care of Older People	Royal College of Emergency Medicine	Yes	Yes	Ongoing1
Time Critical Medications	Royal College of Emergency Medicine	Yes	Yes	Ongoing1
National Ophthalmology Database Audit (NOD) Cataract Audit	Royal College of Ophthalmologists	Yes	Yes	Ongoing1
National Ophthalmology Database Audit Age-related Macular Degeneration Audit	Royal College of Ophthalmologists	Yes	Yes	Ongoing1

National clinical audit	Host organisation	Eligible	Participated	%
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing1
National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing1
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing1
Adult Asthma - National Asthma and COPD Audit Programme	Royal College of Physicians of London	Yes	Yes	Ongoing1
Chronic Obstructive Pulmonary Disease (COPD) - National Asthma and COPD Audit Programme	Royal College of Physicians of London	Yes	Yes	Ongoing1
Fracture Liaison Service Database - Falls and Fragility Fractures Audit Programme (FFFAP)	Royal College of Physicians of London	Yes	Yes	Ongoing1
National Audit of Inpatient Falls - Falls and Fragility Fractures Audit Programme	Royal College of Physicians of London	Yes	Yes	Ongoing1
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Yes	Yes	Ongoing3
National Hip Fracture Database - Falls and Fragility Fractures Audit Programme	Royal College of Physicians	Yes	Yes	Ongoing1
Paediatric Children and Young People Asthma - National Asthma and COPD Audit Programme (NACAP)	Royal College of Physicians	Yes	Yes	Ongoing1
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	No	N/A	-
Pulmonary Rehabilitation - National Asthma and COPD Audit Programme	Royal College of Physicians	Yes	Yes	Ongoing1
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	No	N/A	-
Prescribing Observatory for Mental Health (POMH): Rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	Royal College of Psychiatrists	No	N/A	-
Prescribing Observatory for Mental Health (POMH): The use of melatonin	Royal College of Psychiatrists	No	N/A	-
Prescribing Observatory for Mental Health (POMH): The use of opioids in mental health services	Royal College of Psychiatrists	No	N/A	-
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology & Reconstruction	British Association of Oral and Maxillofacial Surgeons (BAOMS)	No	N/A	-
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	British Association of Oral and Maxillofacial Surgeons	No	N/A	-

National clinical audit	Host organisation	Eligible	Participated	%
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	British Association of Oral and Maxillofacial Surgeons	No	N/A	-
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	British Association of Oral and Maxillofacial Surgeons	No	N/A	-
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers	British Association of Oral and Maxillofacial Surgeons	No	N/A	-
National Audit of Dementia (NAD) round 6	Royal College of Psychiatrists	Yes	Yes	100%
National Clinical Audit of Psychosis (NCAP)	Royal College of Psychiatrists	No	N/A	-
Cleft Registry and Audit Network (CRANE)	Royal College of Surgeons	No	N/A	-
National Vascular Registry (NVR)	Royal College of Surgeons	Yes	Yes	Ongoing1
Serious Hazards of Transfusion (SHOT): UK National Hemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	Yes	Yes	Ongoing1
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine	Yes	Yes	100%
BAUS Penile Fracture Audit	British Association of Urological Surgeons (BAUS)	Yes	Yes	100%
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	The British Association of Urological Surgeons	Yes	Yes	100%
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	British Association of Urological Surgeons	Yes	Yes	100%
Trauma Audit & Research Network (TARN)	The Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing1
UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	No	N/A	-
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	No	N/A	-
National Child Mortality Database (NCMD)	University of Bristol	Yes	Yes	Ongoing1
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	University of Warwick	No	N/A	-

1 The listed National Audits run a continuous data collection cycle; therefore, the percentage of patients submitted in 2024-25 is currently unavailable.
2 The listed National Audits are part of active ongoing studies; therefore, the percentage of patients submitted for 2024-25 is currently unavailable
3 Data collection for the listed National Audits is still ongoing, so the percentage of patients submitted for 2024-25 is not yet available.

Table B: Action from national clinical audit reports

35 national audit publications were issued during 2024-25, four were identified for action and improvement opportunities.

National Clinical Audit	Actions identified
Learning from deaths of children with a learning disability and autistic children	Implement “reasonable adjustments digital flag” to e-Care
NCEPOD Endometriosis Report	Formalise a pathway for the management of patients with endometriosis.
National Audit of Metastatic Breast Cancer Report 2024 (NAoMe)	1. Amend the existing multidisciplinary team MDT template to ensure documentation of metastatic disease (both recurrent and new). 2. Update the clinical nurse specialist initial assessment template to include a frailty review for all patients aged over 70. 3. Modify the MDT outcome sheet to capture the necessary data fields. 4. Enhance the frailty review process for patients over 70, ensuring that a fitness assessment form is completed and uploaded to e-Care. 5. Adjust the MDT template to improve data clarity and ensure all relevant information is captured for Cancer Outcomes and Services Data COSD data set submission, with a specific focus on recurrence.
The Inbetweeners’ - Transition from child into adult healthcare National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	1. Ensure clear communication – adjust existing practice to ensure that letters, including the plan and clear instructions, are sent to both patients and parents as needed. Plans should be tailored to the patient's specific needs. 2. Obtain patient consent – ensure that patient consent is obtained before sending the plan directly to the patient and sharing it with their parents. 3. Improve accessibility – provide an option to translate the plan and letters into a language the patient can fully understand. 4. Implement transition clinics –establish transition clinics across all specialties where possible.

Table C: Action from local clinical audit reports

WSFT completed 155 local clinical audits in 2024-25, with 10 of them identifying SMART (specific, measurable, achievable, relevant, and time-bound) actions for service improvement.

Local Clinical Audit	Actions identified
Audit of referrals to specialist maternal medicine centres or consultants in pregnancy	Creation of a referral proforma.
Identification of interventions to reduce the risk of a cerebrovascular event	Implement automatic calculation of the mean blood pressure during a patient's admission for inclusion on the discharge summary.
An audit review of the dissection and blocking of skin ellipses containing non-pigmented skin cancers	Update skin standard operating procedure.
Are we prescribing appropriate oxygen therapy within 24 hours for paediatric patients admitted to F1	To place e-Care reminder to prescribe O2 upon opening patient notes.
Analysis of the review of clinical radiographs requested pre-operatively in Trauma and Orthopaedics patients	Addition to the WHO safety checklist.
Audit of Daily Board Rounds on Wards (DB-RoW)	Creation of new e-care record template.
Point Prevalence Survey Report 2023	Launch 7 day hard stops on e-Care.
An audit on the practice of reflex immunohistochemical (IHC) staining with cytokeratin on sentinel lymph node biopsies (SNLB) from breast cancer patients	Amend current processes to minimise reflex IHC on breast SLNB, where appropriate, following consensus agreement.
Response to a Local Patient Safety Incident – The management of fluid balance on ward F14 following surgery.	Amendment of post abdominal standard operating procedure.
An audit of current management of patients with acute or chronic liver failure (ACLF) on the intensive care unit	Dissemination of new ACLF guideline

Annex B: Nationally-mandated quality indicators

This section sets out the data made available to WSFT by the Health and Social Care Information Centre (HSCIC) for a range of nationally-mandated quality indicators.

(a) Preventing people dying and enhancing quality of life for people with long-term conditions

Summary hospital-level mortality indicator (SHMI)

	Jan20–Dec20	Dec20-Nov21	Nov21-Oct22	Jan 22-Dec 22	Dec 22-Nov23	Oct 23–Sep 24
WSFT (control limits)	0.9119 (1.08 to 0.92)	0.8954 (0.896 to 1.117)	0.8891 (0.89 to 1.12)	0.9800 (0.89 to 1.12)	0.9679	0.85
Banding a b	As expected	Lower than expected	As expected	As expected	As expected	Lower than expected
National baseline	1.00	1.00	1.00	1.00	1.00	1.00

Source: NHS Digital

(2020 guidance) The England average SHMI is 1.0 by definition, and this corresponds to a SHMI banding of “as expected”. For the SHMI, a comparison should not be made with the highest and lowest trust level SHMIs because the SHMI cannot be used to directly compare mortality outcomes between trusts and, in particular, it is inappropriate to rank trusts according to their SHMI. Trusts are advised to use the banding descriptions i.e. 'higher than expected', 'as expected', or 'lower than expected' in their Quality Account rather than the numerical codes which correspond to these bandings. This is because, on their own, the numerical codes are not meaningful and cannot be readily understood by readers.

WSFT considers that this data is as described as the SHMI rates are reported to the learning from deaths group along with an analysis of other mortality information. These indicate that WSFT is performing well in regard to maintaining mortality below the expected level.

Patient deaths with palliative care coded at either diagnosis or specialty level

	Jan20 – Dec20	Dec20-Nov21	Nov21-Oct22	Jan 22-Dec 22	Dec 22-Nov 23	Oct 23–Sept 24
WSFT	46%	46%	46%	37%	36%	55%
National average	37%	39%	40%	40%	42%	44%

Source: NHS Digital

WSFT considers that this data is as described and shows WSFT’s rate is slightly below the national average. WSFT intends to take, and has taken, a range of actions to monitor and improve performance in this area as part of our mortality reviews, and so the quality of our services. These are described in the “Other quality indicators” section of this report.

(b) Patient reported outcome measures scores (PROMs)

	2016-17	2017-18	2018-19	2019-20	2020-21
Hip replacement surgery (primary) EQ-5D adjusted health gain					
WSFT	0.441	0.479	0.448	0.403	0.464
Comparison	Not an outlier	Not an outlier	Not an outlier	Negative outlier	Not an outlier
National average	0.445	0.468	0.46	0.459	0.472
Knee replacement surgery (primary) EQ-5D adjusted health gain					
WSFT	0.338	0.427	0.327	0.273	0.266

Comparison	Not an outlier	Positive outlier	Not an outlier	Negative outlier	Not an outlier
National average	0.324	0.338	0.34	0.335	0.315

PROMs data publications are currently paused: In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.

(c) Emergency readmissions within 30 days of discharge from hospital

		2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
WSFT	Aged 0 to 15	12.9	12.5	13.1	13.3	11.6	11.5
National average		11.6	11.9	12.5	12.5	11.9	12.5
WSFT	Aged 16 or over	12.2	12.1	12.7	12.7	12.8	12.0
National average		13.6	14.1	14.6	14.7	15.9	14.7

(2021 update) The ongoing review by NHS Digital of emergency readmissions indicators across Compendium, Clinical Commissioning Group Outcomes Indicator Set and NHS Outcomes Framework has been paused due to the coronavirus illness (COVID-19) disruption and re-prioritisation of work across NHS Digital.

(d) Responsiveness to the personal needs of its patients

	2016	2017	2018	2019	2020	2021
WSFT	72.9	69.7	68.6	67.4	68.9	76.5
National average	69.6	68.1	68.6	67.2	67.1	74.5
Highest NHS trust	86.2	85.2	85.0	85.0	84.2	85.4
Lowest NHS trust	58.9	60.0	60.5	58.9	59.5	67.3

Source: NHS Digital

(March 2022 update) - As of the 2020-21 survey, changes have been made to the wording of the five questions, as well as the corresponding scoring regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years.

WSFT considers that this data is as described as each year WSFT participates in a national inpatient survey. Review of this data shows that WSFT is performing at the national average and has performed at or better than the national average in all of the last six years.

(e) Staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their friends or family

If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	2019	2020	2021	2022	2023	2024
WSFT (agree + strongly agree)	86.3	82.6	73.4	67.8	69.9	60.9
England: acute trusts (agree + strongly agree)	70.6	74.3	66.9	63.0	65.0	61.54
Benchmark group best result (agree + strongly agree)	87.4	91.7	89.5	86.4	88.8	89.59
Benchmark group worst result (agree + strongly agree)	39.7	49.7	43.6	39.2	44.3	39.72

Source: National NHS Staff Survey Co-ordination Centre - Picker Institute

WSFT considers that this data is as described as the data is analysed independently. Each year WSFT participates in a national staff survey. WSFT receives a benchmark report that compares the results

with those of other trusts. When given the statement "if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation", the percentage of staff employed by, or under contract to the Trust during the reporting period who indicated they agreed or strongly agreed scored lower than the England average for acute trusts. A review of the 2024 data, show that this is the first time in the last 7 years that WSFT has performed worse than the England acute Trust average on this measure.

(f) Patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE)

	2016-17	2017-18	2018-19	2019-20 Q3 *	2020-21
WSFT	86.62%	92.12%	94.94%	94.39	NA
National average	95.61%	95.27%	95.59%	95.53	

Source: NHS England

*VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. Data is reported for Q3 in 2019-20 only.

(g) Rate per 100,000 bed days of cases of C. difficile infection reported in the Trust amongst patients aged 2 or over

	2018-19	2019-20	2020-21	2021-22
WSFT	8.6	17.0	21.1	24.4
National average	12.2	13.6	15.4	16.2

Source: NHS Digital

WSFT considers that this data is as described as the *C. difficile* infection cases is consistent with the data reported to the Board and described in the *'Other quality indicators'* section of this report.

(h) Number and, where available, rate of patient safety incidents reported within the Trust, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Patient safety incidents (total)

	WSFT number and rate/1000 bed days	Median (all acute non-specialist trusts) Rate/1000 bed days	Comparison to peer group
Apr 2021 – Mar 2022	8,829 (69.4 / 1000 bed days)	53.9 / 1000 bed days	Top quartile (high is good)
Apr 2022 – Mar 2023	10,034*	No longer published	No longer published
Apr 2023 – Mar 2024	11,112*	No longer published	No longer published
Apr 2024 – Mar 2025	9666**	No longer published	No longer published

Sources: NHS England (National Reporting and Learning System -NRLS) and Local incident system (*Datix and **Radar).

Patient safety incidents resulting in severe harm or death

	WSFT number and % of total reported	Average (all acute non-specialist trusts) % of total reported	Comparison to peer group
Apr 2021 – Mar 2022	56 (0.6%)	0.40%	Above peer group average
Apr 2022 – Mar 2023	59 (0.6%)*	No longer published	No longer published
Apr 2023 – Mar 2024	66 (0.6%)*	No longer published	No longer published
Apr 2024 – Mar 2025	57 (0.6%)**	No longer published	No longer published

Data source: NHS Improvement (NRLS) and *Local incident system

*From April 2022 peer group benchmark data no longer issued due to the transition from the NRLS to the 'learning from patient safety incidents' (LFPSE) system.

**From April 2024 incident data is captured in a new system (Radar) which means that data is not directly comparable across years.

WSFT considers that this data is as described as the reporting rates are consistent with the data received by the Board. WSFT intends to take and has taken a range of actions to improve the rate and percentage for these indicators, and so the quality of its services. These are described in the report within the summary in the “Incident reporting and learning” section.

Annex C: Comments from third parties

WSFT Council of Governors

The Council of Governors (CoG), with support from the Board and Trust colleagues, continues to embrace its role to represent both the interests of the Trust as a whole and the interests of the population that it serves. The Governors recognise and fully support the Board of Directors' commitment to improving the high standard of care for our patients.

The governors are keen to harness the power of our local community and collaborate with health and care partners as part of the Suffolk and North East Essex Integrated Care System (ICS). We also collaborate with West Suffolk Alliance and regional partners.

The governors recognise the importance of the West Suffolk Alliance in the delivery of health and care services in the west of Suffolk as well as collaboration with our wider system partners as part of the ICS.

The lead governor and deputy lead governor work with the chair to facilitate effective relations between the Board of Directors and the CoG. This includes joint meetings/workshops with the Board of Directors and attendance of non-executive directors (NEDs) at CoG meetings.

There are three sub-committees of the CoG – the Membership and Engagement Committee, Standards Committee and Nominations Committee.

- **Engagement with members and public:**
    - Governors, in collaboration with Trust staff such as clinical teams, the Trust's engagement team, Future System team and My WiSH Charity, participate in various public engagement activities and events
    - While carrying out engagement activities they encourage members of the public to take interest in Trust services by becoming members of the Foundation Trust. Friends, relatives and acquaintances are also encouraged to join.
    - Members receive regular information about the Trust via a newsletter. They can meet the experts to find out more about modern treatments and how to prevent ill health by attending the 'Medicine for Members' events. Members have voting rights in governor elections and can stand for election themselves. They are invited to attend the Annual Members' Meeting (AMM) where they can meet and question the Trust chair, chief executive officer and governors.
    - The AMM was held in the Apex in September 2024. West Suffolk Hospital landmarked 50-year anniversary and the event focussed on initiatives in diagnostic imaging with a presentation from the WSFT research and development team, highlighting some of the innovative research that is being undertaken to support and advance patient care. Governors and Board members attended. In addition, the meeting included service updates from the CEO and Trust chair and a review of Governor activities delivered by the lead governor
    - Governors join the VOICE network meetings as observers. VOICE is a network of groups, charities and individuals aiming to improve local healthcare services
    - Governors are invited to attend as members of the Committee and have a representation on Experience of Care and Engagement meetings.

- **Governor Engagement Activities:**

  - Governors participate in regular “15 Steps” visits to clinical and non-clinical areas. This is a national initiative from NHS England. Governors, a non-executive director and clinical staff visit a department in order to look at the care provided and the environment as if through the eyes of a patient or visitor. Feedback is given to the department staff
  - Under the guidance of the patient experience team, governors act as ‘secret shoppers’, by positioning themselves in various waiting areas in order to observe the patient experience. Feedback is provided to the department manager
  - Governors join the estates and facilities team to carry out environmental reviews. Department staff and the accompanying estates manager compile action plans with the aim of improving the department environment
  - Governors meet visitors in the Courtyard Café at the West Suffolk Hospital and the Newmarket Community Hospital White Lodge Café in order to conduct a short patient experience questionnaire. The opportunity is taken to have a conversation with the visitor about their experience of the Trust and to encourage them to join as a member.

- **Working with the Board:**

The respective powers and roles of the Trust Board and CoG are set out in their standing orders and Trust Constitution.

  - Governors receive the bi-monthly Board meeting agenda and papers. Governors and members of the public have an open invitation to attend these meetings as observers. Questions relating to the agenda may be asked at the appropriate time on the agenda
  - Governors do not attend the closed Board meeting where matters of a confidential nature are discussed. However, governors do have access to the meeting agenda and approved minutes
  - An interactive engagement session was organised with the director of strategy & transformation to gather input from governors on updating the Trust's strategy. The governors had the opportunity to contribute and found the session very helpful
  - Governors volunteer to observe three Board assurance committee meetings (improvement, insight and involvement), on a rota basis. They complete reports on the meetings which, are submitted to the CoG. All governors will have access to the agenda for these meetings and to the approved minutes. Attendance at these meetings provides insights into the working of the Trust and supports governors in their role
  - The CEO attends CoG meetings and presents a report on which, governors have opportunity to ask questions
  - Executive directors also attend CoG meetings when they have a specific topic to present, for example, the executive director of strategy and transformation recently presented the update on transformational programmes and the sustainability review commissioned by SNEE ICB and the chief finance officer provides financial updates
  - Governors can request, via the Chair, that specific items are added to a CoG agenda.
  - Working with the NEDs has allowed sharing of information to triangulate areas for further consideration and/or improvement
  - Governors, through effective questioning, hold the NEDs to account for the performance of the Board
  - Governors provide feedback to inform the appraisals of the chair and all NEDs to a schedule. The lead governor and senior independent director (SID) conduct the annual appraisal of the Trust chair.
  - The lead and deputy lead governors meet with the Trust chair and Trust and deputy Trust secretary monthly

- **Development of knowledge and skills:**

  - A training and development programme was provided for governors, including a session on how to undertake appraisals for NEDs, and an externally facilitated induction day. The induction day was attended by both governors and NEDs
  - A recent briefing session was delivered by the deputy chief executive and director of strategy and transformation, Suffolk and North East Essex Integrated Care System to give an overview on SNEE Integrated Care Board and composition, ICB responsibilities, Alliance projects, ICS Strategy and Joint Forward Plan.
  - Governors also received a briefing session on CQC Single Assessment Framework, delivered by executive chief nurse
  - Governors may suggest subjects to the Trust Secretary or Chair, they would like to understand better by receiving a brief,
  - Informal governors' meetings and joint governor and NED meetings, facilitated by the lead governor, enhance effective working relationships.

The Governors recognise the contribution made by the staff and volunteers and would like to thank them for their dedication and hard work during continued challenging times. We will continue to develop opportunities for engagement with the public and our members over the next year. The feedback we receive helps us understand people's experiences and priorities.

Suffolk and North East Essex Integrated Care Board

Date: 06 June 2025

The Suffolk and North East Essex (SNEE) Integrated Care Board (ICB) confirm that WSFT have consulted and invited comment regarding the Annual Quality Account for 2024/2025. This has been submitted within the agreed timeframe and SNEE ICB are satisfied that the Quality Account provides appropriate assurance of the service.

SNEE ICB have reviewed the Quality Account and the information contained within the Quality Account is reflective of both the challenges and achievements within the organisation over the previous twelve month period.

SNEE ICB look forward to working with clinicians and managers from the service and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and a good service user experience is delivered across the organisation.

This Quality Account demonstrates the commitment of WSFT to provide a high quality service.

Lisa Nobes
Chief Nursing Officer
Suffolk & North East Essex Integrated Care Board

Suffolk Health Scrutiny Committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2024-25. This should in no way be taken as a negative response. The Committee acknowledges the ongoing engagement and contributions made by the NHS to the work of the Committee and wishes to place on record our thanks for everything being done to maintain NHS services for the people of Suffolk.

County Councillor Jessica Fleming
Chairman of the Suffolk Health Scrutiny Committee

Healthwatch response to the West Suffolk NHS Foundation Trust Quality Account 2024-25

Healthwatch Suffolk thanks WSFT for the opportunity to comment on its Quality Account for 2024/25.

We recognise this has been a period of intensity for the Trust's staff, clinicians and volunteers, and as a Healthwatch, we are also naturally also acutely aware of the heightened needs of the public over this period in time. Healthwatch Suffolk also recognises the additional pressures faced by the Trust, due to the continued and long standing Reinforced Autoclaved Aerated Concrete (RAAC) repair programme.

Patients sharing feedback with us about their experiences of the Trust have been largely positive, with an overall average rating of 4* out of a possible 5*. Half of people's experiences were rated 5*. A quarter of the lived experiences shared with us were wholly negative in their sentiments.

Departments which were associated with more positivity (over 50% of patients reported a wholly positive experience) included: Maternity, Cancer Services, Endoscopy, Respiratory Medicine, Eye Clinic, and Day Surgery. Departments associated with more negativity (over 50% of patients reported a wholly negative experience) included: Dermatology and Gynaecology. Issues raised about parking at the hospital, included the location of 'disabled bays', in that they are *"some distance from the main entrance, and up a hill".*

An example of cancer related care was described in this way; *"Brilliant treatment for bladder cancer. Doctor seen/referred, and op undertaken within a month of first seeing a doctor. After care also brilliant as nurses dealt with blocked catheter quickly and efficiently in his home".* Several people have commented that 'once you get to the surgery and hospital on fast track, treatment is great'.

The most reviewed department at West Suffolk Hospital was A&E, comprised of comments praising the treatment and care received in, the waiting times and/or the kindness and helpfulness of staff. In terms of negative feedback, the reviews mainly highlighted long wait times and dissatisfaction with the treatment and care received, or care navigation after being passed between different departments and services.

Healthwatch Suffolk has worked with several of the Trust's teams and individuals during 2024/25, a working relationship that remains strong. Key examples of such collaborations centred around the provision of Virtual Wards by the Trust (e.g. family carer experiences); the offer to the Trust's patients of having their orthopaedic surgery conducted at the new Elective Orthopaedic Centre (ESEOC) in Colchester; what it is like to wait for Elective Care such as pain management; and patient experiences of back, neck and spinal related services. We thank WSFT for having been so active in its support of the aforementioned initiatives.

We note the two very appropriate quality priorities for 2025/26 of 'Patient Safety', in the form of 'delivering safe care for patients being cared for in temporary escalation spaces (TES)' and 'getting it right for patients and staff: place, service, pathway Patient Safety Incident Response Framework'; and 'Experience of Care', in the form of 'reducing inequalities in healthcare for service users' and 'use feedback and engagement to drive changes that matter to our patients and the public'.

We support the Trust's aim to "reduce/eliminate the use of TES" and that use of such hospital space is safe. A comment Healthwatch Suffolk received about care in TES areas is worthy of note: *"When I was in the bays I was medically looked after but it was noticeable that I didn't get checked if I needed any food or drink or needed the toilet, it seemed when you are in the bays staff seemed too busy".*

We recall that WSFT was unsuccessful in recruiting the Patient Safety Partner role in 2023/24, but was "committed to doing so later in 2024/25". There is no [clear] reference to the appointment of this staff role at the Trust within its draft 2024/25 Quality Account.

In terms of performance against the 2024/25 priorities (e.g. 'reduce inequalities in experience for service users through our Experience of care workplan') the Trust notes; "Of our eight measures of success, we completed one, two are on track for completion in early 2025, three will progress towards completion in 2025-26 and two will require a longer-term framework which is scheduled in the Trust's workplan". Healthwatch Suffolk may be able to support WSFT in its intentions to make more progress on such commitments.

We welcome further extensions to the offer for staff to 'speak up' internally. The Staff Networks are likely to be a trusted source of support. We would encourage the Trust to include short testimonials for the Chairs of the four Networks in its Quality Account each year. Pride, REACH (race, equality and cultural heritage), Parent and Carer and Disability would add value to each Quality Account.

It is great to see the many awards and accolades achieved in 2024/25. West Suffolk maintains an exemplary stroke service when compared regionally and nationally, as is hip fracture care (best in England and Wales). The new Newmarket Community Diagnostic Centre (CDC) saw an impressive 6,000 patients and carried out more than 8,800 scans in its first 100 days.

In seeking to improve quality and safety, we welcome the Trust's introduction of Call 4 Concern (C4C), and we noted the launch in a news item at the time. This public patient safety initiative allows inpatients and their loved ones to call for immediate help if they are worried about their condition deteriorating. We also welcome the Trust's Patient Portal, introduced in 2024, offering patients a better experience in managing their health online.

The overall Care Quality Commission (CQC) rating remains 'requires improvement' with no enforcement action. Core areas of the Trust were last inspected in 2022, and the last trust-wide inspection was in 2019. Of the National CQC patient surveys we particularly note those published in November 2024, on Maternity. The Trust fared 'much better than expected' for the survey question "Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?", and 'somewhat worse than expected' for the question "On the day you left hospital, was your discharge delayed for any reason?".

Adult community services have consistently met the 2-hour urgent community response standard, but the demand for Integrated Neighbourhood Team nursing continues to rise month on month. We note and would like to be informed about the impact of postponing home visits on the delivery of community patient care, which is being monitored by the Trust. In terms of Primary Care access, we congratulate the Trust on the percentage of patients seen within 2 weeks at Glemsford Surgery, now at 99%!

All NHS trusts have delivered their services during times of industrial action, alongside increased prevalences of flu, norovirus and other seasonal illness. We note that these factors have led to the closure of wards and limited WSFT's ability to admit patients who attended ED.

WSFT has recognised 'messages' from its Staff through the 2024 NHS Staff Survey results in its draft Quality Account. Fewer staff responses as compared to 2023 (at 44%), and decreases in 'staff being happy with the standard of treatment provided by the organisation if friends or family needed treatment', now equivalent to the national average, decrease in 'recommending the organisation as a place to work' from 65% to 49%, with the national average standing at 59%. The Trust's most declined scores are 'the organisation takes positive action on health and well-being' now at 41% (national average 55%), and 'would recommend organisation as place to work' now at 49% (national average 59%). Of particular note to Healthwatch Suffolk are 'care of patients/service users is organisation's top priority' that has declined from 76% to 63% (national average 72%) and 'organisation acts on concerns raised by patients/service users' now at 57% (national average 69%).

The Trust's most improved scores are, 'don't work any additional paid hours per week for this organisation, over and above contracted hours' now at 74% (national average 64%) and 'not felt pressure from manager to come to work when not feeling well enough' now at 80% (national average 78%).

We also note that improvements will be required in support of “BME” staff, under the Workforce Race Equality Standard (WRES). Indicator 6 (harassment and bullying) has an increase in the percentage of staff experience such behaviour from 25% to 30%, as compared to 2023/24, and both “White” and “BME” staff feel less confident that the Trust provides equal opportunities for career progression or promotion, both percentages being roughly 5% below the average for acute trusts.

Is there anything to share from the Trust’s newly adopted Schwartz Rounds for 2024/25?

It must be a huge relief to have completed the final phase of the work to refurbish the RAAC planks, as is the news that the ‘new hospital’ (future systems) programme remains on track now that Government confirmed WSFT’s submission will remain in the first wave of projects nationally. This is particularly good news because of the substantial financial deficit the Trust is addressing over the coming few years.

We welcome news of improved waiting times in WSFT’s ED in March, when the Trust achieved 88% performance against the national 4-hour standard. We hope such progress remains achievable in 2025/26. There was also very good progress to note on the early detection of cancer and reducing waiting times for patients with cancer. At the end of March 2025, 83.2% of patients were treated within 62 days, this is above the national requirement of 70% for 2024/25 and 79.1% of patients had cancer ruled out or confirmed within 28 days, also above the national requirement of 77% for 2024/25. The Trust continues to retain its Sentinel Stroke National Audit Programme (SSNAP) top-grade A ranking, something that has been achieved for more than five years. We welcome news that the Trust now has a partnership contract in place to deliver an early supported discharge service (up to 6 weeks) for stroke patients across Suffolk.

We believe the Trust and its patients will benefit from the introduction of its new cloud-based risk management system (Radar) in 2024/25, enabling multidisciplinary reporting of patient, staff and organisational incidents. The second ever Patient Safety Summit has led staff to agree on a theme they would like to see taken forward as a safety improvement project, namely “Getting it right for patients and staff - place, service, pathway”. We also welcome the Trust adopting the Seven Day Service for both the Emergency Department and Inpatients across a wide range of clinical areas to manage weekend admissions and discharges.

News of WSFT clearing a large backlog of referrals for autism assessments in school age children up to the age of 11yrs will have been a huge relief to the relevant families. We acknowledge that the paediatric team is receiving unprecedented levels of referrals for autism assessments within the school age pathway and that it is currently working with the ICB and the mental health trust to consider the model for neurodevelopmental assessment in the future. Healthwatch Suffolk would be happy to collaborate on such a venture, should that be considered helpful.

We note that the average time to complete the verbal Duty of Candour was six working days, while the average for the written of duty candour was 11 days. The largest incident category requiring duty of candour was pressure ulcers, which is not unlike previous years’ outcomes.

WSFT will have welcomed receiving more compliments (666) as compared to the previous year (nearly 600).

WSFT received 204 formal complaints during 2024/25, the highest number recorded since 2019/20, but with a very welcome high 93% first-time resolution rate. Only one complaint was referred to the PHSO and following investigation this was found to not be upheld. Of the two cases referred to the PHSO in 2023/24, one was not upheld. The other was partially upheld by the PHSO and we note that the recommendations have been completed.

Four out of the six top categories of complaints have remained the same since the previous year, but we note that clinical treatment in the emergency department, and appointments, are now amongst the highest subjects for formal complaints in 2024/25. Communication remains the top category of concern

and the number of complaints has increased from 28 in 2023/24 to 40 in 2024/25.

Relevant complaints examples about communication shared with Healthwatch Suffolk by patients and families include; *"How can I tell the hospital that I am not online, but would prefer a paper copy of communication or send a text, this seems to be an ongoing admin issue, if they could just get this bit right I am happy with everything else".* Another came from a nonagenarian cancer patient who described the following; "I was diagnosed with prostate cancer 1 year ago, the attitude of the consultant was rude and so I went to PALS and I got a new consultant and an apology; the hospital handled it well".

As well as responding to and seeking to learn from individual complaints, we note that WSFT identifies themes and trends from local complaints and national publications such as the PHSO. Examples given of such learning outcomes concern communications between staff, patients and relatives, changes in visiting times for birthing partners, additional training for midwives on tongue ties assessments, additional equipment provided to ward staff to improve pressure area care, and a recommendation for Staff to undertake Oliver McGowan training.

Tongue-tie is of interest to us because of the recommendations WSFT adopted following our report in 2018 and the impact it has had. We have one suggestion regarding the Oliver McGowan entry, which has been highly praised by the ICB's Medical Director Dr Andrew Kelso; rather than a recommendation, would this be more impactive were it to be 'required training' for key staff and clinicians?

It is great to know that the Trust's volunteer team organises opportunities for young volunteers at the hospital and including clinical shadowing.

With regards to 'learning from deaths', we note that four (0.38%) of the 1,048 patient deaths during the reporting period are judged to more likely than not have been due to problems in the care provided to the patient. An example of the learning themes from case record reviews and investigations is one about communication between healthcare staff and patients and relatives or carers/loved ones continues to be an area that requires improvement. The Trust has discovered that some mortality reviews have highlighted that family members have been shocked when their relative has died so quickly, despite the patient following a poor trajectory. Clinical staff are being encouraged to use phrases such as "your relative is sick enough to die" and to convey a clear message when having difficult conversations.

We also note that extended wait times in the emergency department "continues to be a national and organisational concern. This results in more patients dying in the department itself rather than on a ward". We welcome the fact that WSFT has listened to families e.g. "Relatives' commented that a side room or quieter area would have improved the care they felt their relative received at the end of their life".

Overall, the Trust has achieved much considering the challenges it, and its partners, have faced during 2024/25 as described in the Quality Account. We have previously invited the Trust to focus more on analysis and outcomes, rather than description and inputs. This year's report reflects a continued such shift, and we are appreciative of this.

Andy Yacoub
Chief Executive

Wendy Herber
Independent Chair

Annex D: Statement of directors' responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement previously issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality accounts.

In preparing the quality accounts, directors are required to take steps to satisfy themselves that:

- the content of the quality accounts meets the requirements set out in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations and supporting guidance
- the content of the quality accounts is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2024 to June 2025
    - papers relating to quality reported to the Board over the period April 2024 to June 2025
    - feedback from SNEE ICB, clinical quality team dated 6 June 2025
    - feedback from Suffolk Health Scrutiny Committee dated 22 May 2025
    - feedback from Healthwatch Suffolk dated 4 June 2025
    - feedback from WSFT governors dated 14 May 2025
    - the Trust's annual complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the latest national patient survey
    - the latest national staff survey
    - the Head of Internal Audit's annual opinion of the Trust's control environment
    - CQC inspection report.
- the quality report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the quality report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Jude Chin
Chair
20 June 2025

Dr Ewen Cameron
Chief executive
20 June 2025

Annex E: Glossary

Clostridium *difficile*	C. difficile is a spore-forming bacterium which is present as one of the normal bacteria in the gut of up to 3% of healthy adults. People over the age of 65 are more susceptible to developing illness due to these bacteria. C. difficile diarrhoea occurs when the normal gut flora is altered, allowing C. difficile bacteria to flourish and produce a toxin that causes a watery diarrhoea. Procedures such as enemas and gut surgery, and drugs such as antibiotics and laxatives cause disruption of the normal gut bacteria in this way and therefore increase the risk of developing C. difficile diarrhoea.
Confidential enquiries	These aim to assist in maintaining and improving standards of healthcare for the benefit of the public (such term to include members of the public for the time being serving a term of imprisonment) by reviewing the care of patients, by undertaking confidential surveys, and by publishing and generally making available the results of such activities.
CQC	The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. The CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish findings, including performance ratings to help people choose care.
CQUIN	The Commissioning for Quality and Innovation (CQUIN) payment framework enables our commissioner to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.
HSMR	Hospital standardised mortality ratio (HSMR) is calculated as a ratio of the actual number of deaths to the expected number of deaths among patients in acute care hospitals. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate; greater than 100 suggests that the local mortality rate is higher than the overall average; and less than 100 suggests that the local mortality rate is lower than the overall average.
NHSE	NHS England (NHSE) is the sector regulator for health services in England.
MRSA	MRSA (*Methicillin Resistant Staphylococcus Aureus*) is an antibiotic-resistant form of a common bacterium called Staphylococcus aureus. *Staphylococcus aureus* is found growing harmlessly on the skin in the nose in around one in three people in the UK.

NCEPOD	National confidential enquiry into patient outcome and death (NCEPOD). NCEPOD promotes improvements in healthcare. It published reports derived from a vast array of information about the practical management of patients.
PROMs	Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre- and post-operative surveys.
Schwartz Rounds	The scheme, called Schwartz Rounds allows NHS staff to get together once a month to reflect on the stresses and dilemmas that they have faced while caring for patients.