NHS
West Suffolk
NHS Foundation Trust

Quality accounts

2025/26

Compassionate care,
healthier communities

Contents

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

Chief executive's statement

Welcome to the 2025 Quality Accounts for the West Suffolk NHS Foundation Trust, a year that has been marked by progress at our Trust against a background of significant change in the NHS.

In the autumn we launched a refreshed Trust Strategy 2025 to 2028, which will guide us over the next three years as we continue the vital work of enhancing the quality of our services. This has the vision to support and develop a healthier West Suffolk where compassionate care helps everyone to thrive. Its five ambitions, powered by our FIRST values of Fairness, Inclusivity, Respect, Safety, and Teamwork, are:

- High quality care
- Joined-up services
- Empowered to improve
- Responsible with resources
- Fit for tomorrow.

The ambitions and priorities are designed to create positive health outcomes for our communities, ensure resources are used sustainably, and strengthen joint working with local community leaders. This is key if we are to fully deliver the promise of our plans for the new West Suffolk Hospital and the Future System that will deliver the right care in the right place for our whole community.

Our new strategy is informed by the Government's 10-Year Health Plan for England, which was published in July 2025 and is aligned to three shifts in the way the NHS works and the care it provides:

- Hospital to community
- Analogue to digital
- Sickness to prevention.

These are ambitious goals, but they reflect the transformation we have been developing and delivering across the organisation. With evolution in the NHS at local, regional and national level – not to mention the shifting expectations of our partners and patients - we need to embrace the opportunities that come from change.

The Trust's teams have achieved across the board on our national targets, delivering the 5% improvement in referral to treatment, the 28-day faster diagnosis standard and 62-day treatment standard for cancer. The Trust has also made significant diagnostic performance improvements, and achieved the 78% 4-hour standard in our emergency department.

Having been in tier 1 for cancer services early last year due to staff sickness and a temporary reduction in activity within high-volume pathways, we improved to tier 2 in April 2025. Our cancer services are achieving against their targets almost across the board, and we have exited tiering for cancer altogether, a remarkable turnaround achieved by this service in just one year.

Other notable achievements during the year included a high ranking for hip fracture care in the National Hip Fracture Database and praise from cancer patients through the Cancer Patient Experience Survey. We have also performed well when surveyed for the training we provide to our foundation and resident doctors, alongside gaining teaching partner status from the University of Cambridge.

Last summer NHS England launched the National Oversight Framework, which aims to take a consistent approach to assessing the performance of NHS providers. In the first quarterly report the WSFT was in a disappointing 90th place but, by the second report, we had risen to 57th - a much fairer reflection of the quality of care we provide. While we will remain in segment three of the four-tier framework as long as we have a financial deficit plan, we should still strive to improve and consolidate our position in the years ahead.

The 2025 NHS Staff Survey brought some positive news, in that our scores improved for 59 of the 99 questions asked, with 19 of those showing significant improvements. There were positive trends around managers and speaking up, but concerning results around burnout and career development. We know there is work to do, particularly for our staff who have disabilities, and we are committed to tackling this so we can offer fulfilling careers to all.

Our colleagues continue to show amazing loyalty to the NHS, often giving a whole life's work of service to our community – long-service awards of 40, 45 and even 50 years are not unusual. Our peer-nominated Putting You First awards continue to share how our people go above and beyond in their compassionate and skilled care for others – from our porters to our digital services, nurses to doctors, educators to our selfless volunteers.

All this has been accomplished while dealing with challenges including strikes by resident doctors, and a winter season that saw an increase in flu and norovirus. Our community vaccination team did sterling work delivering vaccinations against seasonal illnesses to both our staff and members of the public.

We continue to look to the future, including plans for the further development of the Community Diagnostic Centre (CDC) at Newmarket Hospital, which has brought such improvements in care for our patients, closer to home. We have made important progress in plans for the new hospital in Bury St Edmunds, including engagement on the detailed design of the development, and the submission of the Reserved Matters planning application.

The plans for our estate will be informed by the Green Plan 2025-2029 we launched in November, which details the steps we will be taking to become more sustainable and improve the health and wellbeing of colleagues, patients, visitors and our local communities.

In its biggest ever appeal, our My WiSH Charity has launched a £1 million fundraising appeal to power state-of-the-art robot-assisted surgery to west Suffolk. Being able to deliver this advanced technology will greatly benefit our patients and help us attract, train and retain the best clinicians.

My WiSH Charity marked its 30th anniversary in September, an opportunity for us to celebrate its enormous contribution to enhancing patient care and support for our staff. We also value the generous donations of The Friends of West Suffolk Hospital – and of course, the amazing support of our community in fundraising, donations and legacies.

Having appointed our chief finance officer and chief people officer to their permanent roles, we now have a fully substantive executive team. This is an important element of how we develop going forward, giving us stability as we strive to maintain the momentum of all we have achieved, together.

As a leadership group, we provide both the direction and support needed to become a modern and sustainable provider of high-quality care. A key aspect of this work is balancing the books.

Colleagues from every part of the Trust have made significant contributions to the improvement in our financial position, and we are now ahead of our targets to reduce our deficit, with the aim of breaking even by March 2028.

Thanks to these collective efforts, our financial focus is shifting from reducing our costs to improving

our efficiency and productivity – working ‘smarter’, not necessarily harder, so we can do more with what we have.

We still have a significant financial challenge ahead but there is a clear plan to meet it, which includes balancing cost reductions with income we can generate from uplifts in productivity. We continue to explore how more efficient and effective ways of working can enhance the services we provide, and I believe our commitment to continuous quality improvement will be transformative in the years to come.

This Quality Account will 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 priority

- Improve the safe and secure storage of medicines.

Clinical Effectiveness priority

- Implement the sequential steps of the National Safety Standards for Invasive Procedures (NatSSIPs 2) for all invasive procedures across the organisation.

Patient Experience priority

- Aim to meet reasonable adjustments digital flag (RADF) standards.

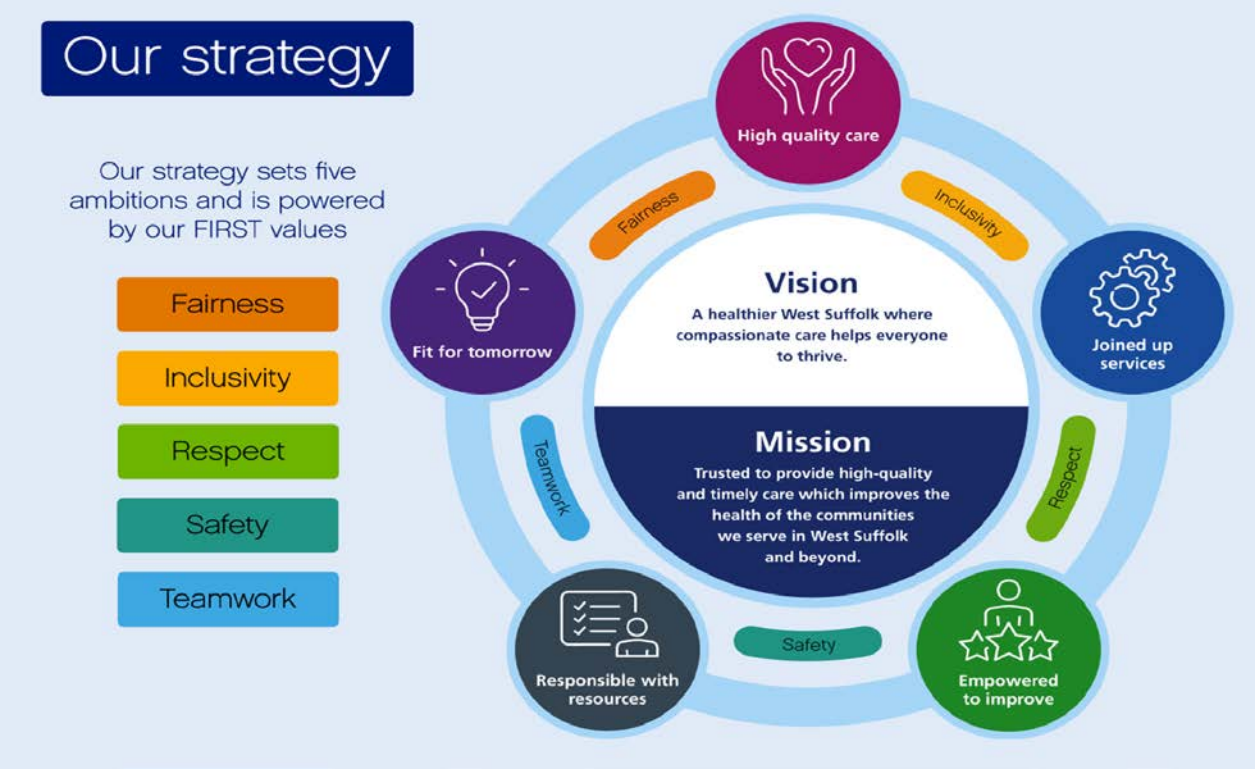
I can confirm that to the best of my knowledge the information contained in the quality report 2025-26 is accurate and has received the full approval of the Trust Board.

Dr Ewen Cameron
Chief Executive Officer
23 June 2026

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.



The image above captures our vision, mission, values, and strategic ambitions for 2025-2028. In 2025-26 the Trust refreshed and formally adopted a revised strategy year which adopts the Department of Health & Social Care's new 10-year Health Plan with its 'three shifts', namely: (i) moving care from hospitals to communities; (ii) from sickness to prevention; and (iii) from analogue to digital. The new strategy has one vision and mission, five ambitions, with each ambition having three strategic priorities all centred around our FIRST values. These include:

- **High quality care**:
  - Improve access, experience, and safety of services
  - Achieve improvements in the greatest health inequalities
  - Embed CQI in everything we do.
- **Joined-up services:**
  - Provide more care closer to home through transformed hospital and community services
  - Create new models of preventative care with our partners
  - Work closely with our partners to create the conditions for success.
- **Empowered to improve:**
  - Nurture a safe, high performing, and inclusive culture
  - Proactively support colleagues' health, wellbeing, and development
  - Strengthen leadership to foster autonomy, accountability, and ensure staff feel valued.
- **Responsible with resources:**
  - Achieve a long-term sustainable financial position
  - Instil shared responsibility for managing all our resources wisely
  - Make efficiency and productivity improvements.

- **Fit for tomorrow:**
    - Accelerate the adoption of technology to enhance our services
    - Improved access to data to enhance decision-making
    - Modernise the way we work to free up time for colleagues.

While the strategy has been crucial in setting the Trust's direction, signalling intent to stakeholders, and galvanising priorities, the next phase in 2026-27 is to ensure the Trust's delivery mechanisms and suite of enabling strategies are structured in a way that maximise our potential to enhance quality for the benefit of all who use our services.

Our vision and priorities align with our alliance partners. The Trust has been an active member in the SNEE Integrated Care System (ICS) through membership of the Integrated Care Partnership (ICP), Integrated Care Board (ICB), and through the West Suffolk Alliance (WSA). Through these groups, the Trust works closely with several public, private, and Voluntary, Community, Faith, and Social Enterprise (VCFSE) stakeholders to progress the development of services for the benefit of the populations we serve.

We worked particularly closely with the SNEE ICB and look forward to developing similar close relationships with the newly created Norfolk & Suffolk ICB throughout 2026. We will also continue working with: Suffolk County Council (SCC), the Suffolk GP Federation, and Primary Care Networks (PCNs). We have valued the relationship we have developed with Healthwatch, which is now known as Knowing Works Community Interest Company. We also engage with a wide range of other important local partners, such as the University of Cambridge, West Suffolk Council, and Abbeycroft Leisure as part of the delivery of services.

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 the divisions' top risks which may affect quality and 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 its assurance committees. As part of the Board's continuous development and search for improvement, reflecting on emerging risks specifically around cyber security, the Board decided in the last quarter of 2025-26 to strengthen its line of assurance by adding a fourth assurance committee focusing specifically on aspects relating to digital and data assurance. This committee reports quarterly to the Board and supports the work of the other three assurance committees of the Board. Together these committees ensure quality is delivered in a coordinated way to support safe, effective and patient-focused healthcare. As highlighted below each assurance committee provides a focus on digital and data, finance, operations, culture, patient and staff safety and quality:

- **Finance & Performance Committee** with a focus on operations, finance and organisational risk
- **People and Organisational Development Committee** focusing on making sure the Trust is engaging and involving people who use the services, the public, the staff and external partners to support high quality sustainable services and organisational development
- **Quality & Patient Safety Committee** with a focus on ensuring there is a culture of high quality, sustainable care and robust systems for learning, continuous improvement and innovation
- **Digital and Data Committee** focusing on reviewing areas of future development as technology and business intelligence opportunities emerge to facilitate technology enabled change

At an organisational level, the Quality and Patient Safety Committee receives updates from specialist groups focusing on quality, safety and clinical effectiveness at topic level with examples such as NICE compliance, falls, pressure ulcers, nutrition, medicines management, infection prevention and safeguarding. 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

Continuous Quality Improvement (CQI) is a Trust strategic priority. The Trust is committed to embedding CQI methodology into all of our workstreams. CQI activity spans frontline teams, divisions and Trust-level priorities.

In 2026-27, the CQI team will focus on strengthening the enabling infrastructure, governance and capability required to support consistent and effective improvement over time. This includes early design, alignment work and ensuring a shared approach to improvement across the enabling strategies portfolio.

Quality priorities for 2026-2027

Our quality priorities have been developed to support our ambition to deliver high quality services and the best possible experience for our patients. The quality priorities have been informed by insight which has been escalated through our governance structures and by listening to what our partners, community and staff tell us.

Patient safety priority

- Improve the safe and secure storage of medicines

Clinical effectiveness priority

- Implement the sequential steps of the National Safety Standards for Invasive Procedures (NatSSIPs 2) for all invasive procedures across the organisation

Patient experience priority

- To meet reasonable adjustments digital flag (RADF) standards

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, through the relevant governance oversight arrangements.

Patient safety priority:

Improve the safe and secure storage of medicines

Why is this a priority?

The safe and secure storage of medicines at the patient's bedside is a known patient safety issue within the organisation and we have a legal and regulatory requirement to be able to meet acceptable standards.

The inability to safely store patients' own medicines at the bedspace has multiple known risks to both patients and staff, including the potential for misappropriation, missing medication requiring resupply, or the potential for missed and delayed doses resulting in adverse patient outcomes and complaints.

What is our target?

To reduce the amount of medication safety storage incidents and improve audit compliance with securing medicines safely.

What will we do to improve our performance?

We will increase our colleagues' understanding of the requirements to store medicines safely, apply systems thinking to consider alternative ways of working, and give colleagues additional facilities to be able to store medicines safely.

How will we measure success?

We will see a reduction in medication safety storage incidents and improved audit data.

How and where will progress be reported?

Progress will be reported via the medication safety group to the Drugs and Therapeutics committee and the Quality Delivery Group (QDG). *Formerly this committee was called Patient Quality and Safety Governance Group (PQASG).*

Clinical effectiveness priority:

Implement the sequential steps of NatSSIPs 2 for all invasive procedures across the organisation

Why is this a priority?

In January 2023, the Centre for Perioperative Care published revised National Safety Standards for Invasive Procedures (NatSSIPs 2), which have been designed to reduce safety errors and improve team cohesion*. NatSSIPs2 has organisational standards for people, process and performance, supported by eight sequential steps**.

To date there has been good adoption of NatSSIPs2 within our surgical footprint, however we want to ensure these standards are fully embedded across the organisation to ensure patient safety and clinical effectiveness for all patients having an invasive procedure.

What is our target?

To fully adopt the organisational standards and sequential steps for safe invasive procedures across the organisation where all invasive procedures are undertaken.

What will we do to improve our performance

Develop a consistent trust wide approach which can be monitored by record keeping on our electronic patient record. The compliance data will be monitored and reviewed at a newly developed Safer Procedures Group.

How and where will progress be reported?

Progress will be reported to the Clinical Effectiveness Governance Group on a quarterly basis, reporting upwards to the Quality and Patient Safety Committee.

*NHS England » National safety standards for invasive procedures (NatSSIPS)

**National-Safety-Standards-for-Invasive-Procedures-2-NatSSIPs-2023.pdf

Patient experience priority:

Aim to meet reasonable adjustments digital flag (RADF) standards

Why is this a priority?

The Equality Act (2010) places a legal duty on all health and care services to make changes to their approach or provision to ensure that services are as accessible to people with disabilities as they are for everyone else. This duty aims to address the recognition that people with a disability may appear to have equal access to care and services, but without specific adjustments being made, that access may not be equitable. Ensuring that patients with disabilities have their disabilities and any reasonable adjustments discussed and recorded centrally for better joined up care and enhancing patient experience. NHS England has now made this mandatory for all qualifying providers.

What is our target?

Ensure we are fully compliant on the standards for the reasonable adjustments digital flag by 30 September 2026.

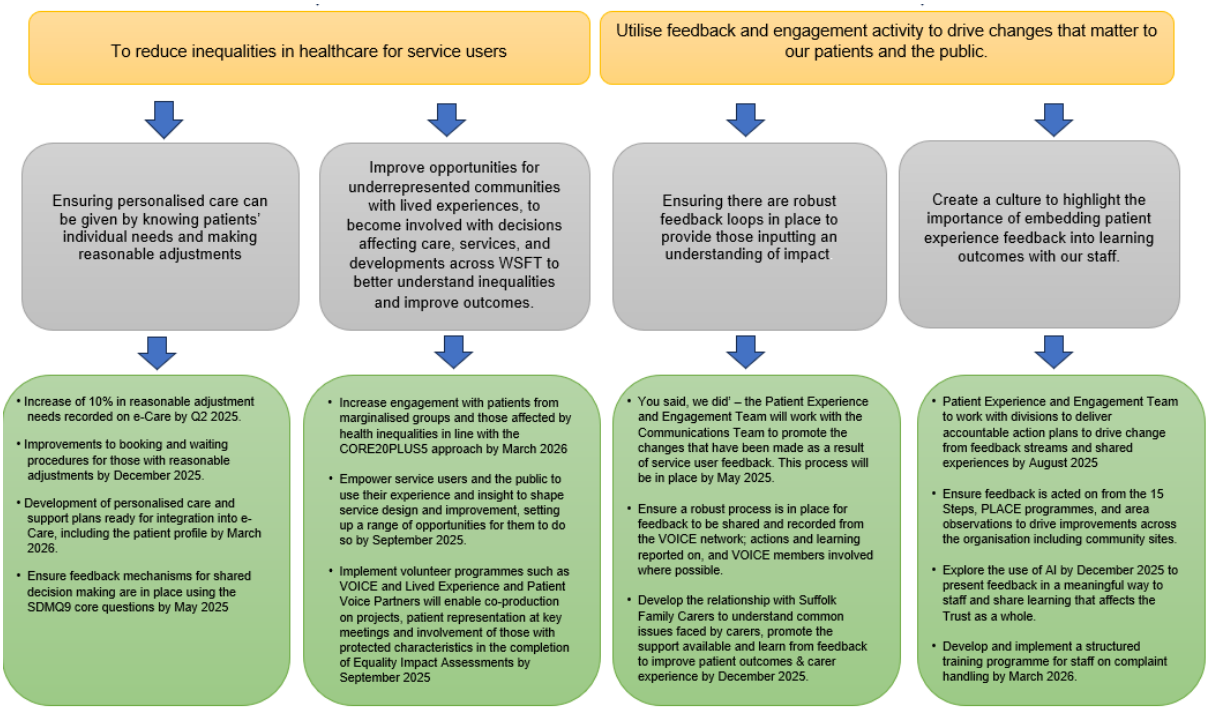
What will we do to improve our performance

Until the Reasonable Adjustments pilot launched in January 2026, neither impairments nor reasonable adjustments were being consistently recorded. Establishing a baseline of how many patients currently have a disability recorded on e-Care and SystemOne will enable us to track improvements in the recording of adjustments and, through ongoing patient engagement, understand the impact this has on patient experience.

Alongside this, we will work closely with key stakeholders across the Trust and community sites to promote the e-Learning for Healthcare RADF training, share patient stories, and provide support to staff as they embed this work into their practice.

How and where will progress be reported?

Quarterly performance updates will be a standard agenda item at the Experience of Care and Engagement Committee (EoCEC) reporting to the Quality and Patient Safety 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 2025-26, 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 2025-26 was **£419.0m**, which represents **92.0% of the total income** generated by WSFT for 2025-26.

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 2025-2026, a total of 55 national clinical audits, including national confidential enquiries were

applicable to the services provided by WSFT. Of these WSFT participated in 90% of the relevant national clinical audits and 100% of national confidential enquiries in which it was eligible.

Five national clinical audits were not undertaken due to organisational capacity constraints within the relevant departments. Non-participation in these audits was formally escalated through the Clinical Effectiveness Governance Group (CEGG) and individual risk assessments were completed for each audit to evaluate any potential impact on the wider organisation.

For the 2026-2027 financial year, WSFT is implementing more robust processes to strengthen participation in national clinical audits. This includes earlier identification of audits that should be participated in, improved oversight and reporting to the divisions to enhance awareness of any capacity or resource challenges and how these might be addressed.

39 national audit publications relevant to WSFT services were issued in 2025-2026. Throughout 2025-26, the clinical audit and effectiveness team experienced a period of reduced capacity due to staff vacancies and an organisational consultation and restructure.

In late 2025, appointments were made to the team and since that time a review of clinical audit processes and associated governance arrangements has been undertaken. This work has focused on strengthening systems and processes to better evidence learning, action planning and service improvement following participation in national audits.

Going forward the team intends to implement a clear and robust process for the monitoring, implementation and assurance of actions identified through national audit publications.

Research and development

Research and development is at the centre of improving health and care for the population that we serve. Research provides the evidence base that underpins continuous improvement in patient pathways, safety and outcomes. The ambition to embed research into everything that we do in healthcare and not as an extra is key to providing high quality, efficient and equitable care in the future. Embedding research enables teams to test, learn and refine practice, strengthening our culture of continuous quality improvement. 442 patients receiving relevant health services provided or sub-contracted by WSFT, were recruited during 2025-26 to participate in National Institute for Health Research (NIHR) portfolio or commercially adopted research studies approved by the research operational committee.

Our vision is to become a research active organisation where every patient has the opportunity to participate in high quality research. A research-active organisation is one that continuously tests, learns and improves care for every patient. Participation in research strengthens our improvement capability and drives better outcomes.

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,

fully reviewed and updated in April 2026, including completion of and Equality Impact Assessment (EIA) 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.
- **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 champions promote speaking up within their teams and networks, and they support and signpost staff wishing to speak up. Services are regularly advertised in regular internal communications including the fortnightly 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 Week 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

During 2025–26, the Trust worked closely with its commissioners to agree a set of shared quality priorities focused on improving patient outcomes, experience and safety.

These priorities were embedded within the NHS Standard Contract and supporting system plans and reflected both national expectations and local population needs. Key agreed areas of focus included:

- **Improving access and timeliness of care**, particularly across elective, diagnostic and cancer pathways
- **Strengthening patient safety and learning**, including the continued implementation of the Patient Safety Incident Response Framework (PSIRF)
- **Improving quality and equity of care**, with a focus on reducing unwarranted variation in outcomes and experience
- **Supporting integrated and community-based models of care**, working collaboratively with partners across the local health and care system
- **Embedding a culture of continuous quality improvement**, supported by robust governance and shared oversight arrangements.

Progress against these agreed goals has been overseen through established contract management, quality governance and system partnership forums throughout the year, with regular engagement between the Trust and commissioners to review delivery, address risks and support improvement. There are also regular meetings with Suffolk GPs as part of clinical interface and with South Norfolk GP's (Breckland Alliance) to share service observations, learning and to understand Service improvements.

What others say about us

The Trust maintains 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 the Trust has not undergone a formal trust-wide inspection since 2019, we have sustained a proactive relationship with the CQC. This has included consistently sharing emerging risks and providing timely, comprehensive responses to all queries raised by the regulator.

	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

Glemsford GP surgery, while still part of WSFT at the time during 2025-2026, maintained a CQC rating of 'Good' during its inspection in June 2025.

The WSFT acknowledges that the CQC has introduced a revised assessment framework since our last inspection. As this framework continues to evolve through consultation, the Trust will maintain its close engagement with the regulator. We anticipate a future inspection under the new regime and welcome the opportunity to demonstrate how the organisation is working towards achieving a 'Good' rating.

Awards and accolades

In October 2025 we launched a refreshed West Suffolk NHS Foundation Trust strategy - *Compassionate care, healthier communities*. The three-year strategy has five ambitions and is underpinned by our FIRST values – Fairness, Inclusivity, Respect, Safety, and Teamwork. Each of the ambitions has strategic priorities and, in this section, we report some of the ways we are striving towards meeting those goals.

Our ambition – High Quality Care

The strategic priorities:

- improve access, experience, and safety of services
- achieve improvements in the greatest health inequalities
- embed continuous quality improvement in everything we do.

Faster diagnosis closer to home: The Newmarket Community Diagnostic Centre (CDC) has been caring for patients since December 2024 but was officially opened in May 2025. In its first year, the CDC saw 37,696 patients and performed 43,693 investigations, significantly reducing diagnostic waiting times. This positive trend has continued and further developments at the site will bring further improvements.

Lung screening programme and smoke-free: We are taking part in the targeted lung cancer screening being rolled out across England by the NHS, which screens people aged between 55 and 75 who have ever smoked. The screening programme is aimed at identifying early-stage lung cancer, giving people a better chance of living longer. We work closely with primary care on this initiative, an example of system working bringing improved care and health outcomes for our community.

Respiratory health was the focus of specialist talk at our Annual Members' Meeting in October. This year we have also embedded smoke-free practices at the West Suffolk Hospital (WSH), with new signage across the site, an expanded smoking cessation team, and increased support for patients and staff who smoke.

Hip fracture care rated highly: For the second consecutive year, the Trust was recognised as a leading provider of hip fracture care, topping the National Hip Fracture Database (NHFD) rankings in England and Wales. The team achieved an outstanding 95.4 per cent compliance score with the national best practice tariff - nearly double the national average of 48.8 per cent. Collaborative, multi-disciplinary working, innovation and pioneering practice all contributed to the results.

Praise from cancer patients: More than 90 per cent of cancer patients rated the experience of the care they received from us as very good or good, according to the 2024 National Cancer Patient Experience Survey.

Recognition for work on patient flow: Collaborative efforts to improve patient flow and support the improvements made in urgent and emergency care was recognised in the national Proud2bOps awards, where our teams reached the shortlist.

The nomination was for the reset of Ward F7 at WSH back to short stay, a whole team effort with consultants and nursing teams in the acute assessment unit and emergency department identifying appropriate patients, empowering Ward F7 to select the most appropriate people to admit to their ward. This increased the number of discharges and reduced length of stay in hospital.

15 Steps to improvement: Local schoolchildren came to the WSH paediatric ward as part of our Little Steps initiative. This has grown from our 15 Steps initiative, designed to identify potential improvements we can make from observations made within 15 steps of entering the area. The children suggested changes to the ward, including more outdoor activities, photos of the staff on the walls and activities for older children.

Extended visiting hours: To give more choice and flexibility for people to spend time with loved ones receiving care, we committed to expanding visiting hours at our hospitals from 1 April 2026, extending from 2pm-8pm to 10am-8pm.

Our ambition – Joined Up Services

The strategic priorities:

- provide more care closer to home through transformed hospital and community services
- create new models of preventative care with our partners
- work closely with our partners to create the conditions for success.

Newmarket Community Diagnostic Centre: As mentioned already, the CDC has reduced waiting times and provided state-of-the-art diagnostic care in a purpose-built facility close to towns and villages in the west of our locality.

The One Haverhill partnership: Members of our Haverhill Integrated Neighbourhood Team have worked with Wellbeing Suffolk and Abbeycroft Leisure to organise marketplace events focused on health and wellbeing. With good turnout and positive feedback from stallholders and attendees, the events are attracting growing interest in an area with poorer health outcomes compared to other areas.

Services recognised at regional awards: Colleagues were recognised for their excellence and innovation at the Suffolk and North East Essex ICS 'Can Do' Health and Care Awards 2025. The Trust had six nominations across five categories, taking three 'runner up' spots as well as one 'highly commended' and two 'commended' accolades.

The nominations included joint projects with system partners, including Abbeycroft Leisure and Suffolk County Council.

Caring for heart failure patients at home: Collaboration between the Trust's cardiac team, virtual ward, and community nursing teams has supported a care pathway which provides intravenous diuretic treatment at home. This provides a better experience for heart failure patients who would previously have been treated as inpatients.

Vaccination campaign: Protecting NHS staff from seasonal influenza is a priority for the Trust. Our community vaccination team provided the free vaccine to colleagues at times and places to suit them, with more than 52% of frontline staff taking up the offer. The team also provided flu, Covid-19 and respiratory syncytial virus (RSV) vaccines to eligible members of the public, including many of our vulnerable patients. Pregnant women were offered RSV and pertussis vaccines, with excellent take-up – recent national figures have shown the RSV maternal vaccine cuts baby hospital admissions by up to 85%.

Cancer support group: in partnership with local charity Cancer Support Suffolk, colleagues from our cancer services have established a monthly drop-in group for people affected by cancer.

Our ambition – Empowered to Improve

The strategic priorities:

- nurture a safe, high performing and inclusive culture
- proactively support colleagues' health, wellbeing and development
- strengthen leadership to foster autonomy, accountability and ensure staff feel valued.

Continuous Quality Improvement: CQI is being embedded across the Trust, empowering staff to identify issues, make changes, and measure the improvements they are making to deliver the best patient care. As well as supporting many QI projects bringing positive change across our services, we are now training CQI Leaders and Coaches who will further promote QI to their colleagues.

Supporting sexual safety: We have implemented a Sexual Misconduct Policy to protect our staff, patients, and visitors, supported by a communications campaign featuring posters and digital display across the Trust, along with regular communication to staff. We have also developed sexual safety guidelines as a resource for staff, and created an online form where people can safely report sexual misconduct.

International Women's Day events: In March, we marked International Women's Day with in-person and online events, as well as articles from some of our staff network chairs. The talks and sessions covered technology and sexual harassment, resilience and wellbeing, and a panel discussion focused on leadership, overcoming challenges, and celebrating achievements.

Accolades for our education and training: In June, we achieved the prestigious Work Experience Quality Standard Gold Award from NHS England, recognising the opportunities we provide for young people interested in an NHS career.

In October, and for the second year running, the Trust was named T Level employer of the year in the Department of Education's regional 2025 National Apprenticeship and Skills Awards. We are the preferred partner for the West Suffolk College for its health and care T Level students, and the number of students getting work experience at the Trust has doubled in two years.

WSFT is the top performing acute trust in the East of England region in the General Medical Council (GMC) trainee survey, as it has been for the last two years. This reflects the experience of our foundation year 1, 2 and 3 doctors.

Our ambition – Responsible with Resources

Strategic priorities:

- achieve a long-term sustainable financial position
- instil shared responsibility for managing all our resources wisely
- make efficiency and productivity improvements.

Financial turnaround: Thanks to the efforts of staff across the Trust, we delivered our financial deficit plan for the 2025-26 financial year. We had agreed a £20.7m deficit for 2025-26, which was an ambitious target. At the end of March 2026, we had achieved this and put ourselves in a good position for the coming year.

Future plan: Our three-year planned trajectory for our finances has been agreed. This shows how we will steadily reduce our deficit until we are breaking even by March 2028, ensuring we will receive financial support as long as we continue to meet our targets.

Support to manage our finances: With our commissioners, we have moved from a block contract to a model which allows the Trust to earn money from our activity. This will allow us to balance cost saving activity – the focus of the past 18 months - with income earned from productivity improvements.

Transformation of administration: The aim of this work is to improve patient experience, and embed flexibility, resilience and consistency in the way we provide administrative support. We also want to create more fulfilling administrative and clerical careers with more development opportunities, aligned with our Trust strategy.

Developed with the input of our colleagues, the approach will focus on establishing three areas: centralised administration hubs; outpatient reception and health records hub; and central medical resource hub. It is expected to be delivered over the next two to three years, beginning in June 2026 with the central medical resource hub.

Our ambition – Fit for Tomorrow

Strategic priorities:

- accelerate the adoption of technology to enhance our services
- improved access to data to enhance decision-making
- modernise the way we work to free up time for colleagues.

Community Diagnostic Centre expansion: Building on the success of our CDC, which uses the latest equipment to give patients accurate and timely results, we aim to expand the diagnostic services at the Newmarket Community Hospital site.

The proposed expansion would provide endoscopy and children’s audiology services and increase capacity, enabling timely access to these services and helping to address health inequalities.

Surgical robot appeal: A £1million fundraising appeal from My WiSH Charity was launched in March to fund the use of advanced surgical robotics at WSH, enabling surgeons to carry out procedures with greater precision while maintaining the same highly skilled clinical leadership patients expect.

The aim is to provide patients with faster recovery times, shorter hospital stays, and an earlier return home. As well as improved patient care, robot-assisted surgery reduces physical strain on surgeons, modernises surgical practice, and will support the Trust to attract, train, and retain the best clinicians.

Green Plan 2025-2028: This was launched in November, and lays out the Trust's plans for the next four years, focusing on carbon reduction, sustainable care, and climate resilience. With the support of colleagues and establishing system-wide partnerships, many of the plan's aims are already under way.

One objective, the nitrous oxide project which has seen the Trust moving to a portable supply, is already complete. Savings have been made across the triple bottom line – People (improved air quality), Planet (annual saving of 132 tonnes of carbon dioxide equivalent), and Profit (an annual saving of £2,700).

Solar panels: During construction, the CDC, and the main Newmarket hospital building were fitted with 128 solar panels, which have generated more than half of the facility's electricity. This has significantly reduced the carbon impact the facility has, saving a considerable amount of money which can be used in other areas to improve care.

Digital first: In planning for our new hospital, we have engaged the public and staff on a proposed 'digital first' approach. This seeks to embrace the use of technology and its opportunities to improve care, while ensuring less digitally engaged patients do not face barriers to accessing healthcare.

Our new hospital: This project continues to progress, including the signing of the Alliance Agreement, which sets out how the partners involved in the project, such as the Trust and the NHS England New Hospital Programme team, will work together to deliver a new hospital for west Suffolk.

It establishes clear roles and responsibilities, shared principles, and a commitment to collaborative decision-making in the best interests of the programme.

In April, the Trust received additional clarity around the amount of funding we will receive to build a new West Suffolk Hospital - another definitive indication of the Government's commitment to our project.

We are now progressing into the second phase of the planning process, known as 'reserved matters' which focuses on the detailed design of the new hospital, and have submitted this application to the West Suffolk Council.

Ahead of this application, and alongside our coproduction approach, we undertook extensive in-person and online engagement with the public and our staff. We invited feedback on the building heights and appearances, access and transport, and the ecology and landscaping of the project, and this informed our application.

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	**99.8%**	99.8%	99.7%
Outpatient care	**99.9%**	99.9%	99.8%
Accident and emergency care	**98.2%**	-	98.5%

(The above figures cover April 2025 to February 2026 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	**96.9%**	99.4%
Outpatient care	**97.3%**	99.6%
Accident and emergency care	**100%**	99.0%

(The above figures cover April 2025 to February 2026inclusive – taken from NHS Digital)

WSFT's Data Protection and Security Toolkit overall score for 2024-25 was 'Standards Not Met' at the time of publication in June 2025. An improvement plan was submitted to NHS Digital and subsequently accepted. The improvement plan was completed, and the Trust's status was updated to 'Standards Met' in February 2026. The assessment for 2025-26 will not be submitted until after publication of the Quality Accounts.

The Trust reported no data breaches to the ICO in 2025-26. However, in November 2025 a third party reported a data breach to the ICO relating to an incident that occurred in June 2024 involving WSFT's patients. This matter is currently being addressed.

PbR clinical coding external audit

WSFT was not subject to the payment by results (PbR) clinical coding external audit during the reporting period 2025-26.

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	6.2%
Secondary diagnosis	9%
Primary procedure	8.5%
Secondary procedure	13.9%

The audit sample was 370 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.

Performance against 2025-26 priorities

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

To deliver safe care for patients being cared for in temporary escalation spaces

The following describes progress against our agreed delivery measures.

<u>Why was this a priority?</u>

Mounting pressure on the NHS has meant organisations have had to consider how and when it can safely deliver care to all those that require it and have had to adapt environments to ensure patients can access healthcare when they need it. This has meant the introduction of Temporary Escalation Spaces (TES) or corridor care to situate patients whilst they wait for a bed to become available. NHS England is clear that corridor care is unacceptable and must not be normalised. It should occur only

in extremis, for the shortest possible duration, and where no clinically safer alternative exists. The practice is recognised as posing significant risks to patient safety, privacy, dignity, infection prevention and clinical outcomes, as well as having a detrimental impact on staff wellbeing and moral distress.

This situation has been defined as a national crisis and is not unique to WSFT or system partners, however WSFT chose to take this guidance as a quality priority for our patients to ensure we are delivering high quality, safe care even at times of extreme system pressure. To ensure we had good oversight of care being delivered to patients in temporary escalation spaces or corridors we have developed robust governance oversight which has been recognised regionally and nationally.

What was our target?

To deliver safe care for patients being cared for in temporary escalation spaces

Performance measures

- Total temporary escalation space (TES) patients per month (Feb 2025 – March 2026)

- Total number of patients per TES area (Arrive by 9, Emergency Department corridor, Acute Assessment Unit corridor)
- Average length of stay for each area
- Number of days per month TES spaces have been utilised

Quality measures

- Incident data
- PALs enquiries/ complaints received
- Patient harm reviews
- Quality audits to ensure compliance with fundamental standards of care
- Staff and patient feedback

What did we do to improve our performance?

- Implemented a multiprofessional steering group to oversee performance and quality data, led by the Head of Nursing for Medicine, with a robust governance structure and Executive oversight at the reporting sub board assurance committee.

- Nursing and operational staff worked together and explored new ways of working and developed a suite of standard operating procedures (SOPS) to ensure consistency and appropriate placement of patients, reviewing inclusion and exclusion criteria through the Temporary Escalation Spaces and Corridor Care meeting.

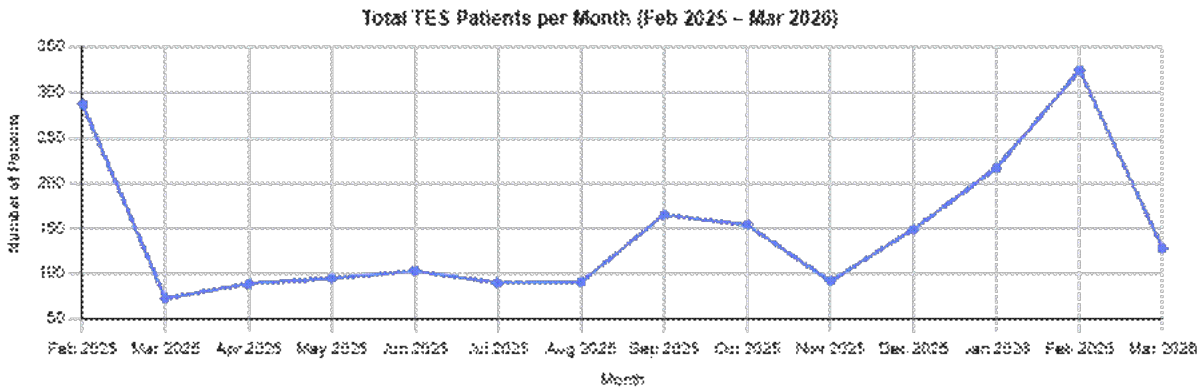
- Risk assessed key patient safety and patient experience indicators when opening TES/Corridor care spaces.

- Developed a suite of communications enabling us to be open with patients who are cares for in temporary escalation spaces, actively seeking feedback on improvements.

- Developed a staff survey to ensure the staff voice was present in decision making for TES/Corridor Care recognising the substantial moral injury for all staff providing care

- As a Trust, our aim is to eliminate the routine use of temporary escalation spaces and corridor care. However, when they are required to maintain patient safety during periods of operational pressure, we ensure that standards of care are upheld. All patients in escalation areas are monitored for safety, experience, and outcomes through our established governance processes.

How did we measure and monitor our performance?



Total TES/Corridor Care usage shows clear seasonal and system-pressure-related variation across the period. February 2025 represents a significant outlier, reflecting a period of norovirus outbreaks, bed closures, and high emergency attendances, which collectively drove increased reliance on escalation spaces.

Following this, TES/Corridor Care usage reduced and stabilised through spring and summer 2025, indicating improved flow and recovery of bed capacity. A further increase is seen during winter 2025-26, peaking in February 2026, consistent with seasonal demand pressures, before improving again in March.

Overall, the pattern demonstrates that TES/Corridor Care continues to be used as a controlled, responsive measure during periods of exceptional pressure, rather than as a routine model of care, supported by strong governance and oversight.

Total performance data indicates that while predictable seasonal pressures have driven increased TES/Corridor Care usage at times, particularly during winter months, evidence shows that escalation remains proportionate, closely overseen, and responsive to emerging risks. This is demonstrated with ED Escalation activity significantly reduced compared with the very high numbers seen last year and Arrive by 9 activity remaining below last year's peak months. Average length of stay is broadly similar between the two years, with no evidence of system deterioration despite lower activity.

Where concerns have been identified most commonly relating to environment or equipment these have been promptly addressed such as call bells for patients.

Incident reporting related to Arrive by 9 and corridor care remains minimal, with low and infrequent numbers recorded over time. Where incidents do occur, a harm review is completed, and no patient harm has been identified. This provides assurance that TES/Corridor Care related incidents are effectively managed and subject to appropriate governance and learning.

We are aware that incident data alone cannot provide assurance of safety and so insight is supplemented with harm reviews, quality audits and patient experience data. Observational audits are led by a Senior Matron and demonstrate that the fundamental standards of care are consistently met for patients cared for in TES/Corridor Care.

What next for 2026?

External assurance and benchmarking: Complete and submit the GIRFT gap analysis and HSSIB audit submission. Current review confirms the Trust is compliant with all HSSIB requirements.

Ongoing quality and safety oversight: Continue to monitor TES/Corridor Care through established governance arrangements, including harm reviews, audits, SPC analysis, and patient experience feedback.

System collaboration: Work with system partners to address upstream factors impacting patient flow and escalation pressures.

Urgent and Emergency Care (UEC) improvement: Progress the UEC stream of work to reduce reliance on TES/Corridor Care, with a clear ambition to eradicate the use of temporary escalation spaces wherever possible.

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?

In line with our strategy to use feedback, learning, research and innovation to improve care outcomes, we aim to reduce inequalities in experience for service users and to utilise feedback and engagement activity to drive changes that matter to our patients and the public

Experience of care measures

- Increase of 10% in reasonable adjustment needs recorded on e-Care by Q2 2025
- Development of personalised care and support plans ready for integration into e-Care, including the patient profile by March 2026
- Ensure feedback mechanisms for shared decision making are in place using the SDMQ9 core questions by May 2025
- Increase engagement with patients from marginalised groups and those affected by health inequalities in line with the CORE20PLUS5 approach by March 2026
- Empower service users and the public to use their experience and insight to shape service design and improvement, setting up a range of opportunities for them to do so by September 2025
- Implement volunteer programmes such as VOICE and Lived Experience and Patient Voice Partners by September 2025
- Ensure a robust process is in place for feedback to be shared and recorded from the VOICE network; actions and learning reported on, and VOICE members involved where possible
- Develop the relationship with Suffolk Family Carers to understand common issues faced by carers, promote the support available and learn from feedback to improve patient outcomes & carer experience by December 2025
- Patient Experience and Engagement Team to work with divisions to deliver accountable action plans to drive change from feedback streams and shared experiences by August 2025
- Explore the use of AI by December 2025 to present feedback in a meaningful way to staff and share learning that affects the Trust as a whole
- Develop and implement a structured training programme for staff on complaint handling by March 2026.

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 four, two are on track for completion in early 2026, and two will progress towards completion in 2026-2027.

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 2026?

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

Progress update

Measures of success	Activities/progress
Increase of 10% in reasonable adjustment needs recorded on e-Care by Q2 2025 and Improvements to booking and waiting procedures for those with reasonable adjustments by December 2025.	Progress on reasonable adjustment work is well underway. A Patient Equity Oversight Group has been established to provide strategic oversight of both measures, supported by dedicated working groups with agreed action plans allocated to key stakeholders. A Reasonable Adjustments policy has now been completed and implemented, ahead of the rollout of the digital flag and reasonable adjustment assessment process. Baseline data is currently being developed in collaboration with the public health team, and a pilot is underway across medical, surgical, and maternity wards to gather feedback and refine the approach. Staff training and engagement have been identified as essential next steps to ensure consistent adherence to reasonable adjustment provision. In line with national requirements introduced in December 2025, which mandate NHS providers to implement the digital flag by 30 September 2026, progress will be monitored through the Experience of Care Committee. Additional support is also being sought from the Quality Improvement (QI) team to embed QI methodology and strengthen delivery and impact.
Development of personalised care and support plans ready for integration into e-Care, including the patient profile by March 2026.	29 patient profiles have been completed since April 2025, 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.
Ensure feedback mechanisms for shared decision making are in place using the SDMQ9 core questions by May 2025	An SDMQ9 survey has been created and promoted via the Trust's communication team. To date, just under 4000 survey responses have been received. The SDMQ9 survey has been promoted via a staff briefing and posters are being printed for display in outpatient areas. Return rates and feedback from these surveys will continue to be monitored.
Increase engagement with patients from marginalised groups and those affected by health inequalities in line with the CORE20PLUS5 approach by March 2026	This engagement work has made significant progress, with recent visits to: ➢ Bury Drop In ➢ Gatehouse ➢ Veterans wellbeing support sessions ➢ Bury Deaf Society VOICE membership continues to grow, with targeted efforts to increase representation from marginalised communities and individuals with protected characteristics. Ongoing relationship-building with these groups remains essential to foster trust and encourage meaningful engagement in discussions about their experiences of accessing healthcare. An engagement plan has been developed to ensure focus on the most relevant communities in relation to health inclusion and inequality, supporting clearer evidence of progress and sustained involvement. This work is ongoing and has now been embedded within the Trust strategy, with specific actions incorporated into the patient experience and engagement workplan to support delivery. In parallel, enabling Trust strategies are being

Measures of success	Activities/progress
	developed and implemented, with health inequalities identified as a key area of focus.
Implement volunteer programmes such as VOICE and Lived Experience and Patient Voice Partners will enable co-production on projects, patient representation at key meetings and involvement of those with protected characteristics in the completion of Equality Impact Assessments by September 2025.	VOICE activity continues to progress, with meetings maintaining good membership from a broad range of community groups who contribute to decision-making and co-production across the Trust. While engagement remains strong, further work is needed to support VOICE members to take a more proactive role, particularly in contributing to Equality Impact Assessments (EIAs). The patient story programme is ongoing, with a continued focus on recruiting lived-experience partners to share their experiences. A Patient Voice Partner role has been developed, advertised, and actively promoted across the Trust, with five partners recruited to date. These partners have been linked into existing projects and have attended key meetings to support collaboration and co-production. In addition, a new engagement toolkit has been developed to support staff leading change across the Trust to work more effectively with patients and local communities, ensuring that engagement reflects genuine co-production.
Develop the relationship with Suffolk Family Carers to understand common issues faced by carers, promote the support available and learn from feedback to improve patient outcomes & carer experience by December 2025.	Engagement and support activity has continued at pace, with 248 discussions and interactions taking place with professionals via email, virtual meetings, and face-to-face contact. Sixty new family carers have been registered during this period, bringing the total number of family carers supported to 83. Capacity has been strengthened through the recruitment of a new support worker (16 hours per week), funded by Suffolk County Council. In addition, a dedicated Patient Voice Partner has been recruited to support work with young carers, focusing on improving how they are identified, recorded, and supported. A young carers webpage has been developed and added to the WSFT website, providing clear information and links to the Suffolk Family Carers young carers team. Further staff training is planned to raise awareness and improve access to referral pathways for support.
Explore the use of AI by December 2025 to present feedback in a meaningful way to staff and share learning that affects the Trust as a whole.	Significant progress has been made in the use of AI across PALS and feedback functions to improve efficiency, quality, and accessibility. PALS is now using AI to support the drafting of responses, including more compassionate wording and the provision of simplified information or explanations for members of the public who require reasonable adjustments. AI has also been introduced to summarise survey feedback and produce reports for a small number of wards, with successful trials within the Gynaecology department, and to support reporting for the Mortality Oversight Group. This has increased effectiveness in analysing and presenting data for reports and meetings and enabled the thematic analysis and summarisation of feedback at scale. An ongoing Quality Improvement trial has demonstrated early results showing a 50% reduction in complaint timeframes. In addition, AI is being used for non-clinical guides and generic documents requiring translation, contributing to a reduction in interpreter and translation costs
Develop and implement a structured training programme for staff on complaint handling by March 2026	A training programme is currently in development to support this work. As part of this process, existing training materials have been collated and reviewed to identify gaps and opportunities for improvement. In addition, training packs have been requested from local organisations and at system level to ensure the programme is informed by best practice and aligned with wider approaches.

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

	2025-26 target	2025-26 actual	2024-25 Target	2024-25 Actual	2023-24 Actual	2022-23 Actual	2021-22 Actual
C. *difficile* - health care associated[1]	81	82	91	83	67	52	37
Ambulance handover within 30 minutes	95%	83.3% (Mar 2026)	95.0%	95.7%			
Maximum waiting time of four hours in ED from arrival to admission, transfer or discharge	78%	78.23% (Mar 2026)	76% (Mar 25)	88.4%	73.95 %	[2]	-
62-day combined referral-to-treatment wait for first treatment - all cancers	70%	79.7% (Mar 26)	70% (Mar 25)	83.2%	76.2%	65.3%	71.5%
28-day faster diagnosis standard (cancer)	77%	76.5% (Mar 26)	77% (Mar 25)	79.07 %	66.4%	67.3%	69.4%
Maximum six-week wait for diagnostic procedures	No target set	86.3% (Mar 26)	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 2026	0	15	0	31			

Positions are at March 2026 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 2025-26. Following positive progress throughout the year, the number of 65-week waits decreased further and although it did not reach the ambition of zero, there were only 15 patients in this cohort at the end of the year.

We also made significant progress on the requirement to reduce 52-week waits to 1% of our total waiting list size, achieving 1.4 % in March 2026 down from 3.4% the previous year, a reduction from 1,223 patients to 422.

Although there was no target for diagnostic tests delivered within six weeks by in 2025-26, capacity constraints specifically in ultrasound, DEXA (dual x-ray absorptiometry), endoscopy and audiology meant that performance deteriorated in the first half of the year. Alongside further increasing activity at the Community Diagnostic Centre (CDC) at Newmarket in Magnetic Resonance Imaging (MRI) and Computed Tomography (CT), additional activity in ultrasound, DEXA and endoscopy has seen the position improve significantly in the second half of the year, and end March 2026 with performance of 86.26% against a forecast of 84%.

Performance remains strong in echocardiography, cystoscopy and urodynamics.

Cancer performance standards were met in March 2026 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 breast and urology, with breast 28-day faster diagnosis improving significantly in Q4, these tumour sites will continue to be a focus in 26/27.

Urgent and emergency care

The four-hour standard within the Emergency Department (ED) has demonstrated sustained month-on-month improvement throughout 2025-26, with performance reaching 78.23% by year end against a target of 78%. This positive trajectory will continue into 2026/27, with a planned year-end target of 82%.

In addition, key Urgent and Emergency Care (UEC) priorities for 2026/27 include a reduction in the number of patients experiencing waits of 12 hours or more in ED, compared to 2025-26 levels. Ambulance handover performance will also remain a focus, with the requirement to maintain an average handover time of 25 minutes.

Delivery of these objectives will be underpinned by the continued implementation and consolidation of workstreams within the UEC Delivery Plan. This will build on progress already made to reduce delays and improve patient flow across the integrated organisation. Key initiatives include embedding the ED Same Day Emergency Care (EDSDEC) model, exploring the development of a Community Same Day Emergency Care (CSDEC) offer, strengthening the use of criteria-led discharge, embedding the GIRFT Model ED guidance and reducing overall length of stay.

Collectively, these actions will support the Trust in eliminating corridor care, improving patient flow, and ensuring timely and safe discharge from hospital.

Stroke services

The national focus, including within WSFT, continues to centre on performance against the Sentinel Stroke National Audit Programme (SSNAP). SSNAP is a major national quality improvement initiative and the primary source of stroke performance data for the NHS. It evaluates stroke care across seven domains and 39 key indicators, covering the entire patient pathway—from admission and acute care through inpatient rehabilitation, community support, and six-month post stroke outcomes.

WSFT delivers a comprehensive acute stroke service encompassing hyper acute, acute, and rehabilitation care. The Trust provides 24-hour access to thrombolysis and thrombectomy, supported by CTAP imaging. During core hours, this service is delivered internally; outside of these hours and at weekends, it is supported by the East of England Stroke and Telemedicine Stakeholder Partnership. Mechanical thrombectomy is provided by Cambridge University Hospital. In addition, WSFT operates a seven day a week TIA service, available 365 days a year.

Over the past 12 months, we have significantly adapted our clinical practice and introduced innovative models of care to respond to changes in SSNAP metrics. While our SSNAP outcomes continue to improve, we have observed fluctuations in scoring due to national metric revisions—for example, KPI 3.2, previously excluded from scoring following last year's update, has now been reinstated in domain calculations. Despite these fluctuations, WSFT remains the highest performing Trust in the East of England and ranks 10th out of 122 nationally, continuing to deliver high quality stroke care in a challenging environment.

WSFT is also one of the few Trusts in the region to provide a 24-hour video triage service in partnership with the East of England Ambulance Service. This supports a streamlined hyper acute pathway, enabling rapid assessment, imaging, and treatment, and ultimately improving patient outcomes.

We hold a contract to deliver an Early Supported Discharge (ESD) service for stroke patients across Suffolk. This service provides up to six weeks of intensive, home based stroke rehabilitation

following hospital discharge, supporting patients to regain mobility and independence. The ESD service is delivered through the Suffolk Alliance—a partnership between WSFT, East Suffolk and North Essex NHS Foundation Trust, and Suffolk County Council—and is further supported by a range of third sector organisations.

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 Integrated Locality Teams cancelling and/or deferring less urgent planned care. The impact of postponing home visits on the delivery of community patient care is being continually monitored. The enhanced demand and capacity requirement have been escalated to the Trust Executive in an aligned business case to mitigate the current position.

Virtual Ward has shown a sustained improvement trajectory to target the 80% occupancy KPI. Patient flow is supported by effective length of stay which is well managed at an average of 8 days. This is significantly below the NHSE target of 14 days. VW audit indicates that this is achieved whilst maintaining appropriate acuity.

The introduction of new target for community 18-week targets within the medium-term planning guidance will be undertaken with a maturity review and action checklist in the following areas prior to introduction of the KPI: -

Action checklist 1: Effective waiting list management

Action checklist 2: Productivity

Action checklist 3: Appointment management

Action checklist 4: Supporting people waiting for community health services

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 continue to be high in the community paediatric medical team and paediatric speech and language therapy service.

Integrated community paediatric services have been actively involved with the recent Suffolk SEND monitoring inspection by OFSTED and CQC and is also a key partner in the SEND Local Area Inclusion Partnership for Suffolk.

The paediatric team continues to receive high levels of referrals for autism assessments in the school age pathway and has responded to the ICB regarding a revised service offer in east and west Suffolk. The team continue to engage with SENCO forums to support appropriate referrals into the team.

Community paediatric audiology team has demonstrated significant improvement in achieving the six-week initial diagnostic assessment target and has also reduced the overall number of children waiting on the caseload. In addition to this the team have provided mutual aid support to other departments in the eastern region to support with waiting timing recovery.

Incident reporting and learning

The Trust's cloud-based risk management system (Radar) was fully embedded throughout 2025-2026 and continued to support 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 remains compliant in its use of the national Learn from Patient Safety Events (LFPSE) system. Further 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 2025-2026 the total number of patient safety incidents reported was 7,187. From that total number, five 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 five PSIIs were commissioned in 2025-2026 according to the following (local and national) categories from our Patient Safety Incident Response Plan (PSIRP).

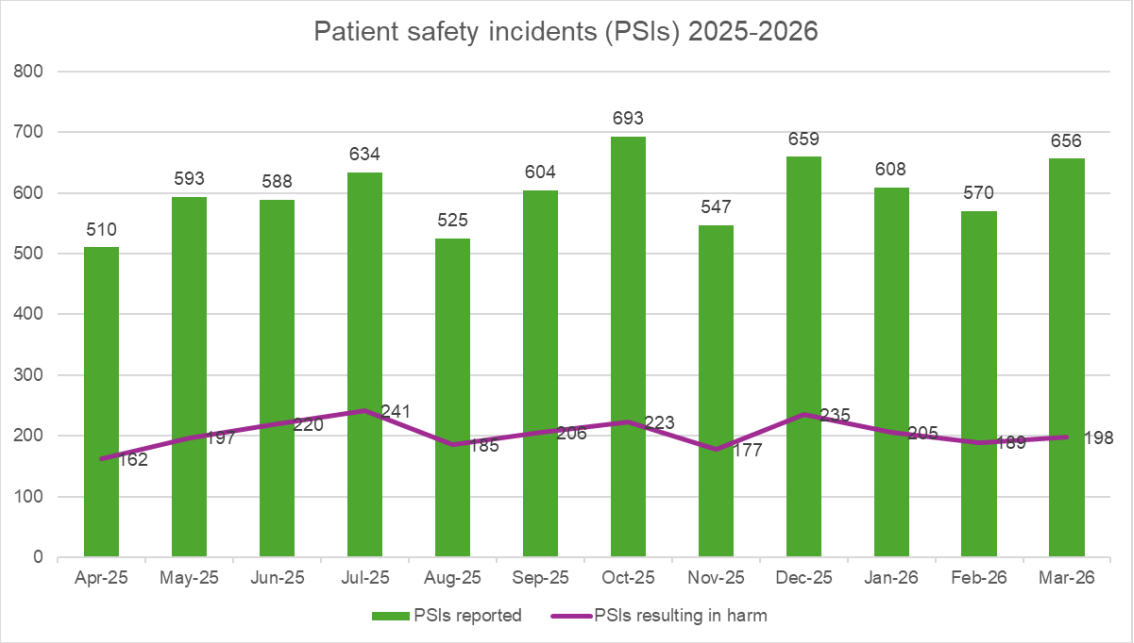
Local	1C. Barriers to effective discharge due to issues in coordination of system	0
	2C. Diabetes, problems with the clinical care/management of diabetic patients when diabetes is not the primary reason for admission to service/hospital	0
	3C. Patient on an end-of-life pathway receiving unnecessary/inappropriate clinical interventions	0
	4C. Barriers to effective inclusivity	1
	5C. Potential for adverse impact on staff wellbeing where fundamentals of care cannot be provided due to staffing challenges	1
	6C. Identified increase in incident of subject theme which has potential for harm	2
National	7C. Never Event	1
	8C. Deaths more likely than not due to problems in care	0

All other patient safety incidents were subject to another method of review. This included local learning documented within our risk management system Radar, as well as centrally coordinated learning responses such as after-action reviews, patient safety reviews, patient safety audits or structured judgement reviews. This approach aligns with the core principles of PSIRF which prioritises system-based learning to drive sustainable safety improvements. To support this, WSFT applies the Systems Engineering Initiative for Patient Safety (SEIPS) model to understand the dynamic system factors influencing events and to inform meaningful improvement.

Patient safety incidents reported

The chart below shows how many patient safety incidents were reported in 2025-2026. The organisation reviews this 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) 2025-2026



Source: Radar
Bar chart comparing total patient safety incidents to harm levels for the 2025-2026 financial year.

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 as per the WSFT PSIRF policy.

Safety actions are formally assigned to a divisional representative and tracked following an investigation pathway using Radar. Automated, interval-based notifications for overdue actions are sent to responsible staff and managers. Action metrics are reported directly to the Patient Quality and Safety committee.

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).

Patient safety actions are managed locally, with clear accountability held by divisional and specialist lead. 2,007 safety actions associated with patient safety incidents were completed in 2025-2026. AFIs identified from the five PSII reports completed in 2025-2026 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)

Following the implementation of our PSIRP on 1st June 2023, we continued to operate under our third iteration during 2025-2026 to ensure we had valuable insight on each of the topics categorised as a local risk. To ensure our safety investigations remain focused on current and high priority patient safety risks, following completion of this activity, we have refreshed our plan for a fourth time for the 2026-2027 financial year and this is awaiting approval form the ICB.

The organisational quality improvement programme for “Getting it right for patients and staff - place, service, pathway – safer handovers”, which was commissioned following a thematic analysis of

areas for improvement undertaken by the patient safety team, continues. Colleagues are initially looking at safer nurse-to-nurse handover form ward to ward by implementing a consistent standard template which ensures critical information is available to staff in a timely and efficient manner to ensure safe, holistic care for our patient.

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 repeat this process of reviewing and theming areas for improvement ahead of the next safety summit scheduled for September 2026 to coincide with World Patient Safety Day.

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 2025-2026, the average time to complete the verbal duty of candour was seven working days, while the average for the written of duty candour was also seven days. The largest incident category requiring duty of candour was pressure ulcers.

Mortality and Learning from Deaths (LFD)

Learning from deaths and mortality review processes:
All inpatient adult deaths (aged 18 years and over) are identified through the Trust’s electronic patient record and recorded on a bespoke mortality database. For adult inpatient deaths, case record reviews are undertaken using the Royal College of Physicians’ Structured Judgement Review (SJR) methodology.

The purpose of the SJR process is to assess the quality of care provided during a patient’s admission when they have passed away, measured against accepted standards of clinical care and treatment. SJRs support organisational learning by identifying where care has been delivered well, alongside opportunities for improvement, including omissions or errors in care processes.

Learning disability and severe mental illness deaths:
Deaths of patients with a learning disability are recorded on the Trust mortality database and reported to the national Learning Disabilities Mortality Review (LeDeR) programme. Deaths of patients with a learning disability and those with a severe mental illness are subject to mandatory SJR commissioning.

Learning and feedback from these reviews are shared through the Mortality Oversight Group as standing agenda items. This includes learning from external reviews and relevant national

programmes, ensuring wider system learning is incorporated into local improvement activity.

Neonatal, stillbirth and maternal deaths:
Neonatal deaths and stillbirths are reported through the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) perinatal mortality surveillance system.

All WSFT stillbirths and neonatal deaths are reviewed locally using the Perinatal Mortality Review Tool (PMRT), or externally by the Maternity and Newborn Safety Investigations (MNSI) programme where cases meet MBRRACE notification and reporting criteria. Learning and findings from these reviews are presented as a scheduled agenda item at the Mortality Oversight Group.

Any maternal deaths are also reported to MNSI for external investigation. There were no maternal deaths during or immediately following delivery in 2025–26. Learning from local MNSI reviews and wider national MNSI findings is incorporated into the Trust's maternity programme of improvement.

Patient safety and mortality:
Where there has been a death, and there is an associated patient safety incident, this is initially classed as fatal and reviewed through the Emerging Incident Review process. This pathway frequently results in the commissioning of an SJR to understand any possible preventability.

Preventability is assessed following SJR using the Hogan et al. (2012) preventability scale. Cases scoring between 4 and 6 are referred for Mortality Peer Review (MPR). Learning and service improvement actions arising from MPR are reviewed and approved by the Patient Safety Panel.

Following MPR, some cases may be referred for a full Patient Safety Incident Investigation (PSII) in line with the Patient Safety Incident Response Framework (PSIRF). Where learning from the MPR process is deemed sufficient and proportionate, further investigation may not be required. Further detail on PSIRF is provided in Section 20.

Engagement with bereaved families:
Bereaved families are offered opportunities to provide feedback on the care received by their relative. This may occur through engagement with the Medical Examiner, the Learning from Deaths reviewer, the Patient Safety Incident Investigator, or the MNSI process. The head of nursing for mortality and deteriorating patient safety provides further opportunity for discussion with bereaved families.

Family feedback is valued as a vital source of learning and is used to support service improvement and enhance compassionate care.

WSFT mortality in 25/26:
During April 2025– March 2026, a total of 1,042 WSFT patients died, including deaths occurring in the Emergency Department at West Suffolk Hospital and across the Trust's community hospitals.

By 31 March 2026, 53 Structured Judgement Reviews (SJRs) had been completed in relation to adult inpatient deaths. As described previously, all deaths of patients under 18 years of age and all maternal deaths are reviewed through separate, dedicated investigation processes in line with national requirements and are therefore excluded from the adult SJR process.

Of the 1,042 patient deaths reported during the 2025–26 period, three deaths (0.28%) were judged to be more likely than not attributable to problems in the care provided, in line with the Hogan et al. (2012) preventability scale.

All three cases were subject to detailed review, ensuring that contributory factors were fully explored and that learning and service improvement actions were clearly identified, implemented, and monitored.

Table to break down total of WSFT deaths in 25/26 period into protected groups:

	Patient deaths						
Quarter	**Total**	**Adults**	**People with learning disabilities**	**People with severe mental illness**	**Under 18-child, neonatal and stillbirths**	**SJRs (adults)**	**Judged Preventable (adults in accordance with Hogan scale)**
Q1 (Apr-Jun25)	249	244	0	1	5	13	0
Q2 (Jul-Sept25)	232	218	3	0	14	18	1 (0.43% of total deaths)
Q3 (Oct-Dec25)	242	240	0	2	2	13	1 (0.41% of total deaths)
Q4 (Jan-Mar26)	319	314	2	0	5	9	1 (0.31% of total deaths)

Learning from Deaths (LfD) Processes for Learning and Improvement

Mortality governance

The Trust has a registered quality improvement project to strengthen engagement with, and use of, shared mortality learning processes through the Trust mortality database. The Learning from Deaths (LfD) team supports mortality governance by:

- Maintaining an updated section within the Trust Mortality Database to enable departments to upload patient mortality reviews
- Providing a standardised mortality review template for departments to complete
- Producing and distributing a monthly mortality report to each ward area, detailing the number of deaths and identifying any known subsequent reviews at that time, including Structured Judgement Reviews (SJRs), incident reported, or related complaints
- Supporting departments to upload completed review templates to the mortality database
- Attending departmental clinical governance, mortality and morbidity, or similar meetings to provide feedback from departmental reviews, SJRs, and shared intradepartmental learning
- Sharing completed SJRs with the departments, teams, and individuals involved in the patient's care, and supporting discussion of findings and learning at departmental governance meetings.

Submitting *Special Thanks and Recognition (STAR)* awards via the Trust RADAR reporting system to recognise exemplary practice and positive care delivery.

Cultivating shared learning

The LfD team promotes organisational learning through a structured and collaborative approach:

- A series of Trust-wide learning bulletins has been developed and shared across the organisation. These bulletins are peer-reviewed via the Shared Learning Forum to enhance clarity and impact before dissemination
- Bulletins are accessible across the Trust and via the LfD intranet page, where content is regularly reviewed, updated, and rotated
- Completed SJRs are routinely shared with those involved in the patient's care. Reflections, learning points, and discussion outcomes are captured within the mortality governance framework
- SJRs where care has been rated as 'poor' by the case reviewer undergo senior peer review. This process supports understanding of contributory factors, identifies opportunities for improvement, and considers the possibility and degree of harm
- Peer review discussions are documented and agreed learning actions are implemented. Peer review findings are typically incorporated into the SJR prior to sharing, to enhance understanding and support meaningful learning discussions.

Involvement of patients' loved ones

The Trust recognises the importance of involving bereaved families in learning from deaths:

- The LfD team aims to contact next of kin who request engagement following interaction with the Medical Examiner service

- Feedback from patients' loved ones is valued as an important source of learning, helping the Trust understand both positive experiences and opportunities for improvement
- With consent, next-of-kin feedback is included within case review records and shared across relevant departments
- Feedback is collated and thematically analysed, with findings shared with the appropriate governance committees to inform improvement
- Where a case review is undertaken and consent has been provided, families may be offered a summary of care document following completion of the review
- Follow-up contact is offered with the head of nursing for mortality and deteriorating patient safety to provide an opportunity for questions or further discussion after receipt of the summary document.

Visibility and education
To strengthen awareness, engagement, and capability across the organisation, the LfD team:

- Attends a range of Trust forums to share learning, case reviews, themes, and patient stories
- Establishes user access to the Trust mortality database and provides training and support
- Works closely with key mortality stakeholders through the Mortality Oversight Group, enabling collaborative working and continuous enhancement of mortality review processes and quality.

Mortality Peer Review (MPR) process:
The Learning from Deaths (LfD) team leads the Trust's Mortality Peer Review (MPR) process. Most patient safety incidents involving a patient who has died while in the Trust's care are, where appropriate, referred for a Structured Judgement Review (SJR).

As part of the SJR process, an independent case reviewer appraises the documented care provided during the final admission against relevant clinical guidance and standards. The reviewer is required to consider both the level of harm and the likelihood of preventability, using the Hogan et al. (2012) preventability scale.

The Trust is committed to being open, responsive, and transparent when patient harm and death occur. Recognising that SJRs rely primarily on retrospective clinical documentation, the MPR process provides an opportunity to explore additional contextual and system-level factors that may not be fully captured in the written record. This includes operational pressures, communication challenges, and environmental or systemic influences on clinical decision-making.

The MPR brings together the relevant clinical teams and healthcare professionals involved in the patient's care to review the findings of the SJR, share perspectives, and collectively reflect on opportunities for improvement.

Following MPR, learning points are agreed and translated into a service improvement action plan. These actions are reviewed and approved by the Patient Safety Panel, providing oversight and assurance before implementation. The Trust has found the MPR process to be an effective and proportionate approach, enabling timely learning and focusing on meaningful service improvements to reduce the risk of similar occurrences for future patients.

Actions and improvements from the MPR process (2025–26)

With patient safety and quality at the centre of all activity, the following improvements have been implemented as a direct result of learning from the MPR process during 2025–26:

- Updated alcohol withdrawal guidance, aligned with national best practice and partner healthcare organisations
- Increased visibility and education for staff and patients regarding the Martha's Rule/*Call4Concern* safety initiative
- Development of bite-size learning resources in targeted areas, with the ability to measure staff engagement

- Improved communication pathways between laboratory services and clinical teams
- Enhanced sharing of learning through structured MPR overview reports
- Strengthened governance arrangements for venous thromboembolism (VTE) initial assessment and reassessment
- Improved identification of deteriorating patients within the Emergency Department
- Auditing of NEWS2 monitoring and escalation practices at departmental level
- Publication of a seven-step learning bulletin focused on type 2 respiratory failure and appropriate blood gas monitoring.

Improving quality and safety – Martha's Rule - Call 4 Concern:

Martha's Rule/Call for Concern patient safety initiative was implemented at West Suffolk Foundation Trust on 1st May 2024 across all inpatient areas (including speciality areas such as ED, maternity, neonatal, paediatrics and intensive care). This initiative provides patients, relatives, carers, and staff with a direct route to request an independent clinical review if they are worried about a patient's clinical deterioration and feel their concerns have not been adequately addressed by the ward team.

As a rule, we identify patient deterioration by assessing physiological signs in conjunction with early warning scores and other diagnostic tests. However, this process can fail if escalation protocol is not followed. In addition, some deterioration signs can be subtle and may not trigger on any diagnostic tool. Patients themselves and their loved ones often recognise deterioration or changes, when clinicians may have not noticed. Martha's Rule allows patients and relatives a platform to voice their concerns if they do not feel listed to by their current clinical team.

WSFT are part of the initial national pilot to launch Martha's Rule led by NHSE patient safety team.

Martha's Rule consists of three separate components:

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted upon in a structured way (also known as the 'patient wellness question')
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to
3. This escalation route will also be available to patients themselves, their families and carers and advertised across the hospital.

Components 2 and 3 are provided by the Critical Care Outreach Team (CCOT), who are a highly skilled team of nurses that offer support across the organisation for those patients that are showing signs of potentially or clinically deteriorating. Call for Concern aims to strengthen patient safety, supports open communication and provides an additional safety net for patients experiencing clinical deterioration.

At present, CCOT aims to support all C4C activations, including those whose concerns falls outside the scope of clinical deterioration. The team facilitates appropriate responses by liaising directly with ward staff and, where necessary, directing callers to the most suitable services, such as PALS, matrons, or relevant specialist teams.

From May 2024 to March 2026, WSH received 274 C4C activations:

- 75 calls were related with acute deterioration (28%)
- 19% of calls made by patients themselves
- 78% by family/carers/friends
- 2% made by staff.

The first component of Martha's Rule, patient wellness question (PWQ), was introduced on Ward F7 in April 2025 within the trial phase. This was then expanded to G4 in September 2025. WSFT was chosen as part of a further national pilot (seven organisations all together) focusing on the

introduction of all 3 components in the emergency department (ED). Components 2 of Martha's Rule have been present in ED since the creation of CCOT in the organisation, where component 3 was included within the initial roll out of Martha's Rule in May 2024. Our PWQ was introduced in ED February 2026 as part of the national pilot.

We are currently working on a plan to launch PWQ Trust wide for all inpatients areas, with the exceptions of:

- Intensive care as an adapted version of our current form might be needed
- Paediatrics - it is nationally recognised that the concern question on nPEWS is a valid PWQ and already in use for some time in our Trust
- Maternity - concern question on national MEWS is also considered as a valid PWQ, WSH is currently working towards the launch of MEWS
- Neonatal patients – NEWTT2 also includes a concerned questions and viewed as a valid PWQ nationally.

Summary of Martha's Rule implementation so far:

- Part of the national pilot site and one of 7 pilots sites for ED and Martha's rule/ PWQ
- Regional and national recognition for forward thinking and 'can do' attitude to full MR incorporation
- Project nurse for Martha's rule, overseen by HoN for DPS/mortality
- All CCOT team attended EPALS and communication course to assist with C4C roll out
- Posters around organisation to promote C4C – currently being updated
- NHSE patient safety team visit as recognised as exemplary centre.

Quality Assurance of Statutory Safeguarding Requirements (2025-26)

Safeguarding is a core statutory responsibility of West Suffolk NHS Foundation Trust (WSFT) and a fundamental component of patient safety, quality of care and regulatory compliance. At WSFT there is robust governance, leadership and quality assurance arrangements in place to meet statutory safeguarding duties for children, young people and adults at risk.

The Trust's safeguarding arrangements are fully aligned with national legislation and statutory guidance, including the Care Act 2014, Children Acts 1989 and 2004, Working Together to Safeguard Children, the Mental Capacity Act 2005, and the NHS Safeguarding Accountability and Assurance Framework. Compliance is supported through clear Board-level accountability, professional leadership, and embedded safeguarding governance structures.

Safeguarding oversight is provided through an established framework incorporating:

- **Executive and Board assurance**, with safeguarding performance and risk reported via the Quality Delivery Governance Group (QDG), Trust Risk Register and Board Assurance Framework
- **Professional leadership** Executive responsibility for safeguarding sits with the Chief Nursing Officer. Delivery of this agenda is led by the Head of Safeguarding, ensuring strategic oversight across adult and children safeguarding, mental capacity, domestic abuse, training and supervision
- **Workforce assurance**, including statutory safeguarding training delivered in line with Intercollegiate guidance and monitored through ESR and divisional governance. The Trust manages a monthly Serious Safeguarding Allegations (Position of Trust (POT), local Authority Designated Officer (LADO) and Section 42 meeting. Training Compliance stands at 95% for Safeguarding Level 1&2 Adult, Children, Level, 1,2,3 (86%) and PREVENT (92%). The Trust has commenced the Oliver McGowan Training in April 2026.
- **Practice assurance**, including safeguarding advice, supervision, case oversight, audits and dip sampling to review the quality and consistency of practice. Trust audits focus on MCA Quality and Child Protection referral. In line with data from NHSE (2024-25), the Trust has experienced similar increases in activity for Safeguarding Referrals (66% see appendix 1), PREVENT

referrals (34%) Adult Safeguarding Enquiries (4.9%) This activity reflects unborn, child and adult referrals.

- **Learning and improvement**, drawing on safeguarding incidents, Safeguarding Adults Reviews (SARs), Child Safeguarding Practice Reviews (CSPRs), and PSIRF processes. Safeguarding Week 2025 focussed on MCA Improvement.
- **Partnership working**, ensuring the Trust meets its statutory duty to cooperate and contributes effectively to local safeguarding partnerships and system learning. The Trust Safeguarding team attends all Suffolk Safeguarding Partnership Governance meetings and ICB directed meetings for Safeguarding Adult and Children and PREVENT.

The Safeguarding Team operates a multi-layered quality assurance approach, enabling triangulation between policy compliance, workforce capability, frontline practice and outcomes. The use of:

- Restorative Safeguarding Supervision (RSS) (617 episodes 2025)
- Mental Capacity Act (MCA) Ambassadors
- Champions for Safeguarding and Domestic Abuse and
- Children's Workforce supervision (597 episodes, 2025).

Learning from reviews and incidents is translated into service improvements education, with progress monitored through established governance routes.

Key risks relate to:

- workforce pressures,
- increasing complexity of safeguarding cases, and
- system-wide change.

These risks are recognised, actively mitigated, and escalated appropriately through Trust governance structures, with continued Executive oversight.

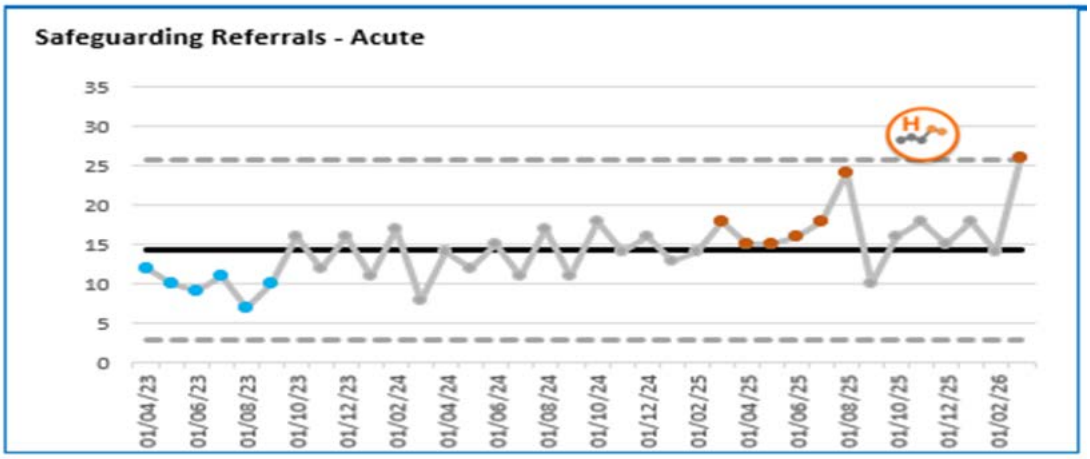
Board Assurance Statement

The Executive Board can be assured that:

- WSFT is meeting its statutory safeguarding responsibilities
- Effective governance and leadership arrangements are in place
- Quality assurance mechanisms provide oversight and early identification of risk
- Learning and continuous improvement are embedded across the organisation.

Safeguarding remains a Trust-wide priority requiring sustained Executive focus to ensure the ongoing protection of vulnerable patients and compliance with statutory and regulatory expectations.

Appendix 1



Complaints management

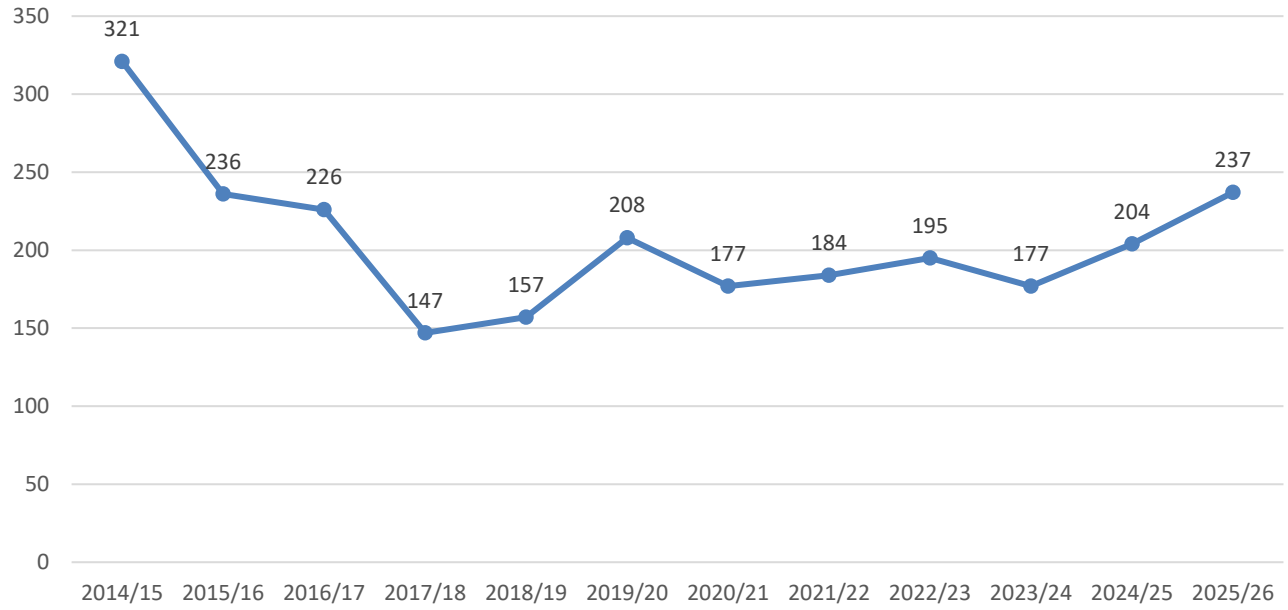
WSFT is committed to providing an accessible, fair and effective means of communication for anyone who wishes to express their concerns with regard to the care, treatment or service provided by the Trust. In responding to and reviewing complaints, WSFT adheres to the NHS Complaints Standards as published 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 by the involvement committee.

WSFT received 237 formal complaints during 2025-202026. The Board monitors complaints and learning each month as part of the quality reporting arrangements.

Number of formal complaints received



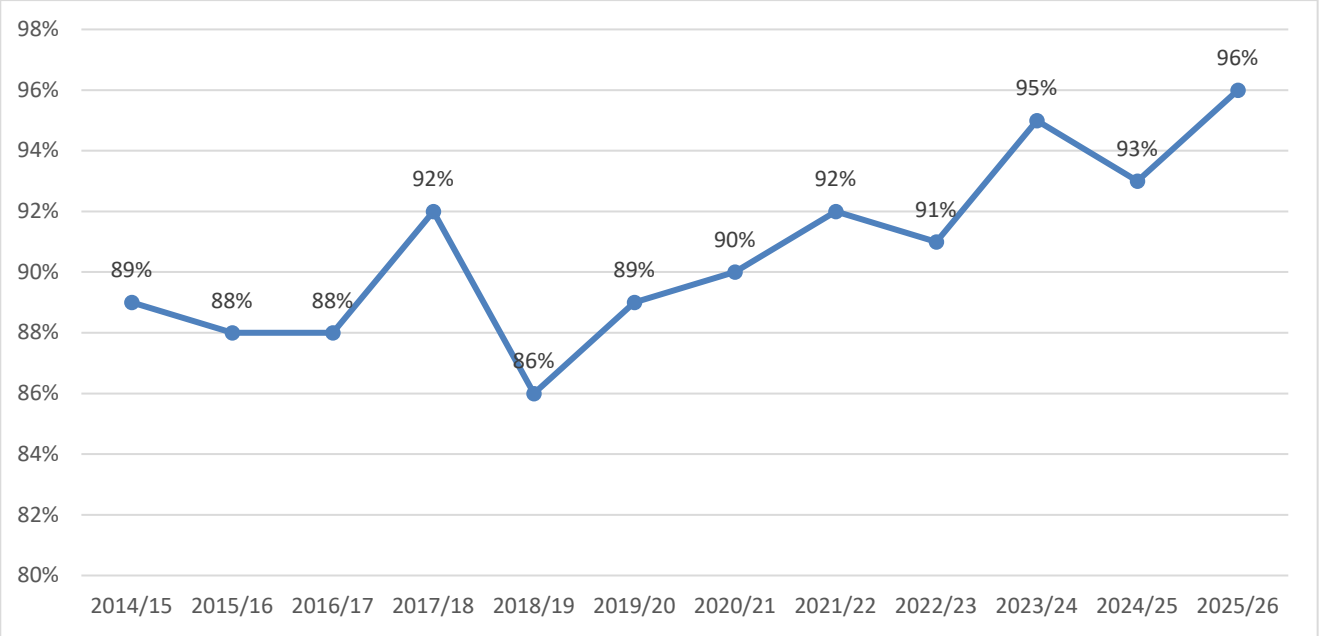
Source: Radar

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 2025-2026, the Trust resolved 238 complaints in total. Of the 238, the Trust successfully resolved 228 at the first stage, with 10 investigations escalating to second stage throughout the year, reflecting a 96% 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: Radar

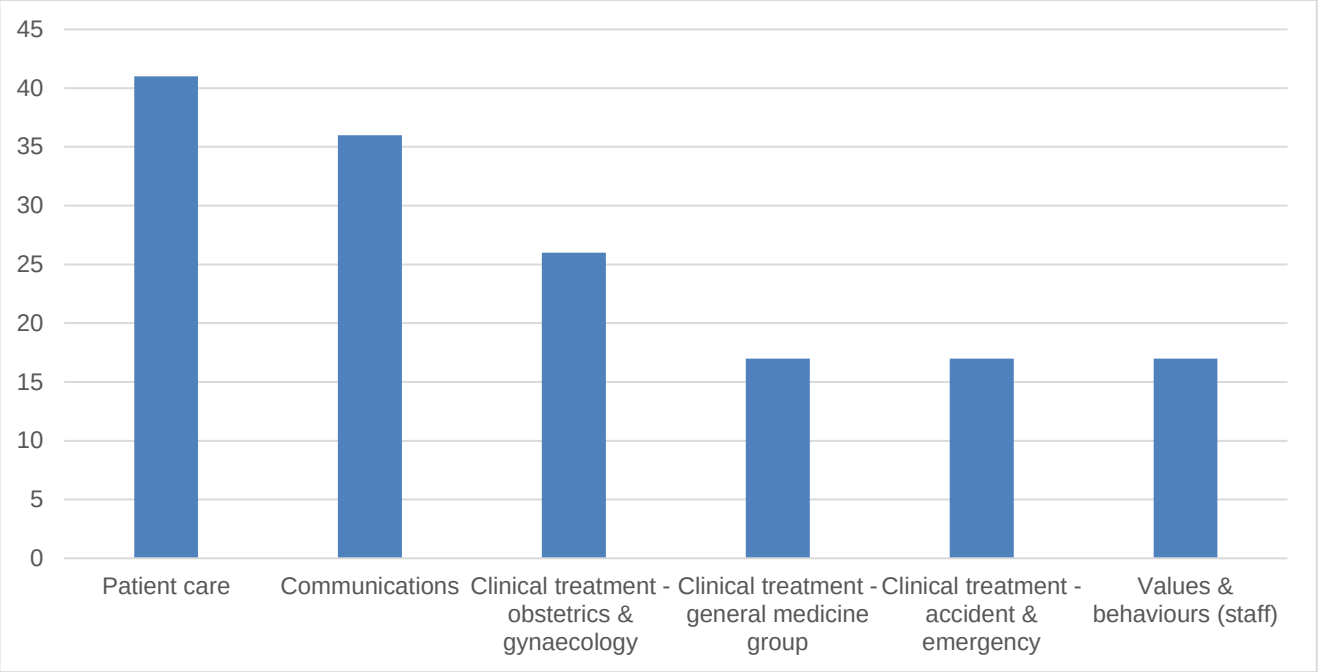
All complaints responded to are recorded as either upheld, partially upheld or not upheld depending on the outcome of the investigation, taking into consideration the details of the complaint and the investigation findings. These outcomes are recorded on the complaints management system.

Out of the 238 complaints responded to in 2025-2026, 62 were upheld, 89 were partially upheld, and 87 were not upheld.

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 2025-2026, one complaint was referred to the PHSO. This complaint was only accepted at the end of March 2026 and therefore the investigation is still on-going.

With only one complaint being referred in 2025-2026, this further demonstrates the thorough and fair investigations and engagement from clinical staff to resolve complaints 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. Five out of the six top categories have remained the same since the previous year, however, clinical treatment for obstetrics & gynaecology have become one of the highest subjects for formal complaints in 2025-2026.

Patient care has become the top category of concern for 2025-2026 with the number of complaints increasing from 30 in 2024-2025 to 41 in 2025-2026. Communication complaints have decreased from 40 in 2024-2025 to 36 in 2025-2026.

Values & behaviours (staff) has also decreased from 26 in 2024-2025 to 17 in 2025-2026. Clinical treatment – general medicine group has increased slightly from 16 in 2024-2025 to 17 in 2025-2026.

For the first time in a number of consecutive years, complaints about appointments have fallen out of the top six highest complaint categories, however the number of complaints has remained the same (13). Complaints relating to clinical treatment in accident & emergency have increased from 14 in 2024-25 to 17 in 2025-2026

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 outcomes from complaints which supports WSFT's quality priorities and other service improvements:

- Visiting times for visitors changed to allow more flexible visiting
- Adaptive cutlery has been implemented to help aid patients with eating at mealtimes
- Actions have been completed to improve communications between staff, patients and relatives
- Permanent DEXA service implemented
- Theatres have acquired gel straps to be used on patients to prevent slipping from table
- Patient experience story used to aid training for medical staff by highlighting the importance of applying walking boot correctly and the importance of prescribing VTE prophylaxis
- QI project completed and policy implemented whereby oral anticoagulants are being used as VTE prophylaxis, thereby removing the need for injections

- Now able to provide CT angiography for paediatric patients after providing training for the staff involved using a paediatric protocol based on guidance provided by the radiology team at CUH
- A working group for paediatric stroke has been set up involving key stakeholders across the region to build a clear pathway for investigation and management of children with stroke in the East of England
- For the ENT local anaesthetic clinic, no digital consent forms will be sent in advance if the patient has not been seen by the team previously in another clinic. Risk of infection is now included as a risk on any intervention/invasive procedure
- In the obstetrics department, in all cases where babies present with significant weight loss (over 10%), feeding difficulties or any other dysmorphism, staff should specifically check for a cleft palate and visualise the whole palate and uvula, in addition to checking for tongue tie
- System Safeguards Introduced: The laboratory system has been updated to prevent the use of 'NOT' or 'NOTW' codes. If a clinician is not stated or not known, the system now generates an error and halts processing. The lab must contact the sample location to identify a responsible clinician before proceeding
- Improved Clinician Identification: The lab now attempts to obtain the GMC number of any clinician not listed in the system, enabling IT staff to add them promptly and ensure future results are correctly routed
- Patient Safety Measures: We have introduced a new protocol advising patients to follow up on test results if they have not received any communication within four weeks. This is part of our commitment to improving communication and safeguarding patient 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 639 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 2025-2026:

- 2024 Adult Inpatient Survey (published September 2025)
- 2024 Children and Young People’s Survey (published May 2025)
- 2025 Maternity Survey (published December 2025).

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.

2024 Children and Young People’s Survey (published May 2025)

Respondents and response rate

- 157 WSFT patients responded to the survey

- The response rate was 19%.

Banding

Much better than expected on 1 question:

- p30_2. Did any of the following bother your child while you were in the waiting area? Noise from other patients

Better than expected on 3 questions:

- p30_1. Did any of the following bother your child while you were in the waiting area? How long my child had to wait
- p30_3. Did any of the following bother your child while you were in the waiting area? Not having enough to do
- p30_4. Did any of the following bother your child while you were in the waiting area? Not having enough to eat or drink

Somewhat better than expected on 2 questions:

- c2. On the hospital ward, were you around people your own age?
- p68. Did staff tell you who to contact if you were worried about your child when you got home?

Somewhat worse than expected on 1 question:

- c13. Did staff talk to you in a way you understood?

Worse than expected on 4 questions:

- c14. Did you feel able to ask staff questions?
- c15. Did you feel like staff listened to what you had to say?
- c17. Did staff take the time to listen to your fears or worries?
- p66. Did staff give you any written information about caring for your child to take home with you?

About the same as other trusts on 56 questions.

2024 Adult Inpatient Survey (published September 2025)

Respondents and response rate
561 WSFT patients responded to the survey

- the response rate was 47%.

Banding

Much better than most expected on 0 questions.

Better than expected on 1 question:

- Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Somewhat better than expected on 3 questions:

- Q28. Were you given enough privacy when being examined or treated?

- Q29. Do you think the hospital staff did everything they could to help control your pain?
- Q46. Overall, did you feel you were treated with kindness and compassion while you were in the hospital?

Somewhat worse than expected on 0 questions.

Worse than expected on 1 question:

- Q8_1. Were you ever prevented from sleeping at night by any of the following? Noise from other patients

Much worse than expected on 0 questions.

About the same as other trusts on 41 questions.

2025 Maternity Survey (published December 2025)

Respondents and response rate
133 WSFT patients responded to the survey. The response rate was 45%.

Banding

Much better than most expected on 0 questions.

Better than expected on 3 questions:

- C7. During your labour, were you ever sent home when you were worried about yourself or your baby?
- G5. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?
- G6. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?

Somewhat better than expected on 1 question:

- G7. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?

Somewhat worse than expected on 0 questions.

Worse than expected on 0 questions.

Much worse than expected on 0 questions.

About the same as other trusts on 54 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 use of AI to simplify patient information
- addition of extra questions in local Trust surveys
- ‘listening ears’ project to support patients sleeping at night
- adaptive cutlery pilot

- availability of snack packs
- focused patient engagement through the Maternity and Neonatal Voices Partnership (MNVP)
- exploring virtual parent education sessions.

National staff survey

The Trust performs a full census of staff and had a response rate of 45%, an increase of 1% on last year, which is 2% below the national average for acute and community trusts but narrows the gap to 2% from 5% last year.

The Trust has improved in 59 out of 99 questions against 2024 (that can be compared to last year and positively scored; 19 of these significantly), with 5 questions showing a significant decline. When comparing the Trust scores against the average of other similar organisations, the Trust is showing that it scored significantly higher in 11 questions, significantly lower in 48 questions, and no significant difference in 42 questions.

The Trust has seen a slight decline in the scores for two of the recommender questions The question of staff being happy with the standard of care provided by the organisation if friends or family needed treatment is 59%, 1% down on last year (national average of 61%); there has also been a 1% decrease in recommending the organisation as a place to work from 49% to 48%, the Trust is below the national average of 57%.

There were five questions that showed a significant decline on last year, and they also represented the biggest declines in scores. These were: enough staff at the organisation to do my work properly decreasing from 27% to 21% (national average 31%); having adequate supplies and equipment to do my work decreased from 47% to 43% (national average 54%); care of patient/service users is organisations top priority decreased from 63% to 59% (national average 72%); never/rarely feel every working day is tiring decreased from 51% to 47% (national average 48%); and not experienced physical violence from patients an service users, their relatives or other members of the public decreased from 88% to 85% (national average 85%). In addition, there were two further questions by which the Trust scored lower than other organisations, that were additional to those most outlined as the most declined scores, these were: organisation acts on concerns raised by patients/service users which was 56% (national average 68%) and there are opportunities for me to develop my career 40% (national average 50%).

In contrast to 2024, when it was the most decreased score, the organisation takes positive action on my health and wellbeing has come out as the most improved score in the 2025 survey increasing from 41% to 45% (national average 53%). Of the other most improved scores there were immediate manager listens to challenges I face increasing from 68% to 73% (national average 71%); immediate manager listens to my opinion before making changes that affect my work increase from 56% to 60% (national average 59%); feedback given on changes made following errors/near misses/incident increased from 49% to 53% (national average 60%); and staff involved in an error/near miss/incident treated fairly increased from 53% to 57% (national average 59%).

The top areas by which the Trust scores higher than similar organisations were: don't work any additional hours per week over and above contracted hours 75% (national average 67%); I can eat nutritious and affordable food at work 63% (national average 56%); organisation offers me challenging work 72% (national average 67%); received an appraisal in the last 12 months 92% (national average 88%); and colleagues are polite and treat each other with respect 73% (national average 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 2025	Average (median) for acute Trusts	WSFT 2024	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	**23%**	23%	**22%**	**21%**	**25%**
	BME	**35%**	29%	**32%**	**31%**	**31%**
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (indicator 6)	White	**21%**	20%	**23%**	**23%**	**23%**
	BME	**23%**	24%	**30%**	**25%**	**28%**
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (indicator 7)	White	**51%**	55%	**54%**	**59%**	**56%**
	BME	**50%**	49%	**46%**	**52%**	**50%**
In the last 12 months have you personally experienced discrimination at work from any of the following – manager/team leader or other colleagues? (indicator 8)	White	**6%**	6%	**7%**	**7%**	**7%**
	BME	**14%**	15%	**16%**	**16%**	**18%**

Actions relating to the WRES are included and identified in the Trust's priorities workplan. This 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, NHS Sexual Safety Charter and data from staff survey and other statutory reports (including pay gap reports).

It includes actions relating to:

- Tackling racial harassment, bullying and discrimination: including becoming an anti-racist organisation, enhancing allyship and being an active bystander across the organisation and upholding our commitments to ensure sexual safety within our healthcare settings.
- Inclusive recruitment: including improving the EDI disclosure rates of protected characteristics amongst our staff, reviewing and strengthening the current recruitment and selection training and restricting access to TRAC for managers who have not completed recruitment and selection training.
- Career development and progression: including supporting colleagues from underrepresented groups to engage with learning and development opportunities, continue with positive action programmes (such as the CEO mentoring programme) and develop bespoke resources for managers to support career conversations with Global Majority staff in areas where there is a lack of progression and/or low Global Majority represented within senior roles.

We will also continue to support our four staff networks and embed our Equality Impact Assessment (EIA) process, including providing additional resources to empower and educate colleagues on how to complete EIAs efficiently for all change activities that impact colleagues and/or patients with protected characteristics and from health inclusion groups.

Development of the quality report

In preparing the quality report, we also sought the views of SNEE ICB, Suffolk Health Scrutiny Committee, 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 uses ongoing1, ongoing2 and ongoing3 to denote the current status of the national clinical audit. The definition of these have been explained in the table below for clarity.

Ongoing1	Ongoing2	Ongoing3
Data collection for the listed national audit is run on a continuous cycle and therefore, the percentage of patients submitted in 2025-2026 is currently unavailable.	The listed national audit is part of an ongoing study and therefore, the percentage of patients submitted for 2025-2026 is currently unavailable.	Data collection for the listed national audit is still ongoing so the percentage of patients submitted for 2025-2026 is currently unavailable.

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

National clinical audit	Host organisation	Eligible	Participated	%
British audit of the investigation and referral of women with Recurrent Urinary tract infection using recent Guidance (BOOMERANG)	The British Association of Urological Surgeons (BAUS)	Yes	No	-
Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	The British Association of Urological Surgeons (BAUS)	Yes	Yes	100%
British and Cosmetic Implant Registry	NHS England	No	N/A	-
British Spine Registry	British Spine Registry	No	N/A	-
Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	Ongoing1
Stabilisation of the critically ill child – Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing2
Managing acute illness in people with a learning disability - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing2
Pleural Procedures - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing2
Rib Fractures - Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	Ongoing2
Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing1
Fractures Liaison Service Database (FLS-DB)	Royal College of Physicians	Yes	Yes	Ongoing1
National Audit of Inpatient Falls (NAIF)	Royal College of Physicians	Yes	Yes	Ongoing1

National clinical audit	Host organisation	Eligible	Participated	%
National Hip Fracture Database (NHFD)	Royal College of Physicians	Yes	Yes	Ongoing1
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	NHS England	Yes	Yes	Ongoing1
Maternal, Newborn and Infant Clinical Outcome Review Programme	University of Oxford / MBRRACEUK collaborative	Yes	Yes	Ongoing1
Mental Health Clinical Outcome Review Programme	The University of Manchester / National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	No	N/A	-
National Diabetes Core Audit	NHS England	Yes	Yes	Ongoing1
Diabetes Prevention Programme (DPP) Audit	NHS England	No	N/A	-
National Diabetes Footcare Audit (NDFA)	NHS England	Yes		Ongoing1
National Diabetes Inpatient Safety Audit (NDISA)	NHS England	Yes	Yes	Ongoing1
National Pregnancy in Diabetes Audit (NPID)	NHS England	Yes	Yes	Ongoing1
Transition (Adolescents and Young Adults) and Young Type 2 Audit	NHS England	Yes	Yes	Ongoing1
National Gestational Diabetes Audit	NHS England	Yes	Yes	Ongoing1
National Audit of Cardiac Rehabilitation	University of York	Yes	Yes	Ongoing1
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	NHS Benchmarking Network	No	N/A	-
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Yes	Yes	Ongoing3
National Audit of Dementia (NAD)	Royal College of Psychiatrists	Yes	Yes	Ongoing3
National Audit of Eating Disorders (NAED)	Royal College of Psychiatrists	No	N/A	-
National Bariatric Surgery Registry (NBSR)	British Obesity & Metabolic Surgery Society	No	N/A	-
National Audit of Metastatic Breast Cancer (NAoMe)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1
National Audit of Primary Breast Cancer (NAoPri)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1
National Bowel Cancer Audit (NBOCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1
National Kidney Cancer Audit (NKCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1

National clinical audit	Host organisation	Eligible	Participated	%
National Lung Cancer Audit (NLCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1
National Non-Hodgkin Lymphoma Audit (NNHLA)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1
National Oesophago-Gastric Cancer Audit (NOGCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1
National Pancreatic Cancer Audit (NPaCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1
National Prostate Cancer Audit (NPCA)	Royal College of Surgeons of England (RCS)	Yes	Yes	Ongoing1
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Yes	Ongoing1
National Adult Cardiac Surgery Audit (NACSA)	National Institute for Cardiovascular Outcome Research (NICOR)	No	N/A	-
National Congenital Heart Disease Audit (NCHDA)	National Institute for Cardiovascular Outcome Research (NICOR)	No	N/A	-
National Heart Failure Audit (NHFA)	National Institute for Cardiovascular Outcome Research (NICOR)	Yes	Yes	Ongoing1
National Audit of Cardiac Rhythm Management (NACRM)	National Institute for Cardiovascular Outcome Research (NICOR)	No	N/A	-
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing1
National Audit of Percutaneous Coronary Intervention (NAPCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
UK Transcatheter Aortic Valve Implantation (TAVI) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Left Atrial Appendage Occlusion (LAAO) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Patent Foramen Ovale Closure (PFOC) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	National Institute for Cardiovascular Outcome Research (NICOR)	No	N/A	-
National Child Mortality Database (NCMD)	University of Bristol	Yes	Yes	Ongoing1

National clinical audit	Host organisation	Eligible	Participated	%
National Clinical Audit of Psychosis (NCAP)	Royal College of Psychiatrists	No	N/A	-
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	NHS Blood and Transplant	Yes	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	British Society for Rheumatology	Yes	No	-
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Yes	Yes	Ongoing1
National Joint Registry	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	Ongoing1
National Major Trauma Registry	NHS England	Yes	Yes	Ongoing1
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	Ongoing1
National Neonatal Audit Programme (NNAP)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	Ongoing1
National Obesity Audit (NOA)	NHS England	No	N/A	-
Age-related Macular Degeneration Audit	The Royal College of Ophthalmologists (RCOphth)	Yes	Yes	Ongoing1
Cataract Audit	The Royal College of Ophthalmologists	Yes	Yes	Ongoing1
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing1
National Perinatal Mortality Review Tool (PMRT)	University of Oxford / MBRRACE-UK Collaborative	Yes	Yes	Ongoing1
National Pulmonary Hypertension Audit	NHS England	No	N/A	-
COPD Secondary Care	Royal College of Physicians	Yes	No	
Pulmonary Rehabilitation	Royal College of Physicians	Yes	Yes	Ongoing1
Adult Asthma Secondary Care	Royal College of Physicians	Yes	No	
Children and Young People's Asthma Secondary Care	Royal College of Physicians	Yes	Yes	Ongoing1
National Vascular Registry (NVR)	Royal College of Surgeons of England	Yes	Yes	Ongoing1
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	University of Warwick	No	N/A	-
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	No	N/A	-
Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists	Yes	No	
Improving the quality of valproate prescribing in adult mental health services	Royal College of Psychiatrists	No	N/A	-
Use of clozapine	Royal College of Psychiatrists	No	N/A	-

National clinical audit	Host organisation	Eligible	Participated	%
Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	Royal College of Psychiatrists	No	N/A	-
Sentinel Stroke National Audit Programme (SSNAP)	King's College London	Yes	Yes	Ongoing1
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	Yes	Yes	Ongoing1
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	No	N/A	-
UK Interstitial Lung Disease (ILD) Registry	British Thoracic Society	No	N/A	-
UK Parkinson's Audit	Parkinson's UK	Yes	Yes	100%
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	-

Table B: Action from local clinical audit reports

WSFT completed 61 local clinical audits in 2025-2026, with one of them identifying SMART (specific, measurable, achievable, relevant, and time-bound) actions for service improvement.

Local clinical audit	Actions identified	Outcome
Audit of stone analysis and metabolic workup post-ureteroscopy	Add mandatory step to the ureteroscopy (URS) operative proforma/checklist.	Updated template for URS cases in operation note.
	Create automatic order bundles for URS stone pathway and a prompt 24-hour urine for recurrent/high-risk patients	Ongoing
	Add required field for 'stone analysis result' and metabolic recommendations.	Result reconciliation now taking place when patients attend follow-up in the stone clinic.

Annex B: Nationally mandated quality indicators

This section sets out the data for the indicators required by NHS England. Quality Accounts - NHS England Digital

Ref	Indicator	WSFT performance 2022/23	WSFT performance 2023/24	WSFT performance 2024-25	WSFT performance 2025-26	National average	Trust statement
12	(a) The value and banding of the **summary hospital-level mortality indicator ('SHMI')** for the trust for the reporting period	December 2022 – November 2023 0.9679	October 2023– September 2024 0.85 Banding: Lower than expected	Oct 2024 – September 2025 1.03 Banding: As expected	December 2024 – November 2025 1.03 Banding: As expected	Reported by NHS Digital	The England average SHMI is 1.0 by definition, and this corresponds to a SHMI banding of "as expected". A coding abnormality was detected for March 2025 data which became evident in September 2025 (reported 6 months in arrears). 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.
	(b) The **percentage of patient deaths with palliative care coded** at either diagnosis or specialty level for the trust for the reporting period.	36%	55%	49%	49%	43.5%	

Ref	Indicator	WSFT performance 2022/23	WSFT performance 2023/24	WSFT performance 2024-25	WSFT performance 2025-26	National average	Trust statement
18	Patient reported outcome measures scores (**PROMS**) for (iii) Hip replacement surgery (primary) "total hip replacement" EQ-5D adjusted health gain	0.428	0.402	0.428	Not yet published	Published by NHS Digital	'Adjusted average health gain' has been used. WSFT considers that this data is as described.
	Patient reported outcome measures scores (PROMS) for (iv) Knee replacement surgery (primary) "total knee replacement" EQ-5D adjusted health gain	0.312	0.292	0.316	Not yet published		
	PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017.						
19	(i) The percentage of patients aged **0 to 14** who are **readmitted to a hospital which forms part of the trust within 28 days** of being discharged from a hospital which forms part of the trust during the reporting period.	15.9%	16.5%	16.3%	14.5%	Published by NHS Digital	The data provided is local data that shows 30-day readmission rates as reporting on 28-day readmission rates has not been a standard for some time. WSFT considers that this data is as described.
	(ii) The percentage of patients **aged 15 or over readmitted to a hospital which forms part of the trust within 28 days** of being discharged from a hospital which forms part of the trust during the reporting period.	13.2%	12.3%	12.4%	12.9%		

Ref	Indicator	WSFT performance 2022/23	WSFT performance 2023/24	WSFT performance 2024-25	WSFT performance 2025-26	National average	Trust statement
20	Responsiveness to the personal needs of its patients	No data available	No data available	No data available	No data available	No longer reported	Previously available and measured through the NHS Outcomes Framework 2021 but this is no longer reported.
21	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 WSFT (agree + strongly agree) Source: National NHS Staff Survey Co-ordination Centre - Picker Institute	67.8	69.9	60.9	**59.4**	England: acute trusts (agree + strongly agree) = 60.8 Benchmark group best result (agree + strongly agree) = 88.4 Benchmark group worst result (agree + strongly agree) = 34.7	WSFT considers that this data is as described as the data is collected and analysed independently. 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 NHS England average for acute trusts and lower than last year. However, a review of the 2025 data, shows that the decline seen by WSFT is mirrored by a decline in the national results score.

Ref	Indicator	WSFT performance 2022/23	WSFT performance 2023/24	WSFT performance 2024-25	WSFT performance 2025-26	National average	Trust statement
23	The percentage of patients who were admitted to hospital and who were risk assessed for **venous thromboembolism** during the reporting period.	No data available	No data available	94.36%	91.20%	92%	WSFT considers that this data is as described.
24	Rate per 100,000 bed days of cases of C. difficile infection reported in the Trust amongst patients aged 2 or over	27.1	40.6	34	Not yet published	23.3	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.

Ref	Indicator	WSFT performance 2022/23	WSFT performance 2023/24	WSFT performance 2024-25	WSFT performance 2025-26	National average	Trust statement
25	The number and, where available, rate of **patient safety incidents** reported within the trust during the reporting period Sources: NHS England (National Reporting and Learning System -NRLS) and Local incident system (*Datix and **Radar).	10,034*	11,112*	9666**	7187 incidents**	No longer published	*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.
	The number and percentage of such **patient safety incidents that resulted in severe harm or death.** WSFT number and % of total reported	59 (0.6%)*	66 (0.6%)*	57 (0.6%)**	61 (0.6%)**	No longer published	

Annex C: Comments from third parties

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 Trust 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 Eastern Education Group University and Professional Development Centre, 73 Western Way, Bury St Edmunds in October 2025. This offered everyone in our community the opportunity to learn more about local health and wellbeing services, as well as a special interest talk about respiratory health from local experts. 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 four Board assurance committee meetings (Quality & Safety, Finance & Performance, People & Organisational Development and Digital and Data Assurance Committee), 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 sessions on CQC inspection framework and virtual wards, and an externally facilitated session delivered by the NHS Providers on ‘effective questioning and challenge’.
    - A recent briefing session was delivered by the director of strategy and transformation, to give an overview on NHS 10 year Health Plan and how the Trust is developing its plans to deliver plan.
    - 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.

Date: 16 June 2026

NHS Norfolk and Suffolk Integrated care Board (ICB) acknowledge the receipt of the 2025/2026 Quality Account from West Suffolk NHS Foundation Trust (WSFT) and welcomes the opportunity to provide this statement.

Based on the information and data available within the report, the ICB supports WSFT in the publication of its Quality Account for 2025/2026. We are satisfied that it incorporates the required mandated elements. The ICB believes that the report reflects some key elements of quality, as defined by the National Quality Board and it demonstrates the Trust's commitment to continuous quality improvement.

The ICB recognises the ongoing challenges experienced by the Trust over the last contractual year. The wider system has continued to experience significant and sustained pressures. In addition, this year has brought organisational changes within NHS commissioning, resulting in the establishment of the Norfolk and Suffolk Integrated Care Board. The broader Integrated Care System footprint offers opportunities to strengthen collaboration with a wider range of system partners to support high-quality healthcare delivery, while maintaining a strong focus on local needs.

The ICB acknowledges the significant progress made across several key areas of performance and clinical outcomes. Notable achievements include the Trusts cancer performance recovery, including 28-day faster diagnosis and 62-day treatment standards. Elective recovery has also seen a significant reduction in long waits improving the quality of care received by patients. The ICB also notes that the Trusts stroke services are among the top-performing trusts nationally and highest in the East of England. The trust has also continued to progress quality or care and patient experience, with >90% of cancer patients rating care as good/very good.

The Trust's work around virtual wards and home care pathways has improved flow and reduced hospital stays. The successful national pilot and subsequent introduction of Marta's Rule (Call 4 Concern) is testament to the Trusts forward thinking and noted by NHSE as an exemplary example of implementation. Staff survey improvement including creating a culture of speaking up is noted as being very positive.

The ICB acknowledges the challenges that have been highlighted within the quality account including but not limited to workforce pressures and staff experience, urgent and emergency care pressure, access and waiting times, financial challenges, quality and safety risks such safeguarding demand and complexity and regulatory and quality rating with a CQC overall rating of Requires Improvement.

The ICB endorses the Quality Priorities set out for 2026/2027 which align well with NHS quality standards and will continue to work collaboratively with the trust to support the delivery of these. The ICB welcomes the Trust's focus on Patient Safety by improving the safe and secure storage of medicines, Clinical effectiveness to fully implement NATSSIPs 2 standards across all invasive procedures and Patient Experience to achieve compliance with Reasonable Adjustment Digital Flag to better identify and meet the needs of patients with disabilities.

While progress is evident, the ICB supports the Trust's identification of areas requiring continued focus, including reducing reliance on corridor care, continued elective recovery, strengthening continuous quality improvement, addressing workforce challenges, delivering financial sustainability and expanding community and digital services.

The ICB recognise the challenges ahead and values the commitment from all staff within the

Trust. The report provides an opportunity to share with patients, families, carers, and staff the extensive work the organisation is undertaking and demonstrates its commitment to improvement. The ICB supports the Trust's corporate priorities and quality improvement initiatives for 2026/2027.

On behalf of NHS Norfolk and Suffolk ICB, I would like to thank you, the individuals involved in developing and producing this account and all Trust staff. We look forward to continuing building on our collaborative relationship to ensure safe, effective care for our patients and local population during 2026/2027.

Kind regards

Karen Watts
Director of Nursing and Quality
NHS Norfolk and Suffolk ICB

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 2025 to June 2026
  - papers relating to quality reported to the Board over the period April 2025 to June 2026
  - feedback from NHS Norfolk and Suffolk ICB, clinical quality team dated 16 June 2026
  - feedback from WSFT governors dated 19 May 2026
  - 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
23 June 2026

Dr Ewen Cameron
Chief executive
23 June 2026

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.