Quality Account 2025-26

Our quality performance, initiatives and priorities

Sue Ryder

Because no one should face death or grief alone

Accessible PDF version

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1.1 Welcome to our Quality Account for 2025-26

Joint statement from our Chief Executive, James Sanderson, and Chair of Trustees, Dr Rima Makarem

At Sue Ryder, we're proud to provide expert palliative and end-of-life care and grief support, offering hope, dignity and kindness when it matters most. In this report, we will shine a spotlight on the quality of our services and highlight the key improvements we've made over the past year.

As Chief Executive and Chair of Trustees, this joint statement is also an opportunity for us to reflect on the

year and share some of Sue Ryder's proudest achievements. These include developing our care services to meet patients' needs, collaborating with others in the healthcare sector to influence positive change and laying the foundations to grow our bereavement services.

Our quality priorities for improvement

Delivering palliative and end-of-life care of the highest standard is incredibly important to us. During 2025-26, we focused on four quality priorities for improvement:

- medicines optimisation
- zero tolerance – pressure ulcers
- bereavement real-time feedback and coproduction
- advance care planning.

In Part Two of this report, you can find out what we have achieved against these priorities, as well as our plans for the year ahead.

Our patients and service users are at the heart of what we do, and in Part Three you can read some inspiring stories from the people we've cared for.

Before we share some of our key achievements from the past year, we also want to be transparent about where further work has been needed.

Sue Ryder Wheatfields Hospice

In 2024, our internal quality reviews and safety controls identified areas for improvement at Sue Ryder Wheatfields Hospice. An improvement plan was swiftly introduced, and our dedicated teams worked at pace to deliver this. However, a Care Quality Commission (CQC) inspection in early 2025

resulted in an ‘Inadequate’ rating for the hospice. We were disappointed with this rating and requested a review based on what we felt were inaccurate and unbalanced findings. Following the review and a further visit in July 2025, the CQC apologised for their error and upgraded the rating to ‘Requires improvement’. While we are pleased with the outcome of the rating review, we recognise that further improvements are needed and these are already underway. Our teams remain focused on delivering the established improvement plan and we’re committed to working with the CQC and our partners to continue our vital work caring for the people of Leeds.

Sue Ryder’s key achievements in the past year

A society that supports everyone through dying and grief

We can’t stop terminal illness, death and grief from happening. But we can stop people from facing them alone. At Sue Ryder, we believe how we die matters, which is why we’re committed to being alongside people through terminal illness, death and grief. However, we recognise that there is an urgent and growing need for change to improve how the healthcare sector cares for people who are dying and grieving. Demand for palliative and end-of-life care across the UK is increasing and many people who have been bereaved are unable to access the support they want and need.

This is why, in 2025, we updated our vision and strategy to include five strategic goals that aim to transform the experience of everyone facing dying or grief in the UK. These goals are:

- Transforming our palliative and end-of-life care
- Growing our grief support
- Using our evidence, voice and campaigns to create positive change

- Ensuring we have a positive impact on communities
- Using our expertise to support wider society.

You can read our vision and strategy in full on our website at **sueryder.org/vision**.

Supporting people with hope, dignity and kindness

Throughout the last year, our specialist healthcare teams have continued to show outstanding commitment to ensuring people approaching the end of their life can access the care and support they need. Developing our palliative and end-of-life care services to meet people's needs has remained a priority.

This year, we were proud to have been awarded a major new NHS contract to expand and enhance our services across the areas served by the NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (NHS BOB ICB). Our new services began in January 2026 and are already strengthening support for people in these communities. This long-term partnership reflects our shared commitment to providing high-quality, joined-up care. Together, we are helping local people access expert palliative and end-of-life care that helps them manage their symptoms, maintain comfort and improve their quality of life, often in the familiar surroundings of their own home.

Another focus this year has been to develop new and innovative ways of providing care to help us reach more people. To support this, we recently introduced a pioneering new AI scribe tool for our clinicians. The tool, called Heidi, helps to automate clinical notes, letters and forms, freeing up more time to spend with patients and families. We are one of the first palliative and end-of-life care providers in the country to adopt this technology, and we are confident that Heidi will support our clinicians to focus more on meaningful face-to-face time with patients, without changing how we care for people.

Growing our grief support

Alongside evolving our palliative and end-of-life care services, we have also taken important steps forward in our commitment to support people through grief.

As part of our strategic goal to grow our grief support, we are transforming our Online Bereavement Counselling Service to meet the rising need for accessible, timely support across the UK. In spring 2026, we introduced Single Session Therapy (SST) as our primary therapeutic model – offering a starting

point of a focused, practical, one-off session, with further sessions where needed. This approach is used across the NHS and internationally, with evidence showing that a single, meaningful conversation can provide crucial clarity and support. In 2025, we also launched a partnership with Child Bereavement UK (recently merged with Winston's Wish) to support more people of all ages. Through this partnership, we aim to offer seamless support from childhood, through adulthood and into later life, marking further progress towards our vision of a society that supports everyone through grief.

Sharing our expertise

One of our values at Sue Ryder is being connected, which means we learn from others and share our own expertise to help more people access the care and support they need.

In line with our values, and our goal to use our expertise to support wider society, we launched the Sue Ryder International Learning Academy in 2025. This new education offer enables us to provide high-quality training and resources in palliative and end-of-life care, clinical skills and grief and bereavement support. Through the academy, we share expert-led, evidence-based training designed to help professionals and communities supporting people through dying, death and grief. Sharing our expertise in this way allows individuals and organisations to build the skills and confidence they need to support people at some of life's most difficult moments.

This year, we established a three-year partnership with Lancaster University, with Dr Maddy French taking up the post of Senior Research Fellow. This collaboration between Sue Ryder and the university's International Observatory on End-of-Life Care – a globally recognised centre for palliative care research – will see Dr French working closely with our teams to help drive forward research that improves care for people at the end of their life and those who are grieving.

Sustainability in our hospices

In 2025, we were proud to launch our five-year Sustainability Strategy. Although we are still in the early stages of our sustainability journey, we are committed to finding innovative ways to use resources more efficiently across our organisation and reduce the environmental impact of our healthcare services. As part of this, we have already begun to reduce

avoidable clinical waste through initiatives such as our ‘Gloves off’ and ‘Aprons off’ campaigns, and we will continue to build on this progress.

To support this work, one of our hospices joined the Greener Palliative Care Award pilot scheme this year. The programme provides a structured framework for progress in environmentally sustainable healthcare, and Sue Ryder Leckhampton Court Hospice was awarded the Greener Palliative Care Bronze Award in March 2026. Building on this success, we plan to introduce the scheme across our other hospices, to help them embed impactful changes within their services and contribute to more sustainable care for the communities we support.

As in 2024-25, this year’s account will focus on the following:

- our commitment to quality
- our priorities for improvement for 2025-26
- our progress against our priorities for improvement
- our priorities for improvement for 2026-27
- our indicators for quality in 2025-26.

As Chief Executive and Chair of Trustees, we are assured through consistent monitoring and reporting that, to the best of our knowledge, the information in this document is accurate.

A heartfelt thank you for your interest in our charity. Last year alone, we gave over 655,000 hours of care. Every second mattered, and you gave us the means to do it. To find out more about our work and how you can support us further, please visit **sueryder.org**.

With best wishes,

Professor Rima Makarem
Chair of Trustees

James Sanderson
Chief Executive

1.2 Our vision and values

At Sue Ryder, we are passionate about giving people the quality of care they deserve.

Our vision

We want a society that supports everyone through dying and grief.

A society where the voices of people who are dying or grieving are heard, where everyone gets the care and support they need and services are integrated within the wider healthcare system.

A society where everybody can have open and honest conversations with their friends and family to help them prepare for death and where people within a life-limiting diagnosis are supported to live well in the time they have left.

Where trusted resources, information and bereavement services are accessible to everybody who needs them and where communities across the country provide support and empathy to those in need so that nobody grieves alone.

Our five strategic goals

To ensure our strategy becomes a reality for people across the UK, we have set ourselves five strategic goals:

- Transforming our palliative and end-of-life care
- Growing our grief support
- Using our evidence, voice and campaigns to create positive change
- Ensuring we have a positive impact on communities
- Using our expertise to support wider society.

Our values

Our values – supportive, connected and impactful – underpin and inform how we approach our work and will help us to deliver our vision.

There when it matters

- **Supportive:** Listen; Respect; Encourage
- **Connected:** Communicate; Collaborate; Share
- **Impactful:** Challenge; Improve; Deliver

Supportive

Equity, diversity and inclusion. We are inclusive, value diversity and actively work to reach different communities with our services, information and support, and ensure they are accessible.

Our people. We want Sue Ryder to be a great place to work and volunteer, where everyone feels they belong. We are committed to creating an inclusive culture in which everyone can thrive, develop and feel valued.

Connected

Working collaboratively. We work in partnership, learn from others and share our expertise to enable everybody to get the best possible care and support.

Our supporters and volunteers. Our work would not be possible without the generosity of our supporters and our volunteers. We will inspire more people to fundraise, donate, volunteer, campaign and advocate for us.

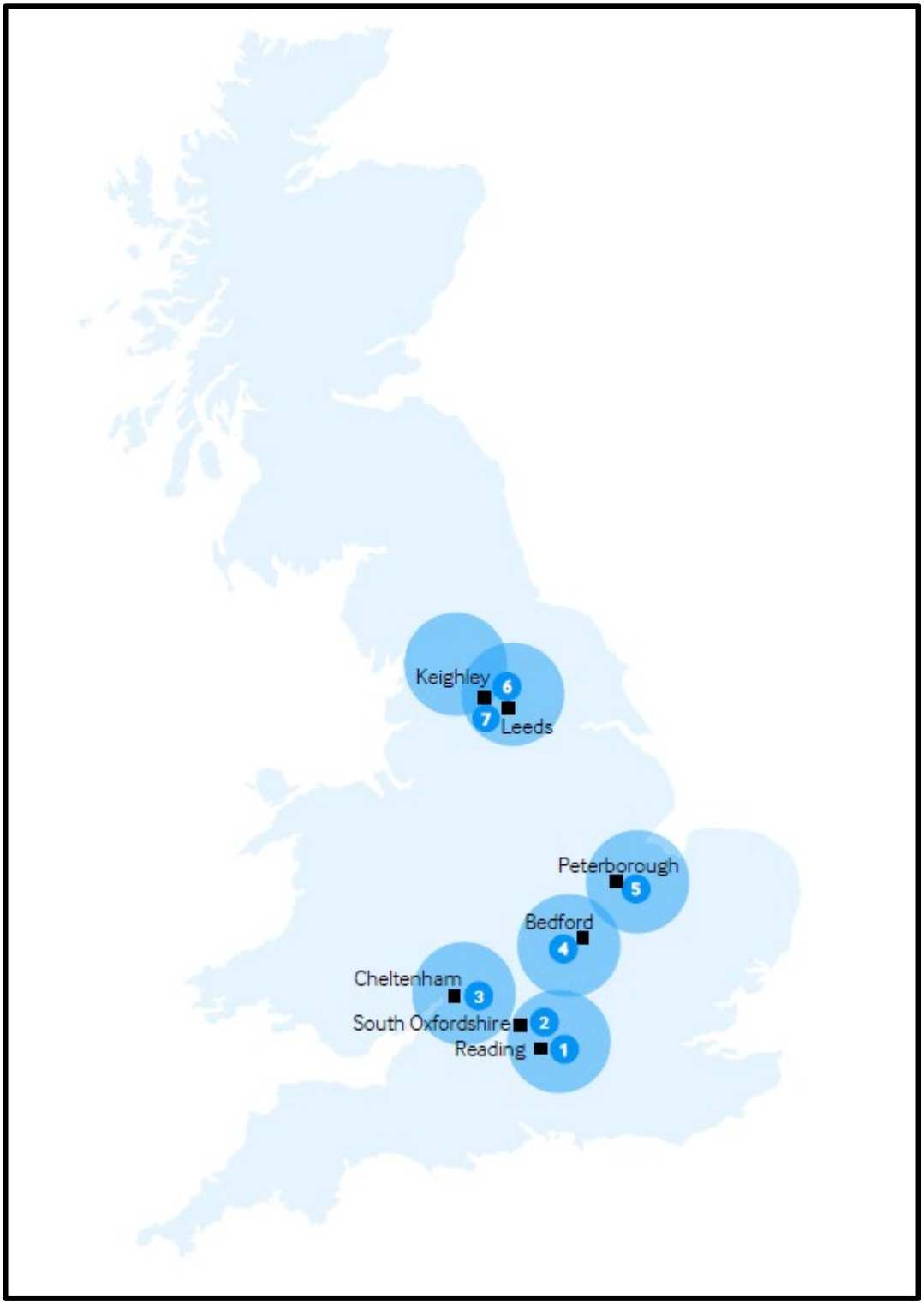
Impactful

Putting people who are grieving or living with a life-limiting condition at the heart of our work. We listen and learn from people who have been affected by dying and grief. We use their experiences to help us design new services, information and resources and to inform the issues on which we raise awareness and campaign for change.

A sustainable organisation. We act responsibly and are committed to becoming a truly ethical and sustainable organisation financially, operationally and environmentally.

You can read more about our vision at **sueryder.org/vision**

1.3 Our service map
April 2025-March 2026



Please note this map is for guidance and is not true to scale.

The large transparent circles indicate community services.

Palliative care

We provide expert care from our specialist centres, in people's homes and out in the community in many areas of the UK.

Sue Ryder South East
Providing inpatient care and community services from our bases at:

1. Sue Ryder Duchess of Kent Hospice, Reading, and Sue Ryder, Theale
2. Sue Ryder Palliative Care Hub South Oxfordshire, Wallingford

We also support patients in dedicated end-of-life care beds in West Berkshire Community Hospital and Wallingford Community Hospital.

Sue Ryder South West
Providing inpatient care and community services from our base at:

3. Sue Ryder Leckhampton Court Hospice, Cheltenham

Sue Ryder East of England
Providing inpatient care and community services from our bases at:

4. Sue Ryder St John's Hospice and Palliative Care Hub, Moggerhanger
5. Sue Ryder Thorpe Hall Hospice, Peterborough

Sue Ryder North East and Yorkshire
Providing inpatient care and community services from our bases at:

6. Sue Ryder Wheatfields Hospice, Leeds
7. Sue Ryder Manorlands Hospice, Keighley

Influencing and campaigning

To speak up for people who are dying and grieving, we work on a national and local level and collaborate with others in the healthcare sector, the Government and key stakeholders.

Sue Ryder Online Bereavement Support

Our national Online Bereavement Support services are there for adults in the UK living with grief, and their families and friends. These include our Online Bereavement Community, Online Bereavement Counselling Service, and our self-help platform Grief Guide.

Sue Ryder Grief Kind Spaces

Drop-in sessions in local communities, led by trained volunteers and giving people who have been bereaved the opportunity to share their experiences in group settings (until 1 May 2026).*

*As demand for our bereavement support continues to grow, we are seeking new and sustainable ways to support even more people. To achieve this, Sue Ryder Grief Kind Spaces are changing to an independently run model, led by local people for their local communities. Sue Ryder's role will shift to equipping them with the tools and guidance needed to run their own spaces. Sue Ryder supervised Grief Kind Spaces, led by Sue Ryder volunteers, will conclude by 1 May 2026, and we will instead be supporting the creation of new community-led groups.

1.4 Putting our work in context

Throughout 2025-26, the discussion and debate around the Terminally Ill Adults (End of Life) Bill to legalise assisted dying dominated the political agenda within the health and care sector. Although Sue Ryder has a neutral position on assisted dying, the debate on the Bill presented many opportunities to raise the importance of palliative and end-of-life care (PEoLC) and equitable access for all.

We played an active role in shaping and responding to the Government's 10 Year Health Plan. By engaging in national consultation and discussions with NHS England, the Department for Health and Social Care (DHSC) and many cross-sector partners, we helped to ensure PEoLC was recognised as integral to the Plan's ambition to shift care from hospital to community. In July 2025, we saw the publication of the Plan for England. Since then, we have continued to try to influence how the Plan is implemented, calling for hospices to be treated as equal partners in new models of care and for sustainable funding to underpin its success for people at the end of their lives.

In our role as joint secretariat to the All-Party Parliamentary Group (APPG) on hospice and end-of-life care, we secured the opportunity for two Sue Ryder colleagues to share their frontline reflections and insights at an evidence session in the inquiry into financial security at the end of life.

In autumn 2025, we delivered a panel event at Labour Party Conference in partnership with the New Statesman, around how strong, sustainable PEoLC provision is central to the Government's mission to create an NHS fit for the future. The Minister for Care, Stephen Kinnock MP, spoke alongside our Chief Executive, James Sanderson. We were also part of joint

sector events with Hospice UK, Marie Curie, and Together for Short Lives at both the Conservative and Liberal Democrat Party conferences.

The announcement of the Modern Service Framework swiftly followed. Through proactive engagement with NHS England and DHSC, we highlighted the need for the framework to deliver consistent access to high quality care closer to home; reduce avoidable hospital admissions; and provide sustainable models of commissioning and delivery aligned with the 10 Year Health Plan. We have shared our evidence and models of care to aid this.

The external economic environment continues to be challenging, particularly with rising costs. However, in January 2026, a further £25m of grant funding was awarded by DHSC to support capital expenditure projects across the charity. This funding has allowed us to make improvements to our hospices and invest in our infrastructure to modernise the care we provide, which increases our ability to support a growing number of patients.

For the first time, Sue Ryder attended the NHS ConfedExpo annual conference in Manchester. This was to build on our wider engagement with health professionals, key decision-makers and partners from across the health and care sector. Our goal was to collaborate, share insights and discuss innovative solutions to deliver high quality care for all. James Sanderson and Melanie Craig, our Chief Operating Officer, spoke to delegates about our drive to make changes to the way palliative care is delivered and introduced our strategic vision around a new model of care, including our ‘Alongside’ initiative.

We also continued using our evidence and voice to support improvements in a wider health and wellbeing context through our ‘business as usual’ activity – engaging with MPs in

parliament and through our services and retail; responding to consultations; and identifying gaps in evidence.

As we move into 2026-27, we will continue to raise the importance of palliative and end-of-life care and bereavement support with the Government and other key stakeholders. We will speak up for people who are dying and grieving by focusing on the reform required to ensure more people can access the care they need, while also highlighting the role of the hospice sector in tackling long-standing issues facing the NHS. We will do this through our work on the Modern Service Framework and its delivery, any further work around assisted dying, and any relevant health legislation announced in the King's Speech.

1.5 Our core services and national service offer for palliative and end-of-life care and grief support

Palliative care:

Inpatient services:

- 24/7 admissions through a range of access points and inclusive of under-represented communities
- beds managed by a specialist medical and nursing team
- beds managed with different models – nurse-led, medically-light and medically-led
- offering physiotherapy, occupational therapy and complementary therapies
- delivering individual programmes of care linked to personal goals and preferences.

Hospice at Home:

- domiciliary visits
- medical and family support.

Seven days a week Clinical Nurse Specialist (CNS) service:

- community nurse prescribers
- assessing, planning and coordinating care for people at home.

Day therapy:

- delivering flexible, responsive ‘packages of care’ tailored to individual need, including virtual/ remote support
- outpatient care
- specific clinics, ‘drop-in’ visits
- long-term conditions programmes
- medical outpatients with interventions.

Patient coordination:

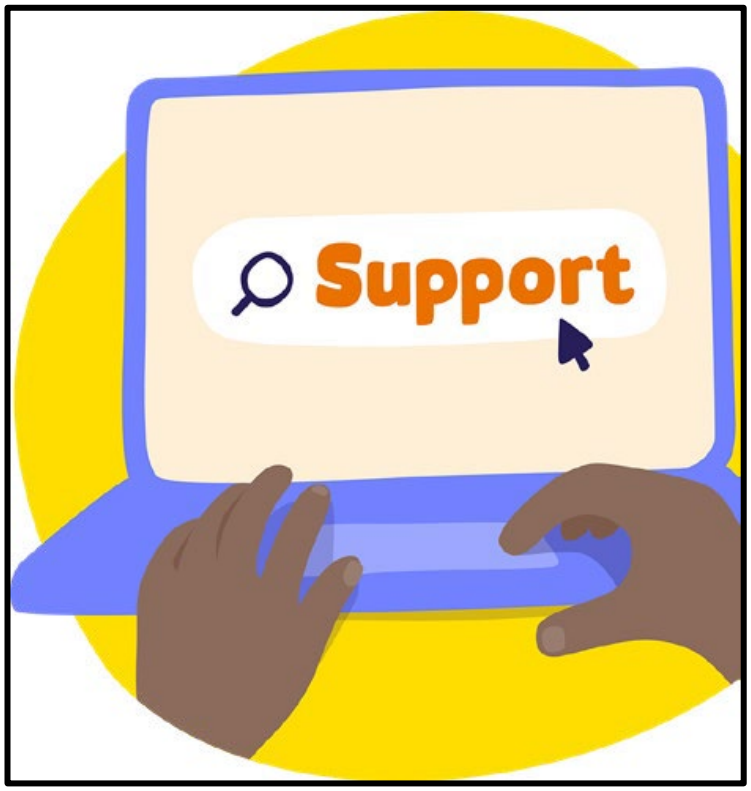
- palliative care coordination.

Carer and Wellbeing Services:

- providing access to psychological support.

Befriending:

- maximised with the support of our valued volunteers.



Bereavement services:

- development of a ‘best practice’ bereavement model
- information, advice and peer-to-peer support
- Online Bereavement Community: a forum for people to talk to others who are grieving, share feelings and support each other
- Online Bereavement Counselling Service: free video sessions delivered by registered counsellors (with an assessment session provided to assess suitability and level of need, as well as providing signposting and grief literacy)

- Grief Guide: expert advice and tools from Sue Ryder's grief specialists, including a space to journal
- Grief Kind Spaces: in-person drop-in sessions led by trained volunteers in community settings (until 1 May 2026)
- information pages to increase people's grief literacy and ability to learn to live with grief
- range of bereavement-related training to external organisations
- signposting to Shout, a text-based mental health crisis de-escalation service.

Across all of our services, we provide access to social work and spiritual support, as well as grief and bereavement services.

Part two: Our priorities for improvement 2025-26

At Sue Ryder, we remain focused on improving the quality of our care, as demonstrated in the achievements of our quality priorities. To support this, the way performance data is used to inform improvements to care delivery was enhanced during 2025-26.

This has encouraged rich conversations about care quality. It has also allowed service leaders to triangulate factors that influence or affect care delivery, escalate concerns and share learnings from their quality improvement activities.

Services now see integrated quality reports monthly with information (key performance indicators) about harm-free care, activity such as length of stay, staffing and leadership. This detail is then aggregated to provide senior leaders and trustees with oversight of key aspects of care across all Sue Ryder services.

2.1 Progress against our priorities for improvement 2025-26

In summary, our four performance improvement priorities for 2025-26 were:

Quality Priority one: Patient safety

Medicines optimisation
The prescribing of multiple medications is commonplace in palliative care. We will support the people who use our services by focusing on the deprescribing process, which involves reviewing and stopping any ineffective medications to improve quality of life. We will review the barriers to deprescribing and develop deprescribing guidelines to support our clinicians. We will actively seek patient feedback on the positive impact of deprescribing too.

Quality Priority two: Patient safety

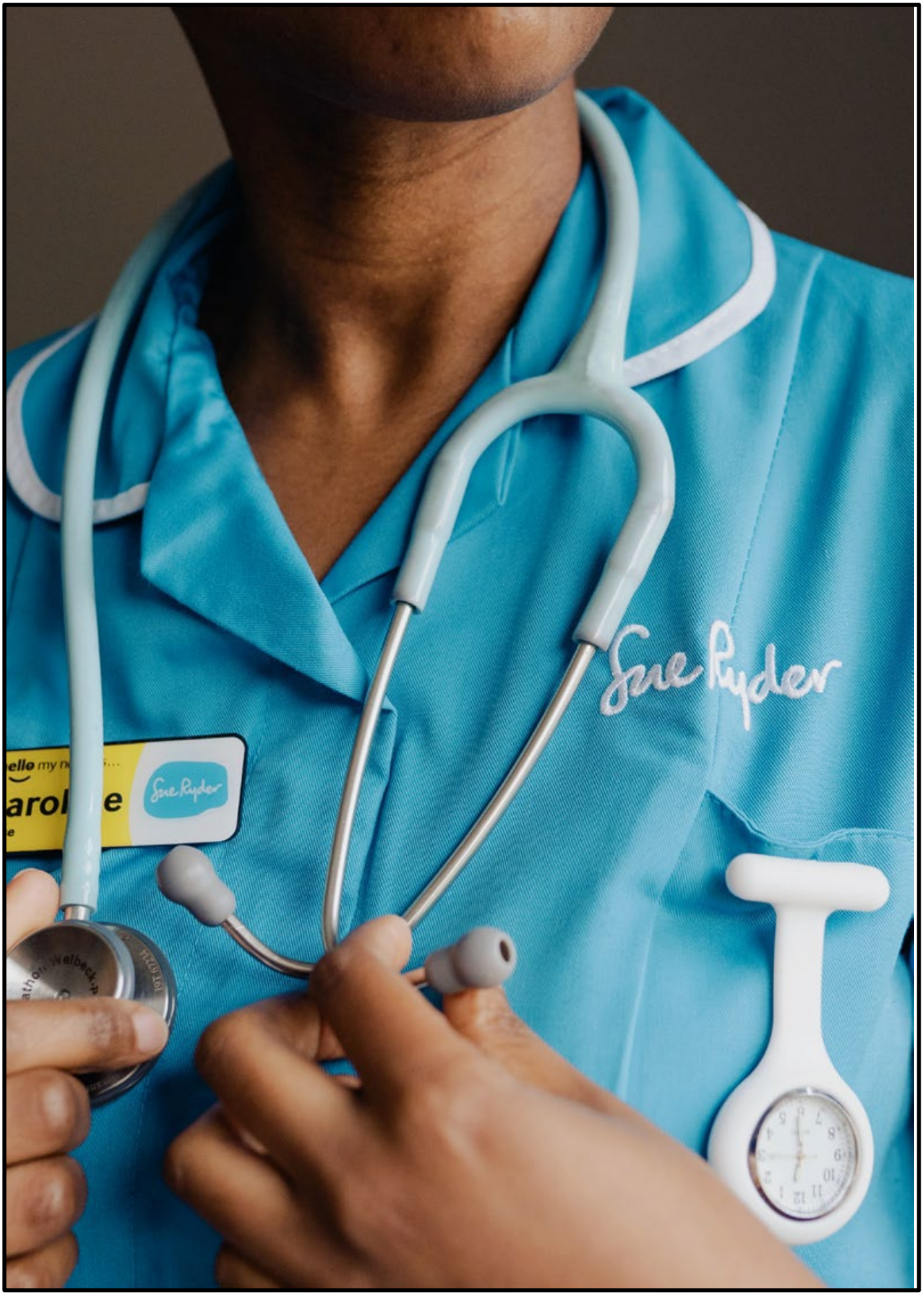
Zero tolerance – pressure ulcers
Pressure ulcers affect over 700,000 people in the UK each year (Wood, Brown, Bartley, et al., 2019), with a notable 11.7% incidence among palliative care patients (Ferris, Price, Harding, 2019). There is solid evidence that educating patients and families can help prevent new pressure injuries (Kim, Park, Kim, Adv Skin Wound Care, 2020). However, studies show that lasting improvements are unlikely without also fostering a culture change around prevention (Yan, Dandan, Xiangli, 2022).

Quality Priority three: Patient experience

Bereavement real-time feedback and coproduction
Gathering feedback about Sue Ryder's bereavement services is vital for improving client experience, involvement and outcomes. We already use several methods to collect feedback, but we want to create even more opportunities by trying out new approaches. We will introduce real-time feedback surveys for all our bereavement clients during their counselling to enable detailed insights into quality and service improvements, which can lead to better outcomes for the people we support. We will develop co-production guidance and pilot this with our bereavement clients for review of our existing services and future developments.

Quality Priority four: Clinical effectiveness

Advance care planning
Advance care planning offers people the opportunity to plan their future care and support. We already provide advance care plans (ACPs), but we want to make them more effective. To do this, we'll check how many patients are offered an ACP and how many take it up, and we'll look at the results of using them. We'll do spot check audits at the start, middle, and end of the year to see where we're improving and where we need to do more work. By using a standardised ACP tool across all our services, we can make sure everyone is working towards the same goals for end-of-life care. To help with this, we'll collaborate with local organisations and Integrated Care Boards (ICBs).


Sue Ryder
Sue Ryder

2.2 Priority one: Patient safety
Medicines optimisation

We said we would:

The prescribing of multiple medications (polypharmacy) is commonplace in palliative care. We will support the people who use our services by focusing on the deprescribing process, which involves reviewing and stopping any ineffective medications to improve quality of life. We will review the barriers to deprescribing and develop deprescribing guidelines to support our clinicians. We will actively seek patient feedback on the positive impact of deprescribing too.

We did:

During 2025-26, we completed an organisation-wide review of deprescribing practice, recognising the impact that multiple medications can have on comfort, symptom burden, and quality of life for people receiving palliative care. This approach was supported by evidence showing that deprescribing in people with life-limiting conditions can reduce medication burden and costs without evidence of harm when delivered in a structured, monitored way, aligning with our focus on safety and comfort.

We aligned our approach to national best practice by drawing on NICE NG5 (Medicines optimisation) and NICE NG56 (Multimorbidity), which emphasise high quality medication review, shared decision-making and the reduction of treatment burden when benefits no longer outweigh risks. Our model mirrors NHS England’s Structured Medication Review principles for tackling problematic polypharmacy through comprehensive, person-centred reviews.

To ensure feasibility and relevance to hospice care, we reviewed deprescribing tools and approaches already in use, and national polypharmacy resources and toolkits. We then designed our own process to support suitable practice within our services and meet our clinical, governance and documentation needs.

Our process was approved by the Medicines Steering Group and piloted at one of our hospices. The pilot reported no safety incidents; clearer, more consistent documentation; and positive patient and family feedback about reduced pill burden and better understanding of what each remaining medicine is for. These results match what other studies have found: that when medicines are reviewed carefully with the person at the centre, people often feel better and, in some cases, their quality of life can improve. For example, one study showed that stopping statins for people with advanced illness did not cause harm and actually improved how well they felt day-to-day. We also strengthened safety by embedding standard processes and recordkeeping, reducing opportunities for error in a complex medicines environment.

Next, we will embed deprescribing prompts into routine multidisciplinary team (MDT) reviews; continue to collect patient/family feedback; and monitor safety and documentation quality.

Case study

During the pilot, clinicians used the agreed process to have more personalised conversations with patients and families about medicines.

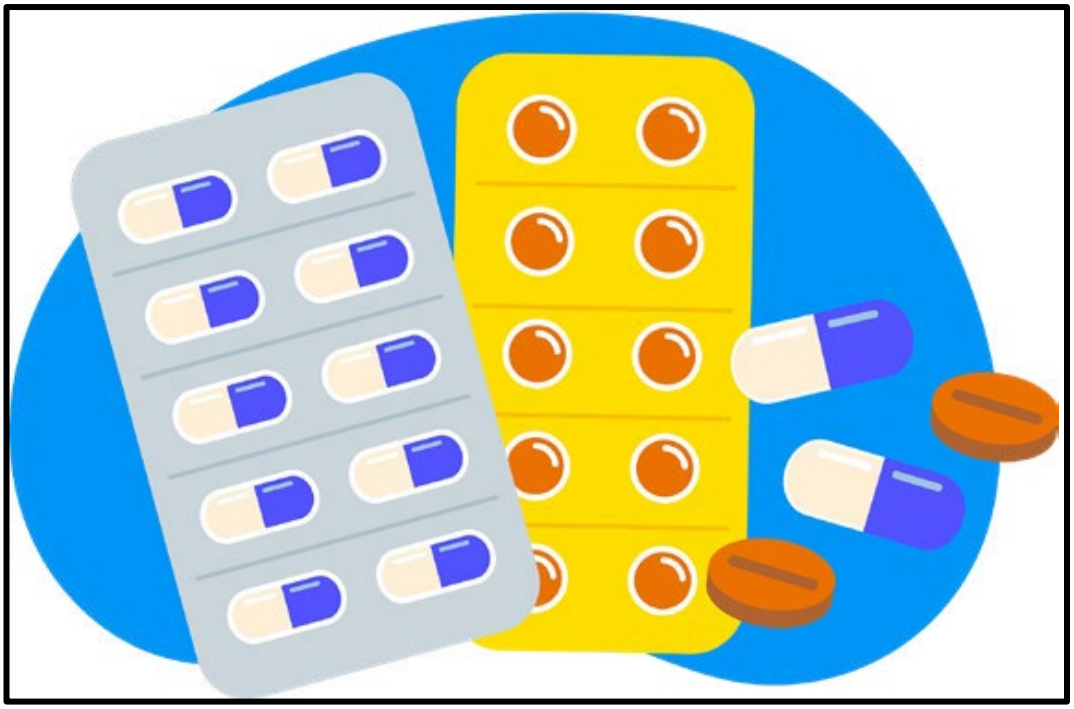
Many people told us they felt overwhelmed by the number of tablets they were taking each day. Using the structured

approach, clinicians explained the purpose of each medicine in clear, reassuring language and discussed together which ones still contributed to comfort and quality of life.

This led to:

- People feeling more in control, with clearer understanding and confidence to make informed choices.
- Families finding daily routines easier, especially where swallowing or fatigue made administration difficult.
- Clinicians reporting improved confidence and consistency, with clearer documentation and shared plans.
- No safety concerns identified, demonstrating careful, collaborative deprescribing in practice.

Patients and families consistently told us that having fewer, more meaningful medicines helped them focus on what matters most – comfort, dignity and time with the people they love. This feedback reinforced that deprescribing is not just a clinical process, it is a key part of delivering person-centred palliative care.



2.3 Priority two: Patient safety
Zero tolerance – pressure ulcers

We said we would:

Pressure ulcers affect over 700,000 people in the UK each year (Wood, Brown, Bartley, et al., 2019), with a notable 11.7% incidence among palliative care patients (Ferris, Price, Harding, 2019). There is solid evidence that educating patients and families can help prevent new pressure injuries (Kim, Park, Kim, Adv Skin Wound Care, 2020). However, studies show that lasting improvements are unlikely without also fostering a culture change around prevention (Yan, Dandan, Xiangli, 2022).

During 2025-26, we said we would make pressure ulcer prevention a zero tolerance priority. We stated that we would review our assessment tools, care planning and evaluation across all services. We said we would strengthen governance by reviewing how technology is used to support documentation, tracking and oversight. We committed to enabling teams to introduce local actions through safety huddles to improve care prompts and escalation. We also said we would review equipment and training to support prevention. Most importantly, we said we would work with patients and families to improve their experience.

We said we would monitor delivery in several ways. We would use clinical audit to check how consistently assessment tools and care plans were being completed and used. We would gather feedback from patients and families about communication, education and involvement in care planning, and use this to make improvements. We would review incidents and audit findings to identify themes and run targeted quality improvement projects. We would assess how well equipment was performing, share learning with teams and make changes

to purchasing if needed. Outcomes data would be reviewed regularly to track progress and maintain improvements.

We did:

- **Made practice consistent:** We embedded best practice assessment and care planning tools/templates in the electronic record, so risks are identified and acted on the same way across services.
- **Clarified actions:** We introduced concise action prompts, so teams know exactly what to do and how to escalate concerns when skin changes are noticed.
- **Audited, learned and re-audited:** Services used short, focused audits (and six-month re-audits) to close gaps in documentation, safety huddles, equipment settings and referrals to dieticians where appropriate to optimise healing.
- **Equipped and trained teams:** We invested in pressure-relieving equipment and provided targeted education.
- **Listened to our patients and their families:** We asked patients and family members what we could do to improve our communication with them about the risks of pressure ulcers. We have improved access to our pressure ulcer prevention leaflet and how we communicate with patients and families about the importance of changing position.

Outcomes

In 2024-25 we recorded 807 pressure-ulcer incidents in total: 255 (31.6%) were acquired in our care, 73 (9.0%) were deteriorations in our care, and 479 (59.4%) were present on admission.

In 2025-26, we recorded a higher number of incidents to the year before (840 in total), reflecting the impact of greater awareness through training and assessment. Monthly incidents fell from 76 to 55 by year end. New pressure ulcers that

developed while people were in our care also reduced, from 24 a month to 20.

Cases where an existing ulcer worsened were halved—from 19 cases in Q2 to 9 in Q4.

We saw small year-on-year falls in category 2 pressure ulcers acquired in our care (from 101 to 98) and suspected deep-tissue injuries (from 60 to 56). This combined picture shows more effective prevention through early identification and off-loading of pressure areas across our services.

More consistent prevention, clearer escalation and regular review led to fewer pressure ulcers by year end, with issues identified earlier and managed promptly.

What's next (early 2026-27)

Establish a National Pressure Ulcer Steering Group to continue and support quality improvement in this area.

Case studies

Sue Ryder East of England:
Sue Ryder Thorpe Hall Hospice
Across IPU and Community teams, a single assessment and care planning approach (PLANC and Purpose-T) is now in place, supporting consistent practice and timely escalation when skin changes are identified. Teams are connected through daily safety huddles. Patient survey feedback has been used to improve the information provided to people and families on skin protection.

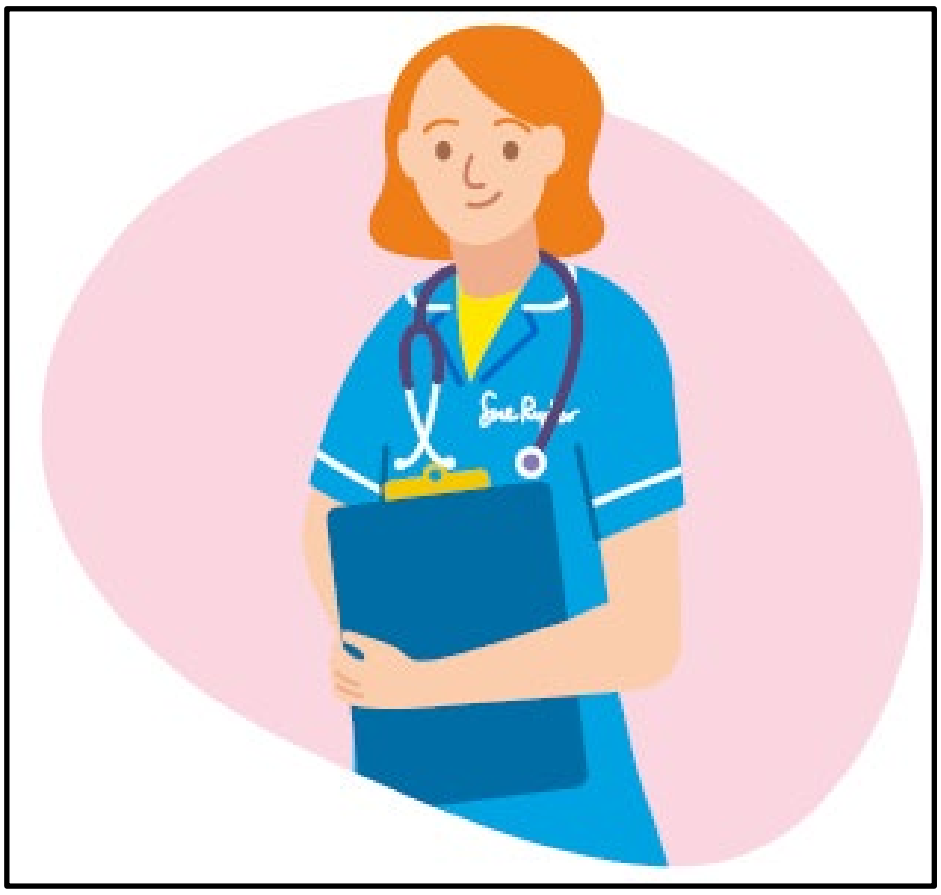
Sue Ryder East of England:
Sue Ryder St John's Hospice
A structured audit programme is established across IPU and Community teams, covering risk assessment, equipment checks and documentation. A twice-yearly audit has been implemented to demonstrate sustained improvement. Purpose-T provides clear escalation triggers for prompt escalation.

Sue Ryder South West:
Sue Ryder Leckhampton Court Hospice
Heel off-loading is now routine for people at higher risk across IPU and Community, with no heel injuries recorded. PLANC is embedded, and the enhanced Purpose-T template is progressing through governance. Updated rounding forms and a simplified wound chart support clear bedside checks and audit.

Sue Ryder North East and Yorkshire:
Sue Ryder Manorlands Hospice
Preventive actions are reviewed daily through the wound-care tracker at safety huddles. Following targeted training and a new dietitian referral process, audit compliance increased from 75.4% to 96%. Documentation quality has improved, with a planned re-audit to sustain progress.

Sue Ryder North East and Yorkshire:
Sue Ryder Wheatfields Hospice
The Purpose-T pathway is operational across IPU and Community teams, supported by strengthened PLANC use and refresher training. Heel off-loading and escalation through safety huddles are routine. Patient information is more accessible, and pressure-relieving mattresses support timely prevention.

Sue Ryder South East:
Sue Ryder Duchess of Kent Hospice,
Sue Ryder Palliative Care Hub South Oxfordshire, Theale office
Preventive actions are reviewed daily through the wound care tracker at safety huddles, including monitoring of healing rates. Heel offloading is now routine for people at higher risk on the IPU. PLANC is embedded. A structured audit programme is established across IPU and Community teams, covering risk assessment, equipment checks and documentation.



2.4 Priority three: Patient experience
Bereavement real-time feedback and coproduction

We said we would:

Gathering feedback about Sue Ryder's bereavement services is vital for improving client experience, involvement and outcomes. We already use several methods to collect feedback, but we want to create even more opportunities by trying out new approaches. We will introduce real-time feedback surveys for all our bereavement clients during their counselling to enable detailed insights into quality and service improvements, which can lead to better outcomes for the people we support. We will develop coproduction guidance and pilot this with our bereavement clients for review of our existing services and future developments.

We did:

During the year, audits were completed to assess the effectiveness of our existing survey tools and how feedback was being used and shared within bereavement services. These findings informed the development of new CIVICA audits, designed to strengthen consistency, oversight and learning from feedback. CIVICA is a digital service user feedback tool and staff received training to ensure feedback could be captured accurately and used meaningfully. We introduced real-time feedback surveys for bereavement clients, enabling people to share their views throughout their therapeutic journey rather than only at its conclusion.

Following feedback from bereavement clients themselves, we did not proceed with the coproduction pilot in the way originally planned. Clients told us that, for this group, taking on a formal

coproduction role did not feel appropriate during a period of grief. We listened to this feedback and adapted our approach. We remain open to involvement from bereavement clients who may feel differently and wish to contribute in this way. In the meantime, we began planning to use existing, well-established service user groups from other areas of Sue Ryder to provide coproduction support for bereavement service development.

These changes have strengthened how we listen to people using our bereavement services and how we respond to what they tell us. Introducing real-time feedback has enabled richer and more timely insight into people's experiences while receiving support, allowing earlier identification of what is working well and where improvements are needed.

The CIVICA system has improved monitoring of feedback and increased visibility of themes, learning and actions at both local and national level. Importantly, we have adapted our approach to coproduction based on client feedback, reinforcing our commitment to person-centred care by ensuring involvement is flexible, respectful and guided by individual readiness.

Following the first weeks of piloting our new model, we identified that understanding effectiveness requires following people's progress over time. After completing the digital triage tool, clients receive tailored information and support that matches their needs. For those who receive counselling, support concludes with a planned discharge when agreed objectives are met, followed by outcome measures to enable comparison before and after intervention.

Feedback is already shaping service development. We have revised wording, added clearer information and identified plans to work with NHS mental health providers once sufficient data is available. People's experiences are therefore influencing the service as it develops ahead of public launch.

We also plan to establish a service user group to provide feedback on wording and service improvements, ensuring the service remains clear and accessible.

To reduce questionnaire fatigue, we reviewed how feedback systems are used. CIVICA remains appropriate for pre-death services but overlaps with our bereavement outcome measures and does not integrate effectively with our clinical systems. Instead, feedback is gathered through a wider outcome questionnaire at one, three and 12 months following support, helping us understand longer-term impact while minimising burden on clients.

Case study

Physiotherapist Vijay, 31, used Sue Ryder's Online Bereavement Counselling Service following the death of his mum and says it has helped him adjust to his 'new normal'.

"I lost my mum three years ago to breast cancer. She had quite an aggressive form of cancer so her treatment was very quick. I had some counselling sessions after she passed away and then I accessed the service again in February. It really suited my schedule being able to do the counselling online. Both times I have found the sessions really helpful, really useful and suitable to the phase I was in at the time.

"It's quite difficult to confide in people who you know, or people who are going through a similar experience. I'm a caregiver at work and I was finding it difficult to compartmentalise my own feelings while taking on other people's problems at work. So having that space to talk things through gave me some tools. It helped me to reform a lot of my thoughts and not be too hard on myself, even though time has passed. I think I have benefitted from it quite a lot. You can be completely vulnerable with somebody you have no relationship with.

"I have a great support network but it can be very difficult to verbalise how you're feeling. It feels like you have lost a big part of yourself when you're grieving. I think just having that platform to talk about things helped me realise how much I have changed in that time – the things you value and the things that make you who you are. The main thing is accepting those emotions as normal and not being too hard on yourself. The world we live in moves at 100mph and I think it was about adjusting to a new normal or working out what is preventing you from embracing a new normal.

“It has strengthened my confidence in myself. If you need answers, it can really hold you back and I needed to be firing on all cylinders, so the counselling has really helped me.”

2.5 Priority four: Clinical effectiveness
Advance care planning

We said we would:

Advance care planning offers people the opportunity to plan their future care and support. We already provide advance care plans (ACPs), but we want to make them more effective. To do this, we'll check how many patients are offered an ACP and how many take it up, and we'll look at the results of using them. We'll do spot check audits at the start, middle, and end of the year to see where we're improving and where we need to do more work. By using a standardised ACP tool across all our services, we can make sure everyone is working towards the same goals for end-of-life care. To help with this, we'll collaborate with local organisations and Integrated Care Boards (ICBs).

We did:

The advance care planning (ACP) quality priority has focused on establishing clarity, consistency and measurable practice across all our Sue Ryder services. A National ACP Working Group has been established and embedded, meeting regularly and delivering agreed outputs. The group has produced a clear organisational definition of advance care planning, providing a shared understanding aligned to Sue Ryder's values and clinical context.

A national scoping exercise and ACP audit tool have been designed and completed across services using Microsoft Forms. This has generated baseline data on current ACP practice, documentation, and uptake. Findings have been

reviewed by the Working Group and have been used to identify variation, gaps, and areas requiring further development.

As a direct result of this, activity will be targeted and evidence-informed. It was recognised that a single standardised ACP process and document could not be implemented at a national level across all services due to regional documents and processes that are maintained within the ICBs.

The ACP working group will continue to meet and drive improvements, with the next phase being to standardise ACP documentation via coding within SystmOne. This will improve audit reliability and reporting. From the gaps identified, work is underway to developing a supporting wellbeing framework to strengthen person-centred outcomes.

The organisational ACP policy has been reviewed and updated, in addition to education and training which is CPD UK accredited and a tiered approach. All new Healthcare employees will complete an ‘Introduction to ACP’ on the standardised induction programme. The Advance Care Planning and ReSPECT training course is accessible to book onto via the National Education Calendar. This priority has therefore delivered governance structures, shared definitions, baseline intelligence, and clear direction for system-level improvement.

“This priority has delivered governance structures, shared definitions, baseline intelligence, and clear direction for system-level improvement.”

2.6 Our Quality Priorities for April 2026-March 2027

Priority one: Clinical effectiveness – Making data tell the story of care

Priority for improvement:

The priority for improvement is to implement a patient journey intelligence model that combines existing operational, safety, outcomes, and patient experience data to move from descriptive reporting to meaningful insight. This will be achieved through a small multidisciplinary working group that maps the patient journey from referral to discharge or death, triangulates key datasets, and uses this intelligence to identify variation, inequity and improvement priorities. The expertise to deliver this model exists within the organisation; however, focused development will be required to strengthen analytical interpretation and narrative reporting skills, ensuring data is consistently translated into action. This pragmatic approach enables improvement within current capacity and embeds intelligence-led learning into routine governance.

For patients and the people who use our services, this work will help us better understand what it is like to receive care from us, from first referral through to ongoing support and end-of-life care. By bringing together this information, we will be better able to identify where care is working well, where people may experience barriers or inequalities, and where improvements are needed to ensure care is delivered with empathy, and is responsive and consistent for all communities.

How this will be monitored and measured:

Delivery of the patient journey intelligence model will be monitored against a clear 12 month plan, overseen by the multidisciplinary working group and reported through existing governance forums. Progress will be measured by achievement of key milestones, improvements in the quality of reporting (including triangulation and identification of variation or inequity), and evidence that intelligence is being used to inform agreed improvement actions and routine governance discussions.

Priority two: Patient safety and experience – Clinical documentation optimisation

Priority for improvement:

Clinical documentation is essential for safe, high-quality hospice care. The time required to complete clinical records during and after consultations can reduce time available for direct patient care and contribute to workforce pressure.

Currently, there is limited organisation-wide data across Sue Ryder hospices on the scale of documentation burden, any variation in documentation workflows, and the impact on clinician time and patient-facing care. Emerging evidence suggests Heidi can reduce clinical documentation time by up to ~50%, equivalent to approximately 1.5-3 hours saved per clinician per day. This quality priority aims to establish a clear baseline of documentation workload and evaluate how digital innovation can reduce this and support improvements.

The introduction of Heidi Ambient Voice Technology presents a significant opportunity to reduce documentation burden. This quality priority will align with Heidi implementation where appropriate and provide an evaluation framework to measure its impact.

How this will be monitored and measured:

We will implement a centrally coordinated, locally delivered model which will be adopted with a central project lead who will oversee consistency, reporting, and evaluation. At each hospice, we will implement a clinical lead responsible for local engagement, escalation and embedding the technology in clinical delivery. This approach ensures consistency while enabling flexibility for local practice variation.

Evaluation will measure impact through baseline and post-implementation comparison of documentation time (target: up to ~50% reduction / 1.5-3 hours per clinician per day), after-hours administrative burden, adoption rates, and documentation quality (completeness and accuracy), alongside clinician experience feedback. Data will be reviewed at regular intervals, with success defined by sustained time savings, high uptake across sites, positive workforce and patient feedback, and maintained and improved documentation standards.

Priority three: Patient safety – Safeguarding

Priority for improvement:

Our safeguarding priority is to ensure that practice across all services is consistently safe, lawful, evidence-based and aligned to national legislation. This will require the effective implementation of Sue Ryder Written Controls at local level, supported by clear governance, high-quality supervision, and accessible guidance. We will build a culture where practitioners are confident in making professional judgements, grounded in the Mental Capacity Act (MCA), statutory safeguarding duties, and best-practice standards. Our objectives will drive continuous improvement, be measurable, and be embedded through communication, training, and audit feedback loops.

How this will be monitored and measured:

We will monitor whether safeguarding supervision is happening as expected and whether it is making a real difference to practice. This will include checking that supervision is planned, structured, reflective, and properly recorded, and that it follows the agreed policy.

We will look at the quality of supervision, not just whether it took place. Supervision discussions will be used to explore risk, strengthen clinical decision-making, and reinforce shared quality expectations. Learning from supervision will be captured and shared through reporting arrangements to show how it is improving practice and supporting safer decisions.

Regular audits will be used to check compliance and consistency across services. Where differences in practice are identified, this will be reviewed through governance processes and addressed locally. Safeguarding supervision questions built

into governance forums will help ensure ongoing oversight and challenge.

For mental capacity, best interests and Deprivation of Liberty Safeguards (DoLS), we will monitor whether staff are following a clear and consistent process. This includes reviewing whether documentation meets legal requirements, clearly explains the rationale for decisions, and shows that people's rights have been properly considered.

We will carry out focused reviews of completed assessments to test the quality of decision-making, identify themes or gaps, and share learning. Practitioner feedback, audit findings, and learning from these reviews will be used to reduce variation and improve confidence and consistency in practice.

Currently, 4 of 7 services are implementing the new safeguarding supervision policy, with variation in the templates used. The aim is to achieve consistent, robust supervision across all services and measure its impact. Processes and documentation for MCA, Best Interests, and DoLS differ across services, resulting in inconsistent patient experiences; however, standardised flowcharts, templates, and shared case discussions will support more consistent and legally sound care for patients who lack capacity.

Safeguarding supervision supports professionals to recognise risks earlier, make better decisions, act promptly, work collaboratively, and remain accountable, leading to safer care and improved patient wellbeing, measured through safeguarding logs, supervision records, and staff feedback. Improved use of MCA, Best Interests, and DoLS ensures safer, more consistent care, greater respect for patient rights, protection from inappropriate restrictions, and stronger legal compliance, meaning patients receive safe, dignified, and person-centred care. This will be measured through:

- DCIQ
- DoLS reports
- documentation quality
- audit results.

Priority four: Patient experience – Accessibility

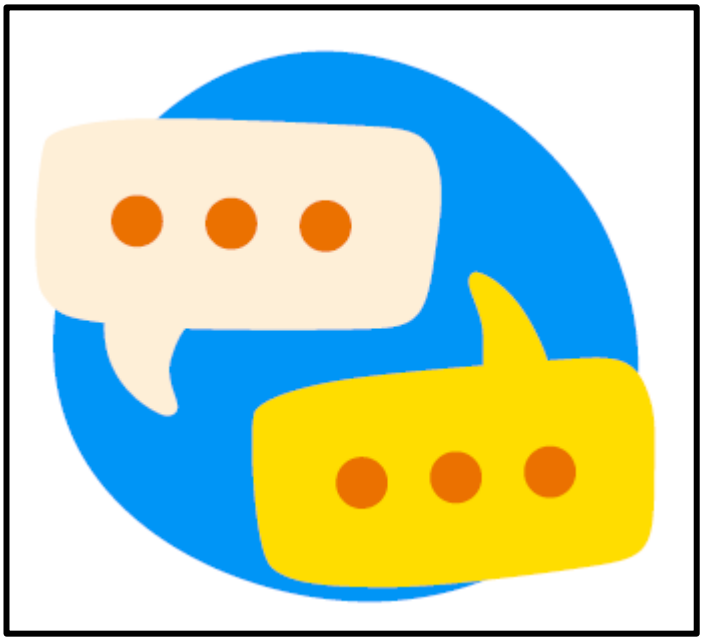
Priority for improvement:

Accessible healthcare is fundamental to delivering safe, effective, and person-centered care (CQC State of Care 2022/23: Access to Care). We will continue to improve equitable access to services by identifying, reducing, and where possible, eliminating barriers to care for patients with diverse accessibility needs. We aim to do this by exploring and implementing innovative digital solutions to support people who need accessible communication, including out of hours. Improved accessibility will support more equitable healthcare delivery, enhance patient experience, reduce missed appointments and delays in care, and contribute to better health outcomes for all population groups.

How this will be monitored and measured:

We will conduct a baseline audit of accessibility across services, including communication systems and digital platforms. We will implement or optimise systems to consistently capture, monitor and flag accessibility needs in patient records, and via incidents and complaints. We will engage with patients, carers, and community groups to co-design improvements. We will know we are successful when we have implemented a suite of digital solutions, such as accessibility apps for healthcare that are based on audit outcomes. We will deliver targeted staff training on those digital

solutions, and we will monitor the use and benefits of the selected innovations that we implement. We will use engagement with patients and staff to gain feedback to continually improve and ensure that accessibility needs are met.



2.7 Statements of assurance

This section contains the mandatory statements of assurance required of all providers of NHS-funded care within their Quality Account. The information provided is relevant to the services Sue Ryder provides.

During the period of this report, 1 April 2025 to 31 March 2026, Sue Ryder provided NHS-funded community care services in our hospices and some care centres, and NHS-funded nursing care in most of our centres.

The income generated by the relevant health services reviewed in the year ending March 2026 represents 14% of the total income generated from the provision of relevant health services by Sue Ryder for year ending March 2026. The statutory income received for palliative services was £14.3m and neurological services was £0.4m during the year (the total across both services being £14.7 for the period).

During the period from 1 April 2025 to 31 March 2026, there were no national clinical audits covering the NHS services that Sue Ryder provides.

During 2025-26, Sue Ryder delivered its annual audit programme across its healthcare services from April to March, providing assurance that care is safe, effective, caring, responsive and well-led. The programme has supported oversight of key areas of care and enabled services to identify, respond to and learn from variation in practice.

The audit programme focused on core areas of care including (but not limited to) medicines management, care planning and documentation, falls prevention, tissue viability, infection prevention and control, and clinical incident reporting. Monthly, quarterly and annual audits enabled regular review of practice,

with findings used locally and organisationally to support improvement.

Audits were undertaken using a standardised digital platform, with defined sampling methodologies and a 90% compliance threshold applied across all audits. Where standards were not met, services implemented improvement actions through Quality Improvement Plans, with re-audit undertaken to ensure changes were effective and sustained. Overall compliance remained high across services, with most audits meeting expected standards.

Audit findings were reviewed alongside incidents, complaints, compliments and feedback from people and families. This supported a more joined-up understanding of care, enabling themes to be identified, learning to be shared and improvements to be targeted where most needed.

Improvements resulting from the audit programme include:

- improved quality and personalisation of care planning documentation
- enhanced approaches to falls prevention and learning following incidents, with greater focus on post-fall review and learning
- increased consistency in tissue viability assessment and management
- strengthened infection prevention and environmental cleanliness standards.

During the year, learning from the audit programme has also informed the further development of the audit approach. This includes a move towards a risk-based model, strengthening how data is used alongside other sources of information, and ensuring audit activity remains focused on improving outcomes and experience for people using our services. This approach enables us to understand what is working well, identify where

care can improve, and continue to strengthen the quality and safety of care for people and families.

The CQC took enforcement action for one of our Sue Ryder hospices, Wheatfields in Leeds, on 3 June 2025 for failing to meet the regulations related to good governance during the period from 1 April 2025 to 31 March 2026. Sue Ryder Wheatfields Hospice has a very detailed action plan to drive quality improvements to meet this regulation. Sue Ryder has not participated in any special reviews or investigations by the CQC during the reporting period.

During the period from 1 April 2025 to 31 March 2026, Sue Ryder was not required to submit records to the Secondary Uses Service for inclusion in the hospital episode statistics.

Under current regulatory requirements, all organisations with access to NHS patient data and systems must publish a Data Security and Protection Toolkit (DSPT) self-assessment to verify adherence to robust data security standards and the proper handling of personal information. For the year ending June 2025, our assessment achieved full compliance across all standards.

It is important to note that the DSPT submission for the current period is not due until the end of June 2026. We are proactively preparing our updated self-assessment. We have a project in progress to work towards achieving Cyber Essentials Plus for our Healthcare Operations before the 2027 submission.

Furthermore, Sue Ryder was not subject to the Audit Commission’s Payment by Results clinical coding audit during the period from 1 April 2025 to 31 March 2026.

Sue Ryder continues to demonstrate improvements with data management:

- improving data quality checks, validation and collection processes
- embedding an Operational Performance Report (OPR) to enable local and national trend analysis
- assembly of regular performance review meetings; enabling open conversations relating to financial, operational and strategical challenges and opportunities
- embedding a system for shared learning through the cascading and monitoring of learning for safety memos
- implementation of a Directorate Summary monthly report to enable organisational oversight.

During the period 1 April 2025 to 31 March 2026, 1,060 Sue Ryder patients died (1,060 in our palliative inpatient units and 0 in our neurological care centre). This comprised the following number of deaths which occurred in each quarter of that reporting period: 284 in the first quarter; 245 in the second quarter; 270 in the third quarter; and 261 in the fourth quarter.

The deaths in our services were expected deaths, and by 31 March 2026, 0 case record reviews and 0 investigations had been carried out in relation to the deaths included above.

2.8 Indicators for quality

Safety

Service user incidents and harm:

- **No. of incidents affecting service users/patients/online clients**
  Palliative 2025-26: 1,577
  Palliative 2024-25: 1,264
  Bereavement 2025-26: 301
  Bereavement 2024-25: 618
  Neurological *2025-26: –
  Neurological 2024-25: 294

- **No. of incidents resulting in severe harm**
  Palliative 2025-26: 0
  Palliative 2024-25: 0
  Bereavement 2025-26: 0
  Bereavement 2024-25: 0
  Neurological *2025-26: –
  Neurological 2024-25: 0

- **Rate of incidents resulting in severe harm**
  Palliative 2025-26: 0.0%
  Palliative 2024-25: 0.0%
  Bereavement 2025-26: 0.0%
  Bereavement 2024-25: 0.0%
  Neurological *2025-26: –
  Neurological 2024-25: 0.0%

*Sue Ryder Neurological Care Centre Dee View Court transferred to Care Concern Group (CCG) on 25 April 2025

Effectiveness

No cases of Clostridium Difficile were acquired within our services during 2025-26.

One case of Clostridium Difficile was acquired prior to the person being admitted to the service.

Clostridium Difficile

- **Clostridium Difficile**
  2025-26 SR: 0
  2025-26 Out: 1
  2024-25 SR: 0
  2024-25 Out: 3

- **Rate per 100,000 occupied bed days**
  2025-26 SR: 0.0
  2025-26 Out: 4.7
  2024-25 SR: 0.0
  2024-25 Out: 8.4

SR = Acquired within Sue Ryder
Out = Acquired external to the service

Healthcare-associated infections (HCAI):

- **Clostridium Difficile**
  SR: 0
  Out: 1

- **Klebsiella**
  SR: 0
  Out: 1

- **MRSA**
  SR: 0
  Out: 1

- **E-coli**
  SR: 0
  Out: 1

- **Pseudomonas aeruginosa**
  SR: 1
  Out: 0

- **Total**
  SR: 1
  Out: 4

SR = Acquired within Sue Ryder
Out = Acquired external to the service

Occupied Bed Days

- **Palliative**
  Data provided by Services 2025-26: 21,377
  Data provided by Services 2024-25: 20,967

- **Neurological***
  Data provided by Services 2025-26: –
  Data provided by Services 2024-25: 14,788

- **Total**
  Data provided by Services 2025-26: 21,377
  Data provided by Services 2024-25: 35,755

*Sue Ryder Neurological Care Centre Dee View Court transferred to Care Concern Group (CCG) on 25 April 2025

Formal complaints about care – April 2025-March 2026

Complaints Response and %

- **Palliative**
  Complaints: 19
  Acknowledged within 3 days: 17 (89%)
  Responded within 20 days: 15 (79%)

- **Bereavement**
  Complaints: 1
  Acknowledged within 3 days: 1 (100%)
  Responded within 20 days: 1 (100%)

- **Total**
  Complaints: 20
  Acknowledged within 3 days: 18 (90%)
  Responded within 20 days: 16 (80%)

Complaints Outcomes

- **Palliative**
  Complaints: 19
  Upheld: 3
  Not upheld: 10
  Partially upheld: 5
  Ongoing: 1

- **Bereavement**
  Complaints: 1
  Upheld: 0
  Not upheld: 1
  Partially upheld: 0
  Ongoing: 0

- **Total**
  Complaints: 20
  Upheld: 3
  Not upheld: 11
  Partially upheld: 5
  Ongoing: 1

- **%**
  Complaints: 100.0%
  Upheld: 15.0%
  Not upheld: 55.0%
  Partially upheld: 25.0%
  Ongoing: 5.0%

We define a formal complaint as ‘an expression of discontent to which a response is required’. With reference to our Complaints Policy, the complaint is considered formal when it is received orally, in writing or electronically, and cannot be resolved within 24 hours of receipt.

There were 20 formal complaints about care during 2025-2026, compared to 50 in 2024-2025.

The target in the Complaints Policy for the initial holding response to complaints is three working days. Where the complaint was initially received by a service, and where the complaint was by a named complainant, 90% were acknowledged within this timescale. The target in the Complaints Policy for the final written response to a complaint is 20 working days. However, the policy does acknowledge that in some instances this is not possible. This would usually be where the investigation is complex. In these cases, all services aim to maintain contact with the complainant, giving a report of progress and in all cases, sending a holding reply within 20 working days.

Of those complaints where the complainant requested a formal response, in 16 out of 20 instances the 20-working day target was met. Where the target time was not met, the complainant was in all cases sent a holding letter to explain the delay. The themes from complaints are very important. They help us to learn and to improve the overall experience for individuals using our services.

The number of complaints across all service areas is low, but we have reviewed those received and the below table details the themes identified (please note, there may be multiple issues within one complaint).

All complaints are discussed within local Quality Improvement Groups at individual services. Feedback and learning to the local teams regarding improvement measures is monitored locally.

Complaints themes

- **Building closer relationships**
  Annual total: 5
- **Improving access and waiting**
  Annual total: 2
- **Improving communication, information and choice**
  Annual total: 4
- **Safe, high quality, co-ordinated care**
  Annual total: 9
- **Total**
  Annual total: 20

Service user feedback

We measure service user satisfaction in a number of ways, including real-time feedback surveys. The questions we ask relate to people's experience of the care and support they receive; how well they are treated by us; and whether they would recommend our services to others if they needed similar care and treatment. Relatives of people using our services are also encouraged to provide feedback, particularly for service users with complex conditions or who may have communication difficulties.

"I felt the Sue Ryder sessions are a very valuable support to anyone experiencing grief. It was so helpful to have a dedicated therapist to talk to each week and discuss how I'd been feeling. They were extremely empathetic, understanding and compassionate."

"The environment is clean and pleasant. The staff are friendly and helpful. My relative has been treated with respect, kindness and dignity."

“I can’t thank the wonderful home care team who looked after my husband enough. They are all the most caring, wonderful, kind and compassionate people and I wouldn’t have coped without them. They will have my eternal gratitude.”

“All of the staff, whatever their role is, are knowledgeable, caring, approachable and definitely go above and beyond.”

“Supported family during last offices. The family said we have been fantastic and they wouldn’t have been able to have managed without our support. They feel their dad has received fantastic care.”

“The care provided to me and my wife has been second to none. I can’t fault it. As an example, the kitchen staff found out that I like the occasional steak, so that is what I am having for tea tonight cooked to my spec.”

Part three: Other information

3.1 Sue Ryder North East and Yorkshire: Sue Ryder Manorlands Hospice

Jo lives with serious lung conditions resulting in fatigue and breathlessness and has struggled with anxiety and confidence.

She said: “I was diagnosed three years ago with COPD and idiopathic pulmonary fibrosis and I also have asthma. They gave me four years at the time.

“I first went to Sue Ryder Manorlands Hospice in April and at the time I didn’t have much confidence. I’m on oxygen now and have that to walk around with so I didn’t leave the house much.

“I was very anxious about my first session but they arranged for a volunteer driver to come and pick me up. Everything is just so personalised. The staff were excellent. They couldn’t do enough for me.”

Initially, Jo attended the six-week Breathe Better programme run by the Community Day Services team with input from an Advanced Clinical Practitioner.

Jo said: “I was having problems with my dad, who has dementia, and I was struggling a lot with the menopause which was affecting my breathing. The ACP spoke to social services about my dad, she also arranged for me to go to a menopause clinic. She arranged for the occupational therapist to come and see me. She got me a perching stool for the kitchen and organised a hand rail for the bathroom. It was just above and beyond. The Breathe Better course covered a lot about my illness which I didn’t know. I really learned about fatigue, about COPD.

“I have found going to the hospice very safe and welcoming and I have felt valued. It’s given me a lot of confidence. After the Breathe Better sessions, I did creative therapy for six weeks. Now I have gone back to do the wellbeing course. I was that low before I went to the hospice, I don’t know what I would have done without them. I have got to the point where I look forward to going. It’s nice to talk with people in a similar situation. I must admit before I went to Manorlands, I did feel alone, but I don’t now.”

3.2 Sue Ryder North East and Yorkshire: Sue Ryder Wheatfields Hospice

When Yvonne's brother Darren was diagnosed with lung cancer, she had a difficult time getting the care he needed. But when Sue Ryder Wheatfields Hospice stepped in she says, "the care was second to none".

"Darren was a complex case. He had chronic epilepsy, PTSD, and hyponatremia. We thought he'd had a stroke. He had a brain scan and the doctor told me and my wife that he had lung cancer which had metastasized to his brain.

"Me and Judi were going to the hospital every day to feed him breakfast and lunch. He couldn't walk as he was paralysed down his right side. He was left in the bathroom on his own, fell on the floor, and cut his face.

"When he got to Sue Ryder though, it was a complete breath of fresh air. The staff cared for Darren, had empathy, and understood his needs. They lowered his bed, put crash mats down in case he had a seizure, and brought him in the garden in his wheelchair. Nothing was too much for them. One of the nurses phoned me at 2am to say they'd had to sedate him. I asked Darren if he liked it at the hospice, and he said, 'I absolutely love it'.

"The staff looked after me and Judi too and were so supportive of us. We slept there the night before Darren passed away, and he died in my arms the next day.

"Darren was 52 when he died on March 31, 2024. There's a big hole in our lives now. It's been difficult in terms of my own grief. I had some online counselling through Sue Ryder which was very helpful.

“On the day Darren passed away, we were sat in the garden, and the Head Chef came out, gave us a hug and asked if we had eaten. When we told her no, we didn’t want anything. She went away, came back soon after and she had brought us some sandwiches. She said, if you won’t have a meal, at least please eat these. It’s the little touches, the way they take care of patients, and the families as well.”

3.3 Sue Ryder East of England: Sue Ryder Thorpe Hall Hospice

Sue Ryder nurse Claire has been awarded the title of Queen's Nurse by the Queen's Institute of Community Nursing. The title is awarded to nurses who have spent at least five years working in community settings and recognises commitment to learning, leadership and excellence in patient care.

Claire, who is Clinical Team Manager of the Hospice at Home service at Sue Ryder Thorpe Hall Hospice in Peterborough, has previously been a District Nurse, set up community-based services in Peterborough while deputy lead nurse for the healthcare federation, and worked in a GP practice.

She said: "My heart is definitely in the community, looking after patients, helping them to stay at home, because I think that's where most people really want to be. What I really love about the community side of nursing is how it allows you to build that rapport with patients. When you go into somebody's home you are a guest, and they need to feel comfortable in your presence.

"I started at Sue Ryder in March 2023. Palliative care was something I had done quite a lot of as a district nurse and I knew that was where I wanted to be. It's just being able to make a difficult time that little bit easier by providing that support for families and enabling patients to stay at home at the end of their life.

"It has been really rewarding being able to shape and mould the service we provide here at Sue Ryder and make quality improvements. The changes we have made have allowed us to increase our capacity, see more patients and improve the quality of care."

Claire attended an awards ceremony in London in November. She said: “It’s nice to be recognised for something I’m so passionate about and I’m also really excited about the opportunities to collaborate with other Queen’s Nurses and share learning and ideas. There are webinars and conferences with other nurses in the region so it’s a great networking opportunity and I will be able to bring those learnings back and share with the team and my peers within Sue Ryder.”

3.4 Sue Ryder East of England: Sue Ryder St John's Hospice

Courtney's dad, Damien, spent his final 24 hours at Sue Ryder St John's Hospice and died, aged 49, 11 days from diagnosis. After his death, Courtney turned to Sue Ryder's online bereavement services and through that support discovered a passion for running.

"In February 2024, following a CT scan, it was confirmed Dad had bowel cancer. It was a terrible time. The hospital palliative care team told us that there was a space for Dad at Sue Ryder St John's Hospice, and we jumped at the chance.

"When we arrived, the Sue Ryder Nurses made sure Dad was made comfortable. There was a whiteboard that said 'Welcome to Sue Ryder, Damien' with a smiley face. In hospitals, it's usually very clinical and formal, but at the hospice, it felt much more personal and welcoming. It helped us relax and feel like we could just be there as his family supporting him.

"Dad was in a lot of pain, so we stepped out of the room so the nurses could help him, and when we walked back in, his face had completely changed. He looked more relaxed and at peace.

"The hospice also helped me with the practical things. I was still so young and I had never experienced anything like this before. I was given a 'what to expect' leaflet which helped me to prepare for what was going to happen to Dad, and they explained what I needed to do for Dad's funeral. Experiencing hospice care has left our family with a lifetime of gratitude for Sue Ryder."

Courtney turned to Sue Ryder's online bereavement services and through this, it was suggested she go out for a run. From there her passion has grown, leading her to apply for a Sue Ryder place in the London Marathon.

"I felt it was my responsibility to navigate through my grief, and I found that running helped me to do that. It stops me from dwelling on the past, it clears my head and helps me think more clearly.

"If I can navigate the last two years, I can get through this marathon. Dad would think I was absolutely bonkers, but at the same time, he would be buzzing for me and really proud."

3.5 Sue Ryder South East: Sue Ryder Duchess of Kent Hospice

Kevin's world was turned upside down when he was admitted to hospital with an injury to his foot and subsequently also diagnosed with cancer. Kevin, 61, has since received support from the team at Sue Ryder Duchess of Kent Hospice.

"I went into hospital in October 2024. I have been diabetic for 25 years but had been completely fit and healthy, I was playing golf in Cyprus in September. I was taken in with a cut on my foot and unfortunately it was a very nasty bug. I was in hospital for eight-and-a-half weeks being treated but the upshot was that they decided that they needed to amputate my foot. Then, while I was in hospital, they picked up that I have cancer of the liver.

"All the wonderful team from Sue Ryder have really gone out of their way to help me, even making home visits to me. One thing I really appreciated is that when the Sue Ryder team come to your home they wear name badges which really helped me to know who was supporting me. When you are feeling unwell it makes a much better experience for you.

"Amy the physio has been absolutely superb. I had been bedridden since October 2024 but she gave me a whole lot of exercises to do to help me strengthen my body because when you stop moving around you get very weak. I had to learn to use crutches. I couldn't even get a wheelchair from the hospital as they had changed supplier, so Amy arranged that for me as well as a ramp. When you are feeling poorly the last thing you feel like doing is chasing people for help. Amy was a breath of fresh air.

“Every step of the way, where I have needed assistance, Sue Ryder has been there for me. I have had an amazing experience. Every time I have seen someone from Sue Ryder they have exceeded my expectations, from the nurses and physiotherapists, to the dietary advice.”

3.6 Sue Ryder South East: Sue Ryder Palliative Care Hub South Oxfordshire

Richard's mum, Sandra, was cared for by the team from Sue Ryder's Palliative Care Hub South Oxfordshire in the final weeks of her life.

"Mum was diagnosed with pancreatic cancer in June 2024. She had support from Sue Ryder over the last month of her life. It was amazing all the equipment that was provided. We had a chair, which was really handy as it meant she could adjust her position, lots of walkers, and it was all delivered at a day's notice. Sue Ryder also provided a hospital bed that we could move up and down so she was able to live downstairs for the last week.

"She had hospice at home care from Sue Ryder too. My dad was caring for her but having the Sue Ryder nurses going in twice a day was really good. It gave my dad some structure and if he had any questions or anything that he was concerned about he could talk to them. There was also a phone line he could call whenever he wasn't sure about anything. The Sue Ryder nurses were actually there the day mum passed away and it was very reassuring to have someone there who knew what to do and could step in or help if needed.

"I look back at mum's last few months and they were as good as they could be under the circumstances. She didn't want to be in a hospital, she wanted to be at home and Sue Ryder made that possible.

"She could sit and see the bird feeders in the garden. I worked from my parents' house two or three days a week and spent time with her. She had family and friends coming in and they

weren’t restricted by visiting hours as they would have been in a hospital. The hospice at home care was fantastic.

“Mum passed away in December 2024. I was going to run Reading Half Marathon anyway and I thought it would be nice to do it for Sue Ryder. Last year was incredibly tough but it felt positive to be doing something good in mum’s memory.”

3.7 Sue Ryder South West: Sue Ryder Leckhampton Court Hospice

Matt, 46, took on a year of physical challenges to celebrate and remember his wife Katy. A former Detective Sergeant at Gloucestershire Constabulary, Katy, found comfort and creativity at Sue Ryder Leckhampton Court Hospice during her illness. She died on September 28, 2024.

“Katy was first diagnosed with cancer in 2016. She went through various treatments, multiple surgeries and never once complained. That was just her, strong, kind, and full of life.

“She started going to Sue Ryder for day services. It was there she got into her painting. She’d retired from the police by then and set up a small art business. Hundreds of people bought her paintings.

“There was a brilliant doctor at Sue Ryder. Katy had real issues with pain control, and he found alternative ways to help her. She went from being almost bedbound to active again, doing things she loved. The care she received was extraordinary.

“Katy spent her final three weeks at Sue Ryder Leckhampton Court Hospice, and I lived there with her, along with her sister, Lucy. We couldn’t have asked for more support, everyone made an impossibly difficult time bearable. We had tea parties in the middle of the night with the nurses and cleaners. It was surreal, but beautiful.

“Katy did more than 20 years in the police before she left and she was a very popular figure. When we went into the hospice, one day they said the police helicopter is going to come up. Everyone was at the hospice windows, and the helicopter came down and took a bow to acknowledge her which was really

special. They also brought the police horses up to the hospice. It really brightened everyone's day. Our eldest dog spent a lot of time at the hospice with us too.

"I can't ever explain how special Sue Ryder is. All the staff, volunteers, cleaners, caterers, nurses and doctors, they're amazing. It's a family. They provide kindness, support, guidance and laughter during a time that's impossible to describe."

3.8 Grief and bereavement services

When his wife Mary died suddenly, Nigel, 76, didn't know where to turn. But when he discovered Sue Ryder's Online Bereavement Community he found the support he so desperately needed.

"My wife Mary died on November 17, 2024. She had lots of health conditions – asthma, COPD, arthritis, back problems, and she had chest infections on a regular basis. One day she fell down the stairs and went into hospital and then once home again, contracted a bad chest infection. A few weeks later she was rushed to hospital. She was put on oxygen, and visits were limited to just immediate family. But she was still texting and emailing from her phone. The next day she had a stroke, and died the following morning.

"I was stunned and completely numb. We had a huge funeral, but I barely remember anything from that day. When I looked for support online, there was a lot of information and it was really overwhelming. Then up popped an advert for Sue Ryder. I went onto the Online Bereavement Community and came across a group where people were sending friendly and chatty messages. It was all women, but I put my hand up and posted my first message. I was welcomed with open arms. We've had the most wonderful chats between us. And not just about grief either – we've talked about blocked drains, how to plaster a wall, all sorts of things!

"It's been an absolute lifeline to me. It's so simple and straightforward to use. There's things I've found I couldn't talk about with family, but I can talk to people on the Online Community like they're my family too. I've received a tremendous amount of support from the group. We all chip in and help each other when someone's having a down day – and

when someone’s had a good day we celebrate that too! It’s absolutely wonderful.

No matter how hard things get I always know the Online Bereavement Community is there. It’s such a vital tool to support so many people through the most difficult time in their lives.”

3.9 Research at Sue Ryder in 2025-26

Research plays a vital role in discovering and informing the best possible evidence-based care for patients and service users, both at Sue Ryder and in the wider healthcare sector. Sue Ryder participated in a variety of research over the past year, overseen by specialist staff in our Research Governance Group.

We await the final published results of this study we participated in:

CHELsea II trial

The study assessed whether giving patients fluids through a drip in the last days of their lives can help prevent delirium. 80 UK hospices and hospitals took part in the study exploring the use of clinically assisted hydration, sponsored by the University of Surrey and funded by the National Institute for Health and Care Research. Sue Ryder Leckhampton Court Hospice and Sue Ryder Manorlands Hospice participated, both meeting their target of securing 20 patients to take part.

Ongoing research:

POST study: Palliative Care and Oncology Survey on Terminology

This international study has been looking at what people who are known to palliative care and oncology services think about the terminology that is used to describe them, for example ‘cancer survivor’. How people view these terms could have important implications for how they receive care services. At Sue Ryder, our Palliative Care Hub South Oxfordshire and Duchess of Kent Hospice have been taking part and recruiting patients.

To date, the questionnaire has been completed by 1,328 people with cancer. The target sample size is 1,532. Preliminary analysis has been undertaken.

Communication about the process of dying: implementing a video resource in hospices

Researchers at Lancaster University are working with Sue Ryder Leckhampton Court Hospice to pilot a video resource to support communication about the dying process with families of patients under hospice care. The video was recorded by Kathryn Mannix, an eminent palliative care doctor and leading expert in public communication and understanding of death and dying. A workshop was held in February 2026 with Sue Ryder staff at the hospice to develop the video-based intervention, with a pilot implementation study planned for later in the year.

Discussing and documenting demographic data in hospices: exploring staff experiences

Maddy French, Senior Research Fellow with Sue Ryder and Lancaster University, is leading a qualitative study with staff in Sue Ryder hospices to explore perspectives on documenting and discussing patient demographic data. The study aims to generate findings to help improve the documentation of such data, which is important for evaluating initiatives addressing inequities in specialist palliative care access and outcomes.

A study looking at a better way to identify and manage delirium in hospices

At Sue Ryder Leckhampton Court Hospice, we have recently opened the DAMPen-D II study (Improving the Detection, Assessment, Management, and Prevention of Delirium in Palliative Care Units: a Cluster Randomised-Controlled Trial, Economic Analysis and Process Evaluation), which will look at improving the detection, assessment, management, and prevention of delirium in palliative care. It is a cluster randomised-controlled trial, which will evaluate a new delirium intervention strategy.

INDIGO Study

Sue Ryder Leckhampton Court and Manorlands Hospices are participating in the INDIGO study – investigating the use of intranasal diamorphine and midazolam in the management of pain and anxiety, and freeing nursing resources, in palliative care. This National Institute for Health and Care Research funded study will eventually involve a randomised controlled trial. At this stage our hospices have been recruiting staff for interviews and focus groups with regards to how the study might work.

Annexes

Annexe 1: Commissioner feedback

Every year we share our draft national Quality Account with the local Integrated Care Systems (ICSs) and local Healthwatch for all our services, asking for their feedback and areas for improvement. We would like to share their feedback with you.

Sue Ryder's response to commissioner feedback: Thank you very much for reviewing our Quality Account 2025-26. We appreciate and acknowledge all the feedback we have received.

Healthwatch Central Bedfordshire

Thank you for sharing Sue Ryder's Quality Account 2025-26 and for the opportunity to provide feedback on the organisation's quality performance, initiatives and priorities. Please also extend our thanks to colleagues involved in developing the report.

We found the Quality Account to be comprehensive, reflective and clearly focused on continuous improvement and person-centred care. It demonstrates a strong commitment to supporting people through palliative and end-of-life care, bereavement and grief support, whilst remaining transparent about challenges and areas requiring further development.

In particular, we were pleased to see the emphasis placed on:

- Advance care planning and improving person-centred conversations around future care preferences.
- Bereavement support and the introduction of real-time feedback mechanisms to better understand people's experiences and outcomes.
- Accessibility as a priority for 2026-27, including the intention to reduce barriers to care and improve inclusive communication approaches.
- The continued focus on safeguarding, governance and learning from incidents and complaints to support safer care delivery.
- We also welcome the transparent reflection regarding Sue Ryder Wheatfields Hospice and the clear commitment to ongoing improvement and partnership working following the CQC inspection findings. The openness shown within the report helps demonstrate a culture of learning and accountability.

The proposed priorities for 2026-27 appear appropriate and aligned with current pressures and opportunities within palliative and end-of-life care. In particular, the focus on using data more effectively to understand patient journeys and inequalities in access has the potential to strengthen service planning and outcomes. We also recognise the potential benefits of digital innovation and documentation optimisation in enabling clinicians to spend more time directly supporting patients and families.

We were additionally encouraged to see the emphasis on co-production and listening to feedback from people using services. The decision to adapt the bereavement co-production approach in response to client feedback demonstrates sensitivity and responsiveness to people's emotional needs and readiness to engage.

We also note strong alignment between several of Sue Ryder's proposed priorities and findings from recent Healthwatch Central Bedfordshire engagement work undertaken with residents, carers and bereaved families across Bedfordshire, Luton and Milton Keynes regarding palliative and end-of-life care experiences. Participants consistently highlighted the importance of earlier advance care planning conversations, improved coordination between services, equitable access to support, culturally responsive care and clearer navigation for families during periods of crisis. It is encouraging to see many of these themes reflected within Sue Ryder's quality priorities for 2026-27, and we would welcome continued opportunities to share lived experience insights that may support future service development and improvement work.

As a broader observation, we would encourage continued focus on:

- Ensuring equitable access to hospice, palliative and bereavement support for underserved and marginalised communities.
- Monitoring the impact of digital innovation on accessibility and inclusion, particularly for people who may face digital exclusion.
- Continuing to strengthen communication with families and carers, particularly around care coordination, advance care planning and safeguarding decisions.
- Overall, this Quality Account reflects a compassionate organisation that is committed to learning, innovation and improving the experiences of people facing dying and grief.

We are happy for this response to be published as part of the final Quality Account.

Kind regards,
Diana Blackmun
Chief Executive Officer, Healthwatch Central Bedfordshire

Healthwatch Oxfordshire

Thank you for letting Healthwatch Oxfordshire have sight of the Sue Ryder organisation draft Quality Account 2025-6 prior to publication. We would like to pass on our thanks to all your staff for continuing to work hard and provide the care and support to South Oxfordshire's residents. The comments below are on the report as a whole, as there is relatively little detail about the specific service you provide to South Oxfordshire residents.

Of note Healthwatch Oxfordshire will shortly be publishing a report on what we have heard from residents about their views

and experience of end of life care, and this will be available on our website here:
https://healthwatchoxfordshire.co.uk/research-reports
We worked closely with members of the Oxfordshire Palliative Care Network to develop this work. This will give you further insights into patient and carer views.

Progress on quality priorities for 2024/2025

- Priority 3 Bereavement real-time feedback and coproduction. It is positive to see user voice being centred, including a responsive approach to co-production and attention to reducing questionnaire fatigue - it would also be good to hear from those who are not engaging with bereavement support and understand what barriers they might face.
- Priority 4: Advance care planning. Good to see advanced care planning highlighted as in our research and conversations we heard that many people in Oxfordshire wanted to know more about this – this highlighted the importance of including cultural appropriateness, timing and support for people to have conversations with their loved ones as well as health and care professionals.

2026-27 quality priorities:

- Quality Priority 1 – Clinical Effectiveness – Making Data Tell the Story of Care - this does mention ‘patient experience data’, it would be good to see this process reflect the importance of patient and carer voice and qualitative insight.
- Quality Priority 2 – Patient Safety and Experience - Clinical Documentation Optimisation – need to demonstrate reassurance that using AI clinical notetaking has adequate accuracy and data protections, and transparency with patients so that they are clearly informed about what will happen with their data.

- Quality Priority 3 – Patient Safety – Safeguarding - this is important and good to see. Will this be integrated with previous work on advanced care planning and involvement of patients and carers in decision-making?
- Quality Priority 4 – Patient Experience – Accessibility – again positive to see emphasis on accessibility, but some concerns too - we know digital and remote tools can support access for some people but do not work for everyone. It would be good to highlight choice and the importance of in-person, face to face options and accessibility for people who are not able to use digital tools for any reason (including cost, confidence, language barriers, communication needs, mobility or sensory impairments), as well as need for auxiliary support for some people to access digital tools (e.g. digital cafés for NHS app) - particularly important in context of palliative and end-of-life care where most people would like control and agency over what happens to them. Again, it is good to see these will be co-designed with community groups - it's important to involve people from very early stages of the design process - co-producing solutions to barriers, rather than just consulting on digital tools.

As noted last year, it will be interesting to see how joint work evolves around emerging neighbourhood health, prevention and shift to community care with NHS Ten Year Plan, and how you might respond.

Kind regards,
Dr. Veronica Barry
Executive Director

Healthwatch Bradford and District

Healthwatch Bradford and District welcomes this opportunity to comment on Sue Ryder's Quality Account for 2025/26.

As the independent champion for people using health and care services, we recognise the important role Sue Ryder plays in delivering palliative and end-of-life care and supporting people and their families during some of the most difficult times in their lives. We welcome the organisation's continued commitment to ensuring that service user and family voices are central to the planning and delivery of care.

We acknowledge the ongoing pressures faced across the health and care system, including financial constraints and increasing demand for hospice and palliative care services. Despite these challenges, we recognise Sue Ryder's continued focus on maintaining high-quality, compassionate care and its commitment to service improvement and development.

We are pleased to see continued emphasis on improving patient and family experience, including work to strengthen bereavement support, enhance care environments, and develop initiatives that support dignity, comfort and emotional wellbeing. The focus on partnership working and engagement with stakeholders is also welcomed.

The Quality Account highlights both achievements over the past year and areas for continued development, demonstrating a commitment to transparency and continuous improvement. We note that service user feedback continues to play an important role in shaping services and informing priorities.

Healthwatch Bradford and District values its ongoing relationship with Sue Ryder and welcomes the organisation's

engagement with our feedback process. We look forward to continuing to work together to support high-quality, person-centred care for local people and their families.

Helen Rushworth
Chief Executive
Healthwatch Bradford and District

NHS Thames Valley Integrated Care Board

NHS Thames Valley Integrated Care Board (TV ICB) has reviewed Sue Ryder's 2025-2026 Annual Quality Account and believes that it is accurate and meets the requirements of a Quality Account.

The National Quality Board now includes the additional dimensions of sustainability, leadership, and equitable care to its definition of quality in addition to the established areas of safety, effectiveness, and experience. The quality of the services provided at Sue Ryder is therefore measured by looking at:

Patient Safety:

Key developments across the patient safety space are still driven by the ongoing implementation of the NHS Patient Safety Strategy, with a focus on system-wide digital, cultural, and operational reforms. A key part of this is the introduction of Martha's Rule – giving patients, families, and staff a way to request a rapid review if they are worried about patient deterioration. Sue Ryder Quality Account can be strengthened by demonstrating if and how Martha's rule applies to its services.

The Patient Safety Incident Response Framework (PSIRF) is a system-based learning, and continuous improvement approach

to incidents. It is now implemented in most Thames Valley provider organisations delivering NHS-funded care and is transforming how we learn and respond to patient safety events as a system. Sue Ryder has embraced and evidenced this transition through its 5 strategic goals discussed within this Quality Account.

It is encouraging to see that Sue Ryder has demonstrated measurable improvements in pressure ulcer prevention, medicines optimisation, implemented a robust audit framework, and is actively working to improve safety governance.

The ICB would like to see further development in organisational reflective learning by strengthening data-driven safety intelligence in addition to focussing on risk escalation.

The ICB is also looking forward to seeing how Sue Ryder will assess and demonstrate objective and measurable progress against the planned improvement workstreams moving into 2026/27 as highlighted within the Quality Account.

Delivering clinically effective patient interventions: One of the aims of the NHS 10-Year Health Plan (published in July 2025) is to improve clinical effectiveness. This is proposed through shifting care from hospitals to the community, moving from analogue to digital, and pivoting from illness to prevention. Sue Ryder has demonstrated this through its adoption of technology to improve consistency in documentation and safeguarding practice (e.g. pioneering a new AI Scribe tool).

Work has started on reducing variation, and standardising advance care planning (ACP) across Sue Ryder through a National Working Group in 2025/26. It was recognised by Sue Ryder that a single standardised ACP process and document could not be implemented at a national level across all services due to variation in regional documents and processes that are maintained within the ICBs. The Thames Valley ICB is keen to

understand more about this work and is keen to explore opportunities to help move this forward in a collaborative way.

It is clear from this Quality Account that Sue Ryder has a digitally supported and robust local audit programme in place driving measurable improvements. Examples mentioned of core areas focussed on during 2025-2026 were medicines management, care planning and documentation, falls prevention, tissue viability, infection prevention and control, and clinical incident reporting.

The National Audit of Care at the End of Life (NACEL) is on the NHS National Quality Account list for 2025-2026 and again for 2026-2027. While formal NACEL participation is contractually mandated for NHS inpatient providers in acute and community hospitals, the VCSE sector also plays a vital role in the delivery of end-of-life care. The ICB would encourage voluntary participation in the NACEL audit to allow Sue Ryder to benchmark their end-of-life care against national standards and potentially identify valuable service improvements.

Patient feedback about care provided:

The primary purpose of gathering patient feedback is to listen to, reflect on and act on the feedback to improve patients' experiences, interactions, safety, and health outcomes.

During 2025-2026 Sue Ryder has evidenced this through a strong shift towards seeking real-time, continuous feedback, and demonstrated responsiveness especially through its bereavement services.

Sue Ryder's commitment to improving feedback systems and oversight is laudable. The ICB remains committed to working with Sue Ryder to ensure that feedback remains proportionate and aligned across patient pathways and systems as far as possible.

Sustainability (environmentally and clinically):

The NHS remains on track to achieve its interim target of an 80% reduction in direct emissions by 2032. (NHS England » Five years of a greener NHS: progress and forward look).

Between 2020 and 2024 in England, the UK Health Security Agency (UKHSA) estimated there were a total of 10,781 heat-associated deaths as a direct consequence of heatwaves. It is encouraging to see the launch of Sue Ryder's five-year Sustainability Strategy in 2025 demonstrating board level commitment to sustainable healthcare delivery. This is demonstrated by Sue Ryder's intentions to roll out the Greener Palliative Care program across all its hospices.

The ICB recognises that Sue Ryder is still in the early stages of its sustainability journey with many initiatives not yet fully embedded, or the full impact evaluated. The ICB would therefore encourage Sue Ryder to seize this opportunity to introduce clear KPIs and qualitative tracking systems to strengthen assurance, governance, and benchmarking over the coming year.

Within this Quality Account, Sue Ryder describes sustainability mainly in operational and environmental terms. An opportunity also presents itself for Sue Ryder to explore initiatives to strengthen its governance processes and cultural adoption around the sustainability of positive service user and population outcomes, including clinical pathways.

Leadership:

The draft Management & Leadership Framework was published by NHS England in September 2025. (NHS England » Management and leadership development). The ICB is excited

to work with Sue Ryder over the coming months to see how this will translate into practice.

Sue Ryder demonstrates clear strategic vision and direction, transparent leadership, with priorities aligned to national direction. However, there is some evidence of variability in leadership effectiveness at service level, highlighting possible gaps in governance assurance and compliance. This may suggest some inconsistencies in translating corporate strategy into frontline practice.

While good strong systems for organisational learning exist, further evidence and assurance that learning is consistently translated into practice and improvements are sustained at scale, would enhance Sue Ryder's leadership profile.

Equitable care:

Reducing health inequalities is a national priority and a key focus for the Thames Valley system.

The ICB would like to see this and a clear alignment between the organisations quality priorities and the overall Integrated Care System goals as set out in the Buckinghamshire, Oxfordshire and Berkshire West Joint Forward Plan (Thames Valley Joint forward plan still in development).

TV ICB is delighted to acknowledge Sue Ryder's continued strategic commitment to equity and inclusion as demonstrated as part of its vision within this Quality Account. This includes several improvement workstreams as well as a number of challenges still faced by the organisation.

It is therefore encouraging to see that equity of access remain a core future priority for Sue Ryder moving into the 2026-2027 financial year.

General:

TV ICB is noting that Sue Ryder has maintained an overall “Good” CQC rating apart from Wheatfields Hospice in Leeds, which achieved a “Requires improvement” rating in 2025.

End of life care is something that affects us all and at all ages: the living, the dying, and the bereaved. Improving the quality of palliative and end of life care for all is captured in the 6 ambitions through the Ambitions Framework (2021-2026) developed by a partnership of national organisations, including Sue Ryder.

Future development of its Quality Account to reflect Sue Ryder’s journey in developing visibility, delivering against, and measuring progress against these ambitions will add further weight to its commitment to quality, the communities and populations it serves, and its commitment to person centred care.

2025/26 has been yet another challenging year for health and social care with significant challenges across our Thames Valley geography across all sectors and landscapes. TV ICB is looking forward to continuing collaborating with its system partners to future proof the NHS for generations to come through developing and delivering the NHS Fit for the Future 10-year health plan.

Yours Sincerely
Sarah Bellars
Chief Nursing Officer NHS Thames Valley ICB


Sue Ryder

Annexe 2: Final statement

This final statement provides assurance that Sue Ryder has fulfilled the legal requirements set out under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations.

Sue Ryder is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. In preparing the Quality Account, we are required to take steps to satisfy ourselves that:

- The content of the Quality Account meets the requirements set out in the NHS England Quality Account requirements 2025-26.
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - relevant committee minutes and papers for the period April 2025 to March 2026
  - papers relating to quality reported over the period April 2025 to March 2026
  - feedback from commissioners.
- The Quality Account presents a balanced picture of Sue Ryder's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable,

conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with the Quality Accounts regulations.

The Quality Account was approved on 22 June 2026 by trustees.

Professor Rima Makarem
Chair of Trustees
22 June 2026

James Sanderson
Chief Executive
22 June 2026

We can’t stop terminal illness, death and grief from happening. But we can stop people facing them alone.

At Sue Ryder we believe how we die matters, which is why we’re committed to being alongside people through terminal illness, death and grief. We provide expert palliative and end-of-life care and grief support, offering hope, dignity, and kindness when it matters most.

Every day, Sue Ryder supports people who are dying or grieving, and because of you, we can be there for countless others. Last year alone, we gave over 655,000 hours of care. Every second mattered, and you gave us the means to do it.

For more information about Sue Ryder

call: **0808 164 4572**
email: **healthandsocialcare@sueryder.org**
visit: **sueryder.org**

facebook: **/SueRyderNational**

instagram: **@SueRyderCharity**

Sue Ryder, 183 Eversholt Street, London NW1 1BU

This document is available in alternative formats on request.

Because no one should face death or grief alone