NHS

East Suffolk and North Essex

NHS Foundation Trust

Quality Account 2020/21

Contents

Who was involved in the development of our Quality Report?

The Trust consulted with the following in the development of its Quality Report and the content within:

- our commissioners, North East Essex Clinical Commissioning Group, Ipswich and East Suffolk Clinical Commissioning Group;
- Essex Health & Wellbeing Board;
- Healthwatch Essex, Healthwatch Suffolk; and
- staff, volunteers, carers and members of the public.

East Suffolk and North Essex NHS Foundation Trust would like to thank those who contributed to the development and publication of this Quality Report.

Our front cover shows:

- The Colchester Hospital Vaccination Hub
- Raymond Wray was the first person to be vaccinated at the Hub.
- Vaccination Hub 'The big weekend'

Part 1 - Statement on quality

Chief Executive's commentary

This is our report to you about the quality of services provided by East Suffolk and North Essex NHS Foundation Trust in 2020/21. It looks back at our performance over the last year and gives details of our priorities for improvement in 2021/22.

This report will update you about the quality of services provided by East Suffolk and North Essex NHS Foundation Trust (ESNEFT) during 2020/21. It looks back at our performance over the year and details some of our achievements. It also sets out our priorities for improvement for the coming 12 months. I hope you enjoy reading it.

The past year has been challenging for everyone, not least the NHS. Our staff have worked tirelessly to respond to the coronavirus pandemic while ensuring we can continue to provide high quality services. In many cases, this has seen us make changes to keep people safe, such as temporarily moving cancer surgery to nearby private hospitals and using telephone and video calls rather than traditional face-to-face consultations. We are incredibly proud of the way our team has responded – not only have they cared for more than 3,000 COVID-19 patients during the year, but also recruited to clinical trials and quickly set up new vaccination hubs and facilities capable of carrying out more than 9,000 tests a week.

In line with national guidance, we suspended many of our elective and non-urgent services in spring 2020 as we prepared for an influx of coronavirus patients. Unfortunately, this has had an unavoidable impact upon our patients and the services we provide, and will continue to affect our waiting times and wider performance for some time. To address this backlog, we will need to work more closely with our health and care partners than ever before so that all of our patients can receive the care they need as quickly as possible.

Away from COVID-19, work has continued to integrate our clinical services following our merger in 2018, which is helping to drive up quality and efficiency while reducing duplication. Data released during the year showed that our joint replacement patients are receiving some of the safest and best treatment in the country. Elsewhere, our diabetes team continued to inform best practice as a project developed in Ipswich to enhance care following surgery was piloted nationally. We also took steps to improve our emergency care pathways by securing £3m in funding to increase capacity at Colchester ED and introduce a new acute same day emergency care unit at Ipswich Hospital. Some really exciting initiatives which will have a major impact on the quality of care we are able to deliver in the future also continued to take shape, most notably our new breast care centre and children's department in Ipswich and elective care centre in Colchester.

This Quality Account will give you more information about some of these initiatives and the areas where our performance is strong, as well as highlighting those where we could do better. I hope you find it informative and interesting.

Finally, I would like to say a sincere thank you to everyone who has supported our hospitals and community services over the past year. This includes patients and carers, our fantastic staff and volunteers, Colchester & Ipswich Hospitals Charity and our NHS and social care partners. I look forward to continuing to work closely with you all over the coming 12 months to address the backlog caused by the pandemic while exploring innovative ways to further improve the quality, safety and consistency of the services we provide.

Nick Hulme
Chief Executive

Part 2 - Priorities for improvement and statements of assurance

2020/21 quality improvement priorities

Progress against the priorities we set as a Trust

Patient safety priority 1

Why was this a priority?

To improve compliance with the Sepsis 6 care bundle

Lead Director

Chief Medical Officer and Chief Nurse

What was our target?

- Timely identification of infection/ sepsis in the Emergency Department (ED) and acute inpatient settings as per the National Guidelines of the 'Sepsis 6' defined above
- Timely treatment of infection/sepsis within 60 minutes

What did we do to improve our performance?

- Introduction of the use of the fluid balance chart to the Community Hospitals.
- Implement mandatory training (e-learning programme) for all clinical staff
- Enable the prescribing of intravenous fluids by nursing staff to manage the early treatment of sepsis
- All new staff are given a teaching session on escalating deteriorating patients and sepsis during their induction programme
- Successful introduction of the ESNEFT Treatment Escalation Plan (TEP) to ensure all patients admitted have a medical plan agreeing the levels of escalation and parameters of treatment in accordance with their clinical condition
- Successful introduction of the Acute Kidney Injury (AKI) bundle, ensuring all patients presenting as acutely unwell are monitored and escalated swiftly.
- Successful standardisation of Sepsis screening tools for inpatients across ESNEFT reducing any uncertainty of the process and treatments required.
- Successful alignment of Inpatient sepsis screening and treatment auditing tool and auditing commenced on both sites this year
- Successful development and roll out of a Sepsis leaflet for all patients who have received antibiotics or had a procedure making them at risk of developing an infection on discharge. This complies with Quality standard 161
- Implemented Sentinel, electronic observation and escalation trigger software to increase awareness and response time to sepsis and the deteriorating patient.

How did we measure and monitor our performance?

- Audits are completed once per month using a randomised sample of all adult patients who attend the ED departments. This audit now monitors the escalation of deteriorating patients in adherence to trust policy, screening these patients for signs of possible infection that may develop into sepsis and delivery of the sepsis 3 & sepsis 6 treatments within the 1 hour national timeframe.
- Audits are completed monthly for 5 patients per ward per month that triggered a escalation and sepsis screen. This audit now monitors the escalation of deteriorating patients in adherence to trust policy, screening these patients for signs of possible infection that may develop into sepsis and delivery of the sepsis 3 & sepsis 6 treatments within the 1 hour national timeframe for adult inpatients.

Did we achieve our intended target?

ESNEFT did not consistently meet our target for timely identification of sepsis through screening, although performance has shown some improvements across both the ED and Inpatient areas. During the Covid-19 surge from December to February, documentation standards fell in all areas, however a deep dive showed that standards were being met in delivery. Delivery of Sepsis 6 in the ED at Ipswich fell from 48.5% to 33.8% and at Colchester increased from 54.6% to 66.1%. Screening for Sepsis decreased across both ED's, from 92.2% to 86.3% at Ipswich and from 86.8% to 86.1% at Colchester. Of note, auditing was impacted during some months of the year in response to the pandemic and therefore the figures do not reflect the full year.

How and where was progress reported?

The audits are fed back to the

2020/21 quality improvement priorities
Progress against the priorities we set as a Trust

clinical areas for discussion in their governance meetings. Action plans are requested from each area to show planned changes for improvement going forward
Monthly results and updates are sent to sepsis and deteriorating patient group and patient safety group and time matters board. Quarterly reports are presented to the Deteriorating Patient Group on a quarterly basis by the Divisions.

Quarterly deep dives into data quality are undertaken by the Sepsis and Deteriorating Patient Nurse Specialists in order to identify areas for improvement. This is presented to the Patient Safety & Clinical Effectiveness Group.

Our key achievements

- Successful introduction of the ESNEFT Treatment Escalation Plan (TEP) to ensure all patients admitted have a medical plan agreeing the levels of escalation and parameters of treatment in accordance with their clinical condition
- Successful introduction of the Acute Kidney Injury (AKI) bundle, ensuring all patients presenting as acutely unwell are monitored and escalated swiftly.

Patient safety priority 2:

To reduce the numbers of inpatient falls

Why was this a priority?

Ensuring that our patients receive 'Harm Free' care during their admission is a key priority for any healthcare provider. The impact on patients following a fall in hospital can be wide ranging and complex.

The Trust is committed to ensuring that, wherever possible, no patient suffers from harm whilst receiving care, and therefore, this was identified as the key patient safety priority for 2020/21.

Lead Director

Chief Nurse

What was our target?

A reduction of inpatient falls per 1000 bed days to be no more than 5.5 within the two acute hospitals. The Community Falls per 1000 bed days' improvement trajectory will be reduced to fewer than 15 falls per 1000 bed days.

What did we do to improve our performance?

- A Trust-wide improvement plan for Falls
- The Falls Prevention inpatient service will be developed within Corporate Nursing and Quality Division, with leadership provided by the Associate Director of Clinical Governance on behalf of the Chief Nurse
- Standardised documents across all sites

How did we measure and monitor our performance?

- Incident reporting of all inpatient falls are monitored through Patient Safety & Quality Team and reported upon via the Ward Safety Dashboard to Matrons Group, chaired by the Chief Nurse.
- Develop a tool to monitor the assessment of the presence or absence of delirium.
- Monthly review of falls activity and trends will form part of the Patient Safety Report.
- Inpatient falls incidents will be triangulated with PALS, Complaints and Safeguarding information to identify any emerging themes and trends to any specific areas of the Trust.

Did we achieve our intended target?

Although the overall number of falls was slightly down on the previous year, the Trust was unable to achieve it's target of less than 5 falls per 1000 bed days (national target is 6 per 1000 bed days). Colchester achieved 6 falls per 1000 bed days, Ipswich 7.5 falls per 1000 bed days resulting in an ESNEFT total of 6.7 falls per 1000 bed days. The Community Hospitals 12.3 falls per 1000 bed days, which is consistent with last year's average.

How and where was progress reported?

Regular reports and updates will be provided to: Sisters & Matrons Meetings, Patient Safety Group, Harm Free Group and Quality & Patient Safety Committee.

Our key achievements

- ESNEFT wide Falls Steering Group established
- Head of Falls Prevention and Falls Specialist roles successfully appointed to
- Daily presence on the wards to promote teaching through joint working

Clinical Effectiveness priority:

To reduce the likelihood of nosocomial infections in our patients

Why was this a priority?

Nosocomial infections are those infections confirmed from microbiological samples obtained greater than 48hours after admission. They can cause other complications whilst the patient is

Part 2 - Priorities for improvement and statements of assurance

2020/21 quality improvement priorities

Progress against the priorities we set as a Trust

in hospital, prolong hospitalisation and potentially lead to patient harm depending on the causative micro-organism. The 48hours only applies to bacteraemia' s and Clostridium Difficile (C.diff) cases. Nosocomial Covid-19 cases are those confirmed 8 days after admission.

Lead Director

Chief Medical Officer and Chief Nurse

What was our target?

To have a zero tolerance for all avoidable nosocomial infections

What did we do to improve our performance?

- Root cause analysis undertaken for all nosocomial infections, including peer review with the CCG for C-Difficile
- Continuous feedback learning from investigations of nosocomial infections to clinical teams
- Continue to promote good practice with antimicrobial stewardship , antimicrobial prescribing audits conducted (saving lives bundle 11 & 12) monthly by Ward Sister/Charge Nurse and Pharmacist/Pharmacy Technician, introduction of comprehensive PPE audits, Routine swabbing for Covid-19 in line with Public Health England (PHE) recommendations; patients are swabbed on admission, Those who test negative upon admission must have a second test 3 days after admission, and a third test 7 days post admission. Patients are re-tested every 7 days thereafter. Isolation of patients presenting with a nosocomial infection. Deep cleans across all areas and enhanced cleaning measures in response to the pandemic.

How did we measure and monitor our performance?

- Completion of monthly saving lives and hand hygiene audits
- Comparative monthly and annual reporting of nosocomial infections

Did we achieve our intended target?

The Trust experienced a challenging year with the spread of Covid-19, however we continue a zero tolerance and have maintained our overall achievements with other nosocomial infections. The Trust had 2 incidences of Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia against a target of 0. A comprehensive action plan is progressing to support improvements, with ward refurbishments at Ipswich Hospital identified as a priority.

How and where was progress reported?

Infection Control Committee, Patient Safety Group and the Integrated Assurance Committee

Our key achievements

- Business Informatics developed an app which offers a daily refresh for patients status with Covid-19 swabbing
- Root Cause Analysis undertaken for all nosocomial cases of COVID-19 to determine the source and identify any lessons learned or changes required
- Comprehensive Personal Protective Equipment (PPE) audit programme commenced, which will be introduced onto the Accountability Framework (AF) moving forward

Clinical Effectiveness priority 2:

To improve the assessment of nutrition and hydration needs for patients and ensure the correct referral and maintenance plans are undertaken.

Why was this a priority?

There is clear medical evidence supporting the fact that good nutrition aids a patient's recovery. On admission to hospital, many patients are at risk due to their illness and an assessment of their nutrition and hydration needs identifies those patients at risk, prompting the teams to ensure those vulnerable persons are supported. Assessment of nutrition needs is done through the Malnutrition Universal Screening Tool (MUST)

Lead Director

Chief Medical Officer

What was our target?

- Ensure that patients have a risk assessment regarding their nutritional status
- Ensure that patients requiring fluid balance charts will have their charts monitored

What did we do to improve our performance?

- Undertook a one day audit to ensure all patients who were at risk and required a fluid balance chart had this recorded

2020/21 quality improvement priorities
Progress against the priorities we set as a Trust

- Identify a group of nutrition champions throughout the Trust to promote healthy and supported mealtimes

How did we measure and monitor our performance?

- MUST scores audited monthly and reported on the Accountability Framework
- MUST actions audited monthly and reported on the Accountability Framework
- Hydration audits across ESNEFT
- Nutrition audits across ESNEFT

Did we achieve our intended target?

Key achievements have been made in progressing our target which was challenging in response to the pandemic and therefore this remains a Trust priority for 2021/22

How and where was progress reported?

Nutrition Steering Group, Patient Safety & Clinical Effectiveness Group

Our key achievements

Relaunch of the Nutrition Steering Group, chaired by the Strategic Lead for Allied Health Professionals
Workplan agreed for the Nutrition Priority Improvement Group
Malnutrition Universal Screening Tool (MUST) redesigned for launch in the new nursing admission booklets

Patient experience priority 1:

To improve clinical outcomes for patients with mental health conditions, improve mental health well-being for staff and transform Mental Health provision across ESNEFT.

Why was this a priority?

This is a national priority to ensure people receive prompt access to ensure parity of both mental health and physical health care. NHSE advises that one in four adults and one in ten children experience mental illness and many more know and care for people who do.

There is evidence that 25-33% of people admitted to acute hospitals also have a mental health condition, with mental health disorders accounting for 5% of all Emergency Department (ED) admissions.

By providing effective mental health support to patients, and expertise to staff where required, we can minimise the time a patient needs to stay in an acute hospital environment and build effective mental health services for children and young people.

ESNEFT staff require support, education and tools to enable them to improve their own well-being and recognise and support patients and carers who require further support.

Lead Director

Chief Medical Officer, Chief Nurse

What was our target?

- Complete a baseline audit to identify the current support in place and variances between sites.
- Recruit and appoint to vacancies to roll out psychiatric liaison services across acute inpatient services.
- Gain understanding of current referral processes into mental health and community services. Map ‘to be’ processes and commence work with system partners to streamline processes.

What did we do to improve our performance?

- Commence tender process for Health Foundation Innovation Hub
- Develop process for performing emotional wellbeing assessments across all inpatients and targeted outpatients – (including detail of responses to positive assessment)
- Communications programme for what support is available for our own staff, what, where, how?

How did we measure and monitor our performance?

- Monitor the ED breaches for patients requiring mental health support.
- Monitor the length of stay for patients who have a mental health co-morbidity
- Monitor provision of staff

Part 2 - Priorities for improvement and statements of assurance 2020/21 quality improvement priorities

Progress against the priorities we set as a Trust

support and training

Did we achieve our intended target?

This is part of the on-going 5 year plan of improvements for mental health as part of the ESNEFT Trust Strategy.

How and where was progress reported?

EMC, Patient Experience Group, Integrated Assurance Group

Our key achievements

- Appointment of Senior Lead for Safeguarding and Complex Health
- Agreed and documented pathway for Patients at Risk of Self Harm, in conjunction with the ED single clerking document.
- Establishment of the ESNEFT Well Being Hub

Patient experience priority 2:

To continue to improve care for patients living with dementia and their carers.

Why was this a priority?

Dementia is overwhelming for the family and other caregivers and support is required for them. We will aim to improve our care to patients with Dementia, both as inpatients and in the diagnosis and management of the disease outside of hospital.

Lead Director

Chief Nurse & Chief Medical Officer

What was our target?

- Increase the usage of the 'This is Me' tool to 50%
- Develop a web page containing Dementia resources for patients and their carers
- Upgrade environments to ensure they are Dementia friendly
- Approval and implementation of the Cognition Screening/ Assessment Tool
- Expand the Dementia Champion role to include cognitive champions

What did we do to improve our performance?

- Deliver excellent care tailored to the person with dementia using the 'This is Me' tool.
- Recognise and assess delirium at the front door to ensure patients are on the delirium pathway of care.
- Ensure people with dementia receive appointment information in a way that supports them to attend.
- Work with the Accessible Information Standards group to support improvements to current patient information.

How did we measure and monitor our performance?

- Measure and monitor the use of the 'This is Me' tool through audit and gap analysis and through the outcome and actions required of the National Dementia Audit.
- Audit compliance with the delirium assessment tool and implement actions as a result of the findings

Did we achieve our intended target?

This is an on-going target with milestones identified for the coming year, strategic aims have been agreed:

- To improve the care and management of patients who have Dementia, their families and their Carers wherever they are cared for in the Trust
- To improve the care of patients who are living with Dementia to ensure they or their families/carers have the opportunity to contribute to their care and receive appropriate support whenever they attend the hospital
- To enhance and improve existing dementia friendly space for patients and their families to enjoy
- To foster a culture of trust-wide staff engagement to focus on improving care for patients – and to provide education and monitoring to allow measurement of the outcomes for patients, families and Carers

How and where was progress reported?

Patient Experience Group, Integrated Assurance Committee.

Our key achievements

Agreed plans and funding to enhance the dementia friendly gardens at Ipswich Hospital

Developed the ESNEFT Dementia web page
Improvements were made to the Constable Suite Garden including the installation of 2 outdoor instruments to give sensory stimulation and activity.

Sunshades, new garden furniture, raised planting boxes and a tool storage facility were all established in the area.

Data published by the National Joint Registry shows Ipswich Hospital performed better than expected for hip and knee revisions for all operations carried out between 2010 and 2020, while Colchester Hospital performed better than expected for knee revisions over the same period.

Our priorities for improvement in 2021/22

Due to the requirements to respond to the Covid-19 pandemic and the challenges this has presented, ESNEFT will focus on the priorities which were identified in 2020/21 for the year 2021/22.

Patient safety priority 1:

To improve compliance with the Sepsis 6 care bundle

Why is this a priority?

The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. It was developed in 2006 by a group of physicians and nurses working on an educational programme to raise awareness and improve the treatment of patients with sepsis.

The management of sepsis from presentation in ED after admission to hospital usually involves three treatments and three tests, known as the 'Sepsis Six'. These should be initiated by the medical/ nursing team within an hour of red flag marker identification unless a non-sepsis rationale is documented by a clinician for diagnosis.

Lead Director

Chief Medical Officer and Chief Nurse

What is our target?

- Timely identification of sepsis in the Emergency Department and acute inpatient settings as per the National Guidelines of the 'Sepsis 6' defined above
- Timely treatment of sepsis within 60 minutes

What will we do to improve our performance?

- Implement clinical sepsis tool to guide screening and treatment
- Implement mandatory training (e-learning programme) for all clinical staff
- Enable the prescribing of intravenous fluids by nursing staff to manage the early treatment of sepsis
- Increase awareness of the signs and symptoms of sepsis for healthcare professionals and the public through education
- Implement Sentinel, electronic observation and escalation trigger software to increase awareness and response time to sepsis and the deteriorating patient.

How will we measure and monitor our performance?

- Audit timely identification and treatment of sepsis
- Monitor compliance with staff training for doctors and nurses
- Compliance with Commissioning for Quality and Innovation (CQUIN) national goals for identification and treatment of suspected sepsis

How and where will progress be reported?

Regular reports and updates to: Deteriorating Patient Group, Patient Safety Group and the Quality and Patient Safety Committee.

Patient safety priority 2:

To reduce the numbers of inpatient falls

Why is this a priority?

Ensuring that our patients receive 'Harm Free' care during their admission is a key priority for any healthcare provider. The impact on patients following a fall in hospital can be wide ranging and complex.
The Trust is committed to ensuring that, wherever possible, no patient suffers from harm whilst receiving care, and therefore, this was identified as the key patient safety priority for 2021/22.

Lead Director

Chief Nurse

What is our target?

A reduction of inpatient falls per 1000 bed days to below 5 within the two acute hospitals. The Community Falls per 1000 bed days' improvement trajectory will be reduced to fewer than 15 falls per 1000 bed days.

What will we do to improve our performance?

- A Trust-wide improvement plan for Falls
- The Falls Prevention

Our priorities for improvement in 2021/22

inpatient service will be developed within Corporate Nursing and Quality Division, with leadership provided by the Associate Director of Clinical Governance on behalf of the Chief Nurse
- Standardised documents across all sites

How will we measure and monitor our performance?

- Incident reporting of all inpatient falls are monitored through Patient Safety & Quality Team and reported upon via the Ward Safety Dashboard to Matrons Group, chaired by the Chief Nurse.
- Develop a tool to monitor the assessment of the presence or absence of delirium.
- Monthly review of falls activity and trends will form part of the Patient Safety Report.
- Inpatient falls incidents will be triangulated with PALS, Complaints and Safeguarding information to identify any emerging themes and trends to any specific areas of the Trust.

How and where will progress be reported?

Regular reports and updates to:

Regular reports and updates will be provided to: Sisters & Matrons Meetings, Patient Safety Group, Harm Free Group and Quality & Patient Safety Committee.

Clinical Effectiveness priority 1:

To reduce the likelihood of nosocomial infections in our patients

Why is this a priority?

Nosocomial infections are those infections confirmed from microbiological samples obtained greater than 48hours after admission. They can cause other complications whilst the patient is in hospital, prolong hospitalisation and potentially lead to patient harm depending on the causative micro-organism.

Lead Directors
Chief Medical Officer and Chief Nurse

What is our target?

- To have a zero tolerance for all avoidable nosocomial infections

What will we do to improve our performance?

- Continue to inform staff and raise awareness of nosocomial infections through educational activities and from IP&C team surveillance at ward level
- Continue to feedback learning from investigations of nosocomial infections to clinical teams
- Utilize other arenas for sharing lessons learnt through nosocomial cases of COVID-19
- Continue to promote good practice with antimicrobial stewardship

How will we measure and monitor our performance?

- Completion of monthly saving lives and hand hygiene audits
- Introduce PPE audits
- Comparative monthly and annual reporting of nosocomial infections
- How and where will progress be reported?

Regular reports and updates to:

Infection Control Committee, Patient Safety Group and the Quality and Patient Safety Committee

Clinical effectiveness priority 2:

To improve the assessment of nutrition and hydration needs for patients and ensure the correct referral and maintenance plans are undertaken.

Why is this a priority?

There is clear medical evidence supporting the fact that good nutrition aids a patient's recovery. On admission to hospital, many patients are at risk due to their illness and an assessment of their nutrition and hydration needs identifies those patients at risk, prompting the teams to ensure those vulnerable persons are supported.

Lead Director
Chief Medical Officer & Chief Nurse

Our priorities for improvement in 2021/22

Due to the requirements to respond to the Covid-19 pandemic and the challenges this has presented, ESNEFT will focus on the priorities which were identified in 2020/21 for the year 2021/22.

What is our target?

- Ensure that patients have a risk assessment regarding their nutritional status within 24hrs of admission to the ward
- Ensure that patients requiring fluid balance charts will have their charts monitored and balanced in accordance with Trust Policy

What will we do to improve our performance?

- Continue to ensure that patients requiring assistance to eat and drink are given adequate support through the use of food charts
- Improve the accuracy of fluid balance records
- Identify a group of nutrition champions throughout the Trust to promote healthy and supported mealtimes

How will we measure and monitor our performance?

- Audit of Fluid balance charts, including further Trustwide one day audits giving senior leaders the opportunity to provide assurance at a glance
- Audit of food charts to provide assurance of the effective and consistent use to support patients with their nutritional needs.

How and where will progress be reported?

Regular reports and updates to:
Nutrition Steering Group, Clinical Effectiveness Group, Quality & Patient Safety Committee

Patient experience priority 1:

To improve clinical outcomes for patients with mental health conditions, improve mental health well-being for staff and transform Mental Health provision across ESNEFT.

Why is this a priority?

This is a national priority to ensure people receive prompt access to ensure parity of both mental health and physical health care. NHSE advises that one in four adults and one in ten children experience mental illness and many more know and care for people who do.

There is evidence that 25-33% of people admitted to acute hospitals also have a mental health condition, with mental health disorders accounting for 5% of all Emergency Department (ED) admissions.

By providing effective mental health support to patients, and expertise to staff where required, we can minimise the time a patient needs to stay in an acute hospital environment and build effective mental health services for children and young people.

ESNEFT staff require support, education and tools to enable them to improve their own well-being and recognise and support patients and carers who require further support.

Lead Directors

Director of Human Resources, Medical Director, Chief Nurse

What is our target?

- Complete a baseline audit to identify the current support in place and variances between sites.
- Recruit and appoint to vacancies to roll out psychiatric liaison services across acute inpatient services.
- Gain understanding of current referral processes into mental health and community services. Map 'to be' processes and commence work with system partners to streamline processes.

What will we do to improve our performance?

- Organisational education programme for: workforce across Nursing and AHP & enhanced by the development of ward link educators at band 6 & undergraduate Programme
- Develop process for performing emotional wellbeing assessments across all inpatients and targeted outpatients – (including detail of responses to positive assessment)
- Communications programme for what support is available for our own staff, what, where, how?

How will we measure and monitor our performance?

- Monitor the ED breaches for patients requiring

Our priorities for improvement in 2021/22

mental health support.
- Monitor the length of stay for patients who have a mental health co-morbidity
- Monitor provision of staff support and training

How and where will progress be reported?
Regular reports and updates to:

EMC, Clinical Effectiveness Group, Patient Experience Group, POD

Patient experience priority 2:

To continue to improve care for patients living with dementia and their carers.

Why is this a priority?
Dementia is overwhelming for the family and other caregivers and support is required for them. We will aim to improve our care to patients with Dementia, both as inpatients and in the diagnosis and management of the disease outside of hospital.

Lead Director
Chief Nurse & Medical Director

What is our target?

- Increase the usage of the 'This is Me' tool to 50%
- Develop a web page containing Dementia resources for patients and their carers
- Upgrade environments to ensure they are Dementia friendly
- Approval and implementation of the Cognition Screening/ Assessment Tool
- Expand the Dementia Champion role to include cognitive champions

What will we do to improve our performance?

- Deliver excellent care tailored to the person with dementia using the 'This is Me' tool.
- Recognise and assess delirium at the front door to ensure patients are on the delirium pathway of care.
- Ensure people with dementia receive appointment information in a way that supports them to attend.

How will we measure and monitor our performance?

- Measure and monitor the use of the 'This is Me' tool through audit and gap analysis and through the outcome and actions required of the National Dementia Audit.
- Audit compliance with the delirium assessment tool and implement actions as a result of the findings
- Work with the Accessible Information Standards group to support improvements to current patient information.

How and where will progress be reported?
Regular reports and updates to:

Patient Experience Group, Quality & Patient Safety Committee.

Provided and sub-contracted services

Provided and sub-contracted services

During 2020/21 the Trust has continued to be contracted for and has provided commissioned acute and community healthcare services, with the inclusion of sub-contracted services as appropriate for relevant health services. These services are overseen and reviewed by appropriate commissioners and regulators, via meetings, data submissions and information reporting in relation to patient safety, patient experience and operational performance.

The commissioners of the Trust services are NHS North East Essex Clinical Commissioning Group & NHS Ipswich & East Suffolk Clinical Commissioning Group together with a number of Associate commissioners for clinical commissioning groups (CCGs) and NHS England for specialised, local area and armed forces healthcare commissioning. Additional services being provided in relationships with other organisations, including West Suffolk NHS Foundation Trust, Essex Partnership University NHS Foundation Trust, Norfolk & Suffolk NHS Foundation Trust, Anglian Community Enterprise CIC, Allied Health Professionals Suffolk CIC and Ramsay Healthcare Ltd.

During 2020-21 the East Suffolk & North Essex NHS Foundation Trust provided and/or subcontracted 93 relevant health services.

The East Suffolk & North Essex NHS Foundation Trust has reviewed all the data available to them on the quality of care in 93 of these relevant health services.

The income generated by the relevant health services reviewed in 2020-21 represents 90% of the total income generated from the provision of relevant health services by the East Suffolk & North Essex NHS Foundation Trust for 2020-21.

Plans to build a new £5.3million Breast Care Centre at Ipswich Hospital have been given the green light. The new centre will transform the experience patients have when they come to hospital by bringing all elements of breast care under one roof – the clinic, the imaging department and hospital breast screening.

Participation in clinical audit

During 2020 /21, 58 National Clinical Audits and 8 National Confidential Enquiries covered relevant health services that East Suffolk and North Essex NHS Foundation Trust (ESNEFT) provides.

During that period ESNEFT participated in 86% of the National Clinical Audits and 38% of the National Confidential Enquiries that it was eligible to participate in. The Pandemic meant that 6 National Clinical Audits (10%) and 5 (62%) of the National Confidential Enquiries were suspended or delayed.

The National Clinical Audits and the National Confidential Enquiries that ESNEFT was eligible to participate in during 2020/21 are as follows:

	National Clinical Audits	
	National programme name	**Work stream / Topic name**
1	Case Mix Programme (CMP)	
2	Chronic Kidney Disease Registry Previously listed under UK Renal Registry	
3	Elective Surgery (National PROMs Programme)	
4	Emergency Medicine QIPs	Fractured Neck of Femur (care in emergency departments)
5		Infection Control (Care In Emergency Departments)
6		Pain in Children
7	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls
8		National Hip Fracture Database (NHFD)
9		Vertebral Fracture Sprint Audit
10		Fracture Liaison Service Database
11	Inflammatory Bowel Disease (IBD) Audit	Inflammatory Bowel Disease (IBD) Service Standards
12		Inflammatory Bowel Disease (IBD) Biological Therapies Audit
13	LeDeR - Learning Disabilities Mortality Review	
14	Mandatory Surveillance of HCAI	
15	National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit
16		NDA Integrated Specialist Survey
17		National Diabetes Inpatient Audit Harms (NaDIA-Harms)
18		National Diabetes in Pregnancy Audit
19		National Core Diabetes Audit
20		National Diabetes Transition (linkage with NPDA)
21	National Asthma and COPD Audit Programme (NACAP)	Adult asthma secondary care
22		Paediatric - Children and young people asthma secondary care
23		Pulmonary Rehabilitation
24		Chronic Obstructive Pulmonary Disease (COPD)
25	National Audit of Breast Cancer in Older People (NABCOP)	

Participation in clinical audit

26	National Audit of Cardiac Rehabilitation	
27	National Audit of Care at the End of Life (NACEL)	
28	National Audit of Dementia (NAD)	Care in general hospitals
29	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	
30	National Cardiac Arrest Audit (NCAA)	
31	National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
32		Myocardial Ischaemia National Audit Project (MINAP)
33		National Audit of Cardiac Rhythm Management Devices and Ablation
34		National Heart Failure Audit
35	National Comparative Audit of Blood Transfusion	2021 Audit of Blood Transfusion against NICE Guidelines
36	National Comparative Audit of Blood Transfusion programme	2021 Audit of the perioperative management of anaemia in children undergoing elective surgery
37	National Early Inflammatory Arthritis Audit (NEIAA)	
38	National Emergency Laparotomy Audit (NELA)	
39	National Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)
40	National Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit (NBOCA)
41	National Joint Registry	
42	National Lung Cancer Audit Programme	
43	National Maternity and Perinatal Audit (NMPA)	
44	National Neonatal Audit Programme (NNAP)	
45	National Ophthalmology Audit (NOD)	Adult Cataract surgery
46	National Paediatric Diabetes Audit (NPDA)	
47	National Perinatal Mortality Review Tool	
48	National Prostate Cancer Audit (NPCA)	
49	National Vascular Registry	
50	Perioperative Quality Improvement Programme (PQIP)	
51	Sentinel Stroke National Audit Programme (SSNAP)	
52	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	
53	Society for Acute Medicine Benchmarking Audit	
54	Surgical Site Infection Surveillance	
55	Trauma Audit & Research Network	
56	UK Registry of Endocrine and Thyroid Surgery	
57	Urology Audits	Renal Colic Audit
58	Urology Audits	Cytoreductive Radical Nephrectomy Audit

Participation in clinical audit

	Confidential Enquiries	
	National programme name	**Work stream / Topic name**
1	Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries
2		Perinatal mortality surveillance
3		Maternal mortality surveillance and confidential enquiry
4	Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia
5		Crohns disease
6		Epilepsy study
7		Dysphagia in Parkinson's Disease
8	Child Health Clinical Outcome Review Programme	Transition from child to adult health services

The National Clinical Audits and National Confidential Enquiries that East Suffolk and North Essex NHS Foundation Trust participated in during 2020/21 are as follows:

	National Clinical Audits			
	National programme name	**Work stream / Topic name**	**Participated In**	**Suspended / Delayed**
1	Case Mix Programme (CMP)		✓	
2	Chronic Kidney Disease Registry Previously listed under UK Renal Registry		✓	
3	Elective Surgery (National PROMs Programme)		✓	
4	Emergency Medicine QIPs	Fractured Neck of Femur (care in emergency departments)	✓	
5		Infection Control (Care In Emergency Departments)	✓	
6		Pain in Children	✓	
7	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	✓	
8		National Hip Fracture Database (NHFD)	✓	
9		Vertebral Fracture Sprint Audit	✓	
10		Fracture Liaison Service Database	✓	
11	Inflammatory Bowel Disease (IBD) Audit	Inflammatory Bowel Disease (IBD) Service Standards	×	
12		Inflammatory Bowel Disease (IBD) Biological Therapies Audit	×	
13	LeDeR - Learning Disabilities Mortality Review		✓	
14	Mandatory Surveillance of HCAI		✓	

Participation in clinical audit

15	National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	✓	
16		NDA Integrated Specialist Survey	✓	
17		National Diabetes Inpatient Audit Harms (NaDIA -Harms)	✓	
18		National Diabetes in Pregnancy Audit	✓	
19		National Core Diabetes Audit	✓	
20		National Diabetes Transition (linkage with NPDA)	✓	
21	National Asthma and COPD Audit Programme (NACAP)	Adult asthma secondary care		✓
22		Paediatric - Children and young people asthma secondary care		✓
23		Pulmonary Rehabilitation	✓	
24		Chronic Obstructive Pulmonary Disease (COPD)	✓	
25	National Audit of Breast Cancer in Older People (NABCOP)		✓	
26	National Audit of Cardiac Rehabilitation		✓	
27	National Audit of Care at the End of Life (NACEL)			✓
28	National Audit of Dementia (NAD)	Care in general hospitals		✓
29	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		✓	
30	National Cardiac Arrest Audit (NCAA)		✓	
31	National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	✓	
32		Myocardial Ischaemia National Audit Project (MINAP)	✓	
33		National Audit of Cardiac Rhythm Management Devices and Ablation	✓	
34		National Heart Failure Audit	✓	
35	National Comparative Audit of Blood Transfusion	2021 Audit of Blood Transfusion against NICE Guidelines		✓
36	National Comparative Audit of Blood Transfusion programme	2021 Audit of the perioperative management of anaemia in children undergoing elective surgery		✓
37	National Early Inflammatory Arthritis Audit (NEIAA)		✓	
38	National Emergency Laparotomy Audit (NELA)		✓	
39	National Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	
40	National Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit (NBOCA)	✓	
41	National Joint Registry		✓	

Participation in clinical audit

42	National Lung Cancer Audit Programme		✓	
43	National Maternity and Perinatal Audit (NMPA)		✓	
44	National Neonatal Audit Programme (NNAP)		✓	
45	National Ophthalmology Audit (NOD)	Adult Cataract surgery	✓	
46	National Paediatric Diabetes Audit (NPDA)		✓	
47	National Perinatal Mortality Review Tool		✓	
48	National Prostate Cancer Audit (NPCA)		✓	
49	National Vascular Registry		✓	
50	Perioperative Quality Improvement Programme (PQIP)		✓	
51	Sentinel Stroke National Audit Programme (SSNAP)		✓	
52	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme		✓	
53	Society for Acute Medicine Benchmarking Audit		✓	
54	Surgical Site Infection Surveillance		✓	
55	Trauma Audit & Research Network		✓	
56	UK Registry of Endocrine and Thyroid Surgery		✓	
57	Urology Audits	Renal Colic Audit	✓	
58	Urology Audits	Cytoreductive Radical Nephrectomy Audit	✓	

Confidential Enquiries			
National programme name	**Work stream / Topic name**	**Participate In**	**Suspended / Delayed**
Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	✓	
	Perinatal mortality surveillance	✓	
	Maternal mortality surveillance and confidential enquiry	✓	
Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	.	✓
	Crohns disease	.	✓
	Epilepsy study	.	✓
	Dysphagia in Parkinson's Disease	.	✓
Child Health Clinical Outcome Review Programme	Transition from child to adult health services	.	✓

Participation in clinical audit

The National Clinical Audits and Confidential Enquiries that East Suffolk and North Essex NHS Foundation Trust participated in, and for which data collection was completed during 2020/21, are listed below alongside the number of cases submitted to each audit or enquiry and the percentage of the number of registered cases required by the terms of that audit or enquiry.

	National Clinical Audits		Colchester Hospital		Ipswich Hospital		Community	
	National programme name	Work stream / Topic name	Cases submitted	%	Cases submitted	%	Cases submitted	%
1	Case Mix Programme (CMP)		699	100%	732	100 %		
2	Chronic Kidney Disease Registry Previously listed under UK Renal Registry		420	100%	652	100 %		
3	Elective Surgery (National PROMs Programme)		Continuous collection					
4	Emergency Medicine QIPs	Fractured Neck of Femur (care in emergency departments)	80	50%	157	98%		
5		Infection Control (Care In Emergency Departments)	0	0%	32	20%		
6		Pain in Children	35	22%	0	0%		
7	Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	6				Combined with Ipswich data	
8		National Hip Fracture Database (NHFD)	762	100%	614	100 %		
9		Vertebral Fracture Sprint Audit			Data collection ongoing to 31st May			
10		Fracture Liaison Service Database			1455	61%		
38	National Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit (NBOCA)	278	100%	207	95%		
39	National Joint Registry		362	100%	221	100 %		
40	National Lung Cancer Audit Programme		100%					
41	National Maternity and Perinatal Audit (NMPA)		100%					
42	National Neonatal Audit Programme (NNAP)		63	93%	55	89 %		
43	National Ophthalmology Audit (NOD)	Adult Cataract surgery	65 cases - 52%					
44	National Paediatric Diabetes Audit (NPDA)		Continuous					

Participation in clinical audit

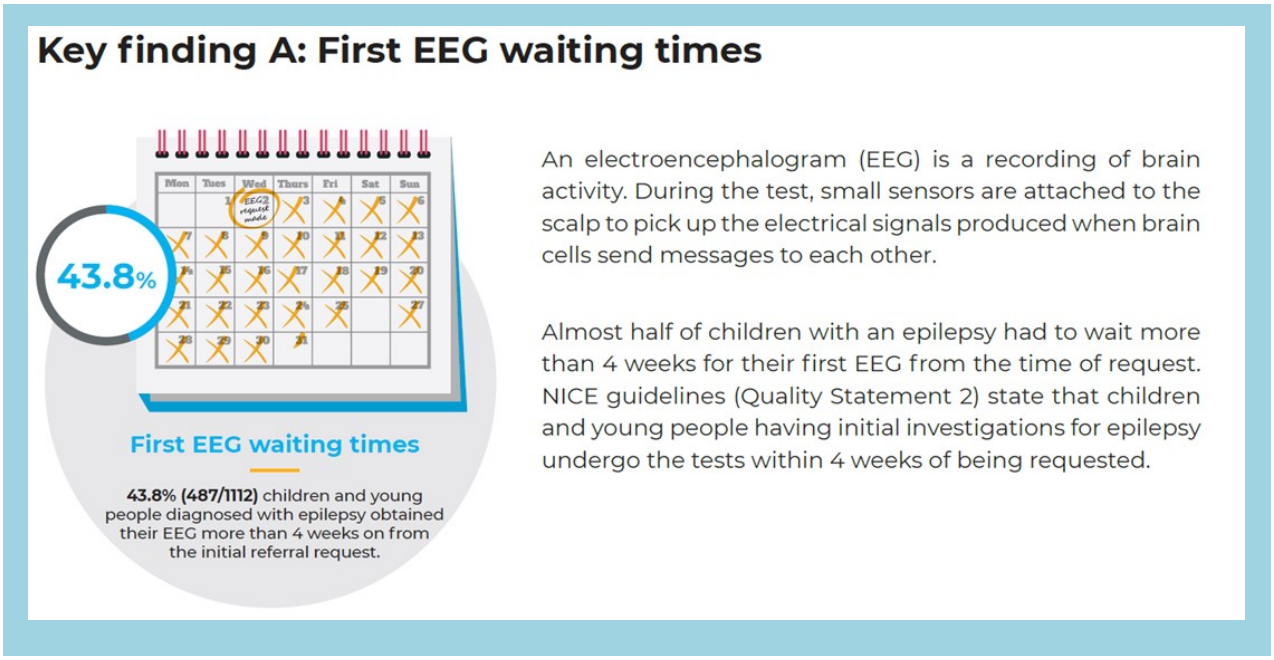
45	National Perinatal Mortality Review Tool		100%					
46	National Prostate Cancer Audit (NPCA)		364	100%	351	100 %		
47	National Vascular Registry		258	100%				
48	Perioperative Quality Improvement Programme (PQIP)		57	100%	8	100 %		
49	Sentinel Stroke National Audit Programme (SSNAP)		688	100%	502	100 %	310	100%
50	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme		0	0%	18	100 %		
51	Society for Acute Medicine Benchmarking Audit							
52	Surgical Site Infection Surveillance							
53	Trauma Audit & Research Network		226	100%	172	100 %		
54	UK Registry of Endocrine and Thyroid Surgery		12	100%	0	0%		
55	Urology Audits	Renal Colic Audit						
56	Urology Audits	Cytoreductive Radical Nephrectomy Audit	Data collection ongoing to Dec 2021					

	Confidential Enquiries		Colchester Hospital		Ipswich Hospital		Community	
	National programme name	**Work stream / Topic name**	**Cases submitted**	**%**	**Cases submitted**	**%**	**Cases submitted**	**%**
1	Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiries	2					
2		Perinatal mortality surveillance	34					
3		Maternal mortality surveillance and confidential enquiry						
4	Medical and Surgical Clinical Outcome Review Programme	Community acquired pneumonia	Data collection delayed					
5		Crohns disease	Data collection delayed					
6		Epilepsy study	Data collection delayed					
7		Dysphagia in Parkinson's Disease	Data collection delayed					
8	Child Health Clinical Outcome Review Programme	Transition from child to adult health services	Data collection delayed					

Participation in clinical audit

During 2020/21 47 National Clinical Audits reports were relevant to ESNEFT and the following are examples of the actions taken to improve the healthcare provided:

Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People



There was a marked difference between our 2 sites, Ipswich being 62.5% and Colchester 40% compared to the national average of 43.8%. Initial discussion revealed the help the Ipswich site were getting from the EEG team in identifying and recording the cohort of children being assessed. What we need to do in order to be able to review this correctly is:

1. To be able to pick up each child who has a first EEG – working with Colchester EEG to identify these patients as they are tested.

2. Be able to record the request date & date of the EEG– review of who and how these requests are made to identify where referral data is lost and how it can then be recorded.

A further local audit then to identify children who do not meet the targets to enable better access for all.

Maternal, Newborn and Infant Clinical Outcome Review Programme - Saving Lives, Improving Mothers' Care Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK.

Background - The emergence of the SARS-CoV-2 virus led to immediate concerns about the impact of infection on pregnant women. Pregnant women were disproportionately infected with influenza A 2009/H1N1, with a high number of deaths due to respiratory complications of the disease.

The care of each women who died in the UK was reviewed independently by one or two MBRRACE-UK pathology, midwifery, obstetric and anaesthetic assessors. The care of selected women, according to their cause of death, was also reviewed by an obstetric physician assessor, infectious diseases physician assessor, psychiatry assessor or intensive care assessor.

All MBRRACE-UK assessments (5-7 per woman), together with the findings from HSIB assessments were then reviewed at a virtual multi-disciplinary chapter-writing meeting to identify lessons learned to improve future care.

Response to the report and it's recommendations – Each recommendation was reviewed against current practice across both sites leading to the updating of site guidance to ensure safe practice.

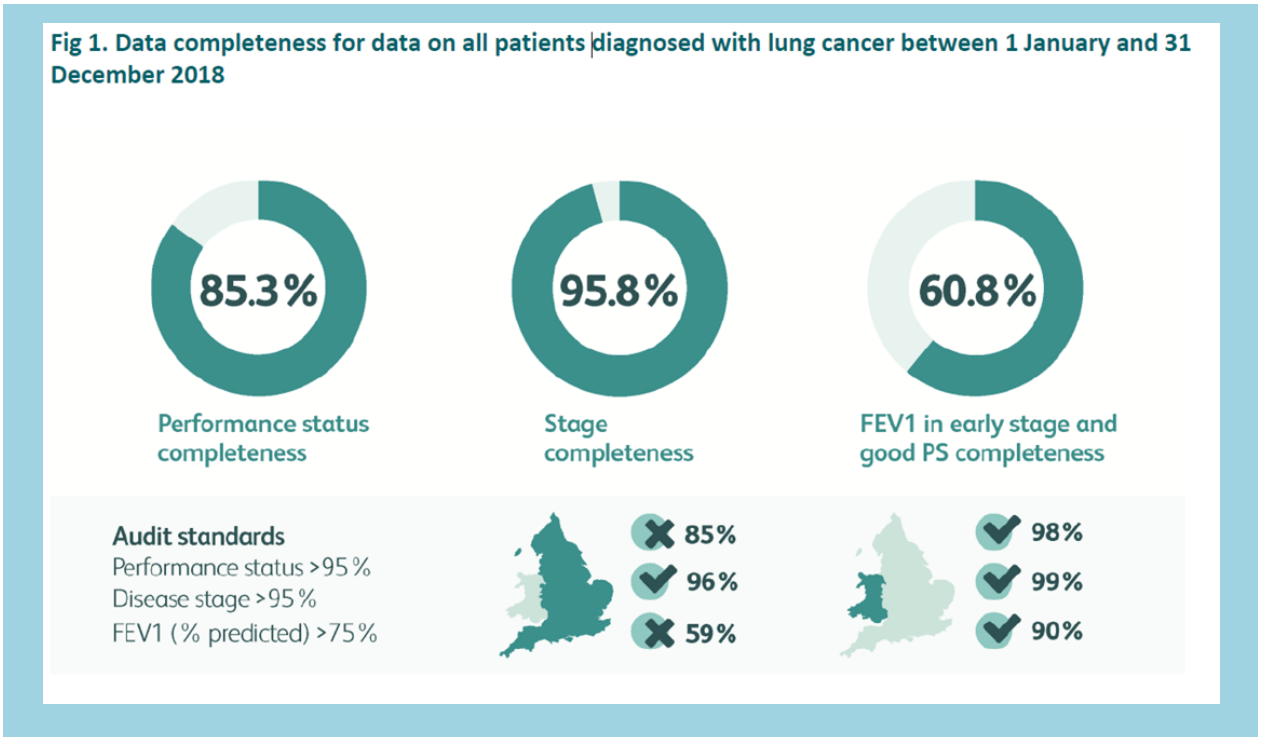
Participation in clinical audit

For example, 5.3 from the report – Messages for mental health care:
Four women died by suicide in the UK during this three month period. It was evident that changes to service provision as a direct consequence of the pandemic meant that women were not able to access appropriate mental health care. Receipt of the specialist care they needed may have prevented their deaths.

Assessors were particularly concerned that referrals appeared to be 'being bounced' between different services, with no one in either service recognising the pattern of repeated referral and the fact that women needed to be assessed by someone with mental health expertise.

The recommendation was that referral with mental health concerns on more than one occasion is considered a 'red flag' which should prompt a clinical review irrespective of usual access thresholds or practice. This has been put into practice & guidance at both sites.

National Lung Cancer Audit annual report (for the audit period 2018) Published Aug 2020



Data Collection:

For ESNEFT:

- Performance status 84.5%
- Stage completeness 96.5%

Participation in clinical audit

National Audits

The 2019 NLCA organisational audit showed that only 67% (90/133) of units had an MDT member with responsibility for data quality, and of these only 18% (16/90) had time in their job plan for this role. Furthermore, only 65% (86/133) of units carried out validation of their COSD data submissions and only 72% (95/132) accessed the CancerStats website to monitor their data quality.

Recommendation 1

Trusts with data completeness below the recommended level should implement the recommendations in our accompanying improvement toolkit, such that both PS and stage should be recorded in at least 95% of cases; for patients with stage I–II disease and PS 0–1, data completeness for FEV1 and FEV1% should exceed 75%.

1. Review your results in the NLCA annual report – even if you have met the recommended standard for data quality, is there anything you can do from the list below to make your results even better?
2. All MDTs should nominate a person who has an interest in and responsibility for the quality of data submitted to the audit.
3. Raise the profile of performance data across the wider MDT at governance meetings or by sharing data. Use the CancerStats website to review data quality in real time.
4. Meet with your MDT coordinator or data manager to discuss how to integrate clinical validation into the Cancer Outcomes and Services Database (COSD) submission process. This process will be iterative so that clinical input reduces over time.
5. Work with National Cancer Registration and Analysis Service (NCRAS) data improvement leads to understand cases missed by COSD.
6. Monitor your results by means of a run chart or control chart and celebrate your success within your organisation when improvements are visible.
7. Integrate data collection into MDT meetings by agreeing a core dataset, displayed on a screen and updated in real time.
8. Check that key fields (eg PS and stage) are completed prior to COSD submission.
9. Discuss issues with data completeness with a colleague from another organisation – you can see who is doing well by reviewing our online datasheet.

It was agreed that data recording although close to national targets could be improved upon, in particular the Ipswich site. The simplest way of doing this is reviewing and discussing their data on a regular basis as outlined in the improvement toolkit.

Participation in clinical audit

Local Audits

The reports of the 177 local clinical audits were reviewed by the provider in 2020/21 and ESNEFT intends to take the following actions to improve the quality of healthcare provided:

Group 1	
Medicine	
Audit	**Description of Actions**
Lipid management in patients with ischaemic strokes or TIAs	Standards Partially met—further actions: •Prioritise Lipids section on the proforma across specialties where patients regarded high risk • Promoting the evidence and simplify practice i.e. high dose Atorvastatin 80mg •Standardize what the follow up lipid monitoring should be – primary or secondary care. Communication between the two. •Identify a strategy if LDL is not available and to standardise across primary and secondary pathways. Should we be considering ratios as an alternative.
Evaluation of Non-Physiological Device Implantation in a District General Hospital for Patients with Intact Atrioventricular Conduction	Standards met
Barriers to living donor	Standards met
Compliance to ESNEFT AKI bundle	Partially met—further actions: Delivering teaching related to AKI and introducing AKI bundle care. Making sure that AKI bundle care is implemented for every patients with AKI. Education and increasing awareness during doctors/ nurses handovers, study days, induction days and while bed side.
Oxygen prescription in the ED	Standards Partially met—further actions: Clinicians are documenting target oxygen range for every patients especially during inductions. Occasional spot checks to ensure compliance with oxygen prescription among clinicians and to encourage safe practice. Increase in number of bite size teaching sessions
Initiation of anticoagulation by ED for newly diagnosed Atrial Fibrillation patients	Standards Partially met—further actions: Promote the use of scoring template on the new CAS card through teaching (RAG score 20) Educate the A+E doctors on guidelines around when to refer to the AF clinic (RAG score 4) - Actions implemented
Causes of graft loss in renal transplant patients	Standards met

Participation in clinical audit

Local Audits

Management of Fractured Neck of Femur in the Emergency Department	Standards Partially met—further actions: Pain score completed at triage as standard Escalate patients with pain score > 4 at triage for rapid assessment with view to prescribing analgesia Appoint an analgesia clinical lead & nurse lead Escalate patients with pain score > 4 at triage for rapid assessment with view to prescribing analgesia Appoint an analgesia clinical lead & nurse lead Introduce colour coded porter x-ray forms with aim of prioritising #NOF Introduce a simplified #NOF Pathway and place around the department
Patient waiting times between referral to cardiac surgery until transfer	Standards Partially met—further actions: Ensure all investigations completed in time and the referral on the online system is fully completed
ESNEFT service review of end of life care during COVID -19 pandemic	Standards met
Local Safety Standard for Invasive Procedures (LocSSIPS) – completion of checklists	Standards met
Intravenous Fluid Administration in Adults in the Emergency Department (NICE CG 174)	Standards Partially met—further actions: Conduct Teaching sessions in SHO and Registrar meetings regarding IVF Administration
An Audit of Pain Management in Adults 18 years and over in the Emergency Department	Standards Partially met—further actions: • Adherence to the pain management national guidance • Pain assessment documentation should be mandatory • A Pain Champion should be appointed at the level of Associate Practitioner
Initial sepsis management in ED setting	Standards met
Consultant sign off	Standards Partially met—further actions: Education in the ED
Assess current performance of meeting clinical standards of care of mental health in ED	Standards Partially met—further actions: Education, Changes to Proforma
Managing COVID-19 at the front door	Standards Partially met—further actions: To create a Checklist for suspected COVID-19 patients to be done on admission To alert the person admitting to the checklist with a sticker prompt
Medical record keeping audit in Capel ward	Standards Partially met—further actions: Education of Junior doctors (Completed)
Management of acute respiratory failure in the ED	Standards Partially met—further actions: Education/clinical lead on RF. Peer-to peer support. Documented template (Actions implemented)
Acute Confusional State and AMTS/CAM	Standards Partially met—further actions: Educate junior doctors about the importance of objective assessment and documentation of cognitive impairment
Adult vital signs	Standards Partially met—further actions: Informed during meetings/via e mail/during induction/ posters in ED Changes in ED CAS card
Total Body CT scan Requisition in Trauma	Standards Partially met—further actions: Conduct Teaching sessions in SHO and Registrar meetings regarding TBCT

Participation in clinical audit

Local Audits

Group 1	
Cancer & Diagnostics	
Audit	**Description of Actions**
Saving Lives	Standards Partially met—further actions: On– going audit, actions taken through the Infection Control Committee
Preventing omitted doses	Standards Partially met—further actions: On– going audit, actions taken through the Medication Governance Group
Consent for Blood Transfusion	Standards Partially met—further actions: Evidence of consent to transfusion recorded + risks/ benefits - continue to monitor in future audits review data in next NCA –medical usage. Record of leaflet given - Discussed in mandatory training and added more explicitly in doctor mandatory training. Transfusion recorded in discharge summary
Beriplex Dosage audit	Standards Partially met—further actions: New protocol is being developed with stroke team to more quickly give anticoagulant reversal in Beriplex patients Risk to patients with major bleeds including intracranial bleeds identified due to length of time to giving the dosage of Beriplex under review with Stroke team and Haematology Consultants. Review of reversal protocols for all patient by Thrombosis group. SPC and national guidelines different to local - To be discussed at audit meeting.
CTPA review of Technical quality and reporting Re-Audit	Standards Partially met—further actions: Reports should include comments about degree of vascular enhancement and motion artifacts.
Audit to assess adequacy of CT Colonography	Standards Partially met—further actions: Buscopan - additional information on consent form to remind staff to scan documentation correctly. Bowel Preparation - additional information on the consent form for radiographers to document this information. Adequate bowel distention - additional information on consent form. Radiographers to attend certified cause.
Lung cancer service audit - Referral into our service, initial investigations and the effect of COVID-19 on your experience	Standards Partially met—further actions: Overall patient satisfaction - No actions or change needed to CNS role in light of COVID-19 pandemic
Annual audit of dysplasia in oesophageal biopsies for year 2019.	All standards met - re-audit 12 months time
Appropriateness of radiotherapy referrals under IR(ME)R	Standards met
Management of unplanned gaps	Standard met/ re-audit annually
CT old age psychiatry	Standards met
Audit of emergency breast attendance outcomes	Standards met

Participation in clinical audit

Local Audits

Clinical Record-keeping	Standards Partially met—further actions: Update policy in line with GMC requirements & re-audit
Consent and Record Keeping Audit	Standards met - no actions
Safety and diagnostic yield of splenic core biopsy	Standards met - no actions
Audit of reporting of cervical biopsies against the Cervical Screening Programme Histopathology reporting handbook	Standards Partially met—further actions: Consider the introduction of a proforma/summary box for reporting cervical biopsies, including a section to identify cases with a 2- or more grade disagreement between cytology and histology. Plan and circulate the proposed proforma to reporting Consultant Pathologists and Consultant Gynaecologists for review/approval. Re-audit in 1 year.
Outcomes of Oncology patients with NSCLC treated with Chemotherapy and Immunotherapy	Standards met: No actions required, this audit was to assess if the outcomes achieved as ESNEFT for this subset of patients was comparable to trial data
Audit of vertebral fracture identification on computed tomography scans	Standards Partially met—further actions: Raise awareness among our colleagues in radiology. Reporting practitioners to routinely examine all imaging studies showing the spine in older adults for moderate/severe grade vertebral fractures. When vertebral fractures are reported they must be reported unambiguously as a “vertebral fracture” with appropriate recommendations for further management.
PIPs Prognosticator at Hospital setting	Standards met—re-audit annually
CTPA according to the wells Score	Standards Partially met—further actions: Introduce a Wells score cut off of ≤4 on referrals, Re-audit data in 6-month time interval to evaluate our performance again
MRONJ Medication related osteonecrosis of the jaw	Standards Partially met—further actions: Dental review prior to starting treatment to reduce the risk of oseteonecrosis of the jaw
Oncotype Dx	Standards met - Oncotype changed plan in 10% of cases , no plan for re-audit
Complications and outcome for lower limb angioplasty	Standards met - re-audit 2 years
The use of CT in catheter-directed thrombolysis	Standards met
Is imaging confirmation of central lines placed via 3CG concordant with guidelines?	Standards met
Radiation incident Review	Standards met - re-audit 2 years
Near Miss Radiation Incident	Standards met - re-audit 2 years
An audit of compliance of immunoglobulin prescribing for secondary antibody deficiency	Standards met
Neutropenic Sepsis - Audit of 'door to needle time' - antibiotic administration for patients with NS (one hour standard) - Oncology & Haem-Onc Patients	Standards Partially met—further actions: Ongoing data collection and reporting - actions taken for improvement through Deteriorating Patient Group
Audit of Deaths within 30 days of last Systemic Ante-cancer therapy (National NCEPOD recommendation 2008) – Clinical oncology and Haemo-oncology patients	Standards met: Ongoing data collection and reporting - discussed at Chemotherapy Governance Group

Participation in clinical audit

Local Audits

Group 2	
General Surgery & Anaesthetics	
Audit	**Description of Actions**
Post - Operative analgesia and patient satisfaction after laparotomy	Standards met
Waiting time in Ipswich Hospital SAU	Standards met
Management of upper GI bleed	Standards met
Trauma antibiotic prophylaxis audit	Standards met
Recognition of patients with red or amber flags and the sepsis six bundle compliance within the adult ward settings (Ipswich site)	Standards met
Auditing the investigation of chronic diarrhoea	Standards Partially met—further actions: Complete - implementing action plan. Present findings to GPs at regional teaching day.
A review of the quality of care provided for patients treated for acute pancreatitis	Standards Partially met—further actions: Complete - implementing action plan. Introduction of acute pancreatitis bundle, including instructions on referral. instructions on when to send autoimmune and viral screens, and what these involve.
CEPOD antibiotic prophylaxis audit	Standards met
Audit of Staff Satisfaction with Support for Patients with Additional Needs	Standards met
Audit of new ITU referral monitoring tool during COVID-19 pandemic	Standards met
Outcomes of Day Case Laparoscopic Cholecystectomies	Standards met
Outcomes of Surgery in COVID-19 Infection: International Cohort Study	Standards met
An Audit of basic and emergency tracheostomy equipment	Standards met
SAFE (Sampling Ascitic Fluid Effectively)	Standards Partially met—further actions: Complete - implementing action plan. Worked with IT to ensure Lorenzo is updated and clinical staff are able to print accurate labels for different test types to minimise waste/errors.
Acute appendicitis: management during the COVID-19 lockdown	Standards met
HAREM Study	Standards met
CASCADE	Standards met
Quality of operation note audit	Standards Partially met—further actions: Complete - implementing action plan. Education and introduction of an Electronic operation note proforma to ensure full completion of patient personal and clinical information.
Audit of follow up of patients who were administered regional analgesia/anaesthesia or general anaesthesia in obstetrics.	Standards met

Participation in clinical audit

Local Audits

Incidence of VAP in tracheostomy patients	Standards met
Covid-19 Urology Telephone clinics	Standards met
Audit to identify the proportion of eligible chronic liver disease patients referred for elective liver transplantation assessment	Standards met
Audit on Perioperative Care of Diabetic Patients	Standards met
Paediatric Airway Management Complications during the COVID-19 Pandemic	Standards met
VTE Assessment Completion Rate	Standards met
VTE Assessment Completion Rate - Re-audit	Standards met
Documentation and efficacy of epidurals on labour ward	Standards met
Review of time to radiological diagnosis of patients presenting with acute bowel obstruction	Standards met
Global-Surg-Covid-19Surg-Week: Determining the optimal timing for surgery following SARSCoV-2 infection	Standards met
Audit of clinical outcomes and resource utilisation of patients admitted to Colchester critical care unit with Covid-19 illness.	Standards met
Rectal Cancer Management During Covid-19	Standards met
GlobalSurg-Covid-19Surg Week: Determining the optimal timing for surgery following SARSCoV-2 infection	Standards met
Central Venous Access colonisation rate during the COVID-19 pandemic	Standards met
Are group and save samples necessary for most Urological elective procedures? A cost-efficacy analysis	Standards met
Ward round proforma: improving patient safety on ward rounds by standardising documentation	Standards Partially met—further actions: Complete - implement action plan. Modify the proforma to better illustrate aspects of ward round most applicable for Urology patients
Mouth Care Re-Audit 2020	Standards met
Capnography in ICU	Standards met
STAT Medication	Standards met

Participation in clinical audit

Local Audits

Group 2	
MSK and Specialist Surgery	
Audit	**Description of Actions**
Third cycle of retrospective Audit of Radiographic Justification & Reporting of OPG's taken in the outpatient department	Standards Partially met—further actions: Complete - implementing action plan. Poster to remind clinicians to include OPGs in records.
Review of adult elective orthopaedic operation notes and benchmark against standards set by RCS (2014) and BOA (2019)	Standards met
Nutritional optimisation of the pre-operative trauma patient	Standards Partially met—further actions: Complete - implementing action plan. Identify which Standards Partially met—further actions: carbohydrate drink tan be administered to patients and order sufficient stock. Identify patients who are likely to be starved longer than 6h whilst awaiting surgery.
Improving efficiency of the trauma theatre	Standards met
Efficacy of Lidocaine 5% Medicated Plaster application to area of localised neuropathic pain	Standards met
Compliance with WHO forms for outpatient minor oral surgery procedures	Standards met
Balloon sinuplasty	Standards met
A Collaborative Audit of Intraoperative Fluoroscopic Radiation Measurements in Orthopaedic Trauma	Standards met
Recovery Flow: Audit to increase number of patients up, dressed and out of bed.	Standards met
Dental trauma – treatment and advice provided in the emergency department	Standards met
Dental trauma – treatment and advice provided in the emergency department - re-audit	Standards met
The Early Impact of COVID-19 on #NOF Service and Outcomes	Standards met
COVID-19 OMFS Trauma and Dental Infection	Standards met
Post-operative care in lower limb arthroplasty: what should we check and document?	Standards met
Elective otological surgery during Covid-19	Standards met
IMPACT Hip Fracture - Covid-19	Standards met
The Early Impact of COVID-19 on #NOF Service and Outcomes	Standards met
VFC discharges	Standards met
Quality of electronic discharge letters in Trauma and Orthopaedics	Standards met
GlobalSurg-Covid-19Surg Week: Determining the optimal timing for surgery following SARSCoV-2 infection - ENT Colch	Standards met
VTE prophylaxis compliance in ENT emergency admissions	Standards met
An Audit to assess the first stage consent written on consent forms for the extraction of a lower wisdom tooth	Standards met

Participation in clinical audit

Local Audits

Group 2	
Women's & Children's	
Audit	**Description of Actions**
Resuscitaire equipment checking	Standards Partially met—further actions: Paediatric team to inform midwifery / theatre teams immediately if equipment used or missing between deliveries.
High dependency care in children	In progress
Hypoxic ischameic encephalopathy	In progress
ATAIN unexpected term admissions to NNU	Standards Partially met—further actions: Reduce avoidable term admissions to NNU by -Educating staff -Improve sepsis screening -Ensure baby's remain with mums in TC
Sepsis and fever in children (rolling)	Standards Partially met—further actions: Continue to use fever and sepsis paperwork for all patients. Continue staff education. Share audit to highlight areas of improvement that are required in documentation. Continue auditing 3 monthly. Assessment paperwork being redesigned and will include sepsis tools rather than these being on separate sheets. This will be used across all of paediatrics – ED, PAU and the inpatient ward. LP pack to be made up.
Appendicitis in children	Standards Partially met—further actions: Continue using successful paediatric assessment workflow document
14 hour consultant review/Facing the future RCPCH	Standards Partially met—further actions: • Consultant body discussion with regards to ensuring reviews of patients within 14 hour timeframe • Awareness of new admissions identified at handover
FreeStyle Libre audit	Standards Partially met—further actions: Review data every 3- 6 months Encourage revision online Libre Academy and to identify barriers for improvement, motivating factors Consider increasing input for existing users before increasing overall numbers Presentation of audit to Diabetes team Letter to all families re: potential removal of funding
Hyperthyroidism in children audit	Standards Partially met—further actions: Team to develop a patient information leaflet.
Neonatal intubation LocSSIP audit	Standards Partially met—further actions: Excellent uptake of Neonatal Intubation Proforma Further emphasis needed on completing all sections of the proforma, especially documentation of ETT position. • The results of the audit summarised and highlighted in the next few weekly neonatal governance meetings that takes place every Thurs/Fri. This is a good platform to encourage people to fill in the "indication", "roles" and "position of ETT tube", especially for catching the new trainees who have rotated. • A specific date of re-audit hasn't been decided yet but would be really useful and ideal in either Q1 or Q2 of 2021.

Participation in clinical audit

Local Audits

Gynae LocSSIP audit Ipswich	Standards Partially met—further actions: Doctors to complete form fully
Colposcopy LocSSIP Colchester	Standards Partially met—further actions: Colposcopy must ensure that the 'correct' and 'disposal' boxes are also filled in when counting out and disposing of swabs. All sub categories in the sharps count must be completed by the RN, then checked and signed by the Colposcopist as correct Further clarification of what classes as an instrument will be distributed. The Lead Nurse Colposcopist is responsible for ensuring compliance throughout both Doctor and nurse led clinics.
Hysteroscopy LocSSIP Colchester	Standards Partially met—further actions: Visual aid to ensure every step in the LocSSIP checklist is properly completed for every patient undergoing a hysteroscopy The NatSSIPS guideline (2015) has been made accessible to the nursing team to ensure the education of why & how each section should be completed Re-audit to ensure compliance
Offer of disclosure of results of Invasive Cervical Cancer audit Ipswich	Standards Partially met—further actions: Re-audit required.
Invasive cancer disclosure policy Colchester	Standards met
Sensitivity and Specifity of pipelle samples at Colchester hospital	Standards Partially met—further actions: evidence to support using pipelle as first line endometrial biopsy method/Cost effectiveness of diagnostic strategies/reduce pressure on hysteroscopy service Review local guideline on investigation of PMB Introduce pipelle as first line endometrial biopsy method RE-audit 3 months after implementation of SOP
Daisy team referrals review	Standards Partially met—further actions: • Mentoring midwives to feel confident in caring for vulnerable women • Providing safeguarding supervision to maternity staff • Reviewing MDT pathways and Multi-agency working • Creating an antenatal clinic at Open Road with MDT input • Working alongside Health in Mind Psychologist reviewing women's needs
Hypnobirthing outcomes	Standards met

Participation in clinical audit

Local Audits

Operative delivery audit Colchester	Standards Partially met—further actions: Standards of documentation can be improved Further training is required for rotational deliveries Notes/Patient records – Medway to be adjusted to capture important information for assisted deliveries – Verbal consent and pre-delivery discussion to be entered into the patient's notes – Medway entry to be made by clinicians for all deliveries • Failed instrumental deliveries, sequential instrument use, second stage caesarean section to be reviewed and an agreed proforma completed • Further training required for OP rotations to reduce incidence of direct OP traction • Measures to reduce blood loss at instrumental delivery • New RCOG proforma for instrumental delivery notes to be incorporated into Medway and Labour notes • Introduce urgency scale with target decision-delivery intervals for "trials" in theatre • Re-audit after implementation of changes
Maternal sepsis	Standards Partially met—further actions: Review other means of identifying more patients to include in the data collection Increase compliance with the 24 hr input output chart Increase compliance with sepsis eLearning
Outcomes for multiple pregnancies Colchester	Standards Partially met—further actions: Recommendations for PPH - Measuring blood loss Uterotonics- early use vigilance Cannulation in labour Prepare for active management of the third stage Inform women of this plan of care AN Recommendations for PET - Commence K2 26/40 Aspirin 150mg OD PO >12 weeks Recommendations for anaemia - Lower threshold for commencing oral iron therapy Additional FBC 20/40 and 32-34/40 Fetal growth surveillance - Audit of EFW compared to BW for multiples to check accuracy in multiples pregnancies

Participation in clinical audit

Local Audits

MVA for early pregnancy loss at Ipswich	Standards Partially met—further actions: All trainees and junior doctors in O&G will become competent in MVA MVA is a core skill for O&G trainees and a central competence register will be kept Plan to have a dedicated procedure room on Stour for MVA and other local procedures
Management of ectopic pregnancy	Standards Partially met—further actions: Percentage of women provided with information containing support group details 1. Educate staff about the importance of given written support information to women experiencing miscarriage. Add prompt to new management of miscarriage (? electronic proforma to encourage staff to signpost women and document their action. Diagnosis of ectopic pregnancy at initial scan Individual case review of all surgically managed ectopic pregnancies by EPU lead and Sonography manager. reduce operations at night if patient stable
Conservative management of CIN2	Standards met
Obstetric swab count audit	Standards Partially met—further actions: Delivery and suturing swab count - Redesign Delivery notes to include swab count - Delivery and suturing swab count - Reminder for midwives to count and counter-sign for swabs to be added to safety briefing Delivery and suturing swab count - Redesign audit proforma -
IA fresh eyes and CEFM	Standards Partially met—further actions: Re audit in 3 months to assess intrapartum risk assessment fetal monitoring tool in labour notes. Business case in place to reduce CTG machines without pulse oximeter. Discuss with labour ward leads when change over to FIGO guidelines.
Midwifery led care	Standards Partially met—further actions: Re-audit 2021 as Covid-19 impacted results
VBAC Ipswich	Standards Partially met—further actions: Continue the use of birth choice proforma for women deciding on mode of delivery following one previous caesarean section: - Will standardise counselling on risk and benefit on options. - Improve documentation.
Mothers with non gestational diabetes - outcomes for mother and infant	Standards Partially met—further actions: Recording baby being fed within first hour and record it -
Room temperature at birth	Standards Partially met—further actions: QI in progress & re-audit

Participation in clinical audit

Local Audits

Analysis of the Referral Pathways of the Developmental Dysplasia of the Hips since the Introduction of Antenatal and Newborn Screening Failsafe Team	Standards Partially met—further actions: 1) Neonates who were breech presentation from 36 weeks gestation regardless of birth presentation, at time of birth from 28 weeks gestation or multiple pregnancy referred for routine 6 week ultrasound Results to be given to Radiology team for action. QIP to change appointment booking system. 2) Appropriate use of referral pathway. Referrals to be made on portal. Teaching of new staff members on referral pathways and portal requests. Update existing staff on referral pathways and new referral system on portal. 3) Did not attend appointments Educating parents on reasons for referral. HCPs who are NIPE trained.
Skin to Skin audit Colchester	Standards met - ongoing actions - Continue daily skin to skin discussion Audit Skin to skin in theatre via Medway Education via mandatory monthly training and at induction Education of theatre team –ODP's, scrub team, recovery team Antenatal education of women
Contraceptive choices following TOP (2019 audit - presented 2020)	Standards Partially met—further actions: This supports thoughts of additional appointments in TOP clinic in order to fit LARC for those having medical TOP if logistically possible Small number of women wanting patches- ordering these so that they are available as a bespoke TTA when they attend for mifepristone Equally for those wanting a different brand of pill- discrepancies in the trust formulary Further registrar trained for insertion of implants in addition to existing staff. However given frequent trainee rotations consider identifying another consultant or registrar early after August rotations to train if no new staff yet trained Consider training nurses and/or midwives for implants- this could also apply to post-procedure slots in TOP clinic for fitting Improving access to coils- consider on call doctors to fit these post procedure Documentation: Space to record patient leaving with no contraception on the checklist along with prompt to give iCaSH leaflet?

Participation in clinical audit

Local Audits

Colposcopy audit - national data	Standards met
Smoking cessation	Presented but waiting for retrospective forms
Neonatal resus proforma completion	Standards Partially met—further actions: 1. Resus proforma to be kept on resuscitation trolley 2. Audit findings to be forwarded to all team members involved in neonatal resuscitation-midwifes, SHO, SpRs, Paeds Consultants 3. 100% compliance with proforma in next audit 4. Resus proforma to be scanned and uploaded to clinical notes section in Evolve
Sodium valproate audit	Standards Partially met—further actions: •Documentation of teratogenicity risk while starting sodium Valproate in girls in Outpatients letter. • After 10 years to mention again about teratogenicity risk in Outpatient letter annually if Valproate continues. • Change to another anti epileptic if possible • After 13 years annually Risk acknowledgement form to be filled and signed by treating Paediatrician/Epilepsy Nurse. • GP trainees made aware during the audit about the importance of PREVENT programme for such patients and the specific contraceptives that can be recommended for such females. • Re-audit in 1 year.
Review of testing for Global Developmental Delay	Standards Partially met—further actions: 1) Standard - First line investigation conducted first - Re audit, discuss at the department to use of the local guidelines - community Paediatrics Trainee - 1 year. 2) Standard - All children at CMR have test - Re audit - Community Paediatrics trainee - 1 year
Red string audit	Standards Partially met—further actions: Any Guidelines and SOPs that may pertain to swab counting have been reviewed and only one required amending. The SOP on swab-counting in Maternity has been amended with the instruction to immediately dispose of the red string after opening the swab pack. This information was disseminated to staff in a variety of formats. Stocks of Birth Notes have been checked and all versions in circulation are the newer 2020 version. The tick-boxes pertaining to the red string have been blacked-out in order to prevent confusion and to maintain one approach which is to dispose of the red string and not let it re-enter the sterile field.

Participation in clinical audit

Local Audits

Review of rest breaks in the paediatric department	Standards Partially met—further actions: 1 - Encourage to take breaks - All staff Immediate. 2 - Discuss with senior if you are experiencing HALT - All staff - Immediate 3 - Ask for a break - All staff - Immediate
SBLCB audit Ipswich	Standards Partially met—further actions: Communication with staff re: findings of audit Feedback to individual staff members if required – acknowledging good practice as well Culture shift regarding documentation. Ensuring all staff understand what is expected Acknowledge the difficulties that we are facing during Covid-19 and gain feedback from the team on how to overcome these
An audit on the screening guidelines for uveitis in children with juvenile idiopathic arthritis	Standards Partially met—further actions: A review of the system is required to drive improvements, so patients are less likely to get delayed/missed. Ideally need Consultant Ophthalmologist cover - one at each site. Currently we have an average of one day a week paediatric cover in Colchester Hospital Re-audit in 6-12 months to see if there is an improvement due to any changes we put in place as a result of this audit.
MCDA twins Ipswich	Awaiting outcome
Adolescent and paediatric gynaecology service at Ipswich hospital	Standards met
Audit on the effectiveness of growth hormone therapy	Standards met
Quality of day 1 postnatal medical review of caesarean sections and obstetric anal sphincter repair/ readmission to maternity (Orwell)	Standards met
Women's experience of care antenatally, birth and postnatal	Standards met
The effect of Covid-19 on Postnatal outcomes	Awaiting outcome
Skin to skin theatre Nov 2020	Awaiting outcome
Pre Kaiser Introduction Audit – October 2020	Awaiting outcome
Provision of demonstration/discussion of reconstitution of formula and sterilising of feeding equipment October 2020	Awaiting outcomeon
Midwife led tongue tie service and Covid-19	Awaiting outcome
Readmissions of babies Birth to 28 days Feeding related issues 2019 -2020	Awaiting outcome
Thermoregulation on the Postnatal Ward	Standards Partially met—further actions: Education to all staff to ensure the documentation of care demonstrates a risk assessment has taken place. Repeat audit to ensure education has been effective.

Participation in clinical audit

Local Audits

Thermoregulation of the newborn in the immediate postnatal period	Standards Partially met—further actions: Education to all staff to ensure the documentation of care demonstrates a temperature has been taken within 60 minutes of birth and any temperature outside the normal range is actioned and referred appropriately. Combine education of thermoregulation with the increased awareness of skin to skin contact as they in linked and integral to fundamental care at birth.. Repeat audit to ensure education has been effective.
MVA for early pregnancy loss at Ipswich	Standards Partially met—further actions: All trainees and junior doctors in O&G will become competent in MVA MVA is a core skill for O&G trainees and a central competence register will be kept Plan to have a dedicated procedure room on Stour for MVA and other local procedures
Adherence to antimicrobial guidelines on children's ward Colchester	Standards Partially met—further actions: Consider the use of benzylpenicllin in URTI + amoxicillin in LRTI If starting IV antibiotics aim to take culture
Hysteroscopy OPD audit	Standards Partially met—further actions: Filling up the forms correctly and fully will improve OP and IP hysteroscopy success More patients can go through the correct procedure, making the process faster, increase in productivity of surgical lists (faster management) Re-audit Dec 2021
Paediatric asthma re-audit	Standards Partially met—further actions: Re establish the role of Asthma link nurses. Increase visibility of CNS on the wards. Consider re implementing asthma as part of the Child health study days. Assess the potential to source online learning. Senior meeting to discuss and create an ongoing plan to enhance standard of care. Asthma Month / Education board. Re organisation of documentation on the ward to encourage use.
Record keeping audit maternity Colchester	Standards Partially met—further actions: Staff to document Vitamin K second-checker - Midweek Memo and flash-message added to Medway to remind staff at every log-in Document Fetal Monitoring has been discussed with the woman - Included on the Fetal Monitoring Risk Assessment sticker Redevelop Record-keeping audit tool in line with current guidance - Delayed due to Covid-19 To audit 5-10 sets of notes monthly as an ongoing audit - Delayed due to Covid-19 Trust Audit Team to perform a general record-keeping audit for Maternity from Jan-April 2021 - in progress

Participation in clinical audit

Local Audits

Group 3	
Integrated Pathways	
Audit	**Description of Actions**
Risk assessment and management of adults with non-hip fragility fractures	Standards Partially met—further actions: Junior doctors as well as consultants to be able to identify fragility fractures and assess their patients' risk for future fractures and offer appropriate treatment
Re-audit- 'The Impact of Speech and Language Therapy in a Community Paediatric ASD Diagnostic Team'	Standards Partially met—further actions: DNA's require addressing. Some are not attending clinic appointments, some are not present for school observations Explore which type of appointment most patients are not attending SaLT's or admin to explore calling schools to confirm visits on the day. Explore possibility of booking something clinically relevant in that slot as an alternative use of resource

Our new Acute Medical Same Day Emergency Care (AMSDEC) unit at Ipswich Hospital. AMSDEC is for patients with conditions such as chest infections or palpitations who need quick treatment, but not a hospital stay. An average of 25 patients will be treated in the unit each day.

Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by East Suffolk and North Essex Foundation Trust in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 6,222. Of these 6,219 were recruited to NIHR portfolio studies.

The emergence of the COVID-19 pandemic in early 2020 led the NHS and NIHR Clinical Research Network to pause current and set up of new research, other than for nationally prioritised COVID-19 studies. Here at ESNEFT we rapidly realigned our teams to set up and run the prioritised COVID-19 studies, all teams across the Trust pulled together, to offer our patients and staff the opportunity to take part in cutting edge COVID-19 research.
The Department of Health is committed to offering patients the opportunity to take part in robust, peer-reviewed research. The organisation remains dedicated to supporting clinical research in order to improve the quality of care we offer and to making our contribution to wider health improvement. We actively seek to attract high quality research to help develop our research portfolio. The number of staff involved within the research fixed workforce, equates to 45.0 wte, while the number of staff involved and departments supporting our research has increased year on year; currently there are over 174 Principal Investigators listed as leads in our research studies. Examples of the COVID-19 studies ESNEFT has been involved in, which demonstrates a commitment to clinical research, which leads to better treatments for patients include:

One of the most significant COVID-19 trials which took place around the globe is called RECOVERY, which stands for Randomised Evaluation of COVID-19 Therapy and is exploring which treatments could benefit adults who have been hospitalised with suspected or confirmed COVID-19.
Here at ESNEFT we recruited participants across Colchester and Ipswich Hospitals. As a direct result of the trial, dexamethasone is now being used regularly to treat patients with COVID-19 after the study showed it can reduce mortality by up to a third.
Senior research nurse Steph Bell said: “RECOVERY has been an absolutely phenomenal study, and is the largest study of potential COVID-19 treatments in the world. It has been great for staff as they have been able to see the results in real time, which is unusual in research as often it can take several years before the findings from trials are incorporated into standard practice.”
Senior research radiographer Celine Driscoll, who has been coordinating RECOVERY study at Colchester Hospital, said:

“RECOVERY has been a real success story here at the Trust. We quickly assembled a large multidisciplinary team from scratch and were swiftly able to offer the trial to our patients.
“We’re proud to have been able to support such an important global study and it’s been very rewarding for the hardworking team members to see its benefits to our patients and be a part of its success.”
In addition to the dexamethasone findings, the trial has now demonstrated that an anti-inflammatory treatment, tocilizumab, reduces the risk of death when given to hospitalised patients with severe COVID-19 and shortens their length of stay. You can read more about the RECOVERY study Here

Over 350 colleagues from across our Trust took part in a groundbreaking study which has found that people who have had COVID-19 may have some immunity from the virus for five months.
The SIREN research study saw 351 ESNEFT staff, together with thousands of other healthcare workers from across the country, take part in regular antibody testing and nasal swabbing starting in the second half of 2020.
The initial results show that only 44 potential reinfections were recorded among 6,614 participants who showed evidence of a previous infection. This indicates that antibodies from a past infection provide 83% protection against catching COVID-19 again for at least five months.
However, early evidence also suggests a small number of people with antibodies may still carry the virus in their nose and throat, and therefore could transmit it to others. You can read more about the SIREN study here SIREN answering the big questions

Over this year over 1 million people have participated in COVID-19 Research in the UK. Global Vaccine Research has led to the approval of three vaccines for the use in the UK. We were extremely proud to take part in a large scale commercial trial of a new COVID-19 vaccine which has been shown to offer nearly 90% protection against the virus. Colchester and Ipswich hospitals were among 35 centres across the UK to test the vaccine. If the Medicines and Healthcare products Regulatory Agency (MHRA) give approval the aim is to roll out the vaccine during the second half of 2021.

Here’s what our ESNEFT participants said about being offered the opportunity to be involved in the vaccine study
“At the beginning of the pandemic I was unable to go back to work at the hospital because I needed to protect my husband, disabled daughter and other members of my family.

Participation in clinical research

"By participating in the vaccine trial it is my way of contributing towards the fight against this awful disease. I have received excellent care throughout and have been impressed by the procedure and information given by the whole research team."
"I have always been well looked after by the NHS, so really wanted to help in any way I could.
"It has been a pleasure and the staff have always been lovely. I'm so pleased to have helped to prove the vaccine to be a good, reliable vaccine and excited to have been a small part in such an important research programme which will be making a huge,

much-needed difference in these worrying times."
Readers wishing to learn more about health research and development and taking part in research, can access the websites of the National Institute for Health Research, at the following address: I want to take part in a research study
At the start of the pandemic we supported a national surveillance project, as part of the Government's response for the need to increase testing for Covid-19 for asymptomatic healthcare workers. Across both Colchester and Ipswich hospitals we set up seven testing stations in under 24 hours and we tested nearly 1,000 staff over a two day period in April 2020.
We are enabling our strategy to increase our activity in our own 'home grown' research. We have employed two Clinical Academic Research Leads, and have been awarded funding for a PHD student.
Strengthening our partnership with our local universities is vital to continue to grow our academic research, we have officially joined forces to promote a greater collaboration with the University of Suffolk to add to our established partnership with University of Essex. We have several home grown, exciting projects and grant applications in the pipeline which will enable us to strengthen our patient involvement in early research planning.

We also launched our new Synapse Centre for neurodevelopmental research, our ultimate aim is to research and improve knowledge in this important field and provide much needed support and new evidence-based personalised approaches to therapies, helping those with a range of neurodisabling conditions including Autism Spectrum Disorder (ASD), Cerebral Palsy and genetic syndromes. To read more about our centre Synapse Centre ESNEFT

Patient and Public involvement (PPI)

We held our first pilot patient café just before the first lockdown which was a great success . Introduced for patients who have completed a research study but are interested in keeping in touch with our research teams and to hear more about the impact of the research which ESNEFT participates in . Having the input, and working together with a cohort of patients who have experienced taking part in research studies in the NHS will be of huge benefit as we start to design and sponsor our own research studies. We intend to arrange another café 2021, virtually, or if able face to face once more.

Monitoring quality

When we talk about quality care we mean care that is safe, responsive to people's needs and contributes to a positive patient experience. Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN payment framework enables our commissioners to reward excellence and innovation, by linking a proportion of the Trust's income to the achievement of nationally and locally-agreed quality improvement goals.

* CQUIN framework stood down during 2020/21

How healthcare is regulated

The East Suffolk and North Essex NHS Foundation Trust (ESNEFT) is required to register with the Care Quality Commission (CQC) and its current registration status is full registration.

ESNEFT has the following conditions on registration - no conditions.

No enforcement actions were taken against ESNEFT in 2020/21. However, the Care Quality Commission did take enforcement action against ESNEFT during 2019/20. An Improvement Notice and a Letter of Contravention were issued to the Trust under Sections 21 and 23 of the Health and Safety at Work Act 1974 by the Care Quality Commission (CQC) and the Health & Safety Executive (HSE) respectively in September 2019 following a short notice, announced, focussed joint inspection to assess the Trust's compliance with the Ionising Radiation (Medical Exposures) Regulations 2017, commonly referred to as IR(ME)R, and the Ionising Radiation Regulations 2017 within Nuclear Medicine at Colchester Hospital. The Trust produced a comprehensive action plan to address issues identified by the CQC and the HSE, both within the area inspected and across the whole of ESNEFT. Following completion of the action plan and a review of the evidence submitted by ESNEFT, the requirements of the Improvement Notice were considered to have been addressed and the Trust compliant. The CQC updated its enforcement registry to confirm this on 10 September 2020. The HSE actions were confirmed as having been closed on 22 November 2020.

ESNEFT has participated in the following special reviews/ investigations by the CQC during the reporting period.

- Provider Collaboration Review (July 2020)
- Focussed inspection of ESNEFT acute maternity units: Colchester site 30 March 2021, and Ipswich site 6 April 2021.

On 16 March 2021, the Health & Safety Executive carried out a short notice, focussed inspection of some administration areas of Colchester Hospital in relation to the management of these areas during the Covid-19 pandemic. The report is awaited.

CQC monitoring and inspection process

The CQC's surveillance model is built on a suite of indicators which relate to the five key questions - are services safe, effective, caring, responsive, and well-led?

The indicators are used to raise questions about the quality of care but are not used on their own to make final judgements. Judgements are based on a combination of what is found at inspection, national surveillance data and local information from the Trust and other organisations. The judgement is based on a ratings approach using the following categories: Outstanding, Good, Requires Improvement, or Inadequate

On an annual basis the CQC request and receive a suite of information known as the Routine Provider Information Request (PIR). The PIR has two parts:

Trust level request

This is the main request, which asks about the quality of our services against the five key questions and about the Trust's leadership, governance and organisational culture. This supports assessment of the Well-led domain for the Trust.

Sector request

This is for specific core services that the Trust provides. For ESNEFT this is for both community and acute services and includes:

- Urgent & emergency services;
- Medical care, including older people's care;
- Surgery;
- Critical Care;
- Maternity;
- Services for Children & Young People;
- End of Life Care;
- Outpatients; and
- Community health inpatient services.

Inspections are carried out using an expert team of inspectors and include as a minimum a review of the Well-led domain, Use of Resources and a least one of the above core areas. These inspections were curtailed during the Covid-19 pandemic, however, the CQC did schedule focussed inspections where concerns had been raised. No focussed inspection took place at ESNEFT.

Inspections by the Care Quality Commission (CQC)

The CQC regulates and regularly inspects healthcare service providers in England. Where there is a legal duty to do so, the CQC rates the quality of services against each key question as Outstanding, Good, Requires Improvement or Inadequate. Healthcare service providers can be re-inspected at any time if services fail to meet the Fundamental Standards of Quality and Safety, or if any concerns are raised.

Services at ESNEFT were inspected between 11 June and 18 July 2019. The CQC inspected 14 core services provided by ESNEFT at two acute locations and one community service. Urgent and emergency care, Medical care, Surgery, Maternity, and Outpatients at Colchester Hospital, as well as Urgent and emergency

How healthcare is regulated

care, Medical care, Surgery, Critical Care, Maternity, Children and Young People, End of life care, and Outpatients at Ipswich Hospital. Community health inpatient services were also inspected.

All core services at Ipswich Hospital were inspected in 2019 following its acquisition by East Suffolk and North Essex NHS Foundation Trust in July 2018. As a result of this, Ipswich Hospital no longer had a CQC rating for any of its core services, as these were dissolved at point of merger.

During this routine inspection, the rating of the Trust remained as Requires Improvement. The Trust was considered as being 'Requires Improvement' because:

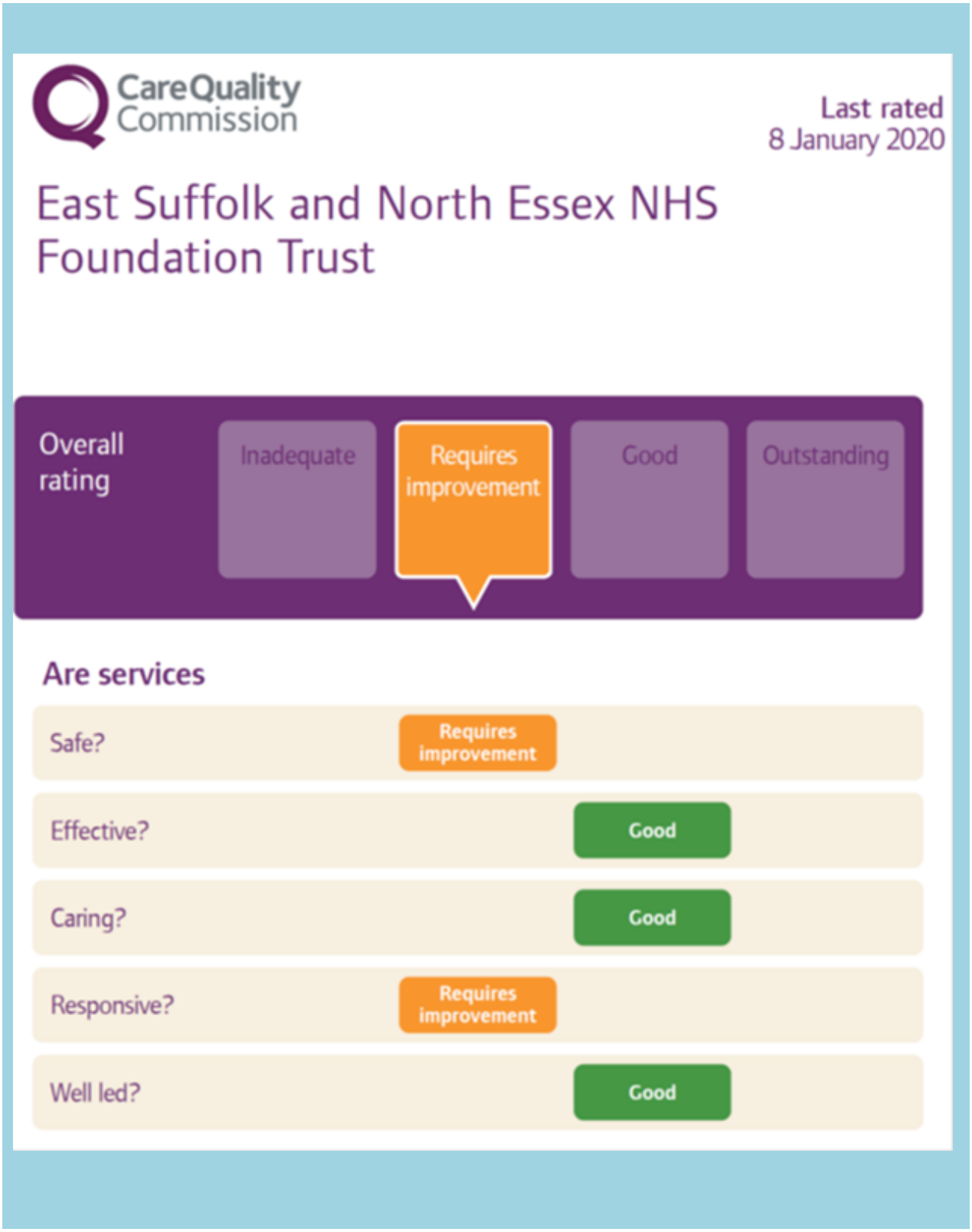
- The CQC rated Safe and Responsive as requires improvement, and Effective, Caring and Well-led as good. The rating took into account the ratings of the core services not inspected during this current visit.
- Four of the 14 core services inspected were rated as requires improvement, and nine core services as good. Services for Children and Young People were considered to be outstanding.
- The decision on the overall ratings takes into account the relative size of the service and the CQC uses its professional judgement to reach fair and balanced ratings.

The 'Must do' recommendations are:

- Mandatory training attendance must improve to ensure all medical staff are aware of current practices, with training compliance being in line with the Trust target.
- Staff must have the appropriate level of safeguarding training for their role.
- Appraisal completion must improve in line with Trust target.
- Patient care records must be accurate, complete and contemporaneous, with pertinent risk assessments completed and updated for all patients.
- Medicines must be recorded and securely stored in line with Trust policy.
- Resuscitation equipment must be checked in line with professional guidance.
- Staff must consistently comply with infection prevention and control measures, including the correct and appropriate wearing of personal protective equipment.
- Staff must undertake thorough risk assessments, including environmental risk assessments, to ensure its premises and facilities are suitable for safe care and treatment of patients with mental health needs.
- Venous thromboembolism (VTE) assessments must be completed for all patients in line with guidance.
- Consent and best interest decisions must be clearly documented in patient records, with mental capacity assessments carried out as soon as there is reason to doubt whether a patient has capacity to make decisions about their care.
- All patient records and confidential patient information must be stored securely to ensure patient confidentiality.
- There must be an effective governance and risk management framework in place to identify, manage and assess all risks.
- There must be clear lines of accountability for patients in the emergency department, with standard operating procedures developed and embedded in all areas.
- The Trust must effectively audit compliance with the WHO five steps to safer surgery checklist.
- Changes made from never events must be fully embedded in clinical practice to minimise the risk of reoccurrence, and learning from incidents must be embedded in clinical practice.
- Administration of hospital prescriptions are monitored and recorded.

The full report is available at https://www.cqc.org.uk/provider/RDE

How healthcare is regulated



Medical Staffing
Rota Gaps

Medical Staffing provide the recruitment service for ESNEFT for medical staff for all grades of doctors.

Medical Staffing Medical Staffing work closely with Health Education East of England and Foundation Schools for all our doctors in training recruitment. We use software called TIS (Trainee Information System) to input information of all doctors in training that are due to rotate to us.

In 2020, ESNEFT remained one of the first choices for FY1 doctors commencing their careers as doctors in the East of England. From 2019, FY1 doctors now stay to complete their FY2 year and this has received positive feedback.

Medical Staffing have continued to work closely with the Iceni Centre and the Iceni Fellowship posts, however Covid-19 has had an impact in on-boarding these doctors.

We also continue to work closely with Royal Colleges to extend our MTI scheme (Medical Training Initiative) which now operates in Surgery, T&O, Medicine, O&G, Anaesthetics.

Rota gaps/vacancies are discussed at the Medical Staffing Steering Forum and the Joint Local Negotiating Committee. Regular Reports are also provided to POD. Any vacancies in our training grade doctors are recruited to by employing Locally Employed Doctors. In August 2020, we were able to recruit into all our training grade vacancies and were oversubscribed by LED doctors wishing to continue their careers at ESNEFT. We were able to over-establish in some areas to support winter pressures and the second surge of Covid-19.

e-roster went live for Medicine Colchester and Anaesthetics Ipswich and the roll out will continue in other areas.

We have active Junior Doctor Forum Meetings and Safer Working Meetings on both sites. We also have the Talk to Sophie Group which support doctors in their careers. This is based at Colchester Hospital currently but will be rolled out at Ipswich Hospital.

A new doctors mess has been created at Colchester Hospital and a satellite Mess at Ipswich Hospital.

A new rest area has opened for junior doctors at Ipswich Hospital. Agnes Okanlawon is a junior doctor now joining the paediatrics team (previously with older people's medicine) and a member of the hospital's junior doctor committee. She said: "It will help make sure doctors get the breaks and rest they need. It's for a small number of people at a time which will help to keep it a quiet area.

Quality Improvement

Quality Improvement faculty

What do we mean by a 'QI approach'?

'Quality improvement' is not the same as 'improving quality'. All provider organisations will be making efforts to improve quality, and this can be done in many ways – including;

Planning (resourcing, restructuring, commissioning, training)
Assurance (periodic checks of quality through audit or inspection)
Control (continuous monitoring of quality with interventions when necessary)

Quality improvement is the use of a systematic method to involve those closest to the quality issue in discovering solutions to a complex problem. It applies a consistent method and tools, engages people (both staff in clinical/ corporate teams and patients/ service users/families) more deeply in identifying and testing ideas, and uses measurement to see if changes have led to improvement.

(Assessing quality improvement in a healthcare provider, CQC 2019)

ESNEFT Quality Improvement

We recognise that staff who are closest to an issue are often the best placed to address it, QI is designed to facilitate that process. At ESNEFT the Quality Improvement (QI) Team have developed a strategy focussed on embedding an organisational improvement mind-set. It focusses on;

- Building QI Capability in staff by teaching them the skills and coaching them, so they have access to the support required to understand problems and address change
  - ◊ We have now trained 168 staff at Bronze level QI and 134 staff at Silver level QI
  - ◊ Conversion from Silver level QI training to registered project is now 33%
- Increasing QI Capacity of skilled QI leaders across the Trust and develop process into the services themselves so QI becomes the 'way we work'
  - ◊ We now have a QI champion job description ready to be built into existing/ developing champion roles or service level job descriptions
- Developing an ethos of Continuous Improvement so that projects are not only delivered as individual examples of improvement but ensure sustainability and spread
  - ◊ 29% of our registered projects are now completed with measurable results of improvement
  - ◊ All projects are measured against a Return on Investment Model to evidence the impact of QI at ESNEFT

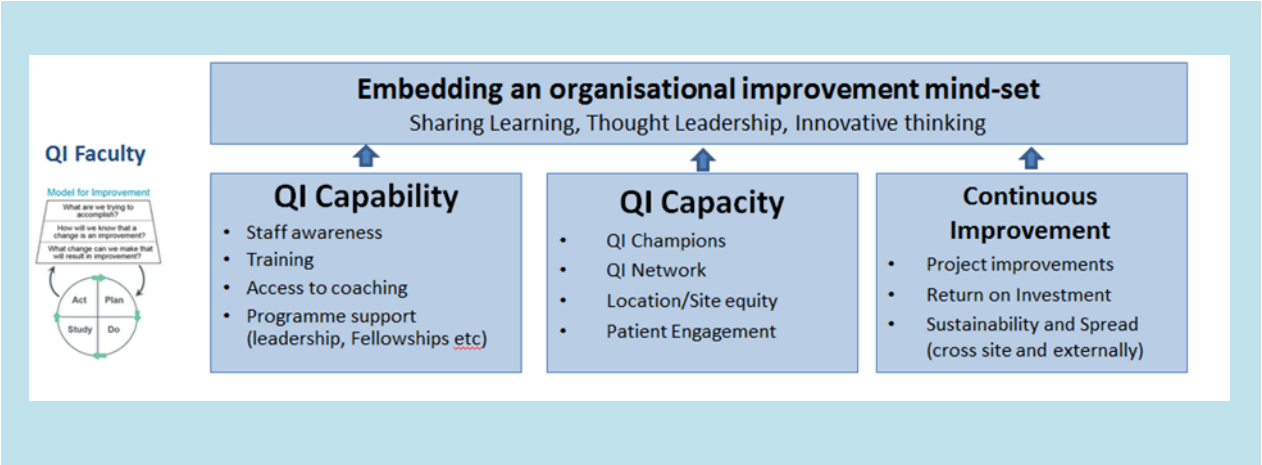
This strategy to building QI as an approach to improvement at ESNEFT underpins the Trusts wider strategies and work streams to give staff the skills and direction to deliver on; locally identified priorities, wider healthcare priorities and quality work streams for the Trust.

This year we have seen improvement work across the Trust including:

- Maternity services focussed on increasing uptake of antenatal women engaging in smoking cessation by 20% from baseline. Education to staff, regular reporting and feedback and increasing hours spent on managing smoking cessation achieved an improvement from the 9% baseline engagement to **58% engagement in cessation services and a 5% reduction in smoke free pregnancies**. This reduces risk of preeclampsia, stillbirth and decreased birth weight. *(QIP 19-042)*
- A Junior Dr led project aimed to increase self-assessed preparedness of FY1 doctors working in General Surgery at Colchester Hospital from 34% to 60%. By creating and introducing an Electronic Handbook (E-Handbook) self-assessed preparedness increased from 34% to 51% just missing the predicted target of 60%. There is further work planned on maintaining the E-handbook's currency and improving its promotion. It has also been highlighted

Quality Improvement

Quality Improvement faculty



as an area for spreading out to other specialism's at Colchester and Ipswich Hospitals. This project also won 'Best Poster' from the Essex Surgical Girls virtual conference in 2020. (QIP 20-190)

- A project in Ophthalmology aimed to reduce the percentage of inappropriate Emergency Ophthalmology referrals received by Colchester Hospital from 16.5% (31/188) per month to 10% by December 2020. (QIP 20-188)
  - ◊ The project focussed on the development and introduction of an online Inpatient Ophthalmology Emergency Referral (IOER) system and an algorithm-based Ophthalmology Emergency Pathway (OEP) supported by the delivery of targeted training and awareness sessions for the relevant staff groups who need to interact with the IOER and OEP.
  - ◊ Working closely with Colchester UTC successfully the project decreased the percentage of rejected referrals from there from 48% to 26%. Following changes the percentage of inappropriate Emergency Ophthalmology referrals received by Colchester Hospital per month had reduced to 11.4% (31/271).
  - ◊ On-going is planned work to focus on addressing the referrals from Community-based Opticians and GP practices. However on average 30 minutes of staff time is saved each time an inappropriate referral is received.
- A project at Colchester Maternity Services set out to reduce term admissions for hypoglycaemia as part of the maternal and neonatal safety collaborative. (QIP 18-043)
  - ◊ Prior to the QI project 10% of NNU term admissions were due to hypoglycaemia, this equated to an average of 5 per month.
  - ◊ A collaborative approach from the MDT created pathways, education for staff and provided appropriate resources and support to staff and mothers.
  - ◊ Results - Admissions for term neonates to the neonatal unit with hypoglycaemia <4 hours old now 0-1 per month= 80% improvement

Quality Improvement

- Dr Hilton from Vascular Surgery led a project which looked at rationalising blood matching in vascular surgery and minimising wasteful cross matching. The introduction of a Maximum Blood Order Schedule (MBOS) is now in use, after approval. There is on-going quality assurance that the MBOS is in use - but potential savings from initial audit suggest there could be between 500 -1000 routine cross matches saved at a value of £7,500-£16,000, this is as well as 225-450 hours of clinical time potentially saved per year. (QIP 18-050)

The Trust now has a state-of-the-art Davinci Xi surgical robot which will help teams to perform complex abdominal-pelvic surgical procedures.

Statements relating to the quality of relevant health services provided

NHS number and General Medical Practice Code validity

East Suffolk and North Essex NHS Foundation Trust submitted records during 2020/21 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data including a valid NHS number for patients seen:
· 99.7% for admitted patient care;
· 99.9% for outpatient care;
· 98.5% for accident and emergency care; and 100% for Community Care.
The percentage of records in the published data including a valid General Medical Practice Code for patients seen:
· 100% for admitted patient care;
· 99.5% for outpatient care;
· 97.6% for accident and emergency care; and 100.00% for Community Care.

Source: NHS and Social Care Information Centre data quality dashboards (November 2020 position published February 2021).

Data Security and Protection Toolkit (The IG Toolkit no longer in use)

East Suffolk and North Essex NHS Foundation Trust (including community services) Data Security and Protection Assessment Report for 2019/20 was graded as standards not fully met (a plan has been agreed) The data security and protection toolkit assessment will be 30th June 2020-2021 for submission.

Clinical coding

East Suffolk and North Essex NHS Foundation Trust was not subject to the Payment by Results (PbR) Clinical Coding Audit during the reporting period.

The National PbR audits were last requested by the commissioner in 2013/14 and 2014/15 for Colchester and Ipswich respectively. The audit is now link to Data Protection and Security Toolkit (DP&ST) commissioned by the Head of Clinical coding and performed by two local NHS Digital approved clinical coding auditors to assess the coding accuracy undertaken by ESNEFT coders' against national standards.

The National PbR audits were specialty based and have now ceased. DP&ST standards audit are randomly selected cross-specialty and audited using the latest audit methodology (V13.0 - 2019/2020).

The result from the audit and its report are to provide meaningful feedback that can be used by the department to identify areas of improvement within the organisation and aid identify and plan future training needs.

This information is shared annually with the Information Governance Lead/ Data Protection Officer who record it within their dataset (toolkit) and is equally readily available upon request from the Head of clinical coding.

Table 2-Data Quality
East Suffolk and North Essex NHS Foundation Trust will be taking the following actions to improve data quality:

Data Quality Indicator	Data Quality or Data Flow	When	Update
Valid NHS Number &Valid GP Practice Code	Data Quality	2021/22	A new mechanism for identifying, allocating and tracking patient demographic validations is currently under development and due to go live in April 2021, which will automatically complete a number of checks between data held on ESNEFT's PASs and data returned from SUS and the National Batch Tracing Service, helping ensure that patients NHS Numbers, GP, GPP, Address and if applicable death details are up to date. Issues identified by the automated process will then be actioned by the newly merged ESNEFT wide Data
Valid NHS Number &Valid GP Practice Code	Data Quality	2021/22	As part of ESNEFT's programme to tender and procure a new ESNEFT wide PAS in the coming years, a data evaluation and optimisation programme will take place during 2021/22 to identify issues with ESNEFT data and optimise ready for migration into a new single ESNEFT wide PAS.

Learning from Deaths

During 2020/21, 3541 of ESNEFT patients died (includes deaths in ED and community hospitals). This comprised the following number of deaths which occurred in each quarter of that reporting period: 848 in the first quarter; 598 in the second quarter; 867 in the third quarter; 1228 in the fourth quarter.

By March 2021, 719 case record reviews and 21 investigations (serious incidents, internal investigations and patient safety incident investigations, under the new Patient Safety Incident Response Framework) have been carried out in relation to 3541 of the deaths included above. In 12 cases, a death was subjected to both a case record review and an investigation.
The number of deaths in each quarter for which a case record review or an investigation was carried out was: 240 in the first quarter; 154 in the second quarter; 212 in the third quarter; 113 in the fourth quarter. (The number of requested reviews was reduced so that clinical care could be prioritised during the pandemic surge.)

2.9% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These are all subject to a detailed incident review to ensure all aspects of learning are captured and addressed.
In relation to each quarter, this consisted of: 1.3% for the first quarter; 1.3% for the second quarter; 7.1% for the third quarter; 0.9% for the fourth quarter. In the third quarter, a number of patients died owing to contracting COVID-19 in hospital, despite all measures being put in place to minimize transmission.
These numbers have been estimated using the summary of care information from the Royal College of Physicians' Structured Judgement Review (SJR) and the national Perinatal Mortality Review tool (PMRT).

There were 3 Serious Incident investigations completed during the reporting period that identified that the death was more likely than not to have been due to problems in the care provided to the patient and related to the following:

- Surgical /Invasive procedure
- Medical Equipment/devices/ disposables incident
- Sub-optimal care of the deteriorating patient

The key learning points identified from the Surgical /Invasive procedure serious incident investigation were:

- There has been a lack of clear and comprehensive communication between members of the clinical teams caring for the patient before and during surgery.
- More consideration should have been given to pre-operative stabilisation as this procedure was undertaken urgently rather than as an emergency (immediately).
- Grafts that are compatible to the EVAR sheath should have been sourced and checked prior to the start of surgery.

The key learning points identified from the Medical Equipment/ devices/disposable serious incident investigation were:

- There should be clear direction regarding the management of NG tubes post insertion and expected documentation to ensure consistent practice.
- The NG tube competency is heavily centred on insertion of the NG tube with a more limited focus on care and management of the NG tube post insertion.
- There should have been a clear risk assessment undertaken following each removal of the patients NG tube.

The key learning points identified from the Sub-optimal care of the deteriorating patient serious incident investigation were:

- There were delays in the pathway which were avoidable and these were largely driven by:-
  - Failure to follow policy that the speciality initially referred to by ED should assess the patient. If after assessment it is, felt more appropriate then refer on to a second speciality. This policy should be highlighted to all specialities that take emergency patient referrals.
  - The lack of appropriate escalation where agreement cannot be reached. Consultant level speciality discussion and decision should occur if this is not resolved by the on-site teams and registrars.
  - Review of the pathways for investigations and CT scans by ED to determine if this may facilitate timely referral to the appropriate speciality.

Some of the key recommendations from the Serious Incident investigations:

- That the reports are shared with individuals involved for reflective learning and evidenced through the appraisal and revalidation process. It should be shared wider with clinical teams as shared learning;
- MDT meetings should dis-

Learning from Deaths

cuss, agree and document: -

- All the key diagnostic tests and investigations with the patient co-morbidities
- Agree the plan of care
- Determine any clinical interventions required prior to significant or anticipated long or high risk surgery with anaesthetic input or other specialist input;
- Any specialised equipment is available and the team is knowledgeable about its use.

- Clinicians should discuss and agree whether there should be a formal escalation when excessive prolonged or high risk surgery is occurring.
- A Standard Operating Procedure should be agreed and embedded into practice to ensure consistent practice and documentation between nursing staff and health care staff for the management of NG tubes.
- The NG tube competency pack should be reviewed to ensure adequate coverage of the management of the NG tube post insertion. This should include documentation and policy/ standard operating procedures are covered.
- Medical staff should be reminded that following a patient removing an NG tube a risk assessment must be undertaken; this should include the appropriateness of the use of mittens or securing the NG tube with a bridle. The outcome of the risk assessment should be communicated with nursing staff, the patient and family.
- A Working Group should be established to review policy and practice pertaining to the management of ED to Specialty referrals. This should include representation from Surgery, Medicine and ED. This will facilitate conversation and awareness and prevent future policy updates being made in isolation. The review should include Management of Upper GI referrals and ED to Specialty level referral policies/practice.
- Radiology and the Emergency Department (ED) teams should review practices pertaining to the ordering and escalation of diagnostic tests when a patient arrives in the Emergency Department. Including out of hours requests.

The learning actions are in progress following the Serious Investigations.

In addition, the Trust is fully compliant with the NHS England/ Improvement requirements to report and investigate cases where hospital-onset COVID-19 is identified. Learning identified in formal reviews undertaken by the Associate Medical Directors for Patient Safety and the nursing teams responsible for patient care have led to changes in patient pathways, bed movements, screening protocols, ward configuration and monitoring. Following changes, there have been measurable improvements in infection rates.

In relation to 2019/20, 225 case record reviews/investigations were completed after March 2020 which related to deaths which took place before the start of the reporting period.

4% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Royal College of Physicians' Structured Judgement Review (SJR) and the national Perinatal Mortality Review tool (PMRT). 1.4% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Learning from Deaths

Since the introduction of Medical

Learning from Deaths

Examiners, the Trust has maintained a 100% record of Medical Examiner scrutiny all deaths which occurred on acute ESNEFT sites. The role has been key in improving communication with the bereaved; providing an opportunity to ask questions and resolve issues. The team continues to identify cases requiring review and provides useful thematic learning.

The Trust participates in many external mortality review programmes such as the Child Death Review Programme, MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), PMRT (Perinatal Mortality Review Tool) and LeDeR (the Learning Disabilities Mortality Review programme).

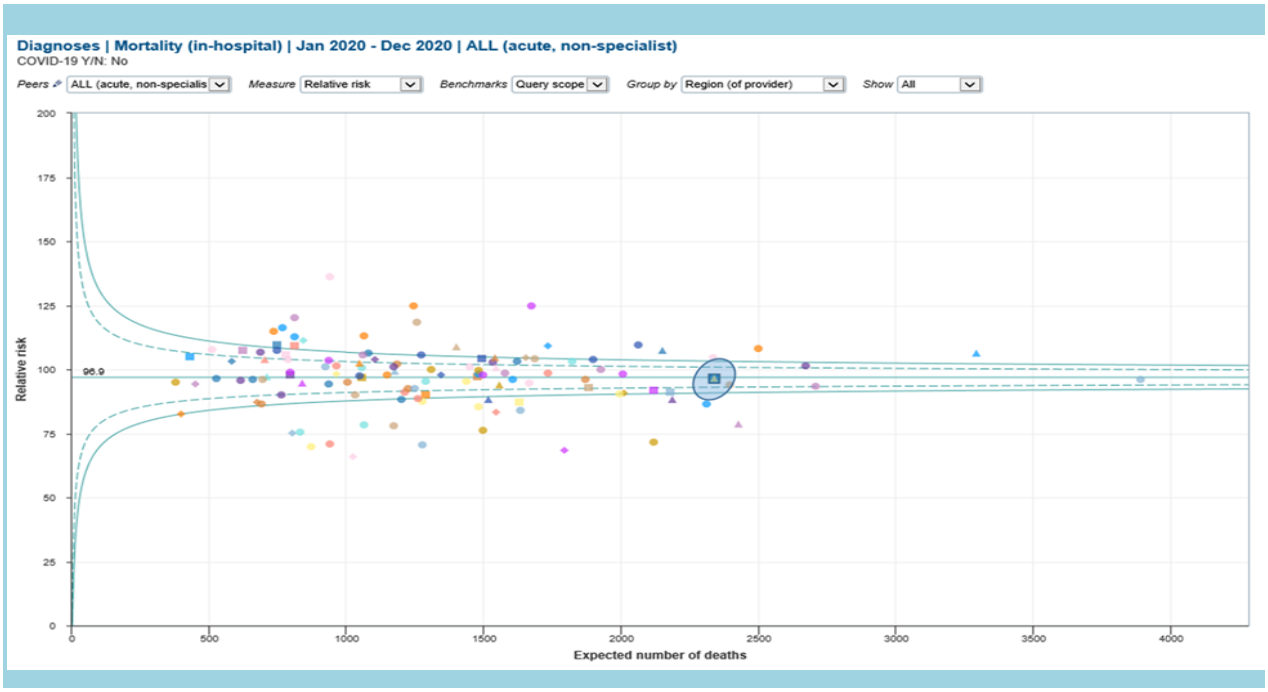
The Trust's two Learning Disabilities and Autism Hospital Liaison Nurse Specialists deliver presentations at induction and the multidisciplinary audit half days, bringing together local learning from SJRs and wider learning from the LeDeR programme, including multi-agency reviews. Future areas of focus include a project to flag and address multiple missed hospital appointments to ensure that patients with Learning Disabilities are supported to attend.

The COVID-19 pandemic presented an immense clinical and logistical challenge to all aspects of the health service. At the beginning of March 2020, patients began to be streamed according to COVID-19 status. Acute pathways saw an unprecedented level of staff engagement and redeployment with emergency rotas providing 16 hours of front door consultant presence 7 days a week, and junior doctors pooled from all specialties providing 3 shifts around the clock. This was supported by retired clinicians and freshly graduated medics.

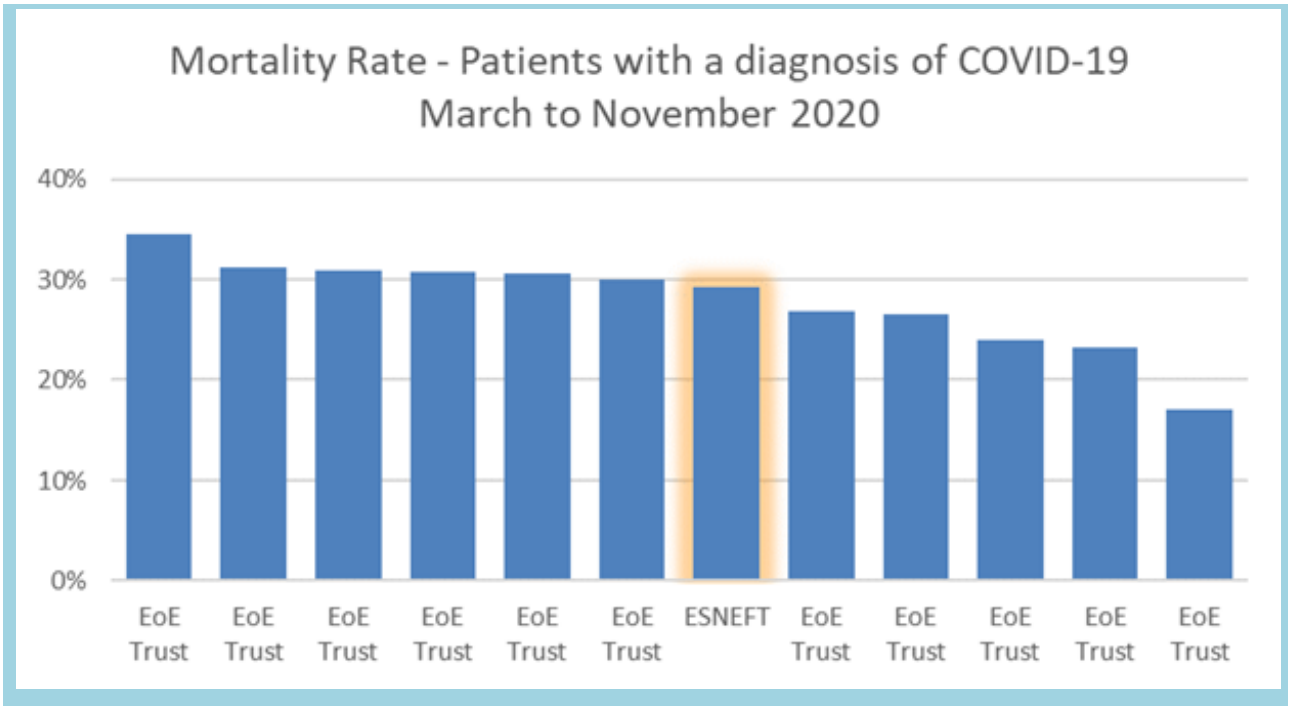
Early senior decision-making was implemented, with escalation plans key to patient safety – there was good evidence of early escalation to critical care where appropriate, with sensitive discussions with patients and family. New pathways and processes were rapidly implemented e.g. direct stroke admissions; increased UTC (urgent treatment centre) to AMSDEC (acute medicine same day emergency care) referrals and a pull model from community teams. Successful staff redeployment included the Orthopaedic team running the 'Green' injury and trauma Emergency Department service. Specialist nurses developed clinical overviews to support nursing staff caring for patients in unfamiliar specialties.

National guidance and research was reviewed daily by the Clinical Reference Group, disseminated for action by local teams and collated on the intranet. As the pandemic progressed and clinical knowledge of the disease increased new approaches to treatment were adopted including invasive ventilation/high flow oxygen in combination with proning to support patient recovery, medication to prevent thrombotic complications and steroid medication to reduce disease progression. Selected national guidance and experience from teams was brought together in a virtual multidisciplinary audit day.

Between March and May 2020, 57 additional casenote reviews were undertaken by senior consultants using an adapted version of the SJR. The tool was designed to collect data around patient condi-



Learning from Deaths



tion on admission (vital signs/ symptoms/frailty/comorbidities/ demographics) and gather evidence around treatment, escalation (including referral to critical care) and outcome as well as proving assurance about the quality of care. Learning from this was used to promote enhanced care elements such as increased attention to saturations and sufficient hydration to maintain a neutral fluid balance.

In January, the Trust rolled out the Virtual COVID-19 ward; an NHS England initiative whereby patients in the recovery phase could be sent home with oxygen treatment, monitoring equipment, supervision plan and clinical contact details. This allowed patients to be supported at home, minimizing deconditioning due to a prolonged hospital stay and freeing up beds for further patient care.

Mortality Ratios

Mortality modelling providers made the decision to remove patients with an admitting diagnosis of COVID-19 from HSMR (hospital standardized mortality ratio) and SHMI (Summary Hospital-Level Mortality Indicator) owing to the fact that the tools were never designed to accommodate a pandemic. Additional fields have been added to data analysis tools to allow trusts to examine benchmarked patient outcome for patients without COVID-19. The funnel plot indicates that mortality for ESNEFT for the 12 months to December 2020 was 'as expected'.

For patients with COVID-19, national mortality outcomes vary owing to both the way the virus has spread across the country and infection rates. Within the East of England, ESNEFT saw average mortality rates in the first wave.

In November, NHS England/ Improvement requested that NHS organizations report all deaths with hospital-onset COVID-19 (a positive swab 8 days or more after admission and COVID-19 cited on the death certificate). ESNEFT developed a standard operating procedure to ensure robust data gathering, reporting and investigation; the Trust has complied in full with the guidance. A root cause analysis (investigation) was requested for every patient who tested positive for COVID-19, 8 days or more after admission and an SJR (mortality review was completed for a third of all deaths). The learning from the reviews has been shared across the Trust in many different forums including emails, safety briefings, meetings and trust-wide staff briefings with the Chief Executive. The Business Informatics team has developed a number of PowerBI applications to both report current COVID-19 activity and support wards in identifying patients who need to be screened according to protocol. Regular screening has been instrumental in reducing contact time where patients are asymptomatic but could pass the virus on. In addition to strict use of PPE and hand hygiene, other measures included a reduction in the number of bed moves and working to discharge medically fit patients as soon as possible.

Core Quality Indicators

The data given within the Core Quality Indicators is taken from the Health and Social Care Information Centre Indicator Portal (HSCIC), unless otherwise indicated.

Indicator: Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality, however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period.

The data made available to the Trust by the HSCIC with regard to:	Reporting period	ESNEFT score	National average	Highest score	Lowest score	Banding
The value and banding of the SHMI for the Trust for the reporting period	Sept 18 -Aug 19	1.099	0.946	1.187	0.687	2
	Jan 19 - Dec 19	1.083	1.004	1.199	0.688	2
	Sept 19 - Aug 20	1.065	1.002	1.182	0.695	2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)	Sept 18 -Aug 19	33%	36.57%	59%	13%	
	Jan 19 - Dec 19	33%	36.40%	60%	10%	
	Sept 19 - Aug 20	32%	36.00%	61%	9%	
	Jan 20 - Dec 20	31%	37.00%	61%	8%	

East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons: The Trust has high standards of clinical coding and a robust mortality review process. The Trust is rated as SHMI Band 2 , 'as expected' which means that based on factors such as the patient case mix, admitting diagnosis and previous medical history, the number of patients dying in hospital or within 30 days of admission is 'as expected'.

East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- ✓ Ensuring that high clinical coding standards are maintained through regular audit, both local and against the Data Security and Protection Toolkit, Data Quality standard.
- ✓ Investigating alerts issued by external providers to ensure that care has been delivered to a high standard.
- ✓ Continuing to promote good documentation which includes clear care plans.
- ✓ Encouraging staff to reflect on care delivered at multiple touch-points including Mortality and Morbidity meetings, where actions and learning can be shared in an open and honest way without apportioning blame.
- ✓ Continuing to learn from feedback given by patients, families and carers.
- ✓ Celebrating and sharing good practice while learning from mistakes, improving both clinical and organizational processes.
- ✓ Becoming an early adopter of the Patient Safety Incident Response Framework (PSIRF) 2020, a programme which provides the NHS with guidance on how to respond to patient safety incidents – with no distinction between incidents and "serious incidents" – for the purpose of learning. A patient safety incident is investigated or reviewed under this framework to understand the circumstances that led to it, for the purpose of system learning and improvement.
- ✓ Delivering training as part of the mandatory programme as well as new initiatives promoted by bodies such as Royal Colleges and NHS England/NHS Improvement. As well as clinical skills and human factors training.
- ✓ Continuing with the Quality Improvement Programme which encourages staff to think about local small-scale improvements.
- ✓ Continuing the work of Medical Examiners who provide additional scrutiny by assessing the quality of care as described in the health record and through discussion with the bereaved.

Core Quality Indicators

Indicator: Patient Reported Outcome Measures (PROMs) scores

PROMs measures a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.

The data made available to the Trust by the HSCIC with regard to:	Site	Reporting period	ESNEFT	National average
The data made available to the Trust by the HSCIC with regard to:	Site	Reporting period	score	National average
	Colchester	2017-18	0.478	0.458
	Ipswich	2017-18	0.538	0.458
	ESNEFT	2018-19	0.490	0.457
	ESNEFT	*2019-20**	*0.556*	*0.46*
The Trust's patient reported outcome measures scores for knee replacement surgery during the reporting period 2019-20* - figures are provisional April - March 20	Colchester	2017-18	0.386	0.337
	Ipswich	2017-18	0.387	0.337
	ESNEFT	2018-19	0.387	0.337
	ESNEFT	*2019-20**	*357*	*0.341*
	ESNEFT	2020-21		

East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons:

- No data published for the reporting period

East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust continues to encourage patients to respond to the PROM's questionnaires and will be a focus in the NHS recovery programme.

Core Quality Indicators

Indicator: Readmission rates

The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
% of patients aged 0-15 years readmitted within 28 days	2010/11	8.79			
	2011/12	8.35		14.94	5.1
% of patients aged 16 years or over readmitted within 28 days	2010/11	9.89			
	2011/12	10.35	11.45	13.8	8.73

East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons:

Recent national data sets are not available for readmission rates as provided by NHS Digital (HSCIC).

East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The Divisions and specialties continue to monitor their readmission rates, with active review in Mortality & Morbidity meetings to identify any adverse incidents requiring further investigation or changes to practice.

Indicator: Responsiveness to the personal needs of patients during the reporting period

The data made available to the Trust by the HSCIC with regard to:	Reporting period	Colchester	Ipswich	ESNEFT	National averag	Highest score	Lowest score
The Trust's responsiveness to the personal needs of its patients during the reporting period	2016/17	66.9	66.9	-	68.1	85.2	60
	2017/18	66.2	66.5	-	68.6	85	60.5
	2018/19	-	-	68.2	67.3	85	58.9

East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons:

- This data is no longer published

East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

The Trust monitors its' responsiveness by actively seeking feedback through the Friends and Family Test and surveys, and this is monitored through the Patient Experience Group.

Core Quality Indicators

Indicator: Staff recommendation (Friends and Family Test) Taken from Question 21d of the NHS staff survey					
The data made available to the Trust by the	Reporting period	ESNEF	National	Highest	Lowest
The % of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends	2017/18 Q3**	62%	71%		
	2017/18 Q4	60%	80%	100%	36%
	2018/19 Q1	75%	81%	0.98	0.53
	2018/19 Q2	72%	81%	100%	39%
	2018/19 Q3	68%	70%	90%	49%
	2018/19 Q4	68%	80%	100%	44%
	2019/20 Q1	73%	81%	98%	51%
	2019/20 Q2	71%	81%	100%	50%
	2020/21	No data	No data	No data	No data

East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons:

- Data collection suspended during the reporting period due to COVID-19

East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust continued to actively seek feedback through the FFT, PALS and Complaints and through surveys, with corresponding actions required for improvement and compliments being managed through the Patient Experience Group

Indicator: Patient recommendation (Friends and Family Test)					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	ESNEFT score	National average	Highest score	Lowest score
all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from A&E (types 1 and 2)	2016/17 (Inpatients)*	94.50%	95.40%	100%	82%
	2017/18 (Inpatients)*	97.60%	95.60%	100%	81%
	2018/19 (Inpatients)*	97.20%	95.50%	100%	77%
* Highest & Lowest Score is based on the position in March in each year	2019/20 (Inpatients)**	96.60%	95.60%	100%	82%
** 2019/20 YTD (April 2019 - Feb 2020) with Highest & Lowest Score being based on Feb 2020 Latest Report)	2016/17 (A&E)*	81.70%	86.20%	100%	46%
	2017/18 (A&E)*	84.10%	86.40%	100%	64%
	2018/19 (A&E) *	83.60%	86.60%	100%	56%
	2019/20 (A&E) **	84.10%	84.40%	100%	40%

East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons:

- Data collection suspended during the reporting period due to COVID-19

East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust continued to actively seek feedback through the FFT, PALS and Complaints and through surveys, with corresponding actions required for improvement and compliments being managed through the Patient Experience Group

Core Quality Indicators

Indicator: Risk assessment for venous thromboembolism (VTE)					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	ESNEFT score	National average	Highest score	Lowest score
% of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period * Q1-Q3 2019-20 High/Low scores at last reported period	**2017/18**	90.55%	95.53%	100%	63.02%
	2018/19	95.38%	95.66%	100%	74.03%
	2019/20*	96.38%	95.47%	100%	71.59%
East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons:					
East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by: • The Trust continues to monitor the compliance with VTE risk assessments on a daily basis and is reported on through the Accountability Framework					

Indicator: Clostridium difficile infection rate						
The data made available to the Trust by the HSCIC with regard to:	Reporting period	ESNEFT score	National average	Highest score	Lowest score	
the rate for 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	Apr 17-Mar 18	Apr 17-Mar 18	35.58	38.28	157.51	0
	Apr 18-Mar 19	Apr 18-Mar 19	Hospital apportion	12.52	40.46	0
	Apr 19-Mar 20	25.3	28.1	115.6	0	
East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons: • Data for reporting period not yet published						
East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by: • The Trust continues to monitor the compliance with C-Diff rates, including root cause analysis in conjunction with the CCG and active reporting through the Infection Control Committee.						

Core Quality Indicators

Indicator: Patient safety incident rate: Patient safety incident rate													
The data made available to the Trust by the HSCIC with regard to:	Reporting period	Colchester Score		Ipswich Score		ESNEFT Score		National average		Highest score		Lowest score	
		Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
the number and rate of patient safety incidents reported within the Trust during the reporting period (please note that the reporting period changed to 'per 1,000 bed days' in April 2014)	Oct16 - Mar 17	3,667	36.77	4,049	36.77	N/a	N/a	696,643	40.52	3,300	68.97	3,219	23.13
	Apr 17 - Sep 17	3,821	39.06	4,630	44.44	N/a	N/a	705,564		10,016	111.69	3,085	23.47
	Oct 17 - Mar 18	3,906	39.2	4,534	38.44	N/a	N/a	730,151		11,325	124	1,311	24.19
	Apr18 - Sep 18	N/a	N/a	N/a	N/a	9,193	44.0	731,348		9,467	107.4	566	13.1
	Oct 18 - Mar 19	N/a	N/a	N/a	N/a	8,455	40.01	765,221		8,289	95.94	1,580	16.90
	Apr 19 - Sep 19	N/a	N/a	N/a	N/a	11,092	55.0	815,852		11,620	103.8	2,173	26.3
	Oct 19 - Mar 20	N/a	N/a	N/a	N/a	10,848	52.8	838,722		11,787	110.2	1,271	15.7
the number and percentage of such patient safety incidents that resulted in severe harm or death during the reporting period		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
	Oct 16 - Mar 17	16	0.4%	22	0.5%	N/a	N/a	2,623	0.4%	6	0.2	47	1.4
	Apr 17 – Sep 17	16	0.5%	24	0.5%	N/a	N/a	2,482	0.4%	13	0.1	19	0.7
	Oct 17 - Mar 18	15	0.4%	19	0.4%	N/a	N/a	2,522	0.3%	5	0	0	0
	Apr 18 - Sep 18	N/a	N/a	N/a	N/a	47	0.5%	2,477	0.3%	14	0.1	3	0.5
	Oct 18 - Mar 19	N/a	N/a	N/a	N/a	45	0.5%	2,458	0.3%	28	0.3	15	0.9
	Apr 19 - Sep 19	N/a	N/a	N/a	N/a	61	0.6%	2,524	0.3%	1	0.0	26	1.2
	Oct 19 - Mar	N/a	N/a	N/a	N/a	93	0.8%	2,536	0.3	4	0.0	19	1.5

Core Quality Indicators

Indicator: Patient safety incident rate
East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons: All incidents are reviewed by the Patient Safety & Quality Team to assess and validate the level of harm reported and ensure those reported as no and low harm are accurately graded. There is also clinical judgement in the classification of an incident as moderate and above harm as it requires moderation and judgement against subjective criteria and processes. All incidents are investigated to ensure that lessons are learned to safeguard future patient care. All patient safety incidents (irrespective of level of harm) are uploaded to the NRLS within one month of reporting; and those initially considered to have caused severe harm or above are reported within 72 hours. On average, 50% of incidents were reported to the NRLS within 2 days of reporting. The last data set reported from the NRLS shows ESNEFT to be slightly above average reporters of incidents. Trusts which are high reporters of incidents are very good indicators of a strong reporting culture. The Trust reported 52.77 incidents per 1,000 bed days for the period of October 2019 to March 2020 (last published data), an increase on the same period in the previous year from 40.01 per 1,000 bed days. We have robust processes in place to capture incidents. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. We have provided training to staff and there are various policies in place relating to incident reporting but this does not provide full assurance that all incidents are reported. The Trust promotes incident reporting through patient safety initiatives and encouraging an open and transparent culture. The percentage of severe harm and death incidents taken from the NRLS report (as mandated by the Quality Account Guidance) for October 2019 – March 2020 is 0.8% and therefore above the 0.3% average for all medium acute Trusts. The levels of harm reported to the NRLS by the Trust changed in 2019 due to the requirement to report levels of harm in response to pressure ulcers not developed within ESNEFT care. Those pressure ulcers developed outside our care, but found on admission were previously reported as no harm incidents as were the requirements at the time. In November 2020, ESNEFT became early adopters of the Patient Safety Incident Response Framework (PSIRF) which replaces the requirements to report under the Serious Incident Framework (2015). ESNEFT has implemented a robust process for the investigation of all incidents despite the initial grading chosen by the reporter. All incidents are reviewed by the Patient Safety & Quality Team and where there is a suspicion of harm or a near miss, further information or a fact finding review is undertaken. Following discussion with the clinical area and in accordance with the ESNEFT Patient Safety Incident Response Plan (PSIRP), the level of investigation is agreed and commenced. This is led by either the clinical teams or by a Patient Safety Manager with the support of a team of clinical experts.
East Suffolk and North Essex NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by: ü Continue to build our culture for reporting patient safety incidents at all levels of harm. ü Continue to provide training at Trust Induction to encourage reporting of incidents and near misses as well as give guidance for risk assessment and escalation of incidents. ü Piloting the Patient Safety Incident Reporting Framework.

Part 3 - Other information

Patient safety

Infection prevention and control

Methicillin resistant Staphylococcus aureus (MRSA)

Achieve Trust Target of zero cases of MRSA bacteraemia/ bloodstream infections in 2020/21.

Staphylococcus aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa without causing any problems. It can also cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure.

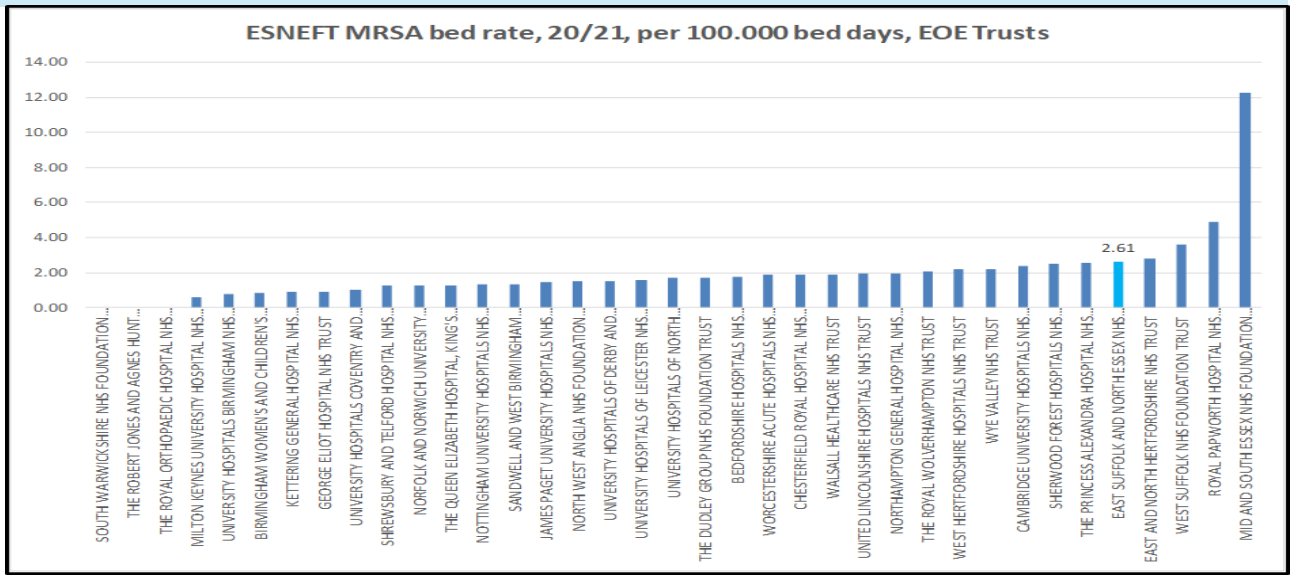
Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin resistant Staphylococcus aureus (MRSA) and often require different types of antibiotic to treat them. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). MRSA and MSSA only differ in their degree of antibiotic resistance: other than that there is no real difference between them. (PHE 2017);

There was 2 cases of MRSA bacteraemia identified across ESNEFT in 2020/21. It is recognised that there is learning related to the timely identification of MRSA carriage and admission screening in the management of high risk patients (at the time of the MRSA bacteraemia the ESNEFT MRSA screening policy was not in place) and surrounding intravenous peripheral device care and management.

Table 3— Number of cases of MRSA bacteraemia apportioned to ESNEFT

Year	Site	Number of cases of MRSA bacteraemia cases apportioned to	Target
2018/19	Colchester	0 cases	1 case
2018/19	Ipswich	1 case	0 case
2019/20	ESNEFT	1 case	0 cases
2020/21	ESNEFT	2 cases	0 cases

The performance of ESNEFT in rates of MRSA bacteraemia, compared with the other hospitals in the East of England region for 2020/21 (2019/20 figure was 1.89)



Patient safety
Infection prevention and control

Clostridium difficile infection

Clostridium difficile infection (*C.diff*) remains an un-pleasant, and potentially severe or fatal infection which occurs mainly in the elderly or other vulnerable groups especially those who have been exposed to antibiotic treatments. In April 2019 changes to the allocation of *C.diff* cases were introduced. Trust apportioned cases (i.e. cases that are considered to have been acquired in that Trust during that admission) are those identified from specimens taken on the second day of admission onwards or if the patient has been an in-patient at the Trust in the previous 4 weeks.

Themes identified from previous post infection reviews
Lessons learnt from post infection reviews includes:

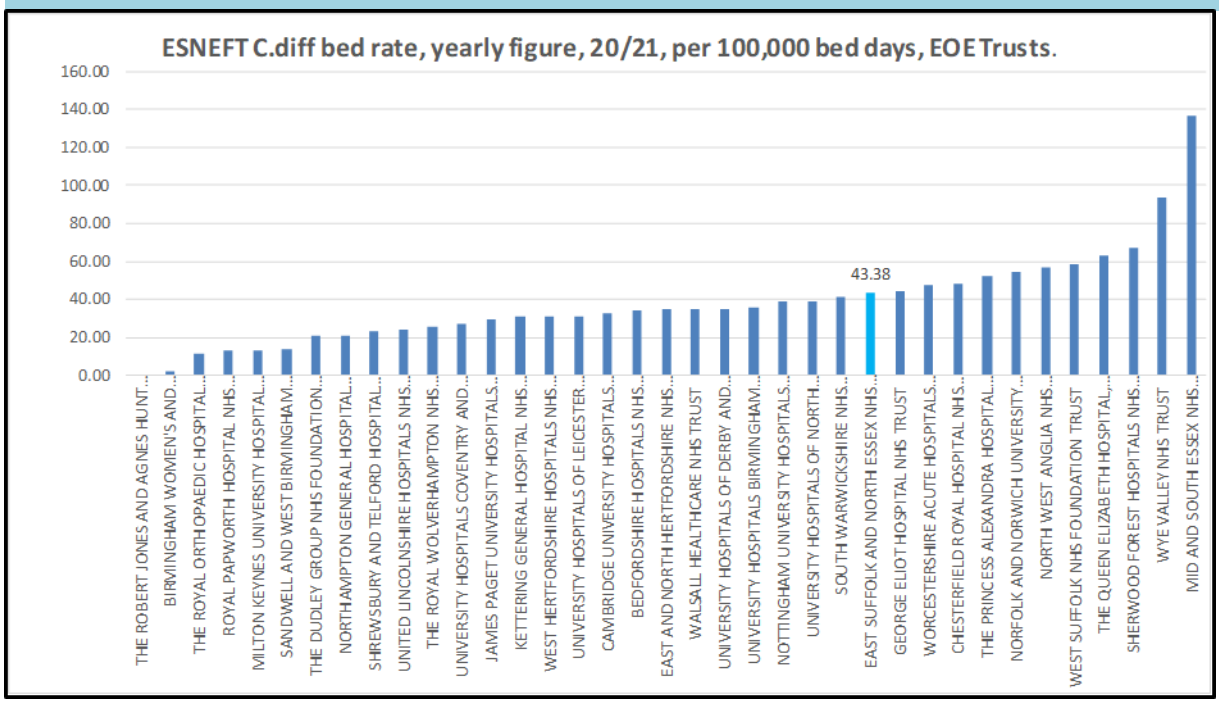
- lack of documented rationale for taking a sample
- appropriate microbiological samples not always obtained prior to commencing antimicrobial treatment (e.g. urine samples not obtained from patients suspected to have a UTI),
- previous microbiology results and previous antibiotic treatment are not always reviewed prior to prescribing antibiotics.

Each Trust apportioned case is subject to a post infection review (please note that this has been replaced by a written online discussion during the Covid-19 pandemic). If all care and treatment is
managed within nationally and locally recognised policy the Clinical Commissioning Group (CCG) scrutiny panel may agree that it is deemed as 'Non trajectory' (2015/16 onwards).

56 (of 99) C difficile cases for ESNEFT have currently been agreed as non- trajectory 2020/21.

- Patients identified as carriers are monitored closely and managed in much the same way as patients with CDI.
- Work continues through post infection reviews with Clinical Commissioning Group to identify areas which may impact on further reduction of cases. Including looking at antimicrobial prescribing in the local health care economy.
- Continue to investigate and invest in new cleaning technologies to support best practice and efficiency including the use of HPV fogging, UVC, micro-fibre

Chart 1– The performance of ESNEFT in rates of Clostridium difficile, compared with the other hospitals in the East of England region for 2020/21 (2019/20 was 34.97)

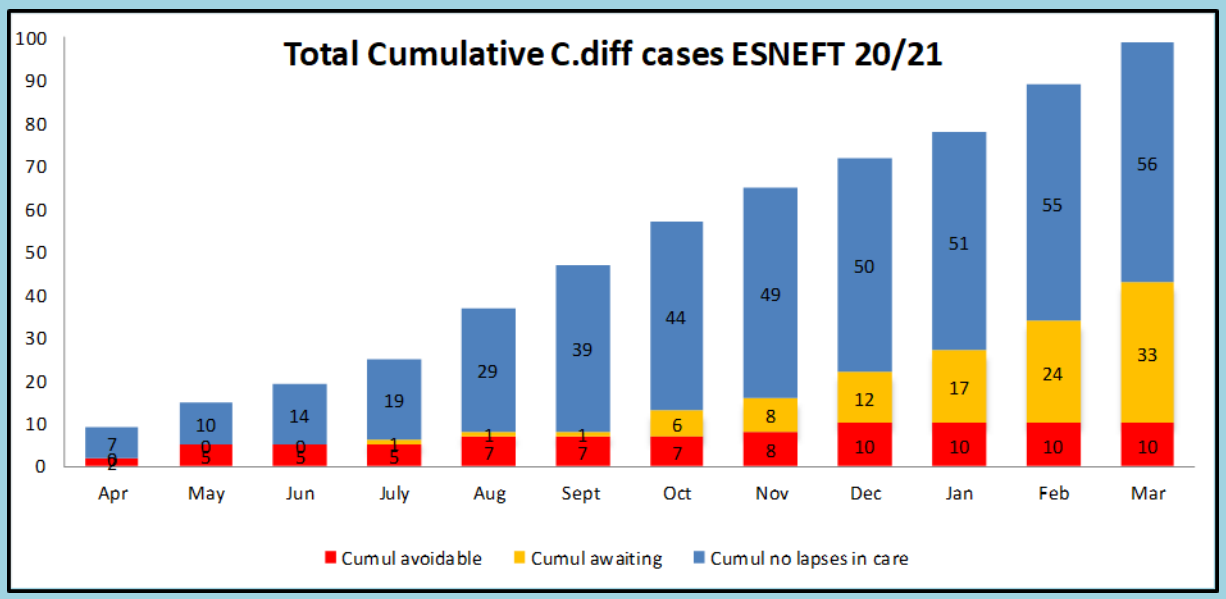


Patient safety
Infection prevention and control

Table 4- Number of C.Diff cases apportioned to ESNEFT

Year	Site	Number of cases of *C.diff* cases apportioned to ESNEFT	Target
2018/19	Colchester	11 trajectory cases – 20 non-trajectory	To not exceed 17 cases
2018/19	Ipswich	3 trajectory case – 22 non-trajectory	To not exceed 17 cases
2019/20	ESNEFT	12 outcome 1 cases, 77 outcome 2 or 3, 7 pending	To not exceed 107 cases
2020/21	ESNEFT	To 23/3/21 – 10 outcome 1 cases, 56 outcome 2 or 3, 33 pending	Unknown, presumed to not exceed 107 cases

Chart 2- Clostridium difficile cases 2020/21, total 99 (2019/20 total 96)



Patient safety
Learning from incidents, SIRIs and Never Events

Learning from incidents

All reported incidents are investigated and any lessons that can be learnt are shared within the clinical area at Divisional Board meetings, and via the intranet for hospital areas outside the scope of the Division involved in the incident. Lessons learnt are also shared at the Trust's Patient Safety & Clinical Effectiveness Group.

In accordance with the Patient Safety Incident Response Framework, ESNEFT agreed and implemented their Patient Safety Incident Response Plan in November 2020. Prior to this the Trust operated under the Serious Incident Framework and completed Serious Incident Investigations in accordance with the 2015 framework.

Prior to November 202, higher level incidents were categorised as Serious Incidents Requiring Investigation (SIRIs) and are reported to the North East Essex Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group. These incidents are investigated, a comprehensive report written and actions implemented and the learning shared.

The percentage of patient safety incidents resulting in severe harm or death is subject to external assurance. The detailed definition for this performance indicator is presented on page 63

The changes we have made as a result of lessons learnt:

- A Local Safety Standards for Invasive Procedures (LocSSIP) page has been created on the Trust intranet to support and guide staff with the use of interventional safety checklists.
- Introduction of a Trustwide chest drain safety checklist and audit plan. In areas where this is used frequently, this is kept in the treatment rooms where the required equipment for the procedure is stored.

Duty of Candour

Open and honest communication with patients is essential to collaborative working and directly impacts the experience and outcomes for the patient as well as for staff in the delivery of safe care.

Healthcare professionals must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

Duty of Candour ensures healthcare professionals are open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested.

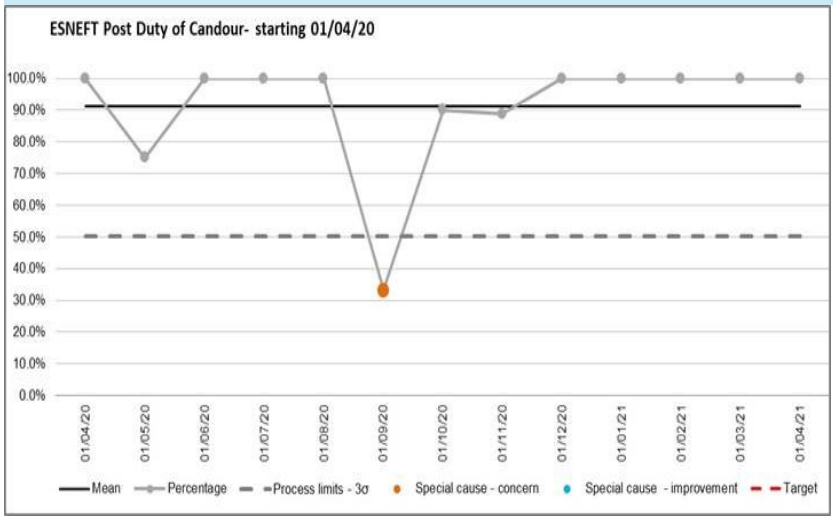
The Trust extends the Duty of Candour process to the 'Being Open' policy which encourages staff to have open and honest conversations for all incidents which are not specific to the Duty of Candour statutory requirements.

What are we doing to make improvements:

Face to face and E-Learning training for the investigation and actions required following incidents;

- Investigation training for ward and division level training;
- Use of 'Hot Spots', ESNEFT wide communication newsletters to share learning and changes from incidents
- Review of current training programme and introduction of refreshed training in accordance with the PSIRF.

Chart 3— Duty of Candour compliance during 2020/21



Patient safety
Learning from incidents, SIRIs and Never Events

Table 5– Adverse events and SIRIs reported

For the year 2020/21 there have been the following adverse events (categorised as low harm to severe harm) reported on the Datix risk management computer system.

Type of adverse event	**No. of adverse events**
Access, Appointment, Admission, Transfer, Discharge	990
Accident that may result in personal injury	1578
Clinical assessment (investigations, images and lab tests)	554
Consent, Confidentiality or Communication	812
Implementation of care or ongoing monitoring/review	3514
Infrastructure or resources (staffing, facilities, environment)	274
Medical device/equipment	157
Medication	983
All other categories	558
Patient Information (records, documents, test results, scans)	663
Treatment, procedure	765
Totals:	10848

Of these, 91 were reported as Serious Incidents Requiring Investigation:

Type of adverse event	**No. of SIRIs**
Surgical Invasive Incident meeting SI criteria	8
Treatment delay meeting SI Criteria	5
Diagnostic incident including delay meeting SI Criteria	4
Suboptimal care of deteriorating patient	3
Slips/trips/falls meeting SI Criteria	3
Maternity/Obstetric incident meeting SI Criteria: Mother and Baby	3
Medical equipment/devices/disposable incident meeting SI criteria	2
Screening Issues meeting SI Criteria	2
Maternity/Obstetric incident meeting SI Criteria: Baby Only	2
Medication Incident Meeting SI Criteria	2
Unexpected/potentially avoidable death	1
HCAI/Infection control incident meeting SI criteria	1
Adverse Media Coverage or public concern about organisation or wider	1
Abuse/alleged abuse of adult patient by staff	1
Abuse/alleged abuse of child patient by staff	1
Totals:	39

Patient safety
Learning from incidents, SIRIs and Never Events

Never Events at East Suffolk & North Essex NHS Foundation Trust

2018/19	2019/20	2020/21
7	7	7

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

In 2020/21 seven incidents were reported which met the definition of a Never Event. Thorough root cause analysis (RCA) is undertaken for Never Events and robust action plans are developed to prevent a similar occurrence.

Wrong Site Surgery (4)

Wrong route administration of medication (1)

Retained Guidewire (2)

The following actions have been taken to prevent recurrence:

- Review of current Human Factors training with relaunch of updated training available to more staff in the clinical areas.
- Relaunch of the PICC service and update to the Trust intranet pages including contact details and clear message to ensure the service is contacted for all insertion requirements.
- Review of site marking requirements in interventional radiology followed by updates to the current safety checklists as required.
- Standardisation of PICC equipment including consumables. The trust's procurement to only place orders of PICCs and consumables in consultation with the PICC Service lead.
- Regular training sessions for staff handling PICC and introduction of ward based PICC champions
- Trauma operating lists are no longer printed until after agreed order and confirmation of procedure in the trauma meeting
- Introduction of the Clinical Opiate Withdrawal Symptoms assessment to support staff to manage patients presenting symptoms

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The nationally agreed list of Never Events for 2020/21 are:

1 Wrong site surgery
2 Wrong implant/prosthesis
3 Retained foreign object post-procedure
4 Mis-selection of a strong potassium containing solution
5 Wrong route administration of medication
6 Overdose of insulin due to abbreviations or incorrect device
7 Overdose of methotrexate for non-cancer treatment
8 Mis-selection of high strength midazolam during conscious sedation
9 Failure to install functional collapsible shower or curtain rails
10 Falls from poorly restricted windows
11 Chest or neck entrapment in bedrails
12 Transfusion or transplantation of ABO-incompatible blood components or organs
13 Misplaced naso- or oro-gastric tubes
14 Scalding of patients
15 Unintentional connection of a patient requiring oxygen to an air flowmeter

There are exclusions to each Never Event.

Patient safety

Learning from incidents, SIRIs and Never Events

Patient Safety Incident Response Framework (PSIRF)

ESNEFT are among the first Trust's in England to introduce a new Patient Safety Incident Response Plan (PSIRP) which sets out how we will learn from patient safety incidents. This will help us to continually improve the quality and safety of the care we provide, as well as the experience which patients, families and carers have when using our services.

Patient Safety Incident Response Plans are being launched as part of a national initiative designed to further improve safety, which ESNEFT is helping to test before it is rolled out across the rest of the NHS in autumn 2021. As part of the project, national guidance – called the 'Patient Safety Incident Response Framework' – is being introduced which outlines how providers such as ESNEFT should respond to patient safety incidents, and how and when an investigation should be carried out.

The national framework defines a number of national priorities which we must investigate locally through an in-depth investigation, called a patient safety incident investigation. This focuses on addressing causal factors and uses improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents. Examples of these are:

- those which meet the criteria set in the never events list 2018
- those which meet learning from deaths criteria.

In addition, ESNEFT has developed a local plan by looking at our past safety data, reviewing our organisational risks and Trust priorities and through discussion with colleagues, patients and their carers. Through this review, we have identified the following things we must investigate:

- Incidents at night or during weekends where the assessment of an inpatient was delayed because ward staff did not carry out effective monitoring to recognise deterioration, or take action to escalate the issue.
- Maternity incidents specific to mothers where a near miss took place because bleeding was not recognised or managed in a timely way. These incidents are not covered by Each Baby Counts
- Medication incidents which happen when blood glucose is not monitored effectively in inpatients.
- Medication incidents which happen when the patient has been prescribed more than one anticoagulation medication.
- Delayed decision making when an inpatient is being managed between two or more clinical specialties which results in an admission or transfer to a higher level bed, such as critical care.
- Nutrition and hydration incidents which take place because of a delay in recognising and managing patients who are at risk of weight loss or other complications as a result of the accuracy of a malnutrition universal screening tool (MUST) risk assessment.

Throughout any investigation, we will provide each patient, family member or carer with a named contact who will help them access support services and listen to their questions or concerns before making sure they are answered openly and honestly.

All investigations will begin as soon as possible after the incident has taken place, and will usually take between one and three months to complete. Learning will then be shared with the relevant teams so that action can be taken to prevent a similar incident from happening again in the future.

Patient safety
Pressure Ulcers

The reduction of inpatient acquired pressure ulcers remains a national priority and is a key element in keeping patients safe and harm free during their admission. ESNEFT continues to work to reduce the harm to patients through the development of pressure damage.

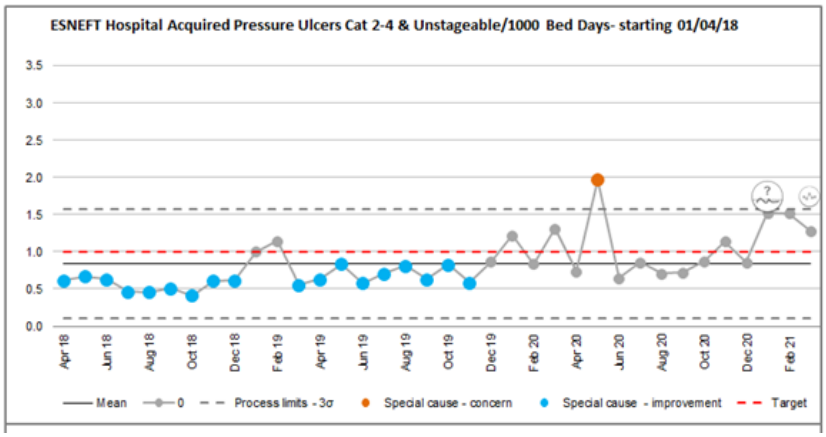
The Trust's aim is to ensure that assessments, care and actions were taken with every patient to ensure that the risk of developing pressure damage during an inpatient stay was reduced and to continue to work to reduce the levels of harm to our patients.

Specific education around pressure area care and prevention to all wards was supported by the Harm Free care Team, with a focus on the introduction of ASKIN (Assess skin, keep moving, incontinence & moisture & nutrition & hydration) was proven to be effective at Colchester Hospital and is in the process of being introduced at Ipswich and the Community Hospitals.

Reduction in pressure damage acquired during admission with a significant reduction in those who suffered heel damage. Consistent use of documentation supporting pressure area care and early support to wards to reduce the risk of damage occurring or deterioration of those admitted with pressure damage.

New equipment such as mattresses and heel protectors was purchased to increase the availability of these to our highest risk patients. Harm Free Panel supports investigation and reporting of pressure damage and includes a panel peer review to support lessons learned and wider trust learning.

Covid-19 introduced further challenges to the prevention of pressure damage, with skin changes unique to patients with severe disease due to changes in their oxygen levels. There were also a much greater number of patients requiring care on the Critical Care Units, therefore presenting as acutely ill and requiring positioning to support their breathing (proning) which presents further risk to pressure damage. Over all incidents of pressure damage increased slightly over the course of the year due to the uniqueness of the Covid-19 pandemic and this was especially evident during the surges, with numbers reducing during times of least pressure and usual activity.



Patient safety
Pressure Ulcers

Clare Buck and Laura Wild Tissue Viability Nurses receive an award for Outstanding Contribution to Improving Patient Care, presented by Ruth May CNO

Clinical Effectiveness
ESNEFT Molecular laboratory (Project 3,000)

On 6th June 2020, the Board approved a business case to establish a molecular laboratory to increase COVID-19 testing capacity, recognising the urgency and importance of this work.

The Board requested an oversight group, which has been established, meeting originally bi-weekly, the frequency of meetings has recently been reduced to monthly.

A successful bid for £5.3m capital investment was secured to build a new dedicated molecular laboratory at Ipswich Hospital.

In November, the Trust was requested to provide an additional service (LAMP testing) under direct contract with DHSC. This will offer improved asymptomatic testing using saliva instead of swabs. The planned capacity (3,500 tests per day) is sufficient to offer testing to every NHS-badged staff member in Suffolk and North East Essex on a weekly basis. At the time of writing, the contract is in the final stages of negotiation.

Key points

The original Project 3,000 objectives are progressing well:

- One final instrument (ThermoFisher Quant Studio 7) is expected to come online in April.
- Lab capacity is now at 2,198 tests per day (including 424 rapid tests), when all instruments are functional. Issues with reliability of instruments have been largely resolved, with the exception of the older Abbott M2000s.
- Maximum testing capacity is now likely to be c2,700 high-throughput tests per day, due to the unavailability (through national allocation) of reagent supply for the Roche 6800. However, the demand for testing at the peak of the last surge in January was comfortably accommodated.
- Staffing is in place for 3 shifts per day, with a mix of substantive, fixed-term, bank and agency. Recruitment to fixed-term posts continues.
- The construction of the new £5.3m Molecular Laboratory is progressing well and is on-track for completion in July.

The scope of this project has increased since the last report to include LAMP testing for asymptomatic screening:

- LAMP (loop-mediated isothermal amplification) is an alternative and much faster assay for COVID-19. The analyser-time for LAMP is c40 minutes compared to 8 hours for our PCR tests.
- Under a separate contract, directly with DHSC, we will create capacity for up to 3,500 samples per day to offer improved asymptomatic testing to all NHS-badged staff in Suffolk and North East Essex.
- A new £1m, 220m2 LAMP laboratory has been constructed and occupied in just over 3 months. Instrument verification is under way and will complete in early April if sufficient positive samples are obtained.

Project outcomes to date

From 4th August, for the first time since the beginning of the pandemic, all patient and staff samples taken in ESNEFT have been tested locally.

The capacity of 3,000 COVID-19 tests per day was set as a national goal for each NHS laboratory. This has been a challenging goal for any lab to meet. Indeed only five of the 93 NHS labs performing these tests have achieved this goal. At 2,700 tests per day,

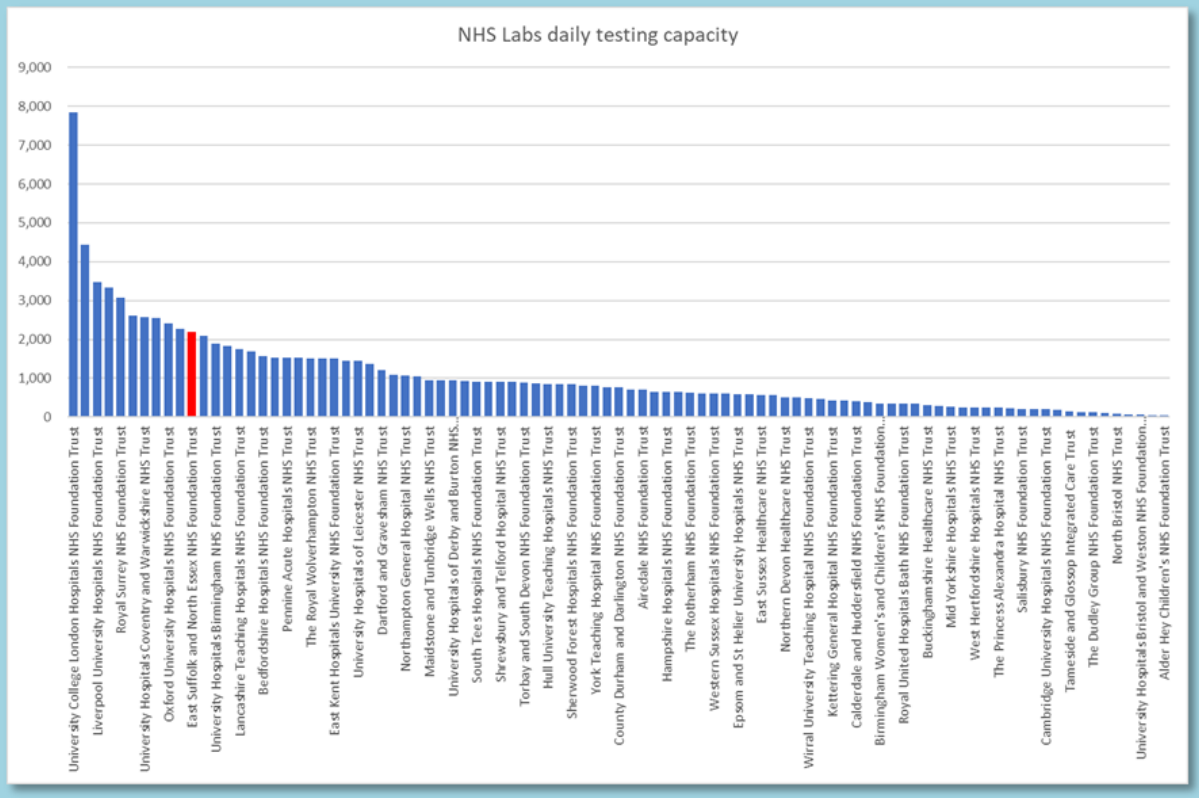
Clinical Effectiveness
ESNEFT Molecular laboratory (Project 3,000)

In the first three weeks of March 2021 ESNEFT undertook the 7th largest volume of NHS tests:

NHS England — NHS COVID-19 P1 Testing Daily Dashboard

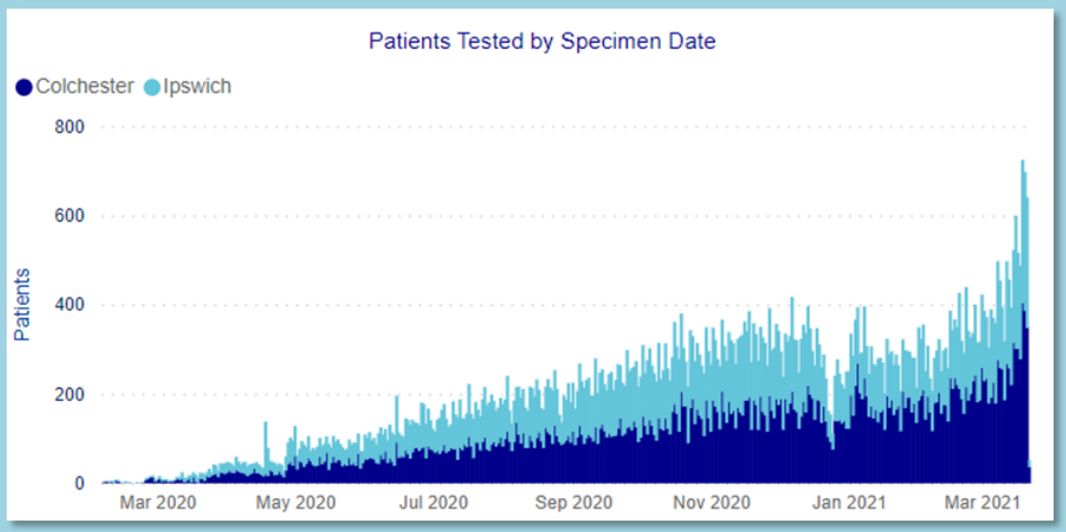
Parent Trust	Current capacity	Total tests	Capacity Surplus (+) / Deficit (-)
University College London Hospitals NHS Foundation Trust	135,151	76,400	58,751
Barts Health NHS Trust	56,340	40,671	15,669
Royal Surrey NHS Foundation Trust	55,440	39,249	16,191
Imperial College Healthcare NHS Trust	79,470	34,432	45,038
King's College Hospital NHS Foundation Trust	47,160	26,221	20,939
Mid and South Essex Hospital Services NHS Trust	40,860	25,394	15,466
East Suffolk and North Essex NHS Foundation Trust	39,444	23,044	16,400
Liverpool University Hospitals NHS Foundation Trust	62,352	22,979	39,373
University Hospitals Birmingham NHS Foundation Trust	32,300	21,037	11,263
The Royal Wolverhampton NHS Trust	29,165	20,635	8,530
St George's University Hospitals NHS Foundation Trust	28,400	20,165	8,235
Pennine Acute Hospitals NHS Trust	25,976	19,241	6,735
University Hospitals of North Midlands NHS Trust	28,248	18,516	9,732
Norfolk and Norwich University Hospitals NHS Foundation Trust	34,386	18,507	15,879

ESNEFT will be the sixth highest capacity NHS lab. We currently have the 11th highest capacity:



Clinical Effectiveness
ESNEFT Molecular laboratory (Project 3,000)

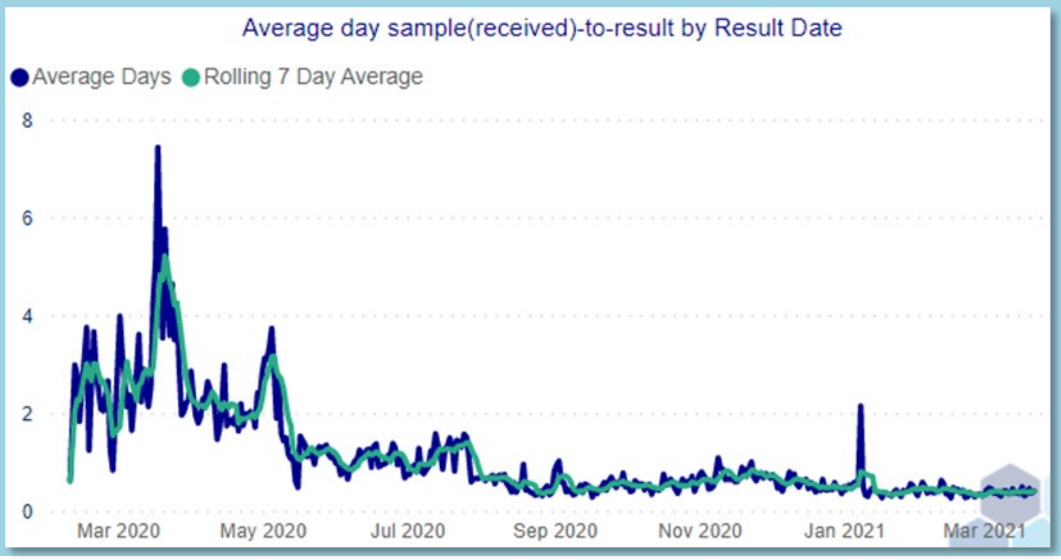
The available capacity has been sufficient to meet all the demand for tests, which has continued to rise:



The pathology service has been active in extending the offer of testing to our communities, including:

Care home residents and staff		Ambulance service
Police services	Fire services	Armed forces
MH Trusts	Schools	Prisons

Despite the increase in activity our sample turnaround times are maintained at c 14 hours, within the national standard of 15 hours:



Clinical Effectiveness

A team of healthcare assistants (HCAs) put lockdown time to good use by learning new clinical skills.

Twelve colleagues who work in the Outpatient clinics at Ipswich Hospital found time to study during the height of the pandemic while clinics were scaled back. Most of the 12 were also redeployed to other jobs in the hospital.

Each completed the NHS Care Certificate – a national qualification with extra learning on basic life support, health and safety, equality and diversity, safeguarding children and adults, privacy and dignity and fluids and nutrition.

Keeping our patients safe during the COVID-19 pandemic

In response to the Covid-19 Pandemic, a level 4 incident was declared nationally. Over the course of the year, this was reduced to level 3 and back to level 4 again, going back to a level 3 in late March 2021. The Trust responded accordingly, flexing governance and patient safety oversight throughout the year.

In response to the evolving nature of the pandemic, the Trust established a Clinical Reference Group (CRG) to provide trust-wide clinical oversight, advice and decision making on clinical matters raised, providing assurance, that appropriate clinical consideration has been given to any decisions.

The Group has been chaired by the Chief Medical Officer, with attendance from all clinical Divisions; medical, nursing, allied health professionals and any core corporate services as required. A strong presence from Infection Prevention and Control was established to ensure swift decision making and sharing of communications across the Trust in response to the ever changing nature of the pandemic. The frequency of meetings varied throughout the pandemic in response to the different levels of response required, from daily to weekly.

The Trust had already used Microsoft Teams to enable cross site working with minimal travel, and through the pandemic increased its use to enable meetings such as CRG and increased the attendance across all meetings. The CRG had oversight of all PHE and other national body guidance to ensure any changes required had full clinical oversight. Support was provided to the Divisions to ensure preparedness and effective risk management, using a comprehensive action plan. This provides a historic log of all changes made at the Trust in response to clinical and patient safety requirements.

The group has also supported the Divisions in ensuring a risk based approach to the standing down and re-establishment of clinical services where required. The group also provides oversight of ensuring any potential harm to patients through the changes of services is identified early in the patients pathway wherever possible.

Second bladder scanner for Radiotherapy department

Colchester & Ipswich Hospitals Charity has funded a second bladder scanner for the Ipswich Hospital Radiotherapy department.
Building on the success they have had with the first scanner, the team can now check bladder levels of more patients without the need to expose patients to radiation.

Increasing Critical Care capacity during the COVID-19 pandemic

During the second wave of the pandemic to increase Critical Care capacity a theatre department was transformed to an area to provide care for Critical Care patients. This transformation happened over a 24 hour period.

The service:

- 6 Theatres and a Recovery Unit
- 24/7 Emergency Theatre
- 4 Theatres working 08.00-17.30 Monday- Friday
- Staff- Nurses, ODPs and TAs

What changes were made to the service to increase capacity:

- Recovery unit- capacity of 4 level 2 patients
- 2 Theatres- capacity of 4 level 3 patients
- Change and re-schedule all staff to accommodate 24/7 rota
- Source all equipment, documentation and pharmacy.

Embracing the impact of COVID -19

The transformed clinical area provided:

- Care for 'Green' (non COVID-19) patients who required critical care with complex needs
- Level 2- support for single failing organ system or post -operative care
- Level 3- Requiring advanced respiratory support and support for at least 2 organ systems.

Staff wellbeing- 2nd wave

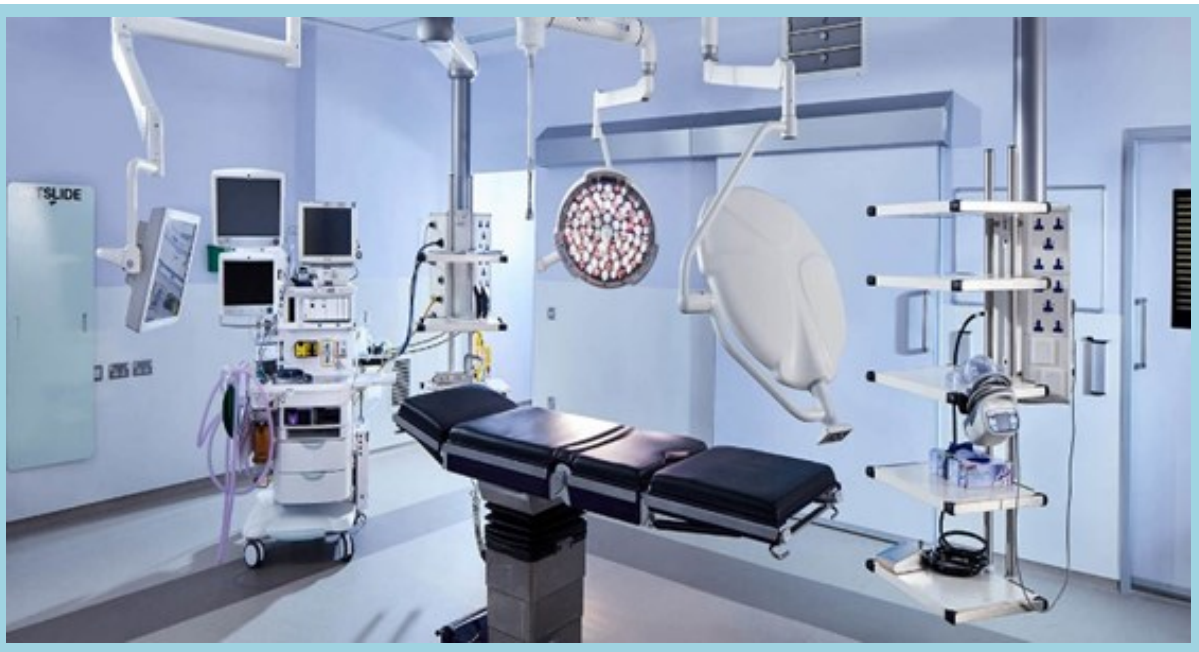
Considerations regarding the support of the staff involved in the transformation of the clinical area and working during the second wave:

- Staff needed to feel listened to regarding their concerns
- The new way of working previously unknown to staff
- Staff needed to feel supported
- Concerns regarding registration
- Staff concerns
- Social isolation
- Mental health of staff
- Burn out .

Considerations regarding the support of the staff following the second wave:

- Cohesion of staff working
- Commitment of staff to the work
- Determination of staff
- Leadership
- Teaching
- Supervision
- Pride
- Aware of need to recover quickly
- Keen to return to elective surgery

Increasing Critical Care capacity during the COVID-19 pandemic



Working in different ways throughout the COVID-19 pandemic

Nurses share their experiences working in a completely different role during the pandemic.

Two children's nurses who have been working in adult intensive therapy unit through the pandemic say the experience has been completely different from their usual nursing shifts.

Fourteen children's nurses from Ipswich and Colchester Hospitals have been working on critical care wards since the beginning of January to help with the additional pressure in those areas. Two of the team, Lois Bemrose, based at Colchester Hospital, and Alice Nash, based at Ipswich Hospital, said it's been a really interesting learning curve and meant a very different working day.

"For a start the patients don't want to run away from you when you go to give them an injection," said Lois. "With children, a lot of reasons they come to hospital are for broken bones, asthma or breathing problems, appendicitis, bronchiolitis or feeding issues with babies. Obviously with ITU it's very different and most patients in ITU are sedated and don't have anyone with them."

Medication, patient checks, paperwork and the equipment are all different between the areas the two nurses said.

Alice Nash, paediatric high dependency coordinator

Alice Nash, who works as a paediatric high dependency coordinator, is familiar with children who have serious conditions, but said it's different caring for an adult.

"We're not used to using ventilators in paediatrics, which has been new, and even the physical size of the patient in ITU is different so takes a lot more staff to move somebody."

Alice and Lois said it's been a "massive challenge", but they were keen to be redeployed, not only to help during the crisis, but also as it would serve as a learning opportunity and develop their skills.

Lois Bemrose, children's staff nurse and paediatric diabetes team member, said: "I thought it would be a good chance to learn some new skills and I've done that.

"My day in ITU includes a lot of bedside safety checks, checking emergency equipment, making

Alice Nash, based at Ipswich Hospital

Working in different ways throughout the COVID-19 pandemic

sure airways and breathing is as expected. We're checking blood gas from the patient's arterial line and running machine checks regularly."

Alice added: "I have far more confidence in managing a patient's airway now. It's also been very different communicating with family members. With children they have their family there, but with people on ITU at the moment they don't, so I've had to adapt the way and how I communicate to a loved one."

Although it's been outside of the nurses' comfort zone, they said they've enjoyed the experience and different working environment.

Lois Bemrose, children's staff nurse and paediatric diabetes team member

Integrated Pathways & Community Services celebrating the community delivery and quality of services through the pandemic

Community Services Reflection and Innovation –

D2A & urgent community response

The integration of Discharge to assess team and urgent community response into our integrated neighbourhood teams has been an excellent development during the past year, this has required ESNEFT to work with all system partners, including the voluntary services. Historically in Ipswich and East Suffolk we have developed stand-alone services that are centrally based in Ipswich covering a large geographical area meeting various service requirements and patient pathways. This has included REACT (admission avoidance) and CAT Plus (PW1) . These teams have been separate to the Integrated Neighbourhood teams (INTs) who provide locality based health and social care. We have always had an ambition to integrate and streamline admission avoidance and discharges from hospital into a locality model within our integrated neighbourhood teams. Covid-19 provided an opportunity and platform to expedite this work. With the publication of the 'Covid-19 – Government Hospital Discharge Service Requirements' in March 2020, Ipswich and East Suffolk Alliance worked collaboratively to rapidly mobilise a true Discharge to Assess model. An integrated discharge hub was set up in the hospital to provide a single point of contact for wards and community hospitals ensuring multi-disciplinary decision making facilitated the correct safe, timely discharge for our patients

Therapy, Nursing and social care staff were moved from the acute hospital setting, out into the community, to support patients, to avoid admission and receive care at home through REACT and same day discharge from hospital through PW1 (CAT Plus and Home First). The eight Integrated Neighbourhood Teams have extended their working hours to cover 8am-8pm, 7 days a week to ensure people get the care they need, when they need it.

Prior to Covid-19, disparate teams saw multiple hand-offs and duplication. REACT were declining 16.6% of referrals secondary to a lack of clinical capacity. The delay in discharge for patients identified as PW1 was 7.4 days, due to capacity restraints, leading to much of the assessment period being spent in an in-patient hospital setting rather than the desired community setting. Additionally, REACT alone were spending 303 hours per week undertaking travel, equating to 8 WTE staff and demonstrating an area where improved efficiency and use of available resources could be enhanced.

Covid-19 provided the golden opportunity to consolidate this learning and re-design pathways of care to provide better patient outcomes, reduced hospital stays, and care closer to home.

The length of stay for patients identified as being suitable for discharge under PW1 reduced from 7.4 days (from point of identification to day of discharge) under the centralised model to 1.5 days under the locality collaborative model

REACT Declined referral rate secondary to capacity, fell from 16.6% under the centralised model of delivery, to 3.9% during the delivery of the locality model.

In addition ESNEFT In December 2020 East of England Ambulance Service (EEAST), worked as a core system partner with Suffolk GP Federation and the East Suffolk and North East Essex Trust Community REACT (Crisis intervention team) considered how decisions not to convey patients to an acute hospital could be supported. The ambulance crews have the opportunity to call a Hotline Managed by Suffolk GP Federation, and have received calls back within 5 minutes to discuss the presentation and agree a management plan. As the3 GP Federation have access to the clinical notes they are able to

Integrated Pathways & Community Services celebrating the community delivery and quality of services through the pandemic

make better informed decisions about community management where appropriate.

This has made real differences to EEAST Crews confidence in decisions not to convey as the have ready access to medical advice. In some cases the decisions not to convey triggers a referral to the community REACT service with assessment within two hours, provision of equipment and wrap around care (where required) to support the decisions to manage at home.

The crews can call REACT directly

Community Hospitals

Aldeburgh community hospital, Felixstowe hospital and Bluebird lodge community hospitals in East Suffolk make up part of the ESNEFT portfolio.

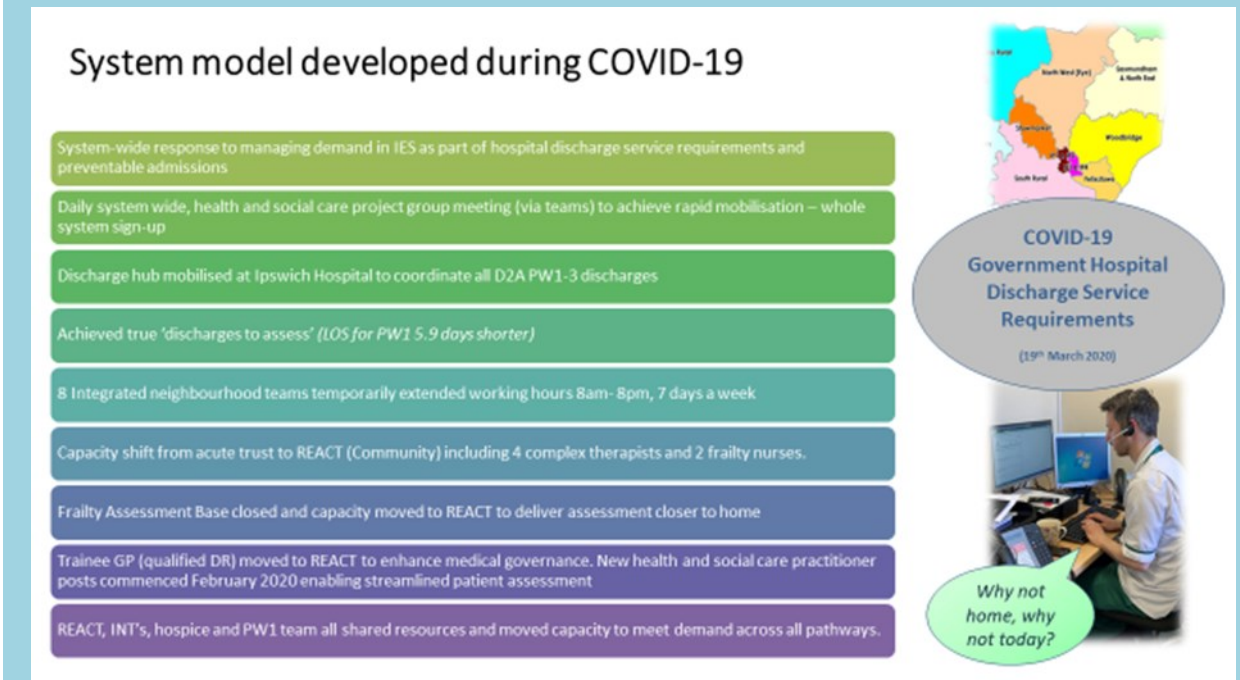
Inpatient discharge from hospital was delayed as care home providers and care agencies were unable to accept Covid-19 + and Covid-19 contact patients due to the concern that this may increase the spread of infection in their premises and amongst care staff.

Increasing numbers of patients required rehabilitation (particularly where they required ITU admission) impacting on the number of acute delays and the deterioration of Stranded Patients metrics

Patients not requiring acute care were unable to be discharged.

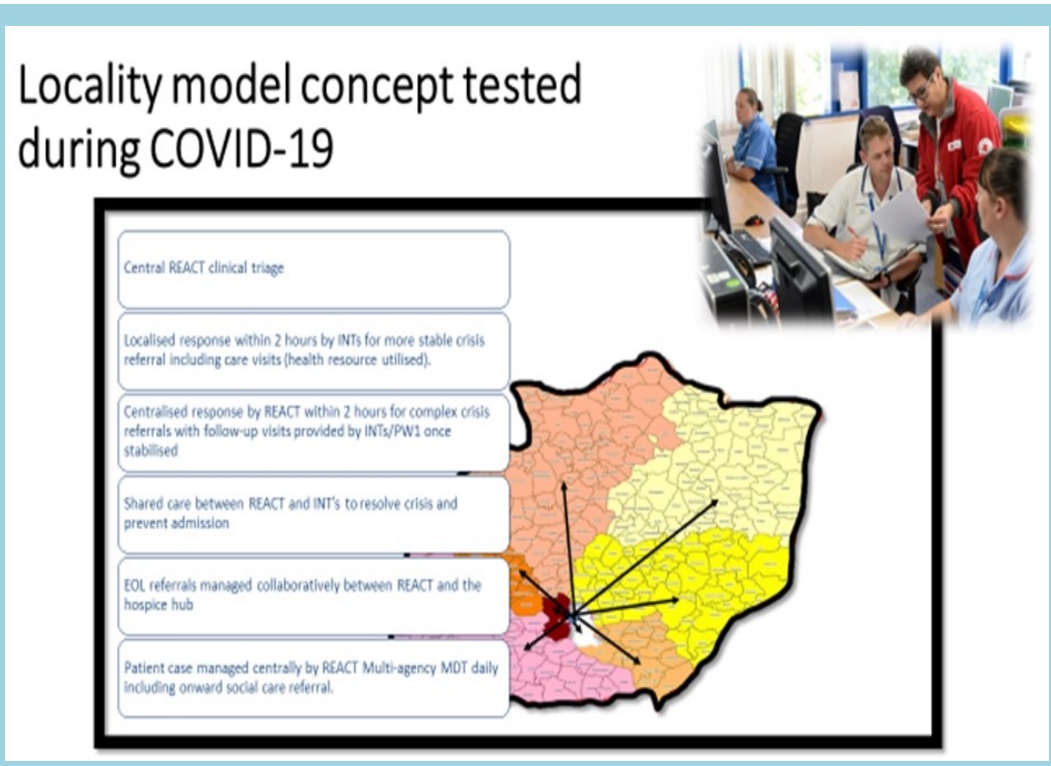
The Redesign of community hospitals and work with local care homes has enabled us to manage patients who required rehabilitation post exposure to Covid-19 as well as patients who have not contracted Covid -19 but need rehabilitation to be cared for

throughout the past year. In addition the development of designated beds for Covid-19 Positive patients and Covid-19 contacts in collaboration between Suffolk County Council, Care Home Providers, and ESNEFT Therapy staff have supported the whole county of Suffolk (Three acute Trusts)



Patient safety

Integrated Pathways & Community Services celebrating the community delivery and quality of services through the pandemic



During the early stages of the pandemic there was recognition that acute flow was compromised by the ability to discharge patients safely to the appropriate destination, and that a number of these patients required re-ablement.

Health and social care worked collaboratively to develop a model of care to support discharge and re-ablement of these patients, delivering compliance with the CQC Designated Premises guidance

Frailty services

The ESNEFT frailty competencies (based on NHS HEE and NHS E Frailty: a framework of core competencies) have been approved and are being rolled out across the community services, and an e-learning module is awaiting approval.

The Geriatrician liaison into the integrated neighbourhood team programme (GLINT) is being developed in Ipswich and East Suffolk.

In north east Essex, there has been a successful roll out of a virtual MDT model which is reviewing patients with frailty in care homes.

The frailty services are working closely with both emergency departments to help embed the use of the Rockwood clinical frailty score in patients over 65yrs to identify patients aged 65yrs and over who are frail.

ESNEFT frailty services and INTs are working closely with the Integrated Care Academy to set up an ICOPE (integrated care for older people) project as part of the WHO ICOPE programme.

The frailty service in Ipswich has been instrumental in setting up the Ipswich and east Suffolk alliance frailty steering board that had its first meeting in Oct 2020. The board has agreed a frailty framework for use in all of its sovereign organisations. A frailty web based solution is currently being developed for use.

Patient safety

Our community team in Aldeburgh received this one from a local residential home to say thank you for their support during the pandemic.

Patient safety
Maternity and the Ockenden Report

Approximately 7,500 women each year choose to birth at Colchester, Ipswich and Clacton hospitals NHS Trust. We provide antenatal, intrapartum and postnatal care and encompass both consultant-led and midwife-led care at all three hospitals.

The Trust is committed to improving quality outcomes for women and babies who use our service. To help us to better understand where we need to make improvements we have recently reviewed a new maternity improvement and performance dashboard. This work will continue as we reflect on the changes with Continuity of care and in light of the recommendations from the recently published Ockenden review.

OCKENDEN review

In 2020 there was an independent report into the care of women and babies at Shrewsbury and Telford NHS Trust. This report highlighted a number of recommendations for all Maternity units and all Trusts were tasked with responding to these to update on their current position.

ESNEFT submitted the required Ockenden assurance tool in February 2021, with clear status and actions identified in relation to the Immediate and Essential Actions (IEAs) set out for all Trusts by the Review. Additional requirements subsequently issued by the Chief Midwife for East of England have also been incorporated.

There is now an ongoing programme of work cross-site, supported by the Transformation team. Project planning is underway, and a dashboard will be available. Progress updates on the seven IEAs are as follows:

1. Patient safety

We are proud to have successfully delivered all NHS Resolution Maternity Incentive Scheme Safety Actions to date and are now working hard to continue this for year 3. We also continue to focus on reducing the number of babies who are stillborn or born in a poor condition and have made progress with our project to deliver the Saving Babies Lives v2

We have maintained excellent rates of staff attending our multidisciplinary obstetric emergency training courses PROMPT and will continue to deliver this so that all our staff get the opportunity to attend. We appreciate that all multidisciplinary staff (MDT) staff need to learn together both in the classroom and in the clinical environment.

We continue to perform well in reducing the numbers of babies who need to be admitted to the neonatal unit (ATAIN) and we consistently perform well with PReCePT programme for women in premature labour and requiring magnesium sulphate administration.

The monthly report on serious incidents, trends and themes is included in the Patient Safety Report and tabled at the Quality & Patient Safety Committee (QPSC), Trust Board and Local Maternity System (LMNSB). Exploring a reciprocal arrangement with neighbouring Trust (Mid-South Essex) for external review of cases meeting the criteria set out in the Ockenden Review, but which don't qualify for Healthcare Safety Investigation Branch (HSIB) investigation.

2. Listening to women and families

ESNEFT works closely with the LMNS and Maternity Voices Partnership (MVP) to ensure that we are listening to and working closely with women and their families to ensure they experience care that is safe, responsive and respectful to their needs and choices throughout their journey with us.

We are currently developing an independent senior advocate role. Once role is created, ESNEFT will develop a programme of assurance of effectiveness using all available feedback mechanisms. The non-executive director (NED) for maternity is a member of the Maternity and Neonatal safety champion forum.

3. Staff training and working together

A full review of clinical and nursing teams will take place over the coming months, to ensure sufficient resource to support the required multidisciplinary training and working. In the interim, additional resource was funded on the Ipswich site to enable twice daily obstetric consultant rounds, which commenced in April 2021.

Patient safety
Maternity and the Ockenden Report

4. Managing complex pregnancies

Ongoing work to ensure that women with complex pregnancies have a named consultant lead, and that there is sufficient maternal medicine clinic capacity to enable robust pathways for management of those women. Regular monthly audits are included in the regular monitoring schedule. Additional joint maternal medicine clinics have been approved for the next six months, pending outcome of the full review of clinical and nursing teams and resource.

5. Risk assessment throughout pregnancy

Monthly audits being implemented on both sites (as part of regular monitoring schedule) to establish compliance with formal risk assessments at every contact, and determine what action required.

6. Monitoring fetal wellbeing

Fetal monitoring leads already in place. Ipswich site implemented FIGO (replacing NICE) on 6th April 2021. Fetal monitoring awareness week to take place in mid May.

7. Informed consent

In partnership with the MVPs, ESNEFT will undertake a patient survey to identify gaps in information. ESNEFT plans refreshed communications (for our women and their families, and also for ESNEFT staff and partner organisations) regarding the Mum & Baby app which has been adopted across the LMNS.

Maternity Transformation- Continuity of Carer

In line with the Maternity Transformation Programme (Better Births) and the 10 year Forward View, both Colchester and Ipswich maternity units went out to a 45 day staff consultation in October 2020. This represents major change across the service, moving from the traditional Community and Unit model of care to the provision of Continuity of care across the service placing the woman at the centre of the care model. Midwives will be expected to follow 'their women' into the hospital for birth should that be her choice of place of birth.

We are now identifying the best way to move forward and implement this.

The Nationally predicted outcomes of implementing Continuity of Carer are:

- 16% less likely to suffer pregnancy loss
- 24% less likely to experience pre-term birth and associated birth complications (40% reduction in ESNEFT pilots)
- 15% less likely to require local analgesia
- 16% less likely to have an episiotomy
- Increase in home births and midwife led care options (ESNEFT home-birth rate 150% increase and Midwifery Led Unit (MLU) rate increase of 54%)
- Improved care experience for women during pregnancy and birth.

Additional outcomes seen within ESNEFT pilot teams, in line with national data outcomes:

- Smoking at time of delivery is lower (in the first quarter the rate was 5.5%) The national target is 6%.
- 45% of woman had an established labour of less than 6 hours duration (all spontaneous vaginal births)

Safety Actions (CNST)

Safety Action 1: National Perinatal Mortality Review Tool

Quarterly report routinely submitted to Integrated Assurance Committee and moving forward QPSC for oversight. Next report will be due in June 2021.

The Trust had one instance of a case which fell outside the timeframe for the Clinical Negligence Scheme for Trusts (CNST), which states that "All perinatal deaths eligible to be notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACEUK) from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death." This was due to a late notification from outside the Trust, but where it meets the required

Patient safety
Maternity and the Ockenden Report

standard for reporting. We therefore continue to meet this standard, but the internal process for notification to governance midwife is under review, and the governance midwife is working with Informatics colleagues to implement an additional weekly failsafe check to ensure no such cases are missed in future.

Safety Action 2: Maternity Services Data Set

All deadlines met to date. December data submission met all required criteria. The last remaining item is Board approval of a locally funded plan for ESNEFT to fully conform with the Maternity Services Data Set (MSDSv2) Information Standards Notice, DCB1513 and 10/2018, agreed with the maternity safety champion and the LMS. The relevant report is being drafted and will go through governance to QPSC at the end of April, Trust Board for May meeting.

Safety Action 3: Avoiding Term Admissions into Neonatal Units (ATAIN)

All deadlines met to date, including review of the COVID-19 period and resulting actions included in the overall plan. Changes to the CNST scheme in March 2021 have removed some of the requirements for this standard.

Board level safety champion oversight of progress against the ATAIN action plan is maintained via regular reporting at monthly Maternity and Neonatal Safety Champion meeting.

Safety Action 4: Clinical Workforce

Neonatal medical workforce component is not currently met at Ipswich, as the relevant BAPM standard (pertaining to dedicated neonatal Tier 2 rota) is not met and there is not currently

an agreed action plan in place to address. The same standard is currently met at Colchester, by a temporary (6 month) arrangement put in place in February 2021. Action plans for both sites are therefore currently being devised, for approval by Board level safety champion and sign off by Trust Board. Discussions will include neonatal safety champions, paediatrics clinical leads, paediatric matrons, head of nursing, paediatric general manager and service managers.

Changes to the CNST scheme in March 2021 removed the requirement relating to the obstetric medical workforce.

Safety Action 5: Midwifery Workforce

Changes to the CNST scheme in March 2021 amended the requirement from a biannual to an annual report to Trust Board on midwifery staffing, with the reporting period expanded to cover 12 months. Required midwifery staffing report is being drafted, for submission to QPSC at end of April, Trust Board early May.

Safety Action 6: Saving Babies Lives care bundle 2

Element 1: Reducing smoking in pregnancy

This element is implemented on both sites. Audit planned to confirm whether 80% compliance threshold met. A joint ESNEFT Smoking Cessation Awareness week took place in March.

Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

On Ipswich site, an alternative intervention is in place (uterine artery doppler flow velocimetry not performed by 24 weeks for high risk pregnancies), LMNS approval of which is pending. Audits planned to confirm whether 80% compliance threshold met, for identification and recording of FGR risk status.

Element 3: Raising awareness of reduced fetal movement (RFM)

Element is implemented on both sites. Audits planned to confirm whether 80% compliance threshold met.

Element 4: Effective fetal monitoring during labour

Both sites are projected to meet the 90% compliance in all staff groups. This is being closely monitored in case of training cancellations etc.

Element 5: Reducing preterm birth

Element is implemented. Audits planned, to confirm whether 85% compliance threshold is met for all three indicators.

Safety Action 7: User feedback including Maternity Voices Partnership

Patient safety
Maternity and the Ockenden Report

Some patient engagement activities are resuming in March / April 2021. Both sites are engaged with the MVPs. Report demonstrating requirements are met will be drafted for submission to QPSC at end May, and Trust Board in early June.

Safety Action 8: MDT Emergency Training Session Compliance

Changes to the CNST scheme in March 2021 removed the requirement for 90% of all staff groups to have completed the training. This is replaced instead by a need for Trust Boards to acknowledge what the completion rate is, and where this falls short of 90%, to affirm the Trust's commitment to enabling all relevant staff to undertake the training. Colchester have met the 90% threshold already, and Ipswich is currently also projected to meet the required 90% compliance in all required staff groups. The scheme will take into account the position as at 15thJuly 2021.

Safety Action 9: Maternity & NN Safety Champions Meeting Update, including attendance

All deadlines met to date, and "Open to All" and "Safety Counts" feedback sessions continue to take place. Displays have been updated to reflect recent changes to safety champion roles and information flow, and the Chief Nurse is initiating some communications work to further explain to staff what

the role of the safety champions is. The second monthly Maternity and Neonatal safety champion meeting took place on 25th March 2021, chaired by Chief Medical Officer (Board level safety

champion), with attendance as follows: Consultant Paediatrician, Children's Matron, Consultant Obstetrician, Director of Governance, HOM, Governance Manager for Gynaecology & Children's, Chief Medical Officer, Trust lead for Children & Young People, Governance Midwife. The Terms of Reference and work plan were further discussed, with some additional aspects for finalisation. The work plan schedule takes effect from April 2021 meeting.

The Chief Nurse (Board level safety champion) is currently reviewing an external report on the Trust's continuity of carer plans and staff consultation process, and quarterly progress reports to

Trust Board are being implemented.

Safety Action 10: 100% of cases reported to HSIB & NHSR Early Notification Scheme

ESNEFT is fully compliant with this action to date, with 100% of qualifying cases notified to HSIB, as per current national process

Patient safety
The Vaccination Hub

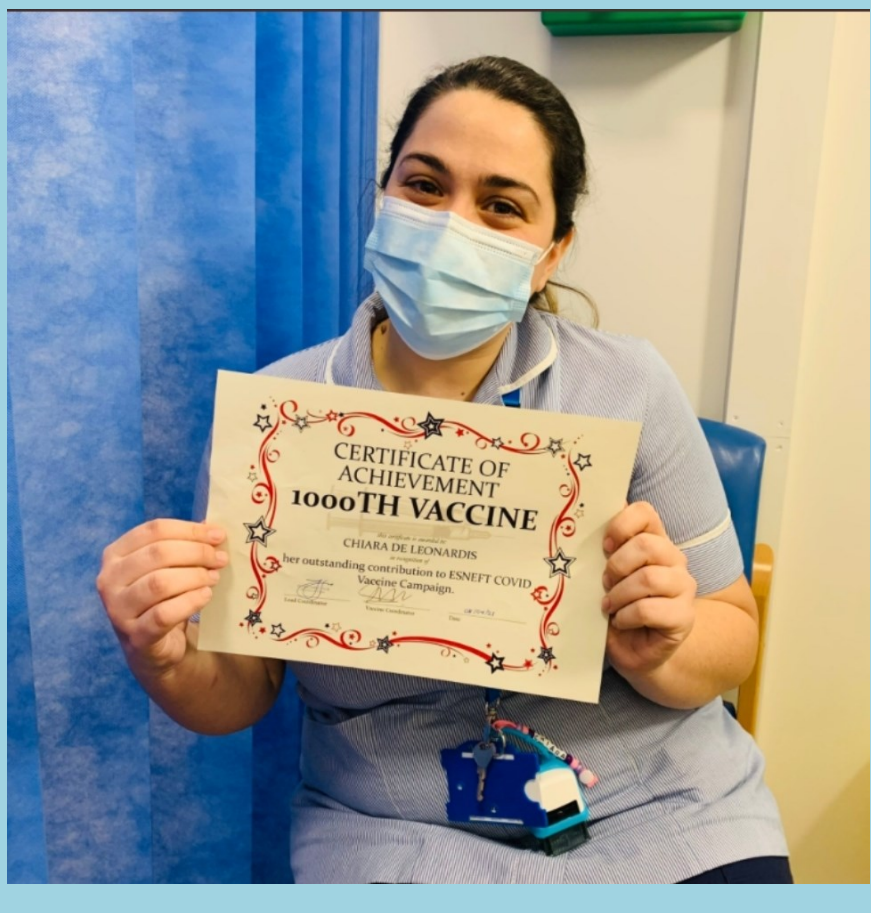
Covid-19 Vaccination Programme

The emergence of Covid-19 in December 2019 and subsequent pandemic has seen unprecedented global challenges, with experts working together to ensure the safe development and distribution of the first Covid-19 vaccines, giving the world hope after such challenging times.

ESNEFT was chosen to implement the Covid-19 Vaccination Programme. Through the hard work and dedication of staff across ESNEFT, the Training Room South building was transformed over just a few days to the first vaccination hub at ESNEFT, with the first vaccination given at Colchester Hospital on the 9th December 2020, the Ipswich Hospital Hub opened its doors at the PGMC on the 4th January 2021. The Hub moved to the PGMC at Colchester Hospital to enable more vaccinations and ensure good social distancing.

A robust governance oversight group was established to ensure all staff were trained and competent with a strong multi-disciplinary leadership team. Robust guidelines were agreed to ensure the safe handling and administration of the vaccine in alignment with the nationwide programme.

As at the 31st March 2021, ESNEFT staff have given 27,342 first doses of vaccine and 15,315 second doses supporting our communities in the role out of the Covid-19 vaccine. Staff and volunteers have worked tirelessly to ensure the safe programme of vaccination at ESNEFT.

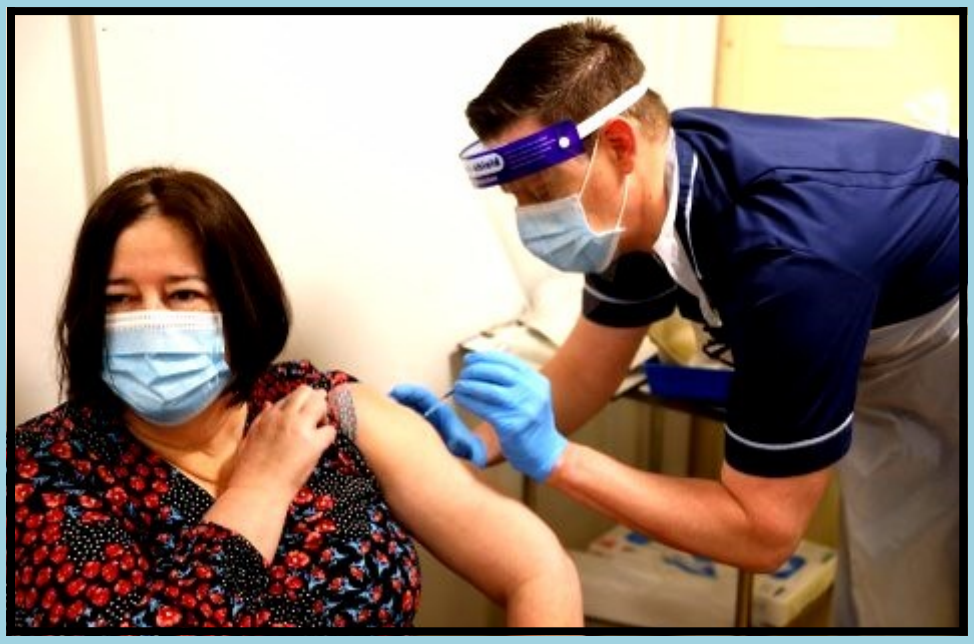


Chiara De Leonardis receives a certificate of achievement for delivering her 1000th vaccine in the vaccination hub at Colchester site.

Patient safety
The Vaccination Hub

The first batch of the COVID-19 vaccine arrives at ESNEFT

Chief Nurse Giles Thorpe administering a vaccine in the Vaccination hub at Colchester site



Clinical effectiveness
Emergency care

Colchester Site Emergency Department

Over the past twelve months our performance has improved and is generally higher than the national performance. However, the Emergency Department performance has been affected because of the COVID-19 pandemic particularly in January 2021.

- Pathways and processes have been set up to ensure the COVID-19 positive patient does not need to stay in the Emergency Department longer than is required. Pathways have been completed and signed off by the ESNEFT COVID-19 Committee which is an MDT panel across the trust.
- The Urgent Treatment Centre is continuing to strengthen pathways with other specialities to ensure the right patient attends the Emergency Department. At present the UTC team are working on the EDDI (Emergency Department Digital Integration) pathways that 111 use to pre-book patients into the UTC. There is still a lot of work to undertake and to utilise local initiatives such as Clacton UTC and community services.
- The Acute Medical Same Day Emergency Care (AMSDEC) department are working closely with the Emergency Department to ensure the appropriate patient is seen outside the Emergency Department by the medical team.
- Previously the CCG approved funding for a band 6 safety nurse. This role has been pivotal in ensuring timely offload of ambulances at busy times and to enable us to cohort where possible. We are now looking at making this a permanent role within our workforce.
- The nursing team have recruited to the increased COVID-19 template to ensure we have the right amount of nurses to care for patients under the COVID-19 pressures.
- Our Sepsis Compliance Assistant is working closely with the nursing workforce to ensure our patients receive the right treatment at the right time. In turn, we have achieved outstanding results for a number of months.
- The Medical rotas are being revised as Colchester have been awarded three HST posts from September 2021.

Clinical effectiveness
Emergency care

Table 6– ESNEFT performance over the last three years: 4 hours to discharge from Type 1 &3 Emergency Attendances

		2018/19		2019/20		2020/21	
	Target	ESNEFT Performance	National Performance	ESNEFT Performance	National Performance	ESNEFT Performance	National Performance
April	95.0%	92.8%	82.3%	89.4%	85.1%	90.6%	90.4%
May	95.0%	95.3%	85.1%	91.3%	86.6%	83.4%	91.2%
June	95.0%	94.6%	85.6%	91.4%	86.4%	95.8%	92.8%
July	95.0%	94.8%	83.5%	88.1%	86.5%	96.7%	92.1%
August	95.0%	93.7%	84.0%	88.6%	86.3%	94.0%	89.3%
September	95.0%	95.5%	83.0%	86.2%	85.2%	93.7%	87.3%
October	95.0%	95.0%	83.1%	84.3%	83.6%	91.0%	84.4%
November	95.0%	92.8%	81.1%	85.0%	81.4%	90.3%	83.8%
December	95.0%	91.2%	79.3%	82.4%	79.8%	84.4%	80.3%
January	95.0%	89.2%	84.4%	82.9%	81.7%	75.8%	78.5%
February	95.0%	90.2%	84.2%	84.9%	82.8%	87.5%	83.9%
March	95.0%	92.7%	86.6%	86.8%	84.2%	94.6%	86.1%
YTD	**95.0%**	**93.4%**	**88.5%**	**86.7%**	**84.2%**	**90.9%**	**86.8%**

Table 7 – Our Emergency performance over the last three years: Type 1&3 activity

Financial Year	ESNEFT Number of Attendances	ESNEFT 4 hr Performance	National 4 hr Performance
2018/19	260,273	93.4%	88.5%
2019/20	245,671	86.7%	84.2%
2020/21	177,355	90.9%	86.8%

Clinical effectiveness

Hospital Standardized Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

What is HSMR?

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a group of 56 common diagnoses, which usually equates to approximately 84% of in-hospital deaths. It is a subset and represents about 35% of admitted patient activity. During the COVID-19 pandemic, this figure has dropped to 71% of all deaths owing to the fact that any patient with a COVID-19 diagnosis is excluded from the metric.

What is SHMI?

The Summary Hospital-Level Mortality Indicator is a ratio of the observed number of deaths to the expected number of deaths for a trust. The SHMI differs from some other measures of mortality by including both in-hospital deaths and deaths of patients occurring within 30 days of discharge from hospital. During the pandemic, any patient with a SHMI diagnosis has been excluded from national reporting owing to the fact that the algorithm was never designed to accommodate a pandemic.

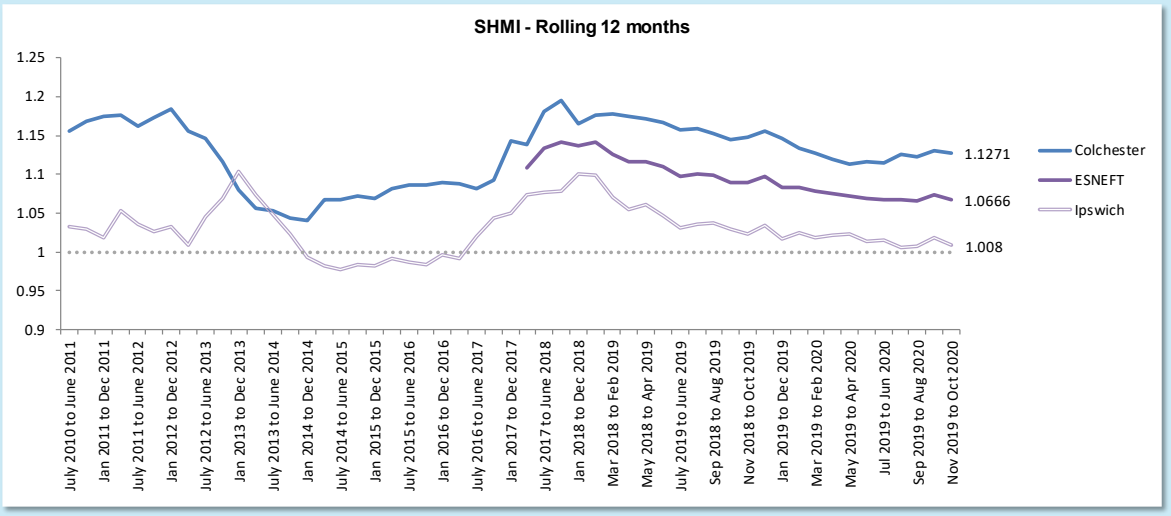
How do they work?

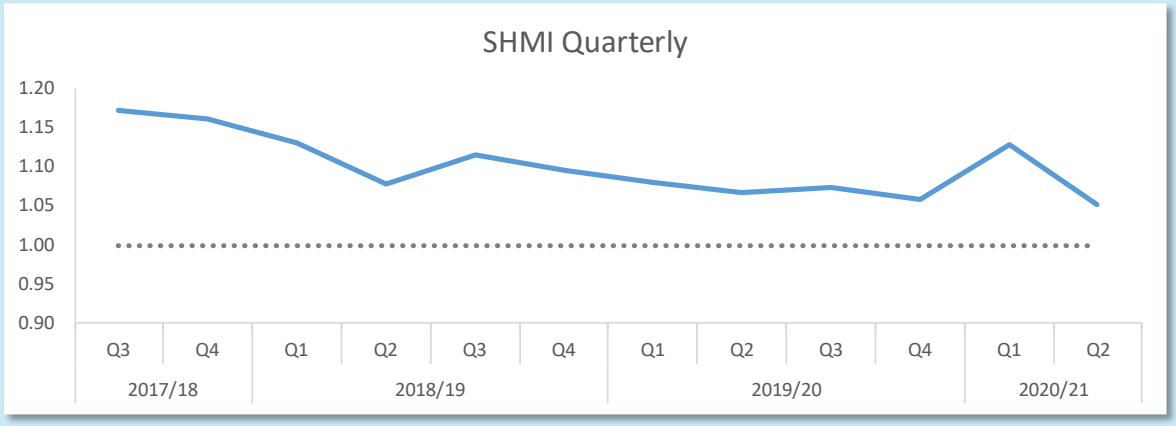
Mortality indicators show whether the number of deaths linked to a particular hospital or diagnosis group is more or less than expected, and whether that difference is statistically significant.

Why are mortality ratios/indicators important?

They are useful in combination with other metrics, providing an indication of where a problem might exist.

***Chart 4**- Mortality: SHMI trend July 2010 –October 2020*





Clinical effectiveness

Hospital Standardized Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

***Table 8** Results summary HSMR and SHMI*

In-hospital mortality/mortality within 30 days of discharge has been reviewed.

Metric	Result
HSMR 12 months to Dec 20	105.2 - within the 'higher than expected' range
HSMR position vs. East of England peers	The Trust is 1 of 7 in the regional peer group of 12 that sit within the 'higher than expected' range.
HSMR diagnosis groups attracting higher than expected death	There are 5 HSMR outlying groups attracting significantly higher than expected deaths: Cancer of Breast — Relative Risk 195.8 — Nº. of Deaths 16 — Nº. of 'Expected' Deaths 8 COPD — 137.4 — 77 — 56 Pneumonia — 118.2 — 401 — 339 Other gastrointestinal disorders — 146.3 — 39 — 27 Fluid and electrolyte disorders — 142.4 — 44 — 31
HSMR Weekday/Weekend Analysis	Weekday HSMR emergency admissions are 'as expected', Weekend emergency HSMR emergency admissions are 'higher than expected'.
Patient Safety Indicators (mortality metrics)	There is 1 alert on the Patient Safety dashboard: for 'deaths in low risk groups': • Viral infection—owing to the COVID-19 pandemic • Alcohol-related mental disorders • Rehabilitation—patients in the last days of life have been transferred to community hospitals previously used for rehabilitation.
SHMI (November 2019 to October 2020)	Published SHMI = 1.0666 'as expected' (band 2). The percentage of patient deaths with palliative care coded during their admission was 32%.

✓ The national benchmark for HSMR is set at 100 and SHMI is set at 1.0000 - trusts with a relative risk below 100 are (statistically) performing better than other acute trusts in terms of lower risk of mortality.

✓ The SHMI for ESNEFT for the 12 months ending October 2020 was 1.0666, in the 'as expected' banding. NHS Digital states that 'a higher than expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance.

✓ The HSMR for the 12 months to December 2020 was 105.2 'higher than expected'.

ESNEFT considers that this data is as described for the following reasons:

✓ The Trust is aware that many patients with long term conditions are admitted for symptom control rather than being treated in their preferred place of care.

✓ The Trust serves a large community of frail older people who are more susceptible to acute problems (e.g. infections, falls) which, when added to a host of chronic diseases result in a higher mortality rate at certain times of year.

ESNEFT has undertaken the following actions to improve HSMR and SHMI, and the quality of its services by:

✓ Working with partner organisations to ensure that patients have their symptoms managed at home (if that is their preferred place of care) where possible, thereby avoiding multiple hospital admissions.

✓ Employing a number of care pathways for conditions such as acute kidney injury, sepsis, COPD and pneumonia so that patients are diagnosed and treated quickly.

✓ Ensuring that the information sent to external mortality bodies is accurate so that 'alarms' correctly identify potential causes for concern. This is achieved through audits of the digitisation of records (Clinical Coding) and through the themed review of health records to ensure that documentation is of a high standard. Audits undertaken in 20/21 revealed that the Trust met/exceeded the Data Security & Protection Toolkit, Data Quality Standard in all procedure and diagnosis coding standards.

✓ Ensuring that incidents concerning patient care are fully investigated, including those identified during mortality reviews, and the learning shared to improve patient safety and experience.

Waiting times for Diagnostic Procedures
Clinical Effectiveness

During the first wave of the COVID-19 pandemic the percentage of patients waiting more than 6 weeks for a diagnostic test significantly increased due to services not fully operating during this time. The impact this has had on patients has been appreciated and during the second wave of the pandemic measures have been taken to try to mitigate delays by services remaining operational where possible. The ESNEFT performance during the reporting year has reflected the National performance.

Chart 5- Percentage of patients waiting over 6 weeks for a diagnostic test at month end

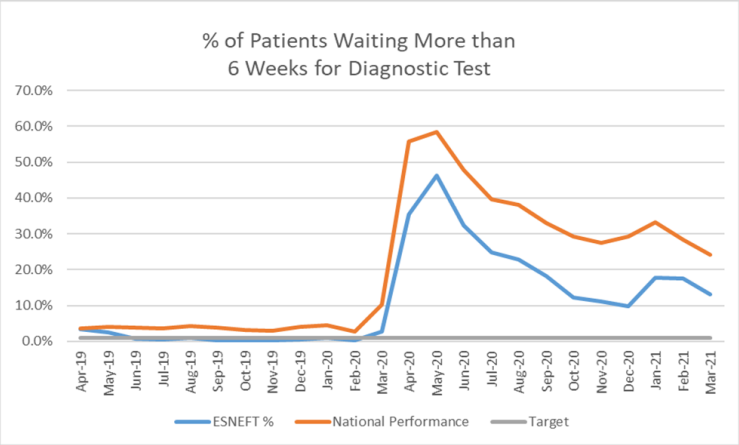


Table 9 Percentage of patients currently waiting under 18 weeks on an incomplete pathway

		2018		2019		2020	
% of Patients Waiting More than 6 Weeks for Diagnostic Test	Target	ESNEFT Performance	National Average	ESNEFT Performance	National Average	ESNEFT Performance	National Average
January	1.00%	0.95%	2.33%	2.44%	3.59%	0.97%	4.42%
February	1.00%	0.36%	1.58%	1.60%	2.30%	0.42%	2.76%
March	1.00%	1.63%	2.07%	1.89%	2.47%	2.70%	10.19%
April	1.00%	0.39%	2.47%	3.50%	3.58%	35.39%	55.74%
May	1.00%	0.83%	2.72%	2.46%	4.08%	46.36%	58.46%
June	1.00%	1.36%	2.87%	0.84%	3.76%	32.26%	47.82%
July	1.00%	1.18%	2.83%	0.50%	3.52%	24.89%	39.60%
August	1.00%	1.64%	3.06%	0.99%	4.31%	22.93%	38.04%
September	1.00%	1.23%	2.67%	0.28%	3.79%	18.18%	33.05%
October	1.00%	1.42%	2.34%	0.19%	3.08%	12.30%	29.22%
November	1.00%	1.84%	2.41%	0.23%	2.94%	11.24%	27.52%
December	1.00%	1.64%	3.30%	0.50%	4.17%	9.78%	29.17%
End of Year position		**1.64%**	**3.30%**	**0.50%**	**4.17%**	**9.78%**	**29.17%**

Clinical Standards for Seven Day Hospital Services
Clinical Effectiveness

Clinical Standards for Seven Day Hospital Services
Clinical Effectiveness

The 7-day services (7DS) programme is designed to ensure that patients admitted as an emergency receive prompt, high quality, consistent care, whatever day they enter hospital.
Of the ten clinical standards, four are deemed of priority:

- Standard 2 - time to first consultant review (no longer than 14 hours)
- Standard 5 - access to diagnostic tests (within 24 hours, 12 hours or 1 hour depending on need)
- Standard 6 - access to consultant-directed interventions
- Standard 8 - ongoing review by a consultant (twice daily or daily depending on need)

How did we measure and monitor our performance?

There is a national requirement that all Trusts meet the four priority standards for 7DS by March 2020.

⇒ **Standard 2** time to first consultant review

⇒ Compliance to this standard had shown an overall trend of improvement over the last three years, however ESNEFT was unable to carry out the biannual audit of seven day services in the year 2020/21 in response to the Covid-19 pandemic. The key requirements identified by specialities to achieve compliance to this standard are: Daily consultant led post take ward rounds to see all new patients on every morning 7 days of the week. Ensuring that there is a scheduled evening consultant ward round within 14 hours of the next morning round, the further development of flexible working job plans to increase predictable on call duties, giving consultants a tool to track patients to avoid breaching the standard and consideration of new roles to make consultant time matter and deliver clinical value. In response to the pandemic, increased numbers of consultant reviews took place across ESNEFT in order to meet the increasing demands to the service and to ensure the safety of our patients. Audits are planned to resume in Quarter 3.

⇒ **Standard 5** access to diagnostic tests

⇒ The Trust stood down a number of services at various points in response to the Covid-19 pandemic according to national guidance. Business planning by the Divisions has taken into account the challenges to access to diagnostic services in response to the current challenges, increasing activity wherever possible. Clinical prioritisation takes place to ensure those persons requiring a diagnostic test are offered one within standards set nationally.

⇒ **Standard 6** consultant-directed interventions

⇒ The Trust was unable to audit Standard 6 during 2020/21 to determine if all 9 standards were met. Audits will take place in the coming year to determine any gaps, taking into account the requirements to flex all services in response to the pandemic.

⇒ **Standard 8** ongoing review by a consultant

- ESNEFT was unable to audit this data during 2020/21.
- There has been an increased consultant presence across the Trust during 2020/21 in response to the pandemic to ensure the safety of patients and the clinical requirements of those patients presenting with Covid-19 and the Trust will review the activity which took place in response, ensuring good practice is carried forward.
  The pandemic showed opportunities to improve both weekday and weekend performance and all divisions are working to carry forward practice wherever possible. The Trust continues to work to embed daily consultant led MDT board rounds on very ward every day.

Patient Experience
End of life care

There is only one chance to get end of life care right. In the final stages of illness, care priorities shift with the focus often changing to palliative care for the relief of pain, symptoms, and emotional distress. Compassionate high-quality care enables us to make a loved one's final weeks or days as comfortable as possible.

A national framework for action (Ambitions for End of Life Care 2015 - 2020) identifies key ambitions to optimise end of life care that include:

- Each person is seen as an individual
- Each person gets fair access to care.
- Maximizing comfort and wellbeing
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help

During the past year, COVID-19 has brought many challenges to providing high quality end of life care. Both palliative care teams have increased support to the wards and dying patients. Watchpoint last days of life launched at Ipswich in September 2020 and this assisted in the ward identification of dying patients there. Watchpoint last days of life has been at Colchester site for 4 years but again usage was considerably higher during the peak COVID-19 months which enabled the palliative care teams to support more patients. Some further COVID-19 focused priorities were:

- End of life guidance disseminated across all wards to ensure appropriate symptom control, communication and care after death
- Rapid review of key end of life learning during the COVID-19 period
- Rapid set up and delivery during the COVID-19 peaks of enhanced systems for quality communication between patients and relatives (Ipad provision and Letters for loved ones)
- Enhanced Specialist palliative care support to patients, relatives and staff at weekends during the Covid-19 peaks

What was our target?

- To deliver high quality, compassionate and dignified end of life care for all patients
- Patients to receive the right care in the right place
- To increase the number of patients dying in the place of their choice.

What did we do to improve our performance?

- Completed a refresh of the Trust End of Life Strategy and planned regular review via Trust end of life board
- By using the Accountability Framework (AF) to monitor the use of the Individual Care Plan for the Last Days of Life (ICP LDL), end of life complaints and the time taken to discharge rapidly deteriorating patients at each site
- Commenced 7-day Specialist Palliative Care at Ipswich to compliment the 7-day service at Colchester
- Butterfly Volunteer Coordinators recruited and a 2.5-day service available on each site (currently paused due to COVID-19 restrictions). These volunteers help ensure patients will not die alone even if there are no relatives or they can't be with them at this time.

How did we measure and monitor our performance?

- Ipswich and Colchester sites participated in the National end of life audit

Patient Experience
End of Life care

- Survey of bereaved relatives across the ICS to highlight areas for specific improvement
- The AF for all wards at ESNEFT recording use of ICPLDL and end of life complaints.
- Ward based review of the ICP LDL to improve quality of completion
- Monitored time taken to discharge of rapidly deteriorating patients.

Did we achieve our intended target?

- ESNEFT strategy completed and shared
- Complaints monitored with fewer recorded than the previous year
- Discharge monitored and review of data
- Butterfly volunteer coordinator and volunteers commenced with the service up and running for 2.5 days on both sites but then stopped due to COVID-19
- Time Garden used when possible due to COVID-19 restrictions and rapid deterioration of patients on wards
- Both palliative care teams providing a 7-day service

How and where was progress reported?

- ESNEFT EOL board monthly meetings
- Patient Experience Group
- Quality and Patient Safety
- Quality Oversight Group.

Our key achievements

✓ Decrease in the number of complaints relating to end-of-life care across the Trust

Patient experience

Improving the patient and carer experience

Chaplaincy

Themes from Chaplaincy Patient Encounters 2020-21

Chaplains focus on offering person-centred care to patients through active listening and being a non-judgemental, accepting presence on wards, in departments and throughout the ESNEFT hospitals, with regular visits to Aldeburgh, Bluebird Lodge, Felixstowe, Clacton and Harwich.

Some of the themes emerging in conversation with patients have been -

Chatting about ordinary, everyday things

Distraction and boredom therapy; orientating patients to time and place; recognising humanity and conferring value; keeping patients connected to the outside world; person centred care; delight in the natural world; spiritual aspects of everyday life

Relationships

Concerns for relatives; concerns for pets; relationship difficulties, family estrangements and the longing for reconciliation; the isolating nature of COVID-19; comfort from talking about family

Life review and reminiscence

Nostalgic conversations that bring comfort and calm in present difficulty; reconciling past and present; integration v despair; forgiveness and absolution; hope, meaning and purpose; recognising humanity and conferring value

Practical needs, concerns and complaints

Immediate practical needs; identifying concerns and gaps in care that can be flagged up with ward staff; signposting and explaining the processes for escalating concerns or getting advice and resolution e.g. Ward Sister, Matron, PALS, Complaints etc.

Practical needs, concerns and complaints

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Facing death

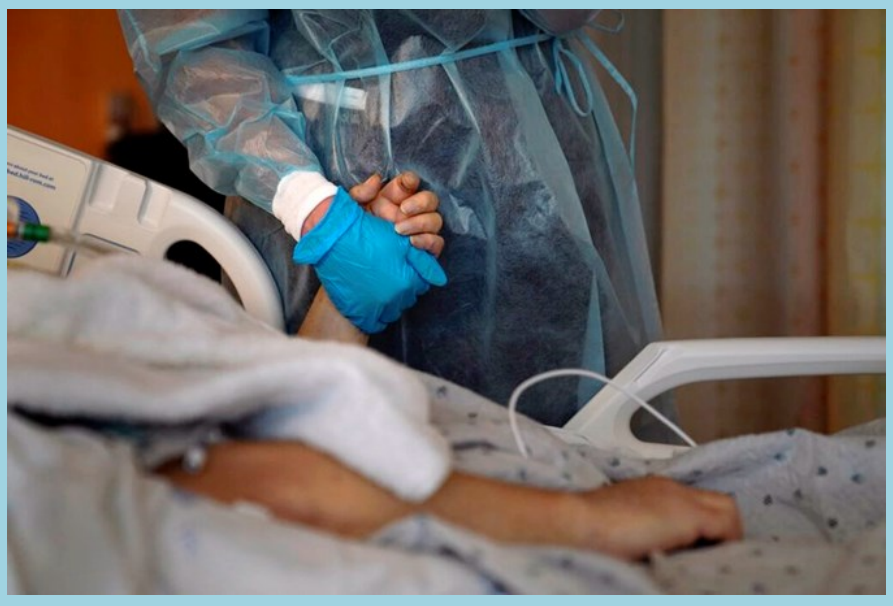
Exploring fears; putting affairs in order; funeral planning; letting go and saying goodbye; bucket lists; realistic hope; concerns for loved ones

Bereavement, Loss and Change

Body dysmorphia of all kinds; death of a loved one; loss of autonomy and increasing dependence; adjusting to life changes e.g. downsizing, no longer being able to drive; facing their new reality; dealing with grief; not being able to attend a loved one's funeral

Faith and Belief

Requests for rites and rituals; exploring challenged or shattered world views; exploring the nature of suffering and the nature of God; finding comfort in faith; hope, meaning and purpose; connecting and reconnecting to faith and belief communities



Patient experience

Improving the patient and carer experience

Chaplaincy

Psychological needs and coping mechanisms

Exploring low mood, suicidal thoughts, despair and signposting to appropriate support; past and present coping mechanisms; exploring new coping mechanisms; hope, meaning and purpose

In addition to patient care chaplains support relatives, carers, visitors, volunteers and staff, which in turn contributes to improved patient experience.

Summary Statistics

Patient and Carer/Family Encounters:

- **4659 patients visited**
- 1780 hours of support
- **1502 carers/family members supported**
- 185 hours support

Funerals

83 baby funerals – religious and non-religious

(Many of these follow on from religious and non-religious baby naming and blessing ceremonies conducted by the chaplains)

24 communal cremations

2 Trust related adult funerals

Emergency Marriages

During COVID-19 restrictions when the registrars were not always able to come into the hospital chaplaincy has facilitated -

4 emergency marriages and 3 wedding blessings for patients at end of life.

Plaudits and thanks

illustrating the range of work chaplains do

“I had email this afternoon from someone saying that a person known to us both has died in Ipswich hospital on Monday having been admitted overnight. No family and no-one could visit. The Chaplains `turned up trumps’: praying with them and being with them when they died. Much appreciated by their friends.”

from a hospice chaplain April 2020

“I recently had a long stay at Ipswich hospital. I would like to pass on my thanks and praises to the chaplain who sat and spoke to me two or three times and also listened to my experiences I was going through and gave me reassurance going forward. Within five minutes of speaking with the chaplain, I was totally at ease, I’m not one for opening up to anybody, I was not in a good place at the time as I’d been severely ill, but he showed me that talking really helped and got him me through It all. Please pass on my thanks and best wishes.”

from a patient August 2020

“I am writing to say a heartfelt thank you for the time you spent talking to mu mother at the end of her life in Ipswich Hospital. You talked to her about art and literature, her two favourite subjects. You have immense kindness and care within you. Your actions gave me great comfort. Knowing that another person wanted to talk with her at that time.

The work you do is so appreciated and so needed, you give me hope and reassure that there are better times to come”

from a relative December 2020

“I expect you already know that my Dad, died last week. I wanted to send you a quick note to say how grateful I am that you and the chaplaincy service were there for him during his hospital stay, especially once we weren’t able to visit him. It is such a comfort now to know that someone was able to sit with him and talk with him face-to-face. One of the nurses told me of an occasion relatively recently when Dad was distressed and wanting to talk, and a chaplain came and prayed with him, and he went straight to sleep. I am so thankful for that, and that his faith sustained him

Patient experience

Improving the patient and carer experience

Chaplaincy

Mr and Mrs Hargreaves following their wedding in the hospital

right to the end. You do an amazing thing."

relative January 2021

"I expect you already know that my Dad, died last week. I wanted to send you a quick note to say how grateful I am that you and the chaplaincy service were there for him during his hospital stay, especially once we weren't able to visit him. It is such a comfort now to know that someone was able to sit with him and talk with him face-to-face. One of the nurses told me of an occasion relatively recently when Dad was distressed and wanting to talk, and a chaplain came and prayed with him, and he went straight to sleep. I am so thankful for that, and that his faith sustained him right to the end. You do an amazing thing."

relative January 2021

"On behalf of Maggie and myself I would like to give you our deepest thanks for our wedding. Despite the present environment you gave us a moving, and (particularly in my case) emotional service. It is a day we will never forget. You certainly went the extra mile to achieved the outcome we both so wished for. Maggie has slept most of the day, I think she has found a certain amount of inner peace, and the will to continue the fight. As I said after the ceremony, we would like to make a donation to the chaplaincy if that is possible, if so could you please let me know how we can do this. We can never thank you enough for all the hard work you both did to achieve this. Time is critical for Maggie. To use her own words

"I feel as if I am sitting on a time bomb".

January 2021

Patient experience
Caring for people with dementia

Caring for people with Dementia

Dementia is a term used for a number of biopsychosocial diseases including Alzheimer's disease, vascular dementia, Lewy Body dementia, fronto-temporal dementia, and many more. Sadly, it is a progressive disease that gradually reduces the person's ability to function in multiple different ways leading to increased dependence on others to provide care and support.

There is currently no cure for dementia and 60,000 people a year die with no other attributable cause. Over 40,000 people under 65 years of age are living with young onset dementia. In 2018, there were approximately 50m people globally living with dementia, and that figure is projected to rise by over 200% by 2050. In the UK, someone is diagnosed with dementia every 3 seconds with projected figure of 2m people living with dementia by 2050, and 225,000 people will develop dementia this year. The cost to the country is estimated to be £26bn. Of the 60% of people with dementia admitted to hospital from their own homes, only 36% returned there with the others discharged into residential care, and approximately 25% hospital beds are occupied by a person with dementia. Patients over 65 years of age with dementia may be in hospital for up to twice as long as a person without dementia.

Being in Hospital with Dementia

Being in hospital can be a challenging experience for people with dementia, and as the disease progresses it can become increasingly difficult for them to make sense of their environment and what is happening to them, particularly if they also have delirium.

It may result in increased anxiety, increased confusion, distress, withdrawal, deconditioning, depression and changes to behaviours, and they can struggle with the busy, unfamiliar environment and people. This can also cause worry and distress to their families and carers. COVID-19 has compounded this as normal visiting has been restricted or suspended, and support in the community from organisations, families, friends and neighbours has not been available in the same way often resulting in isolation, loneliness and carer stress. Many elderly people don't have access to online resources, but ESNEFT has worked hard to keep people in touch via mobile phones and tablets, and many families have found the regular updates from staff helpful. As soon as was safe, visiting appointments opened up enabling that vital contact and, where needed, Ward Sisters were able to allow carers onto the ward to give support with patient care (e.g. to assist the person with mealtimes). Although this was further restricted due to the second wave, restricted visiting has now opened up again.

Admiral Nurses

The Admiral Nurses have continued to support patients, families and staff through the last months despite the challenges we have faced, and we have liaised with hospital teams and external providers to access support for people when they return home as appropriate. Involvement can range from being a listening ear to complex discharge planning with the Multi-Disciplinary Team and has a biopsychosocial, holistic and relationship-based approach to assist teams to achieve the best outcomes for the person and their family. Dementia UK support the Admiral Nurses through offering training, clinical supervision, practice action learning groups and professional development, and through the provision of printed resources and fact sheets for patients and families. The Dementia Liaison Administrator supports the delivery of national reporting requirements for dementia assessment and referral and, amongst many other things, undertakes a monthly qualitative report of patient and carer experiences at Ipswich Hospital, something we are hoping to extend to the Colchester Site in the coming months.

The Admiral Nurses are working on Quality Improvement projects of their own whilst being involved in 2 projects headed up by other teams. One of the projects is to make improvements to the Constable Suite Garden including the installation of 2 beautiful outdoor instruments to give sensory stimulation and activity, sunshades, new garden furniture, raised planting boxes, a tool storage facility and general tidying up. These improvements will increase the range of activities facilitated by the ward Activity Support Coordinator and provide a much improved outdoor space for family and carers to sit with patients. Funds for this have come from a generous donation from the Roundtable and work is due to start early in April so that the garden will be ready for the summer.

Education

The routine dementia education that has been delivered over recent years has been suspended, but the Admiral Nurses have responded to requests for other training as appropriate and have also written education packs for teams as requested. They are currently reviewing existing online education with a view to adding some modules to the Trust Prospectus until classroom based training can resume.

The impact of the COVID-19 pandemic

The impact of COVID-19 has been enormous for people and families living with dementia and cannot be underestimated, but we look forward to the time when the various facilities and support services available onsite for a person with dementia and their carers can be fully opened up again to provide the face-to-face support that was so appreciated prior to the pandemic.

Patient experience
Improving the patient and carer experience

Background

People who use our services are central to everything we do and every member of staff is responsible for ensuring each patient has a fulfilling; positive and inclusive experience.

We strive to provide the best possible care and outcomes for the people we work with and believe that involving people, who use our services in co-design and co- production is simply the right thing to do.

Patient experience & involvement (PEI) means including patients, carers and their families in making decisions about their care. This leads to better health outcomes and an overall improvement in patient experience. There are many different ways to achieve this but it is important we are able to evidence this work and evolve it from a tick-box exercise into a culture of listening to what our patients tell us and act on this to improve our services.

Our patient experience priorities last year covered a number of different areas. The COVID-19 outbreak posed some challenges to delivering some of the patient and carer experience priorities, however this also created many opportunities to be innovative in how we listen and involve patients/ service users. Some of the innovations are detailed in this report. They were primarily influenced by feedback received from patients and also an ambition to offer the opportunity for more people using our services to provide feedback. The following paragraphs describe the progress we have made in the areas we focused on.

Further grow relationships with external organisations, and provide improved opportunities for the public to offer feedback.

This year, the Trust Patient Experience team has made useful new contacts with a range of organisations including;

- The Bangladeshi Women Community Group Suffolk and North Essex
- The Roma Community
- Ipswich and Suffolk Council for Racial Equality
- Suffolk User Forum
- NHS Citizen
- Action for family Carers

We continue to explore various ways to work with local communities and organisations to facilitate improved methods for provision of feedback.

Increasing the number of volunteers available to support the Trust to gather feedback from patients and carers

Alongside the Patient Experience Team the Trust has a number of volunteers who support the patient experience agenda within the Trust. Many of the volunteers recruited provide support for a short period of time, and therefore recruitment continues. In addition to this the Patient Experience Team has established a relationship with a number of organisations NHS England and Improvement (NHSEI), Community Action Suffolk, and Healthwatch Essex, Healthwatch Suffolk, Suffolk County Council, Essex County Council which enables their staff to volunteer and support the Trust with a range of patient experience initiatives.

Deliver a project, focussed on improving patient reporting of nursing and to test interventions which may be useful in influencing this.

Recent results from the National In-Patient Survey identified that improvements were required in regards to patients and their families interactions with nursing staff, noise at night, discharge, danger signs to look out for. Improvement around these identified themes has commenced. These include communication with nursing staff and observed behaviours, collaborating with Hospital Radio team to offer patient information regarding listening to music to improve wellbeing and reduce the impact of noise during their stay and a survey to better understand the impact and source of noise using the patient portal as a platform for engagement has been carried out. The patient experience team is exploring setting up a patient discharge information steering group to address the concerns raised as a result of inadequate information on discharge.

In order to improve patient experience, information relating to patient and carer feedback was shared regularly with nursing teams. As part of the initiative ward teams were encouraged to identify actions needed to improve patient experience in their clinical areas and learn from patients positive experiences aligning their improvement to the ‘BIG 5’; Ward

Patient experience
Improving the patient and carer experience

Culture, Environment, Person Centred Care, Communication, Training and Education.

Our Aims for 2021/22

Key priorities for 2021/22 are:

- To improve the experience of patients who require support with communication needs, in line with the expectations of the Accessible Information Standard
- To continue work to embed Listening Events and evidence the impact they have on improving patient experience
- To improve the experience of people who contact PALS, by ensuring they receive a response within 24 hours of raising a concern.

Patient and Public Involvement in Specialty Services

Oncology

The Breast Care department has been working with patients and carers to better understand experience of the environment and improvements needed, involving them with getting feedback on the design of the new Breast Care Centre at Ipswich Hospital. This has resulted in;

- The team working with patients to co-design the new Breast Care Centre
- Improved selection of music for patients undergoing treatment
- Waiting rooms to be decorated with artwork from around the region.
- Improvement on the design and the layout of the space

Critical Care

In order to support families whose love ones were in critical care during the pandemic, the critical care team introduced a communication process through establishing a family liaison service to provide additional communication with families. Feedback from families have highlighted a positive impact the provision of this service had on provide reassurance and reducing anxiety at a very difficult time.

Trust-wide initiatives to improve the experience of patients in 2020/21

Cardiac patients in the Ipswich and Colchester areas will now be able to have a specialist diagnostic test closer to home following the launch of a new cardiac MRI service at ESNEFT.

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Listening Events

The Patient Experience team supported four Listening Events within the Trust engaging staff, patients and carers during 2020/21 with the aim of gaining a better understanding of both patient and visitor experience of care in our hospitals.

Key Achievements in 2020/21

At the end of 2020/21, the patient experience team worked in collaboration with the Trusts patient and carer ambassadors, partners within the Integrated Care System; Local Council, Voluntary Organisations, Healthwatch Suffolk and Health Essex to facilitate two listening events, aimed at informing the work programmed established as a result of feedback from the 2019 Adult inpatient Survey. From the events, the patient experience team reached out to 146 staff and 48 key partners including patient and carers. The Trust gained over 89 pieces of feedback which provided invaluable information with regards to improvements needed to facilitate better patient experience across the organisation

Interpreting Services

We aim to ensure that patients receive the most appropriate access to interpreting services, at the right time and in the right place. The Trust provides spoken interpreting, translation and sign language services (face to face, video, and by telephone).

To improve patients accessibility to information the Trust website hosts access to 'Browsealoud'. This service provides translation and visual aids to support patients in accessing and understanding information.

Key Achievements in 2020/21

This year, the interpretation and translation policy was implemented across the organisation. This system

Husband and wife Bob and Joan Fisher were admitted to hospital within three days of each other. They had barely spent a day apart in their 67-year marriage and found the separation a heartache. But our ward teams came up with a plan to reunite the sweethearts – daily visits from 92-year-old Bob to 88-year- old Joan.

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provides instant access for telephone appointment, via direct engagements with the provider as teams are able to facilitate the provision of the service effectively and timely. The patient experience team supports teams across the organisation to facilitate translation, face to face and video interpreting service where required. Over 500 interpreting assignments were delivered in 2020/21 and patient and carer feedback have been positive.

In October 2020, following feedback from patients about their experience of the interpreting services in relation to limited communication as a result of COVID-19 pandemic, it was noted that whereby a face to face interpreting service could not be facilitated, the video and telephone interpreting system was a welcome addition to better support patients with cochlear impairments.

Aims for 2021/22

In 2020/21 we will focus on improving access to interpreters, using technology to improve experiences, staff training and providing better information on how to raise a concern. This report provides an overview on the feedback received from patients and carers and the work to improve people's experiences, as well as their involvement in service developments. The collection and use of patient, carer and family feedback continues to be a priority within the organisation.

Positive Engagement with Staff, Patient and Carers

To enable the right improvements to our organisation and services, the Trust actively seeks the views of people who use them. We have continued to engage with patients and the public in variety of ways, to help the Trust make improvements.

The Patient Experience Network

The Trust Patient Experience Network has been in existence since August 2020. Its aim is to strengthen the voice of patient's, carers, staff and system partners across the organisation ensuring that their voice is included through the organisation's decision making processes. Membership within the network continues to grow.

Carers

The Trust has established a caring for carers steering group to support the delivery of the carers agenda at the Trust where carers are seen as partners to ensure a holistic approach in the areas of identification, acknowledgement and support ensuring positives experiences of care for patients and carers.

Mental Health

The patient experience team has engaged with Suffolk User forum to bring the wider patient and carer voice from mental health lived experiences through feedback, patient and carer stories. This will support all mental health service improvement and initiatives across the organisation.

Mock Virtual Clinics

Members of the patient experience network worked with the clinical teams across the Trust to facilitate mock attend anywhere virtual clinics. Feedback highlighted the need for a more simplistic but informative check list, sent out with appointment links including a less complicated trouble shooting guide to understand the process of virtual clinics. Feedback highlighted that attend anywhere letters needed to be clearer and have the right information to enable patients get to the right clinic.

Communicating Optimal Caring in Virtual Consultations

The patient experience team produced a communication guide for optimal caring in virtual consultation; highlighting the need to embraces new technologies as the way patient interact with the health system is shifting toward much greater use of technology. The guide supports teams to achieve a person-centred patient experience and positive outcomes, by providing tools needed to build skill sets that ensure the preservation of relationship-centred caring in virtual interactions/consultations. This guide provided a structure that embeds research-based communication skills throughout common virtual interactions and conversations.

Comfort Pebbles

The patient experience team facilitated the delivery of hand decorated pebbles to patients and staff with support from local volunteers. These contained scribing coordinated messages received by loved ones on the pebbles and hand delivered them to both staff and patients. This was well received and feedback has been positive.

The Ipswich Hospital User Groups Family & Friends Network

Patient experience
Improving the patient and carer experience

A support network was created by the Ipswich Hospital User Group to enable patient experience volunteers at ESNEFT keep in touch over the pandemic. The network hosted 4 virtual meetings, actively been promoting the ESNEFT Staff Wellbeing Fund and they worked in collaboration with Healthwatch, creating a video around co-production foe better patient and carer engagement

Youth Volunteering

A Youth Forum has been set up within the Trust to bring together the voice of patients (age group 13-19); providing feedback on their experiences of youth services and to support transition teams in delivering services that need the needs of young people with in the community. This group also forms part of the Trusts reading panel, providing feedback on patient information and giving valuable insight from the youth's perspective.

At Your Bedside

Suffolk family Carers and Carers First, collaborated with East Suffolk & North Essex NHS Foundation Trust to roll out the 'At My Bedside' scheme which is aimed supporting patients and their friends and family to remain 'connected' during their hospital stay.

Hospital Radio

The patient experience team in collaboration with hospital radio Ipswich and Colchester, has created a Standard Operating Procedures for staff to actively promote the use of hospital radio to request or dedicate songs to patients. By using the hospital bed side entertainment set, family members can call their loved ones at no cost. These also supported patients' wellbeing and open a channel for relatives to communicate with their loved ones over the Covid 19 pandemic.

Hospital Entertainment System

The Patient Experience Team has supported the first stages of scoping the service provision for Hospital Entertainment System at ESNEFT, ascertaining feedback from patients and carers in regards to hospital entertainment. Engaging members of the Patient Experience Network, marginalized groups, voluntary groups and community partners, over 350 pieces of feedback was received. This exercise has been recognised as pivotal in improving peoples' experience of inpatient care at our community hospitals. It is hoped that once lessons learnt have been analysed, the project can be carried out within our acute hospitals

Staff Champions of Patient Experience

We have successful recruited 44 staff champions of patient experience to champion patient experience within their teams and through the organisation. Staff champions actively identify opportunities for innovation across teams to improve the ways in which we empower, collaborate, involve and actively listen to understand, inform and improve our services from the patient and carers' perspective.

End of Life Care

System Partners with the Integrated Care System (ICS) highlighted the difficulties in obtaining End of Life (EOL) feedback. The patient experience team is working with the Trusts EOL team, local Hospice's, CCGs and Healthwatch to understand the benefit of meaningful patient and carer engagement and has thus created an ICS End of Life user group to host a platform where lived experience feedback is captured. Working in collaboration with the Bangladeshi Women's Community Group, the patient experience team has supported teams within the Trust to better understand the barriers faced by patient and carers in regards cultural needs at end of life. This will ensure that a positive experience of end of life care is inclusive in its delivery.

Key Achievements in 2020/21

- We have worked with the Trust volunteering team to continue our recruitment campaign for Patient and Carer Ambassadors so we ensure we can continue championing the voice of our patients and carers.
- We have collaborated with the Trust Communications, Equality and Diversity Teams to ensure that membership with the Patient Experience Network is representative of North Essex and East Suffolk
- We have worked with the Trust Learning and Development Team; implementing a virtual Leadership Passport aimed at providing tools to staff through their leadership journey by creating the option of an interactive patient experience section

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Improving the patient and carer experience

within the passport. Using this platform we have been able to recruit Staff Champions of Patient Experience.

- We have worked with the Training and Education Team to adapt the virtual leadership passport for preceptorship training by adding tasks for staff to obtain a patient story over a 6 month period with support from the patient experience team, colleagues and their tutor. This is aimed to support staff in promoting a person centred care and good communication skills.
- The patient experience team has begun adapting their training tools so as to continue providing training sessions to a range of staff across the Trust, including training around complaints, the use of patient stories and how to involve patient and carers- - such as in recruitment and quality improvement. The team has continued to support monthly sessions on patient and carer experiences and involvement at Trust induction
- The patient experience team has developed a patient stories toolkit to facilitate the collection of patient stories. These stories, volunteered by patients, relatives and staff, are available to clinical teams to support them to better understand how we

Table 10– Friends and Family Test Data April 2019 to March 2020 Suspended during the reporting period due to COVID-19

		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
A&E	Recommender	80.60%	81.80%	85.50%	86.70%	88.00%	83.80%	83.40%	84.00%	84.10%	86.20%	85.50%	89.70%
	Responder	12.40%	12.00%	13.00%	13.50%	12.90%	21.00%	20.40%	20.00%	20.00%	21.10%	21.50%	24.3
Inpatient	Recommender	96.20%	96.00%	96.20%	95.50%	95.60%	96.00%	95.10%	96.10%	95.70%	95.60%	95.40%	95.40%
	Responder	34.70%	36.10%	31.50%	33.70%	38.10%	36.10%	38.30%	38.30%	41.70%	38.40%	37.10%	29.1
Outpatient	Recommender	96.90%	95.90%	96.07%	96.30%	97.32%	97.25%	97.46%	97.17%	97.19%	96.10%	97.60%	98.70%
Birth	Recommender	99.00%	100.00%	97.70%	98.90%	97.80%	97.20%	97.00%	98.20%	97.50%	97.40%	100.00%	100.00%
	Responder	36.70%	33.90%	29.30%	29.30%	31.10%	28.00%	20.60%	30.20%	21.30%	21.90%	18.90%	16.30%
Antenatal	Recommender	95.10%	97.70%	98.30%	100.00%	90.90%	95.00%	96.20%	96.30%	99.00%	96.40%	97.30%	98.70%
Post Ward	Recommender	98.60%	98.80%	98.00%	94.90%	97.10%	94.50%	96.20%	96.90%	98.50%	93.50%	95.10%	97.10%
Post Com	Recommender	97.60%	98.30%	98.00%	100.00%	99.10%	96.40%	98.70%	95.80%	97.90%	99.20%	99.10%	98.80%

Patient experience
Patient and public involvement, community engagement and patient feedback

Table 11— Number of plaudits received by ESNEFT during 2020/21

Month	Quantity received
Apr-20	705
May-20	905
Jun-20	594
Jul-20	2026
Aug-20	1224
Sep-20	2026
Oct-20	1414
Nov-20	1075
Dec-20	954
Jan-21	543
Feb-21	176
Mar-21	738
Apr-21	
Total for 2020/21	**12380**

improve the patient and carer experience. Stories continue to be shared across teams for reflection and learning. The Trust cancer care navigators continue to work in collaboration with the patient experience team by inviting patient and their carers to share their stories for service improvement.

- Members of the Patient Experience Network have supported the Estates Team with providing feedback on the initial stages of the relocation of the day surgery unit; thus ensuring that as an organisation we 'get it right, first time'; creating a channel for capturing peoples experiences from the wider community.

- Letters to Loved Ones: Friends and family members are able to send emails / poems / pictures into a central inbox for loved ones who are in hospital. The patient experience team have been printing these messages and delivering them to relevant wards. This initiative was launched in April 2020 and to date over 1000 emails have been received and letters have been created and delivered from loved ones all over the world including Philippines, Australia and Germany.

- Feedback from family members using the scheme includes; "Thank you so much for all your help and flexibility. It really means a lot." "Thank you for delivering my emails to my dad, it has been amazing to contact him in this way".

Aims for 2021/22

To recruit new members to the Patient Experience Network to ensure the membership of the Network is representative of East Suffolk and North Essex community.

To continue to strengthen links with clinical services and programmes of work related to improving peoples experiences of care at the Trust.

Healthwatch

Patient experience
Patient and public involvement, community engagement and patient feedback

The Trust works closely with Healthwatch Essex and Healthwatch Suffolk and is represented on meetings that they hold aimed at improving the patient and carer experience. These include Black and Minority Ethnic and Diversity Group.

Throughout the year, the Trust receives reports from Healthwatch Essex and Healthwatch Suffolk, which provides feedback on a variety of Trust services, based on the experiences of the people in East Suffolk and North Essex. Projects include inclusion and diversity listening events, Covid-19 vaccination, digital inclusion, co-production training, seeing patients as partners.

Deliver a project, focussed on improving patient reporting of nursing and to test interventions which may be useful in influencing this.

Recent results from the National In -Patient Survey identified that improvements were required in regards to patients and their families interactions with nursing staff. This included communication with nursing staff and observed behaviours.

In order to improve patient experience on communication with nursing teams, patient feedback relating to communication based complaints is shared regularly with nursing teams through the Patient Experience Group. As part of the initiative ward teams are encouraged to identify actions needed to improve patient experience in their clinical areas and learn from patients positive experiences.

Aims for 2021/22

Our key priorities for 2021/22 are:

- To improve the experience of patients who require support with communication needs, in line with the expectations of the Accessible Information Standard
- To continue work to embed Listening Weeks and evidence the impact they have on improving patient experience

National Survey

Inpatient Survey – Published 2nd July, 2020. This survey looked at the experiences of 76,915 people who were discharged from an NHS acute hospital in July 2019. Responses were received from 565 patients at East Suffolk and North Essex NHS Foundation Trust. The results were in line with our peer Trusts for all 12 sections. The Trust scored lower than our peer group in one question regarding knowing which nurse is in charge.

Maternity Survey – The result of the 2019 Maternity Survey were published in January 2020.

- Our Maternity service scored higher than other Trust in 2 questions
- We did not score worse than other Trust for any questions
- We scored about the same as other Trust for 17 questions

Urgent Care Survey – In October 2019 we received the result of the 2019 Urgent Care Survey. Our results is in line with our peer Trusts for all 46 questions. We improved significantly on 3 questions relating to help from staff, clear expectation about medication purpose and information about resuming usual activities when compared to the previous year's survey.

Children and Young People's Survey - In November 2019, we received the results of the 2018 Children and young people's Survey. Our results demonstrated that we scored more positively than other Trust on 4 questions. These related to getting support when worried, being able to ask questions, planning care and information about next steps. When compared to other Trusts, we performed comparably for all other questions.

Aims for 2021/22

We will continue to use the national patient survey results to drive forward improvement and to monitor that activity through the Trusts Patient Experience Group and Patient Experience Network.

Patient experience

Helping older patients regain their independence

A pilot project that's seen carers work alongside clinical teams on two wards at Colchester Hospital to help patients to regain their independence has been hailed a success after receiving fantastic feedback from those taking part.

The reablement initiative has seen four staff from Essex Cares Ltd work with the ESNEFT team on D'Arcy and Tiptree wards - part of the older people's service at Colchester Hospital.

They offer support to help patients regain their independence so that they are able to return home more quickly and with a less extensive package of care in place. This includes support to get up, out of bed and dressed, as well as tips on small changes which could make it easier for patients to manage themselves, such as wrapping material around cutlery handles to help with grip.

The initiative comes in response to national statistics which show that a 10-day hospital stay can cause 10 years' worth of muscle aging, with older patients spending up to 83% of their time in bed and often a further 12% in a chair.

Patient experience
Learning from complaints

What are complaints?

Complaints and concerns can be written or verbal communications from patients and/or relatives who are unhappy regarding an aspect of their interaction with Colchester Hospital. These are a valuable tool to identify trends which enable us to improve the service where it may be necessary.

ESNEFT is committed to providing a complaints service that is fair, effective and accessible to all. Complaints are a valuable source of feedback about our services. We undertake to be open and honest and where necessary, make changes to improve our service.

Complaints Service:

Complaints are always taken seriously as they highlight the times we let down our patients and their families. Each complaint is treated as an opportunity to learn and improve the service we provide. The Trust listens and responds to all concerns and complaints which are treated confidentially and kept separately from the complainant's medical records. Making a complaint does not harm or prejudice the care provided to the complainant.

How complaints are managed within ESNEFT:

We aim to respond to complaints within 28 working days from receiving the complaint. This year 89% of complaints received were responded to within 28 working days or a revised timeframe agreed with the complainant, against a Trust target of 100%.

Every effort is made to contact each complainant within 24 hours of the complaint being logged by the complaints team. These calls, known as 24 hour courtesy calls, are made by a senior manager and are seen as an opportunity to: Take time to understand the exact nature of the complaint as this will help to ensure a thorough and meaningful response; · Gain insight to understand the key issues that need to be resolved; Help build relationships with the complainant, help them to feel part of the process and demonstrate that we take their concerns seriously; and explain the 28 working day timeframe for our response and establish the method in which the complainant would like to receive our feedback, for example a letter or a face to face meeting. This year 94% of courtesy calls were made within the 24 hour standard.

All complaints are assigned to a complaints coordinator who liaises with the complainant and ensures that the service area/responsible for investigating and responding to the complaint does so within the agreed time limits.

Once a complaint investigation has been completed, it is checked by the complaints coordinator to ensure all questions have been answered before being passed to the Chief Executive, Managing Director or another Executive Director to review and sign the letter of response.

Reopened complaints:

During the year 2020/2021 2.5% of complaints received (995) from April 2020 to March 2021 have been reopened. One of the main reasons for reopening a complaint has been identified as poor or inaccurate investigation. In these cases, complaints are returned to the investigating team for further explanation and clarification. Analysis of reopened complaints is being undertaken to ensure that we fully understand why first responses are not meeting the satisfaction of complainants and to enable the complaints team to offer Division appropriate support.

Complaints to the Parliamentary and Health Service Ombudsman (PHSO) :

A total of 12 ESNEFT complaints were subject to independent review by The Parliamentary and Health Service Ombudsman (PHSO) during 2020/2021, with 8 fully investigated.

Complaints are categorised in three ways, depending on their severity

High level	Multiple issues relating to a longer period of care including an event resulting in serious harm.
Medium level	Several issues relating to a short period of care including, for example, failure to meet care needs, medical errors, incorrect treatment, attitude of staff or communication.
Low level	Simple, non-complex issues including, for example, delayed or cancelled appointments, lack of cleanliness, transport problems.

Patient experience
Learning from complaints

So far, one of these cases has been fully upheld, one has been not upheld and the remaining cases are under on-going investigation.

Learning from complaints:

While information drawn from surveys and other forms of patient feedback is important, every complaint received indicates that for that patient or their family, they did not receive the high quality of care they rightly expect.

Complaints are an important method by which the Trust assesses the quality of service it provides. We take all complaints seriously and have taken action in response to them in various ways to improve the quality of the care we provide, as examples on the next page show.

The Trust is working on further Trust wide improvement in identifying, reporting and sharing lessons learned and actions taken from complaints. Lessons learned from complaints are identified and discussed at our Patient Experience Meetings. A work stream meeting, focusing on actions to be implemented following a complaint, has been underway and monthly dashboard reports have been developed to support the Divisions in monitoring outstanding actions.

Through the Divisional Accountability and Performance framework we expect to see clear evidence of learning from complaints in future.

Patient Advice and Liaison Service (PALS):

The PALS team handles queries and concerns in a practical way, resolving and addressing issues at source to prevent matters escalating. This is seen as a positive step towards taking more responsibility for issues as they arise.

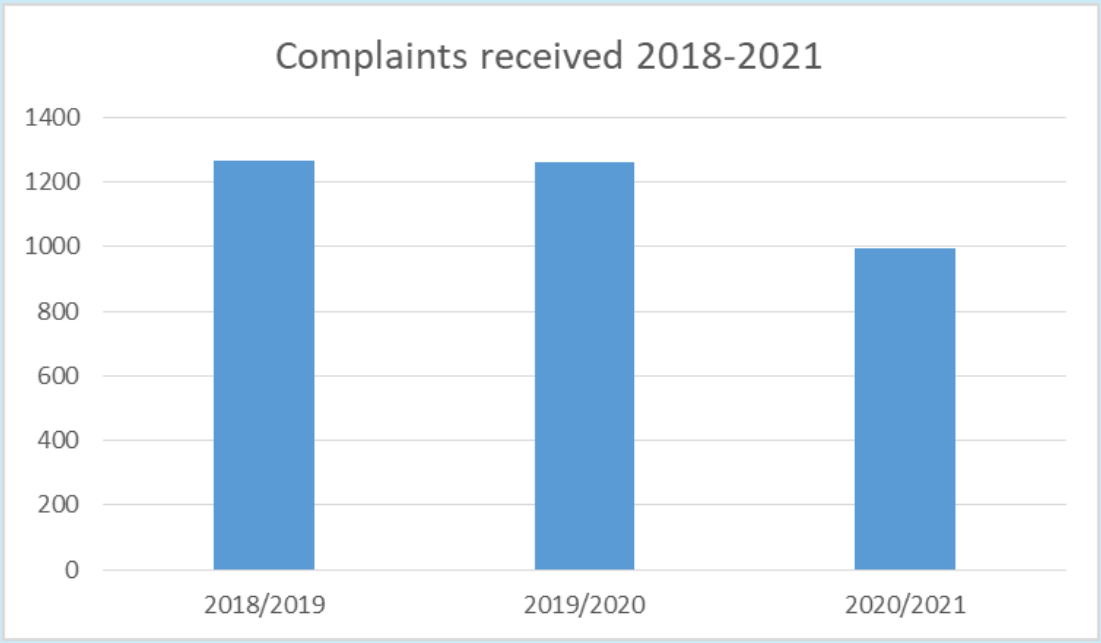
PALS offer patients, carers and visitors: · Advice and signposting– helping to navigate the hospital and its services; · Compliments and comments– PALS can pass on compliments and ideas to improve services; and · PALS can address noncomplex issues informally, often preventing the need to raise a formal complaint.

PALS contacts are graded as either PALS 1 or PALS 2.

PALS 1 are contacts that require straightforward information or signposting, for example, ward visiting times, how a patient can obtain a copy of their medical records, GP services or Ambulance Trust services.

PALS 2 are contacts relating to a matter that needs to be resolved or addressed, for example, ward related issues for inpatients and their families, waiting list enquiries and appointment enquiries

Chart 6– Our performance over the last three years:



Patient experience
Learning from complaints

Chart 7- PALS Queries received for the last 3 years

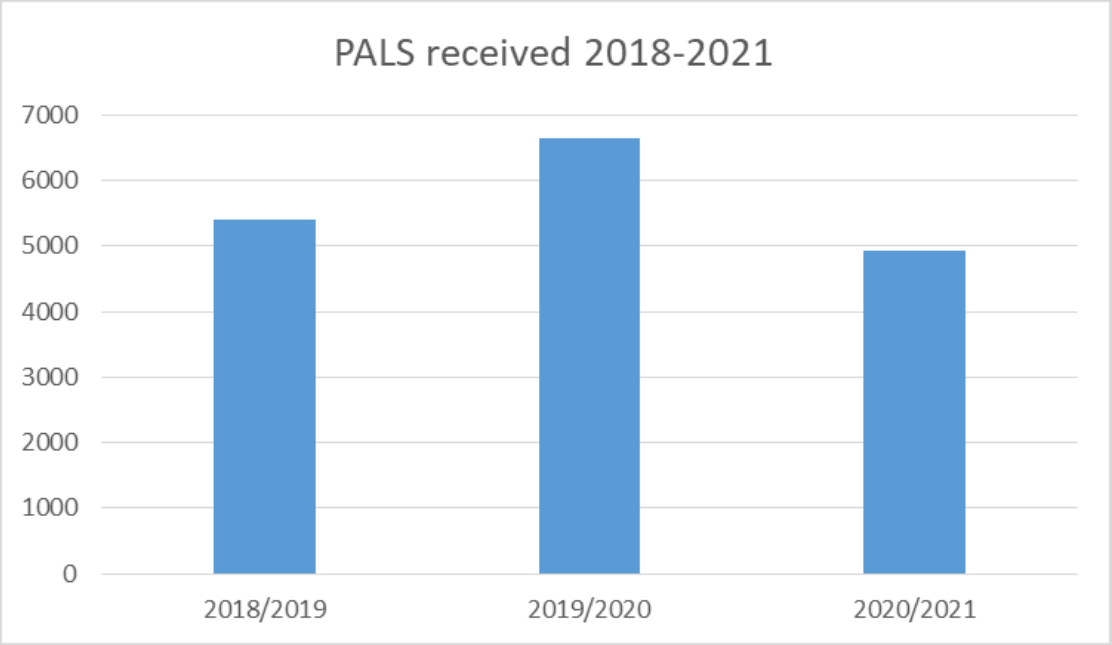


Table 12—East Suffolk and North Essex NHS Foundation Trust Top three subjects of complaints for the last 3 years

Top three subjects of complaint		
2018/19	**2019/20**	**2020/21**
Communication	Access to treatment or drugs	Communication
Access to treatment or drugs	Communication	Access to treatment or drugs
Aspects of Care	Aspects of care	Aspects of Care

Cancer Care Delivery
Referral to Treatment Times (RTT)
And Improving performance

Chart 8—Percentage of patients currently waiting under 18 weeks on incomplete pathway

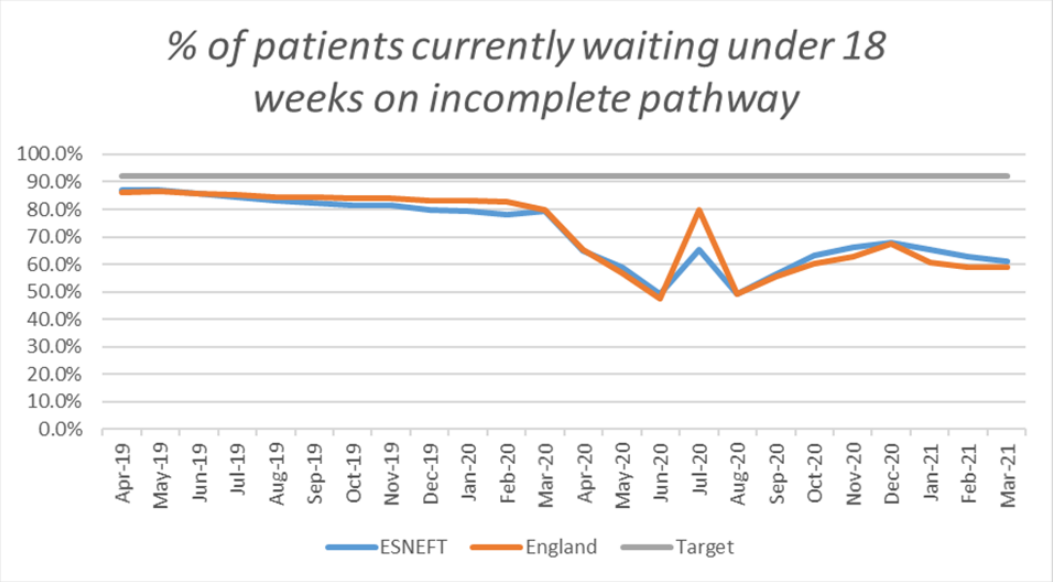


Table 12—Percentage of patients currently waiting under 18 weeks on incomplete pathway

		2018/19		2019/20		2020/21	
% of patients currently waiting under 18 weeks on Incomplete Pathway	Target	ESNEFT Perfor-mance	National Perfor-mance	ESNEFT Perfor-mance	National Perfor-mance	ESNEF Perfor-mance	National Perfor-mance
April	92%	89.2%	87.2%	86.9%	86.1%	65.1%	65.2%
May	92%	90.1%	87.8%	87.1%	86.4%	58.8%	56.9%
June	92%	89.7%	87.5%	85.5%	85.8%	49.0%	47.7%
July	92%	89.7%	87.5%	84.5%	85.3%	65.2%	79.7%
August	92%	89.5%	86.9%	83.4%	84.4%	49.3%	49.3%
September	92%	88.9%	86.3%	82.2%	84.3%	56.4%	55.8%
October	92%	89.0%	86.6%	81.4%	84.2%	63.4%	60.2%
November	92%	89.3%	86.8%	81.4%	83.9%	66.4%	62.6%
December	92%	88.1%	86.2%	79.7%	83.2%	68.0%	67.6%
January	92%	87.4%	86.3%	79.3%	83.0%	65.2%	60.8%
February	92%	87.1%	86.5%	78.2%	82.7%	62.7%	59.0%
March	92%	87.0%	86.3%	79.3%	79.7%	61.1%	58.9%

Cancer Care Delivery
Referral to Treatment Times (RTT)
And Improving performance

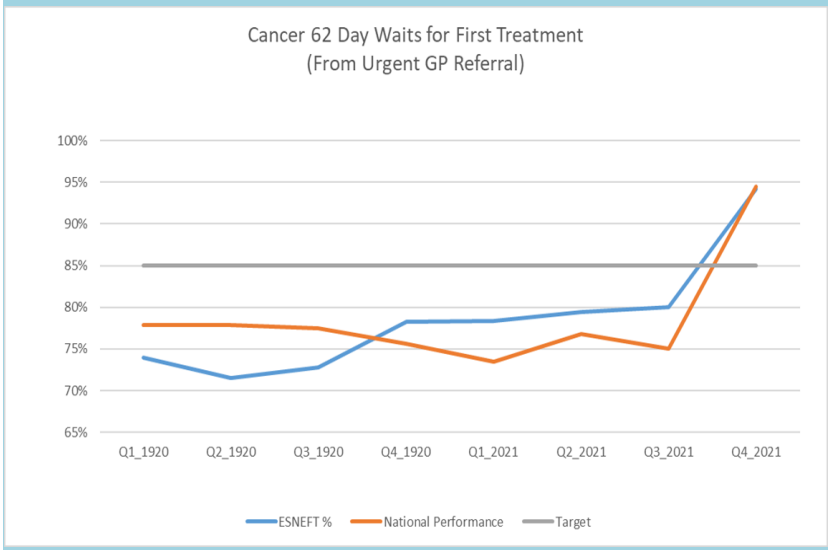
Ensuring that patients referred to our hospitals with a suspected cancer are diagnosed as quickly as possible and receive timely and effective treatment remains a key priority for all staff at Colchester and Ipswich.

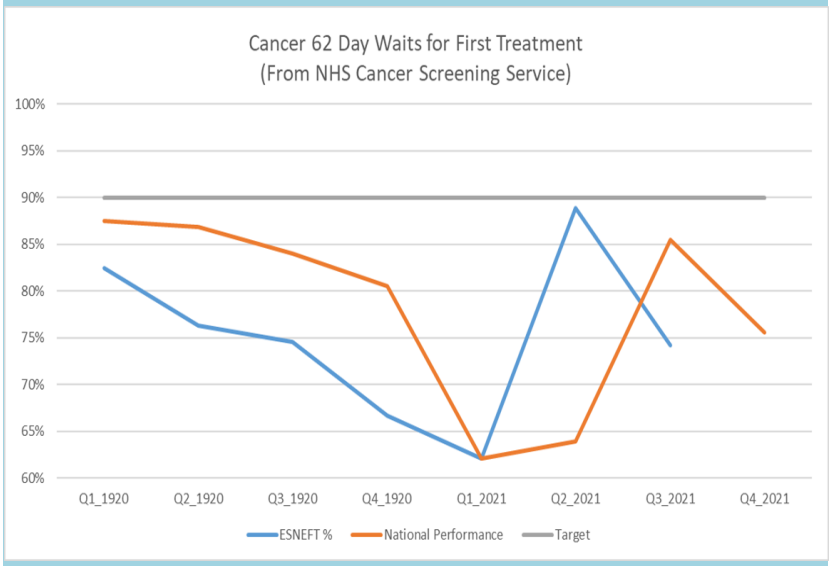
With the Coronavirus Pandemic taking centre stage in terms of NHS resources, patient safety has understandably taken president over performance against the national Cancer Standards. Throughout 20/21 the main focus for NHS England in terms of the provision of cancer services was to ensure that patients were diagnosed and treated as quickly as possible but where the diagnostic or treatment was not available, patients were safety netted to ensure that their condition was monitored.

Patients on a cancer pathway were reviewed in line with newly published changes to national guidance and in line with recommendations by Sir Simon Stevens (phase one) and latterly Dame Cally Palmer. A clinical review process for all diagnosed patients was introduced within 7 days of the first lockdown, which ensured that treatments took place in line with the patient's assessed clinical priority. All services, with the exception of endoscopy continued during the first wave and whilst there were significant delays nationally, ESNEFT recovery was relatively quick. By September 2020 the backlog of patients waiting for endoscopy had been cleared, ahead of many other trusts in the east of England and the provision of hospital services directly relating to the diagnosis and treatments of patients on a cancer pathway, was back to pre-pandemic levels.

On two consecutive months,

Charts 9—Cancer 62 Day Waits





Cancer Care Delivery
Improving performance

October and November 2020, ESNEFT delivered the highest number of primary cancer treatments for patients on a 62 day pathway, that any other trust in the country.

Unfortunately, in December 2020, the effects of the second wave of the pandemic were affecting services across the trusts. The number of Covid-19 positive patients and those requiring intensive support significantly increased to the point that it was becoming increasingly difficult to provide any cancer surgery

By early January, the situation was the same across the region, with every one of our tertiary providers unable to provide treatments. Colchester also struggled with capacity as CCU, main theatres and recovery became designated as Red (Covid-19) areas.

The prioritisation process reinstated with emphasis on theatres. As in the first wave, Oaks private hospital in Colchester were able to support ESNEFT by offering up their theatres for use by the NHS. Nuffield private hospital at Ipswich were also able to support ESNEFT by allowing us to decant the oncology wards from Ipswich hospital to ensure treatments could continue as safely as possible.

ESNEFT were still able to provide almost all diagnostics, although at reduced capacity in some areas and some patient pathways were delayed. Once diagnosed, the treatments options were limited, mainly hormones, chemotherapy and/or radiotherapy. Surgical treatment especially for these patients who were likely to require intensive post-operative support was limited due to the unavailability of HDU/ CCU beds. This was a problem nationally and NHSEI worked quickly with every trust to set up a Mutual Aid system that would endeavour to find an alternative provider for the most unwell patients

Colchester, supported by the Oaks hospital, were able to continue to provide some treatments for both Colchester and Ipswich patients, that would have had to had wait indefinitely if it were not for the clinical and operational teams working flexibly and tirelessly to ensure that patients were still treated as quickly as possible.

Throughout the year, patient safety has been the main concern of the trust rather than performance against national standards. This has been the case for every organisation and is a view supported by NHS national team and the cancer Alliances.

As we emerge from the second wave, recovery of cancer performance will become be prioritised once we have ensured that all of longest waiting patients are treated.

Referrals numbers are for ESNEFT higher than pre-pandemic levels. Work has begun on reviewing pathways and continuing with improvements, many of which were put in place in order to maintain services during the pandemic but have significantly improved some aspects' of patient care

A new recovery trajectory will set out the agreed timeframes for each specialty to deliver against national cancer standards. The operational and clinical teams will continue to work together to ensure that our patients will not be delayed on a cancer pathway

Achieving and sustainably delivering the national standard of 85% remains a priority for the trust, as with many other trusts around the country. To address this the trust continues to support improvements across all aspects of cancer care by ensuring that access to diagnostics and treatment is 'carved out' from routine capacity, ensuring that patient on a cancer pathway

Highlights 2020/21

Key Improvements:

- Virtual MDT meetings using StarLeaf – Allowing clinical teams to 'attend' meetings from anywhere. This was particularly helpful when consultants were shielding or isolating – The meetings could go ahead and remain Quorate
- FIT testing for all patients on a Colorectal pathway – To allow prioritisation of patient with the most urgent need to be seen.
- Patient Cancer helpline for patients worried or concerned about their care and or treatment during the pandemic
- Introduction of Colon Capsule Endoscopy reducing need for more invasive colonoscopy procedure
- Colchester one of first hospitals in UK to provide robotic surgery for colon cancer

Cancer Care Delivery
Improving performance

- Consultant led telephone clinics (including Attend Anywhere) - Telephone clinics allow the patients to discuss their symptoms directly with the consultant, avoiding unnecessary footfall into hospital but allowing the clinical teams to prioritise the patients with the most urgent need.
- New way of 'Tracking PTL's' on Somerset – ESNEFT initiative seen as 'transformational' for cancer services across the UK. Improves accuracy and significantly reduces time MDT Coordinators spend tracking each PTL. ESNEFT to present concept at Somerset National Cancer Registry 'Roadshow' in May 2021
- Launch of new dedicated 'Fast Track Referral' hub (2WW bookings) at Ipswich in Dec 2020 to mirror service at Colchester. Dedicated team working within cancer services, booking appointments for patients referred in on a cancer pathway.

Assurance process – Cancer Delivery

- Cancer PTL management meetings – Weekly Operational meeting with Cancer Performance Leads
- Cancer Site specific operational team meeting (drumbeat) as and when required for specialties that require additional support
- Monthly regional SNEE ICS cancer performance call with NHSI and Cancer Alliance
- Prioritisation of Cancer throughout the Trust – Cancer performance and recovery remains as one of top 3 Trust level priorities.
- 104 day breaches: RCA (Root cause Analysis) completed for every patient and reviewed at the appropriate divisional board. Selection of reports then reviewed further for assurance purposes at a bi-monthly panel led by the trusts Medical Director to review potential clinical harm. Panel report to Trust Board and CCG
- Cancer Board bi-monthly meeting chaired by the Trusts Lead Cancer Clinician, with Lead Cancer Manager and Lead cancer Nurse. Attended by the lead clinician for each tumour site, the Divisional Lead and the Head of Operations and a number of external stakeholders.

Planned Improvements

- Cancer Transformation team to be appointed to support in the delivery of national and local cancer initiatives
- Significant investment in diagnostics including Rapid Access Service project
- Further investment to support the review of additional best practice cancer pathways
- AI technology to support cancer pathway administrative processes – 'bot's to automate the recording of referrals across multiple systems and replace the manual process of sending out MDT outcomes to multiple GP practices
- Additional 'bolt on' packages to improve cancer data capture on Somerset and reduce time taken to track patients.

****The NCEPS was not a requirement for 2019/20 due to the pandemic so there is no report or update.**

Safeguarding

Adult, Domestic Abuse, Children, Dementia and Learning Disability

Duties to safeguard patients are required by professional regulators, service regulators and supported by law. It is imperative that all staff involved with the care and wellbeing of adults and children at risk understand what is meant by abuse and what must happen when abuse is suspected or discovered. Abuse does not just happen outside the organisation, but potentially may occur within it. All ESNEFT staff have a duty of care towards patients. Omissions in care may lead to significant harm (e.g. the development or worsening of pressure ulcers or an increased incidence of falls). The Heads of Safeguarding lead on safeguarding across Ipswich and Colchester acute hospitals, the community of Suffolk and the new Urgent Treatment Centre.

This year ESNEFT has been strengthening the safeguarding governance agenda at both strategic and operational level. Our partnership with other agencies has continued and new members have joined the safeguarding team during the year which has strengthened our ability to safeguard adults at risk, families and young people and children.

Ensuring safeguarding is at the heart of the organisation, within every aspect of patient care, has been a significant priority for ESNEFT and this is why the chosen model for safeguarding is the Whole Family Approach.

Key to the work of the safeguarding families' team is the working in partnership with staff across all directorates as well as multi-agency partners.

The Safeguarding families team is made up of the Head of Safeguarding Children and the Head of Safeguarding adults,3 safeguarding adults leads, 2 Named Nurses for safeguarding children, 2 safeguarding children specialist nurses, 2 safeguarding midwives, a domestic abuse nurse specialist, 2 learning disability nurses, 2 Admiral nurses, supported by the wider team specialist child death nurse, dementia and delirium support practitioner, dementia coordinator and the administration team.

In working together co-delivering training the team are support staff to take the whole family approach and not be limited in their thinking to just the speciality they work in.

Reporting:

Quarterly reports and updates are provided at the Safeguarding adults/ children's Operational Groups and Safeguarding Committee, the operational groups are chaired by the Heads of Safeguarding and has multi-disciplinary representation. The group members work together to address any safeguarding concerns, agree work plans and to lead the strategic direction of safeguarding providing quarterly reports to the Safeguarding Committee chaired by the Director of Nursing as Executive Lead and exception reports to the Quality and Patient Safety Committee, the membership is formed of senior internal and external safeguarding partners working together and holding each other to account for delivering a safeguarding service that meets national and local requirement for the people we serve.

Training:

- There has been a significant increase in safeguarding training compliance across all levels, the team is focusing on delivering the L3 training as set out in the Adult & Children Intercollegiate Roles & Competencies for health care staff, Training in County line and Gang Culture, Domestic abuse, Modern day Slavery and Making safeguarding personal is delivered at L3.

- Trajectories for each quarter are set to achieve the targets agreed in the 2018/19 contract standards. The PREVENT (counter terrorism) target is set by the Home Office at 85% of all staff to be compliant (the Trust has successfully met this throughout the year).

- Key priorities will include continued provision of training to enable staff to remain compliant with training, to work with staff to ensure compliance with MCA and the proposed Liberty Protection Safeguarding (LSP), which are currently due to implemented 1st October 2020.

The Chief Nurse is a member of the Safeguarding Boards and this role is fundamental in sustaining strategic partnership working. The Head of Safeguarding Adults and the Head of Safeguarding Children are members of the NHS England Midlands and East (EAST) Safeguarding Adults, Children & Young Peoples Forum. These forums enable the sharing of best practice regionally and provide an opportunity to shape the safeguarding service and the development of the NHS.

Safeguarding

Adult, Domestic Abuse, Children, Dementia and Learning Disability

Youth worker Rachel Fletcher, pictured, who is based at Colchester Hospital, has sent the seeds to young people from across north Essex and east Suffolk during lockdown, while also keeping in touch remotely and sharing strategies to help those who were struggling to manage.

Rachel, who took up her post last year, said: "Gardening is known to improve mental health, so I decided to get in touch with local garden centres to see if there was anything they could do to help our young people during lockdown.

In addition, Rachel also runs a Youth Forum, which meets in the Children's Outpatient's Department at Colchester every eight weeks and provides feedback on different areas of the hospital and how they could be improved from a young person's perspective.

Speaking Up

Freedom to Speak Up and Raising Concerns

"We encourage our staff to raise concerns openly or anonymously if they prefer, safe in the knowledge they will be supported if they do, to make our trust a positive and trustworthy place to work and receive care."

This vision statement remains extant and the ESNEFT Board self-review tool highlights the support given by the Board to 'Speaking Up ' and 'Raising Concerns' issues. Throughout the course of the pandemic there has been a significant rise in individuals raising concerns and it has been noticeable how supportive senior staff have been and how much effort they have put in to resolving these matters. At the start of the pandemic a 'Wellbeing group' was established that included representation from HR, Occupational Health, Clinical Psychologists, Chaplaincy and Mental Health trainers as well as the Freedom to Speak up Guardian, to allow discussion and to focus support to the different areas that needed that attention. This success was followed by the establishment of a Wellbeing Hub which incorporates all these agencies in one area with a one click link to this support from the Trust Intranet Home page. This group continues to develop the support that it provides to all staff and still meets on a weekly basis. The appointment of a Non-Executive Director as a Wellbeing Guardian has provided additional focus and support and the Freedom to Speak up Guardian has regular contact with him.

The trust has also trained, appointed and has activated 7 Assistant Freedom to Speak up Guardians. This first cohort are spread across both main sites and are primarily, experienced and well regarded staff members who have volunteered their services with the support of their Line Mangers. These Assistants will increase our reach throughout ESNEFT and hopefully will provide additional avenues for staff to raise concerns. We still recognise that there are some members of staff who lack the confidence to raise concerns and still fear the consequences should they do so. Our aim remains to ensure that within ESNEFT, everyone, and whatever their geographical location knows how to access F2SU provision and has access to this service.

We are exploring software systems to support the Guardian. A wellbeing data recording tool, allowing input from multiple agencies with discretion protocols protecting confidentiality for individuals will allow more focused support and better analysis of trends and hot spots. Recent advice from the National Guardians office regarding policy is that NHS England Improvement are responsible for producing the National Freedom to Speak Up Integrated Policy which is in the process of being updated. Once this has been received then the Trust policy will be revisited and amended as necessary.

The East of England Freedom to Speak Guardians assembly, which is overseen by the National Guardians office meets quarterly and ensures an active dialogue is maintained between all Guardians. The provision of training support is a most useful function and was a key feature as we developed our Assistant Guardians network.

Tom Fleetwood, our Freedom to Speak Guardian speaks often with the Chief Executive and Chair, works with other members of the Executive Team on a regular basis, replies quarterly to the National Guardians data collection and reports regularly through the Integrated Assurance Committee

Speaking Up

New Assistant Freedom to Speak Up Guardians appointed

Seven new Assistant Freedom to Speak Up Guardians have been appointed to support and broaden the work of Tom Fleetwood, our Freedom to Speak Up Guardian.

They are Sharon Wyatt, Amanda Amey Jonathan Skargon, Julie Burkey, Sarah Stalley, Linda Peall, and Angela Barker.

Staff Survey

The Trust continues to work towards the achievement of the NHS pledges as outlined in the NHS Constitution to ensure that all staff feel trusted, actively listened to, provided with meaningful feedback, treated with respect at work, have the tools, training and support to deliver compassionate care, and are provided with opportunities to develop and progress.

Unlike in previous years, in 2020 the central NHS took a decision that comparative data between organisations would be unhelpful given the contact of the COVID-19 pandemic. Also the national reports have a different format to previous years.

Overall, the ESNEFT results paint a picture of an organisation that is improving. Many of the areas that caused significant concern in the 2019 survey have demonstrated improving scores. This is in spite of a year in which COVID -19 halted the delivery of any action plan, and only one staff listening event was held in March before the pandemic brought all proactive survey-related work to a halt.

Scores compared to previous year	2019	2020
ESNEFT		
Significantly better	9	20
No significant difference	77	52
Significantly worse	4	3

Levels of engagement

There have also been significant improvements in the areas that combine to create an overall picture of engagement:

	2019	2020
Care of patients/ service users is organisation's top priority	72%	75%
Would recommend organisation as a place to work	57%	61%
If friend/relative needed treatment would be happy with standard of care provided by organisation	67%	71%

Staff Survey

	Most improved from last survey
52%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
55%	Q4f. Have adequate materials, supplies and equipment to do my work
33%	Q4g. Enough staff at organisation to do my job properly
54%	Q5h. Satisfied with opportunities for flexible working patterns
71%	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation

	Least improved from last survey
55%	Q11c. In last 12 months, have not felt unwell due to work related stress
72%	Q2b. Often/always enthusiastic about my job
85%	Q3a. Always know what work responsibilities are
85%	Q16b. Organisation encourages reporting of errors/near misses/incidents
52%	Q4i. Team members often meet to discuss the team's effectiveness

Staff Survey

Significance testing

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.1**	4623	**9.1**	4388	Not significant
Health & wellbeing	**5.7**	4654	**5.9**	4410	↑
Immediate managers †	**6.6**	4651	**6.6**	4423	Not significant
Morale	**6.0**	4552	**6.1**	4353	↑
Quality of care	**7.3**	4184	**7.3**	3917	Not significant
Safe environment - Bullying & harassment	**7.8**	4605	**7.9**	4258	Not significant
Safe environment - Violence	**9.4**	4602	**9.4**	4398	Not significant
Safety culture	**6.5**	4608	**6.5**	4369	Not significant
Staff engagement	**6.8**	4687	**6.9**	4477	Not significant
Team working	**6.3**	4596	**6.3**	4436	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

† The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in this table are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

Next steps:

- This year has been an exceptional year and at the time of release of the results the NHS and ESNEFT specifically have not yet begun fully the process of restart and recovery from the Covid- 19 pandemic. We know that our staff are exhausted and that their mental and physical wellbeing must be our focus for the forseeable future. The process of responsding to these results must be understood in the context of the pandemic response.
- We must also understand that impacts of ongoing reactive situations are often not felt immediately and may be reflected in the 2021 staff survey results and in subsequent years. How we respond to these results this year will make all the difference.
- The national pandemic response was begun on 23 March 2020. ESNEFT at this point had begun work to respond to the previous 2019 survey, and our directorates and teams have not had the opportunity to carry much of the activity within their staff survey response plans.
- Our primary approach within divisions will be to review the 2019 staff survey action plans in the context of these new results. We will work with divisional teams via the HRBPs to update the plans and work with staff in whichever way is best within the context of restart and recovery and with due regard to the pressure that a response may place on services at an already pressured time.
- We will focus on interventions which support staff wellbeing. We will work with our staff governors and the leads of our staff engagement and inclusion networks to agree the areas for prioritisation for response on an organisational level.

Recruitment of additional staff is set to give Colchester Hospital's Vascular Access Service a significant boost and lead to improvements in patient care.

The move will see it increase from a three to five day service, thanks to the recruitment of a new practitioner and a healthcare assistant. This will offer additional support to ward teams and improve patient experience by providing treatment and care quicker.

The service is led by matron Jane Murphy, consultant anaesthetist Dr Joe Adams and lead vascular access practitioner Alice Hadgraft. They also work closely with the Outpatient Parenteral Antimicrobial Therapy (OPAT) and Integrated Rapid Assessment Service (IRAS) teams in the community.

The service first launched in January 2020 and supports patients with the insertion and care of peripherally inserted central catheters (PICC), midlines, ultrasound guided cannulas and in the near future, tunnelled lines.

Workforce
Health and Well-being

During the COVID-19 pandemic it was recognised by the Trust the importance of supporting the staff health and well-being was a priority.

Based on our learning from the initial wave of COVID-19 and predictions on the potential longevity of the pandemic, ESNEFT's COVID-19 Wellbeing Group produced an Outline Business Case, which was approved by Executive Management Committee members during the summer of 2020. This business case proposed an exciting vision for the future provision of wellbeing services for our valued staff and volunteers.

This vision was in the form of a Wellbeing Hub, which would bring together a huge range of services – including several that are new – so that our staff and volunteers can access fast, effective support for their health and wellbeing.

The structure of the Wellbeing Hub is built around the provision of four key services:

- **Health & Wellbeing** – This new team will inspire and motivate everyone working for our Trust to try out a new activity and get fitter, healthier and happier.
- **Emotional Wellbeing** – Many new services are being introduced as part of our commitment to improve everyone's emotional and mental wellbeing. A Consultant Clinical Psychologist will lead the provision of specialist psychological services for everyone at the Trust.
- **Occupational Health** – Our Occupational Health team make sure that our staff are physically fit to carry out their job to the best of their ability, and can put extra support in place where necessary.
- **Raising Concerns** – It is recognised that some staff may feel anxious about raising concerns, which could in turn have a knock-on effect on their wellbeing. We want to make sure that anyone who wishes to can confidentially share a concern.

Emotional Wellbeing

- Dedicated psychological support was provided to 'high need' areas during weekdays and weekends where mental health distress was more prevalent.
- A new Welfare Team was created which was formed of Mental Health First Aiders who were shielding for health reasons. This team made in excess of 2,500 telephone calls to staff and volunteers who were shielding themselves or working from home. During these calls, a number of staff were identified as being in significant mental health distress and in need of immediate psychological support. The Welfare Team continued to make a number of calls to shielding staff during the second lockdown period during November 2020 and the team were pleased to report that staff were less distressed and more accepting of their personal circumstances.
- 'Brew Crew' teams (comprising of our Mental Health First Aider community) visited Wards/departments on request to make staff a hot drink and to listen to them and share the wellbeing support that was available.
- Group relaxation sessions were held for teams on request that included taking time out to focus on calming breathing techniques.
- A partnership arrangement was formed with Mental Health First Aid England who are supporting us on our journey, as we become the first NHS organisation to achieve our vision of training 10% of our workforce as Mental Health First Aiders, and to ensure we are able to effectively introduce mental health awareness training for all staff and leaders. During July to December 2020, another 100 Mental Health First Aiders were trained which now brings the total of MHFAiders for ESNEFT to 180.

Workforce
Health and Well-being

- Relationships and connections were made with key external wellbeing services including Suffolk Wellbeing Service (Suffolk IAPT service), Health in Mind (Essex IAPT service), Suffolk MIND, Essex Partnership University NHS Foundation Trust and Norfolk & Suffolk Foundation Trust.

- Regular discussions were held with CiC, our Employee Assistance Programme provider, and with external psychotherapists, clinical psychologists, counsellors and CBT therapists to ensure adequate capacity is in place to meet the potential demand in colleagues who may need access to therapeutic support.

Health & Wellbeing

- Wellbeing support was put into place for staff who were living in hotel accommodation to keep their family members safe. Food, drink and personal hygiene items were delivered to staff in hotels who became unwell with COVID-19. Regular calls and text messages were made by a Mental Health First Aider over weekend periods to check on their welfare.

- A sub group was formed and chaired by the Associate Director of Charities & Voluntary Services to oversee the programme of work to provide Oasis spaces across the organisation. Temporary rest facilities were also provided for staff on both hospital sites from December 2020 to provide colleagues with additional space in which to take a break from their area of work.

- General wellbeing queries and requests for welfare check calls were responded to and supported via the new wellbeing@esneft.nhs.uk Inbox.

- Connections were made with regional and national NHS wellbeing networks which has seen ESNEFT being recognised by the East of England team as leading the way in the work that is being progressed.

Occupational Health

- Our Head of Occupational Health was invited to be part of a national steering group that is reviewing the rollout of a new integrated national support offer for enhanced Occupational Health provision across 14 pilot sites (systems).

Freedom to Speak Up

- A number of Assistant Freedom to Speak up Guardians were appointed to support Tom Fleetwood, our Freedom to Speak up Guardian.

Marquee rest spaces

Our marquee rest spaces for staff and volunteers will remain open until September, thanks to additional funding from Colchester & Ipswich Hospitals Charity.

The marquees are additional places to have breaks or time out from clinical areas. They are heated and furnished and there is space to social distance too.

Workforce

Volunteering

If you have ever visited or been a patient at any of the Trust hospitals in the East Suffolk or North Essex area, the chances are you will have come into contact with one of our magnificent volunteers.

From the moment you arrived at one of our sites one of our volunteers may have helped you to find the area you were searching for with ward support volunteers, chaplaincy visitors, cancer support information volunteers and end of life care volunteers perhaps supporting you or your loved one during your visit. Many more, all have a role to play. We simply could not do all that we do without our wonderful team of volunteers. They donate their time to help us provide safe and compassionate care for our patients.

The ESNEFT Voluntary Services team, currently structured within the Communications and Engagement Corporate division provide effective, efficient and flexible management of volunteers supporting the recruitment, training, development and management of all volunteers across all ESNEFT sites. The team also provide support to all ESNEFT departments wishing to develop new services utilising volunteers and manage the relationships with and support for third sector organisations and partners operating across sites wherever they involve volunteers.

By giving their time, volunteers make a unique contribution and bring their own credibility to the roles they perform. Involving volunteers provides opportunities for ESNEFT to learn from the perspectives, insight and experience they bring and to work in partnership in developing new approaches They enable staff to deliver high-quality care that goes above and beyond core services.

Prior to COVID-19 we had 683 volunteers across ESNEFT however as the COVID-19 crisis emerged it became clear that we would need to urgently ask many of them to temporarily pause their volunteering with us while we established the risks of the virus to our volunteers and to our patients. Unfortunately, during the first wave this resulted in over 500 volunteers being stepped down from their role either due to their own health and shielding guidance or to some services being temporarily paused and therefore volunteers not being required in their usual roles.

As the COVID-19 crisis emerged we were overwhelmed by the generosity of the public who have wanted to help and support our staff and patients. While we haven't been able to yet return volunteers to all areas due to infection control risks, new services were stepped up urgently to support the emerging needs of our patients and staff.

At the end of February 2021 the number of volunteers at ESNEFT has increased by 33% to 904 [188 active volunteers, 531 temporarily paused due to COVID-19 restrictions but returning, 185 in a stage of the registration process including those cleared and awaiting a placement following the lifting of restrictions].

Highlights from our volunteers are summarised below:

- The staff helpline providing support and guidance was set up within days of the national lockdown announcements on 23 March 2020. Initially volunteers were trained by our HR and Occupational Health teams to run this service 7 days a week between 6am to 10pm answering staff queries as new information and guidance emerged. This service was successfully transitioned to a new fully funded staff helpline with many of the volunteers being offered paid employment.
- Our cancer support service teams utilised volunteers to support with

Workforce
Volunteering

patient enquiries via a telephone service

- Volunteers have helped pack thousands of Coronavirus (COVID-19) swab test kits to cope with the demand. The volunteer team has packed more than 100,000 swab tests over the last few months after they were redeployed to help as the demand increased. The team, made up of 10 volunteers, are currently packing 2,000 test kits a week. Each kit includes two sample bags (as double bagging is required for COVID-19 swabs), the test swab, vial of reagent, decontamination wipe and a request form.
- Over 200 volunteers have supported the delivery of over 73,000 vaccinations, working alongside trained health professionals, they have supported the registration, stewarding and recovery procedures within our two vaccination hubs supporting delivery of services across 12 hour shifts, 7 days a week.
- Our corporate and support staff were asked to volunteer their time to support our existing ward teams by freeing them up to do what they do best. They helped by taking some of the tasks away, that, while important, take up the precious time of our nurses and healthcare assistants who could be looking after our patients. The tasks included family liaison, particularly for our older adults, or those with an impairment, packing and unpacking stock and PPE stock checking, providing support for discharging patients, collecting prescriptions from pharmacy and arranging transport home. Over 200 corporate and support staff voluntarily signed up to support the scheme and between them they completed 643 6-hour shifts between 16 January and 31 March racking up 3,858 hours.

We had intended to consult on our volunteer strategy to support the Trust's Strategy and the NHS Long Term Plan focusing on areas that deliver the biggest impact for patients but that work was delayed due to the pandemic and will now be carried out in 2021. We will be working with other colleagues to support delivery of the patient experience network

In 2021 we will also resume our work with other charities to offer further support and befriending for our older patients and those living with dementia together with developing plans to roll out the NHS Cadets programme for younger volunteers.

Workforce

Education and training of staff

ESNEFT is committed to providing a multi professional learning environment for staff. We seek to ensure our staff, students and trainees received high quality education and training.

Medical Education –

The trust hosts medical students from the following universities:-

- Barts and the London School of Medicine and Dentistry-The Trust has given placements to 159 students: Year 3 – 21 students; Year 4 – 105 students; Year 5 – 33 students.
- University of East Anglia- The Trust has given placements to 58 students across the academic year: Year 2 – 16 students; Year 3 – 24 students; Year 4 – 18 students
- Anglia Ruskin University- The Trust has given placements to 19 students across the academic year: Year 1 – 7 students; Year 2 – 6 students; Year 3 – 6 students.
- Cambridge Clinical School – 263 students across years 4, 5 and 6
- Norwich Medical School – 213 students across years 2, 3 and 4.

Pre-registration Education

There remains ongoing investment to employ a multi-professional administration and clinical Team to support pre-registration education across Colchester and Ipswich Hospital sites and the community services, increasing provision in Allied Health Care Professionals and Midwifery. The Practice Education Facilitators work collaboratively with partner universities supported by excellent administration team to improve student education across the region.

Student teaching and support

The COVID-19 pandemic has had a big impact on student learning this year. During the first wave, healthcare student practice learning was initially paused by Health Education England and Universities. Second and third year nursing, midwifery and AHP students were then invited to “opt in” to deploy into paid placements, enabling the students to continue on their programme and support the workforce to care for our patients. The PEF team facilitated specialist induction and ongoing support to enable successful deployment. Only third year nursing students were deployed during the latter phase.

The PEF team have been responsive and innovative to the challenges which have resulted from the impact of Covid-19 on practice learning and placements. To support students who were unable to be out in practice, the PEF team developed and facilitated multiple virtual placements for the various professions. All placements supported students to increase the depth and breadth of their clinical knowledge and critical thinking, continuously linking theory to practice as they followed patient journeys.

The PEFs are allocated to specific wards and departments which allows them to build relationships with the staff and wider team. The PEFs are highly visible in the clinical areas, offering support, and guidance, including working alongside students or coaching the supervisors to coach, to help students thrive and excel in practice. This year they have also supported the deployment programme to work in different areas to deliver care to our patients.

Whilst many of the usual teaching curriculum has been paused during the year, the PEFs continue to provide day to day support in the clinical areas and bespoke teaching as needed, as well as supporting multi-professional learning.

We continue to see improvement in our evaluations by learners on placement with us and respond quickly to address any areas where improvements could be made.

Our Pre-registration education team were finalists in the Student Nursing Times Awards 2020 for Student Placement of the Year: Hospital. Ensuring our students learn in high quality, safe and effective learning environments is a priority for our team and wider trust. The PEF team were recognised for the many initiatives they have implemented to ensure students are not only supported during their time with us in practice but encouraged to excel and flourish and stay with us on qualification.

Staff consistently aim to ensure that students’ emotional wellbeing needs are met with the support of the PEF team and close partnership working with HEIs. Trust wide training is available for all staff in mental health first aid, with many members of the PEF team being trained.

Provision of Virtual Practice Learning

Supporting learning during a pandemic, proved to have many challenges, but also an opportunity to be creative and innovative to support continuation of practice learning at a time when the COVID-19 cases in the community continued to rise and services changed. The PEF team developed a virtual placement, which was offered to the

Workforce

Education and training of staff

Table 13 - Number of pre-registration students supported in the trust During 2020/2021:

	ESNEFT April 20 – March 21
Student Programme	Number of students
Return to Practice	1
Nursing - Adult	574
Nursing - child	79
Midwifery	138
Mental Health	155
Orthoptic	0
Operating Department Practitioner	49
Physiotherapy	139
Speech and Language therapy	20
Occupational Therapy	56
Dietetics	6
Paramedic	53
Diagnostic radiography	51
Therapeutic radiography	25
Psychology	1

new first year students as well as those students who due to their own risk assessment were unable to enter a physical clinical placement. Virtual placements, were facilitated by the PEF team for the following groups of students:
Adult nursing
• Child nursing
• Midwifery
• Operating department Practitioners
The learning in this placement was active, with the students being offered a variety of resources to choose from and whilst facilitated by a PEF, encourages the student to take responsibility to learn and explore the topic or patient journey.

Implementation of the NMC education standards

With the implementation of the new NMC (2019) Standards for Student Supervision and Assessment, the team have continued to work with partner universities to ensure our staff and students are prepared for the new roles and proficiencies required within these.

Hub and Spoke: Planned associated learning

Hub and Spoke model links specialist (spoke) areas to wards or departments that follow a patient journey. This facilitates greater access to specialists, resources and learning opportunities such as those identified the new Future nurse: Standards of proficiency for registered nurses (NMC 2019), enabling students to be participants in person centered care and procedures. This was found to increase student belongingness, proficiency in skills and professional role development of staff.
Whilst there have been significant changes to the services delivered within the Trust due to the impact of Covid-19, our PEF team have continually re-evaluated practice learning opportunities to support the continuation of programmes and been innovative in the opportunities provided.

Workforce

Education and training of staff

Clinical Placement Expansion

In order to support the continued and sustained growth of the nursing, midwifery and AHP workforce, we have worked with our partner Higher Education Institutes to increase the practice learning opportunities we can offer across the organisation. This has enabled more students to join healthcare programmes and undertake the required learning opportunities in practice.
Whilst the main student body we support are those on traditional pre-registration programmes, we are also seeing increases in clinical apprenticeships and "grow our own" workforce via nurse, nursing associate and new this year, operating department practitioner apprenticeship programmes.

Practice Partners and Students

Responding to the changing landscape of pre-registration education, we were collaboratively with the following universities to support students on healthcare programmes:

Anglia Ruskin University
University of Birmingham
University of East Anglia
University of Essex
University of Hertfordshire
University of Liverpool
University of Sheffield
University of Suffolk

As an organisation we support pre-registration students on a range of different programmes across all our sites both in the acute and community areas. The table below indicates the various programme we provide practice learning opportunities for and the number of students we have supported within the year.

Post- registration education

The Post-Registration education teams of Practice Educators work across Colchester and Ipswich hospital sites and the community. The teams deliver both classroom training and education as well the design and delivery of ongoing programmes such as Preceptorship, clinical induction and OSCE preparation.

Response to the Covid-19 pandemic

Social distancing restrictions required a complete redesign of all education programmes towards a more blended approach utilising virtual learning platforms such as Moodle. Face to face training was moved off site to accommodate large numbers

Over 1000 staff were provided upskilling training to prepare them for redeployment to ward areas. This included Registered Nurses, Healthcare Assistants and administration staff to provide basic ward support.

International nurses

International arrivals were halted due to national restrictions from April to August 2020. Arrivals recommenced in September 2020 with significant increases in cohort numbers to support winter and the pandemic.

The teams deliver OSCE preparation (NMC Part 2 Test of Competence) at both Colchester & Ipswich sites with cohorts of international nurses arriving each month. This detailed programme includes theory, practice and mock examinations in readiness for this examination which is taken approximately 12-16 weeks after arrival in the UK.

Pastoral support for our international nurses is vital so the teams also provide support, guidance and advice in the clinical areas to assist acclimatisation into nursing in the trust, NHS and living and working in the UK.

OET

An Occupational English Test preparation programme was delivered to support international nurses currently working in the trust as HCAs to obtain the English requirements for application to the NMC.

Support in practice

Our Practice Educators have "home wards" with whom they have built relationships with both staff and leaders. Working closely with clinical areas to provide support, guidance, by the bedside training and pastoral care to staff who are struggling, under performance management or are new in post.

Non-registered clinical staff

Our Practice Education Trainers support our non-registered clinical staff in both the classroom and clinical settings with achieving the standards of Care Certificate as well as setting the standard of basic nursing care and providing additional learning opportunities for this group of staff.

There are opportunities for non-registered clinical staff to progress through to registration with the NMC via an apprenticeship route.

Skills passports & clinical competencies

A new Healthcare Assistant skills passport has been approved to support safe practice and development for non-registered clinical staff. Passports for non-registered Allied Health Professionals are currently in development. A move away from clinical competencies and towards robust training continue with some specialist competencies remaining.

Medical device training

Workforce

Education and training of staff

Work continues to support medical device training including documentation to ensure consistency and quality of training. There is a robust process to track and monitor roll outs of medical devices to multiple departments. A project to transfer paper/digital training records to OLM continues.

Education and training opportunities

The Trust continues to support the development of its workforce to ensure that we have appropriately trained and skilled staff to provide safe and effective care for our patients.

Nursing Associates

ESNEFT continues to working collaboratively across Suffolk & North East Essex to promote, support and further develop the implementation of the Nursing Associate role as part of the workforce. A relatively new role which bridges the gap between the Healthcare Support Worker and Registered nurse, ESNEFT are celebrating xxx the first cohort of trainee Nursing Associates to qualify and join the nursing workforce.

Advanced Clinical Practitioners

Advanced Clinical Practitioners (ACPs) are registered practitioners from a range of professions such as; nursing, physiotherapy etc., who work at an advanced level with high levels of autonomy and complex decision making as part of the multi-disciplinary teams to help provide safe, accessible and high quality patient care. This role continues to be developed and embedded within the organisation, with our staff working across a variety of specialties.

Continuing Professional Development

We have supported and developed training in line with service need and the wider healthcare economy and guide by the Sustainability Transformation Partnership.

In reflecting the Trust's objectives and NHS Long Term Plan, the organisation has and will continue to support our multidisciplinary healthcare staff to attend a wide variety of courses and workshops. Enhancing skills ensures that staff are better equipped to provide safe care for patients with more diverse and complex health needs. In collaboration with Health Education England, workforce development has been multi-faceted and has included development in areas such as:

- In hospital including urgent and emergency Care – ongoing developments of the Urgent Treatment Centre has continued to drive the requirement for increased specialist skills to treat acutely unwell patients a i.e.: Care of the Critically ill patient, Non-Medical Prescribing, Consultation & Assessment and trauma courses. Providing care across multiple specialties has required the ongoing need for upskilling in areas such as; cardiac care, management of diabetes, enhancing ophthalmology care, and x-ray interpretation.
- Cancer Care – specialist education to support the delivery of care to patients with cancer and to improve patient experience and outcomes i.e.: Palliative Care, Principles of Haemato-oncology care, Technical Advances in Radiotherapy and Psychology of Cancer Care
- Mental Health - to continue to improve the awareness of mental health conditions and support not only for our patients but also staff i.e.: Mental health awareness workshops and Mental Health First Aid.
- Maternity – to support women with a range of care requirements, education has been supported in a range of areas including; care of the critically unwell women, childbirth Emergencies in the Community, perinatal mental health,
- In the care of children, education has been provided on topics such as; high dependency care of the acutely ill child, allergies, youth mental health and paediatric examination.

Workforce

Valuing Our Staff

Commendation Award for Calvin from Security

**We said thank you to security colleague Calvin Reid who went in at the deep end on a tricky day at work.
Calvin didn't think twice before getting in the lake at Colchester Hospital after a patient left a ward and jumped in.
The patient was taken back to safety and - after a quick change out of his soggy uniform into a pair of hospital scrubs - Calvin was back on duty for another 13 hours.
Chief Executive Nick Hulme gave Calvin one of our Commendation staff awards to say well done and thank you.**

Workforce

Valuing Our Staff

Fran Friston, pictured, is a matron with a big heart and we've said thank you to her with one of our staff Commendation awards for the kindness and compassion she showed to a dying man and his family.

Fran's award was presented to her by Chief Executive Nick Hulme.

Statements from key stakeholders

Ipswich & East Clinical Commissioning Group
North East Essex Clinical Commissioning Group

East Suffolk and North Essex Foundation Trust (ESNEFT)

The North East Essex and Ipswich and East Suffolk Clinical Commissioning Groups (CCGs) confirm that ESNEFT have consulted and invited comment regarding the Annual Quality Account for 2020/21. This has been submitted as a draft within the agreed timeframe and the CCGs are satisfied that the draft Quality Account provides appropriate assurance of the service.

The CCGs have reviewed the draft Quality Account and, to the best of our knowledge, consider that the data is accurate. The information contained within the draft Quality Account is reflective of both the challenges and achievements within the organisation over the previous 12 month period. It is recognised that the COVID-19 pandemic has created additional, unprecedented challenges this year, which has made the report more difficult to compile.

The Ipswich and East Suffolk and North East Essex Clinical Commissioning Groups look forward to working with clinicians and managers from the service, and with local service users, to continue to improve services to ensure quality, safety, clinical effectiveness and a good service-user experience is delivered across the organisation.

This Quality Account demonstrates the commitment of ESNEFT to provide a high quality service. The Clinical Commissioning Groups endorse the publication of this account.

Lisa Nobes
Chief Nursing Officer

Ipswich & East Clinical Commissioning Group
North East Essex Clinical Commissioning Group

17th May 2021

Suffolk Health Scrutiny Committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2020/21. This should in no way be taken as a negative response. The Committee acknowledges the significant additional pressures faced by NHS providers in 2020/21 as a result of the Covid-19 pandemic and wishes to place on record our thanks for everything being done to maintain NHS services for the people of Suffolk in the most challenging of times.

County Councillor Jessica Fleming

Chairman of the Suffolk Health Scrutiny Committee

Statement of assurance from the Board of Directors

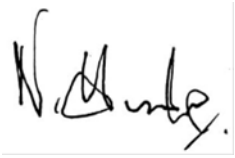
Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation). In preparing the Quality Account, directors should take steps to assure themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the reporting period;
- the performance information reported in the Quality Account is reliable and accurate;
- here 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 measurement of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The Quality Account has been prepared in accordance with any Department of Health guidance. The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board



Glossary

AOS Acute Oncology Service
Bed days The measurement of a day that a patient occupies a hospital bed as part of their treatment.
Care Quality Commission (CQC) The regulatory body for all health and social care organisations in England. The CQC regulates care provided by the NHS, local authorities, private companies, voluntary organisations and aims to make sure better care is provided for everyone in hospitals, care homes and people's own homes.
CCU Critical Care Unit.
Clinical Coding The translation of medical terminology as written in a patient's medical records to describe a problem, diagnosis, treatment of a medical problem, into a coded format.
Clinical Commissioning Group (CCG) CCGs are responsible for commissioning (planning, designing and paying for) all NHS services.
Clinical Delivery Group (CDG) CDGs are sub-groups of one of the Trust's three clinical divisions. Each CDG is accountable to its Divisional Governance Board for all aspects of performance, including patient safety, patient and carer experience, operational standards, financial performance and staff engagement.
Clostridium difficile* or *C.diff A spore-forming bacterium present as one of the normal bacteria in the gut. *Clostridium difficile* diarrhoea occurs when the normal gut flora is altered, allowing *Clostridium difficile* bacteria to flourish and produce a toxin that causes watery diarrhoea.
Colonisation The presence of bacteria on a body surface (such as the skin, mouth, intestines or airway) without causing disease in the person.
CQUIN The CQUIN (Commissioning for Quality and Innovation) framework enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.
Datix A Trust-wide computer system used to record and aid analysis of all incidents, claims, complaints and PALS enquiries.
Dementia A set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning.
Division The hospital is divided into three distinct clinical divisions: Medicine including Emergency Care; Surgery and Cancer; Women and Children and Clinical Support Services. There is an additional division which manages the corporate functions such as Governance, Education, Operations, Human Resources, Finance, Performance, and Information. Each Divisional Board is chaired by a consultant (Divisional Director) together with nursing. and operational leads. The Head of Nursing/Midwifery provides senior nursing and quality of care expertise, with the Head of Operations providing expert operational advice to the Divisional Boards.
DNACPR Do not attempt cardio-pulmonary resuscitation. A formal decision made when it is not in the best interests of the patient to be resuscitated in certain circumstances.
Dr Foster Provider of comparative information on health and social care issues.
ED Emergency Department, also known as A&E, Accident and Emergency Department or Casualty.
Harm-free care National patient safety initiative targeted at high impact areas such as pressure ulcers, catheter care, VTE and falls.
HDU High Dependency Unit.
Quality & Patient Safety Committee The Trust Board sub-committee responsible for overseeing quality within the Trust.
HealthWatch Champions the views of local people to achieve excellent health and social care services in Suffolk.
HSMR Hospital Standardised Mortality Rate. An indicator of healthcare quality that measures whether a hospital's death rate is higher or lower than expected.
North East Essex Clinical Commissioning Group & Ipswich and East Suffolk Clinical Commissioning Group The commissioners of services provided by ESNEFT.
MDT Multi-disciplinary team.
Methicillin Resistant Staphylococcus Aureus (MRSA) MRSA is an antibiotic-resistant form of the common bacterium Staphylococcus Aureus, which grows harmlessly on the skin in the nose of around one in three people in the UK. MRSA bacteraemia is the presence of Methicillin Resistant Staphylococcus Aureus in the blood.
NEWS National Early Warning Score. A system of recording vital signs observations which gives early warning of a deteriorating patient.
MEOWS Modified Early Obstetric Warning Score. A system of recording vital signs observations which gives early warning of a deteriorating obstetric patient.
Morbidity and Mortality (M&M) meetings Morbidity and mortality meetings are held in each Clinical Delivery Group. The goal of such meetings is to derive knowledge and insight from surgical error adverse events. M&M meetings look at: What happened? Why did it occur? How could the issue have been prevented or better managed? What are the key learning points?
NCEPOD National Confidential Enquiry into Patient Outcome and Death.
Never Events Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Operation Red to Green A concept recommended nationally by the Emergency and Urgent Care Intensive Team which ensures all the processes required to support flow through the hospital run 'perfectly' so that there are no unnecessary delays that slow down transfers of care. There is input from the whole organisation and joint working between the Trust and its health partners across Essex. All non-essential meetings are cancelled to ensure that all staff can fully commit to the week, without compromising clinical care.
PALS Patient Advice and Liaison Service. For all enquiries to the hospital such as cost of parking, ward visiting times, how to change an appointment etc.
PEWS Paediatric Early Warning Score
PLACE Patient-Led Assessment of the Care Environment. Annual self-assessment of a range of non-clinical services by local volunteers.
PSG Patient Safety Group.
Q1 or Quarter 1 April - June 2016
Q2 or Quarter 2 July - September 2016
Q3 or Quarter 3 October - December 2016
Q4 or Quarter 4 January - March 2017
RCA Root Cause Analysis. A structured investigation of an incident to ensure effective learning to prevent a similar event from happening.
SHMI Summary Hospital-Level Mortality Indicator. An indicator for mortality. The indicator covers all deaths of patients admitted to hospital and those that die up to 30 days after discharge from hospital.
SI Serious Incident
SLA Service Level Agreement. A contract to provide or purchase named services.
Essex Family Carers A registered charity working with unpaid family carers across Essex, supporting family carers with information, advice and guidance.
SUS Secondary Uses Service. Provides anonymous patient-based information for purposes other than direct clinical care such as healthcare planning, public health, commissioning, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
The King's Fund A charity that seeks to understand how the health system in England can be improved and helps to shape policy, transform services and bring about behaviour change.
VTE Venous Thrombo-embolism. Also known as a blood clot, a VTE is a complication of immobility and surgery.

Definitions for performance indicators subject to external assurance

Percentage of patients risk-assessed for venous thromboembolism (VTE)

Detailed descriptor
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

Data definition
Numerator: Number of adults admitted to hospital as inpatients in the reporting who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool during the reporting period.
Denominator: Total number of adults admitted to hospital in the reporting period.

Details of the indicator
The scope of the indicator includes all adults (those aged 18 at the time of admission) who are admitted to hospital as inpatients including:

- surgical inpatients;
- in-patients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease); trauma inpatients;
- patients admitted to intensive care units;
- cancer inpatients;
- people undergoing long-term rehabilitation in hospital;
- patients admitted to a hospital bed for day-case medical or surgical procedures; and
- private patients attending an NHS hospital.

The following patients are excluded from the indicator:

- people under the age of 18 at the time of admission;
- people attending hospital as outpatients;
- people attending emergency departments who are not admitted to hospital; and
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

Timeframe
Data produced monthly for the 2015-16 financial year.

Detailed guidance
More detail about this indicator can be found on the NHS England website. The data collection standard specification can be found here.
Source: NHS England

Data relating to the percentage of patients risk-assessed for venous thrombo-embolism (VTE) can be found on page 40.

Percentage of patient safety incidents resulting in severe harm or death

Detailed descriptor
Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period.

Data definition
Numerator: Number of reported patient safety incidents resulting in severe harm or death at a trust reported through the National Reporting and Learning Service (NRLS) during the reporting period.
Denominator: Number of reported patient safety incidents at a trust reported through the NRLS during the reporting period.

Details of the indicator
The scope of the indicator includes all patient safety incidents reported through the NRLS. This includes reports made by the trust, staff, patients and the public. From April 2010 it became mandatory for trusts in England to report all serious patient safety incidents to the Care Quality Commission. Trusts do this by reporting incidents on the NRLS.

A case of severe harm is defined in 'Seven steps to patient safety: a full reference guide', published by the National Patient Safety Agency in 2004, as "((any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care", "Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage."

This indicator does not capture any information about incidents that remain unreported. Incidents with a degree of harm of 'severe' and 'death' are now a mandatory reporting requirement by the CQC, via the NRLS, but the quality statement states that underreporting is still likely to occur.

Timeframe
Six-monthly data produced for April to September and October to March of each financial year.

Detailed guidance
More detail about this indicator and the data can be found on the Patient Safety section of the NHS England website and on the HSCIC website in NHS Outcomes Framework > Domain 5 Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm > Overarching indicators > 5b Severity of harm.
Source: NHS England

Data relating to the percentage of patient safety incidents resulting in severe harm or death can be found on page 41.

How to provide feedback on this Quality Account

If you would like to provide feedback on this account or would like to make suggestions for content for future accounts, please email info@ESNEFT.nhs.uk
or write to:

Trust Offices,
Colchester Hospital
Turner Road,
Colchester
Essex CO4 5JL

Thank you

We would like to take this opportunity to thank all those involved with East Suffolk and North Essex NHS Foundation Trust: our fantastic staff and volunteers, all of our patients and visitors, our valuable fundraisers, local media organisations, our local Members of Parliament and health colleagues across the East of England.

Thank you for all that you do to make this a hospital we can all be proud to be part of.

Find out more about the hospital by visiting
our website at www.ESNEFT.nhs.uk

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This report is available online in this format and as an easy-read document at
https://www.esneft.nhs.uk/about-us/clinical-quality/quality-accounts/