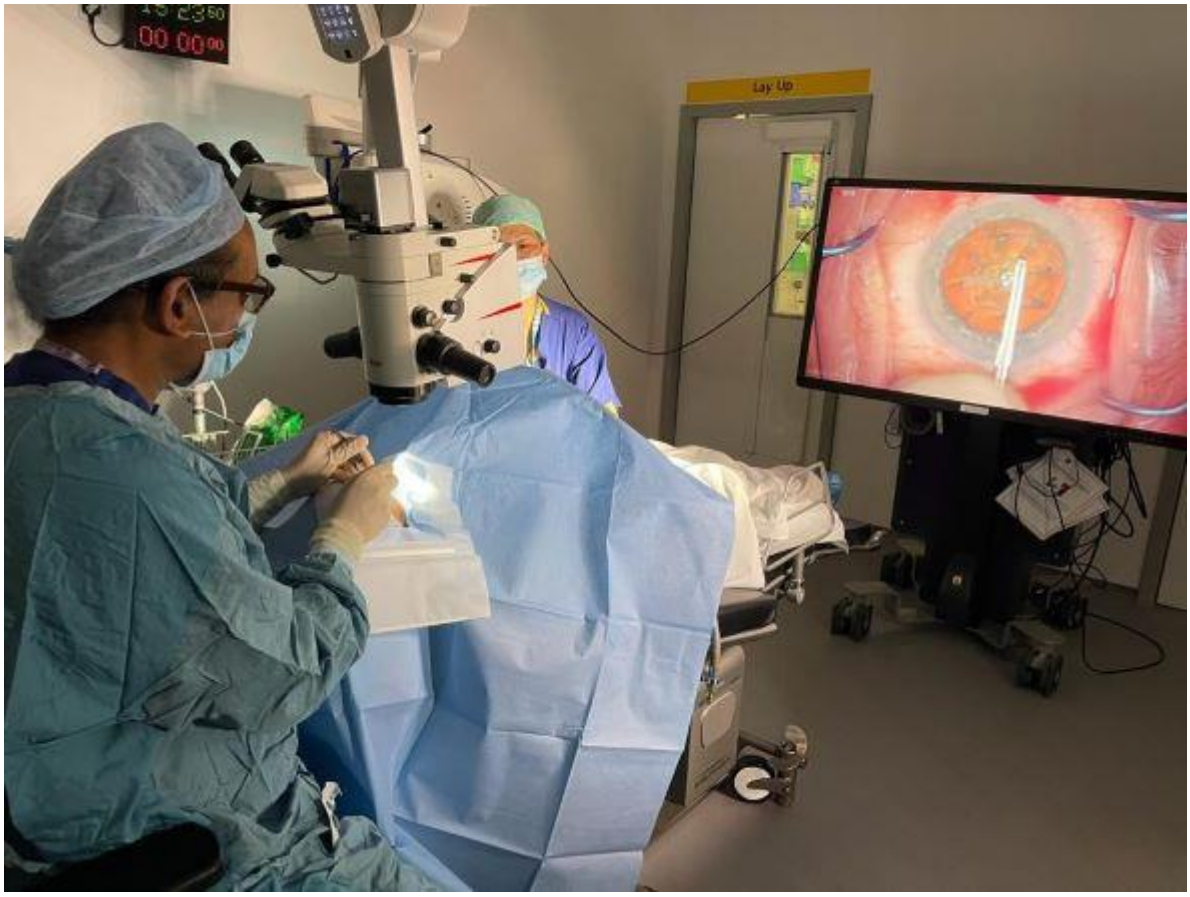
East Suffolk and North Essex NHS Foundation Trust

East Suffolk and North Essex NHS Foundation Trust (ESNEFT)

Quality Account 2021/22



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2021/22 quality priorities

Progress against the priorities we set as a Trust

Patient safety priority one: To improve compliance with the sepsis six 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 sepsis six guidelines.
- Timely treatment of infection/sepsis within 60 minutes.

What did we do to improve our performance?

- Embedded the use of the fluid balance chart in our community hospitals.
- Implemented a mandatory training maternal sepsis e-learning programme for all clinical staff in maternity services.
- Continued to provide a teaching session on escalating deteriorating patients and sepsis to all new staff as part of their induction.
- Rolled out the nationally recognised ALERT (acute life-threatening events – recognition and treatment) course to the Ipswich site. This has been in place in Colchester for some time and uses scenarios to teach ward staff, such as nurses and physiotherapists, how to deliver sepsis six and manage sepsis and deteriorating patients. One course now runs every month on each site.
- Began audits in all adult inpatient areas to make sure that ESNEFT treatment escalation plans are completed. These ensure that all patients have a medical plan in place which agrees the levels of escalation.
- Updated our inpatient sepsis audit tools, continued to audit all adult areas on both sites and began a review of the auditing process in place in Paediatrics and Maternity.
- Introduced the UK Sepsis Trust's maternal sepsis screening tool and the ME(O)WS observation charts to both ED departments to ensure pregnant and postpartum women have a more tailored approach to meet their specific needs. Using the maternal early warning scores in ED will also ensure that deterioration is not missed in this patient group.

- Embedded electronic observation and escalation trigger software called Sentinel across the Trust to increase awareness and response time to sepsis and the deteriorating patient. We are now focusing on adding paediatric early warning scores (PEWS) to the software.

- Successfully introduced the Kaiser tool to maternity services. This is a risk calculator which is used to assess for neonatal sepsis and can reduce antibiotic exposure while highlighting neonates at risk of sepsis so that they can receive assessment and treatment.

How did we measure and monitor our performance?

- Audits are completed once a month using a randomised sample of all adult patients who attend our ED departments. This monitors the screening of patients for signs of infection that may develop into sepsis, as well as delivery of the sepsis three and sepsis six treatments within the one-hour national timeframe.

- Audits are completed monthly for five patients per ward who triggered an escalation and sepsis screen. This monitors the escalation of deteriorating patients in adherence to Trust policy and whether a treatment escalation plan is in place where required. It also includes screening these patients for signs of infection that may develop into sepsis and delivery of the sepsis three and sepsis six treatments within the one-hour national timeframe.

Did we achieve our target?

- We consistently met our target for identification of sepsis through screening in ED. Colchester ED hit 96% compliance for screening patients who scored NEWS ≥5 or three in one parameter, and Ipswich met 90% across the year to date. Inpatient areas showed signs of improvement in screening compliance, with Colchester and Ipswich scoring 68% and 61% respectively.

- Delivery of sepsis six in Ipswich ED has remained at low at 44%, whereas Colchester ED has improved to an average of 78% compliance. Adult inpatient figures across site are broadly similar, with Colchester at 58% and Ipswich at 53%.

- Work is underway to identify and address barriers to compliance affecting sepsis six delivery in these areas.

How and where was progress reported?

- The results of the audits are fed back to clinical areas for discussion in their governance meetings, with action plans requested to show planned improvements.

- Monthly results and updates are sent to the Deteriorating Patient Group and Patient Safety Group.

- Reports are presented to the Deteriorating Patient Group on a quarterly basis by the divisions.

- Quarterly deep dives into data quality are carried out by the clinical nurse specialists for deteriorating patients so that we can identify areas for improvement. These are presented to the Deteriorating Patient Group and Patient Safety Group.

Our key achievements

- Successful implementation of a mandatory training maternal sepsis e-learning programme for all clinical staff in maternity services.
- Rolled out the ALERT course to the Ipswich site.
- Successfully introduced the Kaiser tool to maternity services.
- Introduced maternal early warning scores and sepsis screening tools in our Emergency Departments

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Patient safety priority two: To reduce the number of inpatient falls.

Lead director: Chief Nurse.

Why was this a priority?

Ensuring that patients receive harm free care during their admission is a key priority for any healthcare provider. This is because the impact on patients following a fall in hospital can be wide ranging and complex.

ESNEFT is committed to ensuring that, wherever possible, no patient suffers from harm whilst receiving care. Reducing falls was therefore identified as a key patient safety priority for 2021/22.

What was our target?

- Reduce inpatient falls per 1,000 bed days to below five within the two acute hospitals.
- Reduce the improvement trajectory for community falls to fewer than 15 falls per 1,000 bed days.

What did we do to improve our performance?

- Introduced a Trust-wide improvement plan for falls.
- Started work to develop a falls prevention inpatient service within the Corporate Nursing and Quality Division, with leadership provided by the associate director of clinical governance on behalf of the Chief Nurse.
- Standardised the documents which are used across all sites.

How did we measure and monitor our performance?

- Monitored reports of all inpatient falls through the patient safety and quality team and reported them via the ward safety dashboard to our matrons group, which is chaired by the Chief Nurse.
- Developed a tool to monitor whether the presence of delirium had been assessed.
- Included a monthly review of falls activity and trends in the patient safety report.
- Triangulated inpatient falls with PALS, complaints and safeguarding information to identify any emerging themes and trends to any specific areas of the Trust.

Did we achieve our target?

Although the overall number of falls was slightly down on the previous year, we were unable to achieve our target of less than five falls per 1,000 bed days (national average is 6.63 per 1,000 bed days).

Colchester achieved XX falls per 1000 bed days and Ipswich XX falls per 1,000 bed days, resulting in an ESNEFT total of XX falls per 1,000 bed days. Our community hospitals recorded XX falls per 1,000 bed days, which is consistent with last year's average.

How and where was progress reported?

Regular reports and updates were provided to sister and matron meetings, the Patient Safety Group, Harm Free Group and Quality and Patient Safety Committee.

Our key achievements

- Continued to provide ward-based falls prevention education.
- Ensured the team were present on wards daily to promote teaching through joint working.
- Learnt from incidents via the harm free panel process and by introducing after action reviews.

Clinical effectiveness priority one: To reduce the likelihood of nosocomial infections in our patients.

Lead director: Chief Medical Officer and Chief Nurse.

Why was this a priority?

Nosocomial infections are infections which are confirmed from microbiological samples obtained more than 48 hours after admission. They can cause complications whilst the patient is ill and potentially lead to patient harm, depending on the causative microorganism.

The 48 hours only applies to bacteraemias and Clostridium difficile (C. diff) cases.

Nosocomial COVID-19 cases are those confirmed eight days after admission.

What was our target?

To have zero tolerance for all avoidable nosocomial infections

What did we do to improve our performance?

- Reinstated the saving lives audit care bundle 11 (promote stewardship antimicrobial prescribing – all care settings) and 12 (promote stewardship antimicrobial prescribing – secondary care). This audit was suspended in December 2021 and January 2022.
- Continued to carry out post infection reviews for 100% of hospital-onset healthcare associated (positive two days post admission) C. diff cases.
- Restarted our 'Bug News' newsletter to keep link nurses updated with information about infection prevention and control.
- Continued to provide up-to-date infection prevention and control advice and guidance, including surveillance of positive cases and outbreak management.
- Completed a peripheral vascular device audit in October 2021 following learning from a case of MRSA bacteraemia and cases of MRSA bacteraemias

How did we measure and monitor our performance?

- Monitored our compliance with screening protocols for COVID-19, which included completing a clinical audit of our data to establish clinical variations from the protocol.
- Maintained C. diff panel review meetings.
- Reported our compliance with personal protective equipment (PPE) through the accountability framework.
- Continued to report saving lives and hand hygiene audits.
- Continued mandatory reporting of all gram-negative bacteraemias and methicillin-sensitive Staphylococcus aureus against new 2021/22 definitions and thresholds.
- Maintained our compliance with outbreak management processes to highlight learning and monitor the effects of outbreak interventions.

Did we achieve our target?

We continue to have zero tolerance of all nosocomial infections. The additional measures we have taken to improve our performance were conducted within the confines of a pandemic which saw multiple peaks within the last year.

How and where was progress reported?

Regular reports and updates were provided to the Infection Control Committee, Patient Safety Group and the Integrated Assurance Committee.

Our key achievements

Introducing improvements while continuing to support clinical teams during several waves of COVID-19 infection.

Clinical effectiveness priority two: To improve the assessment of nutrition and hydration needs for patients and ensure the correct referral and maintenance plans are undertaken.

Lead director: Chief Medical Officer and Chief Nurse.

Why was this a priority?

There is clear medical evidence that good nutrition aids a patient's recovery. Many patients admitted to hospital are at risk due to their illness. Carrying out an assessment of their nutrition and hydration needs helps to identify those patients at risk so that teams can provide the appropriate support.

What was our target?

- Ensure that patients have a risk assessment regarding their nutritional status within 24 hours of admission to the ward.
- Ensure that patients who require fluid balance charts have their charts monitored and balanced in accordance with Trust policy.

What did we do to improve our performance?

To come

How did we measure and monitor our performance?

To come

Did we achieve our target?

To come

How and where was progress reported?

Regular reports and updates were provided to the Nutrition Steering Group, Clinical Effectiveness Group and Quality and Patient Safety Committee.

Our key achievements

To come

Patient experience priority one: To improve clinical outcomes for patients with mental health conditions, improve mental health wellbeing for staff and transform mental health provision across ESNEFT.

Lead director: Director of Human Resources, Chief Medical Officer and Chief Nurse.

Why was this a priority?

Making sure that people receive prompt access and parity of both mental and physical healthcare is a national priority. Figures show that one in four adults and one in 10 children experience mental illness, while many more know and care for people who do.

Evidence also shows that between 25% and 33% of patients admitted to an acute hospital also have a mental health condition, while mental ill health accounts for 5% of all ED attendances.

By providing effective mental health support to patients and expertise to staff where required, we can minimise the amount of time patients need to stay in an acute hospital while also building effective mental health services for children and young people.

Our own staff also require support, education and tools to help them improve their own wellbeing, while also recognising support patients and carers who may need further support.

What was our target?

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

What did we do to improve our performance?

- Held workshops across the Trust to understand how to help staff feel more confident when recognising and understanding the mental health needs of patients receiving care at ESNEFT. A model for support of patients’ mental health has been developed which includes pathways across different age ranges and complexities. Pathway leads have been identified and work has started to:
    - Support patients to identify and share their mental health needs and understand how these are impacted by their physical health needs.
    - Recognise ways we can help patients feel safer when receiving care. This applies to emotional, psychological and physical safety.
    - Recognise complexity in need so that we can ensure a timely specialist response and partnership working.

Progress is reported on at a monthly Trust-wide Mental Health Quality Improvement Steering Group.

- Formalised arrangements for Mental Health Act administration at both acute sites with partner mental health trusts to make sure there is appropriate scrutiny and assurance when the Mental Health Act is applied in our hospitals.

- Chair monthly mental health interagency meetings at each site with partners from mental health services, police constabularies, the ambulance service and social care. These forums are used to ensure agreement in relation to system-wide protocols and local referral and communication processes, and also provide an opportunity to share learning and good practice. The two groups join together quarterly to enable wider sharing to improve the patient experience.

- Secured funding for two fixed term children and young people's mental health specialist posts at Colchester Hospital. These have been recruited into and the post holders will start in April 2022.

- Begun delivering training to staff which includes use of the Mental Health Act, undertaking one-to-one therapeutic enhanced observations and mental health awareness for healthcare assistants. We are also working with the mental health liaison teams to identify how they can further support training for our staff.

How did we measure and monitor our performance?

The mental health quality improvement group monitors performance monthly through feedback from the pathway leads and by reviewing governance information in relation to each area of focus. The pathway groups are at a stage where they are considering what outcome measures should be applied to demonstrate how work is progressing.

Did we achieve our target?

The target has been mostly achieved, although performance measures are yet to be fully implemented. There are clearer processes in place for understanding the experiences of people who receive our care and who have mental health needs. Staff needs and concerns in relation to providing safe and effective care for people with complex mental health presentations are also better understood.

How and where was progress reported?

Regular reports and updates were provided to the Mental Health Quality Improvement Steering Group, Executive Management Committee, Clinical Effectiveness Group, Patient Experience Group and People and Organisational Development Committee.

Our key achievements

- Developing plans and starting work to support improvements to the patient experience in relation to mental health across the following pathways:
    - Emergency care
    - Perinatal care
    - Children and young people's services
    - Older people's care

  - Dementia-related care
  - Eating disorders
  - Chronic and lifelong conditions

- Building and strengthening relationships with key partners to enable more effective processes and better outcomes for patients with complex mental health needs.

Patient experience priority two: To continue to improve care for patients living with dementia and their carers.

Lead director: Chief Medical Officer and Chief Nurse.

Why was this a priority?

Family members and others who care for people with dementia often need additional support to help them manage. Our aim is to improve the care we provide to patients with dementia, both as inpatients and in the diagnosis and management of the disease outside of hospital.

What was our target?

- Increase the use of the 'This is me' tool to 50%.
- Develop a webpage containing dementia resources for patients and their carers.
- Continue upgrading our environments to ensure they are dementia-friendly.
- Gain approval for and introduce the cognition screening/assessment tool.
- Expand our dementia champion role to include cognitive champions.

What did we do to improve our performance?

- Undertaken an audit to identify how the 'This is me' tool is being used. Following initial results, we have carried out targeted training and communications to increase understanding among staff.
- Reviewed and improved our intranet and internet pages to ensure that information and signposting is clearer.

How did we measure and monitor our performance?

- Reviewed Datix to ensure there is clearer reporting and understanding of themes in relation to incidents involving people with dementia.

- Contacted carers following a discharge to request feedback in relation to their experiences. This information is shared across the Trust to support learning and improvement.

Did we achieve our target?

- The impact of COVID-19 has presented some barriers to addressing environmental factors. Plans are in place to progress this work and to ensure inclusion of community hospitals.

- Work is taking place to phase out the use of the MOCA screening tool and ensure that mini ACE III is used consistently across the Trust.

- A model for champion roles is being developed and training has been formulated.

How and where was progress reported?

Regular reports and updates were provided to the Patient Experience Group and Quality and Patient Safety Committee.

Our key achievements

- There has been increased networking across the system, with ESNEFT now represented across both counties in their dementia action groups.
- Referral processes to external memory assessment clinics have been streamlined and made easier across both sites.
- There has been closer working with dementia intensive support teams and mental health liaison teams to plan discharges and make sure work is not duplicated.

Our quality priorities for 2022/23

To come

Provided and sub-contracted services

During 2021/22, 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 Trust's commissioners are NHS North East Essex Clinical Commissioning Group and NHS Ipswich and East Suffolk Clinical Commissioning Group, together with a number of associate commissioners for clinical commissioning groups and NHS England for specialised, local area and armed forces healthcare commissioning. Additional services are provided in relationships with other organisations, including West Suffolk NHS Foundation Trust, Essex Partnership University NHS Foundation Trust, Norfolk and Suffolk NHS Foundation Trust, Anglian Community Enterprise CIC, Allied Health Professionals Suffolk CIC and Ramsay Healthcare Ltd.

The income generated by the relevant health services reviewed in 2021/22 represents 94% of the total income generated from the provision of relevant health services by ESNEFT for 2021/22.

Participation in clinical audit

During 2021/22, 47 national clinical audits and seven national confidential enquiries covered relevant health services that East Suffolk and North Essex NHS Foundation Trust provides.

During that period, ESNEFT participated in 98% of the national clinical audits and 100% of the national confidential enquiries that it was eligible to participate in.

The national clinical audits and the national confidential enquiries that ESNEFT was eligible to participate in during 2021/22 are as follows:

National clinical audits				
Count	**Programme**	**Workstream / topic name**	**Relevant**	**Participating**
1	Case Mix Programme		ü	ü
2	Chronic Kidney Disease Registry		ü	ü
3	Elective Surgery (National PROMs Programme)		ü	ü
4	Emergency Medicine QIPs	Pain in Children (care in Emergency Departments)	ü	ü
5	Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	ü	ü
6		National Audit of Inpatient Falls	ü	ü
7		National Hip Fracture Database	ü	ü
8	Inflammatory Bowel Disease Audit		ü	û
9	Learning Disabilities Mortality Review Programme		ü	ü
10	National Adult Diabetes Audit	National Diabetes Core Audit	ü	ü
11		National Pregnancy in Diabetes Audit	ü	ü
12		National Diabetes Footcare Audit	ü	ü
13		National Inpatient Diabetes Audit, including Inpatient Audit – Harms	ü	ü
14	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Paediatric Asthma Secondary Care	ü	ü
15		Adult Asthma Secondary Care	ü	ü
16		Chronic Obstructive Pulmonary Disease Secondary Care	ü	ü
17		Pulmonary Rehabilitation – Organisational and Clinical Audit	ü	ü
18	National Audit of Breast Cancer in Older Patients		ü	ü

19	National Audit of Cardiac Rehabilitation		ü	ü
20	National Audit of Care at the End of Life		ü	ü
21	National Audit of Dementia	Care in general hospitals	ü	ü
22	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		ü	ü
23	National Cardiac Arrest Audit		ü	ü
24	National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management	ü	ü
25		Myocardial Ischaemia National Audit Project	ü	ü
26		National Audit of Percutaneous Coronary Interventions	ü	ü
27		National Heart Failure Audit	ü	ü
28	National Child Mortality Database		ü	ü
29	National Comparative Audit of Blood Transfusion	2021 Audit of Patient Blood Management and NICE Guidelines	ü	ü
30	National Early Inflammatory Arthritis Audit		ü	ü
31	National Emergency Laparotomy Audit		ü	ü
32	National Gastro-intestinal Cancer Programme	National Oesophago-gastric Cancer	ü	ü
33		National Bowel Cancer Audit	ü	ü
34	National Joint Registry		ü	ü
35	National Lung Cancer Audit		ü	ü
36	National Maternity and Perinatal Audit		ü	ü
37	National Neonatal Audit Programme		ü	ü
38	National Paediatric Diabetes Audit		ü	ü
39	National Prostate Cancer Audit		ü	ü
40	National Vascular Registry		ü	ü

41	Respiratory Audits	National Smoking Cessation 2021 Audit	ü	ü
42	Sentinel Stroke National Audit Programme		ü	ü
43	Serious Hazards of Transfusion		ü	ü
44	Society for Acute Medicine Benchmarking Audit		ü	ü
45	Trauma Audit and Research Network		ü	ü
46	Urology Audits	Cytoreductive Radical Nephrectomy Audit	ü	ü
47		Management of the Lower Ureter in Nephroureterectomy Audit	ü	ü

Confidential enquiries				
Count	**Programme**	**Workstream / topic name**	**Relevant**	**Participating**
1	Child Health Clinical Outcome Review Programme	Transition from child to adult health services	ü	ü
2	Maternal and Newborn Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry	ü	ü
3		Perinatal confidential enquiries	ü	ü
4		Perinatal mortality surveillance	ü	ü
5	Medical and Surgical Clinical Outcome Review Programme	Crohn's	ü	ü
6		Epilepsy study	ü	ü
7	National Perinatal Mortality Review Tool		ü	ü

The national clinical audits and confidential enquiries that East Suffolk and North Essex NHS Foundation Trust participated in during 2021/22 are as follows:

National clinical audits		
Count	**Programme**	**Workstream / topic name**
1	Case Mix Programme	
2	Chronic Kidney Disease Registry	
3	Elective Surgery (National PROMs Programme)	
4	Emergency Medicine QIPs	Pain in Children (care in Emergency Departments)
5		Fracture Liaison Service Database

6	Falls and Fragility Fracture Audit Programme	National Audit of Inpatient Falls
7		National Hip Fracture Database
8	Learning Disabilities Mortality Review Programme	
9	National Adult Diabetes Audit	National Diabetes Core Audit
10		National Pregnancy in Diabetes Audit
11		National Diabetes Footcare Audit
12		National Inpatient Diabetes Audit, including Inpatient Audit – Harms
13	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Paediatric Asthma Secondary Care
14		Adult Asthma Secondary Care
15		Chronic Obstructive Pulmonary Disease Secondary Care
16		Pulmonary Rehabilitation – Organisational and Clinical Audit
17	National Audit of Breast Cancer in Older Patients	
18	National Audit of Cardiac Rehabilitation	
19	National Audit of Care at the End of Life	
20	National Audit of Dementia	Care in general hospitals
21	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	
22	National Cardiac Arrest Audit	
23	National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management
24		Myocardial Ischaemia National Audit Project
25		National Audit of Percutaneous Coronary Interventions
26		National Heart Failure Audit
27	National Child Mortality Database	
28	National Comparative Audit of Blood Transfusion	2021 Audit of Patient Blood Management and NICE Guidelines
29	National Early Inflammatory Arthritis Audit	
30	National Emergency Laparotomy Audit	
31	National Gastro-intestinal Cancer Programme	National Oesophago-gastric Cancer
32		National Bowel Cancer Audit
33	National Joint Registry	
34	National Lung Cancer Audit	
35	National Maternity and Perinatal Audit	
36	National Neonatal Audit Programme	
37	National Paediatric Diabetes Audit	
38	National Prostate Cancer Audit	
39	National Vascular Registry	
40	Respiratory Audits	National Smoking Cessation 2021 Audit
41	Sentinel Stroke National Audit Programme	

42	Serious Hazards of Transfusion	
43	Society for Acute Medicine Benchmarking Audit	
44	Trauma Audit and Research Network	
45	Urology Audits	Cytoreductive Radical Nephrectomy Audit
46		Management of the Lower Ureter in Nephroureterectomy Audit

Confidential enquiries		
Count	**Programme**	**Workstream / topic name**
1	Child Health Clinical Outcome Review Programme	Transition from child to adult health services
2	Maternal and Newborn Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry
3		Perinatal confidential enquiries
4		Perinatal mortality surveillance
5	Medical and Surgical Clinical Outcome Review Programme	Crohn's
6		Epilepsy study
7	National Perinatal Mortality Review Tool	

The national clinical audits and national confidential enquiries that East Suffolk and North Essex NHS Foundation Trust participated in, and for which data collection was completed during 2021/22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audits			
Count	**Programme**	**Workstream / topic name**	**Submission rate %**
1	Case Mix Programme		Ongoing
2	Chronic Kidney Disease registry		Ongoing
3	Elective Surgery (National PROMs Programme)		Ongoing
4	Emergency Medicine QIPs	Pain in Children (care in Emergency Departments)	Ongoing
5	Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	Ongoing
6		National Audit of Inpatient Falls	Ongoing
7		National Hip Fracture Database	Ongoing
8	Learning Disabilities Mortality Review Programme		Ongoing
9	National Adult Diabetes Audit	National Diabetes Core Audit	Ongoing
10		National Pregnancy in Diabetes Audit	Ongoing
11		National Diabetes Footcare Audit	Ongoing
12		National Inpatient Diabetes Audit, including Inpatient Audit – Harms	Ongoing
13		Paediatric Asthma Secondary Care	Ongoing
14		Adult Asthma Secondary Care	Ongoing

15	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Chronic Obstructive Pulmonary Disease Secondary Care	Ongoing
16		Pulmonary Rehabilitation – Organisational and Clinical Audit	Ongoing
17	National Audit of Breast Cancer in Older Patients		Ongoing
18	National Audit of Cardiac Rehabilitation		Ongoing
19	National Audit of Care at the End of Life		100%
20	National Audit of Dementia	Care in general hospitals	No data collection
21	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		Ongoing
22	National Cardiac Arrest Audit		Ongoing
23	National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management	Ongoing
24		Myocardial Ischaemia National Audit Project	Ongoing
25		National Audit of Percutaneous Coronary Interventions	Ongoing
26		National Heart Failure Audit	Ongoing
27	National Child Mortality Database		Ongoing
28	National Comparative Audit of Blood Transfusion	2021 Audit of Patient Blood Management and NICE Guidelines	100%
29	National Early Inflammatory Arthritis Audit		Ongoing
30	National Emergency Laparotomy Audit		Ongoing
31	National Gastro-intestinal Cancer Programme	National Oesophago-gastric Cancer	Ongoing
32		National Bowel Cancer Audit	Ongoing
33	National Joint Registry		Ongoing
34	National Lung Cancer Audit		Ongoing
35	National Maternity and Perinatal Audit		Ongoing
36	National Neonatal Audit Programme		100%
37	National Paediatric Diabetes Audit		Ongoing
38	National Prostate Cancer Audit		Ongoing
39	National Vascular Registry		Ongoing
40	Respiratory Audits	National Smoking Cessation 2021 Audit	
41	Sentinel Stroke National Audit Programme		Ongoing
42	Serious Hazards of Transfusion		Ongoing
43	Society for Acute Medicine Benchmarking Audit		100%

44	Trauma Audit and Research Network		Ongoing
45	Urology Audits	Cytoreductive Radical Nephrectomy Audit	
46		Management of the Lower Ureter in Nephroureterectomy Audit	

Confidential enquiries			
Count	**Programme**	**Workstream / topic name**	**Submission rate %**
1	Child Health Clinical Outcome Review Programme	Transition from child to adult health services	100%
2	Maternal and Newborn Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry	Ongoing
3		Perinatal confidential enquiries	Ongoing
4		Perinatal mortality surveillance	Ongoing
5	Medical and Surgical Clinical Outcome Review Programme	Crohn's	100%
6		Epilepsy study	83%
7	National Perinatal Mortality Review Tool		Ongoing

During the 2021/22 reporting period, 44 national clinical audits reports have been published that were relevant to ESNEFT and have been reported on or are currently being reviewed. The following are examples of the actions taken to improve the healthcare provided:

National clinical audit	Action: Based on information available at the time of publication
FFFAP – Falls and Fragility Fracture Audit Programme National Audit of Inpatient Falls Interim Report	We have created an ESNEFT joint site multi-factorial risk assessment which identifies all patients aged 65+ must have a risk assessment plus patients aged 50-64 (and younger) who may be at increased risk due to underlying medical conditions.
NMPA – National Maternity and Perinatal Audit National Maternity and Perinatal Audit – BMI of 30 or over Sprint Audit	Women are risk assessed based on their BMI as per RCOG. We already supporting research in Truffle 2 and Big Baby research projects. All pregnant women have their BMI recorded as this is a mandatory field on the current system in use.
NACAP – National Asthma and COPD Audit Programme COPD Clinical Audit 2019/20	In Ipswich we are consistently better than the national average with priority two and three and always striving to improve. Within Colchester there are improvements being made to increase accurate data reporting. As integration between hospital and GP medical records improves the access to results will get better.
National Diabetes Audit (NDA) National Diabetes Inpatient Audit Harms Annual Report 2020	The NaDIA Harms audit results are not broken down to Trust level data. However, ESNEFT continues to enter the data on a monthly basis. Life-threatening episodes of hypoglycaemia, DKA and HHS are recorded and investigated as serious incidents. This is captured within the NADIA Harms database. Monthly governance meetings review the safety and quality of the inpatient diabetes service.

Epilepsy 12 National Clinical Audit of Seizures and Epilepsies for Children and Young People Combined Organisational and Clinical Audits: Report for England and Wales Round 3 Cohort 2 (2019/20)	We can provide MRI under sedation locally and there is a GA pathway to Addenbrookes. Colchester are currently looking at the possibility of MRI under GA. We follow NICE guidelines on the recording of epilepsy syndrome diagnosis where an MRI is not indicated. Both sites include 12 lead ECG for children with convulsive seizures in their pathways and these are recorded on Evolve. Ipswich 100% of requests for ECG carried out
FFFAP – Falls and Fragility Fracture Audit Programme Facing new challenges The National Hip Fracture Database 2021	Data quality and mortality is improving. Ipswich Hospital had 73% NICE compliant surgery compared to 71% nationally. We were also able to provide 96% of our patients with a prompt orthogeriatric review compared to 89% national and 83% of our patients returned to their original residence compared with 70% national. The service has acknowledged from the data that some areas need to be reviewed and improved and they have already identified where improvements can be made with time to theatre and ensuring patients are out of bed and mobilising on day one.
NPDA – National Paediatric Diabetes Audit Annual report 2019/20	Colchester Hospital has a pump pathway and the service has improved over years. Currently 30.5% are on pumps (30.9% in east of England, 38% nationally) The challenge is to keep up with evolving technologies such as hybrid loops. 17% using rtCGM (19.4% nationally, 15.5% in east of England). Within Ipswich the current percentage on pumps is 26%. This has been static over the last few years. More staff are required to order to support these patients and reinforce the education on using the pumps to get better control of the patients Hba1c. Ideally, if we had the resources, we would like to start all patients on pumps after diagnosis. This is something that is being investigated going forward.
NCMD Second Annual Report National Child Mortality Database Programme	ESNEFT continue to use the NCMD child death case alert functionality. This ensures regular and timely review of all alerts to inform immediate national learning and action, to ensure the safety of other children.
MBRRACE-UK: Maternal Newborn and Infant (MNI) Clinical Outcome Review Programme Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK	ESNEFT ensure early senior involvement of the maternal medicine team for any pregnant or postpartum woman admitted with COVID-19, whatever her gestation and wherever in the hospital she receives care. Both sites have updated their guidance to reflect the recommendations within this report.
SAMBA (Society for Acute Medicine Benchmarking Audit) Samba 2021 Report	Performance against key clinical quality indicators was similar in SAMBA 2021 to SAMBA 2019, suggesting that the performance of acute medical services now is comparable to pre-pandemic performance. Referrals to acute medicine via ED have increased, with 70% of medical admissions referred this way. In Ipswich this figure was 74%.

Clinical Outcome team – local clinical audits (as of 27/01/2022)

Clinical audit is "a quality improvement process that seeks to improve patient care and outcomes through a systematic review against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement to healthcare delivery." – The National Institute for Health and Clinical Excellence (NICE) "Principles for Best Practice in Clinical Audit in 2002".

During 2021/22, ESNEFT's divisions planned to carry out 184 audits. As of 27/01/2022, 74 audits have been completed. A breakdown is as follows:

Division	Planned	Registered	Completed	Ongoing	Overdue
Medicine (Colchester)	18	13	7	5	1
Medicine (Ipswich)	14	14	4	7	3
Cancer and Diagnostics	46	38	15	22	1
General Surgery and Anaesthetics	15	13	6	1	6
MSK and Specialist Surgery	31	22	12	2	8
Women's and Children's	48	40	28	10	2
Integrated Pathways	12	10	2	10	0

The local clinical audits which were completed were reviewed by the Governance and Clinical Outcome teams. The following outcomes were highlighted and actions implemented to improve the quality of healthcare provided:

Group one	
Medicine (Colchester)	
Local clinical audit	**Outcome**
FICB in NOF	• Only 58% of the presented patients underwent a pain assessment within 15 minutes of arrival. • 8% of the notes were compliant with applying and following the Local Safety Standard for Invasive Procedure (LocSSIP). • 58% of the patients had an x-ray to confirm the diagnosis within 90 minutes of arrival at the department. **Standards have not been met.** **Actions:** • Remind nurses/ healthcare assistants about pain scores. • Emphasis on protocols and pathways being reviewed and updated to ensure a focus on the rapid assessment and relief of pain.

	• Guidance to be given to clinicians to request pelvic x-rays promptly when faced with possible NOF fracture. • Offer analgesia promptly to patients with suspected NOF fractures. • Protocols and pathways to be reviewed and updated to ensure a focus on the rapid assessment and relief of pain. • Ensure pain is reassessed. • Emphasising rechecking analgesia effect post procedure. • Encourage compliance with the checklist to ensure that steps are not missed. **Risk:** Severe
LocSSIP – chest drain insertion	Results of 3D cycle demonstrated continuous trend towards improvement in our compliance with both LocSSIPs, which is very reassuring. Plans to convert this into a QIP as next steps.
FICB LocSSIPs audit	Results of 3D cycle demonstrated a continuous trend towards improvement in our compliance with both LocSSIPs, which is very reassuring. Plans to convert this into a QIP as next steps.
Management of respiratory failure in the ED	Performance of arterial blood gases and this occurring within an hour has improved. Oxygen prescription completion has improved, as well as the treatment of the primary diagnosis has markedly improved. **Standards not met:** • Acute respiratory failure patients requiring oxygen supplementation reviewed within one hour of arrival in the ED. • Documentation of respiratory failure identification. • ABG performed. • Correct treatment. • Documented escalation to ED senior or speciality. • Documented reassessment of patients whilst in the ED. • Oxygen prescription completed. **Actions:** • Education/clinical lead on respiratory failure.

	• Peer-to peer support. • Documented template. **Risk:** Manageable
Management of atrial fibrillation (AF) in the ED	**Current audit criteria met the target standards.** However, a decrease was seen in the percentage of CHA2DS2VASc and HASBLED scores calculated compared to last cycle, which could be partly due to having a larger sample size. Percentage of AF clinic referrals have improved, despite AF clinic interruption during the cycle. Overall improvement in AF management in ED from August 2019 to June 2021, despite this minor setback. Scope for further improvement.

Mental health assessment in the ED	• Relatively adequate evidence of risk assessment.
	• Little documented evidence of searching:
	  ○ What if patient is carrying a dangerous object?
	  ○ What if the patient reattends having self-harmed with tools such as needles or cannulas stolen from ED?
	• Very little documented evidence of basic psychiatric assessment.
	
	Standard: Patients at medium/high risk of self-harm or suicide should be searched for objects/medication that may be used to self-harm.
	
	Standard: A mental state examination should be recorded in the patient's ED clinical record.
	
	Action: Junior doctors to be informed at induction about the necessity of completing mental state examinations.
	
	Standard to be re-audited following at least one four-month rotation.

DNACPR and end-of-life care in the ED	**All standards met.**

	ED clinicians are good at understanding dying patients. There was a good completion of valid and correct DNACPR forms and starting the palliative care pathway. There were few numbers of completed treatment escalation plans and very little documented evidence of advance care plan decisions.

Group one	
Medicine (Ipswich)	
Local clinical audit	**Outcome**
Local Safety Standard for Invasive Procedures (LocSSIPs) – completion of checklists in Ipswich emergency care clinical delivery group	36 of the 37 procedures had a checklist in place, albeit one of these should have had two checklists as two procedures were undertaken (so 36 of 38 is the equivalent of 95%). This compliance was far better than the previous audit earlier in the year. A rolling audit will take place every quarter. **No actions are required.** **Risk**: Manageable
Local Safety Standard for Invasive Procedures (LocSSIPs) – completion of checklists	36 of the 37 procedures had a checklist in place, albeit one of these should have had two checklists as two procedures were undertaken (so 36 of 38 is the equivalent of 95%). This compliance was far better than the previous audit earlier in the year. A rolling audit will take place every quarter. **No actions are required.** **Risk**: Manageable
Use of antibiotics according to Trust guidelines	There was a 76.47% compliance with Trust guidelines on antibiotic prescriptions and use in the ED. **Standard:** Non-compliance with Trust antibiotic guideline is 23.53%. **Actions:** ED clinicians to familiarise themselves more with the Trust guidelines on antibiotic use. **Risk:** Manageable

Management of asthma	**Standard:** All patients with acute asthma should have peak expiratory flow rate (PEFR) completed so that we can assess their risk and plan their management according to guidelines. The ED is only achieving 50% of PEFR recordings. Therefore we are failing at the standard. **Actions:** Teaching opportunities, use of sign boards and increasing staff. **Risk**: Manageable

Group one	
Cancer and Diagnostics	
Local clinical audit	**Outcome**
Neutropenic sepsis – mandatory audit of 'door to needle time' – antibiotic administration for patients with neutopenic sepsis (one hour standard) – oncology and haemo-oncology patients	2021/22 – Compliance with door to need time standard of one hour for antibiotics in suspected neutropenic patients for oncology and haematology: • Colchester – 90% • Ipswich – 83% **Actions:** Further training/education and support in the sepsis pathway. **Risk:** Manageable
Mandatory audit of deaths within 30 days of last systemic ante-cancer therapy (SACT) (national NCEPOD recommendation 2008) – clinical oncology and haemo-oncology patients	At Colchester Hospital, the review showed overall low number of 30-day SACT deaths over the two-year audit period. In nearly 70% of the audited cases, the reviewers concluded SACT had not played a role in the cause of death. **Recommendations:** 1. All 30-day SACT deaths must be reviewed in a timely manner by relevant clinicians, and any delay to the process should be highlighted to the Oncology Governance team and audit lead. 2. Data of 30-day SACT deaths must be submitted for national audit as per the Trust's mandatory audit policy. 3. All 30-day SACT deaths flagged with concerns by reviewers and all 30-day SACT deaths in patients treated with radical and/or curative intent must be presented in hospital mortality and morbidity meetings.

Exclusion of the lens of the eye in standard head CT examinations	**One of one Royal College of Radiologists standards met.** 70 scans, with six excluded as per criteria. Of the 64 remaining: • Three orbits partially included but not lenses (4.69%) • One unilateral lens inclusion (1.56%) • 60 bilat lens inclusion (93.75%) This represents a heavy drop off from the last audit in 2014 (43% compliance). On presentation to the department and discussion with radiographer team, this was attributed to new CT scans where gantry tilting is no longer possible, a lack of awareness/training on the agenda for CT radiographers and poor patient compliance/instruction.
CTPA according to the wells score (re-audit)	**Standards met.** Improvement in clinician compliance. **Actions:** Continued education.
Audit of pregnancy status recording	**74% compliant with the Royal College of Radiologists standard.** **Actions:** • Disseminate audit findings to staff members within Diagnostic Imaging. • Look at the current system of recording patient's pregnancy check. • To query the efficacy of the post exam scanning of forms. Is there an alternative way of ensuring this is done effectively? • Will the use of mobile CRIS increase compliance? • New filing system for paper referrals in CT to identify pregnancy check forms for re-scanning. • Re-audit in three months to assess whether practice has changed and if the compliance rate is 100%. • Discuss with the radiographers involved in the non-compliant CRIS events to make them aware of the findings.
Audit of LocSIPP compliance for fine needle aspiration procedures	**Two standards not met 85%.**

	We have identified there is sometimes an issue with consultants completing the forms. The audit means that these can be chased in a timely manner.
Urology cancer patient support and information giving omitted doses	**Five standards met as per NICE guidelines NG131.** • All prescribed critical medicines should be administered within two hours of the prescribed time, unless omitted for an appropriate clinical indication – **98/99% compliant RR4.** • All critical prescribed doses which are omitted due to a clinical reason should have the clinical reason clearly documented in the nursing notes – **62/65% compliant RR6** • All critical prescribed doses which are omitted due to drug unavailable should be due to the medication actually being unavailable (eg. not available within the hospital) – **100/90% compliant RR 4.** **Three standards to be improved on.** **Actions:** training, awareness and education. Re-audit early 2022.
Adherence to the Royal College of Emergency Medicine antidote guidance at Colchester Hospital	**Two standards both met.** All category A medicines available in ED and all category B medicines available in the electronic medicines compendium or other parts of hospital.
Appropriateness of radiotherapy referrals under IR(ME)R	**Standard met.** All patients referred for radiotherapy and reviewed for this audit were appropriate based on their history and evidence of MDT decision making.
Management of unplanned gaps	**Standard met 100%.** All patients were assessed and gap management agree with their clinician. Compensation was in line with RT/Ref/17.
Audit of gap management for category one patients	**Three standards met.** Royal College of Radiologists guidelines state that audits should show that there was no prolongation in overall treatment time in

	excess of two days for at least 95% of the group of category one patients. No patients had prolongation of more than two days due to successful gap management during bank holidays and weekends or hypo-fractionation. For category two patients there should be no prolongation of treatment in excess of two days for 95% of the group, although it is accepted that prolongation of five days may not affect patient outcomes. One of 59 patients had prolongation of three days but this falls within the five day period so was acceptable Category three - prolongation of treatment times are less critical in this group but may require compensation if prolongation extends beyond seven days. No patients extended beyond this time in this group.
Trust-wide consent audit (Radiotherapy) – carried out alongside record keeping audit	**Standard met.** The department is going through a major paperless project, moving the treatment and care records to an electronic solution. The data recorded will be associated with an electronic signature and will be date stamped.
Clinical record keeping (Radiotherapy) – carried out alongside consent audit	**Standard met.** The department is going through a major paperless project, moving the treatment and care records to an electronic solution. The data recorded will be associated with an electronic signature and will be date stamped.
31-day referral to date of death for palliative and emergency radiotherapy treatments	**Standard met.** This is the first audit for 90 day to death for radical patients. Going forward the department will keep a database of deaths within the specified timescale criteria to monitor tumour sites, reasons for death and any co-morbidities which may have contributed to patient deterioration.

Group two	
General Surgery and Anaesthetics	
Local clinical audit	**Outcome**
P-Alice	As this is linked to a national audit, no summary form will be completed nor will any outcomes be known for around 18 to 24 months.
ESWL audit – lithotripsy	**Four of five standards met.** With appropriate selection of cases, ESWL is a reasonably well accepted method of stone treatment. ESWL is a safe procedure with complications mostly managed non-surgically. **Actions:** Make all doctors aware of the need for minimum metabolic evaluation in the form of serum calcium and serum uric acid in all ESWL/stone patients via email and active monitoring.
Primary biliary cholangitis audit	As this is linked to a national audit, no summary form will be completed nor will any outcomes be known for around 18 to 24 months.
Unplanned overnight admissions following day case surgery	1. Surgical reasons predominated the number of overnight admissions. 2. Bleeding, complicated procedure and drain being left in situ were the leading surgical causes. 3. Poor recovery and PONV were the major anaesthetic causes. 4. Urology and general surgery had the highest number of admissions
Two week wait referral to the Colchester Hospital haematuria clinic – a retrospective analysis	**One of four standards met.** Conduct a training session on triage and speeding up the pathway. Expediting dates for patient's investigation at the Radiology Department through appropriate booking and pre-operative assessment to prevent cancellation of surgery. **Actions:** 1. Early pick up of the referrals and booking into the haematuria clinic. 2. Triaging and speeding up the pathway by booking radiological investigations upfront before attending the haematuria clinic. Expediting dates for patient's investigation at the Radiology Department.

	3. Appropriate booking and pre-operative assessment to prevent cancellation of surgery.
End-of-life ICU candidates for organ donation	**Standard not met:** Target 95%, actual 93.3% **Actions:** Education amongst ICU staff needed on what constitutes a valid referral for organ donation. Also need to ensure consistency in monthly referrals

Group two	
MSK and Specialist Surgery	
Local clinical audit	**Outcome**
Post-operative weight bearing instructions for adult patients undergoing surgery for lower extremity fragility fractures (FFPOM)	**No local outcomes.** Department is awaiting national outcomes and will implement those recommendations.
Outcomes following fixation of non-union fracture of the scaphoid	**All standards met.**
Audit of emergency activity in the virtual reality service during the first COVID-19 lockdown	**One of two standards met.** Proactive approach to inform optometrists, ED and GP services of importance of timely referral to virtual reality services may be beneficial in case of any future lockdowns. **Actions:** Staff training session to ensure people are aware of future expectations around potential patient care delays resulting from government restrictions
Prescription of regular medications on admission	**Standard not met:** Target 100%, actual 32 out of 122 (26.2%) Trauma and Orthopaedic inpatient drug charts showed lack of or insufficient prescription of regular medications on admission. **Actions:** Meet with local clinical team to present findings, identify expectations and standards and raise awareness.
Documentation of Medical Council number in clinical records	**Standard not met:** Target 100%, actual 4%. Only 4% of documents include doctor's GMC numbers. Staff training has been undertaken.

	Actions: Meet with local clinical team to present findings, identify expectations and standards and raise awareness
Radiographic justification and reporting of orthopantomography (also known as OPG x-ray) taken in the Outpatient Department	**Standard not met:** Target 100%, actual 0%. Compliance of 0% was due to the OPG machine not being available for use out of hours. **Actions:** Oral to work with speciality surgery CDG to have an OPG machine available 24/7
iSTENT inject G2	**All standards met.**
Nurse-led skin cancer care audit	**All standards met.**
Biologics in psoriasis	**Two of three standards met.** A substantive nurse consultant has been employed in line with the recommendation.
Management of diabetic retinopathy (April 2018 to March 2019)	**All standards met.** Importance of support staff (diabetic eye screening programme and hospital secretaries, fail safe officers, administrative staff and receptionists) in maintaining the current high quality service.
Is there evidence of poor diabetic control in patients who have spondylodyscitis?	**Standard met.** Exposed the underappreciated value of poor control of HbA1c (glycated haemoglobin) in the community and its association with discitis.
Ophthalmology COVID-19 audit – activity, capacity and staff	Disparity between the numbers of staff allocated to different services which did not necessarily reflect patient volume. Local decisions to be made in line with situations.

Group two	
Women's and Children's	
Local clinical audit	**Outcome**
Clinical Negligence Scheme for Trusts (CNST) element audits (including reduced fetal movement)	**Reduced fetal movement audit for Ipswich – zero of one standards met.** No summary received.

	Recommendations disseminated: • Raise awareness of the new British Association of Perinatal Medicine guidelines. • Project to improve compliance of completion of second trimester assessment (all trimester assessments). • Raise awareness with midwives of the importance of documenting discussions around a change in pattern of fetal movements with women. • Ensure translation inserts for the pregnancy wallets are given out to reach non-English speaking/reading women. **Saving Babies Lives care bundle for Ipswich – five of six standards met.** Action plans are in place. CO monitoring was paused due to COVID-19 but has now restarted.
Maternal sepsis screening and sepsis six compliance	**One of two standards met.** (April deep dive data) **Actions:** • Launch the sepsis screening tool, clinical guideline and maternity sepsis e-learning to align with UK Sepsis Trust/ NICE sepsis guideline. • Waiting for the updated clinical guideline approval by the divisional group. • Inform the audit results at the local governance meeting. • Ensure that the frontline staff are informed of the audit results. • Re-audit rolling.
IOL audit	**Standards met.** **No actions.** Re-audit after one year.
Domestic abuse enquiries in pregnancy	**Zero of two standards met.** **Recommendations**: • Raise awareness with midwives regarding the importance of asking public health questions and completing

	risk assessment at booking, first trimester and second trimester or more often if concerns are raised. • Promote the importance of documenting women's emotional wellbeing at every face-to-face appointment as this may lead to more women feeling able to disclose regarding domestic abuse. • Raise awareness of how to refer to domestic abuse support services and/or safety planning. • Raise awareness of the impact of domestic abuse on the unborn/ baby and when to refer to social care services.
Hepatitis B and C – neonates	**One of one standards met.** **Actions:** • Adopted/moved out – letter to GP. • Regular monitoring/screening of the notes of these babies. • Keep a log of antenatal cases so none miss follow up. **Risk:** Manageable
IBD audit (from 2019. Unable to present due to COVID-19. This will be updated with two years of data for comparison)	**One of two standards met.** **Actions:** • All referrals to tertiary care will be copied to local gastro team. • Monitoring drug treatment will be analysed in next audit. • Re-audit 2023. **Risk:** Manageable
Neonatal resus proforma re-audit	**Three of six standards met.** The imperfect results are due to a small number of babies still lacking proformas being completed and or uploaded to evolve. **Actions:** • Circulating audit results with recommendation amongst paediatrics and maternity team. • Addition of option box to tick "please refer to resus note on Badger Net/ continuation sheet". • Reminder of need to have proforma on every resuscitaire and in every delivery room.

	• Document all resuscitations and when resuscitations have not been performed. **Risk:** Manageable
One-to-one care in labour audit	**Two of three standards met.** **Actions:** • Midweek memo to include definitions and when to report lack of one-to-one care. • Thank you to be sent to all staff for prioritising workload and acuity to ensure women are given one-to-one care in labour. **Risk:** Manageable
MEWS/MEOWS on admission audit	**Colchester – three of three standards met.** **Ipswich – zero of two standards met.** **Actions:** • Share results via staff newsletter and request feedback. • Update 'frequency of observations in labour' table provided for all birthing rooms to ensure clarity related to national guidance and best practice (also incorporated into guideline). • MEOWS parameters included on updated labour partogram to improve compliance of moving to MEOWS chart if abnormal parameters present. • Elective LSCS pathway and pink bereavement labour notes / partogram to be updated. • Rolling monthly re-audit.
Obstetric VTE audit	**Zero of standards met**: Target 100%, 98% and 96.5% achieved. **Actions:** The patient needs to score three postnatal for 10 days rather than six weeks unless there are persisting risk factors. Need for six weeks if they scored three from antenatal. • Parity and age can change at birth and score will change – re-do the scoring on Medway at 28 weeks and postnatal • BMI 30 and above scores one. • Encourage smoking cessation as this reduces score and need for LMWH

	Re-audit in six to 12 months. **Risk:** Manageable
Shoulder dystocia	**Zero of one standards met:** Compliance with documentation was 75% rather than 100%. **Actions:** • Training on shoulder dystocia documentation included in statutory training. • Discuss incorrectly completed paperwork with specific staff members. **Risk:** Manageable
GROW	**One of one standards met.** **Actions:** Investigated missed cases and re-audit annually. **Risk:** Manageable
Nocturnal enuresis audit	**One of one standards met.** **Actions:** • Immediate four week assessment after commencing either desmopressin or enuresis alarm therapy. • Monthly telephone clinic. • Asking parents who choose to purchase their own alarm to inform the support secretary when they have started alarm therapy so that a clinic slot can be booked. • Promote patient engagement as this leads to more effective care, quicker resolution and better patient satisfaction. • Short term – assessment template. • Long term – non-medial nurse prescribing. **Risk:** Manageable
Febrile neutropenia – Colchester	**Four of four standards met.** Re-audit not needed short term. **Risk:** Manageable
Multiple pregnancies re-audit of PPH	**Three of three standards met.**

	Continue additional monitoring.
Paediatric headache	**Zero of three standards met.** **Actions:** Improve recording, use of headache diary and use of information leaflet. **Risk**: Manageable (RAG 1).
Cervical cytology following subtotal hysterectomy	**Zero of one standards met.** **Recommendations disseminated:** • Education of health professionals/ surgeons on the importance of informing patients adequately about subtotal hysterectomy, the presence of a cervical stump and the need to continue with the surveillance program against cervical cancer. • Proper and extensive documentation regarding information about subtotal hysterectomy must be made available to patients and GPs. • Ethical follow-up of this audit's subjects should be done to mitigate possible adverse events regarding audit outcomes. • Re-audit not stated. **Risk:** Manageable
Assessing discharge criteria for children with bronchiolitis – Colchester	**Three of three standards met** (100% for all) No action plan or re-audit in short term.
Cow's milk protein intolerance (CMPI)	Summary form being sent. **From presentation, two of four standards met.** Actions suggested: • Diagrams of the iMAP algorithms should be visible on the Children's Assessment Unit and Children's Outpatient Department. These can also be given to new doctors in the Paediatric Department. • Where possible, mothers encouraged to breastfeed on a maternal milk-free diet rather than starting allergy formulas. • Withhold from starting anti-reflux medication on same day as allergy formulas at first presentation.

	• Emphasise to parents the significance and safety of re-challenging milk at home when starting allergy formula / milk-free diets and provide leaflets on this to reduce resistance. • Information should be made available to healthcare workers on the relative costs of treatment with different allergy formulas.
Cat 1 LSCS	**Zero of one standards met.** Actions and monitoring to reduce decision to delivery time. **Risk:** Manageable
Colposcopy MDT audit	**Four of our standards met** – 100% compliance. Higher proportion of cancers being diagnosed clinically rather than screening and going straight to Gynae Oncology MDT – action to discuss all was completed in November 2021. Colchester presentation showed one standard not met, but was already known prior to audit and discussed at MDT. Further plans including electronic patient record in formulation.
Delivery Suite ward round re-audit	**Zero of one standards met in Ipswich.** **Actions:** • Audit tool simplified to capture twice daily ward rounds. • Re-audit Q1/2 2022/23. **Risk:** manageable **Zero of one standards met in Colchester.** **Actions:** • Robust data recording reinforced. • MDT handover needs to be consistent. • Re-audit Feb 2022. **Risk:** manageable
Post-partum haemorrhage across-site quality improvement audit	**One of two standards met.**

	Actions: Cross site post-partum haemorrhage proforma designed and in use – re-audit to monitor success. **No summary received** – rolling data for Ipswich presented. Awaiting cross site data.
Urogynae audit/ recurrence of vaginal prolapse	**Two of two standards met in Ipswich.** **Actions:** Send information to each patient still waiting for surgery from June 2018 to present. Recheck action plan after one year.
Complex pregnancies (named consultant, early specialist involvement, management plan, consultation with woman	**One of three standards met in Colchester** (Medway issue). Actions: • A Medway workflow is to be developed with obstetric input to ensure a unified approach to record-keeping in antenatal clinics. • Obstetricians must add/amend named consultant lead when they review a woman in clinic. • Booking and antenatal risk assessment guideline requires updating to ensure complex pregnancies are referred to the appropriate clinics. • Staff are to be educated once the guideline is updated. • Consider ways of consolidating women's appointments when they receive care from different clinics. **Risk:** Manageable. Re-audit. **Zero of one standards met across ESNEFT** (February 2021 audit). Re-auditing and updating guidelines.
Risk assessment at every antenatal contact, care plan complete, place of birth discussed	**Two of three standards met in Colchester.** **Actions:** Workflow being developed. Re-audit in Q4. **Risk:** Manageable **Standards not met in Ipswich** (February data).

	Re-audit in progress and workflow being developed.
Heavy menstrual bleeding and ambulatory service combined Ipswich audit	**Presentation suggests at least two out of four standards met in Ipswich.** Summary form not received. **Recommendations:** Redesign heavy menstrual bleeding clinic referral documentation and possibly increase clinic capacity.
LocSSIP 028 New invasive procedure in antenatal clinic LocSSIP (Ipswich)	**100% compliance.** No short term actions.
LOCSSIP – maternity 017/B (swab count audit)	**Awaiting summary of Maternity LocSSIP Ipswich.** Actions: • Reminder to complete all fields. • Home birth data to be included in next audit. • Labour ward coordinator second check of count. • Re-audit. **LocSSIP Colchester** – due to be presented in February 2022

Group three	
Integrated Pathways	
Local clinical audit	**Outcome**
Dietetics record card audit	This was a difficult audit as each team and staff within those teams used different methods of documentation (both written and electronic). Therefore, multiple audit proformas had to be used when auditing the record cards. We are currently transitioning to using electronic notes fully and are in the process of developing new electronic dietetic records that will be used department-wide (in addition to our current electronic notes) to reduce variety and standardise our documentation. It is important to note that whilst we may gain consent verbally when we approach a patient, this must be documented to evidence that it took place. Patient records are legal documents and should they ever

	need to go to court, the notes are examined in chronological order. For this reason, the time should always be documented. This also helps when other healthcare professionals are looking at the notes. The nutrition-related standards not met as documented in key findings form part of our basic dietetic assessment which underpins dietetic intervention. **Standards met:** • consent 54% • anthropometry/ nutritional 80% • time 60% • review date 81% • clinical 79% • patient details/ location 85% • aim 91% • plan 98% **Actions:** To make 'feedback to department' mandatory on all our electronic templates before submission, as this underpins dietetic intervention. This will become automatic once we transfer completely to electronic notes. **Risk:** Manageable.
Physiotherapy band 5 induction booklet	There is a need to standardise the induction process for orientating new band 5 physiotherapists, as there are currently discrepancies between departments. Feedback from this staff group is that a departmental induction booklet would help facilitate the induction process. The majority of our band 5 physiotherapists joined the Trust last year. When responding to a survey: • 20% felt that the departmental induction process was fairly sufficient. • 30% felt the process was insufficient. • 20% of the new starters were formally orientated to the department and their rotation. • The majority of the new starters obtained basic departmental information through word of mouth from colleagues rather than having a formal orientated in the department.

	• Some highlighted that there is a lack of standardisation from the department during induction. This created a knowledge gap amongst new starters where some felt that they only found out certain induction-related information much later than others. • All of them felt having an induction booklet as a new starter would be helpful to facilitate the induction process. More than 90% of the respondents wanted the following content in the induction booklet: • an introduction to different rotations offered to band 5s and their respective line manager • drive maps • ward phone numbers / useful bleep numbers • discharge information • on-call information • details about preceptorship • courses offered within the Trust **Standards met:** We have identified that we need to create and distribute induction booklets to new band 5 starters as a quality improvement project. **Actions:** Develop band 5 physiotherapist induction pack. **Risk:** Manageable.

Additional audits that were not pre-planned and approved at the beginning of 2021/22 have also been registered to allow for changes in guidance, service-related issues and any unforeseen situations that arise throughout the year. A breakdown is as follows:

Division	Registered	Completed	Ongoing	Overdue
Medicine (Colchester)	3	1	1	1
Medicine (Ipswich)	8	3	1	4
Cancer and Diagnostics	15	10	2	3
General Surgery and Anaesthetics	29	15	5	9
MSK and Specialist Surgery	44	20	12	12
Women's and Children's	12	5	4	3
Integrated Pathways	12	4	4	4

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

Participation in clinical research

Yellow highlighted YTD these will be updated at the end of March 2022

The number of patients receiving relevant health services provided or sub-contracted by East Suffolk & North East Essex NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 4,231.

Recruitment into studies

During 2021/22, ESNEFT was able to deliver relevant research benefits to 4,231 (6,222 in 2020/21) participants on COVID-19 and non COVID-19 clinical trials, including trials to reduce symptoms, increase survival times and improve quality of life.

Participants Recruited into research studies at ESNEFT 2021/2022				
	NIHR Porfolio	Non Portfolio	Total	%
Commercial				
Non commercial				
Total			4231	100

We remain dedicated to supporting clinical research in order to improve the quality and experience of care for our patients, as well as to make our contribution to wider health improvements. We actively seek to attract high quality research staff to help develop our research portfolio. The number of staff involved within our research and development fixed workforce is 66, while there are currently 124 principal investigators leading active research studies. Our Trust was involved in 90 recruiting clinical research studies during 2021/22 across 28 clinical units.

The outbreak of COVID-19 and associated restrictions had a significant impact on our research portfolio and resulted in the majority of our active research studies being paused in March 2020. We have now restarted all of the studies which have been restarted nationally by the sponsor. During the year, we continued to support 11 COVID-19 NIHR urgent public health studies to help the NHS better understand the range of symptoms caused by the virus and the most effective treatments.

Our Trust is a member of the NIHR Clinical Research Network: Eastern (CRNE), which is responsible for effectively delivering NIHR research in the east of England. The majority of funding for our research activity flows through CRNE, with just over £1.7m allocated for research staff and supporting activity during 2021/22. This funding supports research posts and clinical support departments.

As well as increasing the opportunities for our service users to take part in NIHR portfolio research studies, the Trust has an ambitious strategy for research and development which includes hosting and developing our own research for the benefit of patients and our local community. We are continuing to build our team to deliver that ambition. The team now includes two allied health professional clinical academic research leads, while a joint clinical academic post with Professor Colin Martin from the University of Suffolk (UoS) is in place. We have plans to develop more similar posts with local universities in the future.

Prof Martin is a professor of clinical psychobiology and applied psychoneuroimmunology at UoS and clinical director of the university's Institute for Health and Wellbeing, as well as holding the joint appointment with ESNEFT.

He said: "This is a wonderful and exciting opportunity to develop collaborative multidisciplinary research which is clinically applied, contributes meaningfully to the evidence base and adds significantly to improving care and outcomes."

Evidence shows that trusts which carry out a lot of research activity provide a better quality of care to patients. We are developing several exciting homegrown projects and grant applications from our researchers which will enable us to strengthen our patient involvement in early research planning. Our research teams ensure that our researchers at ESNEFT have the support and the infrastructure in place so that patients can benefit from participating in research.

ESNEFT own account research			
	2020/21	2021/22	Sucessful
Applications for support	51	62	
Grant applications	11	13	3

In addition to the continuing rapid response to COVID-19, our staff have demonstrated the vibrancy and innovative practice of a research active organisation in the last twelve months by producing conference abstracts and publications in high quality academic journals. During 2021/22 (219) articles and abstracts were produced.

Patient and public involvement in research and development

Working with patients who have taken part in NHS research studies and listening to their input is of huge benefit, and we actively encourage their participation when we design and run studies. Paul Charlton, one of our research ambassadors, has described his experiences of palliative care and his involvement in a NIHR funding committee, which is available on the National Cancer Research Institute's website.

How healthcare is regulated

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

ESNEFT has no conditions on registration. No enforcement actions were taken against the Trust in 2021/22.

ESNEFT has taken part in the following special reviews/investigations by the CQC during 2021/22:

- Focused inspection of acute maternity units:
    - Colchester site – 30 March 2021
    - Ipswich site – 6 April 2021
- Engagement call with chief pharmacist: Medicines Safety/ Governance – 24 June 2021.
- Inspection of Ipswich Radiology Department for compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 [IR(ME)R] – 25 November 2021.

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.

The CQC's new strategy for the inspection of services moves towards a process of smarter regulation which enables a more dynamic and flexible approach. Its aim is to provide up-to-date and high quality information and ratings, easier ways of working with CQC and a more proportionate regulatory response. The CQC will inspect in a targeted way which supports services to improve and prioritise safety.

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. Although inspections have been curtailed during the COVID-19 pandemic, the CQC did schedule focused inspections where concerns had been raised. Focused inspections of the Colchester and Ipswich Maternity Units and the Ipswich Radiology Department have taken place during this reporting period.

Inspections by the Care Quality Commission

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 reinspected at any time if services fail to meet the fundamental standards of quality and safety, or if any concerns are raised.

The CQC inspected Maternity Services at Colchester (March 2021) and Ipswich (April 2021). These inspections were part of a series of focused, unannounced inspections of acute maternity services throughout England. Data requests were received in the days following each visit, with information to be returned to the CQC within one week. Detailed data for both sites was collated and approved by the chief nurse prior to upload to the CQC portal within the required timeframe. Following a review of the draft reports for factual accuracy by the division, compliance team, Chief Nurse and Director of Governance, the final reports were published by the CQC on 16 June 2021.

In line with CQC requirements, a detailed improvement plan ('must do' actions) was approved by the Director of Governance and Chief Nurse and forwarded to the CQC by the deadline of 8 July 2021. An improvement plan for the 'should do' actions has also been written, but is not required to be forwarded to the CQC. All actions are reviewed on a weekly basis by the designated action owners and the compliance lead, with a weekly update presented to the divisional management team. Actions are not considered as completed by the divisional management team until there is robust evidence available to demonstrate compliance with each action. There is additional oversight of progress by the Every Birth Every Day (EBED) Programme Board.

The focused inspection of Maternity Services identified eight 'must do' actions, which have been addressed across both sites, irrespective of which site the action originated. They are:

Regulation 12: Safe care and treatment

- The service must ensure staff complete mandatory and safeguarding training in line with the Trust target.
- The service must carry out and record regular baby abduction drills and evacuation drills.

Regulation 17: Good governance

- The service must implement an effective governance system and ensure systems to manage risk and quality performance are effective.
- The service must ensure robust review of incidents to ensure they are appropriately graded and managed to keep women and babies safe and ensure appropriate follow up care is provided.
- The service must ensure a robust strategy and vision to set out clear objectives and direction for the service and staff.
- The service must ensure that women's records are completed in line with Trust policy.

Regulation 18: Staffing

- The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit.
- The service must ensure the delivery suite coordinator is always supernumerary.

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

The Ipswich Radiology Department report of compliance with IR(ME)R regulations was finalised by the CQC on 18 January 2022. IR(ME)R reports are not published by the CQC on

its website, but findings from such reports form the basis of the CQC's annual report of compliance with ionising radiation regulations. All actions will be managed utilising the same methodology as for the Maternity Department actions, with regular feedback on progress to divisional and Trust-wide groups.

Ratings for ESNEFT

Medical staffing – rota gaps

Medical Staffing provide ESNEFT's recruitment service for medical staff for all grades of doctors. We work closely with Health Education East of England and foundation schools for doctors in training, as well as with St Helen's and Knowsley for all of our GP trainees.

We use software called TIS (Trainee Information System) to input information about all of the doctors in training who are due to rotate to us to ensure a smooth transition for both the Trust and the individual.

COVID-19 has seen us adopt some new ways of working, including online ID checks and interviews held on Microsoft Teams. These have been a huge success and will remain in use as they contribute to our Time Matters principles.

Medical Staffing has continued to work closely with the Iceni Centre to create Iceni fellow posts. This programme is due to be extended to other specialties in 2022. We have also worked closely with the royal colleges to extend our medical training initiative scheme, which now operates in Surgery, Trauma and Orthopaedics, Medicine, Obstetrics and Gynaecology and Anaesthetics.

We have a very engaged junior doctor workforce who take part in junior doctor forum meetings and safer working meetings on both sites. We have recently appointed our champion of flexible working and return to practice, who will provide further support to these groups of trainees.

During the year a Trust-wide director of medical education was put in place, along with a deputy for each site. These roles are helping to ensure parity across both sites around training.

We are currently advertising for 11 junior doctor vacancies across both sites.

Quality Improvement

Quality Improvement (QI) is not the same as 'improving quality'. It is a systematic method which involves those closest to the quality issue in discovering solutions to a complex problem. It applies a consistent method and tools, engages staff, patients, service users and families in identifying and testing ideas and uses measurement to see if changes have led to improvements. – Assessing Quality Improvement in a Healthcare Provider, CQC 2019.

ESNEFT QI activity

We recognise that staff who are closest to an issue are often the best placed to address it, and QI is designed to facilitate that process. At ESNEFT, the Quality Improvement team has developed a strategy designed to embed an organisational improvement mindset. It focuses on:

- Building QI capability in staff by teaching them QI skills and coaching them so they have access to the support required to understand problems and address change:
    - we have now trained 255 staff at bronze level QI and 184 staff at silver level
    - conversion from silver level QI training to a registered QI project is now 34%, with a further 26% in planning phases.

- Increasing QI capacity of skilled QI leaders across the Trust and embedding quality improvement processes into our services so that quality improvement becomes the 'way we work':
    - we have a 'QI champion' job description which can be built into existing/developing roles or service level job descriptions, with staff now delivering these roles within the Trust
    - we are aligning our central and local audit and improvement work more closely to ensure a strategic approach and that we are making best use of resource to drive improvements for our patients.

- Developing an ethos of continuous improvement so that projects are not only delivered as individual examples of improvement but ensure sustainability and spread:
    - 41% of our registered projects now go to completion with measurable results of improvement
    - all projects are measured against a 'return on investment' model to evidence the impact of QI at ESNEFT.

Improvement work at ESNEFT

Improvement work which has taken place across the Trust this year has included:

Patient, carer and family experience outcomes:

- Ipswich Dermatology rolled out the Vantage Rego teledermatology system to allow patients with suspect skin lesions to access care remotely during COVID-19. Results of the project were:
    - Approximately 1,000 routine advice and guidance requests were made.
    - 47% of patients were managed in primary care, saving over 400 outpatient appointments.
    - 39% of patients required a routine hospital appointment.
    - 14% of patients were fast-tracked into two-week wait appointment to support faster diagnosis.

The initiative was also named as a finalist in the Quality in Care Dermatology awards.

- The transition team completed a nurse-led project as part of NHSI's Transition Collaborative, which introduced 'transition passports' for young people with cerebral palsy to support them as they move from paediatric to adult services. The project received excellent feedback from patients and their families, including:
    - "(The passport) is a very good idea and a nice, quick and easy way to explain things. It's also helpful when I see a different people at follow-up appointment as I often get asked the same questions. This saves a lot of time!" – a young person.
    - "Over the years there is always a lot of information to tell different professionals. We've only had the passport a few weeks but it's becoming really useful to bring to appointments and to refer back to, as you can't always remember things." – a father

Staff experience:

- A Colchester emergency medicine project aimed to improve the induction of junior doctors through the introduction of an electronic SHO handbook. Staff were invited to suggest ideas for content to ensure the handbook would meet their specific needs. Key outcomes included:
    - 60% of staff said the handbook had an "extreme impact" on patient safety – a 30% improvement from baseline.
    - 60% of doctors said they used the handbook daily in practice.
    - The project was accepted as an e-poster presentation at the Royal College of Emergency Medicine Conference in 2021 and European Union Emergency Medicine Congress in Lisbon 2021.
    - Learning from the project is being fed into similar initiatives to create Trust-wide guidance on induction handbooks.

Productivity and efficiency:

- Colleagues in our Molecular Biology Laboratory completed a project to address delays in turnaround times for COVID-19 testing. As a result of changes made during the project, the team saved 7.64 hours on turnaround times by reducing the process

steps from 21 to nine. Quick wins such as laboratory staff no longer collecting samples from the drive through saved 28 hours of staff time per week. Overall:

- 24-hour COVID-19 result turnaround times improved from 36% to 86%.
- 15-hour COVID-19 result turnaround times improved from 4% to 39%. Further work is planned to further improve these turnaround times and ensure the changes are sustainable.

Cost avoidance:

- A project from the Ipswich Oral and Maxillofacial Surgery Department, which has now been published in the British Journal of Oral and Maxillofacial Surgery (58 (2020) e272-e275), aimed to reduce spend on over-the-counter medicines. By improving communication and the information given to staff, the team were able to save £1,430 over a year.

Revenue:

- A project led by allied health professionals at Colchester Hospital focused on increasing student placement capacity for occupational therapists. It was launched in response to a Health Education England request to increase capacity by 25% to meet future workforce requirements. Following thorough analysis of existing placement models and the experience of staff and students, a new peer learning MDT model of placement was introduced with the aim of not only increasing capacity, but also quality. Results showed:
  - The project increased occupational therapy placement capacity by 27.7%, which is the equivalent of an annual increase in student revenue of £17,602 for the Trust.
  - Feedback was positive, and suggests the MDT placement:
    - was a beneficial model for student learning
    - helped improve people's confidence and preparedness when working within an MDT
    - gave people more confidence in specific clinical tasks such as communication, assessment and management
    - improved people's understanding of the way individual MDT roles support patient care, including referral into different services.

Statements relating to the quality of relevant health service provided

NHS number and General Medical Practice Code validity

During 2020/21, ESNEFT submitted records to the Secondary Uses Service for inclusion in the latest hospital episode statistics.

The percentage of records in the published data which include a valid NHS number for patients seen are:

- 99.5% for admitted patient care
- 99.9% for outpatient care
- 98.3% for accident and emergency care
- 99.4% for diagnostic imaging
- 99.9% for community care

The percentage of records in the published data which include a valid General Medical Practice Code for patients seen are:

- 99.9% for admitted patient care
- 100% for outpatient care
- 99.4% for accident and emergency care
- 99.5% for diagnostic imaging
- 100% for community care

Source: NHS and Social Care Information Centre data quality dashboards (April 2020 – March 2021 position as published July 2020 – June 2021).

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

East Suffolk and North Essex NHS Foundation Trust (including community services) Data Security and Protection Assessment Report for 2020/21 was graded as 'approaching standards', and an improvement plan has been agreed. The Data Security and Protection Toolkit assessment will be 30 June 2021/22 for submission.

The Data Security and Protection Toolkit standards which are audited are randomly selected cross-specialty and audited by two NHS Digital-approved auditors using the latest methodology (V15.0 - 2021/2022).

Data Security and Protection Toolkit – levels of attainment

Acute trust	Standards met	Standards exceeded
Primary diagnosis	>=90%	>=95%
Secondary diagnosis	>=80%	>=90%
Primary procedure	>=90%	>=95%
Secondary procedure	>=80%	>=90%

The purpose of this audit is to fulfil the criteria for the Data Security and Protection Toolkit requirements and assess coding accuracy undertaken by the clinical coding team against

national clinical coding standards. The results of this audit evidence a marked improvement in the level of coding accuracy, linked to an ongoing internal training programme and mentorship, that covers all aspects of coding. This includes reinforcing issues such as improving data extraction/ documentation, coding of mandatory co-morbidities (depth of coding), signs and symptoms diagnosis and Charlson index codes.

Clinical coding

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.

ESNEFT 2021/22 audit result

	Primary diagnosis	Secondary diagnosis	Primary procedure	Secondary procedure
ESNEFT	94.50%	**94.23%**	92.80%	**92.12%**

Data quality

The Trust took the following actions during 2021/22 to improve data quality:

Data quality indicator	Update
Valid NHS number and valid GP practice code	An IT project to procure clinical systems will continue to drive improvements to our performance within the data quality maturity index (DQMI). This is already bringing benefits in parts of the Trust, such as at Colchester Urgent Treatment Centre where the introduction of new software linked to the national Spine system has led to improvements in both NHS number and GMP codes.
Valid NHS number and valid GP practice code	The Trust is about to introduce a combined electronic patient master index across both of our acute sites and all our clinical systems. This will bring us towards “one version of the truth” by helping ensure that update information is getting to all the necessary systems in a timely manner.
Valid NHS number and valid GP practice code	ESNEFT now has a functioning data quality team operating across Ipswich and Colchester hospitals and their respective PAS systems. Reporting of data quality metrics across both sites have been largely aligned and we now have a suite of Power BI reports available for Trust use.
Valid NHS number and valid GP practice code	The data quality team have introduced new weekly checks of our whole electronic patient master index against the national Spine. This flags discrepancies in key patient demographics (such as NHS number and GP registration) for the team to investigate and correct.

Learning from deaths

Data updated to 24/01/2022 - ALL FIGURES TO BE REASSESSED

During 2021/22, 2,531 of ESNEFT's patients died. This figure includes deaths in ED and community hospitals) and can be broken down as follows:

Quarter	Number of deaths	Number of deaths for which a case record review or investigation was carried out
One	692	148
Two	734	136
Three	875	57
Four	230	XX

By January 2022, 336 case record reviews and 12 investigations (patient safety incident investigations/incidents for review, under the new Patient Safety Incident Response Framework) have been carried out in relation to 2,531 of the deaths included above. In seven cases, a death was subjected to both a case record review and an investigation. During the year, the number of requested reviews was reduced to meet the minimum national requirement so that clinical care could be prioritised during the pandemic surges.

0.9% of the patient deaths which took place during the reporting period are judged to be more likely than not to be due to problems with the care which was provided. 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 1.4% for the first quarter; 0.7% for the second quarter; 0% for the third quarter and x % for the fourth quarter.

These numbers have been estimated using the summary of care information from the Royal College of Physicians' structured judgement review and the national perinatal mortality review tool.

Our learning from case record reviews and investigations

There were six deaths identified during the reporting period where the care received was considered to have contributed in some way towards the patients' deaths. Investigations carried out highlighted the following concerns in:

- The management of patients and their early diagnosis in the ED.
- Communication between areas.
- Management of confused patients on the wards.
- Management of patients with complex nutrition problems.
- Nosocomial COVID-19 (probable/definite hospital-onset, hospital-acquired COVID-19 (a positive swab eight days or more after admission and COVID-19 cited on the death certificate).

Key learning points

The key learning points identified from these investigations were as follows:

- Poor handover from one speciality or colleague to another was identified as a contributory factor to certain incidents occurring.
- Learning requirements were identified in specific areas surrounding the assessment of patients' nutritional status, the management of complex nutritional problems and the follow up care once feeding was re-established.
- The use of medication review and reconciliation between drug charts and the patient's own medication were highlighted as an area in which learning was required. (The relationship between drugs and their side effects.)
- Learning needs around the identification of atypical presentation of patients with pulmonary emboli were identified.
- The use of treatment escalation plans were inconsistent across the Trust.
- Occasions were identified where the requesting clinician did not access and act on reports received from investigations that had been requested.

In response to these learning points, the following actions were put in place to reduce the risk of these events occurring again:

- A new pathway was developed to identify and manage the treatment of patients with atypical presentation of a pulmonary embolus.
- Teaching around the use of MUST scores and identifying nutritionally 'at risk' patients at the board rounds and in conjunction with the nutrition team were introduced.
- A timely medication review is now carried out on admission and drugs which may cause confusion and instability are highlighted early in the patient's pathway.
- A sepsis audit has been carried out along with the use of the treatment escalation plan. Results have been shared with clinical areas and at the patient safety and deteriorating patient groups which are attended by the assistant directors of nursing and matrons, and also disseminated to staff.
- Human factors training has been restarted with special attention given to communication, handover and teamwork.
- After action review training has been rolled out within the Trust so that immediate actions can be identified and implemented.
- Work has started to introduce an electronic patient record system which includes a results acknowledgement system so that clinicians are readily able to identify tests which have been carried out and results pending.

The key learning points identified from nosocomial COVID-19 were:

- Early assessment and testing are essential, including pre-admission assessment for planned admissions.
- Frequent re-screening during admission has been instrumental in reducing contact time where patients are asymptomatic but could pass the virus on.
- Strict use of PPE and hand hygiene, with increased cleaning and ensuring good air flow.
- Bed moves only take place if absolutely necessary.
- Patients are asked to wear facemasks where possible.
- Working to discharge medically fit patients as soon as possible.
- Reducing the number of visitors to patient areas.

- Admission-avoidance for positive cases to reduce the number of COVID-19 patients in hospital, which is a known factor in increasing hospital transmission. The Trust has also taken part in the nMABS programme where people who have recently tested positive are risk assessed and safety netted. Monitoring is carried out by telephone by clinical staff who triage, assess and determine whether high risk patients require additional supportive treatment.
- A standard operating procedure was developed to ensure robust data gathering, reporting, investigation and duty of candour processes took place. A root cause analysis (investigation) is also requested for every patient who tests positive for COVID-19 eight days or more after admission.

Impact of actions

As many of the learning actions identified through the investigations are in the implementation process, it will take time to demonstrate that the actions have made an impact. However, early results show:

- Staff on the wards involved in nutrition investigation are able to confirm that each patient is discussed individually on the morning board round and potential problems involving patients with complex nutritional needs are highlighted. Since this process was introduced, there have been no nutrition incidents reported which require a patient safety investigation.
- The PICC line service has been increased and the number of lines used for parenteral feeding have increased.
- More than 80 members of staff have completed the after action review training. It is expected that these staff will now begin performing reviews to help us identify issues early and reduce risk. These will be included in the patient safety review reports.
- The new body map introduced in dermatology is used daily. There have been no further events causing concern since its implementation. We are waiting for the outcome of a local audit to ensure that the patient checking process has improved.
- Success of human factors training is difficult to measure due to its qualitative nature. However, it is felt that further education in communication, teamwork, situational awareness, briefing and debriefing will only improve patient safety and experience.

Learning from deaths

The Trust is fully compliant with all elements of the national learning from deaths process. We also take part 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 the LeDeR (Learning Disabilities Mortality Review) programme.

Since the introduction of medical examiners, the Trust has maintained a 100% record of medical examiner scrutiny all (non-coronial) deaths which occurred on acute trust sites. The role has been key in improving communication with the bereaved by providing an opportunity to ask questions and resolve issues. The team continues to identify cases requiring a mortality review and provides useful thematic learning which is shared at the learning from deaths group.

During the last financial year, the medical examiner team has received numerous plaudits regarding good care for many wards, with critical care staff being the most highly (and frequently) praised. There have also been comments made regarding delays with care or

diagnosis and poor communication. Following feedback from families, we took steps to make sure that loved ones were kept up-to-date by providing additional administration staff on the wards to answer telephones. Mobile phone chargers were also purchased so that inpatients could stay in touch, which promoted positive feedback which praised communication as “excellent”.

The Trust’s two learning disabilities and autism hospital liaison nurse specialists deliver presentations at induction and the multi-disciplinary audit half days. This brings together local learning from mortality reviews and wider learning from the LeDeR programme, including multi-agency reviews. Our staff are currently working to reduce the number of missed screening and outpatient clinic appointments for patients with learning disabilities and autism by establishing the cause and facilitating future attendance. Screening staff are also running sessions at quieter times with longer appointments so that patients can be better supported.

Core quality indicators

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, but 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 NHS Digital with regard to:	**Reporting period**	**ESNEFT**	**National average**	**Highest score**	**Lowest score**	**Banding**
The value and banding of the SHMI for the Trust for the reporting period	Sept 2018 – Aug 2019	1.0991	1.000	1.1886	0.6871	2
	Sept 2019 – Aug 2020	1.0651	1.000	1.1816	0.6946	2
	Sept 2020 – Aug 2021	1.0741	1.000	1.1848	0.7161	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 % is a contextual indicator)	Sept 2018 – Aug 2019	33%	36%	59%	13%	
	Sept 2019 – Aug 2020	32%	36%	61%	9%	
	Sept 2020 – Aug 2021	33%	38%	64%	12%	

ESNEFT 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 two (‘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’.

The following actions have been taken to improve the quality of services and further reduce SHMI:

- Ensuring that high clinical coding standards are maintained through regular audit, both local and against the Data Security and Protection Toolkit and Data Quality Standard.

- Investigating alerts issued by external providers to ensure that care has been delivered to a high standard. For example, the SHMI VLAD (variable life-adjusted display) charts are a type of statistical process control chart which make a visual comparison between an expected outcome and its associated observed outcome. There are 10 VLAD diagnosis group charts, chosen owing to high patient activity with proven risk-modelling. The Trust is undertaking case record reviews where statistical variance is identified.

- Continuing the work of medical examiners who provide additional scrutiny by assessing the quality of care as described in the health record for all deceased patients and through discussion with the bereaved.

- Continuing to promote good documentation which includes clear care plans.

- Encouraging staff to reflect on care delivered at multiple touchpoints, 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, in turn improving both clinical and organisational processes.

- Sharing learning at ward, divisional and Trust level through mortality and morbidity meetings, ward governance meetings, divisional governance meetings and the Learning from Deaths Group, where staff from clinical areas come together to discuss themes and case studies. Staff from the therapies teams who work across all clinical areas are now part of the presentation schedule and have provided invaluable insight into care, both for inpatients and those supported in the community.

- 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 - clinical skills and human factors training.

- Continuing with the quality improvement programme which encourages staff to think about local small-scale improvements.

To come: PROMS information, staff FFT, patient FFT, risk assessment for VTE, C. diff infection rate

Indicator: Readmission rate					
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**	**Colchester score**	**National average**	**Highest score**	**Lowest score**
% of patients aged 0 – 15 years readmitted within 28 days	2010/11	8.79	n/a	n/a	n/a
	2011/12	8.35	n/a	14.98	5.1
% of patients aged 16 years or over readmitted within 28 days	2010/11	9.89	n/a	n/a	n/a
	2011/12	10.35	11.45	13.8	8.73

**Data no longer published*

Indicator: Responsiveness to the personal needs of patients							
The data made available to the Trust by the HSCIC with regard to:	**Reporting period**	**Colchester**	**Ipswich**	**ESNEFT**	**National average**	**Highest score**	**Lowest score**
The Trust's responsiveness to the needs of its patients during the reporting period	2016/17	66.9	66.9	n/a	68.1	85.2	60.0
	2017/18	66.2	66.5	n/a	68.6	85.0	60.5
	2018/19	n/a	n/a	68.2	67.3	85.0	58.9

**Data no longer published*

Indicator: Patient safety incident rate							
Data made available to the Trust by the HSCIC	Reporting period	Colchester score	Ipswich score	ESNEFT score	National average	Highest score	Lowest score

with regards to:													
		No	Rate	No	Rate	No	Rate	No	Rate	No	Rate	No	Rate
the number and rate of patient safety incidents reported within the Trust during the reporting period. Please note the reporting period changed to 'per 1,000 bed days' in April 2014	April 17 – Sept 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 – March 18	3,906	39.2	4,534	38.44	n/a	n/a	730,151		11,325	124	1,311	24.19
	April 18 – Sept 18	n/a	n/a	n/a	n/a	9,193	44	731,348		9,467	107.4	566	13.1
	Oct 18 – March 19	n/a	n/a	n/a	n/a	8,455	40.01	765,221		8,289	95.94	1,580	16.90
	April 19 – Sept 19	n/a	n/a	n/a	n/a	11,092	55	815,852		11,620	103.8	2,173	26.3
	Oct 19 – March 20	n/a	n/a	n/a	n/a	10,848	52.8	838,722		11,787	110.2	1,271	15.7
	April 20 – March 21	n/a	n/a	n/a	n/a	20,903	64.2	1,500,306		32,917	118.7	3,169	27.2
		No	%	No	%	No	%	No	%	No	%	No	%
the number and percentage of such patient safety incidents that resulted in severe harm or death during the reporting period	April 17 – Sept 17	16	0.5	24	0.5	n/a	n/a	2,482	0.4	13	0.1	19	0.7
	Oct 17 – March 18	15	0.4	19	0.4	n/a	n/a	2,522	0.3	5	0	0	0
	April 18 – Sept 18	n/a	n/a	n/a	n/a	47	0.5	2,477	0.3	14	0.1	3	0.5
	Oct 18 – March 19	n/a	n/a	n/a	n/a	45	0.5	2,458	0.3	28	0.3	15	0.9
	April 19 – Sept 19	n/a	n/a	n/a	n/a	61	0.6	2,524	0.3	1	0	26	1.2
	Oct 19 – March 20	n/a	n/a	n/a	n/a	93	0.8	2,536	0.3	4	0	19	1.5

	April 20 – March 21	n/a	n/a	n/a	n/a	261	1.3	6,828	0.4	69	0.2	56	1.7

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

- All incidents are reviewed by the Patient Safety and 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, while those initially considered to have caused severe harm or above are reported within 72 hours. Patient safety incidents are uploaded to the NRLS at least twice a week to ensure they are reported within two days of the event occurring.

- 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 64.2 incidents per 1,000 bed days between April 2020 to March 2021 (the last published data). 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 have various policies in place relating to incident reporting, but this does not provide full assurance that all incidents are reported. We promote 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 April 2020 to March 2021 is 1.3%, and therefore above the 0.4% 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 which did not develop while the patient was in ESNEFT's care. Pressure ulcers which developed outside our care but were found on admission were previously reported as no harm incidents, as were the requirements at the time.

- In November 2020, we became early adopters of the Patient Safety Incident Response Framework, 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 and Quality team and where there is a suspicion of harm or a near miss, further information or a fact finding review is carried out. Following discussion with the clinical area and in accordance with the ESNEFT Patient Safety Incident Response Plan, 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.

To improve this score, and subsequently the quality of our services, we are:

- Continuing to build our culture for reporting patient safety incidents at all levels of harm.

- Continuing to provide training at the Trust induction to encourage staff to report incidents and near misses, as well as giving guidance for risk assessment and escalation of incidents.

- Piloting the Patient Safety Incident Reporting Framework.

Part three – Other information

Infection prevention and control

Methicillin resistant Staphylococcus aureus (MRSA)

Our target was to achieve zero cases of MRSA bacteraemia/ bloodstream infections in 2021/22.

Staphylococcus aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa without causing any problems. However, 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.

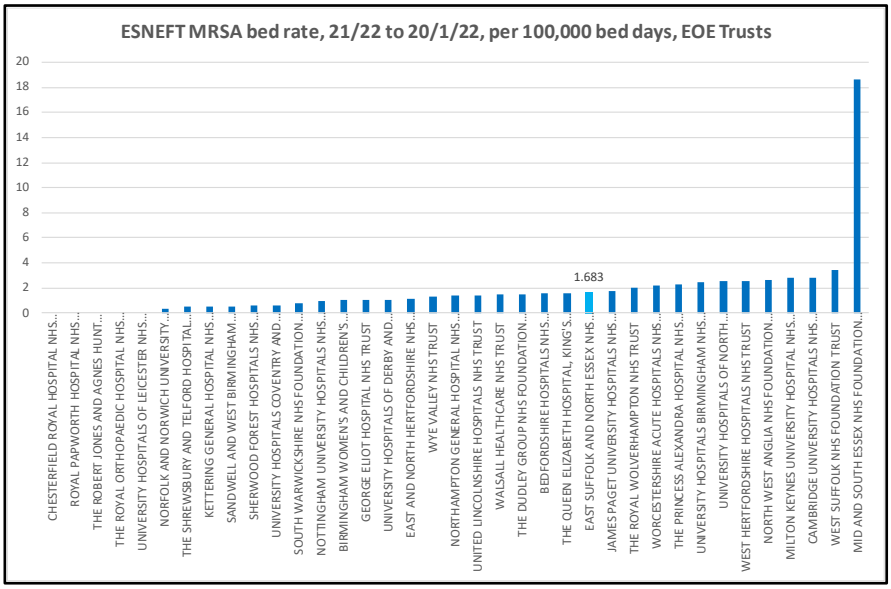
Most strains of S. aureus are sensitive to the more commonly used antibiotics, which means that infections can be effectively treated. However, some S. aureus bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin resistant Staphylococcus aureus (MRSA) and often require different types of antibiotic to treat them. Those that are sensitive to methicillin are termed methicillin susceptible Staphylococcus aureus (MSSA). There is no real difference between MRSA and MSSA, other than their degree of antibiotic resistance (Public Health England, 2017).

There were three cases of MRSA bacteraemia identified across ESNEFT in 2021/22. Learning from these cases relates to compliance with the MRSA screening protocol, care of PICC lines and standards of peripheral vascular access device documentation.

The number of MRSA bacteraemia cases apportioned to ESNEFT

Year	Number of MRSA bacteraemia cases apportioned to ESNEFT	Objective
2019/20	1	0
2020/21	2	0
2021/22	3	0

ESNEFT's performance for rates of MRSA bacteraemia to 20/01/22 compared with the other hospitals in the east of England for 2021/22 stood at 1.68 compared with 2.61 during 2020/21. Please note that not all (37 of 62) trusts have data listed on the system for this report.



Clostridium difficile (C. diff)

Clostridium difficile (C. diff) remains an unpleasant 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.

Changes to the way C. diff cases were allocated were introduced in April 2019. This classified cases which are considered to have been acquired at a trust during an admission as those identified from specimens taken on the second day of admission on the wards, or if the patient has been an inpatient in the previous four weeks.

At ESNEFT, we carry out post-infection reviews for each case apportioned to the Trust so that lessons can be learnt for the future. During 2021/22, these included:

- A recognition of the requirement to isolate when sampling for suspected infective diarrhoea.
- The need to obtain appropriate microbiological samples before starting antimicrobial treatment (for example, urine samples not obtained from patients suspected to have a UTI).
- The need to review previous microbiology results and previous antibiotic treatment before prescribing antibiotics.

During the COVID-19 pandemic, post-infection reviews were replaced with a written online discussion. The outcomes are graded as follows:

- Outcome three – if all care and treatment was managed within nationally and locally recognised policy.
- Outcome two – if there is a patient safety issue to be addressed.
- Outcome one – if lapses in case have been identified.

During 2021/22, 72 of our 99 C. difficile cases have currently been agreed as outcome two or three.

Number of Clostridium difficile cases apportioned to ESNEFT

Year	Number of Clostridium difficile cases apportioned to ESNEFT	Objective
2019/20	• 13 outcome one cases • 85 outcome two or three cases • Total: 98 cases	To not exceed 107 cases
2020/21	• 12 outcome one cases • 88 outcome two or three cases • Eight outstanding result • Total: 100 cases	Not published
2021/22	To 20/02/22: • Four outcome one cases • 72 outcome two or three cases • Total: 76 cases	To not exceed 99 cases

During the year, we have:

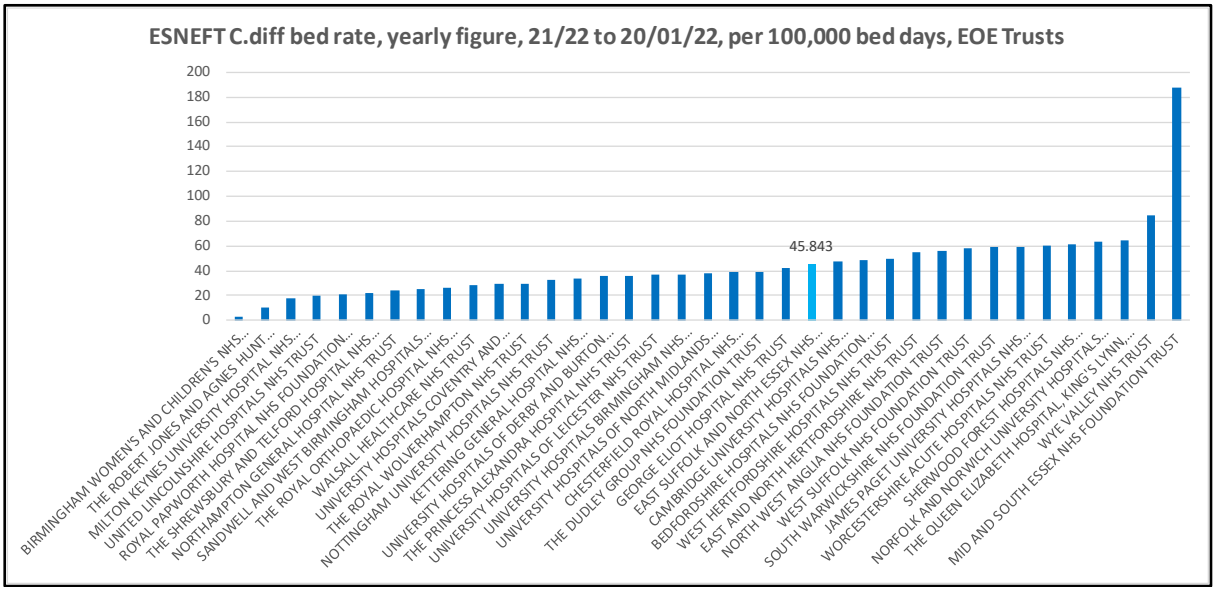
- Closely monitored patients identified as carriers and managed them in much the same way as patients with C. diff infection if they are suffering loose stools.

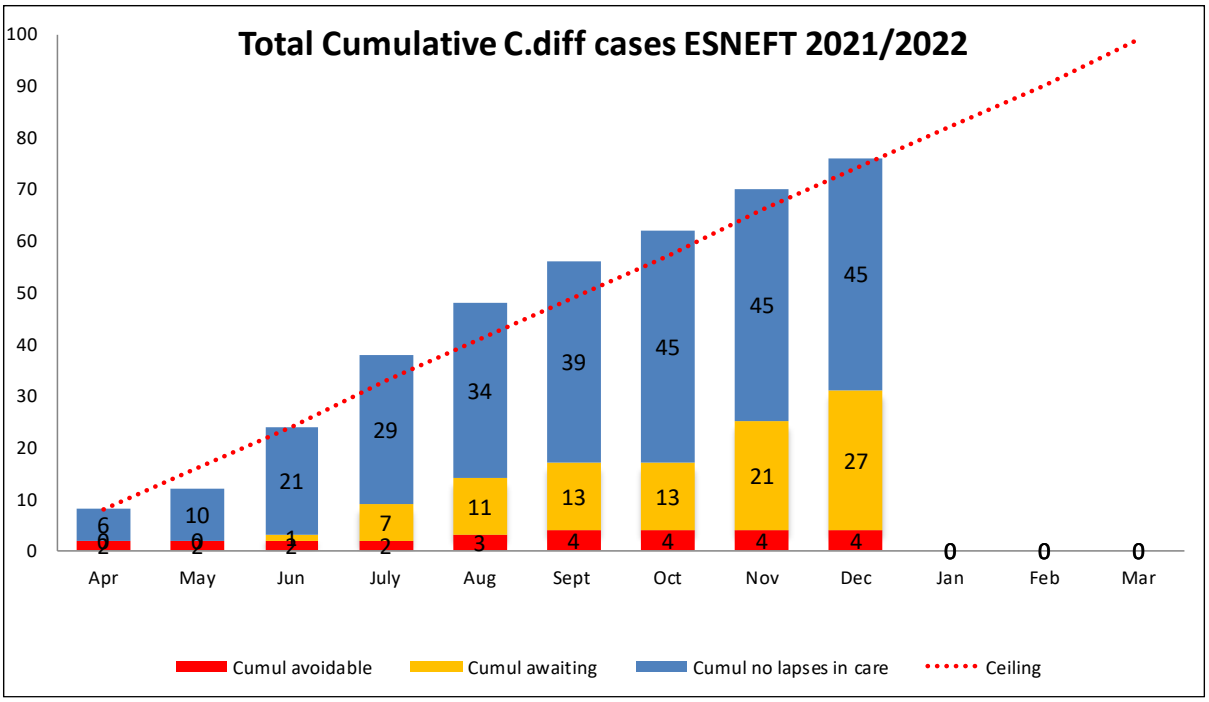
- Continued to work through post-infection reviews with our commissioners to identify areas which may help us reduce cases further. This was temporarily suspended during peaks of COVID-19.

- Continued to investigate and invest in new cleaning technologies to support best practice and efficiency, including the use of HPV fogging, UVC and microfibre.

ESNEFT's performance for rates of Clostridium difficile up to 20/01/22 compared with the other hospitals in the east of England for 202/22 stood at 45.84 compared with 43.38 during 2020/21.

Please note that not all (37 of 62) trusts have data listed on the system for this report.




Total Cumulative C.diff cases ESNEFT 2021/2022
100
90
80
70
60
50
40
30
20
10
0
Apr
May
Jun
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
6
10
21
29
34
39
45
45
45
0
0
0
2
0
2
2
7
11
13
13
21
27
0
0
0
2
2
2
3
4
4
4
4
4
Cumul avoidable
Cumul awaiting
Cumul no lapses in care
Ceiling

Learning from incidents, patient safety incident investigations (PSIIs) and never events

Learning from incidents

We investigate all reported incidents and share any lessons that can be learnt within the clinical area at divisional board meetings and via the intranet to reach staff in areas outside the scope of the division but who are involved in the incident. Lessons learnt are also shared at the Trust's Patient Safety and Clinical Effectiveness Group.

In accordance with the Patient Safety Incident Response Framework, ESNEFT agreed and implemented a Patient Safety Incident Response Plan in November 2020. This was a part of a year-long pilot programme involving 17 sites nationwide.

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 XX.

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

- The pulmonary embolism pathway has been updated and training on the management of pulmonary embolism in the Emergency Department has been incorporated into the induction for new staff.

- The post-partum haemorrhage proforma has been amended to help improve record keeping. A massive obstetric haemorrhage standard operating procedure has also been developed.

Duty of Candour

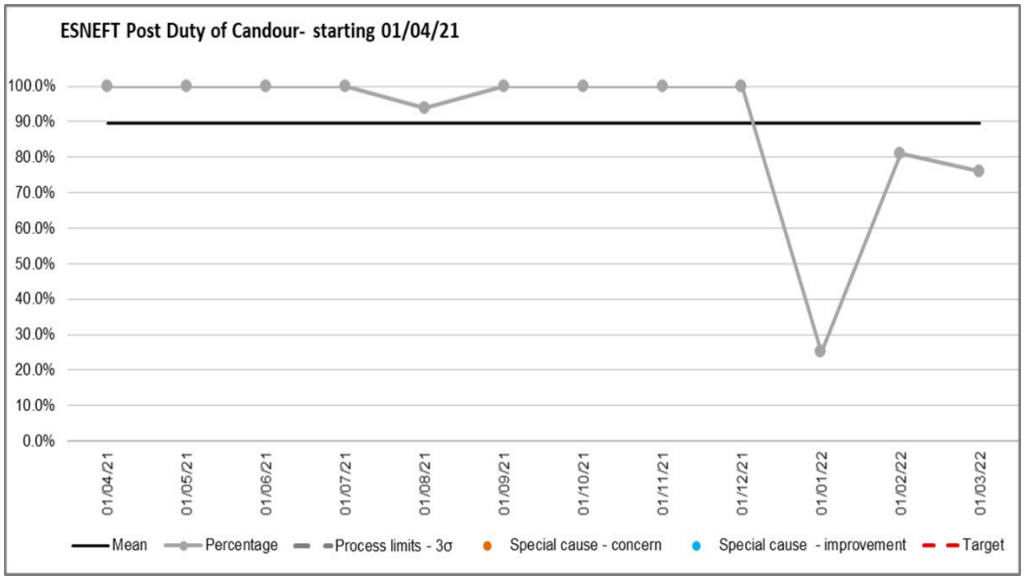
Open and honest communication with patients is essential to collaborative working and directly impacts the experience and outcomes for the patient as well as for staff in the delivery of safe care.

Healthcare professionals must be open and honest with patients when something goes wrong with their treatment or care and 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.

Duty of Candour compliance during 2021/22



What we are doing to make improvements

We:

- Carry out face-to-face and e-learning training for the investigation and actions required following incidents.
- Have introduced after action review training across ESNEFT to facilitate early learning from incidents using a multi-disciplinary approach.
- Use an ESNEFT-wide newsletter called 'Hot Spots' to share learning and the changes we have made following incidents.
- Are reviewing our current training programme and introducing refreshed training in accordance with the PSIRF.

Adverse events and PSIIs reported

During 2021/22, the following adverse events (categorised as low to severe harm) have been reported on the Datix risk management computer system.

Type of adverse event	Number
Access, appointment, admission, transfer, discharge	1,828
Accident that may result in personal injury	3,463
Clinical assessment (investigations, images and lab tests)	773
Consent, confidentiality or communication	1,309
Implementation of care or ongoing monitoring/ review	7,216
Infrastructure or resources (staffing, facilities, environment)	922

Medical device/ equipment	648
Medication	332
All other categories	1,011
Patient information (records, documents, test results, scans)	793
Treatment/ procedure	916
Total	**20,786**

Of these, 16 were reported as patient safety incident investigations (PSIIs):

PSII category	**Number**
Deteriorating patient	3
Maternity	1
Medication (blood glucose)	0
Medication (anti-coagulant)	0
Inpatients (shared care)	0
Nutrition and hydration	1
National priority	11

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 2021/22 are:

1. Wrong site surgery
2. Wrong implant/ prosthesis
3. Retained foreign object post-procedure
4. Mis-selection of a strong potassium 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.

Never events at ESNEFT

2019/20	2020/21	2021/22
7	7	6

In 2021/22, six incidents were reported which met the definition of a never event. Five of these related to wrong site surgery and one to a misplaced NG tube.

Thorough root cause analysis took place and the following actions have been taken to prevent recurrence:

- LocSSIPs have been introduced in two areas while random audits have also been carried out to ensure the procedure is undertaken properly as challenge response.
- A time out pause takes place before commencing a procedure.
- A clear body map which enables more accurate documentation of lesion location has been introduced.
- Referral processes and the use of digital/ non digital documentation in patient care have been reviewed.
- A department location has been changed to facilitate easier patient flow.
- The induction programme for new staff and those not trained in the UK has been reviewed.
- Language support for some new staff is provided where required.
- Human factors training has continued with a view to changing culture and encouraging the use of new vocabulary such as confirmation bias.
- Discussions take place into the use of one standard medication in invitreal injections for macular degeneration.
- Two band 6 clinical posts have been introduced to provide clinical managerial oversight.

Patient Safety Incident Response Framework (PSIRF)

We are one of the first trusts 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.

During 2021/22, we took part in a national pilot to trial PSIRPs, which are due to be rolled out across the rest of the NHS in 2022. As part of the project, national guidance called the ‘Patient Safety Incident Response Framework’ was introduced and 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 sets out national priorities which we must investigate locally through an in-depth patient safety incident investigation (PSII). 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 (revised 2021)
- those which meet national screening programme incidents criteria

ESNEFT 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 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 be-cause 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.

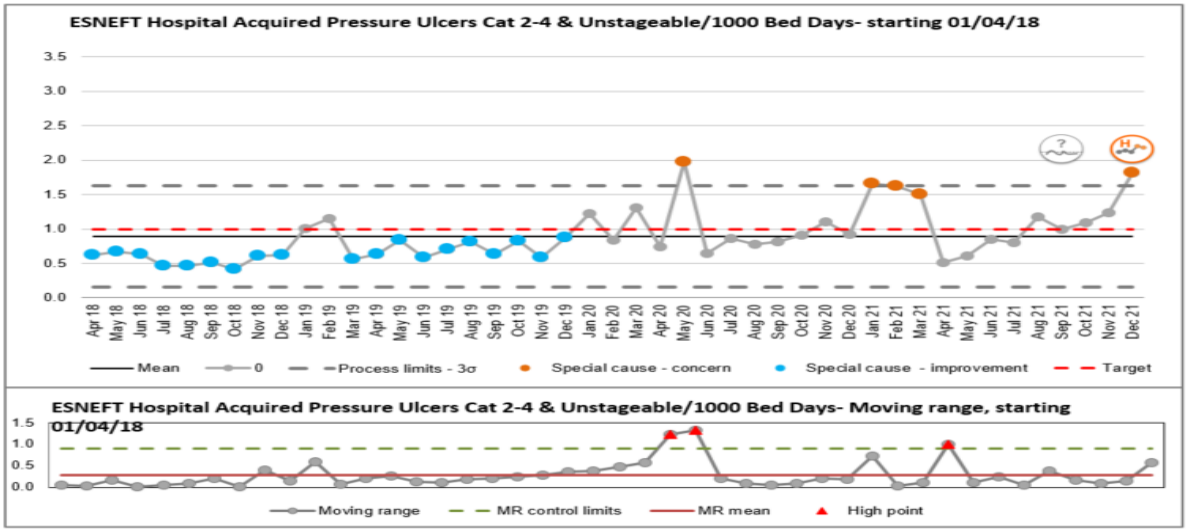
Throughout the PSII, we will provide each patient, family member or carer with a named contact who will help them access support services and listen to their questions or concerns before making sure they are answered openly and honestly. Communication between the lead investigating officer and the patient, family member occurs every two to three weeks to ensure a fully collaborative approach to the investigation.

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

Pressure ulcers

Reducing pressure ulcers acquired on our inpatient wards remains a priority, both across ESNEFT and nationally. It is a key element of keeping patients safe and free from harm during their hospital admission. As such, we strive to reduce the risk of harm to patients through developing pressure damage.

The COVID-19 pandemic has continued to be a challenge when preventing damage, with skin changes and loss of skin integrity becoming apparent for those patients in our care with deranged oxygen levels. During the year, high numbers of critical care patients also needed support as part of their treatment, with acutely ill patients requiring specific positioning (proning) and non-invasive ventilatory support using a mask or similar device. This increased the risk of pressure damage to skin on parts of the head, such as the bridge of the nose, ears and forehead. As a result, we recorded rises in ESNEFT-acquired harm which mirrored the surges in COVID-19 cases experienced at the Trust, with numbers reducing during times of less activity.



The harm free care team provides regular education to wards to ensure timely assessments are carried out and care and treatment plans put in place for every patient admitted into our care. This helps to reduce the risk that they will develop pressure damage during their stay. Although the team also offers focused education, this was reduced during the year as a result of the COVID-19 restrictions, with the majority of sessions taking place virtually using Microsoft Teams.

Ongoing education relating to the ASKIN assessment tool (Assess, Surface, Keep moving, Incontinence, Nutrition) continued during 2021/22.

Falls prevention

Reducing inpatient falls remains a priority, both for ESNEFT and nationally, and is a key element in keeping patients safe and free from harm during their admission. We are continuing to work to reduce the number and severity of falls taking place across all of our wards, both in our acute and community hospitals.

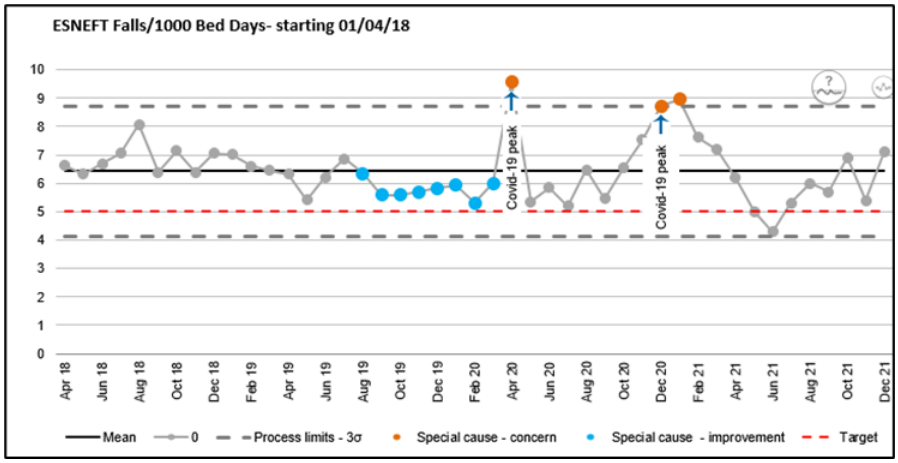
The Trust's aim is to make sure that falls risk assessments, care and actions take place with every patient as appropriate to minimise the risk that they will fall during their admission, in turn reducing the severity and level of harm.

During 2021/22, specific education around falls prevention on wards continued and was supported by the wider harm free care team. There was a focus on making sure preventative actions were carried in a timely manner as part of the multi-factorial risk assessment. Wards have been encouraged to seek support from the falls team when caring for patients with complex needs who are at an increased risk of falling, while additional falls prevention assistive technology has also been used to manage patients deemed at the highest risk. Elsewhere, several areas have benefitted from introducing Baywatch cohort care, although the pandemic has made this work more challenging.

The Trust has recorded a lower number of serious falls resulting in severe harm, which is a result of consistent documentation and early identification of falls risks. The Harm Free Panel has continued to review falls resulting in serious harm so that lessons can be learned and shared across the Trust.

COVID-19 has led to further challenges when preventing of falls as the physical effect on patients and infection control guidance have both had an impact on how falls risk was managed.

Patients recovering from COVID-19 and the step-down from higher dependency areas made managing the highest risk patients challenging. Existing methods of monitoring patients also became more difficult due to the changes made to wards to accommodate isolated COVID-19 patients. As a result, inpatient falls increased slightly over the year due to the impact of the pandemic. This was particularly evident during peaks, with the number of falls then reducing as activity returned to normal levels and pressure on our services reduced.



Molecular laboratory (Project 3000)

On 6 June 2020, our Board approved a business case to set up a new molecular laboratory to increase COVID-19 testing capacity, recognising the urgency and importance of this work. As there was no molecular diagnostic capacity in our integrated care system prior to this, the new laboratory represented a major service improvement.

We successfully bid for £5.3m in capital funds to build the dedicated molecular laboratory (pictured left) at Ipswich Hospital.

The facility opened in April 2021, with equipment transferred to the new accommodation whilst maintaining service levels and turnaround times for results.

Key points

We have achieved the original objectives of Project 3,000:

- Lab capacity is now at 2,198 PCR tests, plus 600 rapid tests per day.
- Staffing is in place for three shifts per day, with a mix of substantive, fixed-term, bank and agency.

The scope of the project has now increased to include LAMP (loop-mediated isothermal amplification) testing for asymptomatic screening, which is a much faster alternative to PCR testing with an analyser time of around 40 minutes compared with eight hours.

The Trust was requested to provide an additional LAMP testing service in November under a direct contract with Department of Health and Social Care. A new £1m (220m^2) LAMP laboratory (pictured) was constructed in just three months and now offers improved asymptomatic testing using saliva instead of swabs.

The laboratory is one of only two in the east of England and is able to carry out 3,500 tests per day, which is sufficient to offer weekly testing to every NHS-badged staff member in Suffolk and north east Essex.

Project outcomes to date

- All patient and staff samples taken in ESNEFT are now tested locally.

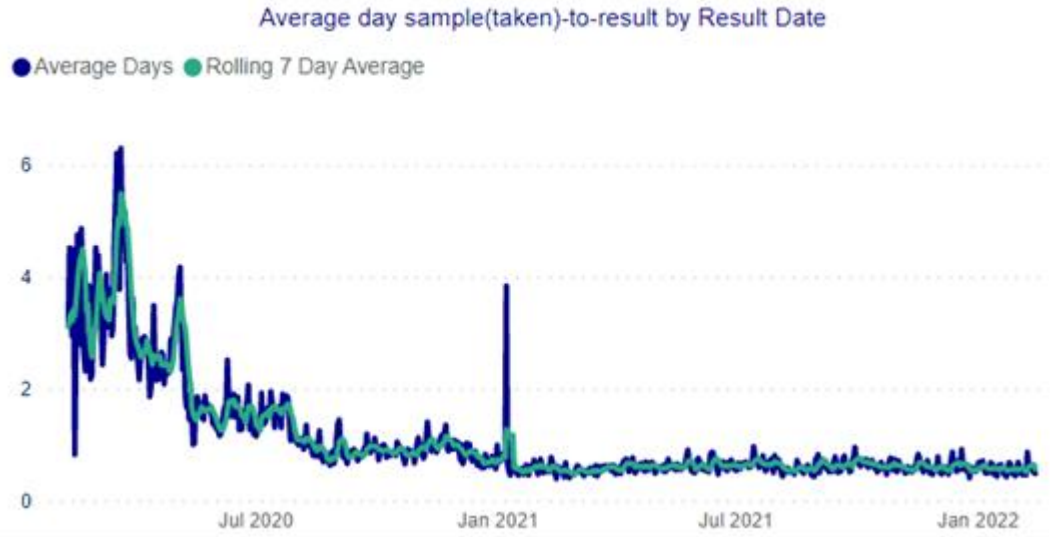
- Our laboratory performs 2,800 tests per day, which is the seventh highest output NHS COVID-19 testing lab in England. Although each NHS laboratory was set a goal of 3,000 tests a day, this has been challenging and has only been met by five of the 93 laboratories which are performing these tests nationally.

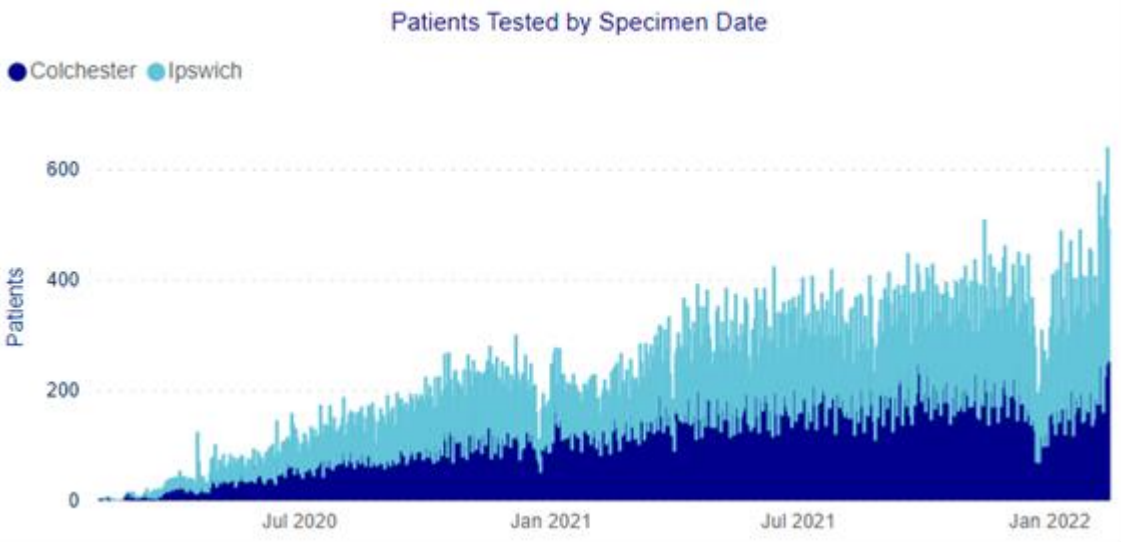
- More than 160,000 PCR tests have been completed since the start of the project with an average turnaround time from the sample being taken to the result available of around 11 hours. This is well within the national target of 15 hours.

NHS COVID-19 P1 Testing Daily Data Summary

This dashboard focuses on the High Throuput/PCR and Rapid Testing issues for the Relevant Dates: 01/01/2022 - 13/02/2022

Parent Trust	Current Capacity	Sum of Total Tests	Capacity Surplus (+) / Deficit (-)	Sum of VoC Panels (No.)	Sum of VoC Tests (No.)	Sum of VoC TaT (hrs)	Sum of Positive Samples Calendar day (No.)
University College London Hospitals NHS Foundation Trust	8,721	2,902	5,819	8	92	34	0
Imperial College Healthcare NHS Trust	4,571	1,930	2,641	7	28	18	0
Barts Health NHS Trust	4,107	2,456	1,651	0	0	0	0
Frimley Health NHS Foundation Trust	3,328	3,342	-14	41	164	23	0
King's College Hospital NHS Foundation Trust	3,205	969	2,236	0	0	0	0
East Suffolk and North Essex NHS Foundation Trust	2,888	1,179	1,709	0	0	0	0
University Hospitals of Leicester NHS Trust	2,708	902	1,806	0	0	0	0
St George's University Hospitals NHS Foundation Trust	2,591	1,272	1,319	0	0	0	0
Sheffield Teaching Hospitals NHS Foundation Trust	2,556	604	1,952	30	60	62	0
University Hospitals Birmingham NHS Foundation Trust	2,555	1,159	1,396	0	0	0	0
Manchester University NHS Foundation Trust	2,500	172	2,328	0	0	0	0
Mid and South Essex NHS Foundation Trust	2,270	1,238	1,032	0	0	0	0




Patients Tested by Specimen Date
Colchester
Ipswich
Patients
600
400
200
0
Jul 2020
Jan 2021
Jul 2021
Jan 2022


Public Health England

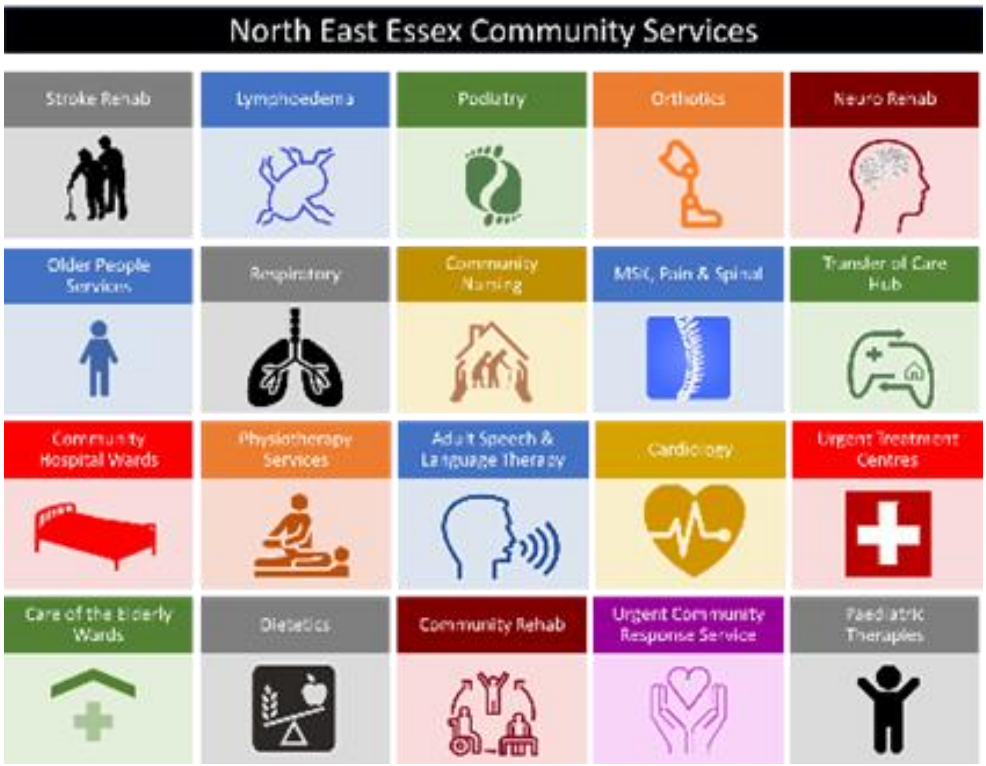
Integrated pathways and community services

To come

North East Essex Community Services (NEECS)

In July 2021, community services in north east Essex were transferred into ESNEFT as part of the North East Essex Integrated Community Services (NICS) collaborative. In January 2022, we also welcomed older adult and therapy services based in north east Essex. The integration of these services has already provided opportunities to improve the patient journey. During this first year, our focus has been to safely transfer services and staff, while also:

- continually improving the patient experience
- optimising patient outcomes
- supporting our workforce



Improving the patient experience

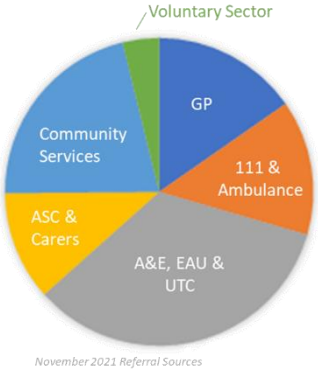
Urgent Community Response Service (UCRS)

The Urgent Community Response Service supports patients who have been identified as in crisis in their own home. It works alongside partners to provide access to a range of health, social care, reablement and voluntary sector interventions based on individual need. The service is designed to:

- Prevent unnecessary conveyances to hospital.
- Enable patients to remain safely at home, with support for their health or care needs.
- Create a single point of referral for clinicians, safe in the knowledge that the patient will be responded to or triaged within two hours.
- Provide support with health interventions and with reablement care and appropriate community voluntary input.
- Reduce hospital footfall, particularly during times of pressure.

The UCRS is made up of physiotherapists, occupational therapies and assistants. This year, we also welcomed advanced nurse practitioners to the team, which has brought additional diagnostic and prescribing competencies.

The team takes referrals from across the north east Essex health and care system. In November, the service received 192 referrals, 66 of which were from acute ESNEFT services and 126 from community colleagues. Of these, just 10 resulted in a hospital admission, which is the equivalent of a 95% admission avoidance rate. (NB up to date stats being collated and will be sent over asap)



Lymphoedema Service

Lymphoedema is a long term and often distressing and isolating condition which can have a significant impact on people's quality of life, as well as their physical and mental wellbeing. The NEECS Lymphoedema Service recognises that engagement and self-managed care are the lynchpins to good patient outcomes, and as such an important part of the service is to provide workshops where patients can ask questions and access peer support. These group meetings were held via Zoom during COVID-19 so that patients could continue to access support, and feedback from those taking part has been very positive.

We are continuing to hold virtual workshops, which are now also being offered to existing patients who would benefit from additional support. We anticipate that we will continue to host some sesssions via Zoom after face-to-face sessions have resumed for those who cannot attend in person or prefer to meet virtually.

The sessions are always well attended by patients and receive positive feedback, including comments such as:

- "I picked up some helpful advice."
- "I was amazed at the amount of information you gave us at your workshop and hope to be able to implement it asap."
- "Thank you for the workshop. I really learned a lot and am raring to go! I'm going to add to my swimming and walking with some yoga. It was really encouraging."
- "I found the whole lymphoedema thing really hard to deal with at first. It really made me feel gloomy in a way that even cancer didn't. I think this session today really helped."
- "Thank you, I found the workshop really helpful."

Patient story

NEECS staff work closely with colleagues on our hospital wards to support patients at the end of life and make sure their wishes are respected. When Mrs X fell and required hospital admission, she initially refused to leave her palliative husband. Eventually, the couple travelled in the ambulance together and, despite Mr X testing positive for COVID-19, the hospital team placed their beds next to each other as soon as possible. Although the community team were unable to keep Mr and Mrs X at home, good communication with the hospital ensured that we were able to support their wish to remain together.

Maximising patient outcomes

Lower Limb Service

The new Lower Limb Service provides leg ulcer clinics in Clacton, Harwich and Colchester, which were previously run by non-specialist community nurses, as well as first assessments for all housebound patients with a leg ulcer in the Tendring area. It also now receives referrals for all patients who have had a wound present for two or more weeks.

The service offers:

- Extensive triage and documentation, with patient education starting at the point of triage.
- Structured and supported self-care, including education around healthy living, weight loss and mental health.
- Best practice care in line with NWCS recommendations, which includes an initial full lower limb assessment including doppler carried out by a specialist nurse.
- Engagement with families, partners and carers to make sure they are involved in the patient's care. Education, a structured care plan and an escalation plan are also in place, including wound photography and virtual reviews where appropriate.
- A 90 minute face-to-face appointment for a first assessment.

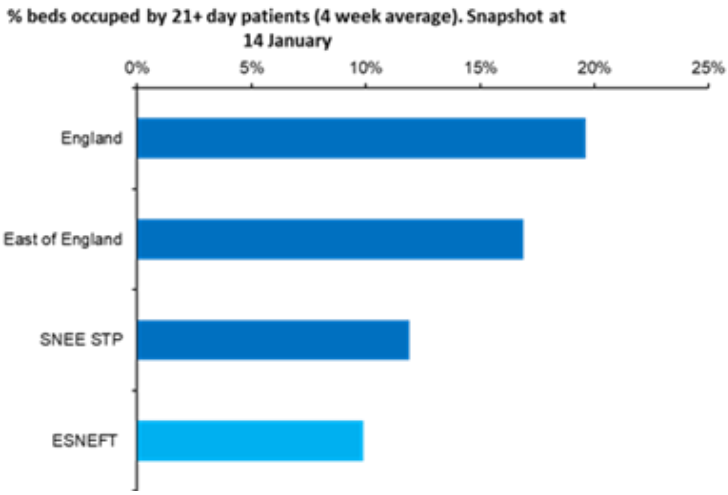
A six-month review of the service showed that healing rates in north east Essex are more than 15% higher than the national average. In addition during its first six months the service:

- Saw 159 patents for first assessment in the community and 82 in clinics.
- Carried out 554 triage and advice phone calls.
- Discharged 65 patients with preventative hosiery.
- Saw average healing rates in clinic of 68.9 days (mean), with 54 of patients healed at the six month audit period (not including high BMI patients). This is higher than the national average of 39% healing rates at one year.

Rehabilitation and discharge

When patients are admitted to hospital, we work hard to ensure that they are able to return to their own home, or an appropraite care setting, as soon as they are ready. On 29 September, the new Waverley rehabilitation ward opened at Fryatt Hospital in Harwich. It provides 20 beds offering the best possible care for patients requiring rehabilitation, in a much improved environment and with excellent facilities. The ward is already making a real

difference to stroke patients, who have previously had extended stays in Colchester Hospital due to their specialist therapy and equipment needs.



The Transfer of Care Hub, which is sometimes referred to as the Discharge Hub, manages discharges from acute and community hospital wards for patients who require additional support and packages of care. The multi-disciplinary team includes leads for nursing and therapies, as well as nurse assessors, case managers and administrative staff. They work alongside colleagues from across the north east Essex health and care system, including adult social care, ECL, housing and our two voluntary sector partners Community360 and CVS Tendring. The service is helping make sure that people are discharged from hospital at the right time. In December 2021, ESNEFT remained lower than both the national and regional level for long length of stay patients.

In January, Ruth May, who is the chief nursing officer for England, visited the hub to hear more about the many ways in which the service is supporting discharge for the most complex patients.

This includes:

- Holding twice-daily system-wide MDTs so that we can work alongside social care, voluntary sector and commissioner colleagues to expedite very complex discharges and to seek out alternative solutions where care provision is stretched.
- Providing an escorted transport service which sees the voluntary sector and our nurses/therapists work together to settle the patient at home and make sure their environment is safe.
- Extending support to carers through the introduction of Age Concern services at our community hospitals and supporting patients who are at end of life to die in their preferred place of care.
- Using personal budgets to provide one-off payments which support discharge home, such as for the repair of a heating system.
- Making follow-up calls after discharge to care homes and to patients who have returned home to resolve any initial problems and prevent readmission.
- Working with housing colleagues to tackle issues around housing and homelessness and provide winter packs and food packages, with the support of the voluntary sector.
- Focusing on social as well as health needs and working with social prescribers to provide wrap-around support. These prescribers offer support for up to six weeks to help individuals to improve their independence and build confidence. They can also signpost to other voluntary services, such as befriending schemes.

Workforce

A skilled and effective workforce is at the heart of our service and making sure our colleagues can access the training and support they need is a priority, both to maintain clinical quality and maximise staff retention. To enhance our offer for those joining our services, we have introduced a new rotational induction programme for community nurses. This allows new starters to spend time in a number of specialist service areas, including the Tissue Viability (Lower Limb) Service, St Helena Hospice and the Triage team. It is designed to:

- Provide a supportive environment which empowers new starters to fulfil their role in the community.
- Ensure competencies are signed off in a more efficient way.
- Enable staff retention.
- Reduce the number of serious incidents with wound care.
- Support new starters, addressing any anxieties.
- Achieve competency and an insight to each service, gaining advanced knowledge and an in-depth understanding of specialist services.

Feedback from the programme has showed that:

- New starters felt well prepared for new roles and had gained confidence from building skills and knowledge with specialist teams.
- Staff felt valued and invested in and had built good relationships to get advice and guidance in practice, promoting autonomy.
- Leads were confident that new starters had the right skill sets and had all achieved the competency sign offs required from the placements.

Loganberry Lodge has presented four colleagues with a certificate of appreciation and thanks in recognition of the valuable contribution they make and help they provide. These clinicians were assigned to Loganberry Lodge during the pandemic to provide therapy assessment and rehabilitation for the large number of patients transferred there temporarily so that they could successfully return home. They have continued to lead Colchester's adult social care/ care home MDT as part of the 'perfect first week' initiative and to support patients in Loganberry.

The colleagues, Joe Phillips (senior occupational therapist), Ambreen Kausar (technical instructor), Naureen Abrar (senior physiotherapist) and Sarah-Jane Mallows (senior physiotherapist) also received a box of chocolates each.

Future plans for NEECS

During 2022/23, we plan to:

- Improve the patient journey into and out of hospital, particularly in relation to the way patients receive inpatient and community-based therapy services and services for older adults.
- Expand our frailty service into community settings and increase use of a frailty score to identifying patients who will benefit from the service.
- Extend the use of patient outcome measures which will help us to understand, and where necessary improve, the impact of our interventions.
- Expand the use of virtual consultations and introduce solutions for virtual monitoring.

Maternity services

ESNEFT provides maternity services at Colchester, Ipswich and Clacton hospitals. We offer a range of consultant and midwifery-led services at all of our sites and deliver approximately 7,500 babies a year.

At Colchester Hospital, the delivery suite is made up of eight birthing rooms with two fully equipped co-located obstetric theatres to support consultant-led care. We also offer a four-bed midwifery-led birthing unit for women who have been identified as low risk of complications. The maternity ward has 26 beds and accommodates both antenatal and postnatal women. Specialist antenatal clinics are provided for vulnerable women and those with diabetes, while we also offer birth choices and a specialist obstetric scanning service. In addition, specialist midwives for safeguarding, bereavement, clinical effectiveness, practice development and infant feeding work within our multi-disciplinary teams.

At Ipswich Hospital, there are six birthing rooms in the delivery suite with three fully equipped obstetric theatres to support consultant-led care, and a three-bed midwifery-led birthing unit for women identified as low risk of complications. The triage area contains four beds. Deben Ward has seven rooms, two assessment rooms and a quiet room which can be used for bereaved families. The maternity ward has 24 beds and accommodates both antenatal and postnatal women. In addition, specialist midwives for cardiotocography, bereavement, clinical effectiveness, practice development, practice improvement, smoking cessation, perinatal mental health and infant feeding work within our multi-disciplinary teams. Ultrasound is provided at Ipswich and Colchester sites and includes fetal medicine specialist services.

We are committed to improving quality and outcomes for the pregnant people and babies who use our services. To help us to better understand where we need to make improvements, we have implemented the ‘Every Birth, Every Day’ (EBED) programme, which focuses on delivering improvements identified by our staff, service users and through external reviews. Progress is monitored through a monthly board meeting which is chaired by the chief executive and attended by internal and external stakeholders. ESNEFT’s Maternity Service is also part of the ‘Maternity Safety Support’ programme led by NHSE/I, which provides us with access to external support from an experienced director of midwifery to help guide the continuous improvement of our services and development of our leadership team.

Maternity strategy

The local maternity and neonatal system (LMNS) has produced a maternity and neonatal system three year strategy, which is planned for draft publication in June 2022. The strategy will provide a vision of how care will be delivered in the next three years, as well as identifying opportunities for further long-term developments. It will provide service users, staff members and stakeholders with clarity on our priorities, including how we ensure safe, personalised care which offers equitable outcomes for all families across Suffolk and north east Essex.

The principles for the development of the strategy are:

1. We want excellent care that keeps us and our babies safe and well.
2. We want maternity and neonatal care that treats people as individuals and understands and meets their needs regardless of where they live, their background or age.

3. We want different ways of receiving support to give us the best start in parenting and our babies the best start in life.

ESNEFT's maternity strategy will build on the LMNS strategy. It will follow the same principles and be co-created with our service-users, staff and stakeholders. Our strategy will detail our plans for providing high quality maternity services, as well as showing how we will deliver the ambitions of 'Better Births', the national Maternity Transformation Programme, the NHS Long Term Plan and ESNEFT's strategic objectives, ambition and philosophy.
To support the drive for improved outcomes, we are implementing changes in line with the national Maternity Transformation Programme, with action targeted at changes to clinical practice and service models. The aim of the Saving Babies' Lives care bundle is to reduce stillbirths and neonatal deaths by improving management of five issues where there is a link to these outcomes:

-
- smoking in pregnancy
- detecting fetal growth restriction
- raising awareness of reduced fetal movement
- improving effective fetal monitoring in labour
- reducing preterm births

We are taking action to increase the proportion of women at less than 27 weeks' gestation who give birth in a hospital with appropriate onsite neonatal care. As we are a level one NNU, we make every effort to transfer these women out to a unit with level three NNU. This will help to reduce intrapartum brain injuries and neonatal mortality as it will ensure women and their babies get expert obstetric and neonatal care.

Midwifery continuity of carer – a better births vision for ESNEFT

Midwifery continuity of carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant people in England. Where safe staffing allows this should be achieved by March 2023, with rollout prioritised to those most likely to experience poorer outcomes first.

The timescale at which we can offer the level of MCoC required cannot be predicted at this time. All building blocks need to be achieved before moving to each new increased percentage of MCoC implementation and we will not proceed until it is safe to do so. Where all building blocks – including staffing – are in place, the recommended pace at which to proceed is to increase at 20% increments every quarter.

Women who receive continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth. They

are 15% less likely to require local analgesia and 16% less likely to have an episiotomy. The model will also lead to an increase in home births and midwife-led care options and an improved care experience for women during pregnancy and birth.

We plan to roll out continuity of carer to 75% of women with a Black, Asian and minority ethnic background and from the most deprived areas we serve in our first phase on the principle of proportionate universalism, to reduce inequalities in stillbirth and pre-term birth rates.

Safety champions

We have appointed safety champions at our Board and on the frontline in our maternity and neonatal services. Our safety champions join peers regionally and nationally whose job it is to promote a safety culture and ensure there is sufficient attention given to safety at all levels of the organisation.

Safety multi-disciplinary team (MDT)

We have implemented a maternity services safety multi-disciplinary team (MDT) to provide a forum and a robust process for staff and their representatives to share the themes from safety issues which have been raised by staff. The MDT will prioritise and identify solutions or decide the most appropriate next steps to resolve or mitigate the issues which have been raised. This creates a feedback loop which demonstrates that action is being taken while also providing a safe space for discussion, challenge, issue resolution and escalation

Maternity voices partnership (MVP)

Better Births describes how maternity services should be co-produced with maternity voices partnerships (MVPs). An MVP is a team of women and their families, commissioners and providers (midwives and doctors) who work together to review and contribute to the development of local maternity care. ESNEFT have strong links with our MVP, which empowers women to get involved and co-produce developments in our services.

Professional midwifery advocate (PMA)

Due to systematic and structural concerns, the PMA role has changed significantly to meet the needs of midwives and the service. To enhance quality of care for women and their families, the advocating for education and quality improvement model was developed to improve the wellbeing of those providing care. Professional midwifery advocates provide this service, having undergone training to offer restorative clinical supervision. We are the first trust in the east of England to employ a full-time PMA to support our staff and lead on the health, safety and wellbeing workstream that underpins the “Every Birth, Every Day” programme. It is hoped that introducing this role will reduce work-related stress absence, improve the retention of staff and help ESNEFT become an employer of choice, in turn boosting recruitment.

Care Quality Commission (CQC)

The CQC published its report into Maternity Services at ESNEFT on 16 June 2021. In line with CQC requirements, a detailed improvement plan ('must do' actions) was approved by the director of governance and chief nurse. An improvement plan for the 'should do' actions has also been compiled but is not required to be shared with the CQC.

All actions are reviewed on a weekly basis by the designated action owners and the compliance lead, with regular updates presented to the divisional management team. The compliance lead also meets regularly with the director of midwifery to review outstanding actions.

In order to ensure the division can be confident of oversight of all CQC actions, the compliance lead does not recommend to the divisional management team that individual actions are recommended for approval until any action outcomes have been reported to the appropriate meeting, and the minutes outlining that discussion have been received. Whilst this can lead to some delays in closure of individual actions, it does allow processes to become embedded within the division.

The CQC inspections of Colchester and Ipswich maternity units in April 2021 resulted in a total of 19 'must do' and 'should do' actions. Of these, 16 have now been closed, with the three outstanding actions underpinned by clear milestones and a project plan to ensure we achieve the required outcomes.

Ockenden review

Following the publication of Donna Ockenden's first report, "Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust" on 11 December 2020, all NHS trusts with maternity services were asked to address seven immediate and essential actions (IEA) to redouble efforts to bring forward lasting improvements in our maternity services nationally.

ESNEFT IEA submission

ESNEFT's Ockenden submission from June 2021 was assessed by the regional team, who provided feedback on 12 October.

- The assessment indicated that 76% of responses were green (satisfactory) and 24% of the responses were red (requiring more evidence).
- ESNEFT challenged seven of the red responses. Six of those challenges were upheld, with ratings changed to green.
- Ownership for Ockenden phase two has been transferred to NHSE. At this time, there is no date when next phase is to be issued.

CNST maternity incentive scheme year three (December 2019 to July 2021) and year four (August 2021 to June 2022)

We are proud to have successfully delivered all of NHS Resolution's maternity incentive scheme safety actions for the latest submission. NHS Resolution requested sight of all supporting evidence to our year three submission to verify that we had met all 10 of the safety actions as per our self-certification. Following scrutiny of all documentation, NHS Resolution has confirmed compliance

The year four scheme started in August 2021 but currently paused due to the national operational pressures caused by COVID-19. The scheme is expected to relaunch in spring 2022, with some amendments to requirements and timeframes. The year four scheme builds on requirements from previous years, including significant changes to some of the criteria for achieving the safety actions. Leads for each action are allocated, together with SROs to support.

Notwithstanding any forthcoming amendments, an overview of each safety action within the CNST maternity incentive scheme is as follows:

Safety action one: national perinatal mortality review tool

A quarterly report is submitted to the Quality and Patient Safety Committee for oversight on usage of the tool and compliance with the required standards.

This standard is currently at risk due to a failure to complete surveillance information within the required timeframe for three Ipswich Hospital cases in autumn 2021. Remedial actions and mitigating processes have been put in place, but NHS Resolution is unable to confirm whether this will be taken into consideration and allow us to claim compliance with the standard.

Safety action two: maternity services data set

In the last maternity services data set submission, ESNEFT did not meet the required number of data quality metrics. We are expecting to recover this position for the next submission and in time for the (yet to be issued) reporting period. This will be achieved through a combination of national improvements made to the Maternity Medway system by the provider, additional code written in-house to improve data capture of certain items, increased usage and population of the Lorenzo system.

Safety action three: avoiding term admissions into neonatal units (ATAIN)

Required audits, reviews, reporting and pathways are either in place or under development but not yet fully embedded. The pause in the scheme has given our teams much-needed additional time to ensure that all activities are in place. A full review and stock take of this action is currently underway.

Safety action four: clinical workforce

The requirements in relation to the obstetric medical workforce are new, and allocation of the lead for this work is currently under discussion given changes to divisional leadership. Assessment of compliance with neonatal and anaesthetics requirements will be undertaken as in previous years. Reporting dates will be determined when the scheme is relaunched with new timeframes.

Safety action five: midwifery workforce

There are no significant changes to this action from last year's scheme. We are waiting for the scheme to be relaunched, which will inform the scheduling of the required midwifery workforce report.

Safety action six: Saving Babies Lives care bundle two

This is made up of five elements:

- **Element one: reducing smoking in pregnancy**

  A referral pathway to smoking cessation services is in place across both Ipswich and Colchester hospitals. The maternity incentive scheme year four requirement is to evidence 80% compliance with CO monitoring at booking and 36 weeks gestation for all women. Currently, Colchester is compliant at booking but falling just short at 36 weeks. Ipswich is currently falling just short at booking, but is considerably below the 80% target at 36 weeks. The paper-based system which is in place at Ipswich has greatly contributed to this. The maternity incentive scheme year four requirement is for evidence to be reported electronically on Lorenzo. Audits of handheld records show a higher compliance than can currently be evidenced electronically. This has been escalated to the risk register. Once the scheme has been updated, we will finalise our reporting dates.

- **Element two: risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction**

  ESNEFT guidelines are compliant with the requirements and the audits which are required are being undertaken. Clarification is being sought from NHS Resolution as to the nature of the risk assessment pathway for fetal growth restriction required at 20 weeks gestation. As the Ipswich site does not currently perform uterine artery Doppler routinely, an alternative pathway has been agreed.

- **Element three: raising awareness of reduced fetal movement**

  This element is implemented on both sites. Audits have been completed and the compliance level achieved for women attending with reduced fetal movements having computerised CTG on both sites. Audits are ongoing to evidence required compliance with women receiving information about reduced fetal movements by 28 weeks.

- **Element four: effective fetal monitoring during labour**

  Both sites have a fetal monitoring lead midwife as required, as well as consultants who complete fetal monitoring as part of their roles. Fetal monitoring training meets the standards required. Projected training compliance is being tracked to meet the required 90% compliance for the MDT, and this is being closely monitored in case of training cancellations.

- **Element five: reducing pre-term birth**

  This element is being addressed by out optimisation quality improvement programme. Specialist pre-term birth clinics are in place in both sites and audits are being carried out to assess compliance with the process indicators.

Safety action seven: user feedback including maternity voices partnership (MVP)

The newly combined MVP which covers our catchment area is currently devising its action plan. This will be shared with ESNEFT in April 2022, with the timing of the related Trust Board report will be determined once the scheme is relaunched.

Safety action eight: local training plan and in-house MDT training compliance

Our mandatory training programme continues to cover all required elements and staff compliance is monitored on an ongoing basis. We await the relaunched scheme for new reporting timeframes or any amendment to the requirement for 90% of each relevant staff group to have completed the specified sessions.

Safety action nine: board assurance on maternity and neonatal safety and quality issues

This year's scheme has required some additional quarterly reporting to ESNEFT's Board which is being implemented through to the Trust-wide performance report. Monthly open sessions hosted by the Board-level safety champion are ongoing, and provide the opportunity for maternity and neonatal staff to raise any safety concerns they have, in addition to other routes. Our monthly safety champion forum is also fully embedded and restarted in February 2022 following a pause resulting from operational pressures.

Safety action 10: 100% of cases reported to the Healthcare Safety Investigation Branch and NHS Resolution's early notification scheme

Our processes continue to meet the requirements of this safety action. We are waiting for the scheme to be reissued as this will dictate the reporting period for the current year.

Staff training

We have maintained excellent rates of staff attending our multi-disciplinary obstetric emergency training courses PROMPT, and will continue to deliver it so that all staff are given the chance to attend. We appreciate that all multi-disciplinary staff need to learn together, both in the classroom and in the clinical environment.

We have been awarded funding from HEE for all maternity staff to receive emotional resilience training. This is core to improving our safety culture, and will also make sure our staff have the necessary skills to maintain their own resilience and support their peers and the people they lead to ensure their wellbeing and emotional safety.

Managing complex pregnancies

Work is ongoing 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 the outcome of a full review of clinical and nursing teams and resources.

Risk assessment throughout pregnancy

Monthly audits are being implemented on both sites as part of our regular monitoring schedule to establish our compliance with formal risk assessments at every contact, and determine any action which may be required.

Monitoring fetal wellbeing

Following a successful digital bid we have received funding to upgrade our cardiotocography monitoring machines across all ESNEFT sites.

Informed consent

In partnership with the MVPs, we are planning to carry out a patient survey to identify any gaps in the information which women and their families receive. We will also refresh the communications we issue to families, staff and partner organisations about to the ‘Mum and Baby’ app, which has been adopted across the local maternity and neonatal system.

COVID-19 vaccination programme

During 2021/22, ESNEFT has continued to play an active role in the COVID-19 vaccination programme. Thanks to the hard work and dedication of our teams, we have provided an Evergreen service to staff, inpatients, outpatients and the public as different cohorts became eligible for the first and second doses of the vaccine, as well as the booster.

The Trust also provided system-wide mutual aid to other vaccination sites through the governance and oversight of our Pharmacy Department. In addition, we facilitated referrals and advice for the wider system through our complex patient clinics under the oversight of our complex patient group.

Robust guidelines have been continually reviewed through our clinical oversight group to make sure the vaccine is being handled and administered safely and in line with developing national guidance.

As at 31 March 2022, ESNEFT staff have given more than 100,000 doses of the COVID-19 vaccination to our communities, with staff and volunteers working tirelessly to ensure the programme has run safely and efficiently.

Emergency care

In April 2021, we were pleased to open our AMSDEC (Acute Medical Same Day Emergency Care) unit in Ipswich. This has ensured that appropriate patients are seen outside the Emergency Department (ED) by the medical team and receive care on the same day care, in turn preventing unnecessary admissions. Building work for the new Urgent Treatment Centre (UTC) and ED for Ipswich also started during the year, with the units due to open in 2023. This will enable us to further strengthen our relationship with GP Federation to ensure the right patient is receiving the right care, in the right place at the right time.

Both EDs have worked closely with our infection control colleagues to ensure patients are being screened and cared for in the appropriate place within the departments as part of our drive to limit the spread of COVID-19. Throughout the year, we have continued to enhance our swab testing processes so that we receive timely results and can make sure patients are receiving care on the right ward within the hospital.

Both Emergency Departments have become part of a mental health inter-agency group, which has helped us build an alliance with our mental health partners and social care colleagues. This has enabled us to support the care of patients suffering from mental health conditions in the ED so that they can be assessed and discharged in a timely way. As part of our working groups, we also review pathways and share data to enable us to measure and track attendance. We have been successful in reviewing the section 136 pathway to ensure patients are managed correctly in the ED.

Throughout the pandemic we have remained committed to supporting our staff so that they can grow while continuing to provide outstanding care to patients. As part of the education given to new staff, we have developed an ED preceptorship programme which has enabled the team to flourish and further improve their clinical skills.

During the pandemic, we identified that further support could be provided to critically ill patients in the ED. A 023 call was developed so that operating department practitioners on the Ipswich site could attend to the Emergency Department and offer their expertise, in turn allowing the ED team to focus on their specialism. This is mirrored on both sites, which helps to enhance the timely delivery of patient care.

The nursing workforce on both sites has reviewed the establishment and made changes to the template to reinforce safe staffing within our Emergency Departments. In Ipswich, we have increased the establishment to cater for more clinically unwell patients. In Colchester, we have made the patient safety nurse a permanent fixture in the establishment to assist at times of extreme pressure and make sure patients receive timely care in the right location.

ESNEFT performance over the last three years: four hours to discharge from type one and three emergency attendances against a target of 95% TO BE UPDATED AT END OF YEAR

	2019/20		2020/21		2021/22	
	ESNEFT performance	National performance	ESNEFT performance	National performance	ESNEFT performance	National Performance
April	89.4%	85.1%	90.6%	90.4%	90.6%	85.4%
May	91.3%	86.6%	83.4%	91.2%	91.9%	83.7%

June	**91.4%**	**86.4%**	**95.8%**	**92.8%**	**88.9%**	**81.3%**
July	**88.1%**	**86.5%**	**96.7%**	**92.1%**	**82.4%**	**77.7%**
August	**88.6%**	**86.3%**	**94.0%**	**89.3%**	**77.7%**	**77.0%**
September	**86.2%**	**85.2%**	**93.7%**	**87.3%**	**81.1%**	**75.2%**
October	**84.3%**	**83.6%**	**91.0%**	**84.4%**	**78.7%**	**73.9%**
November	**85.0%**	**81.4%**	**90.3%**	**83.8%**	**78.3%**	**74.0%**
December	**82.4%**	**79.8%**	**84.4%**	**80.3%**	**74.2%**	**73.3%**
January	**82.9%**	**81.7%**	**75.8%**	**78.5%**		
February	**84.9%**	**82.8%**	**87.5%**	**83.9%**		
March	**86.8%**	**84.2%**	**94.6%**	**86.1%**		
YTD	**86.7%**	**84.2%**	**90.9%**	**86.8%**	**82.4%**	**77.9%**

Our emergency performance over the last three years: type one and three activity

Financial year	ESNEFT attendances	ESNEFT four-hour performance	National four-hour performance
2019/20	245,671	86.7%	84.2%
2020/21	177,355	90.9%	86.8%
2021/22 (up to 28/02/22)	194,093	82.4%	77.9%

Hospital standardised mortality ratio and summary hospital-level mortality indicator

What is the hospital standardised mortality ratio (HSMR)?

The hospital standardised mortality ratio (HSMR) is the ratio of observed deaths to expected deaths for a group of 56 common diagnoses responsible for high levels of mortality. Pre-COVID-19, this would have usually equated to approximately 84% of in-hospital deaths; however, the algorithm that calculates the statistical probability of death was never designed to accommodate a pandemic. From January 2020, any patient with an admitting diagnosis of COVID-19 was omitted from the HSMR calculation. The result has been that the HSMR group currently represents mortality data for around 68% of all in-hospital deaths. The HSMR subset represents about 35% of admitted patient activity.

What is the summary hospital-level mortality indicator (SHMI)?

The summary hospital-level mortality indicator (SHMI) 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 by NHS Digital from national reporting.

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 calculations would predict, and whether that difference is statistically significant.

Why are mortality ratios/indicators important?

In combination with other metrics, they are useful in providing an indication of where a problem might exist. They are a method of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in case mix, such as patient age, deprivation and gender.

Results summary – HSMR and SHMI

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

Metric	Result
HSMR – 12 months to September 2021	109.9 - within the ‘higher than expected’ range,
HSMR position vs. east of England peers	The Trust is one of four in the regional peer group of 13 that sit within the ‘higher than expected’ range.
	There are eight HSMR outlying groups attracting significantly higher than expected deaths:

<table>
<tr><td rowspan="10">HSMR diagnosis groups attracting higher than expected deaths</td><td colspan="4"></td></tr>
<tr><td>Group</td><td>Relative risk</td><td>Number of deaths</td><td>Number of ‘expected’ deaths</td></tr>
<tr><td>Cancer of prostate</td><td>176.0</td><td>19</td><td>10.8</td></tr>
<tr><td>Aortic peripheral and visceral artery aneurysms</td><td>159.9</td><td>31</td><td>19.4</td></tr>
<tr><td>Deficiency and other anaemia</td><td>156.3</td><td>31</td><td>19.8</td></tr>
<tr><td>Aspiration pneumonitis food/ vomitus</td><td>143.6</td><td>81</td><td>56.4</td></tr>
<tr><td>Fluid and electrolyte disorders</td><td>139.9</td><td>55</td><td>39.3</td></tr>
<tr><td>Acute and unspecified renal failure</td><td>126.0</td><td>114</td><td>90.4</td></tr>
<tr><td>Pneumonia</td><td>123.3</td><td>384</td><td>311.4</td></tr>
<tr><td>Congestive heart failure non-hypertensive</td><td>118.4</td><td>184</td><td>155.4</td></tr>
<tr><td>HSMR weekday/weekend analysis</td><td colspan="4">Weekday and weekend HSMR emergency admissions are ‘higher than expected’.</td></tr>
<tr><td>Patient safety indicators (mortality metrics)</td><td colspan="4">Telstra Health (Dr Foster) has removed the patient safety dashboard from its reporting tool.</td></tr>
<tr><td>SHMI (September 2020 to August 2021)</td><td colspan="4">Published SHMI = 1.0741 ‘as expected’ (band two).
The percentage of patient deaths with palliative care coded during their admission was 33% – NHS England 38%.</td></tr>
</table>

As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, undertaking peer comparison using HSMR and SHMI. The national benchmark for HSMR is set at 100 and SHMI is set at 1.0. Trusts with a relative risk/ mortality indicator below the benchmark are (statistically) performing better than other acute trusts in terms of lower mortality risk. Any condition identified with a higher than expected mortality ratio undergoes a clinical review to better understand whether there are any issue with clinical care pathways.

The SHMI for ESNEFT for the 12 months ending August 2021 was 1.0741 (band 2), 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 September 2021 was 109.9, ‘higher than expected’.

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

- It is drawn from nationally reported data.
- The Trust serves a large community of frail older people who are more susceptible to acute problems such as infections and falls which, when added to a host of chronic diseases, result in a higher mortality rate at certain times of year.
- The COVID-19 pandemic resulted in an unprecedented increase in hospital mortality during the first and second waves. Although patients who are admitted with COVID-19 are excluded from mortality ratios, those patients who are confirmed as being COVID-positive once they move from an assessment area to a ward are included. If all patients with COVID-19 are removed from the calculation, the relative risk drops to 103.1 and is deemed 'as expected'.

We are committed to eliminating avoidable harm and improving patient outcomes, and have carried out the following actions to improve quality of our services, HSMR and SHMI.

The Trust is:

- Working with community teams and partner organisations to ensure that patients are supported at home (if that is their preferred place of care), avoiding long stays in hospital which lead to hospital-acquired functional decline. This is also being achieved through the use of 'virtual' wards and 'hospital at home'.

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

- Working with GIRFT (Getting it Right First Time) to improve services and develop pathways for conditions such as ruptured abdominal aortic aneurysm.

- Ensuring that patients at risk of deterioration are identified and escalated quickly.

- Investigating mortality alerts (clinical coding and case-note review) to try to understand why the alert has been generated, provide assurance that care was in line with national/ Trust protocols and provide thematic learning to clinical teams.

- 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.

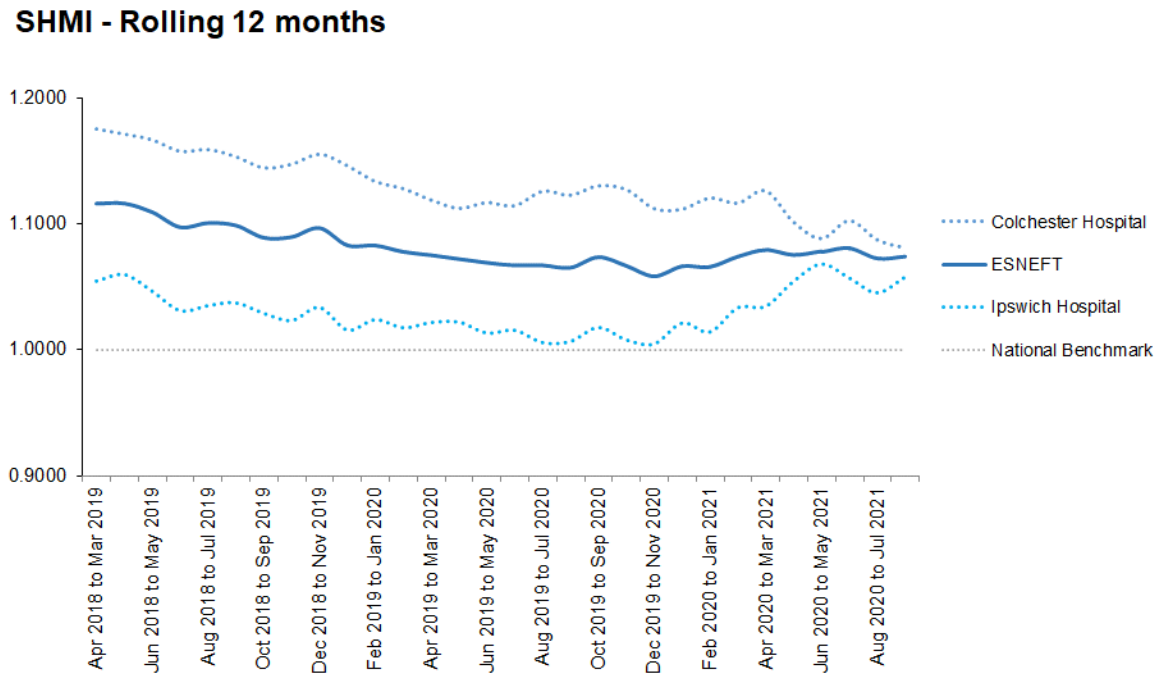
- Ensuring that incidents concerning patient care are fully investigated, including those identified during mortality reviews, and the learning shared to improve patient safety and experience.

- Continuing to measure performance against national benchmarks. Data analysis indicates that the Trust has historically not reflected the high quality of specialist palliative support given to patients at end of life in its clinical coding. This has recently been addressed.

Changes made by Telstra Health UK (Dr Foster) to increase their data capture window will result in a more accurate mortality risk calculation as more chronic conditions will be

included in the algorithm. It is expected that this will increase the expected percentage of in-hospital deaths, thereby reducing HSMR.

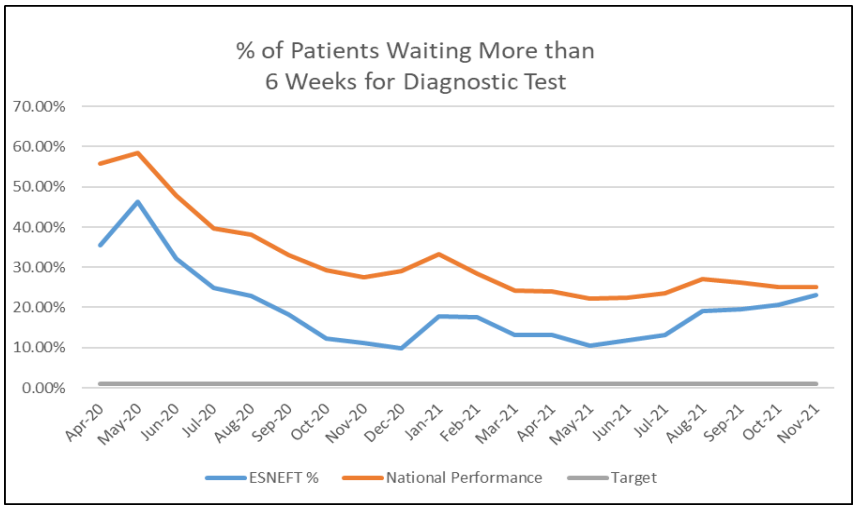
SHMI trend



Waiting times for diagnostics and procedures

During the first wave of the COVID-19 pandemic, the percentage of patients waiting more than six weeks for a diagnostic test significantly increased due to services not fully operating during this time. We recognise the impact this had on patients and took measures to try and mitigate delays during the second wave of the pandemic by ensuring services remained operational wherever possible. Our ESNEFT performance during the year has reflected the national performance.

Percentage of patients waiting over six weeks for a diagnostic test at month end



Percentage of patients waiting more than six weeks for diagnostics tests by month, against a target of 1%

	2019		2020		2021	
	ESNEFT performance	National average	ESNEFT performance	National average	ESNEFT performance	National average
January	2.44%	3.59%	0.97%	4.42%	17.71%	33.34%
February	1.60%	2.30%	0.42%	2.76%	17.50%	28.46%
March	1.89%	2.47%	2.70%	10.19%	13.16%	24.29%
April	3.50%	3.58%	35.39%	55.74%	13.24%	24.03%
May	2.46%	4.08%	46.36%	58.46%	10.56%	22.30%
June	0.84%	3.76%	32.26%	47.82%	11.85%	22.38%
July	0.50%	3.52%	24.89%	39.60%	13.14%	23.51%
August	0.99%	4.31%	22.93%	38.04%	19.22%	27.12%
September	0.28%	3.79%	18.18%	33.05%	19.61%	26.09%
October	0.19%	3.08%	12.30%	29.22%	20.67%	24.98%
November	0.23%	2.94%	11.24%	27.52%	23.09%	25.02%
December	0.50%	4.17%	9.78%	29.17%		
End of year position	**0.50%**	**4.17%**	**9.78%**	**29.17%**		

Clinical standards for seven-day hospital services

The seven-day services programme is designed to ensure that patients admitted as an emergency receive prompt, high quality, consistent care, whatever day they come into hospital.

Of the 10 clinical standards, four are deemed a priority:

- Standard two – time to first consultant review (no longer than 14 hours)
- Standard five – access to diagnostic tests (within 24 hours, 12 hours or one hour, depending on need)
- Standard six – access to consultant-directed interventions
- Standard eight – ongoing review by a consultant (twice daily or daily depending on need)

How we measured and monitored our performance

There had been a national requirement for all trusts to meet the four priority standards for seven-day services by March 2020. However, the programme was paused due to the COVID-19 pandemic, while the standards are currently being reviewed as part of a national consultation.

ESNEFT has made the following progress on the historical standards:

- **Standard two – time to first consultant review**

  Although compliance with this standard had shown an overall trend of improvement over the last three years, ESNEFT was unable to carry out the biannual audit of seven-day services during 2021/22 because of 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, seven days a 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.
  - 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 so that we could meet the increasing demands on the service and ensure the safety of our patients. Audits are planned to resume in quarter three.

- **Standard five – access to diagnostic tests**

  The Trust stood down a number of services at various points in response to the COVID-19 pandemic in line with national guidance. Business planning by the divisions has taken into account difficulties in accessing diagnostic services as a result of the current challenges, and is increasing activity wherever possible. Clinical

prioritisation takes place to make sure patients who need a diagnostic test are offered one within the standards set nationally.

- **Standard six – access to consultant-directed interventions**

  The Trust was unable to audit standard six during 2021/21 to determine if all nine 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 eight – ongoing review by a consultant**

  We were unable to audit this data during 2021/22. There has been an increased consultant presence across the Trust during 2021/22 in response to the pandemic to ensure the patient safety and meet the clinical requirements of patients with COVID-19. The pandemic gave us opportunities to work more flexibly to improve both weekday and weekend care, and all divisions are carrying forward good practice wherever possible. We are continuing to embed daily consultant-led MDT board rounds on a daily basis whilst developing agreed pathways to maximise input from wider clinical team.

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 people's final weeks or days as comfortable as possible.

A national framework for action (Ambitions for End of Life Care 2021 – 2026) identifies six key ambitions to optimise end of life care. These are:

- Each person is seen as an individual.
- Each person gets fair access to care.
- Maximising 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, dying patients and their loved ones. Watchpoint last days of life is now embedded at both Colchester and Ipswich hospitals, where it is assisting wards to identify dying patients.

Usage of Watchpoint last days of life was considerably higher during the peak COVID-19 months which enabled the palliative care teams to support more patients. It is also used to make sure patients and their loved ones can access support from our butterfly volunteers.

Some further COVID-19 focused priorities were:

- Disseminating end of life guidance across all wards to ensure appropriate symptom control, communication and care after death.
- Rapidly reviewing key end of life learning during the COVID-19 period.
- Enhancing specialist palliative care support for 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.
- To make sure patients receive the right care in the right place.
- To increase the number of patients dying in their preferred place.

What did we do to improve our performance?

- Updated our end of life strategy and scheduled regular reviews via our End of Life Board.

- Increased system working across the integrated care system and alliances to improve joint working and decrease the percentage of deaths taking place in hospital.

- Continued to deliver education to nurses to improve their skills in end of life care.

- Used the accountability framework to monitor the use of the individualised care plan for the last days of life.

- Launched a seven-day specialist palliative care service at Ipswich to compliment the seven day service in place at Colchester. Due to extenuating circumstances, the Ipswich service has currently reduced to five days.

- Offer a three day a week butterfly volunteer service to Colchester and Ipswich hospitals, with one volunteer supporting Aldeburgh hospital. These volunteers play a crucial role by making sure that patients will not die alone, even if they have no relatives or their loved ones cannot be with them.

How did we measure and monitor our performance?

- Ipswich and Colchester sites took part in the national end of life audit, which included a survey of bereaved relatives. This will be presented to the Board when it has been published and used to inform quality improvement.

- Used the accountability framework to record the use of the individualised care plan for the last days of life.

- Carried out ward-based reviews of the individualised care plan for the last days of life. to improve their quality.

- By recording the number of patients reaching their preferred place of death.

- Providing a quarterly report into the individualised care plan for the last days of life put together by the audit team.

Did we achieve our intended target?

- The ESNEFT strategy was updated.

- We recorded fewer complaints than the previous year.

- Successful launched the butterfly volunteer service for three days a week on both sites.

- Made use of the Time Garden whenever possible.

- Provided a seven-day service in Colchester.

How and where was progress reported?

- ESNEFT End of Life Board meetings, which are held monthly
- Patient Experience Group
- Quality and Patient Safety
- Quality Oversight Group

Our key achievements

- Decreased the number of complaints relating to end of life care across the Trust.
- Provided specialist palliative care support to colleagues throughout the pandemic.
- Innovation in symptomatic management for patients with COVID-19.
- Seen the number of patients referred to the service continue to increase.

Our chaplaincy service

Chaplains are employed by the Trust to ensure the provision of high quality pastoral, spiritual and religious care for all patients, their families and carers, as well as visitors to ESNEFT's hospitals. Our chaplains focus on offering person-centred, individualised care through active listening and being a non-judgemental, accepting presence across all of our sites, including the community hospitals at Aldeburgh, Bluebird Lodge, Felixstowe, Clacton and Harwich. Chaplains provide a 24 hour on-call service to all ESNEFT hospitals.

Some of the themes from conversation with patients, relatives, carers and visitors in 2021/22 have been:

- **Chatting about ordinary, everyday things,** including 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 and spiritual aspects of everyday life.

- **Relationships,** including concerns for relatives and pets, relationship difficulties, family estrangements and the longing for reconciliation, the isolating nature of COVID-19 and comfort from talking about family.

- **Life review and reminiscence,** including nostalgic conversations that bring comfort and calm, reconciling the past and present, integration versus despair, forgiveness and absolution, hope, meaning and purpose, recognising humanity and conferring value

- **Practical needs, concerns and complaints,** including immediate practical needs, identifying concerns and gaps in care to flag with ward staff and signposting and explaining the processes for escalating concerns or getting advice and resolution.

- **Facing death,** including exploring fears, putting affairs in order, funeral planning, letting go and saying goodbye, bucket lists, realistic hope, concerns for loved ones and emergency marriage.

- **Bereavement, loss and change,** including body dysmorphia of all kinds, death of a loved one, loss of autonomy and increasing dependence, adjusting to life changes such as downsizing or no longer being able to drive, facing a new reality, dealing with grief and not being able to attend a loved one's funeral.

- **Faith, belief and world views,** including 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 and connecting and reconnecting to faith and belief communities.

- **Psychological needs and coping mechanisms,** including exploring low mood, suicidal thoughts, despair and signposting to appropriate support, past and present coping mechanisms, exploring new coping mechanisms and hope, meaning and purpose.

Volunteer and staff support and education

In addition to caring for patients, relatives, carers and visitors, chaplains also support volunteers and staff, which in turn contributes to an improved patient experience. Themes

that have been explored with volunteers and staff during 2021/22 include bereavement and loss, illness, significant life changes, concerns about mental health, relationships at home and at work, workplace trauma, workplace stress, and work pressure. Spirituality and religion, bullying and harassment, COVID-19 vaccination status and other ethical dilemmas have also been discussed.

Chaplaincy and IT have worked together to live stream staff funerals so that colleagues can pay tribute to those who have died in service. Our chaplains also meet with all international nurses before their OSCE exams to provide pastoral support and encouragement.

During the year, chaplains have been involved in educating staff about pastoral, spiritual and religious care by taking part in a range of courses and activities. These include the clinical induction for staff in bands 2 to 4, an end-of-life international nurses study day, butterfly volunteer training, cancer education programmes for HCAs and oncology nurses, a geriatrics training day and child health palliative care study day. The team also host graduate management trainees. This educational activity is designed to help staff feel more confident about caring for the pastoral, spiritual and religious needs of ESNEFT patients, and to better embed high quality pastoral, spiritual and religious care across the Trust.

Summary statistics (April 2021 to January 2022)

Patient and carer/ family encounters:

- 3,943 patients visited and 1,622.6 hours of support provided.
- 1,247 carers/family members supported and 237 hours of support provided.

Funerals:

- 86 religious and non-religious funerals were held for babies. Many of these followed on from religious and non-religious baby naming and blessing ceremonies conducted by the chaplains.
- 24 communal cremations
- Six Trust-related adult funerals

Emergency marriages:

- During COVID-19 restrictions when the registrars were not always able to come into the hospital, chaplaincy conducted or facilitated seven emergency marriages for patients at or near the end-of-life.
- In partnership with IT, we also helped two patients to ‘attend’ a family wedding via live stream.

Baptisms:

- Two baptisms were held in the neonatal units.

Plaudits and thanks

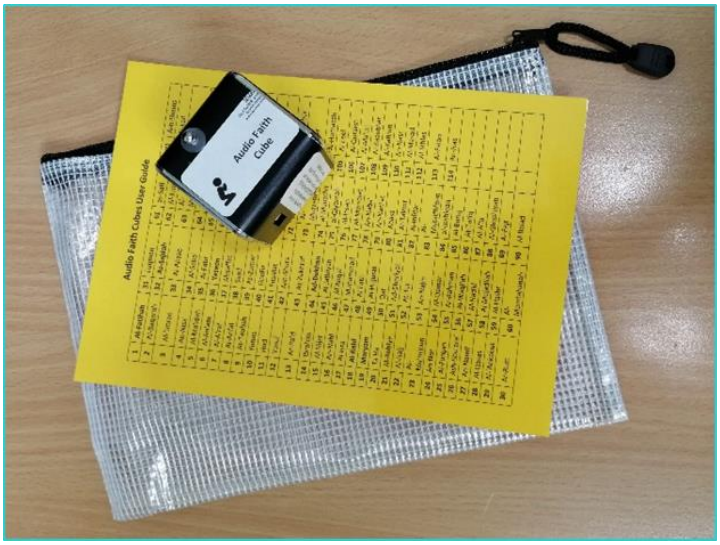
During the year chaplaincy has received the following messages which illustrate the range of work carried out by the team:

- "I wanted to thank you for spending time with my dad whilst he was an inpatient at Ipswich Hospital. Not being able to see him due to COVID-19 was distressing, but knowing that you were able to see him is a real comfort to me and my family. When he was transferred to a different ward I was able to spend the whole day with him and we all got to say our goodbyes. Going through my dad's belongings I am realising the importance of his faith and I know you would have been a real comfort to him." – **patient's daughter, May 2021.**

- "I just wanted to thank you for a deeply moving funeral service for our little granddaughter. My wife and I were very touched with the true sensitivity and kindness that you showed. Our son and daughter-in-law were devastated by the loss of their little one but we feel your lovely service will assist in developing the closure that is needed for them. They will never forget but hopefully will be able to accept and move on." – **the grandparents of a baby who died at 16 weeks gestation, July 2021.**

- "I made a referral for a patient who I felt was reaching the end of their life. A chaplain saw her and offered her a little cross. Her daughter was particularly touched by this, and that chaplaincy were supporting. This enabled me the opportunity to have a very frank conversation with the daughter about prognosis, enabling the daughter to be there for her mother's death. I was also able to use the cross as a way of approaching some advanced care planning which was added to her end-of-life care plan. The cross may be seen as a simple thing, but it opened up so many avenues for discussion. I thank the chaplain for all their support for this patient and myself over what was a busy weekend." – **specialist nurse, August 2021.**

- "During the MDT one of the patients discussed was a Muslim lady with a cancer diagnosis. This patient had been finding it very difficult to engage in any meaningful way with her religion during her illness. She did not wish to see an Imam and had declined chaplaincy involvement… I later visited the ward to provide a Muslim faith cube to her. Her mood lifted and she found the cube quite transformative to her situation and was 'over the moon about it'. Using the cube had enabled her to access her faith anew, and she was particularly thankful to chaplaincy." – **chaplain, August 2021.**



- "Just a note to say thank you for all your help and support in arranging our wedding at Colchester Hospital. It meant so much to both of us to get married before my husband passed. I treasure the photos of that special moment when he gathered very ounce of effort he had left to smile and engage, if only for a few minutes. Your help, understanding and support will remain in my memory for ever. Thank you." – **wife of a patient married at Colchester Hospital, August 2021.**

- "It has been my privilege to have met or spoken with you recently as my father neared the end of his long life. Your kindness, gentleness and sincerity have provided me with much comfort at this most difficult of times. My sister offers her thanks to you as well; we have both much appreciated the calm air of dignity that you brought to his passing." – **relative of a patient, October 2021.**

- "I just wanted to thank you for all the support that you and your team have been giving to my mum, who is currently an inpatient. This is her fourth admission since August last year and you have been supporting her during all of her admissions, which I know she has greatly benefitted from. We as a family have taken great comfort from knowing that she has your support. Thank you to you and the team from myself, and my family." – **relative of a patient, January 2022.**

Mr and Mrs White (pictured) were married at Ipswich Hospital in December 2021. When asked if we could include a picture of their wedding in the Quality Account, they said "Of course you can… if it can help show other people just how amazing the chaplaincy is. You have totally changed my life."

Caring for people with dementia

“Research shows there are more than 850,000 people in the UK who have dementia. One in 14 people over the age of 65 have dementia, and the condition affects one in six people over 80.

“The number of people with dementia is increasing because people are living longer. It is estimated that by 2025, the number of people with dementia in the UK will be more than one million.” (NHS)

“It is estimated that at least one quarter of acute hospital beds are occupied by people with dementia, many of whom would not need to be there were it not for their dementia.” (DH 2016)

ESNEFT dementia specialist practitioners

Admission to hospital can be a stressful and worrying experience for anyone. For people with dementia, some of the challenges can be greater – both for the patient and for their loved ones. Inpatient areas can often be busy, while the unfamiliar noises, routines, staff and environments may increase the confusion a person with dementia experiences and contribute to additional distress.

During 2021/22, we developed new dementia specialist roles, which saw us move away from the Admiral Nurse role description. This has enabled us to continue working closely with carers and families of people with dementia while also tailoring our service to the more specific needs and challenges as experienced by people with dementia who are admitted into our hospitals. At the same time, we have been able to review our training resources and approaches so that we can deliver training in a range of different ways which are more responsive to team requirements. The national reporting requirements relating to dementia were stopped, which gave our dementia liaison administrator additional capacity to support the collection of qualitative feedback from both acute hospital sites. These family and carer experiences are then shared across the Trust to support reflection while helping us improve our services at team and organisational level.

The impact of the pandemic has been far-reaching and has left many people who require inpatient care feeling a greater sense of isolation. We understand the enormous impact this can have on people with dementia, and made sure this was taken into account when visiting was restricted to ensure any detrimental effect was kept to a minimum. Where patients had regular carers in the community, steps were taken to ensure some continuity to enable a degree of familiarity whilst also adhering to enhanced infection control guidance. As the year has progressed, the Trust has reviewed how volunteers from the Alzheimer’s Society can be safely reintroduced to areas in order to engage with patients and offer company to people with dementia.

We recognise that a person’s journey with dementia does not start and end with a hospital admission. For this reason, our dementia specialist practitioners have continued to build relationships with external partners. We have remained active contributors within dementia alliance groups in Suffolk and Essex and have been strengthening our internal processes to ensure that responses to care needs are more seamless for patients and their families when additional assessments for future care planning are required.

Continuing to improve the care for patients living with dementia and their carers

We have identified a number of key areas where focused work is taking place to continue to improve the care provided for people with dementia, from the point of first contact with ESNEFT, throughout admission and during a safe and supported discharge. Our Trust-wide dementia and delirium workgroup has also identified the need to ensure we adopt a consistent approach to dementia screening across ESNEFT, with a renewed focus on training teams and providing information to help them use the assessment tools.

During the year, we have also focused on reviewing and promoting the 'This is me' leaflet while supporting teams to ask patients and their families and carers to share completed versions when someone is admitted to hospital. This is because the leaflet helps our staff to better understand the person with dementia while providing additional knowledge of their life experiences which could help us to provide more personalised approaches to meeting their needs. This will remain a priority focus area, with audits completed and feedback collected to understand the impact the initiative has had and the positive outcomes it has helped to achieve.

Our dementia specialists have started to build a collaborative approach to identifying how a diagnosis of dementia may increase the risk of falls and pressure ulcers. Over the next year, it is our ambition to continue to support colleagues to understand the behaviours and symptoms associated with dementia and how our approaches could be adapted so that opportunities to reduce risks of physical deterioration are not missed. We will achieve this by using different approaches to training, working more closely with falls specialists and tissue viability nurses and using incident data to help us understand key factors which may be influencing risk.

Improving the patient and carer experience

People who use our services are central to everything we do. Every member of staff is responsible for ensuring each patient and their loved one has a 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 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. While there are many different ways to achieve this, it is important we are able to evidence the steps we are taking to listen to what our patients tell us and act on their feedback to improve our services.

COVID-19 made it more challenging to deliver some of our patient and carer experience plans. However, it also created many opportunities to be innovative in how we listen and involve patients, loved ones, carers and service users.

Throughout the reporting year, including at the peak of the COVID-19 pandemic, we continued to collaborate with our communities and respond to their feedback and concerns, which is a crucial part of addressing health inequalities. Whilst we recognise that more needs to be done, we are proud of the progress we made during 2021/22 to address issues that are important to our local population.

One clear message from some of our patient groups, particularly those from Black, Asian and minority ethnic communities, and those with limited or no ability to speak English, was that communication for inpatients was sometimes challenging. This issue was exacerbated by the fact that visitors were unable to attend alongside their unwell loved ones to help support or translate, and because staff were dealing with the pandemic. This made clear the need to do more to address language barriers through our interpreting service, DA Languages, and to better coordinate and explain these sensitive areas of concern. Communities were also concerned about how patients would be fed and cared for without visitors, how they would regularly communicate with carers and that we could not follow patients' faith preferences. To help address this, we continued our 'letters to loved ones' initiative to support loved ones to correspond with patients during the pandemic, while exceptions were made to allow some relatives to visit their loved ones with the agreement of ward sister and matron.

We recognise that much more needs to be done, and we will continue to explore various ways to work with our communities and local organisations to improve the ways we receive feedback. We have also identified areas of concern which we will be including in our patient experience strategy, which will span the next three to five years. Our Patient Experience team has formed a small working group, which includes patient representatives and members of the Council of Governors, to develop the draft strategy, which will then be shared with clinical staff for further input and engagement.

Our bi-monthly Patient Experience Group is chaired by our chief nurse and is regularly attended by divisional staff, public governors and patient representatives. The information provided by the group includes contact with PALS and complaints, patient experience updates, divisional reports, action plans and learning across the organisation. It also discusses the Friends and Family Test and local and national surveys.

ESNEFT Friends and Family Test scores

Emergency Department (all figures are percentages)

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Recommender	88.88	86.77	83.68	81.82	80.29	80.48	77.43	81.23	81.78	82.41		
Responder	24.00	23.00	22.00	20.00	20.00	21.00	21.00	19.00	19.00	20.00		

Inpatient (all figures are percentages)

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Recommender	93.21	93.10	93.23	93.12	91.32	92.43	91.17	92.67	92.46	92.41		
Responder	26.00	27.00	24.00	26.00	21.00	22.00	22.00	23.00	23.00	24.00		

Birth (all figures are percentages)

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Recommender	100.00	83.33	90.00	81.25	100.00	87.50	100.00	n/a	75.00	100.00		

Outpatient (all figures are percentages)

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Recommender	93.89	93.33	92.95	93.72	93.63	92.20	92.64	93.09	93.46	93.65		

Antenatal (all figures are percentages)

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Recommender	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	92.86		

Postnatal ward (all figures are percentages)

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Recommender	98.33	98.04	91.18	87.88	100.00	96.30	95.65	100.00	71.43	100.00		

Postnatal community (all figures are percentages)

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Recommender	100.00	100.00	94.74	100.00	100.00	100.00	75.00	100.00	100.00	n/a		

Our Patient Experience team

Our Patient Experience team work closely with a number of volunteers who support our patient experience agenda. This includes side-by-side volunteers who support patients with dementia by walking around the ward with them, as well as reading to them and singing during their inpatient stay. During the year, our Patient Experience team has received support from Admiral Nurses and the Alzheimer's Society to actively recruiting more of these volunteers, who help to reduce the confusion these patients can experience during their admission.

We are also working with local colleges so that students who are keen to gain practical experience can support patients on our care of the elderly wards with brushing or washing their hair and hand care.

As a result of COVID-19, our planned '15 steps' programme was put on hold until spring 2022. This initiative will see governors and patient representatives form part of a team which visits wards, departments and community sites and provides feedback to ward sisters and matrons to help drive further improvements.

The Patient Experience team is also supporting our divisions to set up patient panels across the Trust by arranging and facilitating meetings and recruiting new members. The panels will then form an overarching ESNEFT patient panel which reports to the Patient Experience Group and Quality and Patient Safety Assurance Committee. Panels are already in place for audiology, cancer, diabetes and children and young people.

Patient representatives and members of the Patient Experience team have continued to hold virtual coffee mornings every month to keep the representatives fully engaged and informed about the work which is taking place to improve the patient and carer experience.

Engagement throughout 2021/22

Despite the challenges of the COVID-19 pandemic, we have continued to engage with patients, carers, the public and our communities during 2021/22. Examples include:

- Dame Clare Marx Elective Orthopaedic Centre project – A focus group which included patient representatives and was led by a clinical lead has been held. Feedback from the patient representatives was very positive, and they said the Trust made them feel welcomed and involved throughout the process.

  In addition, the Patient Experience team has assessed the business case proposals for the centre against NSHE/I consumerism standards.

- Engaging with our multi-ethnic communities – We have continued to work with Suffolk County Council's Public Health Engagement Teams, who have been working

on the ground during COVID-19, to better understand the health needs of our multi-ethnic communities. This has helped to build trust and provided feedback on people's perceived barriers to using our services. This initiative will also be used to share correct information about how to access our services, the remit of the Urgent Treatment Centre and Emergency Department, outpatient appointments and who to go to for help after discharge. As well as strengthening the trust these groups have in ESNEFT, we hope the project will also improve health inequalities within these communities.

- Working with St Elizabeth Hospice – During the year, our patient experience and end of life teams have begun working together more closely, for example by using complaints to develop shared learning. Arrangements have also been made for the head of engagement at St Elizabeth Hospice to carry out a walkabout at Ipswich Hospital to look ways we can work more collaboratively together.

- The Sight Loss Council and the Thomas Pocklington Trust – During spring 2022, a blind patient will visit both Colchester and Ipswich hospitals to carry out a walkabout and give advice on how we can improve the experience of the blind and visually impaired people. This initiative was planned during the year but put on hold due to COVID-19.

- Co-production training with Healthwatch Suffolk – Colleagues from across ESNEFT attended co-production training hosted by Healthwatch Suffolk to encourage the consideration of co-production with any new services or service improvement while also supporting system partnership working.

- Ipswich Hospital Radio and Colchester Hospital Radio – Posters were handed out to every ward to let patients know how to access hospital radio and make a request. Representatives of our patient experience team also took part in a two-hour afternoon programme on Colchester Hospital Radio on 23 December where we discussed patient experience while playing favourite Christmas songs.

- Time Matters day – To mark Time Matters day on 30 November, we visited main reception, Outpatients and EAU to talk to patients and staff and listen to their views and experiences. As part of the day, the chair also completed a walkabout of the hospital with the interim chief executive and visited the PALS office to hear the views of staff.

- Showcasing our patient and staff stories – The Trust is now recording staff and patient stories on Microsoft Teams to share with the Board. During the year, a patient was invited to talk about his experience of care and discharge at the Board, and went onto attend a patient experience meeting to observe our work. He also shared his views on the discharge process at a Discharge Assurance Group meeting, where he also heard more about the improvements we have made to the discharge process.

- Celebrating unpaid carers' week 7 to 13 June – Unpaid cares' week gave us an opportunity to bring the role of the carer to the forefront and listen to the experiences of this important group. Although this year's celebrations were limited as a result of COVID-19 restrictions, they included:

    - Sharing a carer's story on our website, intranet and staff newsletter to remind colleagues of the support which carers can provide for patients, especially those with dementia, learning disabilities and communication issues.

- Welcoming the ‘conversation bus’ from Suffolk Family Carers to Ipswich Hospital car park to offer on-the-spot support for carers. This was particularly useful as our on-site carers’ cabin has been temporarily closed during COVID-19.

Patient and public involvement and community engagement

Throughout the year, we have developed ongoing projects with our patient and public panels. These activities have been led by the engagement team and include the following programmes:

- Elective Orthopaedic Centre at Colchester Hospital
- Children's Department at Ipswich Hospital
- Breast Care Centre at Ipswich Hospital
- Urgent Treatment Centre and Emergency Department at Ipswich Hospital
- Community Diagnostic Centre at Clacton Hospital

Feedback has been used to influence the way services are being designed and built by making sure our project teams understand the requirements and needs of the communities which will be using the new facilities

Topics that have been included in discussions on these projects have included layout, signage, patient flow and creating a welcoming environment.

Learning from complaints

Complaints and concerns can be written or verbal communications from patients and/or relatives who are unhappy about an aspect of their interaction with our hospitals. They are a valuable source of feedback and help us to identify trends which enable us to further improve.

ESNEFT is committed to providing a complaints service that is fair, effective and accessible to all. We undertake to be open and honest and – where necessary – make changes to improve the services we provide.

Complaints service

Complaints are always taken seriously as they highlight the times we have let down our patients and their families. Each complaint is treated as an opportunity to learn and improve. 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 which is provided to the complainant.

How complaints are managed within ESNEFT

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, cleanliness or transport problems.

Our target is to respond to 100% of complaints within 28 working days of receiving the complaint. This year, we responded to 91% of complaints within 28 working days or a revised timeframe agreed with the complainant.

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.
- 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 by 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 or 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.

Top three subjects of complaints for the last three years

2019/20	Access to treatment or drugs Communication Aspects of care
2020/21	Communication Access to treatment or drugs Aspects of care
2021/22	Communication Access to treatment or drugs Aspects of care

Reopened complaints

During 2021/22, 2.7% of complaints which were received between April 2021 to March 2022 (a total of 991) 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 carried out to make sure 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 27 ESNEFT complaints were subject to independent review by the Parliamentary and Health Service Ombudsman during 2021/22, with nine fully investigated.

So far, one of these cases has been partially upheld, one has not been upheld and the remaining cases are under ongoing investigation.

Learning from complaints

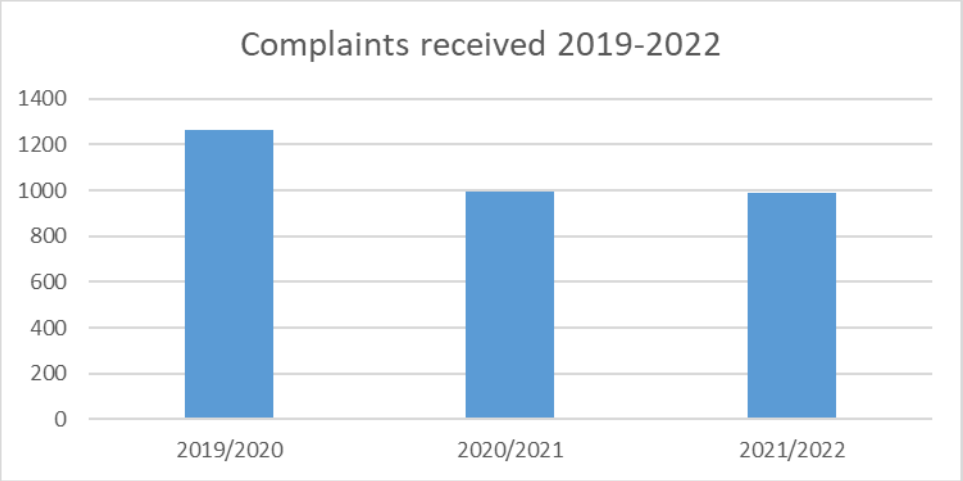
While information drawn from surveys and other forms of patient feedback is important, every complaint we receive indicates that for that patient or their family, they did not receive the high quality of care they rightly expect.

Complaints are an important method by which the Trust assesses the quality of the services it provides. We take all complaints seriously and have taken action in response to them to improve care. We are also working on improving the way we share lessons learned and actions taken from complaints across the Trust.

Lessons learned from complaints are identified and discussed at our patient experience meetings. Monthly dashboard reports have also been developed to support the divisions to monitor outstanding actions.

Through the divisional accountability and performance framework we expect to see clear evidence of learning from complaints in future.

Complaints received over the past three years



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 offers a range of services to patients, carers and visitors, including:

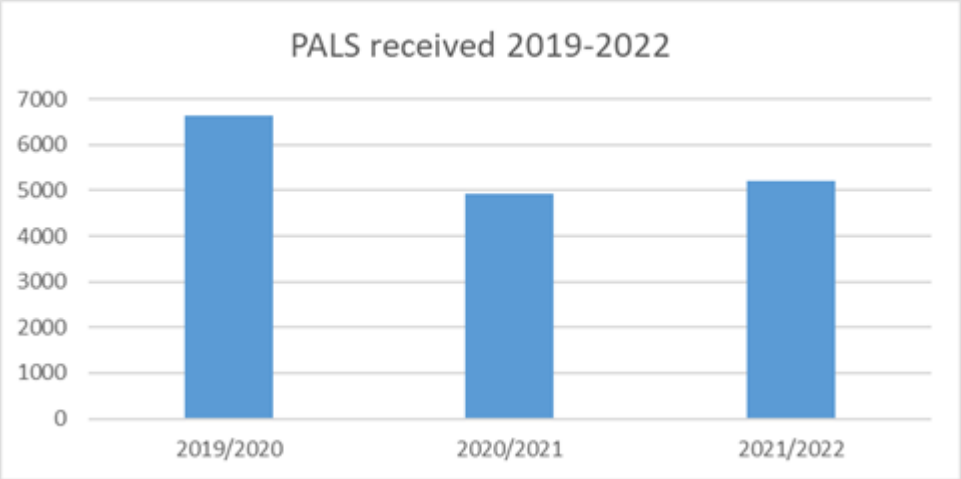
- Advice and signposting: helping to navigate the hospital and its services.
- Compliments and comments: PALS can pass on compliments and ideas to improve services.
- Addressing non-complex issues informally, often preventing the need to raise a formal complaint.

PALS contacts are graded as either PALS one or PALS two:

- PALS one: Contacts that require straightforward information or signposting, for example ward visiting times, how a patient can obtain a copy of their medical records or providing information about GP services or the ambulance trust.

- PALS two: 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.

PALS queries received over the last three years

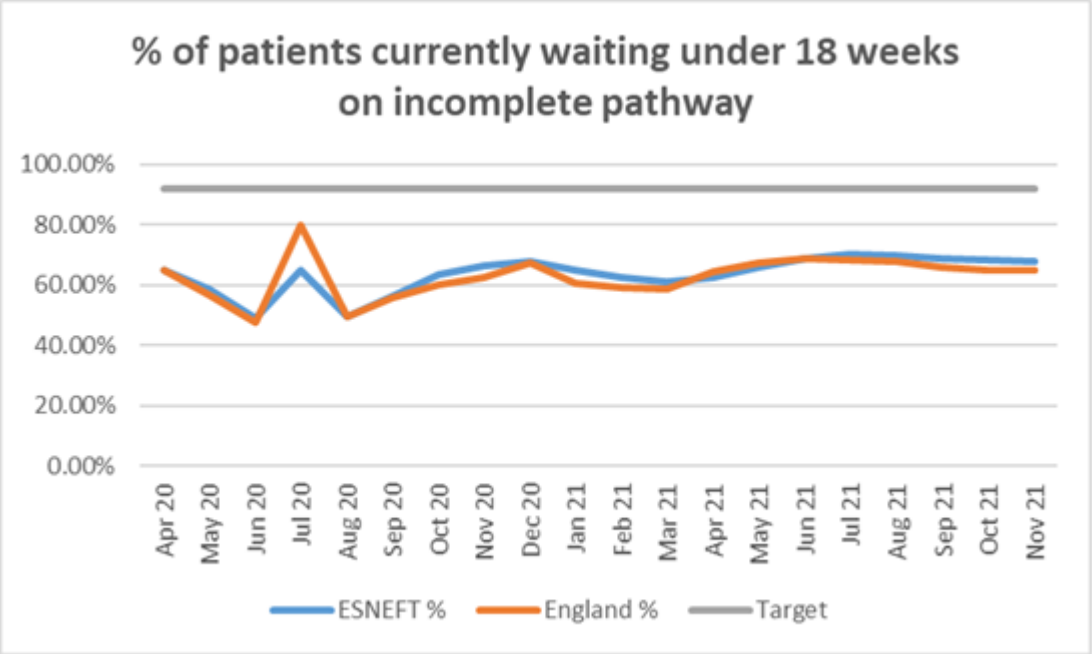


Number of plaudits received by ESNEFT during 2021/22

Month	**Number received**
April 2021	990
May 2021	1,259
June 2021	1,672
July 2021	1,594
August 2021	891
September 2021	1,002
October 2021	638
November 2021	666
December 2021	893
January 2022	584
February 2022	To come
March 2022	To come
Total	**To come**

Cancer and referral to treatment times (RTT)

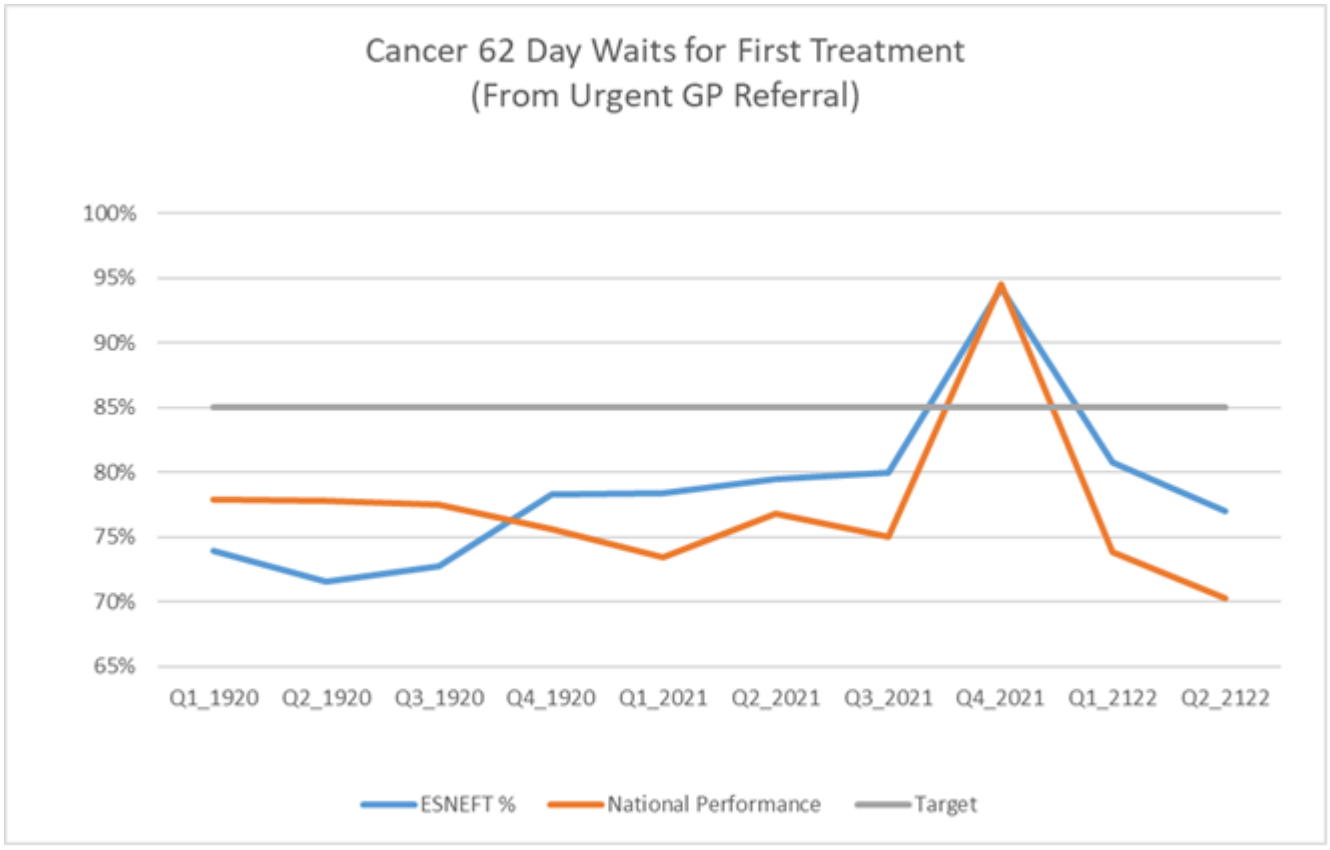
Percentage of patients currently waiting under 18 weeks on incomplete pathway

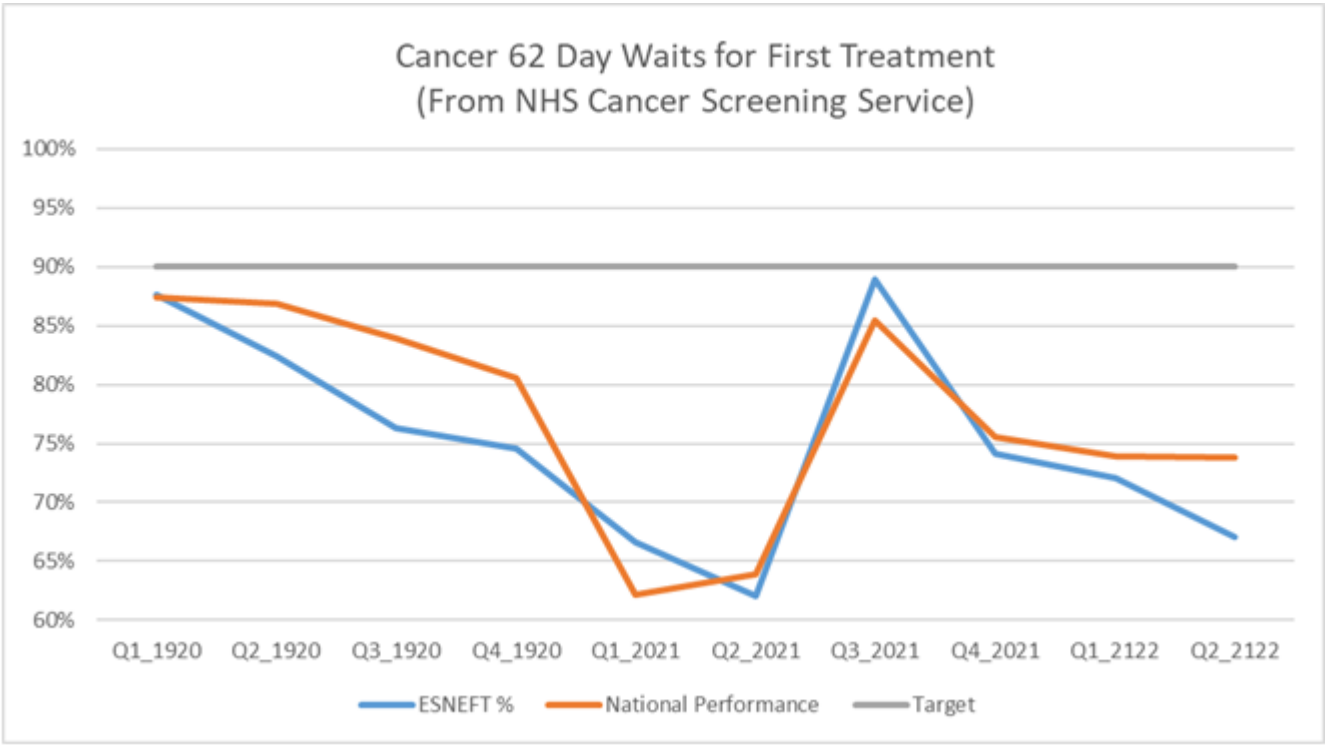


Percentage of patients currently waiting under 18 weeks on incomplete pathway against a target of 92%

	2019/20		2020/21		2021/22	
	ESNEFT performance	National average	ESNEFT performance	National average	ESNEFT performance	National average
April	86.9%	86.1%	65.1%	65.2%	62.7%	64.7%
May	87.1%	86.4%	58.8%	56.9%	65.8%	67.5%
June	85.5%	85.8%	49.0%	47.7%	68.9%	68.9%
July	84.5%	85.3%	65.2%	79.7%	70.4%	68.5%
August	83.4%	84.4%	49.3%	49.3%	69.8%	67.8%
September	82.2%	84.3%	56.4%	55.8%	68.7%	65.8%
October	81.4%	84.2%	63.4%	60.2%	68.2%	64.9%
November	81.4%	83.9%	66.4%	62.6%	67.7%	64.8%
December	79.7%	83.2%	68.0%	67.6%		
January	79.3%	83.0%	65.2%	60.8%		
February	78.2%	82.7%	62.7%	59.0%		
March	79.3%	79.7%	61.1%	58.9%		

Cancer – 62 day waits



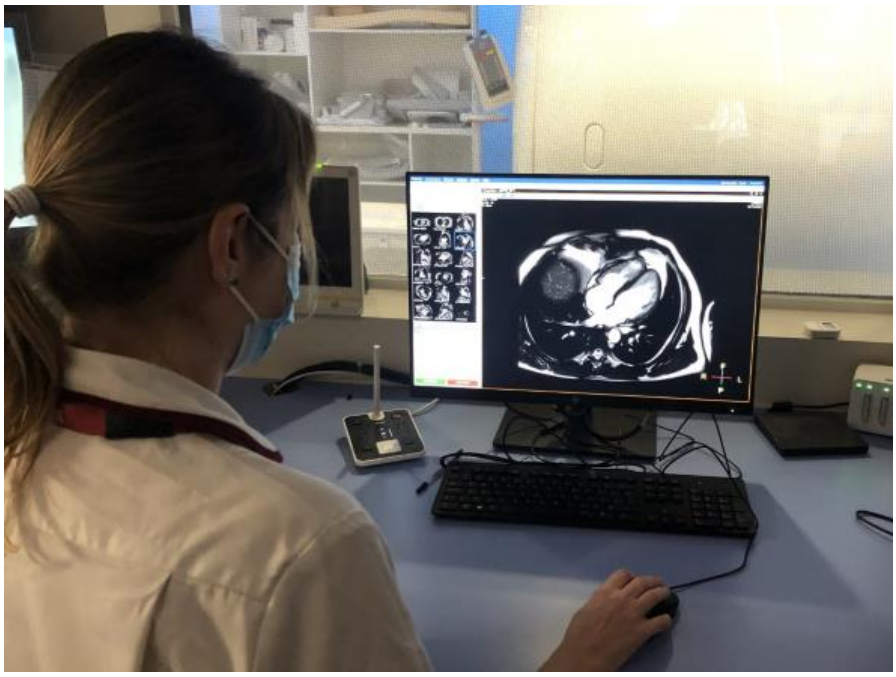


Ensuring that patients referred to our hospitals with a suspected cancer are diagnosed as quickly as possible and receive timely and effective treatment has remained a key priority for our staff during 2021/22. With COVID-19 taking centre stage in terms of NHS resources,

patient safety has understandably has been the main focus of our clinical and administrative teams rather than performance against the national cancer standards.

NHS England and NHS Improvement's directive for cancer services was to ensure that patients were diagnosed and treated as quickly as possible, and for this to be done in parallel with the national recovery of cancer services following the second wave of COVID-19. With the exception of endoscopy during the first wave, all diagnostic services for patients on a cancer pathway continued, which meant ESNEFT started 2021/22 in a relatively strong position in terms of improved cancer performance and return to pre-pandemic levels of activity. This position was sustained throughout the spring, with the Trust achieving 83.7% against the 85% standard for 62-day first performance in April, which was above our local recovery trajectory projections. Our performance remained above 78% until September, which was around 10% above the England average and consistently higher than other trusts nationally who treat a similar number of patients on a 62-day first pathway.

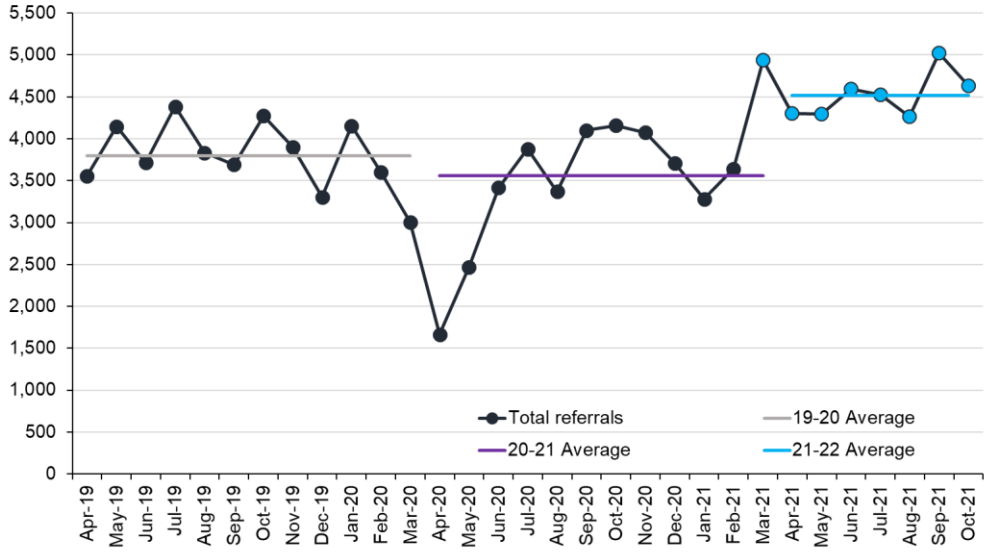
By later summer, however, workforce vacancies and COVID-19 isolation had started to impact our ability to maintain performance. Oncology capacity reduced due to staff having to isolate and waiting times for chemotherapy treatment increased as a result. The team worked hard to hold waiting times which are normally 10 to 14 days at three weeks, with staff working additional hours wherever possible. Daily capacity reviews, clinical escalation for urgent treatments and training additional staff helped us to make sure that the service recovered as quickly as possible without compromising patient care.



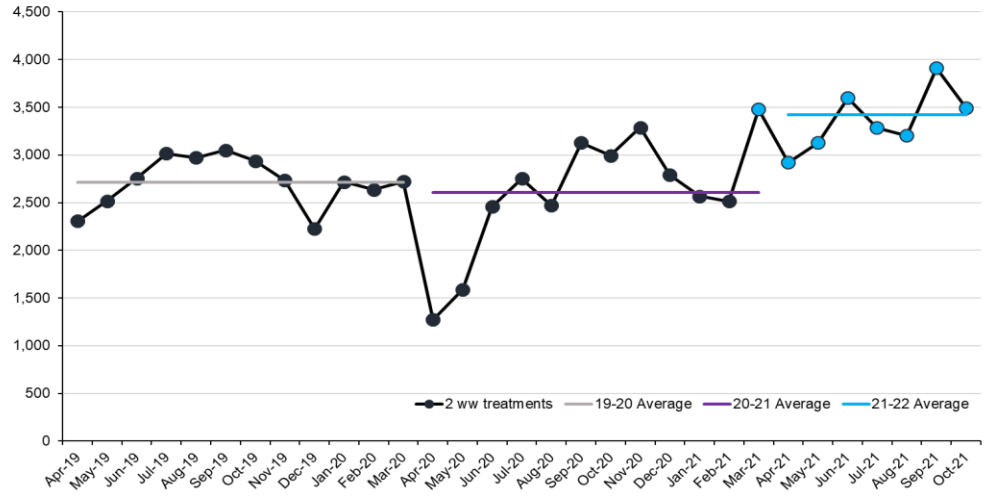
The greatest challenges have been in diagnostics, where consultant vacancies within the medical imaging service have impacted the turnaround times for computerised tomography (CT) scans, magnetic resonance imaging (MRI) and interventional radiology (IR). Additional diagnostic capacity was sourced with external providers and in November 2021, the east of England's first Community Diagnostic Hub opened in Clacton, which has had a positive effect on diagnostic turnaround times and increased CT capacity. Despite the challenges ESNEFT faced, we saw and treated (by volume) more patients on a 62-day first pathway in November 2021 than in any previous month since ESNEFT was formed in July 2018.

Activity levels increased significantly during 2021/22, with two-week wait suspected cancer referrals up by 36% when compared to pre-COVID-19 baseline data from 2019/20. The number of patients treated on a 62-day consultant upgrade pathway also increased by 67%. This huge increase in activity reflects the hard work the teams across ESNEFT are doing to ensure patients are diagnosed and treated as quickly as possible.

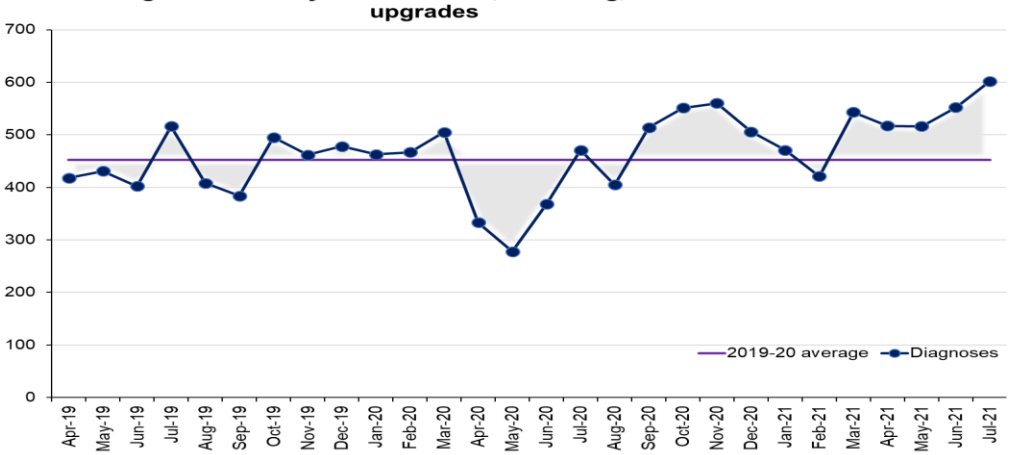
Total monthly cancer referrals - ESNEFT



Total monthly two week wait treatments - ESNEFT



Total diagnoses - 62 day first treatment, screening, and consultant upgrades



As always, patient safety remains a priority for the Trust, which is especially significant when considered in relation to the recovery of performance against national standards. This has been the case for every organisation and has been supported by the NHS national team and the cancer alliances. As we emerge from the pandemic, recovery of cancer performance is a priority, along with the reduction in the number of patients waiting longer than 62 days on a cancer pathway.

Work is ongoing to review pathways and identify improvements before agreeing new recovery trajectories for all of the main cancer standards. Each division is responsible for agreeing a recovery timeframe for each of their tumour sites and operational and clinical teams will continue to work together to ensure that patients are not unnecessarily delayed.

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, we continue to support improvements across all aspects of cancer care by making sure that access to diagnostics and treatment is 'carved out' from routine capacity. This is ensuring that patients on a cancer pathway are seen, diagnosed and treated for their cancer as quickly as possible, whilst high quality of care is maintained.

Highlights of 2021/22

Key improvements made to our cancer services during 2021/22 include:

- Rapid Diagnostic Service – we implemented the vague symptoms pathway in spring 2021 and the breast pain pathway in November 2021.

- Vantage solution to two-week wait pressures – we have worked closely with colleagues in our integrated care systems to use the Vantage software tool, which has mandatory fields on a two-week wait form. This will improve referral quality, ensuring more accurate triage for patients.

- GRAIL study – ESNEFT was chosen to take part in the GRAIL study, which uses a blood test to test for different types of cancer. This is being piloted in partnership with Kings College London, GRAIL, the NHS and Cancer Research UK.

- Introduction of the Community Diagnostic Hub in Clacton.

- Continuation of our consultant-led telephone clinics – these allow patients to discuss their symptoms directly with the consultant, avoiding unnecessary footfall into hospital but ensuring the clinical teams can prioritise patients with the most urgent need.

- New way of tracking patient tracker lists on Somerset (electronic system) – this ESNEFT initiative was rolled out across all tumour sites in 2021/21 and has been hailed as regional best practice and described as 'transformational' for cancer services across the UK. We presented the concept at the Somerset National Cancer Registry 'roadshow' in May 2021 and have received interest from other trusts as a result.

- Cancer patient tracker list management meetings – weekly operational meeting with cancer performance leads have taken place.

- Monthly regional Suffolk and North East Essex Integrated Care System cancer performance telephone calls with NHS Improvement and the region's cancer alliance.

- Prioritisation of cancer throughout the Trust – cancer performance and recovery remains one of our top three priorities.

- 104-day breaches – we have completed a root cause analysis for every patient and reviewed these cases at the appropriate divisional board. A selection of these reports were then reviewed further for assurance and to assess potential clinical harm at a bi-monthly panel led by the Trust's Chief Medical Officer. This panel reports to Trust Board and clinical commissioning group.

- Cancer board bi-monthly meeting chaired by the Trust's lead cancer clinician with the lead cancer manager and lead cancer nurse. The lead clinician for each tumour site, the divisional lead, head of operations and a number of external stakeholders also attend these meetings.

- Cancer transformation team to be appointed to support in the delivery of national and local cancer initiatives.

Improving our patients' experience of cancer care

The face of cancer care is changing rapidly as the number of people diagnosed, treated and living with and beyond cancer increases nationally. ESNEFT is one of the largest providers of primary cancer care in England, treating more than 400 patients every month. Innovations in detection and treatments, such as robotic surgery and novel therapies to target cancer cells, have improved outcomes for our patients.

A radical shift in service delivery and approach across the pathway is currently underway to increase capacity so that all of our patients receive timely treatment and support. Caring holistically and with compassion will remain our focus as we make these improvements.

Our achievements during 2020/21 include:

- **Developing a cancer telephone helpline and our websites.**
  The impact of the first wave of COVID-19 on appointments and treatments caused significant anxiety for our patients. In response, we set up telephone helplines at Colchester and Ipswich hospitals within a week, with the service taking almost 4,000 enquiries within its first four months. Staff working on the helplines liaised closely with clinical teams, in turn ensuring safe care and improved patient experience. Feedback from patients was incredibly positive, and included comments such as: "The helpline was my life raft keeping me afloat during a terrible time" and "It was great to be able to speak to someone straight away and have your worries sorted. Nothing was too much trouble." The initiative proved such a success that it also received runner up recognition in the national Patient Experience Network awards.

  The pandemic also gave us the opportunity to develop our online resources and launch a new website for the John Le Vay Cancer Support and Information Centre at Ipswich Hospital, which includes health and wellbeing information, signposting and videos. We are now developing a mirror website for the Cancer Wellbeing Centre at Colchester.

- **Taking part in the national cancer patient experience survey (CPES).**
  As a result of the pressures caused by COVID-19, the 2020 CPES was offered to trusts on a voluntary basis. ESNEFT was one of 55 to take part. Whilst national and regional comparisons cannot be made, the survey provides useful results at a trust level. Comments received included praise for excellence in care, whilst others indicated areas where communication could be improved. The survey also provided us with insights into the impact the pandemic had on our patients, which included difficulty taking in information during virtual appointments or when family were unable to be present. While we recognise that COVID-19 presents virtual opportunities, further learning is required so that we can find the optimal offer for each individual's personalised needs.

  The CPES report is being analysed and an action plan due in March 2022.

- **Introducing our Cancer Patient Panel.**
  Our newly-formed Cancer Patient Panel was set up in July 2021 and is made up of five patient representatives and the lead cancer nurse. Its aim is to contribute to the continuous improvement of cancer services by making sure that co-production takes place and the views of service users are sought, coordinated and fed back to the Trust. To date, members have been involved in staff education and reviewing patient literature. Areas of focus for the future include improving empathetic and compassionate communication and developing a network of peer-to-peer buddy support. The Patient Experience team supports the group's work and a drive to expand its membership.

- **Appointing a pre-diagnosis clinical nurse specialist.**
  We recognise that some patients who are referred to our services to investigate possible cancer experience a complex or lengthened pathway. In October 2021, we launched a 12-month pilot in response to feedback from patients, which saw the introduction of a non-site specific pre-diagnosis clinical nurse specialist to help us achieve earlier diagnosis while supporting patients safely through the pathway. Although the specialist was temporarily redeployed to support ESNEFT's response to COVID-19, the service has successfully supported a number of patients who have co-morbidities, frailty or have anxiety about their investigations or the risk of COVID-19. At the end of the pilot, the impact the project has had on referrals, timely management and the patient experience will be evaluated.

- **Developing out pre-habilitation and recovery pathways**.
  These pathways focus on areas such as physical activity, nutritional management, wellbeing and psychological support and aim to improve both our patients' outcomes and their quality of life.

  'Fit for Life' is an ESNEFT pilot open to all cancer specialities. It is run in partnership with CanRehab fitness professionals, who offer online and face-to-face workshops involving:

  - **Baseline pre-assessment** – to assess risk factors, provide information and make joint decisions on interventions which will bring maximum benefit
  - **Pre-habilitation interventions** – which always includes physical activity, and can also incorporate dietary support and psychological wellbeing
  - **Follow-up post-treatment** – where assessments are repeated and exercise continues.

The initiative has been registered as a quality improvement project and a full evaluation will be carried out with support from the University of Suffolk. Videos showcasing our patients have also been produced to help promote the benefits of taking part.

- **Continued to work towards national targets to introduce personalised self-managed follow up**.
  This initiative is designed to make sure that patients receive education, surveillance, remote monitoring and rapid access to clinical support for symptoms or concerns which meets their individual needs following completion of their treatment. After redesigning services and recruiting within our breast, colorectal and prostate cancer services, we are on track to meet the national implementation deadline of March 2022. Our focus will move to thyroid and endometrial cancers during 2022/23.

Safeguarding

It is the duty of all staff employed by ESNEFT to be able to identify and raise concerns in relation to suspected or discovered abuse or improper treatment of individuals who are in receipt of our care. This also includes any action which may deprive a person of their liberty without lawful authority and omissions in care which may lead to significant harm.

The safeguarding team works across the Trust to support staff safeguard patients, and includes specialists in midwifery, children and young people and adults and older adults. We work closely with safeguarding partners and authorities to ensure that a response to raised concerns is timely, effective and meaningful.

Since the end of 2021, the safeguarding team have embedded a new structure to ensure that there is a stronger organisational response to any safeguarding concerns that arise. These changes have also allowed closer working with the complex health team in recognition of the frequent overlap of concerns which exist due to the vulnerabilities that people with dementia, learning disabilities and mental health needs may experience. For this reason a new post of senior lead for safeguarding and complex health has been introduced to support a strategic overview for these services. Operational leadership has also been reviewed and two heads of safeguarding families introduced on both sites to further support closer working across the organisation and within the ICS partnerships.

The safeguarding families and complex health team has continued to grow over the past 18 months so that we can support ESNEFT to robustly respond to abuse and neglect. We have also extended to cover the north Essex community services and introduced an additional adult safeguarding post to ensure we have domestic abuse specialism at both sites. As a result, our team is now made up of four safeguarding adults leads, two safeguarding adult specialist practitioners, two named nurses for safeguarding children, three safeguarding children specialist nurses, two safeguarding midwives, two learning disability nurses and two dementia specialists.

Through close partnership working, we have secured fixed term funding from the local authority and NHSE to extend our complex health team. A learning disability assistant practitioner is now in post in Colchester and directly supports teams to meet the complex needs of people with a learning disability and make use of reasonable adjustments. In addition, we have successfully recruited to two children and young people mental health specialist posts which will also be based in Colchester. These posts are timely in respect of the increased requirement for hospital admission of children and young people with complex mental health needs, which is representative of the national challenges faced in response to reduced availability of specialist services. There has been a requirement for a significant amount of joint working with our children's safeguarding specialists and mental health services due to the overlap of factors which impact the health and wellbeing of these individuals.

The team has continued to work together to provide training across the Trust which incorporates a 'think family' approach. This has been reviewed to make sure it complies with mandatory training for safeguarding children and safeguarding supervision which has supported improvements in these areas.

Reporting

The safeguarding and complex health team provide a quarterly report to the Trust. This includes a review of compliance, safeguarding trends, training and learning from reviews.

The reports are also shared as part of the operational group and Safeguarding Committee. These forums enable a focus across the organisation and with external partners to support the escalation of concerns arising from thematic reviews and actions for improvement, as well as identifying good practice. This gives us a formal opportunity to work together and hold each other to account for delivering a safeguarding service that meets national and local requirement for the people we serve.

In the last year there has been a requirement to review the impact of COVID-19 on safeguarding concerns arising in direct clinical care, the organisation and across the wider health and care system. This learning has been shared and has been taken into account, alongside wider learning, when the Trust has had to respond to subsequent waves of COVID-19. As a result of the review, a Trust-wide discharge assurance group has been introduced to triangulate learning from patient experience, safeguarding and patient safety so that we can improve our discharge processes.

The adult safeguarding team have been carrying out audits and providing training to support improved understanding and compliance with the Mental Capacity Act. This is to ensure that where deprivation of liberty occurs, the appropriate legal frameworks are applied and necessary assessments are made. This ongoing work has been vital in preparing ESNEFT for the implementation of liberty protection safeguards, which has been delayed nationally but will require all organisations to have increased responsibilities and accountability. Alongside this, there has been a formalised contract to ensure mental health act administration across both sites. A programme of training around use of the mental health act has also been developed to ensure that when used it is legally valid and patients are supported in understanding and exercising their rights. In addition, the Trust has formed a mental health improvement steering group to maintain our focus on identifying and supporting the mental health needs of our patients.

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, so that we can make ESNEFT a positive and trustworthy place to work and receive care.

Effective speaking up arrangements help to protect patients and improve the experience of everyone who works at the Trust. We know the main reasons that staff do not speak up are because they fear they might be victimised or because they do not believe anything will change. At ESNEFT, we want to create a culture where our staff feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care, or which affects their experience at work. This includes concerns relating to patient safety and quality of care, as well as bullying and harassment. To help us achieve this, our managers need to feel comfortable having their decisions and authority challenged. Speaking up needs to be embraced by everyone working at ESNEFT and should be welcomed and seen as an opportunity to learn and improve.

All NHS trusts and foundation trusts are required to employ a lead Freedom to Speak Up guardian as part of their contract. Guardians are also employed in primary care and some charities. Their role is to ensure patient safety and staff wellbeing, as well as supporting staff raising concerns. Tom Fleetwood, ESNEFT's current Freedom to Speak Up guardian, has been in the role for the last five years and was one of the first guardians appointed in the east of England. He is now supported by eight assistant guardians, who have received full training and have been in post since May 2021. The contact details of the guardian and his assistants are published on the raising concerns page on the intranet and are also accessible through the Wellbeing Hub.

As part of national speak up month in October, a revamped raising concerns/ Freedom to Speak Up poster was produced and is now being distributed across all ESNEFT sites. Listening sessions take place regularly and are publicised in our staff newsletter and on the intranet. In addition, articles which highlight the principles of raising concerns and Freedom to Speak Up, as well as the mechanisms which are in place to support staff, are also shared with colleagues using our internal communication channels.

The past 12 months have been challenging, and as a result there has been a steady increase in the number of concerns raised with the Freedom to Speak Up guardian. This has also been the case at other trusts across the east of England. Many concerns specifically relate to the pandemic and cover areas such as PPE, working from home, redeployment and return to work. Support from senior management when issues have been raised has continued to be excellent, with concerns addressed and action taken.

Raising concerns remains a key element of ESNEFT's induction programme and the guardian also contributes to the management leadership induction programme. Freedom to Speak Up is also one of the four key pillars of the Wellbeing Hub. The guardian meets regularly with the Chair, Chief Executive and the Director of People, and has a monthly meeting with the wellbeing guardian. He reports to the People and Organisation Committee on a quarterly basis, and to the Board of Directors annually.

Staff survey

To come

Workforce health and wellbeing

This year, we fully launched our Wellbeing Hub to help support the health and wellbeing of our staff. It is built around the provision of four key services:

- Health and wellbeing
- Emotional wellbeing
- Occupational Health
- Raising concerns

The hub also works closely with colleagues from chaplaincy, Staffside, health and safety, patient safety, organisational development and employee relations to better understand the organisational factors which affect staff wellbeing.

Health and wellbeing

Our new health and wellbeing team aims to inspire and motivate everyone working for our Trust to try new things and get fitter, healthier and happier. During the year, they have provided activities such as yoga, massages and bite-size fitness sessions, while also coordinating Brew Crews, publicising webinars on topics such as stress management and sleep and supporting a broad range of health and wellbeing initiatives.

In 2021/22, the team began providing wellbeing calls for all staff who are off work due to stress, anxiety or depression, as well as for those who are absent long-term for any reason, to check on their wellbeing and offer support. In addition, our employee assistance programme continued, which gives staff access to services such as financial and legal advice and counselling for issues not related to work.

During the year, we put up wellbeing boards across our sites to provide information about topics such as physical health and financial wellbeing. Our website is also kept up-to-date, while health and wellbeing information is included weekly in Team ESNEFT News, which is emailed to all staff. During the winter, we also promoted a winter wellbeing toolkit through newsletters and our Twitter account.

Thanks to the generosity of Colchester & Ipswich Hospitals Charity, we opened an oasis space in Ipswich this year, which provides a calm, relaxing environment where staff can take a break away from wards, clinics or offices. A similar oasis in Colchester is due to follow soon.

During the coming 12 months, we will continue to work with One Life Suffolk and Provide to explore different health promotion activities, which will include giving staff access a diabetes prevention programme called ‘healthy you’.

Emotional wellbeing

Our new staff psychology service offers individual psychological therapy and assessment for colleagues across ESNEFT. It also supports psychological debriefs, runs training around psychological wellbeing and offers team support.

The development of the staff psychology service has helped us to increase our focus on the emotional wellbeing of our staff in relation to the COVID-19 pandemic. All teams were

offered debrief sessions following the second wave, while an estimated 320 staff at year end have accessed individual psychological support via the service. Evidence-based interventions have been offered to help staff manage areas such as work-related trauma, stress and HR issues. The service had also run team training on 'processing a difficult day,' as well as drop-in clinics where teams can access psychological support. Referrals processes have been clearly established and staff are able to self-refer.

We now have around 400 mental health first aiders (MHFAs) working across the Trust, who provide emotional support within teams and signpost colleagues to relevant services. We continue to offer training to staff and provide monthly support to those who have already completed their training.

Our MHFAs also support our Brew Crews, who visit wards and departments with packs of tea or coffee (in line with infection control guidance) and provide information about the support which is available.

Schwartz rounds were paused during the pandemic, but have now re-started and provide much-needed time for staff to reflect together on the emotional impact of their work.

Occupational Health

Our Occupational Health (OH) 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.

During the year, the team has continued to provide expert advice during the pandemic to the Trust at strategic level and a fast, effective OH response to staff, human resources and managers. The service gives all staff the opportunity to self-refer daily and speak to an OH duty nurse without the need for an appointment. The duty nurse service also provides risk assessments for employees who have unfortunately had a sharps or splash injury, allowing them to report this injury and have it assessed promptly. Immunisation clinics are available each day but need to be booked in advance.

Senior members of the team provide OH advice to committees such as the strategic workforce group, weekly infection control meetings and health and safety committee. Our OH consultant was also involved in the development of the individual COVID-19 risk assessment and continues to feed into updates to assure the Trust and our staff that we are complying with our legal responsibilities to keep all employees safe in the workplace.

The OH team delivered the 2021/22 seasonal flu vaccine to our staff, and also played an integral role in planning and delivering the COVID-19 booster programme for health care staff and clinically vulnerable people. As well as providing medical support to the vaccine hubs, the team also advised the hubs, GPs and ESNEFT consultants on the preferred COVID-19 vaccine for individual staff and patients with a complex medical history.

Our OH service expanded in June 2021 when the ACE (Anglian Community Enterprise) OH service TUPE transferred into ESNEFT. This has given colleagues in North Essex Community Services access to a large OH service at Clacton, Colchester and Ipswich hospitals. This enhanced provision includes an OH consultant and increased number of community and public health specialist – occupational health, OH clinic nurses, technicians and administrators. This expansion has also given us the opportunity to digitise the previous ACE OH records.

During the year, the Trust became one of the first in the region to launch a dedicated menopause service run by a nurse specialist and specialist GP. All staff are welcome to self-

refer for a confidential assessment and advice on managing the impact of the menopause and peri-menopausal symptoms. A menopause policy has also been developed, while the team plan to provide training and education for employees and managers across the Trust over the coming year. The menopause clinics are hosted by the OH service and part of the wellbeing hub.

Raising concerns

We recognise 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 raise any concerns they may have.

Our Freedom to Speak Up guardian continues to be available to staff who want to raise concerns and is now supported by eight assistant guardians.

Volunteering

Our volunteer service covers all volunteering across ESNEFT and is coordinated in-house from a centralised office at Ipswich Hospital. Its management team has grown and is now made up of a business development manager funded by Colchester & Ipswich Hospitals Charity, together with two volunteer coordinators and four voluntary services administrators (three WTE).

Although volunteering largely stopped during the early part of the pandemic, we have now been able to start building up the service once more by adopting flexible approaches to our registration process and by reviewing the roles which volunteers could safely carry out.

Volunteers played a key role in keeping the COVID-19 vaccination hubs at both Colchester and Ipswich hospitals running smoothly, with more than 150 lending support during the last 12 months. This fantastic response has showcased their adaptability and resilience, and their contribution has been greatly appreciated by staff and patients alike.

The welcoming service has returned at both Ipswich and Colchester hospitals as clinical services have been reinstated. This sees 25 volunteers provide our patients with support, directions and a reminder to wear a mask or sanitise their hands when they arrive on site. In addition and where COVID-19 restrictions allow, 30 volunteers have returned to our care of the elderly wards and some community hospitals to support clinical staff during a time of increased pressure.

We have also reintroduced butterfly volunteers to support patients who are at the end of their life, while our cancer wellbeing and information centres have reopened to visitors with volunteer support. We have also continued to register many new volunteers to allow these services to be maintained. We will end the year with approximately 200 regular volunteers on our sites fulfilling a variety of roles.

During the last 12 months we welcomed colleagues from Community360 as we began delivering community services in north east Essex, and very much look forward to working closely with them to develop our volunteer offering for local people.

The expansion of our voluntary services team means we are better placed to exploit the opportunities available to us in the coming 12 months while continuing to develop our services to meet the needs of the Trust. Work will also continue on our new volunteer database, which will allow us to streamline our registration process while providing our future volunteer with one platform for their application, registration, induction and ongoing mandatory training.

Education and training of staff

ESNEFT is committed to providing a multi-professional learning environment for our staff and aim to ensure our staff, volunteers, students and trainees receive high quality training.

Medical education

The Trust hosts medical students from various universities. Numbers can fluctuate, but during the 2021/22 academic year, we gave placements to the following students:

Barts and the London School of Medicine and Dentistry	Year three – 22	Year four – 102	Year five – 33		157 total
Anglia Ruskin University	Year one – 39	Year two – 6	Year three – 6		51 total
University of East Anglia (Colchester Hospital)	Year two – 29	Year three – 24	Year four – 18	Year five – 1	72 total
University of East Anglia (Ipswich Hospital)	Year two – 84	Year three – 120	Year four – 40		244 total
University of Cambridge	Year four – 135	Year five – 24	Year six – 112		271 total

We support the training of physician associates and currently have two on education placement with the Trust from Anglian Ruskin University and 13 on student placements.

Talent for Care and apprenticeships

During 2021/22, our Talent for Care team supported the sign up of 146 new apprentices. Overall, this equates to 285 apprentices on programmes across 43 different standards/ frameworks.

We are active members of the Suffolk and North Essex ICS Health and Care Academy and are heavily involved with the health ambassador scheme, both of which aim to promote roles in health and social care. We also support the St John Ambulance NHS cadet scheme, which encourages people to explore voluntary opportunities.

The team have been involved in the promotion and recruitment of 16 people to the Kick Start programme, which is aimed at 16 to 24-year-olds who are receiving universal credit and at risk of long-term unemployment. The scheme gives them a paid work experience supported by a leaning and skills programme.

We are also working regionally to support the introduction of allied health professional apprenticeships.

Pre-registration education

A multi-professional team of practice education facilitators (PEFs) and administrators support pre-registration education across ESNEFT. The team provide a range of services to non-medical learners and the staff who supervise them in practice, including specific programmes of teaching, developing new and innovative ways to support practice learning and offering pastoral support.

There is also a big focus on promoting and improving the culture of learning across the organisation to make sure we provide a safe and inclusive learning environment for learners. The pre-registration education team play an essential role in recruiting and educating learners and supporting the development of high quality, adaptable and resilient healthcare professionals to meet the needs of the public we serve.

Student teaching and support

The pre-registration team have been responsive to the challenges caused by COVID-19 on practice learning and placements. This includes facilitating bespoke learning opportunities in collaboration with partner universities to support students who have missed practice time so that they can reach registration in their chosen profession.

The PEFs are allocated to specific wards and departments which allows them to build relationships with the staff and wider team. They are highly visible in the clinical areas and will offer support and guidance, as well as working alongside students or coaching supervisors to help students thrive and excel in practice.

Although much of the usual curriculum was paused last year, the team has now relaunched a programme of teaching and multi-professional forums for students, while also developing

new programmes to support the changing requirements in education standards, such as future nurse and midwife. We continue to receive positive evaluations from our learners and respond quickly to address any areas where improvements could be made.

Our staff strive to make sure that the emotional wellbeing needs of our students are met. A range of resources are available, while many of the PEF team are also trained as mental health first aiders.

In line with the Trust's ongoing drive to grow its own workforce, the PEFs are providing education and support to increasing numbers of clinical apprentices, including nursing associate apprentices and degree nurse apprentices.

Hub and spoke: Planned associated learning

The hub and spoke model gives staff greater access to specialists, resources and learning opportunities by linking specialist (spoke) areas to wards or departments which follow a patient journey. The PEF team has introduced this model mainly across nursing areas and is now developing it for radiography and our operating theatres.

Clinical placement expansion

Clinical placement expansion is an ongoing project which is designed to support the continued and sustained growth of the nursing, midwifery and AHP workforce. It sees us work closely with our partner higher education institutes to increase the practice learning opportunities we can offer across ESNEFT. This has enabled more students to join healthcare programmes and undertake the required learning opportunities in practice. This year, the team has developed a multi-professional peer learning project, which sees occupational therapy and physiotherapy students supervised and assessed by the different professions. This will be rolled out into other areas after helping to increase capacity while improving confidence and the preparedness of students.

Practice partners and students

We have collaborated 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
- University College London

We support pre-registration students on a range of different programmes across all our sites. The table below indicates the various programme we provide practice learning opportunities for and the number of traditional pre-registration students we have supported between April 2021 and March 2022.

Student programme	Number of students
Clinical psychology	1
Diagnostic radiography	62
Dietetics	3
Midwifery	146
Midwifery (short)	4
Nursing (adult and mental health)	7
Nursing (adult)	636
Nursing (child and mental health)	1
Nursing (child)	94
Nursing (mental health)	138
Occupational therapy	60
ODP	31
Paramedic	70
Physiotherapy	134
Physician associate	16
Return to practice	17
SALT	44
Therapeutic radiography	30

Post-registration education

The post-registration education team of practice educators work across both the Colchester and Ipswich hospital sites, as well as within the north Essex and east Suffolk community. They deliver classroom training and education, and also design and deliver ongoing programs such as preceptorship, clinical induction and OSCE preparation.

Preceptorship programme

The multi-professional preceptorship programme for newly registered professionals has been adapted to accommodate COVID-19 restrictions, and is now a mixture of face-to-face, live virtual sessions and self-directed learning using a platform called Moodle. In January 2022, 495 members of staff were taking part in the programme with support from the post-registration team.

International nurses

Our team delivers OSCE preparation (NMC part two test of competence) with new cohorts of international nurses arriving monthly at both Colchester and Ipswich hospitals. This detailed programme includes theory, practice and mock examinations to help the nurses prepare for the OSCE exam, which they take 12 to 16 weeks after arriving in the UK.

Between April 2021 and January 2022, we supported 226 overseas nurses to complete the OSCE programme, all of which are now working as registered nurses.

The team also provides pastoral support, guidance and clinical advice to help our international nurses to successfully adapt to living and working in the UK.

Support in practice

Our practice educators are allocated 'home wards' with which they work closely to build productive relationships with staff and leaders. Working closely with specific clinical areas means they are able to provide support, guidance, bedside training and pastoral care to staff who are struggling, under performance management or are new in post. Due to the pandemic, the support the team is able to provide has been limited during the past year.

Non-registered clinical staff

Our practice education trainers support non-registered clinical colleagues in both the classroom and clinical settings to help them achieve their standards of care certificate and ensure they are aware of the fundamentals of nursing care. The team also offers additional learning opportunities for these staff.

An accelerated version of the care certificate has been launched for existing staff which takes into account their current skills and experience. An optional bands 2 to 4 development programme is also available for staff who have completed the care certificate and wish to complete further learning. This is a mixture of face-to-face study sessions and learning using the Moodle platform. They are also given the opportunity to talk about their career and how they would like to develop, such as by completing an apprenticeship to progress into an NMC-registered role.

Clinical induction

As recruitment has increased, the team has developed a different way of delivering clinical induction to support onboarding. Clinical induction is now a modular programme made up of virtual events held on Microsoft Teams, practical sessions and virtual learning. Developing the programme has more than doubled capacity, which is making sure our new starters are inducted in a timely manner

Medical device training

Work continues to support medical device training, including making sure the right documentation is in place to ensure consistency and quality. There is also a robust process in place to track and monitor the roll out of medical devices to different departments.

A Trust wide audit carried out in 2021 identified more than 12,000 medical device training records, which are being transferred to OLM.

Education and training opportunities

We continue to support the development of our workforce to ensure that we have appropriately trained and skilled staff to provide safe and effective care for our patients.

Mandatory training

Although all but essential training was suspended for periods during 2021/22, we continued to support staff to complete training to keep our patients and themselves safe. We have a suite of training requirements which are mapped to all roles across the Trust and delivered using a combination of face-to-face and e-learning. Compliance currently stands at 87.30%.

Corporate learning and organisational development

As 'licence to lead', the Trust's previous leadership programme, was halted due to the pandemic, we have had to explore new and innovative ways of delivery.

Reflecting the changing needs of the organisation and the effect that recent events have had on staff, the Trust commissioned a number of supportive interventions including individual and team coaching and decompression sessions.

Support for leaders continued with the delivery of NHSE/I leadership circles. Covering 10 subjects, the hour-long sessions were designed to allow leaders to discuss and solve issues and difficulties relating to leading in a pandemic. We also continued to offer bite-size sessions covering having meaningful conversations, appraisal and a variety of health and wellbeing interventions.

Work is currently taking place on a leadership development pathway which will include our coaching and mentoring opportunities within the organisation. We are also commissioning a senior leadership development programme with two other levels under development, along with an aspirational talent management programme with a working title of 'leaders of tomorrow'. This pathway will include a management essentials toolkit of offering everything from how to guides to facilitated sessions which will support our leaders with the operational elements of managing and leading our colleagues.

We are also developing an overall learning and organisational development catalogue which will include all opportunities for learning and education at ESNEFT in a learning hub.

Employment of disabled people – training

The Trust continues to ensure that all staff have equal opportunities to develop new skills or enhance existing skills and advance their careers. This includes mandatory training, clinical skills, personal development and apprenticeships. We recognise that some staff will have additional needs when starting or returning to the workplace and their corporate and local induction should reflect this.

It is the line manager or supervisor's direct responsibility to ensure that staff with additional needs are properly inducted into the Trust and are treated equitably during their employment. All staff are required to undertake equality and diversity training, with compliance currently standing at 94.95%.

According to role requirements, training is also provided in dementia, deprivation of liberties, learning disabilities, the Mental Capacity Act and safeguarding vulnerable adults.

Continuing professional development

We have supported and developed training in line with service need and the wider healthcare economy.

In reflecting our objectives and NHS Long Term Plan, the Trust has and will continue to support multi-disciplinary healthcare staff to attend a wide variety of courses and workshops. This allows them to enhance their skills so that they 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 – patients are accessing services with increasing complexity and at various stage of urgency, which has continued to drive the requirement for increased specialist skills to treat acutely unwell patients. Providing care across multiple specialties has required the ongoing need for upskilling in areas such as acute stroke care, cardiac care, management of diabetes, and ultrasound training.

- Cancer care – specialist education in palliative care and advanced communication has taken place to support the delivery of care to patients with cancer and to improve their experience and outcomes.

- Mental health – we have continued to improve awareness of mental health conditions and support not only for our patients but also our staff, for example by holding mental health awareness workshops, mental health first aid training, debrief training and additional leadership and coaching.

- Maternity – education has taken place in a range of areas including care of the critically unwell women, newborn and infant physical examination and practical obstetric multi-professional training so that we can support women and babies with a range of care requirements.

- Children's services – education has been provided on topics such as high dependency care of the acutely ill child, oncology care and paediatric examination.

Advanced clinical practitioners

Advanced clinical practitioners (ACPs) are registered practitioners from a range of professions such as nursing and physiotherapy. They work as part of a multi-disciplinary team at an advanced level with high levels of autonomy and complex decision making to help provide safe, accessible and high quality patient care

This year, Health Education England has established the Centre for Advancing Practice to oversee the workforce transformation of advanced level practice. As part of this work, the Clinical Education Department has been delivering information and Q&A sessions regarding the development of the advanced practitioner and consultant roles while also supporting workforce planning and requirements.

Professional nurse advocate

Three staff in the post registration team have completed or are currently undertaking professional nurse advocate training so that they can provide restorative clinical supervision to colleagues. Additional staff in our critical care units have also trained to be professional nurse advocates to ensure we are able to offer restorative supervision across the Trust.

Library services

The libraries at the Ipswich and Colchester sites work together to provide a comprehensive service to ESNEFT staff and students on placement. They offer integrated and efficient services in line with Health Education England's vision for NHS library services and give staff access to a wide range of resources, ensuring clinical and managerial decisions are based on the best available evidence. Library staff provide expert evidence searches, training and document supply. Both libraries are open for study 24/7.

Valuing our staff

ESNEFT staff commendations

During 2021/22, we continued to celebrate the hard work and dedication of our staff by inviting patients, carers and colleagues to nominate those who go above and beyond to provide the best possible care and services. Our winners were:

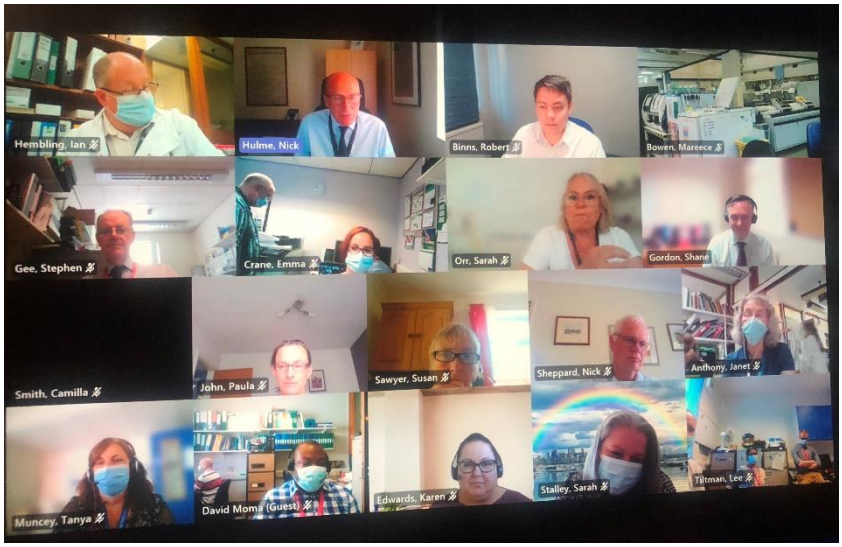
We were asked by a patient to say a special thank you to Colchester Hospital breast surgeon **Ros Jacklin.** The patient was devastated when she was diagnosed with cancer and knew her mental health problems were going to make treatment even more difficult.

"Kind and caring" Ros contacted many of the mental health professionals supporting the patient to make sure all her care was coordinated in the best possible way. She calmed the patient and helped her overcome her fears and worries at every hospital visit.

We also gave an award to our very own Mr Fix-It – hospital craftsman **Mark Hazelton**. Mark wasn't going to let a missing part stand in the way of getting a job done when the children's unit at Ipswich Hospital needed some extra heating. Knowing he had the exact part at home, he nipped back to collect it before fixing the heating, keeping our young patients toasty.

Hospital clinical skills technician **Colin Gray** put his NHS colleagues under the spotlight when he captured a series of iconic photographs – called 'The Eyes Behind the Mask' – on the Ipswich Hospital COVID-19 ward.

We turned the camera on Colin and surprised him with a staff commendation award. It's not only his photography skills that are worthy of the accolade. His colleagues say he "works tirelessly" and "his dedication to the team is outstanding."



COVID-19 put pathology services under a microscope. We confirmed the results from our labs…our **pathology team** is top class! We surprised staff in the department with a commendation for playing a crucial part in our response to the pandemic.

It came after the team helped us move from being able to process zero COVID-19 tests a day to 3,000, making ESNEFT one of the top NHS centres in the country.

Rob Haynes, who works in the Radiotherapy team, is a favourite with patients and staff alike. Described as “caring and devoted” by colleagues, he built a great rapport with a patient who was having daily trips to the department from her ward bed.

When her final treatment was booked, Rob was due to be on a day off. However, he was so determined to wheel the patient to her final and landmark appointment, that he popped on his uniform and came in for one special final portering service.

Ipswich Hospital ED nurse **Esther Akintaju** was given a commendation after helping to save a patient’s life. Esther noticed the seriousness of the patient’s condition – easily confused as food poisoning – and gave first-class care.

Despite it being a typically busy day in the ED, Esther made sure no stone was left unturned and every test was carried out until a blocked bowel was diagnosed. The patient said: “I owe my life to this dedicated, professional and knowledgeable nurse…Esther is a credit to the NHS.”

When ESNEFT colleagues bravely left their day jobs to join the fight against COVID-19 in critical care units, who did they look to for help? It was NHS stars like nurse **Louis Robinson.**

Louise works at Colchester Hospital and is known for her "caring and hardworking" nature. It's what new colleagues needed the most when they were redeployed to the COVID-19 frontline. On one busy shift, Louise supervised four colleagues as they looked after critically ill patients. They complimented Louise for her support and friendliness and for making "a potentially very scary experience a nice shift."

Karen Tonks from our finance team showed incredible kindness and professionalism when she found herself on the phone with someone who was thinking about suicide.

The patient themself said it was that phone call which stopped them ending their life and said Karen cheered her up, motivated her, and gave her a fresh start.

Newly-qualified nurse **Olivia Smith** was given an award after saving the life of hospital housekeeper Chris Hunton.

During a night shift, Olivia – who was still a student at the time – heard a loud crash and found Chris collapsed on the floor in the corridor outside the ward. She put all her student nursing skills in practice, realised he was in cardiac arrest, called for help and started CPR.

Chris had open heart surgery and is now back fighting fit at work. And we are pleased to say that now Olivia is a qualified nurse she has chosen to stay and work with us… on the same ward as Chris.

Statements from key stakeholders

Statement of assurance from the Board of Directors

Glossary

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 and voluntary organisations and aims to make sure better care is provided for everyone in hospitals, care homes and people's own homes.

Clinical coding: The translation of medical terminology as written in a patient's medical records to describe a problem, diagnosis and treatment of a medical problem into a coded format.

Clinical commissioning group (CCG): Groups which are responsible for commissioning (planning, designing and paying for) all NHS services.

Clinical delivery group (CDG): Sub-groups 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.

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 Trust is divided into distinct clinical divisions: medicine, women's and children's, cancer and diagnostics, musculoskeletal and special surgery, integrated pathways, surgery, gastroenterology and anaesthetics and north east Essex community services. There is an additional division which manages corporate functions such as governance, education, operations, human resources, finance, performance and information. Each Divisional Board is chaired by a consultant 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.

Emergency Department (ED): Also known as A&E or Accident and Emergency.

Harm-free care: National patient safety initiative targeted at high impact areas such as pressure ulcers, catheter care, VTE and falls.

Quality and Patient Safety Committee: The Trust Board sub-committee responsible for overseeing quality within ESNEFT.

Healthwatch: An organisation which champions the views of local people to achieve excellent health and social care services.

Hospital standardised mortality rate (HMSR): 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 and Ipswich and East Suffolk Clinical Commissioning Group: The commissioners of services provided by ESNEFT.

MDT: Multi-disciplinary team.

Methicillin resistant Staphylococcus aureus (MRSA): 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 MRSA in the blood.

National Early Warning Score (NEWS): A system of recording vital signs observations which gives early warning of a deteriorating patient.

Modified Early Obstetric Warning Score (MEOWS): A system of recording vital signs observations which gives early warning of a deteriorating obstetric patient.

Morbidity and mortality meetings: Meetings are held in each Clinical Delivery Group which aim to gain knowledge and insight from surgical error adverse events. The meetings explore what happened and why, how the issue could have been prevented or better managed and key learning points.

Never events: Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Patient Advice and Liaison Service (PALS): A service which answers all enquiries to the hospital such as cost of parking, ward visiting times and how to change an appointment etc.

PEWS: Paediatric Early Warning Score.

Root cause analysis (RCA): A structured investigation of an incident to ensure effective learning to prevent a similar event from happening again.

Summary hospital-level mortality indicator (SHMI): An indicator for mortality which covers all deaths of patients admitted to hospital and those that die up to 30 days after discharge from hospital.

Secondary uses service (SUS): 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.

Venous thrombo-embolism (VTE): A VTE is a complication of immobility and surgery and is also known as a blood clot.

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 report who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool.
- 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
- inpatients 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
- 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
- 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.

Detailed guidance: More detail about this indicator can be found on the NHS England website.

Data relating to the percentage of patients risk-assessed for VTE can be found on page XXX.

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', which was 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.

Data relating to the percentage of patient safety incidents resulting in severe harm or death can be found on page XXX.

How to provide feedback on the 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

Alternatively, you can write to:

Trust Offices
Colchester Hospital
Turner Road
Colchester
Essex CO4 5JL

Thank you

We would like to thank everyone involved with East Suffolk and North Essex NHS Foundation Trust. This includes 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 Trust we can all be proud to be part of.

Find out more about our services by visiting www.esneft.nhs.uk

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