NHS
East Suffolk and North Essex
NHS Foundation Trust

East Suffolk and North Essex NHS Foundation Trust

Quality Account

2022 / 23

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Part one – statement on quality

Chief Executive's commentary

Every day, we touch the lives of thousands of people who need our care and who live in east Suffolk and north Essex.

Our 12,000 colleagues work in hospitals, the community and in people's own homes to deliver safe, compassionate care to a population of almost one million people. The quality of that care is the focus on this report, which highlights the progress we have made in the last 12 months and our priorities for the coming year.

It is a comprehensive account of our work in addressing areas where we need to do more, as well as reflecting on our key achievements.

It is shared widely with all our partners in health and social care at an early stage as well as our stakeholders to make sure it is representative and accurate. My thanks to everyone who has been involved in producing this final account.

Much work is already underway to achieve our quality priorities for 2023/24, which are:

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

Patient experience priority: To continue to improve our care to those at the end of their life and support patients who have limited treatment options.

Patient safety priority: To work with partners to improve access to mental health support for patients admitted to hospital.

During 2022/23, we also published our Quality Strategy. This sets out our commitment to improving the quality of care for our patients over the next five years and how we will make this a reality. It is closely aligned with ESNEFT's ambition to offer the best care and experience, its strategic objectives, and the Trust's Time Matters philosophy.

The strategy recognises that the COVID-19 pandemic has created unprecedented challenges since 2020. At the same time, global and local learning has accelerated changes in our provision of quality services and highlighted inequalities in healthcare access and outcomes. A flexible approach, underpinned by quality improvement methodologies, is key to continuous improvement of our services at such a time of rapid change and recovery.

Nick Hulme
Chief Executive
East Suffolk and North Essex NHS Foundation Trust

Part two – priorities for improvement and statements of assurance

Quality priorities for 2022/23

Progress against the priorities we set as a Trust

Patient safety priority – medication safety:

- **To improve the safe prescription, administration and dispensing of medications in our hospitals and communities**

Lead directors: Chief Medical Officer and Chief Pharmacist

Why was this a priority?

This priority supports our ambition to deliver quality care and reduce avoidable harm. Safe antimicrobial prescribing, medicines on discharge and omitted doses remain key priorities for ESNEFT. By reducing the number of missed doses (especially of critical medicines), ensuring safe and appropriate antimicrobial prescriptions and making sure every patient leaves their place of care with the correct medications, we can support their healthcare journey whilst ensuring their safety at all times.

The 'safe and secure handling of medicines' standards underpin the Trust's medicines governance processes and provide a strong foundation on which to build the quality priorities.

What is our target?

- Reduce the number of critical medicine doses omitted.
- Improve the quality of prescribing of antimicrobials and drive the antimicrobial stewardship agenda forward.
- Improve the management of medicines given to our patients on discharge from our services and make sure they receive the right medication and the right information.
- Demonstrate compliance with our 'safe and secure handling of medicines' audit performance.

What did we do to improve our performance?

- Audited the number of 'blank boxes' for critical medicine doses on medication administration records.
- Drove improvements and raised awareness by launching the 'no blank challenge safety cross'.

- Revised the critical medicines list and included guidance on how to access medicines out of hours while improving the intranet search function to enable staff to easily locate stock lists.
- Used the ‘saving lives’ audit to continue to drive improvements in the management of antimicrobials and presented the results to doctors at Grand Rounds to promote more medical involvement in the audit to enhance learning and awareness of good practice.
- Reviewed the antimicrobial stewardship strategy and launched a revised ‘Microguide Live’ app to assist prescribers in antimicrobial choice.
- Introduced a focus on patients on IV antibiotics at the daily board round to ensure regular review and launched an intravenous to oral antibiotic tool to assist with decision making.
- Reviewed the way antibiotic usage is reported and shared to improve prescribing and included key messages in the Chief Medical Officer’s newsletter.
- Reviewed therapeutic drug monitoring and the bespoke drug chart for gentamicin with an aim to roll out Trust-wide in 2023/24.
- Undertook ‘Micropharm’ (microbiologist and antimicrobial pharmacist) ward rounds, with formal referral of patients in need of specialist review of their antimicrobial therapy.
- Focused on antimicrobial therapy and good practice during antibiotic awareness week in November.
- Set up a penicillin de-labelling (removal of inappropriate penicillin allergy status label after review) project group.
- Launched the SAFEDIS checklist Trust-wide during world patient safety week, with a later audit of practice to monitor improvements.
- Integrated the senior role of medication safety officer into the organisation.
- Included the pharmacy matron in the medication safety agenda and at various forums to improve communication of key issues with nursing colleagues.
- Provided a forum for the medication safety agenda through the Medication Safety Working Group.
- Upheld the ‘safe and secure storage of medicines’ agenda, with a focus on controlled drugs.
- Introduced pharmacy service posters to wards to improve clinical staff’s understanding of the team’s roles, availability and opening times.
- Completed the process of updating/installing compliant controlled drugs cabinets across the Trust.
- Ensured 100% compliance with quarterly controlled drugs audits, capturing the data on the ADIOS system accordingly.
- Refurbished the clinic rooms at Ipswich Hospital to optimise space, improve drug storage and ensure compliance with HBN recommendations.

How did we measure and monitor our performance?

- Maintained the SAFEDIS audit across the Trust to provide assurance that nurses and midwives meet the professional standards for discharge medication, and that patients are adequately counselled.
- Monitored complaints and incidents linked to medication errors (especially relating to missed doses, antimicrobial prescribing, discharge medicines and controlled drugs) to identify any themes, trends or areas for improvement.
- Used the omitted doses audit to drive improvement in the practice of medicines administration.

- Audited the completion of the no blank challenge safety crosses.
- Provided monthly reports to wards, divisions, groups and committees showing compliance with the 'saving lives' bundles and reported back to the Antimicrobial Stewardship Group accordingly.
- Provided monthly reports to wards, divisions, groups and committees showing compliance with controlled drugs processes and reported back to the Controlled Drugs Steering Group accordingly.
- Monitored progress with the 'safe and secure handling of medicines' agenda through audit and discussions at the Medication Safety Working Group.

Did we achieve our target?

- We made significant progress with the medication safety quality priority in 2022/23 despite the nursing and pharmacy teams facing challenges with capacity.
- We saw a reduction in omitted doses. A thematic review of Datix incidents relating to omitted doses is planned for 2023/24.
- We have seen continued good practice with antimicrobial prescribing through the 'saving lives' audit and are aiming to increase the number of areas we audit in the coming year.
- We have monitored discharge errors and are planning a thematic review 2023/24. An addition question asking whether incidents are discharge related is being added to the Datix form to enable better reporting and learning from themes.

How and where was progress reported?

Regular reports, updates and actions were captured and monitored by the Medications Safety Working Group, Antimicrobial Stewardship Group, Medicines Governance Group, Controlled Drugs Steering Group, Patient Safety Group and the Quality and Patient Safety Committee.

Clinical effectiveness priority:

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

Lead directors: 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 a minimum of 95% of 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?

- Completed a thematic review of nutrition related incidents over a 12-month period.
- Carried out focussed learning from the two most common categories; nil by mouth status and nutritional advice delayed/not followed, linking with dietetics, nutrition team and ward MDTs.
- Developed a nutrition quality improvement project which focussed on getting the basics right on the wards. This included allocating workstream leads, putting reporting systems in place and establishing mechanisms for ongoing monitoring.
- Carried out a baseline assessment of national standards for food and drink, to develop a work plan for gaps identified.
- Launched revised oral nutrition and hydration policies across the Trust.
- Linked with the volunteer coordinator to plan a relaunch of our meal time volunteers. Role descriptor, competencies and training packages have been reviewed, with a launch planned in March 2023 during nutrition and hydration week.
- Continued to develop links between the Nutrition Steering Group and Mental Health Board to address the needs of patients with eating disorders. This has seen the senior responsible officer for eating disorders become co-chair of Nutrition Steering Board. This work involves links with the MEAD group, North East London NHS Foundation Trust (NELFT) and Essex Partnership University NHS Foundation Trust (EPUT).
- Continued to run weekly nutrition ward rounds at Ipswich Hospital and worked to embed them at Colchester Hospital. A recruitment plan has also been put in place to ensure capacity for weekly rounds.
- Reviewed the Trust's compliance with three point training to nasal gastric (NG) competencies to ensure that all three steps are completed to enable effective placement of NG tubes and reduction of incidents related to NG tube placement.

How did we measure and monitor our performance?

Through audits, patient surveys, complaints and incidents reviews and quality improvement project reviews and updates.

Did we achieve our target?

No. We currently have nine months' of data for 2022/23 showing an average of 80.78%.

How and where was progress reported?

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

Our key achievements

In addition to the improvements listed above, we carried out a full review and relaunch of the Nutrition Steering Group giving areas of focus and ensuring every division is represented with an emphasis on shared learning. We have received positive feedback from group members regarding focus and engagement.

Patient experience priority:

- **To continue to improve care for those at the end of their life and support patients who have limited treatment options.**

Lead directors: Chief Medical Officer and Chief Nurse

Why is this a priority?

There is only one chance to get end of life care right. In the final stages of illness, care priorities shift with the focus often changing to palliative care for the relief of pain, symptoms, and emotional distress. Compassionate, high quality care enables us to make a loved one's final weeks or days as comfortable as possible by offering the person at end of life, and those identified as important to them, choice around decisions concerning their treatment and care. This includes creating an individual plan of care tailored to the needs, wishes and preferences of the dying person which is agreed, coordinated and delivered with compassion.

What was our target?

- To deliver high quality, compassionate and dignified end of life care for all patients
- To make sure patients to receive the right care in the right place
- To increase the number of patients dying in the preferred place

What did we do to improve our performance?

- Began operating a seven-day face-to-face palliative care service at Ipswich Hospital as well as Colchester Hospital following successful recruitment.
- Recruited an additional butterfly volunteer coordinator, allowing us to expand the service to five days on both acute sites and offer support at the community hospitals.
- Restructured the End of Life Steering Group and continued to improve the way we collect data with regard to preferred place of care.

How did we measure and monitor our performance?

- All hospital sites took part in the national end of life audit, which included a survey of bereaved relatives. The results will be presented to Board after publication and used to inform quality improvement.

- Used the accountability framework on all wards recording use of Integrated Care Priorities for the Last Days of Life (ICPLDL).
- Carried out ward-based review of the ICPLDL to improve their quality.
- Recorded the number of patients reaching their preferred place of death.
- Received a quarterly ICPLDL report from the audit team.
- Completed monthly reviews of complaints and six-monthly thematic reviews.

Did we achieve our target?

- The ESNEFT strategy was updated.
- We continued to monitor complaints monitored and complete thematic reviews.
- We expanded the butterfly volunteer service to run five days a week on both acute sites.
- We began providing a seven-day palliative care service at Ipswich to match the service already provided at Colchester Hospital.

How and where was progress reported?

- End of Life Steering Group monthly meeting
- Patient Experience Group
- Quality and Patient Safety Committee
- Quality Oversight Group

Our key achievements

- Increased the communications skills training offered to staff
- Launched the “How can I support you?” tool
- Expanded the Butterfly volunteer service

ESNEFT’s Butterfly volunteer service

Our quality priorities for 2023/24

In order to ensure we are continuing to deliver high quality services and the best possible experience for all of our patients who are receiving care at one of our hospitals or within the community, ESNEFT engaged with stakeholders to agree the following priorities for 2023/24.

Clinical effectiveness priority:

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

Lead directors: Chief Medical Officer and Chief Nurse

Why is 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. Patients who are at risk of malnutrition require an effective management plan to meet their complete nutritional requirements. People's nutritional status is affected by a number of different factors and can therefore change rapidly. Regular review of the nutrition support care plan by a care professional enables the plan to be adapted to best meet the current needs of the person.

What is our target?

- Increase the accuracy of patient risk assessments regarding their nutritional status on admission to hospital and ensure that actions are taken in response.
- Ensure that patients who require assistance with eating and drinking are given the support they need.

What will we do to improve our performance?

- Ensure that patients who need help to eat and drink are given adequate support, including through the use of food charts.
- Link NHS England's eight new national standards for food and drink to the nutrition workplan.
- Focus on care planning alongside MUST data to ensure timely, accurate completion and review and develop a training plan to improve nutrition care plans, metrics and processes for review.
- Review the current training requirements for nutrition and hydration.

How will we measure and monitor our performance?

- Increase compliance with MUST risk assessments.
- Demonstrate sustained improvements on CQUIN outcomes.
- Carry out audits of food charts.

- Audit the use of the red tray, which ensures that patients who need assistance receive support to eat and drink.

How and where will progress be reported?

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

Patient experience priority:

- **To continue to improve our care to those at the end of their life and support patients who have limited treatment options.**

Lead directors: Chief Medical Officer and Chief Nurse

Why is this a priority?

There is only one chance to get end of life care right. In the final stages of illness, care priorities shift with the focus often changing to palliative care for the relief of pain, symptoms, and emotional distress. Compassionate, high quality care enables us to make a loved one's final weeks or days as comfortable as possible by offering the person at end of life, and those identified as important to them, choice around decisions concerning their treatment and care. This includes creating an individual plan of care tailored to the needs, wishes and preferences of the dying person which is agreed, coordinated and delivered with compassion.

What is our target?

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

What will we do to improve our performance?

- Increase the use of end of life support tools to help us identify patients in the last year of life in a timely way.
- Discuss the wishes of the patient and their families and document on the My Care Choices Register (MCCR) in north east Essex and support the development of EPaCCS (electronic palliative care coordination systems) across Suffolk.
- Access a patient's MCCR on every emergency admission in Colchester.
- Work with system partners to improve the provision of end of life care at home.
- Use national and locally recognised tools, such as the ReSPECT form, yellow folder, individual care record for the last days of life, SPICT and MCCR/ EPaCCS.
- Promote coordinated care for discharge planning, enabling patients to die in their preferred surroundings, be that at home, hospital or hospice.

- Facilitate palliative and end of life care training and education for staff using innovative and creative approaches to learning.
- Provide continued access to specialist palliative care assessments, seven days a week.
- Provide advice, support and signposting to patients thought to be in the last year of life and their loved ones through our new Butterfly Service and Information Centres at Colchester and Ipswich hospitals.
- Support patients and their loves in the last days of life by providing them with a visit from a Butterfly Volunteer, who help to ensure that no one dies alone.
- Advertise the support available in the last hours and days of life using “How we can SUPPORT you” posters, leaflets and roller banners.

How will we measure and monitor our performance?

- Monitor themes from complaints relating to end of life care and share them with clinical staff.
- Review end of life dashboard data in partnership with alliances.
- Audit the use of individual care records for the last days of life to ensure best possible practice.
- Accountability framework for use of individualised care plans for the last days of life.

How and where will progress be reported?

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

Patient safety priority:

- **To work with partners to improve access to mental health support for patients admitted to hospital.**

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

Why is 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 is our target?

- To identify the trends and themes in relation to patient need and the support which is in place, along with any variances between sites.
- To work with system partners to ensure there is a responsive and appropriately trained workforce which can meet the mental health needs of patients receiving care.
- To work with system partners to streamline processes to enable more effective partnership working.

What will we do to improve our performance?

- Arrange an education programme for our nurses and allied health professionals and develop ward link educators at band six and as part of the undergraduate programme.
- Develop processes for performing emotional wellbeing assessments across all inpatients and targeted outpatients, to include detail of responses to positive assessment.
- Run a communications programme to increase awareness of the support which is available to staff.

How will we measure and monitor our performance?

- Monitor ED breaches for patients who require mental health support.
- Monitor length of stay for patients who have a mental health co-morbidity.
- Monitor the use of restrictive interventions, including the use of the Mental Health Act, restraint and use of rapid tranquilisation for management of risks relating to mental health.
- Monitor the provision of staff support and training.

How and where will progress be reported?

Regular reports and updates will be provided to the Mental Health Improvement Steering Group, Patient Experience Group and People and Organisational Development Committee.

Provided and sub-contracted services

During 2022/23, 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 Suffolk and North East Essex Integrated Care Board, together with a number of associate commissioners 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, Allied Health Professionals Suffolk CIC, Suffolk GP Federation CIC and Ramsay Healthcare Ltd.

The income generated by the relevant health services reviewed in 2022/23 represents 99% of the total income generated from the provision of relevant health services by ESNEFT for the year.

Clinical services at ESNEFT

Participation in clinical audit

During 2022/23, 50 national clinical audits and five national confidential enquiries covered relevant health services that East Suffolk and North Essex NHS Foundation Trust provides.

During that period, we participated in 96% of the national clinical audits and 100% of the national confidential enquiries which we were eligible to take part in.

The national clinical audits and national confidential enquiries the Trust was eligible to participate in during 2022/23 are as follows:

National clinical audits				
Count	**Programme**	**Workstream / topic name**	**Relevant**	**Participating**
1	Case Mix Programme		✓	✓
2	Elective Surgery (National PROMs Programme)		✓	✓
3	Emergency Medicine QIPs	Care of Older People	✓	✓
4		Mental health self-harm	✓	✓
5	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People		✓	✓
6	Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	✓	✓
7		National Audit of Inpatient Falls	✓	✓
8		National Hip Fracture Database	✓	✓
9	Gastro-intestinal Cancer Programme	National Oesophago-gastric Cancer	✓	✓
10		National Bowel Cancer Audit	✓	✓
11	Inflammatory Bowel Disease Audit		✓	✓
12	Learning Disabilities Mortality Review Programme		✓	✓
13	National Adult Diabetes Audit	National Diabetes Core Audit	✓	✓
14		National Diabetes Footcare Audit	✓	✓
15		National Diabetes Inpatient Safety Audit	✓	✓
16		National Pregnancy in Diabetes Audit	✓	✓
17	National Asthma and Chronic Obstructive	Adult Asthma Secondary Care	✓	✓

18	Pulmonary Disease Audit Programme	Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓
19		Paediatric Asthma Secondary Care	✓	✓
20		Pulmonary Rehabilitation- Organisational and Clinical Audit	✓	✓
21	National Audit of Breast Cancer in Older Patients		✓	✓
22	National Audit of Cardiac Rehabilitation		✓	✓
23	National Audit of Care at the End of Life		✓	✓
24	National Audit of Dementia	Care in general hospitals	✓	✓
25	National Cardiac Arrest Audit		✓	✓
26	National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management	✓	✓
27		Myocardial Ischaemia National Audit Project	✓	✓
28		National Audit of Percutaneous Coronary Interventions	✓	✓
29		National Heart Failure Audit	✓	✓
30	National Child Mortality Database		✓	✓
31	National Early Inflammatory Arthritis Audit		✓	✓
32	National Emergency Laparotomy Audit		✓	✓
33	National Joint Registry		✓	✓
34	National Lung Cancer Audit		✓	✓
35	National Maternity and Perinatal Audit		✓	✓
36	National Neonatal Audit Programme		✓	✓
37	National Ophthalmology Database Audit		✓	✓
38	National Paediatric Diabetes Audit		✓	✓
39	National Perinatal Mortality Review Tool		✓	✓
40	National Prostate Cancer Audit		✓	✓

41	National Vascular Registry		✓	✓
42	Perioperative Quality Improvement Programme		✓	✓
43	Renal Audits	National Acute Kidney Injury Audit	✓	✓
44		UK Renal Registry Chronic Kidney Disease Audit	✓	✓
45	Respiratory Audits	Adult Respiratory Support Audit	✓	✓
46	Sentinel Stroke National Audit Programme		✓	✓
47	Serious Hazards of Transfusion UK National Haemovigilance Scheme		✓	✓
48	Society for Acute Medicine Benchmarking Audit		✓	✓
49	Trauma Audit & Research Network		✓	✓
50	UK Parkinson's Audit		✓	✓

Confidential enquiries				
Count	**Programme**	**Workstream / topic name**	**Relevant**	**Participating**
1	Child Health Clinical Outcome Review Programme	Testicular torsion	✓	✓
2		Transition from child to adult health services	✓	✓
3	Maternal and Newborn Infant Clinical Outcome Review Programme		✓	✓
4	Medical and Surgical Clinical Outcome Review Programme	Community Acquired Pneumonia	✓	✓
5		Crohn's Disease	✓	✓

The national clinical audits and confidential enquiries that ESNEFT participated in during 2022/23 are as follows:

National clinical audits		
Count	**Programme**	**Workstream / topic name**
1	Case Mix Programme	
2	Elective Surgery (National PROMs Programme)	
3	Emergency Medicine QIPs	Care of Older People

4		Mental health self harm
5	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	
6	Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database
7		National Audit of Inpatient Falls
8		National Hip Fracture Database
9	Gastro-intestinal Cancer Programme	National Oesophago-gastric Cancer
10		National Bowel Cancer Audit
11	Learning Disabilities Mortality Review Programme	
12	National Adult Diabetes Audit	National Diabetes Core Audit
13		National Diabetes Footcare Audit
14		National Diabetes Inpatient Safety Audit
15		National Pregnancy in Diabetes Audit
16	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Adult Asthma Secondary Care
17		Chronic Obstructive Pulmonary Disease Secondary Care
18		Paediatric Asthma Secondary Care
19		Pulmonary Rehabilitation-Organisational and Clinical Audit
20	National Audit of Breast Cancer in Older Patients	
21	National Audit of Cardiac Rehabilitation	
22	National Audit of Care at the End of Life	
23	National Audit of Dementia	Care in general hospitals
24	National Cardiac Arrest Audit	
25	National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management
26		Myocardial Ischaemia National Audit Project
27		National Audit of Percutaneous Coronary Interventions
28		National Heart Failure Audit
29	National Child Mortality Database	
30	National Early Inflammatory Arthritis Audit	
31	National Emergency Laparotomy Audit	
32	National Joint Registry	
33	National Lung Cancer Audit	
34	National Maternity and Perinatal Audit	
35	National Neonatal Audit Programme	
36	National Paediatric Diabetes Audit	
37	National Perinatal Mortality Review Tool	
38	National Prostate Cancer Audit	
39	National Vascular Registry	

40	Perioperative Quality Improvement Programme	
41	Renal Audits	National Acute Kidney Injury Audit
42		UK Renal Registry Chronic Kidney Disease Audit
43	Respiratory Audits	Adult Respiratory Support Audit
44	Sentinel Stroke National Audit Programme	
45	Serious Hazards of Transfusion UK National Haemovigilance Scheme	
46	Society for Acute Medicine Benchmarking Audit	
47	Trauma Audit & Research Network	
48	UK Parkinson's Audit	

Confidential enquiries		
Count	**Programme**	**Workstream / topic name**
1	Child Health Clinical Outcome Review Programme	Testicular torsion
2		Transition from child to adult health services
3	Maternal and Newborn Infant Clinical Outcome Review Programme	
4	Medical and Surgical Clinical Outcome Review Programme	Community Acquired Pneumonia
5		Crohn's Disease

The national clinical audits and national confidential enquiries that ESNEFT participated in, and for which data collection was completed during 2022/23, 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	Elective Surgery (National PROMs Programme)		Ongoing
3	Emergency Medicine QIPs	Care of Older People	Closes Oct 2023
4		Mental health self harm	Closes Oct 2024
5	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People		Data collection to Nov 2023
6	Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database	Ongoing
7		National Audit of Inpatient Falls	Ongoing
8		National Hip Fracture Database	Ongoing

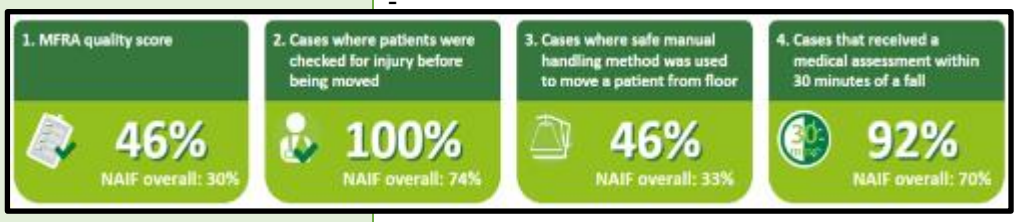
9	Gastro-intestinal Cancer Programme	National Oesophago-gastric Cancer	65 - 74%
10		National Bowel Cancer Audit	65 - 74%
11	Learning Disabilities Mortality Review Programme		100%
12	National Adult Diabetes Audit	National Diabetes Core Audit	Ongoing
13		National Diabetes Footcare Audit	Ongoing
14		National Diabetes Inpatient Safety Audit	Ongoing
15		National Pregnancy in Diabetes Audit	Ongoing
16	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme	Adult Asthma Secondary Care	Ongoing
17		Chronic Obstructive Pulmonary Disease Secondary Care	Ongoing
18		Paediatric Asthma Secondary Care	Ongoing
19		Pulmonary Rehabilitation-Organisational and Clinical Audit	Ongoing
20	National Audit of Breast Cancer in Older Patients		Ongoing
21	National Audit of Cardiac Rehabilitation		Ongoing
22	National Audit of Care at the End of Life		100%
23	National Audit of Dementia	Care in general hospitals	100%
24	National Cardiac Arrest Audit		Ongoing
25	National Cardiac Audit Programme	National Audit of Cardiac Rhythm Management	Final submission 30 June 2023
26		Myocardial Ischaemia National Audit Project	Final submission 30 June 2023
27		National Audit of Percutaneous Coronary Interventions	Final submission 30 June 2023
28		National Heart Failure Audit	Final submission 8 June 2023
29	National Child Mortality Database		100%
30	National Early Inflammatory Arthritis Audit		Ongoing

31	National Emergency Laparotomy Audit		Final submission 31 June 2023
32	National Joint Registry		95%
33	National Lung Cancer Audit		Ongoing
34	National Maternity and Perinatal Audit		100%
35	National Neonatal Audit Programme		
36	National Paediatric Diabetes Audit		Final submission May 2022
37	National Perinatal Mortality Review Tool		100%
38	National Prostate Cancer Audit		100%
39	National Vascular Registry		Final submissions May and June 2023
40	Perioperative Quality Improvement Programme		Ongoing
41	Renal Audits	National Acute Kidney Injury Audit	Ongoing
42		UK Renal Registry Chronic Kidney Disease Audit	Ongoing
43	Respiratory Audits	Adult Respiratory Support Audit	Final submission 31 May 2023
44	Sentinel Stroke National Audit Programme		Final submission 2nd May 2023
45	Serious Hazards of Transfusion UK National Haemovigilance Scheme		100%
46	Society for Acute Medicine Benchmarking Audit		100%
47	Trauma Audit and Research Network		Ongoing
48	UK Parkinson's Audit		

Confidential enquiries			
Count	**Programme**	**Workstream / Topic name**	**Submission rate %**
1	Child Health Clinical Outcome Review Programme	Testicular torsion	25%
2		Transition from child to adult health services	87%

3	Maternal and Newborn Infant Clinical Outcome Review Programme		Ongoing
4	Medical and Surgical Clinical Outcome Review Programme	Community Acquired Pneumonia	92%
5		Crohn's Disease	83%

During 2022/23, 42 national clinical audit 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
National Audit of Inpatient Falls (NAIF) Annual report 2022: Working together to improve inpatient falls prevention	New multi-factorial falls risk assessment developed and printed; an audit also put in place run by the falls team to reinforce the importance of this. Actions can be seen to be working with the latest published NAIF KPI review. - 
National Asthma and COPD Audit Programme: Pulmonary rehabilitation 2021 organisational audit - summary report	The East Suffolk Pulmonary Rehabilitation Service is meeting four out of six KPIs and have mitigated against the two they cannot achieve, namely a 30-metre walkway not being available and the inability to offer domiciliary visits. The North East Essex Team met four of their five KPIs and were putting in place a SOP so that they were fully compliant.
SAMBA 2022 Report	Ipswich achieved good scores above the national average in all the clinical quantity indictors, for example: • Percentage of unplanned admissions with early warning score recorded within 30 minutes of hospital arrival – median unit performance: 75%. Ipswich: 77% • Percentage of unplanned admissions reviewed by a competent clinical decision maker within four hours of hospital arrival – Median unit performance: 82%. Ipswich: 97%
SSNAP 2021 Acute Organisational Audit	From the recommendations two areas are being looked at in Colchester: • The nurse to 10 beds ratio which was too low • Access to clinical psychology An ICS wide business case is being put together, but proactively the team is using the 0.48wte available

	psychologist budget to create a 0.78wte band 4 counsellor post.
National Diabetes Inpatient Safety Audit 2018 – 2021	All recommendations were met, but the team was continuing to educate staff around diabetes self-management in hospital. Promotion included: • Diabetes team continuing to encourage all wards to complete SAM form. • Diabetes team educating staff on their team days. Promotion of SAM form by the team during hypo awareness week • All staff email promoting SAM form – to be sent on a regular basis. • Snapshot audit on a month's data with planned repeats.
Cardiac Rhythm Management Device Procedure Report 2020/21	The report was reviewed and presented at Ipswich and was very positive, with all recommendations being met and no actions forthcoming. In Colchester it has prompted a review of the methods of data entry and the support available for this.
NACAP Adult asthma and COPD 2021 organisational audit	At Ipswich seven-day respiratory specialist advice was not available to all patients admitted with an asthma/COPD exacerbation. The division is working towards increasing the number of consultants and seven-day working.
NEIAA Year Four Annual Report	ESNEFT was highlighted as an outlier for the performance against NICE quality standard 33 (statement 2), which states that patients referred with suspected persistent synovitis should be seen within three weeks of referral. Through the work that has been done NEIAA have informed the Trust that at quarter three, our data indicates that we are no longer at risk of being an outlier.
Improving understanding: The National Hip Fracture Database report on 2021 (NHFD 2022 annual report)	At Ipswich all KPIs were being met with no performance below average and in the red. Two areas have been targeted from the 2021 data: • Incidence of delirium post op • Mobilised out of bed the day after surgery Current data for 2022 shows that these have been improved within the current audit year. **Of note** – for KPI 0 admission to a specialist ward, Ipswich Hospital was the third best in the country.

Clinical Outcome team – local clinical audits

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 2022/23, ESNEFT's divisions planned to carry out 152 audits. As of 27/03/2023, 53 of those audits have been completed with 48 underway and due to finish soon. This equates to a compliance against planned audits of 34%, or 65% with current audits awaiting final results. A breakdown is as follows:

Division	Planned	Registered	Complete	Ongoing
Medicine (Colchester)	16	13	8	5
Medicine (Ipswich)	6	6	3	3
Cancer and Diagnostics	35	24	8	16
General Surgery and Anaesthetics	20	10	4	6
MSK and Specialist Surgery	28	9	4	5
Women's and Children's	35	33	22	11
Integrated Pathways	12	6	4	2
Total	**152**	**101**	**53**	**48**

The ongoing impact of COVID-19 together with periods of significant clinical pressures and industrial action have led to important decisions on prioritisation. Divisions have used their governance structures to ensure resources are focussed on maintaining the best patient care and levels of safety. Incomplete audits are therefore being reviewed by each division's clinical and operational leadership to ensure appropriate action is taken during 2023/24.

It is important to note that although plans are an important element of the strategic framework, they can be subject to change based on ESNEFT's priorities. Patient care and allowing clinical staff to undertake their primary remit of ensuring our patients receive the best possible care and treatment will always remain at the forefront.

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:

Medicine (Colchester)	
Title	**Outcome**
Trauma call in the Emergency Department (ED)	**Aim**: Assess compliance with current East of England trauma guidelines and Trust guidelines for trauma calls in adults. Identify areas for improvement, **Outcome**: Two of four standards met • Time to CT scan within 60 minutes: Target 100% / Actual 100% • Primary survey documentation completed: Target 100% / Actual 100% • Secondary survey documentation completed: Target 100% / Actual 80% • Time to tranexamic acid within 30 minutes: Target 100% / Actual 0%

	Key findings: • Average time for tranexamic acid being given is longer than the recommended 30 minutes • Average time to CT with major trauma team was within target of 60 minutes (removing outliers) • When major trauma team was involved, time to CT was shorter • 82% of trauma calls were attended by major trauma team • Time of primary survey and secondary surveys not always mentioned, as sometimes written in retrospect • Not all findings from trauma call were documented in designated section on trauma proforma • Documentation was not always uploaded on Evolve • Dedicated list of patients involved in trauma calls for future clinical audit purposes **Actions**: • Improve secondary survey documentation • Improve documentation of timing of primary and secondary survey • Ensure upload of trauma documentation on Evolve • Improve time to tranexamic acid to comply with 30 minutes (if clinically indicated) **Assurance**: The outcomes indicate that ESNEFT are 50% complaint overall. With implementation of the agreed action plan, it is expected that compliance with all standards will be achieved over the next financial year
Management of pulmonary embolism within emergency care	**Aim**: To assess the compliance with the pulmonary embolism (PE) proforma in the ED and Acute Medical Same Day Emergency Care (AMSDEC) **Outcome**: One of three standards met • To assess utilisation of, and compliance with, the new (PE) proforma: Target 60% / Actual 12.4% • To assess the pick-up rate of high and intermediate-high risk (PE) patients and if thrombolysed: Target 90% / Actual 80% • To assess the computed tomography pulmonary angiogram (CTPA) positivity rate: Target 15-37% / Actual 26% **Actions**: • To facilitate awareness among the AMSDEC and ED clinical staff on the availability and usefulness of the pulmonary embolism proforma • To enhance awareness among the medical registrars to request for a pulmonary embolism proforma while receiving related referrals from the ED staff • Re-audit 01/10/2023

	Assurance: Where standards have not been met, an action plan is being implemented to improve care for patients with pulmonary embolism. This is under the supervision of a consultant-led team, working towards improving standards
Diabetic ketoacidosis /hypoglycaemia management in emergency care	**Aim**: To identify whether further education was required within ED on the identification and management of diabetic ketoacidosis (DKA) **Outcome**: Standards not met • DKA protocol commenced within one hour (1000ml 0.9% sodium chloride and FRII commenced): Target 90% / Actual 79% • Basal insulin prescribed: Target 90% / Actual 61% • Venous blood gas, blood gas and ketone checks on time: Target 90% / Actual 78% • Correct fluid administration: Target 90% / Actual 78% **Key findings**: There is an overall delay in the treatment required being given when needed. Although the overall percentage is good, but with some further education the target could be achievable **Areas of good practice**: Overall percentage compliance encouraging **Areas for improvement**: All four targets of 90% have not been achieved: • Diabetic ketoacidosis protocol commenced within one hour (1000ml 0.9% sodium chloride and FRII commenced): 79% • Basal insulin prescribed: 61% • Venous blood gas, blood gas and ketone checks on time: 78% • Correct fluid administration: 78% **Actions**: • Training within ED is being organised, focussing on diabetic ketoacidosis and how to implement the protocol correctly • Re-audit retrospectively three months from the training and review if there has been improvement **Assurance**: Based upon the outcomes, compliance against the standards measured is below target. With the implementation of the action plan, improvements are expected and will be monitored via further audits
Neutropenic sepsis	**Aim**: To determine the extent to which current management of neutropenic sepsis in ED complies with NICE guidelines **Outcome**: Three of eight standards met

	• IV antibiotic commenced in ED: Target 100% / Actual 92% • Recommended antibiotic regimen (NICE or Microguide) commenced: Target 100% / Actual 90% • Full blood count: Target 100% / Actual 100% • Urea and electrolytes: Target 100% / Actual 100% • Liver function: Target 100% / Actual100 % • C-reactive protein: Target 100% / Actual 98% • Lactate: Target 100% / Actual 98% • Blood cultures taken: Target 100% / Actual 90% **Key findings**: • Majority of patients (44 out of 50) received IV Meropenem in keeping with local guideline (Microguide), One patient received IV Tazocin, the NICE recommended antibiotic • One patient received ciprofloxacin, one patient received Teicoplanin • Three patients received no antibiotic in ED. Blood cultures were only taken in 90% of patients • The appropriate bloods (except blood cultures) where taken in >98% of patients **Action**: • Improvement with administering intravenous antibiotics within the ED has commenced • Further progress with commencing the correct regimen and taking blood cultures to be introduced **Assurance**: There are encouraging signs with the outcomes identified, and with the action plan currently being implemented, that the Trust should reduce morbidity and mortality rates
Children under one year old (ED consultant sign off)	**Aim**: • To find out whether children under one year had appropriate senior review prior to discharge if seen by the junior doctor • To find out if children under one year are safely discharged from the ED after repeat observation **Outcome**: One of five standards met • All infants with PEWS>4 to be transferred to paediatric resus unit for management by the ED and paediatric teams: Target 100% / Actual 100% • All infants with PEWS <3 to be transferred to CAU: Target 100% / Actual 28% • Infants with minor injuries and/or trauma to be seen by ED consultant between hours (9-24) or at least staff grade ED doctor between off hours (24-9) or sent to CAU if not possible: Target 100% / Actual 78% • All infants to have repeated observation before ED discharge: Target 100% / Actual 53%

	• All infants presenting to ED triaged within 15 minutes and documented in A&E card: Target 100% / Actual 4% **Key findings**: • Our triage time is lower than standard by 96% • Our management of children with PEWS >4 in resus is 100% • Transfer of children under three months with PEWS <3 to CAU is 100% • Review of consultant/staff grade in term of minor injuries/trauma is lower than standard by 22.2% • Repeat observation prior to discharge is lower than standard by 47.2% **Actions**: • Update the guideline with regards to Children's Assessment Unit transfer as currently children under three have direct transfer facilities, rest are assessed in ED • Staff (including receptionists) raise awareness of the guideline so that priority is given to children less than one year old at presentation • Reminders to nurses and doctors that all children less than one year old should have repeat observations prior to discharge • Reminders to staff (nurses and doctors) that all children less than one year must have senior review prior to discharge • Re-audit planned **Assurance**: Alterations to pathways and guidelines should support delivery against all of the targets in this audit to meet the standards that were met. This work is underway and will be reviewed within the clinical teams

Medicine (Ipswich)	
Title	**Outcome**
Local Safety Standard for Invasive Procedures (LocSSIPs) – completion of checklists in Ipswich emergency care CDG	**Aim**: To ensure that Local Safety Standard for Invasive Procedures (LocSSIP) checklists are completed for invasive procedures carried out across the division **Outcome**: Standard not met • Completion of (LocSSIP) checklists: Target 100% / Actual 80% **Key findings**: The audit found checklists in place for 32 out of 40 (80%) of procedures tested, covering January, February and March 2022 data. This is a drop from the 95% compliance in the previous audit, and so we plan to audit again later in the year. Results

	have been communicated to the consultants involved with a reminder that checklists should be completed **Actions**: • An updated a paracentesis (LocSSIP) is currently going through the governance process in surgery, gastroenterology and the anaesthetics and medicine divisions. Publication and communication of this should improve future compliance • Re-audit planned **Assurance**: Introduction of the new LocSSIP and review of data should provide us with assurance that we are improving our compliance with this target
Re-audit medical record keeping at Capel Ward	**Aim**: • To ensure that there is strict adherence to the standards of record keeping on the acute medical wards • To compare statistics with same/similar audit done in October 2018 for improvement • To make sure these findings are communicated and made available to all staff • Support clinical audit, research, allocation of resources and performance planning **Outcome**: Standard not met • Medical record keeping standard hospital guideline: Target 100% / Actual 94% **Key findings**: • Name and ID documented in 94% of patients' medical notes • Date and time of entries written down in about 94% of entries • All entries with signature (junior and middle-grade) in 94% of patients' notes • Consultant signature seen in 94% of patients' charts • Bleep number mentioned in 94% of patients' charts • Not all pages are named/contain identifiable details of the patient i.e. name and hospital number on both sides • A fair amount of doctors do not put down their bleep numbers – bleep numbers are needed for constant communication between colleagues on cases seen • There is, however, significant improvement in medical documentation in the acute medical department over the last four years **Action**: • Educate junior doctors **Assurance**: Further education for junior doctors will lead to an increase against the standard

Audit of stroke/bleeding risk assessment for newly diagnosed atrial fibrillation patients presenting to Emergency Assessment Unit	**Aim**: To avoid anticoagulation in new atrial fibrillation patients who are at high risk of bleeding after risk assessment (HAS-BLED/ORBIT scoring) **Outcome**: Standard not met • NICE Guideline to avoid anticoagulation in new atrial fibrillation patients who are at high risk of bleeding after risk assessment: Target 100% / Actual 80% **Key findings**: • Outcome of the audit has been satisfactory after the measures taken post initial cycle of audit • Current results of the audit have shown significant improvement and we have achieved the aim of the audit. However, we felt there is still room for improvement and as per request from the other consultants of the acute medicine department, we have considered to continue the audit and planned for a third cycle of audit in months of April/May 2023 **Areas of good practice**: • Documentation of risk assessment improved from 43% to 80% during the re-audit assessment **Actions**: • Educate junior doctors • Information posters on the wards • Re-audit 01/05/2023 **Assurance**: Significant improvement has taken place since the previous audit and we are confident that the implementation of the agreed action plan will continue to increase compliance

Cancer and Diagnostics	
Title	**Outcome**
Appropriateness of radiotherapy referrals under IR(ME)R	**Aim**: A compliance audit to ensure all referrals are completed appropriately for site and diagnosis status **Outcome**: Standard met • To ensure all referrals for radiotherapy are completed appropriately for site and diagnosis status, due to the potential for unnecessary or unjustified exposures to radiation: Target 100% / Actual 100% **Key findings**: All patients referred for radiotherapy and reviewed for this audit were appropriate based on their history and evidence of multidisciplinary team decision-making. All the referral data given was accurate and 100% compliant

	Action: • Annual re-audit August 2023 **Assurance**: There are no risks identified due to full compliance with the standard
Diagnostic yield of computerised tomography of the kidneys, ureters and bladder scans in terms of renal calculi and alternative diagnoses	**Aim**: Computerised tomography of the kidneys, ureters and bladder (CT KUB) use should be monitored to ensure that they have a reasonable diagnostic yield and are not being requested/performed inappropriately for non-specific abdominal pain **Outcome**: One of two standards met • (CT KUB) should detect calculi: Target 44-64% / Actual 31% • (CT KUB) should detect alternate diagnoses: Target 6-18% / Actual 11% **Key findings**: • 64% showed no history of haematuria on requests • 85% showed no past history of calculi on requests • 58% had normal computerised tomography report with no urinary tract calculi or alternative diagnoses detected • This would highlight computerised tomography of the kidneys, ureters and bladders being inappropriately requested for vague/general abdominal symptoms **Action**: • Poster/presentation of findings to ED and surgical teams the possibility of requesting abdominal ultrasound as a first line investigation in those patients with a lower probability of renal calculi to minimise radiation exposure **Assurance**: With the awareness of the audit outcome shared and implementation of the action plan, compliance against the standard is expected and will be monitored
Audit of reporting of cervical biopsies against the cervical screening programme reporting handbook	**Aim**: To review the effectiveness of the department in completing a cervical biopsy histology proforma **Outcome**: 14 of 20 standards met. • Specimen type: Target 100% / Actual 100% • Number of pieces: Target 100% / Actual 100% • Dimension: Target 100% / Actual 100% • Number of levels: Target 100% / Actual 100% • Transformation zone (yes/no): Target 100% / Actual 100% ○ If no (ectocervix/endocervix only) : Target 100% / Actual 90% • Cervical intraepithelial neoplasia (CIN) (yes/no): Target 100% / Actual 100% • Predominate cervical intraepithelial neoplasia (CIN) grade: Target 100% / Actual 88%

	• Other cervical intraepithelial neoplasia (CIN) grade: Target 100% / Actual 88% • Crypt involvement by cervical intraepithelial neoplasia (CIN) (yes/no): Target 100% / Actual 88% • High grade cervical glandular intraepithelial neoplasia (CGIN) (yes/no): Target 100% / Actual 100% • Stratified mucin-producing intraepithelial lesion (SMILE) (Yes/no): Target 100% / Actual 100% • Human papillomavirus (HPV) related changes (yes/no): Target 100% / Actual 100% • Invasive malignancy (yes/no): Target 100% / Actual 100% • P16 (block positive/normal expression/not performed): Target 100% / Actual 100% • Is the histology two or more grades lower than cytology (yes/no/not know): Target 100% / Actual 100% • Do the histological features require MDT discussion (yes/no/not known): Target 100% / Actual 100% • Adequacy/other histological features/comments: Target 100% / Actual 56% • Diagnosis: Target 100% / Actual 96% • SNOMED (this is a clinical coding structure/language used in histopathology): Target 100% / Actual 100% **Key findings**: The collected data was 100% in 14 of the 20 fields. The general 'adequacy/other histological features/comments' section was left blank in 22 cases. One of these cases did state in a previous section that the specimen was best regarded as adequate, but this was not further stated in this section **Action**: • Recommend the addition of 'adequacy' as its own section, with 'yes/no' response, which would hopefully improve conveying this important information to the clinician and colposcopist **Assurance**: Via circulation of the outcomes and the implementation of the action plan, it is expected that compliance will improve, which will have a positive impact on the information being extracted and the highlighting of any discrepancies, which will lead to understanding and taking the appropriate actions sooner
Non-medical referrer compliance to procedure (IRMER)	**Aim**: Non-medical staff must be authorised by the Diagnostic Imaging department under Ionising Radiation (Medical Exposures) Regulations (IRMER) legislation. Staff work to an agreed written procedure and this sets out which exams they are authorised against. This random check provides evidence that staff are working as authorised **Outcome**: Standard not met

	• Non-medical referrer agreements: Target 100% / Actual 98.8% **Key findings**: A very small percentage had referred outside of their scope of practice, these were minor discrepancies and there was no risk to any patient **Action**: • Staff have been reminded and an annual audit occurs to continually highlight any discrepancies
Management of unplanned gaps	**Aim**: A compliance audit (BSI standards), to assess if all patients are being compensated for any treatment gaps in accordance with departmental protocol **Outcome**: Standard met • RCR guidelines for managing gaps in treatment: Target 100% / Actual 100% **Key findings**: Protocol was correctly followed; all patients were adequately compensated within the time frame and with the clinicians consent **Action**: • Re-audit August 2023 **Assurance**: There are no risks identified due to full compliance with the standard
Re-audit diagnostic yield of computerised tomography of the kidneys, ureters and bladder scans in terms of renal calculi and alternative diagnoses	**Aim**: Re-audit of the previously conducted and discussed, in clinical governance meeting, CT of the kidneys, ureters and bladder (CT KUB) audit **Outcome**: Standard not met • British Association of Urological Surgeon (BAUS) guidelines for management of acute ureteric colic: Target 44-64% / Actual 36% **Key findings**: • Alternative diagnoses were found in 11% (similar to the initial audit), which comes within the targeted guidelines (6-18%) • The diagnostic yield of (CT KUB) for detecting calculi improved from the initial audit. It is 36 % (previously about 31 % and the guideline is 44 – 64%) • There was an improvement in the (CT KUB) scan requests, with more requests mentioning a history of haematuria or calculi • This audit has now been completed twice, and methods have been introduced to improve the diagnostic yield of (CT KUB). An improvement has been demonstrated. A

	repeat audit if necessary could be arranged by the audit lead in 12-24 months' time or as required **Actions**: • Sharing the re-audit results with the ED team • Stress about importance of requesting abdominal ultrasound as a first line investigation in patients with a lower probability of renal calculi to minimise radiation exposure • Stress about importance of adding urinary-specific questions in the CareFlow request system (e.g. is there haematuria? or urinary tract calculi?), that the requester is mandated to fill. This can help highlight the possibly inappropriate requests to the duty radiologist and prompt further discussion • Re-audit after three months regarding detection rate of urinary tract calculi on (CT KUB) from ED **Assurance**: An improvement towards the standard was achieved during the re-audit. With the awareness of the re-audit outcomes shared, as well as those of the previous audit, and implementation of the action plan, further improvement and compliance against the standard is expected
Omitted doses (six monthly audit)	**Aim**: To audit the rate and documentation of omitted medicines against Trust medicine policy **Outcome**: Colchester: Standards not met • Prescribed critical medicine doses administered within two hours of prescribed time, unless appropriately omitted: Target 100% / Actual 98% • Prescribed critical medicine doses omitted for clinical reasons should have the reasons documented in the nursing notes: Target 100% / Actual 86% • Prescribed critical medicine doses omitted due to the drug being unavailable should be due to the drug actually being unavailable: Target 100% / Actual 61% • Inappropriate omissions of critical medicines should be reported on Datix: Target 100% / Actual 0% • Critical medicine doses should have blank boxes in the administration record: Target 100% / Actual 97% Ipswich: Standards not met • Prescribed critical medicine doses administered within two hours of prescribed time, unless appropriately omitted: Target 100% / Actual 97% • Prescribed critical medicine doses omitted for clinical reasons should have the reasons documented in the nursing notes: Target 100% / Actual 82% • Prescribed critical medicine doses omitted due to the drug being unavailable should be due to the drug actually being unavailable: Target 100% / Actual 56%

	• Inappropriate omissions of critical medicines should be reported on Datix: Target 100% / Actual 0% • Critical medicine doses should have blank boxes in the administration record: Target 100% / Actual 94% **Key findings**: • 97-98% of prescribed critical medicines are being administered within two hours of the prescribed time. There is a good level of assurance that prescribed critical medicines are administered in a timely fashion • Failed adherence to timely administration of prescribed critical doses will remain an issue of concern until significant sustained adherence can be shown; the Trust needs to promote safe medication practices to improve adherence (see recommendations). This audit will be repeated six monthly to monitor improvement or causes for concern **Actions**: • Any medication that is omitted for clinical reasons without documentation will be challenged by pharmacy staff • The 'no blank' challenge will be relaunched to tackle this, with results collated and fed back to ward areas monthly • Remind all staff of their professional and ethical duty to report omissions of critical medicines; this recommendation remains a standing action • The audit outcomes to be taken to sisters and matrons meeting and to continue to circulate and re-emphasise educational materials for timely administration of critical medicines i.e. how to obtain medication, importance of documentation, the critical list and when to contact pharmacy or medical staff, and when to report on Datix • Re-audit planned 01/05/2023 **Assurance**: Implementation of the agreed action plan, the aim is to increase compliance and meet the standard targets, which will in turn improve patient care surrounding their medication needs
National safety standards for invasive procedures and Local Safety Standard for Invasive Procedures (NatSSIPs and LocSSIPs) generic checklists for: • marrow procedures • PICC line insertion	**Aim**: To establish if implementation of Local Safety Standard for Invasive Procedures (LocSSIPs) has been successful in departments for bone marrow aspiration (BMA) and peripherally inserted central catheter (PICC) line insertions **Outcome**: Standards not met • Departmental bone marrow (LocSSIP) (minor omissions in completion of LocSSIP): Target 100% / Actual 77.5% • Departmental (PICC) line (LocSSIP) (PICC lines cross site): Target 100% / Actual 88.75%

	Key findings: As a separate project – to look at possible alignment of documentation and consent forms across both hospital sites, as different types are still in use even on EVOLVE (electronic medical records system) **Action**: Re-audit planned (October 2023) **Assurance**: Based upon the outcomes of the audit and the compliance against the targets set, a separate project and further audit will take place in order to look at how documentation can be improved, with the aim of seeing an increase in compliance

General Surgery and Anaesthetics	
Title	**Outcome**
COVID-19 trach - percutaneous tracheostomy adherence to LocSSIP/FFICM standards	**Aim**: Previous audit showed that approximately two thirds of patients who have had tracheostomy performed during their stay on ICU did not have a follow-up appointment booked **Outcome**: One of two standards met • All ICU tracheostomy insertion procedures must include a checklist and LocSSIP: Target 100% / Actual 100% • Patients discharged from the critical care unit must have access to an intensive care follow-up programme which can include review of clinical notes, patient questionnaires to assess recovery and an outpatient clinic appointment two to three months' post hospital discharge: Target 100% / Actual 73% **Key findings**: • Increase in number of percutaneous tracheostomy was observed in this audit cycle vs last audit cycle in 2018 (90% in 2021 vs 70% in 2018) • Good compliance with safety checklist use • Percutaneous tracheostomy showed similar outcome vs surgical tracheostomy • 86% of tracheostomy performed within two days of decision made (percutaneous tracheostomy – 95% within two days) • Majority de-cannulated in intensive care unit, 82% of all tracheostomy remains in situ for >seven days • Doing much better at following patients up in this audit cycle (12% with no follow up booked in 2021, vs 65% in 2018) **Actions**: • Patients who have not been offered a follow up appointment were identified • Follow up appointment will be offered • A standardised screening questionnaire/proforma for follow up clinic to be produce in order to help with

	screening for tracheostomy related issues and to identify patients who will need ear, nose and throat input **Assurance**: By implementing the action plan, this should improve the chances of all patients being provided with the follow-up care they require
Re-audit of two week wait referral to the Colchester haematuria clinic, a retrospective analysis	**Aim**: To evaluate the effectiveness and outcome of the two-week wait referral to the haematuria clinic, and waiting times until the patients get diagnosis/decision to treat and first definitive treatment for cancer **Outcome**: One of three standards met • Two-week wait (urgent referral to specialist review): Target 93% / Actual 92% • 31-day wait (diagnosis/decision to treat to first definitive treatment): Target 96% / Actual 65% • 62-day wait (GP urgent referral to first treatment): Target 85% / Actual 100% **Key findings**: • At this period, there was increased capacity and clinic sessions than during COVID-19 • Eight sessions of flexible cystoscopy clinic with a 25 minutes per patient slot • 170 patients attended on account of haematuria (a 54% increase compared to the first cycle audit) • 108 males (63.5%) and 62 females (36.5%). Age range 23 – 97 years (mean 70.5 years) • 41 (24.1%) had non-visible haematuria, 129 (75.9%) had visible haematuria • 26 patients had cancer diagnosed: 24 bladder cancers and two renal cancers • Two week wait review improved from 84% to 92% • All patients with cancer were reviewed within two weeks • 31day wait target not met 65% • All cancer cases were treated within 62 days from referral **Areas of good practice**: • Two week wait review improved from 84% to 92% • All patients with cancer were reviewed within two weeks • All cancer cases were treated within 62 days from referral **Areas for improvement**: • 31 day wait target not met **Actions**: • Encourage patients to honour their appointments

	• Arrange radiological investigations on day of their examination if clinically fit. Appropriate booking and pre-operative assessment • Aim for a one-stop haematuria clinic, whereby a staff triages the patients and books investigations before attending the clinic **Assurance**: Implementation of the action plan will improve compliance and minimise any risks to patients
Testicular ultrasound audit	**Aim**: To assess the rates of negative scrotal explorations. To evaluate the methods to reduce rates of negative exploration rates (TWIST score) **Outcome**: One of three standards met • NICE guidelines for suspected testicular torsion: Target 100% / Actual 100% • Documentation of the TWIST score items: Target 100% / Actual 50% • Negative scrotal exploration for testicular torsion: Target 25% / Actual 82% **Key findings**: • Rates of negative scrotal exploration for testicular torsion is high (82%)* • This might be influenced with the clinical examination experience and the surgeon threshold of suspicion • Careful documentation of the TWIST score items might help in clinical judgement and future stratification of the patients who requires surgical exploration • Unnecessary scrotal explorations might be avoided in 82.92% of patients if TWIST score is reported and considered *N.B. Our practice is concurrent with the NICE guidelines **Actions**: • TWIST score forms to be available in ED, Surgical Assessment Unit, Children's Assessment Unit • Educate the clinical urology team regarding TWIST score • Re-audit 2022 onwards prospectively • Re-audit 2021 data retrospectively **Assurance**: With education and highlighting the outcomes of the audit, the re-audit aims to produce improved compliance

MSK and Specialist Surgery	
Title	**Outcome**
One year survival rate and visual outcomes for descemet membrane	**Aim**: To audit the outcomes of new endothelial corneal transplant surgery since its introduction to the department in 2017

endothelial keratoplasty (DMEK) surgery	**Outcome**: Standards met • Primary failure rate: Target 6% / Actual 7% • Graft rejection rate: Target 2% / Actual 0.01% • Graft detachment rate: Target 2% / Actual 2.2% **Key findings**: Endothelial transplant surgery in Ipswich hospital has a similar success rate in terms of one year survival comparable to the most favourable published guidelines **Action**: No actions. Although another hospital audit is not planned, a continuous reporting audit for all transplant surgeries continues to happen with the eye bank and NHS transplant services **Assurance**: There are no risks identified due to full compliance with the standards
Effectiveness of continuous (fixed and "treat and extend") regimen of aflibercept treatment in wet age-related macular degeneration (AMD); Year 2014 cohort- five year results	**Aim**: To evaluate the long-term results within a cohort of wet age-related macular degeneration (AMD) patients on follow-up for seven years post initiation of aflibercept anti-VEGF therapy under the domain of clinical effectiveness and quality assurance. To obtain right information for users, providers and commissioners of healthcare **Outcome**: Standards met • Standards set by Vision 2020 UK ophthalmic public health committee, (seventh indicator of eye health): Visual acuity outcomes of anti-VEGF therapy at baseline and at one year after starting treatment for wet AMD. Compare these local outcomes with relevant benchmark standards: Target 100% / Actual 100% • Quality measures set by Royal College of Ophthalmologists (commissioning guidance 2021): Outcomes based on drug used and their long-term effectiveness and compare with relevant benchmark standards (This re-audit of aflibercept 'drug' and seven-year outcome, satisfies the quality measure): Target 100% / Actual 100% • Quality measures set by Royal College of Ophthalmologists (commissioning guidance 2021): Proportion of patients with loss of VA of 10 or more ETDRS letters post loading at 12 months and 24 months from initiation of treatment. Proportion of eyes with VA better or equal to 70 letters (6/12) at month 12. (This re-audit showed results well beyond 12 months, up to 84 months outcome): Target 100% / Actual 100% **Key findings**: The results of re-audit prove the long-term effectiveness and quality assurance of aflibercept anti-VEGF treatment in wet age-related macular degeneration (AMD) at Ipswich Hospital. So,

	continue with current organisational model of AMD service setup and treatment protocol **Actions**: • These local re-audit results will be incorporated in any future design of service, choice of drugs, treatment protocols and pathways in wet age-related macular degeneration (AMD) service • The results of this re-audit are being used to create treatment pathway for the new drug approved for wet age-related macular degeneration (AMD) in July 2022 (NICE TA 800) • The audit design and results can be replicated to compare other anti-VEGF drugs used in wet age-related macular degeneration (AMD) **Assurance**: There are no risks identified due to full compliance with the standards
Audit of LocSSIP (Local Safety Standards for Invasive Procedures) for WHO checklist completion (oral surgery)	**Aim:** Patient safety checklist to ensure correct patient in room, patient aware of the surgery to be performed, confirms medical history, post op care discussed, ensures the whole team working the same and continuity for the patient **Outcome**: Standard not met. • LocSSIP (Local Safety Standards for Invasive Procedures): Target 100% / Actual 92.6% **Key findings**: • Compliance 92.6% with an increase of 31.6% since the first audit in 2020 • Overall staff completing the audit were 98% compliant • Temporary members of staff not familiar with form were not completing fore entirely • No harm or risk has come from completing the form **Actions**: • Create poster to display as a reminder • Share audit with team at next team meeting • Update all new staff to ensure form completion sept team meeting • Re-audit planned to commence from 01/04/2023 **Assurance**: Overall compliance has increased significantly since 2020. The vast majority of staff are completing the checklist as appropriate and from the findings of the audit, there are minimal risks to patient safety. With the implementation of the action plan and planned audit ready to commence, improvements to the overall compliance are expected

Women's and Children's	
Title	**Outcome**
Gestation related optimal weight (GROW)	**Aim**: Audit completion of risk factors for fetal growth restriction (FGR) at booking. Learning from missed cases below third centile **Outcome**: Standard met • Risk assessment for FGR at booking completed: Target 80% / Actual 100% **Key findings**: • 100% of records examined had risk factors for fetal growth restriction completed at booking, 92% correct risks identified at booking, 72% had all risks identified at booking • Incorrect plotting, no referral for ultrasound scan following second episode of reduced fetal movement, first plot below 10th centile, accelerated growth not recognised, ultrasound scan/induction of labour not offered when appropriate, Timing of standardised fundal height measurements/ultrasound scan **Action**: No actions were identified due to exceeding the expected compliance target **Assurance**: There are no risks identified due to full compliance with the standard, having even exceeded the target
Sepsis deep dive	**Aim**: Assess compliance with sepsis six in inpatient obstetric departments **Outcome**: Standard not met • Sepsis screening compliance (Ipswich): Target 90% / Actual 80% • Sepsis screening compliance (Colchester): Target 90% / Actual 70% • Sepsis six compliance (Ipswich): Target 90% / Actual 44% • Sepsis six compliance (Colchester): Target 90% / Actual 30% **Key findings**: Ipswich maternity • Overall compliance with completing full sets of observations on time and increasing observation frequency has reduced significantly • Large increase in escalating (or documenting the escalation) when required according to policy, 26%-85% • The appropriate response time (or documentation of response time) has also improved from 53-85% • Overall sepsis screening compliance has improved (Indicator E10 on the accountability framework),

	however, completion of the sepsis six within 60 minutes remains poor • Blood cultures, lactate and fluid balance compliance have improved significantly, however, compliance with giving IV antibiotics and an IV Fluid challenge within one hour remains very low • No patients were included who only had amber flags Colchester maternity • Slight improvement in observations being completed on time and all elements being recorded, however, reduction in the MEWS being calculated correctly • Appropriate escalation (or documentation of escalation) has improved from 50% - 88% • Use of fluid balance charts and high dependency unit charts has decreased – unsure of any clear reasons for this • Overall sepsis screening compliance has improved (Indicator E10 on the accountability framework), however, completion of the sepsis six within 60 minutes remains poor (Indicator E20 on the accountability framework) **Actions**: • Weekly audits to track improvement and identify key issues • All maternity staff to complete the new maternal sepsis e-learning • Feedback surveys to gain anonymous staff feedback on sepsis training and screening • Change maternity safety briefing sheets, coordinators on shift to review MEWS charts daily for any score ≥5 (Colchester) and one red or two amber flags (Ipswich) • Clinical nurse specialist to continue ad-hoc teaching and teaching on the PROMPT courses • Past case studies to be included on the PROMPT courses • To consider introducing pyrexia as an indicator for a sepsis screen on the sepsis screening tool, following several recent cases where ladies have become septic following pyrexia (proposal to be raised at DP group) • Launch of national maternity early warning scores • Consider introducing foetal tachycardia into the sepsis screening tool (proposal to be raised at DP group) • Devise a maternity care assistant teaching day for both sites, including performing observations and escalating deteriorating patients within the day • Merge ESNEFT escalation policies following introduction of the national MEWS • Introduce sepsis champions into midwifery • Roll out the new high dependency unit chart (Ipswich)

	Assurance: Where compliance against sepsis screening and the sepsis six remains low, we are confident that implementing the action plan, will make it possible to increase compliance and mitigate the potential for patients to deteriorate
Maternal sepsis, modified early warning score (MEWS)/modified early obstetric warning score (MEOWS) and fluid balance chart compliance audit at ESNEFT	**Aim**: • To monitor the compliance with sepsis screening and sepsis six delivery within maternity services on a monthly basis (data added to the accountability framework) • To identify any areas needing improvement and pinpoint concerns as they arise • To share findings and support maternity to improve compliance as needed • Ensure that the quality standards are met as per National Institute for Health and Care Excellence (NICE) guidelines on sepsis screening and compliance **Outcome**: Two of five standards met • Observations completed in full and on time: Target 90% / Actual 75% • Fluid balance charts for all 'triggering' patients: Target 90% / Actual 75% • Sepsis six compliance (red flag sepsis): Target 80% / Actual 67% • Sepsis screening compliance (NICE quality standard): Target 90% / Actual 100% • Sepsis bundle (amber flag sepsis): Target 80% / Actual 100% **Key findings**: • 100% compliance with sepsis screening for all patients scoring >five or three in one parameter • Amber flag sepsis - 100% compliance with one hour senior review and three hours intravenous antibiotics delivery if indicated • Sepsis six (red flag sepsis) – 67% • The reason for low sepsis six compliance is a lack of fluid balance charts • There is confusion around when/why patients need fluid challenges • Fluid balance charts aren't being used effectively • Observations aren't always being fully completed or rechecked regularly enough **Actions**: • Present audit results at Deteriorating Patient Group, Patient Safety Group and governance half day • Emphasis on commending and completing fluid balance charts, discussions to be help with clinical effectiveness midwives and teaching rolled out

	• Emphasis on the importance of completing full sets of observations and increasing observation frequency as per policy. Taught on PROMPT (PRactical Obstetric Multi-Professional Training) days and to be encouraged by senior staff • Monthly audits planned **Assurance**: With the implementation of the action plan, particularly focussing the attention around further teaching and emphasis on completing the relevant charts, it is expected that compliance will increase. However, in the standards that were met, the service exceeded the target by some distance
Ectopic pregnancy audit (diagnosis)	**Aim**: To assess current diagnosis, management and follow-up of patients with confirmed ectopic pregnancy against standards in NICE guideline and RCOG guideline **Outcome**: Two of six standards met • Proportion of tubal ectopic pregnancies identified on initial scan: Target 90% / Actual 78% • Negative laparoscopy rate following USS diagnosis of tubal ectopic pregnancy: Target 0% / Actual 0% • Proportion of women with ectopic pregnancy offered all relevant management options: Target 100% / Actual 92.8% • Percentage of women suitable for laparoscopic management of ectopic pregnancy managed laparoscopically: Target 100% / Actual 100% • Number of non-emergency cases having surgery between 8pm and 8am: Target 0% / Actual 5% • Percentage of women provided with information containing support group details: Target 100% / Actual 75% **Key findings**: • Improvement in number of ectopic pregnancies diagnosed on initial scan (however college target 90% so some room for improvement) • Improvement in number of women being offered appropriate treatment options • All surgeries performed laparoscopically • No negative laparoscopies • Only one patient operated inappropriately out of hours • Doubled on referral for bereavement services following ectopic **Areas of good practice**: • Improvement in number of ectopic pregnancies diagnosed on initial scan (however college target 90% so some room for improvement) • Improvement in number of women being offered appropriate treatment options

	• No negative laparoscopies **Area for improvement**: • One patient had surgery out of hours **Actions**: • Any woman referred from ED in early pregnancy should ideally be reviewed face to face by a member of the gynae team • Standardised algorithm for treatment options and follow-up of ectopic pregnancies • If salpingectomy, no follow-up should be required • Follow-up human chorionic gonadotropin <20 if not salpingectomy • When discharging from Stour Ward, ensure bereavement referral is being completed **Assurance**: Findings have been shared, including the improvements seen, with all appropriate stakeholders and the ongoing action plan will be monitored to ensure delivery against the targets
Invasive cancer audit disclosure compliance	**Aim**: To audit all women diagnosed with cervical cancer in the period who have a cervical screening history within 10 years of diagnosis. This audit of disclosure is the first cross site audit for ESNEFT since the appointment of a joint cervical screening provider lead (CSPL) in August 2020 and encompasses measures against the two different sets of NHSCSP guidance in place at the time **Outcome**: Eight of nine standards met. • To audit the offer of disclosure to patients diagnosed at ESNEFT: Target 100% / Actual 100% • To audit the re-offer of disclosure to patients diagnosed at ESNEFT: Target 100% / Actual 100% • To audit the written outcome of any disclosure or duty of candour meetings to patients (and /or family of) diagnosed at ESNEFT: Target 100% / Actual 100% • To audit that patients diagnosed at ESNEFT are listed at colposcopy MDT (to register case with clinicians and CSPL): Target 100% / Actual 100% • To audit that patients diagnosed at ESNEFT are re-listed at colposcopy MDT (for classification purposes): Target 100% / Actual 100% • To audit that review and disclosure process is completed within 12 months of diagnosis: Target 100% / Actual 50% • To audit that all disclosing clinicians have completed the appropriate e-learning on disclosure and duty of candour: Target 100% / Actual 100% • To audit that for all cases where any classification is Unsatisfactory a SIAF is completed and investigated in

	accordance with SQAS advice: Target 100% / Actual 100% • To audit that ESNEFT duty of candour policy is followed for all patients where any classification has been unsatisfactory: Target 100% / Actual 100% **Key findings**: CSPL to complete audits in approximately 10 months to enable offer of disclosure within 12 months. This is a new measure introduced with the increased complexity of the process. The service feels that the slight delays identified in this audit were to be expected and that these will hopefully not recur. Workload and support for CSPL to be monitored to ensure current contracted time available is appropriate especially in view of increased complexity of cervical cancer audit and disclosure requirements **Actions**: • Audit to be presented at appropriate ESNEFT audit meeting/s and included in CSPL cervical screening annual report for 2022/23 • Re-audit in January 2024 to include all 2020, 2021 (again) and all 2022 cases • Continue to re-audit then on an annual basis including previous three years to capture any delayed requests for disclosure – eg. January 2025 would include 2021, 2022 and 2023 • Offers of disclosure letters to be consistently sent out in a more timely manner. Suggestion is for first letter within four weeks of audit completion and second letter eight weeks' later. ESNEFT guidance to be updated to reflect this **Assurance**: With the majority of standards met, key findings shared within the department and an action plan for further work in place, no risk to patient care has been identified
Constipation	**Aim**: This audit looks for newly referred children with constipation and see how far the assessment and management are following the NICE guidelines **Outcome** Standard not met • NICE quality standard (QS62) guideline: Target 100% / Actual 85.4% **Key findings**: • 85.7% of children and young people with constipation receive a full assessment before a diagnosis of idiopathic constipation is made • 96.4 % children and young people with idiopathic constipation receive oral macrogols as first-line treatment • 75% of children and young people with idiopathic constipation starting dis-impaction therapy have their

	treatment reviewed by a healthcare professional within one week • There was only one new diagnosed child with idiopathic constipation started maintenance therapy. He hasn't had his first treatment review by a healthcare professional within six weeks • There was only one new diagnosed child with idiopathic constipation starting laxative treatment. He has not received written information about laxative • The NICE guideline standard (children and young people with idiopathic constipation that does not respond to initial treatment within three months are referred to a healthcare professional with expertise in the problem) was not applicable to secondary care management of constipation because all children will be seen by a paediatrician and/or clinical nurse specialist **Actions**: • Roll out of paediatric constipation assessment form to be used to assess constipation by all paediatricians in children's outpatient and children's assessment unit • Roll out of a 'constipation information pack' for parents and carers to be handed out to all children/ young people diagnosed with constipation • The clinician who has assessed the child for dis-impaction, should arrange follow up with in one week either telephone or on ward review **Assurance**: With the implementation of the action plan, we are confident that all children will receive the assessment and the management they require
Neonatal intubation Local Safety Standards for Invasive Procedures (LocSSIP), At Ipswich, umbilical venous catheter (UVC) and umbilical arterial catheter (UAC) will also be audited	**Aim**: To improve the quality of documentation **Outcome**: Standards not met • Pre procedural check: Target 100% / Actual 95.5% • Timing of medication: Target 100% / Actual 66.67% • Confirmation of tube position and changes – x-ray position: Target 100% / Actual 75% • Signed by consultant: Target 100% / Actual 40% **Key findings**: Data for the LocSSIP is 95.5% complete for two months (December 2022 and January 2023) **Actions**: • To follow up with further data collection • Complete the LocSSIP form for the invasive procedure carried out in the neonatal unit **Assurance**: Further work is required in order to achieve improvements against the standards. By understanding where the department currently sits, the sharing of findings and

	implementation of the action plan should ensure that progress is made
Developmental dysplasia of hip - failsafe re-audit	**Aim**: To investigate the appropriate use of developmental dysplasia of the hips (DDH) referral pathway and to assess if patients are being referred appropriately against national guidelines and local guidelines **Outcome**: Standards not met • Neonates who were breech presentation from 36 weeks gestation regardless of birth presentation, at time of birth from 28 weeks gestation or multiple pregnancy referred for routine six week ultrasound: Target 95% / Actual 82% • Neonates who have positive screening examination referred to orthopaedic clinic as an outpatient: Target 100% / Actual 66% • Those with a family history of DDH were seen within the six week timeframe: Target 95% / Actual 67% **Key findings**: • One child with abnormalities detected was seen within the guideline time • No other babies had abnormalities detected **Areas of improvement**: Radiology ultrasound appointments. 12% of routine six-week ultrasounds breached. However, no inappropriate referral notes. All babies seen by 10 weeks of age. Also four appointments did not attend. **Actions**: • Referrals only to be made through Medway portal • Guideline recently updated with streamlined referral pathway • Results to be shared with radiology department • Discuss with radiology how to streamline process • Consider alternative referrals within four weeks to prevent breaches • Further education of parents as to importance of screening • Leaflets details DDH and the need for screening • Chase up those patients that did not attend **Assurance**: With the implementation of the action plan, it is expected that patients will receive a referral and treatment within the timeframe outlined in the guidance, which should have a positive impact on the care patients receive
Audit of sick day rules for patients on steroids	**Aim**: • Determine whether patients prescribed hydrocortisone had a correctly calculated surface area, baseline steroid dose and sick day steroid dose in the last 12 months

	• Assess whether emergency intramuscular (IM) hydrocortisone had been prescribed in the preceding 12 months • Determine whether patients/carers were provided with verbal and written explanation of sick day rules for hydrocortisone dosing within three months of diagnosis • Determine whether training for administration of intramuscular (IM) hydrocortisone was requested within three months of diagnosis **Outcome**: Two of seven standards met • Has body surface area been calculated in the last 12 months?: Target 100% / Actual 100% • Has dose in mg/m2 been calculated in last 12 months?: Target 100% / Actual 100% • Have sick day rules been explained in last 12 months?: Target 100% / Actual 61.5% • Has emergency hydrocortisone dose been prescribed in last 12 months?: Target 100% / Actual 77% • Sick day rules explained within first three months of diagnosis: Target 100% / Actual 85% • Training requested for IM hydrocortisone within first three months of diagnosis: Target 100% / Actual 85% • Written information about emergency hydrocortisone provided: Target 100% / Actual 61.5% **Key findings**: For the 12 months from 01/01/21 to 31/12/21: • There were 0 hospital admissions relating to hydrocortisone or the related conditions in this time period. **Actions**: • Liaise with Addenbrooke's Hospital (tertiary paediatric endocrine centre) regarding the introduction of a paediatric steroid treatment card such as that outlined by British Society for Paediatric Endocrinology and Diabetes (BSPED) • Alter template of clinic letters for paediatric endocrine clinics, to include a section of sick day rules at the bottom which can be filled in/updated at each appointment • Introduce a new local guideline on hydrocortisone dosing for adrenal/pituitary conditions, based on dosing information in the British national formulary and clinical guidelines from BSPED • Following the introduction of the above measures, a plan should be made to re-audit after a period of several months **Assurance**: The audit showed that there are standards not met. However, the risk is deemed to be low as there were no admissions relating to the area audited. The audit did not take

	into account that many patients may already be aware and have a supply of necessary medication. Therefore risk is minimal, and is one of quality not safety. An action plan is being implemented to ensure improvements are made
Sickle cell audit	**Aim**: Assess management of sickle cell disease (acute presentation) in children in Colchester Hospital against national guidelines **Outcome**: Standards not met • Pain score at presentation: Target 100% / Actual 61.5% • Pain relief within 30 mins of presentation (as appropriate): Target 100% / Actual 77.3% • Reassessment of pain within 30 mins of receiving pain relief: Target 100% / Actual 71.4% • Discussion with tertiary unit: Target 100% / Actual 81.9% • Follow up booked: Target 100% / Actual 83% **Areas of good practice**: Good compliance with initial observations, investigations, IV antibiotics and transfusion as appropriate. **Areas for improvement**: Our management of pain fell below compliance. Provision of flow chart for management would be beneficial. **Actions**: • Creation of flow chart for management in acute presentation • Introduction to sickle cell disease management during doctor's induction **Assurance**: With the introduction of the action plan and education, compliance and better treatment is expected
Midwifery-led care	**Aim**: • To assess the number of women booking and birthing under the provision of midwifery-led care • Assess instances where women suitable for midwifery-led care have not been able to access it • Consider outcomes for women birthing under midwifery-led care **Outcome**: Standard not met • All women to be able to access the birth centre facilities with an appropriate risk assessment: Target 100% / Actual 17% **Key findings**: Midwifery-led care women are not consistently given a choice of place of birth and the majority are delivering on the obstetric ward. This is due to Brook Ward being partially closed

	Actions: • Brook Ward relaunch • Re-audit (30/06/2023) **Assurance**: With the reopening of Brook Ward, the sharing of the audit outcomes with the staff and the planned re-audit, it is expected that substantial improvements towards compliance against the standard will be made
Induction of labour (IOL) audit (quality standard 60 states outpatient induction audit needed)	**Aim**: To determine what elements of the induction of labour (IOL) pathway are working well and to identify where improvements are required. This audit will inform the IOL pathway improvement project of areas requiring focus alongside the feedback from a service-user survey **Outcome**: Colchester: three of five standards met • Evidence of informed discussion when planning/booking (IOL): Target 100% / 77% • Evidence of written information given or signposted: Target 100% / 14% • Vaginal birth after caesarean IOL consent form completed (only for) - Colchester: Target 100% / 100% • Outpatient IOL meeting the criteria: Target 100% / 100% • Location of IOL: Target 100% / 100% Ipswich: Standards not met • Evidence of informed discussion when planning/booking (IOL): Target 100% / 73% • Evidence of written information given or signposted: Target 100% / 62% **Key findings**: Colchester: • 25% of women that were eligible had an outpatient IOL • Concerning delays • 44/73 (60.2%) women delayed between admission and their first treatment for IOL. Two patients had prolonged spontaneous rupture of membranes • Insignificant delay between subsequent IOL agents • 15/42 (35%) of women were delayed in having an artificial rupture of membranes. Four women were delayed for >24 hours • Reason for delay: acuity on labour ward, staffing issues • Effective IOL rates 76% Ipswich: • 27% no documentation of informed consent • 38% no written information • Three vaginal birth after caesarean (VBAC) – no documentation re increased risks at time of consent (VBAC IOL consent)

	• Post-dates and RFM most common indication for IOL • All VBAC were offered balloon catheter IOL • Rates of after IOL are stable – 31% of all births in December 2022 • IOL does not increase lower segment caesarean section • Nova Suite appears to have had a positive impact on delays **Actions**: Colchester: • Survey regarding patient satisfaction of IOL inductions • Review outpatient IOL guidance/criteria • Establishing guidelines for other forms of IOL • Patient information leaflet on induction of labour Ipswich: • Continue periodic audit with analysis • Continue work towards restart of outpatient IOL • Continue to monitor and record operational issues such as delays in IOL and measure these against outcomes • Ensure documentation of consent and offering written information **Assurance**: Colchester: Induction pathway improvement project in progress which is addressing the standards that weren't met. The risk regarding written information is moderate, despite the low compliance, because the team are assured that verbal discussion are being held with patients Ipswich: Staff are to be made aware of the importance of consent and offering written information is documented in the patient's notes. By implementing these actions, an increase in compliance is expected
Category one lower segment caesarean section (LSCS) Ipswich – category one caesarean sections and category one trials	**Aim**: • To determine the understanding of the multidisciplinary team about timings concerning category one caesarean sections and trials of assisted vaginal deliveries • To determine if we are meeting the NICE standard for the time from decision to delivery for category one caesarean sections and trial of assisted vaginal delivery **Outcome**: Standards not met • Perform category one caesarean birth as soon as possible, and in most situations within 30 minutes of making the decision: Target 100% / Actual 64.7% • Perform category one assisted vaginal delivery as soon as possible, and in most situations within 30 minutes of making the decision: Target 100% / Actual 64.7% **Key findings**:

	64.7% of category one expedited delivery were done within 30 minutes, 35.3% were not **Actions**: • Emergency bleep for category one C-section • Re-audit 30/05/2023 **Assurance**: Action plan put in place to focus attention on category one caesarean sections and re-audit planned to ensure compliance is measured, with improvements expected
Post-menopausal bleeding (PMB) clinic utilisation and outcomes	**Aim**: • To examine the utilisation of post-menopausal bleeding (PMB) clinic slots to identify delays in achieving 28 faster diagnosis standard • To ensure outcomes for patients are safe and effective **Outcome**: Standard not met • PMB faster diagnosis target: Target 100% / Actual 48% **Key findings**: • 35% of PMB slots used by non two-week wait cases • Twp-week wait referral quality poor in some cases • Cancers diagnosed but not treated within national targets • 28 FDS not meet in most cases – delays in admin, action results • General anaesthetic and myosure pathways prolonged and patients lost to follow-up **Actions**: • Re-audit of PMB clinics • More robust admin and pre-admission strategies in place • Re-audit underway **Assurance**: With non-compliance of the standard, delays in treating endometrial cancer and other incidental pathologies remains a cause for concern. Based on the outcomes, an action plan was put together and is already being implemented. It is anticipated that progress towards the standard will be made, which will have a positive impact on patient risk
Saving Babies Lives (SBL) care bundle element two – risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, incorporating growth assessment protocol (GAP)/ gestation	**Aim**: To demonstrate compliance for The Clinical Negligence Scheme for Trusts and Saving Babies' Live care bundle version two **Outcome**: Standards not met • Completion of birth centiles: Target 85% / Actual 76.31% • Antenatal referral for small for gestational age (national average): Target 52.6 % / Actual 17.14%

related optimal weight (GROW)	• Antenatal detection for small for gestational age (national average): Target 59.4% / Actual 31.43% **Key findings**: Themes from the quarter collated and shared: • Incomplete GROW charts • Inaccurate data entry on Medway • Failure to refer following deviations **Actions**: • Themes shared with staff via email/social media • Point for improvement in data entry identified and shared • Individual follow up as required • Discussion with Perinatal Institute • Themes shared with staff at governance half day • Findings introduced into STAT training • Re-audit quarter two data All actions complete **Assurance**: Implementation of the action plan aims to increase compliance and ensure that the service detects babies who are small for gestational age/growth restriction far sooner and limits the risk factor for stillbirth
Fetal anomaly screening	**Aim**: To assess the level to which we are meeting the standards for the fetal anomaly screening programme (FASP) standards for newly referred fetal anomalies **Outcome**: Three of seven standards met • Women seen within three working days following identification of anomaly on ultrasound: Target >97% / Actual 98.8% • Women who cannot be seen within three working days are seen in a tertiary unit within five working days: Target >97% / Actual 100% • Women who are seen in fetal medicine unit at Colchester Hospital and referred to a tertiary unit seen within five working days: Target >97% / Actual 100% • Women with high chance combined test offered appointment within three working days: Target >97% / Actual 100% • Women opting for invasive testing being offered an appointment within three working days of receipt of result: Target >97% / Actual 93.75% • The number of women with each of the 11 conditions compared to national rates: Target >97% / Actual 0% • Quantitative fluorescence polymerase chain reaction (QF-PCR) results from invasive testing received within three calendar days: Target >97% / Actual 82.1% • Microarray results from invasive testing received within 14 calendar days: Target >97% / Actual 66.6%

	Key findings: Time to report results is the main issue. **Actions**: • Proactively chasing our lab for results before they breach – two days for QF-PCR and 12 days for microarray • Discussions with lab about communicating results • Increase fetal medicine unit capacity for invasive testing • Re-audit next year's key performance indicators to monitor improvement **Assurance**: The risk to patient care would be minimal. There is no risk of bleeding, therefore no clinical risks to be applied
Informed choice re-audit Ockendon	**Aim**: • Demonstrating compliance to include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period • To ensure women's choices are respected and that there a discussion if the woman has requested a care pathway which may differ from that recommended by the clinician • To ensure women are enabled to participate equally in all decision making processes and to make informed choices about their care **Outcome**: Colchester: One of two standards met • Q41 – Women must be enabled to participate equally in all decision-making processes: Target 100% / Actual 89% • Q42 – Women's choices following a shared and informed decision-making process must be respected: Target 100% / Actual 100% Ipswich: One of two standards met • Q41 – Women must be enabled to participate equally in all decision-making processes: Target 100% / Actual 98% • Q42 – Women's choices following a shared and informed decision-making process must be respected: Target 100% / Actual 100% **Key findings**: • Most women had a discussion about mode of birth by 28 weeks • Additional information to support decision-making was given to most women at Ipswich (69%), less likely at Colchester (23%) • Ipswich 63%, Colchester 73% of women had a documented birth plan and they were followed in all

	cases (clinical need sometimes initiated a change in plan but women's wishes were respected) • Risks are clearly highlighted on obstetric records, but little is written to demonstrate that benefits have been discussed • Very little evidence of identification of woman's wishes or supportive discussions on what was important to the woman • Very little evidence that plans were made with joint decision-making between the woman and her health professional • Unable to retrospectively capture women who requested lower segment caesarean section during their labour or induction **Actions**: • Re-share information on the use of personalised care and support plans and use them to discuss woman's wishes on Mum and Baby app. • Ipswich notes have now been updated to include confirmation from the woman that she understands her care plan and agrees with it (this should not replace documentation of the discussion) • Re-audit planned **Assurance**: Not all standards were met, but positives on both acute sites and detailed findings will be shared with staff. With an action plan focussed on the right areas and a re-audit planned, projected improvements should follow
Local Safety Standards for Invasive Procedures (LocSSIP) - maternity 017/B (swab count audit) plus snapshot re-audit	**Aim**: To ensure compliance with the Local Safety Standards for Invasive Procedures (LocSSIP) checklist for swab counts in maternity (excluding theatres) **Outcome**: One of two standards met • Swab counts are documented for every vaginal birth and suturing undertaken outside of theatre: Target 100% / Actual 67% • A yellow wristband should be used to highlight any swab intentionally left in situ (one per retained object): Target 100% / Actual 100% **Key findings**: • Target of 100% compliance not met (set at 100% because a retained foreign object is a never event) • Although poor compliance – compliance has increased from last year • On the whole the majority of checklists were completed but just not completely – only two records were found to have no checklist completion at all • As with previous audit – if an item was not used it was often left blank (usually tampons as they are rarely used)

	• 'Red string discarded' box – this was the most missed item on all the checklists. This was changed since the last audit to be more visible, but the notes audited still contained the old version • As this has affected results so dramatically, we have planned a small snapshot re-audit using more recent notes that do feature the amended checklist, which, it is expected, will provide some reassurance • Overall the items that were missed were usually as a result of the checklist not being completed in full – eg. where items were not used, or no tick to confirm the count was correct. More education / reminders needed on full completion of checklist **Actions**: • Consider amending the checklist in the notes to be more user friendly • Re-audit planned (August 2023) – snapshot of notes featuring the new documentation • Ensure yellow wristbands are available in every delivery room – these should be listed in the cupboard contents for room checks • Further reminders to be shared in staff communications regarding clear completion in full **Assurance**: There has been an increase in compliance and although one of the standards was not met, with the findings shared and action plan implemented, further improvement towards compliance is anticipated
Domestic abuse enquiries in pregnancy – Ipswich	**Aim**: To monitor compliance with women being routinely asked about domestic violence at least three times in their pregnancy and to ensure appropriate follow up management is provided **Outcome**: Standard not met • All women are routinely asked about domestic violence at least three times in their pregnancy: Target 100% / Actual 76% **Key findings**: • Four records (8%) were not asked at all during their pregnancy • 24% were not asked three times – however not always possible if partner present at appointments **Actions**: • To remind staff regarding importance of asking regarding domestic abuse and documenting this • To ensure staff are aware of the meaning of the public health codes within the notes • Re-audit planned 15/12/2024

	Assurance: Although standard not met, there are circumstances which can have an impact in obtaining the information required, as outlined in the key findings. With the outcomes shared with staff and action plan being implemented, it is anticipated that progress with compliance will be made

Integrated Pathways	
Title	**Outcome**
PASCOM (podiatric and surgical clinical outcome measurement)	**Aim**: To ensure patient outcomes and experiences are recorded onto the national audit tool (PASCOM). Identifies good practice and areas for development **Outcome**: Two of four standards met • Completion of Manchester–Oxford foot questionnaire (MOXFQ) by patient prior to surgery, and entered onto PASCOM: Target 100% / Actual 90% • Sequella entered onto PASCOM: Target 100% / Actual 100% • Surgery type is recorded onto PASCOM: Target 100% / Actual 100% • Six-month post-surgery Manchester–Oxford foot questionnaire (MOXFQ) completed by patient and recorded onto PASCOM: Target 100% / Actual 80% **Key findings**: • Post-surgery Manchester–Oxford foot questionnaire (MOXFQ) is apparently being sent to patients at six months post op • Difficulties arise when patients don't return them • To look at alternative methods, such as email to see if this improves return rate **Actions**: • Staff to ensure pre op Manchester–Oxford foot questionnaire (MOXFQ) is completed prior to surgery • Staff to ensure MOXFQ post-surgery questionnaire is sent to patient six months after surgery **Assurance**: No significant risks, although feedback from patients on good practice or highlighting areas for development could be missed. By implementing the actions, it is anticipated that compliance will improve
Departmental hand hygiene audits – carried out over all allied health professionals, dietetics, physiotherapists and occupational therapists	**Aim**: To ensure all staff are up to date with the hand hygiene policy **Outcome**: Standards not met • According to the World Health Organisation (WHO) what are the five 'moments for hand hygiene': Target 100% / Actual 90%

	• What areas of the hands are frequently missed when washing?: Target 100% / Actual 26% • What action should you take if you develop sore hands?: Target 100% / Actual 90% • Do you require wetting your hands prior to using the foam soap?: Target 100% / Actual 90% **Key findings**: • Higher failings in areas than previous years • More quizzes returned for 2022 • Area in which failed in frequently – staff to be reminded and approached at time of seeing not just when auditing **Actions**: • Send out results • Team leads to address areas in which failed with individuals • Circulate and remind of hand hygiene policy • Look up and send out updated frequently missed areas when washing hands • Send out five moments of hand hygiene • Complete all mandatory training regards hand hygiene • Re-audit (January 2023) **Assurance**: The planned actions are expected to increase compliance, which should in turn minimise the risk of infection, thus improving patient care
Audit to assess the compliance with malnutrition universal screening tool (MUST) screening and implementation of the MUST action plan in care homes	**Aim**: To assess care homes accuracy in MUST screening and assess if care homes are implementing food first strategy to reduce risk of malnutrition **Outcome**: First cycle: five of 10 standards met. Re-audit: six of 10 standards met • Have weight/MUAC been completed as appropriate? (weekly/monthly based on nutritional risk): Target 95% / Actual 84%. Re-audit: Target 95% / Actual 86% • Correct BMI score: Target 90% / Actual 94%. Re-audit: Target 90% / Actual 100% • Correct weight loss score: Target 90% / Actual 84%. Re-audit: Target 90% / Actual 86% • Correct total MUST score: Target 90% / Actual 90%. Re-audit: Target 90% / Actual 86% • Have residents who have moved into the care home within the last 12 months been screened for malnutrition within 72 hours: Target 100% / Actual 94%. Re-audit: Target 100% / Actual 100% • Was there evidence of an up-to-date nutritional care plan (based on latest MUST screening): Target 95% / Actual 49%. Re-audit: Target 95% / Actual 60% • Food record chart in place if scored 1+ on MUST: Target 85% / Actual 80%. Re-audit: Target 85% / Actual 100%

	• Are food first recipes being used? (eg. homemade milkshake): Target 80% / Actual 100%. Re-audit: Target 80% / Actual 100% • Snacks available to include sweet, savoury and texture modified: Target 100% / Actual 100%. Re-audit: Target 100% / Actual 100% • Evidence of communication of nutritional need within the care home: Target 100% / Actual 100%. Re-audit: Target 100% / Actual 100% **Key findings**: Between the initial audit and the re-audit it was evident that there had been improvements in weekly/monthly weight checks, correct BMI score calculation, and weight loss score calculation, screening within 72 hours of admission and having a up to date care plan and food record charts in place **Actions**: • We noted care homes care plan software often calculates % weight loss incorrectly. Calculate % weight loss by using the highest weight over the past six months • Consider the use of over-the-counter nutritional supplements • Staff to document any snacks, nourishing drinks offered and eaten on food record chart to evidence food first implementation • Dietitian to provide training on the process of screening using MUST, writing a detailed nutritional care plan and how to review nutritional care plan after implementing nutritional advice • Nutritional action plans need to be updated on a monthly basis in line with latest MUST screening results and tailored to the resident • All staff who are involved in the provision of food and fluid provision need an easy way of knowing who is at risk of malnutrition so they can provide additional snacks, nourishing drinks etc. • Re-audit planned next financial year, date not confirmed as yet **Assurance**: Although compliance between first and second cycle did increase, overall, not all standards were met. With the introduction of a robust action plan, it is expected that compliance will increase once again, with patients being comprehensively screened and the appropriate measures taken to combat against any possible risks

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 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.

The COVID-19 pandemic presented a unique set of challenges and required innovative new ways of working to provide an effective response. As part of that response, the NHS adopted special payment arrangements for 2020/21 and 2021/22, removed the requirement for trusts to sign formal contracts and disapplied financial sanctions for failure to achieve national standards. The CQUIN financial incentive scheme was also suspended for the entire period. To support the NHS to achieve its recovery priorities, CQUIN was reintroduced from 2022/23.

NHS England identified a number of clinical priority areas where improvement was expected during the year. The following are the clinical priority areas highlighted for adoption in agreement with NHS Suffolk and North East Essex Integrated Care Board:

- Staff flu vaccinations
- Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
- Anaemia screening and treatment for all patients undergoing major elective surgery
- Malnutrition screening in the community
- Assessment, diagnosis and treatment of lower leg wounds
- Assessment and documentation of pressure ulcer risk

The following table demonstrates ESNEFT's performance against the CQUIN indicators for 2022/23:

CQUIN information					
CQUIN number	**Definition**	**Q1**	**Q2**	**Q3**	**Q4**
CCG1	Staff flu vaccinations - Percentage of staff who have received the annual flu vaccine (70-90%)				
CCG3	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions - adherence to evidence-based steps in the identification and recording of deterioration, enabling swifter response to reduce the rate of cardiac arrest and the rate of preventable deaths in England (20-60%)				
CCG6	Anaemia screening and treatment for all patients undergoing major elective surgery (45-60%)				
CCG13	Malnutrition screening in the community (50-70%)				

CCG14	Assessment, diagnosis and treatment of lower leg wounds (25-50%)	
CCG15	Assessment and documentation of pressure ulcer risk (40-60%)	

Key
Green: Standard achieved Red: Standard not achieved
Amber: Standard partially achieved Grey: Development, implementation or not deliverable for this Quarter

A giant crane arrived at Colchester Hospital in February to lift the first building blocks of our brand new £64 million elective orthopaedic centre into place

Participation in clinical research

Recruitment into studies

During 2022/23, ESNEFT delivered relevant research benefits to 4,832 (5,335 in 2021/22) participants on clinical trials, including trials to reduce symptoms, increase survival times and improve quality of life.

We remain dedicated to supporting clinical research in order to improve the quality and experience of care for local people as well as making our contribution to wider health improvements. We actively seek to attract high quality research and research staff to help develop our research portfolio. The number of staff involved within our research and development workforce continues to grow, and stood at 75 in 2022/23 (compared with 68 in 2021/22), while we had 141 principal investigators leading active research studies in 2022/23 (149 in 2021/22). Our Trust was involved in 113 recruiting clinical research studies during 2022/23 across 29 clinical units.

Participants recruited into research studies at ESNEFT during 2022/23				
	NIHR portfolio	**Non portfolio**	**Total**	**%**
Commercial	1,014	0	1,014	21
Non commercial	2,996	822	3,818	79
Total	4,010	822	4,832	100

Our Trust is a member of the NIHR Clinical Research Network: East of England (CRN EoE), which is responsible for effectively delivering NIHR research in the east of England. The majority of funding for our research activity flows through CRN EoE, with just over £1.9m allocated for research staff and supporting activity during 2022/23. 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, we also have an ambitious strategy for research and development. This is aimed at hosting and developing locally developed research for the benefit of patients and the community surrounding ESNEFT. We have set up an agile team to deliver this ambition, which includes two allied health professional clinical academic research leads, two paediatric clinical academic research practitioners and two joint clinical academic posts with the University of Suffolk and Anglian Ruskin University.

Evidence shows that trusts which carry out a lot of research activity provide a better quality of care to patients. We now have a portfolio of 21 sponsored locally-developed studies, 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 to help them enable patients to benefit from taking part in research.

ESNEFT locally-developed research				
	2020/21	**2021/22**	**2022/23**	**Successful**
Applications for support	59	70	88	n/a
Grant applications	11	13	18	15

Over the past 12 months, our employees have demonstrated the vibrancy and innovative practice of a research active organisation by producing a total of 206 conference abstracts

and publications in high quality academic journals. These examples demonstrate that a commitment to clinical research leads to better treatments for patients.

Patient and public involvement in research and development

We recognise the huge benefits which feedback from our patients can bring to research and development and actively encourage participation in designing and running studies. This year, 89 people were interested in shaping our research, 48 of which took part in our patient and public involvement groups.

For more information about health research and how to take part, visit the National Institute for Health Research website: www.nihr.ac.uk/patients-carers-and-the-public/i-want-to-take-part-in-a-study.htm

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 2022/23.

ESNEFT has taken part in the following special reviews/investigations by the CQC during the reporting period:

- Focussed inspection of ESNEFT Medical/Older People's wards: Colchester Hospital, November 2022
- Focussed inspection of Maternity Services: Colchester Hospital, March 2023

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 inspection of services is moving 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, to support 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 at least one of the core areas. Although inspections have been somewhat curtailed during the post-COVID-19 period, the CQC has continued to carry out focussed inspections where concerns have been raised. Focussed inspections of Colchester Hospital's Medical/Older People's wards and Maternity Services have taken place during this reporting period.

Inspections by the Care Quality Commission (CQC)

The CQC regulates and regularly inspects healthcare service providers in England. Where there is a legal duty to do so, the CQC rates the quality of services against each key question as outstanding, good, requires improvement or inadequate. Healthcare service providers can be 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 the Medical/Older People's wards at Colchester Hospital in November 2022. This unannounced, focussed, inspection was carried out because the CQC had received information of concern about safety and quality. Six of the medical care and older

people's wards were inspected. As this was a risk-based inspection, the core services were not inspected. The CQC continues to monitor all services as part of its ongoing engagement processes.

Following a review of the draft report for factual accuracy by the division, compliance team and Chief Nurse, the final report was published by the CQC in February 2023.

In line with CQC requirements, a detailed improvement plan ('must do' actions) was approved by the Chief Nurse and forwarded to the CQC. 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 monthly 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 by the Quality and Patient Safety Committee.

The focussed inspection identified six 'must do' actions which have been addressed across the Ipswich site as well as Colchester to ensure to best practice is in place across ESNEFT. They are:

Regulation 12: Safe care and treatment

- The Trust must ensure the safe and effective discharge of patients back to the community.

Regulation 15: Premises and equipment

- The Trust must ensure that staff comply with infection prevention control principles.

Regulation 17: Good governance

- The Trust must ensure that staff comply with legislation to protect patient privacy and confidential information.
- The Trust must ensure they operate effective governance processes.

Regulation 18: Staffing

- The Trust must ensure staff receive up to date mandatory training, including safeguarding training at an appropriate level.
- The Trust must ensure that the service has enough staff to care for patients and keep them safe.

The full report is available at: https://api.cqc.org.uk/public/v1/reports/6ebaba9b-335b-4df1-be67-09564c31d766?20230202095441

The CQC also carried out an unannounced focussed inspection of Maternity Services at Colchester Hospital in March 2023. At the time of writing, the requested evidence has been submitted and a report will be published in due course.

Ratings for ESNEFT

Last rated 08/01/2020

Ratings	
Overall rating for this service	**Requires improvement**
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Staff at Colchester celebrate after being named Training Hospital of the Year 2022

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 holding interviews online. 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. ESNEFT is also the lead employer for a new initiative called Global Health Fellows, which has been funded by Health Education England and will see appointments made regionally.

The Trust is very engaged in the regionally-funded medical support workers scheme, which places overseas doctors in roles to support them in obtaining their GMC registration to allow them to work as doctors in the UK. At February 2023, we had four in place, two of which had received their registration and were due to start as locally employed doctors before applying for national training numbers.

We continue to work 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 monthly engagement events, junior doctor forum meetings and safer working meetings on both sites.

We currently do not have any junior doctor vacancies as we over-established to help with seasonal variances. Our consultant vacancies are also the lowest in the region.

Quality Improvement

Quality improvement (QI) is not the same as 'improving quality'. It is the use of 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 more deeply in identifying and testing ideas, and uses measurement to see if changes have led to improvement.

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

At the same time, all provider organisations will be making efforts to improve quality. This can be done in many ways, including:

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

ESNEFT QI activity

We recognise that staff who are closest to an issue are often the best placed to address it. QI is designed to facilitate that process. At ESNEFT, the Quality Improvement 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 426 staff at bronze level QI and 250 staff at silver level
    - conversion from silver level QI training to a registered QI project is now 50%

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

- Developing an ethos of **continuous improvement** so that projects are not only delivered as individual examples of improvement but ensure sustainability and spread:
    - 49% 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

This year a variety of work has taken place across the Trust to improve patient care and staff experience. Whether large or small, these change projects continue to be promoted, shared and discussed internally and externally to make sure best practice is adopted as widely as possible.

An example of this is an initiative led by our junior doctors to introduce a Greatix system across some of our wards for positive staff reporting, with the aim of boosting morale. Following the success of this project, the team worked with wellbeing colleagues to launch a Trust-wide Greatix system.

Other examples of improvement work this year include:

Patient, carer and family experience outcomes

A project led by maternity services which aimed to improve levels of vaginal birth after caesarean (VBAC) took place. A new clinic was set up, alongside referral and management pathways, with advice and guidance for staff and patients. Following the roll out, data shows women seen in VBAC clinics had a higher VBAC intention rate, and a higher VBAC success rate. The initiative also received lots of positive feedback, including:

- “It was incredible! Natural birth, healthy baby and I didn’t have any more than a graze. They helped me prepare for this. I knew that an elective section could just be a familiar and easy option, but VBAC was so empowering. The midwives were incredible, I feel like I had prepared my body and my mind to be able to deliver naturally. I almost wish I could relive the moment again…it was so different to an emergency section.”

The team is planning to carry out ongoing work around equity of referral and ensuring provision of information regarding mode of delivery is in line with Ockendon (2022).

Staff experience

A project led by one of the academic foundation trainees at Ipswich Hospital aimed to improve confidence and attitudes in working within multi-disciplinary teams (MDTs). MDT simulation scenarios were constructed and delivered, with results showing increases in medical and nursing students’ self-reported interprofessional socialisation and valuing scale (ISVS). One attendee commented:

- “I felt like it opened the eyes of the nurses and doctors and hopefully has the potential to change how everyone works in the future.”

A research project is now taking place at the Trust to continue and develop this work.

Productivity and efficiency

A nurse-led project focussed on introducing a cardiac assessment bay (CAB) at Colchester Hospital. This came after issues with flow and best practice were identified, including delays in cardiology reviews and starting early treatment, along with longer lengths of stay.

Following process mapping and stakeholder engagement, proposals were made to convert space in the cardiology ward to create a CAB and implement new pathways for acute coronary syndrome patients. Although peaks in COVID-19 limited the use of the CAB, improvements when it has operated include:

- 1.03 day reduction in time to ACU/CAB admission
- 0.54 day reduction in time to first cardiology consultant review
- 1.5 day reduction in time to tertiary referral
- 6.24 day reduction in length of stay

Cost avoidance

An ongoing project to improve continence management across ESNEFT has continued. This came as a result of national drivers and to counteract the negative impact of poor management, which includes increases in falls, pressure ulcers and costs when inappropriate equipment is used.

The initial project aimed to improve the continence service through the appropriate use of containment products, care plans and assessments on D'Arcy, Peldon, Fordham and Birch wards. As a result:

- Nearly every patient on these wards now receives baseline assessments and continence care plans as a result of the development of care plan guides, education and local support.
- Savings of £835.78 were made on the four trail wards between April and June compared with the same period the previous year. Over 12 months, this could equate to a saving of £3,343 for these four wards.
- The project won the Dorothy Mandelshtam award from the Association for Continence Advice.

The project has proved such a success that it has now been rolled out across the Trust and has achieved the following results:

- Improvements in collection devices being considered (3.9% to 91% at Ipswich, 35% to 81% at Colchester)
- Baseline continence assessments completed (29% to 51% at Ipswich, 0% to 77% at Colchester)
- Rationale for use of containment products (1.1% to 20% at Ipswich, 0% to 67% at Colchester)

In addition, the Trust's spend on containment products in quarter four during the year of the roll out has been the lowest of the last four years by a minimum of £7,777, suggesting overall financial benefits as well as improved quality.

The new interventional radiology and cardiac angiography unit at Colchester Hospital

Statements relating to the quality of relevant health service provided

NHS number and General Medical Practice Code validity

During 2021/22, ESNEFT submitted records to the Secondary Uses Service for inclusion in the latest Hospital Episode Statistics.

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

- 99.7% for admitted patient care
- 99.9% for outpatient care
- 99.0% for accident and emergency care
- 99.6% for diagnostic imaging
- 99.9% for community care

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

- 99.9% for admitted patient care
- 100.0% for outpatient care
- 99.5% for accident and emergency care
- 100.0% for diagnostic imaging
- 99.9% for community care

Source: NHS and Social Care Information Centre data quality dashboards (April 2021 – March 2022 position, as published July 2021 – June 2022).

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 2021/22 was graded as 'approaching standards', and an improvement plan has been agreed. The Data Security and Protection Toolkit assessment will be on 30 June 2022/23 for submission.

Data Security and Protection Toolkit – levels of attainment

	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 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 which covers all aspects of coding. This includes reinforcing issues identified by the audit, such as improving data

extraction/ documentation, coding of mandatory co-morbidities (linked to depth of coding), signs and symptoms diagnosis and Charlson index codes.

Clinical Coding

ESNEFT was not subject to the Payment by Results (PbR) Clinical Coding Audit during the reporting period.

However, an internal audit was commissioned to assess our coding accuracy across our acute sites against national standards, and to fulfil the audit requirements set out in data quality standard one of the Data Security and Protection Toolkit. The results for ESNEFT are as follows:

Primary diagnosis	Secondary diagnosis	Primary procedure	Secondary procedure
93.0%	94.3%	90.7%	93.2%

Data quality

During 2022/23, the Trust has been taking the following actions to improve data quality:

Data quality indicator	Update
Valid NHS number and valid GP practice code	We are working to introduce a combined electronic patient master index across both of our sites and all of our clinical systems. This will help bring us towards “one version of the truth” while helping to ensure that update information is reaching all the necessary systems in a timely manner.
Valid NHS number and valid GP practice code	The suite of Power BI reports available to us is ever evolving as we make more data quality issues visible to the Trust. The Data Quality team also add additional checks and validations into their standard processes to further enhance the quality of our data.
Valid NHS number and valid GP practice code	The Data Quality team continue to perform 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.
Valid NHS number and valid GP practice code	We have created a Data Quality Forum which meets quarterly. It includes representatives from both operational and corporate areas and enables colleagues to discuss current data quality performance and areas of concern or improvement.

Learning from deaths

During 2022/23, 3,608 of ESNEFT's patients died (includes deaths in ED and community hospitals). This comprised the following number of deaths which occurred in each quarter of that reporting period: 824 in the first quarter; 826 in the second quarter; 984 in the third quarter; 974 in the fourth quarter.

By April 2023, 432 case record reviews and 18 investigations (patient safety incident investigations/incidents for review, under the new Patient Safety Incident Response Framework) have been carried out in relation to 3,608 of the deaths included above. In 15 cases, a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was: 113 in the first quarter; 117 in the second quarter; 136 in the third quarter; 68 in the fourth quarter. (The number of requested reviews has been reduced to cover the minimum national requirement so that clinical care could be prioritised during the pandemic surges and severe winter pressures.)

0.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These are all subject to a detailed incident review to ensure all aspects of learning are captured and addressed. There are 13 patient safety investigations not yet fully complete or awaiting final approval as to whether care elements contributed to death.

In relation to each quarter, this consisted of: 0% for the first quarter; 0.7% for the second quarter; 0% for the third quarter; 0% for the fourth quarter.

These numbers have been estimated using the summary of care information from the Royal College of Physicians' Structured Judgement Review (SJR) and the national Perinatal Mortality Review Tool (PMRT). In other reviews, factors were identified that could have possibly contributed to patient death. These learning points have been shared both within teams and across the Trust and have been discussed at the Learning from Deaths Group.

A summary of learning from case record reviews and investigations conducted in relation to the deaths identified above

Investigations carried out highlighted the following concerns in:

- Need to improve inter-speciality referral.
- Recognition of uncommon diagnosis such as aortic dissection.
- Management of nasogastric tube feeding.
- Management of risk for patients transferred out of hours.
- Support for patients at risk of falling.

Key learning points

The key learning points identified from these investigations included the need for action around falls prevention, NG feeding, VTE screening/treatment and human factors awareness.

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

- Bed rails awareness training for all new staff. The bed rail policy has also been reviewed and updated.
- “Bay watch” (patient area for patients at high risk of falling) rules to be clearly displayed at the bay entrance.
- Prior to commencing NG feed or administering medication, the tube length at the nostril and the PH level to be checked and countersigned by two nurses.
- The VTE (venous thromboembolism) patient information leaflet ‘preventing blood clots’ to be reviewed and promoted.
- The thrombosis group to monitor compliance with the Trust VTE policy and consider expanding the audit criteria to include VTE prophylaxis and risk assessment completion, providing support to areas not achieving the target in the Accountability Framework.
- Human factors training; an awareness of human factors in the workplace and how those factors can affect patient safety.

Impact of actions

As many of the learning actions identified through the investigations are currently being implemented, it will take time to demonstrate their impact.

2021/22 update

In relation to 2021/22, 109 case record reviews/investigations were completed after March 2022 which related to deaths which took place before the start of the reporting period. 1.1% of the patient deaths are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Royal College of Physicians’ Structured Judgement Review (SJR), the national Perinatal Mortality Review Tool (PMRT) and reviews carried out as part of the PSIRF.

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, we have maintained a 100% record of medical examiner scrutiny of all (non-coronial) deaths which occurred on our acute 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. From April 2023, there will be a phased introduction of the review of community deaths.

Communication issues are a common theme identified by the bereaved. We are actively promoting effective communication through:

- Clinical and non-clinical communication skills courses
- Promotion of proactive and reactive communication
- 'Letters to Loved Ones' – a supported correspondence programme

Severe clinical pressures over the winter resulted in poor flow through our hospitals. Higher discharge needs caused increased length of stay, reducing the number of available beds. This, coupled with increases in emergency admissions and high patient acuity, contributed to patients experiencing delayed ambulance transfers and sometimes long waits. In response, the Trust opened additional escalation areas to relieve pressure on the Emergency Departments and assessment areas. Although risks were managed and everything that could be done was done, we know from national reviews that patient outcomes can be affected where there are delays moving the patient to a ward areas. Excessive delays were incident-reported and reviewed with learning identified.

The Trust serves an area with a large number of residential care homes for patients with learning disabilities and autism. Our learning disabilities and autism hospital liaison nurse specialists deliver presentations at induction and 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 continuing to work on reducing 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 familiarisation sessions at quieter times with longer appointments so that patients can be better supported. Following the publication of the national LeDeR report and findings from local mortality reviews, the team is also starting work on a cross-health community constipation awareness programme and is working with epilepsy nurses to look at reducing risk, including SUDEP (sudden unexpected death in epilepsy). In addition, patient electronic discharge summaries include a reminder to GPs to complete annual health checks to ensure issues are identified early.

Other themes from SJRs and actions have included:

- Occasional delays in the escalation of care of patients, especially when patients were deteriorating. This is an area of continued focus for the Trust; however, there were also numerous references to patients being quickly identified and reviewed by clinical staff. Monthly audits are submitted to the deteriorating patient team and wards have action plans to ensure focus on local learning as well as wider adoption of good practice. The CQUIN for 2021/22 regarding documentation of early warning scores, escalation and clinical response for unplanned admissions to critical care will continue into 2023/24.
- Introduction of second on-call senior medical support out-of-hours on both acute sites to further support patient care.
- Nutrition – a new group has been established to review incidents and address recurring themes.
- Development of a risk assessment tool to address multiple bed moves and ensure patients are cared for safely in the best specialty area for their illness.
- Alcohol withdrawal support and alcohol-related conditions – a new webpage has been created, increasing the number of referrals to our alcohol liaison nurse specialists and improving timely care for patients.
- The need for early senior obstetric assessment to improve the planning and care for women who experience preterm rupture of membranes at extremes of prematurity and secondly greater visibility of missed appointments for follow-up.
- A designated telephone for ambulance crews seeking maternity advice has been set up.

- A new acute oncology service telephone contact e-form has been developed to capture information for clinical assessment.
- Training has been delivered to emphasise early senior advice after mortality reviews identified knowledge gaps in the management of fluid balance in complex patients.
- Review and further focus on recognition and management of complications from diabetes and acute kidney injury (AKI). Monthly audits indicate improved compliance with the AKI care bundle.
- Delays in identification of end of life and advance care planning – the Trust will be adopting the national Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) from March 2023. This form will support clinician-patient discussion in planning care in the event of deterioration.

Poppies at the entrance to Bluebird Lodge in Ipswich

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	Dec 2019 – Nov 2020	1.0582	1.000	1.1869	0.6951	2
	Dec 2020 – Nov 2021	1.0782	1.000	1.1949	0.7161	2
	Dec 2021 – Nov 2022	1.0931	1.000	1.2219	0.6454	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)	Dec 2019 – Nov 2020	31%	36%	59%	8%	
	Dec 2020 – Nov 2021	33%	39%	64%	11%	
	Dec 2021 – Nov 2022	38%	40%	66%	13%	

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 an integral 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 such as clinical skills and human factors training.
- Continuing with the quality improvement programme which encourages staff to think about local small-scale improvements.
- Working across the health community to identify and begin to reduce health inequalities by helping patients to a healthier life while ensuring everyone has equitable access to health and care services.

Indicator: PROMS

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

No data published for the 2022/23 reporting period.

Indicator: Patient recommendation (Friends and Family Test)					
The data made available to the Trust from Envoy with regard to:	**Reporting period**	**ESNEFT score**	**National average**	**Highest score**	**Lowest score**
All acute providers of adult NHS-funded care, covering services for inpatients and patients discharged from A&E (types one and two)	2019/20 (Inpatients) *	96.60%	95.60%	100%	82%
	2021/22 (Inpatients) **	92.47%	94.56%	100%	77%
	2022/23 (Inpatients) ***	92.03%	94.56%	100%	66%
	2019/20 (A&E) *	84.10%	84.40%	100%	40%
	2021/22 (A&E) **	80.29%	77.48%	100%	29%
	2022/23 (A&E) ***	79.56%	79.67%	95%	38%

* 2019/20 YTD (April 2019 – Feb 2020) with highest A&E (types one and two) and lowest score based on Feb 2020 report

No scores for 2020/21 due to COVID-19 suspension

** 2021/22 YTD (April 2021 – Feb 2022) with highest and lowest score based on Feb 2022 report

*** 2022/23 YTD (April 2022 – Feb 2023) with highest and lowest score based on Feb 2023 report

Indicator: C. difficile healthcare acquired infection rate 2022												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
ESNEFT	5	5	6	6	4	6	7	8	11	16	5	5
England	512	479	527	615	535	586	640	704	608	672	562	495

Indicator: Patient safety incident rate								
Data made available to the Trust by the HSCIC with regard to:	**Reporting period**	**ESNEFT score**		**National average**		**Highest score**		**Lowest score**	
		No	**Rate**	**No**	**Rate**	**No**	**Rate**	**No**	**Rate**
The number and rate of patient safety incidents	Apr 19 – Sep 19	11,092	55.0	815,852		11,620	103.8	2,173	26.3
	Oct 19 – Mar 20	10,848	52.8	838,722		11,787	110.2	1,271	15.7

reported within the Trust during the reporting period. Please note the reporting period changed to 'per 1,000 bed days' in April 2014	Apr 20 – Mar 21	20,903	64.2	1,550,306		32,917	118.7	3,169	
	April 21 – Mar 22	26,000	66.6	1,767,264		49,603	54.4	3,441	23.9
The number and percentage of such patient safety incidents that resulted in severe harm or death during the reporting period.	Apr 19 – Sep 19	61	0.6	2,524	0.3	1	0.0	26	1.2
	Oct 19 – Mar 20	93	0.8	2,536	0.3	4	0.0	19	1.5
	Apr 20 – Mar 21	261	1.3	6,828	0.4	69	0.2	56	1.7
	Apr 21 – Mar 22	216	0.8	7,116	0.4	181	0.4	3	0.1

East Suffolk and North Essex NHS Foundation Trust continues to focus on reducing harm and improving patient safety.

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. Our safety managers use 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 66.6 incidents per 1,000 bed days for the period of April 2021 to March 2022 (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 there are 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 2021 to March 2022 is 0.8% 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 found on admission were previously reported as no harm incidents, as were the requirements at the time.

Our performance reflects that we utilise nationally reported verified data from the NRLS. Therefore we continue to work to reduce avoidable harm and improve outcomes for patients, staff and all service users.

Safety is at the heart of everything we do. We therefore continue to develop our strategy by embedding learning from incidents into all aspects of clinical and non-clinical practice.

We:

- Have introduced After Action Review (AAR) 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.

To improve our performance, 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.
- Further delivering AAR training across the Trust.
- Piloting a new section of our Datix management system in response to the changing needs of the Tissue Viability Service by developing our use of digital systems to support information gathering. This will allow both the acute and community services to ensure more active monitoring and improve shared learning from incidents.
- Having a clear focus on issues identified that cause the most preventable harm to patients within our Patient Safety Incident Response Framework workstreams.
- Continuing to report themes and trends monthly while providing additional support and collaborative working for clinical areas where there are increases in falls, pressure ulcers and other high harm incidents.

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 2022/23.

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.

There were three hospital-onset, healthcare associated (HOHA) cases at ESNEFT in 2022/23 where a specimen is taken on the third day of admission onwards (i.e. ≥ day three when day of admission is day one).

There was one community-onset healthcare-associated (COHA) cases. This is any case not determined to be HOHA but where the patient was discharged within 28 days prior to the current specimen date (where date of discharge is day one).

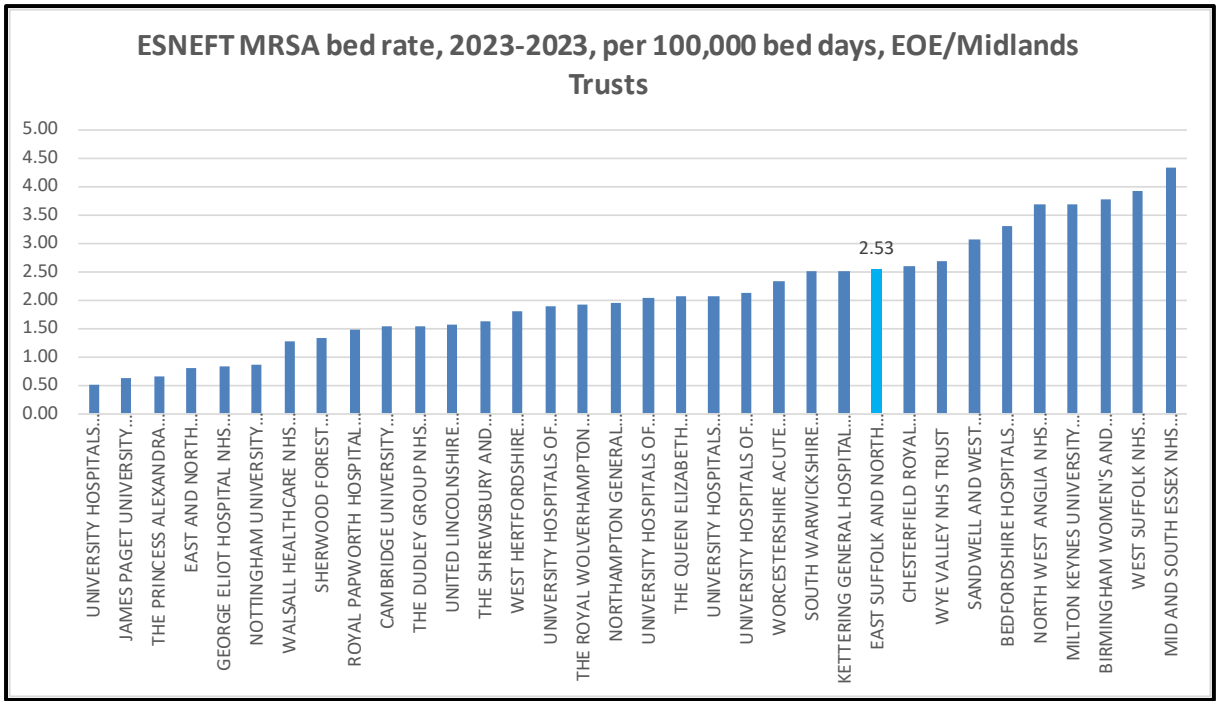
Learning from these cases relates to compliance with the MRSA screening and decontamination protocol, recognising positive results, compliance with hand hygiene and PPE practices and standards of peripheral vascular access device documentation.

The number of MRSA bacteremia cases apportioned to ESNEFT in 2022/23

Cases	Total	Objective
Three HOHA cases One COHA case	Four	None

ESNEFT's performance in rates of MRSA bacteraemia to 31/03/2023 compared with other hospitals in the east of England for the year 2022/23 is shown in the chart. The 2021/22 figure was 2.61.

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



Clostridioides difficile (C. diff)

During the year, a change has been made to the nomenclature and C.diff is now known as Clostridioides difficile.

Clostridioides difficile (C. diff) is an unpleasant and potentially severe or fatal infection that 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.

Updated national guidance was published in 2022 noting changes to the type of stool considered as suitable for testing for C.diff and changes to the antibiotic treatment regime for C.diff infections. These are reflected in the Trust's policy for Clostridioides difficile and unexplained diarrhoea procedure.

Each hospital-onset, healthcare associated (HOHA) case with lapses in care is subject to a post-infection review. Lessons learnt from reviews carried out during the year included:

- A recognition of the requirement to isolate when sampling for suspected infective diarrhoea.
- The need to take a stool sample as soon as infectious diarrhoea is considered.
- Consideration to prescribe the correct antibiotics as per current antimicrobial prescribing guidelines.

The outcomes of these reviews 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 breach in policy leading to patient safety issue but not C. difficile.
- **Outcome one** – if lapses in care have been identified.

During 2022/23, 76 of our 102 C. difficile cases have currently been agreed as outcome two or three (non-trajectory). There are currently 20 cases awaiting a final decision.

Number of C. difficile cases attributed to ESNEFT 2022/23

Year	Number of cases of apportioned to ESNEFT	Objective
2020/21	• 12 outcome one cases • 88 outcome two or three cases Total – 100 cases	107 cases
2021/22	• Five outcome one cases • 101 outcome two or three cases Total – 106 cases	99 cases
2022/23	• 7 outcome one cases • 89 outcome two or three cases • 18 cases under review Total – 114 cases	102 cases

During the year, we have:

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

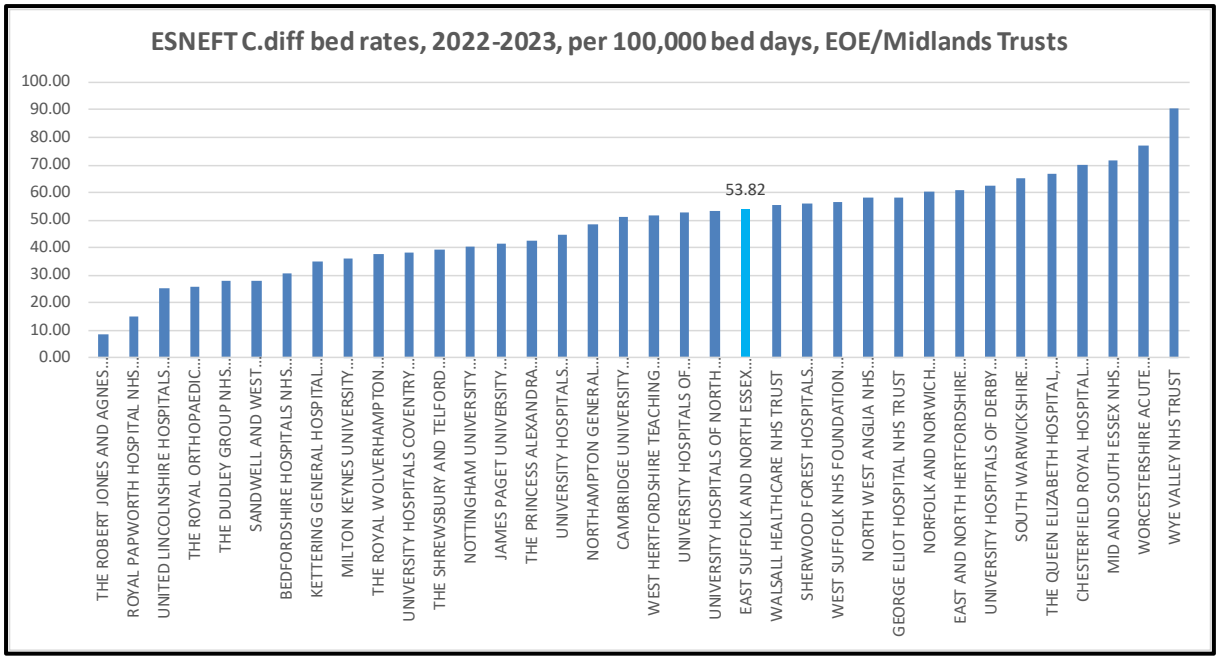
- Modified the post-infection review process to review only those cases with identified learning with our integrated care system colleagues. The ESNEFT IPC team appropriates outcome three decisions internally.

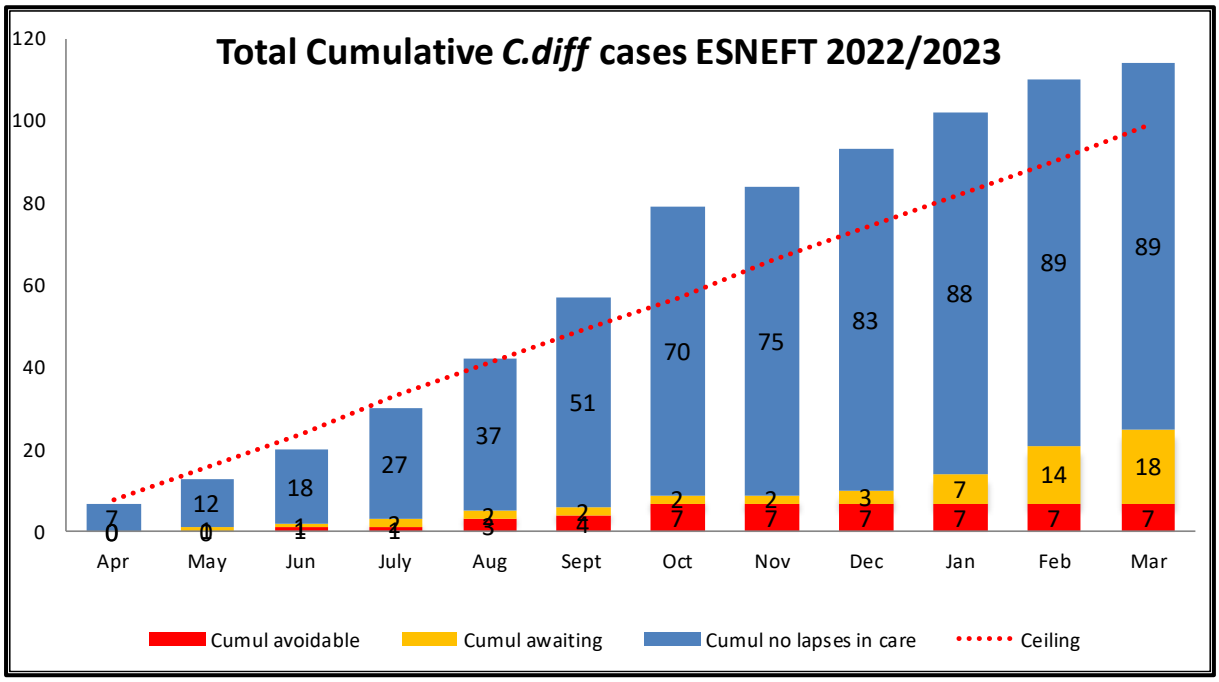
- Prepared and updated an ESNEFT care pathway for managing suspected infectious diarrhoea or diarrhoea of an unknown cause. This was shared with clinical areas in spring 2023.

- Relaunched the isolation posters for nursing patients in side rooms with infectious diseases.

ESNEFT's performance for rates of Clostridium difficile up to 31/03/23 compared with the other hospitals in the east of England for 2022/23 is show in the chart below. The 2021/22 figure was 47.41.

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





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 Group and Clinical Effectiveness Group.

The changes we have made as a result of lessons learnt

- All pre-operative assessments should go through a centralised and standardised electronic pre-assessment process as per GIRFT recommendations.
- Pre-operative assessment processes for out of area/tertiary referrals should either be the same as for local patients or there needs to be mechanisms to ensure these patient's pre-assessment is done at their local hospital and the information in made available to ESNEFT.
- Changes in clinical presentation from those in pre-assessment should prompt a reassessment and further investigations with clear documentation of discussions and rationales.

Work takes place on Ipswich Hospital's new Emergency Department and Urgent Treatment Centre

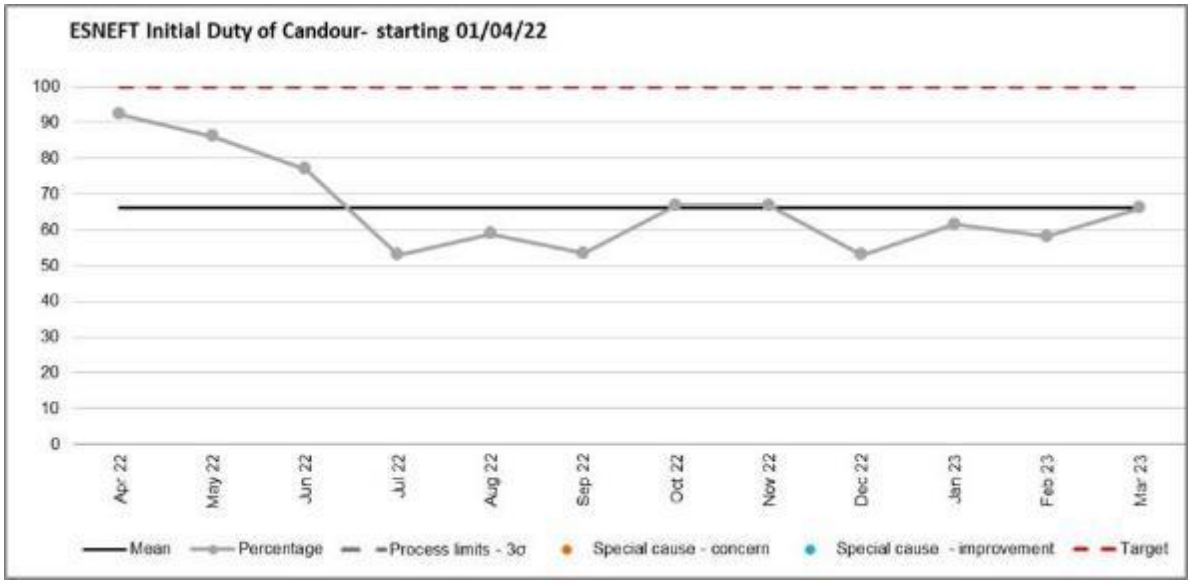
Duty of Candour

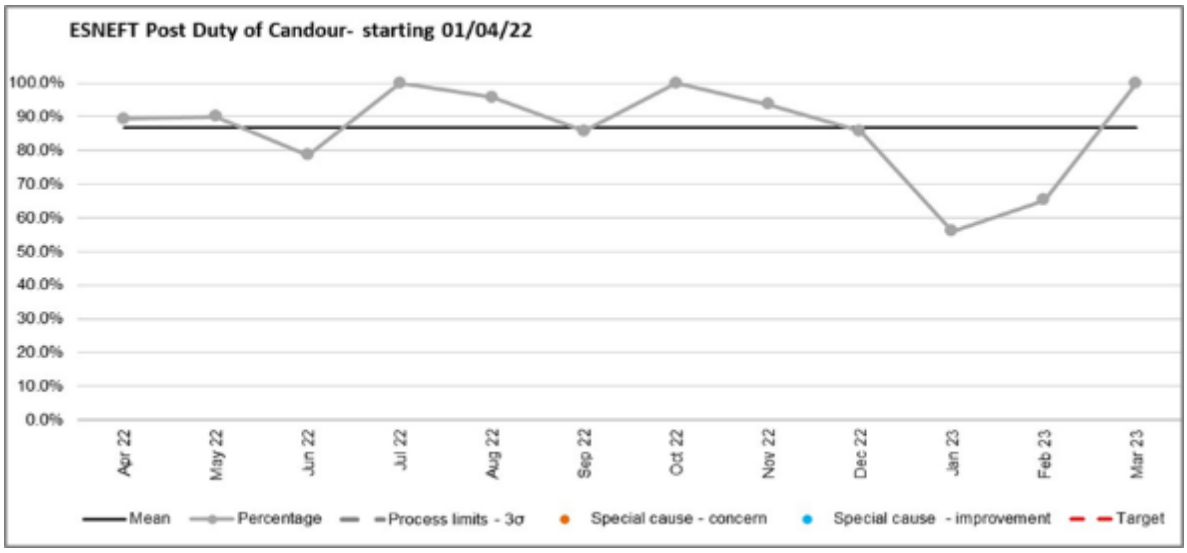
Saying sorry is always the right thing to do and is not an admission of liability. We urge our staff to always be compassionate towards the needs of the patient and their family.

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.

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 2022/23





From the data provided, Duty of Candour is embedded within our community and hospitals. However, further work is required to continue to increase compliance across all areas.

What we are doing to make improvements

We are:

- Making Duty of Candour training mandatory from April 2023.
- Adding a mandatory Duty of Candour and open and honest conversation prompt on our incident management system so if incidents are finally approved as moderate harm or above, staff will be prompted to record the relevant information.
- Carrying out face-to-face and e-learning training for the investigation and actions required following incidents.
- Ensuring a responsible Duty of Candour lead has been identified to hold a face-to-face Duty of Candour conversation with the patient and/or their relative/carers.
- Ensure the timing of letters and meetings meets local and national standards.
- Offering a choice of feedback (for example, with varied methods, times and dates) and confirming the patient's choice in writing.
- Reviewing our current training programme and introducing refreshed training in accordance with the PSIRF.

Adverse events reported

During 2022/23, the following adverse events (categorised as low harm to severe harm) have been reported on the Datix risk management computer system.

Type of adverse event	Number of adverse events
Abusive, violent, disruptive or self-harming behaviour	56
Access, appointment, admission, transfer, discharge	104
Accident that may result in personal injury	1502
Anaesthesia	17
Clinical assessment (investigations, images and lab tests)	108
Consent, confidentiality or communication	69
Diagnosis, failed or delayed	41
Implementation of care or ongoing monitoring/ review	9437
Infrastructure or resources (staffing, facilities, environment)	59
Labour or delivery	247
Medical device/ equipment	113
Medication	181
All other categories	40
Patient Information (records, documents, test results, scans)	30
Treatment, procedure	272
Total	**12,276**

Never events

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

The nationally agreed list of never events for 2022/23 are:

1. Wrong site surgery
2. Wrong implant/ prosthesis
3. Retained foreign object post-procedure
4. Administration of medication by the wrong route
5. Mis-selection of a strong potassium solution
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Failure to install functional collapsible shower or curtain rails
9. Falls from poorly restricted windows
10. Chest or neck entrapment in bedrails
11. Transfusion or transplantation of ABO-incompatible blood components or organs
12. Misplaced naso- or oro-gastric tubes and feed administered
13. Scalding of patients
14. 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	April 2022 to Jan 2023
7	**7**	**6**	**3**

The list below shows a breakdown of the three incidents which were reported as never events having met the definition of a never event.

Incident date	Reported	Type	Category	Sub category
30/08/2022	05/09/2022	Patient incident	Anaesthetics / clinical management	Clinical management – wrong site
27/09/2022	27/09/2022	Patient incident	Anaesthetics / clinical management	Clinical management – wrong site
03/01/2023	11/01/2023	Patient incident	Anaesthetics / clinical management	Clinical management – wrong site

Learning from never events

Thorough early learning reviews, structured judgment reviews, patient safety reviews and patient safety incident investigations took place and the following actions have been taken to prevent recurrence:

- The consent forms to be uploaded on to the digital system once it had been signed. At the time of the check there was no paper copy to check at the bedside. The team now has the paper copy of the consent at the time out and the site of operation is confirmed at that time against the consent form.
- Marking the operation site is now carried out by the consultant podiatric surgeon. The band seven podiatrist still performs the local anaesthetic block after the checks are made with the patient and the paperwork, but the consultant podiatric surgeon is responsible for marking the surgical site.
- We understand that a white board has been introduced in theatre and is being used daily to define the staff present and their role for that day.
- At the time of 'time out', a change of culture now results in all action being halted in the operating theatre. There is silence in the theatre while the task carried out at the bedside of the patient to confirm correct patient, side, site and allergies.
- When specimens are handed out from the sterile operating field, the circulating practitioner requests written confirmation of the labelling. The specimen form is still signed and checked by the consultant podiatric surgeon.
- Sign out following the procedure requires all those present to take part and confirm the procedure that has taken place, the labelling of any specimens and the postoperative instructions identified.
- Staff should be encouraged to voice their opinions within the team meetings such as briefing, time out and sign out.
- Team training and human factors training should be considered in order to encourage staff team building.

Patient Safety Incident Response Framework (PSIRF)

During 2022/23, we successfully completed our Patient Safety Incident Response Framework (PSIRF) pilot.

As an early adopter of PSIRF, we have been able to provide feedback to the national Patient Safety Strategy. This has allowed for a more proportionate and greater range of responses to our safety incidents (such as early learning reviews, structured judgement reviews, thematic reviews, patient safety reviews and patient safety incident investigation), with a focus on a Just Culture, openness and candour.

This is also allowing us to increase the involvement of affected patients, families and staff and improve our existing governance and oversight procedures. Although these principals were evident in our existing system, we will continue to build on these further in 2023/24.

Pressure ulcers

Reducing pressure ulcers acquired at our Trust remains a priority and is a key element of keeping patients safe and free from harm during their journey through the healthcare system. As such, we strive to reduce the risk of harm to patients through the prevention of pressure damage.

During the past year, we commissioned an independent review looking at all tissue viability services across the Trust, including the recently joined tissue viability nurse service in North East Essex Community Services. The review was carried out by a highly experienced independent nurse and identified examples of notable practice, as well as areas the service could be more streamlined and improved.

Notable practice seen included a new 'learning from incidents' forum set up by the Suffolk community matron and a strong desire from band seven managers to take more ownership of pressure ulcer validation and investigation actions. All tissue viability nurses also showed their passion for giving evidence-based patient care.

Senior management and our tissue viability services are working towards actioning the remaining recommendations, which are summarised below:

1. All areas should report all categories of pressure ulcers without exception to ensure compliance with the national framework, consistency and benchmarking across the Trust. This will be incorporated into education plans going forward.

2. Datix should be easy to understand and complete for the reporter to make sure accurate data is completed initially while reducing the workload of validators in correcting. Work has started with the Datix team to update the current system.

3. Datix completed for wounds that do not constitute a clinical incident or are direct duplicates of a previous report for the same patient should be rejected and removed from data collection to prevent double reporting. The functionality of Datix is being looked at to find a solution.

4. All areas should follow a consistent approach to investigation of category three and above pressure ulcers, with lessons learned identified and SMART actions documented. A new gap analysis investigation tool has been developed and this will be governed through a new tissue viability nurse review panel and a relaunch of the Harm Free Care Panel as a 'learning from incidents' forum.

5. All area senior managers should have oversight of all categories of pressure ulcers and outstanding investigations/ actions in their area. A new SOP for validation and investigation is in progress to outline roles and responsibilities of those involved in pressure ulcer incidents.

6. Tissue viability nurse specialists should not be expected to validate all Datix pertaining to wounds but should have oversight and clinical input of all category three pressure ulcers or above.

7. All areas should have one updated, over-reaching pressure ulcer prevention and management policy, with relevant sections for community and hospital where there are differences in practice.

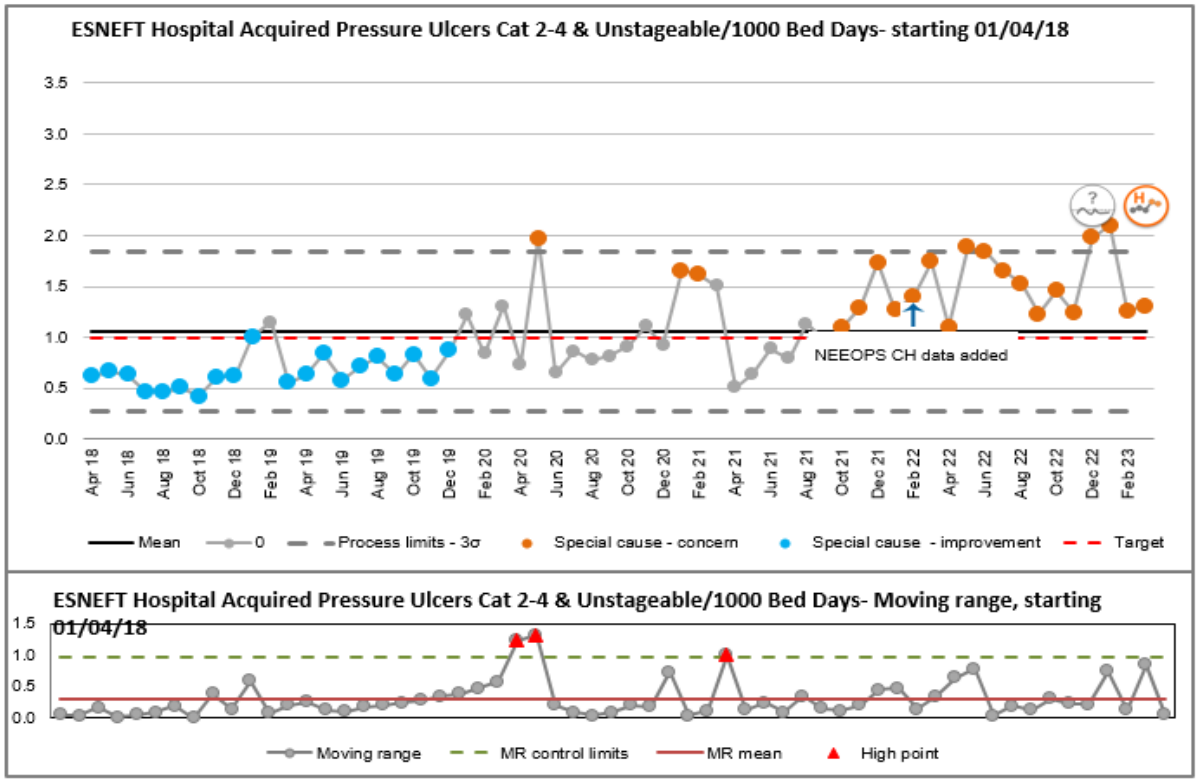
8. All areas should have clear referral criteria for tissue viability, with pathways and guidance for those wounds not needing specialist tissue viability nurse input. New referral criteria have been devised to enable more appropriate use of the tissue viability nurses' time with complex patients.

9. The tissue viability nurse teams need a clear, defined organisational structure with leadership at each site reportable to a strategic lead nurse. Each team member needs clarity as to their role and place within the larger team. All tissue viability nurse

teams need to understand each other's work, challenges and differences through collaborative working and improved communication channels. An away day took place in October to initiate closer working relationships between the four area teams, while organisational structure and leadership is being reviewed.

10. All tissue viability nurses should have access to clinical supervision (ideally from a professional nurse advocate or peer), professional development plans and clear personal objectives, and should receive regular feedback from their line manager with one-to-one reviews. They should also have protected time for continuing professional development and mandatory training within their working hours. This is being planned by the leadership teams.

11. All tissue viability nurse teams should have a clear, consistent means of communicating patient handovers and share information between areas. A new peer forum has been set up to improve handover communication between hospital and community teams, alongside new communication sections in Datix.



Falls prevention

Reducing inpatient falls remains a key patient safety 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 both the incidence and severity of falls taking place across all our wards, both in our acute and community hospitals.

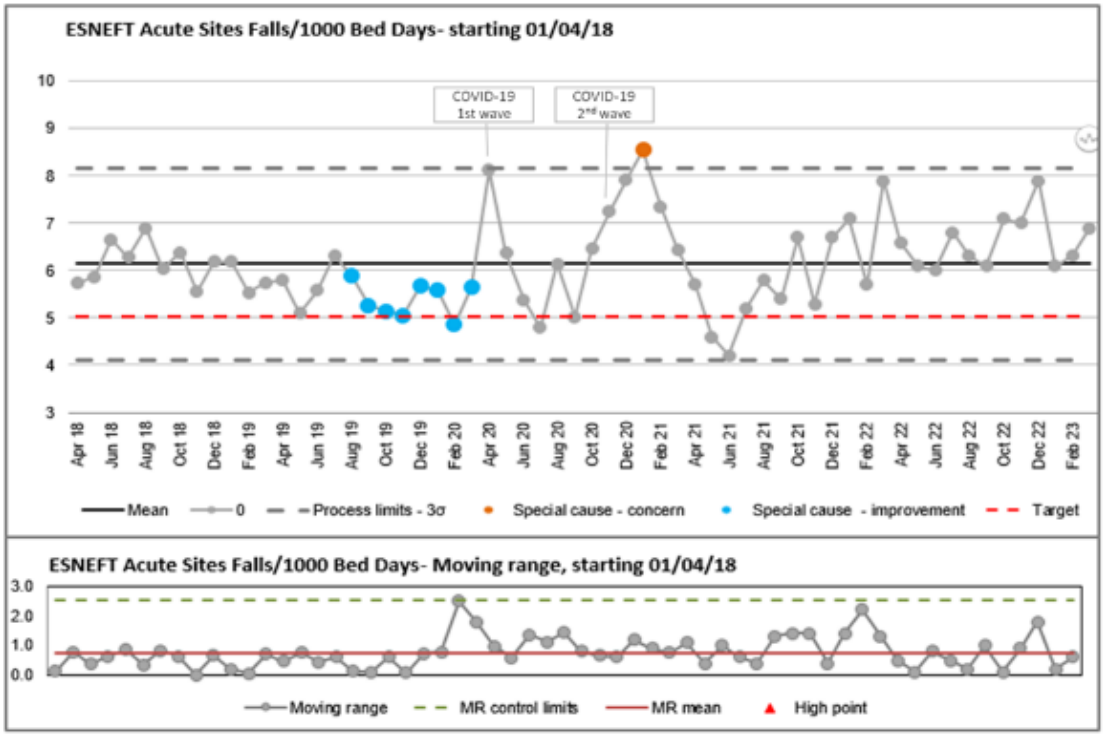
The Trust's aim is to make sure that falls risk assessments, care and actions take place with every patient as appropriate to minimise the risk that they will fall during their admission, in turn reducing the severity and level of harm.

During 2022/23, specific education around falls prevention on wards continued and was supported by the wider Harm Free Care team. There continued to be a focus on ensuring timely multi-factorial falls risk assessments are carried out, as well as preventative actions to minimise falls risk. Wards have continued to seek advice from the falls team when caring for patients with complex needs who are at an increased risk of falling. Education around the use of assistive technology and safe use of bed rails has also continued to ensure patients are individually risk assessed and an appropriate care plan put in place. Elsewhere, Baywatch cohort care has continued and remains an effective tool in reducing inpatient falls, although infection control requirements can make this work more challenging.

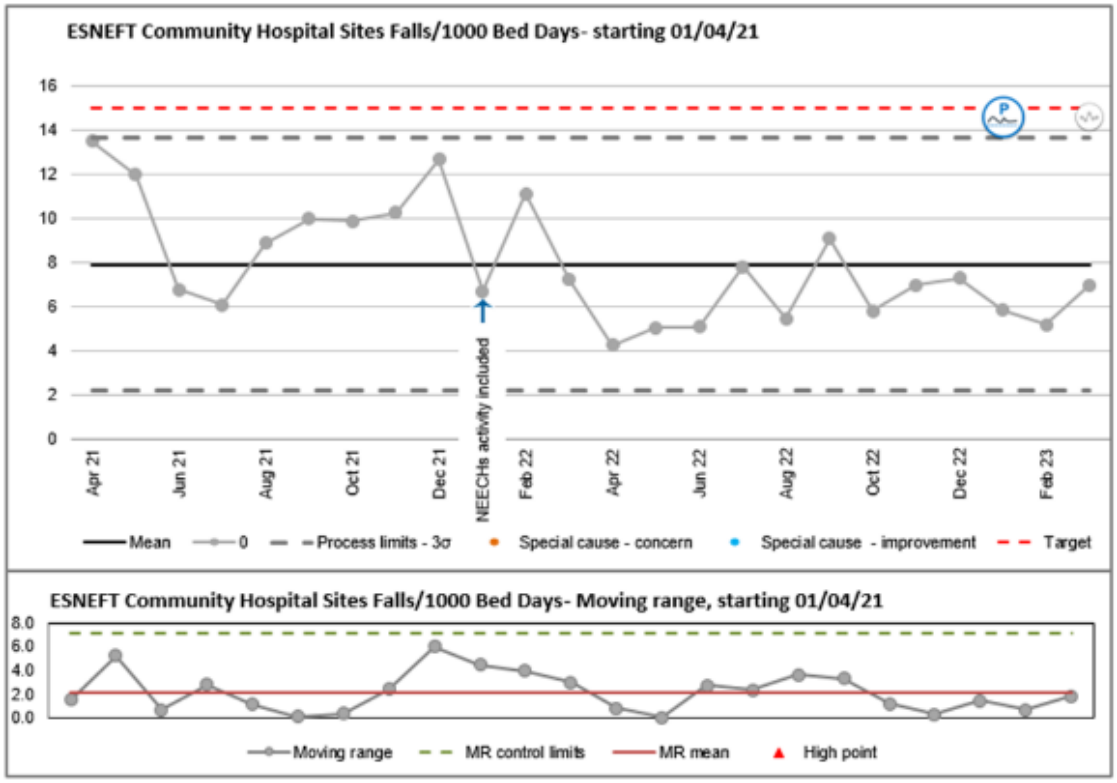
There were 2,968 inpatient falls across the Trust in 2022/23, which is an increase on the previous year (2,497). However, our bed base has increased due to the partnership with Clacton and Harwich Hospitals. Of these falls, 70 resulted in serious harm (63 of which were in our acute hospitals and seven in community hospitals), which is an increase on the previous year (34). Falls resulting in serious harm continue to be reviewed via the Harm Free Panel process or during After Action Reviews as part of the new Patient Safety Incident Response Framework (PSIFR), which focusses on learning from incidents at ward level.

COVID-19 and other infections continue to present a challenge when managing patients deemed at high risk of falls. Existing methods of monitoring patients became more difficult due to the changes to accommodate isolated COVID-19 patients. As a result, inpatient fall numbers have continued to fluctuate, with patients often having an increased length of stay due to reduced flow throughout the Trust as a result of both local and national pressures.

ESNEFT acute site falls per 1,000 bed days from April 2018 to March 2023



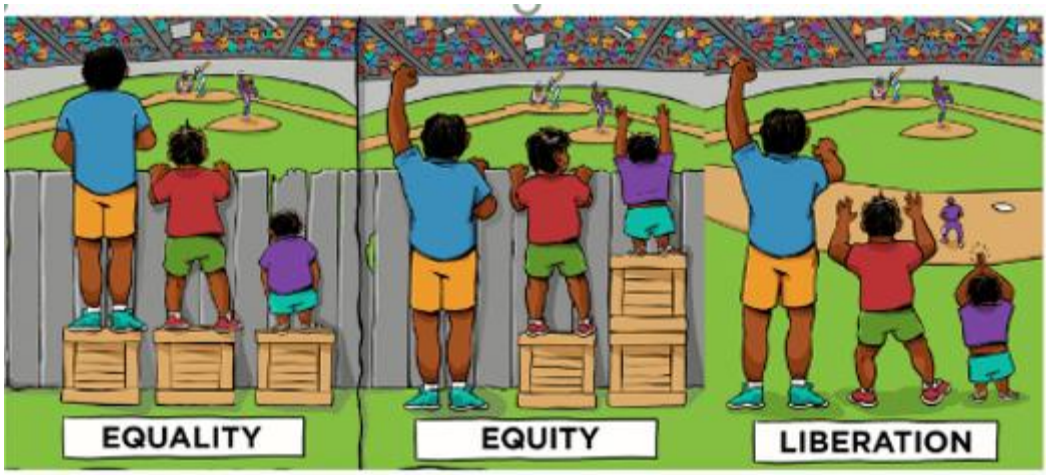
ESNEFT community hospital site falls per 1,000 bed days from April 2021 to March 2023



Charity funds have been used to buy a new MR200 monitor, which allows cardiologists to assess a patient's heart rate, blood pressure and oxygen levels while they are having an MRI scan

Health inequalities

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies" (NHS England).



What are we doing to tackle health inequalities?

The local healthcare system's approach is to provide equitable access to services and risk factor management across alliances by:

- Holding virtual ward rounds in nursing homes and introducing virtual clinics.
- Reconfiguring services, such as AMSDEC outreach and the Clacton Diagnostic Hub, to give priority to Tendring residents.
- Improving access to translating services and offering tailored support in maternity.
- Supporting patients on our waiting lists by linking to community services and social prescribers to provide advice and help with any wellbeing needs.
- Prioritising patients with learning disabilities to take into account reasonable adjustments and timely assessments.

Within the Trust an inequalities working group has been set up and a four-year strategy developed. The strategy aligns with the CORE20Plus5 approach (most deprived 20% of the community core ICS groups with poorer outcomes plus five clinical areas of health inequalities, which include diabetes for adults and asthma for children and young people).

Our ambition outlined in the strategy is to "ensure equitable access to our services and improve health outcomes for all our patients". This is supported by four key objectives:

- Get everyone involved in equity.
- Identify and monitor health and healthcare inequalities using data.
- Understand the causes of inequities and barriers resulting in them.
- Create change together with our partners and communities and measure its impact.

The aims and ambitions of the Health Inequalities Working Group are:

- To work with community partners and the ICS to align approaches and provide tailored support to our communities.
- To implement population health management and personalised care approaches to improve health outcomes and ensure equitable access to our services within our localities.
- To promote self-care and keeping well to our patients and consider how we can reduce health inequities that have been magnified by the COVID-19 pandemic.

In order to deliver the strategy, the work has been divided into two strands: risk factor management and equity of access. Key projects which have taken place so far include:

Risk factor management:

- Offering support to our adult inpatients and staff to make healthier eating choices.
- Rolling out our tobacco treatment service across our inpatient wards, which is seeing referrals increase each month.
- Running a healthy eating pilot for children and young people in the Tendring district called “Nourish”, which led to positive outcomes including an improvement in physical activity and reduction in blood pressure.
- Improving pre-operative assessment to manage co-morbidities and help patients “keep well” before surgery.

Equity of access:

- Launching a pilot in the CO15 postcode area to unblock barriers causing “did not attends” and cancellation rates in our most deprived areas.
- Commencing a review of data behind higher asthma admission and attendance rates for children and young people from our most deprived areas. We are also working with GPs and pharmacies to improve asthma management and care.

The next steps for the health inequalities group include:

- Talking to patients in our most deprived communities to find out what matters to them.
- Rolling out pictorial menus across pilot inpatient wards.
- Expanding our tobacco treatment service into pre-operative assessment clinics.
- Commencing “Nourish” in central Ipswich.
- Engaging with GP and pharmacies in Ipswich and Clacton to understand current asthma care.
- Reviewing clinic capacity at Clacton Hospital to reduce the need for Tendring patients to travel to Colchester.

Making Every Contact Count (MECC)

MECC is an approach to behaviour change that uses the millions of day-to-day interactions which organisations and people have with others to support them to make positive changes to their physical and mental health and wellbeing.

Drawing on behaviour change evidence, MECC maximises the opportunity within routine health and care interactions for a brief or very brief discussion on health or wellbeing factors to take place.

We have used MECC to support patients around mental health, healthy eating, finance, housing and carer responsibilities. MECC has now been rolled out to over 240 clinics across the Trust, with plans to expand into community settings and primary care, linking with social prescribers.

Accessible information

Information is an important part of the patient journey and a key element in the overall quality of patient and carer experience of the NHS. It plays a significant part in providing patients and carers with the information they need to make informed decisions about healthcare and give informed consent. ESNEFT is committed to providing clear, meaningful and accurate patient information which can be provided in the format most accessible to the individual patient.

We aim to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We take into account the provisions of the Equality Act 2010 and promote equal opportunities for all.

We aim to satisfy the requirements of the Accessible Information Standard (AIS), which ensures that people who have a disability or sensory loss, such as hearing impairment, visual impairment, cognitive impairment, speech difficulty or learning disability, receive information that they can access and understand.

We are committed to ensuring that ESNEFT, as an organisation which provides NHS care and/or publicly-funded adult social care, will follow the AIS. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

It is important, therefore, that information is presented in an accessible way, and – where appropriate – in a range of languages and formats that are easily used and understood.

We believe that providing accessible information will help to improve access to services, promote social inclusion and enable people to make more informed choices about their care. For staff, the provision of accessible information will aid communication with service users, while also supporting choice and reducing inequalities and barriers to good health.

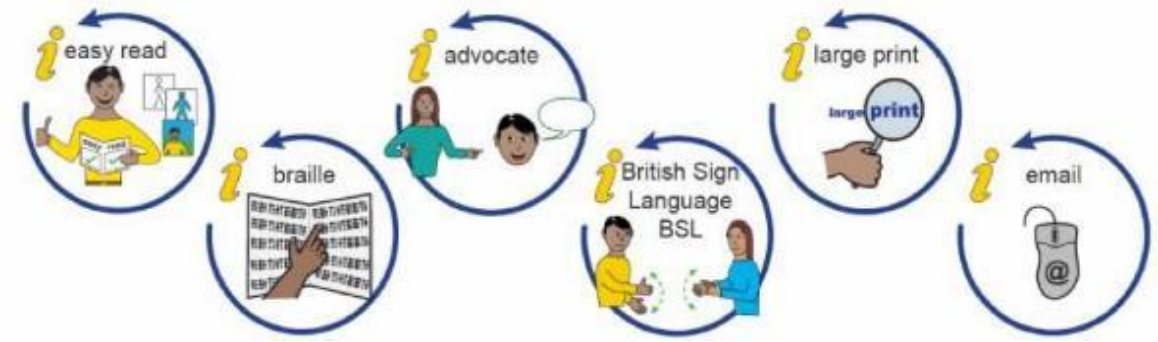
By law (Section 250 of the Health and Social Care Act 2012), all organisations which provide NHS care or adult social care must follow the standard in full. In 2017, NHS England published a revised version of the standard, which requires organisations to:

- Ask people if they have any information or communication needs and find out how to meet those needs.
- Record that the question has been asked, even when it is answered with a negative.
- Record those needs clearly and in a set way.
- Highlight or flag the person's file or notes so it is clear they have information or communication needs and how to meet those needs.

- Share people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
- Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

This may also include providing information and correspondence in formats patients and carers can read and understand, for example in audio, braille, easy read or large print.

During the past year, a working group has been reviewing the systems in place at ESNEFT to ensure the AIS is met. This work initially focused on meeting the information and communication support needs of patients with learning disabilities and visual impairments at Ipswich Hospital, and will be rolled out to Colchester in early 2023/24.



Virtual wards

We are constantly striving to improve the quality of care we provide for our patients. Virtual wards have emerged as a promising solution to achieve this goal. A virtual ward enables patients to receive care in their own homes while still receiving the support and monitoring they need from healthcare professionals. In accordance with the 'Delivery Plan for recovering Urgent and Emergency Care Services – Jan 2023', the NHS has successfully rolled out 7,000 virtual ward beds, with capacity increasing by nearly 50% since the summer. The national ambition is to scale up capacity ahead of next winter to more than 10,000, with a longer-term ambition of reaching 40 to 50 virtual ward beds per 100,000 people. For the ESNEFT footprint, this ambition would equate to capacity for 320 patients.

The benefits which virtual wards provide towards improving patient care and clinical outcomes include:

- **Patient-centred care:** Virtual wards enable patients to receive care in a familiar and comfortable environment which has proven to increase patient satisfaction and engagement. There have been high patient experience satisfaction levels reported from virtual wards schemes across the NHS, which is mirrored in the local experience in ESNEFT.

- **Improved clinical monitoring:** The cutting-edge remote monitoring technology used in virtual wards can help healthcare professionals detect and manage potential

complications earlier. This can lead to better clinical outcomes, reduced hospital readmissions and improved patient safety.

- **Enhanced care coordination:** Virtual wards provide a platform for better care coordination between healthcare professionals, patients and their families. This can lead to improved communication and collaboration, resulting in better patient care, clinical outcomes and long term disease management.

- **Increased access to care:** Virtual wards can help improve access to care for patients who may have limited mobility or live in remote areas. This can lead to better patient outcomes by ensuring timely access to healthcare services.

By leveraging technology and innovative care models, ESNEFT can improve the delivery of healthcare services while also achieving better patient outcomes.

The new main entrance at Ipswich Hospital

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. There is an induction of labour suite called Nova Ward for women and pregnant people who are having their labour induced, which is made up of a four-bedded bay, one single room and an area for mobilisation. 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 England, 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 strategy. The strategy provides a vision of how care will be delivered in the next three years, as well as identifying opportunities for further long-term developments. It provides 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 east Suffolk and north Essex.

The principles 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 pre-term 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 two neonatal unit (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 rolled out and 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. 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

In March 2022, Donna Ockenden produced her final report which followed her initial report published in December 2020.

The first report outlined local actions for learning (LAfL) and immediate and essential actions (IEAs) to be implemented across the maternity system in England.

In the final report, the independent maternity review team identified a number of new themes which needed to be urgently shared across all maternity services to bring about positive and essential change. The report included a recommendation was that all the IEAs should considered by all trusts across England in a timely manner.

The 15 areas of action identified in the final report are listed below. ESNEFT's compliance with these actions has been led by the quality assurance clinical project lead, with update reports shared through the Trust's governance reporting processes to ensure there is full oversight of progress against each action area.

Action areas

Section one: workforce planning and sustainability – the recommendations from the Health and Social Care Committee report entitled 'The Safety of Maternity Services in England' must be implemented.

Section two: safe staffing – all trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

Section three: escalation and accountability – staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.

Section four: clinical governance leadership – trust boards must have oversight of the quality and performance of their maternity services. In all maternity services, the Director of Midwifery and Clinical Director for Obstetrics must be jointly operationally responsible.
Section five: clinical governance – incident investigation and complaints handling – incident investigations must be meaningful for families and staff. Lessons must be learned and implemented in practice in a timely manner.

Section six: learning from maternal deaths – maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology. In the case of a maternal death, a joint review panel/investigation of all services must include representation from all applicable hospitals/clinical settings.

Section seven: multidisciplinary training – staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG and emergency skills training.

Section eight: complex antenatal care – local maternity systems, maternal medicine networks and trusts must make sure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance.

Section nine: pre-term birth – the LMNS, commissioners and trusts must work collaboratively to ensure systems are in place to manage women at high risk of pre-term birth. Trusts must implement NHS Saving Babies Lives Version Two (2019).

Section 10: labour and birth – women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units.

Section 11: obstetric anaesthesia – in addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available to address incidences of physical and psychological harm.

Section 12: postnatal care – trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant reviews. Postnatal wards must be adequately staffed at all times.

Section 13: bereavement care – trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.

Section 14: neonatal care – there must be clear pathways of care for the provision of neonatal care. The review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care.

Section 15: supporting families – care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Care providers must actively engage with the local community and those with lived experience.

Clinical Negligence Scheme for Trusts (CNST) – year four

CNST incentivises 10 maternity safety actions, Trusts which can demonstrate they have achieved all 10 standards will recover the element of their contribution relating to the CNST maternity incentive fund, as well as a share of any unallocated funds.
The year four scheme started in August 2021 but was paused due to COVID-19. The scheme relaunched in April 2022, with some amendments to requirements and timeframes, and required trusts to complete their submission by the beginning of February 2023.

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 a quality assurance clinical project lead to oversee compliance.

Safety action one was presented as non-compliant for one element. We also declared non-compliance for both safety action five and safety action nine.

Safety action one: Are you using the national perinatal mortality review tool to review perinatal deaths to the required standard?

Safety action one requires trusts to demonstrate use of the national perinatal mortality review tool (PMRT) to review perinatal deaths to the required standard. Year four of the scheme covers the reporting period from 6 May 2022 to 5 December 2022.

Part of the standard requires that 95% of all baby deaths which are suitable for review using the PMRT from 6 May 2022 will have been started within two months of the death. At ESNEFT, two cases breached this timescale with the investigation starting one day outside the required timeframe. The Trust has met all other requirements set out in this standard.

Governance processes have been introduced to avoid a recurrence of late reporting and have been reviewed by the Director of Governance to provide additional assurance to the Trust Board. An SOP is now in place, which includes a failsafe escalation plan for any element within four weeks of the deadline to ensure this is not missed in the future.

Safety action two: Are you submitting data to the maternity services data set (MSDS) to the required standard?

All requirements set out in this standard have been met by ESNEFT. A maternity services digital strategy was approved by the Local Maternity Strategy Board on 7 September 2022. ESNEFT MSDS data has been successfully submitted for the relevant period.

On the monthly scorecard issued by NHS Digital for October 2022, ESNEFT met all 12 mandatory criteria.

Safety action three: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the avoiding term admissions into neonatal units (ATAIN) programme?

All requirements set out in this standard have been met by ESNEFT:

- In accordance with this standard, pathways of care into transitional care have been jointly approved by maternity and neonatal teams, with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

- Pathways on both sites have been fully implemented and are audited quarterly. Audit findings are shared with the neonatal safety champions, Local Maternity Neonatal Safety Board and the integrated care system.

- A data recording process is in place for capturing all term babies transferred to the neonatal unit regardless of their length of stay, together with a data recording process for capturing existing transitional care activity.
- A further data recording process is being used to inform future capacity management for late pre-term babies who could be cared for in a transitional care setting.
- Commissioner returns for Healthcare Resource Groups (HRG) activity as per neonatal critical care minimum data set version two are available and shared on request with the ODN, LMNS and commissioners to inform capacity planning as part of the family integrated care component of the national critical care transformation review and future development of transitional care to minimise separation of mothers and babies.
- Reviews of babies into the neonatal units continue on a quarterly basis and findings have been shared with the Board level safety champion.
- An action plan to address local findings from the audit of pathways into transitional care and from ATAIN has been agreed with the neonatal safety champions and Board level safety champions.

Safety action four: Can you demonstrate an effective system of medical workforce planning to the required standard?

ESNEFT has met all elements of this standard, which includes criteria relating to:

- Obstetric medical workforce
- Anaesthetic medical workforce
- Neonatal medical workforce
- Neonatal nursing workforce

Safety action five: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Trusts must demonstrate an effective system of midwifery workforce planning to the required standard, as follows:

- A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
- Trust Board to evidence midwifery staffing budget reflects establishment, as calculated above.
- The midwifery coordinator in charge of labour ward must have supernumerary status, which is defined as having no caseload of their own during their shift, to ensure oversight of all birth activity within the service,
- All women in active labour receive one-to-one midwifery care,
- A midwifery staffing oversight report that covers staffing/safety issues must be submitted to the Board every six months during the maternity incentive scheme year four reporting period.

The final element has not been met by ESNEFT. The Trust is currently completing a Birthrate plus assessment and is awaiting the report to feed into the workforce plan.

Safety action six: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle?

All elements of this standard have been met. ESNEFT has demonstrated compliance with all five elements of the care bundle, which are:

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth restriction
- Raising awareness of reduced fetal movements
- Effective fetal monitoring during labour
- Reducing pre-term birth

In order to strengthen the Saving Babies Lives programme within ESNEFT, we have developed an action plan of areas for further improvement. This includes increased compliance with both CO monitoring and recording, and recording that women are given information regarding reduced fetal movements prior to 28+0 weeks of pregnancy. Additional quality improvement work is also taking place to increase compliance with antenatal corticosteroids.

Safety action seven: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your maternity voices partnership (MVP) to coproduce local maternity services?

ESNEFT works closely with the North East Essex and Ipswich and East Suffolk MVPs and has met all requirements set out in this standard.

Safety action eight: Can you evidence that maternity unit staff have attended an in-house multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

All requirements set out in this standard have been met by ESNEFT. A local training plan is in place which covers all six required core modules and is made up of the following elements:

- Saving Babies' Lives study day – covering the Saving Babies' Lives care bundle, fetal surveillance in labour and personalised care, with the same programme delivered on each site.
- K2 e-learning – covering fetal surveillance in labour.
- Growth assessment protocol e-learning completed in e-lfh.
- Maternity statutory training study day – covering personalised care and care during labour and the immediate postnatal period. The same programme is delivered on each site.
- PROMPT one day training – covering maternity emergencies and multi-professional training, including neonatal life support. There are minor differences in the programmes delivered at each site, but both still cover all of the required elements.
- Additional newborn life support sessions for neonatal staff.

The other parts of this standard require that >90% of specified staff groups have attended specific elements of the training, within a 12 month period, as follows:

- 90% of each relevant staff group has attended an in house one-day multi-professional training day which includes maternity emergencies.
- 90% of each relevant staff group has attended an in-house one-day multi-professional training day which includes antenatal and intrapartum fetal monitoring.
- 90% of the team who would be involved in the immediate resuscitation of newborns and managing deteriorating newborns have attended in-house neonatal life support training or a newborn life support course starting from the launch of MIS year four in August 2021.

The Trust has evidenced that >90% of each staff group meet the training requirements.

Safety action nine: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

The requirement of this standard is that Board level safety champions present a locally agreed dashboard to the Board quarterly, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues. Staff feedback from frontline champions and walkabouts, minimum staffing in maternity services and training compliance should also be included.

Whilst quarterly reports have been provided and meet the requirements for incidents, themes and actions, minimum staffing and training compliance, there is no written evidence in the November report that issues raised in the engagement meetings and Board level walkabouts have been escalated and discussed at Board.

All other requirements set out in this standard have been met by ESNEFT.

Safety action 10: Have you reported 100% of qualifying incidents under NHS Resolution's early notification scheme from 1 April 2021 to 5 December 2022?

All elements of this standard have been met and the Trust is 100% compliant and reported all eligible cases.

In addition to reporting to Healthcare Safety Investigation Branch (HSIB), there is a requirement that the Trust Board is assured that:

- The family have received information on the role of HSIB and NHS Resolution's early notification scheme.
- Where required, there has been compliance with regulation 20 of the Health and Social Care Act 2008 in respect of duty of candour.

The Trust is also 100% compliant with these elements of the standard.

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.

Emotional resilience training which has been rolled out to all maternity staff using funding from Health Education England. 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 make sure 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.

Charitable funding has been used to buy a new specialist system which means patients who have been unable to have MRI scans in the past can now access the tests under anaesthesia

Emergency care

During the year, building work on the new Urgent Treatment Centre (UTC) and Emergency Department (ED) at Ipswich Hospital has picked up pace. The ED team has been involved in the plans, and is also working with system partners to agree pathways which will ensure patients can access specialty care as early in their emergency journey as possible.

Throughout 2022/23, the ED's clinical skills nurse has worked closely with the nursing team to ensure all training and education needs are met, while a variety of continued professional development modules are also available. Sepsis champions have been identified across the department to increase its focus on the illness and make sure patients can begin potentially life-saving treatment as soon as possible. In addition, all new staff are given a competency booklet and complete a detailed induction programme, which includes the opportunity to experience all areas within emergency care.

Staff in Ipswich have a good relationship with the regional Emergency Care Support Team, who keep them informed of the most up to date improvement opportunities. During the coming year, the team will roll out electronic observations to provide improved oversight of the clinical condition of all patients while highlighting acuity within the ED. This significant step will feed into the electronic patient record which is currently being developed at ESNEFT.

At Colchester, the ED has been redesigned, with work due for completion by April 2023. This will enable staff to care for time critical and life-threatening emergencies in a new resuscitation department, which has more space and new equipment which will help the Trust provide a higher standard of care. Majors capacity is also being increased to make sure our sickest patients are being cared for in the right place, in turn reducing the time they need to wait.

During the first quarter of 2023/24, a new mental health assessment area will open at Colchester. This will help the mental health team, who will be co-located in the ED, to see and treat patients in crisis in a timely manner. It is hoped the project will reduce the time patients wait for a mental health assessment while building our relationship with colleagues in the mental health trust.

NHS Chief Executive Amanda Pritchard officially opens the new Breast Care Centre at Ipswich Hospital during March

ESNEFT performance over the last three years: four hours to discharge from type one and three emergency attendances against a target of 95%

	2020/21		2021/22		2022/23	
	ESNEFT performance	National performance	ESNEFT performance	National performance	ESNEFT performance	National Performance
Apr	90.6%	90.4%	90.6%	85.4%	75%	75%
May	83.4%	91.2%	91.9%	83.7%	78%	76%
Jun	95.8%	92.8%	88.9%	81.3%	75%	75%
July	96.7%	92.1%	82.4%	77.7%	77%	74%
Aug	94.0%	89.3%	77.7%	77.0%	76%	74%
Sep	93.7%	87.3%	81.1%	75.2%	75%	74%
Oct	91.0%	84.4%	78.7%	73.9%	67%	72%
Nov	90.3%	83.8%	78.3%	74.0%	68%	72%
Dec	84.4%	80.3%	74.2%	73.3%	66%	69%
Jan	75.8%	78.5%	76.0%	74.3%	73%	75%
Feb	87.5%	83.9%	74.9%	73.3%	72%	72%
Mar	94.6%	86.1%	74.3%	71.6%	69%	72%
YTD	90.9%	86.8%	80.9%	76.7%	73%	74%

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
2020/21	177,355	90.9%	86.8%
2021/22	238,768	80.9%	76.7%
2022/23	250,238	73%	74%

Stroke care

Performance

During 2022/23, Colchester's stroke team achieved a top level of performance (band A) in the SSNAP (Sentinel Stroke National Audit Programme) national audit, despite facing huge challenges at the front door. In the last seven years, it has consistently achieved a top banding of A, except for two quarters where it scored B.

Innovation

An artificial intelligence system called e-stroke, developed by Oxford-based Brainomix, has been introduced at both acute sites. The technology automatically flags blockages to clinicians to help guide treatment decisions. It also allows the Trust's stroke teams to securely and instantaneously share scans 24/7 with colleagues at specialist centres and gain a second opinion to support fast diagnosis and treatment. This helps to make sure patients who need a procedure called thrombectomy, which is used to remove a clot and is only carried out at specialist sites, can be transferred as quickly as possible.

Therapy

During the past 12 months, the therapy team has:

- Introduced a new volunteer induction programme. Four volunteers now spend time talking or playing games with patients during the week.
- Supported the MDT to upskill band two and three staff and develop their core stroke competencies to promote rehabilitation.
- Begun leading international trials as principal investigators. This includes the AVERT trial, to which four participants have been recruited, in turn meeting our target.
- Worked with the University of Essex to plan research into wearable technology in stroke rehabilitation.
- Developed plans to refurbish the occupational therapy kitchen for assessment and intervention.
- Drawn up plans to introduce secure interactive TV for technology-based rehabilitation.

Nursing

During 2022/23, the nursing team has:

- Completed a variety of courses to enhance their knowledge and skills, including the acute care course, consultation and assessment, diabetes, wound care and acute care.
- Attended a stroke conference in Liverpool to network and enhance their knowledge.
- Attended three team days during the year to develop their stroke-specific skills.
- Took part in a developmental study day for band two and three staff in March and began a developmental programme in conjunction with the therapy team to upskill our band two HCAs.

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 76% of all in-hospital deaths. The HSMR subset represents about 34% 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 December 2022 (data published March 2022)	108.4 - within the ‘higher than expected’ range
HSMR position vs. East of England peers	The Trust is one of seven in the regional peer group of 12 that sit within the ‘higher than expected’ range

<table>
<tr><td></td><td colspan="4"></td></tr>
<tr><td rowspan="5">HSMR diagnosis groups attracting higher than expected deaths</td><td colspan="4">There are three HSMR outlying groups attracting significantly higher than expected deaths:</td></tr>
<tr><td>Group</td><td>Relative risk</td><td>Number of deaths</td><td>Number of ‘expected’ deaths</td></tr>
<tr><td>Acute bronchitis</td><td>141.8</td><td>53</td><td>37</td></tr>
<tr><td>Pneumonia</td><td>116.7</td><td>444</td><td>380</td></tr>
<tr><td>Septicaemia (except in labour)</td><td>119.8</td><td>287</td><td>240</td></tr>
<tr><td>HSMR weekday/weekend analysis</td><td colspan="4">Both weekday and weekend emergency HSMR is ‘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 (12 months to November 2022)</td><td colspan="4">Published SHMI = 1.0931 ‘as expected’ (band two)

The percentage of patient deaths with palliative care coded during their admission was 39% – NHS England 40%</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 coding and clinical review to better understand whether there are any issue with data quality and clinical care pathways.

The SHMI for ESNEFT for the 12 months ending November 2022 was 1.0931 (band two), in the ‘as expected’ banding. NHS Digital states that ‘a higher than expected’ number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a ‘smoke alarm’ which requires further investigation. Similarly, an ‘as expected’ or ‘lower than expected’ SHMI should not immediately be interpreted as indicating satisfactory or good performance.

The HSMR for the 12 months to December 2022 was 108.4, ‘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 has resulted in an unprecedented increase in hospital mortality. 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 104.4 and is deemed marginally ‘higher than expected’.

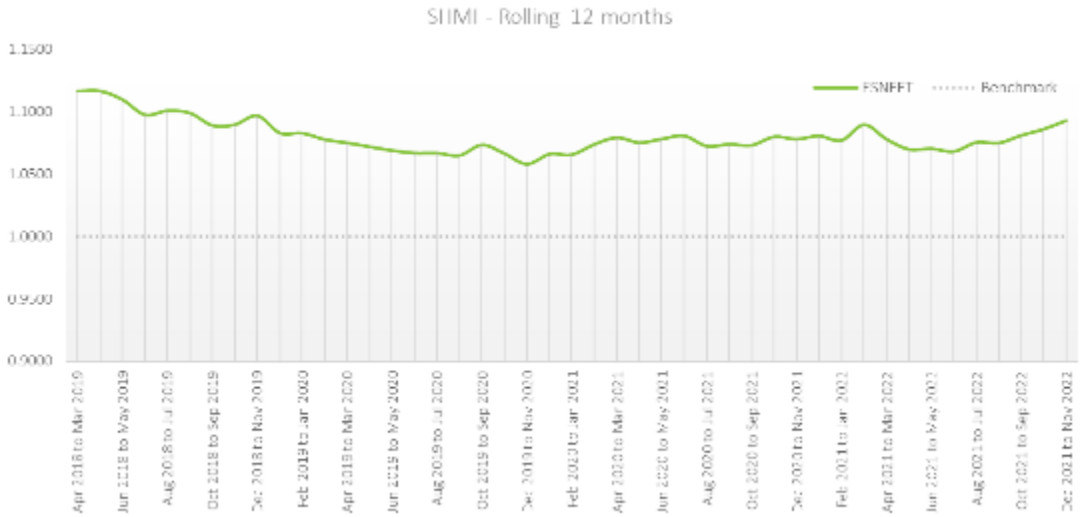
We are committed to eliminating avoidable harm and improving patient outcomes and have carried out the following actions to improve quality of our services, HSMR and SHMI.

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’.
- Using a new escalation ‘safety net’ for outpatients attending clinics and being identified as requiring urgent triage and admission.
- Employing a number of care pathways for conditions such sepsis, pulmonary embolism and COPD so that patients are diagnosed and treated quickly. Following audit, a new AKI tool has been launched with education.
- Following GIRFT (Getting it Right First Time) recommendations and learning to improve services and develop future pathways.
- 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 clinical coding and the themed review of health records to ensure that documentation is representative of the care provided and of a high standard.
- Ensuring that incidents concerning patient care are fully investigated using PSIRF (Patient Safety Incident Reporting Framework), including those identified during mortality reviews; and the learning shared to improve patient safety and experience.
- Developing new interactive e-learning packages and sim-training (simulation-based training) to increase learning and engagement. In addition, in-house videos are being made accessible for staff to access learning at a time convenient to them.
- Continuing to measure performance against national benchmarks.

Preparing a patient meal

SHMI trend



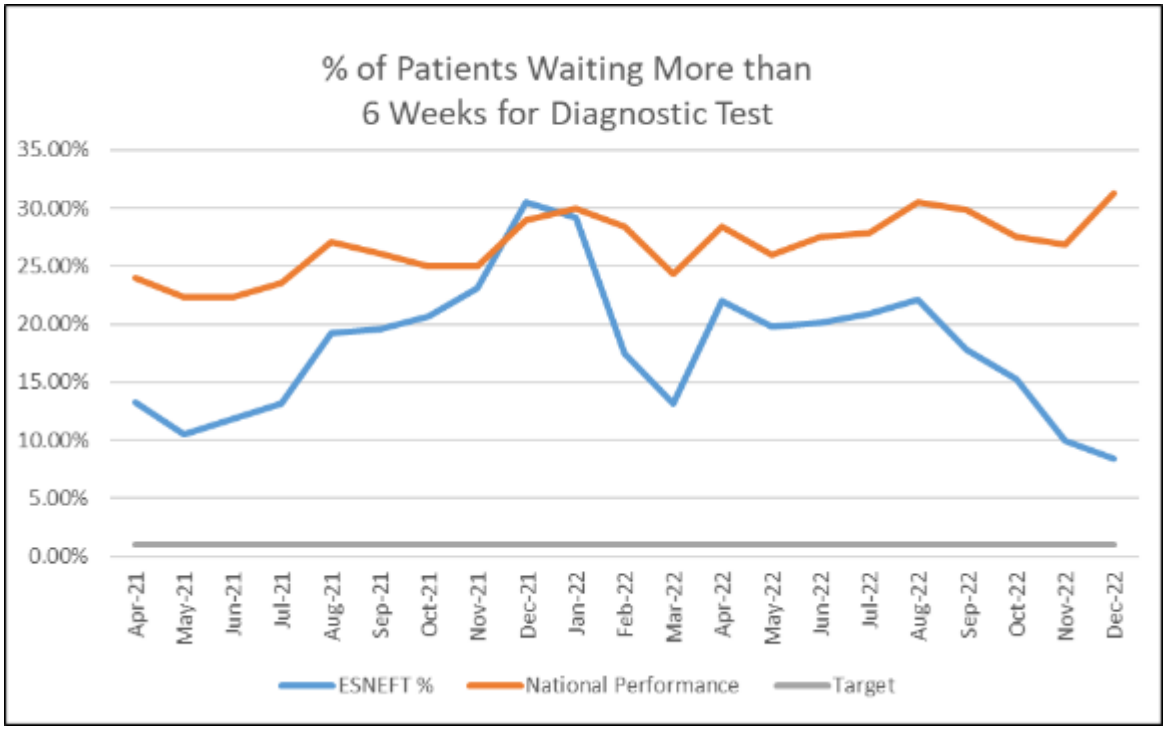
The ICENI Centre at Colchester Hospital

Waiting times for diagnostics and procedures

At times during the COVID-19 pandemic, we found it challenging to fully deliver to our maximum efficiency. As a result, the percentage of patients waiting more than six weeks for a diagnostic test increased, reaching a peak in December 2021 when we exceeded the national average.

Since then, our services have been operating to an extremely high, highly efficient standard well below the national average. Current performance indicators indicate that ESNEFT is now operating within the NHS 2025 standard of 5%, and aims to maintain this output.

Percentage of patients waiting more than 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%

	2020		2021		2022	
	ESNEFT performance	National average	ESNEFT performance	National average	ESNEFT performance	National average
January	0.97%	4.42%	17.71%	33.34%	29.16%	30.00%
February	0.42%	2.76%	17.50%	28.46%	17.50%	28.46%
March	2.70%	10.19%	13.16%	24.29%	13.16%	24.29%
April	35.39%	55.74%	13.24%	24.03%	21.96%	28.40%
May	46.36%	58.46%	10.56%	22.30%	19.76%	26.01%
June	32.26%	47.82%	11.85%	22.38%	20.14%	27.48%
July	24.89%	39.60%	13.14%	23.51%	20.91%	27.90%

August	22.93%	38.04%	19.22%	27.12%	22.08%	30.51%
September	18.18%	33.05%	19.61%	26.09%	17.80%	29.84%
October	12.30%	29.22%	20.67%	24.98%	15.24%	27.50%
November	11.24%	27.52%	23.09%	25.02%	9.97%	26.87%
December	9.78%	29.17%	30.49%	29.01%	8.44%	31.28%
End of year position	**9.78%**	**29.17%**	**30.49%**	**29.01%**	**8.44%**	**31.28%**

Life-sized mannequins, known as whole-body phantoms, have been introduced at ESNEFT to allow students to simulate the radiotherapy pathway

Clinical standards for seven-day hospital services

The NHSE seven-day services programme is designed to ensure that patients admitted as an emergency receive prompt, high quality, consistent care, whatever day and whatever time of day they are admitted to hospital.

The programme identifies 10 clinical standards, of which four are deemed high 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 was a national requirement for all NHS 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 and national guidance was updated in 2022. The focus has changed from an audit-dependent model to a wider review including triangulation with clinicians' job plans, clinical incidents and continuous improvement.

As part of our clinical effectiveness programme, we have chosen to focus on the two key elements this year – standards two and eight:

- **Standard two – time to first consultant review.** All emergency admissions to be seen and receive a thorough clinical assessment by a suitable consultant within 14 hours from the time of admission.
- **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. Diagnostic activity has now returned to pre-pandemic activity. 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.** We were unable to audit standard six during the year to determine if all nine standards were met. Audits will take place in the coming year to determine any gaps.
- **Standard eight – ongoing senior review and shared decision-making.** A minimum of a daily senior review, seven days a week, unless there is documented evidence of an appropriate delegated review/alternative frequency review plan. Evidence should be documented that patients and their families have been made aware of review outcomes and management plans.

Review plan

The review will initially focus on 11 wards at our two acute hospitals:

- Ipswich Hospital wards: Lavenham, Stour, Kesgrave, Shotley and Somersham
- Colchester Hospital wards: Wivenhoe, Mersea, Stanway, Langham, Nayland and West Bergholt

The Trust will use an audit tool based on the national template used in previous audits which reviews patient care during the first six days of admission. The results of this audit will be discussed by our Quality and Patient Safety Committee in 2023/24.

Celebrating the completion of the first phase of our children's department redevelopment in November

End of life care

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

A national framework for action (Ambitions for End of Life Care 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

In the last year, we have refreshed our end of life strategy based on the above ambitions. We have played an active role in the North East Essex End of Life Alliance and the Ipswich and East Suffolk End of Life Alliance to improve services across our communities. We also input regularly into the ICS End of Life Group.

We continue to actively monitor complaints. Between January 2021 and December 2021, we received 31 end of life care complaints, which is the equivalent of 1.7 % of the total number of deaths. Between January 2022 and December 2022, this increased slightly to 35, which equates to 2.4% of total deaths. We have completed two six-monthly thematic reviews of complaints and the consistent theme is communication. As a result, we have increased the communication skills training which is offered to staff and rolled out a tool to support patients and carers called "How can I support you?"

During 2022/23, we also expanded our butterfly volunteer service to cover five days on both acute sites and also offer support at the community hospitals.

In addition, we have been actively involved in the ICS plan to roll out the ReSPECT tool for emergency treatment plans, with the launch taking place in March 2023. We continue to be involved in plans to have an electronic palliative care register in Suffolk.

Our chaplaincy service

Patient, family, carer and visitor support

ESNEFT's chaplains provide high quality pastoral, spiritual and religious care for all patients and their families and carers, as well as visitors to our hospitals. They focus on offering person-centred, individualised care through active listening and being a non-judgemental, accepting presence on wards and in departments across the whole Trust. The chaplains also provide a 24-hour on-call service for all of ESNEFT's hospitals.

The chaplaincy team is made up of the head of chaplaincy, six Trust chaplains, two bank chaplains and a small number of volunteers, and has this year recruited a Muslim honorary chaplain and a Humanist honorary chaplain. All chaplains take part in continuous professional development, with two chaplains currently studying for their PgCert in chaplaincy studies and one having just submitted their masters' dissertation.

At the request of patients, families, carers, and visitors, chaplains provide the following:

- Bedside meditation, prayer and holy communion
- Audio cubes with faith or belief texts and music
- Wooden comfort crosses and hearts
- Non-religious and religious end-of-life ceremonies, services, baptism and blessings for babies, children and adults
- Non-religious and religious funerals (mostly for babies but also some adult-related funerals)
- Support with calls or video calls to family, friends and faith or belief community representatives
- Livestreaming weddings or funerals at the bedside or in the chapels
- Faith and belief texts and other pastoral, spiritual or religious resources
- Emotional support with PALS and complaints cases
- Emergency marriages, civil partnerships, renewal of vows and wedding and same sex relationship blessings

The chaplains also work with the bereavement midwives at Ipswich and Colchester hospitals to arrange ESNEFT's annual 'remembering precious babies' services.

This year's theme was 'feathers', as many of the parents whose babies have died have described feathers appearing in unexpected places at unexpected times, bringing comfort that their baby or loved one is safe and sending them a feather to bring reassurance and hope.

The chaplains provide a weekly Sunday service on Hospital Radio Colchester and take part in ‘pause for thought’ on the Sunday breakfast programme on Hospital Radio Ipswich. They also arrange a Christmas carol service and daily reflections over the festive period for both hospital radio stations.

Some of the themes emerging in conversation with patients, relatives, carers and visitors in 2022/23 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 and conversation about the legacy they will leave.
- **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, legacy conversations, emergency marriage or civil partnerships, renewal of vows and relationship blessings.
- **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 and livestreaming funerals at the bedside.
- **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.

Chaplaincy volunteers

During 2022/23, the chaplains have been working with voluntary services to enable chaplaincy volunteers to return safely to the wards following COVID-19. All chaplaincy volunteers have undergone refresher training, completed their mandatory training and signed their volunteer agreement, and began returning to the wards in February.

Our volunteers are required to abide by the UK Board of Health Chaplains Code of Conduct and receive supervision from the chaplains, with regular one-to-one and group reflection on practice sessions, along with an annual review. The chaplains are now beginning to recruit new volunteers and will run the first post COVID-19 pandemic chaplaincy volunteer training course in early 2023/24.

Staff and volunteer support and education

In addition to care of patients, relatives, carers, and visitors, chaplains provide significant support to volunteers, students and staff, which in turn contributes to improved patient experience. Themes that have been explored with these groups during 2022/23 include bereavement and loss, illness, significant life changes, concerns about mental health and relationships at home and at work. HR issues, continuing professional development, revalidation, workplace trauma, stress, work pressure, moral injury, spirituality and religion, bullying, harassment and ethical dilemmas have also been discussed.

The chaplains are trained in mental health first aid and psychological first aid, and when requested provide psychological first aid debriefs for individuals and teams who have experienced a traumatic incident at work. They also meet with all international nurses before their OSCE exams to provide pastoral support and encouragement.

Chaplaincy and IT have worked together to livestream staff funerals so that colleagues can pay tribute to those who have died in service. They have also facilitated a number of staff memorial services with the family's knowledge and permission, including for Dame Clare Marx. Sadly, our chaplains also supported a team where a colleague died to suicide, and worked with them and the family to plan and conduct the funeral.

In addition, chaplaincy provided support following the death of Her Majesty Queen Elizabeth II, coordinating books of condolence and providing prayers and reflective resources for staff and visitors to all ESNEFT sites.

Chaplaincy had significant involvement in interfaith week this year and attended an EEFA conference in Ipswich, which explored the challenges of becoming more inclusive in a diverse society with its many faiths and beliefs. The conference focussed on the values of wisdom, humility, openness, transparency and meeting people heart-to-heart which should underpin all chaplaincy work.

Within the Trust, chaplaincy hosted presentations from the Jehovah's Witness Hospital Liaison Committee and Faiza, our Muslim honorary chaplain, on how to best support patients from these communities. Colleagues from the UK Sikh Chaplaincy Group also led the annual Sikh prayer day session at Colchester Hospital.

During the year, chaplaincy hosted a number of students on placement from regional theological colleges, local parishes and from the PgCert in chaplaincy studies run by Guys and St Thomas's Hospitals. One student said: "Thank you so much … for providing me with such a wonderful placement. I felt really sad to leave today but also so grateful for the opportunities and experiences I have had… it's such a privilege to work with your team and experience hospital chaplaincy. Thank you for growing the chaplaincy seed that I have, making me feel so welcome and for all the encouragement you have given me."

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 inductions, hub and spoke training, Butterfly volunteer training and cancer education programmes for HCAs and oncology nurses. 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 2022 to February 202)

Patient and carer/ family encounters:

- 6,282 patients visited and 2,250 hours of support provided.
- 2,831 carers/family members supported and 462 hours of support provided.

Staff encounters:

- 5326 staff members supported and 635 hours of support provided
- 24 debriefs conducted

Funerals:

- 113 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
- Nine Trust-related adult funerals
- One funeral for a staff member

Emergency marriages:

- Four emergency marriages
- One same sex relationship blessing
- One wedding blessing
- One renewal of marriage vows

Baptisms:

- Two baptisms – one baby and one adult

Plaudits and thanks

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

- “Thank you so much for the lovely service you led for baby D and her dear mummy and daddy. It was beautiful. I thought the three candles were perfect. My daughter and I have talked about the grieving process following miscarriage and it was so important to her to include her previous miscarriages in the service for baby D. Your attention to baby D when reading to her was so touching for me as M's mum. Today, we spent the day with M and J working in their garden. They are ‘on the mend’ and although I know it will take time, I feel sure the kindness and understanding you have shared with them, has helped enormously in this process.” – **grandparent of baby, April 2022.**

- “During the last days of my nan’s life we requested a chaplain to visit her … and as a family we wanted to thank him for bringing us some much needed comfort at a very difficult time. He left us two wooden hearts, one for my nan to hold and keep after she passed away and another for myself so that I could stay connected with her. I still have the wooden heart now and it sits next to a photo of my nan at my home. His kind words really meant so much and we will be forever grateful for him taking the time to come and see us and my nan.” – **granddaughter of a patient, June 2022.**

- “I cannot thank (the chaplain) enough for his kindness and advice. I have not seen or spoken to my wife since June 30, but he understood my worries and concerns. Today he has made me a very happy man and also I hope my wife by taking the time to visit her armed with a phone which enable us both to speak. No one will ever know what that act of kindness means to me or my wife. In life we sometimes are blessed to come in contact with outstanding people, and I thank God we have with this chaplain.” – **patient’s husband, July 2022.**

- “Huge thanks to the chaplaincy team for all the care and support to make our baby’s funeral and naming ceremony so special, and for the support given to us as bereaved parents. Your impact will forever be remembered and appreciated.” – **bereaved parents, August 2022.**

- “Every day you and your team touch the lives of our patients, their loved ones, staff colleagues and volunteers. The work that you all do is invaluable and never more so when times are hard. I wanted to thank you for the extraordinary work you are all doing at this time to support patients and colleagues distressed and upset by the passing of Her Majesty The Queen. Your attention to detail in the beautiful prayer cards and order of services, the condolence sheets and the candles, and the personal support you are giving to us is so appreciated. You are the embodiment of our Trust values, kind, optimistic and appreciative in all circumstances.” – **Chief Executive, August 2022.**

- “I wanted to thank you for taking the time to talk to me. At the time I was experiencing a crisis with my mental health, and I found being in hospital under the circumstances difficult. As a Christian it was a great comfort to be able to talk and pray with you. Thank you for treating me with respect and being non-judgemental.” – **patient, September 2022.**

- “The chaplains … deserve so much credit for the work they do. They visited us before mum’s death and were such a comfort. The chaplain was exactly the person we needed to see at the time … so empathetic, sympathetic, comforting, intuitive, respectful, insightful and wise. We will never forget the time the chaplain spent with us in the hours following mum’s death and I cannot begin to imagine what that period

would look like without their calm, loving presence in the room." – **patient's daughter, October 2022.**

- "Thank you so much for all your help, support and guidance you have given me. I became a Muslim just over seven weeks ago and I am so happy. I have found where I need to be spiritually and feel extremely blessed." – **staff member, October 2022.**

- "Thank you for your support and input with the students who have sought help from the chaplaincy. Whether it has been for a traumatic clinical event or for other pastoral reasons the students have been consistent in sharing how 'excellent' and 'magic' you were in their time of need. You adapted your skills and experiences according to the person in front of you, for that we know you have made a difference." – **Pre-reg practice education facilitator team, December 2022.**

- "I want to express my gratitude to the chaplains for their visits and the comfort they gave to my mum, and us a family, when she was so poorly during her stay on Kesgrave ward. The chaplain's kindness and support meant so much to us all. Mum is now home and doing well. A huge thank you to your wonderful team – you made such a difference!" – **patient's daughter, December 2022.**

- "Very sadly my darling mother died last night**.** I just wanted to say how much she and I enjoyed meeting you and the support and love from chaplaincy in her last week meant so much to us both." – **patient's daughter, January 2023.**

Caring for people with dementia

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 2022, we recruited two dementia specialist support workers – one based at Ipswich Hospital and one at Colchester. Under the supervision of our dementia specialist practitioners, they provide support for carers including signposting to community services. They also help patients and their carers to complete "This is me" and encourage care homes to send in patient's care plans on admission. In addition, they provide one-to-one support in line with complex healthcare planning to assess our patient's needs and to provide a level of familiarity and consistency in environments which people living with dementia may find challenging.

A rolling monthly audit of "This is me" began in January 2023 on our care of the elderly wards alongside quarterly audits on all inpatient wards. The results will be fed back quarterly through the Safeguarding Committee and directly each month to clinical teams and divisions, alongside offers of support with training where improvements could be made. The outcome of the audits and factors which support improvement will also be shared within the Dementia and Delirium Steering Group and Patient Experience Group.

The Trust is continuing to work with the integrated care board to increase the use of care home and nursing home care plans to share information which will help hospital staff to meet the individual needs of the patient during an admission. This will reduce the risk of omissions in care arising while providing consistency and an improved patient experience.

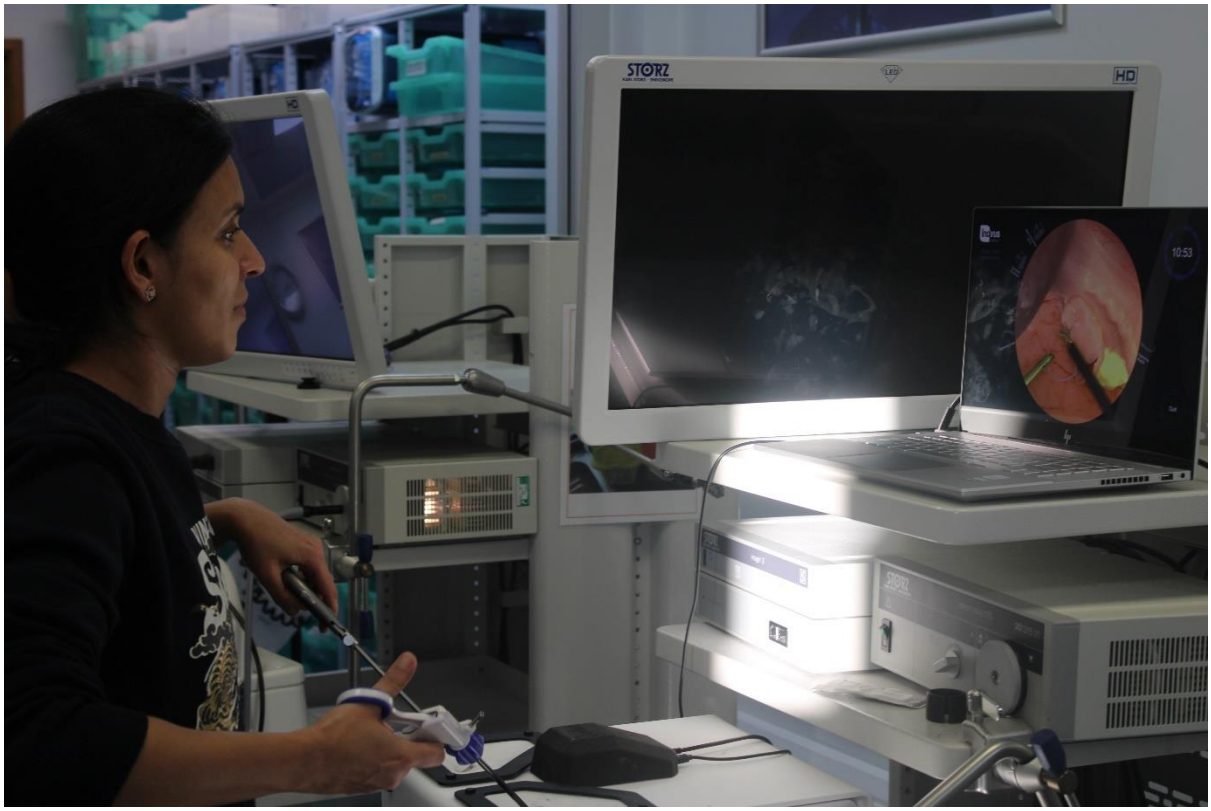
During 2022/23, a page was added to the ESNEFT website to signpost patients and carers to our dementia specialist nurses, as well as community support for carers and national dementia charities. We are also continuing to update our intranet page to make sure that staff have access to information which will help them support patients and their families.

The Mini Ace cognitive assessment tool has now been introduced across our sites following agreement from the Dementia and Delirium Steering Group. The 4AT screening tool, which is already in place at Ipswich, is also being rolled out to Colchester to improve the identification and treatment of delirium.

During the year, we replaced our 'dementia champions' with a new role of 'cognitive champions'. The aim of his role is to build confidence among the staff who are providing care to these patients, in turn improving their outcomes. Further work will take place in 2023/24 to discuss the teaching and support which will be required to help further develop our cognitive champions over the coming year.

We have continued to use Datix reporting to help identify common themes for people living with dementia. This has highlighted that people with dementia are more likely to be involved in falls, and experience tissue viability issues and incidents of aggression as a result of confusion and distress due to environmental difficulties. To help address this, our dementia specialists have been liaising closely with the Trust's leads for falls and tissue viability to enable a joined-up approach to training and assessment. We have also worked with the complex health team to develop a half-day training package to support clinical staff who are responding to distressing behaviours, which includes the use of de-escalation techniques.

Elsewhere, we have begun a quality improvement project to introduce activity trolleys across inpatient area to give patients access to resources which will help improve their wellbeing and reduce boredom. Ongoing work to source appropriate items and secure funding for the project is now taking place.



Laparoscopic surgery simulation training

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 serve and believe that involving people who use our services in co-design and co-production is 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.

Throughout the reporting year, we continued to collaborate with our communities and respond to their feedback and concerns. Whilst we recognise that more needs to be done, we are proud of the progress we made during 2022/23 to address issues that are important to local people.

ESNEFT Friends and Family Test recommender scores 2022/23 (percentages)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ED	82.35	81.48	77.87	79.77	83.52	82.73	78.32	79.47	77.14	87.77	81.59	78.24
Inpatient	90.61	91.84	92.26	92.43	91.56	91.28	91.29	92.18	92.230	92.83	93.22	92.93
Outpatient	93.27	93.18	92.98	93.88	93.51	93.75	93.00	93.89	94.17	94.14	94.17	94.22
Antenatal	88.89	100.00	100.00	88.89	90.91	88.89	100.00	95.54	93.10	100.00	100.00	100.00
Birth	100.00	100.00	100.00	100.00	50.00	100.00	96.77	96.00	97.50	94.74	100.00	79.17
Postnatal ward	81.25	96.55	100.00	94.12	100.00	95.56	97.08	93.75	96.97	96.34	95.56	93.33
Postnatal community	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Our Patient Experience team

Some of the work that has been carried out by the Patient Experience team during 2022/23 includes:

- Forming a working group – which included patient representatives and members of our Council of Governors – to develop our patient experience, carers and co-production strategy for the next five years. This will be shared with clinical teams, the Patient Experience Group and Quality and Patient Safety Assurance Group for further comment and then published on our website.

- Launching the 15 Steps programme. This sees patient representatives, complainants, governors and Board members visit different parts of the Trust and provide feedback, which is also shared at the Patient Experience Group.
- Beginning a series of informal visits to give Board members and governors the chance to speak to staff and patients at our acute hospitals and community sites.
- Involving patient representatives in PLACE (Patient-Led Assessments of the Care Environment), which take place alongside the Estates team.
- Sharing patient and staff stories either in person or via video links at every Board and Patient Experience Group meeting.
- Working with our acute hospitals, Healthwatch and learning disability ambassadors to improve the patient experience.
- Working with external agencies to create a carers handbook to support patients, their carers and Trust staff.
- Holding recruitment drives to attract more service users to attend our user groups so that we can listen and engage with patients and carers to embed improvement and change.
- Continuing to hold regular coffee mornings with our patient representatives.
- Holding a complaints workshop which looked at how we communicate with patients who provide feedback. A revised letter template has been produced as a result and divisions are making courtesy calls sooner to offer meetings to patients and their loved ones. This helps us provide immediate support while reducing the time it takes to complete an investigation. Initial feedback has been incredibly positive.

Engagement throughout 2022/23

We have continued to engage with patients, carers, the public and our communities during 2022/23. Examples include:

- **Dame Clare Marx Elective Orthopaedic Centre project** – a focus group which included patient representatives and was led by a clinical lead has continued to meet. Feedback from the patients has been very positive, and they said the Trust made them feel welcome throughout the process. They have actively been involved with designs and making changes to benefit future patients.

- **Engaging with our multi-ethnic communities** – we have continued to work with Suffolk County Council's public health engagement teams 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 help us 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. We hope the project will also improve health inequalities within these communities.

- **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 when new services are developed or service improvements made. This also supports partnership working across the system.

Patient and public involvement and community engagement

Throughout the year, we have developed ongoing projects with our patients, carers and families, and through our patient and public panels.

These activities have been led by the Patient Experience and Engagement teams and include the following programmes. Some of these projects are ongoing over a number of years and some are shorter term pieces of work:

- Elective Orthopaedic Centre at Colchester Hospital
- Children's Department at Ipswich Hospital
- Breast Care Centre at Ipswich Hospital
- Virtual wards programme
- Review of the work of cancer clinical nurse specialists
- Developing our upcoming Patient Experience Strategy
- The 15 Steps programme
- Tammy Tours visits
- Recruitment to patient panels
- Relaunch of our patient app
- Sharing patient stories at both public and private Board meetings
- Engaging with less heard groups
- Involving patients in new building projects and service improvements

We asked the public membership of our foundation trust to help us determine the priorities for our nursing, midwifery and AHP strategy, as well as our quality priorities for 2023/24.

Feedback from patients 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.

Prince William meets staff at Ipswich Hospital's Emergency Department

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 or community services. 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.

Between 1 April 2022 and 31 March 2023, we received 1,424 complaints compared to 1,217 during 2021/22. Of these, 78.26% were responded to within the 28 working day (or an agreed revised) timeframe.

Every effort is made to contact each complainant by the end of the next working day once the complaint has been logged. These 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 to help us respond thoroughly and in a meaningful way.
- Gain insight to understand the key issues that need to be resolved.
- Help build relationships with the complainant so that they feel part of the process while demonstrating 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, 92.9% of courtesy calls were completed.

Following receipt, 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

2020/21	Communication Access to treatment or drugs Aspects of care
2021/22	Communication Access to treatment or drugs Aspects of care
2022/23	Communication Access to treatment or drugs Patient care

Reopened complaints

During 2022/23, 145 complaints 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.

Reopened complaints are generally resolved with either a face-to-face meeting or a further letter of response.

Complaint response training will begin in June 2023 in order to ensure more robust investigation and response.

Complaints to the Parliamentary and Health Service Ombudsman (PHSO)

ESNEFT received a total of 20 contacts from the PHSO between 1 April 2022 and 31 March 2023. Of these contacts, seven were an enquiry only, seven were assessed but not taken further into an investigation, two were fully investigated yet not upheld and four are currently open and under 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 learning 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 from 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:

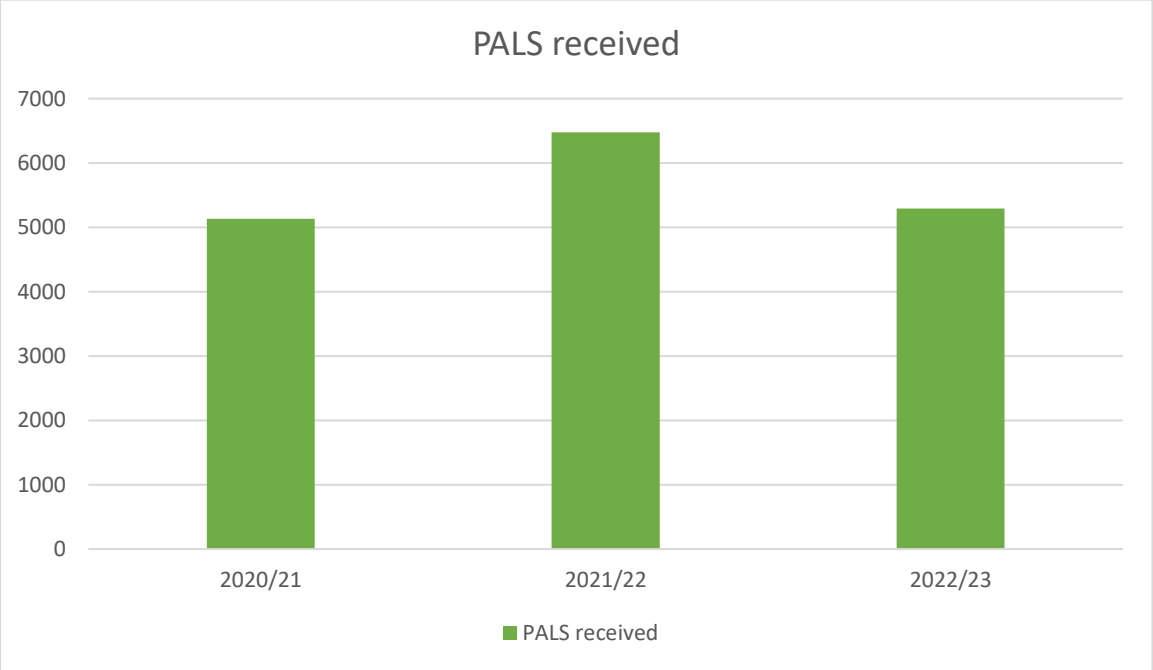
- Advice and signposting: helping to navigate the hospital and its services.
- Compliments and comments: PALS can pass on compliments and ideas to improve services.
- Addressing non-complex issues informally, often preventing the need to raise a formal complaint.

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

- **PALS one:** Contacts which 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



The number of PALS contacts in 2022/23 stood at 5,291, which is a reduction of 18.32% when compared with 2021/22, when we received 6,478 contacts.

Compliments

The Trust received 10,279 compliments between 1 April 2022 and 31 March 2023. Compliments were received in several forms, including letters, cards, gifts, emails and through the local press. Where staff are named they are, where possible, informed to help boost morale and improve their experience at work.

Number of plaudits received by ESNEFT during 2022/23

Month	Number received
April 2022	577
May 2022	1,620
June 2022	1,121
July 2022	623
August 2022	1,539
September 2022	712
October 2022	759
November 2022	721
December 2022	1,324
January 2023	554
February 2023	367
March 2023	362
Total	**10,279**

More than 200 patients have benefitted from being operated on using robotic technology at ESNEFT over the last two years

Patient-led Assessment of the Care Environment (PLACE)

Patient-Led Assessment of the Care Environment (PLACE) restarted in 2022. The assessments took place in October, November and December, with the team working around COVID-19 in the various wards and departments. As many trusts faced challenges carrying out the assessments due to ongoing restrictions, NHS Digital extended the window for submitting results on two occasions.

PLACE was introduced in 2013 to replace Patient Environment Action Team (PEAT). It is the annual appraisal of a range of non-clinical aspects of a hospital or healthcare facility made by patient assessors in conjunction with Trust staff. The patient assessors are volunteers who use our services, while the Trust is represented by the Estates and Facilities departments, which are responsible for the majority of the non-clinical services such as cleaning and maintenance. The assessments are carried out in both the NHS and independent healthcare sector.

PLACE assessments are led by patients, which means the results reflect their perspective of the non-clinical aspects of care and how they impact on patients, their families and carers. Aspects of the assessment include:

- how clean the environment is
- what condition the environment is in, both inside and outside the hospital
- how well the buildings meet the needs of the people using them
- the quality and availability of food and drinks
- how well the environment protects people's privacy and dignity
- whether the hospital buildings are equipped to meet the needs of people with dementia
- whether the hospital is able to meet the needs of people with disabilities.

As the national results for 2022 have not yet been published, it is not possible to compare ESNEFT's scores with neighbouring trusts or the national average. However, the table overleaf indicates how each inpatient site was scored and how they performed against the Trust as a whole.

The sites which were assessed were Colchester, Ipswich, Felixstowe and Aldeburgh hospitals, plus Bluebird Lodge in Ipswich, the Fryatt Hospital in Harwich and Clacton Hospital.

PLACE assessors

The role of the assessor is to be a critical friend. It requires people who are unbiased and objective who can:

- assess what matters to patients and the public
- report what matters to patients and the public
- ensure the patient/public voice plays a significant role in determining the outcome

At least half of the assessment teams should be made up of patient assessors working alongside someone from the Facilities team, such as the hotel services manager, a matron or infection control nurse. Teams are always accompanied by a scribe who records observations and scores throughout the day. Anyone who takes part in the assessments is offered training each year.

Scope of the assessment

At both acute hospitals, a minimum of 25% of the wards (or 10, whichever is the greater) and a similar number of non-ward areas must be assessed. This allows the PLACE team to make informed judgements about those parts of the hospital it does not visit.

As community sites are generally much smaller, the whole site is assessed.

The assessments aim to:

- Include all buildings of different ages and conditions.
- Include departments/wards where a high proportion of patients have dementia or delirium.
- Include an assessment of the food on offer to patients on the day of the assessment which takes into account temperature, appearance, taste and texture.
- Include an assessment of the external aspects of the site including grounds and gardens, signage and wayfinding.
- Consider how accessible the hospital is to people with various disabilities.
- Consider the patient environment and how clean it is, ensuring that areas where patients are not permitted, such as sluice rooms, waste holds and kitchens, are not included.

Each team makes the final decision on which patient areas they will inspect, but must ensure that the wards and areas chosen reflect the range of services and buildings across the hospital.

Scoring

Scores are based on what is observed at the time of the assessment and are based on how the site on how it delivers against the defined criteria and guidance.

To achieve a pass, all aspects of all items must meet the definition/ guidance as set out in the assessment criteria. A qualified pass is awarded when the criteria are generally met, but there may be a minor exception, for example one wall in a ward is not up to the required standard.

Timescales

PLACE assessments must be carried out between September and the end of November, with individual trusts able to decide when they will go ahead. At ESNEFT, the assessments will be carried out at the same time every year.

Once they receive their results, trusts must formally respond to the assessments and develop plans for improvement. ESNEFT's action plan which will be reviewed quarterly.

Results

The results of the PLACE assessments were submitted in December 2022 and will be published in spring 2023. The scores achieved by the different hospital sites are detailed in

the below), along with the Trust average score. Sites which achieved higher than the average have been detailed in green, with those which are lower, detailed in red.

Location	Cleanliness	Food	Privacy and dignity	Condition, appearance and maintenance	Dementia	Disability
Colchester	98.1%	80.2%	80.1%	96.1%	68.8%	68.2%
Ipswich	95.7%	82.9%	72.8%	92.2%	69.1%	68.3%
Aldeburgh	99.4%	90.1%	93.6%	94.1%	92.6%	95.0%
Bluebird Lodge	98.6%	86.1%	72.0%	84.4%	80.3%	80.1%
Felixstowe	98.8%	92.4%	73.6%	88.4%	74.2%	79.3%
Fryatt	99.6%	91.7%	81.1%	99.6%	91.4%	89.4%
Clacton	98.8%	77.4%	80.8%	97.9%	76.2%	79.9%
Trust average	**97.2%**	**82.2%**	**77.0%**	**94.3%**	**70.7%**	**70.2%**

Areas identified for improvement as a result of the assessments include making sure:

- colour is used effectively to enhance patients orientation/coordination, for example by painting doors and bays in different colours
- there are accessible areas for washing and toilet facilities for parents, relatives, guardians or carers that stay overnight (they do not have to be on the ward)
- day rooms/social space is provided on wards and are appropriately furnished
- the 'dementia friendly' ward and department programme is extended
- wi-fi is available in public areas
- finger foods are available for specific groups of patients
- patients have access to a lockable storage space
- there is a large, accurate and silent clock clearly visible in all patient areas

The Director of Estates and Facilities will report the results of the assessments to the Trust Board once they have been published. We will also review our PLACE action plan to take into account all sites and the actions required to comply with the PLACE assessment criteria.

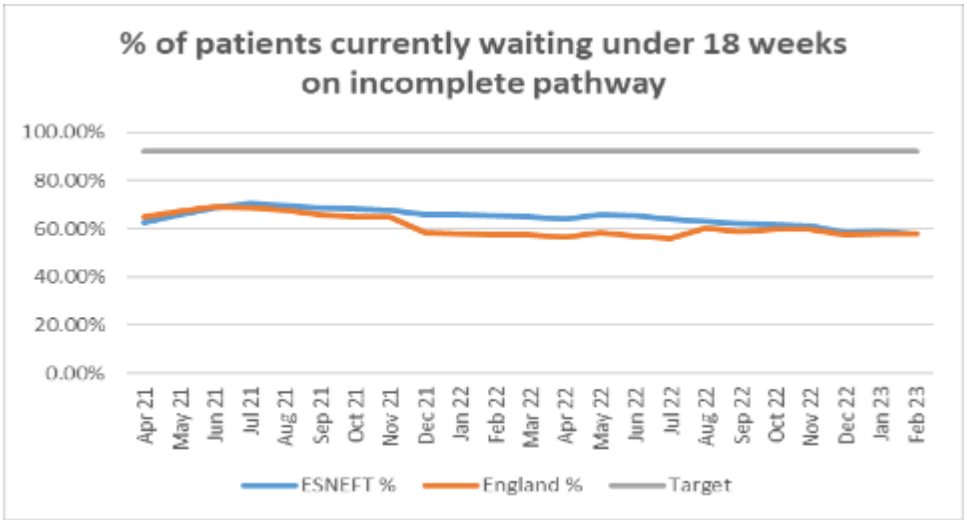
Conclusion

Some of the changes made during the pandemic have had an adverse impact on the environment. ESNEFT will use innovation and introduce further changes to increase the scores in specific areas as required.

Continued investment in the patient environment via the ward refurbishment program in our acute hospitals, along with the introduction of a refurbishment programme at our community sites, will contribute significantly to ensuring that PLACE results improve in future years.

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 an incomplete pathway against a target of 92%

	2020/21		2021/22		2022/23	
	ESNEFT performance	National average	ESNEFT performance	National average	ESNEFT performance	National average
April	65.1%	65.2%	62.7%	64.7%	64.00%	56.60%
May	58.8%	56.9%	65.8%	67.5%	65.96%	58.34%
June	49.0%	47.7%	68.9%	68.9%	65.21%	57.08%
July	65.2%	79.7%	70.4%	68.5%	63.84%	55.92%
August	49.3%	49.3%	69.8%	67.8%	63.29%	60.33%
September	56.4%	55.8%	68.7%	65.8%	61.97%	58.96%
October	63.4%	60.2%	68.2%	64.9%	61.81%	59.66%
November	66.4%	62.6%	67.7%	64.8%	61.26%	59.59%
December	68.0%	67.6%	66.0%	58.2%	58.37%	57.55%
January	65.2%	60.8%	65.7%	57.8%	58.63%	57.84%
February	62.7%	59.0%	65.5%	57.6%	58.00%	58.01%
March	61.1%	58.9%	64.92%	57.46%	N/A	N/A

Cancer performance

Ensuring that patients who are referred to our hospitals on a suspected cancer pathway are diagnosed as quickly as possible and receive timely and effective treatment remains a key priority for the Trust. Improving our cancer performance whilst still in the post-COVID-19 recovery phase has presented additional challenges, particularly in terms of the volume of suspected cancer referrals received, as referrals have increased on average by 35% since February 2020.

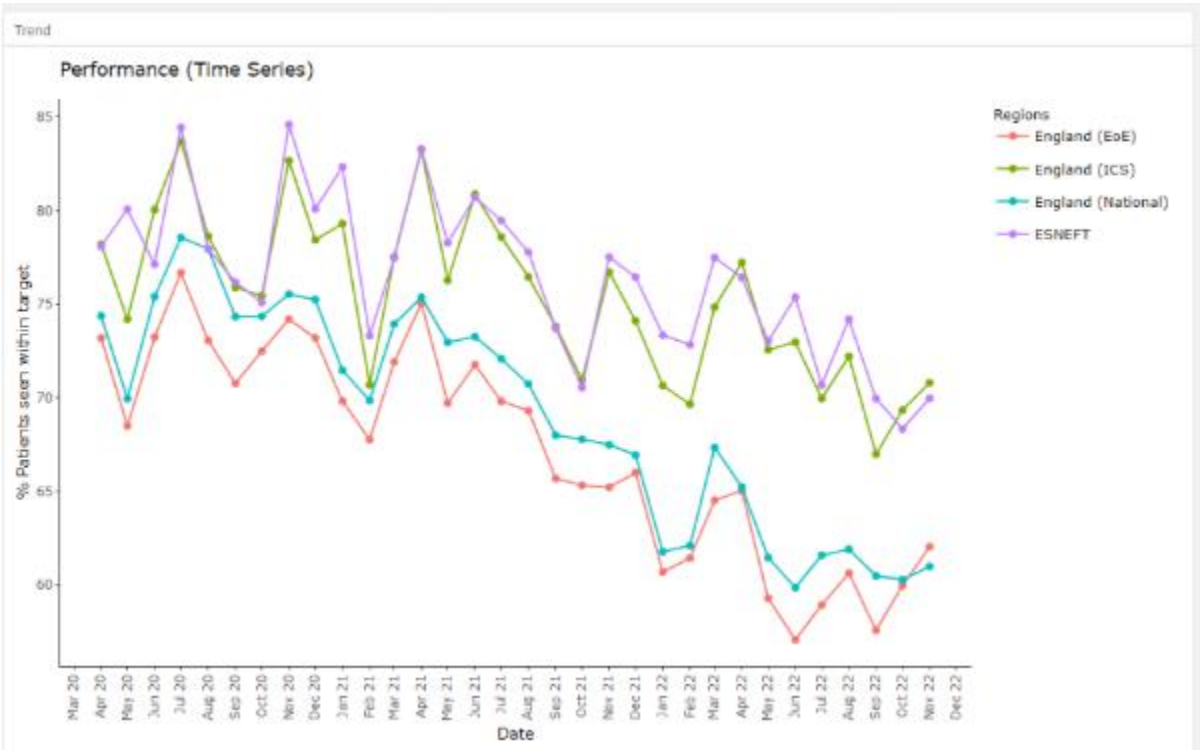
This increase has sometimes delayed first appointments and diagnostic waiting times, particularly for patients referred on colorectal, breast or skin pathways as these areas have seen the greatest numbers of patients referred. This reflects the national picture and as such, the national cancer recovery plan and cancer planning guidance for 2023/24 focuses on supporting trusts and primary care to improve referral pathways and processes.

Delayed appointments and increased waiting times can be upsetting and frustrating for everyone, and particularly for people referred in on a suspected cancer pathway. We have worked hard this year to ensure that where delays have occurred, additional capacity was created as quickly as possible but we acknowledge that in some areas that has taken longer than we anticipated.

As 2022/23 draws to a close, waiting times for a first appointment have significantly improved and those improvements will continue throughout 2023/24.

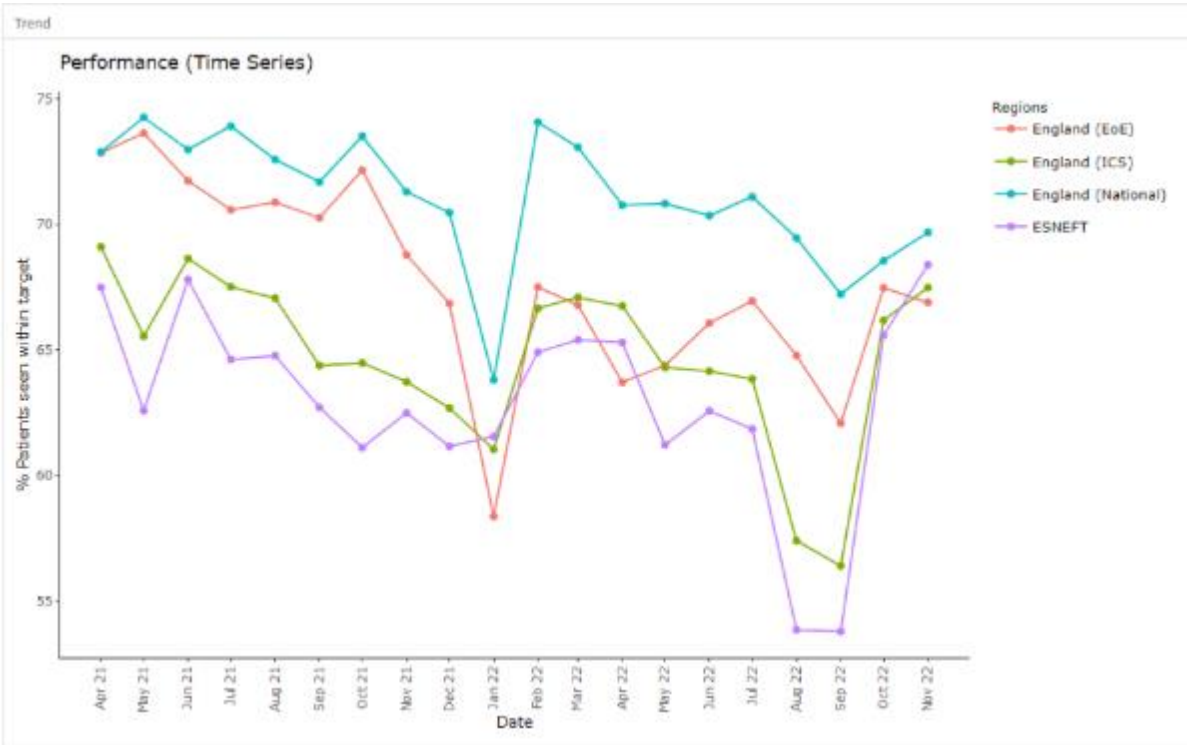
62-day standard (85%) waits by month

ESNEFT has continued to out-perform the national trend.

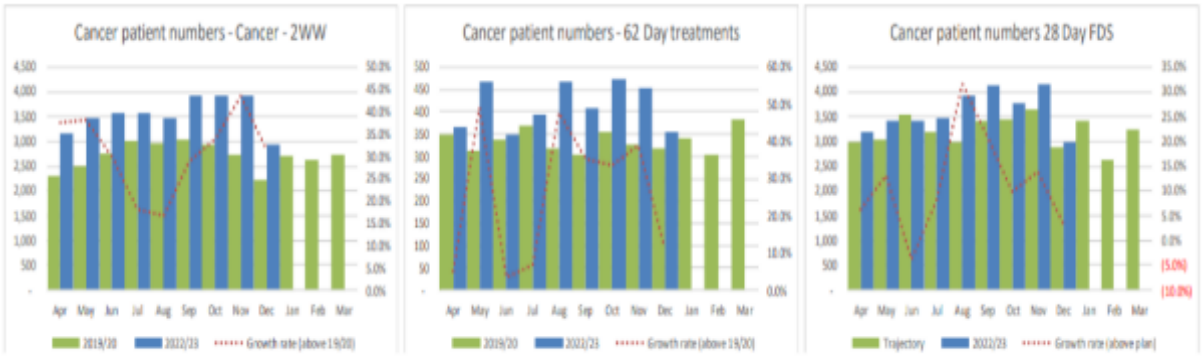


28 (day) faster diagnosis standard (75%) – waits by month

The overall trend is downwards nationally. ESNEFT's performance improved in Q3 and Q4.



Growth in patient numbers – 2019/20 and 2022/23



Referrals

Cancer - 2WW	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	2,307	2,516	2,755	3,015	2,971	3,050	2,937	2,733	2,226	2,718	2,636	2,721
Trajectory	na	na	na	na	na	na	na	na	na	na	na	na
2022/23	3,176	3,472	3,578	3,563	3,468	3,930	3,931	3,921	2,926			
Var.	869	956	823	548	497	880	994	1,188	700			
Growth rate (above 19/20)	37.7%	38.0%	29.9%	18.2%	16.7%	28.9%	33.8%	43.5%	31.4%	#N/A	#N/A	#N/A

The Trust's 62-day performance (treating patients diagnosed with cancer within 62 days) remains higher than both national and east of England performance but remains below the standard of 85%

Nationally NHS England has taken a back seat approach to performance outcomes this year, placing the emphasis on reducing the cancer backlog – and particularly the longest waiting patients – and returning activity levels to pre-COVID-19 numbers.

NHS England's priorities and operational planning guidance for the year set out the objectives for the recovery of elective services. The directive to deliver 'complete recovery and improve performance against cancer waiting time's standard' had two main objectives for cancer:

- **Return the number of people waiting for longer than 62 days to February 2020 levels (based on national average in February 2020).** For ESNEFT, this number is 185 from a starting point of more than 500, equating to 12% of the total cancer PTL. Trust final position was 211 patients, reducing our backlog to just 6% of PTL and achieving joint top position in the region in terms of overall cancer backlog recovery.

- **Meet the increased level of referrals and treatment required to reduce the shortfall in the number of first treatments**. ESNEFT had already met this requirement, having returned to pre-COVID-19 levels of activity by the end of 2020/21. Activity has continued to increase throughout 2022/23.

As we were already working at pre-pandemic levels and above, our focus throughout the latter part of the year has been recovering performance at specialty level. Cancer recovery plans are in place and updated via a weekly highlight report and presented by service leads at the cancer recovery meeting. This meeting, chaired by the Director of Operations, ensures that executive level support is in place to help overcome the more challenging barriers to delivery.

As additional recovery support, the cancer performance team hold daily Red2Green meetings with the most challenged tumour sites. This enables the operational teams to work through daily escalations in a 'today's work today' approach, which has significantly helped the speed at which we have been able to reduce the waiting list backlog.

Patient safety remains a priority for the Trust, which is especially significant when considered in relation to the recovery of performance against national standards. By clinically triaging referrals within 24 hours – and particularly in the specialties with significant increase in referral numbers – we have been able to safety net those patients with significant red flag symptoms and prioritise where necessary.

Reducing the number of patients waiting more than 62 days on a cancer pathway, achieving the 28 day faster diagnosis standard, improving overall cancer performance and ultimately patient experience will be our main priorities during 2023/24.

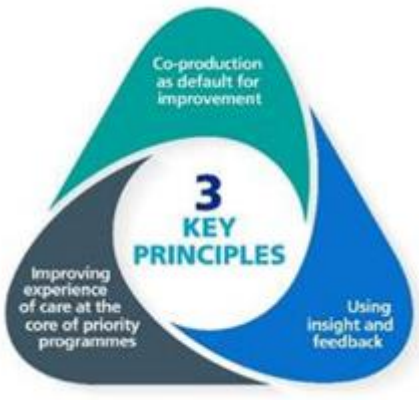
Highlights of 2022/23

During 2023/24, we made several key improvements made to our cancer services. These included:

- Successfully recruiting into a number of long-term consultant radiologist and pathologist vacancies which has helped reduce the waiting and reporting times for diagnostic pathways.
- Launching the ESNEFT breast pain pathway, which is a fast-track specialist service for patients with breast pain but no other cancer signs or symptoms.
- Opening the new Breast Care Centre at Ipswich Hospital to provide state of the art facilities and equipment while increasing capacity and improving the experience of patients.
- Launching of the skin analytics service in dermatology which uses artificial intelligence to provide 'first read reporting' of teledermoscopic skin lesion images. This allows clinical teams to discharge those patients with benign lesions (no cancer) quickly, reducing the waiting times for patients who require further treatment.
- Opening two new non-site specific clinics at Felixstowe and Clacton, which are able to provide clinical diagnostic support to primary care for patients whose symptoms are vague in nature and do not meet cancer referral criteria, but about which the GP has concerns. These clinics can fast-track access to certain diagnostics and refer to the relevant hospital specialty if required.
- Increasing the diagnostic capacity at Clacton Community Diagnostic Centre, with all main diagnostic modalities now available. This is significantly reducing the need for people living in the Tendring area to travel to Colchester.
- Introducing a same day CT service for the non-site specific clinics in Clacton, allowing patients to have diagnostics completed on the day of their first appointment, negating the need to attended further appointments and improving the time taken to receive a diagnosis.
- Introducing an 'experience of care' survey for patients referred to a non-site specific clinic so that we can use patient feedback to continue to improve.
- Reviewing the gynaecology pathway to reduce the number of days before a first appointment.
- Improving the ESNEFT-developed cancer dashboard TRACE to enable more efficient and effective tracking. This has improved clinical appointment and diagnostic turnaround times.
- Reducing the number of patients waiting longer than 62 days on a cancer pathway.
- Expanding our pre-diagnosis clinical nurse specialist-led service to support patients who may, for a variety of reasons, have a delayed pathway of care before they have a confirmed diagnosis of cancer. This can be anything from providing clinical support to people with multiple co-morbidities to carrying out diagnostic tests with patients who are too anxious to attend appointments.

Experience of cancer care

Nationally, NHS England has prioritised patient and carers' experience of care, treatment and support alongside clinical effectiveness and safety in the delivery of high quality cancer care. Within ESNEFT, we work with service users and system partners across primary care, as well as the charity and voluntary sectors, and follow the three guiding principles of co-production. This uses insight and feedback to drive improvement and ensure that all plans and programmes aim to improve the experience of care and tackle health inequalities.



We continue to take a caring, holistic and compassionate approach to the delivery of personalised care and support based on what matters most to patients, at the right time and the most suitable place for the individual.

Our achievements during 2022/23 include:

- **The national cancer patient experience survey (CPES)**
  Most recent data, published in July 2022, demonstrated ESNEFT was within or above the expected range for all questions. Areas that scored above the national average included being given information about a key contact person and systemic anti-cancer treatment, feeling able to discuss worries and fears and administration was efficient. Due to changes in how questions were asked, it was not possible to make comparisons to previous years. However identified areas for improvement include support for late effects of treatment and consistency in how difficult news is explained with sensitivity.

- **Cancer Patient Panel**
  Our Cancer Patient Panel follows the principles of co-production and uses insights from service users to make meaningful improvements for our population, and has grown in membership over the past year. Its actions link to the CPES findings and have included the development of patient and carer voices videos to support newly-diagnosed patients, as well as an education resource for staff on the impact of breaking bad news sensitively. The group, which reports to our Cancer Board, is also building a repository of 'buddy' support available to enhance access to peer support.

- **Cancer clinical nurse specialist (CNS) workforce review**
  In February 2023, phase two of the Macmillan-funded cancer CNS workforce review was completed. This took into account CPES insights, as well as patient feedback. Taking forward key workforce recommendations will be a focus for both the Trust and wider system throughout 2023/24. This program of work aims to develop a skilled, resilient workforce based on the current and future meets needs of patients in the context of a modern NHS.

- **Developing 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 specialties. 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

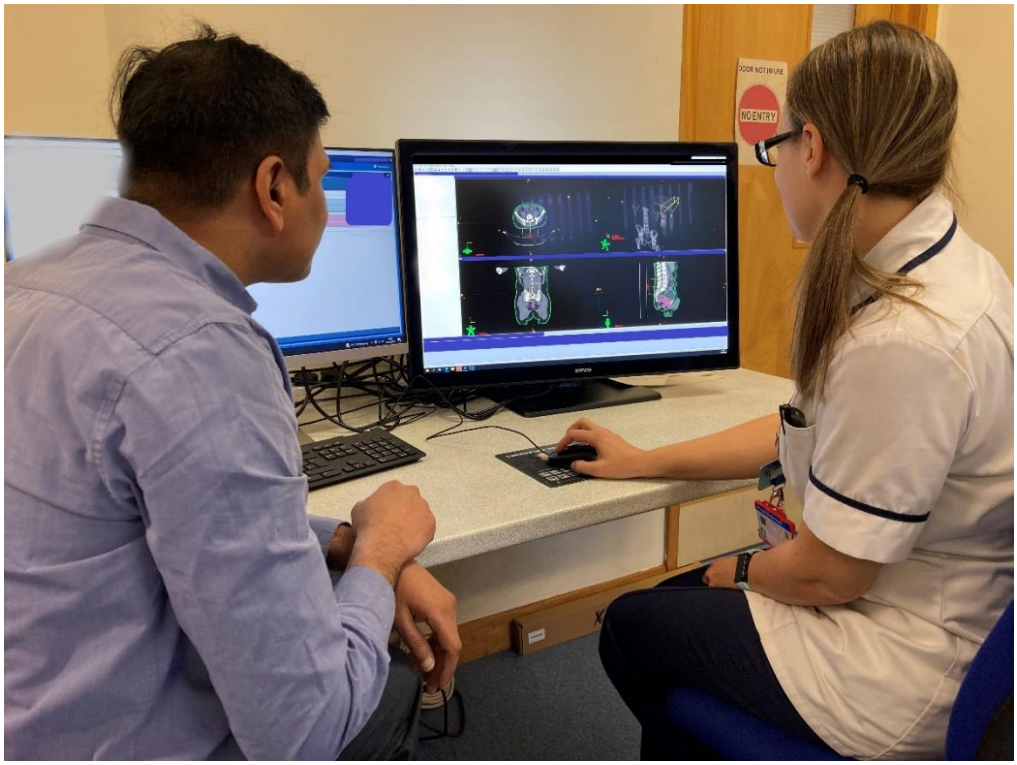
  The initiative has been registered as a quality improvement project and a full evaluation will be carried out with support from the University of Suffolk. Videos showcasing our patients have also been produced to help promote the benefits of taking part.

- **Digital pre-rehabilitation**
  We are working in partnership with ONKO to offer patients access to online health optimisation support with the aim of reducing treatment complications and leading to better quality of life outcomes.

  Currently all breast, colorectal and upper GI patients are offered the programme. During 2023/24 we will be scoping a universal offer so that all cancer sites have the opportunity to access this service.

- **Quality of life**
  We have an established Quality of Life Steering Group, with a working group focusing on analysing data and planning how we can use the results to improve services and patient experience. We are working closely with NHS England and NHS Digital to pilot further functionality and begin to integrate this work with other transformation projects.

- **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 have implemented a digital system which enables tracking and robust surveillance of patients. Our focus will move to thyroid and endometrial cancers during 2023/24.



Three new specialist monitors have been funded by the research team for use in radiotherapy at Ipswich Hospital

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 receiving 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.

In keeping with a “Think Family” approach to safeguarding, ESNEFT supports patients, families and staff by maintaining an integrated model to reach across divisions. The team consists of specialists in maternity, child and adult safeguarding who work across our hospitals and the community. We continue to have strong working relationships with our partners across the integrated care system including health, social care and police. This ensures that there is a coordinated and transparent approach to enabling safe and proportionate strategies for protection and prevention of harm through neglect and abuse.

The team has started to provide joint child and adult safeguarding supervision for staff to enable and support thinking about the impact of safeguarding concerns across families and age ranges. We have also developed training opportunities which allow holistic thinking when concerns are raised regarding individuals. In the last year, we have developed additional training to support newly qualified practitioners during preceptorship and started to provide training and information sessions for students undertaking placements within the Trust. This supports our goal to raise our team’s profile to strengthen staff understanding of their responsibilities in relation to safeguarding.

The safeguarding team continues to work closely with complex health colleagues to provide effective and seamless care for patients who may require support from both teams. In the last year we have also introduced two posts to support the work of our learning disabilities nurses. Colchester has introduced a learning disability associate practitioner role, which has increased the level of at the bedside support people with learning disabilities receive to help their independence, safety and familiarity when receiving inpatient care. In Ipswich, a trainee learning disabilities advanced clinical practitioner post has been introduced to work within our community teams to help reduce the number of preventable admissions for people with learning disabilities.

In 2022/23, we worked with the Ministry of Justice to introduce an independent domestic violence advocate post in Ipswich. This role provides an additional layer of support for patients who disclose experience of domestic abuse while ensuring effective communication with partner agencies to enable safety planning. The postholder has also supported staff who have asked for advice in relation to their own experiences of domestic abuse. The funding for this post has now been extended to 2025.

The team continues to work with partners to support preparedness for the implementation of Liberty Protection Safeguards (LPS), although nationally the date for this has been delayed. Work is also taking place to strengthen understanding of the Mental Capacity Act and how to assess of mental capacity across ESNEFT through a tailored audit and training programme.

As a result of learning from safeguarding concerns, we have introduced a process at Ipswich Hospital to ensure that patients who are subject to section 42 enquiries have a discharge meeting ahead of leaving hospital. This has enabled stronger processes to ensure the individual’s safety. We also hold regular meetings with colleagues from social care across both sites so that we can respond to safeguarding factors which are impacting upon patient’s wellbeing in a timely way.

Reporting

The safeguarding and complex health team provide quarterly reports and an annual report to the Trust. These include 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.

As part of our work around improving discharges, we have continued to chair a discharge forum. At Ipswich Hospital, a process has been introduced to ensure that where individuals are subject to safeguarding enquiries in relation to their safety upon discharge, a formal meeting is undertaken to enable multi-agency communication to manage this safely and effectively.

The adult safeguarding team has continued to carry out audits and provide training to support improved understanding and compliance with the Mental Capacity Act. This will ensure that where deprivation of liberty occurs, the appropriate legal frameworks are applied and necessary assessments made. This ongoing work is vital in preparing ESNEFT for the introduction of liberty protection safeguards, which has been delayed nationally but will require all organisations to have increased responsibilities and accountability.

ESNEFT has become one of only six centres in the UK to begin using the latest microwave ablation technology, which offers pinpoint treatment for complex tumours

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. This will help us to make ESNEFT a positive and trustworthy place to work and receive care.

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top. At ESNEFT, support from senior management has continued to be excellent, with concerns addressed and action taken.

Our vision statement is: “Role modelling by leaders is essential to set the cultural tone of the organisation. Leadership has the biggest impact on how staff behave and actions speak louder than words. Staff take their cues on how to behave from the behaviour, decisions and communication style of their leadership. So, as a leader, it is essential that we embody the culture and behaviours that we want to see.”

Tom Fleetwood has been ESNEFT’s Freedom to Speak Up guardian for the last five years. He meets monthly with both the Wellbeing guardian and the Director of Workforce, is a member of the Wellbeing Steering Group and is one of the four quarters of our Wellbeing Hub. He is also a member of the Equality, Diversity and Inclusion (EDI) Steering Group, briefs our bi-monthly Staff Partnership Forum and takes part in staff inductions. Our guardian has encouraged the Board to complete the latest self-reflection tool, which will help to:

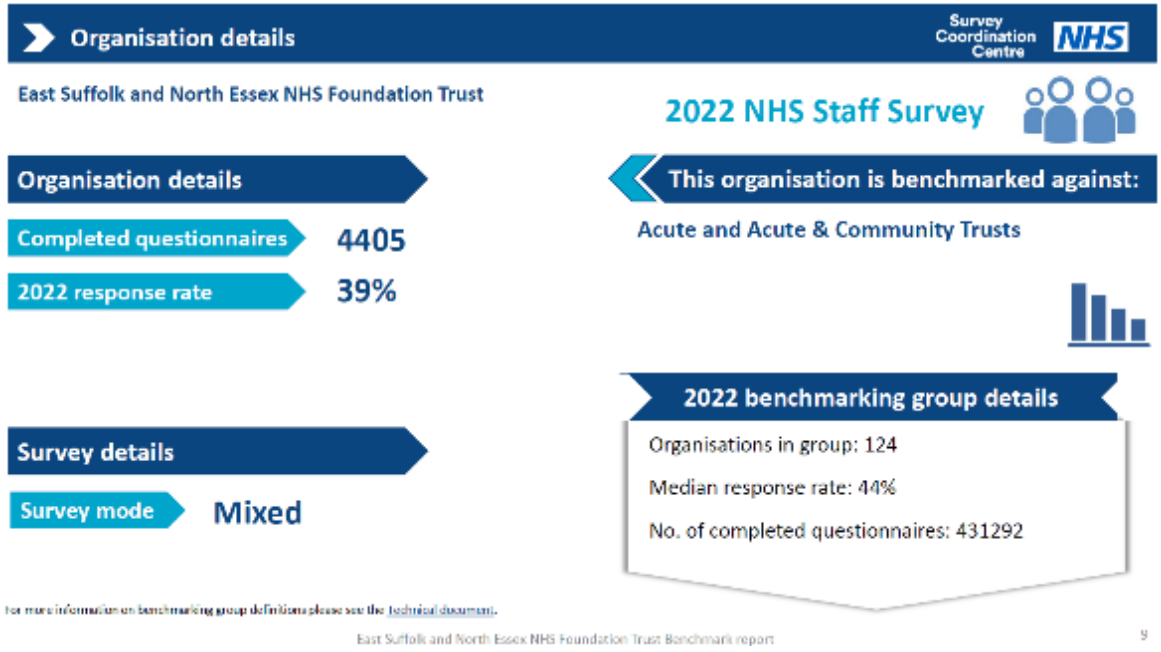
- build a culture that is responsive to feedback from staff
- ensure that ESNEFT focuses on learning, to continuously improve the quality of care we provide and the experience of our staff, patients and service users
- improve staff survey scores and other staff experience metrics
- demonstrate to regulators or inspectors the work we are doing to develop our speaking up arrangements

The guardian role is wide-ranging and complex. Not only does it involve responding to staff who speak up and supporting them, but it also requires the guardian to work with peers across the region. ESNEFT’s guardian is an original member of the East of England Group, which meets quarterly and includes input from the National Guardians’ Office.

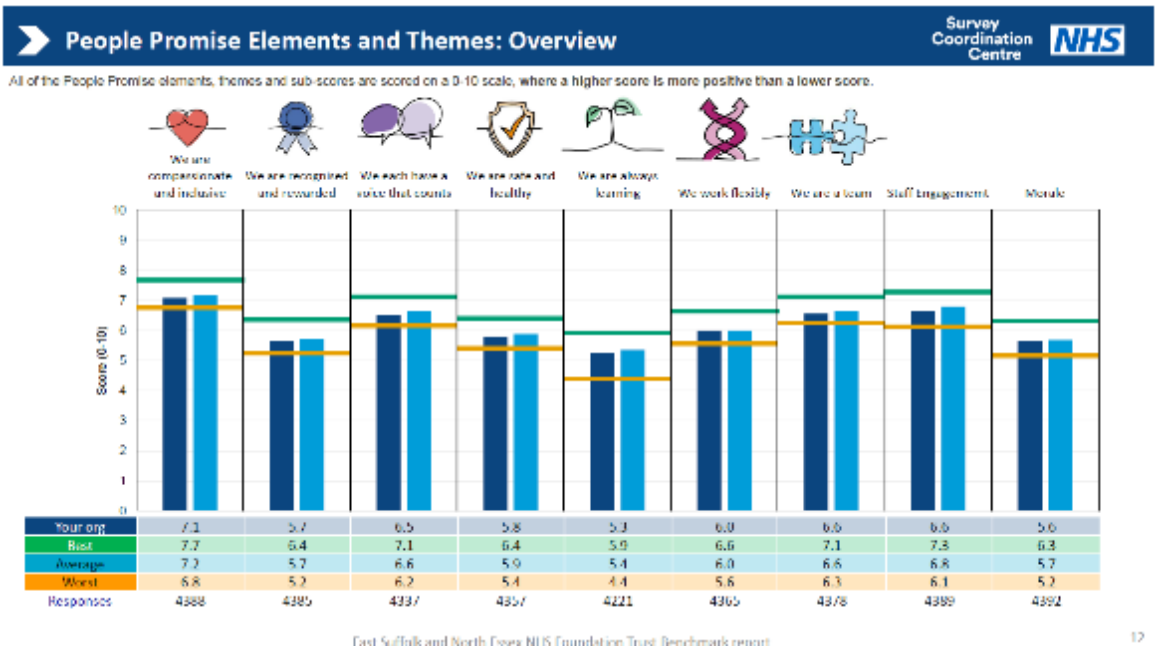
However strong an organisation’s speaking-up culture, there will always be some barriers to speaking up. Finding and addressing these barriers is an ongoing process. At ESNEFT, staff networks provide a place for people to come together and share their experiences. It is therefore crucial that the guardian builds strong connections with all staff networks as part of the work to understand the barriers some people face to speaking up. The very purpose of staff networks is to make a difference, so working with them to co-create solutions is the right way forward.

NHS Staff Survey

The NHS Staff Survey 2022 was snt to 11,339 staff across ESNEFT. A total of 4,405 people completed the questionnaire, which equates to a 38.8% response rate. This compares to 5,063 in 2021/22 (49%) and 4,547 in 2020/21 (45%).



Nationally, the staff survey is aligned with the NHS People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience. The promise is made up of seven elements and our results against each of the themes are shown below:

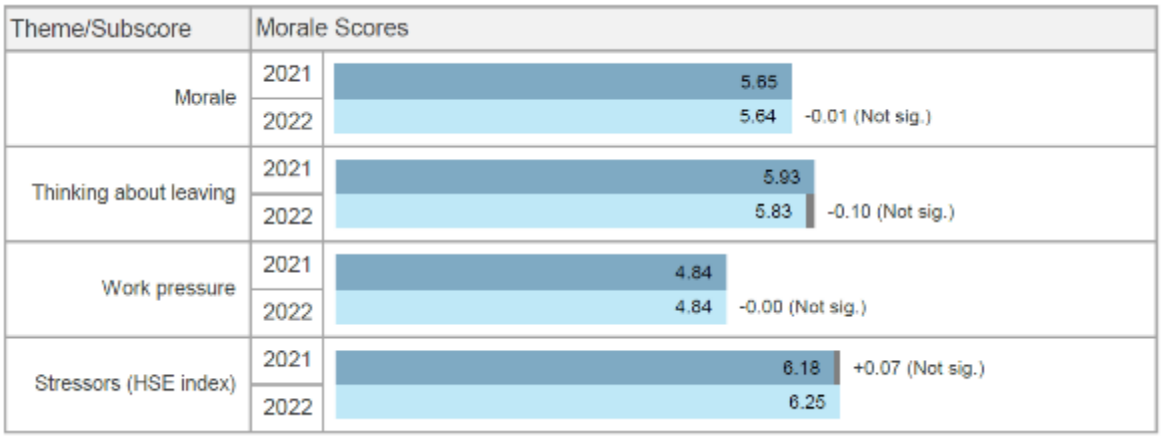


Staff engagement and morale

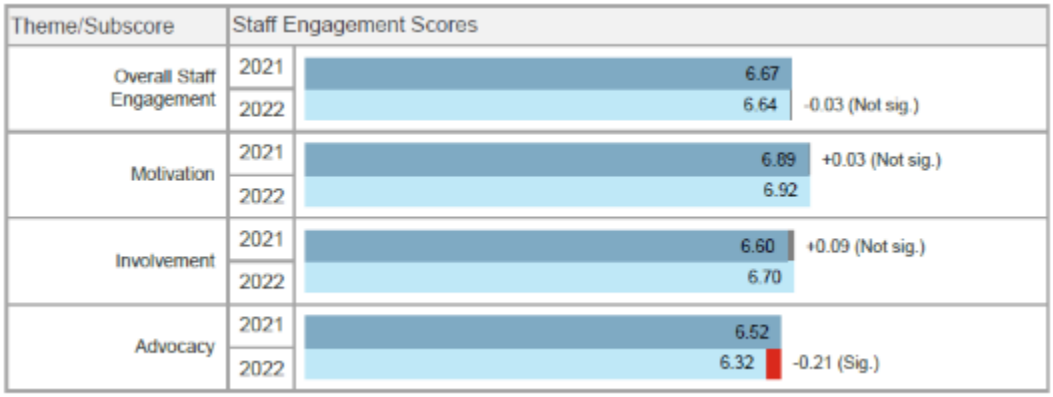
- We have made significant improvements in 19 questions and significant declines in seven.
- We have broadly comparable results to those of other acute and community trusts who took the survey with Iqvia.
- Our morale and engagement scores remain in line with last year.

Morale subscores

Presented below are the scores for each of the subscores which make up the morale section. Scores from 2021 have also been included for comparison. The percentage difference between the 2021 and 2022 scores is represented by the coloured gap between the bars. Significant differences between the years have also been identified.



Engagement subscores



Significantly better scores

Question		2021	2022	Difference
3a	I always know what my work responsibilities are.	85.3%	86.8%	+1.5%
3e	I am involved in deciding on changes introduced that affect my work area / team / department.	45.0%	47.9%	+2.9%
3f	I am able to make improvements happen in my area of work.	50.4%	52.7%	+2.3%
6b	My organisation is committed to helping me balance my work and home life.	40.0%	42.1%	+2.0%
6d	I can approach my immediate manager to talk openly about flexible working.	64.6%	66.9%	+2.2%
7a	The team I work in has a set of shared objectives.	70.5%	72.3%	+1.8%
7b	The team I work in often meets to discuss the team's effectiveness.	51.8%	55.2%	+3.5%
7g	In my team disagreements are dealt with constructively.	52.5%	55.4%	+2.9%
8b	The people I work with are understanding and kind to one another.	67.9%	70.4%	+2.5%

11c	During the last 12 months, I have felt unwell as a result of work related stress.	48.8%	45.5%	-3.3%
16c05	Experienced discrimination on grounds of disability.	8.8%	5.2%	-3.6%
21a	In the last 12 months, I have had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.	85.3%	87.7%	+2.4%
21b	The appraisal / review helped me to improve how I do my job.	16.0%	19.3%	+3.3%
21c	The appraisal / review helped me agree clear objectives for my work.	25.8%	29.9%	+4.1%
21d	The appraisal / review left me feeling that my work is valued by my organisation.	24.6%	27.4%	+2.8%
22b	There are opportunities for me to develop my career in this organisation.	49.6%	52.9%	+3.3%
22c	I have opportunities to improve my knowledge and skills.	63.0%	65.8%	+2.8%
22d	I feel supported to develop my potential.	47.4%	50.0%	+2.7%
22e	I am able to access the right learning and development opportunities when I need to.	48.2%	51.7%	+3.6%

Significantly worse scores

Question		2021	2022	Difference
4c	I am satisfied with my level of pay.	31.8%	24.4%	-7.4%
11d	In the last three months, I have come to work despite not feeling well enough to perform my duties.	55.1%	58.6%	+3.5%
19a	I would feel secure raising concerns about unsafe clinical practice.	74.6%	69.0%	-5.6%
19b	I am confident that my organisation would address my concern.	54.0%	51.8%	-2.2%
23a	Care of patients / service users is my organisation's top priority.	70.1%	67.6%	-2.5%
23c	I would recommend my organisation as a place to work.	53.9%	51.0%	-2.9%
23d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	62.9%	57.5%	-5.4%

Top 10 scores

The top 10 scores for the Trust are shown below. EDI and wellbeing feature positively, while the results show that staff are having appraisals:

1	13b	In the last 12 months, I have personally experienced physical violence at work from managers.	0.8%
2	13c	In the last 12 months, I have personally experienced physical violence at work from other colleagues.	1.6%
3	16c04	Experienced discrimination on grounds of sexual orientation.	2.8%
4	16c03	Experienced discrimination on grounds of religion.	3.6%
5	16c05	Experienced discrimination on grounds of disability.	5.2%
6	16a	In the last 12 months, I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	8.1%
7	16b	In the last 12 months, I have personally experienced discrimination at work from a manager / team leader or other colleagues.	8.6%
8	3b	I am trusted to do my job.	91.0%
9	21a	In the last 12 months, I have had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.	87.7%
10	3a	I always know what my work responsibilities are.	86.8%

Bottom 10 scores

However, the bottom 10 scores clearly show that appraisal quality requires further work:

1	21b	The appraisal / review helped me to improve how I do my job.	19.3%
2	5a	I have unrealistic time pressures (Never / Rarely).	21.2%
3	3i	There are enough staff at this organisation for me to do my job properly.	23.2%
4	4c	I am satisfied with my level of pay.	24.4%
5	21d	The appraisal / review left me feeling that my work is valued by my organisation.	27.4%
6	21c	The appraisal / review helped me agree clear objectives for my work.	29.9%
7	4b	I am satisfied with the extent to which my organisation values my work.	37.4%
8	10c	I work additional UNPAID hours for this organisation, over and above my contracted hours.	59.5%
9	3g	I am able to meet all the conflicting demands on my time at work.	41.1%
10	11d	In the last three months, I have come to work despite not feeling well enough to perform my duties.	58.6%

Next steps

In response to the results, we are:

- Developing plans against the three top recommendations and the bottom/ most declined scores within each division.
- Supporting divisions to review their own results. HR business partners will work with divisions to consider common themes, look at exemplars and explore how to share good practice
- Planning a series of listening events for early 2023/24. These staff experience roadshows will explore advocacy, appraisals and other significant issues.
- Working with BI to develop our capabilities with textual data with the goal of performing a sentiment analysis and text classification on our free text results for the first time.

Clacton Community Diagnostic Centre

Workforce health and wellbeing

Our Wellbeing Hub is focused on supporting 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 meets monthly 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 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.

The team provide 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 gives staff access to services such as financial and legal advice and counselling for issues not related to work.

Financial wellbeing has been a significant concern for many staff this year and the wellbeing team has established regular meetings to ensure that all possible support is available to staff. This has included working closely with Colchester & Ipswich Hospitals Charity, which has set up a staff benevolent fund that will be fully launched over the next few months.

We continue to use the 34 wellbeing boards across our sites to provide information about topics such as physical health and financial wellbeing. The intranet is kept up-to-date, while health and wellbeing information is regularly included in Team ESNEFT News, which is emailed to every member of staff, and through our fortnightly health and wellbeing newsletter.

During the coming 12 months, we will continue to work with OneLife Suffolk and Provide to explore different health promotion activities, which will include smoking cessation and weight management.

Emotional wellbeing

Our 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.

An estimated 700 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.

We have now trained over 500 health first aiders (MHFAs) across the Trust, who provide emotional support within teams and signpost colleagues to relevant services. Our MHFA staff circulate fortnightly newsletters to their colleagues and are able to join our monthly MHFA drop-in sessions to support the work they do.

We have also relaunched our Schwartz Rounds, which give staff much-needed time to reflect together on the emotional impact of their work.

Occupational Health

Our Occupational Health (OH) service provides specialist occupational health advice to all ESNEFT staff as well as some of our colleagues from the integrated care board, local government, primary schools and academies, as well as medical students at university.

The team give advice and support to both employees and employers on an individual's ability to do their job and whether the job is having an impact on their health. They have continued to provide fast, effective and expert advice over the last 12 months on a number new potential health hazards that have had an impact on staff, including monkeypox, nitrous oxide exposure and ionising radiation. The number of venues at which staff can access in-person support also increased during the year to four, with the service now available at Ipswich, Colchester, Clacton and Hartismere hospitals.

Senior members of team also provide advice to the Strategic Workforce Group, Health and Safety Committee and the weekly Infection Control Committee. This includes advice on the individual COVID-19 risk assessment and its effectiveness so that the Trust can comply with its legal responsibility to keep all staff safe in the workplace.

The OH team delivered the 2022/23 seasonal flu vaccine to colleagues, and also played an integral role in planning and delivering the COVID-19 booster programme for healthcare 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.

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.

We now also offer a fast-track physiotherapy service which allows staff to self-refer and receive a telephone consultation within 48 hours and a face-to-face appointment, if needed, within five working days.

During 2023/24, the team will continue to work alongside health and safety colleagues to support mangers to identify work-related hazards so that appropriate risk assessments can be carried out to determine whether any health surveillance is required. A robust training and development programme is also in place for the coming years which forms the basis of a

five-year succession plan to ensure we can continue to deliver a safe, effective service in the future.

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.

The entrance to Colchester Hospital

Volunteering

Our volunteering service is coordinated in-house from a centralised office at Ipswich Hospital which covers all volunteering across ESNEFT.

The volunteer management team includes a business development manager, who is funded by Colchester & Ipswich Hospitals Charity. They work alongside three volunteer coordinators (2.4 WTE via Community 360 to cover North East Essex Community Services) and four voluntary services administrators (3.2 WTE).

In the last 12 months we have worked to reestablish our base number of volunteers following a lengthy pause for many due to the COVID-19 pandemic. We estimate that our total number of volunteers will have reduced by almost two thirds compared to pre-March 2020, and currently have 260 active volunteers across our sites.

As many roles have changed or cease to exist as a result of different working practices introduced during the last three years, we have been working with colleagues from across the Trust to establish the new need for volunteers. This work has helped us to reestablish links to many ward and clinical areas, and we look forward to supporting both our existing and new ward teams.

During the past year, we have established a new role in Critical Care at Ipswich Hospital, while infant feeding support volunteers are once again operational in our maternity wards. PAT dogs and their owners are gradually returning to our hospitals, and provide a much-appreciated distraction for both patients and staff. We are currently forging a new working relationship with Essex Therapy Dogs, which we hope will lead to an expansion in PAT dog visits in Colchester Hospital and Clacton and Harwich Community Hospitals over the next 12 months.

We look forward to welcoming our chaplaincy volunteers back to our hospitals in the near future and expect there to be 16 volunteers across all Trust sites when the service resumes.

We reopened new volunteer registrations in September using a new system called Better Impact. This coincided with our team attending an ESNEFT recruitment fair at the Colchester United stadium and carrying out several visits to schools, which helped to prompt an increase in applications from 16 to 18-year-olds.

We are continually developing Better Impact and have so far used it for volunteer scheduling, sending email communication to volunteers and hosting mandatory training. The functionality provided by the system also allows us to send birthday and get well wishes to our volunteers, further enhancing our ongoing relationship.

In December, our Chair hosted Christmas celebration events for our volunteers at both acute hospitals. It was the first time we have been able to hold these events in three years, and they were very well received by the volunteers.

Going into the new financial year we look forward to increasing our volunteer numbers across all ESNEFT sites, providing support to every department with an identified need. We will further develop and integrate Better Impact into our working practices and look to engage with the communities we serve to promote volunteering opportunities.

Education and training of staff

We are committed to providing a multi-professional learning environment to ensure our staff, volunteers, students and trainees receive high quality training.

We continue to support the development of our workforce to make sure we have appropriately trained and skilled staff to provide safe and effective care for our patients. We achieve this by working closely across organisational development, apprenticeships and clinical education to identify learning needs and look at the opportunities for delivery.

During the year, we have continued to work towards the compilation of a learning catalogue which includes all areas of learning and education, as well as establishing a dedicated learning hub on our intranet pages.

Medical education

The Trust has around 1,500 medical students, postgraduate doctors and dentists in training in any academic year.

The Medical Education Department is responsible for providing and quality assuring their teaching, training, supervision and day to day support. Administration teams and teaching and lecture facilities are based in Post Graduate Medical Education Centres at both acute hospitals.

Undergraduate medical education

ESNEFT hosts medical students from several medical schools, with students attending modules of varying lengths at both our main hospital sites.

Medical students on placement for the 2022/23 academic year:

	Ipswich Hospital	Colchester Hospital
University of East Anglia	**335**	**60**
University of Cambridge	**266**	
Anglia Ruskin University		**31**
Barts and The London School of Medicine and Dentistry		**200**
Total	**892**	

Physician associate students

ESNEFT has up to 15 physician associate students from UEA and Anglia Ruskin rotating through a number of our departments during the year to gain the competencies to complete their postgraduate course.

Postgraduate medical and dental education

Dental training

Dental Foundation Training is a one-year vocational training programme after dental school. Its purpose is to “enhance clinical and administrative competence and promote high standards through relevant postgraduate training to meet the needs of general dental practice in the NHS.”

ESNEFT hosts two Foundation Dental Training Schemes at Ipswich Hospital, where there is a dedicated dental skills suite with phantom heads. The two groups attend a number of courses online, at Cambridge and at Ipswich. Ipswich provides the hands -n teaching courses, covering topics such as oral surgery and prosthetics.

The Mid and South Essex scheme has a group size of 13 and they attend 13 hands-on courses between September and May 2023. The Suffolk and North East Essex scheme has a group size of 14, and will attend 12 courses.

ESNEFT also trains five core dental trainees each year. These trainees are in their first year of secondary care training following their foundation year and typically work with orthodontics and oral and maxillofacial surgery.

Junior doctors in training

ESNEFT employ and train around 590 junior doctors in training each year. The majority are recruited by Health Education England and will stay with ESNEFT for a minimum of a year.

We teach at all levels, from foundation training to core and higher specialty training. We place trainees in most medical and surgical specialties, as well as other areas such as anaesthetics, paediatrics, obstetrics and gynaecology. Trainees in their foundation and core years will rotate through various specialties and departments within our hospital sites, and also through our psychiatry partnerships, primary care and other external care settings.

In conjunction with our GP practices, we also train GP trainees in their first two years at ESNEFT and again in their final year in GP practice. We welcome around 40 new GP trainees to our Trust each year.

We are also responsible for the quality assurance and educational governance around the training and education of the junior doctors and dentists in training at ESNEFT. This includes their induction, teaching, skills training, allocation of supervision, portfolio management and progression to the next levels of training.

Pre-registration education

A range of student teaching and support we provide includes:

- A hybrid model of teaching and placement for first year nursing students. Our aim is to enhance their experience and increase their confidence in placement by providing teaching led by practice education facilitators (PEFs) which centres on case studies.

- Extended clinical visits for up to three hours at a time for students provided by PEFs in the clinical placement area. These sessions enable students to focus on an area where they would like to improve their knowledge and skills.
- A programme of teaching sessions supported by specialists including palliative, safeguarding and continence care.
- Expansion of apprentice programmes across nursing and AHPs supported in clinical placement by the education team.
- Support for increased numbers of return to practice nurses, midwives and AHPs.
- The continued expansion of the hub and spoke programme to allow additional learning opportunities for all students.
- Further education student placements to encourage learners to take up posts at the Trust on completion of their course.
- Future nurse and future midwife skills to support specific skills acquisition in line with NMC requirements.

Pre-registration students and placements April 2022 – March 2023

The tables below show the programmes we provided during 2022/23 for practice learning opportunities and the number of pre-registration students who have been given placements. During the year, we supported 1,258 students through 2,385 placement episodes.

Student programme	Total number of placement episodes
Apprentice Nursing Associate	29
Diagnostic Radiography	51
Health and Social Care	41
Midwifery	466
Midwifery – Return to Practice	5
Midwifery (short)	11
Nursing (Adult and Mental Health)	6
Nursing (Adult)	955
Nursing (Child and Mental Health)	3
Nursing (Child)	110
Nursing (Mental Health)	29
Nursing Degree Apprentice	114
Nursing Degree Apprentice (Child)	12
Occupational Therapy	80
Occupational Therapy Apprentice	2
ODP	72
ODP Apprentice	31
Orthoptics	3
Paramedic Science	102
Physiotherapy	186
Speech and Language Therapy	26
Student Nurse Associate	29
Therapeutic Radiography	22
Total	**2,385**

Student programme	Total number of students
Apprentice Nursing Associate	26

Diagnostic Radiography	51
Health and Social Care	41
Midwifery	142
Midwifery – Return to Practice	2
Midwifery (short)	5
Nursing (Adult and Mental Health)	5
Nursing (Adult)	468
Nursing (Child and Mental Health)	2
Nursing (Child)	58
Nursing (Mental Health)	28
Nursing Degree Apprentice	53
Nursing Degree Apprentice (Child)	8
Occupational Therapy	78
Occupational Therapy Apprentice	2
ODP	25
ODP Apprentice	8
Orthoptics	3
Paramedic Science	33
Physiotherapy	159
Speech and Language Therapy	24
Student Nurse Associate	15
Therapeutic Radiography	22
Total	**1,258**

During the year, we worked with the following universities to support students on healthcare programmes:

- Anglia Ruskin University
- University of Essex
- University of Suffolk
- University of East Anglia
- University of Hertfordshire
- University of Liverpool
- University of Sheffield
- University of Suffolk
- University College London
- University of Cardiff
- University of Nottingham
- University of Coventry
- University of Derby
- Colchester Institute
- Suffolk New College

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 programmes such as preceptorship, clinical induction and OSCE preparation. The team also

offer clinical and pastoral support to non-medical clinical staff in their wards and departments.

Preceptorship programme

The multi-professional preceptorship programme for newly registered professionals is now a mixture of face-to-face, live virtual sessions and self-directed learning using a platform called Moodle. We now have approximately 600 members of staff taking part in the programme with support from the post-registration team.

New national frameworks for nursing, midwifery and AHPs have been introduced during the year, while a quality mark for achieving set standards with a national accreditation process for preceptorship is planned in 2024.

International nurses

In 2022, ESNEFT became the first trust in the east of England to receive the NHS Pastoral Care Quality Award in recognition of the support we provide to international nurses.

Our team delivers OSCE preparation (NMC part two test of competence) to 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. We also offer robust on-boarding while supporting staff clinically and pastorally to settle into the UK.

Between January and March 2023, we recruited an additional 35 international nurses. Over the next year, we plan to welcome another 120 nurses from a variety of countries, including India, the Philippines, Nigeria and Zimbabwe. We have also received our first cohort of internationally recruited nurses for community posts.

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. We also offer additional learning opportunities for these staff, such as career progression and one-to-one sessions. An accelerated version of the care certificate is now in place for existing staff which takes into account their current skills and experience.

Healthcare support worker taster days are currently running across the Trust to provide a realistic insight into the role. This takes place in collaboration with the outreach team to ensure ESNEFT offer equal opportunities to our diverse local communities.

Numerous initiatives have taken place to support recruitment and retention across the Trust during the year, with several more due in the coming months. We have also introduced a new induction programme for band two to four colleagues to ensure high quality and relevant training is provided. This programme is now seven days long, having been extended by two days, and consists of a shadow shift and a structured pastoral session. A community-specific induction programme is also in place for both our registered and unregistered staff members.

Medical device training

Work continues to support medical device training, including making sure the right documentation is in place to ensure consistency and quality. We are in the process of rewriting our Trust medical device training policy and developing a robust system to track and monitor the roll out of medical devices and transfer the information to OML. A new digital process will be developed to ensure that the process is effective.

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. Career development conversations are available and our post-registration team can facilitate these and signpost to the relevant department.

Several apprenticeships are also available at the Trust, including nursing associates and HCAs.

Statutory and mandatory training

The Trust has a suite of statutory, mandatory and role essential training requirements that are mapped in a matrix across all roles and signed off annually. Training is delivered using blended methodology with a combination of e-learning and face-to-face sessions. Statutory and mandatory training is aligned to the Skills for Health Core Skills Training Framework and is monitored through our performance meetings. Compliance currently stands at 87.5%.

Corporate learning and organisational development

In June 2022, we launched the ESNEFT Leadership Development Pathway for all leaders at ESNEFT.

This began with our visible leader programme which is delivered by The King's Fund, followed by the engaging leader with NHS Elect and the emerging leader, which is delivered internally.

This comprehensive pathway is made up of management and leadership apprenticeships, specialist programmes and our mandated management essentials, which includes recruitment and selection and leading in allyship.

We are also creating a personal development catalogue which will be available on our intranet and will encompass all learning and development opportunities across the faculty's remit. In addition, we have trained eight mentors and are looking to introduce a coaching qualification and develop our own coaching and mentoring network within the Trust.

Our Organisational Development and Culture team continue to support colleagues by providing advice, away days and development days which can be supported by psychometric testing and 360 degree questionnaires and feedback.

We are also working with business psychologists Zeal Solutions, who have worked with NHS Employers and trusts across the country, to develop a cultural audit. The results will be triangulated with the NHS Staff Survey to define a cultural transformation plan and bespoke ESNEFT supportive leadership 360 degree questionnaire.

Employment of disabled people – training

We continue to make sure that all staff have equal opportunities to develop new skills or enhance their existing skills and advance their careers. This includes offering 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 complete equality and diversity training, with compliance currently standing at 95.95% at January 2023.

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

Equality, diversity and inclusion

Our reverse mentoring programme launched in late 2022/23 and saw 20 colleagues from ethnic backgrounds and our EMBrace staff network mentoring our executive and non-executive directors. This hugely powerful programme created such an impact that we identified several areas of focus for the organisation as well as recommissioning the programme for 2022/23 with two cohorts. Reverse mentoring has also been extended to colleagues with all protected characteristics who are now mentoring our senior leaders.

During 2022/23, we achieved Disability Confident employer level two status and are aiming to achieve level three status by summer 2023. The Trust recognises the importance of the scheme, which will help us recruit and retain great people while also:

- challenging attitudes and increasing understanding of disability
- drawing from the widest possible pool of talent
- securing high quality staff who are skilled, loyal and hard-working
- improving employee morale and commitment by demonstrating fair treatment

Our LGBTQIA awareness sessions have now been running for 18 months in partnership with Colchester-based charity Outhouse. These highly valued sessions have significantly developed our awareness of the LGBTQIA community and its needs, as well as helping to break down barriers with a dedicated section on trans and non-binary topics.

Our staff networks have continued to expand and develop. During the year, elections were held for our ESNable disability network and take place for EMBrace and LGBTQIA networks in early 2023/24. These networks regularly hold events, as well as attending staff conferences to promote their plans and increase their membership and allies.

During the year, we also set up a new network for our armed forces colleagues. Its leads have provided training across the Trust and took part in various events during armed forces week.

Our cultural ambassadors, who have been trained by the Royal College of Nursing (RCN), have continued to assist with employee relation casework throughout the year and will support the Trust's recruitment and selection training during 2023/24.

Staff networks

ESNAble

During the year, ESNAble appointed a new chair and vice chair. Following feedback from members, the network also developed a new logo and looked to promote itself more widely through Trust communications to all staff. As a result, its membership grew during the final few months of 2022/23.

In the coming 12 months, ESNAble plans to set up regular meetings for its members and leadership team, identify and introduce membership roles while hosting information and awareness raising events. The network will also work with the Communications team to highlight its work while making sure it is fully aligned with ESNEFT's objectives around disability and can support the Trust to achieve relevant disability recognition.

LGBT+

In partnership with Outhouse, our LGBTQ+ Friends Network provided a series of LGBTQIA sessions for our staff to help break down barriers and further support awareness and care. This included hosting a stall at our nurses' day and allied health professionals' conferences, where network leads engaged with staff and talked about projects and future plans.

A Pride event was also held in Colchester to celebrate all things LGBTQIA and promote the projects taking place at ESNEFT. In addition, the network was invited by the integrated care board's LGBTQ+ Friends Network to talk about projects, share learning and give a presentation regarding the introduction of an inclusive pregnancy status form.

Our LGBTQ+ Friends Network is currently developing its plan for 2023/24 and is also being assessed by the NHS's rainbow pin badge scheme.

EMBRace

EMBRace celebrated equality, diversity and inclusion and our BAME workforce at a special conference organised to mark International Day of the Midwife and International Nurses' Day in May. Later in the summer, Ruth May, Chief Nursing Officer for England, and Professor Anton Emmanuel, Head of Workforce Race Equality Standard for NHS England, attended our Filipino Sports Fest. Around 200 members of staff took place in the event, which was featured in the Nursing Times. In addition, more than 100 staff joined a Bollywood night, which was hosted by colleagues from India.

EMBRace also celebrated Black History Month in October and held a reverse mentoring webinar. Similar events are planned for the coming 12 months.

Armed Forces Network

Our newest network held a series of events at both acute sites to mark armed forces week in June, with local veteran services and agencies joining the celebrations alongside 154 Medical Reserve Regiment.

The network also provided support and/or awareness stands at various events including Clacton veterans' day, Woodbridge Royal British Legion's 100th birthday, a veterans' roadshow and various Royal British Legion conferences. Insight events also took place at the Personnel Recovery Centre at Merville Barracks to raise awareness of the Career Transition Partnership.

The network also supported our Chaplaincy team at various events to mark Remembrance Sunday.

Continuing professional development

We have supported staff development in line with service need and workforce plans and with an ongoing commitment to providing equity of access to training and development.

ESNEFT continues to encourage and support multi-professional healthcare staff to develop their skills by taking part in a wide variety of courses, conferences and workshops, which ultimately leads to improved care for patients.

We have continued with wider Trust programmes such as clinical supervision, advanced communication, After Action Review and human factors. In addition, we have supported new programmes, including tissue viability, customer care and coaching.

Other areas of development over the past year include:

- **In hospital, including urgent and emergency care** – providing care across multiple specialties has highlighted the ongoing need for upskilling in areas such as acute stroke care, adult acute care, advanced trauma training cardiac care, management of diabetes and ultrasound training.

- **Cancer care** – specialist education in palliative care and advanced communication has taken place. Head and neck cancer, consultation and assessment and non-medical prescribing courses have also been arranged to support the delivery of care and improve experience and outcomes for our patients.

- **Mental health** – we have continued to raise awareness of mental health conditions and the support which is available for patients and staff by holding mental health awareness workshops, mental health first aid training, debrief training and additional leadership coaching. Trauma informed care is a quality priority for the Trust and we have developed a programme for delivery over the next three years. Understanding the impact of trauma is an important and powerful way in which we can take steps to make the care we provide feel safer, more comfortable and accessible to all patients. Adopting trauma informed thinking and approaches is known to positively impact health outcomes, engagement and wellbeing and supports better staff experiences.

- **Maternity** – education has taken place in a range of areas, including care of the critically unwell women, biomechanics for birth, neonatal transitional care

programmes, emergencies in the community, newborn and infant physical examination and practical obstetric multi-professional training. This is allowing our teams to support women and babies with a range of care requirements.

- **Children's services** – we have provided education on high dependency care of the acutely ill child, diabetes care, oncology care and paediatric examination.

Advanced clinical practitioners

Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision-making. It is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice – leadership and management and education and research – with demonstration of core capabilities and area-specific clinical competence. We continue to work closely with system partners and Health Education England to further develop the advanced practice role.

We value the contribution our advanced clinical practitioners make to service delivery and high-quality patient care, and have appointed a full time corporate lead for advanced clinical practice to develop these roles across the Trust. There has been a significant expansion in the number of trainee advanced clinical practitioners at ESNEFT over the past 12 months, increasing from just five 2021/22 to 23 in 2022/23 across all areas, including maternity and learning disability and autism.

Professional nurse advocate

The professional nurse advocate programme is a level seven accredited training programme that equips nurses to facilitate restorative clinical supervision, develop cultures of learning and development and monitor and improve care in clinical practice.

The programme is the first of its kind for nursing, not just in England but across the world. It was launched during the pandemic and viewed as a critical part of recovery for patients, services and the workforce.

We are working towards ensuring 1:20 ratio of professional nurse advocates and will be hosting two celebration events in early 2023/24 to recognise those who have already passed the training module. Over the next year, we are also planning to host an information day and create a peer forum to increase the number of professional nurse advocates at ESNEFT.

Library services

Our libraries provide a comprehensive and proactive service to all ESNEFT staff and students on placement in line with Health Education England's vision for NHS libraries. The service is benchmarked and assessed via the Quality and Improvement Outcomes Framework.

ESNEFT's libraries are open for study 24/7 and give staff access to a wide range of physical and online resources, ensuring clinical and managerial decisions are based on the best available evidence. Library staff provide expert evidence searches, training and document supply.

Valuing our staff

ESNEFT staff commendations

At ESNEFT we value, recognise and congratulate our staff through a number of recognition schemes. These include:

- Our biannual staff awards ceremony
- Staff commendations
- Long service awards
- Greatix peer-to-peer thank you messages
- Retirement lunches

Information about some of the colleagues who won staff commendation during 2022/23 is included over the next few pages.

Never underestimate a helpful hospital secretary…they are worth their weight in gold.

Just ask our diabetes team where they'd be without the skills and support of medical secretary **Jodie Borley**.

Jodie played an instrumental role in keeping things running during the COVID-19 pandemic and with her finger on the pulse has made a huge difference to our patients at Ipswich Hospital.

Marvellous microbiology duo **Hasina Ali** (left) and **Jose Mas** are typical laboratory staff who work quietly and diligently behind the scenes. But on an extraordinary night in Colchester Hospital's COVID-19 urgent testing labs, they earnt themselves staff commendation awards.

The pair thought they were in for an average night shift analysing tests. But an unexpected change in the technology meant the associate practitioners had to make an update every 15 minutes to keep the testing machines up and running.

A commendation award went to a ward sister who reunited a married couple when they found themselves in hospital at the same time.

The husband was being cared for following an operation when his wife was then admitted to another ward after falling.

Colchester Hospital D'Arcy Ward sister **Alyce England** knows the importance of family and love on patients' recovery and arranged for them to be together in a room with two beds on her ward.

It wasn't easy as both patients had different teams caring for them, but Alyce showed compassion and determination to bring the couple back together.

Hospital ward hostess **Donna Pearl** gives exceptional service to patients.

One of Donna's patients put her forward for the award, saying "the hospital is lucky to have her"…and we couldn't agree more.

Donna is known for her acts of kindness while serving meals to patients at Ipswich Hospital. She often nips back to the kitchen if a patient has a special request, and her caring nature often persuades poorly patients to eat.

There's never an easy way to deal with death. But there are people who can offer kindness when it's needed at the most difficult of times.

We said thank you to children's nurse **Clair Tatum** who helped a family when a young patient died in hospital after a long-term illness.

Clair came to work during the middle of the night when she wasn't on duty to be a familiar face for the family dealing with their loss.

There's only ever one chance to get end of life care right and Clair did everything she could.

Operating department practitioner (ODP) **Tracy McGuire** was part of a team who attended a cardiac arrest at Ipswich Hospital. The patient died and Tracy realised they were in a department not used to dealing with death.

She took the lead and called back-up from theatres – ODP Lisa Grover, nurse Nicola Treanor and theatre assistant Carly Bamling – and together they performed last offices. This means preparing the body for transfer to the mortuary while respecting cultural wishes of the patient.

Tracy also handled the paperwork and liaison with the bedsite team to make sure the body wasn't unnecessarily transferred across the hospital. She made sure the patient was cared for with respect and dignity.

Time and again our patients write to us to tell us about an outstanding receptionist.

His name is **Matthew Bullard** and he works on the front desk of our Breast Care Clinic at Ipswich Hospital.

One patient said: "He's a credit to you - so friendly, welcoming and helpful."

Another said: "If anyone is suited to this role, it's him." And another said: "He is a shining example of all that is good about the NHS."

Epilepsy nurse **Shelley Anderton** was nominated after spotting that changing a patient's medications could significantly improve their life.

The patient has a learning disability and Shelley's intervention meant they were seen by a specialist team who changed the medication prescription. This helped their physical health, mental health and quality of life.

Her nomination for this award said her proactive thinking changed the patient's life "immeasurably".

Physiotherapist **Esther Simpson** won a commendation award after a patient thanked her for saving his life.

The patient had visited the hospital for a physio appointment after being injured in a fall, but it wasn't just his physical health he was struggling with. He was feeling suicidal because of the impact of his injuries and planned to take his own life.

Esther saw his desperation on the day of the appointment and helped him begin to put his life back on track.

Statements from key stakeholders

Healthwatch Essex

Healthwatch Essex is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it.

We recognise that quality accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by ESNEFT. In this case, we have received no additional feedback, and so offer only the following comments on the ESNEFT Quality Account.

- What is encouraging to see, is that there is a priority focus on medication safety. This is of high importance when talking with citizens of Essex and medication is always something which is raised.
- Its positive to see the improvements being made to nutrition in patients, including examples such as the development of the nutrition quality improvement project.
- We are pleased that serious consideration has been undertaken when valuing patient and public involvement in research and development. Working for an organisation which values and promotes patient voice, we feel this is vital for all organisations to take forward. It's encouraging to see the beliefs and huge benefits of lived experience and using citizens and patient voice to shape services.
- Although three never events does not sound like many, it would be encouraging for the numbers to be reduced moving forward with a target of zero.
- During 2022/23, 145 complaints have been reopened. It would be good to see this number decrease moving forward. The main reasoning being poor or inaccurate investigation would suggest the potential for further training needed.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by working hard to evidence that lived experience we hope we can continue to support the encouraging work of ESNEFT.

Dan Potts
Engagement Manager
12 May 2023

Healthwatch Suffolk

Healthwatch Suffolk (HWS) thank the Trust for the opportunity to comment on the Quality Account for 2022/23. We recognise this has been a period of extreme intensity for the Trust's staff, clinicians and volunteers and – as a Healthwatch – we are also naturally acutely aware of the heightened needs of the public during these past 12 months. Patients sharing feedback with us about their experiences of the Trust have been largely positive about 'treatment and care' for example, and largely negative about 'communication'.

We are pleased to read a commitment to co-production in some instances, following training provided by HWS. Early examples of putting to good use this cultural change concern cancer care and maternity services, the latter involving the Maternity Voices Partnership. Three key principles are referenced, but there is no indication of the source of these principles. It may be worthwhile for the Trust to revisit the co-production principles that were themselves co-produced in Suffolk, and used in the aforementioned training that took place in 2021/22.

There are several other references to patient and family carer engagement, some of which are listed here: nutrition, quality improvement, cancer, the orthopaedic centre, involvement in user groups and more. The Trust has also worked with public health colleagues to learn about the specific needs of 'multi-ethnic communities'. We would suggest that reaching out to such communities directly would lead to a more informed position on the part of the Trust. The list of the Patient Experience and Engagement team projects is really worthy of note because of the range of examples given. Information and signposting about how the public can find out more about these projects would be helpful and help to improve the public's understanding of how the Trust seeks to involve people with lived experience.

The subject of patient and family experience is found throughout the Quality Account, which is very much welcomed by HWS. We note the following as examples: the role of the Patient Experience Group, reflections on virtual wards, the Patient Safety Incident Reporting Framework, the chaplaincy service, cancer care, maternity, Duty of Candour, the Patient-Led Assessment of the Care Environment provision, the complaints process and accessibility.

We have some thoughts to share on a few of the experience references in the Quality Account.

It is disappointing to discover that the introduction of maternity's continuity of care model is further delayed but understand the need for workforce stability and capability to be a pre-requisite for such a model to be adopted by the Trust. The positive features of continuity of care are listed, and this underlines its importance.

Two specialist dementia support workers have been appointed in order to support carers, patients and for signposting purposes. This is good news and HWS's findings on dementia healthcare (published May 2023) has recommendations that will be of interest to these support workers and their colleagues.

A complaints workshop has led to a new letter template. This will be welcome news to patients and families that have concerns that lead to the need for a formal complaint.

The return of the 'public voice initiative' titled Patient-Led Assessment of the Care Environment (PLACE) in 2022 is very good news. HWS in particular notes the dementia

friendly example, whereby areas identified for improvement following the PLACE assessments include colour used effectively to enhance patients' orientation/coordination, accessible areas for washing and toilet facilities for parents, relatives, guardians or carers that stay overnight, day rooms/social space provided on wards and appropriately furnished, finger foods for specific groups of patients, patients having access to lockable storage space, and a large, accurate and silent clock, clearly visible in all patient areas.

The introduction of a 'quiet room' for bereaved families to use on the Deben (maternity) Ward is also noteworthy, as are the numerous plaudits that are recorded in the report.

The Patient Experience team is noted to have "worked with our acute hospitals, Healthwatch and learning disability ambassadors to improve the patient experience". Later in the Quality Account there are good examples of work with learning disability ambassadors and the acute hospitals, but there are sadly no examples of work that involved Healthwatch Suffolk or Healthwatch Essex. Examples of 2022/23 collaborative work with Healthwatch Suffolk that might have been referenced are the evaluation of patient experiences of being on elective care waiting lists, and compliance with the accessible information standard, a campaign named 'Your Care, Your Way'. Both these projects were developed in support of national Healthwatch England campaigns.

The entry for 'healthwatch' in the glossary could be improved by including the 'statutory and independent' nature of a local healthwatch.

The Trust adopted the new Patient Safety Incident Response Framework. Incidents are reviewed by the Patient Safety and Quality teams, with plans for improvements.

In 2022 we asked the Trust to try and explain why 'the delivery of sepsis six in Ipswich has remained at low at 44%, whereas Colchester has improved to an average of 78% compliance'. Sepsis six remains a challenge for the Trust.

There were roughly 12,000 cases of 'adverse events' (low to severe harm) during 2022/23, a significant fall in number from the circa 20,000 that were recorded in the previous year.

Duty of Candour is a very important principle by which every NHS trust operates, locally connected with the Trust's 'Being Open' policy. There continues to be a particular challenge in consistency for community services regarding pressure ulcers. Perhaps a bespoke co-produced solution might be a way forward, for the benefit of the patients affected by such situations. Positive news concerning Duty of Candour is the decision to make the training mandatory from April 2023, and for face-to-face conversations to take place with patients and their families. Other positive changes are more timely letters being sent, and giving people a choice of feedback options, all confirmed with the patients.

Over 10,200 plaudits have been received (as compared to 12,000 in the previous year) and key complaints themes include communication, access to treatment or drugs and patient care. Communication is repeated elsewhere as a concern, as it was identified as a key issue in two end of life thematic reviews. It was good to note that these reviews led to new staff training being introduced titled 'How can I support you?'

The number of re-opened complaints cases make up something like 10% of all complaints, and any trends regarding the re-opening of cases should be monitored.

It is good to note that the statutorily required adherence to the accessible information standard (AIS) is clearly referenced more than once in this year's Quality Account. We had asked for this to be rectified in 2021/22 and welcome how the Trust is acting on its

responsibilities, citing several examples. The AIS working group is established and has initially focused on learning disabilities in Ipswich. Its focus in 2023 will be Colchester.

Accessibility does also span other aspects of NHS service provision. During 2022/23, the Trust expanded the use of virtual consultations and introduced virtual rounds in nursing homes and virtual clinics. It would help to know what 'virtual rounds' are in practice, and how they are viewed by patients.

Virtual wards are now established nationally and we note NHSE/I's ambitions for ESNEFT to maintain as many as 320 at some point in the future. All the main benefits of such virtual wards are helpfully listed, but with the growing number of virtual beds planned, the public would also wish to understand any potential or actual drawbacks from the scheme.

The digitalisation of hospital care and management has grown exponentially over the past three years. This Quality Account highlights several examples such as for cancer pre-rehabilitation, quality of life, and personalised self-managed follow-ups. The benefits to the Trust are clear, as they are for the majority of patients and their family carers. There are however some two in 10 people who may be digitally excluded, or are faced with barriers in the form of digital literacy and digital poverty. We would advise the Trust to consider adopting the Healthwatch Suffolk digital transformation guiding principles, developed in collaboration with the local integrated care system, and used by commissioning, procurement and provider specialists, in addressing such barriers.

Equality, diversity and inclusion has more of a focus this year, as compared to 2021/22. The presence of the Health Inequalities Working Group and Equality Diversity and Inclusion Steering Group are welcomed, thereby helping the Trust to be more cognisant of both service and workforce equality matters.

Staff networks are evolving and are having more direct access to the Trust's Board is important. A quote or two from the network chairs would add to the evidence provided. Healthwatch Suffolk notes the absence of any policy or provision for the menopause and perimenopause, or at least there is no reference to such in the Quality Account.

In 2021/22 we welcomed the Trust's commitment to invite the Sight Loss Council to conduct a visit (walk throughs) of both acute sites in the spring of 2022. There is unfortunately no reference to such visits in the report. Tackling inequalities is only ever best achieved with the help of lived experience, and such specialist visits are encouraged by us.

The persistent pressures on midwifery, much of which is attributed to the number of job vacancies that require filling, and the wide spectrum of experiences faced by people using maternity services at the Trust, means that the quality and safety of maternity provision remains inconsistent. We do however believe that the appointment of a domestic abuse advocate in 2022/23 has been very well made, especially as staff have also accessed the service offered by this appointee. Funding is secured through to 2025 and so next year's Quality Account will hopefully offer an indication of a legacy plan should the role be discontinued.

It's heartening to note that volunteering is becoming more prevalent since the past three years of the pandemic. The Butterfly volunteers now have a coordinator, and the network now operates for five days a week. Volunteers are rightfully recognised for the impact they make throughout the Quality Account. The 'no one dies alone' principle is excellent and there are other notable, and diverse, volunteering news items to highlight: meal time volunteering has been re-launched, stroke care has a new volunteering induction programme, there are now 16 chaplaincy volunteers (the collaboration with the East of

England Faiths Agency is to be commended), patient assessor volunteers, infant feeding volunteers and critical care volunteers. We also recognise the efforts of the Trust to seek younger volunteers through visits to schools.

The statistic concerning the number of patients admitted into the Trust with a mental health condition is of particular note (between 25-33%), especially as the two adjoining secondary mental health NHS trusts are consistently unable to accept timely referrals from ESNEFT and other acute trusts in this part of our region. We note that progress about the care for such patients is reported to the Mental Health Improvement Steering and the Patient Experience groups. The Trust's generic safeguarding 'Think Family' approach is also key to ensuring patients, their family carers, and staff, feel supported.

As in the previous year's Quality Account, there is surprisingly very little in the way of referencing the Trust's waiting lists for elective care considering the very large numbers on such lists both locally and nationally. In 2022, ESNEFT worked with Healthwatch Suffolk in order to discover the experiences of waiting lengthy (and unspecified) periods of time for a hospital intervention, whilst living with often debilitating and progressively worsening physical health conditions. The report involved West Suffolk Hospital and the James Paget University Hospital, bringing to the fore what our integrated health and care systems could do differently in order to help mitigate against the many impacts such long waits make on people's lives. There are two notable actions being taken by the Trust concerning waiting times – cancer care's 'today's work today' approach, and the linking of patients with social prescribers and community services.

We end our statement on the critical subject of culture. There has been much progress and we would include the following as examples: learning from never events such as 'time out' practice in operating theatres, the Trust being an early adopted of the Patient Safety Incident Response Framework pilot ('Just Culture'), the appointment of Board 'safety champions', the launch of the leadership development pathway for different levels of leadership roles and the Freedom to Speak Guardian role. We would suggest that a quote from this guardian might add further strength to the evidence being recorded in this Quality Account.

Incident reporting as a percentage of severe harm or death for the period is 0.8%, which is double that of the national 'like-for-like' average of 0.4%. This is understandably a concern.

Finally, we were surprised to read nothing about the actions taken by the Trust in order to mitigate, where possible, against the impact on patients and families, from the national pay disputes during the latter end of the 2022/23 period.

Overall, the Trust has achieved much considering the challenges it, and its partners, have faced during 2022/23 as described in its Quality Account. We have previously invited the Trust to focus more on analysis and outcomes rather than description and inputs. This year's report reflects such a shift and we are appreciative of this.

Andy Yacoub
Chief Executive
22 May 2023

Wendy Herber
Independent Chair
22 May 2023

NHS Suffolk and North East Essex Integrated Care Board

The Suffolk and North East Essex (SNEE) Integrated Care Board (ICB) confirm that ESNEFT have consulted and invited comment regarding the annual Quality Account for 2022/23.

This has been submitted within the agreed timeframe and the ICB is satisfied that the Quality Account provides appropriate assurance of the service.

The ICB has reviewed the Quality Account (and enclose some feedback for your consideration). The information contained within the Quality Account is reflective of both the challenges and achievements within the organisation over the previous 12 month period.

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

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

Lisa Nobes
Chief Nursing Officer
23 May 2023

Glossary

Bed days: The number of days 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 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.

Clostridioides difficile (formerly clostridium difficile) or C. diff: A spore-forming bacterium present as one of the normal bacteria in the gut. C. difficile diarrhoea occurs when the normal gut flora is altered, allowing C. difficile bacteria to flourish and produce a toxin which 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 way the Trust's services are divided. Clinical divisions include 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.

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.

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: Held in each Clinical Delivery Group 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.

Suffolk and North East Essex Integrated Care Board (SNEE ICB): The commissioners of services provided by ESNEFT.

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 thromboembolism (VTE): A complication of immobility and surgery which is also known as a blood clot.

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.