



Month 8
(November)

Integrated Performance Report

East Suffolk and North Essex NHS Foundation Trust
Board of Directors

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| | | | | | |
|--------------|---|---------|---|-------------|---|
| ACE | Accreditation of Care at ESNEFT | FINN | Finn Clinic (Physiotherapy) | PACS | Picture Archiving Communications System |
| ADOS | Autism Diagnostic Observation Schedule | FOT | Forecast Outturn | PIL | Patient Information Leaflet |
| AECU | Ambulatory Emergency Care Unit | FYE | Full Year Effect | POD | People & Organisational Development Committee |
| AF | Accountability Framework | HCAI | Health Care Associated Infections | PSII | Patient Safety Incident Investigation |
| AMD | Associate Medical Director | HCSW | Health Care Support Worker | PSR | Patient Safety Response |
| AMSDEC | Acute Medical Same Day Emergency Care | HOHA | Healthcare Onset Healthcare Associated | PTL | Patient Tracking List |
| APC | Admitted Patient Care | HQIP | Healthcare Quality Improvement Partnership | QEH | Queen Elizabeth Hospital |
| ASD | Autism Spectrum Disorder | HRBP | HR Business Partner | QI | Quality Improvement |
| C&D | Cancer & Diagnostics | HSMR | Hospital Standardised Mortality Ratio | QIP | Quality Improvement Project |
| CAD | Computer Aided Dispatch | I&ES | Ipswich & East Suffolk | QTD | Quarter To Date |
| CAELR | Cardiac Arrest | IA | Industrial Action | R2G | Red 2 Green |
| CDEL | Capital Departmental Expenditure Limit | ICB | Integrated Care Board | RAG | Red Amber Green |
| CDG | Clinical Delivery Group | ICU | Intensive Care Unit | RES | Routine Elective Services |
| CHPPD | Care hours per patient day | IPC | Infection Prevention & Control | RhD | Rhesus D antigen |
| CIP | Cost Improvement Plan | IV | Intravenous | RI | Risk Indicator |
| CNS | Clinical Nurse Specialist | KPI | Key Performance Indicator | RM | Registered Midwife |
| CNST | Clinical Negligence Scheme for Trusts | LD | Learning Disabilities | RN | Registered Nurse |
| CO | Clinical Outcome | LFPSE | Learn from Patient Safety Events | RSV | Respiratory Syncytial Virus |
| COHA | Community Onset Healthcare Associated | LLOS | Long length of stay | RTT | Referral to Treatment |
| COPD | Chronic obstructive pulmonary disease | LMNS | Local Maternity and Neonatal System | SB | St Barnabas |
| CUSUM | Cumulative Sum | LoS | Length of Stay | SBL | Saving Babies Lives |
| DAM | Divisional Accountability Meeting | MACIES | Medicine and Community - IES | SDEC | Same Day Emergency Care |
| DCIQ | Datix Cloud IQ | MACNEE | Medicine and Community - NEE | SGA | Surgery, Gastroenterology & Anaesthetics |
| DM01 | Diagnostics Waiting Times and Activity | MBRRACE | Mothers & Babies: Reducing Risk Audits & Confidential Enquiries | SHMI | Summary Hospital Mortality Indicator |
| DQ | Data Quality | MCCD | Medical Certificate Cause of Death | SJR | Structured Judgement Review |
| EAU | Emergency Assessment Unit | MCI | Marie Curie | SMR | Standardised Mortality Ratio |
| ECDS | Emergency Care Data Set | MDT | Multidisciplinary Team | SNCT | Safer Nursing Care Tool |
| ED | Emergency Department | MHLT | Mental Health Liaison Team | SOP | Standard Operating Procedure |
| EDD | Expected Date of Discharge | MNSI | Maternity & Newborn Safety Investigations | Turbo rooms | Rapid solutions to problems team |
| EDI | Equality, Diversity & Inclusion | MSE | Mid and South Essex Foundation Trust | UCR | Urgent Community Response |
| EEAST | East of England Ambulance Service | MSK | Musculoskeletal | UEC | Urgent & Emergency Care |
| ELR | Early Learning Review | NDD | Neurodevelopmental disorder | UECC | Urgent & Emergency Care Centre |
| EMC | Executive Management Committee | NEE | North East Essex | VTE | Venous thromboembolism |
| ENT | Ear Nose & Throat | NHSE | NHS England | VTELR | Venous thromboembolism |
| EoE | East of England | NMAAC | Nursing, Midwifery & Allied Health Prof Advisory Committee | W&C | Women's & Children's |
| EPUT | Essex Partnership University NHS Foundation Trust | NOF | NHS Oversight Framework | WDES | Workforce Disability Equality Standard |
| ER | Employee Relations | NQM | Newly Qualified Midwife | WRES | Workforce Race Equality Standard |
| ESDEC | East Suffolk Same Day Emergency | NSFT | Norfolk & Suffolk NHS Foundation Trust | WTB | Working Towards Bronze |
| ETOC | Enhanced therapeutic observations | NSS | National Staff Survey | WTE | Whole Time Equivalent |
| F&F | Friends and Family Test | OH | Occupational Health | YTD | Year to Date |
| F/U | Follow Up | OLM | Oracle Learning Management | | |
| fDNA testing | Fetal DNA testing | OPAT | Outpatient Parenteral Antimicrobial Therapy | | |

This month's performance report provides detail of the November performance for East Suffolk and North Essex NHS Foundation Trust (ESNEFT).

The NHS Oversight Framework (NOF) for 2025/26 was published in June 2025 following a 3-month period of consultation. The framework describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

A range of agreed metrics that promote improvement and help to quickly identify where support is required fall under the following five themes:

- **Access to Services**
- **Effectiveness and Experience of Care**
- **Patient Safety**
- **People and Workforce**
- **Finance and Productivity**

The NOF is a one-year framework, which will be reviewed in 2026/27 to incorporate the ICB operating model and to reflect the 10 Year Health Plan. A focused set of national priorities, including those set out in the planning guidance for 2025/26, underpin the framework aiming to strengthen local autonomy. These are presented alongside wider contextual metrics that reflect medium term goals in areas such as inequalities and outcomes. The contextual metrics do not constitute part of the score but will inform how NHS England responds to segmentation

Every ICB and provider will be allocated a segment (ICBs will though not be subject to segmentation until 2026/27). This indicates its level of delivery from 1 (high performing) to 4 (poorly performing) with an additional segment 5 to indicate the most intensive support requirement. To reflect the importance of the NHS living within the budget it is allocated, reduce waste and increase productivity to deliver growth against demand, a financial override is in place that will mean that unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3.

The Trust is considering how the recent release of the NOF, including its scope and scoring methodology, should potentially impact on its own performance management tool (the AF) and its wider reporting. Q2 data has now been published (11 December 2025). This is only the second set of national data published. Overall, the Trust's rank has improved to 82 (86) out of 134 acute providers. Further detail about this publication and the Trust's performance is detailed in subsequent slides.

As part of the Trust's 2023 Well Led Review, a redesign of the Integrated Performance Report (IPR) was agreed. The format that follows in this report now includes a slide that highlights high level trends and hotspots that broadly cover the five national themes as well as local priorities. The trends and hotspots highlighted are shown as areas that have seen improvement in the month and areas that require further work.

Before each section of the report a more detailed trends and hotspots update is also provided showing metrics which highlight performance in key areas of the domain and include more detail on the issues raised in the high-level trends and hotspots. Spotlight reports are also included to provide more detail on performance across each domain, and where necessary, corrective actions that are being implemented.

Information on elective recovery, including comparison to 19/20 performance, is now included as part of the slides detailing performance. Detailed commentary is provided about RTT recovery.

The Accountability Framework (AF) is the mechanism by which the Trust holds both Clinical and Corporate Divisions to account for their performance. The AF is the primary performance management regime to cover all aspects of divisional business plans. As a consequence, its purpose is to ensure that the Trust delivers its promises to patients and stakeholders. The domains covered in the AF broadly cover the five national themes laid out above and a review is held at the end of each financial year to consider metrics included, their weights and their targets. Divisional Accountability Meetings to discuss Divisional Accountability to review October took place on the 2nd and 3rd of December. Corporate divisions AF meetings were cancelled.

| NOF Publication | | | | | | |
|---|---|------------------|-------------------|--------------------|---------------------|------------------------|
| REF | Metric | Data period - Q2 | Metric Score - Q2 | Provider rank - Q2 | Provider value - Q2 | Q1 - Q2 value movement |
| Access to Services | | | | | | |
| AS1 | Percentage of cases where a patient is waiting 18 weeks or less for elective treatment | Sep-25 | 3.52 | 109/131 | 56.46% | ↓ |
| AS2 | Difference between planned and actual 18 weeks performance | Sep-25 | 1.00 | 49/131 | 0.91% | ↓ |
| AS3 | Percentage of patients waiting over 52 weeks for elective treatment | Sep-25 | 3.43 | 103/131 | 3.23% | ↓ |
| AS4 | Percentage of patients waiting over 52 weeks for community services | Sep-25 | 3.07 | 83/120 | 4.90% | ↓ |
| AS5 | Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral | Sep-25 | 3.32 | 88/118 | 72.62% | ↓ |
| AS6 | Percentage of patients treated for cancer within 62 days of referral | Sep-25 | 2.67 | 63/118 | 68.75% | ↑ |
| AS7 | Percentage of emergency department attendances admitted, transferred or discharged within 4 hours | Sep-25 | 2.74 | 73/123 | 74.00% | ↓ |
| AS8 | Percentage of emergency department attendances spending over 12 hours in the department | Sep-25 | 3.06 | 82/119 | 10.23% | ↓ |
| Effectiveness and experience of care | | | | | | |
| EE1 | Urgent Community Response 2-hour performance | Sep-25 | 2.1 | 45/89 | 85.86% | ↓ |
| EE2 | Summary Hospital Level Mortality Indicator | | 2.00 | | | |
| EE3 | Average number of days from discharge ready date to actual discharge date (including zero days) | Sep-25 | 1.63 | 27/125 | 0.42 | ↑ |
| EE4 | CQC inpatient survey satisfaction rate | | 2.00 | | | |
| Patient Safety | | | | | | |
| PS1 | NHS Staff Survey – raising concerns sub-score | 2024 | 2.89 | | | → |
| PS2 | CQC safe inspection score (if awarded within the preceding 2 years) | | | | | |
| PS3 | Number of MRSA bacteraemia cases (12 months) | Sep-25 | 3.40 | 100/134 | 6.00 | ↑ |
| PS4 | Proportion of C. difficile infections versus threshold (12 months) | Sep-25 | 3.40 | 99/134 | 1.34 | ↑ |
| PS5 | Proportion of E. coli bacteraemia versus threshold (12 months) | Sep-25 | 3.30 | 96/134 | 1.27 | ↑ |
| People and workforce | | | | | | |
| PW1 | Sickness absence rate | Jun-25 | 1.38 | 27/205 | 4.1% | ↓ |
| PW2 | NHS staff survey engagement theme score | Jun-25 | 2.85 | | | → |
| Finance and productivity | | | | | | |
| FP1 | Planned surplus/deficit | | 1.00 | | | → |
| FP2 | Variance year-to-date to financial plan | Sep-25 | 3.00 | 158/205 | -0.69 | ↓ |
| FP3 | Implied productivity level | Jun-25 | 1.52 | 23/134 | 5.83% | ↑ |
| Total metric score | | | 53.28 | | | |

- **ESNEFTs overall segment has remained at a 3.** The average metric score has improved marginally from 2.48 to 2.47.
- The Trust's rank has improved to **82 (86) out of 134 acute providers** nationally.
- The financial override is now applicable, meaning that the Trust was not able to score higher than a 3.
- Domain scores do not inform the overall average score/segment per se. They are for information and provide an aggregated assessment of how an organisation is performing in those individual areas. Acknowledging this, the poorest performing domains are: **Access to services** and **Patient Safety**.

Below is the summary position for **East of England providers**:



Total 134 Acute Providers



| Region | Trust Type | Trust Subtype | Trust Code | Trust Name | Quarter | Average metric score | Average metric rank score | Adjusted segment (after financial override) | Adjusted Segment Rank | Financial Override |
|--------|-------------|--------------------|------------|---|------------|----------------------|---------------------------|---|-----------------------|--------------------|
| East | Acute trust | Acute - Specialist | RGM | Royal Papworth Hospital NHS Foundation Trust | Q2 2025/26 | 1.33 | 1 | 1 | 1 | No |
| East | Acute trust | Acute - Large | RWH | East and North Hertfordshire Teaching NHS Trust | Q2 2025/26 | 2.1 | 35 | 2 | 21 | No |
| East | Acute trust | Acute - Teaching | RWG | West Hertfordshire Teaching Hospitals NHS Trust | Q2 2025/26 | 1.83 | 17 | 3 | 31 | Yes |
| East | Acute trust | Acute - Small | RGR | West Suffolk NHS Foundation Trust | Q2 2025/26 | 2.27 | 55 | 3 | 57 | Yes |
| East | Acute trust | Acute - Medium | RC9 | Bedfordshire Hospitals NHS Foundation Trust | Q2 2025/26 | 2.34 | 66 | 3 | 66 | Yes |
| East | Acute trust | Acute - Teaching | RGT | Cambridge University Hospitals NHS Foundation Trust | Q2 2025/26 | 2.37 | 71 | 3 | 71 | No |
| East | Acute trust | Acute - Large | RGN | North-West Anglia NHS Foundation Trust | Q2 2025/26 | 2.46 | 81 | 3 | 81 | Yes |
| East | Acute trust | Acute - Large | RDE | East Suffolk and North Essex NHS Foundation Trust | Q2 2025/26 | 2.47 | 82 | 3 | 82 | Yes |
| East | Acute trust | Acute - Teaching | RD8 | Milton Keynes University Hospital NHS Foundation Trust | Q2 2025/26 | 2.55 | 90 | 3 | 90 | Yes |
| East | Acute trust | Acute - Teaching | RM1 | Norfolk and Norwich University Hospitals NHS Foundation Trust | Q2 2025/26 | 2.74 | 108 | 4 | 108 | Yes |
| East | Acute trust | Acute - Small | RQW | The Princess Alexandra Hospital NHS Trust | Q2 2025/26 | 2.86 | 119 | 4 | 119 | Yes |
| East | Acute trust | Acute - Large | RAJ | Mid and South Essex NHS Foundation Trust | Q2 2025/26 | 2.93 | 126 | 4 | 126 | Yes |
| East | Acute trust | Acute - Teaching | RGP | James Paget University Hospitals NHS Foundation Trust | Q2 2025/26 | 3.08 | 129 | 4 | 129 | Yes |
| East | Acute trust | Acute - Small | RCX | The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust | Q2 2025/26 | 3.29 | 134 | 4 | 134 | Yes |

Total national ranks in terms of adjusted segments, including the East of England provider performance:

| Segment | Q1 | Q2 | Q1 | Q2 | Q1 | Q2 |
|-----------|---------------------------|-----|-----------|-----------|-------------------------|----|
| | Total number of providers | | Rank | | Number of EoE providers | |
| 1 (Best) | 16 | 20 | 1 - 16 | 1 - 20 | 1 | 1 |
| 2 | 11 | 8 | 17 - 27 | 21 - 29 | 1 | 1 |
| 3 | 76 | 76 | 28 - 102 | 30 - 103 | 6 | 7 |
| 4 (Worst) | 31 | 30 | 103 - 134 | 104 - 134 | 6 | 5 |
| | 134 | 134 | | | | |

Of the 134 providers, only 29 (27) have achieved segment 1 or 2 (approximately 22%) including only 2 East of England organisations. The vast majority of providers are in segments 3 and 4 (approximately 78%). The East of England does have a disproportionately higher amount of **segment 4 providers** (EoE 36% compared to 22% nationally).

| | Areas of Improvement | Areas requiring further work |
|--|--|---|
| <p><u>QUALITY</u></p>  | <p><u>Mortality</u></p> <ul style="list-style-type: none"> Rolling 12-month crude mortality rates in HSMR and SMR continue to indicate downward trends <p><u>Quality</u></p> <ul style="list-style-type: none"> Continued reduction in the rate of falls across the Trust at 5.2 per 100 bed days | <p><u>Mortality</u></p> <ul style="list-style-type: none"> Rolling 12-month crude mortality rates in HSMR and SMR continue to indicate downward trends NHSE Digital has reversed its decision to record same day emergency care in the emergency care data set. Although the aim is to include data in the admitted patient care data set spring 2026, it will be many months before trust informatics teams nationally will be able to adjust clinical systems <p><u>Quality</u></p> <p>There has been a review of the ACE programme during the pause for Epic implementation including how data sets will be utilised from the Epic dashboards. Going forward the number of follow up visits for wards achieving Bronze will increase to support assessment of impact of quality improvement plans. Visits will restart in February 2026.</p> <p>Patient safety reporting is under review to strengthen an outcome and learning focus rather than process reporting. This report will be enhanced to reflect the developments made.</p> |
| <p><u>PERFORMANCE</u></p>  | <ul style="list-style-type: none"> Both sites saw improvement across the UEC metrics as stabilisation from Epic improvement with a 10.6% improvement on 4-hour performance in Ipswich and ESNEFT above plan submitted for November, with improvements in 12 hour waits also. No patients over 65 weeks for any reason and improvement in those patients waiting over 52 weeks. Improvement in Activity levels following the planned reductions – still some areas where improvements are slower to return. Improvement month on month for Cancer Elective Focus throughout November with Elective Roadshows, speciality Deep Dives, tactical weekly and Turbo rooms all to support validation and education with a dedicated focus on data quality i.e. duplicate referrals, appts with no next steps and DNA appts. This supported the reduction of the total waiting list size. | <ul style="list-style-type: none"> The Trust achieved 73.3% performance against the A&E 4-hour standard in November. Both sites are working towards approved recovery plans with good progress seen in non admitted pathways and December performance on track to improve over November. Taskforce workstreams inpatient flow and frailty admission prevention will supplement and enable the improvements required for our patients waiting longer than 12 hours. Time to care week planned week commencing 15th December across both sites to support further improvements to Handover 45 and LOS. Turbo rooms and focus for Cancer as per Elective approach Resolution of PACS issues to support the improvement in all pathways in Cancer, DM01 and RTT. Focus is on the 62-day backlog with additional capacity planning underway for November onwards. Returning to pre-go live activity levels for those areas still not back to plan |

| | Areas of Improvement | Areas requiring further work |
|--|--|--|
| <p>FINANCE</p>  | <ul style="list-style-type: none"> • Bank costs in November were £4.1m which is the lowest it has been all year and on the ceiling target for the month. Cumulatively the Trust has exceeded the bank ceiling by £2.9m (£35.5m v £32.6m). • Agency costs in November were £0.7m. Reported monthly costs have dipped under the 25/26 ceiling set for the first time this year (£0.1m). Cumulatively the Trust has exceeded the agency ceiling by £1.9m (£8.4m v £6.5m). • £3.3m of cost improvement plans were delivered in November which was an improvement on the £3.1m delivered in October. | <ul style="list-style-type: none"> • The Trust reported an actual deficit of £1.5m in November, £2m adverse to plan. This means that the cumulative position has moved to a deficit £11.6m. This is behind plan by £7.8m. Renewed energy needs to go into the Trust's recovery plans (both central schemes and those locally developed by divisions). • While the in-month delivery of CIP improved on the prior month by £0.2m, this was still below the target delivery by £0.9m (target £4.3m). • £18.4m year to date of cost improvement plans have been delivered for the year, against a target of £26.8m. • Capital expenditure cumulatively underspent against CDEL by £18.9m at the end of November. The main drivers of this underspend were Building for Better Care (£12.1m) and Estates & Facilities (£5.5m). |
| <p>WORKFORCE</p>  | <ul style="list-style-type: none"> • The Trust is -1.3WTE at variance to plan across all workforce (across agency, bank and substantive workforce) • The Trust is reporting 5.11% sickness absence, which is above target of 4%. Wellbeing calls alongside supportive absence management processes are in place to support colleagues to return to work safely. • The Trust is reporting a 5.54% voluntary turnover rate. • National Staff Survey (NSS) – The survey closed on 28 November with a response rate of 50.3% this year, reaching the 2025 target of 50%. Results are due to be released in March 2026. • Various leads have supported the Sexual Safety Charter Framework Self-assessment on the 49 additional actions within the framework. This provides the current status of the actions, gap analysis and further actions to take forward to close the gap. A self-assessment has been undertaken to review our progress against the additional 49 actions, the outcomes will be reported to the EMC/POD/Board in due course. | <ul style="list-style-type: none"> • The Retention Team is currently working closely with two departments holding listening sessions to gather information about staff experience that feeds into a report for the commissioning management team. Feedback sessions for staff have been arranged for Jan 2026. • New Staff are invited to 1, 3 and 6 month review meetings as part of new starter programme gaining insight into their early experience working at the Trust. Feedback is shared with HRBP's to support with divisional improvements. • EDI Training has restarted post implementation of Epic system, although numbers of participants are low. The EDI team is continuing to support on EDI related concerns. • Further work to complete the gap analysis actions from the Sexual Safety Charter Framework. • October saw the launch of freedom to speak up month, revising our training, speak-up guide and speaking to staff about the importance of raising concerns |

The **Accountability Framework (AF)** is the Trust's principal performance management tool.

The AF is the mechanism used to hold both Clinical and Corporate divisions to account for their performance and to ensure that Trust resources are converted into the best possible outcomes, for both the quality of services and treatment, as well as the value for money of the work performed.

The AF therefore encapsulates the Trust's vision and more detailed objectives, resourcing, delivery, monitoring performance, course correction and evaluation.

Changes to the AF are agreed on a monthly basis through the Informatics Programme Board and actioned the following month. The AF policy was updated and agreed through the Executive Management Committee in October 2022.

Aggregated AF Score Classification Explained

| Domain Scores | Aggregated AF Score | |
|---|---------------------|----------------------|
| Two or more domains scoring '1' | 1 | Inadequate |
| Three or more domains scoring '2' or below, with / or any domain score of '1' occurring once only | 2 | Requires Improvement |
| Other combinations of domain scores between an overall domain score of '2' and '4' | 3 | Good |
| Two or more domains scoring '4' and no domain scoring below a '3' | 4 | Outstanding |

2025/26 reporting – Month 7

This report summarises the month 7 (2025/2026) performance reported in the Accountability Framework (AF). The October performance accountability meetings took place on the 2nd and 3rd of December.

Clinical divisions performance

| | Cancer and | | | | Medicine and | | | | Medicine and | | | | Surgical Division | | | | Women and Children | | | |
|---------------------|------------|---|---|---|--------------|---|---|---|--------------|---|---|---|-------------------|---|---|---|--------------------|---|---|---|
| Caring | 4 | 3 | ↓ | ↔ | 3 | 3 | → | ↔ | 3 | 3 | → | ↔ | 2 | 2 | → | ↔ | 3 | 3 | → | ↔ |
| Responsive | 2 | 2 | → | ↔ | 2 | 2 | → | ↔ | 2 | 1 | ↓ | ↔ | 1 | 1 | → | ↔ | 1 | 1 | → | ↔ |
| Safe | 3 | 2 | ↓ | ↔ | 2 | 2 | → | ↔ | 2 | 2 | → | ↔ | 2 | 3 | ↑ | ↔ | 3 | 3 | → | ↔ |
| Effective | 3 | 4 | ↑ | ↔ | 3 | 3 | → | ↔ | 4 | 3 | ↓ | ↔ | 2 | 1 | ↓ | ↔ | 3 | 4 | ↑ | ↔ |
| Well-Led | 2 | 2 | → | ↔ | 1 | 1 | → | ↔ | 2 | 2 | → | ↔ | 2 | 2 | → | ↔ | 3 | 2 | ↓ | ↔ |
| Use of Resources | 1 | 1 | → | ↔ | 1 | 2 | ↑ | ↔ | 1 | 1 | → | ↔ | 1 | 1 | → | ↔ | 1 | 1 | → | ↔ |
| Aggregated AF Score | 2 | 2 | → | ↔ | 1 | 2 | ↑ | ↔ | 2 | 1 | ↓ | ↔ | 1 | 1 | → | ↔ | 1 | 1 | → | ↔ |

Summary Divisional Performance

- Cancer and Diagnostics maintained a score of 2 and Medicine & Community IES improved from a 1 to a 2.
- Medicine and Community NEE declined from a score of 2 to a score of 1 in month.
- Women and Children and Surgical Division maintained a score of 1 in month.

Corporate performance

The October Corporate performance accountability meetings were cancelled due to operational pressures.

| | Communications | | Estates & Facilities | | Faculty of Education | | Finance & Information Services | | Governance | | Human Resources | | ICT | | Medical Director | | Nursing | | Operations | | Research & Innovation | | | |
|---------------------|----------------|---|----------------------|---|----------------------|---|--------------------------------|---|------------|---|-----------------|---|-----|---|------------------|---|---------|---|------------|---|-----------------------|---|---|---|
| Well-Led | 3 | 3 | → | ↔ | 3 | 2 | ↓ | ↔ | 3 | 3 | → | ↔ | 2 | 3 | ↑ | ↔ | 3 | 3 | → | ↔ | 3 | 3 | → | ↔ |
| Use of Resources | 4 | 4 | → | ↔ | 2 | 1 | ↓ | ↔ | 1 | 3 | ↑ | ↔ | 3 | 3 | → | ↔ | 2 | 2 | → | ↔ | 2 | 3 | ↑ | ↔ |
| Aggregated AF Score | 3 | 3 | → | ↔ | 3 | 2 | ↓ | ↔ | 2 | 3 | ↑ | ↔ | 3 | 3 | → | ↔ | 3 | 3 | → | ↔ | 3 | 3 | → | ↔ |

Summary Corporate Services Performance

- Finance & Information improved from a 2 to a score of 3 (Good).
- Estates & Facilities and Nursing declined from a 3 to a 2 in month.
- All other corporate CDGs maintained a score of 3 (Good).

| | | | | |
|---------------------|--------------|------------------------|--------|---------------|
| Score Rating | 1 Inadequate | 2 Requires Improvement | 3 Good | 4 Outstanding |
|---------------------|--------------|------------------------|--------|---------------|

| Mortality | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 |
|---------------------|--------|--------|--------|--------|--------|--------|--------|
| 12-mth rolling HSMR | 100 | 122.1 | 113.0 | 111.5 | 110.0 | 108.6 | 108.7 |
| SHMI | 1 | 1.09 | 1.08 | 1.07 | 1.07 | TBC | TBC |

| Incidents & Complaints | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|----------------------------------|--------|--------|--------|--------|--------|--------|--------|
| Total incidents reported | - | 3,231 | 3,402 | 3,042 | 3,058 | 3,003 | 3,252 |
| Never Events | 0 | 1 | 1 | 0 | 1 | 0 | 0 |
| Mixed Sex Accommodation Breaches | 0 | 305 | 267 | 206 | 206 | 70 | 44 |
| Total complaints reported | - | 117 | 116 | 97 | 110 | 133 | 88 |
| Overdue Complaints | 0 | 0 | 0 | 1 | 1 | 7 | 10 |
| Complaint Response Compliance | 95% | 95.4% | 97.5% | 97.2% | 100.0% | 98.1% | 93.0% |
| Total PALs Enquiries | - | 349 | 319 | 366 | 567 | 815 | 633 |
| Duty of Candour (Initial) | 100% | 86.4% | 95.5% | 91.2% | 85.1% | 90.5% | 87.3% |

| Infection Control | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|-------------------|--------|--------|--------|--------|--------|--------|--------|
| C.Diff | 0 | 17 | 11 | 16 | 17 | 12 | 9 |
| MRSA | 0 | 1 | 0 | 0 | 2 | 0 | 0 |
| MSSA | 0 | 4 | 8 | 4 | 6 | 3 | 10 |
| E.Coli | 0 | 13 | 14 | 16 | 7 | 11 | 9 |

| Harm Free Care | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|----------------------------|--------|--------|--------|--------|--------|--------|--------|
| VTE Risk Assessments | 95% | 68.75% | 75.64% | 65.71% | 63.30% | N/R | 94.74% |
| Total falls (acute) | - | 185 | 196 | 199 | 203 | 186 | 178 |
| Serious Harm falls | 0 | 3 | 4 | 0 | 3 | 3 | 5 |
| Category 3 Pressure Ulcers | 0 | 17 | 17 | 16 | 10 | 18 | 34 |
| Category 4 Pressure Ulcers | 0 | 1 | 0 | 0 | 0 | 1 | 0 |

| FFT | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|-------------------------------------|--------|--------|--------|--------|--------|--------|--------|
| F&F: Inpatients % Recommending | 90% | 92.9% | 94.8% | 93.2% | 90.5% | N/R | 93.9% |
| F&F: A&E % Recommending | 90% | 87.4% | 86.6% | 87.5% | 85.4% | 78.6% | 73.7% |
| F&F: Day Case % Recommending | 90% | 96.0% | 97.6% | 97.4% | 95.3% | 97.4% | 83.3% |
| F&F: Birth % Recommending | 90% | 100.0% | 100.0% | 90.0% | 83.3% | N/R | 100.0% |
| F&F: Post Natal Ward % Recommending | 90% | 88.9% | 100.0% | 80.0% | 100.0% | 50.0% | N/R |
| F&F: Antenatal % Recommending | 90% | 50.0% | 84.6% | 85.7% | 100.0% | 100.0% | 100.0% |

Areas of Improvement

Mortality

- Rolling 12-month crude mortality rates in HSMR and SMR continue to indicate downward trends.

Quality

Infection Prevention and control

Continued reduction trend for C Difficile infection over past 3 months however continued work through the improvement programme required to sustain this.

Significant improvement seen in compliance with VTE risk assessment which is marginally under the Trust target for the first time in the year.

Sustained reduction in MSA breaches following implementation of new pathway at the Ipswich site.

Areas requiring further work

Mortality

- NHSE Digital has reversed its decision to record same day emergency care in the emergency care data set. Although the aim is to include data in the admitted patient care data set spring 2026, it will be many months before trust informatics teams nationally will be able to adjust clinical systems.

Quality

It is anticipated that the complaint response compliance will improve in Q4 following delays encountered during the period of EPIC mobilisation where there was a rise in the number of complaints and workload prioritisation. The number of complaints raised in month has significantly reduced following the rise seen alongside Epic implementation as anticipated.

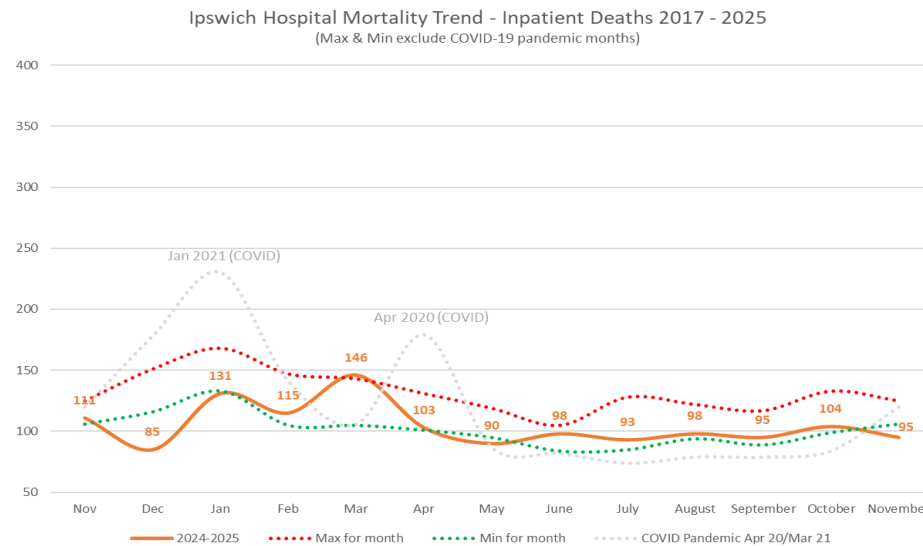
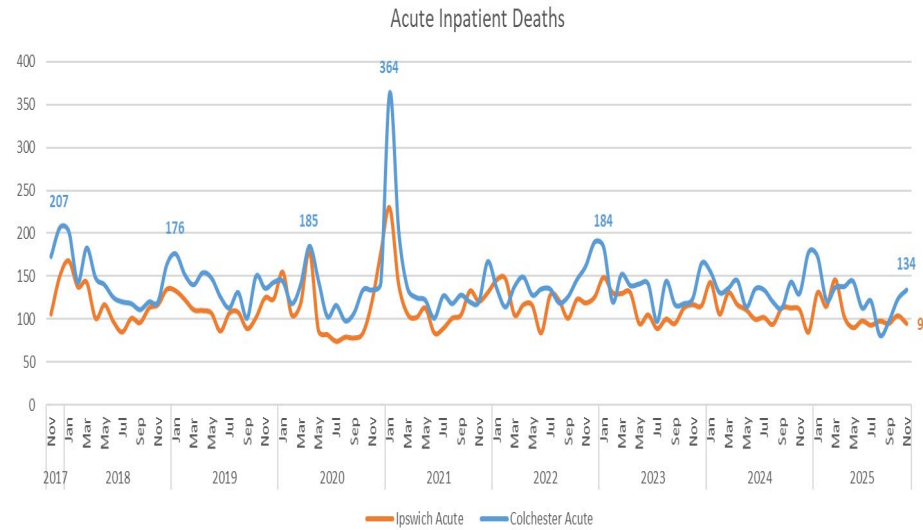
PALS enquires remain higher than the monthly average, but a downward trend is being seen.

Mortality Trend Data – All inpatients and ED attenders

November 2025

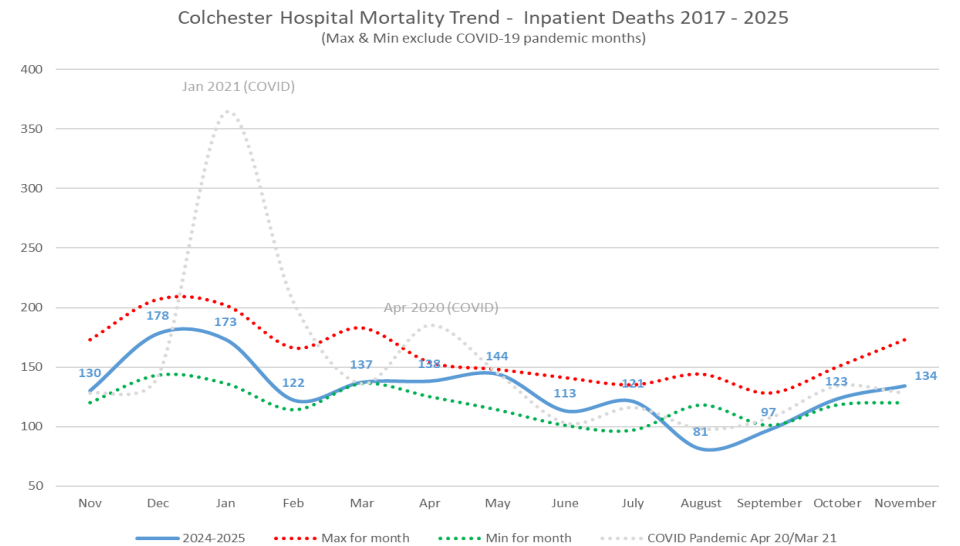
229 acute inpatient deaths (227 in October):

- Ipswich 95 – below seasonal ‘norm’
- Colchester 134 – lower end of seasonal ‘norm’
- 29 deaths in SDEC (31 in October)



| IP = inpatient SDEC=same day emergency care | Nov 2025 No. Deaths | Nov 2024 No. deaths | Rolling 12 mths avg |
|---|------------------------|------------------------|------------------------|
| Ips acute IP | 95 (104) | 111 | 106 |
| Col acute IP | 134 (123) | 130 | 130 |
| Ips SDEC | 13 (13) | ED 11 | ED 11 |
| Col SDEC | 16 (18) | ED 15 | ED 14 |
| E Suffolk Comm | 0 (4) | | |
| NE Essex Comm | 9 (5) | | |
| Virtual ward | 1 (2) | | |

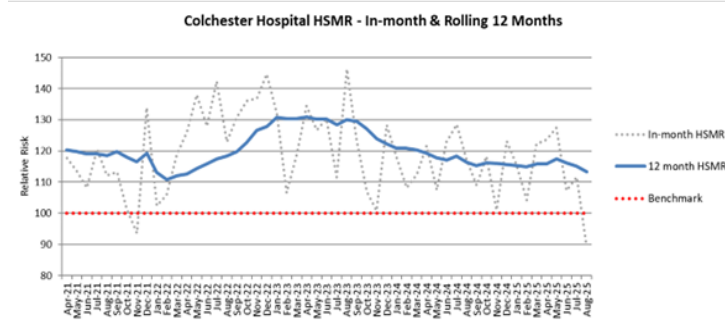
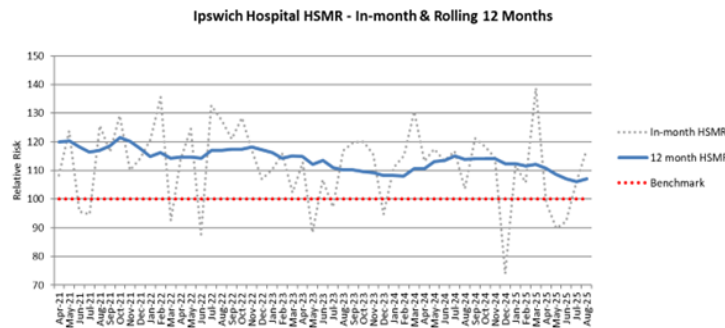
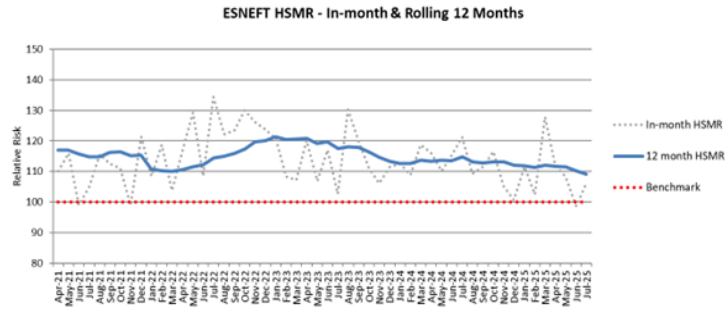
Figure in brackets = previous month



Mortality Ratios - Data Source DF Intelligence (Telstra Health)

Summary

- ESNEFT 12-mth HSMR+ to August 2025, 108.7, 'higher than expected'
- ESNEFT 12-mth all-diagnoses (SMR+) to August 2025, 108.1, 'higher than expected'
- ESNEFT has the sixth highest crude mortality rate in the peer group (ordinary admissions)

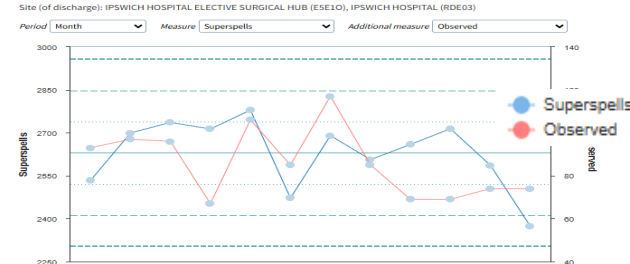


Dr Foster Summary – 12 months to August 2025

| Aug 2025 - 12 month rolling data except where specified | ESNEFT | IPS | COL |
|---|--------------------|--------------------|--------------------|
| HSMR+ in-month | 101.0 | 117.1 | 89.4 |
| HSMR+ | ▲ 108.7 | ▲ 107.1 | ▼ 113.4 |
| HSMR+ Lower confidence limit | ▲ 104.4 Outlier | ▲ 100.7 Outlier | ▼ 107.4 Outlier |
| HSMR+ with emergency cases removed | ▲ 109.8 Outlier | ▲ 107.1 Outlier | ▼ 115.4 Outlier |
| HSMR+ Death rate (nat. >3.7%) (emergency cases removed) | > 3.6% | ▲ 3.3% | > 4.4% |
| All diagnosis groups (SMR) | ▲ 108.1 | ▲ 106.7 | ▼ 110.6 |
| Lower confidence limit (all) | ▲ 104.3 Outlier | ▲ 101.0 Outlier | ▼ 105.4 Outlier |
| SMR+ with emergency cases removed | ▲ 109.4 Outlier | ▲ 106.7 Outlier | ▼ 113.2 Outlier |

Increasing HSMR+ rates over the last few months at Ipswich Hospital are being driven by a reduction in the number of HSMR+ discharges, coupled with a stable mortality rate.

Diagnoses - HSMR | Mortality (in-hospital) | Sep 2024 - Aug 2025 | Trend (month)

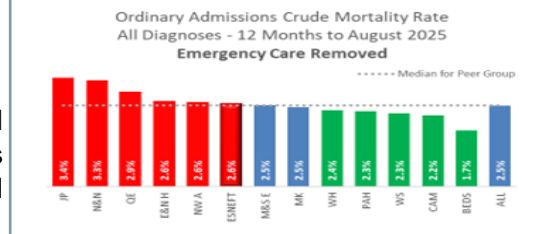
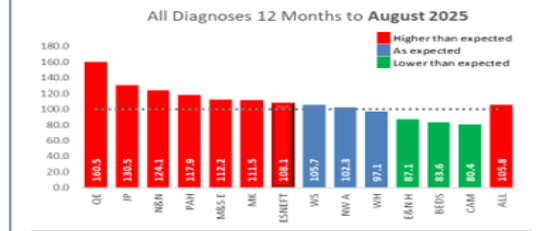
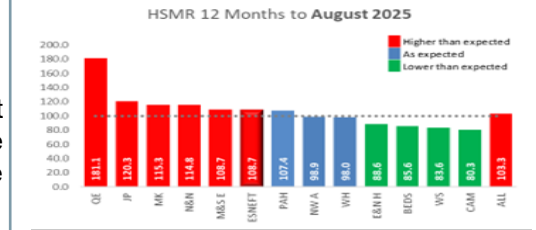


Weekend/Weekday HSMR Admissions

In the 12 months to August 2025, both weekday and weekend ESNEFT HSMR emergency admissions were 'higher than expected'. Only Ipswich Hospital weekday admissions were 'as expected'.

National & Regional Peer Group

The Trust's mortality ratios are currently 'higher than expected'. The region is currently regarded as being 'higher than expected'. Many peer trusts have significant volumes of uncoded spells, particularly West Suffolk (30% discharges) and QEH (19% discharges), so the data should be used with caution. QEH has seen a drop in the number of discharges over the last two years coupled with a drop in the 'expected' % deaths.



Crude Mortality Rates

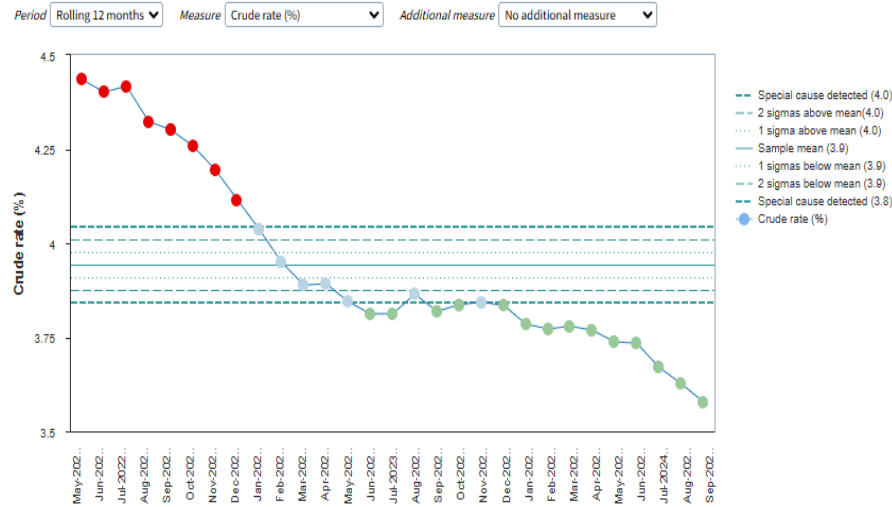
ESNEFT rolling 12-month trend data for crude mortality rates in HSMR+ and SMR+ (emergency cases removed) indicate a downward trend between April 2023 and August 2025.

For August 2025, ESNEFT mortality for ordinary admissions were 2.1% compared to a national rate of 2.1%

- Colchester 1.6%
- Ipswich 2.4%

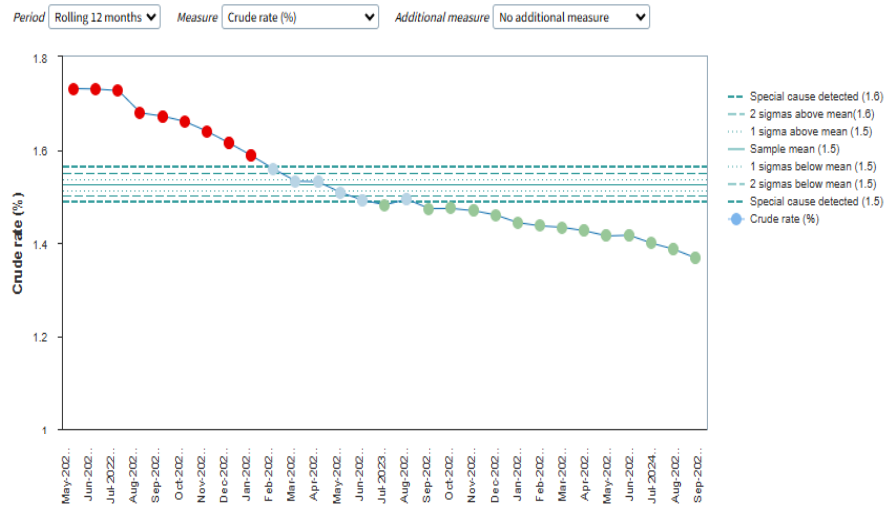
Diagnoses - HSMR | Mortality (in-hospital) | Apr-23 to most recent | Trend (rolling 12 months)

Specialty (of discharge): GENERAL SURGERY, UROLOGY, BREAST SURGERY, Colorectal Surgery, Hepatobiliary and Pancreatic Surgery, UPPER GASTROINTESTINAL SURGE...



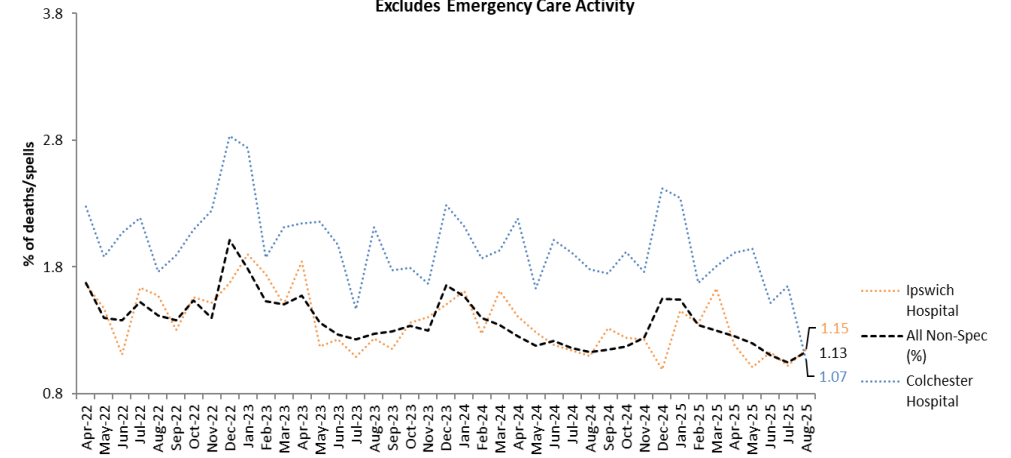
Diagnoses | Mortality (in-hospital) | Apr-23 to most recent | Trend (rolling 12 months)

Specialty (of discharge): GENERAL SURGERY, UROLOGY, BREAST SURGERY, Colorectal Surgery, Hepatobiliary and Pancreatic Surgery, UPPER GASTROINTESTINAL SURGE...



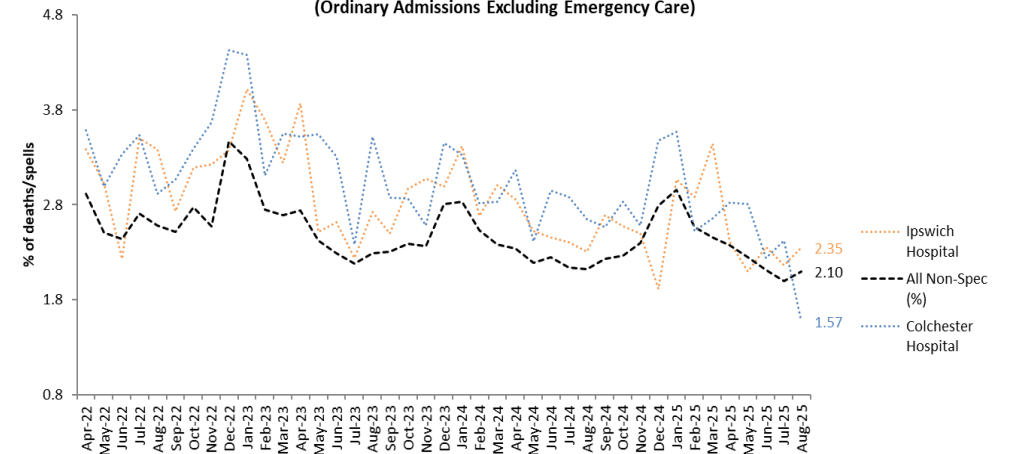
All Diagnosis Groups - Crude Mortality Rates (All patient types)

Excludes Emergency Care Activity



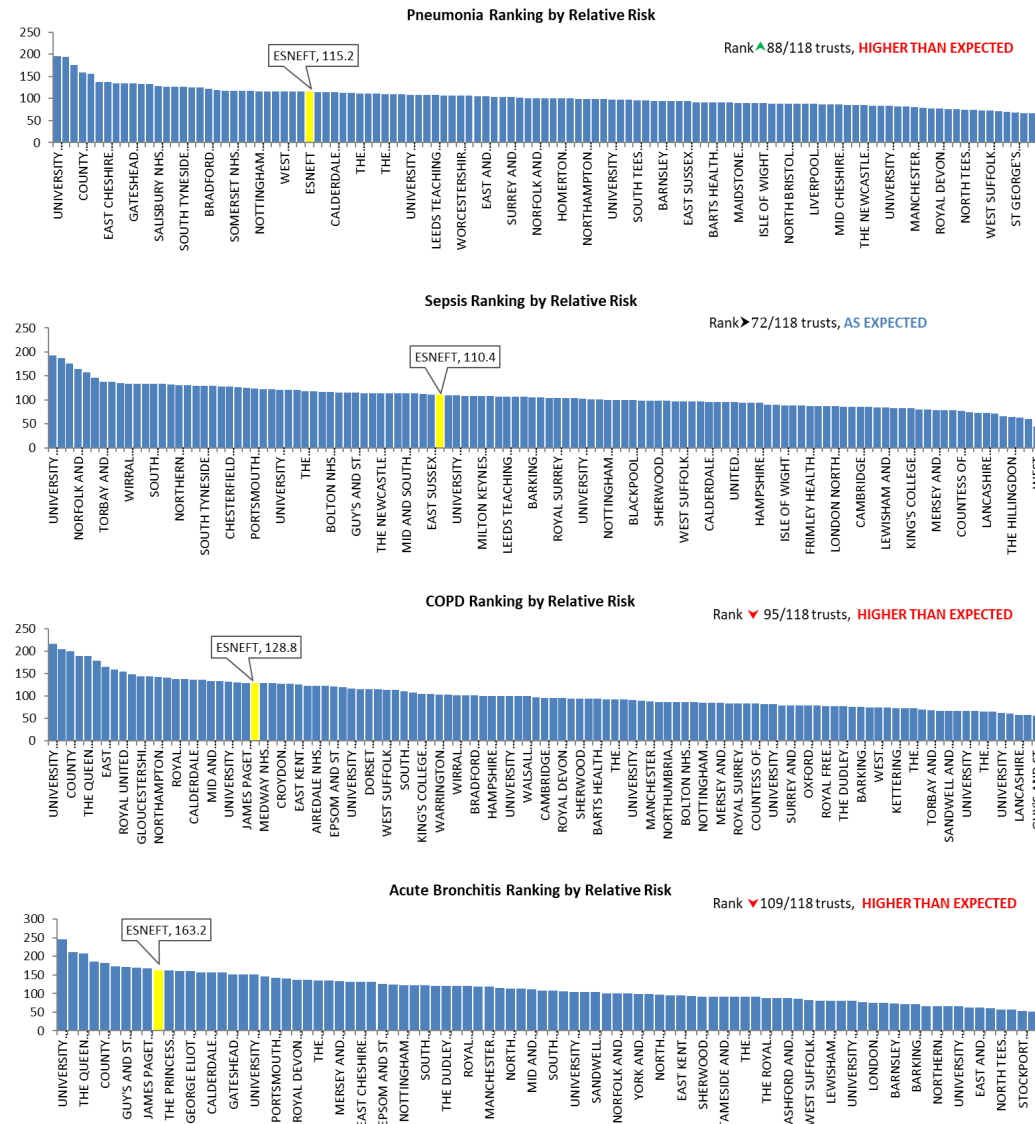
All Diagnosis Groups - Crude Mortality Rates

(Ordinary Admissions Excluding Emergency Care)



Risk-Adjusted Mortality: High Risk Conditions – Source Dr Foster: Results to August 2025

3 of the 4 high risk groups are showing 'higher than expected'.



A review this year of pneumonia cases overseen by the AMD for Patient Safety did not identify any significant issues in care.

Each month, Deteriorating Patient CNSs/Resus Officers screen all deaths where the patient died with sepsis/septic shock on the death certificate. Cases are highlighted for review if care deficits are identified.

Performance within the COPD group has slipped since 2023/4. The crude mortality rate has increased from 4.4% to 4.9%. The CUSUM chart indicates that a peak in activity in Jan/Feb 2025 resolved without triggering. This group has always struggled with diagnostic accuracy on admission. Analysis from the 12 months to September 2025 indicates that 48/75 patients had COPD on their death certificate - 21 in part 1A and 15 with infective exacerbation. Other deaths in this group had a wide range of other conditions, not all of them respiratory.

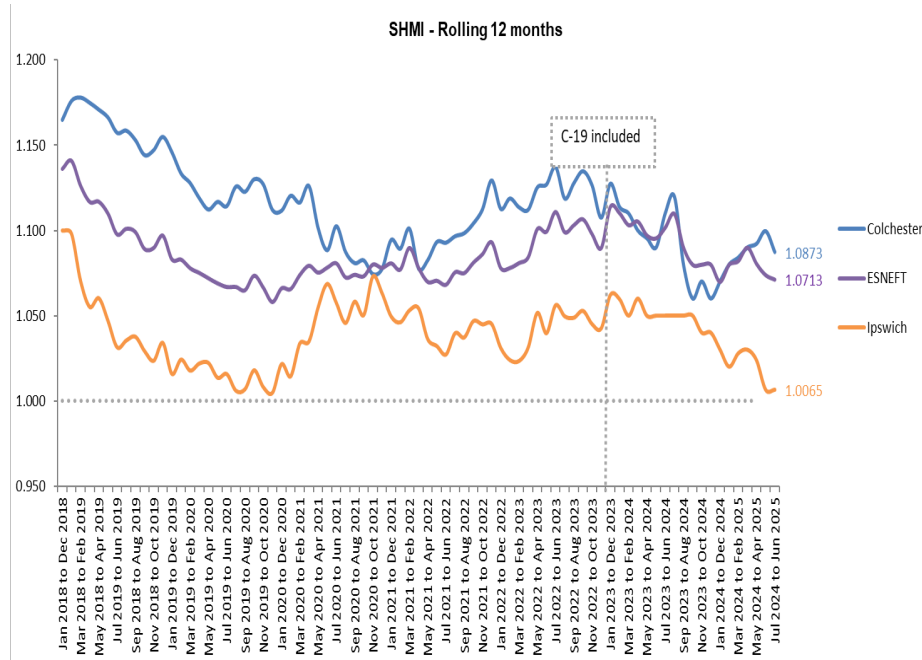


Analysis of the acute bronchitis group indicates that other acute trusts do not code as many cases to this this group as ESNEFT. This may account for poor benchmarked performance.

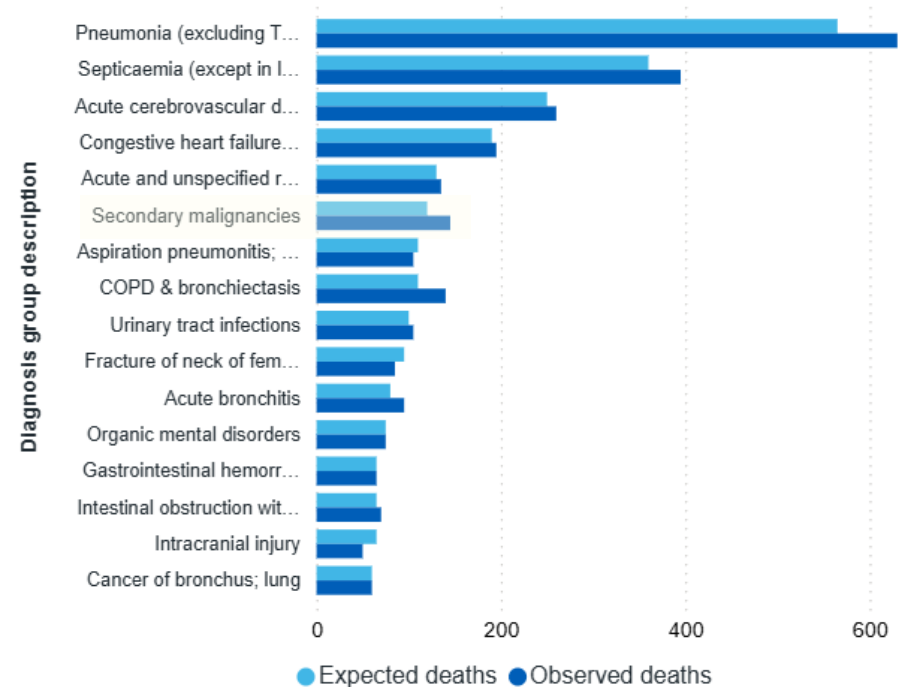
All SHMI diagnosis groups are 'as expected' with the exception of secondary malignancies which are 'higher than expected' – performance has deteriorated since September 2024.

ESNEFT SHMI to June 2025 was 1.07 'as expected'.

Colchester 1.09 as expected
Ipswich 1.00 as expected.



Comparison of observed and expected deaths by diagnosis group



SDEC Update

NHSE Digital posted 25/11/2025 that: “A decision has been taken to change the reporting approach to speciality Same Day Emergency Care (SDEC) activity from the Emergency Care Data Set (ECDS) as specified in version 4.0 of the ECDS Information Standard Notice to the Admitted Patient Care (APC) data set, with the expectation this is implemented from Spring 2026. We will provide guidance on updated recording and reporting expectations by early 2026 but in the meantime, we ask providers in the process of shifting SDEC reporting into ECDS to pause and retain their current status quo.”

ESNEFT recently migrated SDEC to the ECDS with the roll-out of Epic.



Description:

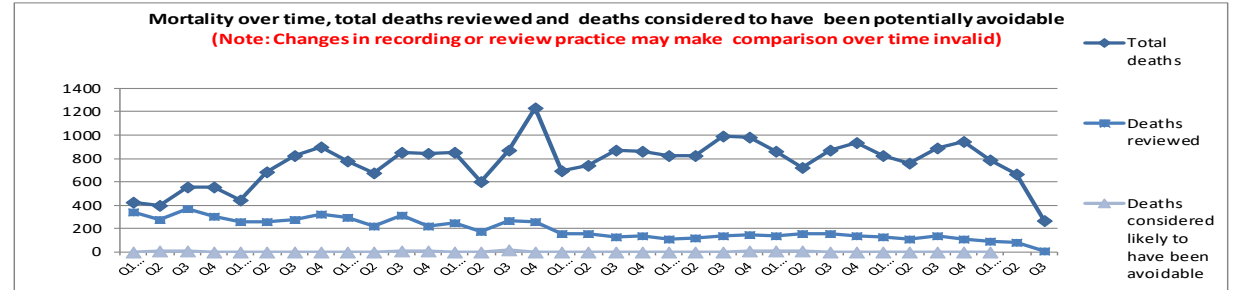
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Potentially Due to Problems in Healthcare (does not include patients with identified learning disabilities)

| Total Number of Deaths in Scope | | Total Deaths Reviewed | | Total No. of deaths considered to have been possibly due to problems in healthcare (Score <=3) | |
|---------------------------------|---------------------|---------------------------|---------------------|--|---------------------|
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| 268 | 215 | 9 | 29 | 0 | 0 |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 268 | 667 | 9 | 84 | 0 | 0 |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 1725 | 3423 | 184 | 488 | 1 | 9 |

Time Series: Start date 2017-18 Q1 End date 2025-26 Q3



Total Deaths Reviewed by Mortality Methodology Score

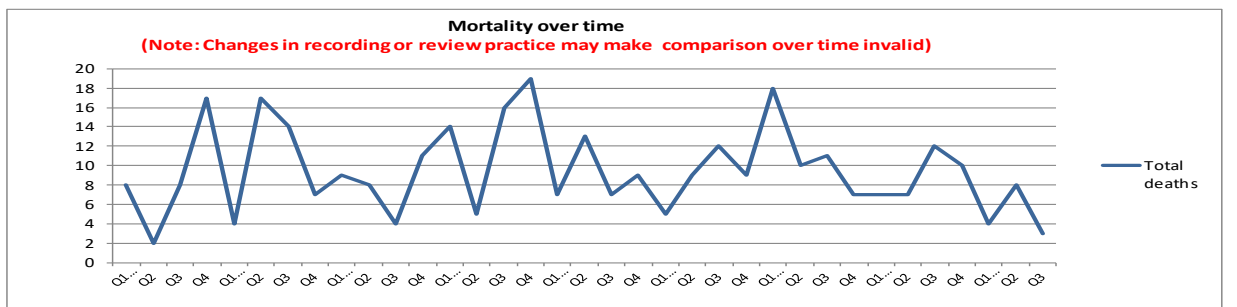
| Score 1 | Score 2 | Score 3 | Score 4 | Score 5 | Score 6 |
|--|---|--|--|--|--|
| Definitely due to problems in healthcare | Strong evidence there were problems in healthcare | Probably due to problems in healthcare (more than 50:50) | Probably due to problems in healthcare but not very likely | Slight evidence that death was due to problems in healthcare | Death was definitely not due to problems in healthcare |
| This Month 0 0.0% | This Month 0 0.0% | This Month 0 0.0% | This Month 0 0.0% | This Month 1 12.5% | This Month 7 87.5% |
| This Quarter (QTD) 0 0.0% | This Quarter (QTD) 0 0.0% | This Quarter (QTD) 0 0.0% | This Quarter (QTD) 0 0.0% | This Quarter (QTD) 1 12.5% | This Quarter (QTD) 7 87.5% |
| This Year (YTD) 0 0.0% | This Year (YTD) 1 0.6% | This Year (YTD) 0 0.0% | This Year (YTD) 5 3.0% | This Year (YTD) 15 9.0% | This Year (YTD) 145 87.3% |

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Due to Problems in Healthcare for patients with identified learning disabilities

| Total Number of Deaths in scope | | Total Deaths Reviewed Through the LeDeR Methodology (or equivalent) | | Total No. of deaths considered to have been potentially due to problems in healthcare | |
|---------------------------------|---------------------|---|---------------------|---|---------------------|
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| 3 | 3 | 0 | 0 | 0 | 0 |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 3 | 8 | 0 | 0 | 0 | 0 |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 15 | 36 | 43 | 289 | 26 | 273 |

Time Series: Start date 2017-18 Q1 End date 2025-26 Q3



Mortality Review Dashboard

April 2023 to March 2025, 19 SJR-reviewed deaths where issues in healthcare may have contributed to death – see next slides for detail.

| | | | |
|----------|---|---|--|
| Trust | ESNEFT (Colchester Apr 17 - Jun 18, Ipswich & Colchester from Jul 18) | Total deaths include inpatients, paediatrics, maternity, ED | Please note, where it is indicated that care contributed to death (score 1, 2 or 3), the case is escalated to the Patient Safety Team for PSR/PSII - this result may be revised following MDT review. The results shown below are for SJRs only. |
| Org Code | 432 | Total deaths also includes patients with LD reviewed under SJR criteria by local team - additional LeDeR death reviews are shown separately | |
| Month | October | | |
| Year | 2025-26 | | |

| | | Not all deaths are subject to mandatory review. | | | | | | | | | Review of mandatory case records | | | | |
|----------------|-----------|---|-----------------------|--|--|----------|----------|----------|----------|---|----------------------------------|--|----------------------|---------------------------------|-------------------------------------|
| Financial Year | Month | Total Deaths | Total Deaths Reviewed | Deaths likelihood > 50% contributed to death | Deaths judged to have been due to problems in healthcare | | | | | Deaths judged not due to problems in care | LD Deaths | No. deaths subject to case record review | No. reviews returned | % Case record reviews completed | No. case record reviews outstanding |
| | | | | | Defin 1 | Evidnc 2 | >50/50 3 | <50/50 4 | Slight 5 | | | | | | |
| 2024-25 | April | 284 | 39 | 1 | 0 | 0 | 1 | 0 | 2 | 36 | 1 | 24 | 23 | 96% | 1 |
| 2024-25 | May | 270 | 47 | 1 | 0 | 0 | 1 | 0 | 4 | 41 | 4 | 31 | 30 | 97% | 1 |
| 2024-25 | June | 267 | 40 | 1 | 0 | 1 | 0 | 1 | 3 | 35 | 2 | 23 | 23 | 100% | 0 |
| 2024-25 | July | 264 | 41 | 0 | 0 | 0 | 0 | 0 | 3 | 37 | 3 | 25 | 24 | 96% | 1 |
| 2024-25 | August | 236 | 35 | 0 | 0 | 0 | 0 | 1 | 2 | 32 | 1 | 18 | 17 | 94% | 1 |
| 2024-25 | September | 263 | 38 | 2 | 0 | 1 | 1 | 1 | 2 | 33 | 3 | 20 | 20 | 100% | 0 |
| 2024-25 | October | 299 | 54 | 2 | 0 | 1 | 1 | 3 | 7 | 42 | 0 | 30 | 30 | 100% | 0 |
| 2024-25 | November | 275 | 41 | 0 | 0 | 0 | 0 | 1 | 3 | 37 | 4 | 22 | 22 | 100% | 0 |
| 2024-25 | December | 316 | 41 | 1 | 0 | 1 | 0 | 0 | 4 | 36 | 8 | 25 | 24 | 96% | 1 |
| 2024-25 | January | 358 | 47 | 1 | 0 | 0 | 1 | 1 | 5 | 40 | 4 | 31 | 31 | 100% | 0 |
| 2024-25 | February | 269 | 30 | 0 | 0 | 0 | 0 | 2 | 1 | 27 | 5 | 18 | 18 | 100% | 0 |
| 2024-25 | March | 322 | 35 | 0 | 0 | 0 | 0 | 0 | 1 | 35 | 1 | 24 | 22 | 92% | 2 |
| 2025-26 | April | 278 | 36 | 1 | 0 | 1 | 0 | 0 | 4 | 31 | 1 | 26 | 21 | 81% | 5 |
| 2025-26 | May | 274 | 27 | 0 | 0 | 0 | 0 | 2 | 3 | 21 | 0 | 16 | 13 | 81% | 3 |
| 2025-26 | June | 238 | 28 | 0 | 0 | 0 | 0 | 1 | 2 | 25 | 3 | 20 | 17 | 85% | 3 |
| 2025-26 | July | 244 | 31 | 0 | 0 | 0 | 0 | 0 | 1 | 29 | 1 | 22 | 18 | 82% | 4 |
| 2025-26 | August | 208 | 24 | 0 | 0 | 0 | 0 | 1 | 2 | 16 | 4 | 19 | 14 | 74% | 5 |
| 2025-26 | September | 215 | 29 | 0 | 0 | 0 | 0 | 1 | 2 | 16 | 3 | 15 | 8 | 53% | 7 |
| 2025-26 | October | 268 | 9 | 0 | 0 | 0 | 0 | 0 | 1 | 7 | 3 | 23 | 8 | 35% | 15 |

Learning from Deaths meeting 5 December 2025 – meeting limited to one presentation owing to clinical pressures

- **Coroner has stated that all deaths of children aged 0-17 must be referred to the coroner.**
- **SOP from Coroner will outline visiting rights for bereaved parents.**
- **Thematic review underway for paediatric emergency transfers to tertiary surgical centres.**
- **Actions taken following the death of a patient who experienced a massive haemorrhage.**

Biannual Update – Women’s and Children’s Services

Meetings are ongoing between the division and mortuary staff to facilitate parental viewing. Training/competencies are being rolled out across the Children’s Band 7 nursing teams. The ADN advised that guidance had recently been revised to ensure that all deaths of children aged 0 to 17 years of age are referred to the coroner. A coroner’s SOP, developed in conjunction with the police, will be issued shortly.

Paediatrics are undertaking a thematic review of deaths following transfer to tertiary surgical units. A local SOP is to be drafted for paediatrics (acute abdomen pathway). Addenbrooke’s are working on a regional acute abdomen pathway, which will include important information to communicate to the tertiary unit for transfer (PEWS). Early themes include the effective communication of case-urgency between ESNEFT, the PaNDR team (Paediatric and Neonatal Decision Support and Retrieval Service) and the tertiary centre.

There has been issues in EpicEPR with regard to sudden and unexpected death in infancy and childhood (SUDIC) – bereavement documentation and processes are not yet built – this has been raised with the relevant RDG.

A case study involved the very sad death of a young Gynae patient.

Summary of findings, areas for improvement and safety actions

Recognition of critical blood loss and timely escalation to a consultant: All staff should understand the signs and symptoms of hypovolaemia and ensure early recognition, management and escalation. Training sessions for the gynaecology team (medical and nursing) for deteriorating gynaecology patients are planned to commence in February 2026 and will be undertaken twice per year going forwards for continued learning.

Transfer to theatre in a timely fashion as per NCEPOD recommended standards: The NCEPOD recommended standards must be incorporated into standard practice in gynaecology to ensure there is no similar delay in transfer to theatre in the future. A local audit of transfer to theatre intervals compared to NCEPOD standards should be undertaken. A SOP for categorisation of gynaecology patients requiring surgery is in development, aimed to be approved in January 2026 to aid the team with decision making and timely transfer to theatre depending on condition, in line with NCEPOD recommendations.

Measuring and Recording Blood Loss and Fluid Balance: The ward needs to implement more robust processes of measuring, recording and escalation of fluid balance, including timely measured blood loss. This must include full details of estimated blood loss within the 24-hour period. Further training has been undertaken across the nursing team to ensure that blood loss is measured (not estimated) wherever possible. Fluid balance charts are now in EpicEPR, and training and audit of compliance is ongoing.

Review of the Massive Haemorrhage Protocol to ensure an anaesthetist is included in the protocol (completed October 2024).

Prostap Clinic Referrals Review: The team will review the referral process into the Prostap clinic to ensure that referrals are clear and streamlined, thereby reducing potential confusion or delays. The referral process is under review to reduce delays wherever possible. The Prostap guideline has recently been reviewed and updated to ensure the criteria for use is clear.

Cases where care may have contributed to death

Where an investigation identified that care may have contributed to death:

6 SJRs/Datixes

1 ELR* (different grading to SJR)

1 PST Review (TBC)

| SJR Summary – where care may have contributed to death (separate to PSIRF outcomes) – final assessment to be agreed | | |
|---|---------------------------|---|
| Sep 2024 | Datix | Suspicion that a tubogram (procedure using contrast to determine if a drain/tube is blocked) introduced bacteria into the patient's abdominal cavity resulting in spontaneous bacterial peritonitis, sepsis and death. |
| Sep 2024 | ELR | Patient discharged on Dexamethasone with no PPI cover, which may have caused duodenal perforation. When attended A&E, CT appropriately requested but the report wasn't escalated by radiology and no one checked the report. When deteriorated overnight, no escalation and no TEP. Action - HotSpot |
| Oct 2024 | Datix | Early management of sepsis in this patient could have led to avoidance of death. Needed early recognition of gas gangrene and escalation to specialist teams including diabetes foot and vascular surgery. |
| Oct 2024 (NEW) | TBC – PST review required | Raised by ME central line should have been removed promptly at first suspicion of line infection and MRI was delayed (Datix 16688) – graded as 'probably avoidable' but supporting narrative advises 'Patient was frail with multiple comorbidities. Death was not preventable despite best medical management. Line sepsis, osteomyelitis of the metal work in the vertebra contributed to the death.' |
| Dec 2024 | Datix | Patient presented to ED with chest pain and should have had an urgent ECG within 15 minutes of arrival. This would have resulted in an immediate transfer to Papworth Hospital. Follow-up now with Patient Safety Team. |
| Jan 2025 | Datix | Prolonged wait outside ED owing to lack of beds, delays in treating signs of sepsis on arrival, delay in the delivery of acute coronary syndrome treatment, failure to monitor according to trust protocols, delays to escalation to ITU - clinical opinion requested by Patient Safety team. |
| Apr 2025 (Not currently included) | Datix | <i>Awaiting post mortem examination results – young patient admitted with vertigo. Her death was likely a result of Neuroleptic Malignant Syndrome with exposure to Quetiapine shortly before death - lethal hyperthermia (with resultant DIC). The root cause of her presentation might well have been an autoimmune encephalitis (and most probably Anti-NMDA-R Encephalitis from an abrupt immunological recognition/response to an existing ovarian teratoma/dermoid cyst containing neuronal tissue) – TBC</i> |
| April 2025 | Datixes | Self-harm – the patient safety team and the divisional director of nursing have chased investigators for their final report. The ELR identified that the patient was reviewed daily by the pain team owing to chronic abdominal pain, but had declined analgesia other than paracetamol and amitriptyline as she had found medication to be ineffective. Staff noted a new confusion with agitation and insomnia. DOLS, MCA and BI were completed as the patient was declining treatment. The patient's son expressed concern and was advised that a mental health review had been requested. EPUT identified low mood but 'no concerns' and the patient was deemed to be 'low risk'. Early learning points note that there was no evidence that 1:1 enhanced support was requested when the patient's mood worsened. Safety-netting advice from EPUT would have been helpful. Although the behaviour chart was completed inconsistently, what was documented indicated limited restlessness and agitation. The patient should have been re-escalated when she became more delusional and expressed hopelessness. |

Accrediting Care at ESNEFT (ACE)

Summary

Care Accreditation provides us with the tools to undertake a comprehensive assessment of quality of care at ward, unit and team levels. It does this by bringing together key measures into a single, overarching framework, from across nursing and clinical care, as relevant to us and to our patients.

Percentage of grading across all standards for the twenty-four wards included:

Bronze – 38%

Silver - 31%

Gold – 4%

Working towards Bronze – 27%

Focus EpicEPR: Accrediting Care at ESNEFT (ACE) results for wards visited in Q2;

| | Ward | D’Arcy | Waldgringfield | Somersham | ED CH | ED IH | Aldham |
|-----------|---|--------|----------------|-----------|--------|--------|--------|
| Standards | Individualised Care | Silver | Bronze | Silver | Silver | Bronze | WTB |
| | Dignity and Respect | Silver | Silver | Silver | WTB | Silver | WTB |
| | Safeguarding, Complex Health and Consent | Silver | WTB | Silver | Gold | Silver | WTB |
| | Leadership , Education and People | Bronze | Bronze | Bronze | Silver | Silver | Silver |
| | Harm Free Care | WTB | Bronze | WTB | Bronze | WTB | Bronze |
| | Delivering Safe Care | WTB | Silver | Bronze | Silver | Bronze | Silver |
| | Nutrition and Hydration | WTB | Silver | Silver | Bronze | Silver | Bronze |
| | Clinical Governance | Bronze | Silver | Silver | Bronze | WTB | WTB |
| | Infection Prevention and Control & Environment Safety | Bronze | Bronze | Silver | WTB | WTB | WTB |
| | Overall | Bronze | Bronze | Silver | Bronze | Bronze | Bronze |



Accrediting care at ESNEFT

Accrediting Care at ESNEFT (ACE)

Summary

Care Accreditation provides us with the tools to undertake a comprehensive assessment of quality of care at ward, unit and team levels. It does this by bringing together key measures into a single, overarching framework, from across nursing and clinical care, as relevant to us and to our patients.

The ACE programme recommenced in December, meaning next month's report will include EAU Ipswich and Birch ward's return visit

The nursing audit programme recommenced in November with changes made due to EpicEPR

Data from all wards since inception of programme

| Ward→ | Haughley | EAU | Peldon | Washbrook | Martlesham | Brightling sea | West Bergholt | Shotley | Stanway | Stow upland | Layer Marney | Birch | Grundis burgh | Needham | Stour | Easthorpe | Debenham | Nayland | D'Arcy | Waldgring field | Somer sham | ED CH | ED IH | Aldham | |
|---|----------|--------|--------|-----------|------------|----------------|---------------|---------|---------|-------------|--------------|--------|---------------|---------|--------|-----------|----------|---------|--------|-----------------|------------|--------|--------|--------|--------|
| Individualised Care | Bronze | Bronze | Bronze | Silver | Silver | Bronze | Silver | Gold | Silver | Silver | Bronze | WTB | WTB | Bronze | Silver | Gold | Silver | Bronze | Silver | Bronze | Silver | Silver | Bronze | WTB | |
| Dignity and Respect | WTB | WTB | WTB | Bronze | Silver | Silver | Silver | Silver | Bronze | Bronze | WTB | WTB | Bronze | Bronze | Bronze | WTB | WTB | WTB | Silver | Silver | Silver | WTB | Silver | WTB | |
| Safeguarding, Complex Health and Consent | Silver | Gold | WTB | Silver | WTB | Silver | WTB | Bronze | WTB | Gold | Gold | Bronze | Silver | Silver | Gold | WTB | Silver | Silver | Silver | WTB | Silver | Gold | Silver | WTB | |
| Leadership, Education and People | Silver | Bronze | Bronze | Silver | Silver | WTB | Bronze | Silver | Bronze | Bronze | Silver | Bronze | WTB | Bronze | Silver | Silver | Bronze | Silver | Bronze | Bronze | Bronze | Bronze | Silver | Silver | Silver |
| Harm Free Care | Silver | WTB | WTB | WTB | Bronze | Bronze | WTB | Silver | Bronze | WTB | Bronze | Bronze | WTB | WTB | WTB | Bronze | WTB | WTB | WTB | Bronze | WTB | Bronze | WTB | Bronze | |
| Delivering Safe Care | Bronze | Bronze | Bronze | Bronze | Bronze | Bronze | Bronze | Silver | Bronze | Bronze | WTB | Bronze | Bronze | Bronze | Silver | Bronze | Bronze | Bronze | WTB | Silver | Bronze | Silver | Bronze | Silver | |
| Nutrition and Hydration | Gold | WTB | WTB | Silver | WTB | WTB | WTB | Silver | Bronze | Bronze | WTB | WTB | Bronze | WTB | Bronze | WTB | Bronze | WTB | WTB | Silver | Silver | Bronze | Silver | Bronze | |
| Clinical Governance | Silver | Bronze | Silver | Silver | WTB | Bronze | WTB | Silver | Silver | Bronze | Silver | Bronze | WTB | WTB | Bronze | Silver | Silver | Bronze | Bronze | Silver | Silver | Bronze | WTB | WTB | |
| Infection Prevention and Control & Environment Safety | Silver | Silver | Bronze | Bronze | Silver | Bronze | Gold | Silver | Bronze | WTB | Bronze | Bronze | WTB | Bronze | Bronze | Bronze | Bronze | Bronze | Bronze | Bronze | Bronze | Silver | WTB | WTB | WTB |
| Overall | Silver | Bronze | Bronze | Bronze | Bronze | Bronze | Bronze | Silver | Bronze | Bronze | Bronze | WTB | Bronze | Bronze | Bronze | Bronze | Bronze | Silver | Bronze | Bronze | Bronze | Silver | Bronze | Bronze | Bronze |

| Standard | Most common grading achieved from data so far |
|---|---|
| Individualised care | Silver |
| Dignity and Respect | Working towards Bronze |
| Safeguarding, Complex Health and Consent | Silver |
| Leadership, Education and People | Tied Bronze and Silver |
| Harm Free Care | Working towards Bronze |
| Delivering Safe Care | Bronze |
| Nutrition and Hydration | Working towards Bronze |
| Clinical Governance | Silver |
| Infection Prevention and Control & Environment Safety | Bronze |



Accrediting care at ESNEFT



Clinical Outcome (Audit)

Progress Against Planned Audits – Snapshot Mid Nov

Planned Audits 2025-26: Split by Division

| Division | Proposed | Registered | In Progress | Complete | Complete - With Actions | Overdue | On Hold | Agreed to Discontinue |
|-----------|----------|------------|-------------|----------|-------------------------|---------|---------|-----------------------|
| C&D | 55 | 1 | 10 | 8 | 6 | 12 | 0 | 0 |
| Corporate | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MaCIES | 5 | 0 | 1 | 1 | 3 | 1 | 0 | 2 |
| MaCNEE | 19 | 0 | 4 | 0 | 0 | 2 | 0 | 6 |
| MSK SS | 43 | 0 | 9 | 4 | 7 | 5 | 0 | 0 |
| SGA | 17 | 0 | 8 | 0 | 6 | 16 | 0 | 0 |
| W&Cs | 41 | 0 | 6 | 2 | 1 | 0 | 0 | 3 |

Key Focus Tasks for Nov/Dec/Jan

- 1: Review Planned audits & highlight any of 'risk if not completed'
- 2: Register & start planned audits starting with higher risk first
- 3: Prepare for audit planning discussions 2026-27 with Audit team in Dec/Jan

Planned Audits Completed in November from 2025-26 Plan

- * **CD24-088:** Audit of Adherence to Management of the RhD Negative Mother using fDNA testing and Anti D Immunoglobulin in Pregnancy
- * **IP25-001:** QI Polypharmacy - Post fall medication review - any fall patients admitted from virtual frailty ward/UCR/Cleric
- * **MACIES25-001:** Audit of the use of prolonged-release opioids and transdermal patches following fracture of humerus, neck of femur and/or pubic rami on discharge from acute and community hospitals.
- * **MACNEE:** – 0
- * **MSK SS:** – 0
- * **SGA25-061:** To measure infection control practices against local and national standards
- * **SGA24-081:** Retrospective review of mortality and morbidity during first 12 months after discharge from ICU.
- * **WC25-024:** Open Access - Service Evaluation
- * **WC25-033:** Audit of the Hyponatraemia Pathway in Labour

Updates from RSM Audit Actions

- New Audit & Improvement SOP live & shared across divisions
- New KPIs x2 introduced & baseline measured from 2024-25 & shared across divisions
- New KPIs monitored on new dashboard & reported first time in Nov across Divisions
- CO team & governance managers collaborating on improving audit action tracking

Supporting QI
13 QI projects supported by audit team to collect baseline data
3 still in progress



Clinical Audit Awards



Moving towards HQIP Best Practice
Developing access to central records via excel for visibility, transparency & shared learning

Planned Audits Completed in November from 2024-25 plan that were carried over

- * **C&D:** 1 of 26 Adherence To Guidelines In Stopping Anticoagulation Prior To Interventional Radiology Procedures CD24-102
- * **MACIES:** Cleared all 11 (4 discontinued)
- * **MACNEE:** 1 of 9 Pneumonia MEDCOL24-031
- * **MSK SS:** 0 of 13
- * **SGA:** - 0 of 34
- * **W&C:** - 0 of 2

QI Project Benefits – 8 projects completed in November

QIP23-446
Developing parent / carer knowledge and confidence to support childrens' sensory needs .

Co-design with 71 families
 Sensory workshops
 Community based






Parent confidence  99% in understanding sensory needs of autistic child
 More able to self-manage dysregulation & avoid professional intervention

Adopted elsewhere &
 Spreading across Essex

QIP25-571B
Bridging the gap between discharge from critical care and attending a face-to-face follow-up appointment

Co-design with 28 CCU patients with Faster follow up for improved recovery



Patient satisfaction  20%
 Improved recovery
 Early identification of referral
 Waiting list  57%
 Less travel & parking

Explore MyChart function for self-referrals

QIP25-597
Reducing the carbon footprint with electronic ENT Patient Information

Collaboration between ENT & the Green Team
 QR codes for patient info





Less paper & printing costs
 Carbon footprint 2500 kgCO₂e
 Time saved on admin & paper stock management

Share across ESNEFT via Green Champion Network

QIP25-638
Review of CT and Ultrasound Sensitivity in the Diagnosis of Suspected Appendicitis

Correlation of sensitivity between ultrasound & histopathology results
 Monitoring, education & reinforcing protocols



Correlation sensitivity  34%
 Improved diagnostic accuracy of suspected appendicitis

QIP25-640
Hot Swollen Joints – optimising treatment & plan of care

Education, communication & surveys with T&O colleagues
 Visual aids & prompts



Diagnostic investigations moved towards best practice
 ESR  53% LFT  14%
 Blood Culture  15%
 Radiographs  13%

Expand to medical team and ED clinicians

QIP25-643
Assessing smoke exposure in paediatric patients

Awareness posters, proforma, education & communication for Drs



More children under 5 with asthma/wheeze having smoking exposure assessed  29%

Area to improve : 44% of the children were readmitted with worsening symptoms with only 19% of their parents given smoking cessation advice

QIP25-648
Communication & Swallowing Education for Carers of People with Dementia

Co-design with family members & carers
 Dementia friendly, eating & drinking educational sessions
 Community based



Increased confidence for carers in communicating, planning activities and addressing eating & drinking difficulties

Continue sessions with more support for advertising them
 Develop videos & info packs to share

QIP25-649
Time Matters: Sculpting a Dynamic SOP for Returner's Clinic Excellence

Service user feedback
 Developed new SOP
 Awareness campaign



Appropriate referrals  44%
 Quality of referrals improved
 New referral cap to 20 per day

Opportunity to build into Epic
 Better able to mesaure demand & capacity

Patient Safety – Incident Reporting

There was an increase in Datix submitted for November. Highest patient related incidents reported continue to be pressure ulcers and falls.

There were a total of 3,252 (3,003) incidents reported in November. 1,647 of these incidents were Patient Safety related. There were 41,398 (44,137) admissions resulting in 73.5 incidents per 1,000 bed days across ESNEFT.

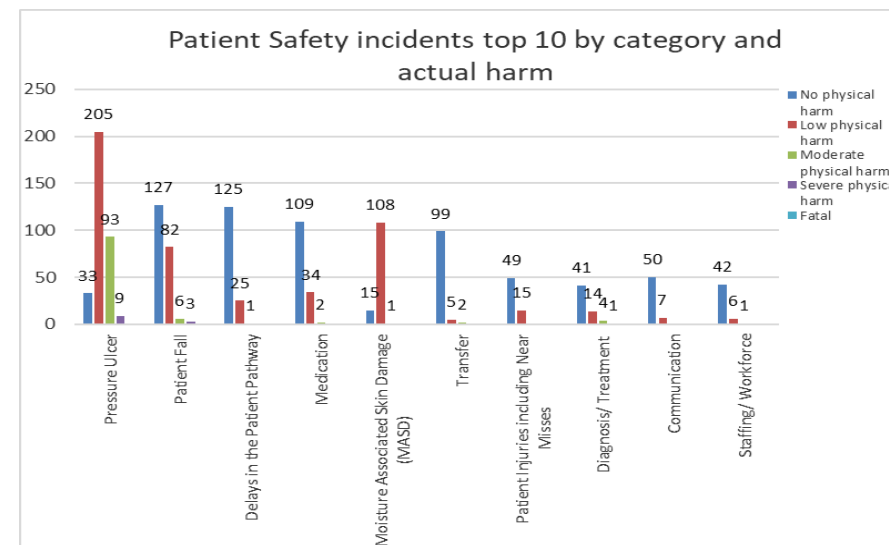
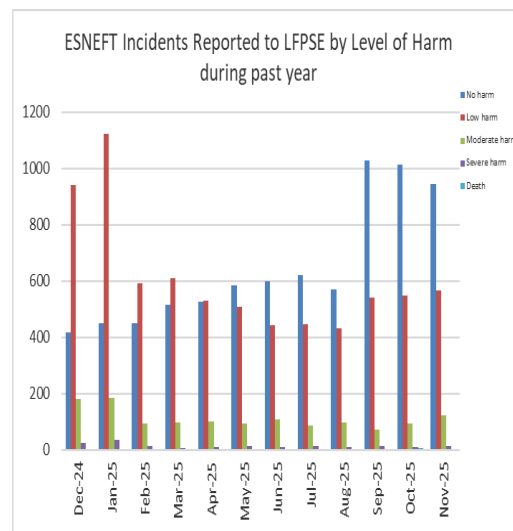
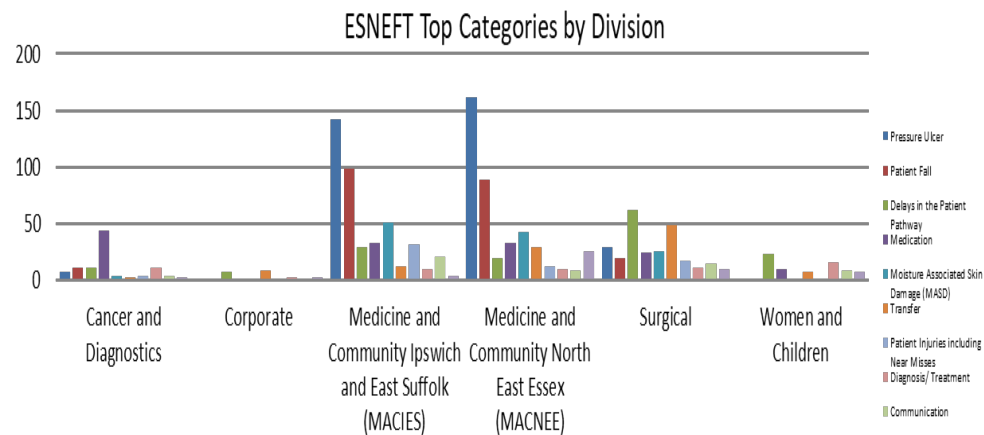
The highest reported category was Pressure Ulcer damage with 340 (279) incidents reported, 9 of which were severe harm, with 7 being within both Suffolk and NEE Community, 1 recorded on Brightlingsea Ward and 1 other recorded on Birch Ward. There were 93 moderate harm incidents.

The 2nd highest reported category was Patient Falls with there being 218 (232) incidents reported with 3 reported as severe harm on Nayland Ward, Bramford Ward and Ipswich Emergency Department, all were unwitnessed. A further 6 were reported as moderate of which 5 were unwitnessed.

The 3rd highest reported category was Delays in the Patient Pathway with 151 (170) incidents. 1 was reported as moderate harm with the remainder being low and no harm.

| Division | DatixWeb | DCIQ | Total |
|------------------------|-----------|-------------|---------------|
| Surgical | 3 | 421 | 424 ↑ |
| Corporate | 44 | 225 | 269 ↑ |
| MACIES | 4 | 206 | 210 ↑ |
| MACNEE | 3 | 177 | 180 ↑ |
| Cancer and Diagnostics | 1 | 96 | 97 ↑ |
| Women & Children | 0 | 31 | 31 → |
| Total | 55 | 1156 | 1211 ↑ |

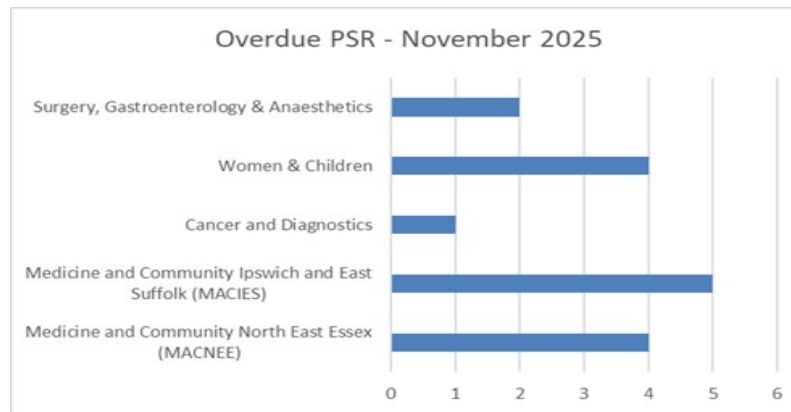
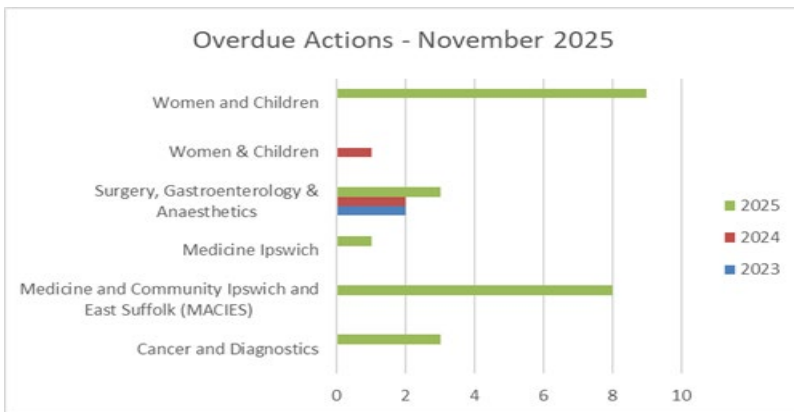
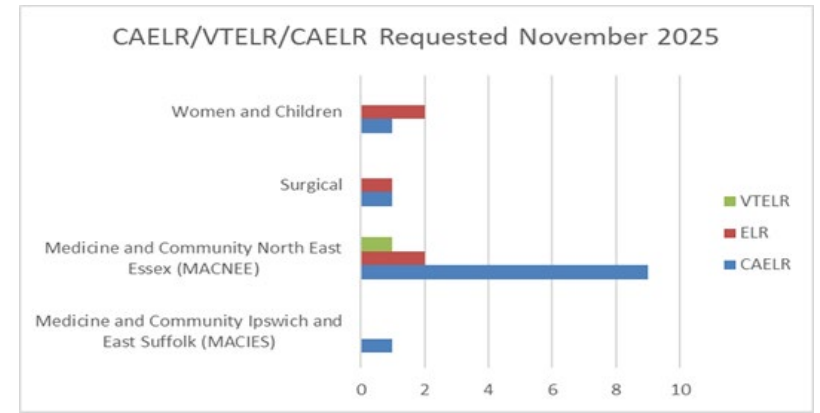
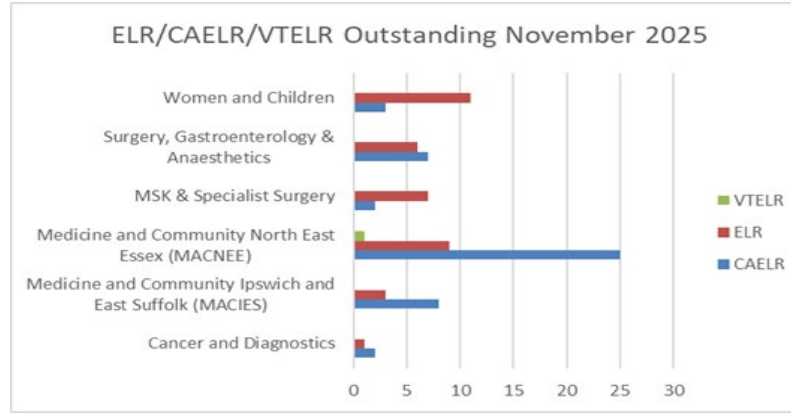
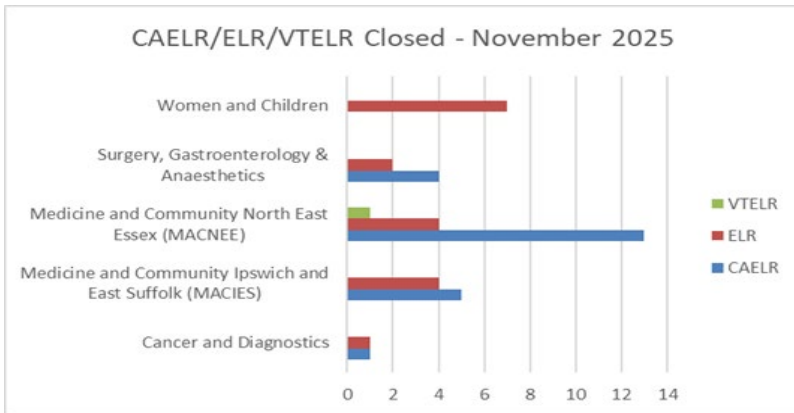
The Surgical division have the highest number of overdue incidents with 424.



Patient Safety – Early Learning Reviews, Never Events, Patient Safety Reviews & Patient Safety Incident Investigations

Early Learning Review (ELR), Cardiac Arrest (CAELR), Venous thromboembolism (VTELR), Patient Safety Review (PSR), Patient Safety Incident Investigations (PSII)

- 12 CAELR's, 5 ELR's and 1 VTELR were closed in November 2025.
- 47 CAELR's, 37 ELR's and 1 VTELR are currently outstanding in November 2025.
- 23 CAELR's, 18 ELR's and 1 VTELR were closed in November 2025.
- 2 PSR's were requested in November 2025. Both were for Medicine & Community Ipswich and East Suffolk (MACIES) Diagnosis – Wrong/missed and Delay in clinical assessment being performed.
- 6 PSR's were completed in November 2025. 5 for Women & Children and 1 for Surgery, Gastroenterology & Anaesthetics.
- One PSII was declared in November 2025. 2025-PSII003 (62,641) This PSII was declared to look at the organisational learning for boarding and escalation Trust wide.
- 96 Incidents of ESNEFT acquired pressure damage at moderate harm or above where reporting in November 2025. 4 full gap analysis were requested in November 2025



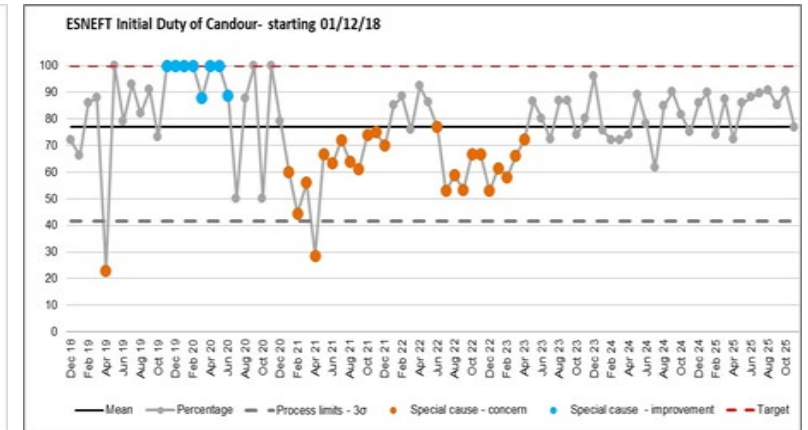
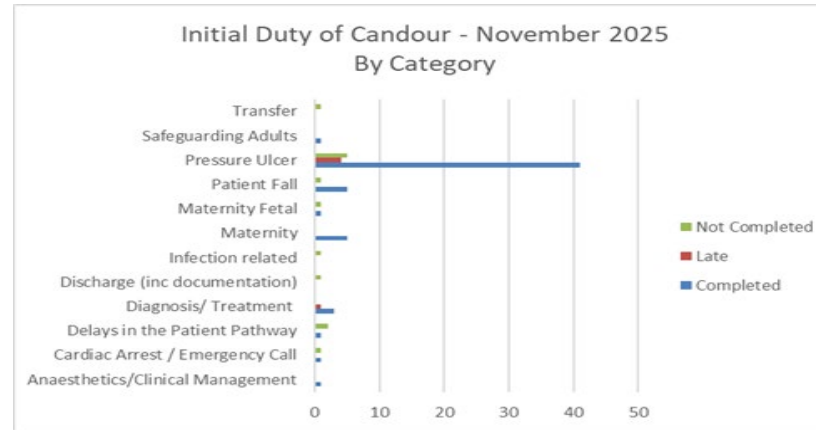
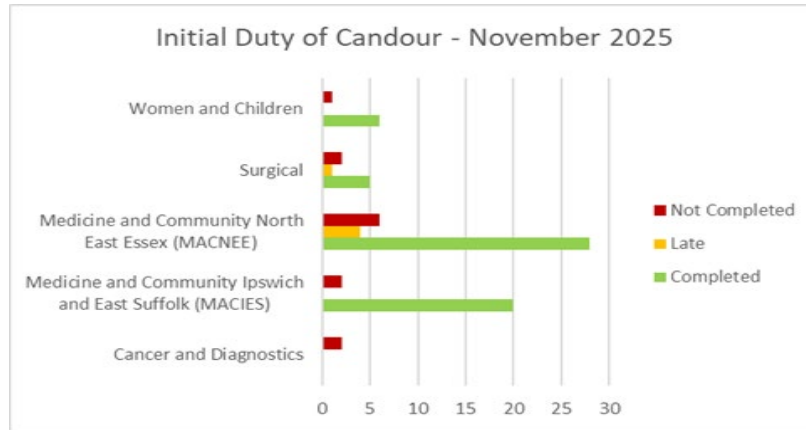
| Type | Current Reports | Declaration | 3 Month Due date | Status update - September 2025 |
|----------------------|-----------------|-------------|------------------|--------------------------------|
| Maternity Escalation | 2025-PSII003 | November | | |

Patient Safety – Duty of Candour

There was a decrease in initial Duty of Candour compliance. Improvements though are still to be made with post Duty of Candour

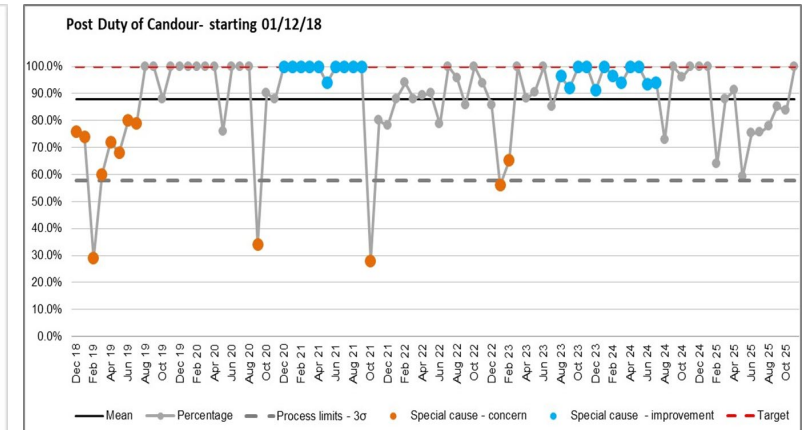
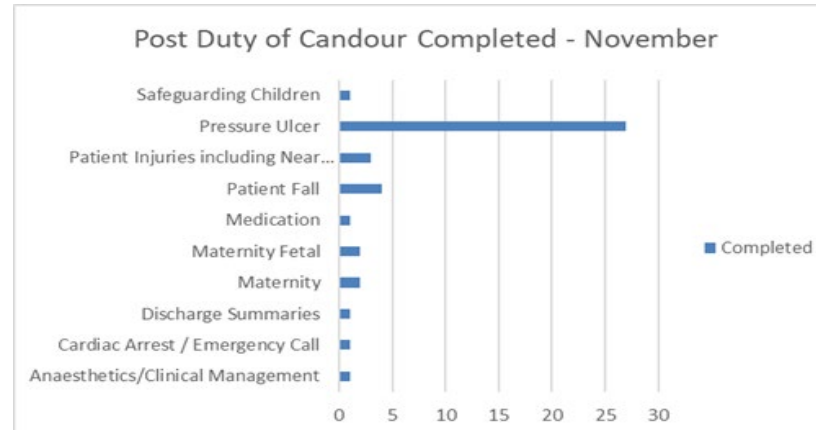
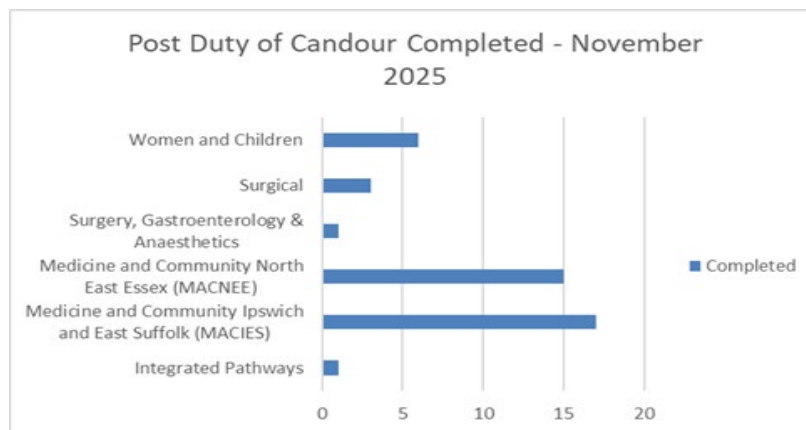
Initial Duty of Candour

Initial Duty of Candour compliance for November 2025 is 76.6% (90.5%)

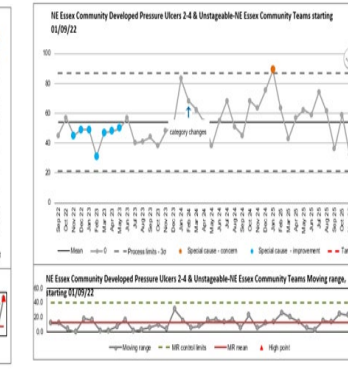
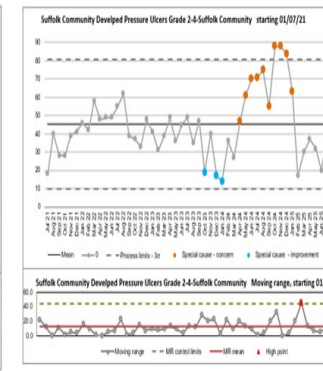
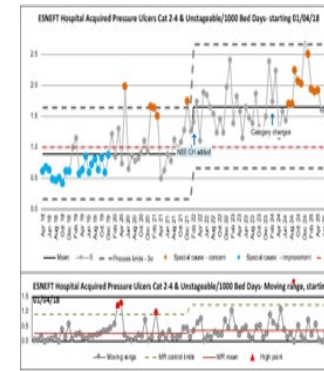
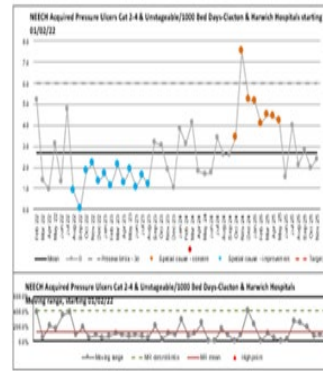
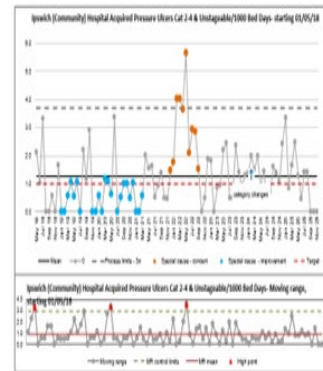
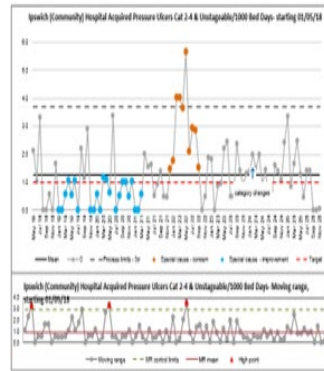
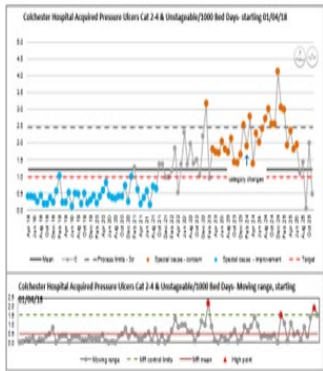


Post Duty of Candour

Post Duty of Candour compliance for November 2025 is 100% (83.7%)



Patient Safety – Tissue Viability



| Colchester Acute | | | |
|-------------------------|-----|------|--|
| Cat 2 | 29 | 22 | |
| Cat 3 | 10 | 24 | |
| Cat 4 | 0 | 0 | |
| Prev. & in-mth total | 39 | ↑46 | |
| Rate per 1,000 bed days | 2.0 | 0.48 | |

| Ipswich Acute | | | |
|-------------------------|------|------|--|
| Cat 2 | 19 | 8 | |
| Cat 3 | 8 | 8 | |
| Cat 4 | 1 | 0 | |
| Prev. & in-mth total | 28 | ↓16 | |
| Rate per 1,000 bed days | 1.47 | 0.05 | |

| Ipswich Community Hospital | | | |
|----------------------------|------|------|--|
| Cat 2 | 0 | 1 | |
| Cat 3 | 0 | 0 | |
| Cat 4 | 0 | 0 | |
| Prev. & in-mth total | 0 | ↑1 | |
| Rate per 1,000 bed days | 0.00 | 0.00 | |

| Essex Community Hospital | | | |
|--------------------------|------|------|--|
| Cat 2 | 5 | 4 | |
| Cat 3 | 0 | 2 | |
| Cat 4 | 0 | 0 | |
| Prev. & in-mth total | 5 | ↑6 | |
| Rate per 1,000 bed days | 1.96 | 2.38 | |

| ESNEFT | | | |
|-------------------------|------|------|--|
| Cat 2 | 53 | 35 | |
| Cat 3 | 18 | 34 | |
| Cat 4 | 1 | 0 | |
| Totals | 72 | ↓69 | |
| Rate per 1,000 bed days | 1.66 | 0.24 | |

| Suffolk Community Teams | | | |
|-------------------------|----|----|--|
| Cat 2 | 32 | 60 | |
| Cat 3 | 5 | 25 | |
| Cat 4 | 2 | 5 | |
| Prev. & in-mth total | 39 | 90 | |

| Essex Community Teams | | | |
|-----------------------|----|----|--|
| Cat 2 | 23 | 15 | |
| Cat 3 | 35 | 12 | |
| Cat 4 | 1 | 1 | |
| Prev. & in-mth total | 59 | 28 | |

Service Commentary

We have seen a decline in category 2 Pressure Ulcers in our acute hospitals, which was our yearly aim.

There has been an increase in pressure ulcers in Suffolk Community, which may link in with the increase of infected wounds also present.

Community Matron, Safeguard Lead and Tissue Viability Nurse Lead are aware and have formulated an action plan around recognition of infection and early intervention.

Patient Safety – Falls

Falls Monthly Numbers

| | CH | IH | Suffolk | NEECS | Acute Total | Community Total | ESNEFT Total | |
|---------|----|----|---------|-------|-------------|-----------------|--------------|-----|
| Nov-23 | | 99 | 96 | 12 | 8 | 195 | 20 | 215 |
| Nov -24 | | 84 | 80 | 18 | 8 | 164 | 26 | 190 |
| Nov -25 | | 89 | 89 | 21 | 9 | 178 | 30 | 208 |

In November there was a reduction in falls in both acute hospitals, meeting the national falls per 1,000 bed days target. There has also been a reduction in serious harm incidents. One of these incidents is due a collapse of medical reasons, rather than a direct fall.

Ipswich were on target to see less than 70 falls, but in the later part of November, there were increased falls in ED and Haughley.

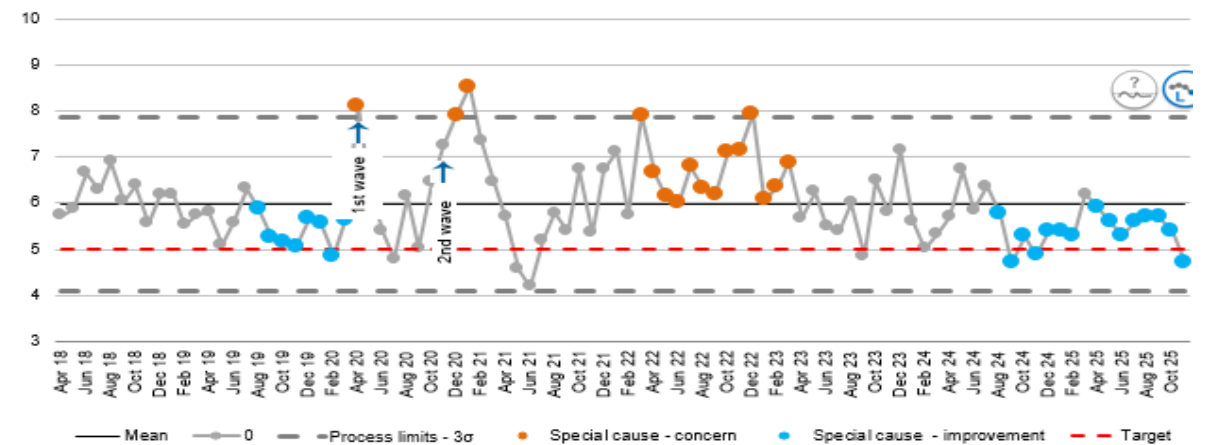
The Falls team, along with the wards continue to embrace Epic and the opportunities it provides. There have been noted improvements in post falls medical reviews, which is encouraging .

With regards to the QI project for the Yellow Falls Prevention Kits, there was not a reduction in falls, but the teams in the UEC felt the benefit of using the kit, due to the visibility it provides. The base wards also felt the benefit as the kit provided better visibility of patients. This will be explored, taking into consideration the green agenda, and discussing the opportunities for yellow blankets with the new laundry provider.

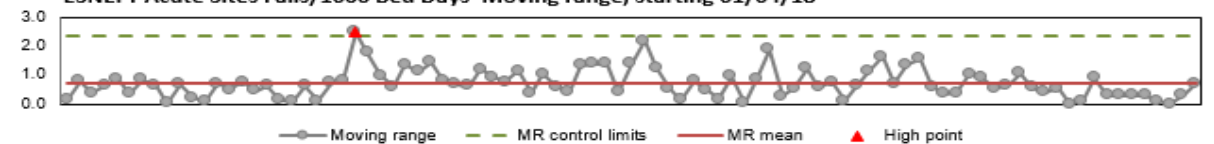
Falls per 1,000 Bed Days (Acute)

| Falls/1,000 Bed Days | | | | | | | | |
|----------------------|------------------|---------------|-------------------|-------|--------|-----------------------|--------------------------|-------------------------|
| | Colchester Acute | Ipswich Acute | Ipswich Community | NEECS | ESNEFT | ESNEFT Acute Bed Days | YTD Acute Falls/Bed Days | YTD Comm Falls/Bed Days |
| Nov-24 | 5.0 | 4.6 | 9.5 | 3.5 | 5.0 | 4.8 | 5.6 | 6.9 |
| Aug-25 | 6.3 | 5.2 | 3.5 | 2.9 | 5.4 | 5.7 | 5.6 | 4.6 |
| Sep-25 | 5.7 | 5.6 | 5.6 | 6.4 | 5.7 | 5.6 | 5.6 | 4.8 |
| Oct-25 | 5.5 | 5.2 | 7.9 | 7.5 | 5.6 | 5.4 | 5.6 | 5.2 |
| Nov-25 | 5.2 | 5.2 | 10.1 | 3.4 | 5.3 | 5.2 | 5.5 | 5.4 |

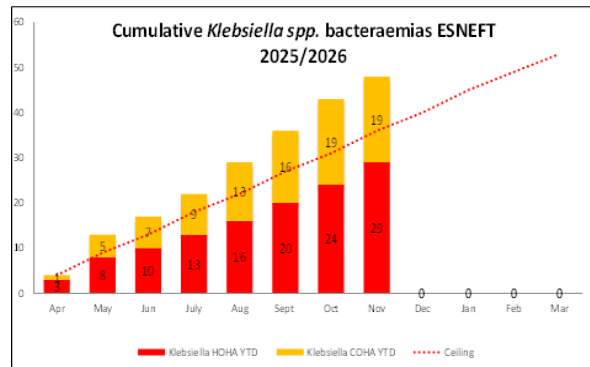
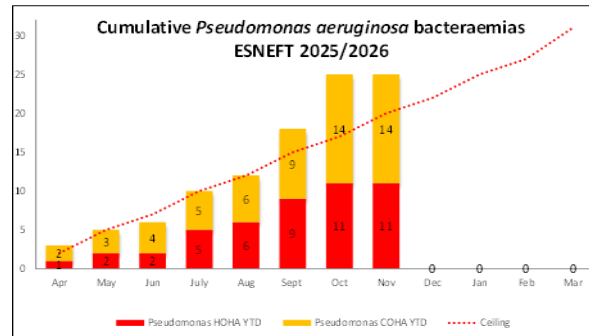
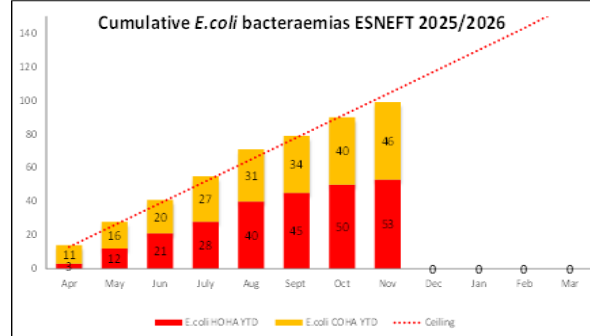
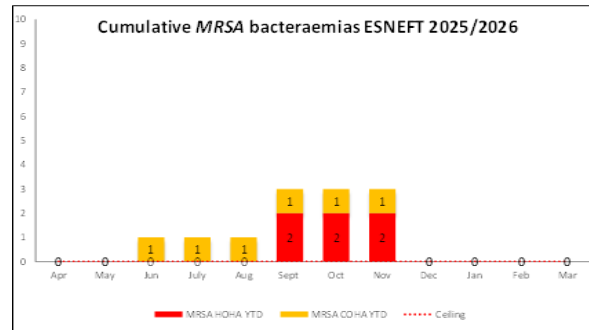
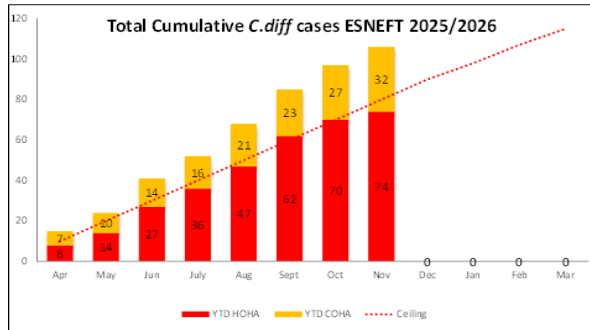
ESNEFT Acute Sites Falls/1000 Bed Days- starting 01/04/18



ESNEFT Acute Sites Falls/1000 Bed Days- Moving range, starting 01/04/18



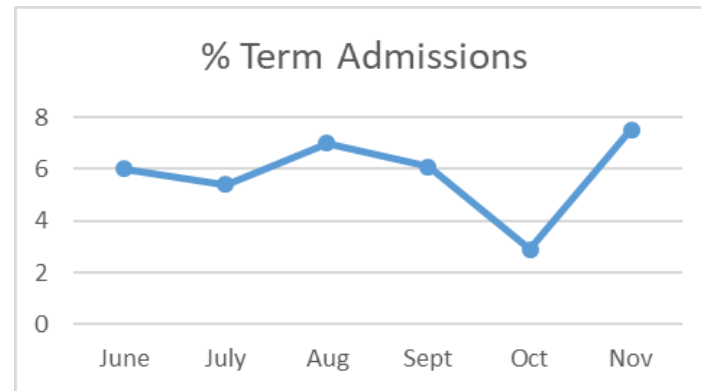
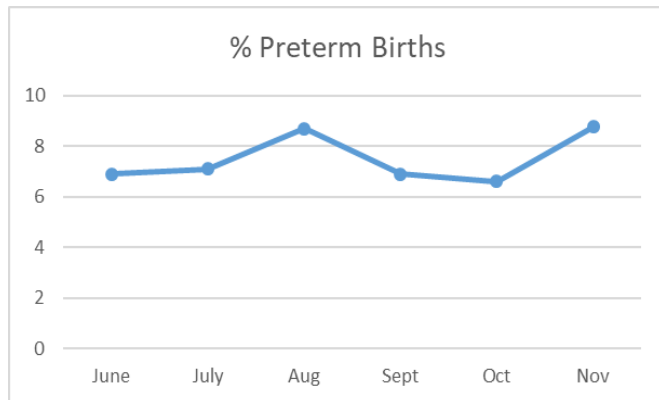
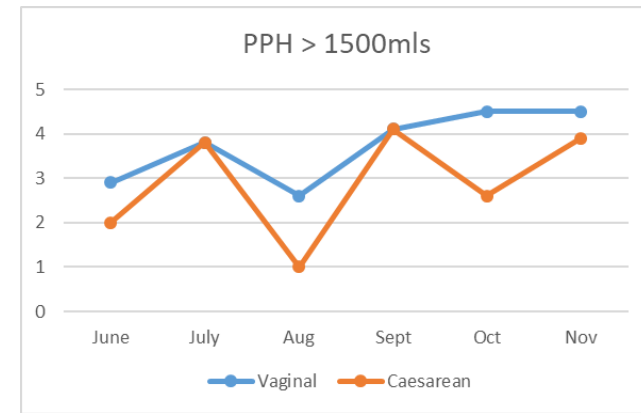
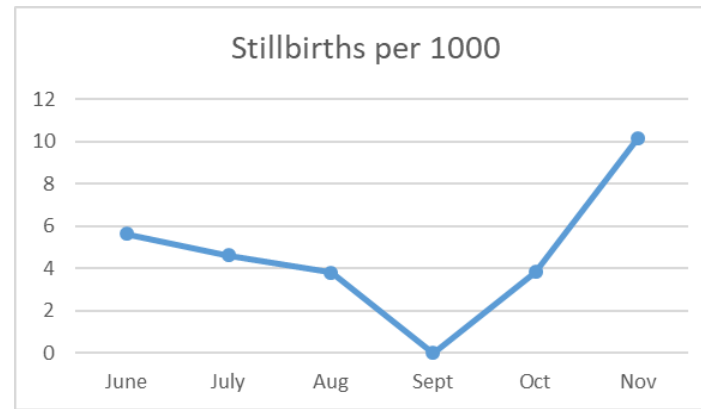
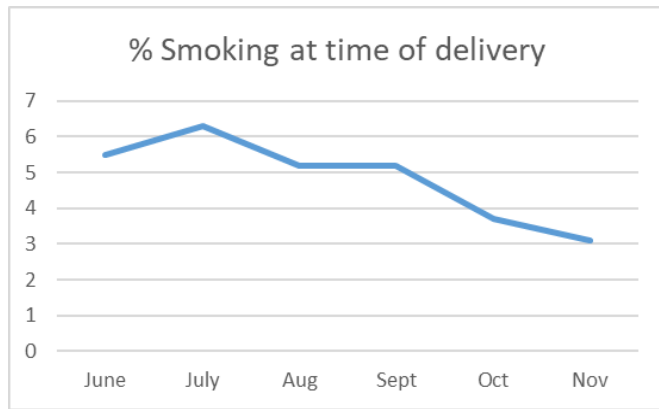
Patient Safety – Infection Prevention and Control - October 2025 figures – HCAI figures



| Infection | ESNEFT Total for month | Category | Trajectory | Total for year HOHA/COHA to end Oct Not inc Nov | Total for year total HCAI not inc Nov | EoE performance/benchmark (Upward arrows indicate a ESNEFT is above the benchmark, and are therefore an outlier) |
|-----------------|------------------------|----------|------------|--|---------------------------------------|---|
| <i>C diff</i> | 9 | 4 HOHA | 115 | 74 | 106 | ↑ |
| | | 5 COHA | | | | |
| <i>MRSAb</i> | 0 | 0 HOHA | 0 | 2 | 3 | ↑ |
| | | 0 COHA | | | | |
| <i>E coli</i> | 9 | 3 HOHA | 124 | 53 | 99 | ↑ |
| | | 6 COHA | | | | |
| <i>Kleb spp</i> | 5 | 5 HOHA | 47 | 29 | 48 | ↑ |
| | | 0 COHA | | | | |
| <i>Pseudo A</i> | 0 | 0 HOHA | 29 | 11 | 25 | ↑ |
| | | 0 COHA | | | | |
| <i>MSSAb</i> | 10 | 9 HOHA | N/A | 34 | 46 | ↑ |
| | | 1 COHA | | | | |

| | |
|---|------------------------------------|
| ↑ | Above (worse) than region average |
| ↔ | Equal with region average |
| ↓ | Below (better) than region average |

Patient Safety – Maternity Dashboard, SBL and CNST updates



Data has been pulled from EpicEPR which is still being tested for data quality. There remains some inaccuracies in the data, which are being worked through.

Stillbirth rates have increased in November at 10.14 (this equates to 5 cases), the rolling rate is 3.74, above the national average at 3.54. All of the cases are being reviewed through MIRG and the PMRT process. This will continue to be monitored closely with any identified learning shared through appropriate forums. A more detailed report will be provided to MNIB.

Preterm births are over the national aim of 6%, which the PARTNER trial aims to improve.

ATAIN continues to fluctuate each month. A deep dive is currently underway to develop a QI project.

Patient Safety – Maternity Dashboard, SBL and CNST updates

Risk and Governance Update for Maternity

PSII

Number of new declared – 0
Currently open – 1

PSR

Number of new declared – 1
Currently open -4

ELR

Number of new declared – 8

MNSI

Number of new declared – 0
Currently open – 0
Completed -0

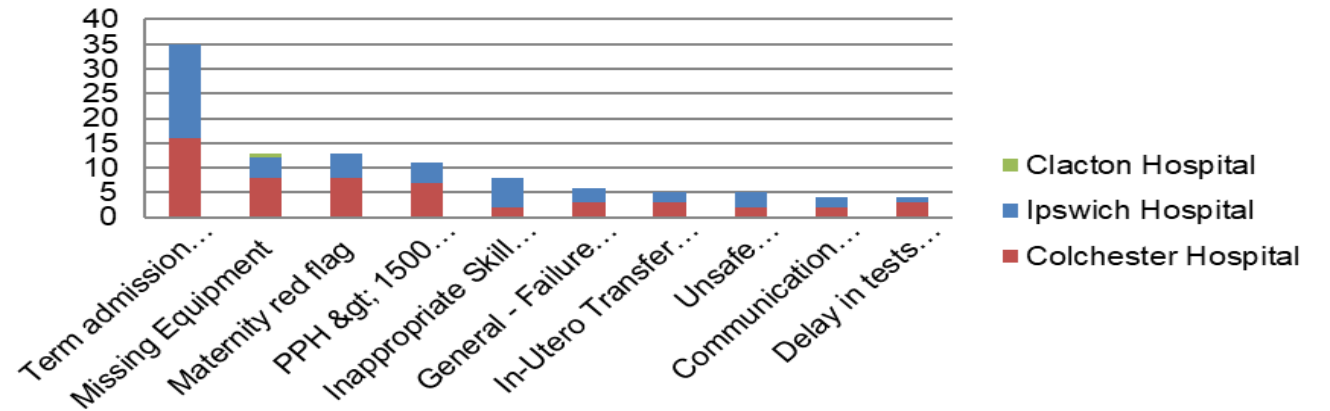
Complaints

New –9
Call back compliance – 4 out of 5 completed.
Response compliance – 100%

Risk Register

New risks – 0
Closed risks – 0

Top 10 reported incidents @lastmonth



Learning from complaints

| ID | Location - Ward / Dept / Team | Description | Subject (primary) | Outcome code | Lessons learned |
|-------|-------------------------------|--|--------------------------|------------------|---|
| 9852 | Delivery Suite (Col) | Concerns raised regarding delays to be seen and complications following stitches. | Admission and discharges | Partially upheld | Delay in patient being seen and transferred out of Triage due to Epic being implemented which affected the effectiveness. Right sided labial tear was not visualised and identified and repaired during the first examination. |
| 10331 | Lexden Ward (Col) | Complications following IV drip flushing. | Patient care | Upheld | Debrief regarding use of Ferinject was not documented. New combined consent form being developed, alongside increasing the awareness amongst our clinical staff of our patient information leaflet (PIL) to be given to patients. |
| 11022 | Orwell Ward (Ips) | Referral to FINN clinic was not made, staff have been unable to use the new EPR system which has directly impacted the patients care, and there has been an overall lack of communication. | Appointments | Upheld | Staff did not take the appropriate action when patient contacted Orwell Ward and identified they had not received an appointment. Issues with new computer system and not understanding how to proceed. Patient was able to follow up themselves to get the correct referral. |

Patient Safety – Maternity Dashboard, SBL and CNST updates

| SA1 - On track | SA2 - Complete | SA3- On track | SA4 - Complete | SA5 - Complete |
|--|--|--|---|--|
| <ul style="list-style-type: none"> Compliant Paper drafted for Trust CNST meeting Dec 25 | <ul style="list-style-type: none"> Compliant Approved at Trust CNST meeting Nov 25 | <ul style="list-style-type: none"> Compliant Paper drafted for Trust CNST meeting Dec 25 | <ul style="list-style-type: none"> Compliant Action plan in place for Tiers 1&3 neonatal workforce and monitored through risk register Paper approved at Trust CNST meeting Nov 25 | <ul style="list-style-type: none"> Compliant Paper approved at Trust CNST meeting Nov 25 |
| SA6 - Complete | SA7 - Complete | SA8 – On track | SA9 - On track | SA10 - On track |
| <ul style="list-style-type: none"> Compliant Q1 report submitted Aug 91% implementation Paper approved at Trust CNST meeting Nov 25 | <ul style="list-style-type: none"> Compliant Paper approved at Trust CNST meeting Nov 25 | <ul style="list-style-type: none"> Compliant Paper drafted for Trust CNST meeting Dec 25 | <ul style="list-style-type: none"> Compliant Paper drafted for Trust CNST meeting Dec 25 | <ul style="list-style-type: none"> Compliant Paper drafted for Trust CNST meeting Dec 25 |

Patient Safety – Maternity Dashboard, SBL and workforce updates

SBLv3.2

91% implemented on Q1 data. Awaiting Q2 validation from LMNS

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) |
|-----------------------|----------------------------|---|--|--|---|
| Element 1 | Smoking in pregnancy | Partially implemented | 90% | Partially implemented | 90% |
| Element 2 | Fetal growth restriction | Fully implemented | 100% | Fully implemented | 100% |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% |
| Element 4 | Fetal monitoring in labour | Fully implemented | 100% | Partially implemented | 60% |
| Element 5 | Preterm birth | Partially implemented | 96% | Partially implemented | 92% |
| Element 6 | Diabetes | Partially implemented | 83% | Partially implemented | 83% |
| All Elements | TOTAL | Partially implemented | 96% | Partially implemented | 91% |

Workforce

- 2025 nil incidents cross site of coordinator losing supernumerary status or 1-2-1 in labour not being provided.
- Sickness rate remains above Trust average and high for the region. Daily sickness meetings in place at Colchester, with twice weekly meetings for staffing reviews.
- Fully recruited cross site – recruited above template to allow for preceptors. First wave started with additional preceptor recruitment planned for January 2026
- Over establishment of RMs with NQM starting in Trust in October and more to commence in early 2026

Patient Experience

Executive Summary

The Trust received a much lower number of new complaints in November 2025, with 88 new complaints - a significant reduction from 133 in October 2025. The compliance rate for courtesy call completion remained high at 98%, but 8 late replies in one Division has caused the complaint response compliance to drop from 98% to 93%.

The total number of complaints completed in November was 106 and coupled with the reduced number of new complaints for November, this has seen the overall number of open complaints reduce in total. After seeing a new high number of PALS enquires logged for October (815), the Trust has seen that number drop to 633 in November 2025. This total comprised of 240 enquiries for the Surgical Division and 122 for the Women's & Children Division and all Divisions saw a reduction in the total number of new PALS received.

Learning from Complaints

Complaint about communication from Sexual Health Centre

- Staff member repeatedly misgendered the patient and their partner. Learning taken from the complaint and shared in the complaint reply– To be discussed with staff member at next 1:1. Staff have been reminded of the 'Supporting transgender service users and staff policy'. Concerns raised by the patient were discussed in departmental meeting to raise awareness and reinforce best practice. A "Do's and Don'ts: Supporting Transgender, Non-Binary, and Gender Questioning People" grab sheet was shared with all staff, and they attended an additional refresher training session on inclusivity.

Ombudsman Update

Update for November 2025

- The Trust is still seeing regular communication from the Ombudsman's office, and during November 2025 this has resulted in three formal communications. One of these communications from the Ombudsman was requesting copies of the patients' medical records and the Trust's complaint file. The other two were in relation to ongoing complaints where the Ombudsman was asking for the Trust's comments on the ongoing cases, including a draft report they have completed.

Reopened Complaints

No complaints needed to be formally reopened

- No complaints needed to be formally reopened in November 2025. The Trust had 13 complaints that have been subject to a further review, and the reasons for those additional reviews are that six complainants requested to meet with the investigating teams. Three other complainants supplied additional concerns to be reviewed, three complainants disputed our information, and the final reopened complaint resulted from feedback being received from the PHSO.

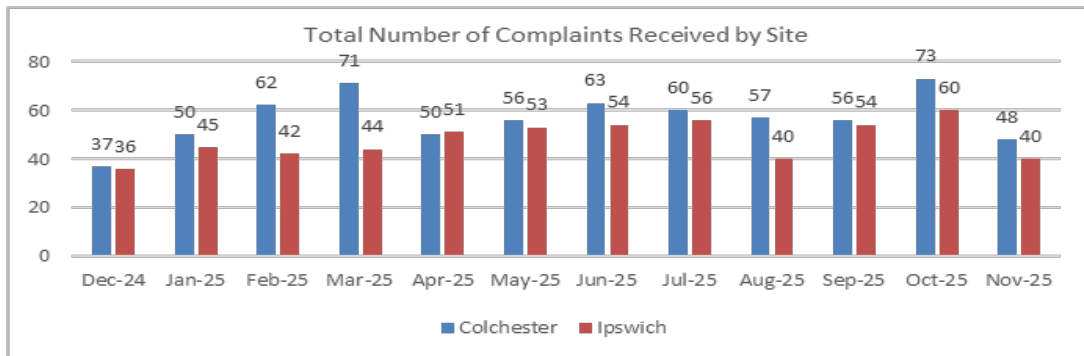
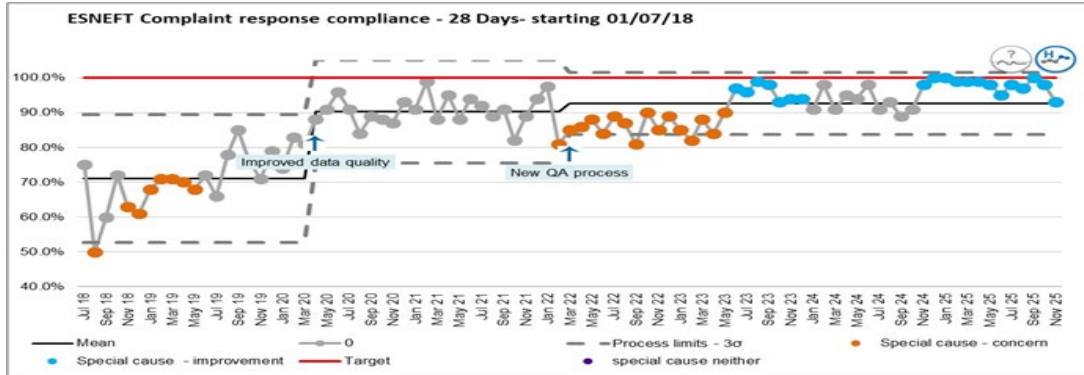
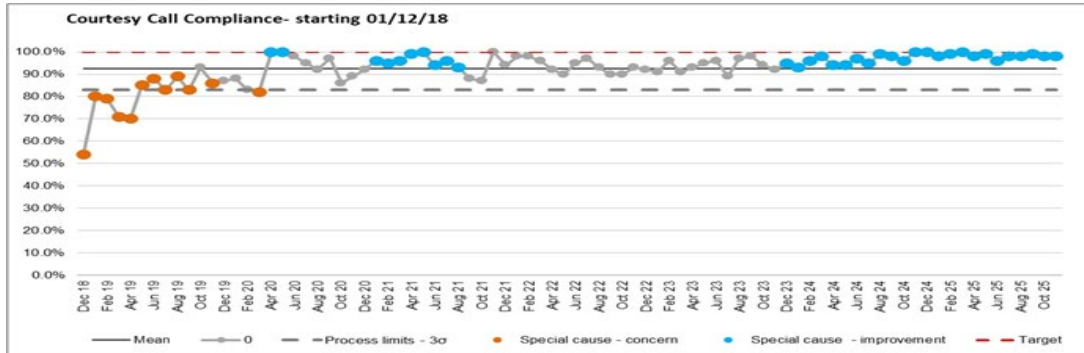
PALS update

Only 1 PALS needed to be converted to a complaint in November 2025

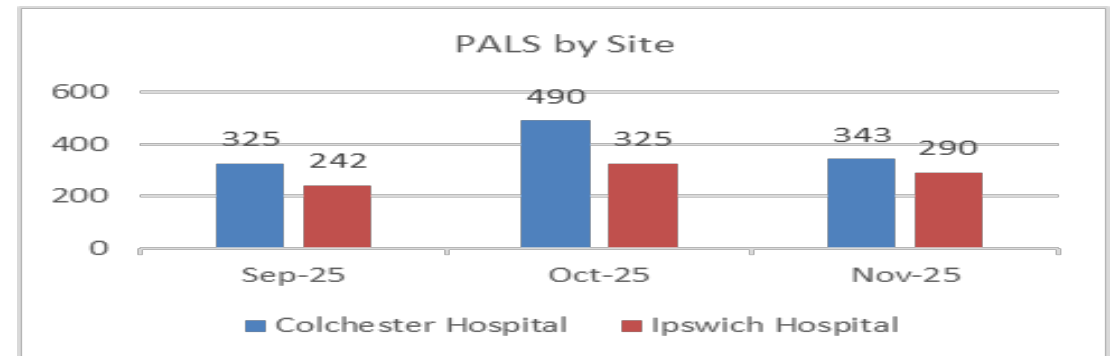
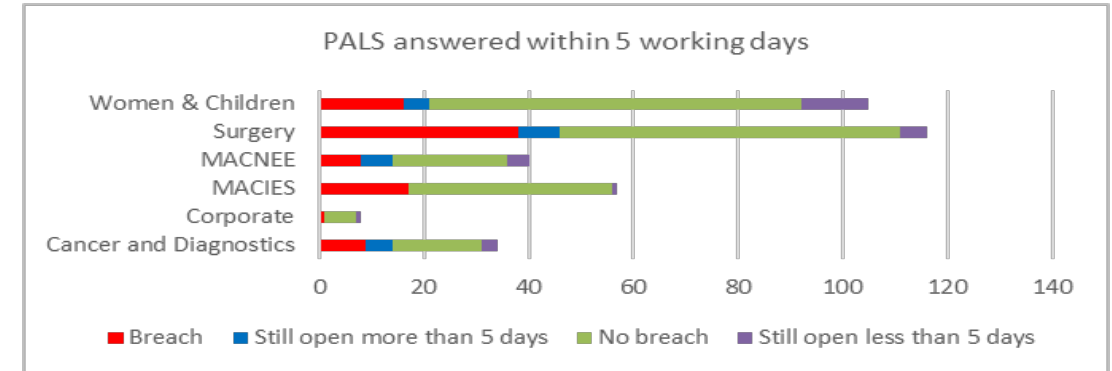
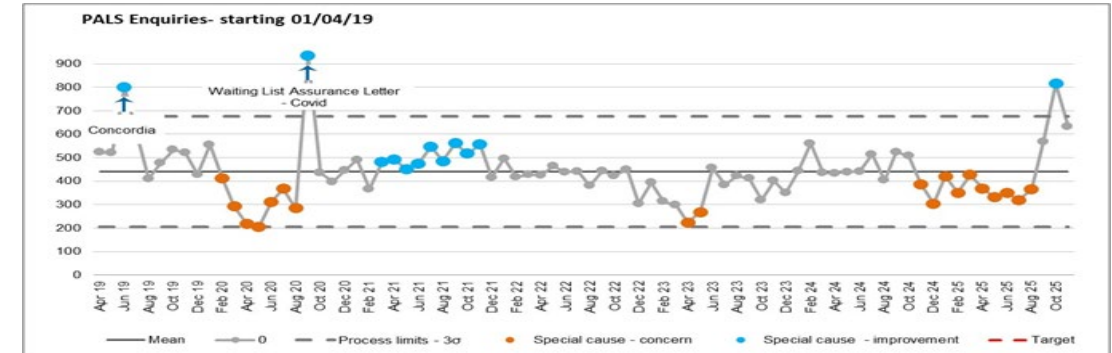
- The total number of PALS enquiries has reduced from the high in October, and the monthly total for November 2025 was 633. It is hoped that this drop is linked to the implementation of the new EpicEPR system, and PALS are continuing to direct patients towards the use of MyChart, explaining the benefits for patients. There has been a reduction in the number of waiting list and appointment-based concerns, and hopefully more people are able to get updates through MyChart and are not needing to contact PALS around this type of issue.

Patient Experience

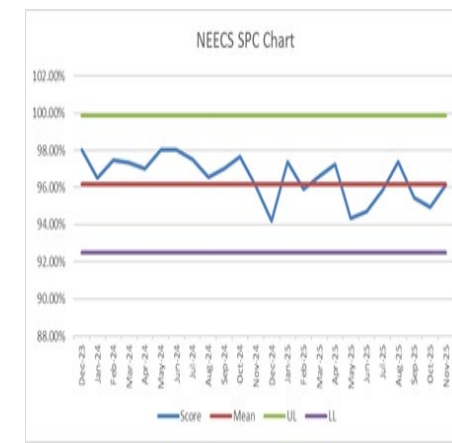
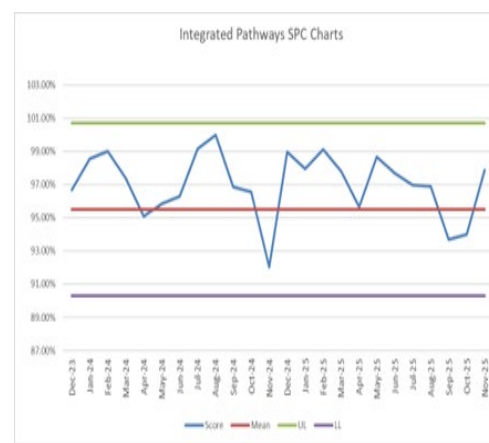
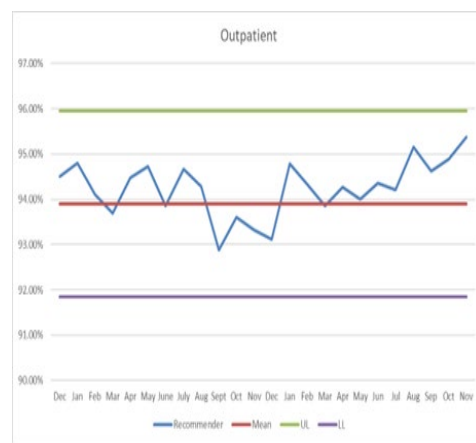
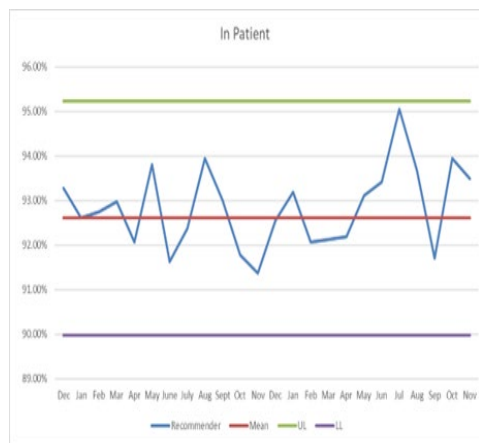
Complaints



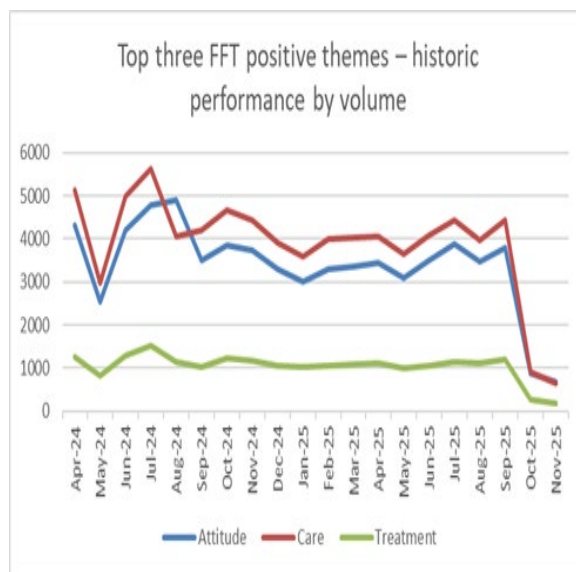
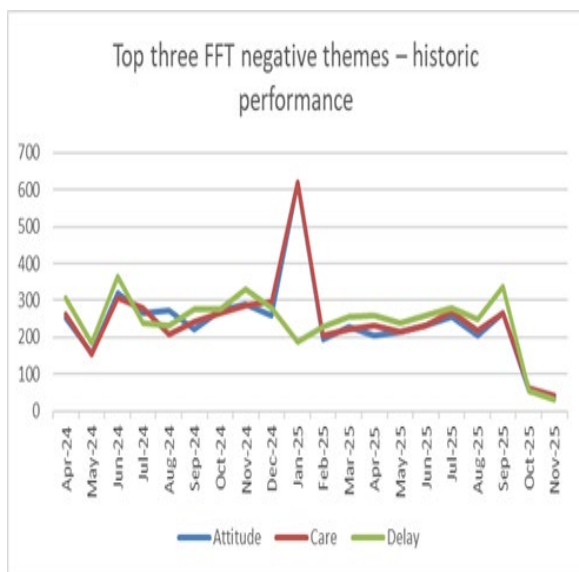
PALS



Patient Experience – Friends & Family

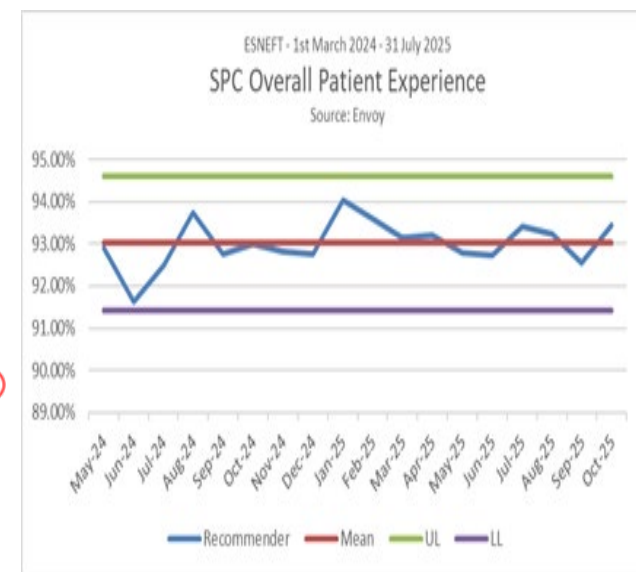
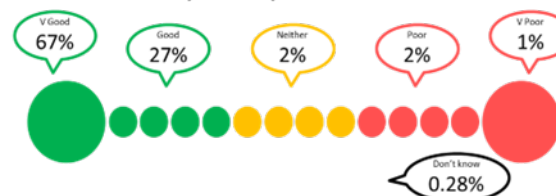


Top themes from Friends and Family for negative and positive comments for the month

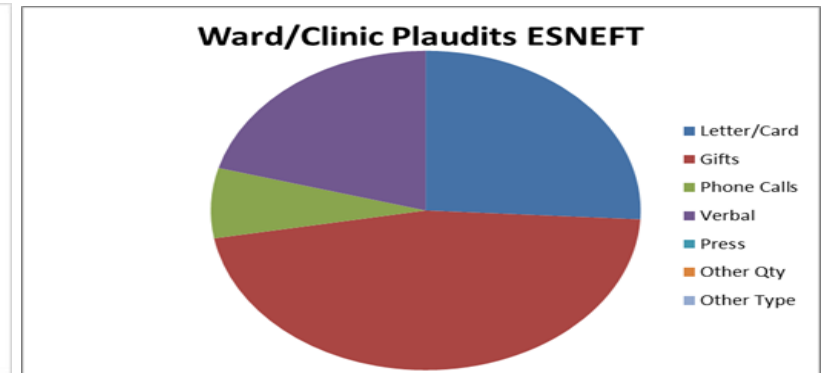
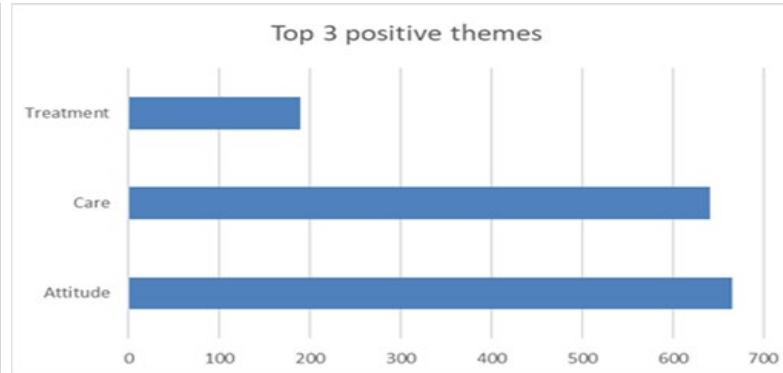
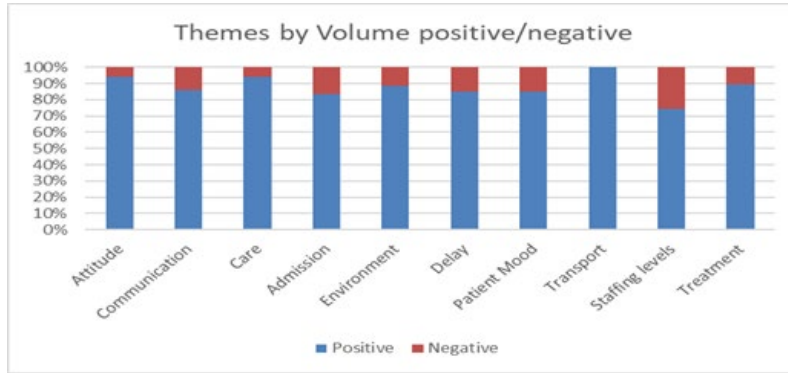


| FFT Response | Ipswich | Colchester |
|-----------------------|---------|------------|
| Very good/Good | 94.8% | 93.4% |
| Poor/Very poor | 2.0% | 4.5% |
| Neither good nor poor | 3.3% | 2.1% |

Friends and Family Test responses



Patient Experience – Friends & Family



There were **367** plaudits sent in to wards and clinics for ESNEFT.

Top 3 negative themes in November and contributors

Delay – Patients commenting on waiting for tests and test results along with being forgotten about while waiting for care.

Attitude – Patients feeling that staff are abrupt and telling them to “get on with it” while others have commented on lacking compassion.

Care – Triage area in Colchester close to doors with people coming and going and patient notes not being referred to.

Online Feedback

Ipswich Paediatric ED - I just wanted to email to say a huge thank you to your paediatric A&E and children's assessment unit teams. On Saturday my toddler, was brought in with RSV. The teams made us feel so well cared for and really listened to our concerns- we felt like we were the only ones in the hospital, thanks to their care. A special shout out to a nurse, you remembered us from your earlier shift in the morning and were therefore able to advocate for her when her presentation changed later in the evening, we appreciated you being there.

Colchester Maternity - I hope you are well today. I wanted to get in touch to pass on my thanks and praise for the medical team who looked after me at Colchester Hospital last week.

MACCIES Cardia Rehab - 'Suffolk Cardiac Rehab is brilliant. The Suffolk Cardiac Rehab based at the hospital is brilliant, they saw me for 6-8 weeks after my heart attack, I felt very cared for by them.

ENT Ipswich - Just visited ENT, went in 1 hour early and the lady who treated me ,I can't thank her enough , Been deaf for a week and hard of hearing for few years, this lady has not just got my hearing back, but hearing is the best its been, Really hope this lady at ENT gets my compliment, made such a difference to my life now to have hearing back but 100% better than been for years

Palliative Care – Feedback from relative - Thank you to MCI and SB Palliative Care CNS's, for your kindness giving hearts and blankets somehow this made a difference

| Emergency Care | | | | | | | | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Areas of Improvement | Areas requiring further work |
|--|--|--|--|--|--|--|--|--------|--------|--------|--------|--------|--------|--------|----------------------|------------------------------|
| A&E: Total Wait - 4 Hour Performance | | | | | | | | | 78.4% | 76.5% | 75.6% | 75.0% | 71.8% | 70.1% | | |
| A&E: Time to initial assessment | | | | | | | | - | 83.7% | 85.1% | 81.0% | 76.4% | 29.8% | 34.6% | | |
| ESNEFT Mental health Attendances | | | | | | | | - | 421 | 383 | 387 | 342 | 368 | 369 | | |
| Inpatients | | | | | | | | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | | |
| ESNEFT Total Spells | | | | | | | | - | 19,547 | 20,378 | 18,452 | 19,841 | 13,950 | 15,354 | | |
| ESNEFT Daily average LLOS patients | | | | | | | | - | 151 | 159 | 176 | 177 | 187 | 259 | | |
| Cancer | | | | | | | | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | | |
| Cancer: 62-day wait performance | | | | | | | | 81.2% | 66.1% | 70.2% | 65.1% | 70.7% | 58.7% | 61.3% | | |
| Cancer: 28 Day Faster Diagnosis Standard | | | | | | | | 83.5% | 72.5% | 73.9% | 74.9% | 72.3% | 66.2% | 65.4% | | |
| Diagnostics | | | | | | | | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | | |
| Diagnostics: % Patients waiting 6 weeks or longer | | | | | | | | 5% | 6.9% | 6.1% | 12.4% | 13.1% | 23.1% | 26.3% | | |
| RTT | | | | | | | | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | | |
| RTT: Incomplete pathway >65 weeks | | | | | | | | 0% | 0.01% | 0.02% | 0.01% | 0.01% | 0.01% | 0.00% | | |
| RTT: Incomplete pathway >52 weeks | | | | | | | | 3.5% | 3.44% | 3.17% | 3.19% | 3.23% | 3.33% | 3.25% | | |

- Improvements in 4 hours standard and 12 hours waits seen.
- Colchester focus on SDEC model which will operate 24/7, workforce to be reviewed.
- Challenges to offload ambulances continued, however improvement in month seen. Additional capacity to come online end of December.
- No patients over 65 weeks for any reason and improvement in those patients waiting over 52 weeks.
- Improvement in Activity levels following the planned reductions – still some areas where improvements are slower to return.
- Improvement month on month for Cancer
- Elective Focus throughout November with Elective Roadshows, speciality Deep Dives, tactical weekly and Turbo rooms all to support validation and education with a dedicated focus on data quality i.e. duplicate referrals, appts with no next steps and DNA appts. This supported the reduction of the total waiting list size.
- The Trust achieved 73.3% performance against the A&E 4-hour standard in October.
- Inpatient and frailty taskforce to implement recommended changes.
- SDEC models to improve the 'offer' on both sites
- Additional capacity to be in place for Colchester end of December
- Time to care week in December will have a multi-disciplinary approach to reduce delays and safe patient discharge.
- Continued focus on reducing the 62-day backlog and improving the diagnostic element of the pathways timelines.
- Returning to pre go live activity and recovering overall positions for Cancer, Elective and Diagnostics throughout the 60 day stabilisation programme.
- Validation of PTLs and key work queues
- Focus with clinical colleagues on reducing both the triaging referrals and outcoming work queues to get to doing today's work today.

* The target is the Trust's local target and trajectory submitted to NHSE, as identified for May 2025.

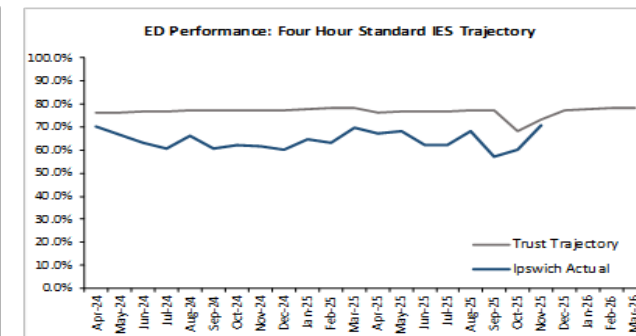
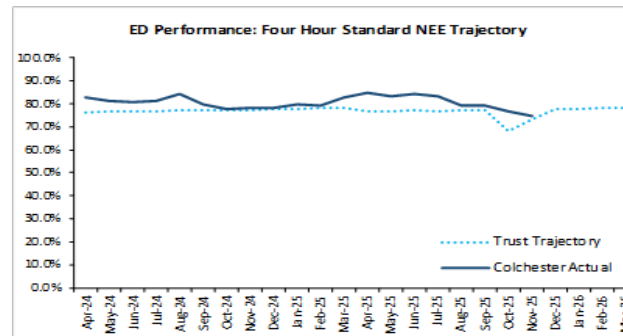
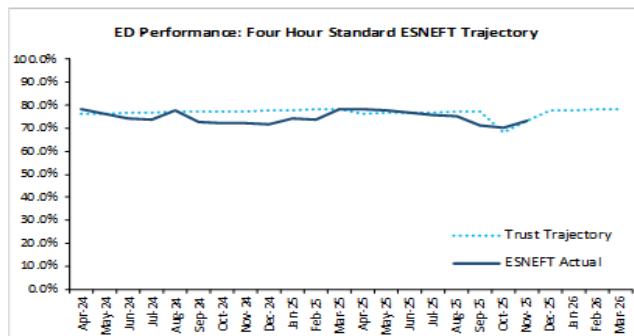
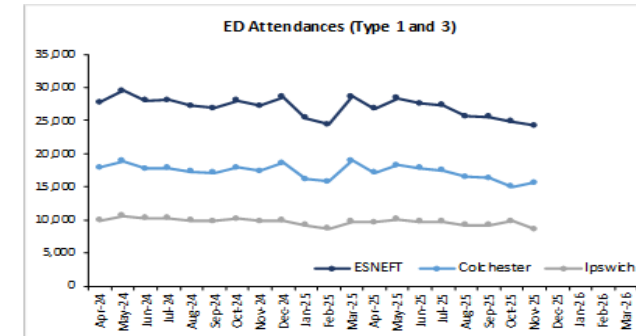
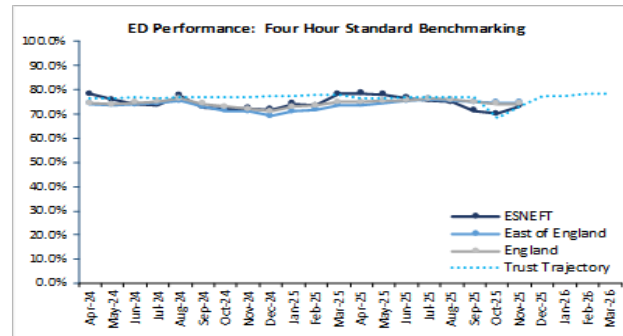
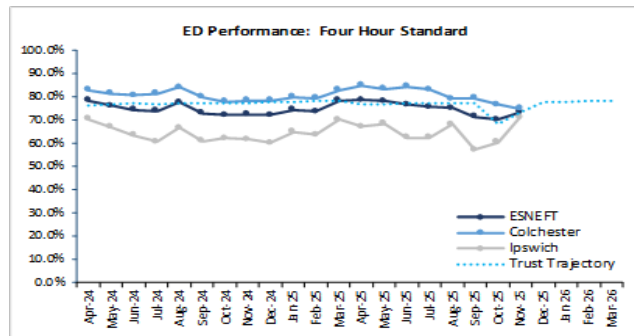
| Performance Measure | Trust Agreed plan | Reporting Month | | | Trend | | | |
|------------------------------------|---|-----------------------------|--------|-------|---------|---------|--------|-------|
| | | ESNEFT | Col | Ips | ESNEFT | Col | Ips | |
| Emergency Department | Four hour standard (Whole Economy) | 73.2% | 73.3% | 74.6% | 70.9% | 3.2% | (1.9%) | 10.6% |
| | Time to initial assessment - 95th pct | Not in Trust Submitted plan | 92 | 115 | 42 | (41) | (39) | (15) |
| | Time to initial assessment- percentage within 15 minutes (new measures) | Not in Trust Submitted plan | 34.6% | 36.9% | 32.5% | 4.8% | 8.2% | 1.5% |
| | Time to treatment - median time in department | Not in Trust Submitted plan | 48 | 30 | 119 | (8) | (7) | (18) |
| | Average (mean) time in department- non-admitted patients (new measure) | Not in Trust Submitted plan | 233 | 260 | 237 | (14) | 9 | (41) |
| | Average (mean) time in department- admitted patients (new measure) | Not in Trust Submitted plan | 767 | 751 | 787 | (9) | 5 | (37) |
| | Patients spending more than 12 hours in A&E | 963 | 1,695 | 1,001 | 694 | (373) | (124) | (249) |
| | Proportion of ambulance handovers within 15 minutes (new measure) | Not in Trust Submitted plan | 8.6% | 6.8% | 10.7% | 3.7% | 3.3% | 4.1% |
| Cancer | % Patients seen within 2 weeks from urgent GP referral | Not in Trust Submitted plan | 58.5% | | | 9.2% | | |
| | % patients meeting 28 day faster diagnosis | 81.1% | 65.4% | | | (0.9%) | | |
| | % patients waiting no more than 62 days for treatment | 79.6% | 61.3% | | | 2.6% | | |
| Diagnostics | % patients waiting 6 weeks or more for a diagnostic test | Not in Trust Submitted plan | 26.3% | | | 3.1% | | |
| | Diagnostic waiting list | Not in Trust Submitted plan | 20,645 | | | 1,500 | | |
| RTT | % of incomplete pathways within 18 weeks | 57.3% | 54.2% | | | (1.8%) | | |
| | Total RTT waiting list (open pathways) | 87,850 | 93,737 | | | (3,915) | | |
| | Total 52+ weeks waiters | 1,723 | 3,044 | | | (209) | | |
| | % of RTT waiting list at 52+ weeks | 2.0% | 3.2% | | | (0.1%) | | |
| | Total 65+ weeks waiters | 0 | - | | | (5) | | |
| % of RTT waiting list at 65+ weeks | 0.0% | 0.00% | | | (0.01%) | | | |

The Trust is currently working through the activity stabilisation period of EpicEPR development. As such, there may be elements of data incompleteness and/or data quality impacts in some metrics. Where possible these have been reviewed and corrected, but some issues may remain.

UEC: November saw improvements with both sites with Emergency care metrics. ESNEFT is over its plan for the month, with a 10.6% improvement at the Ipswich site with further improvements made across both sites in ambulance handovers – despite this they remain too long. Focus remains on sustaining improvement despite the expected seasonal variation with focus remaining on the UECC improvement plan supported by the patient flow taskforce.

Elective – Cancer, Elective and Diagnostics: Improvements were seen across most of the metrics compared to October and there was a focus in November on activity stabilisation from EpicEPR Go Live. Activity levels in some specialities were off track against plans before Go Live. There was a significant reduction in the overall waiting lists and no patients for the first month this year, waiting over 65 weeks.

Whole Economy performance for ESNEFT in month improved by 3.18%, but was below the national standard of 78% in November 25. Local performance was below both National and Regional average for October (Nov national not yet available). Colchester performance declined by 1.9% and Ipswich performance improved by 10.6%. Overall, ESNEFT attendances decreased by 622 (2.5%) with Colchester attendances increasing by 3.8% and Ipswich attendances decreasing by 12.1%.



4-hour standard- ESNEFT whole economy

73.3%

↑ vs 70.13% last month

**includes Clacton and Harwich*

4-hour standard- Colchester

74.6%

↓ vs 76.5% last month

4-hour standard- Ipswich

70.9%

↑ vs 60.4% last month

Attendances - ESNEFT

24,233

↓ vs 24,855 last month

Colchester

November saw the site challenged with significant exit block, and increased attendances to the department. This has contributed to a decrease in the 4-hour standard. To ensure recovery to the 4-hour standard being achieved, a recovery plan is in place against all agreed trajectories.

Ipswich

During the month of November, some of the anticipated improvements of EpicEPR have started and will support departments in relation to productivity, visibility and more accurate reporting.

Although Ipswich did not meet the national target of 78% or the Trust trajectory of 72% an improvement of over 10% in the 4-hour standard performance was reported in November. This was the highest achievement this year. Type 1 data has shown particular improvement in line with opening the SDEC area 24/7.

The number of ambulance handovers increased in November for ESNEFT by 5.2%, with the number at Colchester increasing by 2.8% and increasing by 8.3% at Ipswich.

Number of handovers - ESNEFT

4,654

↑ vs 4,425 last month

Number of handovers - Colchester

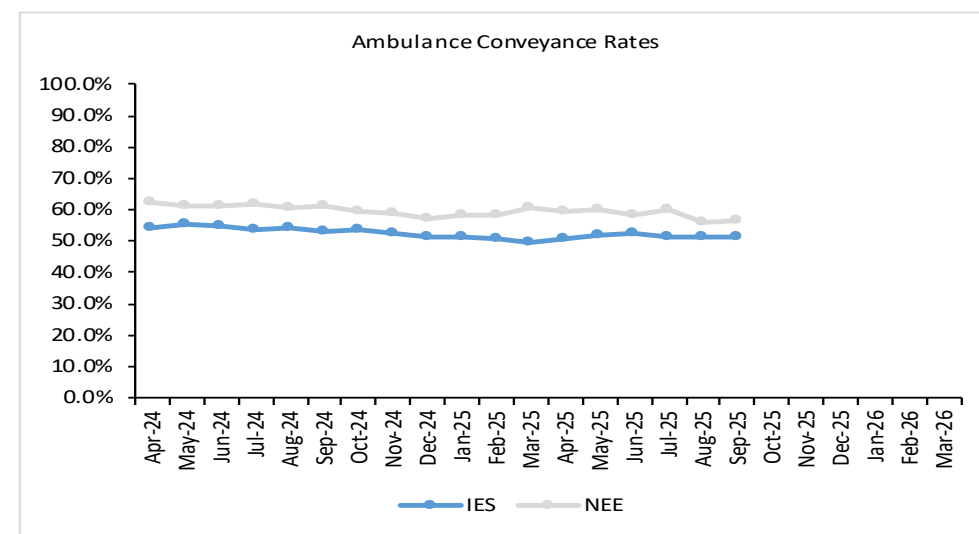
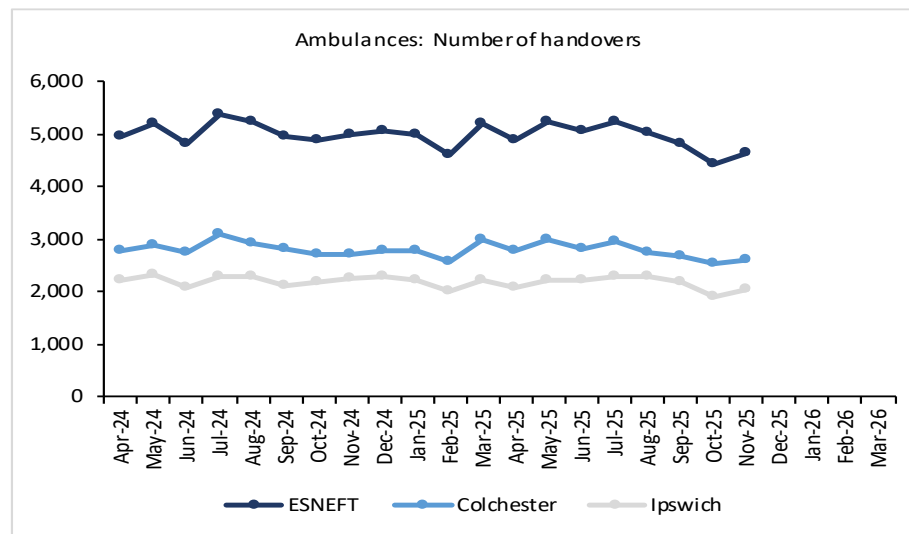
2,598

↑ vs 2,527 last month

Number of handovers - Ipswich

2,056

↑ vs 1,898 last month



**Ambulance conveyance rates not received for October/November

Colchester

There was notable increase in demand for the Emergency Department in November, particularly with demand for Resus. There is regular liaison and communication with the Ambulance Service to ensure that they are using Same Day Emergency Care and the Urgent Treatment Centre, where possible. This is to ensure the Emergency Department is protected for life and limb. There has been good direct utilisation of Same Day Emergency Care services averaging 5 conveyances there per day.

Ipswich

Due to changes in the CAD system last month, it is expected the 8.3% increase reported in ambulance handovers is due to accurate reporting in line with usual levels of demand.

With the pressure currently being experienced in the Emergency Department and wider hospital, there is a need for reviewing conveyance avoidance pathways and working with EEAST colleagues to identify any other alternative ways of working to reduce conveyance for suitable patients.

ESNEFT performance for handovers within 15 minutes increased by 3.7% in month. At Colchester, the proportion of patients handed over within 15 mins increased by 3.3% and at Ipswich it increased by 4.1%. Overall, the number of handovers between 15 and 30 minutes increased by 9.3%, between 30 and 60 minutes decreased by 1.8%, and the number handed over after 60 minutes decreased by 11.2%.

Handovers within 15 minutes - ESNEFT **8.6%**

↑ vs 13.4% last month

Handovers within 15 minutes - Colchester **6.8%**

↑ vs 3.6% last month

Handovers within 15 minutes - Ipswich **10.7%**

↑ vs 6.6% last month

Handovers within 15 – 30 minutes - ESNEFT **33.5%**

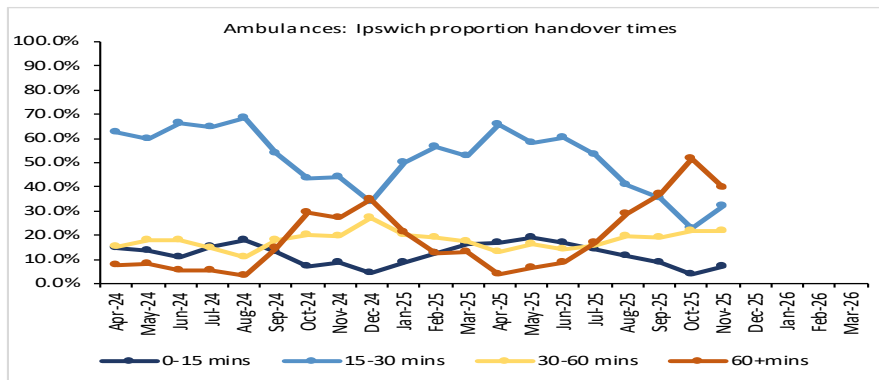
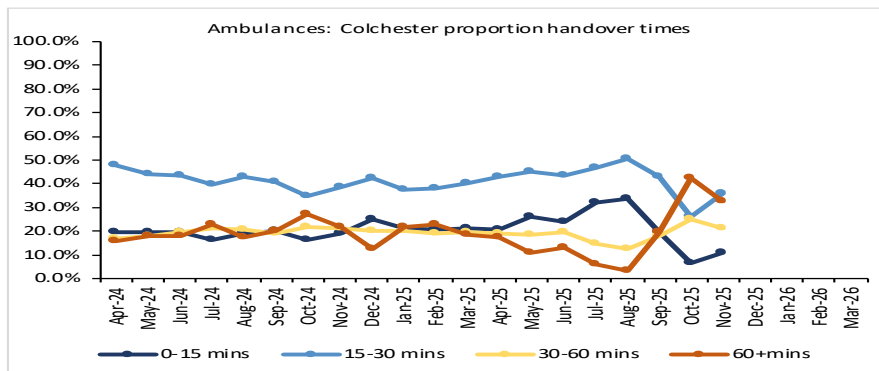
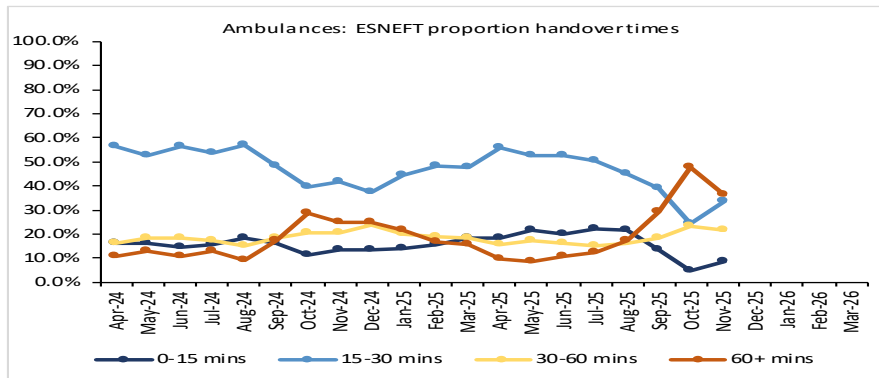
↑ vs 24.2% last month

Handovers within 30 – 60 minutes - ESNEFT **21.5%**

↓ vs 23.3% last month

Handovers over 60 minutes - ESNEFT **36.4%**

↓ vs 47.6% last month



Colchester

November saw significant challenges with exit block. However, teams are assured that normal Initial Assessment processes were followed. Those people who are fit to sit and those able to utilise alternative internal pathways did so. In turn this has improved the 15-minute handover performance. The site continues to ensure that where possible, all alternative pathways are utilised to enable timely ambulance handover performance.

Ipswich

Familiarisation with EpicEPR has improved levels of productivity for clinicians and administrative staff which has positively impacted ambulance offloads. Teams are also using a secure chat function between majors and the initial assessment area to expedite moves when beds are ready. Currently teams are working with EEAST colleagues on escalation plans at times of increased pressure to maintain patient safety and experience. Work is ongoing with acute medical colleagues to plan a trial of direct access to AMSDEC to align with regional offers.

Overall, the time to initial assessment in ED improved, with the number of patients assessed within 15 minutes increasing by 4.8%. Colchester increased by 8.2% and Ipswich increased by 1.5%. Average time in department for admitted patients decreased by 9 minutes, and decreased by 14 minutes for non-admitted patients. The number of patients staying in the department for 12 hours decreased by 18.0% compared to the previous month.

Time to initial assessment (% patients within 15 mins)

34.6%

↑ vs 29.8% last month

Time to initial assessment: (95pct)

92 min

↓ vs 133 min last month

Average time in dept – non-admitted

233 min

↓ vs 247 min last month

Average time in dept – admitted

767 min

↓ vs 776 min last month

Time to treatment – median time in dept. (60 mins)

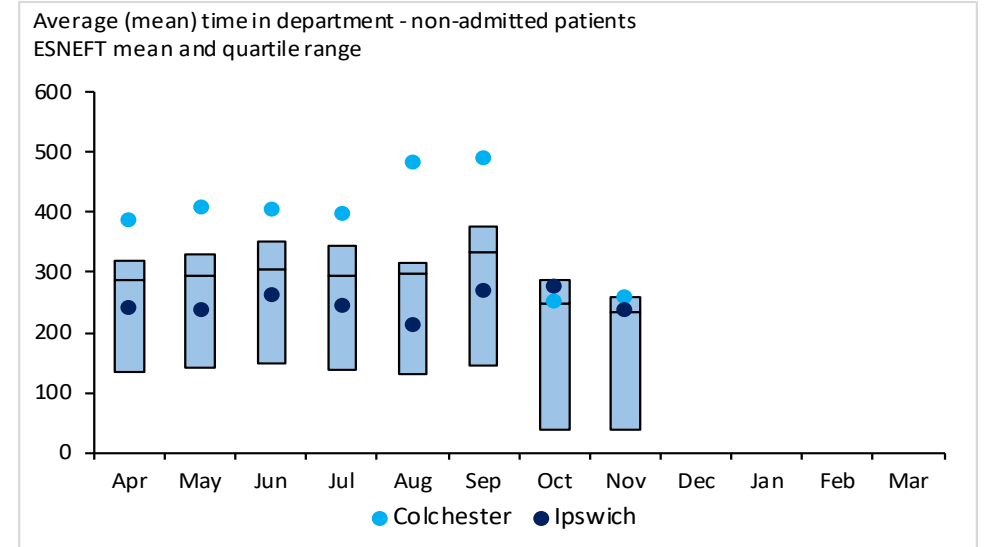
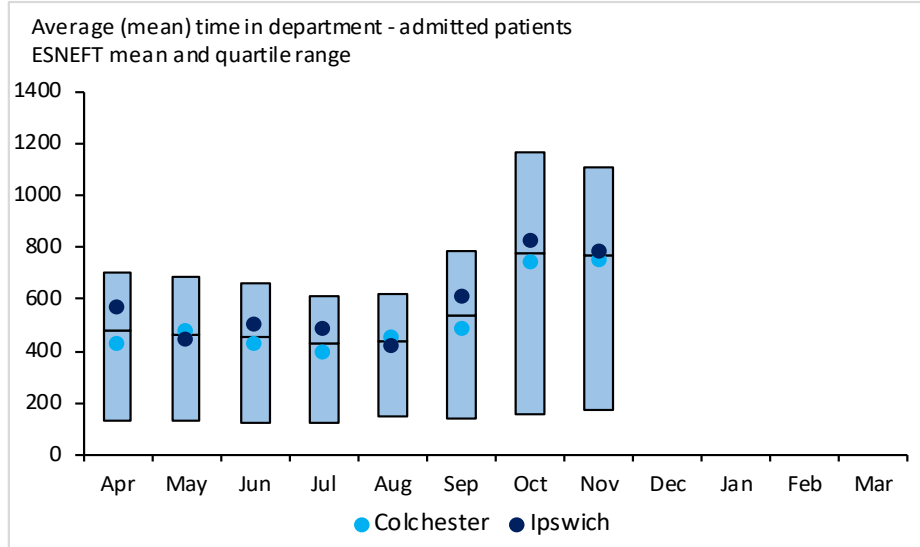
48 min

↓ vs 56 min last month

12-hour patients

1,695

↓ vs 2,068 last month



Colchester

Proficiency with EpicEPR in times of extremis is improving in line with following normal operational protocols. This is resulting in improvements in a number of metrics. However, 12-hour performance remains challenged. To ensure that there is a whole site focus to this improvement this is being led by the inpatient flow management team.

Ipswich

Similarly to other areas of UEC performance, improvements have been seen compared to October, aligned to the familiarisation of EpicEPR.

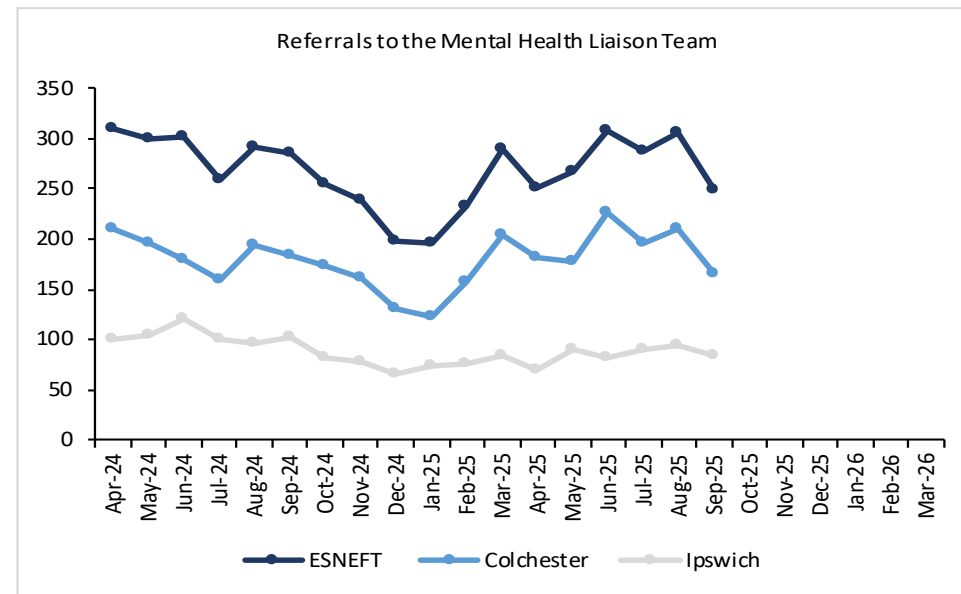
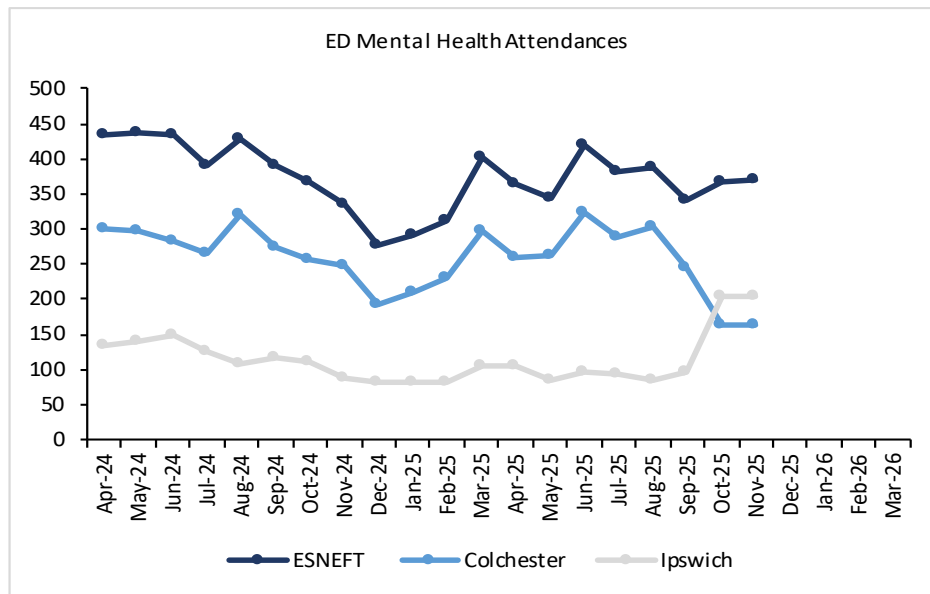
The ED recovery plan actions focused on time in department, and teams have seen an improvement in both admitted and non admitted time in department. Continued work with specialities to ensure community heralded patients are moved to the right place on arrival to the department. Furthermore, during December's Time to Care week, there will be a focus on accurate streaming at the front door and empowering clinicians to implement the ED transfer standards of care.

Mental Health ED attendances increased by 0.3% across ESNEFT compared with last month. In Colchester attendances increased by 0.6% and in Ipswich attendances decreased by 0.0%.

Mental Health referral data post EpicEPR Go-Live is currently not available.

MH attendances - Colchester
164
↑ vs 163 last month

MH attendances - Ipswich
205
→ Vs 205 last month



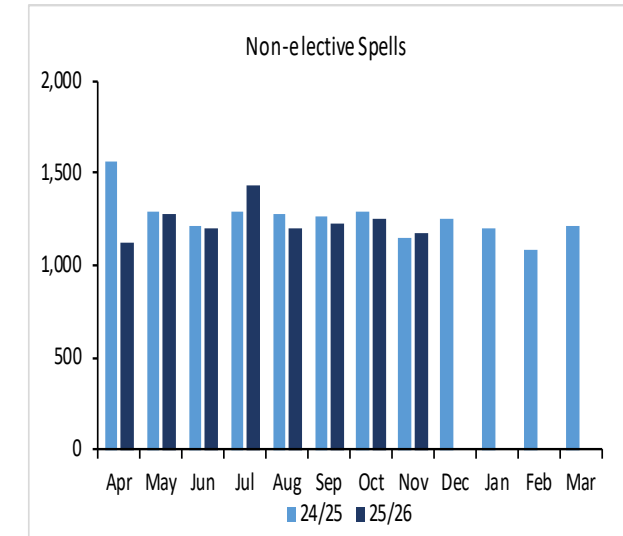
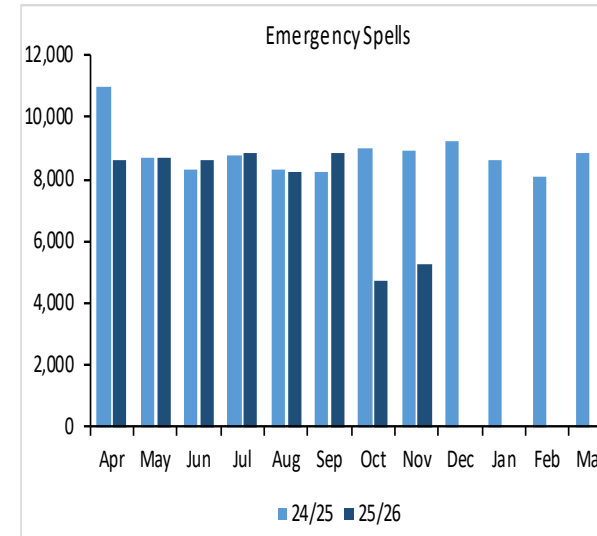
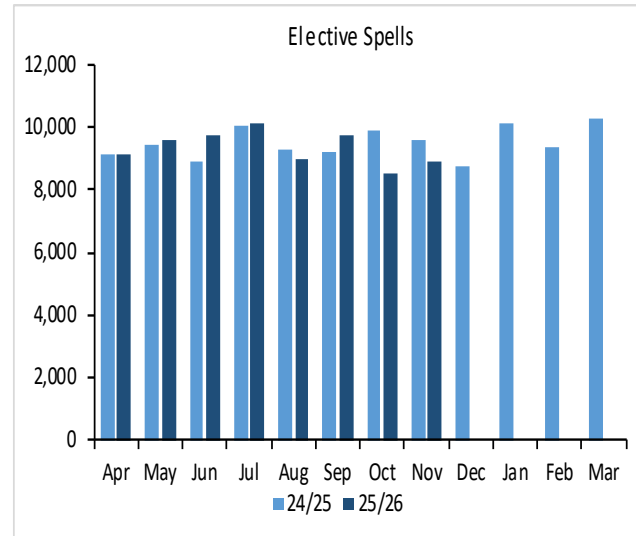
**Reporting post Epic is currently being developed.

An area of concern has been highlighted due to NSFT and EPUT engaging late on in the EpicEPR process which has resulted in difficulties in accessing referrals, as well as staff not always referring to the MHLT due to confusion regarding the new EPR. This has resulted in some patients not being assessed within required timeframes and increased risks for those individuals as a result. Work is ongoing to address this.

Colchester in particular has experienced high numbers of patients experiencing delays in accessing Mental Health beds from ED. System communication and support is in place to ensure escalation.

There has been a slight increase on both sites in the application of the Mental Health Act, use of Risk Indicator (RI) and Enhanced therapeutic observations (EToC).

Total spells increased by 5.8% in month for ESNEFT. Emergencies increased by 11.9% and non-electives decreased by 6.8%. Elective spells increased by 4.2% relative to October. Compared with the same period 24/25, elective activity has decreased by 7.3%, emergencies have decreased by 40.4% and non-electives have increased by 2.4%. However, the growth in emergencies is a reflection of a number of significant service changes, including the introduction of the Ambulatory Emergency Care Unit (AECU).



Note, Same Day Emergency Care (SDEC) recording in EpicEPR has reduced the number of Emergency Admissions (effective from October).

Colchester

Contingency beds remain open as well as bedding in the frailty end of ESNEFT Same Day Emergency Care (ESDEC) to manage demand. RAG patient review meetings continue across all wards with a number of complex patients with extended LOS. Time to Care week will take place in the week before Christmas with collaboration from system partners to support patients getting home, or to an alternative care setting ahead of the festive period. Acuity has been high, with flu and respiratory admissions.

Ipswich

Ipswich, continued to utilise temporary escalation beds. These opened in October including the Stroke gym and 9 additional beds in Aldeburgh Hospital. At the end of the month, Waveney was opened as a medical escalation ward which now has 27 patients.

Another Time to Care week will run in December to focus on alleviating delays within the hospital and working with system partners to support discharges.

Elective spells

8,886

↑ vs 8,525 last month

Emergency spells

5,298

↑ vs 4,734 last month

Non-elective spells

1,170

↓ vs 1,255 last month

Total spells

15,354

↑ vs 14,514 last month

The average number of long length of stay (21+ days) patients across ESNEFT increased by 72 in month and is 139 patients above the trajectory. Colchester increased by 47 patients and Ipswich increased by 25 patients.

ESNEFT – Daily average LLOS patients

259
 ↑ vs 187 last month

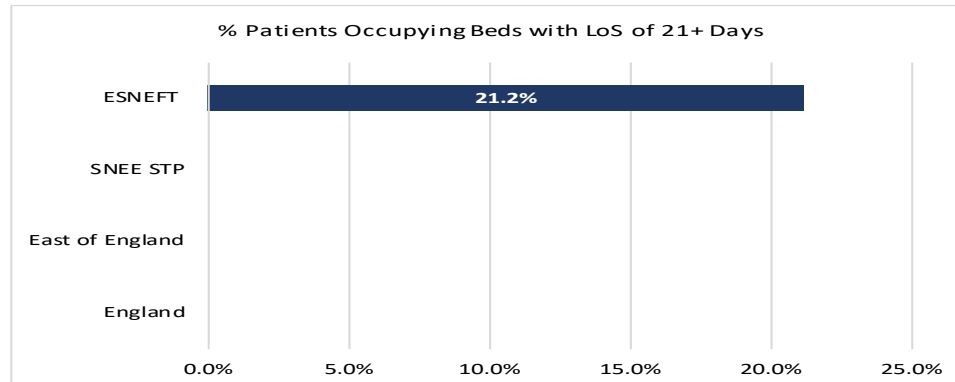
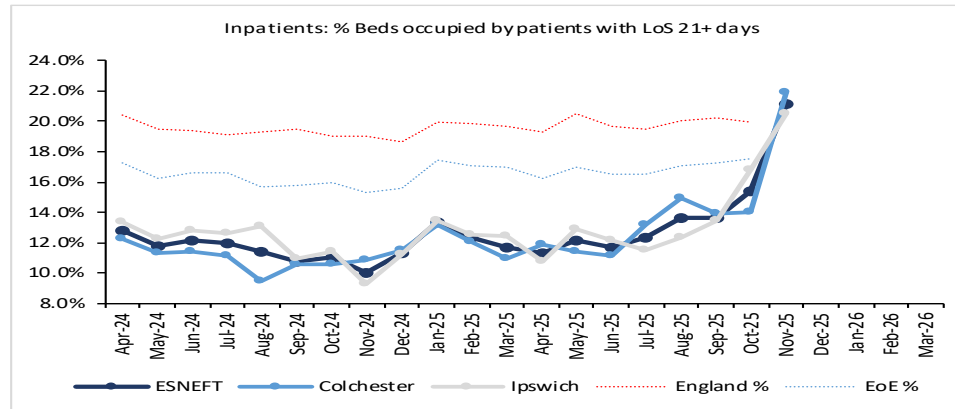
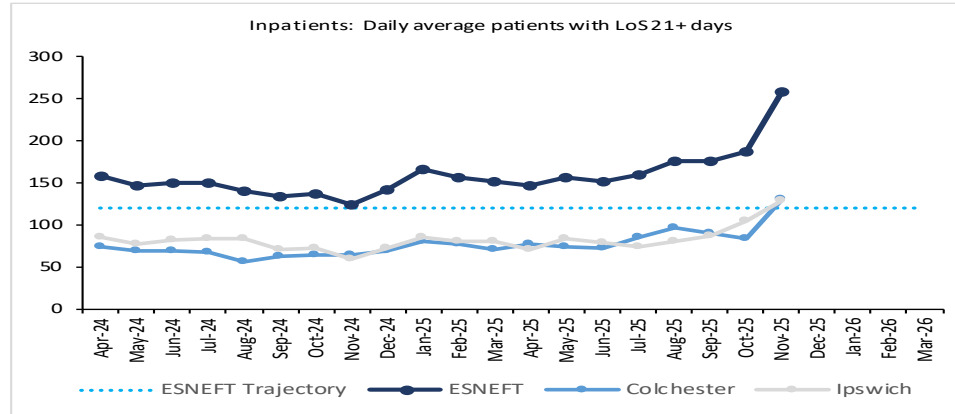
Colchester – Daily average LLOS patients

130
 ↓ vs 83 last month

Ipswich – Daily average LLOS patients

129
 ↑ vs 104 last month

***National/Regional data for November was not available at time of submission.*



Note It is possible that due to the recent implementation of EpicEPR in Community Hospitals, the inclusion of these figures in the overall patient Length of Stay (LoS) is contributing to increase seen in month. This will require further review to ensure accurate reporting and alignment with organisational standards.

Colchester

There has been an increase in complex patients which has led to more patients waiting over 21 days. There have been significant challenges with mental health patients throughout November, both at the front door and on the deeper wards which was impacting on this increase.

Daily complex meetings have been stood up and the MH patients are discussed daily on the Sit Rep call and escalated accordingly. A Time to Care week is planned for the 15th December.

Ipswich

The Trust set up an ESNEFT focus group looking at Patient Flow in late October. This task group is being held weekly led by the Transformation team to look across both Colchester and Ipswich sites, to ensure uniformity and promote change to improve length of stay. Targeted work on the wards this month was to focus on Expected Date of Discharge (EDD) to improve the accuracy of ward discharges.

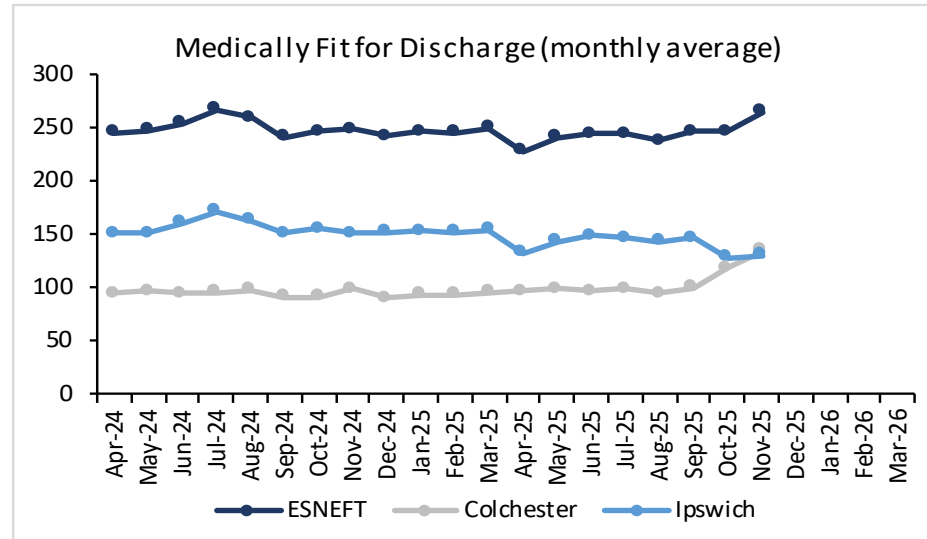
Teams continue to run weekly Time to care, MDT's on each medical ward reviewing our complex and long length of stay patients. There is a continued drive on Time to Care initiatives implementing the revised Board round Standard Operating Procedure (SOP) and preparing for the next event in December to prepare the Trust for the festive bank holiday

The average number of medically fit for discharge patients has increased by 7.3% in month for ESNEFT. Colchester increased by 13.6% and Ipswich increased by 1.6%.

Medically fit discharges - ESNEFT
264
 ↑ vs 246 last month

Medically fit discharges - Colchester
134
 ↑ vs 118 last month

Medically fit discharges - Ipswich
130
 ↓ vs 146 last month



Colchester

The discharge data is being monitored closely. An increase in admissions is creating strain on the system which is contributing to the growth in MFFD patients. Complex patients, as described on the previous slide, are medically fit but cannot move. The winter period has set in, and this is reflected in the number of patients in the hospital. Lack of discharges over a weekend create further pressure, particularly on a Monday and Tuesday as the hospital catches up. The changes in EpicEPR have also made it easier to record a patient as medically fit, so this is being reviewed daily to ensure accurate data capture.

Ipswich

Medically fit for discharge patients remained static in November. Discharge to assess meetings were re-launched to drive improvements in discharges across Community Hospitals, to drive down length of stay for our medically fit for discharge patients. As part of the new Patient Flow Focus group, teams are specifically looking at medically ready patients and identifying these patients in EpicEPR to reduce delays in discharge planning and decision making, alongside system partners.

ESNEFT performance in month improved by 9.2% for two week waits and improved by 2.6% for 62 day first treatments. The 28 day faster diagnosis rate declined by 0.9% compared to the month before and is below ESNEFT's internal trajectory to meet 81.1% in month.

62-day wait performance

61.3%

↑ vs 58.7% last month

Two week wait performance

58.5%

↑ vs 49.2% last month

28-day faster day diagnosis performance

↓ 65.4%

vs 66.2% last month

Patients treated at 63+ days

1,141

↑ vs 1,117 last month

Patients treated at 104+ days

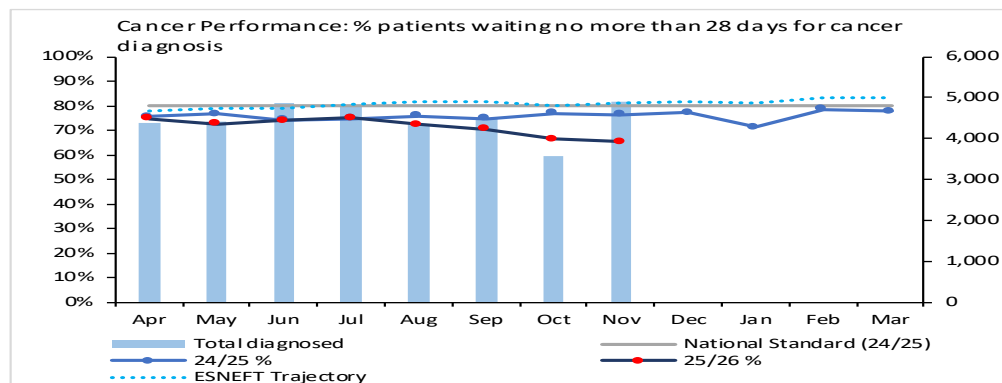
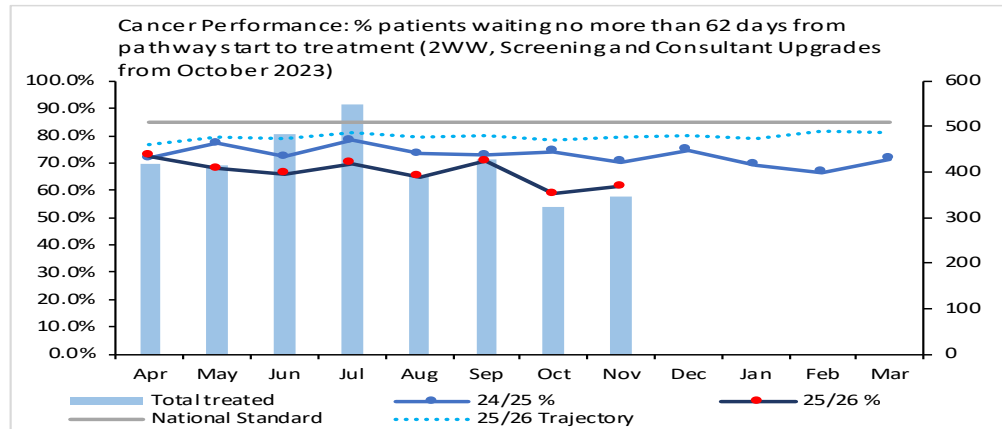
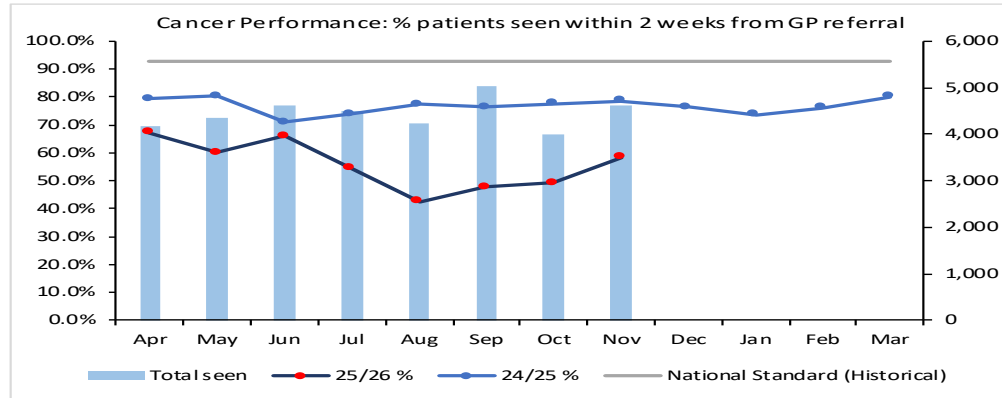
54

↑ vs 44 last month

62-day PTL size

6,365

↓ vs 7,010 last month



Service Commentary

Data Quality (DQ) issues continue to impact overall numbers in the PTL, but work continues at pace to resolve these. EpicEPR are reviewing where changes can be made in the system to resolve data capture inaccuracies and additional training for the MDT tracking teams will support to ensure any changes are relayed to ensure tracking quality continues to improve.

The Cancer Task Force and associated programme of works as well as daily Red to Green for colorectal and urology are having a positive impact on PTL numbers. A more focused piece of work next week as part of cancer turbo rooms will look at validation of the backlog, work up and booking of patients with a confirmed diagnosis. In the lead up to the holidays, as always, additional service team and CNS support will be calling patients with benign results to ensure they have the news before Christmas. This not only means a much better Christmas for those patients, but this will also have a positive impact on 28 FDS performance.

From when the data shown was run, there have been further improvements:

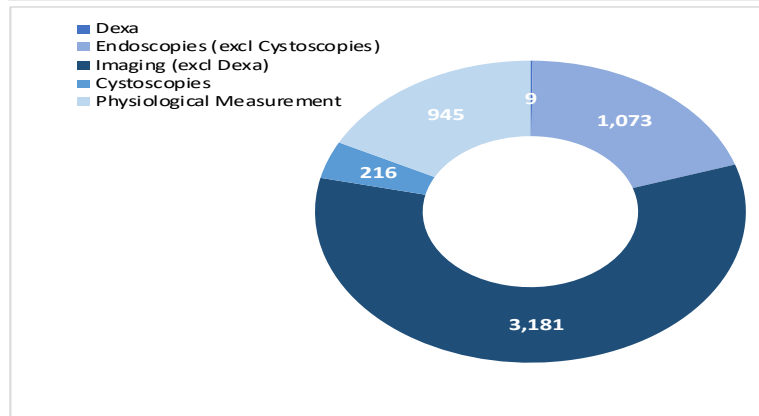
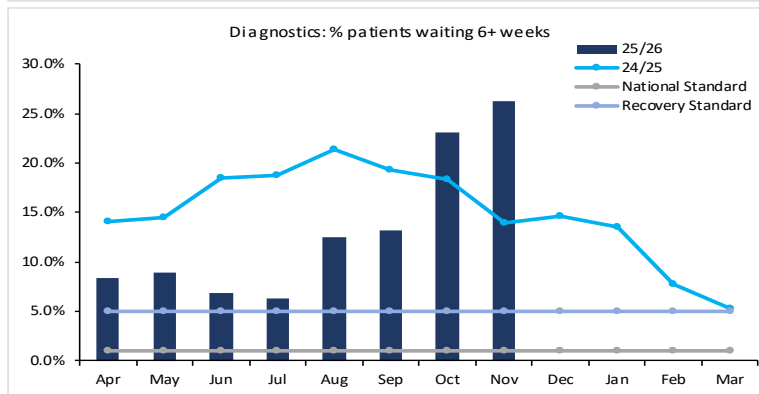
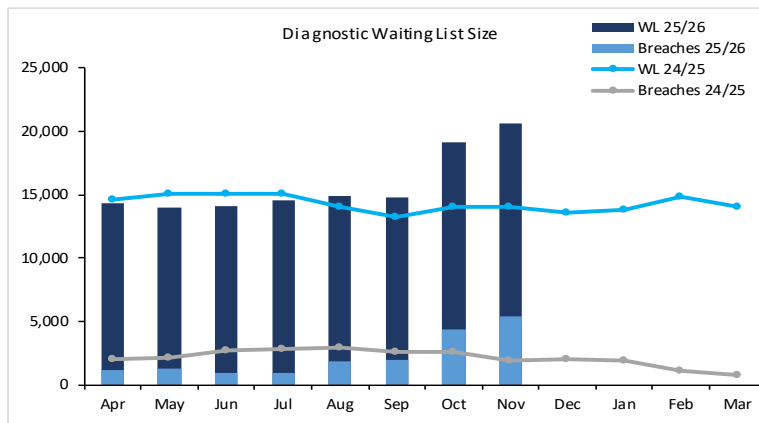
- The overall PTL size is now 5,661, down a further 704 patients.
- The backlog is now 1,013, down by a further 128 patients. 100 patients in the total backlog are waiting next steps with a tertiary provider.

6 week performance declined by 3.1% in month. The number of 6 week breaches increased by 997 with the waiting list increasing by 1,500 (7.8%). Ipswich currently holds the greatest proportion of the breaches at 62.8%. Of the Ipswich breaches, non-obstetric ultrasound constitute 48.2% of the site total. At Colchester non-obstetric ultrasound account for the greatest proportion of breaches (29.3%).

% patients waiting > 6 weeks
26.3%
 ↑ vs 23.1% last month

DM01 6-week breaches
5,424
 ↑ vs 4,427 last month

DM01 Waiting List
20,645
 ↑ vs 19,145 last month



Service Commentary

DM01 performance declined in November with growth in the waiting list and the backlog.

The DM01 PTL grew over and above expected levels at Go Live. Focused Turbo rooms in November have supported additional training around user error which is seeing the waiting list reduce.

DM01 patents waiting have been impacted through August to November by the known PACs issue. The division continue to work through these issues.

At present the proportion of the population waiting at ESNEFT is in line with national rates but with less patients waiting 13+ weeks.

All services remain committed to returning to upper quartile performance within the financial year.

Performance against the 18-week standard declined by 1.76% in month. Performance is below the national average and below the regional average for September**. The proportion of patients waiting 65 weeks or more has reduced by 0.01% and the proportion of patients waiting 52 weeks or more has decreased by 0.08%.

Open pathways within 18 weeks - ESNEFT

↓ **54.23%**
vs 56.0% last month

Open pathways within 18 weeks - National **

60.7%

65+ week waits - ESNEFT

↓ **0.00%**
vs 0.01% last month

65+ week waits - National

0.2%

↓ vs 3.33% last month

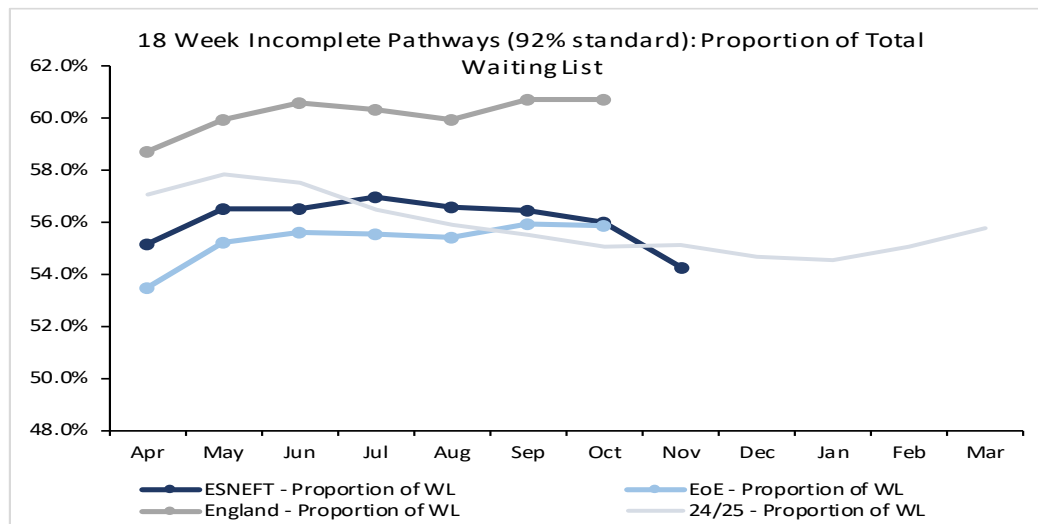
52+ week waits - ESNEFT

3.25%
↓ vs 3.33% last month

52+ week waits - National

2.5%

**National reporting is one month in arrears with only September's available at time of this submission.



**November 25 is not fully validated and will be updated accordingly.

Service Commentary

ESNEFT performance deteriorated against the October position. However, performance is ahead of plan (including the plan factoring in the Go-Live impact).

The Trust remains on track to meet the national priority target of a 5% improvement from baseline; however, it is noted the coming months require steep improvement, against an uncertain period of industrial action.

The 52+ week wait % reduced from October to November. ESNEFT are above trajectory for to clear the waiting list.

Following agreement for mutual aid support to MSE, the Trust anticipates a steep increase in patients over 52 and 65 weeks on the PTL. This is being closely monitored and supported by NHSE, and teams are working to identify patients in this cohort as they will sit on the ESNEFT PTL.

Elective inpatient activity decreased by 0.9% in month, with day case activity increasing by 5.2%.

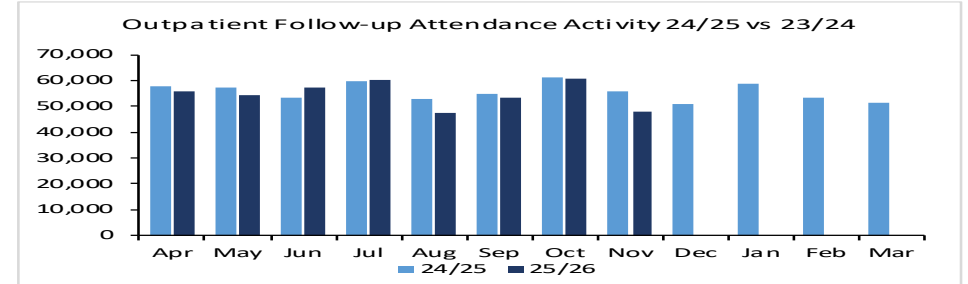
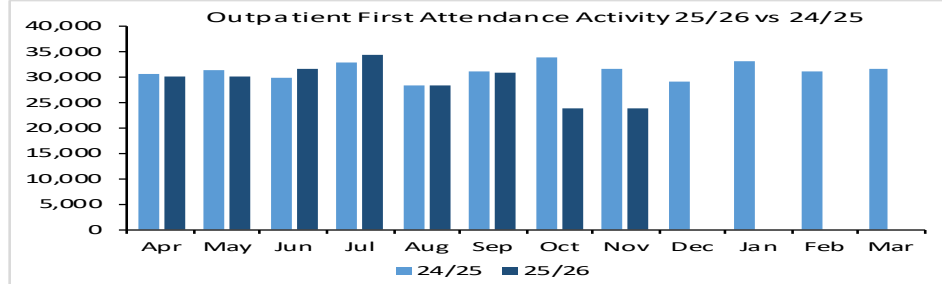
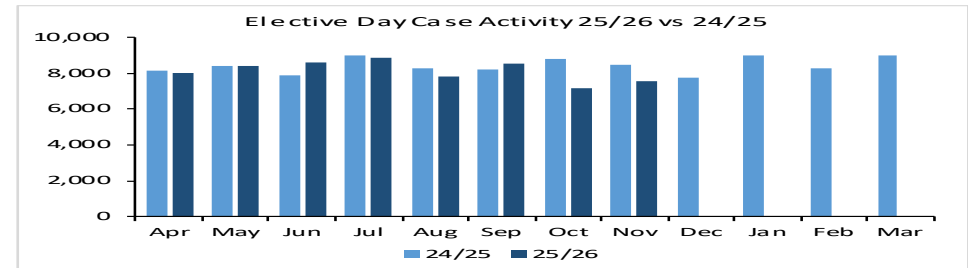
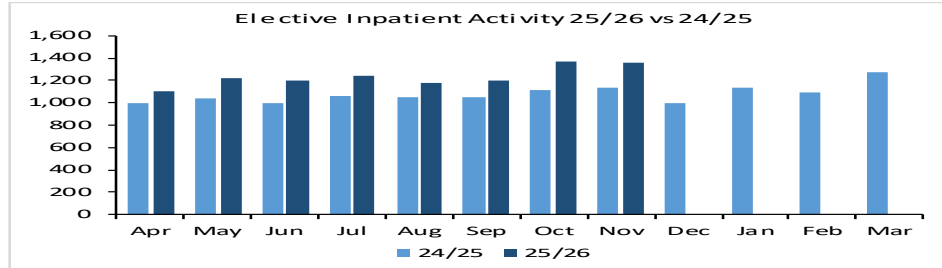
Outpatient first attendances decreased by 0.6% while follow-ups decreased by 21.1%.

Elective inpatients
1,357
↓ vs 1,369 last month

Elective daycase
7,529
↑ vs 7,156 last month

Outpatient First Appt
23,874
↓ vs 24,021 last month

Outpatient F/U Appt
47,781
↓ vs 60,522 last month



Outpatients

As part of Epic Stabilisation, clinic activity was reduced with services increasing through November. Services identified that activity was behind plan in terms of increasing to pre-EpicEPR levels. This is being monitored through centralised stabilisation reviews.

MyChart

In November, the Trust relaunched "Validation contact" with patients, this was previously delivered through text message, however November moved to using MyChart (EpicEPR). Since commencing in November 27,651 patients have been contacted via MyChart with some patients confirming they no longer need an appointment.

Theatres

Whilst down on the previous month, inpatient activity increased compared to the November 24/25 position.

Daycase activity

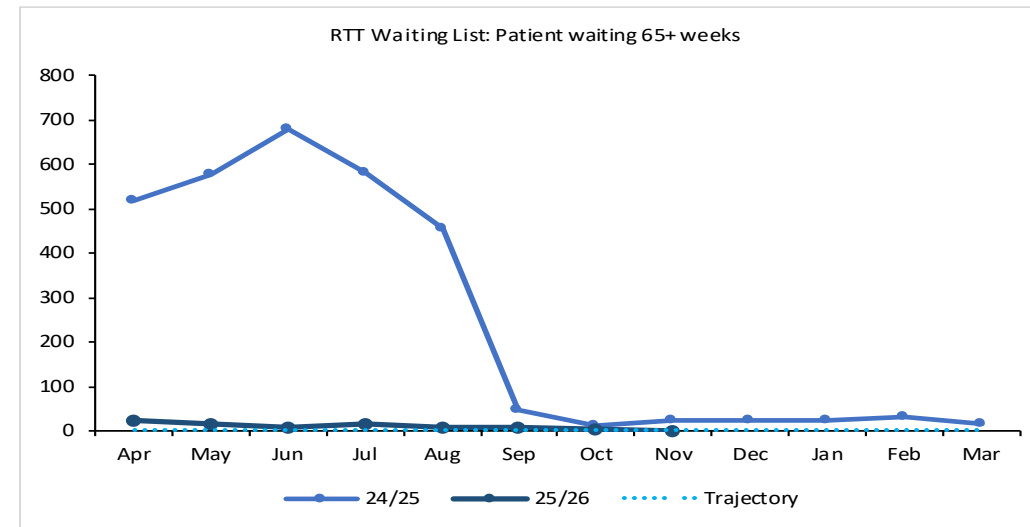
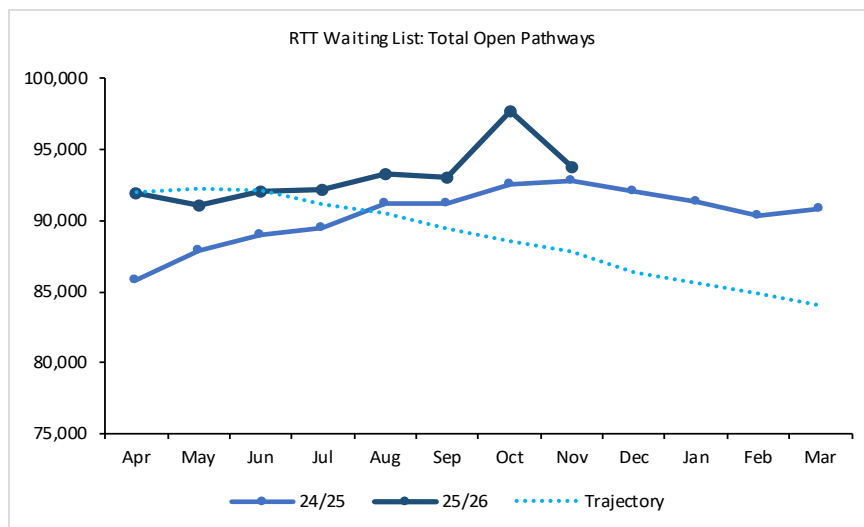
Activity increased in November compared to October; but was down against the same time last year. The levels are being tracked against services plans with actions in place to recover to expected levels.

The ESNEFT RTT waiting list has decreased by 4.0%, but is above the trajectory set for the month by 5,887. Patients waiting 65 weeks or more decreased by 5 to 0. At Ipswich the 65+ cohort decreased by 1 patient, while at Colchester the cohort decreased by 4 patients. The number of patients waiting 52 or more weeks decreased by 209 to 3,044. At Ipswich, the number of 52+ week waiters decreased by 91 and at Colchester the number decreased by 9.

RTT open pathways
93,737
 ↓ vs 97,652 last month

65+ week waiters
0
 ↓ vs 5 last month

52+ week waiters
3,044
 ↓ vs 3,044 last month



Service Commentary

November saw the completion of the planned 'Activity Stabilisation' period post Go Live of Epic EPR. At the end of September, prior to Go Live, ESNEFT had 89,958 patients waiting internally, 93,053 including Oaks RES patients. A total of 116.1 per 1k of the population.

Growth in October was over and above anticipated figures due to migration and user challenges. Following focused support using 'Turbo Rooms', peer to peer training and increased PTL support, there has been a reduction at the end of November to 93,737. As at the end of October there were no patients over 65 weeks with confidence this will be maintained month on month and focus moving to 52+ week reduction.

November saw a reduction in patients waiting over 52 week waits versus the previous month. 52 week wait cohorts are reducing however, are above current trajectory. All services continue to work to the national expectation of 52+ week patients being a maximum of 1% of total PTL size.

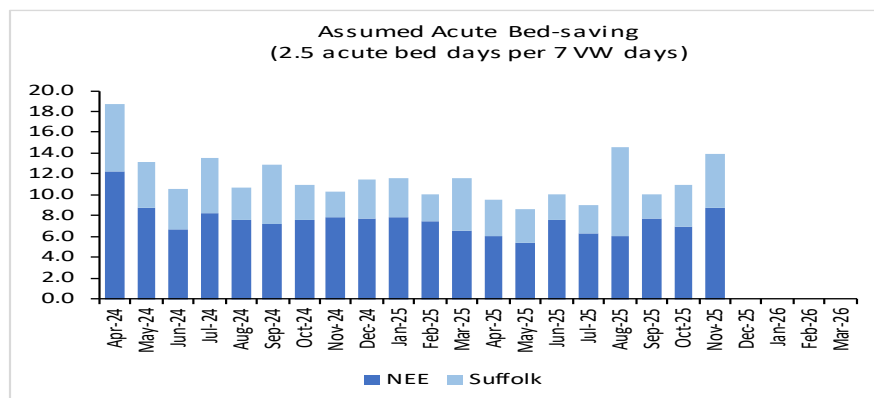
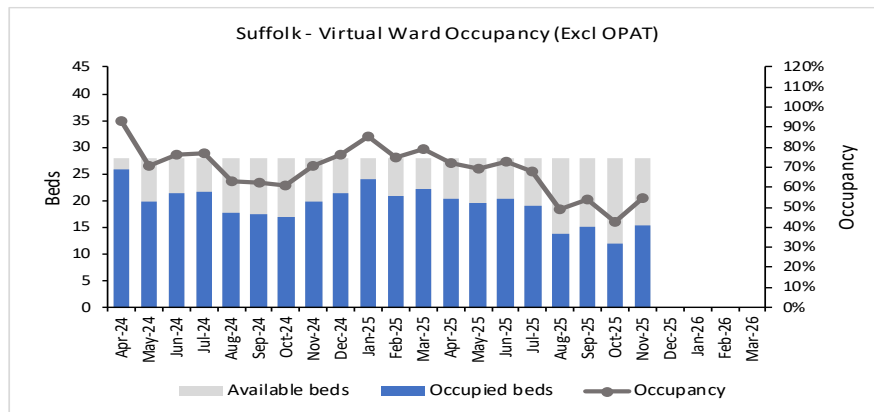
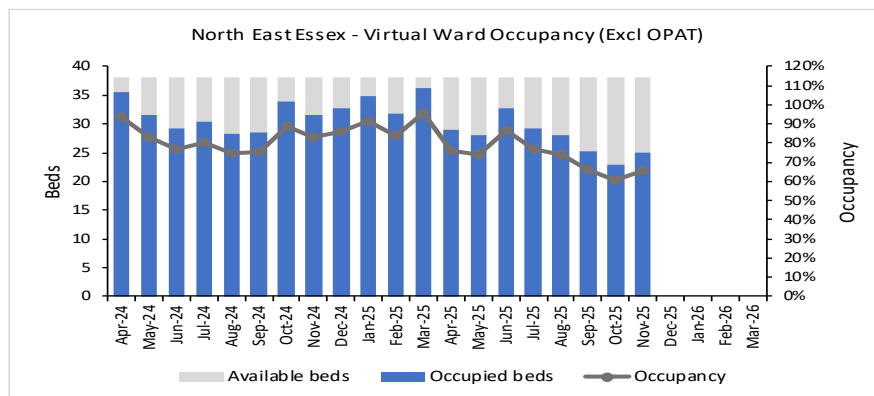
Industrial Action (IA) is a continued risk to elective provision. In November, the risk was able to be minimised, and teams are currently assessing the December impact which is anticipated to be more challenging given increased leave alongside increased emergency activity.

Excluding OPAT, virtual ward occupancy increased by 8.0% compared to the month before. Average length of stay increased by 0.7 days and the assumed bed saving on ESNEFT acute sites increased by 3.0 to 13.9.

Virtual Ward occupancy
61.1%
 ↑ vs 53.0% last month

Virtual Ward ALoS
5.50
 ↑ vs 4.80 last month

Virtual Ward – assumed acute bed saving**
13.9
 ↑ vs 10. last month



Service Commentary

The percentage utilisation figures are still subject to adjustment and checking of accuracy, as the Trust transitions from the 'Virtual Ward' model to a 'Hospital at Home' approach with a primary focus on avoiding admissions to base wards.

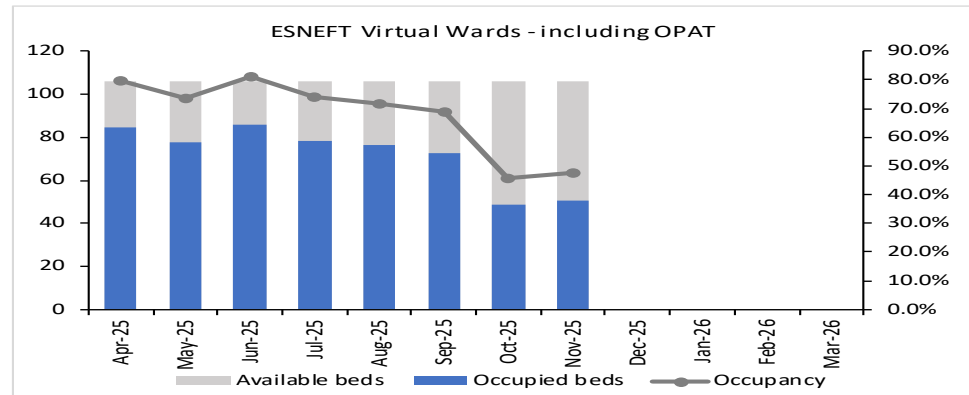
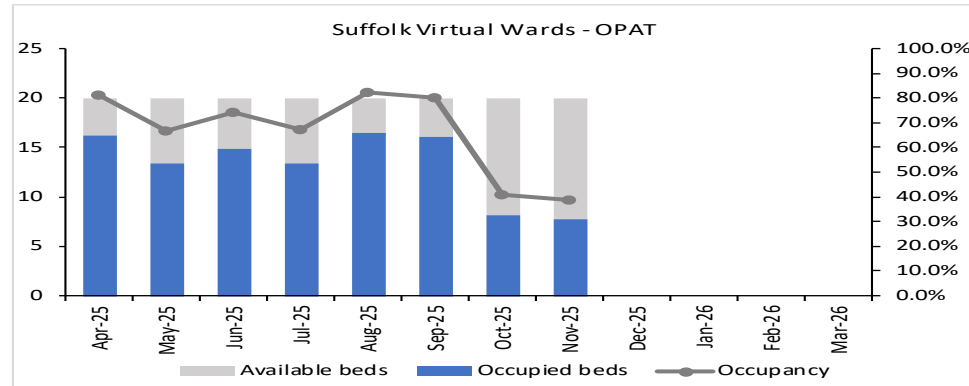
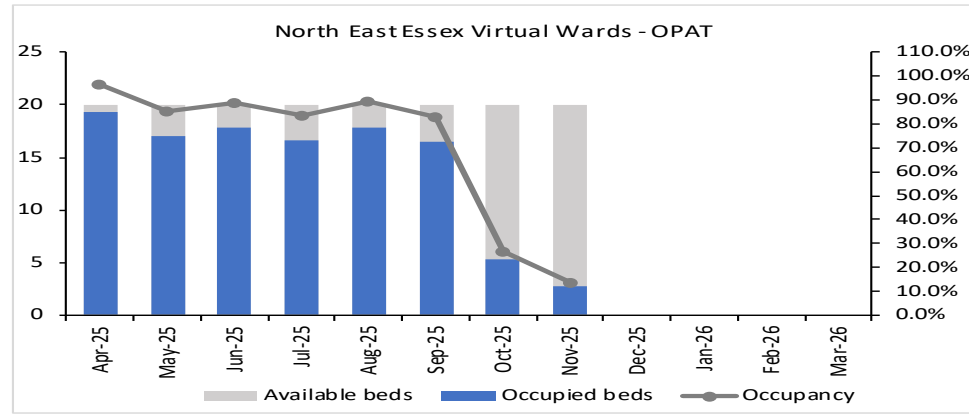
The new model is based on frailty pathways and continues to perform well. Divisional oversight on capacity shows utilisation often above the stated maximum capacity.

Full delivery of the transition to hospital at home is dependent on a number of staffing moves which are not expected to be fully completed until January.

**Acute bed saving assumes a reduction of 2.5 bed days in an acute setting for every 7 days in the virtual ward, further to the analysis performed by the Advanced Analytics Team in December 2023.

Including OPAT, in month Virtual Ward occupancy in North East Essex decreased by 48.8% compared to the previous month, and in Suffolk occupancy decreased by 42.1%.

Overall, in ESNEFT, Virtual Ward occupancy decreased by 45.8%.

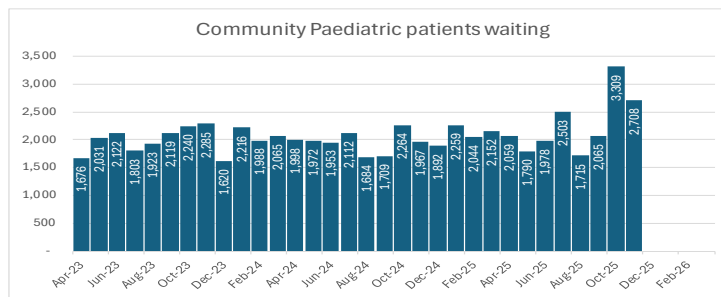


There are 2,708 Community Paediatric patients, including Paediatric Neurology. Following a significant rise in patients waiting around Go-Live, the number of patients waiting has declined following much work to cleanse the impacts of Go-Live and new ways of working, as well as treatments provided to patients. The number of patients waiting remains higher than it was before Go-Live.

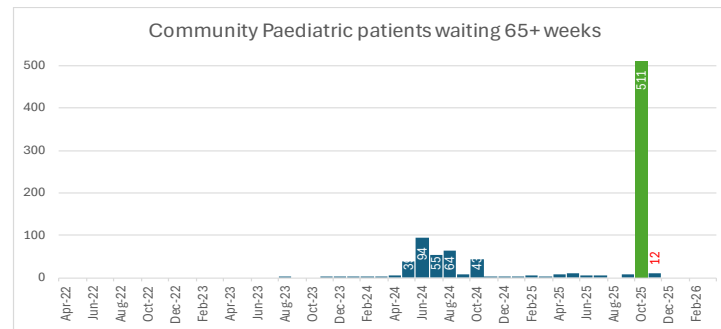
Excluding admin events, the number of treatments provided in November was high at 502, compared to a previous high of 439.

Community Paediatrics has a dedicated patients waiting dashboard to support.

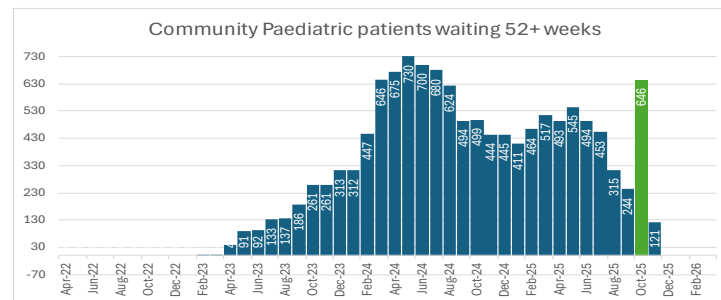
Total patients waiting trend



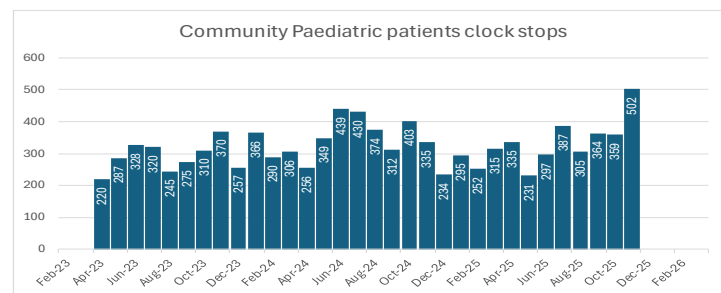
Patients waiting 65+ weeks trend



Patients waiting 52+ weeks trend



Patient treatments trend



There are 2,708 patients on the ESNEFT NDD pathway. The current waiting time is 47 weeks for a 1st appointment, 52 weeks for a subsequent ADOS assessment (1,455 patients waiting) and 8-10 weeks for an outcome diagnosis.

Referral demand

Average over last 12 months is 234 per month.

The service is in discussion to increase ADOS capacity by February 2026 by reviewing job plans and training an ASD nurse and clinical psychologist. This will not be enough to manage incoming referrals or backlog.

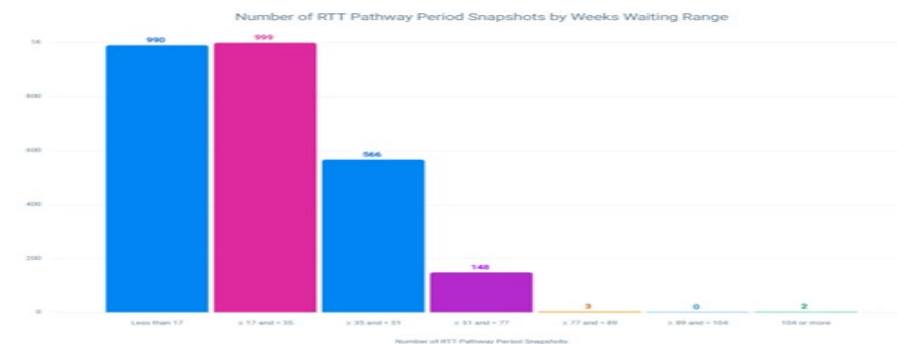
As part of Commissioning intentions, there is a plan to submit an updated business case requesting funding for insourcing or additional sessions from April 2026.

Follow up capacity reduced by 30% in October due to the EpicEPR rollout and clinic reduction. This has increased back to normal templates from November. There was further reduction in capacity from October due to two doctor retirements and an ADHD Nurse specialist resignation.

Community Paediatrics is now recorded as non-RTT. However, teams are still aiming for 65% 18-week compliance by March 2026.

Current clock stops are an average of 250.

End of month patients waiting week bands



| Revenue | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Areas of Improvement | Areas requiring further work |
|--|--------|----------|----------|----------|----------|----------|----------|--|--|
| Performance Against Control Total (YTD) | 0 | 32 | (357) | (1,743) | (4,173) | (5,770) | (7,796) | <ul style="list-style-type: none"> Bank costs in November were £4.1m which is the lowest it has been all year and on the ceiling target for the month. Cumulatively the Trust has exceeded the bank ceiling by £2.9m (£35.5m v £32.6m). Agency costs in November were £0.7m. Reported monthly costs have dipped under the 25/26 ceiling set for the first time this year (£0.1m). Cumulatively the Trust has exceeded the agency ceiling by £1.9m (£8.4m v £6.5m). £3.3m of cost improvement plans were delivered in November which was an improvement on the £3.1m delivered in October. | <ul style="list-style-type: none"> The Trust reported an actual deficit of £1.5m in November, £2m adverse to plan. This means that the cumulative position has moved to a deficit £11.6m. This is behind plan by £7.8m. Renewed energy needs to go into the Trust's recovery plans (both central schemes and those locally developed by divisions). While the in-month delivery of CIP improved on the prior month by £0.2m, this was still below the target delivery by £0.9m (target £4.3m). £18.4m year to date of cost improvement plans have been delivered for the year, against a target of £26.8m. Capital expenditure cumulatively underspent against CDEL by £18.9m at the end of November. The main drivers of this underspend were Building for Better Care (£12.1m) and Estates & Facilities (£5.5m). |
| FOT Variance to Plan | 0 | - | - | - | - | - | - | | |
| YTD CIP variance to plan | 0 | (3,448) | (5,468) | (6,696) | (6,105) | (7,322) | (8,340) | | |
| Forecast CIP FYE Variance to Plan | 0 | (17,121) | (16,828) | (16,441) | (14,348) | (13,822) | (10,980) | | |
| Capital | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | | |
| Capital variance (in month) | | 1,188 | 1,946 | 1,332 | (248) | (30) | 5,839 | | |
| Capital variance (YTD) | | 10,012 | 11,958 | 13,290 | 13,042 | 13,012 | 18,851 | | |
| *(Overspend)/Underspend | | | | | | | | | |
| Balance Sheet | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | | |
| Cash YTD | | 23,522 | 31,007 | 27,906 | 20,453 | 28,066 | 27,537 | | |

Performance against Control Total

Deficit

£11.6m

Performance against CT for the year to date

Behind Plan

£7.8m

Deterioration of £2.0m in the month

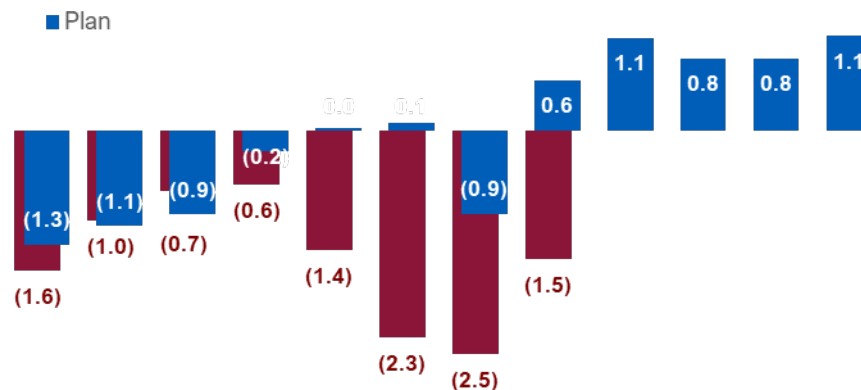
Monthly Performance against Control Total

The Trust has a financial control total (CT) set by NHSE which informs the Trust financial plan for the year. For 2025/26 the target is to achieve a break-even position or better. The planned delivery of this target is not profiled evenly across the year. Deficits have been planned in early months as CIP schemes are expected to deliver more as the year progresses (including EPIC efficiencies).

When measuring financial performance against this control total certain items are excluded, e.g. capital donations, impact of PFI UK GAAP and impairments.

After adjusting for these items, the Trust's plan for November was a surplus of £0.6m. The Trust failed to meet this CT for the month incurring a deficit of £1.5m (an adverse variance of £2.0m).

Monthly Adjusted Financial Performance Compared to Plan



In Month

The Trust incurred a deficit of £1.5m for November. Overspends on expenditure have been partly mitigated by increases in income. IA impacted in the month amounting to £0.3m.

| <u>I&E Overview (November)</u> | <u>Plan</u> £000 | <u>Actual</u> £000 | <u>Fav/(Adv)</u> £000 |
|---------------------------------------|---------------------|-----------------------|--------------------------|
| Income | 99,669 | 102,525 | 2,856 |
| Pay | (58,974) | (61,653) | (2,679) |
| Non Pay | (38,499) | (39,784) | (1,285) |
| Non Operating | (1,434) | (1,386) | 48 |
| Surplus / (Deficit) | 762 | (298) | (1,060) |
| Less: Other Non CT Items | (188) | (1,153) | (965) |
| Adjusted financial performance | 574 | (1,451) | (2,025) |

Year to Date

The cumulative position has moved to a deficit £11.6m. This is behind plan by £7.8m. £0.7m related to IA action.

| <u>I&E Overview (YTD)</u> | <u>Plan</u> £000 | <u>Actual</u> £000 | <u>Fav/(Adv)</u> £000 |
|---------------------------------------|---------------------|-----------------------|--------------------------|
| Income | 799,497 | 816,215 | 16,718 |
| Pay | (477,593) | (494,325) | (16,732) |
| Non Pay | (310,488) | (319,727) | (9,239) |
| Non Operating | (12,357) | (12,407) | (50) |
| Surplus / (Deficit) | (941) | (10,244) | (9,303) |
| Less: Other Non CT Items | (2,827) | (1,320) | 1,507 |
| Adjusted financial performance | (3,768) | (11,564) | (7,796) |

Bank Above Ceiling

£2.9m

Bank is cumulatively over the ceiling

Agency Above Ceiling

£1.9m

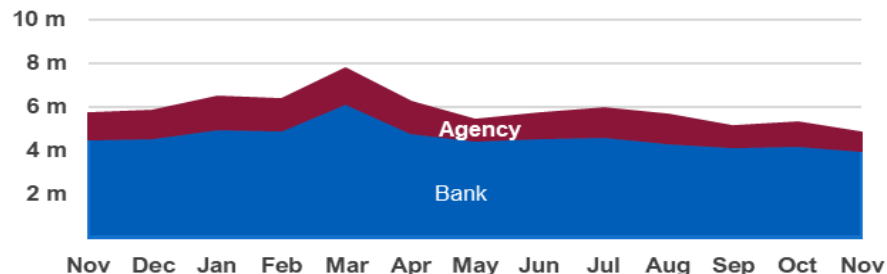
Agency is cumulatively over the ceiling

Temporary Pay Expenditure

Bank expenditure is the most significant element of temporary pay expenditure.

Temporary Pay Trend

Expenditure over the last 13 months



Bank Expenditure

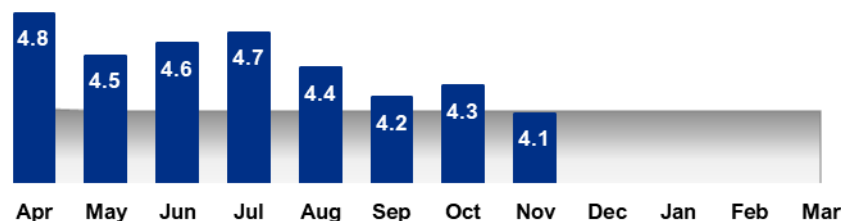
Bank expenditure accounted for 7.2% of all pay costs (year to date). Nursing are the staff group most reliant on bank, with bank making up 10.2% of nursing costs.

Bank Ceiling

Bank costs in November were £4.1m which is the lowest it has been all year and on the ceiling target for the month. Cumulatively the Trust has exceeded the bank ceiling by £2.9m (£35.5m v £32.6m).

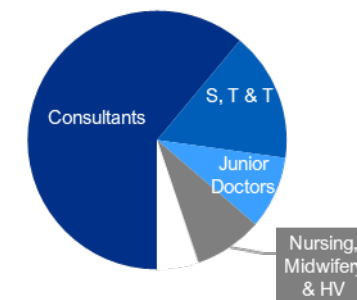
Monthly Bank Expenditure (£m)

Compared to ceiling



Agency Expenditure

Agency expenditure accounted for 1.7% of all pay costs (year to date). Consultants are the staff group most reliant on agency with agency making up 6.3% of consultant costs

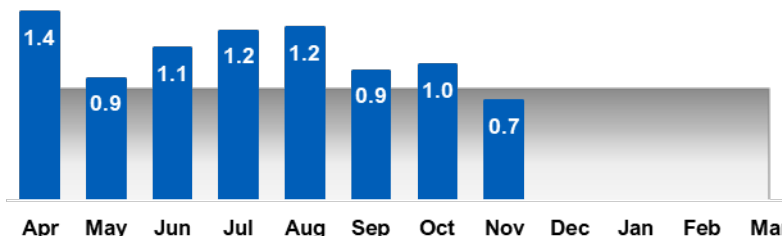


Agency Ceiling

Agency costs in November were £0.7m. Reported monthly costs have dipped under the 25/26 ceiling set for the first time this year (£0.1m). Cumulatively the Trust has exceeded the agency ceiling by £1.9m (£8.4m v £6.5m).

Monthly Agency Expenditure (£m)

Compared to ceiling



Cost Improvement Programme (CIP)

Under Delivery

£8.3m

Actual delivery of £3.3m in the month against a plan of £4.3m

In Month

£3.3m of cost improvement plans were delivered in November against a target of £4.3m.

Year To Date

£18.4m year to date of cost improvement plans have been delivered for the year, against a target of £26.8m.

| | Plan | Actual | Over/(Under) | |
|---------------------------------|---------------|---------------|-----------------|--------------|
| | £000 | £000 | £000 | % |
| CIP Delivery (YTD) | | | | |
| Cancer and Diagnostics | 4,229 | 2,136 | (2,093) | (49%) |
| Medicine and Community IES | 4,020 | 2,469 | (1,550) | (39%) |
| Medicine and Community NEE | 3,849 | 1,883 | (1,966) | (51%) |
| Surgical Services | 6,341 | 2,946 | (3,395) | (54%) |
| Women's and Children's Services | 2,834 | 640 | (2,194) | (77%) |
| Total Operations | 21,273 | 10,074 | (11,199) | (53%) |
| Estates & Facilities | 3,005 | 1,569 | (1,436) | (48%) |
| Corporate Services | 2,477 | 2,076 | (402) | (16%) |
| Other Non Divisional | - | 4,696 | 4,696 | 100% |
| Total Trust | 26,756 | 18,415 | (8,340) | (31%) |

Cash Flow

Cash Balance

£27.5m

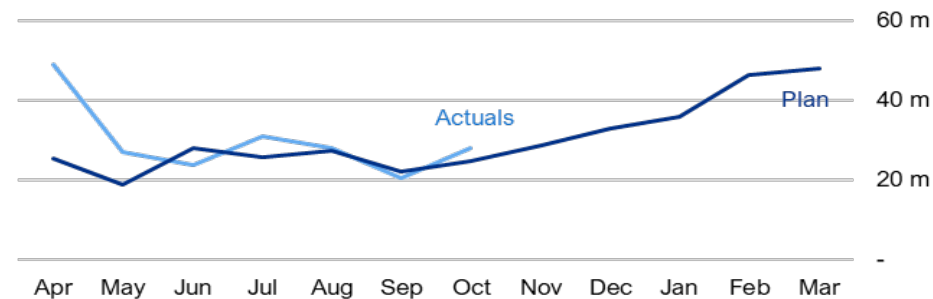
Less than plan by £1.1m

Cash Balance

The Trust held cash of £27.5m at the end of November; which was £1.1m less than projected in the plan. Although the Trust is incurring a deficit the expected cash shortfall has not yet been realised because of underspends on the capital programme. When the capital programme recovers to plan, a cash shortfall will occur and potentially necessitate tighter payment controls and the seeking of cash support from NHSE. This is likely to be exacerbated by the Trust's plan profile which expects higher surpluses in later months.

Monthly Cash Balances

Compared to Plan (with Forecast)



Opening Balance v Movement in Receivables

In the Trust plan it was assumed that ERF owing to the Trust for 24/25 would not be paid until later in the new year (as had happened in prior years). However, ERF was fully paid in March (£18.3m). At the point of payment it was too late to adjust the Trust plan and therefore two lines in the cashflow have material underlying variances which effectively offset each other. These lines are 'Cash at start of period' and 'Movement in Receivables'.

Cash Management Actions

The Trust's cash balance requires more active management of creditor payments to ensure liquidity is maintained throughout the month. This is because during the month at its nadir the cash level is as low as circa £4m.

| Statement of Cash Flows (Summary) | Plan £000 | Actual £000 | Fav/(Adv) £000 |
|--|-----------------|-----------------|-------------------|
| Cash Flows from Operating Activities | | | |
| Surplus/(deficit) from operations | 11,416 | 2,163 | (9,253) |
| Non-cash items in operating surplus/(deficit) | | | |
| Depreciation and amortisation | 27,804 | 23,592 | (4,212) |
| Impairment losses/(reversals) | - | - | - |
| Capital donations (cash and non-cash) | (2,261) | (1,055) | 1,206 |
| Movement in Receivables | 11,505 | (16,696) | (28,201) |
| Movement in Inventories | - | (1,294) | (1,294) |
| Movement in Payables | 1,941 | (585) | (2,526) |
| Movement in Other liabilities | 3 | 11,982 | 11,979 |
| Movement in Provisions | (188) | (1,262) | (1,074) |
| Tax (paid) / received | - | 1,488 | 1,488 |
| Net Cash (Outflow) from operating | 50,220 | 18,332 | (31,888) |
| Cash Flows from Investing Activities | | | |
| Interest received | 864 | 1,506 | 642 |
| Purchase of Capital Assets | (67,499) | (44,485) | 23,014 |
| Proceeds from Sales of Assets | - | 137 | 137 |
| Donations to purchase Assets | 2,261 | 1,000 | (1,261) |
| PFI lifecycle prepayments | (1,112) | (1,114) | (2) |
| Net Cash (Outflow) from investing | (65,486) | (42,956) | 22,530 |
| Cash Flows from Financing Activities | | | |
| Public dividend capital received | 11,565 | 5,662 | (5,903) |
| Loans repayments | (631) | (638) | (7) |
| Capital lease and PFI payments | (6,983) | (6,269) | 714 |
| Interest paid including leases and PFI | (1,413) | (1,471) | (58) |
| PDC dividend (paid)/refunded | (7,781) | (7,300) | 481 |
| Net Cash (Outflow) from financing | (5,243) | (10,016) | (4,773) |
| Net increase / (decrease) in cash | (20,509) | (34,640) | (14,131) |
| Cash at start of period | 49,136 | 62,176 | 13,040 |
| Cash at end of period | 28,627 | 27,537 | (1,090) |

Capital Expenditure

Behind CDEL

£18.9m

An increase to the cumulative underspend of £5.9m compared to last month

Underspends on a range of schemes, the most significant being Building for Better Care projects (£12.1m)

Year To Date

Capital expenditure has cumulatively underspent against CDEL by £18.9m at the end of November, with £23.1m spent against a £43.8m plan

| | Plan £000 | Actual £000 | Fav / (adv) £000 |
|----------------------------------|---------------|----------------|---------------------|
| Capital Expenditure (YTD) | | | |
| Medical Equipment | 1,599 | 1,288 | 311 |
| ICT | 3,488 | 1,849 | 1,639 |
| Estates & Facilities | 8,637 | 3,137 | 5,500 |
| Building for Better Care | 21,968 | 9,853 | 12,115 |
| Schemes | 5,713 | 6,628 | (915) |
| Financing (PFI, ROU and leases) | 2,354 | 1,434 | 920 |
| Total Capital Programme | 43,759 | 24,189 | 19,570 |
| Other Adjustments | | | |
| PFI Lifecycle Costs | - | - | - |
| PFI Residual Interest | 504 | 504 | - |
| Disposals | - | (488) | 488 |
| Donated | (2,261) | (1,054) | (1,207) |
| Capital Expenditure | 42,002 | 23,151 | 18,851 |
| CDEL | 42,002 | 42,002 | - |
| Performance against CDEL | - | 18,851 | 18,851 |

Drivers of Underspend

The capital programme is underspent across a range of schemes including:

Building for Better Care (underspend £12.1m); most material being Clacton STAR with a £8.4m underspend. There was minimal spend in November and the most recent valuation has not been received. There continues to be a struggle to evidence a catch-up on programme.

Estates & Facilities (underspend £5.5m); in particular, the backlog programme is £2.1m underspent, while a business case for new funding of electrical elements (£2.4m) is still awaited.

Forecast

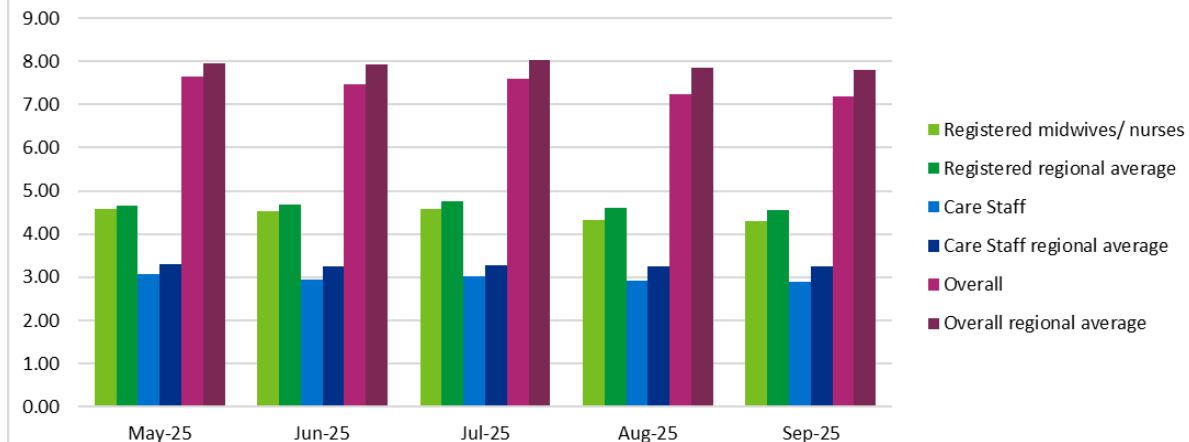
The current forecast is to achieve plan but there is a significant amount of delivery required to fulfil our capital programme in the remainder of the year, and this carries a significant risk of underspending against our CDEL.

| Workforce Metrics | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Areas of Improvement | Areas requiring further work |
|--|--------|--------|--------|--------|--------|--------|--------|--|---|
| Vacancy (excluding Agency) | 3.50% | 4.9% | 4.8% | 4.0% | 3.6% | 3.4% | 3.0% | <ul style="list-style-type: none"> The vacancy rate has decreased to 3% in November from 3.4% in October. Time to hire parameters have been amended nationally and is now reported from advert live to employment checks complete based on a 3-month rolling basis. The Time to Hire for month 6 based on the new parameters is 52 days [average 2 days below model hospital comparator Trusts]. | <ul style="list-style-type: none"> There is continued focus on hard to recruit consultant vacancies utilising head-hunters and international recruitment drives. 178 HCSW's appointed via the assessment centre – 106 will commence on the apprenticeship pathway. Monthly assessment centres take place at alternate sites. Consultant vacancies are currently at 31 WTE. 8 consultants are going through on-boarding with recent appointments to Obstetrics & Gynaecology, Histopathology, & Acute Medicine. |
| Proportion of temporary staff (Bank & Agency) | - | 9.3% | 9.6% | 8.9% | 8.8% | 7.9% | 7.7% | <ul style="list-style-type: none"> Bitesize training sessions focussed on absence are continuing and the sickness review group continues to meet on a monthly basis and is making good progress. There is a focus on those who have been absent over 3 months as well as complex cases by the ER Team who are targeting progress with OH and managers. | <ul style="list-style-type: none"> Retention Partners continue to hold the 8 week individual meetings with HCSW Level 2 Apprentices. Feedback from this staff group is reported to the Internal Delivery Strategy & Performance Group. Meetings for November cohort on Colchester site to take place in December. |
| Sickness | 4% | 4.1% | 4.4% | 4.4% | 4.6% | 5.1% | 5.1% | <ul style="list-style-type: none"> The Absence Policy has been updated, and training sessions have been adjusted accordingly. Targeted work focussing on the management of short-term sickness absence is underway. A SOP is being developed in relation to automated processes for informing and guiding managers in relation to both Long term and short-term sickness with a view to minimise short term persistent absence and encourage earlier intervention for Long term absence. | <ul style="list-style-type: none"> International Nurse pipeline continues. The next cohort is in January. For the International Nurse upskilling programme, the final cohort of 8 is to commenced in September (37). Sickness absence has increased this month to 5.11% and was above the target of 4%. The main reasons for absence were Anxiety, Stress and Depression which is 1.31% of the workforce, followed by Cold, Cough, Flu - Influenza at 0.79%. The total number of employees who have been absent for 3-6 months, and over 6 months, remains steady and on-going targeted work continues by the ER & OH teams, including regular joint meetings discussing ongoing cases. |
| Mandatory Training | 90% | 93.7% | 93.6% | 92.8% | 92.1% | 91.9% | 91.7% | <ul style="list-style-type: none"> Mandatory Training has remained above target for 30 consecutive months. Individual meetings held by Retention Partner for each cohort of the HCSW Apprenticeship Academy to offer support and promote hub. Meetings for October cohort on the Ipswich site took place in November. Meetings with November cohort to take place in Colchester in December. Feedback from this staff group is reported to the Internal Delivery Strategy & Performance Group. | |

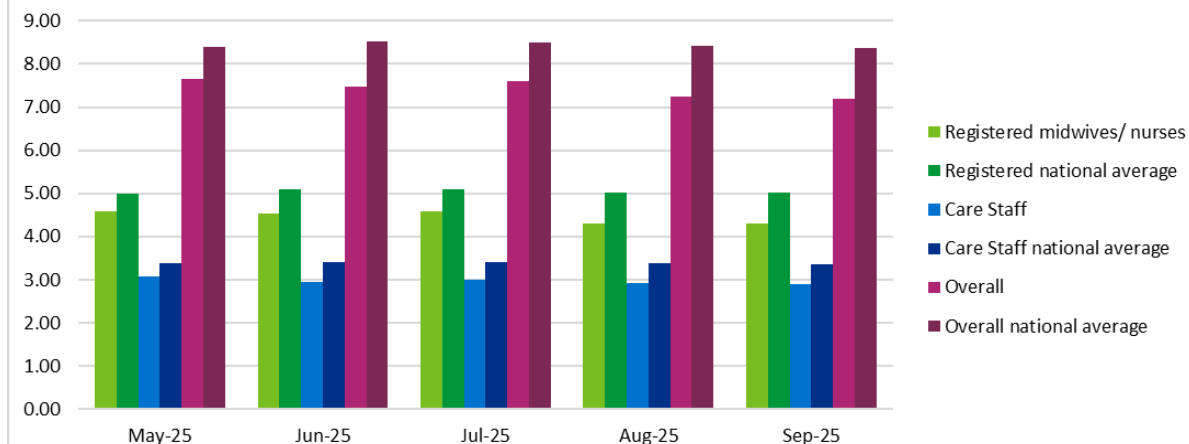
| Workforce Metrics | Target | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Areas of Improvement | Areas requiring further work |
|--|--------|--------|--------|--------|--------|--------|--------|---|---|
| Appraisals | 90% | 88.8% | 86.1% | 85.7% | 84.2% | 81.2% | 81.9% | <ul style="list-style-type: none"> Leadership Development training: 1,795 completed/103 soon to complete, plus a further 2,112 attending management bitesize training. Along with 3,745 staff engaging in the suite of EDI training in the last year. National Staff Survey (NSS) – The survey close on 28 November with a 50.3% response rate. Results due March 2026. Ad hoc requests from leaders as part of their development journey will still be run and aligned to one of the experienced facilitators in the Trust to provide feedback. The Trust is proposing to teach another cohort of facilitators within the next few months and have asked the current team to recommend any colleagues before they launch a recruitment campaign. 'My Career Matters: The number of career conversations taking place across the Trust has grown to 1,179 from 1,134 conversations since the previous report. The results of career conversations can now be linked to recruitment opportunities so we can target those that are ready soon and ready now with career options. We also have data available for our WRES and WDES reporting for conversations that have taken place to monitor opportunity for all staff. Targeted contact with apprenticeship opportunities delivered both internally and externally will commence as well as targeting employees for leadership development and masterclass signposting. | <ul style="list-style-type: none"> Voluntary turnover rate is 5.54% (a marginal increase from previous month 5.46%). Nursing & Midwifery voluntary turnover is 4.20%, an increase from 3.98% in October and a substantial decrease from 5.80% in November 2025. Management of 52 formal employee relations cases (including disciplinary and grievance) as well as informal cases is ongoing. 17 opened in month and with 8 cases closed. November's Appraisal compliance rate increased to 81.9% from 81.2%. The Trust is under target for Appraisals. Bitesize training for appraisals is now being delivered through the Management Masterclasses. Improvements to the offer of career conversations, management masterclasses have been a focus for the divisions and HR, OD support to improve the quality of the conversations during appraisals. A range of measures to support staff wellbeing continues. As a continuation of the work to promote flexible working, a refresh of the flexible working offering was emailed to senior managers on 4th September. It highlights access to training and promotes the team rostering programme. This is to precede the flexible working case studies piece to be published at the beginning of October. Supportive 360 Leadership reviews: There are currently no open 360 projects and as EpicEPR is introduced, the launch of any new ones is being paused until the New Year. A project is lined up for then with the MACNEE division. This will be run as three cohorts with a total of 337 staff being invited to participate. |
| Voluntary Turnover | 7% | 5.8% | 5.6% | 5.7% | 5.5% | 5.5% | 5.5% | | |
| Ward Fill Rates (ESNEFT) | 95% | 90.9% | 91.2% | 89.7% | 91.5% | 88.3% | 91.4% | | |
| Care Hours Per Patient Day (ESNEFT) | - | 7.13 | 7.27 | 7.02 | 6.89 | 7.09 | 7.19 | | |
| Executive team turnover | - | 0 | 1 | 0 | 0 | 1 | 1 | | |

| Care hours per patient day | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 |
|-----------------------------|-------------|-------------|-------------|-------------|-------------|
| Registered midwives/ nurses | 4.58 | 4.54 | 4.58 | 4.32 | 4.37 |
| Care Staff | 3.07 | 2.94 | 3.01 | 2.91 | 2.92 |
| Overall | 7.66 | 7.48 | 7.59 | 7.23 | 7.29 |

Care hours per patient day - Regional Benchmark



Care hours per patient day - National Benchmark



Care Hours Per patient Day (CHPPD) **

CHPPD is an NHS England metric calculated by combining the hours of staff on duty in a month in a department and dividing by the average number of patients occupying beds in the department at midnight. It is a key indicator of staffing levels in an NHS organisation but does not directly show whether care is safe, effective or responsive.

ESNEFT'S Registered Nursing & Midwifery, Care Staff (HCSWs) and overall CHPPD consistently falls under both the regional and national average (regional/national data for October is not yet available).

Safer Staffing

The Annual Staffing Review is almost complete utilising the Safer Nursing Care Tool (SNCT) audit data triangulated against patient outcomes and professional judgement. 96 wards/departments have participated in individual meetings to review their nursing budgeted establishments with a recommendations expected to be provided to Board in the next few months.

A Safer Staffing benchmarking self-assessment exercise was submitted to NHSE for review. There was consensus on the majority of metrics which scored "green". A very small number of elements were deemed by NHSE as "amber" who recommended changes to this monthly Board Integrated Performance report. A revaluation will take place in quarter 4.

International recruitment

There have been significant challenges in placing a number of international nurses into clinical areas at Ipswich hospital. These nurses are being transported to Colchester site to support the newly opened Boxted ward.

** The care hours data presented is currently under review: both the Trust's own calculations (ensuring that they are consistent with national guidance; and all appropriate nursing areas are captured). Benchmarking data (both regional and national) is also being scrutinised. The analysis currently excludes Specialist and Mental Health Trusts, but the treatment of community provision / trusts needs further consideration. National data is only available up to August 2025.

| | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 |
|------------------------|--------|--------|--------|--------|--------|--------|
| Qualified day | 85.3% | 87.9% | 86.5% | 84.5% | 85.7% | 84.0% |
| Qualified night | 90.8% | 93.1% | 93.6% | 90.4% | 92.1% | 87.5% |
| Unqualified day | 84.4% | 83.8% | 85.0% | 85.5% | 86.8% | 83.7% |
| Unqualified night | 105.2% | 104.2% | 106.3% | 105.8% | 109.6% | 105.2% |
| Overall (average) fill | 89.7% | 90.9% | 91.2% | 89.7% | 91.5% | 88.3% |

Fill rates

NHS providers are required to submit data (Nursing, Midwifery and care Staff Staffing Fill Rate Indicator) on staffing levels on a monthly basis via the UNIFY return. The data shows actual vs planned hours (budgeted template vs actual hours worked). This data is published on the ESNEFT website and appears on the NHS Choices website.

A target of 95% fill is set by the majority of NHS trusts. ESNEFT consistently falls under this target due to several reasons;

- In November the Registered Nursing & Midwifery sickness rate was 5.49% against a target of 4%. The sickness rate for HCSWs was 7.03% against a target of 4%.
- Vacancy rate for RN/RMs stands at 3.6% and 5.11% for HCSWs.

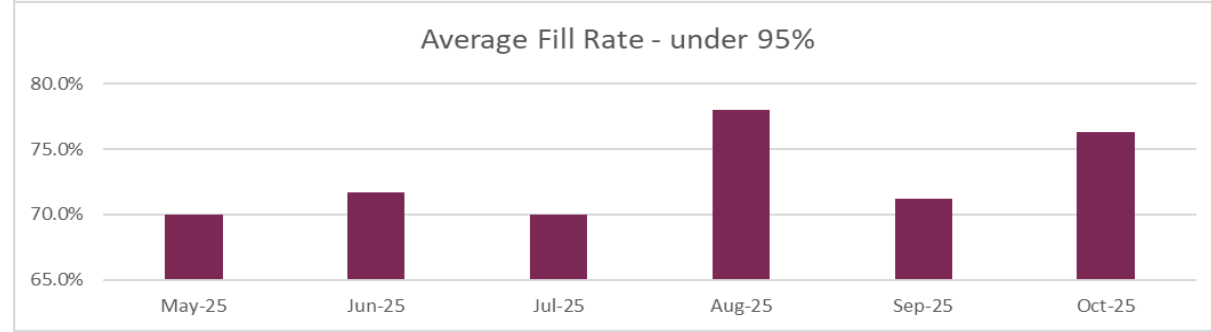
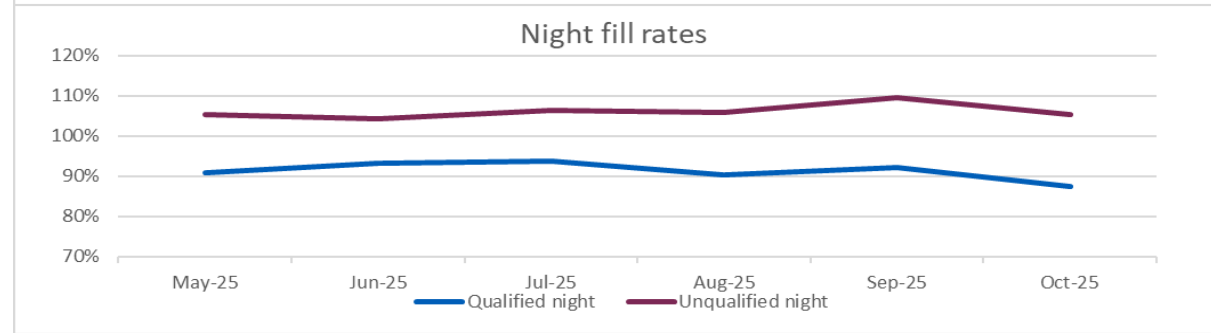
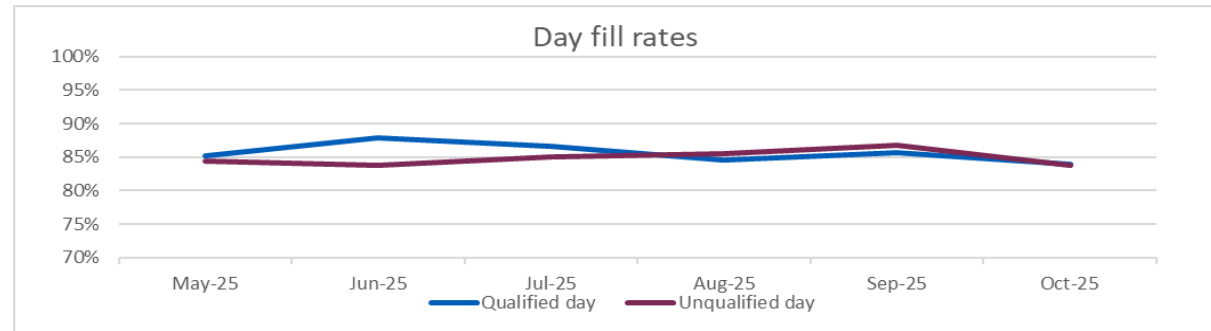
Bures model

A decision is awaited regarding expansion of the Bures model at Colchester- expanding the RN pool to fill staffing gaps as well as expansion of the ETOC Service in response to patient demand for 1 to 1 care. The proposal also includes launching an RN pool and ETOC service at Ipswich site.

Retention

43 wards are now participating in team rostering. Data indicates that there is a reduction in unfilled shifts at the point of roster approval (reducing the number of shifts sent to bank) particularly at weekends. Feedback from staff and managers has been very positive. A 12-month review report will be presented to NMAAC in December with the view to roll out Team rostering across all nursing teams.

Work will be undertaken to compare a number of roster metrics such as net hours, annual leave distribution, additional shifts and unavailability in team rostering wards compared to non team rostering wards/departments.



Workforce Dashboard

November 2025

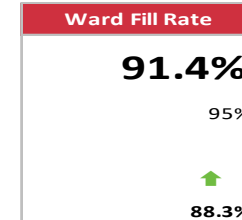
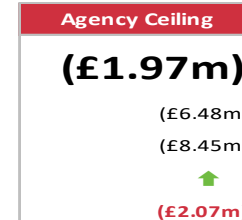
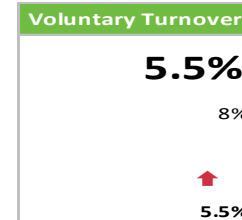
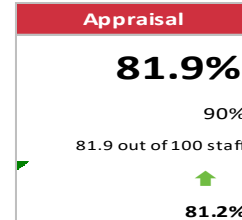
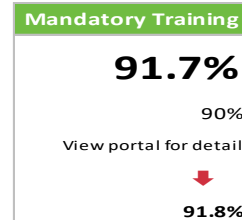
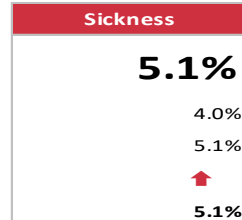
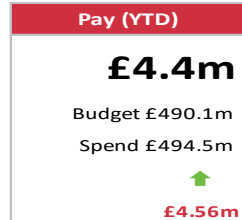
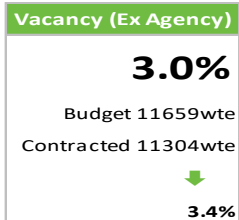
Trust Level



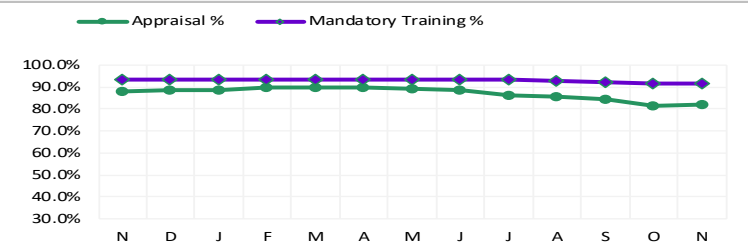
Key Metrics

Performance

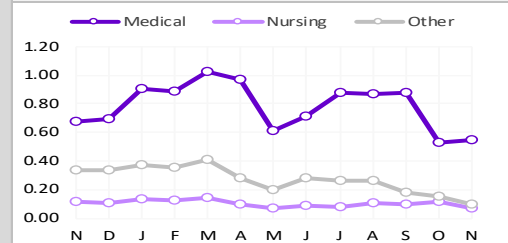
Target
Achieved
Vs Prior Month
Prior Month



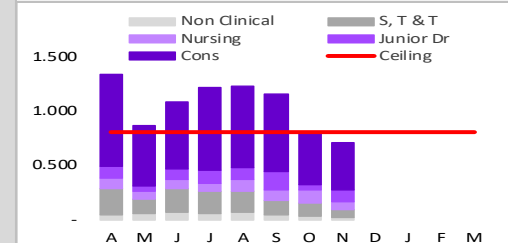
Appraisals & Mandatory Training Compliance %



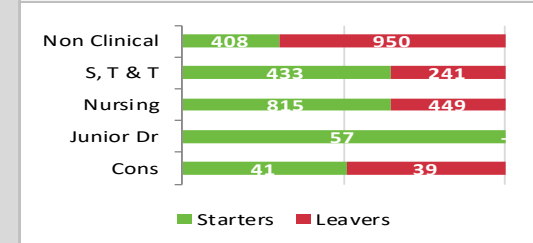
Agency Trends (ex Locum) £m



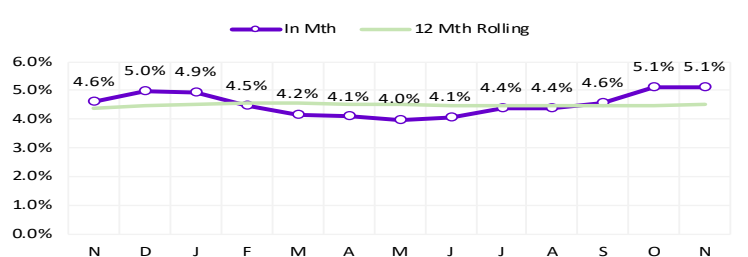
Agency Ceiling £m



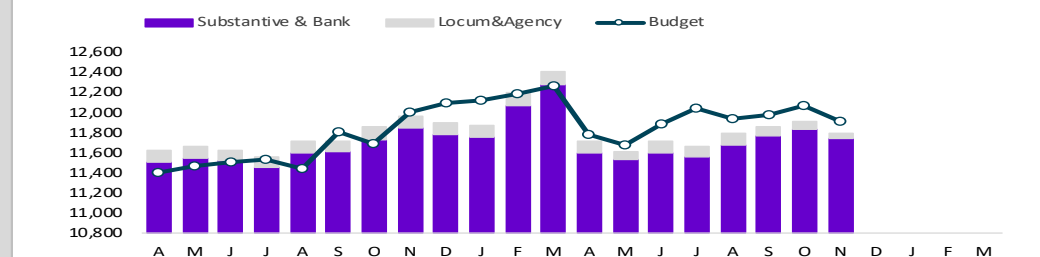
Starter - Leavers (12Mth Rolling) Headcount



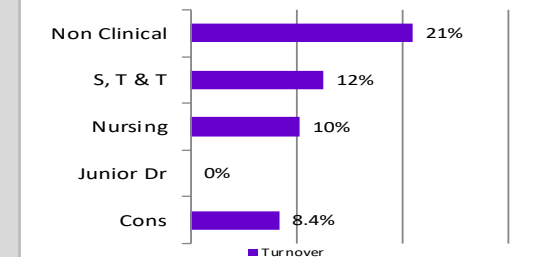
Sickness %



Workforce Trends wte



Turnover by Staff Group Headcount



| | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 | Apr 25 | May 25 | Jun 25 | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 |
|--|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|--|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|

| All Staff | | | | | | | | | | | | | |
|----------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Headcount | 12,760 | 12,782 | 12,872 | 12,932 | 12,991 | 12,589 | 12,491 | 12,568 | 12,579 | 12,641 | 12,765 | 12,734 | 12,791 |
| Establishment (including agency) | 11,805 | 11,877 | 11,895 | 11,971 | 12,042 | 11,566 | 11,533 | 11,591 | 11,629 | 11,623 | 11,684 | 11,696 | 11,659 |
| In post | 11,214 | 11,223 | 11,261 | 11,409 | 11,413 | 11,004 | 11,007 | 11,024 | 11,076 | 11,154 | 11,262 | 11,302 | 11,304 |
| Vacancy | 592 | 654 | 634 | 562 | 628 | 562 | 526 | 567 | 554 | 468 | 422 | 394 | 355 |
| Vacancy % | 5.0% | 5.5% | 5.3% | 4.7% | 5.2% | 4.9% | 4.6% | 4.9% | 4.8% | 4.0% | 3.6% | 3.4% | 3.0% |
| Establishment (excluding agency) | 11,805 | 11,877 | 11,895 | 11,971 | 12,042 | 11,566 | 11,533 | 11,591 | 11,629 | 11,623 | 11,684 | 11,696 | 11,659 |
| Vacancy (excluding agency) | 592 | 654 | 634 | 562 | 628 | 562 | 526 | 567 | 554 | 468 | 422 | 394 | 355 |
| Vacancy % (excluding agency) | 5.0% | 5.5% | 5.3% | 4.7% | 5.2% | 4.9% | 4.6% | 4.9% | 4.8% | 4.0% | 3.6% | 3.4% | 3.0% |

| Turnover | | | | | | | | | | | | | |
|--|------|------|------|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| ¹ Turnover (12 Month) | 9.2% | 9.0% | 8.9% | 8.9% | 12.0% | 12.7% | 13.2% | 12.4% | 12.4% | 12.4% | 12.2% | 12.6% | 12.8% |
| ¹ Voluntary Turnover (12 Month) | 6.6% | 6.5% | 6.3% | 6.4% | 6.1% | 6.0% | 6.2% | 5.8% | 5.6% | 5.7% | 5.5% | 5.5% | 5.5% |
| ¹ Starters (to Trust) | 171 | 105 | 174 | 147 | 119 | 132 | 201 | 141 | 116 | 93 | 233 | 158 | 135 |
| ¹ Leavers (from Trust) | 116 | 113 | 107 | 83 | 147 | 187 | 168 | 80 | 93 | 92 | 87 | 131 | 97 |

| Sickness | | | | | | | | | | | | | |
|------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| % In Mth | 4.6% | 5.0% | 4.9% | 4.5% | 4.2% | 4.1% | 4.0% | 4.1% | 4.4% | 4.4% | 4.6% | 5.1% | 5.1% |
| WTE Days Absent In Mth | 15,366 | 17,267 | 17,207 | 14,115 | 14,667 | 13,485 | 13,565 | 13,468 | 14,987 | 14,982 | 15,321 | 17,714 | 17,225 |

| Mandatory Training & Appraisal Compliance | | | | | | | | | | | | | |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Mandatory Training | 93.5% | 93.4% | 93.2% | 93.5% | 93.2% | 93.3% | 93.2% | 93.7% | 93.6% | 92.8% | 92.1% | 91.8% | 91.7% |
| Appraisal | 87.8% | 88.8% | 88.4% | 90.0% | 89.7% | 89.6% | 89.1% | 88.8% | 86.1% | 85.7% | 84.2% | 81.2% | 81.9% |

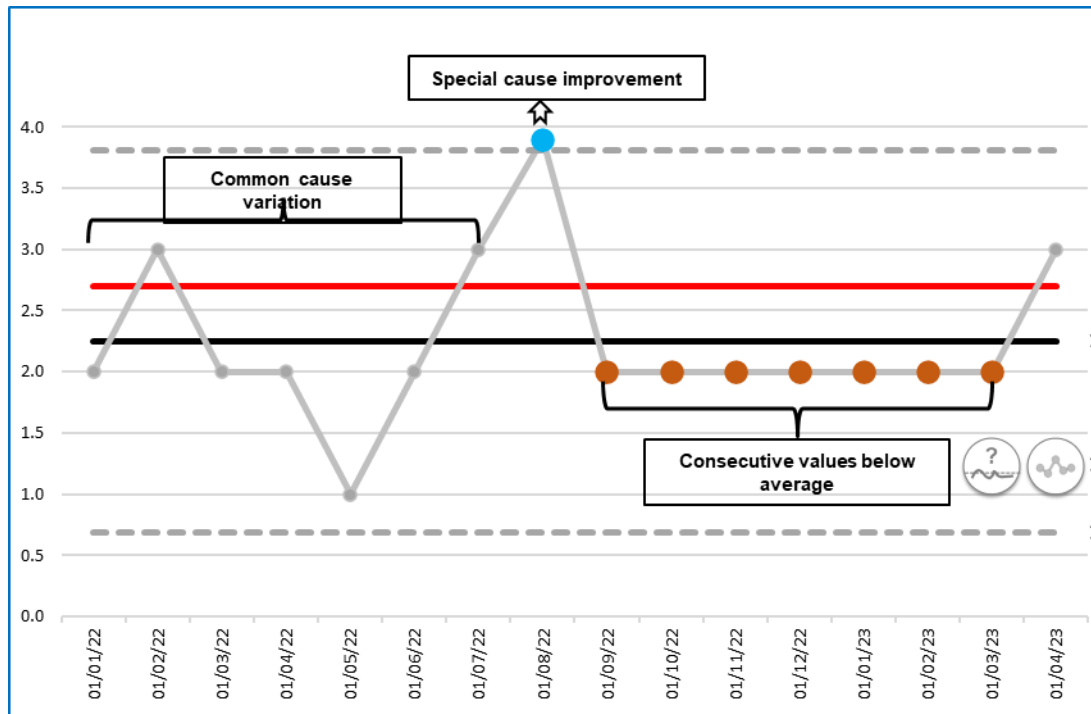
| Temporary staffing as a % of spend | | | | | | | | | | | | | |
|---|--------|--------|--------|--------|---------|--------|--------|--------|--------|--------|--------|--------|--------|
| Substantive Pay Spend | 53,024 | 52,373 | 52,986 | 53,036 | 92,922 | 55,052 | 54,843 | 55,088 | 55,370 | 57,306 | 56,786 | 57,978 | 56,627 |
| Overtime Pay Spend | 148 | 170 | 134 | 146 | 158 | 201 | 183 | 167 | 137 | 153 | 169 | 173 | 250 |
| Bank Pay Spend | 4,564 | 4,636 | 5,001 | 4,969 | 6,167 | 4,830 | 4,499 | 4,599 | 4,683 | 4,409 | 4,339 | 4,159 | 4,053 |
| Agency Pay Spend | 1,124 | 1,134 | 1,419 | 1,369 | 1,580 | 1,350 | 875 | 1,090 | 1,218 | 1,238 | 1,162 | 802 | 714 |
| Total Pay Spend | 58,859 | 58,314 | 59,539 | 59,520 | 100,828 | 61,433 | 60,401 | 60,943 | 61,407 | 63,106 | 62,455 | 63,112 | 61,644 |
| Agency & Bank % | 9.7% | 9.9% | 10.8% | 10.6% | 7.7% | 10.1% | 8.9% | 9.3% | 9.6% | 8.9% | 8.8% | 7.9% | 7.7% |
| Agency % | 1.9% | 1.9% | 2.4% | 2.3% | 1.6% | 2.2% | 1.4% | 1.8% | 2.0% | 2.0% | 1.9% | 1.3% | 1.2% |

| Nurse staffing fill rate | | | | | | | | | | | | | |
|---------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| % Filled | 87.7% | 85.0% | 86.6% | 86.2% | 86.0% | 88.7% | 89.7% | 90.9% | 91.2% | 89.7% | 91.5% | 88.3% | 91.4% |

¹ Excludes training grade junior doctors

| | Nov 24 | Dec 24 | Jan 25 | Feb 25 | Mar 25 | Apr 25 | May 25 | Jun 25 | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 |
|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Nursing (Qualified) - excluding Midwives | | | | | | | | | | | | | |
| Establishment (including agency) | 3,439 | 3,496 | 3,502 | 3,540 | 3,541 | 3,546 | 3,555 | 3,598 | 3,581 | 3,572 | 3,575 | 3,588 | 3,573 |
| In post | 3,258 | 3,267 | 3,268 | 3,310 | 3,309 | 3,280 | 3,305 | 3,297 | 3,305 | 3,310 | 3,351 | 3,379 | 3,413 |
| Vacancy | 182 | 229 | 235 | 230 | 232 | 266 | 249 | 301 | 277 | 262 | 224 | 209 | 160 |
| Vacancy % | 5.3% | 6.5% | 6.7% | 6.5% | 6.5% | 7.5% | 7.0% | 8.4% | 7.7% | 7.3% | 6.3% | 5.8% | 4.5% |
| Nursing (Band 5) - excluding Midwives | | | | | | | | | | | | | |
| Establishment (including agency) | 1,604 | 1,629 | 1,628 | 1,646 | 1,646 | 1,671 | 1,679 | 1,698 | 1,703 | 1,701 | 1,688 | 1,683 | 1,667 |
| In post | 1,520 | 1,522 | 1,526 | 1,552 | 1,552 | 1,541 | 1,554 | 1,545 | 1,550 | 1,558 | 1,599 | 1,614 | 1,648 |
| Vacancy | 84 | 107 | 102 | 94 | 94 | 130 | 125 | 153 | 153 | 143 | 89 | 69 | 19 |
| Vacancy % | 5.2% | 6.6% | 6.2% | 5.7% | 5.7% | 7.8% | 7.4% | 9.0% | 9.0% | 8.4% | 5.3% | 4.1% | 1.1% |
| Nursing (Band 4) | | | | | | | | | | | | | |
| In post Band 4 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| In post Band 4 Pre Reg | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Nursing (Apprentice, B2 & B3) | | | | | | | | | | | | | |
| Establishment (including agency) | 1,466 | 1,461 | 1,465 | 1,475 | 1,465 | 1,477 | 1,458 | 1,478 | 1,471 | 1,457 | 1,495 | 1,492 | 1,470 |
| In post | 1,285 | 1,296 | 1,305 | 1,318 | 1,323 | 1,328 | 1,330 | 1,336 | 1,328 | 1,321 | 1,346 | 1,376 | 1,403 |
| Vacancy | 182 | 165 | 159 | 157 | 142 | 149 | 128 | 142 | 144 | 135 | 149 | 116 | 67 |
| Vacancy % | 12.4% | 11.3% | 10.9% | 10.6% | 9.7% | 10.1% | 8.8% | 9.6% | 9.8% | 9.3% | 9.9% | 7.8% | 4.5% |
| Consultants | | | | | | | | | | | | | |
| Establishment (including agency) | 558 | 554 | 556 | 559 | 571 | 565 | 556 | 547 | 555 | 555 | 560 | 567 | 567 |
| In post | 498 | 497 | 502 | 506 | 503 | 500 | 505 | 502 | 504 | 505 | 512 | 517 | 515 |
| Vacancy | 60 | 57 | 54 | 53 | 68 | 65 | 51 | 44 | 51 | 49 | 48 | 50 | 51 |
| Vacancy % | 10.8% | 10.2% | 9.8% | 9.5% | 11.9% | 11.5% | 9.2% | 8.1% | 9.2% | 8.9% | 8.6% | 8.9% | 9.1% |
| Junior Medical | | | | | | | | | | | | | |
| Establishment (including agency) | 847 | 854 | 857 | 860 | 862 | 858 | 842 | 882 | 914 | 900 | 905 | 915 | 922 |
| In post | 844 | 829 | 835 | 858 | 842 | 812 | 827 | 828 | 825 | 998 | 895 | 872 | 861 |
| Vacancy | 3 | 25 | 22 | 2 | 20 | 46 | 15 | 54 | 89 | (98) | 10 | 43 | 61 |
| Vacancy % | 0.4% | 2.9% | 2.6% | 0.2% | 2.3% | 5.4% | 1.8% | 6.1% | 9.7% | -10.9% | 1.1% | 4.7% | 6.6% |
| Scientific, Technical and Therapeutic | | | | | | | | | | | | | |
| Establishment (including agency) | 2,363 | 2,376 | 2,365 | 2,379 | 2,384 | 2,389 | 2,373 | 2,414 | 2,461 | 2,451 | 2,436 | 2,483 | 2,497 |
| In post | 2,144 | 2,151 | 2,162 | 2,198 | 2,206 | 2,201 | 2,197 | 2,205 | 2,214 | 2,230 | 2,289 | 2,290 | 2,315 |
| Vacancy | 219 | 225 | 203 | 181 | 179 | 189 | 176 | 209 | 248 | 220 | 147 | 194 | 182 |
| Vacancy % | 9.3% | 9.5% | 8.6% | 7.6% | 7.5% | 7.9% | 7.4% | 8.7% | 10.1% | 9.0% | 6.0% | 7.8% | 7.3% |

¹ Excludes training grade junior doctors



Upper control limit: Any data point above this line is an extreme value not expected within the normal variation

The target: An achievable target should be set within the control limits

The mean: Average score across the recorded time frame

Assurance & Variation: See below key

Lower control limit: Any data point below this line is an extreme value not expected within the normal variation

| Variation | | Assurance | | | |
|--|--|--|--|--|---|
| | | | | | |
| Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values. | Special cause of improving nature or higher pressure due to (H)igher or (L)ower values | Common cause with no significant changes | Metric has (F)ailed to meet the target for the last 6 (or more) data points. | Metric has (P)assed the target for the last 6 (or more) data points. | Inconsistent performance against target |