Ref Id	Description	Accountable Officer	Lead for Status Updates	Planned Completion Date	Status Tracking	1) What is being delivered? 2) What new functionality will there be? 3) What will ESNEFT teams/services be able to do? 4) Expected Benefits/Improvements?
	Corporate Changes					
C1	Corporate Transformation: Agile Working - The first formally designated agile workspace will be operational for staff working away from their normal place of work	Mike Meers	Cara Gosbell	30-Jun-21	On Track	The design for Colchester includes relocated Junior Doctor mess and office space for a maximum of circa 90, meeting rooms, breakout rooms and DMT hubs. Ipswich Site - Work to identify agile workspace will be paused until the reallocation of space to support clinical and non-clinical services post Covid19 has concluded 1) Office environments enabling the Trust's workforce to carry out duties in a more efficient and effective way when working across multiple sites. 2) The provision of facilities by the Trust to enable staff, working for (or on its behalf), to have secure and reliable access to any of the Trust's information systems which they have been authorised to use. Agile working enables staff to access such systems remotely (i.e. away from a specific base) which in turn results in the more timely updating of systems, faster and more informed decision making and overall improved efficiencies. 3) Staff will be able to book a desk at a hospital site where they can base themselves to undertake their work when away from their main location, knowing that they will have access to IT systems and facilities. 4) A better working environment for staff when working between sites, efficient utilisation of office accommodation.
C2	Corporate Transformation: Rationalisation of Estate for Corporate Big 4 Finance, HR , ICT and Estates	Mike Meers	Cara Gosbell	01-Mar-21	On Track	1) A Single site location for the corporate Big 4 functions (ICT, HR, Finance, Estates) 2) n/a 3) Improved communications and co-location of teams with aligned corporate functions 4) Release of existing accommodation occupied by corporate functions. Release of backlog maintenance budgets to improve clinical environments.

C4	Reporting of IES Community Datasets (same as acute data)	Shane Gordon	Sean Whatling	31-Mar-21	On Track	1) Data automation from Systm1 Community module into MS Azure and accessed through Power BI 2) Data integration with Acute data and easier access for Operational teams 3) Access data reporting through the same web-based access as Acute data reporting 4) Daily (1 day in arrears) data reporting replacing monthly reporting, Power BI access replacing spreadsheets, access anywhere with Wi-Fi/4g connection
C6	PHE TUPE transfer	Alison Power	Bee Anthony, Alex Vester	31-Oct-21	On Track	1) Repatriation of Microbiology services in-house. 2) Improved control over service performance. 3) Drive forward transformation required in Microbiology - particularly on COL site. 4) More resilience in the service in terms of workforce.
C7	NEE/ACE tender	Neill Moloney	Ali Armstrong	28-Feb-21	On Track	1)NEE Alliance Care Closer to Home Collaborative Contract 2)Redesign integrated community services ensuring improved service performance to our local communities 3)Drive forward transfomation required to allow veritcal and horzitonal integration of care services in NEE 4)patients seen right place,right time with a focus on prevention and and asset based support and care
C8	Pathology Logistics tender complete	Alison Power	Bee Anthony, Shelley Garry	30-Apr-21	On Track	1) Re tender exercise for Pathology logistics for community work 2) Improvements to service to incorporate ad hoc arrangements into main contract 3) Continue and enhance GP logistics for pathology 4) Market test for costings but still maintain and improve service

C9	Endoscopy Insourcing tender complete	Karen Lough	Shume Begum	31-Dec-21	On Track	1)Endoscopic insourcing via YMS currently provides 4 x all day lists across ESNEFT as well as delivering 2 x BCSP endoscopic lists per month. This service bridges the interregnum caused by 8.43 WTE consultant vacancies across Gastroenterology. YMS have a temporary contract which expires December 2020 (via a tender waiver) and as such the intention is to commence a procurement exercise in Oct 2020 to ensure a new supplier is in place by year end. 2)It is expected the successful provider will deliver the same level of activity as per current levels although this will decrease as vacancies are filled. (N.B. Colchester have managed to fill 2 x vacancies with NHS Locums). Undertaking a competitive tender will ensure the new supplier is VFM. 3)ESNEFT teams will work in partnership with the Insourcing provider to ensure the service can run all 3 theatres 7 days per week, utilising a 4th room on an ad hoc basis to support backlog clearance and spikes in demand. 4)This exercise will ensure VFM and eradicate need for a tender waiver. Having a provider in place reduces the risk of loss of activity due to medical or nursing absence within the substantive workforce.
C10	NEESPS disaggregation	Alison Power	Bee Anthony, Sarah Stalley	31-Oct-20	On Track	**Status:** On track for dissolution on 31st October. 1) Dissolution of NEESPS partnership with WSFT. 2) Improved control over service performance. 3) Future collaborative working opportunities with WSFT being explored. Opportunity for ESNEFT to drive forward changes in Histology. 4) Changes in Histology will drive faster TAT for cancer patients.

Ref Id	Description	Accountable Officer	Lead for Status Updates	Planned Completion Date	Status Tracking	1) What is being delivered? 2) What new functionality will there be? 3) What will ESNEFT teams/services be able to do? 4) Expected Benefits/Improvements
	Estates Capital Builds/Developments					

E1	Ipswich 3rd MRI commissioned.	Paul Fenton	Belinda Ling, Sinead Hendricks-Tann	31-Jan-21	On Track	1) A third static MRI scanner for the Ipswich site. 2) The new scanner will have the capability to perform cardiac MRI and will provide more MRI capacity for the Ipswich site. 3) ESNEFT will have the capability to repatriate cardiac MRI work from other centres and will have the opportunity to improve turnaround times for MRI with this additional capacity in place. 4) The main benefit is that this will be an increase in MRI capacity for the Ipswich site. Pre Covid Ipswich were reliant on a mobile to meet the gap between demand and capacity. Having this static MRI in place will remove the need for a mobile and also ensure we have a robust solution in place for MRI capacity when we no longer have access to the ISP.
E2	Aseptic Unit Upgrade (Col)	Paul Fenton	Stephen Pullen	31-Dec-20	On Track	1) A new regulatory compliant Aseptic manufacturing unit 2) New technologies will allow electronic monitoring of; room differential pressures, High Efficiency Particulate Air (HEPA) filter pressures and continuous particle counting in isolators and will also support remote in-process checks via cameras. A new segregated manufacturing area will allow manufacturing of hazardous products whilst minimising the risk of cross contamination to other product types. The facility, with the appropriate equipment and staff, will allow increased productivity. 3) Continue to provide a responsive service of supply of aseptically manufactured chemotherapy, radiopharmaceuticals and general intravenous products to the Trust, manufactured under the Medicines and Healthcare products Regulatory Agency (MHRA) licence. 4) The main benefits are compliance with regulatory (MHRA) standards, resilience in product supply for internal use and future proofing for expected increased demand and the ability to generate income for the Trust, with sufficient staffing levels.

E3	Interventional Radiology and cardiac angiography (IRCA) unit (CoI)	Paul Fenton	David Cohen	30-Apr-21	On Track	1) Replacement facilities for Interventional Radiology and Cardiac Angiography services 2) Complete service in one custom built location, including three labs and eight recovery bays 3) Vascular IR accreditation, repatriation of IR work and new IR procedures as well as Cardiology procedures designated for local units 4) Shared patient pathway, with improved patient & staff safety, dignity, respect & privacy alongside equipment reliability, supporting staff recruitment and retention, whilst also delivering accreditation compliance
E4	IH Breast Unit development completed	Paul Fenton	Mark Finch	28-Feb-22	On Track	1)A consolidated unit for breast services, covering imaging services, treatment, consultation and examination facilities. 2)Improved patient pathway and increased capacity. 3)Improve the patient experience. 4)Improvements in terms of patient dignity and clinical environment, plus efficiency improvements to the breast staff.
E5	IH Childrens Dept upgrade completed	Paul Fenton	Mark Finch	30-Sep-22	On Track	1)A ward configuration reducing LOS, improving patient pathway and increasing efficiency. 2)Better isolation facilities, improved facilities to adolescents, one operational department rather than two fragmented wards. 3)Reduce LOS, enable flexibility of outpatient services and paediatric investigative services. 4)Improved estate efficiency, reduced LOS, improved patient experience and reduction in backlog liability.
E6	Estate Strategy - rationalisation of IH North-end	Paul Fenton	Cara Gosbell	TBA	On Track	1)Release / disposal / development of land which ranges to a poor to derelict condition. 2)This is subject to further negotiations, however the direction of travel points towards a One Public Estate Approach, beneficial to the entire healthcare system. 3) Improve patient care within the ICS, provide better facilities to public sector employees. 4)Potential revenue stream, reduction in backlog liabilities.

E7	Estate Strategy - Commencement of Tower Block refurb	Paul Fenton	Project Lead yet to be assigned	TBA	On Track	1) Conversion of a 9 story tower block to provide repurposed, relieving space pressure. 2) Corporate space which removes the requirement of poor estate utilisation, enabling the north end estate rationalisation. 3) Work within a suitable environment as a corporate function, within the remit of agile working whilst considering COVID constraints. 4) Model hospital and ERIC improvements.
E8	Estate Strategy - Use & development of St Clements land	Paul Fenton	Mark Finch	Q3/4 21/22	On Track	1) An alternative building from which the Ipswich Hospital Nursery can be run, plus a community facility which can also be used for training, recreation and education. 2)Appropriate nursery, training, development and community facilities. 3)Attend training events and group events reducing the need for external facilities resulting in revenue reduction. 4) Revenue reduction
E9	Estate Strategy - Urology dept – Relocation to sufficiently sized area	Paul Fenton	Project Lead yet to be assigned	Q2/3 21/22	On Track	1)Increased urology space through relocation in to current retail area. 2)Appropriate clinical space to run urology services. 3)Maintain patient flow through the department. 4)Enabler for increased endoscopy space and JAG accreditation through expansion in to current urology space.
E10	Estate Strategy - Endoscopy dept - Extension in to Incumbent Urology Area	Paul Fenton	Mark Finch	Q4 22/23	On Track	Narrative to be added upon completion of OBC. 1)Expansion of existing endoscopy space in to current Urology area and reconfiguration of the department to achieve JAG accreditation. This will realise a long term ambition that has been in the planning stages since 2013. 2)Additional treatment space with up to 5 x Endoscopy suites, adequate staff facilities and single sex segregation 3)Achieve JAG accreditation and mitigate clinical risk. 4)Clinical excellence, efficient throughput and recognition of achieved industry standards.

E11	Estate Strategy - IH Staff accommodation upgrade	Paul Fenton	Cara Gosbell	Q4 20/21	On Track	1) The transfer of ownership of up to 8 community properties from NHS Property Services to the Trust 2) Additional flexibility in the use and configuration of the properties 3) Have more control over the use and occupation of the properties in order to deliver services more effectively and efficiently 4) Cost avoidance on current lease payments vs ownership costs, more responsive and better coordinated maintenance and repair responses, greater control over building compliance and (re)configuration
E12	Transfer NHSP Community properties	Paul Fenton	Anne Finn	Q4 20/21 for first 3 Properties	On Track	1) The transfer of ownership of up to 8 community properties from NHS Property Services to the Trust 2) Additional flexibility in the use and configuration of the properties 3) Have more control over the use and occupation of the properties in order to deliver services more effectively and efficiently 4) Cost avoidance on current lease payments vs ownership costs, more responsive and better coordinated maintenance and repair responses, greater control over building compliance and (re)configuration

E13	Ipswich EAU Reconfiguration (Building, Clinical & Operations)	Karen Lough	Carolyn Tester	31-Dec-20	On Track	No longer funded through STP Programme - brought forward through UEC Winter capital allocation. 1)The introduction of a fully functional AMSDEC model at Ipswich hospital will provide an additional second floor building, immediately above the existing Emergency Assessment Unit; 12 ambulatory recliner chairs, assessment and procedure rooms, plus 2 trolleys upstairs; a sustainable sized department for Medical Emergency Assessment to support future growth, combining increased trolleyed area on the ground floor and ambulatory area on the first floor. 2) Ability to support changed model of care for fast track to medical assessment from primary care, ED, 111, ambulance and clinics to avoid unnecessary ED; Ability to book into next day AMSDEC 'hot clinic' slots 3) Ensure rapid assessment, diagnosis and treatment of emergency care ambulatory patients; in accordance with the National 'Same Day Emergency Care' model. Enables staff to work in an appropriately resourced area to ensure maximised patient outcomes for ambulatory care. 4) Ability to fast track patients straight to EAU/AMSDEC directly from primary care, ED, 111, ambulances and clinics; Reduce length of time for patients in the emergency assessment unit; Rapid senior medical review, assessment and diagnosis/treatment same day; Sufficient physical and staffing capacity to safely manage all medical emergency patients at the front door; Cultural change for patients and staff, assuming that in being treated in chairs as opposed to trolleys, waits and stays will be shorter; Assistance in ensuring EAU reverts to an assessment area only overnight, without the need to bed patients; Quantifiable financial benefits include: AMSDEC service supporting 20 patients per day, of which 19 will be treated as same day emergency care avoiding overnight admission. When compared to current practices and current patient cohort, we anticipate a

E14	Ipswich UTC & SAU (Building, Clinical & Opeations)	Karen Lough	Carolyn Tester	30-Apr-22	On Track	1) This will deliver a transformed front door model for emergency patients, ensuring patients are seen and treated in a timely manner; right time, right place and right clinician, utilising clinical teams within ESNEFT and across our wider integrated system. ED becomes place of care for critically ill/injured patients only 2) Streaming and redirection of patients to the appropriate setting, UTC build and staffing to treat minor injury and illness patients, direct booking of patients into UTC via 111, direct bookings into GP practice appointments from emergency front door where appropriate, fast track to specialty pathways, true SAU same day emergency care model, access to shared care patient information 3) Access shared care records to jointly support patients; for both primary and secondary care staff, shared education between primary and secondary care, work in an uncrowded environment which is fit for purpose for assessing, diagnosing and treating emergency ambulatory care patients 4) Reduction in unnecessary emergency care admissions, deliver sustainable emergency care quality standards, ensure patients are seen and treated in the right setting, by the right clinician in a timely manner, improved patient outcomes and experience.
E15	Ipswich ED Reconfiguration (Building, Clinical & Opeations)	Karen Lough	Carolyn Tester	30-Apr-23	On Track	1) Provide a sustainable and fit for purpose environment for which to manage critically ill and injured patients 2) Automated and integrated system across primary and secondary emergency access points, pathways to ensure streamlined pull from ED, safe environment for mental health assessment, improved infection control and social distanced physical space 3) Work in an uncrowded department, seeing and treating only those patients requiring their service, optimising patient and staff outcomes and experience 4) Deliver sustainable ED quality standards, future-proofed to manage expected growth over the next 10 years, integrated primary and secondary care to jointly manage emergency care patients across our system, improved flow through the emergency care system.

E16	Colchester ED Reconfiguration (Building, Clinical & Operations)	Alison Power	Ali Armstrong	31-May-22	On Track	1)) Provide a sustainable and fit for purpose environment for which to manage critically ill and injured patients 2) Automated and integrated system across primary and secondary emergency access points, pathways to ensure streamlined pull from ED, safe environment for mental health assessment, improved infection control and social distanced physical space 3) Work in an uncrowded department, seeing and treating only those patients requiring their service, optimising patient and staff outcomes and experience 4) Deliver sustainable ED quality standards, future-proofed to manage expected growth over the next 10 years, integrated primary and secondary care to jointly manage emergency care patients across our system, improved flow through the emergency care system
E17	Colchester FAU/MAU reconfiguration (Building, Clinical & Operations)	Alison Power	Ali Armstrong	31-May-22	On Track	1)The colocation of AMSDEC and Frailty will support our ambition to achieve deliver enhanced 7 day SDEC 2) The increased ambulatory area will have improved assessment and treatment facilities, retain easy access to diagnostics and discharge facilities, with own access and drop off points 3) Assess and treatment patients, right place, first time, improved direct links with test/learn service in Clacton, offer managed appt times 7days 4) improved integrated working, reduction in the number of assessments, reduction in unneccessary addmissions, enhance working with Integrated Discharge SPA and community resurces, direct access to EAU
E18	Colchester SAU reconfiguration (Building, Clinical & Operations)	Alison Power	Ali Armstrong	31-Dec-22	On Track	1)A newly designed SAU which provides flexibility of space, allowing delivery of increased SDEC procedures in line with national guidance 2)Increased treatment and ambulatory space 3)The increased space will allow teams to manage surge more effectively from both ED and direct admissions as per SDEC guidance 4)Improved offer to patients, focus on confidentiality , timeliness, access to diagnostics, improved pathways as per SDEC guidance

E19	Elective Orthopaedic Centre complete	Karen Lough	Andrew McLaughlin	31-May-22	On Track	1) A new elective orthopaedic centre on the Colchester site. 2) 5-8 laminar flow theatres and between 48-100+ beds. Direct access from Northern Approach Road. 3) The new EOC will be one of the largest elective orthopaedic centres in the UK suitable for designation as the regional orthopaedic centre and may also be used as a 'Green' facility during any future pandemic. 4) Shorter waiting times; reduced cancellations; standardisation of care; improved physical environment for patients and staff; and, greater opportunities for training, education, research and innovation.
E20	Replacement Day Surgery Unit @ Colchester complete	Karen Lough	Andrew McLaughlin	TBA	On Track	1) A replacement day surgery unit at Colchester in the space vacated by orthopaedics in Constable Wing. 2) Replacement DSU with improved facilities in a modern building that has room for future expansion. 3) Increase the use of day surgery with the creation of a 23-hour unit to free up inpatient capacity. 4) Improved clinical space; laminar flow theatre for trauma; and, convenient patient drop-off and access.
E21	Replacement Endoscopy Unit @ Colchester complete	Karen Lough	Andrew McLaughlin	TBA	On Track	1) A replacement endoscopy unit at Colchester in the old Elmstead DSU. 2) Replacement Endoscopy Unit with improved facilities in a modern building with room for expansion. 3) Provide more endoscopy and bowel screening lists in a JAG compliant unit with improved patient access. 4) More spacious, JAG compliant, facility providing improved privacy, dignity and infection control.

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	Human Resources & Workforce					

H2	On/Off Boarding - Implemented new corporate process for all staff who start, leave or move role within the Trust	Leigh Howlett	Deborah O'Hara	31-Mar-21	On Track	1) A robust process for staff joining / moving between roles / leaving that is fully integrated across all corporate services processes and systems. 2) Removal of time delays through e-forms that brings together all staff information required into a single place and feeds the various systems. 3) An example is that the ECF process for straight replacements (no establishment change in any way) will no longer require Trust vacancy panel sign off (only Finance and Division). 4) Staff have everything they need on their first day at work; Managers have time back to be able to manage their services; Clinical managers have time back to be able to perform clinical work; All managers understand the on/off-boarding processes, and when they should be completed; Corporate teams are prompted and signposted to carry out their on/off-boarding duties with sufficient time
H3	Deliver and embed the Health & Care Academy	Leigh Howlett	Sharon Wyatt	31-Oct-20	Complete	**Status:** Academy launched virtually in October 2020 as planned. 1) Virtual Care Academy in partnership with health and care partners started virtually. 2) New portal to access roles and learning about careers in health and care 3) Access a source of future employees 4) Improved recruitment from community groups that may not otherwise consider a career in health or care
H5	Delivery plan for the Wellbeing Hub which sets out how this will support staff in improving their mental, physical and financial health	Leigh Howlett	Jo Wood	30-Sep-20	Complete	**Status:** Wellbeing Hub launched as planned and as outlined. Recruitment of clinical and support staff in progress. 1) Health & Well Being Hub that brings together support and services for staff and volunteers physical, mental and financial wellbeing 2) New clinical services (such as the menopause clinic and dedicated psychological support) plus coordination of services that can be provided by other partners (such as stop smoking) as well as staff initiated initiatives such as the running club. 3) Access a broad range of Health and Well being opportunities 4) Reduce sickness absence particularly by reducing stress, anxiety and depression sickness rates. Improve the over all health & wellbeing and morale of our workforce.

H6	Deliver the management leadership competencies and passport to embed an inclusive and compassionate leadership culture	Leigh Howlett	Sharon Wyatt	30-Nov-20	On Track	**Status:** On track, plan for launch second week of November, ahead of schedule. 1) Competency framework of management skills and competencies for all staff and leadership passport to chart progress 2) Leadership training than matches our values and behaviours 3) Access training in all aspects of management and leadership 4) Improved staff satisfaction, decrease in employee relation cases, improved staff survey scores, improved staff retention and reduction in turnover
H7	'Work from anywhere' policy and framework publised so our staff can work from home or any Trust location effectively and supported by their manager	Leigh Howlett	Leigh Howlett	31-Dec-21	On Track	**Status:** On track, first draft of policy going out for comment week commencing October 26th 1) Working anywhere policy to support staff working from home and other areas in the Trust estate 2) Technological support and IT kit, such as soft phones. A framework for staff and managers to deploy staff flexibly. Guides for managers on managing remote staff. 3) Routinely work from home and remotely as part of their job and contract of employment/JD. 4) Improved work life balance, reduction in the required estate for corporate functions, increased staff satisfaction
H8	e.Job plans for all clinical workfroce (NHS long-term plan)	Leigh Howlett	Dionne Saxon	31-Mar-21	On Track	**Status:** E-job plan in place, policy in place, training completed. Working with divisions to ensure outstanding job plans are completed, some disruption due to Covid activity. 1) E-job planning for non medical staff 2) Electronic job planning system embedded with AHPs and other non medical staff 3) Improve the deployment of staff to better meet service need, ensure staff work in support of 7 day services appropriately 4) Clarity of role for staff and their workloads and need for staff (less and more)

H9	e.Rostering complete across ESNEFT for all AfC staff	Adrian Marr	Simon Oliver	31-Mar-21	At Risk	**Status:** As of Sept '20 circa 87%, however hitting 100% by March '21 is at risk at this time. 1) electronic roster for all non medical staff. 2) Central visibility of the workforce, integration to ESR so overtime, enhancements, sickness, on-call pull directly into ESR. All leave management (annual leave, maternity, carers leave etc). Staff app that will be available for staff to see shift information at home and request leave at home. 3) See at glance workforce information, monitor annual leave, see gaps in the roster. 4) Accurate payroll, real-time information available, forward looking information available, sickness accuracy, ensuring right skills in the right place - i.e. qualified nurse fills a qualified gap on the roster. Acuity templates linked to finance to ensure roster match budget. Control on additional bookings.
H10	e.Rostering complete across ESNEFT for all Medical staff	Adrian Marr	Simon Oliver	TBA	On Track	**Status:** As of Sept '20 live in a couple of areas. The big bang for Juniors was postponed as preparatory work was not completed by Division & HR. Project team reviewing next steps, one of issues is Locum on duty support as impacting operationally. 1) electronic roster for all medical staff. 2) Central visibility of the medical workforce, integration to ESR so additional shifts, sickness, on-call pull directly into ESR. All leave management (annual leave, maternity, carers leave etc). Staff app that will be available for staff to see shift information at home and request leave at home. 3) See at glance workforce information, monitor annual leave, see gaps in the roster. 4) Accurate payroll, real time information available, forward looking information available. Sickness reporting is exceptional poor for medics so this will be a significant improvement. Ensuring right skills in the right place - i.e. Doctor covers appropriate shift. Control on additional bookings. Eventually job plans linked to actual work.

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	Quality Improvements					
Q1	Delivery of compliance with sepsis 6 care bundle in Emergency assessment areas	Angela Tillett	Julie Sage	31-Mar-22	**On Track**	1) The sepsis screening tool and Sepsis 6 care bundle is a combined form currently in use on all sites including community hospitals. The screening tool signposts staff to request a medical review where the clinician can then indicate if sepsis is suspected and requires treatment. If the latter, then the Sepsis 6 care bundle must be delivered in full within an hour of identifying that the patient could be septic/to prevent sepsis developing. 2) Teams working in inpatient areas are now using Sentinel, an electronic observations tool, which will correctly calculate the NEWScore based on the accurate input of physiological parameters (historically, human error played a small part in the failure to identify deterioration) - the NEWScore is a trigger for undertaking a sepsis screen. The tool has the facility to centralize the recording of observations to remotely identify triggering patients, allowing for more comprehensive auditing of compliance to protocols than used to be achievable when observation charts were stored in the patient folder. Audit has identified that the vast majority of patients who trigger for suspected sepsis have an increasing NEWScore and that while staff know the protocols, they sometimes fail to apply them owing to human factors. 3) The Educator role has proved key in the Colchester ED, with root cause analysis identifying training needs which have been delivered on a one to one basis. This role would be key in improving compliance in other patient areas. 4) Expected benefits include better patient outcome and reduced length of stay. If left untreated, sepsis is often fatal or delayed treatment can lead to life-changing results such as amputation which result in a reduced quality of life.

Q2	Reduce the number of inpatient falls to be in line with national target (5.5/1000 bed days)	Melissa Dowdeswell	Jo Field	31-Mar-22	**On Track**	1)(i)Ward based training programme now in progress - priority led based on incident numbers & severity (ii)Site specific and joint-site Falls Steering Group meetings now established (iii)Revision of Harm free Panel process - falls incidents reviewed separately with key learning points summarised and shared with Divisions (iv) Engagement of Community Falls Co-ordinator for collaborative working across acute and community hospital settings. 2)(i)New Falls Practitioner in post - working closely with wards following Datix incident reporting (ii)Harm Free Care Team upskilling in progress to address skills shortfall in relation to falls prevention. 3)Increased visibility of Harm Free Team members in ward areas to facilitate support and implementation of the Falls Strategic Plan and Falls Prevention Workplan. 4)Expected benefits/outcomes - reduction in falls incidents and falls resulting in serious harm.
Q3	Getting it right first time (GIRFT) programme improvements (Various recommendations with different timescales per Speciality) To be measured through top 3 patient benefits	Angela Tillett	Sharon Austin	March Annually	**On Track**	1) Specialities that have received a GIRFT review have received a report identifying changes that will bring about improved care/reduced expenditure. They are progressing with the top 3 priorities identified within their areas. 2) the functionality will be different for each speciality. 3) The reports will include areas of "good practice" within other Trusts, specialities will be able to contact them to discuss pathways etc accordingly. 4) Improvements will be by speciality but focused on improving quality of patient care, reducing expenditure on complications, litigation, procurement and unproven treatments

Q4	Continue to improve our care to those at the end of their life, timely transfer to preferred place of care in <24hrs	Angela Tillett	Julia Thompson	31-Mar-21	**On Track**	1)Recent transformation support agreed to process map and understand where improvements can be made to improve patients meeting their preferred place of care in a timely manner. Patients are currently seen by palliative care/IRAS/ discharge team any of whom may be involved in discharge process. Time taken to discharge has improved but due to complexity of some of these patients it remains difficult to discharge <24 hours. 2) Red2green app will facilitate; increased collaborative working with discharge/palliative care teams on key wards; using My Care Choices Register to pre-empt patient need; thematic reviews and improved data collection to understand barriers; closer working with CCG to streamline process. 3) Increased data collection to include palliative care team and IRAS patients who are being discharged within 24 hours but don't get referred to the discharge team. Therefore increase number of patients getting home <24 hours. 4)To increase the number of patients who are recognised as rapidly deteriorating, being discharged to their preferred place.

Q5	Improve clinical outcomes for patients with mental health conditions, improve mental health well-being for staff and transform Mental Health provision across ESNEFT	Melissa Dowdeswell	Rebecca Pulford	31-Mar-22	**On Track**	There is a planned key stakeholder event in October for all parties across the system to attend a pathway mapping event - this is innovative work that will be undertaken to agree patient pathways for all pathways and a combined agreed mental health policy will be developed following this. There is a collaborative piece of work with EPUT to work to provide a place of safety for patients who are medically fit and require a mental health intervention within the Colchester site. The ED and Crisis teams have visited the Southend site and a working group has been established. The key priorities focus on environment, pathways and workforce, clear KPIs are being developed to ensure activity is monitored appropriately. The ADoN for Medicine ED Matron and EAU Matron are now key attendees at the monthly psychiatric liaison system wide meeting and represent the Colchester site in these meetings. The ADoN for medicine has completed a bid and submitted this to the CCG for training for front door staff (ED and EAU) and key areas on our wards to upskill our workforce in the treatment, care and assessment for people presenting and requiring admission for a mental health need. 1)Full implementation of all age core 24 across both Ipswich and Colchester hospital 2)Roll out of mental health first aid training to 250 staff by April 2021 3)Implementation of childrens key workers on Colchester and Ipswich hospital for Tier 4 presentations (MH, LD and Autism) for every admitted child 4) Expected benefit of all three interventions: early recognition of patients, children and staff and intervention for emotional and mental health presentation and as such reducing impact on individual.

Q6	Improve Interventional safety by embedding a safety culture	Angela Tillett	Sally Cornish	31-Mar-22	**On Track**	1) Human Factors training in revised form recognising the procedural needs of ward based areas with increased Divisional Director and Senior Nursing input. Newly developed intranet site with master checklist of all LocSIPPs. Regular auditing of LocSIPPs to be included in Annual Audit Plans. Sharing of learning from Never Events and new SI framework by development of educational events and E-Learning Awareness package and videos. Revised WHO checklist developed and launched. 2)Staff can refer to Mastercheck list and use Intranet as central repository. Raising awareness of human factors in responding to Never Events. Learning via Human Factors delivery and E-learning. 3) Use safety checklists appropriately and consistently. 4)Reduction in Never Events and incidents of avoidable harm. Improved outcomes for patients.

Q7	Mortality (SHMI), SHMI within expected range from end of 2019/20 with a reduction over 3-5 years	Angela Tillett	Julie Sage	31-Mar-22	**On Track**	1) SHMI (Summary Hospital-Level Mortality Indicator) is a mortality model that compares the number of patients who die (in hospital or within 30 days of discharge) to the number 'expected' to die, based on presenting diagnosis and casemix adjustment. 2) The main drivers in the indicator are the number of deaths and the quality of clinical documentation/ coding which give an indication of the complexity of the patient. The Trust is in the process of rolling out/improving compliance with a number of ESNEFT documents that work to promote the application of nationally recognised best-practice care bundles and tools which promote better communication between the MDTs. The Learning from Deaths group is focusing on ensuring that issues identified during reviews are cascaded across the trust. Specialties are moving towards a cross-site reflective Mortality and Morbidity learning process rather than a casenote review. 3) Bundles such as those for sepsis and AKI ensure that large groups of patients receive consistent care, irrespective of the specialty they are in. The tools set out identification, assessment and treatment steps while sign-posting staff to the correct specialty support should the patient require it. Forms such as the TEP (treatment escalation plan) are designed to be an easily accessible summary of a conversation between the patient and their consultant, where decisions regarding comfort and treatment options are clearly laid out for nursing and medical staff. 4) Care bundles help to support staff in providing timely holistic treatment which in turn reduce mortality and long term harm should deterioration occur. TEPs indicate to on-call teams what treatment would be given by the team that knows the patient best, while respecting patient wishes. In addition, where the patient is unlikely to recover, a copy can be sent home with the patient to support community partners should readmission be considered. The Trust will need to invest time in training and audit to provide assurance that care bundles are being used effectively. In some areas, staffing levels are such that there is insufficient time set aside for non-clinical work to allow the time necessary to share learning from reflective practice.

Q8	7 day consultant-led service models incl. specialty assessment units. Deliver national requirements by end of 2022/23	Angela Tillett	Crawford Jamieson	31-Mar-23	**On Track**	1) Clinical Divsions to employ flexible team job planning to deliver maximum 7 day consultant daily review 2) Use of predictable working within flexible job planning to move towards sustainable delivery of weekend review rounds 3) Achieve progression towards meeting NHS E standards 4) Improved patient safety, improved appropriate weekend discharge form hospital
Q9	Nutrition - Effective management and increased awareness on importance of nutrition, ensuring all patients receive appropriate nutrition or nutritional intervention	Melissa Dowdeswell	Penny Cason	31-Mar-23	**On Track**	1) The delivery of appropriate nutritional care to all patients through the prompt recognition of individuals requirements. Referrals to specialist clinical support will be timely and the correct maintenance management plans will be put into place to ensure those at risk due to their illness are given the best support possible. 2) An educated workforce with the skills and knowledge to ensure delivery of appropriate nutritional care to all patients, supported by clinical experts accessible across the acute and community settings. 3) Provide expert advice and support through Dietetics, Speech and Language Assessment and Medical Management of patients requiring nutritional support and advice. Nutrition Champions will be identified across the Trust who will be given the skills and training to promote recognition of individual requirements and advise on supportive interventions. 4) Patients at risk due to their nutrition and hydration needs will be accurately assessed and the appropriate interventions put in place to ensure that no harm comes to patients due to their nutritional needs.
Q10	95% of staff receive Flu vaccine	Leigh Howlett	Margaret Grant	28-Feb-21	**On Track**	1) Flu Plan to deliver vaccination target 2) FluVa will reduce need for staff to fill in forms 3) be vaccinated 7 days a week 4) reduction in the incidence of flu absence in our workforce

Q11	To ensure that all inpatients with an AKI are quickly identified and treatment initiated in line with the Trust AKI Care Bundle.	Angela Tillett	Julie Sage	31-Mar-21	**On Track**	In the UK up to 100,000 deaths each year in hospital are associated with acute kidney injury. Up to 30% could be prevented with the right care and treatment, [NCEPOD Adding Insult to Injury]. Wang et al. advise that an estimated one in five people admitted to hospital each year as an emergency has acute kidney injury. 1) The Acute Kidney Injury (AKI) care bundle has been use on the Ipswich site for a number of months and was rolled out across Colchester Hospital during September 2020. 2) The locally devised bundle, based on best-practice evidence, prompts staff to undertake a thorough patient assessment, guiding doctors and nurses through diagnosis, assessment, treatment, escalation, monitoring and discharge protocols to either restore kidney functionality, prevent further damage or prevent deterioration of a pre-existing chronic disease (CKD). The bundle can be used for patients on admission and for those who go on to develop an AKI during an inpatient stay. The bundle is also a record of interventions and sign-posts staff as to when specialty support is required so that the patient can be escalated and care coordinated in a timely manner. 3) The form will summarize care for the multidisciplinary team and support effective communication with the GP on discharge so that care can be safely transferred to the community. 4) Initially, there will be a need to provide greater resources to teams such as nephrology, urology and nutrition & dietetics as there will be an increase in specialty referrals; however, this could be offset against a shorter length of stay and better patient outcome [NHS costs are estimated to be £434-620m pa]. Fewer patients will die and the number of patients requiring care for Chronic Kidney Disease (outpatient appointments, dialysis and transplant) will reduce.

Q12	Development and implementation of a system wide Pressure Ulcer framework	Melissa Dowdeswell	Kay Hamilton	TBA	**On Track**	1) Seek to develop a Alliance wide Multi-Agency Framework for the Prevention and Management of Pressure Ulcers – Introduce a Multi-Agency steering group, which might include Safeguarding Teams, Social Services, GP's, Care Agencies and Care Providers. Deliver consistent agreed best practice approach to the prevention and management of pressure ulcers across the SNEE Integrated Care System 2) Utilise the framework in order to set out a consistent and clear approach on the prevention and management of pressure ulcers across all health settings, applying to all age groups. Prevention and measurement for improvement through the consistent delivery of best practice within the health and social care community, with improved communication and outcomes for the patient/service user. 3) Utilise the multi-agency framework for pressure ulcer prevention and treatment pathway to align with the principles in the NICE Clinical guideline (CG 179) published in 2014 which clearly outlines the principles for prevention of pressure ulcers in all ages groups. Fully embed the primary drivers within the pathway for the prevention of pressure ulceration: Skin inspection, assessing the risk of pressure ulceration, reliable implementation of prevention strategies, identification and categorisation of pressure ulcers, and education. 4) The collective aspiration is to achieve harm free care and to use the learning from incidents of pressure ulceration to improve care quality and people's direct experience. Reduce new incidents of pressure damage, reduce increase need for additional services such as Community nursing and increased care packages, reduce incidence of admission related infections from pressure ulcers. Ensure consistent high standards of clinical practice across the Alliance. Introduction of a system wide assurance framework. Explore the potential to accredit the framework education element with Health Education Institutes.

Q13	Implementation of the Patient Experience Network co-produced with our partners	Melissa Dowdeswell	Annette Agetue-Smith	30-Sep-21	On Track	1) An enhanced communication platform to maximise involvement with our patient and their carers. Strengthening the work already taking place with our Patient and Carer User Groups by building already existing relationships with staff, patients, their carers and the community ensuring we are working together in recruitment and training, making improvement to the all services across the whole organisation 2) A dynamic platform with varying opportunities for Patient, Carer, Staff engagement and involvement to enhance the Trusts relationship with our patient, their carers and the community to further invigorate an engagement and involvement partnership involving all system stakeholders and partners. 3) Proactively engage and involve patient and carer user groups, insight and improvement ambassadors, and patient and carer ambassadors to listen, learn and act upon lived experiences 4) Staff will have a broad perspective on what our patients are saying, by actively listening to people from all parts of the community ensuring equality, diversity and inclusion is a golden thread which weaves through our organisations. Always Events: Always Event 1: Improve patient engagement and communication; Always Event 2: Improve the patient journey; Always Event 3: Meet care needs This will support our vision; 'To exceed the expectations of our patients at all times'. This vision, depicts the Trust philosophy that 'Time Matters' getting the basics right the first time round and making every moment count; enabling us offer and deliver the best care possible.

Ref Id	Description	Accountable Officer	Lead for Status Updates	Planned Completion Date	Status Tracking	1) What is being delivered? 2) What new functionality will there be? 3) What will ESNEFT teams/services be able to do? 4) Expected Benefits/Improvements
	Clinical Services & Process Changes / Deployments					

S1	Development of a Rapid Diagnostic Centre (RDC) to enable early identification and timely referral of suspected cancer patients	Alison Power	Pat Harvey	31-Mar-21	On Track	1) ESNEFT is part of a 5 year programme to develop a RDC model across SNEE and we are currently in year 2 of its development. The RDC forms two parts 1) to establish a vague symptom service to support early identification of Cancer for patients who have vague or worrying symptoms. 2) To develop a rapid diagnostic pathway for all tumour sites to allow the earlier and faster diagnosis of Cancer and subsequent treatment. 2) The RDC allows early identification, timely referral, assessment of symptoms and triage, co-ordinated testing (to ensure fewer visits for tests as possible), timely diagnosis and onward referral as appropriate. 3) By switching the pathway to allow for a faster and earlier diagnostic, instead of a traditional outpatient first model, acute clinical teams will receive patients onto a Cancer pathway with a cancer diagnosis allowing them to decide the best course of treatment for there care earlier in the pathway. 4) By implementing this service, patients received onto the Cancer pathway, will have had diagnostics already been confirmed, meaning that patients will have faster and earlier access to treatment for there cancer treatment.
S2	Scope the potential to develop a diagnostic network (learning from principles with the East Midlands Radiology Consortium – EMRAD) to enable to fully utilise diagnostic capacity either across an ICS or regional foot print.	Alison Power	Bee Anthony	30-Nov-20	On Track	1) Establishment of a wider diagnostic network. 2) Special interest groups - access to specialist reviews. 3) Joint procurement opportunities such as PACs. Recruitment and retention schemes relating to training rotation programme for Juniors. 4) Investment available for capital equipment is more likely in a wider network. Reputational benefits through networking. Patient access to specialist reviews through image sharing.
S3	Reconfiguration of micro biology services – West Suffolk split and repatriation from PHE 31st October	Alison Power	Bee Anthony	31-Mar-21	On Track	1) Repatriation of Microbiology services in-house. 2) Improved control over service performance. 3) Drive forward transformation required in Microbiology - particularly on COL site. 4) More resilience in the service in terms of workforce.
S4	Transformation phlebotomy services - Roll out of Swift Queue	Alison Power	Bee Anthony	31-Mar-21	On Track	1) electronic booking system across phlebotomy service 2) Patients will be able to book appointments in line with capacity of service in line with time matters strategy 3) Flex workforce and plan around demand of service, allows for social distancing to be managed using time slots 4) Better use of workforce and improved patient experience

S5	Mental Health - New areas adjacent to ED at CH & IH	Alison Power	Rebecca Pulford	TBA	On Track	1)With the implementation of Core 24 Psychiatric liaison services in Colchester and Ipswich hospital facilities identified to safe assessment for patients no longer requiring Physical health but requiring acute MH assessment 2)Within the UTC/Emergency care footprint 3)Fulfil the responsibilities of care of MH patients who have required physical care to be cared for in a safe and dignified area for ongoing MH assessment 4) Once physical care episode complete transfer to shared care with Mental health partners to an area that is safe and dignified for patients and outside of the 4 hour ED standard.
S6	Frailty: 7 day service in place frailty at Colchester. Both sites to achieve 70 hour target	Alison Power	Ali Armstrong	30-Sep-20	Late	**Status:** Colchester, Frailty cover currently is Mon to Friday - 7am to 7.30pm. Plan was to go live in December, providing the same cover across the 7 days. However, not had additional funding for this granted and will now complete an internal business case to see if they can secure funding going forward. Ipswich, Frailty cover currently is Mon to Friday - 8am to 6.30pm 1) Increase existing frailty services to cover 7 days 2) Increased cover and support for frail patients across the full 7 day week 3) Refer to frailty specialists for advice and planning to support the patient with the right care, avoiding unnecessary ED attendance and/or admission. Increased number of patients supported with multi-disciplinary plans to support them staying at home. 4) Reduced ED attendances and emergency admissions/readmissions. Improved patient experience, with improved outcomes and clear shared care plans to enable the patient to remain in their home setting wherever possible
S7	BAAGS (Straight to test, Advice&Guidance, Blue Card, Good News Letters, Virtual Consultations) completed for CDG's Cohort #1	Karen Lough	Mark Pepper	30-Nov-20	On Track	1) Introduction of a suit of initiatives to include Straight to test, Advice&Guidance, Blue Card, Good News Letters and Virtual Consultation to assist with Outpatient demand 2) In Colchester hospital Advice and Guidance will be available for GPs via eRS and Attend Anywhere Video Consultation Platform is now available on both sites 3) Teams will be able to discharge patients following receipt of investigations, patients will where appropriate be able to initiated follow ups themselves(blue Card), Video Consultations offer an alternative to face to face appointments. Where possible pathways will be re-designed to allow patients to have tests prior to first outpatient appointment

S8	BAAGS (Straight to test, Advice&Guidance, Blue Card, Good News Letters, Virtual Consultations) completed for CDG's Cohort #2	Karen Lough	Mark Pepper	31-Jan-21	On Track	4)Combined this suit of initiatives will reduce demand on outpatients and improve patient experience
S9	Completion of Telederm pilot in IES	Karen Lough	Angela Ashton	31-Mar-21	On Track	1) Vantage's Rego Teledermatology System for routine and urgent skin lesion advice & guidance requests 2) Images taken by either patient or GP are submitted as part of advice & guidance process 3) Review images prior to referral to determine next course of action, either referral into dermatology service or advice & guidance provided to primary care to manage the patient, negating the need for an outpatient appointment 4) Reduced referrals into dermatology service that could have been managed in primary care creating capacity within the service
S10	Completion of Telederm pilot in NEE	Karen Lough	Angela Ashton	31-Mar-21	At Risk	1) Consultant Connect system for advice & guidance requests 2) Images taken by GP are submitted as part of advice & guidance process 3) Review images prior to referral to determine next course of action, either referral into dermatology service or advice & guidance provided to primary care to manage the patient, negating the need for an outpatient appointment 4) Reduced referrals into dermatology service that could have been managed in primary care creating capacity within the service

S11	Digitalised Pre-Op system across both hospitals.	Karen Lough	Mark Pepper	31-Mar-21	On Track	1)Introduction of a digitalised pre-operative system on both acute sites 2)Currently Pre-op assessment on both sites is paper based and does not easily allow for cross site working. The new system will link into other hospital systems and pull through blood test results etc. it also RAG rates patients based on co-morbidities into Red/Amber/Green which denotes the level of input required for their pre-op 3)The system will enable the Trust to have a streamlined/standardised POA service 4)It will provide Improved patient experience and safety, patients will be able to input data in their own time, reducing the amount of time required by the nurses to input the data. It will automate scores to assist with triage with straightforward 'ASA 1-2' patients (anticipated to be 30-40%) not requiring a nurse led assessment and need only attend hospital for basic assessment and investigation (i.e. MRSA screen / ECG / pre-op bloods). Through using NICE recommendations on pre-operative investigations the system will help to rationalize the pre-op investigations ordered reducing unnecessary blood tests, whilst ensuring the Trust has the opportunity to interact with the patient remotely (i.e. from home) which can support better demand and capacity planning, improved throughput, improve waiting list management and optimisation of high risk patients, reduced surgery cancellations and improve theatre utilisation
S12	Identification of Services to move from Acute to Community Locations	Karen Lough	Angela Ashton	31-Mar-21	On Track	1) Review of community/other locations for viability of moving either services or parts of services from the Acute site 2) 3) 4) Better utilisation of space, and creating capacity within the Acute Hospital Setting
S13	Services moved from Acute to Community Locations	Karen Lough	Angela Ashton	31-Mar-22	On Track	1) Review of community/other locations for viability of moving either services or parts of services from the Acute site 2) 3) 4) Better utilisation of space, and creating capacity within the Acute Hospital Setting
S14	Test results in 7 days	Karen Lough	TBA	31-Mar-22	On Track	1) To be advised when scoped 2) 3) 4)

S15	Increase 23 hour day surgery model	Karen Lough	Project Lead yet to be assigned	31-Mar-22	On Track	1) Day surgery units at both sites but only staffed until late evening. Patients not fit for discharge at that time are moved to in patient beds. 2) Replacement DSU on Colchester site in Constable Wing will offer improved facilities in a modern building with room for expansion and conversion of existing in patient ward facilities will allow for 23 hour recovery option subject to funding for staffing. On Ipswich site the existing day surgery unit would benefit from some work to improve patient shower facilities. 3) Increase the proportion of elective surgical activity undertaken in the day surgery units without impacting on the in patient capacity. 4) Greater separation of elective and non-elective surgical pathways to deliver a better patient experience and minimise risks of cancellations due to bed pressures
S16	Improved integrated community service	Karen Lough	Angela Ashton	31-Mar-22	On Track	1) Identification and review of services to redesign patient pathways to deliver integrated services 2) 3) 4) Improved patient journey and experience as care is where needed by the appropriate clinician
S17	Transformation of theatre booking process	Karen Lough	Mark Pepper	31-Mar-23	On Track	1) Introduction of the 6/4/2 booking process 2) Increased oversight and standardisation of theatre bookings and Scheduling with a view to all lists having a clinician assigned at 6 weeks out, booked at 4 weeks and lock down at 2 weeks 3) 4)Theatres will have more notice of what is scheduled to ensure the correct equipment and skill sets are available for lists. It will reduce the amount of short notice dropped lists and allow patients increased notice of their operation date

S18	Implemented a Patient activation programme	Karen Lough	Project Lead yet to be assigned	31-Mar-23	On Track	1) Patient engagement (Related concepts include empowerment, enablement, activation and perceived control) is defined as a concept that combines a patient's knowledge, skills, ability and willingness to manage their own health and care with interventions designed to increase activation and promote positive patient behaviours 2) Yet to be detailed. 3) 4) Patient engagement plays a key role in achieving the Triple Aim goals identified by the Institute for Healthcare Improvement to: - Improve the patient experience of care (quality and satisfaction) - Improve the health of populations - Reduce the cost of care

Ref Id	Description	Accountable Officer	Lead for Status Updates	Planned Completion Date	Status Tracking	1) What is being delivered? 2) What new functionality will there be? 3) What will ESNEFT teams/services be able to do? 4) Expected Benefits/Improvements
	ICT Systems & Changes / Deployments					
I1	Ipswich instance of Critical Care solution cross site	Mike Meers	Andrea Craven	31-Mar-21	On Track	The Innovian Critical Care system and monitoring at the Ipswich is officially unsupported from December 2020 as the hosting platform is to be decommissioned. This has provided the Trust with an opportunity to align the CCMIS across both sites to support cross site working, interoperability and secure a 'value for money' system. 1) Unified Critical Care solution for ESNEFT 2) Supports shared patient pathways, single drug catalogue 3) Cross site working by clinical staff, increased robustness of rotas, reduced reliance on temporary staffing. Supports safe and consistent monitoring of transferred patients. 4) Anticipated financial savings from aligned clinical systems, improved patient care/patient safety, system resilience. Improved governances and audit review. Performance measurement improved re activity reports.

I2	Colchester instance of Critical Care solution cross site	Mike Meers	Andrea Craven	30-Jun-21	On Track	1) Unified Critical Care solution for ESNEFT 2) Supports shared patient pathways, single drug catalogue 3) Cross site working by clinical staff, increased robustness of rotas, reduced reliance on temporary staffing. Supports safe and consistent monitoring of transferred patients. 4) Anticipated financial savings from aligned clinical systems, improved patient care/patient safety, system resilience. Improved governances and audit review. Performance measurement improved re activity reports.
I3	Evolve Roll-out Colchester, Structured Evolve Messaging for Primary Care Discharge Notifications	Mike Meers	Andrea Craven	31-Aug-21	On Track	The overall aims of the initiative include improving patient safety and experience of care, aiding the standardisation of processes, reducing inefficiencies and enabling undue variation in performance to be progressively eliminated. The deployment will be a lens for many long-standing problems in patient pathways but very much an opportunity to address these issues and implement solutions. The opportunity to share records with partners and patients can be a transformative change in how we safeguard our patients, and how we work with GPs, other providers and patients. Having this central, modern platform will allow us to be an active leader in innovating new ways of working and thus enhancing our reputation as a health partner who can take forward and take part in technical initiatives to improve patient pathways. 1) Digitised health record at Colchester to mirror that of Ipswich 2) Upload of documents directly into digital record. Delivery of eforms to replace paper forms and workflow. 3) Ability to recall patient records at any location (including off site), by multiple end users at one time, to support patient care. 4) Common experience of digital records across ESNEFT. Rapid access to notes without having to rely on paper notes. One record library is scanned, this will free up space in Health Records Library Colchester to be repurposed for other uses. Over all the project aim to be improving patient safety and experience of care, aiding the standardisation of processes, reducing inefficiencies and enabling undue variation in performance to be progressively eliminated

I4	Ipswich Wide Electronic Requesting and Results Pathology	Mike Meers	Andrea Craven	31-Dec-20	On Track	Currently, the percentage of electronic requests across the ESNEFT is low. Paper requests require transcription which has introduced errors (thereby adding a clinical risk) and processes have slowed down due to resource constraints, resulting in unnecessary delay in processing requests to produce outcome reports. The con-concurrent project to replace Lab Centre at Ipswich as part of the LIMS programme has a hard-dependency on the ICE deployment which provides an alternative platform for Lab results viewing. The project will deliver a standardised way of requesting and viewing results for both pathology and radiology across ESNEFT which uses the same system as used by GP's. This positions the Trust to take advantage of moving towards a Unified/Enterprise ICE system when available in V8. It also represents a single solution that can be used to support results acknowledgement across ESNEFT. 1) ESNEFT ICE solution for unified order comms for Pathology and Radiology 2) Replaces disparate ways of requesting currently (Lorenzo/Medway) with single solution. 3) Place electronic orders in common system for inpatient/outpatient activity 4) Delivers a standardised way of requesting and results viewing. Enables completion of Winpath Enterprise deployment at Ipswich. Becomes a platform for trust to move towards results acknowledgement which will support patient safety.
I5	Colchester Wide Electronic Requesting and Results Pathology	Mike Meers	Andrea Craven	31-Jul-21	On Track	

I6	Integrated health data available from multiple providers (HIE)	Mike Meers	Andrea Craven	31-Aug-20	**Complete**	**Status:** COMPLETED 1) The aim is too build upon the Cerner Health Information Exchange across the STP footprint utilising existing development from West Suffolk to enable shared patient data from disparate systems across the health and care economy for direct care purposes.18/19 will roll-out the existing scope and connectors in place at West Suffolk for the remainder of the community and primary care sites including the extension of a connector for Liquid Logic for social care. The Business case includes costs to facilitate up to 10 connections on the Cerner HIE alongside those already in place. Extensions to include other acute feeds will not be rolled out until 2019/20. 2) Click through with patient in context from Evolve to HIE 3) HIE to provides interoperability between Acute, Community, Primary Care, Community and Mental Health and care systems. Users will have access to a read only view of the patient record across the STP 4) Access to patient record across the STP expected to reduce number of calls to primary care to establish key clinical data, hence improving holistic view of patient and their improving patient care.
I7	WinPath Enterprise Ipswich Site Go Live	Mike Meers	Andrea Craven	30-Jun-22	**On Track**	**Status:** Business case going to Investment Group in Oct '20 detailing a 9 stage plan which means full Winpath Go Live at Ipswich is now expected to be completed by Jun 2022 however elements such as Histology can be delivered sooner (Jun 2021) as it is not dependant on the v7.24 upgrade. 1) Single lab information management system across ESNEFT. 2) Maintains existing functionality 3) Streamlines the service of pathology 4) Opportunities to create efficiencies in working practice

I8	ESNEFT Wide Electronic Requesting and Results Reporting Radiology	Mike Meers	Andrea Craven	30-Sep-21	On Track	Currently, the percentage of electronic requests across the ESNEFT is low. Paper requests require transcription which has introduced errors (thereby adding a clinical risk) and processes have slowed down due to resource constraints, resulting in unnecessary delay in processing requests to produce outcome reports. This positions the Trust to take advantage of moving towards a Unified/Enterprise ICE system when available in V8. It also represents a single solution that can be used to support results acknowledgement across ESNEFT. 1) ESNEFT ICE solution for unified order comms for Pathology and Radiology 2) Replaces disparate ways of requesting currently (Lorenzo/Medway) with single solution. 3) Place electronic orders in common system for inpatient/outpatient activity 4) Delivers a standardised way of requesting and results viewing. Enables completion of Winpath Enterprise deployment at Ipswich. Becomes a platform for trust to move towards results acknowledgement which will support patient safety.
I9	Unified Evolve Cloud for ESNEFT	Mike Meers	Andrea Craven	30-Jun-21	On Track	The project to migrate the supporting infrastructure behind Evolve Ipswich to a Cloud-based model hosted in the supplier Kainos' Azure tenancy which completed in Feb 19 was the first phase of moving to a unified Evolve Cloud environment for ESNEFT . The next phase is to work with the supplier to move the Colchester infrastructure for Evolve to the Cloud. The migration to the Cloud will provide a more stable, resilient platform and a managed service provided by Kainos will release resource in the Infrastructure team to be utilised elsewhere. Frequent updates included in the Managed Service contract will also mean that we can utilise future development tools as soon as they become available. A key enabler for this project will be the development of a Master Patient Index (MPI), options for which are being consider in 19/20. 1) Migration of Colchester Evolve to Cloud 2) Functionality will be kept aligned between Ipswich and Colchester 3) Have a common experience of Evolve 4) Removes dependency on 'on site' support provision. Provides a more resilient platform with a managed service contract.

I10	Vital signs solution fully deployed across ESNEFT	Mike Meers	Andrea Craven	28-Feb-21	On Track	1) Delivery of Sentinel as eObservation system of choice for ESNEFT. 2) Real time data capture of NEWS2 (National Early Warning Score) for patients observations 3) Move away from paper based obs recording (CH) to eObs solution. Standardisation of solution across ESNEFT (replacing Nervecentre eObs at IH) 4) Electronic capture of real-time information can be shared, integrated, reported and exploited for automatic workflows and escalations
I11	Fully deployed shared order communications across all investigations and services orders	Mike Meers	Andrea Craven	28-Feb-21	On Track	Completion of I4, I5 and I8 1) The proposal is to deliver enabling work for the future implementation of an "Enterprise model" of ICE to support a complete solution for order-communications across the STP (Strategic Transformational Partnership), including; Ipswich Hospital, Colchester Hospital, West Suffolk Hospital, GP and community sites in Suffolk and North-East Essex. 18/19 will see the roll-out of licensing to ensure the STP footprint is covered for Pathology results reporting across Acute, Community, Primary Care and Out of Hours provision. Including the availability of GP Download functionality for NEESPS pathology reporting and the provision of Open Health Connect links between the legacy ICE environments
I12	Fully Digitised Clinical and Operational processes for ESNEFT	Mike Meers	Andrea Craven	30-Jun-24	On Track	1) Completion of I4 & I5 aligned with the procurement of a Unified PAS (I17) and Technology Refresh Programme will support the Trust move in the direction of a fully digitised clinical process. No earlier than 31/12/23 (IH) and 30/06/24 (CH) once the system is embedded 2) Clinical data will be captured electronically which will be enabler for delivering digital processes via workflow 3) Aim is to capture information once and share real time across multiple platforms at point of patient care 4) Improved patient care. Improved reporting. Greater efficiencies of capturing data once to be repurposed elsewhere in the system. Supports shared/integrated records of care.
I13	ICT systems single sign-on core clinical applications	Mike Meers	Mark Caines	30-Nov-21	On Track	1) This project seeks to explore the Single Sign-On functionality that Imprivata offers, by providing a subset of clinicians the opportunity to trial the software in a short pilot. This will then be extended out to a pilot in one shared clinical area, and a benefits realisation piece will be completed to define how useful the software this and whether the trust should look to invest in the Imprivata product for a trust-wide single sign-on solution. 2) Single sign on application implemented to a subset of Clinicians 3)Single/simple Login for multiple applications Self-Service Password reset functionality 4)Quicker Login on Times to key Clinical Applications

I14	Paperless Health Records Functions	Mike Meers	Andrea Craven	01-Oct-21	On Track	1) Delivery of Sentinal as eObservation system of choice for ESNEFT. 2) Real time data capture of NEWS2 (National Early Warning Score) for patients observations 3) Move away from paper based obs recording (CH) to eObs solution. Standardisation of solution across ESNEFT (replacing Nervecentre eObs at IH) 4) Electronic capture of real-time information can be shared, integrated, reported and exploited for automatic workflows and escalations
I15	Longitudinal Health and Care Record Integration Complete	Mike Meers	Andrea Craven	30-Jun-24	On Track	1) A Unified PAS will afford the opportunity to provide true interoperability across systems including SystmOne, Evolve and other systems of care record. Data will be structured, using FHIR messaging which in turn creates data repositories that can be repurposed across the health system, supporting improved access to clinical information and saving time having to repeatedly ask the patient the same information. The scope/roadmap for this is in development. No earlier than 31/12/23 (IH) and 30/06/24 (CH) once the system is embedded. 2) To be confirmed as part of development 3) Access information in the right place/right time to support patient care 4) Clinical efficiencies gained via immediate access to wide range of health data
I16	New PAS live across ESNEFT	Mike Meers	Andrea Craven	01-Oct-23	On Track	1) Currently Colchester has System C PAS and Ipswich has Lorenzo PAS. The Trust ambition is to move to a unified PAS solution across ESNEFT that can be fully integrated to all downstream systems and community SystmOne. The benefits will be improved patient care delivered via standardised processes at each site which support shared pathways, simpler reporting and national returns from one system of record, and cost savings/efficiency gains from having just one single PAS to support. 2) To be defined as part of development 3) Access a single patient administration record with a view to delivering a true Electronic Patient Record (EPR) 4) Standardised ways of working/Shared pathways/Streamlined reporting/Improved access to data at point of care

I17	Patient Portal - online follow-up live	Shane Gordon	Peter Cook	31-Mar-21	On Track	1) The ability for clinical and administrative teams to interact with patients through the use of e-forms, 2) Patients and clinicians will have the ability to interact remotely within certain parameters and where makes sense. 3) This will help to inform clinicians ahead of patient interactions or where appropriate negate the need for some face to face/telephone activity 4) Making interaction more flexible and potentially more timely, increasing accessibility, and reducing travel time and costs. Patients will have greater control and be able to self-manage their follow up activity after treatment. In many cases this will result in less phone calls, correspondence and outpatient appointments, thus reducing clinical and
I18	Unified Radiology System ESNEFT	Mike Meers	Andrea Craven	30-Apr-21	On Track	1) Single instance of CRIS across ESNEFT, cloud hosted solution. 2) No new functionality but benefits will come from single instance/shared pathways across ESNEFT. 3) Cross site reporting supporting flexible working across the division 4) Creates efficiencies with service and reduces clinical risk of over radiation of patients by having single system of record
I19	Unified ESNEFT PACS	Mike Meers	Andrea Craven	31-Jul-22	On Track	**Status:** Depends on the approach being taken for a regional solution so date is tentative at this time. 1) Move from separate systems for Picture Achieving and Communication (storage of diagnostic images) at Ipswich and Colchester to a single system of choice. The system of choice may be determined by regional solution. TBC. 2) TBC but expected to be like for like functionality where benefits will come from single instance/shared pathways across ESNEFT. 3) Site wide standardised access to image repository for diagnostics with ability to share images regionally 4) Single system standardises practice. Ability to flex diagnostics reporting resources
I20	Unified Community ESNEFT Infrastructure - East Suffolk	Mike Meers	Mark Caines	01-Dec-20	On Track	1)Standard ICT Infrastructure deployed to 10 Community sites for which ESNEFT are the Anchor tenant 2) ESNEFT Wi-Fi - Staff & Patient Wi-fi, GovRoam & Complete Tech Refresh of IT Kit 3)Access Trust IT services as if they where on a Acute site or remotely with VPN. 4)Faster Access to key Clinical systems such as Evolve & systmOne Agile working not limited by physical Location.

I21	SMARTcare (Track & Traceability) - Inventory management system and Point of Care scanning implemented and live in T&O	Shane Gordon	Baz Wicks	31-Jul-21	On Track	1) Inventory Management for Goods and Supplies, especially medical devices, managing the end to end supply chain through theatres. 2) Scanning of stock to shelves via an electronic system and using bar code scanning, where stock levels can be viewed, and stock levels set to trigger auto-replenishment. 3) Stock takes reduced to minutes, time for finding items significantly reduced, scanning of items used at the point of care to the patient including medical devices such as implantable devices. 4) Released time to care as clinical staff will know where items are, and selected items will be replaced automatically rather than staff having to re-order. Items used will be tracked via the system, rather than staff manually recording into patient notes and external notifications like the National Joint Registry. Expected financial benefit from reducing and rationalising stock held, using the rich data on items purchased and used, and from knowing where items are, and which items are due to expire. Compliance with GS1 adoption, and EU legislation on tracking medical devices.
I22	SMARTcare (Track & Traceability) - Product Recall implemented and live in T&O	Shane Gordon	Baz Wicks	31-Jul-21	On Track	1) Inventory Management system will capture medical devices used and any devices implanted electronically at the point of use with the patient 2) This will enable Product Recall via the electronic system 3) Action product recalls in a matter of minutes rather than days/weeks 4) Quicker, more accurate, electronic product recall. Reducing potential issues and potentially increasing patient safety and peace of mind
I23	SMARTcare (Track & Traceability) - Inventory management system and Point of Care scanning implemented in theatre areas completed (Priority areas of Cardiology and Interventional Radiology)	Shane Gordon	Baz Wicks	31-Jul-22	On Track	1) Inventory Management for Goods and Supplies, especially medical devices, managing the end to end supply chain through theatres. 2) Scanning of stock to shelves via an electronic system and using bar code scanning, where stock levels can be viewed, and stock levels set to trigger auto-replenishment. 3) Stock takes reduced to minutes, time for finding items significantly reduced, scanning of items used at the point of care to the patient including medical devices such as implantable devices. 4) Released time to care as clinical staff will know where items are, and selected items will be replaced automatically rather than staff having to re-order. Items used will be tracked via the system, rather than staff manually recording into patient notes and external notifications like the National Joint Registry. Expected financial benefit from reducing and rationalising stock held, using the rich data on items purchased and used, and from knowing where items are, and which items are due to expire. Compliance with GS1 adoption, and EU legislation on tracking medical devices.

I24	SMARTcare (Track & Traceability) - Roll-out SDS closed loop for stock management implemented in theatres and procedure rooms implemented	Shane Gordon	Daniel Imoh	31-Dec-21	**On Track**	1) Extension of the Sterile services bar code scanning system into theatres and procedure rooms, so that items and trays are scanned to shelf and throughout their use, including scanning to the patient at the point of use. 2) This will enable clear visibility of tray location at all times, and the items on each tray, and scanning to the patient when used. 3) Replace manual paper processes with electronic system using bar code scanning. Know where items are, when they have been used, and on whom they have been used 4) Released time to care through automating processes: stock management, patient association, product recall, investigation due to adverse event such as Infection. Reduced spend from reduced reprocessing, potential reduced loan sets from using one inventory across ESNEFT and knowing what items are available.
I25	SMARTcare (Track & Traceability) - Point of Care scanning: in theatres and procedure rooms: patient association of equipment and instruments implemented and live	Shane Gordon	Daniel Imoh	31-Dec-21	**On Track**	1) Extension of the Sterile services bar code scanning system into theatres and procedure rooms, so that items and trays are scanned to shelf and throughout their use, including scanning to the patient at the point of use. 2) This will enable scanning to the patient when used. 3) Replace manual paper processes with electronic system using bar code scanning. Know when items have been used, and on whom they have been used 4) Released time to care through automating processes: patient association, product recall, investigation due to adverse event such as Infection