NHS

East Suffolk and North Essex

NHS Foundation Trust

Quality Account 2019/20

Contents

Who was involved in the development of our Quality Report?

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

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

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

Our front cover shows:

- The Cancer Wellness Centre at Colchester Hospital
- The Children's Ward Team at Ipswich Hospital
- The Ipswich Hospital Diabetes Team
- The ICT Team
- Staff on Capel and Stradbroke wards

Part 1 - Statement on quality

Chief Executive's commentary

This is our report to you about the quality of services provided by East Suffolk and North Essex NHS Foundation Trust in 2019/20. It looks back at our performance over the last year and gives details of our priorities for improvement in 2020/2021.

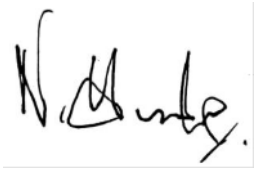
This year has been one of consolidation for East Suffolk and North Essex NHS Foundation Trust (ESNEFT), which celebrated its first anniversary on 1 July 2019 following the merger of Colchester and Ipswich hospitals. Throughout these 12 months we have continued to build on the successes of our legacy organisations while placing an unrelenting focus on quality and safety. It gives me great pleasure to share some of our achievements through this Quality Account.

During the year, we have continued to use the opportunities which arose from the merger to improve the care we provide while reducing overheads and duplication. We have begun integrating clinical services to benefit our patients, opened new facilities to enhance the experience which people have while using our services and looked for innovative ways to further boost safety. This has all been achieved against a backdrop of rising demand and continued financial challenges.

One of the most significant events to affect our Trust, staff, patients and local communities during 2019/20 was COVID-19 (coronavirus). Although the impact of the pandemic only began to hit towards the end of the period covered by this Quality Account, there is no doubt that it will continue to affect our services long into 2020/21. As you know, acute hospitals temporarily suspended non-urgent and elective activity to help us manage a predicted influx of patients with coronavirus. Taking this action undoubtedly helped us to cope during the peak of the pandemic, but will inevitably have a significant impact on waiting times and our wider performance in the coming months and years as we work to address the backlog. It will be essential for all health, social care and other partners to work even more closely than usual during this period to find new and innovative ways to reduce waits so that we can make sure everyone receives safe, effective care as quickly as possible.

As chief executive, I am incredibly proud of our staff and their achievements since ESNEFT was formed. However, we know there are always things we could do better to enhance the experience which everyone has when using our hospitals and community services. I hope that this Quality Account will give you more information about the areas where we are performing well, as well as those where there is still room for improvement, and that you enjoy reading it.

Finally, I would like to express my gratitude and thanks to everyone who has supported our work during the past 12 months, including our staff, patients, carers, volunteers, Colchester & Ipswich Hospitals Charity and our NHS and social care partners. We look forward to continuing to work closely with you all during the coming 12 months as we tackle the aftermath of COVID-19 and take steps to further improve the safety and quality of the care we provide.



Nick Hulme
Chief Executive

Nick Hulme
Chief Executive

Part 2 - Priorities for improvement and statements of assurance

2019/20 quality improvement priorities

Progress against the priorities we set as a Trust

Patient safety priority 1

To improve compliance with the Sepsis 6 care bundle

Why was this a priority?

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

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

Lead Director

Medical Director and Chief Nurse

What was our target?

- Timely identification of sepsis in the Emergency Department and acute inpatient settings as per the National Guidelines of the 'Sepsis 6' defined above
- Timely treatment of sepsis within 60 minutes
- Compliance with Sepsis 6 in ED >90% at end of 12 months

What did we do to improve our performance?

ESNEFT

- ✓ Updated the ESNEFT Infection and Sepsis: Antenatal, Intrapartum and Postnatal Management in Hospital and Community guideline
- ✓ Community midwives are informed of the sepsis screening tool for community and action plan if identified sepsis symptoms
- ✓ Maternal sepsis eLearning is available to all staff working in obstetrics department
- ✓ Incorporated Sepsis sessions in PROMPT Training
- ✓ Paediatric sepsis eLearning is available to all staff working with children
- ✓ The audit results, concerns and recommendations are reported to paediatric local governance team, sepsis and deteriorating patient meeting every month and at patient safety meeting quarterly.

Colchester site

- ✓ Increased the ED sepsis audit tool to encompass escalation of the deteriorating patient and clinical review, together with sepsis screening, delivery of the sepsis six treatments including time of antibiotic and iv fluid prescription and delivery to show the root cause for any non -compliance to enable action plans to be completed.
- ✓ 1:1's given to all ED staff involved in the care of patients that were non-compliant by the educational department lead for personalised advice and teaching to be given
- ✓ Regular teaching on team days given on induction and throughout the year to the ED staff nursing and medical
- ✓ NEWS and E-learning training is now mandatory for all clinical staff looking after non pregnant adults.. The e-learning packages have been aligned for staff at both sites.
- ✓ Sepsis champions on each inpatient ward now audit a peer ward monthly on escalation, sepsis screening and sepsis treatments.
- ✓ Monthly sepsis champion meetings are now running and deliver teaching and a forum to discuss any issues and formulate strategies to increase inpatient audit compliances.
- ✓ All new staff are given a teaching session on escalating deteriorating patients and sepsis during their induction programme
- ✓ Sepsis sessions are provided to Midwives who attend the Statutory Maternity training
- ✓ Face to Face teaching on the Paediatric Sepsis Screening Tool took place in Oct-Dec 2019 to ensure medical and nursing staff where completing the forms appropriately and completely at Colchester site.
- ✓ Creation of Children's Dashboard which enables medical and nursing leads

2019/20 quality improvement priorities
Progress against the priorities we set as a Trust

to review trends in Sepsis, PEWS, Fluid and O2 Audits and to discuss any action that is required at Colchester site.

Ipswich site

- ✓ Auditing initially increased to monthly and then aligned with the Colchester site audit tool to encompass escalation of the deteriorating patient and clinical review, together with sepsis screening, delivery of the sepsis six treatments including time of antibiotic and iv fluid prescription and delivery to show the root cause for any non - compliance to enable action plans to be completed.
- ✓ Monthly meetings now occur between the Deteriorating patient nurse specialist and ED clinical lead and matron to discuss the prior months results and formulate plans for improvement
- ✓ All action plans now documented on trust template and re visited monthly at these meetings.
- ✓ Monthly teaching sessions in ED run for the nursing staff and by the clinician for medical staff and sepsis and escalation has been a focus this year.
- ✓ NEWS and E-learning training is now mandatory for all clinical staff looking after non pregnant adults.. The e-learning packages have been aligned for staff at both sites.
- ✓ Sepsis champions have been highlighted for each inpatient ward
- ✓ Sepsis champion meetings have been arranged from March 2020 for teaching and in preparation for ward auditing.
- ✓ From March 2020 peer ward audits will commence monthly to align with Colchester site and therefore can be reported as ESNEFT next year.
- ✓ All staff now given teaching on sepsis during their trust induction
- ✓ AOS lead for ESNEFT appointed and action plan formulated to align services for neutropenic patients across both sites

How did we measure and monitor our performance?

ESNEFT

- Audits are completed once per month using a randomised sample of all adult patients who attend the ED departments. This audit now monitors the escalation of deteriorating patients in adherence to trust policy, screening these patients for signs of possible infection that may develop into sepsis and delivery of the sepsis 3 & sepsis 6 treatments within the 1 hour national timeframe.
- Monthly action plans are produced and reviewed on a monthly basis by the nursing lead, clinical lead and deteriorating patient champion.
- Monthly Door to needle time audits are carried out for neutropenic patients. Themes for non-compliance are now also reported and all non-compliant episodes are Datix for review.

Did we achieve our intended target?

Colchester site

- ✓ We have achieved an increase in the screening of patients for sepsis within ED from 75% to consistently over 80% since August 2019 and reached the 90% target for November 2019
- ✓ We have achieved a steady increase in the delivery of the sepsis six treatments from 50% to 60% with completion of fluid charts remaining the reason for non-compliance.
- ✓ The sepsis six treatment compliance has increased from 62% now ranging between 63%-88% steadily rising month on month
- ✓ Inpatient areas compliance for sepsis screening has fluctuated between 59-100%. An increase on last year, but with the aim of becoming consistent improvement next year.
- ✓ Inpatient sepsis 3 treatments have increased to between 42%-100%. Larger data sets to be collected next year for a more reliable set of results to be gained.

Colchester site

- Sepsis champions on each inpatient ward now audit a peer ward monthly on escalation, sepsis screening and sepsis treatments.
- All ward sisters are sent the results and asked to put a plan in place to prevent reoccurrence of the reported issue.

Part 2 - Priorities for improvement and statements of assurance

2019/20 quality improvement priorities

Progress against the priorities we set as a Trust

- ✓ Neutropenic door to needle time compliance has increased and remained for the majority of months above the 90% target set.

Ipswich site

- ✓ ED sepsis screening compliance has reached the ≥90% target for the past 9 months
- ✓ Ed sepsis 6 compliance has fluctuated between 30-70% compliance, an increase from 24% last year. Auditing processes and actions plans are now in place to have less fluctuation and more stability of results moving forward.
- ✓ ED sepsis 3 treatment compliance has steadily risen to 60% with more work in progress moving forward.
- ✓ There has been a steady increase in the door to needle time compliance from 70% to consistently over 80%

How and where was progress reported?

- ✓ The audits are fed back to the clinical areas for discussion in their governance meetings.
- ✓ Action plans are requested from each area to show planned changes for improvement going forward
- ✓ Monthly results and updates are sent to sepsis and deteriorating patient group and patient safety group and time matters board.
- ✓ Quarterly reports are sent and presented to the patient safety meeting

Our key achievements

- ✓ Sepsis treatment has reduced on the risk register from 16 to 12
- ✓ Number of SI's relating to sepsis has decreased from 5 to 2 awaiting Datix decision
- ✓ Dr foster shows trend in mortality in relation to patients admitted with sepsis has reduced over the past 18 months 17.5 % to 15.5%
- ✓ Ed sepsis screening consistently over 85% on Colchester site and above 90% on the Ipswich site
- ✓ Increase in the delivery of sepsis 6 and 3 treatments on both sites
- ✓ DTN time at Colchester site above 90% target consistently achieved
- ✓ Standardised auditing and reporting for ED and neutropenic patients achieved
- ✓ ESNEFT e-learning packages in place and mandatory for NEWS and sepsis for staff looking after non-pregnant adult patients.

Patient safety priority 2:

To reduce the numbers of inpatient falls

Why was this a priority?

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

The Trust is committed to ensuring that, wherever possible, no patient suffers from harm whilst receiving care, and therefore, this was identified as the key patient safety priority for 2019/20.

Lead Director

Medical Director and Chief Nurse

What was our target?

A reduction of inpatient falls per 1000 bed days to below 5 within the two acute hospitals. The Community Falls per 1000 bed days improvement trajectory will be reduced based on the national best practice and benchmarking completed in quarter 1.

What did we do to improve our performance?

ESNEFT

- ✓ Across both acute sites consistent checks for Lying and Standing Blood Pressure were introduced to identify where a discrepancy may increase the risk of a patient from falling when mobilising.
- ✓ Medication reconciliation for those at high risk of falls and those over the age of 65, to identify medications that may impact on balance and blood pressure.

Colchester site

- ✓ Staff continued to apply the principles of Bay watch for those at highest risk during admission. This was consistently applied across the inpatient areas to support those patients at increased risk of falling when mobilising independently.
- ✓ The Trust also invested in technology to support

2019/20 quality improvement priorities
Progress against the priorities we set as a Trust

patients in side rooms and areas of the ward where direct supervision is difficult to implement.

✓ Consistent application of these principles and methods of working saw the wards maintain a consistently low number of falls.

Ipswich site

✓ Staff introduced the principles of Bay watch at the end of the summer across the inpatient wards. This increase in staff support and monitoring for the highest risk patients is to increase supervision and support to patients when mobilising who might be at increased risk due to clinical conditions, balance issue or sensory impairment.

✓ A goal to complete a Lying and Standing Blood Pressure check, medication review, and provision of mobilisation equipment when needed within 24 hours of admission were also incorporated into actions taken to reduce the number of patients falling during their stay.

How did we measure and monitor our performance?

Colchester site

✓ Falls per 1000 bed days each month were calculated to track and monitor performance.

✓ Daily monitoring of the Trust reporting system was used to support ward areas with patients who appeared to fall on more than one occasion, and to monitor outcomes or levels of harm suffered as a result of the fall. This allowed for early interventions to be identified and support provided to the wards and patients.

Ipswich site

✓ Falls per 1000 bed days each month were calculated to track and monitor performance.

✓ At Ipswich the Quality Improvement Team supported a 90 day intensive implementation phase for Bay Watch in the Autumn with daily monitoring of progress and number of patients who had fallen.

✓ Daily monitoring of the Trust reporting system was used to support ward areas with patients who appeared to fall on more than one occasion, and to monitor outcomes or levels of harm suffered as a result of the fall.. This allowed for early interventions to be identified and support provided to the wards and patients.

Did we achieve our intended target?

Community

✓ The community Hospitals have exceeded their target and are consistently under 13 falls per 1000 bed days at the end of the year.

Colchester site

✓ Colchester consistently achieved the national target of 5 or less falls per 1000 bed days for this year.

Ipswich site

✓ Ipswich has not consistently met the 5 falls per 1000 bed days prior to the Quality Improvement 90 day challenge. However during this time the target was met. The final part of the year has seen a significant increase in admission which has seen the site struggle to continue to meet this target, however the Integrated Care Wards have reduced their number of falls consistently in the last two quarters.

How and where was progress reported?

✓ Monthly monitoring was completed by the Harm Free Care Team with monthly reporting to the Patient Safety Group and Commissioners.

✓ Several actions were also linked to a national CQUiN which required quarterly reporting of the impact of those actions.

✓ Weekly monitoring was provided for the Trust's Heat Map to allow individual areas to monitor their progress which linked in with monthly Accountability Frames work reporting.

Our key achievements

Colchester site

✓ Consistent application of Bay Watch principles and falls reduction actions resulted in consistently low

Part 2 - Priorities for improvement and statements of assurance

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Progress against the priorities we set as a Trust

numbers of Falls reported at this site.

Ipswich site

- ✓ A consistent 3 month reduction in falls numbers during the Quality Improvement period which has continued to have lower reported falls in the Integrated Pathways wards. Consistently application of Bay Watch and fall reduction actions continues to obtain consistency in reporting numbers.

Clinical Effectiveness priority:

Getting it right first time (GIRFT) programme improvements

Why was this a priority?

GIRFT is a National Programme working with frontline clinicians to identify and reduce unwarranted variations in service delivery and clinical practice. Speciality visits have taken place within surgical, medical and diagnostic areas. Recommendations and areas to review as opportunities to reduce variation and improve patient experience following the visit are being worked through within specialities.

Lead Director

Medical Director

What was our target?

Within 8 weeks' of receipt of GIRFT speciality report, specialities to have identified top 3 recommendations for improvement and produced action plan accordingly.

What did we do to improve our performance?

- ✓ Regular meetings with specialities to ensure continued engagement and progress.
- ✓ Specialities reported on milestones for improvement via GIRFT Programme Board, raising any risks accordingly.

How did we measure and monitor our performance?

- ✓ Performance was measured via our Business Information data, plans are on-going for "dashboards" to be introduced for completed recommendations to ensure Business as Usual.
- ✓ Update reports to GIRFT Programme Board for monitoring progress
- ✓ Transformation Lead dedicated to supporting clinical teams with planning and improvements to include facilitation of Kaizen weeks.

Did we achieve our intended target?

All areas visited have identified top 3 priorities, some recommendations have been achieved whilst others continue to be progressed. As each speciality completes a recommendation, the GIRFT report is reviewed and a further "priority" added to ensure the 3 priorities is a continuing programme of improvement.

How and where was progress reported?

- ✓ Clinical Effectiveness Group
- ✓ Quality and Patient Safety Group
- ✓ Time Matters Board (replaced by Executive Management Committee)
- ✓ Elective Care Programme Board

Our key achievements

- ✓ Identified Trust wide common issues and actioned accordingly.
- ✓ Working cross speciality to improve patient pathways
- ✓ Increased number of laparoscopic and day case surgery
- ✓ Reduced number of 3rd and 4th degree tears (maternity)
- ✓ Procurement opportunities achieved within general surgery and orthopaedic specialities
- ✓ Increased number of cataract operations per list
- ✓ Reductions in LoS

Undertook a "Kaizen" style approach with Vascular team outcomes:

- ✓ Reduction in SIs reported
- ✓ Outpatients straight to diagnostic test prior to OPA
- ✓ Next day assessment following Stroke referral for Carotid patients
- ✓ Introduction of telephone follow up and wound clinic to reduce readmission
- ✓ Reviewed ruptured AAA pathway, improvements identified currently being completed.

2019/20 quality improvement priorities
Progress against the priorities we set as a Trust

Patient experience priority:

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

Why was this a priority?

There is only one chance to get end of life care right. In the final stages of illness, care priorities shift with the focus often changing to palliative care for the relief of pain, symptoms, and emotional distress. Compassionate high quality care enables us to make a loved one's final weeks or days as comfortable as possible. A national framework for action (Ambitions for end of life care 2015 - 2020) identifies key ambitions to optimise end of life care that include:

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

Work towards these ambitions assists with providing increased choice and agreed care plans that are tailored to the needs, wishes and preferences of the dying person. Continued work on these ambitions helped to maintain the good CQC rating achieved at both sites for end of life care and increase the rating to Outstanding for Caring at Ipswich. There is continues work towards our goal of having outstanding end of life care for all ESNEFT patients at the end of their lives.

Lead Director
Medical Director

What was our target?

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

What did we do to improve our performance?

- ✓ By using the Accountability Framework (AF) to monitor the use of the ICP LDL, end of life complaints and the time taken to discharge rapidly deteriorating patients at each site
- ✓ Increased education due to increased nursing role at Ipswich
- ✓ Commenced 6 day Specialist Palliative Care at Ipswich alongside the already 7 day service at Colchester
- ✓ Butterfly Volunteer Coordinators recruited and a 2.5 day service available on each site

How did we measure and monitor our performance?

- ✓ Ipswich and Colchester sites participated in the National end of life audit
- ✓ Survey of bereaved relatives at both sites to highlight any areas for specific improvement
- ✓ The AF for all wards at ESNEFT for use of ICPLDL.
- ✓ Recording of discharge data to record how long it is taking us to get people home
- ✓ Ipswich now have robust means of monitoring and recording number of deaths where Individual Care Plans for the Last Days of Life have been used
- ✓ Took part in the National Audit NACEL
- ✓ CQC inspection at Ipswich site

Did we achieve our intended target?

- ✓ ESNEFT strategy completed – awaiting printing
- ✓ Alignment of KPIs achieved
- ✓ Complaints monitored and less recorded than the previous year
- ✓ Discharge monitored
- ✓ Butterfly volunteer coordinator and volunteers recruited with the service up and running for 2.5 days on both sites
- ✓ Time Garden use increased
- ✓ Timely discharge is still a challenge and we are working with our internal teams and system partners to improve this
- ✓ Recruitment to CNS posts in Ipswich allowing for 6 day service (aiming towards 7 days in the next financial year) and EOL nurse to teach the wards and see dying patients

Part 2 - Priorities for improvement and statements of assurance

2019/20 quality improvement priorities

Progress against the priorities we set as a Trust

How and where was progress reported?

- ✓ To the ESNEFT EOL board monthly meetings
- ✓ Patient Experience Group,
- ✓ Quality and Patient Safety
- ✓ Time matters Board
- ✓ Ipswich/ East Suffolk EOL Programme board and the North Essex EOL Alliance Board.

Our key achievements

- ✓ Decrease in the number of complaints relating to end of life care across the Trust
- ✓ Setting up the Butterfly Volunteers service
- ✓ Commencement of Blanketeers at Ipswich
- ✓ 6 Day face to face palliative care nursing service at Ipswich alongside 7 day service at Colchester
- ✓ CQC report at Ipswich – good for all end of life services with the exception of caring, which achieved outstanding
- ✓ All sites contributed to NACEL (National Audit for Care at End of Life)
- ✓ Improved management of syringe pumps at both Colchester and Ipswich, leading to more pumps being available for patients

Clinical effectiveness, Patient Experience and Staff Experience priority:

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

Why was this a priority?

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

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

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

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

A new model of care is required to take forward this agenda, including the leadership and governance of the mental health and physical health integration.

This projects seeks to implement developments which are relevant to the Acute Trust environment in context of: the priority actions from the "Five Year Forward View for Mental Health" (Feb 16), the four priorities of the STP Mental Health Alliance, and the "Implementing the Five Year Forward View for Mental Health" roadmap. However, as a next step on from this ESNEFT want to lead on the development of a “Mentally Healthy Hospital” concept.

Lead Director

Chief Nurse

What was our target?

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

Aim: Creating, and setting the standard for, a mentally healthy hospital, by making it everyone’s business to promote good mental health and prevent poor mental health

- To set up a 5 year programme of work to

2019/20 quality improvement priorities
Progress against the priorities we set as a Trust

deliver the aim and create a vision. With specific targeted improvements in year one.

Vision: A mentally healthy hospital is one that adopts a whole-hospital approach to mental health and wellbeing, alongside physical care. It is a hospital that supports patients, carers and staff with preventing poor mental health and enabling good mental health by supporting the development of the strengths and coping skills that underpin resilience, through provision of a wide range of tools. It is a hospital that supports patients, carers and staff with urgent access to the help they might need in crisis, and works closely with partner organisations to ensure a "no wrong door" approach. A mentally healthy hospital sees positive mental health and wellbeing as fundamental to its values, mission and culture. It is a hospital where patients, carers and staff mental health and wellbeing is seen as "everybody's business".

What did we do to improve our performance?

Programme of work commenced:

Crisis services

- Deliver a 7 day NHS - right care, right time, right quality by Improving access to psychiatric liaison services and ensure crisis response 24 hours a day x 7 days a week (Core24), aligned to the Suffolk Community Mental Health work-stream.
- Ensure compliance with the Mental Health Act is embedded in our policies and processes.
- Develop MH Booklet and pathway for patients at risk of self harm and/or absconding.

Children & Young Peoples services

- Develop childrens and young peoples mental health services as a priority, and the implementation of the Future in Mind recommendations, focused on early intervention and quick access to good quality care, and ensure people living with long term mental health problems have their physical health needs met whilst in our care.
- Improve clinical training and education to support conversations with CYP about their mental health.

TMB 6.5.3 Proactive Pathways Interventions

- Increase access to evidence based psychological therapies through preventative intervention in pathways and actively promoting good mental health into physical care pathways, starting with targeted patient cohort of patients living with long term conditions: Diabetes, Respiratory and Cardiology. This includes promoting Living Life to the Full and providing access on-site, and co-delivering support and enabling direct access to IAPT services in clinics and on wards, through joint education programmes, direct referral by self and clinical staff, and on-site provision.
- Improve parity of esteem between physical and mental health services, recognise the relationship between physical and mental health, ensure people living with long term mental health problems have all their physical health needs met whilst in our care, including screening and health checks.
- Develop an agreed and documented pathway for Patients at Risk of Self Harm, in conjunction with the new ED single clerking document.

Workforce Mental Health and Wellbeing

- For our own workforce, there are three main threads to the work-stream: raise awareness and understanding of holistic wellbeing; provide training and education for management and peer support focusing on Mental Health first aid and prevention; providing a robust support model if required.
- Adoption of the mental health core standards as outlined in "Thriving at Work" by Stevenson and Farmer review of mental health and employers (October 2017), as this work was produced with the whole of the public sector in mind, and therefore can be adopted across the Alliance.

Long term model for Mental Health Leadership and Care

Part 2 - Priorities for improvement and statements of assurance

2019/20 quality improvement priorities

Progress against the priorities we set as a Trust

- Ensure the continued focus on the Mental Health agenda and parity of esteem with physical health services, through developing a robust leadership and governance model, which will embed the priorities within our service delivery.
- Ensure good relationships with STP Mental Health Alliance partners, and the continued co-creation of improved models of care and system working

How did we measure and monitor our performance?

- Performance Dashboard at Ipswich Hospital for Psychiatric liaison
- ED performance and response time to be seen in both Hospitals.
- Referral rates and admission rates for patient's primary coded under Mental Health codes on both sites.

Did we achieve our intended target?

Our targets evolved and have been co-produced with services and services users over the year

How and where was progress reported?

Project Steering Board

- ✓ Monthly steering board to provide oversight, and monitor progress, which will be attended by all the work-stream leads, project lead and SRO, along with system partners. Highlight reports generated.
- ✓ Project Steering board meetings will be timetabled to enable timely reporting of progress to the

Project Work streams

- ✓ Project and workstream objectives, key milestones created
- ✓ Recognising the cross-organisational nature of the project, the project team will consist of representatives from applicable divisions and directorates to enable successful delivery.

Project representation from the following functions/ organisations:

- ✓ Clinical SRO's
- ✓ Adult Operations
- ✓ Paediatrics
- ✓ Providers: EPUT, Herts Parts, ACE, NSFT: IAPT services and Psychiatric liaison
- ✓ LLTTF
- ✓ STP Alliance finance and governance support
- ✓ CCG transformation leads
- ✓ Healthwatch
- ✓ Service Users via appropriate groups/forums

Our key achievements

- ✓ The amalgamation of psychiatric liaison and out of hours services to create one team- reduction in waiting times in ED
- ✓ Secured additional funding to Psychiatric Liaison service and Core 24 service funding on Ipswich site to commence April 2020
- ✓ Mental Health Act Systems and processes created
- ✓ MH booklet and patients at risk of self-harm pathway
- ✓ Improve information sharing across physical and mental health services Provide access to Evolve for Mental Health providers
- ✓ Develop Psychiatric oversight of psychiatric liaison service for CYP
- ✓ Living Life to the full online physiological tool introduction in pilot wards and outpatients. Patients are able to obtain instant on line support via IPADs funded by ESNEFT hospital charities.
- ✓ Improving Access to Psychological Therapies: NSFT trained physiological practitioners imbedded into Long Term Condition pathways: Cardiology, Diabetes and Respiratory Workforce Wellbeing: extended roll out of 'Emotional needs Training' delivered by Suffolk MIND to ESNEFT leaders and workforce.
- ✓ Commencement of in house training 'Mental health first Aid course'
- ✓ Living life to the full on line programme available to all ESNEFT staff.
- ✓ ESNEFT is a key Alliance partner in the Suffolk Mental health transformation programme.
- ✓ Mental health link worker with Felixstowe frailty clinic twice a week.

2019/20 quality improvement priorities

Progress against the priorities we set as a Trust

Our priorities for improvement in 2020/21

Qualitative information from a number of sources including patient surveys, staff surveys, complaints, compliments and the views of users and user groups at a community engagement event has helped inform the Trust's priorities for 2019/20.

Patient safety priority 1:

To improve compliance with the Sepsis 6 care bundle

Why is this a priority?

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

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

Lead Director

Chief Medical Officer and Chief Nurse

What is our target?

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

What will we do to improve our performance?

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

How will we measure and monitor our performance?

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

How and where will progress be reported?

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

Patient safety priority 2:

To reduce the numbers of inpatient falls

Why is this a priority?

Ensuring that our patients receive 'Harm Free' care during their admission is a key priority for any healthcare provider. The impact on patients following a fall in hospital can be wide ranging and complex.
The Trust is committed to ensuring that, wherever possible, no patient suffers from harm whilst receiving care, and therefore, this was identified as the key patient safety priority for 2019/20.

Lead Director

Chief Nurse

What is our target?

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

What will we do to improve our performance?

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

How will we measure and monitor our performance?

- Incident reporting of all

Our priorities for improvement in 2020/21

inpatient falls are monitored through Patient Safety & Quality Team and reported upon via the Ward Safety Dashboard to Matrons Group, chaired by the Chief Nurse.

- Develop a tool to monitor the assessment of the presence or absence of delirium.
- Monthly review of falls activity and trends will form part of the Patient Safety Report.
- Inpatient falls incidents will be triangulated with PALS, Complaints and Safeguarding information to identify any emerging themes and trends to any specific areas of the Trust.

How and where will progress be reported?

Regular reports and updates to:

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

Clinical Effectiveness priority 1:

To reduce the likelihood of nosocomial infections in our patients

Why is this a priority?

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

Lead Directors

Chief Medical Officer and Chief Nurse

What is our target?

- To have a zero tolerance for all avoidable nosocomial infections

What will we do to improve our performance?

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

How will we measure and monitor our performance?

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

Regular reports and updates to:

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

Clinical effectiveness priority 2:

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

Why is this a priority?

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

Lead Director

Chief Medical Officer & Chief Nurse

What is our target?

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

What will we do to improve our performance?

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

How will we measure and monitor our performance?

- Audit of Fluid balance charts
- Audit of food charts

How and where will progress be reported?

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

Our priorities for improvement in 2020/21

Qualitative information from a number of sources including patient surveys, staff surveys, complaints, compliments and the views of users and user groups at a community engagement event has helped inform the Trust's priorities for 2020/21.

Patient experience priority 1:

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

Why is this a priority?

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

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

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

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

Lead Directors
Director of Human Resources, Medical Director, Chief Nurse

What is our target?

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

What will we do to improve our performance?

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

How will we measure and monitor our performance?

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

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

EMC, Clinical Effectiveness Group, Patient Experience Group, POD

Patient experience priority 2:

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

Why is this a priority?

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

Lead Director
Chief Nurse & Medical Director

What is our target?

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

What will we do to improve our performance?

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

How will we measure and monitor our performance?

- Measure and monitor the

Our priorities for improvement in 2020/21

use of the 'This is Me' tool through audit and gap analysis and through the outcome and actions required of the National Dementia Audit.

- Audit compliance with the delirium assessment tool and implement actions as a result of the findings
- Work with the Accessible Information Standards group to support improvements to current patient information.

How and where will progress be reported?

Regular reports and updates to:
Patient Experience Group, Quality & Patient Safety Committee.

Provided and sub-contracted services

Provided and sub-contracted services

During 2019/20 the Trust has continued to be contracted for and has provided commissioned acute and community healthcare services, with the inclusion of sub-contracted services as appropriate for relevant health services. These services are overseen and reviewed by appropriate commissioners and regulators, via meetings, data submissions and information reporting in relation to patient safety, patient experience and operational performance.

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

During 2019-20 the East Suffolk & North Essex NHS Foundation Trust provided and/or subcontracted 93 relevant health services.

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

The income generated by the relevant health services reviewed in 2019-20 represents 91% of the total income generated from the provision of relevant health services by the East Suffolk & North Essex NHS Foundation Trust for 2019-20.

New beds to boost patient care

Critical care patients at Ipswich and Colchester hospitals can now take part in rehabilitation more easily following the introduction of new state-of-the-art beds.

Roz Yale, critical care matron, said: “They will make a real difference to the rehabilitation we are able to provide for our patients by allowing us to safely move them into a wide variety of different positions.

Participation in clinical audit

During 2019 /20, 57 National Clinical Audits and 9 National Confidential Enquiries covered relevant health services that East Suffolk and North Essex NHS Foundation Trust (ESNEFT) provides.

During that period ESNEFT participated in 93% National Clinical Audits and 89% National Confidential Enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that ESNEFT was eligible to participate in during 2019/20 are as follows:

National Clinical Audits Table 1	
Heart and Circulatory System	
1	National Audit of Cardiac Rhythm Management (CRM) 2019/20
2	National Audit of Pulmonary Hypertension (NAPH) 2019/20
3	National Vascular Registry 2019/20
4	National Cardiac Arrest Audit (NCAA) 2019/20
5	National Audit of Cardiac Rehabilitation 2019/20
6	Myocardial Ischaemia National Audit Project (MINAP) 2019/20
7	National Audit of Percutaneous Coronary Interventions (PCI) 2019/20
8	National Heart Failure Audit 2019/20
Acute	
9	Major Trauma Audit (TARN) 2019/20
10	Assessing Cognitive Impairment in Older People/Care in Emergency Departments UK Parkinson's Audit 2019/20
11	Society for Acute Medicine's Benchmarking Audit (SAMBA) 2019/20
12	National Audit of Seizure Management in Hospitals (NASH3) 2019/20
13	RCEM Mental Health - Care in Emergency Departments 2019/20
14	RCEM Care of Children in Emergency Departments 2019/20
15	National Joint Registry (NJR) 2019/20
16	National Emergency Laparotomy Audit (NELA) 2019/20
17	Case Mix Programme (CMP) 2019/20
18	Perioperative Quality Improvement Programme (PQIP) 2019/20
19	(FFFAP)Falls & Fragility Fractures Audit Programme Fracture Liaison Service Database 2019/20
20	FFFAP National Hip Fracture Database 2019/20
Women and Children	
21	National Maternity & Perinatal Audit (NMPA) 2019/20
22	National Paediatric Diabetes Audit (NPDA) 2019/20
23	National Neonatal Audit Programme (NNAP) 2019/20
24	UK Cystic Fibrosis Registry 2019/20
25	National Audit of Seizures and Epilepsies in Children & Young People (Epilepsy12) 2019/20
26	National Pregnancy in Diabetes Audit 2019/20
27	MBRRACE - Perinatal Mortality Surveillance 2019/20
Older People	
28	Sentinel Stroke National Audit Programme (SSNAP) 2019/20
29	National Audit of Dementia 2019/20
30	National Audit of Intermediate Care (NAIC) 2019/20
31	National Audit Inpatient Falls 2019/20

Participation in clinical audit

National Clinical Audits Table 1 continued	
Long Term Conditions	
32	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) 2019/20
33	National Early Inflammatory Arthritis Audit (NEIAA) 2019/20
34	Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit 2019/20
35	BAUS Urology Audit - Cystectomy Audit 2019/20
36	BAUS Urology Audit - Female Stress Urinary Incontinence Audit 2019/20
37	BAUS Urology Audit - Nephrectomy Audit 2019/20
38	BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL) 2019/20
39	BAUS Urology Audit - Radical Prostatectomy Audit 2019/20
Cancer	
40	National Lung Cancer Audit (NLCA) 2019/20
41	National Smoking Cessation Audit 2019/20
42	National Audit of Breast Cancer in Older People (NABCOP) 2019/20
43	Head & Neck Cancer Audit (HANA) 2019/20
44	National Prostate Cancer Audit 2019/20
45	National Oesophago-gastric Cancer (NOGCA) 2019/20
46	National Bowel Cancer Audit (NBOCA) 2019/20
Haematology	
47	Serious Hazards of Transfusion (SHOT) 2019/20
Other	
48	National Diabetes Inpatient Audit (NaDia) 2019/20
49	National Audit of Care at the End of Life (NACEL) 2019/20
50	Elective Surgery (National PROMs Programme) 2019/20
51	Mandatory Surveillance of Bloodstream Infections & Clostridium Difficile Infection 2019/20
52	Surgical Site Infection Surveillance Service 2019/20
53	National Diabetes Foot Care Audit 2019/20
54	National Core Diabetes Audit 2019/20
55	National Diabetes Transition 2019/20
56	Learning Disability Mortality Review Programme 2019/20
57	NDA Core Diabetes Audit 2019/20
National Confidential Enquiries	
1	MBRRACE - Perinatal Morbidity and Mortality Confidential Enquiries 2019/20
2	MBRRACE - Maternal Mortality Surveillance and Mortality Confidential Enquiries 2019/20
3	MBRRACE - Maternal Morbidity Confidential Enquiries 2019/20
4	NCEPOD Long-term Ventilation: Admission to Hospital Questionnaire
5	NCEPOD Acute Bowel Obstruction Clinician Questionnaire
6	NCEPOD Long-term Ventilation: Community Team Questionnaire
7	NCEPOD Long-term Ventilation: Lead Clinician (Ongoing care) Questionnaire
8	NCEPOD Out of Hospital Cardiac Arrest: Clinical Questionnaire
9	NCEPOD Dysphasia in people with Parkinson Disease: Clinician Questionnaire

Participation in clinical audit

The National Clinical Audits and National Confidential Enquiries that East Suffolk and North Essex NHS Foundation Trust participated in during 2019/20 are as follows:

National Clinical Audits Table 2		Colchester Hospital	Ipswich Hospital	Community
Heart and Circulatory System				
1	National Audit of Cardiac Rhythm Management (CRM) 2019/20	Y	Y	N/A
2	National Vascular Registry 2019/20	Y	Y	N/A
3	National Cardiac Arrest Audit (NCAA) 2019/20	Y	Y	N/A
4	National Audit of Cardiac Rehabilitation 2019/20	Y	Y	Y
5	Myocardial Ischaemia National Audit Project (MINAP) 2019/20	Y	Y	N/A
6	National Audit of Percutaneous Coronary Interventions (PCI) 2019/20	Y	Y	N/A
7	National Heart Failure Audit 2019/20	Y	Y	Y
Acute				
8	Major Trauma Audit (TARN) 2019/20	Y	Y	N/A
9	Assessing Cognitive Impairment in Older People/Care in Emergency Departments UK Parkinson's Audit 2019/20	Y	Y	N/A
10	Society for Acute Medicine's Benchmarking Audit (SAMBA) 2019/20	Y	Y	N/A
11	National Audit of Seizure Management in Hospitals (NASH3) 2019/20	Y	Y	N/A
12	RCEM Mental Health - Care in Emergency Departments 2019/20	Y	Y	N/A
13	RCEM Care of Children in Emergency Departments 2019/20	Y	Y	N/A
14	National Joint Registry (NJR) 2019/20	Y	Y	N/A
15	National Emergency Laparotomy Audit (NELA) 2019/20	Y	Y	N/A
16	Case Mix Programme (CMP) 2019/20	Y	Y	N/A
17	Perioperative Quality Improvement Programme (PQIP) 2019/20	Y	Y	N/A
18	(FFFAP)Falls & Fragility Fractures Audit Programme Fracture Liaison Service Database 2019/20	Y	Y	N/A
19	FFFAP National Hip Fracture Database 2019/20	Y	Y	N/A
Women and Children				
20	National Maternity & Perinatal Audit (NMPA) 2019/20	Y	Y	N/A
21	National Paediatric Diabetes Audit (NPDA) 2019/20	Y	Y	N/A
22	National Neonatal Audit Programme (NNAP) 2019/20	Y	Y	N/A
23	UK Cystic Fibrosis Registry 2019/20	Y	Y	N/A
24	National Audit of Seizures and Epilepsies in Children & Young People (Epilepsy12) 2019/20	Y	Y	N/A
25	National Pregnancy in Diabetes Audit 2019/20	Y	Y	N/A
26	MBRRACE - Perinatal Mortality Surveillance 2019/20	Y	Y	

Participation in clinical audit

National Clinical Audits Table 2 continued		Colchester Hospital	Ipswich Hospital	Community
Older People				
27	Sentinel Stroke National Audit Programme (SSNAP) 2019/20	Y	Y	N/A
28	National Audit of Dementia 2019/20	Y	Y	Y
29	National Audit Inpatient Falls 2019/20	Y	Y	Y
Long Term Conditions				
30	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)2019/20	Y	Y	N/A
31	National Early Inflammatory Arthritis Audit (NEIAA) 2019/20	Y	Y	N/A
32	BAUS Urology Audit - Cystectomy Audit 2019/20	Y	N/A	N/A
33	BAUS Urology Audit - Female Stress Urinary Incontinence Audit 2019/20	N/A	Y	N/A
34	BAUS Urology Audit - Nephrectomy Audit 2019/20	Y	Y	N/A
35	BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL) 2019/20	Y	Y	N/A
36	BAUS Urology Audit - Radical Prostatectomy Audit 2019/20	Y	N/A	N/A
Cancer				
37	National Lung Cancer Audit (NLCA) 2019/20	Y	Y	N/A
38	National Smoking Cessation Audit 2019/20	Y	Y	N/A
39	National Audit of Breast Cancer in Older People (NABCOP) 2019/20	Y	Y	N/A
40	Head & Neck Cancer Audit (HANA) 2019/20	Y	Y	N/A
41	National Prostate Cancer Audit 2019/20	Y	Y	N/A
42	National Oesophago-gastric Cancer (NOGCA) 2019/20	Y	Y	N/A
43	National Bowel Cancer Audit (NBOCA) 2019/20	Y	Y	N/A
Haematology				
44	Serious Hazards of Transfusion (SHOT) 2019/20	Y	Y	N/A
Other				
45	National Diabetes Inpatient Audit (NaDia) 2019/20	Y	Y	N/A
46	National Audit of Care at the End of Life (NACEL) 2019/20	Y	Y	N/A
47	Elective Surgery (National PROMs Programme) 2019/20	Y	Y	N/A
48	Mandatory Surveillance of Bloodstream Infections & Clostridium Difficile Infection 2019/20	Y	Y	N/A
49	Surgical Site Infection Surveillance Service 2019/20	Y	Y	N/A
50	National Diabetes Foot Care Audit 2019/20	Y	Y	N/A
51	National Diabetes Transition 2019/20	Y	Y	N/A
52	Learning Disability Mortality Review Programme 2019/20	Y	Y	N/A
53	NDA Core Diabetes Audit 2019/20	Y	Y	N/A

Participation in clinical audit

National Clinical Audits Table 2 continued		Colchester Hospital	Ipswich Hospital	Community
National Confidential Enquiries				
1	MBRRACE - Perinatal Morbidity and Mortality Confidential Enquiries 2019/20	Y	Y	N/A
2	MBRRACE - Maternal Mortality Surveillance and Mortality Confidential Enquiries 2019/20	Y	Y	N/A
3	MBRRACE - Maternal Morbidity Confidential Enquiries 2019/20	Y	Y	N/A
4	NCEPOD Long-term Ventilation: Admission to Hospital Questionnaire	N/A	Y	N/A
5	NCEPOD Acute Bowel Obstruction Clinician Questionnaire	Y	Y	N/A
6	NCEPOD Long-term Ventilation: Lead Clinician (Ongoing care) Questionnaire	N/A	Y	N/A
7	NCEPOD Out of Hospital Cardiac Arrest: Clinical Questionnaire	Y	N/A	N/A
8	NCEPOD Dysphasia in people with Parkinson Disease: Clinician Questionnaire	Y	Y	N/A

Participation in clinical audit

The National Clinical Audits and National Enquiries that East Suffolk and North Essex NHS Foundation Trust participated in, and for which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits Table 3		Colchester Hospital			Ipswich Hospital			Community		
		Cases submitted	Cases Expected	%	Cases submitted	Cases Expected	%	Cases submitted	Cases Expected	%
Heart and Circulatory System										
1	National Audit of Cardiac Rhythm Management (CRM) 2019/20	438	438	100%	455	455	100%			
2	National Vascular Registry 2019/20	425	425	100%	N/A	N/A	N/A			
3	National Cardiac Arrest Audit (NCAA) 2019/20	73	73	100%	43	43	100 %			
4	National Audit of Cardiac Rehabilitation 2019/20	381	381	100%	516	516	100 %	Data combined with Ipswich Site		
5	Myocardial Ischaemia National Audit Project (MINAP) 2019/20	236	236	100%	236	236	100 %			
6	National Audit of Percutaneous Coronary Interventions (PCI) 2019/20	391	400	98%	365	400	91%			
7	National Heart Failure Audit 2019/20	480	480	100	480	480	100%	Data combined with Ipswich Site		
Acute										
8	Major Trauma Audit (TARN) 2019/20	95	458	21%	167	359	47%			
9	Assessing Cognitive Impairment in Older People/Care in Emergency Departments UK Parkinson's Audit 2019/20	170	600	28%	454	600	76%			

Participation in clinical audit

National Clinical Audits Table 3 cont		Colchester Hospital			Ipswich Hospital			Community		
		Cases sub-mitted	Cases Ex-pected	%	Cases sub-mitted	Cases Ex-pected	%	Cases submitted	Cases Ex-pected	%
10	Society for Acute Medicine's Benchmarking Audit (SAMBA) 2019/20	3	3	100%	3	3	100%			
11	National Audit of Seizure Management in Hospitals (NASH3) 2019/20	30	30	100%	30	30	100%			
12	RCEM Mental Health - Care in Emergency Departments 2019/20	0	52	0%	52	52	100%			
13	RCEM Care of Children in Emergency Departments 2019/20	0	0	0%	227	227	100%			
14	National Joint Registry (NJR) 2019/20	779	779	100%	810	800	100%			
15	National Emergency Laparot-omy Audit (NELA) 2019/20	144	170	85%	163	180	91%			
16	Case Mix Programme (CMP) 2019/20	438	400	100%	455	400	100 %			
17	Perioperative Quality Im-provement Programme (PQIP) 2019/20	42	42	100%	142	142	100 %			
18	(FFFAP)Falls & Fragility Frac-tures Audit Programme Frac-ture Liaison Service Database 2019/20	N/A	N/A	N/A	2035	2485	100%			
19	FFFAP National Hip Fracture Database 2019/20	45	45	100%	43	45	100%			
Women and Children										
20	National Maternity & Perina-tal Audit (NMPA) 2019/20	10	10	100%	10	10	100%			
21	National Paediatric Diabetes Audit (NPDA) 2019/20	Data collection continues to 25th June 2020								
22	National Neonatal Audit Pro-gramme (NNAP) 2019/20	32	32	100%	30	30	100%			
23	UK Cystic Fibrosis Registry 2019/20	Data collected external to the trust								
24 **	National Audit of Seizures and Epilepsies in Children & Young People (Epilepsy12) 2019/20	20	20	100%	39	40	98%			

Participation in clinical audit

National Clinical Audits Table 3		Colchester Hospital			Ipswich Hospital			Community		
		Cases submitted	Cases Expected	%	Cases submitted	Cases Expected	%	Cases submitted	Cases Expected	%
25	National Pregnancy in Diabetes Audit 2019/20	25	25	100 %	27	27	100 %			
26	MBRRACE - Perinatal Mortality Surveillance 2019/20	22	22	100 %	22	22	100 %			
Older People										
27	Sentinel Stroke National Audit Programme (SSNAP) 2019/20	163	181	90%	124	154	81%			
28	National Audit of Dementia 2019/20				No data collection 19/20					
29	National Audit Inpatient Falls 2019/20	16	20	80%	16	20	80%	Data combined with Ipswich		
Long Term Conditions										
30	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)2019/20	495	495	100 %	589	589	100 %			
31	National Early Inflammatory Arthritis Audit (NEIAA) 2019/20	132	130	100 %	27	130	21%			
32	BAUS Urology Audit - Cystectomy Audit 2019/20				0	0	0%			
33	BAUS Urology Audit - Female Stress Urinary Incontinence Audit 2019/20	0	0	0%	1	1	100 %			
34	BAUS Urology Audit - Nephrectomy Audit 2019/20	42	44	96%	29	17	100 %			
35	BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL) 2019/20	2	34	6%	15	6	100 %			
36	BAUS Urology Audit - Radical Prostatectomy Audit 2019/20	0	13	0%						
Cancer										
37	National Lung Cancer Audit (NLCA) 2019/20	113	113	100 %	100	104	96%			
38	National Smoking Cessation Audit 2019/20	0	138	0%	138	138	100 %			
39	National Audit of Breast Cancer in Older People (NABCOP) 2019/20	Data collected external to the trust, report not published until July 2020								

Participation in clinical audit

National Clinical Audits Table 3		Colchester Hospital			Ipswich Hospital			Community		
		Cases sub-mitted	Cases Ex-pected	%	Cases sub-mitted	Cases Ex-pected	%	Cas-es sub-mitt ed	Cases Ex-pecte d	%
40	Head & Neck Cancer Au-dit (HANA) 2019/20	Data collection continues to October 2020								
41	National Prostate Cancer Audit 2019/20	8	8	100%	10	11	100%			
42	National Oesophago-gastric Cancer (NOGCA) 2019/20	296	296	100%	191	90	100%			
43	National Bowel Cancer Audit (NBOCA) 2019/20	39	130	34%	32	130	25%			
Haematology										
44	Serious Hazards of Trans-fusion (SHOT) 2019/20	40	40	100%	40	40	100%			
Other										
45	National Diabetes Inpa-tient Audit (NaDia) 2019/20				36	36	100 %			
46	National Audit of Care at the End of Life (NACEL) 2019/20	39	40	98%	39	40	98%			
47	Elective Surgery (National PROMs Programme) 2019/20									
48	Mandatory Surveillance of Bloodstream Infections & Clostridium Difficile Infection 2019/20	ESNEFT Response			153	153	100%			
49	Surgical Site Infection Surveillance Service 2019/20	1271	1271	100%						
50	National Diabetes Foot Care Audit 2019/20	Data collection continues to 10th July 2020, current Ipswich figures 350 of 500 (70%)								
51	National Diabetes Transi-tion 2019/20	No data collection 19/20								
52	Learning Disability Mor-tality Review Programme 2019/20	No data collection 19/20								
53	NDA Core Diabetes Audit 2019/20				2765	3000	92%			

Participation in clinical audit

National Clinical Audits Table 3		Colchester Hospital			Ipswich Hospital			Community		
		Cases submitted	Cases Expected	%	Cases submitted	Cases Expected	%	Cases submitted	Cases Expected	%
National Confidential Enquiries										
1	MBRRACE - Perinatal Morbidity and Mortality Confidential Enquiries 2019/20	17	17	100%	21	22	96%			
2	MBRRACE - Maternal Mortality Surveillance and Mortality Confidential Enquiries 2019/20	1	1	100%	1	1	100%			
3	MBRRACE - Maternal Morbidity Confidential Enquiries 2019/20	1	1	100%	1	1	100%			
4	NCEPOD Long-term Ventilation: Admission to Hospital Questionnaire				4	4	100%			
5	NCEPOD Acute Bowel Obstruction Clinician Questionnaire	3	8	38%	7	7	100%			
6	NCEPOD Long-term Ventilation: Lead Clinician (Ongoing care)				1	1	100%			
7	NCEPOD Out of Hospital Cardiac Arrest: Clinical Questionnaire	9	9	100%						
8	NCEPOD Dysphasia in people with Parkinson Disease: Clinician Questionnaire	4	4	100%	4	4	100%			

The reports of 38 National Clinical Audits were reviewed by the provider in 2019/20 and ESNEFT intends to take the following actions to improve the quality of the healthcare provided:

National Audit of Care at the End of Life

Background:

The National Audit of Care at the End of Life (NACEL) was commissioned in October 2017 by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. Delivery of the audit is managed by the NHS Benchmarking Network (NHSBN), supported by a multi-disciplinary Steering Group and Advisory Group. Dr Suzanne Kite, Consultant in Palliative Medicine, and Elizabeth Rees, Lead Nurse for End of Life Care, Leeds Teaching Hospitals NHS Trust, provide joint clinical leadership of the audit. Both acute sites participate in the National Audit.

Aim:

The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute hospitals. The audit monitors progress against the five priorities for care set out in One Chance To Get It Right and NICE Guideline (NG31) and Quality Standards

Participation in clinical audit

(QS13 and QS144).

The clinical lead for the audit reported that the key areas of good practice include:

- ✓ Overall good recognition of the final days of life
- ✓ Recording of mental capacity
- ✓ Governance across both sites

Areas for significant improvement include:

- Documentation of assessment and action on the needs of families (e.g. social, practical, cultural, psychological and spiritual)
- Areas for continued optimisation
- Individual Care Plans for Last Days of Life (ICPLDL) design(s) to optimise data capture and promote best practice
- ICPLDL use, full completion and full involvement and AGREEMENT of patient/families
- Documentation of assessment of mental capacity in relation to patient involvement in key aspects of their care
- All aspects of the 5 priorities of care

Future plans:

- EOLC is part of the Time Matters QI project – key areas include ICPLDL, Education, SPICT, Care after Death, Complaints and Rapid Discharge
- EOLC is one of the Trust priorities
- We have just submitted the data to NACEL audit for 2019 and this will be published next year – CQC and NHSI use this data
- We will continually monitor views of bereaved relatives
- Continual auditing of ICPLDL
- Aligning Ipswich and Colchester Care Planning documents

National Audit of Dementia Care in General Hospitals

Background:

This report looks at the quality of care provided to people with dementia in general hospitals, specifically aspects of care delivery known to impact upon people with dementia as inpatients. In recent studies, up to 42% of people over 70 who have an unplanned hospital admission have dementia. People with dementia often face increased difficulties when in hospital, including:

- Increased confusion and disorientation
- Length of stays longer than people without dementia
- Potentially avoidable complications, such as dehydration or falls
- Delays when leaving hospital

Audit Standards:

The National Audit of Dementia (care in general hospitals) measures the performance of general hospitals against standards relating to care delivery which are known to impact upon people with dementia while in hospital. These standards have been derived from national and professional guidance, including NICE Quality Standards and guidance, the Dementia friendly Hospitals charter, and reports from Alzheimer's Society, Age UK and Royal Colleges.

Audit standards are measured across the following themes:

- Assessment
- Information and communication
- Staffing and Training
- Nutrition
- Discharge and hospital transfer
- Governance

Participation in clinical audit

National Audits

Chart 1- Ipswich Hospital Results:

The Learning Disability Mortality Review (LeDeR) Programme

Background:

This is the third annual report of the English Learning Disabilities Mortality Review (LeDeR) programme. It presents information about the deaths of people with learning disabilities aged 4 years and over notified to the programme from 1st July 2016 – 31st December 2018. A particular focus is on deaths for which a review was completed during the last calendar year (1st January – 31st December 2018). Both acute sites participate in the programme.

ESNEFT participate in the programme by:

- Ensuring the two LD Nurse Specialists (one on each site) complete the LeDeR notifications and report quarterly to the Safeguarding Operational Group & Committee.
- Learning Disability nurses attending the relevant CCG LeDeR working groups and the Site Director of Nursing attending the Suffolk LeDeR Steering Group.
- ESNEFT having a Learning Disability work plan and this includes our learning actions from LeDeR, this work plan is reviewed regularly and monitored by the ESNEFT Safeguarding Adults Operational Group.
- Ensuring that the Safeguarding Steering Groups membership include senior representatives from ESNEFT and external partner agencies, including both CCGs having oversight of the work plan and progress in achieving the actions, if there are any concerns or good practice these will be taken by the chair, the Director of Nursing, to the Quality & Patient Safety Committee, which is a sub-committee of the Board.
- Including any learning from LeDeR reviews in the Learning Disability training programme

Participation in clinical audit

National Audits

- The Mortality & Morbidity group reviewing all deaths of those patients which have a LD and these reports form part of the LeDeR reviews. One of our LD Nurse Specialists is also a reviewer for the CCG

NCEPOD - Failure to Function, A review of the care received by patients who died in hospital following an admission with acute heart failure.

Aim:

To identify and explore avoidable and remediable factors in the process of care for patients with acute heart failure admitted to hospital as an emergency, and who died during the admission.

- Prompt recognition and diagnosis of heart failure and rapid initiation of a heart failure pathway
- Appropriate documentation and management of heart failure
- Prompt senior review and follow-up throughout admission
- Escalation of care decisions and planning including admission to critical care
- Assessing multidisciplinary team approach
- Assessing adequate communications with patient, families and carers
- Examining the management of the 'acute' end of life pathway and ceilings of treatment including appropriateness of interventions
- Equity of access for mechanical support / transplant centre and escalation decisions
- Organisational aspects of care delivery for heart failure patients on acute, general or cardiology wards to include aspects of staff training.

Lead response for Colchester:

"Overall the heart failure service at Colchester Hospital is well established and working well in collaboration with the community Heart

Table 4- Examples of Local Action Plan showing where compliance is met and where there are planned actions for the Ipswich Hospital site

Recommendation	Is The Service Compliant?	Evidence or Planned Action For Compliance
Medical Directors and Directors of Nursing should ensure that people with dementia admitted as an emergency are assessed for delirium using a standardised tool such as the 4AT or Confusion Assessment Method (CAM) (NICE CG 103 1.2)11 and consider the symptom of pain as contributory factor.	In progress	• Within UTC scope of work redesign of emergency clerking proforma is ongoing. • Plans to introduce 4AT as screening tool to replace existing CAM
Hospital discharge teams should ensure that discussions take place with people with dementia and their carers and include: • The place of discharge • Support needs • A record of the discussion in the notes.	Yes	Good MDT input into discharge and documentation of plans in notes / nursing / therapy notes.

Participation in clinical audit

Local Audits

Failure (HF) service provided by Anglian Community Enterprise (ACE) (subcontractor).
In conclusion, there are little areas that require improvement and the team is highly motivated. Our aim is to provide a safe HF service that is effective, patient oriented and meets all the criteria and recommendations from NICE."
Dr Ioannis Kountouras Consultant Cardiologist, HF audit lead.

National Ophthalmology Database Audit

Aim:
Cataract surgery remains the most frequently undertaken NHS surgical procedure with approximately 400,000 cataract operations undertaken in England and 20,000 in Wales during 2016-2017. The Health Quality Improvement Partnership (HQIP) has commissioned the National Ophthalmology Database (NOD) Cataract Audit to report on all NHS funded cataract surgery in England and Wales.

Audit:
Two primary indicators of surgical quality are audited. These are, firstly, the index surgical intraoperative complication of rupture of the posterior lens capsule or vitreous prolapse or both (abbreviated as PCR), and secondly Visual Acuity (VA) Loss (doubling or worse of the visual angle) related to surgery.

Areas of good practice for Ipswich Hospital:
There is good use of the Electronic Medical Record to record preoperative and intraoperative data.

Despite the trust having limited postoperative data we fall well within the national expected PCR limits which means that not only do our patients receive good care, but that our trainees learn and perform cataract surgery in a safe and controlled environment.

Area for improvement for Ipswich Hospital:
For the first cycle of data there was a low return rate of post-operative information, it was felt locally that the return rate has improved and it is anticipated that the second cycle of data will show a higher return rate (aiming for > 40%). If the post-operative return rate does not achieve above 40%, the Head of Ophthalmology will discuss at the Local Ophthalmologist's Committee to encourage the return of data.

Table 5—Examples of recommendations, evidence and planned actions across both sites:

Recommendation	Evidence or Planned Action For Compliance
A guideline for the clinical management of acute heart failure should be available in all hospitals; NICE Guidelines CG187	Both sites provide 7DS for Cardiology reviews, NT-proBNP testing (less well used at CGH). CG187 was presented 04/07/2019 to the CGH medical division journal club as part of review of BNP testing.
An echocardiogram should be performed for all patients with suspected acute heart failure as early as possible after presentation to hospital, and within a maximum of 48 hours as it is the key to diagnosis, risk stratification and specialist management of acute heart failure. *(All Clinicians, Lead Physiologists and Medical Directors)* This recommendation supports NICE guideline CG187 rec 1.2.4	Both hospitals follow NICE and will perform echo on patients with raised BNP levels when the patient has not recently already had an echo. Most echos are done within 48 hours. Unlike IPS, CGH do not have a weekend echo service and a business case for extended working is being submitted.

Participation in clinical audit

Local Audits

The reports of the 251 local clinical audits were reviewed by the provider in 2019/20 and ESNEFT intends to take the following actions to improve the quality of healthcare provided:

Trust wide large scale NEWS & Sepsis audit

The Trust continues to regularly audit compliance with the use of nationally recommended NEWS protocol and Sepsis screening and treatment. As a result of this audit wards have intensified the frequency of auditing, using a more comprehensive audit tool, addressing issues at the time with staff. A ward education pack has been produced and circulated to the ward teams. The trust has also instigated the development of electronic vital signs monitoring.

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

Monthly audit of DNACPR form completion takes place in line with the Documentation Audit Proposal (September 2017). Every ward is audited on a 3 monthly rolling basis. Feedback is provided immediately following the audit with the report being disseminated via relevant heads of nursing.

Compliance has remained static around the 91.5% mark with reports being discussed at the Resuscitation Committee.

This is in addition to the work surrounding DNACPR decision making by the End of Life Steering Group and the EOL work stream as part of the 'Every Patient, Every Day' improvement programme.

Last Days of Life Audit

This audit looks at the care provision for patients at the end of their life and whether the Integrated Care Record for the Last Days of Life (ICRLDL) is utilised and the compliance with the completion of the ICRLDL. Utilising the ICRLDL has assisted in the provision of good end of life care. Improvement work focuses on the identifying patients within the last days of life, as per the 'Every Patient, Every Day programme'.

Classic Safety Thermometer Audit

The Safety Thermometer (Classic) is an audit undertaken for all inpatients once a month looking at pressure ulcers, falls with harm, catheters with a Urinary Tract Infection (UTI) and new Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE).

Wristband Audit

In line with the Trust's Wristband policy, 5 patients per ward are audited every 6 months across both sites. This is to ensure that patients across the Trust are wearing the correct wristband, in terms of colour and that all information printed on the band is correct and legible.

Paperless routine blood requests

Nursing and clinical colleagues on Easthorpe Ward have taken part in a successful trial to request and collect routine blood tests electronically.

The move to a paperless process has worked so well it will be rolled out to other inpatient wards at Colchester Hospital.

Participation in clinical audit

Local Audits

Group 1	
Medicine	
Audit	**Description of Actions**
Functionality of the R.A.T department in Colchester General Hospital	Provide more teaching on pain assesment Better staffing for the RAT Bay More space for treating patients Familiarisation of the ED booklet
RCEM Feverish Child Audit	Education of clinical staff through teaching sessions
How many patients receive sepsis 6 within the first hour	Reminders at board round
Management of asthma in paediatrics	Topic presentation at next teaching session
IV fluid prescription in the ED adherence to NICE guidelines	No actions
Emergency intra-hospital transfers from the emergency department	Develop Standard Operating Procedure (SOP) and agree with colleagues (ED and Anaesthetics) Devise a Checklist, agree with colleagues Implement SOP and Checklist – with training, launch and supervision Audit Checklist
Transient loss of consiousness	TLOC bundle ECG classes & bundle 1.Bundle & DVLA guideline reading 2.Teaching to junior doctors 3. Advert in hospital computer Bundle
Management of staggered overdose of paracetamol	No actions
Mortality pattern in stroke	No actions
Service Evaluation of Ipswich Hospitals Physiologist led valve clinic	No actions
Infective Endocarditis Re-audit/Quality Improvement project	Continued effort and work is required to attain 100% targets on all measures so regular audits are required
Rotablation Outcomes	No actions
How frequently are DNACPR and TEP forms completed in hospital inpatients known to the hospital specialist palliative care team?	To be reported back to deteriorating patient group To present at meeting to educate people more about TEP forms
To establish the present practice of Do Not resuscitate Forms (DNAR) with the concomitance of the Treatment Escalation Plan form (TEP).	No actions
Opioid use in CGH	No actions
Management of malignant bowel obstruction	Guidelines will be promoted with surgical teams and in SAU

Participation in clinical audit

Local Audits

Oxygen prescribing in the ED	No actions
Acute Confusional State and AMTS/CAM	Educate Junior doctors about the importance of recording AMTS
Pain in adults	Educate the staff nurses, HCAs and the junior doctors in proper pain assessment Formal pain scoring within the recommended time frames Initiating administration of analgesia as early as possible once the pain has been identified
Management of paracetamol poisoning	INR, U&Es, LFTs, Glucose, INR, LFTs, U&Es, Venous pH/Bicarbonate
Fractured Neck of Femur	Introduce a #NOF pro-forma/ pathway - Appoint a #NOF clinical lead - Appoint a pain clinical lead and nurse lead Pain score assessment to be completed, as a standard at nurse triage - Review +/- amend CAS card front sheet Nursing staff to escalate patients seen to be in severe pain to a clinician in order to have an urgent, assessment with a view to analgesia administration Nursing staff to escalate suspected fractured nof to a clinician in order to perform a rapid assessment with a view to requesting x-rays - Introduce a specific box for suspected nof fracture x-ray requests - Introduce colour coded porter x-ray forms to prioritise nof patients
Consultant sign off	Introduction of electronic tick box “senior sign off” prior to discharge Adjustment of CAS card to demonstrate these standards (place in visible area) Introduction of “supervising consultant” to review patients seen by junior doctor for discharge
Compliance to Antibiotic Guidelines in the ED	To promote the importance of using the correct guideline for the correct patient. Visibility of guidelines and which to use when could also be key in driving up compliance Link in with new ED Pharmacist to help promote the importance of taking cultures and complying with trust and community guidelines. Further work required in ED to highlight to staff the importance of taking microbiology samples where appropriate to enable us to focus treatment. An audit on cultures taken in ED is documented on the Trust Antimicrobial Stewardship Plan
Trauma call audit	Trauma call time to intervention Time to CT Trauma call documentation
Management of ACS in the ED	ECG < 10 min Re-Audit – as there was no data stratification between self- presenting patients and patients brought in by the ambulance, who therefore had ECG done at the pre-hospital stage. ED medical / nursing staff education Aspirin 300 mg PO 1.Re-Audit – as there was no data stratification between self- presenting patients and patients brought in by the ambulance, who therefore had ECG done at the pre-hospital stage. ED medical / nursing staff education

Participation in clinical audit

Local Audits

Cancer & Diagnostics	
Audit	**Description of Actions**
Audit of Referrals to the AOS Service	Re-audit
Outcomes of treating Stage 3 NSCLC patients	Re-audit
Notification to GP within 24 hours of diagnosis of SCC or MM	Re-audit
Audit of the Stable Prostate Cancer f/up service	'Complete – no recommendations'
Patient experience survey of the Clinical Nurse Specialist Service in Uro-oncology	'Complete – no recommendations'
Patient support & Information Giving - a patient survey	'Complete – no recommendations'
Suspected and Confirmed Metastatic Spinal Cord Compression – Colchester Site	'Complete – no recommendations'
Patient experience of receiving an HNA	Implement e-learning package, encourage and monitor compliance, Monthly monitoring and reporting compliance, bi-monthly steering group and team meetings, Disseminate audit report, bi-monthly steering group and team meetings, newsletter
Implementation of image guided RT with simultaneous boost followed by MRI based adaptive Brachytherapy in Cervical Ca patients	'Complete – no recommendations'
Patient satisfaction Survey - pre-treatment	'Complete – no recommendations'
NG24 - NICE GUIDELINE - Blood Transfusion (Nov'15)	'Complete – no recommendations'
QS138 - Blood Transfusion (Dec'16)	'Complete – no recommendations'
12 month summary 2018 - Audit of Deaths within 30 days of last Systemic Ante-cancer therapy (National NCEPOD recommendation 2008) – Clinical oncology and Haemo-oncology patients	'Complete – no recommendations'
Audit on use of Octaplex in Colchester General Hospital (carried over from 2018/19)	'Complete – no recommendations'
Acute management of sickle cell crisis in ED	Now QI project
Retrospective audit of the use of TPO agonist in patients with ITP at Ipswich	Re-audit
Imaging the Male Breast	'Complete – no recommendations'
Audit of day case surgery - re-audit	'Complete – no recommendations'
Re-Audit of Nodal Harvest in Axillary nodal clearance in breast cancer patients	'Complete – no recommendations'
Audit detailing the taking, transfer to PACS, reporting and presentation of specimen X-rays at the MDT 6 months	'Complete – no recommendations'

Participation in clinical audit

Local Audits

Breast screening assessment clinic - patient satisfaction (Colchester/ Broomfield)	'Complete – no recommendations'
Antibiotic Prescribing and Urine Dipstick Testing for UTI	Share results with prescribers, Review pathways with Physicians, Future audit of catheterised patients?
Audit to assess the completeness of cervical loop excision and punch biopsy opathology reports (required audit from cervical screening QA	'Complete – no recommendations'
C-difficile reporting.	Complete - no recommendations
IMER Audit - Pregnancy Process Checks (Regulatory audit)	Complete - no recommendations
Re-Audit of minimising Radiation dose in CT of kidneys, ureters and bladder (CT-KUB)	Complete - no recommendations
Radiology Annual Patient Survey	To review the appointment letters to in all area to make sure information is clear and the instructions to patients are easy to follow, to review the signage to the radiology department at the PCC and create a map to show the direction to the radiology department..
Reporting Radiographer peer review	Complete - no recommendations
Infection Control in The Radiology Department	Review the details of our local policy and procedures for infection control with CT & US radiographers, nurses, the booking clerks, and radiologists. Re-audit
Are Ultrasound (U/S) guided core biopsies of the breast in women aged up to 30 always benign (B2) if the ultrasound appearance of the lesion is classified as benign (U2)?	Complete - no recommendations
CT Pulmonary angiography – review of technical quality and reporting standards	Reports should include comments about the degree of vascular enhancement and motion artifacts (if present), - If the scan is not diagnostic, clinicians should be advised to consider other scan modalities or repeat scan if clinically
The use of CT in catheter-directed thrombolysis	Complete - no recommendations
The use of ultrasound in AKI	Consider need to vet scan requests so that imaging only performed if no cause identified or any suspicion of obstruction.
Comparative evaluation of SWI and T2* GRE in detection of intracranial microbleeds.	The audit has demonstrated that SWI has better sensitivity in detection of cerebral microbleeds and enables better lesion characterization. These findings have been discussed at audit presentation and consultant meeting. Plans are to replace the T2*GRE sequence with SWI in MRI Brain protocol. This would be in line with current MRI protocols in larger teaching

Participation in clinical audit

Local Audits

Head CT- lens exclusion (re-audit)	Emphasize to radiographers the importance of excluding the eye, Persuade supervising radiologists to avoid making exclusions to the protocol. Re-audit
Review of Non-Medical Referrers to Radiology	Complete - no recommendations
Streamlining imaging protocol in technetium-99m-Tektrotyd somatostatin receptor SPECT/CT	Re-audit
Radiotherapy Department pre-treatment planning	Initial information needs to be given by a radiographer rather than clerical staff to ensure all information is provided and questions can be answered. Re-audit
Prostate and Pelvic Nodes Radiotherapy Referrals Audit	The protocol "Prostate + SV 74/66Gy in 37# to be reinstated within Casper – occurred in November 2018, Complete an audit to check that all radiotherapy prescriptions, currently included in clinical protocols, match those included on Casper for all treatment sites – currently being completed. This should be completed annually, A new table should be included in all clinical protocols to ensure all necessary staff within the radiotherapy department have read the protocol and sign indicating they are aware of any changes. It is then their responsibility to update any additional departmental protocols, including the referral system, and to make all staff in their area aware of the changes
Radical Prostate rescans	Re-audit
Repeat CBCT Audit for Radical Prostate patients.	Complete - no recommendations
An audit assessing the satisfaction of care received by patients undergoing radiotherapy for a head and neck cancer	Further audit
Monitoring the prescribing of sodium valproate	Complete - no recommendations
INTRATHECAL CHEMOTHERAPY AUDIT	Complete - no recommendations
Re-audit to determine adherence to Pharmacy Endorsements on drug charts across the Ipswich Hospital	Complete - no recommendations
Audit to determine compliance with the NPSA alert for storage and handling of Potassium Chloride Concentrate within Ipswich Hospital	Complete - no recommendations

Participation in clinical audit

Local Audits

Group 2	
General Surgery & Anaesthetics	
Audit	**Description of Actions**
Audit of electrolyte checking prior to prescribing bowel prep for lower GI endoscopy	Complete - no recommendations
Management of gall bladder polyps	Complete - no recommendations
Sedation and Delirium assessment in a district Critical Care Unit	1. Sharing of results with CCU team – nurses and doctors 2. Education of juniors and incoming trainees to adopt thorough documentation strategies during ward rounds/ prescribing. ´ Changes to the induction pack for future trainees 3. Discussion with Careview Team to explore possibility of adding specific alerts, or changing some dropdown menus 4. Review of sedation and delirium policies and ensuring all nursing staff and
Tracheostomy in ITU	1. Sharing of results with Critical Care Team 2. Meeting with Carevue team to consider editing ITU discharge summary / include automated referral to outpatient services 3. Review of the induction pack to future juniors regarding discharge summary details on tracheostomy insertion 4. Changes to patient follow up with the establishment of the CCU follow up team
Vascular Surgery Thrombolysis Audit	1. Introducing MDT approach for all patient that may benefit arterial thrombolysis 2. Introducing Thrombolysis Pathway for ITU/ HDU/ Vascular Ward 3. Creating an official arterial thrombolysis pathway in acute limb ischemia to posted on intranet to be available for the whole TRUST
Are patients with acute cholecystitis treated with 1 week of diagnosis?	
Post - Operative analgesia and patient satisfaction after laparotomy	

Participation in clinical audit

Local Audits

Management of Acute Severe Ulcerative Colitis Audit (MASC)	
Post-operative analgesia requirements after laparasopic nephrectomy - should we introduce a standardised regimen for analgesia to the enhanced recovery pathway?	
Prescription of extended VTE prophylaxis in elective colorectal cancer patients on enhanced recovery pathway	1. The operation note needs to clearly state extended VTE prophylaxis and the prescription needs to reflect this
Outcome of Colonic Stenting in patients with bowel obstruction secondary to bowel cancer	Complete - no recommendations
Influence of reginal versus general anaesthesia on outcome following femoropipliteal and femoro-distal bypasses	Complete - no recommendations
Possible causes of overnight stay for patients breast surgery (day cases)	Complete - no recommendations
Decompensated Cirrhosis Care Bundle – First 24 Hours	Complete - implementing action plan
Critical limb ischaemia pathway	
Outcomes of colonic stenting in patients with bowel obstruction secondary to bowel cancer	Complete - no recommendations
Management of Acute Severe Ulcerative Colitis Audit (MASC)	
Dose of haemofiltration prescribed and actually administered in critically ill patients and reasons for interruptions	Abandoned
Audit of colonoscopy referrals	Complete - no recommendations
Recognition of patients with red or amber flags and the sepsis six bundle compliance within the adult ward settings (Ipswich site)	
Quadratus Lumborum Block – A simple audit	
Are we following the AKI care bundle up to standards in post-operative surgical patients	Complete - no recommendations
Management of upper GI bleed	
Bladder biopsy for red patches- an audit of outcomes	Complete - no recommendations
Indications for flexible cystoscopy- avoiding unnecessary cystoscopies	Complete - no recommendations
An audit evaluating factors that lead to delayed ileostomy reversal, post anterior resection with formation of a reversible ileostomy.	

Participation in clinical audit

Local Audits

Does the current informed consent process and information leaflet system provide patients with enough written information to feel adequately prepared for their laparoscopic cholecystectomy?	
Cholecystectomy: adequacy of pre-op information	
Pre-operative Airway Assessment Audit	1. Recommendation for further education on importance of preoperative airway assessment and documentation 2. Previous grade of intubation if patients have undergone previous anaesthetics should always be documented as is a true objective measure of intubation difficulty
EUS Audit – 2018	Complete - no recommendations
To audit the compliance with ESNEFT guidelines (mirroring national guidelines) of diabetic patients having elective surgery in a one month period on the Colchester site	
BAUS Urology Audit - Cystectomy Audit 2019/20	
BAUS Urology Audit - Nephrectomy Audit 2019/20	
BAUS Urology Audit - Radical Prostatectomy Audit 2019/20	
Case Mix Programme (CMP) 2019/20	
Inflammatory Bowel Disease (IBD) Rgistry, Biological Therapies Audit 2019/20	
National Bowel Cancer Audit (NBOCA) 2019/20	
National Cardiac Arrest Audit (NCAA) 2019/20	
National Emergency Laparotomy Audit (NELA) 2019/20	
National Oesophago-gastric Cancer (NOGCA) 2019/20	
National Prostate Cancer Audit 2019/20	
National Vascular Registry 2019/20	
Perioperative Quality Improvement Programme (PQIP) 2019/20	
Investigating and managing renal colic: Are we following NICE guidelines?	Complete - no recommendations
Pain outcomes in paediatric day case tonsillectomies	
Epidural Patient Satisfaction Survey	
Inpatient management of visible haematuria	
Aug 2019: Re-Audit Of Trauma Theatre Efficiency 1st Case Send & Start Times	1. Lorenzo data not informative enough to explain day to day reasons for inefficiency delays & previous word template too difficult and inaccessible for registrars to contribute to accurate data collection 2. T&O Registrar to collect information on day to day timing via whatsapp with other registrars & with clinical lead for convenience, further highlight who is not contributing data & highlights daily issues to help make plans to move forward 3. Information collated each day to be discussed at end of day debrief with rest of theatre team on daily basis for constant re-evaluation and identification, so issues not forgotten and as reminder that standards must be met

Participation in clinical audit

Local Audits

GI bleed Audit	Complete - no recommendations
The Cappuccini Test: An Audit of Supervision	
CT scans in emergency General Surgery	
Theatre Emergency Buzzer Response	
Handover to CCU	1. Targeted education to ODP, nurses, anaesthetists 2. Put a laminate on main building theatres and on CDS 3. Re-audit in 3 months with the aim to achieve > 75% of handover forms completed
Auditing the investigation of chronic diarrhoea	
Assesment of the guidelines on the management of Iron Deficiency Anemia	
A review of the quality of care provided for patients treated for acute pancreatitis	
Adequacy of patient handover to post-anaesthetic recovery nurse by anaesthetist	
Perioperative pain control of proximal femoral fractures	
Use of analgesia in renal colic	1. Patients with renal colic should receive NSAIDs as first line analgesia 2. Patients with renal colic should receive IV paracetamol as 2nd line analgesia
Variceal Bleed Audit	
CEPOD antibiotic prophylaxis audit	
Does ERSPC risk calculator improve clinical decision making and enhance patient journey along the prostate cancer diagnostic pathway?	
Audit of Staff Satisfaction with Support for Patients with Additional Needs	
Perineal hernia rates following extralevator abdominaperineal excision with biological mesh reinforcement	
Ruptured abdominal aortic aneurysms	
Trauma antibiotic prophylaxis audit	
Completion of Bed Space Cleaning Form	
One-Stop Haematuria Audit (Re-audit)	
Difficult Airway – Front Of Neck Access (FONA)	
Anaesthetics Cappuccini Test Audit	
Balloon Sinuplasty	

Participation in clinical audit

Local Audits

Group 2	
MSK and Specialist Surgery	
Audit	**Description of Actions**
Investigation and management standards for necrotising otitis externa	Abandoned
Outcomes and Progression of Keratoconnus in patients who have undegone Photochemial Corneal Crosslinkning Treatment	Complete - no recommendations
Audit of temporal artery biopsy to evaluate the appropriateness and true negative rates	Complete - no recommendations
Operation Note Writing: Adherance to Good Surgical Practice Guidelines	1. Evolve operation note
Prospective audit of tonsillectomy outcomes	Complete - no recommendations
Dural Teat in Spinal Surgery and it's outcome	Complete - no recommendations
Acute management of Epistaxis	Complete - no recommendations
RF Denervation of SIJ and Simplicity	Complete - no recommendations
Re-audit on the uptake of influenza and pneumococcal vaccination in patients with autoimmune inflammatory rheumatic disease's in the Rheumatology Clinic	1. Identifying the eligible patients who were not offered the vaccinations 2. Inform the responsible clinicians of the identified eligible patients who were not offered the vaccinations 3. Inform the responsible primary care providers of the identified eligible patients who were not offered the vaccinations to ensure this is offered 4. Raising patient and staff awareness for vaccination eligibility during vaccination season
RF Denervation of SIJ and Simplicity	1. To continue data collection and present results to colleagues in future
Audit of occult hip fractures	
One Year Evaluation of Management of Ankle Fractures	Complete - no recommendations
NICE Guidelines for Lower Limb Arthroplasty VTE Thromboprophylaxis And to evaluate the impact of VTE prophylaxis on stroke incidence	
National Ophthalmology Audit 2019/20	
Retrospective re-audit of radiographic justification and reporting of orthopantograms (OPGs) taken in Ipswich Hospital Oral and Maxillofacial Department 2018-2019.	1. In our next departmental audit meeting, the results of the second cycle of the audit will be discussed 2. A poster in each of the clinical rooms, with detailing of briefly what to include in radiographic justifications and reporting 3. Further audit in 4-6 months to review progress

Participation in clinical audit

Local Audits

Retrospective re-audit of radiographic justification and reporting of orthopantograms (OPGs) taken in Ipswich Hospital Oral and Maxillofacial Department 2018-2019.	1. In our next departmental audit meeting, the results of the second cycle of the audit will be discussed 2. A poster in each of the clinical rooms, with detailing of briefly what to include in radiographic justifications and reporting 3. Further audit in 4-6 months to review progress
Cataract surgery following intravitreal injection	Complete - no recommendations
Colchester Hospital Audit of Orthopaedic Surgery Post Operative Notes (CHAOS PN)	1. Surgical Template
Evaluation of the shoulder perioperative information base on a level of patient satisfaction. A service evaluation proposal	
Assessment and management of children and adults with periorbital cellulitis	Abandoned
Use of tranexamic acid in epistaxis to reduce rebleeding rates	Abandoned
Complication of recurrance rate in extracapsular dissection of parotid lesions compared to superficial parotidectomy	Abandoned
The importance of Fracture Liaison Services at District General Hospitals	Complete - no recommendations
Tranexamic Acid in Hip Fracture Surgery - National Audit of Practice	
Efficacy of acute pain management	1. Implementation of enhanced pre-operative recovery programme
The effect of delay to surgery on morbidity, mortality and length of stay following periprosthetic fracture	Complete - no recommendations
Looking at the standards of Trauma Procedure Operative Notes	Complete - no recommendations
National Joint Registry (NJR) 2019/20	
Patient sastisfaction survey for SEN clinics	Complete - no recommendations
Frequency of wax removal on the ENT department	Abandoned
Elective Surgery (National PROMs Progamme) 2019/20	
Repeated audit on biologics for patients with psoriasis	
National Early Inflammatory Arthritis Audit (NEIAA) 2019/20	
Internal Qa Re- Audit Of Management Of Diabetic Retinopathy April 2016-March 2017 & April 2017- March 2018	Complete - no recommendations

Participation in clinical audit

Local Audits

Audit of certificate of visual impairment (CVI) registration for Colchester Eye Centre Patients	1. All eligible patients offered. Completed forms taken by consultant to PA
Assessing time taken from request to completion of imaging for acute conditions in ENT surgery	
Joint preserving operations for patellofemoral arthritis service provision audit	Complete - no recommendations
Adherence to GIRFT Knee Arthroplasty Surgery Documentation Audit	1. Surgeons to check operation notes of most compliant surgeons and make a new operation note template for knee arthroplasty
Assessing time taken from request to completion of imaging for acute conditions in ENT surgery	
Patient Survey – Dermatology Patch Test Clinic	
A Collaborative Audit of Intraoperative Fluoroscopic Radiation Measurements in Orthopaedic Trauma	
Audit of Stoke Referrals to Orthoptic Department	
Re-audit Colchester Hospital Audit of Orthopaedic Surgical Post-Operative Notes	Complete - no recommendations
Review of assessment & treatments for Intermittent Distance Exotropias	Complete - no recommendations
A work-based study to evaluate patient preferences of information sources to aid decision making within an orthopaedic speciality	
review of adult elective orthopaedic operation notes and benchmark against standards set by RCS (2014) and BOA (2019)	
Are AP and Velpeau views being performed for all shoulder dislocations and proximal humeral fractures?	Complete - implementing action plan
Percutaneous Needle Fasciotomy	
Audit of anti-neuropathic prescribing for patients referred onto the spinal pathway for radicular pain	
Staff understanding of acutely ill patients on Saxmundham Ward	Complete - implementing action plan
Vertical deviations squint surgery audit	Complete - no recommendations
Yag Re audit	Complete - implementing action plan
Appropriateness of 2ww referrals Re-Audit	
Colchester hospital Audit of Orthopaedic Surgical-site marking (chaos-sm).	Complete - implementing action plan
Audit Of Cataract Surgery By A Single Surgeon	Complete - implementing action plan
The role of viscogonioplasty in angle closure cataract surgery	Complete - no recommendations
Referrals for Giant cell Arteritis	1. Update referral pathway – new proforma has been designed and will be piloted 2. Re-audit referral times 3. Introduce FTP
Xen45 outcomes	Complete - no recommendations
MIs Spinal Surgery Audit	Complete - no recommendations
Balloon sinuplasty	
quality of pelvic radiograph	
Adherence to GIRFT Hip Arthroplasty Surgery Documentation Audit	
Re-Audit Adherence to GIRFT Knee Arthroplasty Surgery Documentation Audit	

Participation in clinical audit

Local Audits

Women's & Children's	
Audit	**Description of Actions**
Looking At the effectiveness of Thermoregulation At Ipswich Hospital During the first Hour of care in neonates	Re-audit for required sample size
Quality Improvement project on blood testing involving Neonates on daily Total parenteral Nutrition	Reaudit late 2020 after NICE guidance published
Obesity in Paediatrics: what is the burden on secondary care?	Business case presented during audit presentation.
Diagnosis and Management of ADHD and compliance with NICE guidelines	Reaudit in 2020 with more cases
Use of Ondansetron in paediatric patients with gastroenteritis induced vomiting.	Reaudit in next year
Paediatric IV fluids – adherence to local guidance	Local induction - guidance should be emphasised - not just for paeds. Reaudit.
Audit of compliance with the BSH guideline for the management of acute chest syndrome in sickle cell disease	Feed back the audit results to departmental colleagues, with education Assign re-audit
Reaudit of the quality of ADOS referrals in the department, following introduction of new protocol and referral system	School report/ home questionnaire/ school questionnaire - hese will now be required at time of referral as the system is now on the portal
Audit on autism spectrum disorder assessment and diagnosis	Reaudit 2022
HIE	Re-audit with 2 year outcomes included
Equipment on Resuscitaires	Stringent checks. Reaudit.
Febrile Children and Sepsis	Continue to complete checklist on all patients. Educate all staff on sepsis 6 and LP checklists.
Evaluation of the Paediatric Enuresis Service	Reaudit in 1 year
Newly diagnosed diabetes	Complete but awaiting documentation
Obesity Management	Reminder emails. 10 minute teaching. Reaudit.
Review of RAST testing in paediatrics	Complete no recommendations
Cow's milk protein allergy	Complete no recommendations
Cerebral Palsy Management in <16yrs at ESNEFT : a need for better MDT collaboration?	Business case suggested from presentation - for MDT approach.
Newborn Hearing Screening Patient Satisfaction Survey	Keep an eye on the results around patients receiving written information about the NHSP. Unlikely to be ever 100%. Happy with anything over 95%
Paediatric IBD audit	Complete but awaiting documentation
Review of safety of supervised food challenges	Complete no recommendations
Kaiser sepsis calculator	Complete but awaiting documentation
Radiology reporting audit	Complete but awaiting documentation
Neonatal jaundice	Improve documentation and education regarding when to start phototherapy Improve documentation and education regarding SBR monitoring Improve documentation and education regarding when to check rebound SBR
Early Onset Neonatal Sepsis – Babies appropriately managed according to NICE standards	Reaudit
Antenatal detection and management of Congenital heart disease in a DGH over a 5 year period	No actions

Participation in clinical audit

Re-audit of the First Hour of Care	Completion of FHOC documentation Third cycle of audit
Total Laparoscopic hysterectomy	Increase rates of TLHs at CGH (protracted timescale) Reaudit 2021
Audit on the use of Who checklist in Colposcopy	Ensure instrument box (even for standard instruments) is filled in - not left blank. Highlight importance of WHO checklist at gynae meeting and importance of 100% compliance with swab counts.
Audit on superovulation	Present findings to colleagues Agreed to update Ovulation Induction Guideline Re-audit when more cycles have been performed
Novasure failrate audit	Complete but awaiting documentation
Reduced Foetal Movements audit	Reminder to women to present sooner Reminder to staff regarding documentation and discussion with senior doctor in all cases of reduced fetal movement. Clearer pathway regarding who should receive ultrasound scanning - ultrasound scan capacity. Reaudit.
Follow up readmission to Orwell postnatal ward	To continue to gather data consistently, review Datix and enable further investigation of common factors. Share results with col-leagues.
Re-audit of the First Hour of Care	Completion of FHOC documentation Third cycle of audit
Induction of labour Nova Suite Audit	Continue auditing and analyse 6 monthly Continue to work towards offering outpatient IOL Continue to monitor and record operational issues such as delay in IOL and measure these against outcomes. Audit use of propess sticker.
HDU Care on Deben Ward	Audit form devised and placed in clinical areas Prospective data collection by all clinical staff Re-audit
3rd degree tear re-audit	Audit loop closed
Birth choices	Complete no recommendations
Intermittent Auscultation Fresh Eyes	Monthly spot checks communicate to staff via WOTB and facebook page Speak to core team to support others that work on Brooke: refer to working ob Brook handbook Communicate findings in audit meeting.
STOMP - 3rd and 4th degree tears	Complete but awaiting documentation
Audit of term babies admitted to NBU with hypoglycaemia	Complete no recommendations
Post partum haemorrhage re-audit	Complete but awaiting documentation
Effectiveness of consultant presence on CAU	Consultant presence within CAU has shown that there has been a reduction in the need for children to attend CAU on the same day, with almost 1/5 of referrers being given advice and 11% being seen in rapid access clinic.
Maternal sepsis screening and sepsis 6 compliance	• Face to face training to front line clinical staff • Mandatory eLearning on Moodle for maternal sepsis • Incorporate the Sepsis session on PROMPT • Needs to review quality assurance of the data collected –deep dive audit • 24 Hr fluid chart audit • Supply of patient information leaflet on Sepsis to every clinical area with QR code • Community audit on sepsis screening
Outpatient hysteroscopy (from 2018/19 plan)	No actions (presented Feb 2020)

Participation in clinical audit

Local Audits

Group 3	
Integrated Pathways	
Audit	**Description of Actions**
Monitoring compliance of NPSA guidance and local policy (PP442) for insertion of nasogastric tubes	Type of tube inserted is recorded: Training / raise awareness. Patient details recorded on sticker: Training. Date and time of NG insertion recorded: Training / raise awareness. Rationale for out of hours insertion: Training to Drs / raise awareness. Correct sticker used for medical notes: training / raise awareness. Fixation allows for visual inspection: Training / raise awareness. Gastric aspirate attempt 3 x after insertion: Training / raise awareness. When CXR required date and time documented: Training to Drs / Raise awareness. Tube length documented prior to all meds, water, feed: Training / raise awareness. PH documented prior to all meds, water, feed: Training / Raise awareness
Are acute and community dieticians recommending prescriptions of oral nutritional supplements (ONS) appropriately and in accordance with local prescribing guidelines?	Ensure appropriate rejecting of referrals. Encourage total MUST score to be calculated when weight, BMI and weight change has been calculated. Amend GP letters to include MUST score as a mandatory drop down. On feedback to department I will discuss the importance of calculating total MUST score as this is an ACBS indicator for the appropriate prescribing of ONS. Feedback to department and discus treatment options for patients with a MUST score/ other ACBS indicators which do not indicate ONS to discuss with the patient Food First options and OTC supplements. To ensure underlying medical problems that could contribute to weight loss have been documented to provide support to the ONS request and demonstrate the departments worth by assessing the patient holistically before commencing ONS. Likely meeting this target. To continue to assess and promote Food First where appropriate. To document when Food First may not be suitable or achievable by the patient if not provided Food First advice. This provides evidence to the GPs that ONS is required. If ACBS indicators are not met, offer the patient Food First advice and consider recommending OTC supplements. Promote a 1 week trial or use of the sample service. For the department to look at processes for reviewing patients who started a 1 week prescription. Currently there is a variable practice of the patient taking responsibility to call and the dietitian calling the patient. For high risk patients to ensure dietitian has made contact if the patient has not called within the 2week time frame. To review department procedures regarding ONS trials to allow this to happen. At present often an overall treatment goal was set which may have been vague however a goal specifically for the use of ONS was not set. To update current letters to allow an ONS specific treatment goal. This is an important discussion to have with patients so they are aware that it may be discontinued and when. Good adherence to this standard. To raise awareness of prescribing guidelines to encourage 1st line product choices. To ensure a clear target for the use of ONS on initiation and to discuss this with the patient. On review if this goal has been met they can be discontinued appropriately.

Participation in clinical audit

Local Audits

Investigating the clinical need for weekend working for SALT in acute wards	Business case for increase in staffing + increase in staff with 7 day service.
'Get it on time' - an audit to determine the adherence to national standards for medicines management for patients with Parkinson's disease admitted to Ipswich Hospital	Ward based pharmacy staff training session. Pharmacists to endorse electronic discharge letters with 'GP please add specific administration times for PD medications to SCR' to overcome issues regarding incorrect prescribing and hypothesised overreliance on SCR during admission clerking Patient/carer and PD clinic letters should be used preferentially during admission clerking and L2MR, and SCR should be used as a secondary source. . Add ropinirole (IR & MR formulations) to emergency PD boxes to ensure that doses are not omitted/delayed due to medication being unavailable Use of Parkinson's UK 'Get it on Time' stickers on drug charts for patients who are prescribed timed medications for PD. . Add ropinirole (IR & MR formulations) to emergency PD boxes to ensure that doses are not omitted/delayed due to medication being unavailable Use of Parkinson's UK 'Get it on Time' stickers on drug charts for patients who are prescribed timed medications for PD. . Prescribers and/or pharmacists/medicines management pharmacy technicians to annotate allergy box on PD patient drug charts with 'PD patient – do not prescribe metoclopramide, haloperidol or prochlorperazine'. Extension of specialist PD nurse service to 7 day working. Specialist PD nurses to consider patient's suitability
Do patients feel they are getting support with eating and drinking on the stroke unit	Liaise with nursing/catering staff to ensure all patients offered menu on daily basis. Liaise with Catering team about reported limited menu choices for patients on modified diet. Discuss if a physical menu could be available in future for patients on modified diet. - Consider monitoring patients at mealtimes to observe if patients are receiving all the necessary support, they require to eat safely. This may help to more accurately establish the likelihood occurrence of something harmful. - Create training package for nursing staff to both provide education around safe eating drinking strategies and problem solve issues around mealtime support.
Re-audit 'The Impact of the Speech and Language Therapist Role in the ASD diagnostic pathway in reducing waiting list time for ADOS'.	No recommendations
Therapies notes audit	Staff informed of areas of noncompliance – each area to look at paper work to see if further changes can be made to help improve adherence to the standards. All new staff to be given pocket notes standards crib sheet
Therapies notes re-audit	Staff informed of areas of noncompliance – each area to look at paper work to see if further changes can be made to help improve adherence to the standards. All new staff to be given pocket notes standards crib sheet
Do tailored medication reviews of the severely frail in primary care impact on falls and admission rates.	Local Guidelines/pathway

Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by East Suffolk and North Essex Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 3,876. Of these 3,578 were recruited to NIHR portfolio studies. This ranks the Trust as the second highest recruiting organisation in the East of England in 2019/2020 and represents a significant increase in the opportunities we can offer our patients.

The Department of Health is committed to offering patients the opportunity to take part in robust, peer-reviewed research. The organisation remains dedicated to supporting clinical research in order to improve the quality of care we offer and to making our contribution to wider health improvement. We actively seek to attract high quality research to help develop our research portfolio. Our Trust was involved in 109 recruiting clinical research studies during 2019/2020, across 27 of the 30 NIHR specialty therapy areas. The number of staff involved within the research fixed workforce equates to 44.0 wte while the number of staff involved and supporting the research has increased year on year; currently there are over 141 Principal Investigators listed as leads in our research studies, an example of the studies we are involved in, that demonstrate a commitment to clinical research leads to better treatments for patients include:

Adjuvant Systemic Treatment of Premenopausal Women With Hormone Receptor–Positive Early Breast Cancer: Lights and Shadows:
We took part in the Suppression of Ovarian Function Trial (SOFT) which evaluated the role of ovarian function suppression (OFS) in pre-menopausal woman with early breast cancer. The first results of SOFT, after a median follow-up of approximately 5 years, showed clinically meaningful improvement in outcomes with the addition of OFS to tamoxifen for women who remained premenopausal after chemotherapy. The Journal of Clinical Oncology link is here: https://ascopubs.org/doi/full/10.1200/JCO.18.02433
Readers wishing to learn more about health research and development and taking part in research can access the websites of the National Institute for Health Research, at the following address: https://www.nihr.ac.uk/patients-carers-and-the-public/i-want-to-learn-about-research/ https://www.nihr.ac.uk/patients-carers-and-the-public/i-want-to-take-part-in-a-study.htm

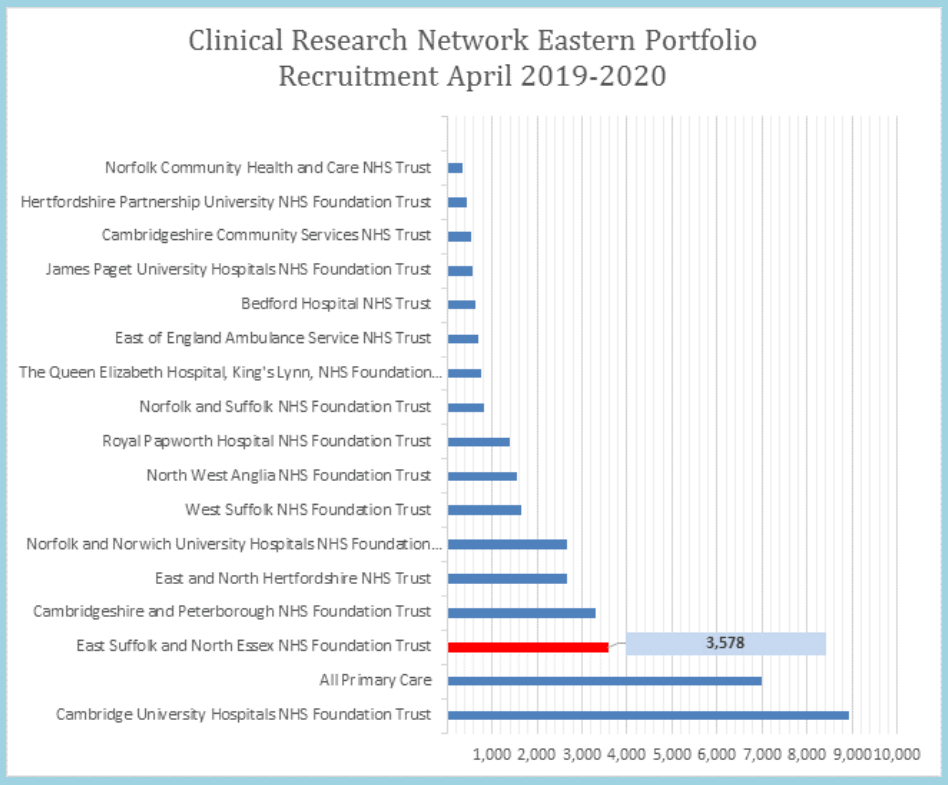
The Trust's employees have demonstrated the vibrancy and innovative practice of a research active organisation in the last twelve months by producing conference abstracts and publications in high quality academic journals. 175 articles and abstracts were produced.

We are enabling our strategy to increase our activity in our own in-house research. We have have officially joined forces in a new partnership to promote greater collaboration in the areas of health and wellbeing with University of Essex and plan to create many more new partnerships. We are also employing clinical academics within the areas of to be advised as interviews planned before the end of March 2020

Professor Rayman one of our leading researchers at the Trust has been awarded an MBE in The Queens New Year honours list for his work in developing research and services

Participation in clinical research

Chart 2-



Pictured below, left to right, are, Professor Maria Fasli, University of Essex Executive Dean (Science and Health), Professor Anthony Forster, University of Essex Vice-Chancellor, Helen Taylor, ESNEFT Chair and Dr Shane Gordon, ESNEFT's Director of Strategy, Research and Innovation.

Monitoring quality

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

The CQUIN payment framework enables our commissioners to reward excellence and innovation, by linking a proportion of the Trust's income to the achievement of nationally and locally-agreed quality improvement goals. A proportion of Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Trust and commissioners which they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/. The CQUIN schemes followed the schema of the national CQUIN formats, available at the web link above. They were:

- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery;
- Staff Flu Vaccinations;
- Alcohol and Tobacco – Screening & Brief Advice;
- Three High Impact Actions to Prevent Hospital Falls;
- Same Day Emergency Care – Pulmonary Embolus/ Tachycardia/ Community Acquired Pneumonia;
- Hospital Medicines Optimisation;
- Spinal Surgery Network;
- Increased Access to breast screening;
- Increased Access to bowel screening;
- Improving AAA Screening uptake in GP Practices with poor uptake;
- Trauma;
- Armed forces policy;
- Dental dashboard.

Table 6 demonstrates the actual performance for the CQUIN indicators for 2019/20 for East Suffolk and North Essex NHS Foundation Trust

Monitoring quality

Table 6– Actual performance for the CQUIN indicators for 2019/20

CCG Scheme						
Scheme	**Sub-scheme**		**Q1**	**Q2**	**Q3**	**Q4**
Staff Flu Vaccinations		Improving the uptake of flu vaccinations for front line staff within Providers				
Antimicrobial Resistance		Lower Urinary Tract Infections in Older People				No data
		Antibiotic Prophylaxis in Colorectal Surgery				
Alcohol and Tobacco		Screening				Due to Covid no reporting
		Tobacco Brief Advice				Due to Covid no reporting
		Alcohol Brief Advice				Due to Covid no reporting
Three High Impact Actions to Prevent Hospital Falls		Three High Impact Actions to Prevent Hospital Falls	NA			Due to Covid no reporting
Same Day Emergency Care		Pulmonary Embolus				Due to Covid no
		Tachycardia with Atrial Fibrillation				Due to Covid no reporting
		Community Acquired Pneumonia				Due to Covid no reporting

Specialist Commissioning Scheme						
Scheme	Sub-scheme		Q1	Q2	Q3	Q4
Hospital Medicines Optimisation		Improved efficiency in the IV Chemotherapy Pathway				
Hospital Medicines Optimisation		Completion of Blueteq for specific medications				
Hospital Medicines Optimisation		Faster Adoption of Prioritised best value medication				
Hospital Medicines Optimisation		Anti- Fungal Stewardship				
Spinal Surgery		Spinal Surgery				
Trauma		Improved reporting of Trauma data to TARN				
Improving Breast Screening		Improved take up of screening – targeting low take up areas/GP Practices				
Improving Bowel Screening		Improved take up of screening – targeting low take up areas/GP Practices				
Improving AAA Screening in GP Practices with poor uptake		Improving AAA Screening in GP Practices with poor uptake				
Armed forces policy		Armed forces policy				
Dental Quality dashboard		Dental Quality dashboard				

Key

Green Standard achieved Red Standard not achieved

Amber Standard partially achieved Grey Development, implementation or not deliverable for this Quarter

How healthcare is regulated

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

ESNEFT has the following conditions on registration - no conditions.

The Care Quality Commission has taken enforcement action against ESNEFT during 2019/20. An Improvement Notice and a Letter of Contravention were issued to the Trust under Sections 21 and 23 of the Health and Safety at Work Act 1974 by the Care Quality Commission (CQC) and the Health & Safety Executive (HSE) respectively in September 2019 following a short notice, announced, focussed joint inspection to assess the Trust's compliance with the Ionising Radiation (Medical Exposures) Regulations 2017, commonly referred to as IR(ME)R, and the Ionising Radiation Regulations 2017 within Nuclear Medicine at Colchester Hospital. The Trust produced a comprehensive action plan to address issues identified by the CQC and the HSE, both within the area inspected and across the whole of ESNEFT. The Improvement Notice required improvements to be completed by 18 November 2019.

ESNEFT has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

CQC monitoring and inspection process

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

The indicators are used to raise questions about the quality of care but are not used on their own to make final judgements.

Judgements are based on a combination of what is found at inspection, national surveillance data and local information from the Trust and other organisations. The judgement is based on a ratings approach using the following categories: Outstanding, Good, Requires Improvement, or Inadequate

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

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

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

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

Inspections are carried out using an expert team of inspectors and include as a minimum a review of the Well-led domain, Use of Resources and a least one of the above core areas.

Inspections by the Care Quality Commission (CQC)

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

Services at ESNEFT were inspected between 11 June and 18 July 2019. The CQC inspected 14 core services provided by ESNEFT at two acute locations and one community service. Urgent and emergency care, Medical care, Surgery, Maternity, and Outpatients at Colchester Hospital, as well as Urgent and emergency care, Medical care, Surgery, Critical Care, Maternity, Children and Young People, End of life care, and Outpatients at Ipswich Hospital. Community health inpatient services were also inspected.

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

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

- The CQC rated Safe and Responsive as requires improvement, and Effective, Caring and Well-led as good. The rating took into account the ratings of the core services not inspected during this current visit.
- Four of the 14 core services inspected a were rated as

How healthcare is regulated

requires improvement, and nine core services as good. Services for Children and Young People were considered to be outstanding.

- The decision on the overall ratings takes into account the relative size of the service and the CQC uses its professional judgement to reach fair and balanced ratings.

The 'Must do' recommendations are:

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

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

How healthcare is regulated

Medical Staffing
Rota Gaps

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

Medical Staffing

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

In 2019, ESNEFT was the first choice for FY1 doctors commencing their careers as doctors in the East of England. Also in 2019, all FY1 doctors stayed with ESNEFT to complete their FY2 training to provide a better training experience.

Medical Staffing have continued to work closely with the Iceni Centre and have created Iceni Fellow posts in Surgery for doctors to come to ESNEFT for a 12 or 24 month period to learn new skills. We have also worked closely with Royal Colleges to extend our MTI scheme (Medical Training Initiative) which now operates in Surgery, T&O, Medicine, O&G, Anaesthetics.

Medical Staffing were shortlisted for ESNEFT Team of the Year in 2019 due to the recruitment that was completed which meant that we were in a position to declare no training or trust grade vacancies for the August rotation. Rota gaps/vacancies are discussed at the Medical Staffing Steering Forum and the Joint Local Negotiating Committee. Regular Reports are provided to POD.

We have active Junior Doctor Forum Meetings and Safer Working Meetings on both sites.

In August 2019, we have a total of 12 training grade doctor vacancies.

- We commenced the recruitment process and was able to recruit Locally Employed Doctors into all of these posts.
- Due to the changes to IMT (Internal Medicine Training) we have had 2 x two month gaps that we have not been able to fill and this has resulted in the department using agency locums.
- We have also had doctors complete their training midway through their rotation (3 doctors) and also two doctors have resigned from training due to personal reason.

Careers day for doctors of the future Doctors of the future got a hands-on look at what it takes to enjoy a career in medicine at the Iceni Centre at Colchester Hospital. Teenagers from schools across Suffolk and Essex went behind the scenes at our careers day to get an idea of what medical training is like

Time Matters

TIME MATTERS

Background

Building on the success of the first 'Time Matters' week in November 2018, in November 2019 ESNEFT held a week long (7 days) series of events with a focus on out of hours experiences of patients and staff with a greater focus on clinical services as opposed to corporate services that was the focus in 2018. This was a fully inclusive event and covers all teams across ESNEFT, both clinical and non-clinical teams in the acute and community settings.

Too often, our current systems and ways of working add unnecessary stress and frustration. Throughout ESNEFT, we focus on unblocking barriers which cause time delays throughout our every day-to-day business, preventing us from being able to best serve our patients, staff and ourselves.

The Time Matters Week 2019 (TMW2019) series of engagement gave us the opportunity to build on sharing our philosophy, ambition and objectives, listening and working with patients and staff to see what it means to them and how they can contribute.

The aims of Time Matters Week 2019 were:

- 'Time Matters, let's keep talking', continuing a social movement for all staff across the organisation to personally contribute to 'Time Matters'. Having fun and building energy across the organisation.
- 'Time Matters' to everyone in the organisation, whoever and wherever they are. Hence all staff are involved and play their part in contributing to the vision and every contribution is valued.
- The primary focus of the directors and senior managers was to be visible in supporting areas across the organisation; having face-to-face contact with teams, to gain knowledge of areas outside of their day-to-day responsibilities, to listen, observe, gently enquire, share expertise and to lead the ambition for the organisation around Time Matters.
- To enable innovation, encouragement of ideas, empowerment and support to release 'non value-added time' and improve time to care
- To build 'interconnectedness' – i.e. what affects one of us affects us all
- To build 'ingenuity' – i.e. there's nothing we can't achieve if we set our minds to it .

During the 7 day period, the key focus of Directors and senior managers and service leads was on engagement with staff and patients to understand what 'Time Matters' really means to them and how we can work together across the ESNEFT organisation to lead, support, advise, empower and change to embrace and embed the philosophy of Time Matters in our everyday business.

The view being that Time Matters contributions will undoubtedly take the form of:

- Staff thinking about what Time Matters means and making changes themselves and within their teams
- Some changes may re-

Table 7 Engagement Data Collected

Data Source	Data Collected
Staff & Patient Survey	677
Inflatapod's video comments	166
Show & Tell /Fix-it sessions	368

Time matters

New blood test clinic opens its doors
A new phlebotomy clinic will make it quicker and more convenient for patients to have blood tests in Ipswich.
The Landseer Road Phlebotomy Clinic was opened by BBC Radio Suffolk's Mark Murphy, pictured here with ESNEFT colleagues. Patients can book their appointment by phone or online rather than dropping in, helping staff to manage demand and prevent people from waiting for their blood test during busy times.

quire management / divisional level support

- Other more complex changes may require wider organisation / system support

The week consisted of the following events:

- Daily debrief – Lead by Director of the Day, teams sharing ideas and issues identified during the day.
- Inflatapod – Open to staff and patients to leave a video message.
- Question & Answer sessions with Directors – Open invite for staff to come and ask questions or share ideas.
- Fix-It and Show'n'Tell events - HR, Workforce, Estates, IT, Business Informatics teams provided real-time 'fix-it' support to staff along with showcasing forthcoming changes, Apps (e.g. Patient Portal) and estate builds.
- Survey – open access to staff to submit their views and patients (inpatients and outpatients) responses facilitated by staff volunteers entering responses into the survey.

The Findings

The findings of TMW2019 are:

- Some issues being raised are within the gift of the staff in the areas to resolve within their own teams and departments.
- Overwhelming level of staff feedback on engagement with Senior Leaders during the week – they have felt listened to and valued.
- Patient feedback has mostly been extremely positive across all areas.
- Communication across the organisation particularly on wards, clinical areas and back office support staff needs a whole new approach to reach staff.
- Outpatient appointments has been a key factor from waiting times to receiving a first appointment and patient letters, signposting and subsequent waiting time in clinic will be a key focus going forward with last minute clinics being problematic.
- Fantastic engagement during the week with Divisions identifying, owning and

Time Matters

NET service expands into Suffolk
In May, Colchester Hospital's neuroendocrine tumour (NET) service was expanded to treat people in east Suffolk.
Now patients don't need to travel long distances for their care.

solving actions.

- Out of hours engagement has been informative and appreciated by all those involved.
- Car parking is still problematic for patients and staff, with comments from patients that they are arriving 2 hours before appointment to ensure they can get a space or schedule an afternoon appointment as it's easier to park. Comments from staff that patients are arriving in clinic stressed and frustrated by parking.
- IT and Intranet is still a key issue for staff; speed of equipment or response time of systems and the usability of the intranet, staff struggling to find information.

Next Steps

Although good progress has been made in resolving issues and implementing new ideas raised in the 2018 Time Matters week, much of the larger-scale organisational-wide items raised by staff and patients during TMW2019 are similar to last year. Most of these are currently being addressed by various projects and initiatives across ESNEFT. However, the speed of change and implementation is slower than expected by our staff and patients.

The EMC is undertaking a piece of work to review the strategic transformation of ESNEFT to narrow our focus to accelerate delivery of the most important priorities.

The key findings and proposed actions from TMW2019 are being factored in the prioritisation process to redraft the drivers and align corporate & clinical priorities under a new programme structure reporting to EMC/ODG.

Teams have been encouraged to make TMW principles integral to the way they work and continuously involve their teams in identifying issues and processes that are not working to support their patients and themselves, also to feel empowered to change within their service.

Time matters

Launch of Better Births
Maternity and Transformation colleagues were joined by new parents for the launch of Better Births - a new way of working for midwives.
The event celebrated the work of six trailblazing Continuity of Carer teams who are working across north Essex and Suffolk to give personalised care and support to women in pregnancy, labour and when they go home too.

The Collingwood Centre

The Collingwood Centre was possible after a successful fundraising drive by Colchester and Ipswich Hospitals Charity raised £3.25million following the launch of the Cancer Centre Campaign in 2014.

The contemporary building brings together chemotherapy, Haematology and radiotherapy under one roof, alongside a wellness centre that will offer counselling and support services for patients and their families.

The centre provides a combined oncology and haematology unit with an improved environment for patients receiving treatment due to the increase in size and facilities. The new environment is more modern, comfortable and welcoming, creating a significantly better experience for patients, their families and carers.

The hospital's 'old' facilities in the Mary Barron Chemotherapy Suite and Haematology Day Unit were cramped with little space for friends and family to accompany loved ones and no space to expand.

One of the first people to receive treatment in the £3.25million unit was Roger Sharman, 75, from Ardleigh. He was diagnosed with multiple myeloma in March 2016 and receives chemotherapy and immunotherapy alternately every two weeks at the hospital.

He visited The Collingwood Centre on Monday 11 November for the first time.

Roger said: "I'm impressed, it looks really good. It's bright and spacious.

"Where we were before was getting a little bit dated so this is a fresh start and it will mean a lot to the staff too.

"I've been seeing the same nurses and faces for the last three and a half years, you get to know them and the other patients – that means a lot to me."

The Collingwood Centre is more modern, comfortable and welcoming, providing a significantly better experience for patients, their families and carers. It will replace the hospital's now merged Mary Barron Suite and Haematology Day Unit.

We are extremely grateful for all the support from the public with the fundraising and have also worked closely with the Colchester Cancer Services User group to ensure the design of the new unit meets the needs of our patients.

After making a generous £1million donation to the campaign, a donor who wishes to remain anonymous, was invited to name the new chemotherapy and haematology suite, which will be known as the Collingwood Centre.

Construction started in January 2019 and the new unit was occupied form November 2019.

Peter Wilson, chairman of the fundraising committee, said: "Our thanks go out to all the people who have supported us. This unit, together with the radiotherapy building, will provide a centre of excellence for cancer treatment at Colchester.

The Collingwood centre

Patients are now being treated at Colchester Hospital's new, state-of-the-art cancer centre after a successful fundraising campaign. The Collingwood Centre is helping to improve patient care for people living with cancer in north Essex.

Quality Improvement

Quality Improvement faculty

Quality in the NHS has been defined by NHS England and was used as the basis of the NHS England Outcomes Framework. It is as follows:

- Safety-doing no harm to patients
- Experience of Care-this should be characterised by compassion, dignity and respect
- Effectiveness of Care-including preventing people from dying prematurely, enhancing quality of life and helping people to recover following episodes of ill health.

The Institute of Medicine defines the six dimensions of quality as follows:

- Safety-avoiding harm to patients from care
- Timeliness-avoiding non-instrumental delays for patients and clinicians
- Effectiveness-aligning care with the best of clinical science
- Efficiency-reducing waste in all its forms
- Equity-closing racial, ethnic and other gaps in health status and care
- Patient-centeredness-customising care to the needs, resources, values and background of each individual patient and carer

QI is a systematic approach to improving health services based on iterative change, continuous testing, measurement and empowerment of frontline teams to bring about these changes. The main ethos is that the patient should be at the centre of any QI programme, they bring their unique knowledge and experience and are expert on the experience of being a patient and often an expert in their illness.

QI is an integral part of all clinical encounters it requires:

- Individual and team improvement capabilities
- Improvement methodology : effective, easy for staff to learn and engage
- Supporting structure: education, training, project management and governance
- Links with external improvement communities and/or national benchmarking

The difference between QI and audit is that audit is performed against a set of standards whereas the QI model takes a problem or an issue and enables staff to make small test changes, before rollout occurs, this then leads to a clear process and improves sustainability. QI methodology looks at processes and uses a set of tools and techniques that supports implementation of improvements.

The QI Faculty continues to build capability and knowledge within the organisation to bring about change. The Faculty offers QI training or support for individuals or teams to help with the development and monitoring of projects. They also offer mentorship and coaching throughout the project progress.

The QIF provides links between different clinical teams, patient groups involved in QI and also drive forward trust wide learning from QI.

The QI faculty has placed a support structure for QI development within the Trust from ward to board and in all staff groups. Training, coaching, spreading learning, co-ordination and monitoring are the key roles of the QIF. This will help to develop a QI ethos and expertise across the trust in order to improve care for patients and their families.

Quality Improvement

A Walk-In Initial Preoperative Assessment Clinic. Improving Quality and Saving Time for Surgical Patients.

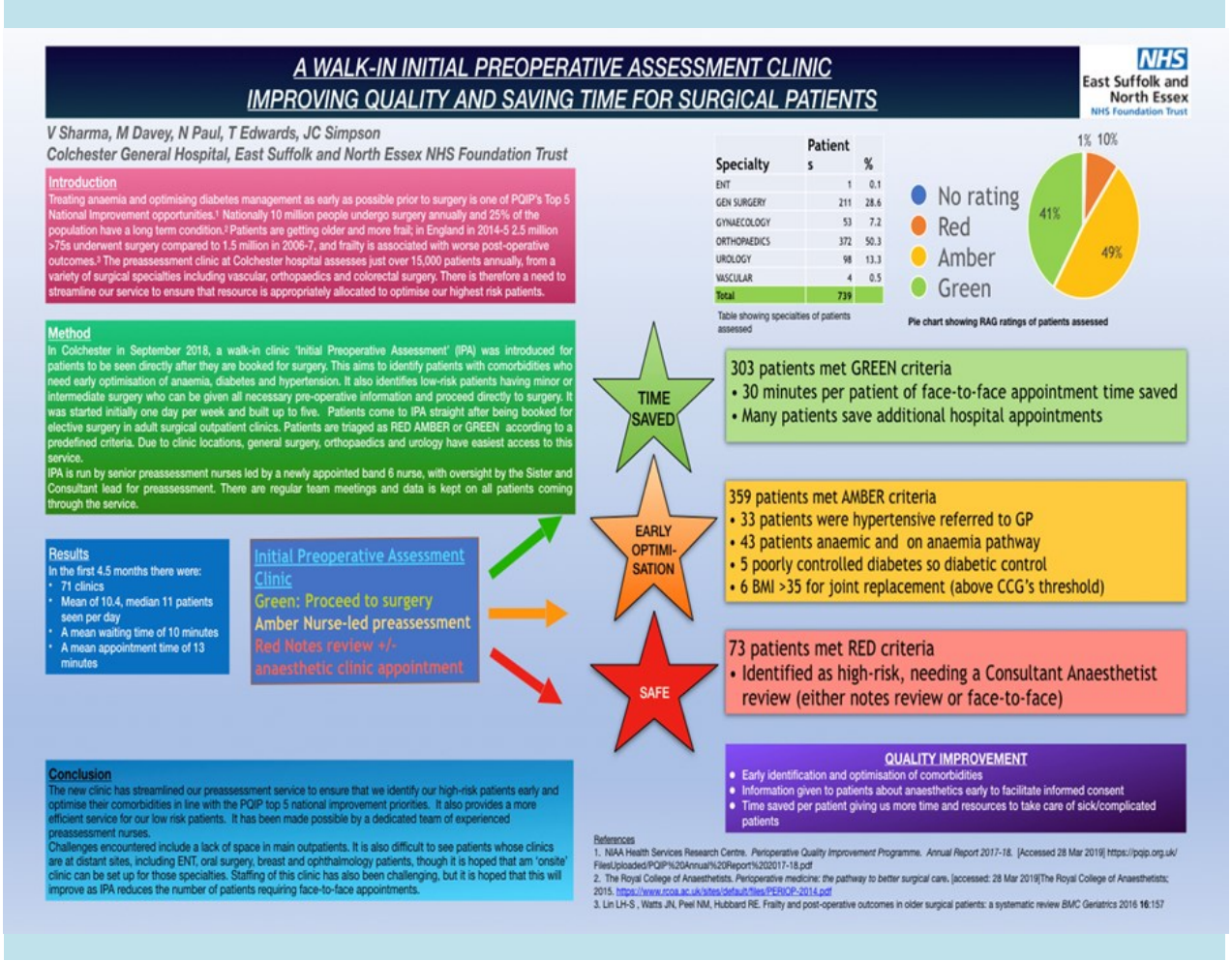
In May 2019 the work done in pre-assessment by our excellent pre-assessment nurses and led by Maria Davey and beautifully presented by Vivek Sharma at 'Anaesthesia', the RCoA's conference in London to 400 delegates from around the country and the world. Vivek won the competition for the best presentation. The Poster below explains the QI journey with successful outcomes.

Quality Improvement NHSI Transition Collaborative: Cerebral Palsy

This project is led by Elizabeth Thomas Lead Nurse Transition Team ESNEFT, working with the

Quality Improvement

Quality Improvement faculty



support of Dr Andrea Turner: Consultant Paediatric Lead, Dr Ben Marlow: Consultant Community Paediatrician, Stephanie Baker: Learning Disabilities/ Autism Liaison Nurse, Amy Bruce: Matron for Children's Services and Marika Havers: Sister, Children's Community Nursing Team.

The aim of the project is to improve the experience of all young people and families when moving from children's to an adult service and to achieve the best possible long term health outcomes for young people with long term conditions. The passport has been developed to provide an uninterrupted, coordinated approach to healthcare across the transition pathway and organisational boundaries and to drive change within organisational cultures to embrace and embed developmentally appropriate care, understanding and meeting the unique needs of young people.

The passport has been developed to enable the patients to present to healthcare staff across the acute and community settings their details, medical history and preferred communication methods at each attendance. On each attendance staff are asked to add a summary of the care given during that admission/appointment which allows for understanding the history and requirements moving forward.

The passport includes:

- Preferred methods of communication
- Health history and current health needs

Quality Improvement

Pictured: The Quality Improvement project 'Patient held records'

- Professional teams (acute, community, AHP's, Social Care, Education, etc.)
- Medications Interventions
- Pain management
- Functional abilities
- Personal Care & Care Plans
- Mobility
- Nutrition/hydration/ gastrostomy
- Sleeping & Behaviours
- Specialist equipment
- Professional review document
- Appointments

Statements relating to the quality of relevant health services provided

NHS number and General Medical Practice Code validity

East Suffolk and North Essex NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data including a valid NHS number for patients seen:
· 99.39% for admitted patient care;
· 99.83% for outpatient care;
· 97.41% for accident and emergency care; and 99.98% for Community Care.
The percentage of records in the published data including a valid General Medical Practice Code for patients seen:
· 99.72% for admitted patient care;
· 99.79% for outpatient care;
· 97.54% for accident and emergency care; and 100.00% for Community Care.

Source: NHS and Social Care Information Centre data quality dashboards.

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

East Suffolk and North Essex NHS Foundation Trust (including community services) Data Security and Protection Assessment Report for 2019/20 was graded as standards not fully met (a plan has been agreed)

Clinical coding

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

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

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

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

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

Table 8 -Data Quality
East Suffolk and North Essex NHS Foundation Trust will be taking the following actions to improve data quality:

Data Quality Indicator	Data Quality or Data Flow	When	Update
Valid NHS Number &Valid GP Practice Code	Data Quality	Colchester UTC – October 2019 on-wards	The IT projects for the procurement of clinical systems at the Trust will continue to make improvements to our performance within the DQMI, for example the introduction of new soft-ware within Colchester Urgent Treat-ment Centre will see an improvement in both NHS number and GMP codes due to this system being linked to the national Spine system.
Valid NHS Number &Valid GP Practice Code	Data Quality	2020/21	ESNEFT are currently investigating a combined electronic patient master index across both of our sites and all of our clinical systems. The introduc-tion of such a system will help bring us towards "one version of the truth", helping ensure that update infor-mation is getting to all the necessary systems in a timely man-ner.
Valid NHS Number &Valid GP Practice Code	Data Quality	2020/21	The 2 data quality teams, one based at Colchester and one at Ipswich will both be under Business Informatics from April 2020 helping to ensure consistent approaches to tackling DQ challenges and for better allocation of resource to update patient records.

Learning from Deaths

During 2019/20, 3148 of ESNEFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 777 in the first quarter; 692 in the second quarter; 845 in the third quarter; 834 in the fourth quarter.

By March 2020, 792 case record reviews and 23 investigations have been carried out in relation to 3148 of the deaths included above.

The number of deaths in each quarter for which a case record review or an investigation was carried out was: 287 in the first quarter; 193 in the second quarter; 225 in the third quarter; 87 in the fourth quarter.

0.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These are all subject to a detailed serious incident review to ensure all aspects of learning are captured and addressed.

In relation to each quarter, this consisted of: 0.3% for the first quarter; 0% for the second quarter; 1.8% for the third quarter; 0% for the fourth quarter.

These numbers have been estimated using the summary of care information from the Royal College of Physicians' Structured Judgement Review (SJR) and the national Perinatal Mortality Review tool (PMRT).

Lessons Learned from Case Record Review and Actions

In the first case, a review undertaken using the PMRT identified room for improvement in the antenatal care of a patient which resulted in a stillbirth. The GROW (Growth Related Optimal Weight) and Saving Babies' Lives(2) programmes were fully implemented with training for all midwifery staff. (Foetal growth restriction is by far the single strongest risk factor for stillbirth after 34 weeks gestation, and it accounts for approximately 50 per cent of all stillbirths before 34 weeks gestation.)

In the second case, the serious incident investigation found that abnormal results from diagnostics were not automatically flagged and acted upon. The Trust Critical, Urgent and Significant Unexpected Finding Policy, has been updated to ensure that where clinically indicated, abnormal x-rays result in a CT scan, with an automatic follow-up to the relevant specialty.

The third case involves possible delays in surgery; this is still under review and may be subject to an internal investigation.

Case four has resulted in a change to local induction procedures, implementation of recommendations of Management of Acute Upper GI Bleeds: NICE guideline [CG141] audit including OGD requests for suspected UGIB with compulsory risk assessment scoring and use of the British Society of Gastroenterology Upper GI Bleed bundle.

Case 5 is still awaiting recommendations.

The Impact of the Actions taken following Case Record Review and investigation

For the first case, the implementation of the Grow programme has seen improvements in foetal monitoring which has resulted in a significant reduction in the number of stillbirths. The ESNEFT stillbirth/1000 births rate has been below the national average for the last nine months.
For the second case, the process for flagging abnormal findings on scans has been taken forward by the radiology team.

Previous Reporting Period

In relation to 2018/19, 447 case record reviews/investigations were completed after February 2019 which related to deaths which took place before the start of the reporting period.
0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Royal College of Physicians' Structured Judgement Review (SJR) and the national Perinatal Mortality Review tool (PMRT).
0.3% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Medical Examiners

The Medical Examiner programme was developed following the findings of the Shipman Enquiry and forms part of the Coroner's and Justice Act 2009. In April 2019, in line with new guidance, the Trust introduced the role of Medical Examiner. The team works within the bereavement suite, reviewing all deaths, ensuring accurate death certification with the responsible clinical team and providing support to bereaved families and carers. The Trust has since maintained 100% compliance with the review of all non-coronial deaths. The team brings with it wide-ranging expertise and experience, with good interaction between the Medical Examiners and clinicians. The legal paperwork is now being processed efficiently, with reduced waits for relatives as well as greater accuracy of certification and additional feedback for any concerns relating to patient care and the learning process.

Every family/carer is offered the opportunity to speak with a Medical Examiner, either on the phone or face to face. With a take up of around 5%, this gives the bereaved an opportunity to ask questions about the care of their loved one, including clinical decisions, treatment and health condi-

Learning from Deaths

tions.

Medical Examiners have been able to provide an explanation about the effects of a disease or condition and subsequent treatment, which can be help with understanding and allaying concerns. Feedback from families has been that care was "excellent" "could not have been better" or "the staff were fantastic".

Mortality and Morbidity Meeting Trustwide

The Trust follows a robust process for determining those cases subject to mandatory mortality review, in line with National Guidance published March 2017. Deaths are screened by staff not involved in the patient's care using predefined criteria and multiple data sources, including: the trust incident and complaint reporting tools, the patient administration system and responses to the Chief Executive's letter of condolence. In addition, feedback from the Bereavement Services Manager/other staff, external alerts raised by Dr Foster Intelligence, and any concerns raised by GPs are included along with service/diagnosis group reviews and themed work from Quality Improvement projects. Furthermore, staff are encouraged to review any death where lessons can be learned.

All specialties hold Mortality and Morbidity (M&M) meetings where cases are discussed in detail and learning and actions identified. These are presented at the Learning from Deaths Group and thereafter to the Clinical Effectiveness Group, Quality and Patient Safety Group and the Trust Board. Staff are encouraged to consider human factors, clinical/organizational issues and identify training needs.

Within the M&M meetings for the Older Persons' Service, it was identified that there was a need for nursing colleagues to be able to initiate and facilitate timely conversations about how the patient would like to be cared for at the end of life (resuscitation status). The division enabled training from St Helena's Hospice for seven senior nurses who have been able to support patients in understanding their condition, working with the medical team on a plan of care. The team is also working hard to minimize the number of ward-moves for patients with delirium and dementia as this is a key component of safety drives such as falls prevention.

The Emergency Department teams have regular board rounds to ensure that patients who may be at risk of developing complications are always seen by a Consultant in Emergency Medicine before discharge from the department. In addition, training has been given on the 'Silver Trauma' Safety Alert from the Royal College of Emergency Medicine. This study identified a high risk of mortality following a fall in older patients, with traumatic brain and chest injuries being the most common cause of death. The team now focuses on early trauma scanning, anticoagulation reversal, pain relief, hydration and correct referral pathways.

Reviews of our Systemic Anti-Cancer Therapy (SACT) 30 day mortality have highlighted in a small number of cases the need for better documentation of plans for dose reduction in patients with poorer performance status. Where there is a clinical need to minimize dose reductions, especially in cases where cure is still a potential outcome, this must be established in the patient's clinical notes in consultation with the patient. For those patients receiving chemo with curative intent with poorer performance status, there is detailed review and agreement by two prescribing consultants.

Other examples of learning and quality improvement include:

- ✓ The Stroke Service has been commended for low mortality due to excellent MDT support and retention of general medicine expertise through continued participation in the Acute Medicine rota. Reviews have, however, identified that patient care could be improved with weekend input from Speech and Language therapy. The Trust is working towards the provision of seven day services across all specialties.
- ✓ Antibiotic stewardship: the urology team has been working closely with Microbiology prior to starting antibiotics for patients with indwelling tubes (catheters/stents/etc.) to avoid unnecessary use of antibiotics, thereby preventing the risk of resistance.
- ✓ In Cardiology, there is a team focus on care planning to ensure that patient needs are met should the patient deteriorate. Work has also started to prioritize transoesophageal echocardiograms for patients at risk of infective endocarditis based on patient need.

The Trust participates in many external mortality review programmes such as LeDeR (for patients with Learning Disabilities), the Child Death Review Programme, MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) and PMRT (Perinatal Mortality Review Tool). In January, representatives from the HSIB (Healthcare Safety Investigation Branch) met with team members to discuss national findings from perinatal mortality reviews, sharing best practice with regard to antenatal screening, monitoring during labour and care of the newborn immediately following delivery.

The Trust's two Learning Disabili-

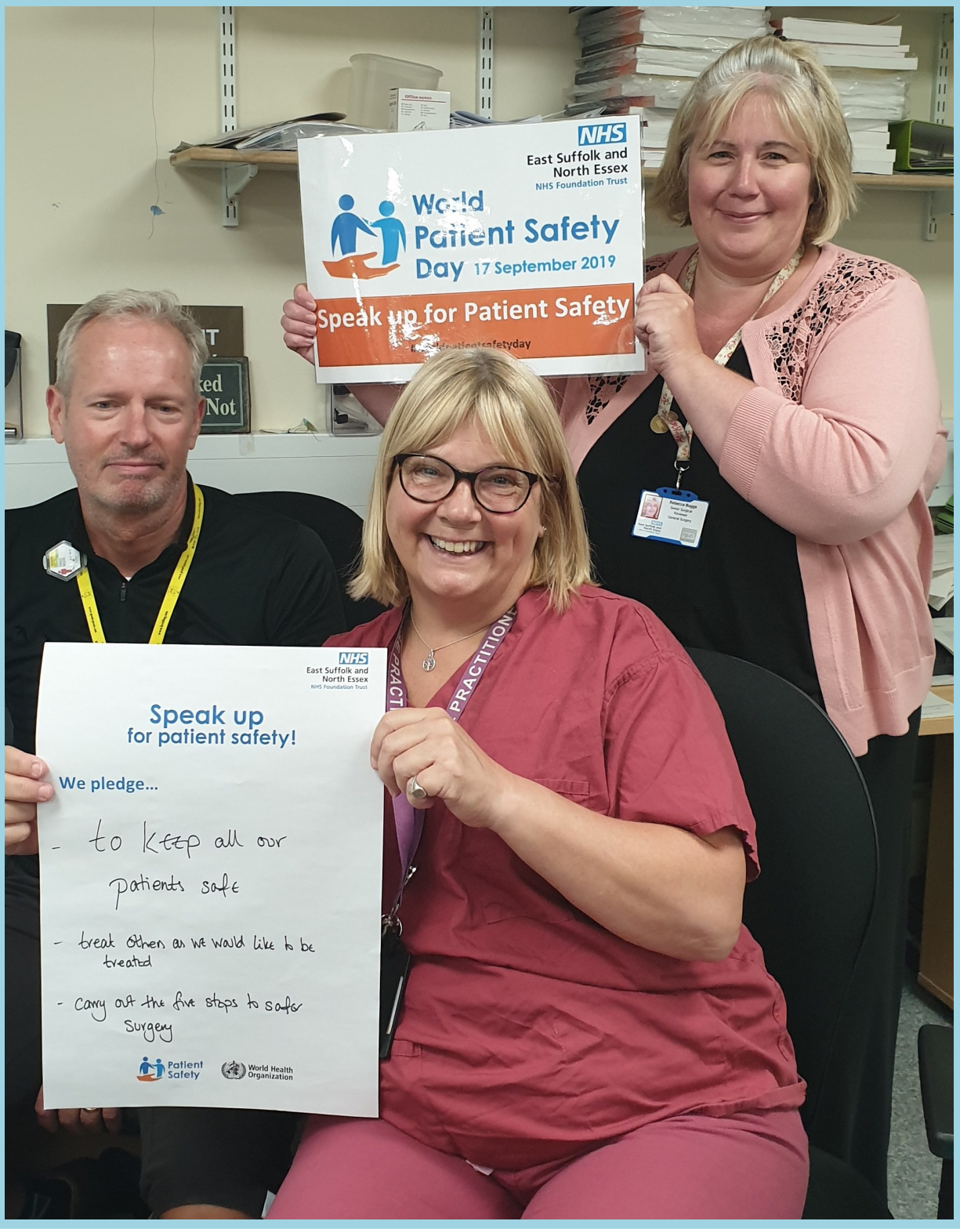
Learning from Deaths

ties and Autism Hospital Liaison Nurse Specialists deliver presentations at induction and the multi-disciplinary audit half days, bringing together local learning from SJRs and wider learning from the LeDeR programme. Staff are encouraged to look for 'subtle signs' that there may be health problems where the patient has cognitive and communication difficulties, as well as listening to those close to the patient who will be best able to understand if there has been any change suggestive of illness.

Staff Pledge on World Patient Safety Day at Colchester Hospital

Learning from Deaths

Staff Pledge on World Patient Safety Day at Colchester Hospital



Core Quality Indicators

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

Indicator: Summary Hospital-Level Mortality Indicator (SHMI)

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

The data made available to the Trust by the HSCIC with regard to:	Reporting period	ESNEFT score	National average	Highest score	Lowest score	Banding
The value and banding of the SHMI for the Trust for the reporting period	Jul 18 - June 2019	1.098	1.002	1.197	0.697	2
	Sept 18 -Aug 19	1.099	0.946	1.187	0.687	2
	Jan 19 - Dec 19	1.083	1.004	1.199	0.688	2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)	Jul 18 - June 2019	32.00%	36.31%	60.00%	15.00%	
	Sept 18 -Aug 19	33.00%	36.57%	59.00%	13.00%	
	Jan 19 - Dec 19	33.00%	36.40%	60.00%	10.00%	

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

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

- ✓ Ensuring that high clinical coding standards are maintained through regular audit.
- ✓ Investigating alerts issued by external providers to ensure that care has been delivered to a high standard.
- ✓ Continuing to promote good documentation which includes clear care plans.
- ✓ Encouraging staff to reflect on care delivered at multiple touch-points including Mortality and Morbidity meetings, where actions and learning can be shared in an open and honest way without apportioning blame.
- ✓ Continuing to learn from feedback given by patients, families and carers.
- ✓ Celebrating and sharing good practice while learning from mistakes, improving both clinical and organizational processes.
- ✓ Implementing the new Serious Incident framework.
- ✓ Delivering training as part of the mandatory programme as well as new initiatives promoted by bodies such as Royal Colleges and NHS England/NHS Improvement. As well as clinical skills, human factors training
- ✓ Continuing with the Quality Improvement Programme which encourages staff to think about local small-scale improvements.
- ✓ Continuing the work of Medical Examiners who provide additional scrutiny by assessing the quality of care as described in the health record and through discussion with the bereaved.

Core Quality Indicators

Indicator: Patient Reported Outcome Measures (PROMs) scores

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

The data made available to the Trust by the HSCIC with regard to:	Site	Reporting period	ESNEFT score	National average	Highest score	Lowest score
The Trust's patient reported outcome measures scores for groin hernia surgery during the reporting period	Colchester	2016-17				
	Colchester	2017-18				
	Ipswich	2016-17				
	Ipswich	2017-18				
	ESNEFT	2018-19				
The Trust's patient reported outcome measures scores for varicose vein surgery during the reporting period	Colchester	2016-17				
	Colchester	2017-18				
	Ipswich	2016-17				
	Ipswich	2017-18				
	ESNEFT	2018-19				
The Trust's patient reported outcome measures scores for hip replacement surgery during the reporting period	Colchester	2016-17	No Data	0.437		
	Colchester	2017-18	0.478	0.458		
	Ipswich	2016-17	0.534	0.437		
	Ipswich	2017-18	0.538	0.458		
	ESNEFT	2018-19	0.490	0.457		
The Trust's patient reported outcome measures scores for knee replacement surgery during the reporting period 2019-20* - figures are provisional April - Sept 19	Colchester	2016-17	No Data	0.325		
	Colchester	2017-18	0.386	0.337		
	Ipswich	2016-17	0.378	0.325		
	Ipswich	2017-18	0.387	0.337		
	ESNEFT	2018-19	0.387	0.337		
	ESNEFT	2019-20*	0.349	0.348		

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

- Inconsistent patient returns have led to inadequate data for analysis with regard to groin hernia and varicose vein surgery

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

- Improvements in systems to ensure better patient returns are being developed.

Core Quality Indicators

Indicator: Readmission rates

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

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

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

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

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

✓ improved rigour to identify causes for re-admissions through speciality reviews.

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

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

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

✓ The indicator as reported nationally is the national data set and confirms local data analysed and reported internally

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

✓ Feedback from patients, relatives and carers from sources such as local engagement events, Friends & Family test, Patient Advice & Liaison Service and complaints are reviewed to ensure that areas for improvements are identified and actioned.

Core Quality Indicators

Indicator: Staff recommendation (Friends and Family Test) Taken from Question 21d of the NHS staff survey					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	ESNEFT score*	National average	Highest score	Lowest score
The % of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends	2017/18 Q3**	62%	71%		
	2017/18 Q4	60%	80%	100%	36%
	2018/19 Q1	75%	81%	0.98	0.53
	2018/19 Q2	72%	81%	100%	39%
	2018/19 Q3	68%	70%	90%	49%
	2018/19 Q4	68%	80%	100%	44%
	2019/20 Q1	73%	81%	98%	51%
	2019/20 Q2	71%	81%	100%	50%

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

- National Average is BASED ON ACUTE TRUSTS
- Highest and Lowest is as at Reporting Quarter

East Suffolk and North Essex NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:
Since April 2014, the Staff Friends and Family Test (FFT) has been carried out in all NHS trusts providing acute, community, ambulance and mental health services in England.

The aim is for all staff to have the opportunity to feed back their views on their organisation at least once per year. The Staff FFT is helping to promote a big cultural shift in the NHS, where staff have both the opportunity and confidence to speak up, and where the views of staff are increasingly heard and are acted upon.

Research has shown a relationship between staff engagement and individual and organisational outcome measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation generally. It is therefore important that we strengthen the staff voice, as well as the patient voice (NHS England).

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

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

Adoption of choice of FFT delivery in wards, sms or paper could relate to the slight decrease in inpatient recommendation due to the time frame being outside of immediate care and the positive increase in in A&E due to one methodology over hospital ED sites.

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

- ✓ Adopting sms FFT in the Emergency Department
- ✓ Teams working with wards to raise awareness with patients and carers of the importance of FFT
- ✓ We will adopt the new National FFT

Core Quality Indicators

Indicator: Risk assessment for venous thromboembolism (VTE)					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	ESNEFT score	National average	Highest score	Lowest score
% of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	**2017/18**	90.55%	95.53%	100%	63.02%
	2018/19	95.38%	95.66%	100%	74.03%
* Q1-Q3 2019-20 High/Low scores at last reported period	**2019/20***	96.38%	95.47%	100%	71.59%

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

- The indicator as reported nationally is the national data set and confirms local data analysed and reported internally

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

✓ Twice daily report from informatics on outstanding VTE RAs which go to all ward sisters to highlight to their medical teams to complete;

✓ Support from the VTE nurse team in capturing any outstanding VTE RAs in EAU/MDU/SAU and wards;

✓ A weekly and monthly VTE RA report is provided to the divisions which identifies their performance looking at elective and non-elective admissions, they then deal with any performance issues in their area;

✓ Weekly report is generated and sent to the medical director, divisional directors and associate directors of nursing to inform them of any issues around VTE RA non-compliance and this is addressed with those.

Indicator: Clostridium difficile infection rate						
The data made available to the Trust by the HSCIC with regard to:	Reporting period	ESNEFT score	National average	Highest score	Lowest score	
the rate for 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	Apr 16-Mar 17	Apr 16-Mar 17	41.14	36.73	147.23	0
	Apr 17-Mar 18	Apr 17-Mar 18	35.58	38.28	157.51	0
	Apr 18-Mar 19	Apr 18-Mar 19	Hospital apportioned 28.25	12.52	40.46	0

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

The Trust has made great strides in reducing the number of people affected by CDI, however, the rate of improvement has slowed over recent years and it is recognised that some infections are a consequence of factors outside of the control of the NHS organisation that detected the infection. (NHS England 2016/17). Each case identified in the Trust is subject to post infection review. If all care and treatment is managed within nationally and locally recognised policy the Clinical Commissioning Group (CCG) scrutiny panel may agree that it is deemed as 'Non trajectory'. (2015/16 onwards).

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

✓ Patients identified as carriers are monitored closely and managed in much the same way as patients with CDI.

✓ Work continues through scrutiny panel reviews with the local Clinical Commissioning Group to identify areas which may impact on further reduction of cases. Including looking at antimicrobial prescribing in the local health care economy with a particular focus on Lower urinary tract infections.

✓ The incidence of cases of Clostridium difficile is higher in Medicine and Care of the Elderly Wards, 7 of the 8 Wards have had a significant investment in refurbishments in the past 4 years. This supports the appropriate positioning of patients in an environment which allows for better isolation with an ability to clean effectively. Further investment is planned for the IH site.

✓ Work continues to investigate and invest in new cleaning technologies to support best practice and efficiency including the use of HPV fogging, UVC and micro-fibre for example

Core Quality Indicators

Indicator: Patient safety incident rate: Patient safety incident rate													
The data made available to the Trust by the HSCIC with regard to:	Reporting period	Colchester Score		Ipswich Score		ESNEFT Score		National average		Highest score		Lowest score	
		Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
the number and rate of patient safety incidents reported within the Trust during the reporting period (please note that the reporting period changed to 'per 1,000 bed days' in April 2014)	April 16 - September 16	3,789	39.79	3,486	35.44	N/a	N/a	673,865	39.89	3,620	71.81	2,305	21.15
	October 16 - March 17	3,667	36.77	4,049	36.77	N/a	N/a	696,643	40.52	3,300	68.97	3,219	23.13
	April 17 - September 17	3,821	39.06	4,630	44.44	N/a	N/a	705,564		10,016	111.69	3,085	23.47
	October 17 - March 18	3,906	39.2	4,534	38.44	N/a	N/a	730,151		11,325	124	1,311	24.19
	April 18 - September 18	N/a	N/a	N/a	N/a	9,193	44.0	731,348		9,467	107.4	566	13.1
	October 18 to March 19	N/a	N/a	N/a	N/a	8,455	40.01	765,221		8,289	95.94	1,580	16.90
	April 19 to September 19	N/a	N/a	N/a	N/a	11,092	55.0	815,852		11,620	103.8	2,173	26.3
the number and percentage of such patient safety incidents that resulted in severe harm or death during the reporting period		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
	April 16 - September 16	16	0.4%	27	0.8%	N/a	N/a	2,516	0.4%	30	0.8	6	0.3
	October 16 - March 17	16	0.4%	22	0.5%	N/a	N/a	2,623	0.4%	6	0.2	47	1.4
	April 17 - September 17	16	0.5%	24	0.5%	N/a	N/a	2,482	0.4%	13	0.1	19	0.7
	October 17 - March 18	15	0.4%	19	0.4%	N/a	N/a	2,522	0.3%	5	0	0	0
	April 18 - September 18	N/a	N/a	N/a	N/a	47	0.5%	2,477	0.3%	14	0.1	3	0.5
	October 18 to March 19	N/a	N/a	N/a	N/a	45	0.5%	2,458	0.3%	28	0.3	15	0.9
	April 19 to September 19	N/a	N/a	N/a	N/a	61	0.6%	2,524	0.3%	1	0.0	26	1.2

Core Quality Indicators

Indicator: Patient safety incident rate
East Suffolk and North Essex NHS Foundation Trust considers that this data is as described for the following reasons: All incidents are reviewed by the Patient Safety & Quality Team to assess and validate the level of harm reported and ensure those reported as no and low harm are accurately graded. There is also clinical judgement in the classification of an incident as moderate and above harm as it requires moderation and judgement against subjective criteria and processes. All incidents are investigated to ensure that lessons are learned to safeguard future patient care. All patient safety incidents (irrespective of level of harm) are uploaded to the NRLS within one month of reporting; and those initially considered to have caused severe harm or above are reported within 72 hours; The last data set reported from the NRLS shows ESNEFT to be slightly below average reporters of incidents, however does show a slight increase from 38.79 incidents per 1000 bed days to 40.01 incidents per 1000 bed days. Trusts which are high reporters of incidents are very good indicators of a strong reporting culture. We have robust processes in place to capture incidents. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. We have provided training to staff and there are various policies in place relating to incident reporting but this does not provide full assurance that all incidents are reported. The Trust is promoting incident reporting through patient safety initiatives and the current patient safety culture is being explored to identify areas for improvement. The percentage of severe harm and death incidents taken from the NRLS report (as mandated by the Quality Account Guidance) for October 2018 – March 2019 is 0.03% and therefore just above the 0.03% average for all medium acute Trusts. ESNEFT has implemented a robust process for the investigation of all potential serious incidents despite the initial grading chosen by the reporter. All incidents are reviewed by the Patient Safety & Quality Team and where there is a suspicion of harm or a near miss, further information or a 'Incident Requiring Further Review (IRFR)' is requested. The IRFR is presented at SI Panel, held twice weekly and chaired by either the Medical Director or Chief Nurse; and a decision made as to level of harm caused and whether or not the incident fits SI criteria. Within the open reporting culture of the Trust, staff are encouraged to identify and escalate any Serious Incidents (SIs) and as with any other incident the Trust reviews SIs for trends and themes to look for opportunities for improvement. ESNEFT will be one of the 7 early adopter Trusts for the new Patient Safety Incident Response (PSIR) framework which will replace the current Serious Incident Framework (SIF).
East Suffolk and North Essex NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by: ✓ Continue to build our culture for reporting patient safety incidents at all levels of harm. ✓ Continue to provide training at Trust Induction to encourage reporting of incidents and near misses as well as give guidance for risk assessment and escalation of incidents. ✓ Piloting the Patient Safety Incident Reporting Framework.

Part 3 - Other information

Patient safety

Infection prevention and control

Methicillin resistant Staphylococcus aureus (MRSA)

Achieve Trust Target of zero cases of MRSA bacteraemia/ bloodstream infections in 2019/20.

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

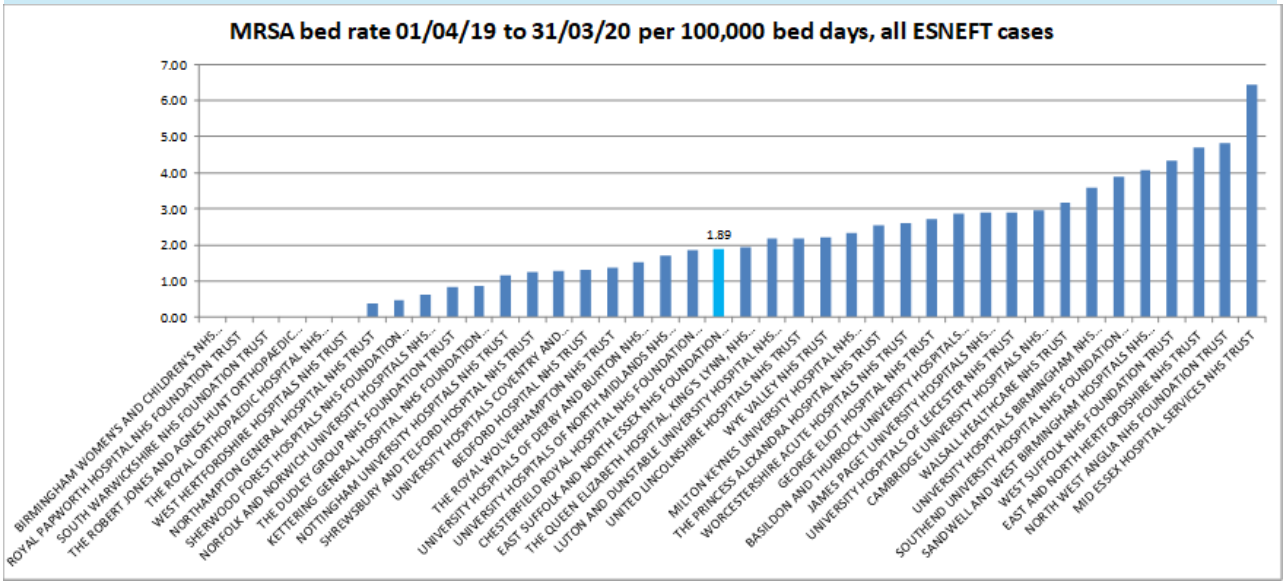
Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin resistant Staphylococcus aureus (MRSA) and often require different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

Table 9 — Number of cases of MRSA bacteraemia apportioned to ESNEFT

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

There was 1 case of MRSA bacteraemia identified across ESNEFT in 2019/20. It is recognised that there is learning related to the timely identification of MRSA carriage and admission screening in the management of high risk patients (at the time of the MRSA bacteraemia the ESNEFT MRSA screening policy was not in place) and surrounding intravenous peripheral device care and management.

Chart 3 – The performance of ESNEFT in rates of MRSA bacteraemia, compared with the other hospitals in the East of England region for 2019/20



Patient safety
Infection prevention and control

Clostridium difficile infection

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

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

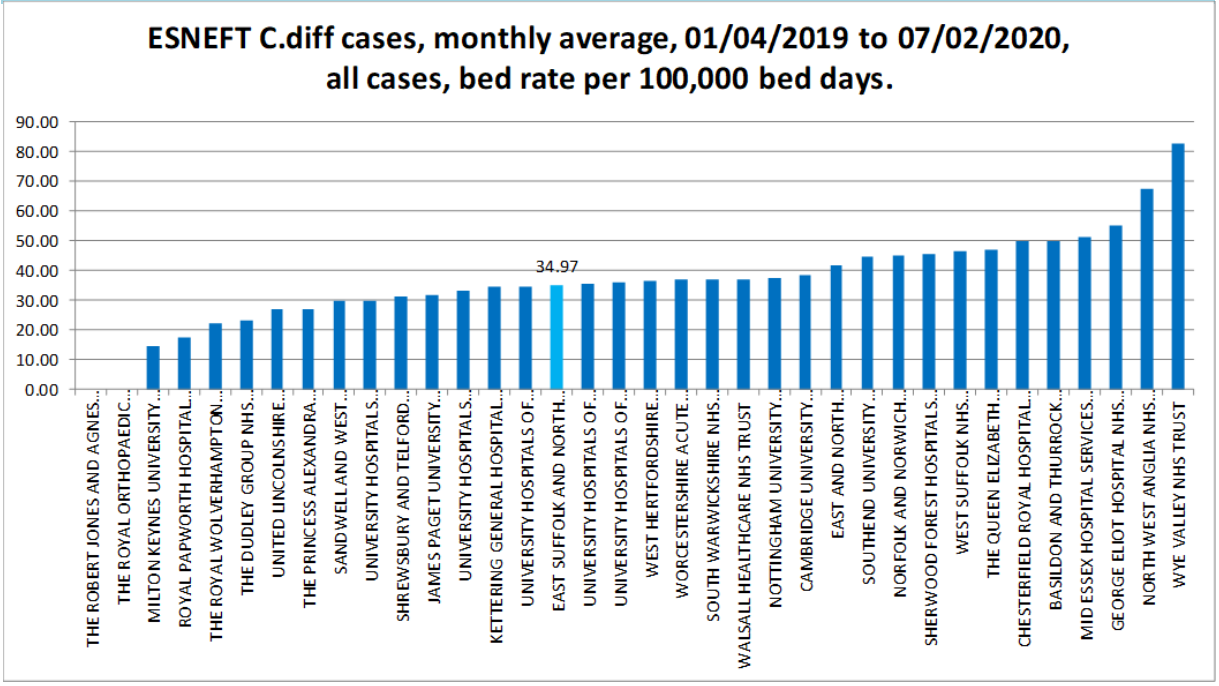
- lack of documented rationale for taking a sample
- appropriate microbiological samples not always obtained prior to commencing antimicrobial treatment (e.g. urine samples not obtained from patients suspected to have a UTI),
- previous microbiology results and previous antibiotic treatment are not always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

Each Trust apportioned case is subject to a post infection review. If all care and treatment is managed within nationally and locally recognised policy the Clinical Commissioning Group (CCG) scrutiny panel may agree that it is deemed as 'Non trajectory' (2015/16 onwards).

77 (of 96) C difficile cases for ESNEFT have been agreed as non - trajectory 2019/20.

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

Chart 4 – The performance of ESNEFT in rates of Clostridium difficile, compared with the other hospitals in the East of England region for 2019/20

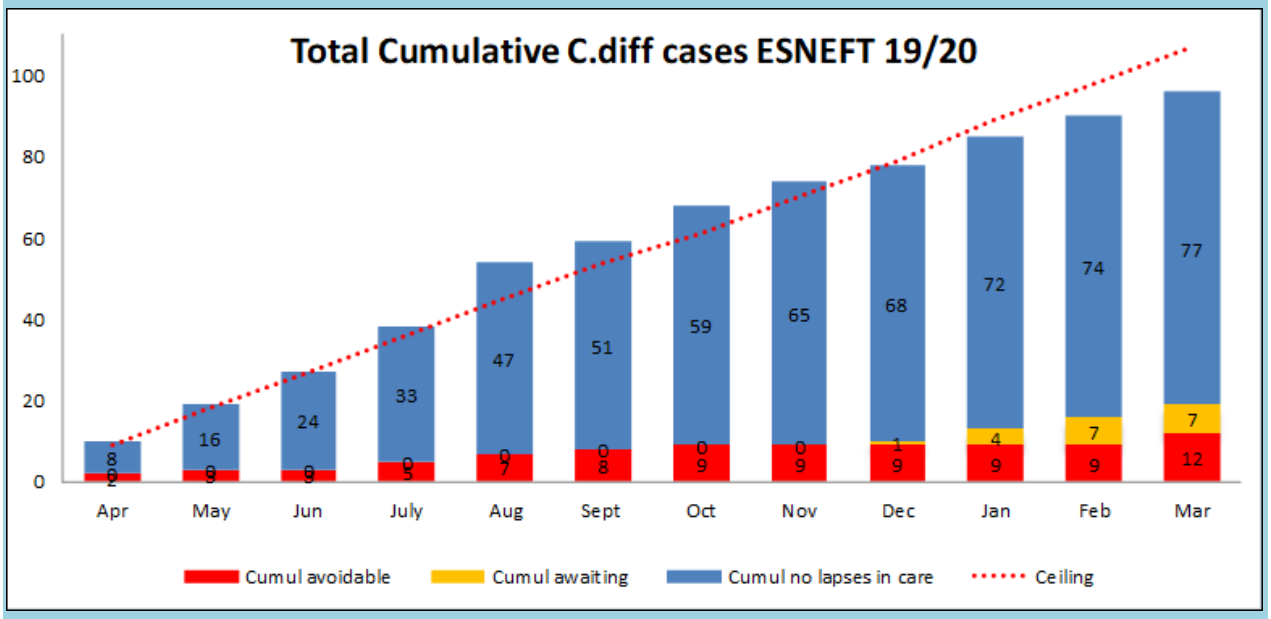


Patient safety
Infection prevention and control

Table 9- Number of C.Diff cases apportioned to ESNEFT

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

Chart 5 - Clostridium difficile cases 2019 /20



Patient safety
Learning from incidents, SIRIs and Never Events

Learning from incidents

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

It is important that when serious incidents occur, they are reported and investigated in a timely manner, not only to ensure that the correct action can be taken, but also to ensure the Trust learns from the incident to help prevent recurrence.

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

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

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

- MRSA screening practices have been aligned across all hospitals to support early identification of MRSA, isolation and treatment as required to reduce the likelihood of spread.
- Capacity reviews have been undertaken to ensure adequate space in theatres and outpatients clinics to see patients requiring urology procedures.

Duty of Candour

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

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

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

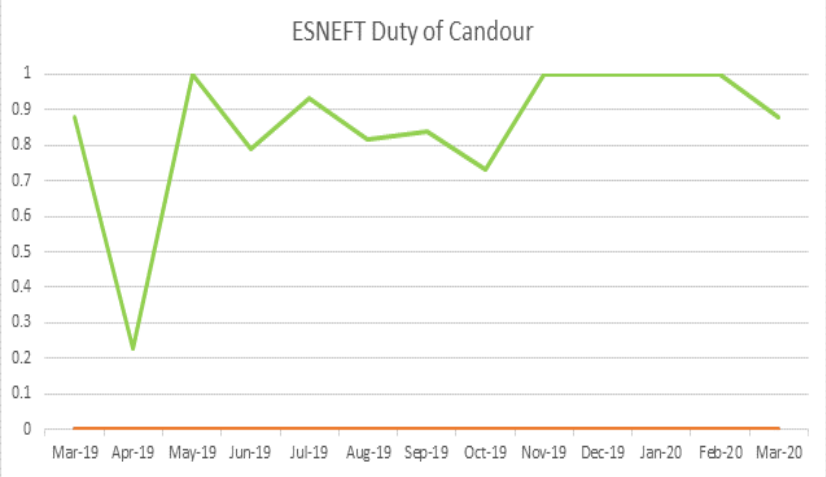
The Trust extends the Duty of Candour process to the 'Being Open' policy which encourages staff to have open and honest conversations for all incidents which are not specific to the Duty of Candour statutory requirements.

What are we doing to make improvements:

Face to face and E-Learning training for Incidents, SI's and Duty of Candour;

- Root Cause Analysis Training for SI's;
- Introduction of the Trust's License to Lead Programme and the module 'Managing Governance'
- Review of process of sharing SI's and lessons learned within the area affected and wider as a Trust.

Chart 6— Duty of Candour compliance during 2019/20



Patient safety
Learning from incidents, SIRIs and Never Events

Table 10– Adverse events and SIRIs reported

For the year 2019,/20 there have been the following adverse events (categorised as low harm to severe harm) reported on the Datix risk management computer system.

Type of adverse event	No. of adverse events
Abusive, violent, disruptive or self-harming behaviour	231
Access, Appointment, Admission, Transfer, Discharge	2030
Accident that may result in personal injury	3664
Anaesthesia	67
Clinical assessment (investigations, images and lab tests)	1362
Consent, Confidentiality or Communication	1679
Diagnosis, failed or delayed	313
Implementation of care or ongoing monitoring/review	5950
Infrastructure or resources (staffing, facilities, environment)	563
Labour or Delivery	867
Medical device/equipment	369
Medication	2145
Other - please specify in description	537
Patient Information (records, documents, test results, scans)	1445
Security	1
Treatment, procedure	1038
Totals:	22261

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

Type of adverse event	No. of SIRIs
Diagnostic incident including delay meeting SI Criteria	20
HCAI/Infection control incident meeting SI criteria	20
Maternity/Obstetric incident meeting SI Criteria: Mother and Baby	4
Maternity/Obstetric incident meeting SI Criteria: Baby Only	6
Maternity/Obstetric incident meeting SI Criteria: Mother Only	5
Medication Incident Meeting SI Criteria	6
Slips/trips/falls meeting SI Criteria	22
Suboptimal care of deteriorating patient	10
Surgical Invasive Incident meeting SI criteria	6
Treatment delay meeting SI Criteria	20
Apparent/actual/suspected self inflicted harm meeting SI criteria	1
Pressure Ulcer meeting SI Criteria	3
Totals:	123

Patient safety
Learning from incidents, SIRIs and Never Events

Never Events at East Suffolk & North Essex NHS Foundation Trust

2017/18	2018/19	2019/20
3	7	7

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

In 2019/20 seven incidents were reported which met the definition of a Never Event. Thorough root cause analysis (RCA) is undertaken for Never Events and robust action plans are developed to prevent a similar occurrence.

Surgical/invasive procedure (4)

Medication (1)

Wrong Site Surgery (1)

Medication incident (1)

Medical equipment (1)

The following actions have been taken to prevent recurrence:

- ✓ Regular dedicated lists for PICC line insertion.
- ✓ A trained nurse delivered service outside the theatre environment for PICC line insertion.
- ✓ Insulin Safety Week held which compromising of short training session for all medical, nursing, allied health professionals and Pharmacy.
- ✓ Bite-size online education sessions hosted by the Cambridge Diabetes Education Programme.

Never Events

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

The nationally agreed list of Never Events for 2019/20 are:

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

There are exclusions to each Never Event.

Improving Critical Care handovers
Colleagues have launched a new document to improve handovers when a patient leaves Ipswich Hospital's Critical Care Unit (CCU). It is added to a patient's notes when they are transferred to a ward.

Antimicrobial stewardship work highlighted at national event
Pharmacy technician Julie Chatters, based at Colchester Hospital, was recently asked to speak at the national Clinical Pharmacy Congress to share her experience of working within antimicrobial stewardship at ESNEFT.

Medication safety

Prevention of harm from medication

The Trust remains committed to the safe, efficacious and cost-effective use of medicines. Following the merger a Medication governance task and finish group was established and agreed the first priority was to review and produce an ESNEFT Medication Policy for healthcare professionals. This will help to harmonise practice and ensure high standards of medication-related policy and practice across the two sites.

We have established a review of the medicines governance framework, which includes:

ESNEFT Medicines Optimisation Committee (MOC) that oversees all medicines related policies and procedures. This committee reports to the Quality and Patient Safety Committee on a monthly basis.

ESNEFT Medication Safety Committee (MSC) continues to engage with representatives from all clinical areas in the Trust for both hospital sites and the community services. The MSC is accountable to the MOC and is responsible for implementing local and national medication safety alerts and actions.

An ESNEFT Medication Safety Officer is in place to ensure medication safety work is highlighted at ward level and good practice shared.

Collaborative Working

2019/20 saw both sites continue to work closely together producing joint publications which included an update to the joint Critical Medicines List. Cross-site harmonisation of Pharmacy and medicines audit plans, which include the safe use of opioids and quality of prescribing.

ESNEFT Antimicrobial Stewardship has developed significantly with both teams agreeing a number of joint antimicrobial policies to promote safe and effective use of antibiotics. There is now an ESNEFT Antimicrobial stewardship group.

Publication of an electronic ESNEFT medicines formulary which currently links with Ipswich and East Suffolk CCG.

Further development of a Controlled Drug steering group to ensure compliance with the roles and responsibilities of a controlled drug accountable officer. Also, a response to the Gosport report was produced and continues.

Our Priorities

A priority for the medication safety agenda 19/20 was to ensure that thematic reviews of medication incidents reported within the Trust are undertaken regularly to ensure the Trust is responsive to trends and areas of high risk practice. The Medication Safety team also submit medication incident data quarterly to the regional Medical Safety Network team. Internal thematic reviews are produced and discussed at the Medication Safety Committee alongside regional medication incident benchmarking reports.

Datix reports are sent out to pharmacy staff on a quarterly basis and any themes are identified and acted upon. These reports are used in discussion with ward staff in risk and governance meetings and help create an open communication channel between ward staff and their pharmacists in relation to medication errors.

Patient safety alerts are monitored and recommendations actioned and tracked at the meeting. This year no medication-related alerts have been issued.

Oral chemotherapy administration and chemotherapy competence has been discussed, with particular interest on non-cancer specialist wards, and this has led to a change in the medicines policy to state that chemotherapy drugs should not be prescribed or administered before the consultant haematologist or consultant oncologist have been consulted. Discussions are ongoing about competencies and the chemotherapy policy.

Work is ongoing in producing a junior doctor's guide. A previous version was available in Colchester but this had a lack of governance and pharmacy input. The committee have also agree representation from junior doctors at the meetings.

Never Events and Serious Incidents

Medication-related never events are discussed at the meeting and actions are followed up. One never event was followed up by the committee and involved the incorrect syringe used and consequently an overdose of insulin used in an insulin infusion for a paediatric patient. Changes to the diabetic chart were made in response to this.

Another serious incident that went to coroner's court involved a delirium patient who received too much lorazepam IV and too quickly. Rapid tranquilisation and delirium guidance is to be harmonised and an audit completed. Lorazepam stock for wards will now be packed down and the labelling has additional information regarding monitoring and dosages for adult patients.

Medication Audits

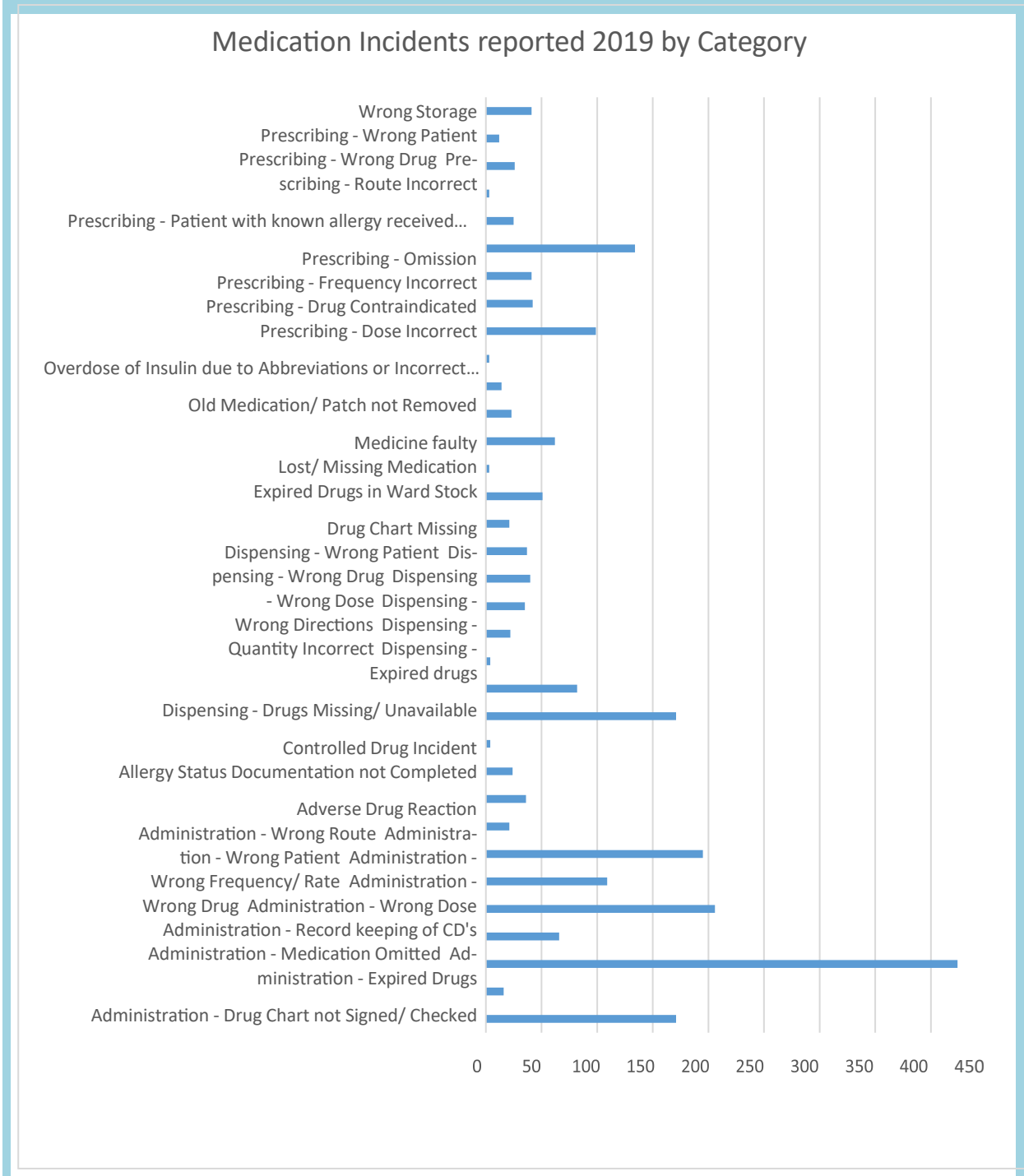
Ongoing audits include omitted and delayed doses audit that was being completed monthly until September. The frequency of this audit has been reduced to allow for more time to complete recommendations based on the results between audits and to show demonstrable change.

The safe and secure storage of medicines audit is completed every 6 months and the action plan is brought to the committee for follow-up.

Medication safety

Prevention of harm from medication

Chart 7 -



Clinical effectiveness
Stroke care Colchester Site

Through excellent collaboration, innovative skills, commitment and a 'can do' attitude, the multi-disciplinary team on the Stroke Unit has been successful in performing to high standards.

Table 11 -Stroke Sentinel National Audit Programme (SSNAP)

	Q3 18-19	Q4 18-19	Q1 19-20	Q2 19-20
Score	88	86	91	92
Rating	A	A	A	A

Performance:

Colchester Stroke Unit is very proud to have maintained the top rating of "A" in the Stroke Sentinel National Audit Programme (SSNAP) since Q1 2016-17, and this score has shown consistent improvement over the past 3 quarters.

Colchester is in Top 5% in latest (July-Sep 2019) clinical SSNAP audit(and is 4th in the country.

Colchester site is in the top 10% the SSNAP Organisational Audit (8/10 metrics satisfied) – It did not satisfy 2 metrics – Adequate number of psychologists per 10 beds and MRI as first line of imaging for TIA.

Colchester site's stroke specific mortality is below national average (April 2017-March 2019: Relative risk=0.95) despite having the highest pre-stroke frailty in the country as per 'Get It Right First Time' (GIRFT) data. This has been achieved through providing high quality care which is a testimony to the commitment of the members of the multidisciplinary team.

Colchester is in Top 5% in latest (July-Sep 2019) clinical SSNAP audit(and is 4th in the country.

Colchester site is in the top 10% the SSNAP Organisational Audit (8/10 metrics satisfied) – It did not satisfy 2 metrics – Adequate number of psychologists per 10 beds and MRI as first line of imaging for TIA.

Colchester site's stroke specific mortality is below national average (April 2017-March 2019: Relative risk=0.95) despite having the highest pre-stroke frailty in the country as per 'Get It Right First Time' (GIRFT) data. This has been achieved through providing high quality care which is a testimony to the commitment of the members of the multidisciplinary team.

Training and education:

Colchester Stroke Unit organised and hosted a 'bite-size' stroke regional study day in Spring 2019 for nurses and AHPs covering many key areas of stroke care in a single day. This received very positive reviews and is going to be repeated on March 6th 2020.

We have an on-going programme of team days facilitated by our Advanced Nurse Practitioner and Clinical Skills Nurse. The Team Days run three times a year with each day repeated 6 times to ensure that each member of the nursing staff can attend each of the 3 team days. Programmes are mostly focused on improving specialist stroke knowledge and skills within the team. Completion of the Stroke Competency Toolkit (SCoT); a set of multidisciplinary competencies for all our staff, is proactively encouraged and set as objectives at staff appraisals.

Unfortunately post graduate stroke modules have not been available at our local universities so these team days have been key in improving specialist knowledge. We have also ensured attendance at local and national stroke conferences and shared new learning on our return. A post graduate stroke module is due to start at Anglia Ruskin University in January 2021 which we eagerly await.

Five of our Associate Practitioners have undertaken their foundation degree, two have since qualified as Registered Nurses (RN), and another is currently undertaking nurse training.

All Deputy Sisters/Charge Nurses have now completed or are in the process of completing the ESNEFT Leadership course. This has proved very valuable as part of their development and the associated QI projects they are completing have assisted in introducing new innovations and processes.

Recruitment and retention has been good over the past year in the Stroke Unit, we currently do not have any Band 5 vacancies despite Stroke being a physically and emotionally demanding area to work.

We have an on-going bespoke e-module training on oral care in stroke care – an often neglected area in training. This was created by therapists and nurses on our Unit and then adopted by the East of England.

Innovation

A new approach to ensuring good nutrition for our patients was developed this year. We called this the 'eating buddy' initiative and the Band 2, 3, and 4 staff have received focused training on nutrition and swallow deficits so that patients receive safe and appropriate meals to their individual needs. This helps improve nutritional intake aiding participation in rehabilitation thus improving outcomes from stroke.

The Stroke Unit Therapists run activity groups most weekday mornings to offer alternative ways of patients receiving therapeutic interventions whilst being in a social setting. Groups such as art groups, Tai Chi and singing are available.

Clinical effectiveness
Stroke care Colchester Site

Discharge planning can be complex for patients following stroke and staff struggle to know how to arrange aspects of discharge. One of our experienced Associate Practitioners is currently preparing a 'Discharge Directory' to help sign post ward staff in areas of discharge planning which should result in more seamless discharges and improve length of stay.

Research:

Current research we are participating in is as follows

- ✓ ORION4 - Injectable liver enzyme inhibitor to reduce production of LDL cholesterol in high risk patient groups - currently have 73 participants at varying stages of treatment.
- ✓ DNA - Lacunar 2 - Trying to establish genetic causality in Lacunar Strokes
- ✓ SoStart - Reintroduction of anticoagulation in A/F patients who have had haemorrhagic stroke.
- ✓ OPTIMAS - To establish the optimum time to introduce DOAC's post stroke in A/F
- ✓ SNOBBS - To establish the most reliable type of Stroke Scoring Scale in order to establish a national standards.

Summary:

All members of the multidisciplinary team are dedicated to maintaining the overall stroke unit performance through sustained clinical engagement, supervision within the clinical environment, assisting and supporting junior and new team members, promoting a culture of constructive challenge, listening to concerns and creating an on-going positive working environment.

Extra help for disabled patients

Ipswich and Colchester hospitals have Changing Places facilities. They are dedicated for people with profound learning and physical disabilities who are unable to use the toilet / changing facilities independently.

Urgent Treatment Care

The Urgent Treatment Care (UTC) at Colchester opened on 1st October 2019 as a GP led 24/7 service offering appointments that can be booked through 111 or through a GP referral, and equipped to diagnose and deal with many of the most common ailments people attend A&E for. At Colchester this includes minor injury and minor illness.

The UTC will improve emergency care services for patients across North East Essex with the intention of ease the pressure on the hospital, leaving other parts of the system free to treat the most serious cases.

Referral pathways have been developed from the UTC into community services, mental health services, AMSDEC (a service which allows for assessment and treatment in hospital and discharge on the same day), surgical and orthopaedics. These pathways allow patients who arrive at the UTC to be referred directly to the correct place for treatment without having to go through A&E unnecessarily. Since opening, the UTC has resulted in a 20% reduction of attendances at A&E at Colchester which allows patients seen in A&E to have a more focused service.

The service currently sees mostly walk-in self referred patients and takes a small number of arrivals by ambulance. Next steps will be to increase the ambulance arrivals to the UTC and continue to reduce demand on A&E with that. Further referral pathways will be developed for direct to specialty referrals. The service is seeing an increase in attendances month on month since the opening of the service so further work will be undertaken to manage this demand with development of alternative community pathways and streaming patients away from the UTC when their condition could be managed elsewhere, for example at a Pharmacy.

UTC at Ipswich

Our plans to design and build a combined Urgent Treatment Centre and Emergency Department are on track for completion in November 2022.

The Outline Business Case was submitted to NHSE/I in January 2020 and is currently awaiting approval. This forms the 'stream 1' element of the STP £69.3m capital money. Our detailed designs for the new UTC/ED front door model are ready for going out to tender and we are working with our clinical teams around the transitional phasing elements of the programme. The build programme is planned to commence in October this year, concluding in November 2022. We are continuing to work closely with clinical, operational and contracting teams across ESNEFT and our wider system, to agree the workforce, finance, contracts, IT systems and governance elements to ensure that the new proposed clinical model is ready in accordance with the programme timeframes. (Where possible, some aspects of the clinical pathway changes will be delivered in advance of the build programme).

Respiratory patients will be able to receive more care in the community thanks to a new initiative.

It is designed to reduce unnecessary hospital admissions and keep people in their own homes for longer.

Around 25 community physiotherapists have been trained to assess and treat people with COPD and other respiratory issues so that their condition can be managed at home rather than needing an admission into hospital.

They began receiving referrals from GPs from 2 December, and are being supported by a team of respiratory champions, who can offer specialist advice if any patients need further care or their condition is more serious and needs escalating.

The bespoke training was organised by Kirsty Peck, a senior respiratory physiotherapist at Ipswich Hospital, who developed the package alongside respiratory physio colleagues at the acute trust and COPD and pulmonary rehabilitation staff from the community.

Clinical effectiveness
Emergency care

Waiting for treatment for a long time can potentially impact on clinical outcomes and certainly does not result in a good patient experience.

The Emergency Department has faced challenges in achieving the 95% target of patients spending four hours or less from arrival to admission, transfer or discharge. There has been an increased activity particularly in relation to ambulance admissions.

- ✓ An 'Urgent Treatment Centre' has been in operation since October 2019 on the Colchester site. This brand new development sees a range of patients that would have previously self-presented to the Emergency Department at Colchester. Colchester Emergency Department now sees a 20% reduction of type 1 activity.
- ✓ A brand new 'Acute Medical Same Day Emergency Care' (AMSDEC) has been opened on the Emergency Assessment Unit at Colchester Hospital. AMSDEC will aim to rapidly treatment investigate patients with medical conditions referred from a GP, UTC or ED so that they can go home the same day. This service is offered 0800-200hrs 7 days a week.
- ✓ Colchester and Ipswich received funding from the CCG for a band 6 safety nurse this role has been pivotal for both departments to ensure timely offload of ambulances and at times of pressure ensuring that patients are cohorted to enable a 15minute turnaround.
- ✓ The HALOs also assist with supporting this process, however Ipswich have only had a HALO since August 2018 and operates 10:00 – 22:00.
- ✓ Active nursing recruitment has been a focus for the Senior Nursing team, which has shown significant improvement in our vacancy rate which for Colchester is currently 6.5% vacancy.
- ✓ To ensure a robust escalation process on both sites, a 'Trigger tool' is completed relating to the pressures within the department, which automatically calculates an 'Operation Pressure Escalation Level' (OPEL) score, which automates a text message which is sent hourly to all Managers and external stakeholders of the trust.
- ✓ There have been initiatives taken both locally within Emergency care and also in the wider Trust, for a commitment to long term bookings of Doctors to
- ✓ ensure a higher fill rate
- ✓ If a patient is recognised as potential sepsis at Colchester, an Emergency 'Code Sepsis' is initiated to ensure prompt assessment and treatment

Clinical effectiveness
Emergency care

Table 12 – ESNEFT performance over the last three years: 4 hours to discharge from Type 1 &3 Emergency Attendances

		201718		2018/19		2019/20	
	Target	ESNEFT Performance	National Performance	ESNEFT Performance	National Performance	ESNEFT Performance	National Performance
April	95.0%	89.7%	85.7%	92.8%	82.3%	89.4%	85.1%
May	95.0%	89.4%	84.6%	95.3%	85.1%	91.3%	86.6%
June	95.0%	89.7%	86.1%	94.6%	85.6%	91.4%	86.4%
July	95.0%	86.3%	85.5%	94.8%	83.5%	88.1%	86.5%
August	95.0%	89.2%	85.4%	93.7%	84.0%	88.6%	86.3%
September	95.0%	88.7%	84.6%	95.5%	83.0%	86.2%	85.2%
October	95.0%	89.3%	84.8%	95.0%	83.1%	84.3%	83.6%
November	95.0%	92.4%	83.0%	92.8%	81.1%	85.0%	81.4%
December	95.0%	87.6%	77.3%	91.2%	79.3%	82.4%	79.8%
January	95.0%	91.6%	77.2%	89.2%	84.4%	82.9%	81.7%
February	95.0%	90.9%	76.9%	90.2%	84.2%	84.9%	82.8%
March	95.0%	92.6%	76.4%	92.7%	86.6%	86.8%	84.2%
YTD	**95.0%**	**89.8%**	**88.3%**	**93.4%**	**88.5%**	**86.7%**	**84.2%**

Table 13 – Our Emergency performance over the last three years: Type 1&3 activity

Financial Year	ESNEFT Number of Attendances	ESNEFT 4 hr Performance	National 4 hr Performance
2017/18	240,160	89.8%	88.3%
2018/19	260,273	93.4%	88.5%
2019/20	*245,671*	*86.7%*	*84.2%*

Clinical effectiveness

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

What is HSMR?

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a group of 56 common diagnosis, which make up approximately 83% of in-hospital deaths. It is a subset and represents about 35% of admitted patient activity.

What is SHMI?

The Summary Hospital-Level Mortality Indicator is a ratio of the observed number of deaths to the expected number of deaths for a trust. The SHMI differs from some other measures of mortality by including both in-hospital deaths and deaths of patients occurring within 30 days of discharge from hospital.

How do they work?

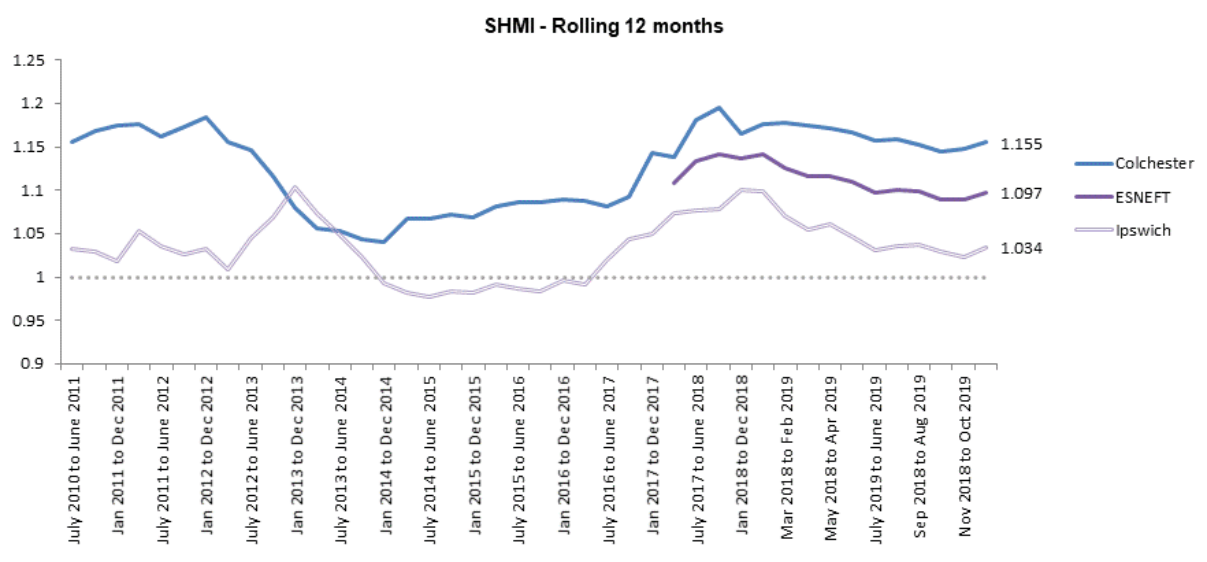
Mortality indicators show whether the number of deaths linked to a particular hospital or diagnosis group is more or less than expected, and whether that difference is statistically significant.

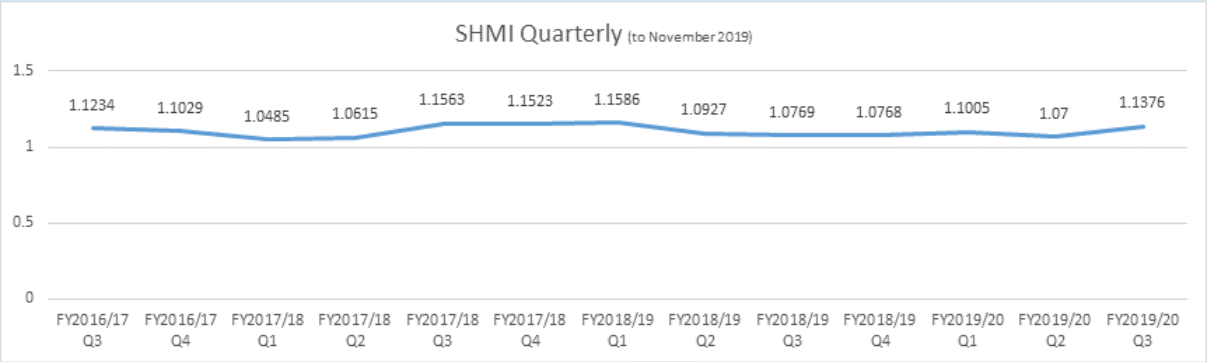
Why are mortality ratios/indicators important?

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

They are a method of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in case mix (e.g. patient age, deprivation, gender etc.).

Chart 9- Mortality: SHMI trend July 2010 – November 2019





Clinical effectiveness

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

- The national benchmark for HSMR is set at 100 and SHMI is set at 1.0000 - trusts with a relative risk below 100 are (statistically) performing better than other acute trusts in terms of lower risk of mortality.
- The SHMI for ESNEFT for the 12 months ending September 2019 was 1.0892, in the 'as expected' banding. NHS Digital states that 'a higher than expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance.
- The HSMR for the 12 months to January 2020 was 104.3, 'higher than expected'.

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

- The Trust is aware that many patients with long term conditions are admitted for symptom control rather than being treated in their preferred place of care.
- The Trust serves a large community of frail older people who are more susceptible to acute problems (e.g. infections, falls) which, when added to a host of chronic diseases result in a higher mortality rate at certain times of year.

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

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

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

✓ Ensuring that the information sent to external mortality bodies is accurate so that 'alarms' correctly identify potential causes for concern. This is achieved through audits of the digitisation of records (Clinical Coding) and through the themed review of health records to ensure that documentation is of a high standard.

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

Table 14- Results summary for December 2018-November 2019

In-hospital mortality, for all in-patient admissions to ESNEFT for the period December 2018 to November 2019 has been reviewed. The SHMI is updated and rebased quarterly.

Metric	Result
HSMR	104.3 for the 12 months to January 2020, within the 'higher than expected' range
HSMR position vs. East of England peers	The Trust is 1 of 7 in the regional peer group of 15 that sit within the 'higher than expected' range.
HSMR diagnosis groups attracting higher than expected deaths	There are 3 outlying groups attracting significantly higher than expected deaths: Pneumonia Relative risk 113.5 - 533 deaths, 470 'expected' Fluid and electrolyte disorders Relative risk 143.9 - 48 deaths, 33 'expected' Respiratory failure, insufficiency, arrest (adult) Relative risk 145.8 - 36 deaths, 25 'expected'
HSMR Weekday/Weekend Analysis	Weekday HSMR emergency admissions are 'as expected', Weekend emergency HSMR emergency admissions are 'higher than expected'.
Patient Safety Indicators (mortality metrics)	There are no alerts on the Patient Safety dashboard.
SHMI (December 2018 to November 2019)	Published SHMI = 1.0970, 'as expected' (band 2) The percentage of patient deaths with palliative care coded during their admission was 33.4%.

Waiting times for Diagnostic Procedures
Clinical Effectiveness

The percentage of patients waiting over 6 weeks for a diagnostic test at month end has fluctuated throughout the year, however on average remains below the National Average but slightly above the Target. Services have been reviewed to provide assurance the resources available are being used to full potential. Each service reports independently to the Divisions and Trust Board and targets are monitored via the Accountability Framework.

Chart 10- Percentage of patients waiting over 6 weeks for a diagnostic test at month end

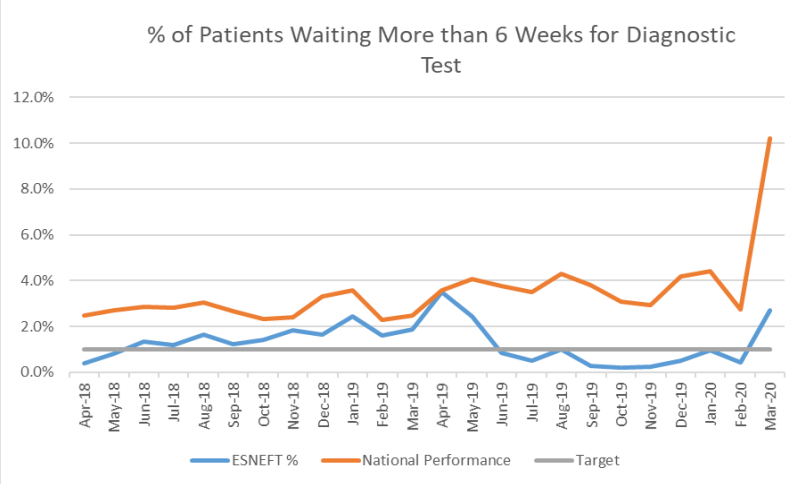


Table 15 Percentage of patients currently waiting under 18 weeks on an incomplete path-

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

Clinical Standards for Seven Day Hospital Services
Clinical Effectiveness

Clinical Standards for Seven Day Hospital Services Clinical Effectiveness

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

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

How did we measure and monitor our performance?

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

Will we achieve our intended target and what have we done to improve our performance?

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

- Compliance to this standard has shown an overall trend of improvement over the last three years and ESNEFT continues with biannual audit of seven day services to provide assurance that this trend continues.
  The key requirements identified by specialities to achieve compliance to this standard are: Daily consultant led post take ward rounds to see all new patients on every morning 7 days of the week. Ensuring that there is a scheduled evening consultant ward round within 14 hours of the next morning round, the further development of flexible working job plans to increase predictable on call duties, giving consultants a tool to track patients to avoid breaching the standard and consideration of new roles to make consultant time matter and deliver clinical value

- **Standard 5** access to diagnostic tests

- The Trust achieved the overall standard required, however upper GI endoscopy availability on the weekday and weekend service fell short, as did Echocardiography at the weekend. Both the Division of Surgery & Anaesthetics and Medicine are reviewing their business planning for the coming year in order to work towards achieving the standard.

- **Standard 6** consultant-directed interventions

- The Trust met the overall standard achieving 8/9 of the standards, access to interventional endoscopy at the Colchester site is available 7 days/week, but there is not 24hr access available. The provision of service forms part of the business planning for the Division.

- **Standard 8** ongoing review by a consultant
  - According to the Autumn 2019 audit data, this standard was not met
  - All patients requiring twice daily review were reviewed by all specialities audited. It is evident from the above audit data that we have opportunities to improve both weekday and weekend performance. This challenge aligns to trust work to embed daily consultant led MDT board rounds on very ward every day as well as the patient flow project led by the Logistics Division.

Daily Consultant review is particularly challenging in some specialties, particularly at the weekend. However, the Trust has a number of mechanisms in place to make sure that unwell patients are identified and seen by the right grade of doctor including Watchpoint, an in-house software system which flags patients requiring review.

Patient experience
Improving the patient and carer experience

Critical Care Unit

New artwork improves visitor experience in Critical Care

Visitors to the Critical Care Unit will be better prepared to know where to go and what to do and expect when arriving to visit a loved one.

Following a series of patient experience listening events, the ward identified that patients and relatives found the Critical Care Environment daunting, despite the care and support given by the staff. The ward team worked with patients and carers who took part in the listening event and agreed that poster and visible information would support the friends and relatives of patients in Critical Care. Sister Tamasin King found that the design agency, Marles & Barclay work with a number of healthcare providers and who helped create the visual communications posters which are now in place.

The aim of the large infographics is to help explain where to go, how the department works and what each piece of equipment does as the noises and environment can be quite intimidating and daunting.

The new informational artwork was introduced and is clearly visible and understandable to all by a combination of words and pictures. General visitor information specific to family rooms in critical care includes how visitors can help the patients and how they can look after themselves

Funding for the new signage was given by Colchester & Ipswich Hospitals Charity as this was to improve visitor and patient experience.

Visitor feedback supports the new signage, one visitor said:

“We found seeing a pictorial version of the equipment really useful. It’s very clear and although the staff take a lot of time and care to explain what to expect in words, somehow it’s easier to take in as a picture. It’s suitable for all ages and you can refer back to it in your own time too. I think it’s a great addition to the department.”

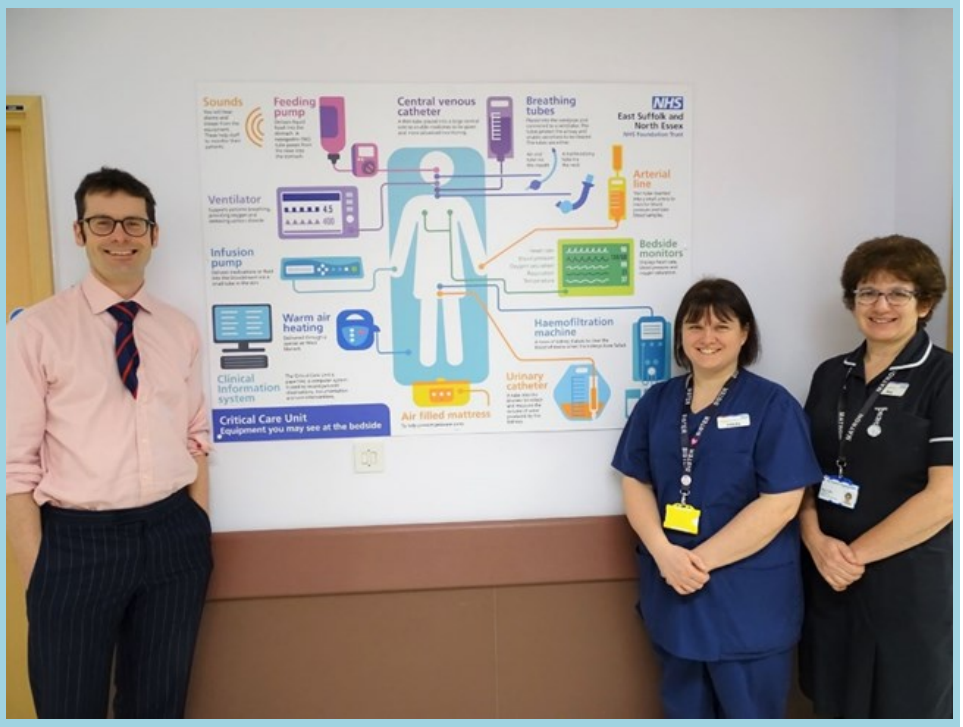
Music Therapy

Improving the patient and carer experience

Young patients at Ipswich Hospital will be given the chance to use music to help them

Patient experience
Improving the patient and carer experience

New artwork to improve visitor experience in Critical Care
Artwork to support people visiting our Critical Care departments has been put up at Colchester and Ipswich hospitals.
The artwork was funded by Colchester & Ipswich Hospitals Charity following feedback from patient experience evenings and will help improve visitor experience.



express themselves with the introduction of a new music therapy service.

The initiative aims to give children who are receiving care the chance to spend one day a week making music under the guidance of hospital staff and a therapist from Suffolk Music Therapy Services. The aim is to boost their confidence and self-esteem while providing an outlet to help them express their feelings during their treatment.

Ipswich Hospital is just one of 12 hospitals in the UK providing music therapy. It has been made possible by local charity the Jess Grant Celebration, which was set up in memory of Jess, who used music to help her cope with more than three years of treatment for a rare bone cancer before she passed away last year aged just 15.

Anita Grant, Jess's mum and co-founder of the charity, said: "we are now raising money for other children suffering from medical conditions so that we can fund the provision of music therapy."

Sensory Training

Improving the patient and carer experience

1 in 30 people in the UK have a sight impairment and 1 in 6 have a hearing impairment.

Episodes of unexpected hospitalisation, attending elective care or an outpatient appointment for people living with sensory impairment can be quite frightening and distressing through being in a new environment that you are unable to communicate or know how to navigate this unknown area and people. This can lead to heightened anxiety and can reduce confidence, wellbeing and independence.

Essex County council identified a need within Health and Social Care providers regarding awareness and support for staff to feel confident not only to understand sensory impairment but to best support needs of people living with sight, hearing and dual sensory (deafblind) impairments.

Colchester Hospital was invited to be part of the pilot training course that secured the funding for ECL to deliver free sensory champion

Patient experience
Improving the patient and carer experience

Music Therapy on children's ward

The hospital is one of just 12 in the UK offering music therapy. It is thanks to local charity the Jess Grant Celebration.

training within Essex health and social care organisations. The training requirements and champion role were coproduced with Colchester hospital and other providers of the pilot and sensory impaired people who use local services.

The sensory champion training which is being delivered in both Colchester and Ipswich sites aims to encourage staff to explore any preconceptions they may have, ask the awkward questions and ultimately instill confidence and break down barriers when caring or communicating with patients or carers.

Training can emphasis the importance of line of sight to the patient and reminds staff of the importance of person centered approach to care and care planning. The training will provide staff with tools and confidence to support other colleagues within ESNEFT when caring for a patient with sensory impairment and loss ensuring a whole patient centered experience through being responsive to the patient's needs.

The ESNEFT Learning Development Nurse Specialist said the training had given her the confidence to use the new techniques immediately and has reported that patients and cares have already given feedback on how this has made their experience better and patient centered.

Patient Portal

Improving the patient and carer experience

Feedback from patients and the high percentage of contact with PALS indicated that appointments were causing patients and staff to become stressed due to patients not being in control of referrals, cancelations or losing letters that had been sent.

The aim of the patient portal is to enable people to manage their appointments and care online from wherever they are. It will help to keep people in control of their health by giving them access to the information we hold about them and letting them manage their appointments online.

It will allow patients to see their results and communicate with their clinicians, saving them time and reducing stress.

There is a 3 stage roll for the next 3 years of the portal to test each new function as it is added and allow for feedback and any adaptations that this feedback highlights around patient and carer needs.

Patient experience
Improving the patient and carer experience

85% of the Trusts patients that took part in the survey use technology and 73% of those indicated they would welcome the ability to manage appointments online. 76% said they would find it helpful to view their appointment letters online and 65% would prefer to have virtual outpatient appointments.

A pilot of the project was launched in Ipswich hospital in November in two Ipswich hospital departments lasting 4 weeks, where patients signed up to be able to see their appointment letters only where there was a 30% sign up of 1557 invitations. Feedback was taken and app issues were resolved.

Future developments to the patient portal include being able to requesting changes to appointments, communication with our doctors, nurses and therapists.

A new 'Staying active' leaflet is now available to all acute and community wards.

Responsiveness to personal needs of patients

More and more evidence shows by empowering older patients and their families to keep mobile and active while they are in hospital helps them recover quicker, maintain their independence and gets them back to their own homes sooner.

The recent national campaign #EndPjParalysis has highlighted that one week in hospital for people over 80 can lead to a 10 to 20% reduction in muscle power, aerobic capacity and loss of independence.

Hospital admission for older people often leads to prolonged periods of reduced mobility and functional decline. Our patients become deconditioned as a result of ill health but, also often the constraints of the hospital environment.

Mobility is frequently viewed as the domain of the physiotherapists but promoting independence in hospital needs to be a multidisciplinary endeavor and embedded into ward culture and practice.

The new ESNEFT leaflet explains and reassures patients and their families that keeping active is beneficial. It addresses the myths that patients should stay in bed and be looked after. Staff support patients and family members when giving them the leaflet and answer any questions around the best ways to keep active safely, advise which clothes, suitable footwear and mobility aids to bring and who to ask for help if needed. It includes an activity diary to document and monitor their progress if they wish.

Hospital admission for older people often leads to prolonged

Women's and Children's

Community Care for newborns and mums

Responsiveness to personal needs of patients

Research shows that around half of babies who have a tight frenulum have difficulty feeding, while the condition can also cause problems for breastfeeding mothers, such as low milk supply and mastitis

Babies in east Suffolk can now get treatment for tongue-tie closer to home following the launch of a dedicated clinic at Ipswich Hospital.

The new clinic offers quick and painless tongue-tie divisions to make it easier for babies to feed. It will be led by midwife and infant feeding co-ordinator Linda Page, who has been specially trained to carry out the procedure on babies who are up to 10 weeks old.

The clinic will bring treatment closer to home for parents and their newborns, who previously had to travel to Norwich for a division. It will initially cater for five babies each week.

"We are really pleased to be able to launch this new clinic at Ipswich Hospital, which should make a real difference to families across east Suffolk," said Linda. "

"The procedure is very simple to carry out, and only takes a few seconds to complete. Mums are able to start feeding their baby straight afterwards, with many finding it much easier once the division has taken place.

Patient experience
Improving the patient and carer experience

Listening to the patient & carer voice

Responsiveness to personal needs of patients

Patients leaving Critical Care at Ipswich Hospital will now have an improved transition onto a ward.

Feedback from 'In your shoes', staff listening events and the ICU steps follow up service held throughout last year highlighted the need for staff on wards to better understand the patients journey and needs when moving from in critical care to a ward and its impact on the patients' needs especially around differentiation of level of care given.

Critical Care Outreach Team member Claire Grey, Specialist Physiotherapist Vicky Jeffrey, Senior Specialist Speech and Language Therapist Kate Revell and Dietetics Team Lead Helen developed the CCU rehab handover form aimed to improve the quality of information handed over to ward staff when patients leave the Critical Care Unit (CCU) at Ipswich Hospital, leading to benefits in patient safety, continuity of care and communication between staff and patients.

The document is available on the Evolve system and a patient's progress and goals throughout their Critical Care stay, highlighting key information such as diet modifications, mobility and psychological state. It is added to a patient's notes when they are transferred to a ward ensuring staff can immediately see all previous and ongoing therapy.

Extra support for east Suffolk's care homes

Improving the patient and carer experience

Care home residents are now receiving additional support to help them stay well and out of hospital.

It's all thanks to a new community service running across east Suffolk.

The care home initiative sees a small team of specialist nurses and therapists work with the area's 86 care homes to provide training and education to staff so that they can proactively support

Music Therapy on children's ward
Here's young patient Charlie enjoying a music therapy session on the ward at Ipswich Hospital.
The hospital is one of just 12 in the UK offering music therapy. It is thanks to local charity the Jess Grant Celebration.

Patient experience
Improving the patient and carer experience

Dedicated ward clerk raises cash for bladder scanner
Five years of fundraising has paid off for Ipswich Hospital ward clerk Sharlene Williamson who has raised £6,825 for a new bladder scanner for Capel Ward, where she works.
The new scanner will help diagnose a wide range of bladder problems and save time for patients as they will no longer have to wait or go off the ward for a CT scan or ultrasound.

their residents to stay well. This can include support with everything from taking observations and catheter care to falls prevention, exercise advice, wound care and managing challenging behaviour.

The team, which is made up of a senior physiotherapist, senior nurse, tissue viability specialist nurse and dementia specialist nurse, also offer a reactive service for people going into crisis so that they can provide the right support to keep them at home and prevent a hospital admission.

The aim is to help reduce avoidable hospital admissions by equipping care home staff with the skills they need to monitor their residents' health and recognize when a condition may be getting worse. We encourage them to call us with any questions they may have, and can offer help or specialist advice on areas such as dementia, pressure ulcers and physiotherapy.

"We can also help reactively with residents who are deteriorating or in crisis. This done by monitoring their condition and completing a holistic assessment of the individual and the situation. We liaise with other teams and GPs to ensure the resident remains in their own home, rather than having an admission to hospital for preventable reasons.

Care in the Community

Responsiveness to personal needs of patients

Respiratory patients will be able to receive more care in the community thanks to a new initiative.

The aim is to reduce unnecessary hospital admissions and keep people in their own homes for longer.

Around 25 community physiotherapists have been trained to assess and treat people with COPD and other respiratory issues so that their condition can be managed at home rather than needing an admission into hospital.

Referrals from GPs from and are being supported by a team of respiratory champions, who can offer specialist advice if any patients need further care or their condition is more serious and needs escalating.

Patient experience
Improving the patient and carer experience

The bespoke training was organised by Kirsty Peck, a senior respiratory physiotherapist at Ipswich Hospital, who developed the package alongside respiratory physio colleagues at the acute trust and COPD and pulmonary rehabilitation staff from the community.

Ally Roberts, professional lead physiotherapist and integrated therapy clinical lead, said:

"We are really proud of this project and hope that it will make a real difference to patients by allowing them to receive treatment in their own homes, where they are most comfortable and best able to recover.

"At the same time, it will help us to manage patient flow over the winter by ensuring only those patients who really need treatment in an acute hospital are admitted to our beds.

"Kirsty and her team did a fantastic job to develop the comprehensive education programme, which attracted excellent feedback from everyone who attended. The whole project has been a great example of working across organisational boundaries to benefit patients.

"Better patient experience – Being able to stay in their own home and receive care and reduce disruption to independence.

Better patient care - Improved support in their own homes reducing extra stress of going through an unexpected hospital admission process and w through varying departments.

The Reverend Linda Grace Peall (pictured centre) has been named as ESNEFT's head of chaplaincy. Linda was welcomed to the Trust at her commissioning and licensing service at Ipswich Hospital.

Patient experience
Improving the patient and carer experience

A grateful couple have shared their deepest thanks to big hearted Colchester Hospital staff who came together to arrange a blessing of their relationship.

Peter Hare and Toni Bennett, from Harwich, have been together for 13 years.

Peter, 71, has been receiving care on Nayland Ward since October for a series of complex medical conditions.

A relationship blessing was held for them in The Time Garden at Colchester Hospital on Wednesday, 29 January.

Nayland Ward sister Jenny Chapman said: “Peter’s been with us for a few months and during that time he has, on and off, been extremely poorly so to be able to do this was so special.

The ceremony was conducted by East Suffolk and North Essex NHS Foundation Trust’s Lead Chaplain Allison Cline-Dean and was attended by ward staff, as well as Peter and Toni’s family and friends.

The generous ward team all made personal donations to pay for food and drink and Marks & Spencer, who have a Simply Food store at the Turner Road site, donated flowers to the couple for the ceremony.

Peter will be leaving the hospital soon to be cared for in the community.

Peter and Toni, centre, are pictured with Nayland Ward team members (left to right) healthcare assistant Darren Mollam, Dr Princey Vimal, Dr Sofia Mota, ward sister Jenny Chapman and advanced nurse practitioner Ian Bell.

Patient experience
Caring for people with dementia

It is estimated that globally the number of people living with dementia will increase from 50m (2018) to 152m in 2050, a 204% increase. There are currently 850,000 people living with dementia in the UK with a projected rise to 1.6m by 2040. 225,000 people will develop dementia this year, that's one every 3 seconds, and the cost of dementia to the UK is expected to double in the next 25 years from £26bn to £55bn in 2040. There are over 200 types of dementia with some types being very rare, and although mainly affecting older people, dementia can affect younger adults and children. Young onset (under 65 years) account for 42,325 people in the UK.

There are 700,000 unpaid carers of people with dementia, and 2/3 of people with dementia live at home, mostly supported by unpaid carers. On average, people with dementia stay in hospital twice as long as other patients over 65, and 1:4 beds in acute care are occupied by a person with dementia.

Fix Dementia Care, a report based on a collection of information from carers and their families, (Alzheimer's Society. 2016) states *" The respondents told us that the longer people with dementia were in hospital, the worse the effect on their dementia symptoms and their physical health. Hospital stays had led to weight loss, incontinence, exhaustion, pressure sores, bruising, reduced mobility, loss of communication skills and depression. Of the 60 per cent of people with dementia who went into hospital from their own home, only 36 per cent returned there, most of the rest were discharged into residential care."*

Dementia can affect the way a person makes sense of and relates to their environment and the people they encounter. Hospitalisation has a negative effect and can increase anxiety and distress, particularly if there is a superimposed, multifactorial delirium (acute confusional state caused by acute illness, trauma, hip fracture or other underlying causes). People with dementia/ delirium may find the busy and unfamiliar hospital environment distressing and this may lead to increased confusion, deconditioning and reduced well-being, and this in turn can be upsetting for carers. ESNEFT has supported a programme of environmental improvements to better support people living with dementia and accessing hospital services. A multidisciplinary Dementia and Delirium Steering group meets quarterly, developing action plans to improve the support we give to patients and carers living with dementia.

The two Admiral Nurses at ESNEFT offer support to the person with dementia, their family and the staff caring for them through person-centred, holistic care and advice based on triadic relationships, signposting and onward referral as appropriate, supporting national reporting requirements and national audits, education and training (as per Health Education England Tiers 1,2 & 3 training core skills), representing our hospitals and working in partnership with external service providers and stakeholders, promoting best practice, and participating with patient and carer experience groups. The Admiral Nurses are passionate about enabling and equipping staff to deliver high quality care through training and development programmes which incorporate a biopsychosocial, empathic approach to care, considering the impact of dementia on the lived experience for the patient and the carer.

The support the Admiral Nurses receive from Dementia UK through attendance at monthly Practice Development and Clinical Supervision Days, Masterclasses, Forums and Communities of Practice enables them to deliver evidence based, up-to-date approaches to developing and improving care. Dementia U.K. offers a range of printed information and support resources that are used to inform people with dementia and those who care for them. The Dementia Liaison Administrator supports families by giving a pack with information about support in the community and produces a report each month of feedback given by families about care received. This feedback is used to inform improvements. Where requested, support is available to members of staff who are experiencing dementia in their own families.

The dementia team work alongside carer support agencies (Carer's First and Suffolk Family Carers) to offer emotional and practical advice to families including future planning, admission avoidance, dementia prevention and strategies to enhance quality of life after diagnosis.

Patient experience
Caring for people with dementia

Both sites within ESNEFT support John's Campaign to enable named carers to be present at all times to support the patient in hospital which can reduce stress and anxiety for both the patient and the carer. It is hoped that that the Carer's passport and badge scheme at the Ipswich site will soon be rolled out across the Trust.

Currently, the Admiral Nurse Service is headed up by one Admiral Nurse on each acute site, supported by the wider team which includes the Dementia Liaison Administrator, the Dementia and Delirium Assistant Practitioner and lead consultants on each site. The number of Admiral Nurses within the acute setting nationally is still small and Dementia UK are working to increase the numbers for this vital role . ESNEFT is leading the way in Essex and Suffolk by having 2 full time Admiral Nurses in post offering the specialist care that our patients living with dementia and their families (who may be at crisis point) so deserve at a time which is potentially distressing and difficult.

Dementia garden's volunteer makeover

Local teenagers have given up some of their summer holiday to tidy up the Ipswich Hospital dementia garden.

The youngsters volunteered as part of a National Citizen Service (NCS) project, and have been working alongside Ipswich Hospital's head of grounds and gardens Peter Chapman.

The youngsters have been busy wood staining, weeding, pruning and tidying the garden - used by patients, relatives and colleagues - next to the Constable Suite.

Patient experience
Measuring and reporting the patient experience

Family or friends recommenders - Patients

Results are monitored by the Information Department, Divisions, Patient Safety & Experience Group and Trust Board using the Integrated Performance Report; and any outlying scores trigger a review.

Actions to be taken to improve the results going forward:

Reviewing results within the relevant CDG and Division

al meetings and at Patient Safety & Experience Group meetings and any actions required to improve

responses are taken;

Teams working with wards and clinics to review feedback to make improvements;

Emphasising the importance of submission of good returns and the satisfactory

outcome scores achieved in multidisciplinary team meetings

Table 16– Friends and Family Test Data April 2019 to March 2020

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

Patient experience
Measuring and reporting the patient experience

Plaudits

Plaudits are patient/carer/family members way of expressing their praise for individual staff members or overall service received.

They are able to do this through various methods such as:

- Patient advice and liaison service (PALS)
- Verbally, gifts and cards given directly to wards
- User groups
- Patient led assessments of the care environment (PLACE)
- Listening events
- Comment boxes within the Trust

Next steps

- Review of plaudit recording and dissemination of information to staff and the community

You said we did

Feedback is obtained through various methods such as:

- User groups
- Patient Story to the public board
- Learning from complaints
- Listening events
- Volunteers
- Community links with organisations

Patient representatives support staff in the Trust will not only bring the patient, carer relative voice but also support to make changes where possible and letting the community know what has been done (You said we did). This information is also disseminated via newsletters and put on patient information boards around the hospitals.

Next Steps

- Improving communication within the community setting
- Best practice shared across the Trust

Both plaudits and patient experience are monitored at the patient experience group for staff.

Table 17— Number of plaudits received by ESNEFT during 2019/20

Month	Quantity received
Apr-19	1426
May-19	1651
Jun-19	1076
Jul-19	2349
Aug-19	1901
Sep-19	1612
Oct-19	1783
Nov-19	1667
Dec-19	2642
Jan-20	
Feb-20	
Mar-20	
Apr-20	
Total for 2019/20	**16107**

Patient experience

Patient and public involvement, community engagement and patient feedback

A patient 'You said, We did' poster

You said	We did
The new disabled car park makes the journey to the main entrance longer	Within 10 days of telling us we dropped the kerb at the end of the parking to create a shorter and direct path to the main entrance
You said that the children's ward could supply children's toilet seats	12 new children's toilet seats were ordered
There is a problem with lost hearing aids, teeth and glasses	We found a box which could have a plastic mould to hold these items and we have tried it on 2 wards this year and reduced loss significantly. We will share this information within the trust
There is nowhere on the Colchester site to leave feedback outside of the wards	We have purchased boards with comments boxes for both carers specific and general feedback and information
You should include more information about c sections and around emergency c sections in the pregnancy Journey	We invited a patient representative to work with us on this and then ask other patients to feedback on what is written before implementing it into a programme.

Patient experience
Learning from complaints

What are complaints?

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

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

Complaints Service:

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

How complaints are managed within ESNEFT:

We aim to respond to complaints within 28 working days from receiving the complaint. This year 90% of complaints received were responded to within 28 working days or a revised timeframe agreed with the complainant, against a Trust target of 100%.

Every effort is made to contact each complainant within 24 hours of the complaint being logged by the complaints team. These calls, known as 24 hour courtesy calls, are made by a senior manager and are seen as an opportunity to: · Take time to understand the exact nature of the complaint as this will help to ensure a thorough and meaningful response; · Gain insight to understand the key issues that need to be resolved; Help build relationships with the complainant, help them to feel part of the process and demonstrate that we take their concerns seriously; and explain the 28 working day timeframe for our response and establish the method in which the complainant would like to receive our feedback, for example a letter or a face to face meeting. This year 84% of courtesy calls were made within the 24 hour standard.

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

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

Reopened complaints:

During the year 2019/20 3.95% of complaints received (1105) from April 2019 to March 202 have been reopened. One of the main reasons for reopening a complaint has been identified as poor or inaccurate investigation. In these cases, complaints are returned to the investigating team for further explanation and clarification. Analysis of reopened complaints is being undertaken to ensure that we fully understand why first responses are not meeting the satisfaction of complainants and to enable the complaints team to offer Division appropriate support.

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

A total of 25 complaints were referred to the PHSO, with 5 fully investigated. During the reporting period, 3 cases were partially upheld, 1 case not upheld and no

Complaints are categorised in three ways, depending on their severity

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

Patient experience
Learning from complaints

cases were fully upheld.

Learning from complaints:

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

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

It is acknowledged that there needs to be further Trust wide improvement in identifying, reporting and sharing lessons learned and actions taken from complaints.

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

Patient Advice and Liaison Service (PALS):

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

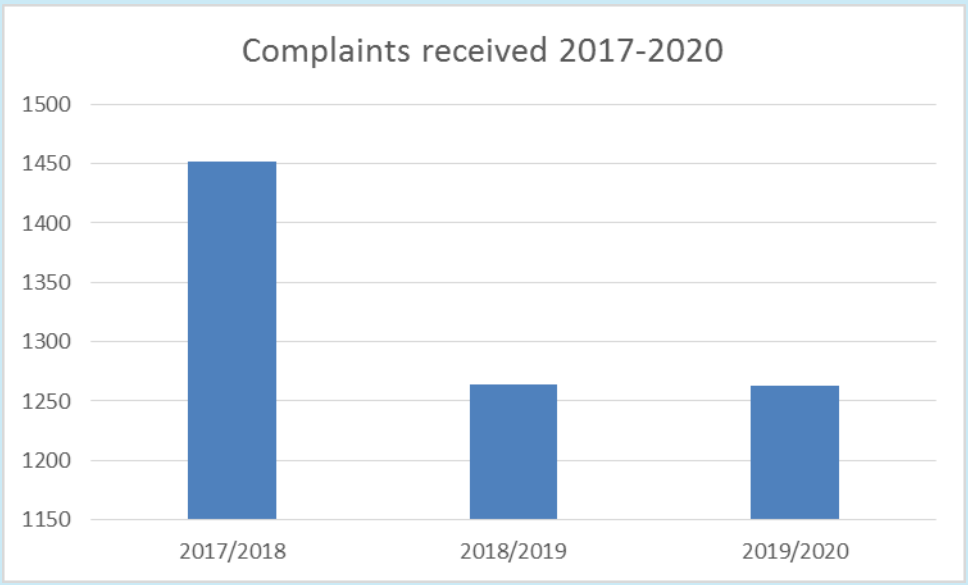
PALS offer patients, carers and visitors: · Advice and signposting– helping to navigate the hospital and its services; · Compliments and comments– PALS can pass on compliments and ideas to improve services; and · PALS can address noncomplex issues informally, often preventing the need to raise a formal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

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

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

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

Chart 11– Our performance over the last three years:



Patient experience
Learning from complaints

Chart 12- PALS Queries received for the last 3 years

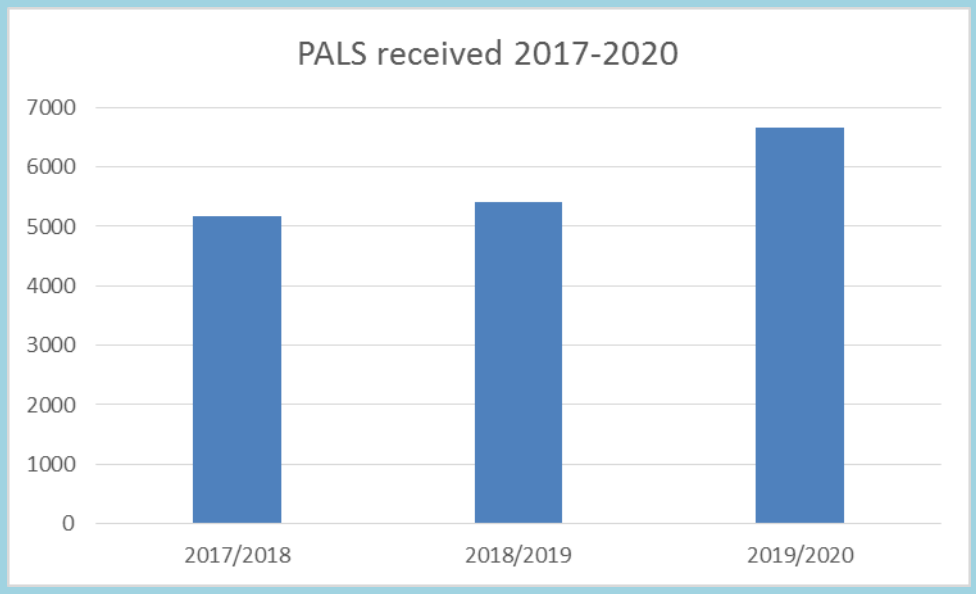


Table 18—East Suffolk and North Essex NHS Foundation Trust Top three subjects of complaints for the last 3 years needs updating

Top three subjects of complaints		
2017/18	**2018/19**	**2019/20**
Access to treatment or drugs	Communication	Access to treatment or drugs
Communication	Access to treatment or drugs	Aspects of care
Values and behaviours of staff	Aspects of Care	Communication

Patient experience
Patient-Led Assessment of the Care Environment (PLACE)

Patient experience Patient Led Assessment of the Care Environment (PLACE)

The Patient Led Assessment of the Care Environment or PLACE is the annual appraisal of a range of non-clinical aspects of hospital/ healthcare by patient assessors in conjunction with Trust staff. The patient assessors are volunteers from the local community who use the healthcare services provided by the Trust and the Trust is represented by the Estates & Facilities departments as they are responsible for the majority of the non-clinical services such as cleaning and maintenance. The assessments are carried out in both the NHS and independent healthcare sector in England.

PLACE was introduced in 2013 and was designed to replace the Patient Environment Action Team (PEAT). The PLACE assessments went through a major review in 2018/19, which resulted in a significant number of questions being changed. It is important to note that PLACE assessments are still led by Patients which means it is their perspective of the non-clinical aspects of care and how they impact on patients, their families and carers which is what is considered in the assessment.

The aspects of the assessment include:

- how clean the environment is;
- what the condition of the environment is – both inside and outside the hospital;
- how well the buildings meet the needs of the people who use it;
- the quality and availability of food and drinks;
- how well the environment protects people's privacy and dignity;
- whether the hospital buildings are equipped to meet the needs of dementia sufferers;
- whether the hospital is able to meet the needs of people with disabilities.

The 2019 PLACE assessments were carried out for the first time as East Suffolk & North Essex Foundation Trust (ESNEFT) and it can be noted that the scores achieved by each of the hospital sites (acute and community) were in general equal to or higher than the national average.

The PLACE initiative encourages the involvement of patients, the public and other stakeholders with an interest in Healthcare. The Patient Assessors who assisted with the 2019 annual PLACE assessments consisted of people from all walks of life who want to be involved and help shape the non-clinical aspects of healthcare in the hospital sites provided by the two Trusts that became ESNEFT in July 2018. The sites which were assessed were Colchester, Ipswich, Felixstowe and Aldeburgh hospitals, and Bluebird Lodge in Ipswich.

The role of the patient assessor

The role of the assessor is to be a critical friend, and requires people who are unbiased and objective in order that they can:

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

The assessment teams must always consist of at least 50% Patient assessors and during the 2019 assessments, the teams were usually made up of two or three patient's assessors, one or two member of the Facilities Team such as the Hotel Services Manager, a Matron or Infection Control nurse. Teams are always accompanied by a 'scribe' who records observations and scores throughout the day.
Anyone who takes part in the assessments is offered training/re-training on an annual basis.

Scope of the assessment

At both Colchester and Ipswich, a minimum of 25% of the wards (or ten, whichever is the greater) and a similar number of non-ward areas must be assessed. Each area assessed should allow the PLACE team to make informed judgements about those parts of the hospital it does not visit. With regards to the Community sites, as these are generally much smaller the whole site is assessed. The documentation provided for the assessments considers the different types of sites and the facilities they offer, and aims to:

- Where possible, focus on areas of the hospital not included in recent PLACE assessments so that over a

Patient experience
Patient-Led Assessment of the Care Environment (PLACE)

period of time all areas will be assessed, (Acute sites only);
- Include all buildings of different ages and conditions; and
- Include departments/wards where a high proportion of patients have dementia or delirium.
- Include an assessment of the food on offer to patients on the day of the assessment taking into account temperature, appearance, taste and texture.
- Include an assessment of the external aspects of the site including grounds and gardens, signage and wayfinding.
- Consider how accessible the hospital is to people with various disabilities.
- Consider the patient environment and how clean it is, ensuring that areas where patients are not permitted, i.e. sluice rooms, waste holds and kitchens are not included.

Each team makes the final decision on which patient areas they will inspect, but they must ensure that the wards and areas chosen are reflective of the range of services and buildings across the hospital, which is why there is specific paperwork for general wards, emergency department, outpatient departments, community sites and mental health.

Scoring

Scores are based on what is observed at the time of the assessment and therefore are a snapshot of what was observed on the day of the assessment. It is made clear to assessors that they must score the hospital site on how it delivers against the defined criteria and guidance.
To achieve a pass, all aspects of all items must meet the definition/ guidance as set out in the assessment criteria. When the definition criteria are not met, the score will either be a fail or a qualified pass. A qualified pass is awarded when the criteria are generally met, but there may be a minor exception, i.e. the walls on a ward are mostly in a good state of repair, but one wall may not be up to the required standard. This is detailed and a qualified pass is awarded/scored.

The organisational food assessment, addresses the catering services provided by the organisation, and the Ward assessment which addresses the quality (taste, texture and temperature) of the food provided. All questions in the Ward-based component have a maximum score of 2 with the exception of Food Temperature which uses a Yes/No methodology.
Assessment teams therefore need to be able to exercise judgement, and will discuss and agree which score to apply.

The assessments

Up until 2018, Trusts were given six week's notice by the Health and Social Care Information Centre (HSCIC) of the specified timeframe during which their PLACE assessment must occur. In 2019, this changed and Trusts were able to decide when the assessments would be carried out between September and the end of November, due to the national changes earlier in the year. PLACE going forward will therefore be carried at this time every year.

Up until 2018, Trusts were given six week's notice by the Health and Social Care Information Centre (HSCIC) of the specified timeframe during which their PLACE assessment must occur. In 2019, this changed and Trusts were able to decide when the assessments would be carried out between September and the end of November, due to the national changes earlier in the year. PLACE going forward will therefore be carried at this time every year.

Results of the PLACE assessments

The ESNEFT in-patient hospital sites have essentially scored fairly well against the revised PLACE criteria and also against neighbouring Trusts. Cleanliness, Food and the Condition of our buildings scored well, whilst the scores for Privacy& Dignity, Dementia and Disability indicate the need for improvement.

The results of the assessments and the resulting action required for improvement has been summarised below:

- Has colour been used effectively to enhance patients orientation / co-ordination e.g. doors and bays painted in a different colour
- Are there accessible areas for washing and toilet facilities available for parents, relatives, guardians or carers that stay overnight (they do not

Patient experience
Patient-Led Assessment of the Care Environment (PLACE)

have to be on the ward directly)

- Provide day rooms/social space on wards that are appropriately furnished
- Extend the 'dementia friendly' ward and department programme
- Is internet access (Wi-Fi) available in public areas
- Make finger foods available for specific groups of patients
- Ensure patients have access to a lockable storage space
- Is there a large, accurate and silent (approx. 18 inch/45cm diameter) clock clearly visible in all patient areas?

The results of the PLACE assessments were submitted in November 2019 and published in January 2020. The scores achieved by the different hospital sites and the national average are detailed in Table 1 (see below). Tables 2,3,4,5 and 6 detail the individual score for each of our sites at ESNEFT.

Table 19 - PLACE Overall Scores with the 2019 national average and the overall score achieved by ESNEFT hospital sites in 2019

PLACE CRITERIA	Cleanliness	Food and Hydration	Privacy and Dignity	Condition, Appearance & Maintenance	Dementia	Disability
National Average	98.6%	92.2%	86.1%	96.4%	80.7%	82.5%
Colchester Hospital	99.76%	93.46%	82.43%	99.18%	72.22%	80.31 %
Ipswich Hospital	98.95%	92.61%	83.49%	94.53%	77.57%	78.99 %
Bluebird Lodge	100%	92.82%	85.42%	100%	82.29%	79.04 %
Felixstowe	100%	84.42%	82%	96%	76.64%	77.99 %
Aldeburgh	99.12%	92.82%	82.98%	96.62%	82.01%	82.97 %

Patient experience
Patient-Led Assessment of the Care Environment (PLACE)

Chart 13—Ipswich hospital site in 2019 against the 2019 national average score

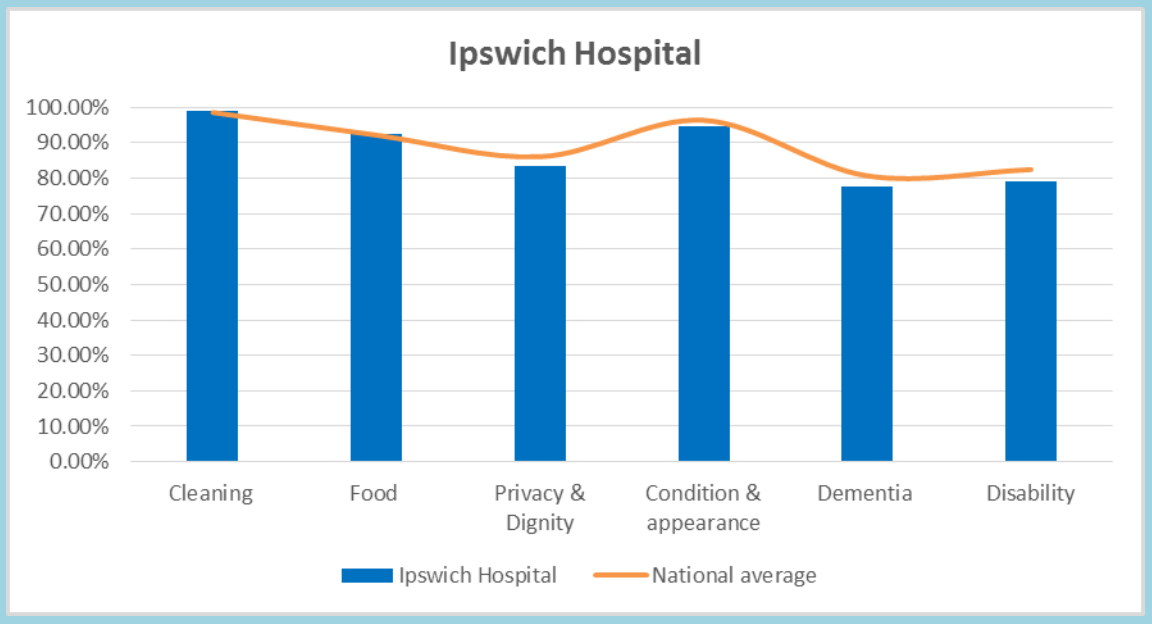
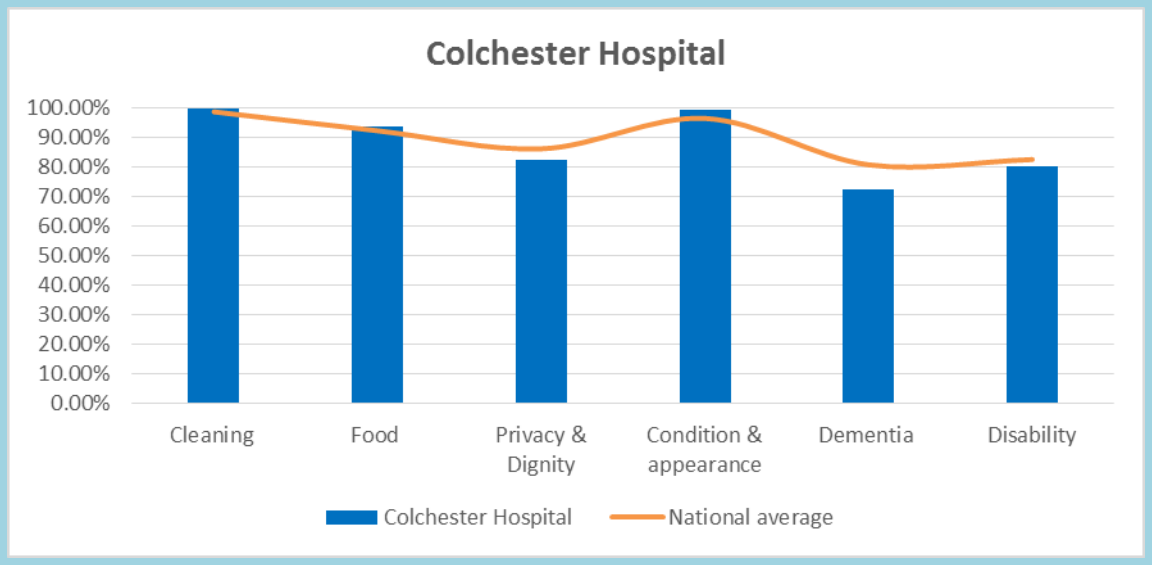


Chart 14—Colchester hospital site in 2019 against the 2019 national average score



Patient experience
Patient-Led Assessment of the Care Environment (PLACE)

Chart 15 -Bluebird lodge hospital site in 2019 against the 2019 national average score

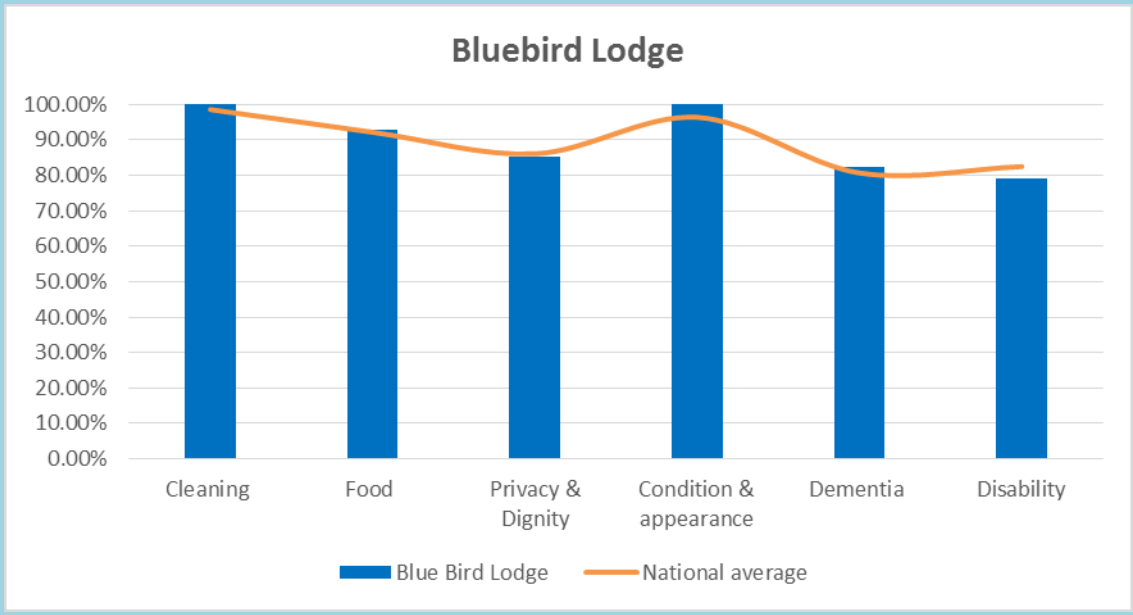
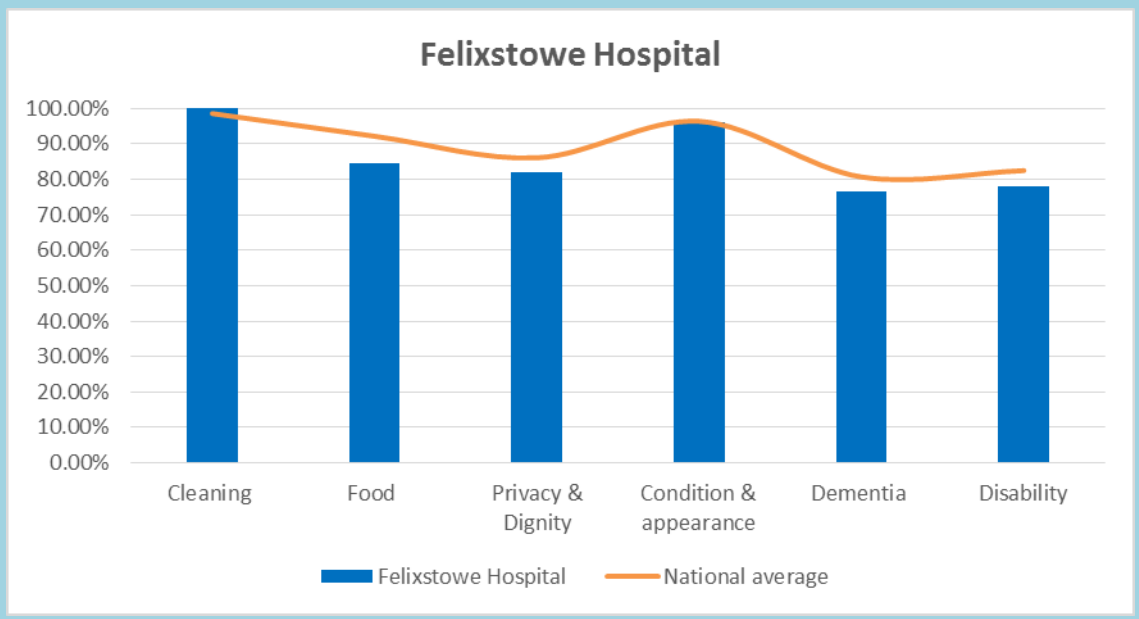
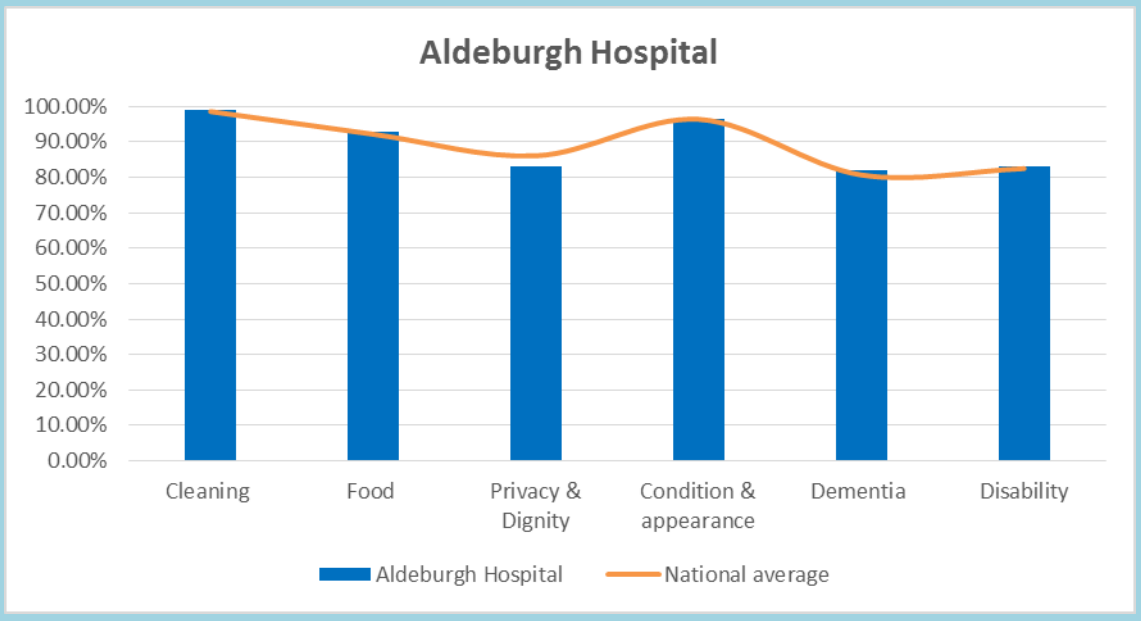


Chart 16—Felixstowe hospital site in 2019 against the 2019 national average score



Patient experience
Patient-Led Assessment of the Care Environment (PLACE)

Chart 17 - Aldeburgh hospital site in 2019 against the 2019 national average score



Conclusion

The PLACE process has undergone change at both a national and local level. The local changes have included the formation of a trust wide PLACE assessment team. Assessors from both acute sites underwent training and have formed a cohesive group who have enjoyed the challenges of visiting new sites, which will continue into in this year and beyond.

Continued investment in the patient environment via the ward refurbishment program in the acute hospitals and the introduction of a refurbishment programme within the Community sites will contribute significantly to ensuring that PLACE results improve both on this year's results as well as being able to achieve the national average.

Next Steps

The Director of Estates & Facilities reports the results of the PLACE assessments to the Trust Board once they have been published and are in the public domain. The report includes information relating to not only how well the Trust performed, but also considers the national average and performance against other local Trusts.

The Trust will review and revise the PLACE Action Plan to take into account all sites and the action required in order to evidence compliance with the PLACE assessment criteria. This will then be presented to a meeting of those who take part in the process on the various sites.

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

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

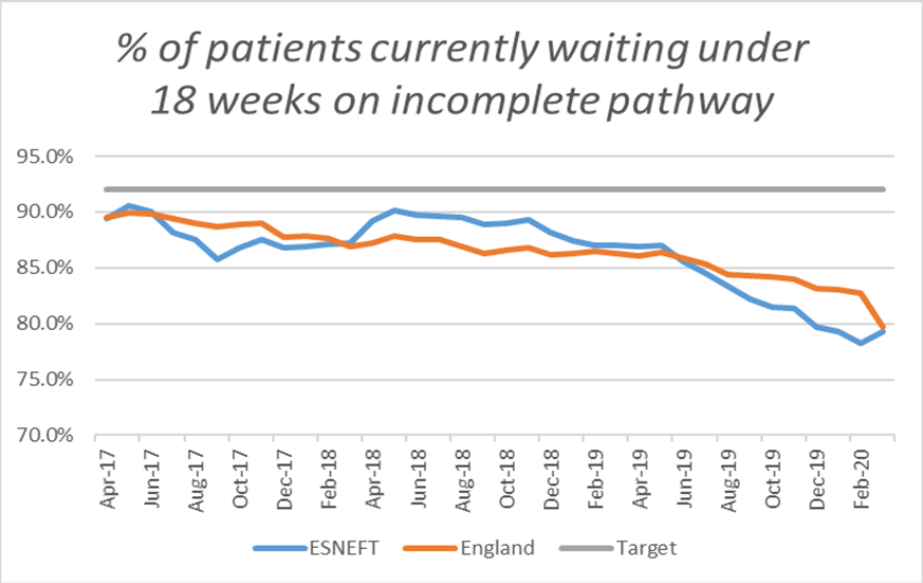


Table 20—Percentage of patients currently waiting under 18 weeks on incomplete pathway

		2017/18		2018/19		2019/20	
% of patients currently waiting under 18 weeks on Incomplete Pathway	Target	ESNEFT Performance	National Performance	ESNEFT Performance	National Performance	ESNEFT Performance	National Performance
April	92%	89.4%	89.5%	89.2%	87.2%	86.9%	86.1%
May	92%	90.6%	90.0%	90.1%	87.8%	87.1%	86.4%
June	92%	90.1%	89.9%	89.7%	87.5%	85.5%	85.8%
July	92%	88.1%	89.5%	89.7%	87.5%	84.5%	85.3%
August	92%	87.5%	89.0%	89.5%	86.9%	83.4%	84.4%
September	92%	85.8%	88.7%	88.9%	86.3%	82.2%	84.3%
October	92%	86.8%	88.8%	89.0%	86.6%	81.4%	84.2%
November	92%	87.5%	89.0%	89.3%	86.8%	81.4%	83.9%
December	92%	86.8%	87.7%	88.1%	86.2%	79.7%	83.2%
January	92%	86.9%	87.8%	87.4%	86.3%	79.3%	83.0%
February	92%	87.1%	87.6%	87.1%	86.5%	78.2%	82.7%
March	92%	87.2%	86.9%	87.0%	86.3%	79.3%	79.7%

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

Ensuring that patients referred to our hospitals with a suspected cancer are diagnosed as quickly as possible and receive timely and effective treatment remains a key priority for all staff at Colchester and Ipswich. Focus this year has been on reducing overall waiting times by ensuring that as many patients as possible received a diagnosis or are confirmed as non-cancer with 28 days of referral. This will ultimately ensure that earlier treatment is available and overall patient experience improved.

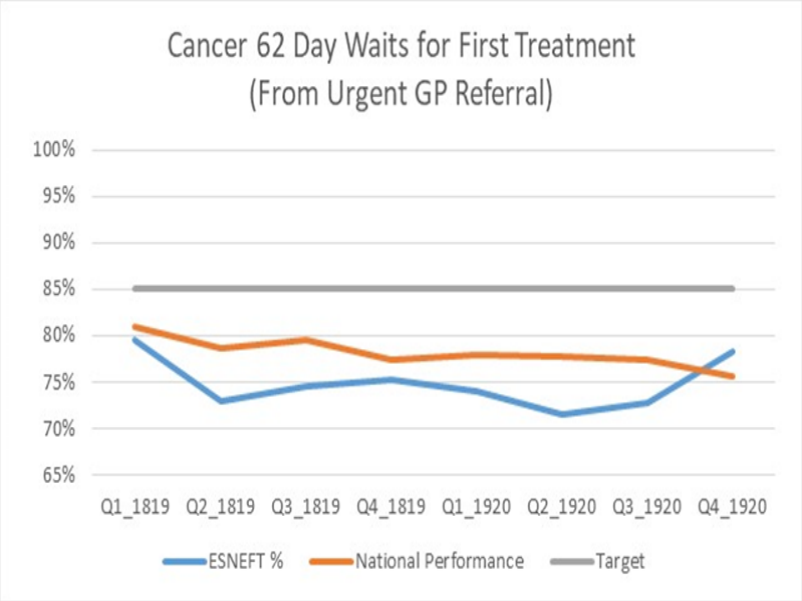
Although performance against 62 day first standard remains below the 85% national performance target, improvements made to a number of individual specialty pathways has been significant. This has resulted in a significant reduction in the number of patients waiting longer than 62 days on a cancer pathway, despite experiencing an increase in referrals across every tumour site. This improvement is a direct result of investment in to cancer services to support the streamlining of diagnostic services and administrative processes for a number of clinical pathways including the introduction of Straight to Test (STT) diagnostics where recommended as best practice.

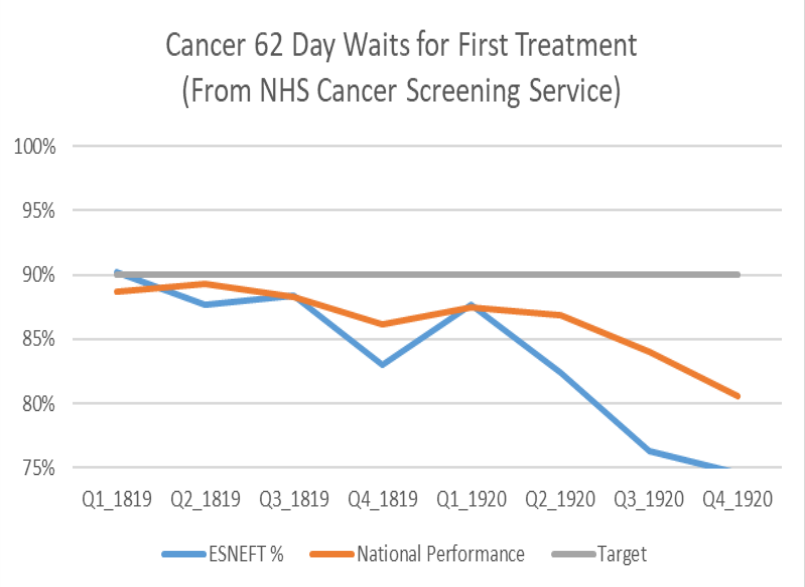
Achieving and sustainably delivering the national standard of 85% remains a challenge for the trust, as with many other trusts around the country. To address this the trust continues to support improvements across all aspects of cancer care by ensuring that Cancer remains one of the top 3 priorities.

Highlights 2019/20

Key Improvements:

Charts 19—Cancer 62 Day Waits





Cancer Care Delivery
Improving performance

Helping cancer patients get a faster diagnosis
Patients having investigations for suspected bowel cancer at Ipswich or Colchester hospitals are now able to get a diagnosis or the all clear more quickly thanks to a new straight-to-test service.
The service sees a team of four nurses assess urgent GP referrals over the phone before offering them a colonoscopy within seven days. Previously, patients would be given an initial outpatient appointment within 14 days, then wait another two weeks for their tests.
It has been introduced at Ipswich Hospital following its success at Colchester, where it has been running for two years.

Hydration for Radiotherapy patients
Ipswich Hospital's Radiotherapy team has introduced hydration bottles to encourage drinking and support patients' wellbeing. Here's the first patient with their bottle at their pre-treatment planning appointment.

Cancer Care Delivery
Improving performance

- Replacement of Infoflex cancer system at Ipswich hospital with Somerset National Cancer Registry – Both hospitals are now using the same system to record cancer waits which has significantly improved recording of activity and subsequently improved data quality across all cancer standards
- Introduction of STT MRI in prostate and STT Colonoscopy in colorectal pathway at Ipswich hospital (already in place at Colchester)
- Introduction of LA (local anaesthetic) Template biopsies for patients on a prostate pathway, negating the need for pre-assessment clinics, general anaesthetic and increased length of stay for a many patients
- Same day CT (walk-around service) for patients on a lung, colorectal, urology or gynae pathway
- Additional capacity for CT guided biopsies to improve lung pathway
- Improved turnaround times for diagnostics: Radiology and Pathology working to a maximum wait of 7 days to complete diagnostic test and report on it, for all patients on a cancer pathway.

Challenges:

- Processes relating to the delivery of care pathways differ slightly on each hospital site. However, good improvement noted in many areas with the introduction of best practice timed pathway guidance (Lung, Colorectal and Prostate) to support the delivery of the new 28 day Faster Diagnosis Standard (FDS) however, some challenges remain within individual teams. Further support to be provided from the Cancer Alliance and ICS (Integrated Care System)
- MDT – Patient referral for treatment to tertiary centres – Logistical challenge. Ipswich pathways face out towards Norfolk and Cambridge whilst Colchester's face towards the south of Essex and into London. This situation is unlikely to change within the next 12 to 24 months due to the logistical challenges. Full consideration as to how we potentially merge cancer pathways between Colchester and Ipswich sites must include a full review of the direct impact on a) the tertiary centres b) individual patient pathways (i.e. may need to travel further for treatment)
- Time – Operational management. A number of staff have operational responsibility for cancer delivery at both Colchester and Ipswich hospitals
- Clinical vacancies: Substantive recruitment of several key consultant positions across a number of tumour sites
- MDT Coordinator (cancer pathway trackers) vacancies: Changes to recruitment process to support timely appointment of suitable staff.

Assurance process:

- Cancer Recovery Plan - To ensure that all issues have been identified and are being addressed the trust has produced a detailed Cancer Recovery Plan which, supported by a robust escalation process, allows us to identify any potential issues or blocks to a patient's cancer pathway. The plan includes tumour site-specific actions as well as an overarching objective to improve communication and face to face engagement with all departments.
- Cancer Red 2 Green – Twice weekly meetings led by the Cancer Performance team, with each tumour site to ensure that all patients that may potentially have a delayed pathway of care are discussed and immediate resolution can be sought to the issue; which can include direct escalation to the Executive team where necessary.
- Monthly cancer performance call with NHSI and local CCG leads to provide update on current and forecast position and risks to delivery.
- Increased understanding of cancer waiting time rules amongst the admin staff

Cancer Care Delivery
Improving performance

and generally raising the profile of the importance of cancer waits within the trust.

- Prioritisation of Cancer throughout the Trust – Cancer performance and recovery named as one of top 3 Trust level priorities.

Planned Improvements

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

Business as Usual – Cancer delivery

- Mandated weekly Cancer PTL meetings – Executive led supported by the Lead Cancer Manager. Attendance required from General Manager or Deputy
- Weekly cancer reports – Submitted to NHSE/I and CCG's
- Twice-weekly cancer Red to Green meetings – Full review of longest waiting patients – Lead by cancer Performance Manger with service teams and MDT coordinators. Aim is to identify and mitigate any issues that may delay a patient's pathway of care.
- 104 day breaches: A weekly 104 day report is also sent to NHSI/CCG with monthly panel led by the trusts Medical Director to review potential clinical harm. Panel report to Trust Board
- The Root Cause Analysis (RCA) process for every patients treated outside of the 62 day standard.
- Cancer Board bi-monthly meeting chaired by the Trusts Lead Cancer Clinician, with Lead Cancer Manager and Lead cancer Nurse. Attended by the lead clinician for each tumour site, the Divisional Lead and the Head of Operations. External attendance from CCG cancer lead and CSUG (Cancer Support User Group)

Cancer Care Delivery
Patient Experience

The National Cancer Patient Experience Survey (NCPES) is a National Department of Health initiative designed to monitor and drive forwards improvements in a cancer patient's experience of their care.

It is run annually, and captures the experience of all cancer patients right from their first presentation to their GP, through diagnosis and treatment and through to their discharge from care

The NCPES results which were published in Aug 2019 captured the experience of cancer patients who experienced care at the Trust in April, May and June 2018. This is the first results reported as ESNEFT rather than Ipswich and Colchester.

The results

The results for ESNEFT in 2018 were positive

Table 21—National Cancer Patient Experience Survey (NCPES) Performance in areas monitored by PHE

Question	ESNEFT
Involved with decisions re care & treatment	79%
Given name of CNS to support them	96%
Easy / very easy to contact the CNS	88%
Treated with dignity & respect while in hospital	89%
Told who to contact if worried / had concerns after discharge from hospital	95%
GPs & nurses at GP Practice did everything they could to support them while they were having cancer treatment	56%

Cancer Care Delivery
Patient Experience

Table 22—NCPES: Areas of good practice – better than National Average

Topic	% greater than NA
Given practical advice and support dealing with side effects and treatment	5%
Given name of CNS who would support during treatment	5%
Got understandable answers to important question all or most of the time	3%
Given advice re support groups	4%
Given information about the impact of cancer on day-to-day activities	5%
Given information about financial help	8%
Staff explained how operation had gone in an understandable way	4%
Able to discuss worries or fears with staff during visit (OPD)	5%
Given information about whether radiotherapy was working	7%
The administration of care was good/very good	3%
Length of time for attending clinics and appointments was right	9%

Key achievements

- ✓ Mary Barron and the Haematology Day Unit merged to become the The Collingwood Centre at Colchester Hospital – a brand new state of the art chemotherapy day unit.
- ✓ The Cancer Wellbeing Centre was opened to offer support, advice, complimentary therapies and counselling to people affected by cancer, patients and families, on the Colchester site.
- ✓ The successful bid for a two year Macmillan pilot for all ESNEFT cancer patients to be supported by a team of cancer care navigators who will help by signposting to local support in the community and provide psychological support after diagnosis and treatment.
- ✓ Participation in an NSHE Cancer Collaborative project working in co-production with patient users to develop cancer information webpages on the hospital intranet.
- ✓ Embedding the outreach Clinical nurse specialist role for lung cancer patients at Ipswich following successful evaluation on completion of the trial period
- ✓ The introduction of a 0.5WTE family support worker at Colchester to mirror the Ipswich service

Cancer Care Delivery
Patient Experience

Table 23—NCPES: Areas for improvement (lower than National Average)

Topic	% worse than National Average
Patient told they could bring a family member or friend when first told they had cancer	7%
Patient felt they were told sensitively that they had cancer	3%
Told by hospital staff they could get free prescriptions	5%
Patient's family or someone close definitely had opportunity to talk to doctor (urology)	23%
The length of time waiting for the test to be done was about right (UGI)	17%
Patient told they could bring a family member or friend when first told they had cancer (gynae)	30%
Patient had confidence and trust in all doctors treating them (lung)	28%
Patient definitely given enough support from health or social services during treatment (colorectal)	16%
Give info / results in understandable way (Gynae)	15%
Taking part in cancer research discussed with patient (gynae)	20%
Taking part in cancer research discussed with patient (UGI)	20%
Taking part in cancer research discussed with patient (urology)	12%

Key actions

- Develop CNS workforce to be able to better respond to patients' needs including scoping the use of the Band 4 Support Worker and Band 8a CNS leads for MDTs across ESNEFT to provide clinical leadership
- Support and develop the new CNSs in Gynae to provide best practice clinical nurse specialist support
- Continue fundraising through the Blossom appeal at Ipswich to develop a designated new Breast Centre
- Recovery package & survivorship roll out
- Embed the personalised self-managed follow up within Breast, Colorectal and Prostate MDTs
- Work with local Clinical Commissioning Groups (CCG's), the Cancer Alliance North and Public Health England to develop Rapid Diagnostic Clinic pathways
- Develop an ESNEFT 'Cancer Charter' in collaboration with patient users in response to NCPES and ESNEFT patient feedback

Patient Experience Survey and data collection

National: NCPES is repeated annually. Patients now being surveyed for 2019 survey which will be published in September 2020
Local: ESNEFT Real time patient experience is captured via FFT, informal interviews in OPD areas, complaints, PALS, local level surveys

Safeguarding

Adult, Domestic Abuse, Children, Dementia and Learning Disability

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

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

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

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

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

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

Reporting:

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

Training:

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

Safeguarding

Adult, Domestic Abuse, Children, Dementia and Learning Disability

Members of the Colchester United squad have visited the Children's Ward at Colchester Hospital.

- Trajectories for each quarter are set to achieve the targets agreed in the 2018/19 contract standards. The PREVENT (counter terrorism) target is set by the Home Office at 85% of all staff to be compliant (the Trust has successfully met this throughout the year).
- Key priorities will include continued provision of training to enable staff to remain compliant with training, to work with staff to ensure compliance with MCA and the proposed Liberty Protection Safeguarding (LSP), which are currently due to implemented 1st October 2020.

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

Speaking Up

Freedom to Speak Up and Raising Concerns

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

The vision statement encapsulates the current drive from the Board to ensure that at all levels of the Trust, our staff know that they will be supported, if they raise a concern. We recognise that there are still individuals who struggle to make their voice heard and that some have a lack of faith that they will be listened too, or fear that they will be victimised should they do so. This is not peculiar to ESNEFT and other parts of the NHS have similar challenges but it demands action from all of us.

We have just finalised a standalone page on the Trust intranet that provides all the information that an individual wishing to raise a concern, speak up or whistle blow needs. This includes pointers to potential sources of advice, policy documents that could provide guidance, websites that might be helpful and email and addresses for our Freedom to Speak Guardian.

We have re-vamped out induction and each new employee now receives a trifold pamphlet reflecting much of the advice on the intranet page and with similar pointers to those who might help.

Our speaking up policy reflects national policy and the Guardian remains a member of the East of England Freedom to Speak Guardians assembly, which is overseen by the National Guardians office. The Raising Concerns Steering Group which offers support and direction to the Guardian is about to be re-designated as the Speaking Up Safely Group and will encourage input from other parts of the organisation including Equality and Diversity and Health and Wellbeing.

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

Pictured below Tom Fleetwood speaking to a staff member

Speaking Up

and reports quarterly to POD and annually to the Main Board

Gosport Independent Panel Report

In its response2 to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS trusts and NHS foundation trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the trust.

In her response on behalf of ESNEFT, the Medical Director highlighted the following actions for the Freedom to Speak Guardian all of which are complete:

Issue	Assurance	Action	Responsibility	Date for completion and updates 20.01.2020
The concerns of patients, their families and staff were not heard soon enough and lives could have been saved.	ESNEFT has a whistle-blowing policy and FTSUG. ESNEFT has a duty of care and being open policy. There is a well-established concern/complaint process. PALs are accessible in house via a website to raise issues 24/7. The PALs team monitor issues for themes and escalate to Chief Nursing Officer.	Review and relaunch Raising Your Concerns policy. Re-promote the role and contact number of the FTSUG. Ensure FTSUG is part of the induction process.	HR team FTSUG FTSUG	Complete. Current policy reflects National Guidance in every respect. Complete - Raising Concerns Steering Group reconvened 21/05/19. Director of Communications to take forward promotion of role which will include the establishment of a team of Assistant FTSU's (Freedom to Speak Up) Complete – FTSU as part of the induction process.

Staff Survey

Equality and Diversity

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

This document summarises the findings from the NHS National Staff Survey 2019, carried out by Picker, on behalf of East Suffolk and North Essex NHS Foundation Trust. Picker was commissioned by 21 Combined Acute Community Trust organisations to run their survey – this report presents the results in comparison to those organisations.

A total of 90 questions from the survey can be positively scored. 90 of these can be compared historically between NSS18 and NSS19. The results include every question where the organisation had the minimum required 11 respondents.

We use the results of the NHS Staff Survey to make improvements to working conditions and patient care, we pay particular attention to the diversity in our workforce in terms of the nine protected characteristics (Equality Act 2010). We want to ensure that all groups staff have a positive experience of the organisation. The section below provides an analysis of the demographic profile of those who have respondents to the survey by:

- Age
- Gender
- Disability
- Religion and Belief
- Sexual Orientation
- Race and ethnicity
- Full time staff vs part time staff

We will be working closely with our Inclusive Staff Networks to ensure we improve staff experience for our diverse workforce. A key part of this work will be delivering our NHS Workforce Race Equality Standard and Workforce Disability Equality Standard Action plans which help to ensure that staff experience improves, which ultimately improves patient care and experience.

9683	9683	49%	50%	39%
Invited to complete the survey	Eligible at the end of the survey	Completed the survey (4742)	Average response rate for similar organisations	Your previous response rate

57%	Q21c. Would recommend organisation as place to work
67%	Q21d. If friend/ relative needed treatment would be happy with standard of care provided by organisation
72%	Q21a. Care of patients/service users is organisation's top priority

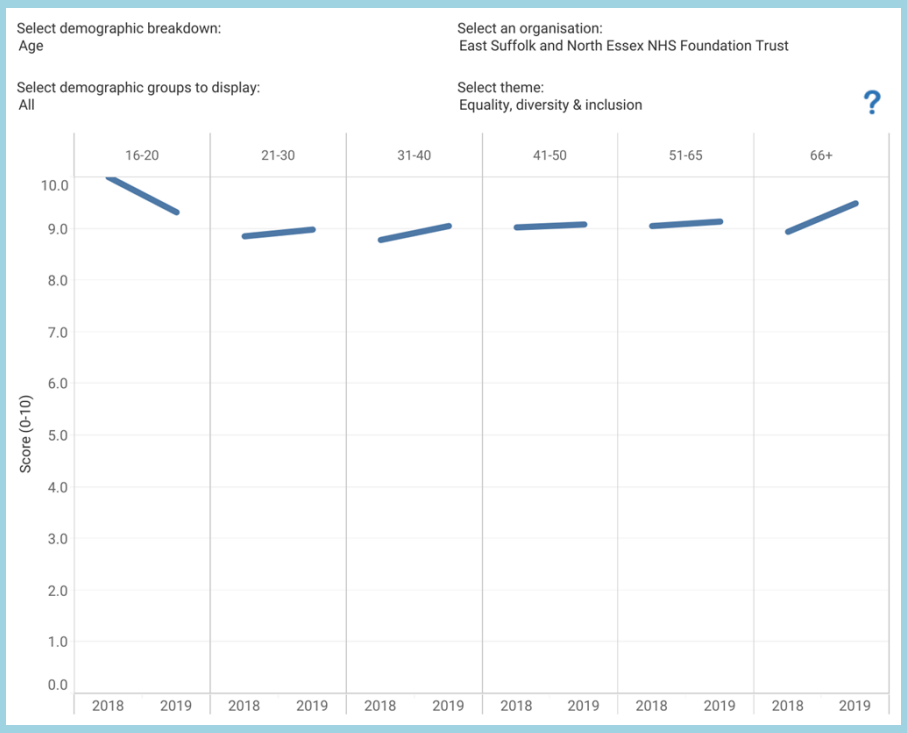
Historical comparison*

Comparison with average*

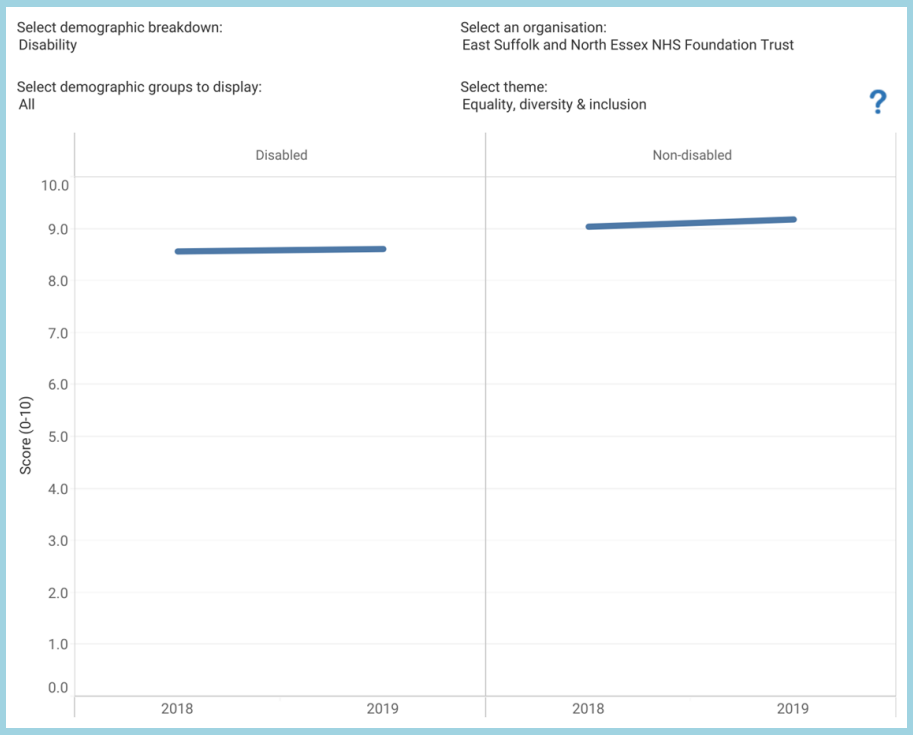
*Chart shows the number of questions that are better, worse, or show no significant difference

Staff Survey
Equality and Diversity

NHS Staff Survey 2018 – 2019 Demographic Analysis – Age

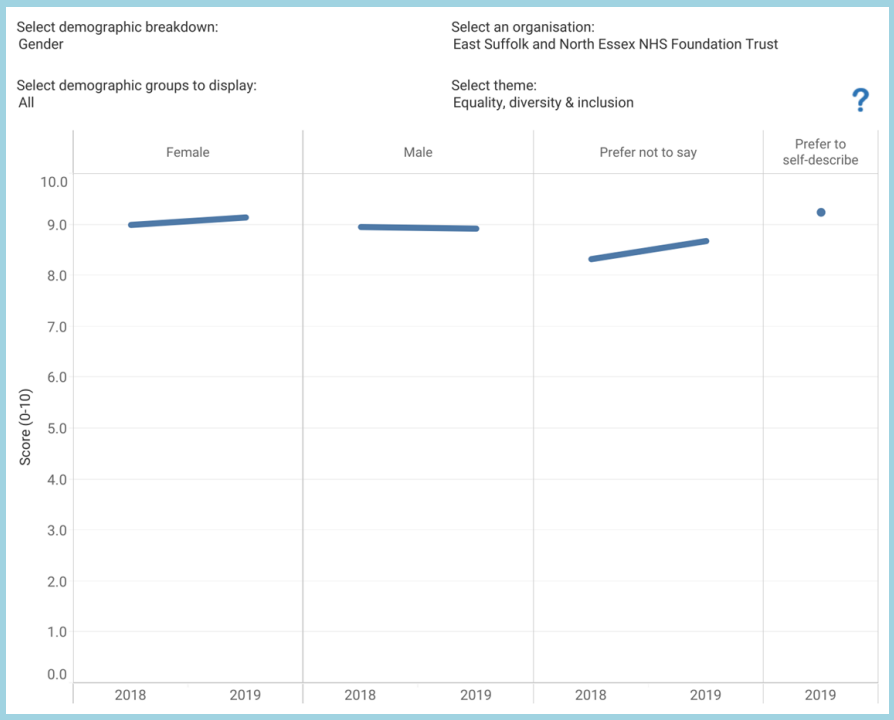


NHS Staff Survey 2018 – 2019 Demographic Analysis – Disability Profile

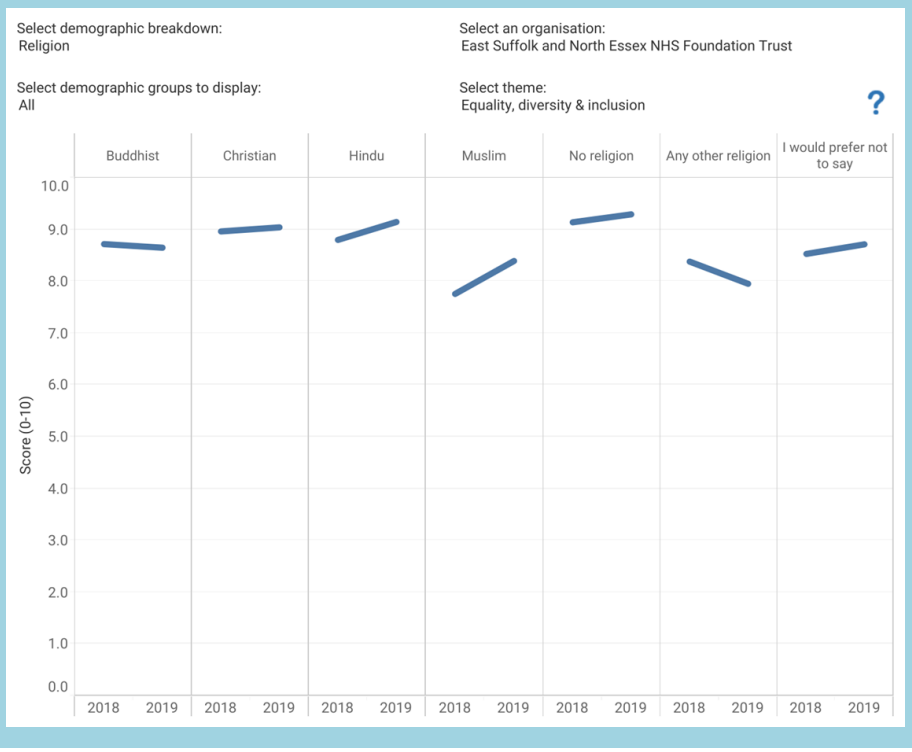


Staff Survey

NHS Staff Survey 2018 – 2019 Demographic Analysis – Age

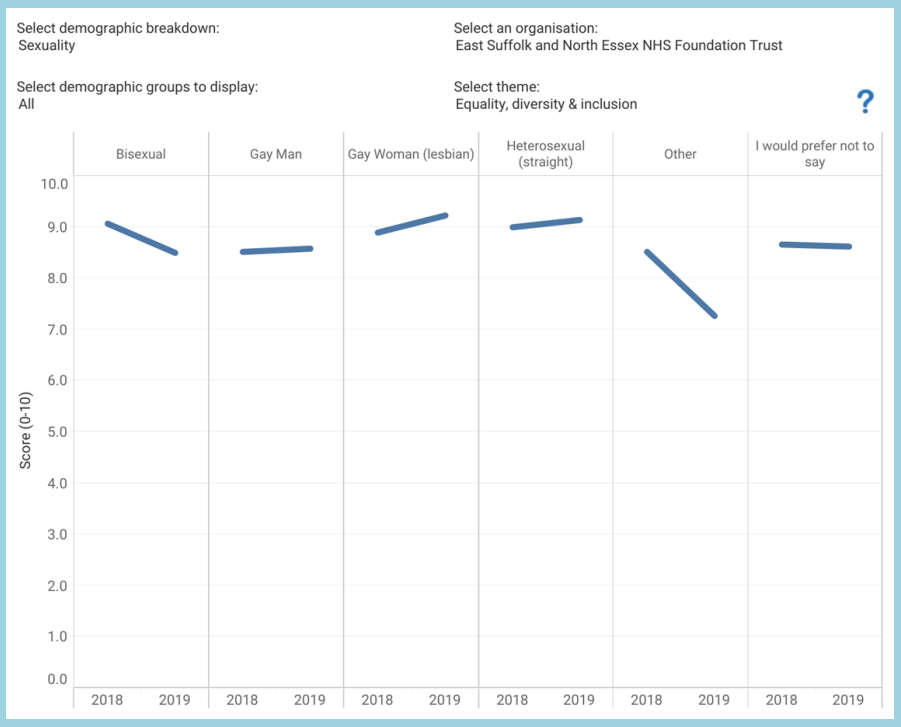


NHS Staff Survey 2018 – 2019 Demographic Analysis – Religion and belief

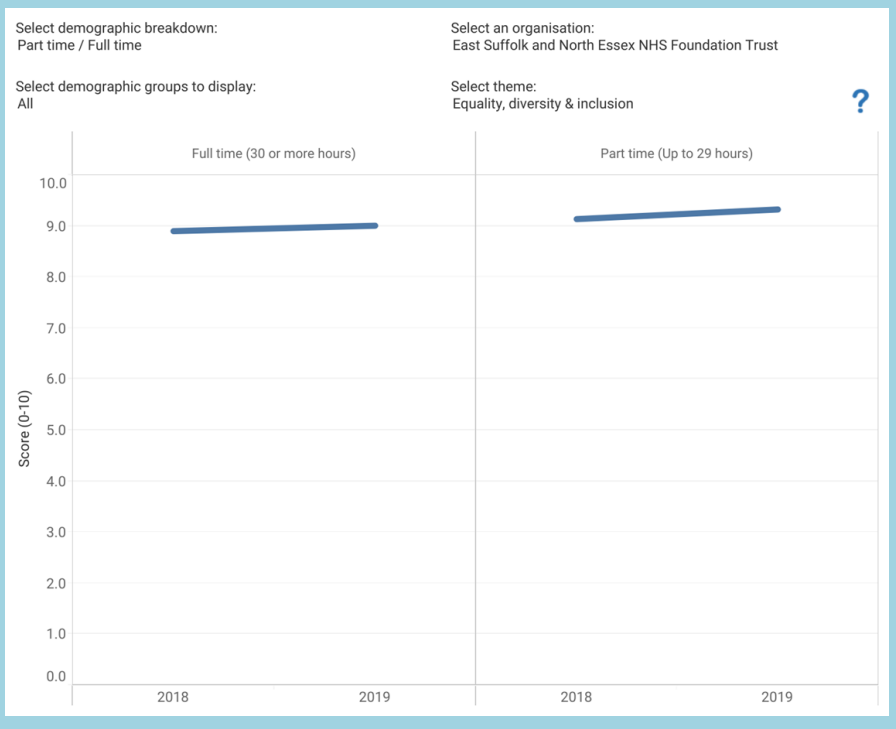


Staff Survey
Equality and Diversity

NHS Staff Survey 2018 – 2019 Demographic Analysis – Sexual Orientation



NHS Staff Survey 2018 – 2019 Demographic Analysis – Part time and Full time staff



Workforce
Health and Well-being

The Trust is committed to providing an efficient and effective Health and Well-being service which is accessible to all staff. This includes direct rapid access to physiotherapy as well as access to an Employee Assistance Programme.

Significant focus has been placed on workforce mental health initiatives this year. Some of the highlights have included the following.

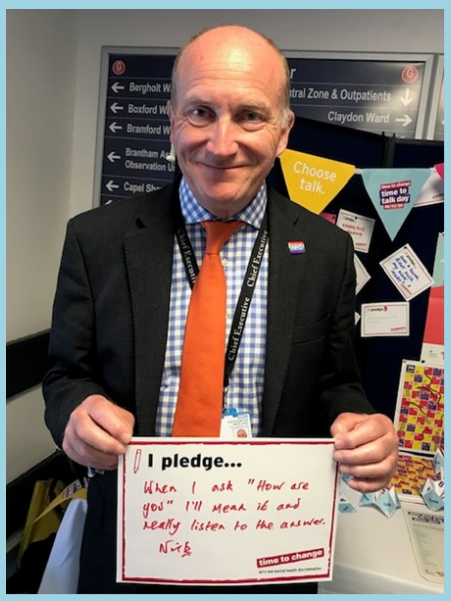
From August 2019 to March 2020, a total of 80 colleagues were qualified as Mental Health First Aiders through Mental Health First Aid England. These colleagues have already started to make a real difference in their areas of work.

With the support of our Mental Health First Aiders, the organisation marked 'Time to Talk' Day by visiting all Trust sites and many departments to raise awareness of mental health in the workplace and to invite staff to make a pledge. This event was very well received and really helped to reinforce how much the organisation cares for not only the physical, but the mental wellbeing of all staff.

The Trust has continued to work in partnership with Suffolk Mind to deliver Your Needs Met training and to continue with our ongoing project to analyse how well the needs of staff are being met.

Fourteen of our eighty Mental Health First Aiders.

Workforce
Health and Well-being



Workforce

Health and Well-being

Schwartz Rounds

Schwartz Rounds are structured monthly one-hour meetings and are available to all staff, volunteers and colleagues working at our various sites. The purpose is to reflect on the emotional experience of working in healthcare, rather than finding solutions to problems. Evidence shows that staff who attend Rounds feel more supported, valued and connected with others.

We have experienced Rounds with varying degrees of emotional content and audience sharing. Schwartz Rounds in 2019/20 have included the following topics:

- Coping with Grief and Loss
- The Power of Exercise
- Hot Chicks – Understanding the Impact of Menopause
- Celebrating our Valued AHP's.

Swartz Rounds

Workforce

Volunteering

Our volunteers service is now co-ordinated in house from a centralised office based at Ipswich Hospital for all volunteers across ESNEFT having migrated the service back in house during 2019 at Colchester Hospital. The service has gone from strength to strength over the past 12 months. We have secured funding for a voluntary services business development manager post from the Colchester & Ipswich Hospitals Charity, restructured and recruited a new team. A new database system was installed in December 2019 allowing us to manage all of our volunteers from a centralised system. The recruitment process also moved from a paper based application to online solutions which shortens the process for all.

Highlights from our volunteers are summarised below:-

- ✓ Over 500 active volunteers across the Trust providing more than 3,650 hours a month of voluntary services
- ✓ 15 young volunteers between the ages of 16-19 delivering Ward Support in Surgery and Gastro, The Emergency Department, Children's Wards, Maternity and Critical Care
- ✓ 7 new volunteers roles identified (Woolverstone Wing Support, Butterfly Volunteers, Cancer Wellbeing Centre, Weight Management Clinic, Phlebotomy, Welcoming Service in Colchester, Ward based roles in Medicine division, Eye Clinic patient support), all providing direct benefit to our patients
- ✓ We now have 7 visiting therapy dogs across the sites which are very popular on our children's, adults and older people wards
- ✓ All our volunteers attend corporate induction training and are carefully vetted and subject to DBS checks before contact with patients can take place. Volunteers complete their mandatory training within 3 months of commencing their placement and in April 2020 this will move over to electronic system with a full management dashboard
- ✓ We have 19 volunteers in our emergency departments to provide extra support to our patients, 15 volunteers helping our pharmacy teams, 58 welcome service volunteers, 8 who help with medical records scanning and other admin support, 20 dementia companions, 25 specially trained end of life care volunteers, 74 League of Friends volunteers and many more providing fantastic support to our patients, their families and our staff.
- ✓ We have increased the number of volunteers in the Emergency Departments from 11 to 19 increasing volunteer cover to include evenings and weekends, the butterfly role has been established over 3 days per week in partnership with the Ann Robson Trust and the Ipswich Buggy service has launched.

In early 2020 we will be consulting on our volunteer strategy to support the Trust's Strategy and the NHS Long Term Plan but focusing on areas that deliver the biggest impact for patients. We will be working with other colleagues to support delivery of the patient experience network and with other charities to offer further support and befriending for our older patients and those living with dementia together with developing plans to roll out the NHS Cadets programme for younger volunteers.

Workforce

Education and training of staff

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

Medical Education –

Undergraduate Education
The trust hosts medical students from the following universities:-

- Barts and the London School of Medicine and Dentistry
- University of East Anglia
- Anglia Ruskin University
- University of Cambridge

Numbers can fluctuate but during the 18/19 academic year the Trust gave placements to the following students:-

- Barts and the London School of Medicine and Dentistry – 169
- University of East Anglia – 30 – plus numbers to go in here from IH site – waiting on info from Kay Wilson
- Anglia Ruskin University – 6
- University of Cambridge

Pre-registration Education

Continued investment has been made in employing multi-professional Practice Education Facilitators (PEFs) to support pre-registration education across Colchester and Ipswich Hospital sites and the community services. The PEFs work collaboratively with partner universities to improve student education across the region.

Student teaching and support

The Practice Education Facilitators are allocated to specific wards and departments which allows them to build relationships with the staff and wider team. The PEFs are highly visible in the clinical areas, offering support, and guidance, including working alongside students or coaching the supervisors to coach, to help students thrive and excel in practice.

The team have developed and deliver a regular curriculum of teaching including; skills training, year/branch specific. Utilising simulation manikins and other education resources, they are able to support the students to develop and practice clinical skills in a safe environment, bringing together theory and practice. Regular multi-professional student forums are facilitated to: share learning, provide support (learning or pastoral) and deliver stand-alone specialist teaching as requested by students. These give students an opportunity to have a voice in how we support student learning.

We have seen a continued improvement in our evaluations by learners on placement with us, and respond quickly to address any areas where improvements could be made.

Implementation of the new NMC education standards

With the implementation of the new NMC (2019) Standards for Student Supervision and Assessment, the team have continued to work with partner universities to ensure our staff are prepared for the new roles within these. As well as providing an update session for current supervisors in practice, we have developed a 2 day workshop for those new to supervising students. This not only includes; theories relating to teaching and learning, but also more practical elements relating to assessment, feedback, developing action plans and supporting the diverse needs of students (e.g. learning, health, cultural, social etc). Feedback from these sessions indicates that staff feel more confident in supporting students and this is reflected in student evaluations.

Hub and Spoke: Planned associated learning

As part of our work to improve the learning environment for students, we have been extending the roll out of a Hub and Spoke model across all sites and aim to have full implementation by end of 2020.

This links specialist (spoke) areas to wards or departments that follow a patient journey. This facilitates greater access to specialists, resources and learning opportunities such as those identified the new Future nurse: Standards of proficiency for registered nurses (NMC 2019), enabling students to be participants in person centered care and procedures. This was found to increase student belongingness, proficiency in skills and professional role development of staff.

Collaborative Assessment Learning Model (CALM)

The roll out of the CALM continues across all sites including nursing and midwifery. This approach, moves away from a traditional mentoring role to a more collaborative team approach to supporting learning in practice. Students will be coached daily by

Workforce

Education and training of staff

Table 24 - Number of pre-registration students supported in the trust During 2019/2020:

	ESNEFT April 19 – March 20
Student Programme	Number of students
Return to Practice	12
Child	78
Adult Nursing	563
Midwifery	123
Mental Health	34
Orthoptic	6
Operating Department Practitioner	35
Physiotherapy	131
Speech and Language therapy	25
Occupational Therapy	63
Dietetics	14
Paramedic	96
Diagnostic radiography	27
Therapeutic radiography	7
Psychology	1

registered practitioners and will be allocated patients to lead care for, dependant on their experience and prior learning. Students are encouraged to participate in peer learning and development of new clinical skills, increasing competence, confidence and leadership and inter-professional working.

Extended induction

The team have developed an extended induction to better prepare students for the realities of placement learning, clearly articulating what they would be exposed to and ensure they had the skills to begin. This was facilitated by PEFs in a skills lab and in the areas, the students are to be placed, to help the transition into the nursing/midwifery team. Students reported, this reduced anxiety and provide confidence to begin participating in care. A big focus is on mental health and wellbeing, encouraging students to think about and identify potential stressors as well as coping strategies and how to access additional help and support.

Standardised detailed welcome pack and individual ward student information packs are provided to prepare and support student learning. Students are also provided with Clinical Pocket reference books, pen torches and pens, another way to help them feel part of our team.

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

Workforce

Education and training of staff

with many members of the workforce and PEF team being trained to be mental health first aiders.

The PEF team are constantly looking for ways to develop staff and students to support excellence in the dynamic world of practice learning.

As an organisation we support pre-registration students on a range of different programmes as listed below across all our sites both in the Acute and Community areas.

Responding to the changing landscape of pre-registration education, we support students from the following universities:

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

Post- registration education

In 2019 the Post-Registration education teams of Practice Educators were fully established post-merger across Colchester and Ipswich hospital sites and the community. The teams deliver both classroom training and education as well the design and delivery of ongoing programmes such as Preceptorship, clinical induction and OSCE preparation.

International nurses

The teams deliver OSCE preparation (NMC Part 2 Test of Competence) at both Colchester & Ipswich sites with cohorts of international nurses arriving each month. This detailed programme includes theory, practice and mock examinations in readiness for this examination which is taken approximately 12 weeks after arrival in the UK. In 2019- 196 nurses undertook this examination after attending the trusts' OSCE preparation programme and 100% passed to obtain their nursing registration. A small number of these nurses were already employed in the trust as HealthCare Assistants and were supported throughout their application.

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

NMC Education Standards Gap analysis

The new NMC "Future nurse: Standards of proficiency for registered nurses" came into pre-registration education curriculums in September 2019 increasing the range of clinical skills that new registrants will need to obtain. This has implications for the current registered nurse workforce and therefore a gap analysis was undertaken to identify any skills gaps. As a result the post-registration team have rolled out a new ECG update training workshop for nurses with chest auscultation training, competency and support to be rolled out in spring 2020.

Support in practice

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

Non-registered clinical staff

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

Clinical competencies

A new RN clinical skills passport was launched across ESNEFT, followed by updated Assistant Practitioner and new International Nurse Learner passports. 2020 will see the development of a Healthcare Assistant and passports for clinical roles. Emphasis is moving away from clinical competencies to professional accountability and self-assessment supported by robust and consistent training. Some core clinical competencies have been retained and updated in 2019, approved though the multi-disciplinary Post-registration education group.

Medical device training

A robust policy for medical device training was established in 2019 with a project to identify and develop training documents for all high and high risk specialist devices across the trust. In addition medical device training records are being transferred onto the OLM system to sit alongside all other staff training records.

Non-registered clinical career pathway

Workforce

Education and training of staff

As part of the Trust's commitment to 'growing our own' staff, a non-registered pathway has been developed that provides the structure through which non-registered clinical staff can progress and develop a career whilst also being paid through the apprenticeship scheme.

Education and training opportunities

The Trust continues to support the development of its workforce to ensure that we have appropriately trained and skilled staff to provide safe and effective care for our patients. We have supported and developed training in line with service need and the wider healthcare economy and guide by the Sustainability Transformation Partnership.

Advanced Clinical Practitioners (ACP)

In response to the dynamic landscape of healthcare and the demands on the organisation, the Trust has continued to support and further development and implementation of the Advanced Clinical Practitioner role. Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a broad spectrum of settings. Advanced Clinical Practitioners enable innovative solutions to enhance patient's experience and outcomes.

Nursing Associates

Following a nationwide review held by Health Education England in 2015, it identified a skills gap between healthcare assistants and registered nurses. Following public consultation the Nursing Associate role was created with the intention that Nursing Associates will support but not replace registered nurses. ESNEFT is working collaboratively across Suffolk & North East Essex to promote, support and further develop the implementation of the Nursing Associate role as part of the workforce.

Talent for Care and Apprenticeships –

During 2019/2020 the East Suffolk and North Essex Foundation Trust (ESNEFT) Talent for Care team supported the sign up of 95 new apprentices. Overall this equates to 248 apprentices on programmes across 41 different standards/frameworks.

Support for events continued throughout the year across and involved visiting primary & secondary schools, colleges and Universities in Suffolk & Essex. Over 500 hours volunteered to support promotion of ESNEFT & NHS Careers with a range of differing activities.

Talent for Care has supported over 300 individuals to experience different areas and roles across ESNEFT using work placements and work experience opportunities.

The Trust has been working with Health Education England to support regional Health & Care Academies. This will involve a Junior academy aimed at 14 – 16 year olds with Taster days on site and a Senior academy aimed at 16 – 18 year olds with a 12 week programme. Due to COVID, programmes are currently being planned as virtual programmes.

Continuous Professional Development

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

Leadership – recognising the importance of developing the leadership and communication skills of staff Trust-wide in order to support staff in driving change and improving the services we offer ie: License to Lead Program which includes elements such as Coaching Conversations, Team Development and problem Solving & Decision Making.

Mental Health Awareness – to continue to improve the awareness of mental health conditions and support not only for our patients but also staff ie: Mental health awareness workshops and Mental Health First Aid.

Urgent and Emergency Care – changes and creation of the Urgent Treatment Centre has continued to drive the requirement for increased specialist skills to treat acutely unwell patients ie: Caring for the Critically Unwell Woman (maternity), Non-Medical Prescribing, Consultation & Assessment and Intensive Neonatal Nursing.

Cancer Care – specialist education to support the delivery of care to patients with cancer and to improve patient experience and outcomes ie: Brachytherapy Principles in Practice, End of Life Palliative Care, Technical Advances in Radiotherapy and

Workforce

Corporate Learning, Organisational Development

Contemporary Radiotherapy Planning.

Long Term Conditions – increase specialist skills to support the management of long term conditions and patients with complex needs ie: Diabetes Management, Nurse Led Intravitreal Injection Service, Management of Parkinson's Disease.

Employment of disabled people – Training

The Trust continues to ensure that all staff have equal opportunities to develop with others, develop new skills or enhance existing skills and advance their careers. This includes mandatory training, clinical skills, personal development and apprenticeships.

The Trust recognises that some staff will have additional needs when starting or returning to the workplace and their corporate and local induction should reflect this. This includes staff who:-

- Qualified abroad
- Are returning to work after prolonged absence
- Are training part time
- Are under the age of 18
- Have a disability

It is the line manager or supervisors direct responsibility to ensure that staff with additional needs are properly inducted into the Trust by way of local induction and are treated equitably during their employment with the Trust.

All staff are required to undertake equality and diversity training. Compliance currently stands at 94.57%.

According to role requirements training is also provided in the following areas:-

- Dementia
- Deprivation of Liberties
- Learning Disabilities
- Mental Capacity Act
- Safeguarding of the Vulnerable Adult

The Trust has continued working with Suffolk Mind to deliver "Your Needs Met" session for staff and has also rolled out Mental Health First Aid Training to over 50 staff across the Trust with a programme developed to continue throughout 2020/21.

Corporate Learning and Organisational Development and effectiveness

Work continued on the Organisational Development plan and concluded in summer 2019. Outputs included action learning sets, the introduction of a leader's induction and coaching for divisional management teams.

The trust has continued to deliver leadership training both as a stand-alone programme and also tailored programmes for clinical leads and consultants. The Trust has continued (in partnership with the Essex Leadership Group) to deliver Mary Secole local.

Leadership events continued through 2019/20 with two days for our senior leaders with a focus on the staff survey and the launch of our values, leadership behaviours and our new appraisal and career conversation framework. Three days were facilitated for our middle managers in September 2019 and again concentrated the launch of our values, leadership behaviours and our new appraisal and career conversation framework. We celebrated teams and individuals who has been nominated for our annual staff awards and heard their stories on how they had made a difference to the organisation and to patient care.

Library Services

The libraries on Ipswich and Colchester sites work together to provide a comprehensive service to ESNEFT staff and students on placement. In 2019 a Library Services Lead was appointed to provide strategic direction and further develop integrated and efficient services in line with Health Education England's vision for NHS Library services. Via the library service ESNEFT staff have access to a wide range of resources, ensuring clinical and managerial decisions are based on the best available evidence. Library staff provide expert evidence searches, training and document supply. Both libraries are open for study 24/7.

Mandatory Training

There has been good progress in compliance for mandatory training. The Trust now has one suite of training requirements all of which are mapped to specific roles. Delivery of taught session has been reviewed and staff can now receive updates in a numbers of subject areas in one session as opposed to attending superheat

Workforce

Corporate Learning, Organisational Development

ones to make effective use of time.

Staff Engagement – Organisational Development and Leadership.

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Workforce

Valuing Our Staff

Pictured: Michelle Wills ESNEFT Commendation award winner. She has been hailed an NHS hero after giving CPR to a gentleman who collapsed in his garden.
Michelle, from our Stowmarket community neighbourhood team, was carrying out a home visit when she popped out to get some dressings from her car.
She heard shouting from a garden nearby and rushed over, spotting the emergency and giving CPR until the ambulance arrived.
Despite the distress, Michelle then went back to her car, got the dressings and went straight back to her patient.
To show her how proud we are, our Chief Executive Nick Hulme surprised Michelle with a staff Commendation award at a team meeting.

Workforce

Valuing Our Staff

Pictured: Alison Markham Commendation winner. During radiotherapy it is important for patients to eat well and regularly. Certain foods are recommended as the side effects of the treatment can cause swallowing difficulties. For some people this is a big change - they may not be used to certain foods or how much they cost...

But specialist Speech and Language Therapist Alison stepped in to help. She didn't want anyone to have to choose whether or not they ate, and that's why Alison's an ESNEFT Commendation winner. She has gone above and beyond to make sure her patients' nutritional needs are met.

Alison worked tirelessly hard to enable herself and her colleagues to support patients with a clinical need to use local food banks. This means they can continue to eat the right things while they're having their treatment.

Director of Nursing Catherine surprised Alison with her award at Colchester Hospital. She was joined by principle speech and language therapist Ruth, who nominated Alison, and the rest of the team.

Statements from key stakeholders

Response to ESNEFT Account 2019-20 from Healthwatch Essex and supported by Healthwatch Suffolk

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

We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by ESNFT. In this case, we have received quality of feedback about services provided by the acute hospital, and so offer only the following comments on the ESNEFT Quality Account.

- What has been very encouraging has been the way ESNEFT has remained focused on its delivery of high-quality care, financial control, and improvement of services, whilst also being part of the ICS transformation process taking place in this part of Essex and Suffolk.
- HWE is very encouraged by the approach to patient complaints and compliments, its patient engagement both internally and externally and its positive attitude to working with external agencies through The Alliance and its closer working partnership within Essex & Suffolk.
- The commitment to the current workforce is impressive and the positive approach to decreasing the temporary staff will have a robust reward in future delivery of services. However like so many HWE will seek reassurance around future workforce recruitment and retention.
- HWE is reassured that ESNFT has recognised its current under performance and has set in place future measures around ensuring quality.
- HWE is impressed by the way the quality account uses patient experience and patient successful care comes from such listening. Patients are seen very much as part of the success of the services and it is good to read of real patient impact.

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

Samantha Glover

Chief Executive Officer, Healthwatch Essex

October 2020

Statements from key stakeholders

NHS
Ipswich and East Suffolk
Clinical Commissioning Group

NHS
North East Essex
Clinical Commissioning Group

East Suffolk and North Essex Foundation Trust (ESNEFT)

The North East Essex and Ipswich and East Suffolk Clinical Commissioning Groups (CCGs) confirm that ESNEFT have consulted and invited comment regarding the Annual Quality Account for 2019/20. This has been submitted within the agreed timeframe and the CCGs are satisfied that the Quality Account provides appropriate assurance of the service.

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

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

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

Lisa Nobes
Chief Nursing Officer

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

22nd October 2020

Statements from key stakeholders

Suffolk Health Scrutiny Committee

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

County Councillor Jessica Fleming

Chairman of the Suffolk Health Scrutiny Committee

Statements from key stakeholders

East Suffolk and North Essex NHS Foundation Trust

Response to stakeholder comments

East Suffolk and North Essex NHS Foundation Trust thanks its stakeholders for their comments on the 2019/20 Quality Report.

Statement from the Council of Governors on the Quality Account 2019/20

The Governors of East Suffolk and North Essex NHS Foundation Trust are pleased to have the opportunity to comment on the draft Quality Account for 2019/20.

The Council comprises of elected and appointed governors representing their membership, communities, staff, stakeholders and the wider public. Together the Council supports the work of the Trust whilst representing the views and interests of their membership and to offer guidance of those they serve in Trust decisions. We prioritise patient care, the wellbeing of the staff and assisting the Trust to make the right decisions. We also ensure the Non-Executive Directors are actively holding the Board to account.

There is an importance to all Governors to be included in the work of the Trust. This includes having an open and honest relationship with Non-Executive Directors and the Board. By listening, learning and reporting, we work with the community so we hear comments being made and provide a conduit both ways with the Trust. Governors have observed assurance committees and attended public meetings of the Board. We also take the opportunity to work with Non-Executive Directors on hospital walkabouts to meet and listen to patients and staff. External engagement activities have included attending county shows, parish meetings and being active with the public consultation for the proposed elective care centre.

Looking forward our priorities will be to implement the new strategic plan, learn from CQC and staff survey and help implement actions according to this. Our governors will continue to engage in the major building projects to ensure they are most effective. We will support and respond to major impacts on ESNEFT such the Covid-19 pandemic. Through our work in committees we will continue to assure the NED's hold the executive to account and have regular meetings with the Chair.

Statement of assurance from the Board of Directors

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- ✓ the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20
- ✓ the content of the quality report is not inconsistent with internal and external sources of information including: – board minutes and papers for the period April 2019 to [the date of this statement]

– papers relating to quality reported to the board over the period April 2019 to [the date of this statement]

– feedback from commissioners dated—not applicable due to COVID19 and change in requirements

– feedback from governors dated 31/03/2020

-feedback from local Healthwatch organisations dated October 2020

-feedback from overview and scrutiny committee dated —not applicable due to COVID19 and change in requirements

– the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated– not published at time of report

– the [latest] national patient survey 02/07/2020

-the national staff survey 18/02/2020

– the Head of Internal Audit's annual opinion of the trust's control environment issued on 12/06/2020

– CQC inspection report dated 08/01/2020

- ✓ the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- ✓ the performance information reported in the quality report is reliable and accurate
- ✓ there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- ✓ the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- ✓ the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

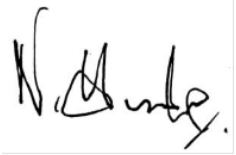
By order of the board

26th November 2020

Chairman

26th November 2020

Chief Executive



Glossary

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

Definitions for performance indicators subject to external assurance

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

Detailed descriptor
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

Data definition
Numerator: Number of adults admitted to hospital as inpatients in the reporting who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool during the reporting period.
Denominator: Total number of adults admitted to hospital in the reporting period.

Details of the indicator
The scope of the indicator includes all adults (those aged 18 at the time of admission) who are admitted to hospital as inpatients including:

- surgical inpatients;
- in-patients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease); trauma inpatients;
- patients admitted to intensive care units;
- cancer inpatients;
- people undergoing long-term rehabilitation in hospital;
- patients admitted to a hospital bed for day-case medical or surgical procedures; and
- private patients attending an NHS hospital.

The following patients are excluded from the indicator:

- people under the age of 18 at the time of admission;
- people attending hospital as outpatients;
- people attending emergency departments who are not admitted to hospital; and
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

Timeframe
Data produced monthly for the 2015-16 financial year.

Detailed guidance
More detail about this indicator can be found on the NHS England website. The data collection standard specification can be found here.
Source: NHS England

Data relating to the percentage of patients risk-assessed for venous thrombo-embolism (VTE) can be found on page 40.

Percentage of patient safety incidents resulting in severe harm or death

Detailed descriptor
Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period.

Data definition
Numerator: Number of reported patient safety incidents resulting in severe harm or death at a trust reported through the National Reporting and Learning Service (NRLS) during the reporting period.
Denominator: Number of reported patient safety incidents at a trust reported through the NRLS during the reporting period.

Details of the indicator
The scope of the indicator includes all patient safety incidents reported through the NRLS. This includes reports made by the trust, staff, patients and the public. From April 2010 it became mandatory for trusts in England to report all serious patient safety incidents to the Care Quality Commission. Trusts do this by reporting incidents on the NRLS.

A case of severe harm is defined in 'Seven steps to patient safety: a full reference guide', published by the National Patient Safety Agency in 2004, as "((any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care", "Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage."

This indicator does not capture any information about incidents that remain unreported. Incidents with a degree of harm of 'severe' and 'death' are now a mandatory reporting requirement by the CQC, via the NRLS, but the quality statement states that underreporting is still likely to occur.

Timeframe
Six-monthly data produced for April to September and October to March of each financial year.

Detailed guidance
More detail about this indicator and the data can be found on the Patient Safety section of the NHS England website and on the HSCIC website in NHS Outcomes Framework > Domain 5 Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm > Overarching indicators > 5b Severity of harm.
Source: NHS England

Data relating to the percentage of patient safety incidents resulting in severe harm or death can be found on page 41.

How to provide feedback on this Quality Account

If you would like to provide feedback on this account or would like to make suggestions for content for future accounts, please email info@ESNEFT.nhs.uk
or write to:

Trust Offices,
Colchester Hospital
Turner Road,
Colchester
Essex CO4 5JL

Thank you

We would like to take this opportunity to thank all those involved with East Suffolk and North Essex NHS Foundation Trust: our fantastic staff and volunteers, all of our patients and visitors, our valuable fundraisers, local media organisations, our local Members of Parliament and health colleagues across the East of England.

Thank you for all that you do to make this a hospital we can all be proud to be part of.

Find out more about the hospital by visiting
our website at www.ESNEFT.nhs.uk

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