NHS

East Suffolk and North Essex

NHS Foundation Trust

Quality Report 2018/19

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, West 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 Aldeburgh Community Hospital Dementia Sensory Garden

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 2018/19. It looks back at our performance over the last year and gives details of our priorities for improvement in 2019/2020.

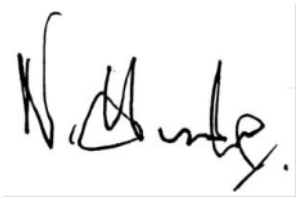
This year has seen a new beginning as we merged the two Trusts that ran Colchester and Ipswich Hospitals to create a new organisation that is the biggest in East Anglia, East Suffolk and North Essex NHS Foundation Trust. East Suffolk and North Essex NHS Foundation Trust (ESNEFT) provides hospital and community health care. We serve a wide geographical area with a population approaching 800,000 residents. Our aim is to deliver high quality care services from two main hospitals in Colchester and Ipswich, six community hospitals, high street clinics and in patients' own homes. I am delighted to share some of our achievements with you through our Quality Report for the period of April 2018 to March 2019.

As Chief Executive, my prime focus is the safety of patient services, ensuring they are consistently accessible, consistently of high quality and continually serving the needs of the local community. The merged organisation has created an opportunity to improve care for patients and provide a quality service for all. Merging means we will spend less money on overheads and duplication, releasing more money for our services, leading to the delivery of safe and compassionate care, serving the needs of the local community. The merger provides the opportunity to successfully integrate clinical services, strengthening them in the short term to give a solid foundation for securing additional services and transformation in the years ahead.
Patient safety and quality are at the heart of everything that we do. As Chief Executive I am incredibly proud of what we, at ESNEFT, have achieved so far and with the Board, I have committed myself to deliver further year-on-year improvements. We hope that you find this Quality Report describes our achievements to date and our plans for the future. This report is designed to assure our local population, our patients and our commissioners that we provide high quality clinical care to our patients. It also shows where we could perform better and what we are doing to improve.

In 2018-19 our *"Time Matters"* programme was formed to drive improvement in a systematic and caring way. This focuses on key work streams, including Urgent Care, Quality Improvement, improving care for Patients at End of Life and improving outcomes for patients who require support from the Mental Health providers. The flow of patients through our Emergency Department, Assessment Units, Wards and back home again is the most important issue we face. I'm delighted with the progress we've made in reducing the time patients are in the Emergency Department before being assessed and a medical management plan made.

I am grateful to our many partner organisations, including health, social care and voluntary organisations, for their support and contributions to the Trust.

To the best of my knowledge and belief, the information contained in this Quality Report is accurate.



Nick Hulme
Chief Executive

Part 2 - Priorities for improvement and statements of assurance

2018/19 quality improvement priorities

Progress against the priorities we set as a Trust

Patient safety priority

To improve compliance with the Sepsis 6 care bundle

This includes the screening patients for signs of possible sepsis if they trigger a screen which is NEWS 3 in 1 parameter, NEWs ≥5 or a suspicion of infection within the emergency department, inpatient areas, maternity and paediatrics (Colchester site) and EWS ≥2 or a suspicion of infection (Ipswich site)

As the merger of Colchester and Ipswich hospitals occurred this year the sepsis pathways and systems are different between the sites they have been reported separately this year. We hope to align the sepsis services within all specialities in the forthcoming year and will report as ESNEFT next year.

Why was this a priority?

Sepsis costs the NHS £2.5 billion every year in bed days. NHS England, RCP and CEM have all produced recommendations for the urgent need for national adherence to a clear sepsis management programmes within all health institutions. Year on year more patients are developing sepsis therefore it is paramount to focus on this as a key area.

The key to reducing the incidents of sepsis is the early recognition of the patient who has the signs of possibly going on to develop sepsis and treatment within 1 hour of this recognition with the sepsis six. These are oxygen therapy, IV antibiotics, IV fluids, the taking of bloods and blood cultures, lactate measurement and the completion and monitoring of input and output charts.

Lead Director

Medical Director and Chief Nurse

What was our target?

- ✓ Timely identification of sepsis within the ED department, inpatient areas, maternity and paediatric areas as per national guidelines. ED target set was >90%
- ✓ Delivery of the sepsis six treatments within one hour of presentation in ED and within one hour of identification within all inpatient areas. >60% target set
- ✓ Delivery of the sepsis 3 (IV antibiotics, IV fluids and oxygen therapy) target set > 90%

What did we do to improve our performance?

Colchester site

- ✓ Refined the ED sepsis screening tool to facilitate earlier identification of the deteriorating patient and earlier clinical review with the use of a sepsis screening tool
- ✓ Regular teaching on team days given throughout the year to the ED staff nursing and medical
- ✓ E-learning training is mandatory for all adult clinical staff and bespoke sepsis e-learning packages were developed for maternity and paediatric staff to also complete.
- ✓ A maternity sepsis screening tool was developed and is now in use
- ✓ Training on sepsis is now given monthly to all maternity medical and nursing staff on their mandatory days.
- ✓ A system was developed for ED paediatric staff to screen children on arrival to the ED
- ✓ A sepsis screening tool had been refined for the paediatric inpatient areas and is going through the governance process for sign off.
- ✓ A PGD for the administration of IV antibiotics was developed for use by the outreach team to improve the timely delivery of antibiotics and to complement the already in place PGD for IV fluids.
- ✓ A Sepsis champion was highlighted on each ward to facilitate ongoing teaching in their clinical areas and perform peer audits monthly.
- ✓ All new staff are given a teaching session on sepsis during their induction programme.
- ✓ Implementation of sepsis boxes in each clinical area to facilitate timely delivery of the sepsis 6 treatments.

Ipswich site

- ✓ Sepsis screening tool introduced into the ED department
- ✓ Regular auditing commenced and aligned with the Colchester site
- ✓ Sepsis e-learning package developed and now in use for staff nursing adult patients
- ✓ Introduction of the sepsis box in all clinical areas
- ✓ Introduction of a sepsis screening tool for the adult inpatient areas to facilitate timely delivery of the sepsis six treatments
- ✓ A yearly audit completed of the use of the sepsis screening tool in adult inpatient areas
- ✓ Introduction of a sepsis screening tool in the maternity inpatient area

2018/19 quality improvement priorities
Progress against the priorities we set as a Trust

- ✓ All staff now given teaching on sepsis during their trust induction

How did we measure and monitor our performance?

Colchester site

- ✓ Audits are completed twice per month using a randomised sample of all adult patients who attend the ED department. This audit currently monitors the screening of sepsis and timely delivery of the sepsis six treatments if required. This audit has just been refined to complete a more in-depth audit of the deteriorating patients with ED
- ✓ Leaps are produced every month from this audit for ongoing learning to take place.
- ✓ An audit is completed monthly on a randomised sample of all the paediatric patients that attend ED with a red flag sepsis marker to measure compliance with screening and iv antibiotic delivery
- ✓ Every ward self-audits 5 patients every month who triggered a sepsis screen and weather screening, clinical review, delivery of treatment was given in a timely manner and in accordance with trust policy.
- ✓ A prevalence audit is carried out weekly and recorded monthly. This is a combination of the sepsis champions peer auditing another ward during the first week of the month, the deteriorating patient and sepsis nurse specialist auditing for one day in week 2 and 3 of the month the last week in the month a sepsis champion audits. the audit comprises of looking at all patients that have triggered a sepsis screen according to trust policy within 48 hours of the audit taking place and monitoring the screening of sepsis, escalation and timely clinical review and delivery of the sepsis six treatments if required.
- ✓ The above did include the paediatric inpatient areas but since January they will audit their own areas using the same methodology and report back their findings monthly.
- ✓ Compliance of all mandatory e-learning is monitored
- ✓ Compliance with CQUIN is completed
- ✓ Monthly audits of door to needle time for neutropenic sepsis patients completed on both sites.

Ipswich site

- ✓ Audits have commenced that are completed twice per month using a randomised sample of all adult patients who attend the ED department. This audit currently monitors the screening of sepsis and timely delivery of the sepsis six treatments if required.
- ✓ Compliance with CQUIN is completed
- ✓ Monthly audits of door to needle time for neutropenic sepsis patients completed on both sites.
- ✓ A yearly audit was completed to gain the compliance of sepsis screening in inpatient areas and the delivery of the sepsis six treatments

Did we achieve our intended target?

Colchester site

- ✓ We achieved an increase in the screening of patients for sepsis within the ED from 58% to 75%
- ✓ We achieved a slight decrease in the timely delivery of the sepsis six from 52% to 50% however this was mainly the non-compliance completion of fluid charts that contributed to this decrease. The delivery of the sepsis 3 (IV antibiotics, IV fluids and oxygen) was 62%
- ✓ We achieved an increase in the screening of inpatient areas for sepsis from 40%to 58%
- ✓ We now have increased our compliance for sepsis six delivery in inpatient areas from 24% to 30% with antibiotic delivery now 86%
- ✓ We have focused on the ED departments and going forward work will be concentrated on the inpatient areas also to increase these compliances.

Ipswich site

- ✓ Compliance figures measured from November 2018 to now screening within ED 67%
- ✓ Compliance figures measured from November to now sepsis six delivery within ED 24%
- ✓ Compliance figures measured from November till now sepsis 3 delivery in ED 52%
- ✓ The yearly audit comprising of 30 patients showed compliance with sepsis screening inpatients was 50% sepsis six delivery as 33% and sepsis 3 delivery as 78%
- ✓ Inpatient areas will commence auditing monthly in May 2019 and the audit methodology will

Part 2 - Priorities for improvement and statements of assurance

2018/19 quality improvement priorities

Progress against the priorities we set as a Trust

be aligned across both sites.

How and where was progress reported?

- ✓ The audits are fed back to the clinical areas for discussion in their governance meetings.
- ✓ Regular reports and updates are sent to:-
- ✓ Patient safety and experience group,
- ✓ Deteriorating Patient and sepsis group
- ✓ Time matters board
- ✓ Presentation given at QPS meeting this year.

Our key achievements

Colchester site

- ✓ Screening of sepsis in the paediatric department from 0% to 66%(Colchester site)
- ✓ Increase in the screening of sepsis in the adult ED department and delivery of the sepsis 3 treatments
- ✓ Implementation of a sepsis screening tool within the maternity clinical areas (Colchester site)
- ✓ Implementation of a sepsis screening tool within the paediatric inpatient areas (Colchester site)
- ✓ Regular auditing commenced to monitor compliance of sepsis screening and treatment delivery in Maternity
- ✓ Regular auditing commenced to monitor the compliance of sepsis screening and treatment delivery in paediatric ED and inpatient areas
- ✓ Bespoke e-learning packages now mandatory for all specialties within the trust (Colchester site)

Ipswich site

- ✓ Introduction of sepsis screening tools in ED
- ✓ Introduction of sepsis screening tools in inpatient areas and Maternity
- ✓ Commencement of regular auditing of sepsis screening and delivery of the sepsis treatments in ED
- ✓ Introduction of the mandatory sepsis e-learning package

Clinical Effectiveness priority:
To improve access to psychiatric liaison services for hospital inpatients

Why was this a priority?

High profile reviews, (DOH, Kings Fund, NCEPOD) have identified that patients who have a primary long term Mental health condition or develop a mental health condition secondary to their physical presentation have poorer physical outcomes

- ✓ People with long term physical health have high rates of mental health condition
- ✓ Patients with severe mental health conditions have reduced life expectancy largely attributed to poor physical health
- ✓ Poor management of medically unexplained symptoms which lack an identifiable organic cause and limited support for the wider psychological aspects of physical health and illness. Mental health liaison services within our acute general hospitals (Colchester and Ipswich) deliver care to patients presenting to our Emergency departments with an acute mental health presentation, often associated with self-harm, the service also in reaches into inpatient wards when an acute mental health episode is identified. The service provision and effectiveness varies on both sites, the providers of services on the Colchester site is Essex Partnership University Trust and on the Ipswich site Norfolk and Suffolk foundation Trust.

The amendment to the Health and Social care Bill (2012) sets out clear legislative requirement to reduce inequalities and enshrines

2018/19 quality improvement priorities
Progress against the priorities we set as a Trust

in law the commitment in England's Mental Health strategy 'No Health care without Mental Health'. The concept of 'Parity of esteem' has been coined, in essence valuing mental health equally with physical health; improving the quality of all service users care and experience, improving the physical health of those with mental health problems, the mental health of those with physical health problems and reducing the stigma and discrimination experienced by those with mental health problems. In order to address this within Colchester and Ipswich Hospital we need to: 1. Continue to develop with mental health partners the Mental Health Liaison services 2. Embark on a Transformation programme with the ESNEFT clinical and non-clinical workforce the wider system partners and patients to purposefully move to a time when 'Parity of esteem' can be delivered, recognised and measured.

Lead Director
Chief Nurse

What was our target?
- ✓ All patients with long term Mental health condition in inpatient and outpatient settings are managed on an integrated care pathway not specific to their physical system they present.
- ✓ All inpatients and outpatients are assessed using an Emotional needs assessment tool at regular intervals.
- ✓ Referral pathways are present to address, physical, mental or emotional needs identified in assessment.
- ✓ The Mental Health Strategy for ESNEFT is weaved into the Clinical Strategy and every transformation programme.
- ✓ A method of measurement and assurance of delivery is reported to Board level.
- ✓ Identified NED and Board Director for Mental health.

What did we do to improve our performance?
- ✓ We have increased provision on the Ipswich Site:
- ✓ Specific Psychiatrist for older people supported by an Advanced Nurse Practitioner in Older peoples mental health.
- ✓ Teaching programme across the Trust. Psychiatric liaison service available to all inpatient wards 6 days a week.
- ✓ In reach services to ED 24/7. On site until 2100hrs.
- ✓ Community services- Older people – specifically dementia care working together with REACT team (community response team) mental health nurse specialist employed and working in REACT team.
- ✓ Colchester Hospital good in reach into ED, New mental health assessment space within the ED department.
- ✓ Good network of psychological therapies within long term conditions outpatients.

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 patients primary coded under Mental Health codes.

Did we achieve our intended target?
There is still more work to be done, we have a five year transformation plan. We are delivering the requirement but patients do still experience long waits to be seen or transferred to specialist mental health facilities from our ED department. Particularly out of hours. We are working with the CCG in collaboration as part of a wider system transformation.

How and where was progress reported?
- ✓ Time matters Board
- ✓ Quality Committee once a quarter.

Our key achievements
- ✓ Increase investment into psychiatric liaison in Ipswich.
- ✓ Recruitment of an Older peoples psychiatrist and specialist nurse
- ✓ Integration of the REACT Community team with Dementia intensive support teams.
- ✓ Increased awareness throughout the hospital delivering several MDT workshops both internally and system wide
- ✓ Collaborated with UEA for joint appoints with phycology
- ✓ Worked with local university to redesign health based non-medical accredited programmes to support the learning and delivery of physical and mental health care.
- ✓ Revised the Ipswich ED Adult mental health referral form
- ✓ Devised and implemented electronic referral that pulls through to data dashboard
- ✓ Set up a Transformation Board – 5 year plan – Aim to create 'Mentally healthy Hospital' within 5 years.

Part 2 - Priorities for improvement and statements of assurance

2018/19 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) 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 will help maintain the good CQC rating achieved at both sites for end of life care and 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
- ✓ To update CHUFT EOL strategy 2018 -2020 and continue to work towards the ambitions of the Ipswich Hospital EOL Strategy prior to the development of an integrated ESNEFT EOL strategy
- ✓ To reduce the number of end of life complaints, and to ensure learning from these is disseminated across ESNEFT.
- ✓ To increase the number of patients dying in the place of their choice.
- ✓ To increase the use of clear plans for care at the end of life on an appropriate trust template at Colchester and Ipswich
- ✓ To increase the use of systems for sharing important patient care choices and decisions (e.g. My Care Choices at Colchester)
- ✓ To open the Time Garden at Colchester
- ✓ Provide Memorial services at ESNEFT for deceased adult patients.

What did we do to improve our performance?

- ✓ Continued education and training on end of life care and post-merger alignment of mandatory training and eLearning across ESNEFT
- ✓ A new joint project was developed between East Suffolk CCG, Ipswich Hospital and St Elizabeth Hospice, Ipswich that has helped work to optimise time to discharge home for patients eligible for fast track continuing health care funding in the last few weeks of life
- ✓ Realignment of Trust groups, meetings and systems for monitoring and directing end of life care to optimise innovative working across the region by close engagement with CCGs, Hospices, GPs and other key stakeholders
- ✓ Provide electronic systems at Ipswich for optimising 'just in case medication' administration to patients discharged from hospital
- ✓ Secured initial funding to enable the recruitment of 3 additional staff to help optimise end of life care plan use, support early identification of patients in the last days of life, optimise symptom control, facilitate 7 days a week specialist palliative care nursing support, improve communication and further optimise systems for data gathering to support future improvements in end of life care. These posts are now awaiting recruitment.
- ✓ A new electronic process has been developed to facilitate surveys of bereaved relatives across the trust and is awaiting full implementation
- ✓ Establish new key performance indicators on the trust wide, ward based scorecard (accountability framework) to better measure parameters that can improve end of life care, target ward areas that may need additional support and promote ward level responsibility for improvements. These are:
  - ◊ The percentage of deaths that occur where there is a clear plan or record on Trust paperwork
  - ◊ The number of complaints relating to end of life care
  - ◊ Time to discharge from identification as being in the last few weeks of life

How did we measure and monitor our performance?

- ✓ Ipswich and Colchester sites participated in the National end of life audit
- ✓ Both sites required some optimisation of documentation of communication with family and assessing their needs, and use of individual plans of

2018/19 quality improvement priorities
Progress against the priorities we set as a Trust

care. Colchester in addition requires optimisation in recognition of dying and involvement with decision making. Both sites were stronger than the national average on multiple areas with high scores for governance. Palliative Care Team staffing was recognised as in need of improvement at Ipswich

- ✓ Colchester Hospital measures the use of 'individual care plans for dying patients' monthly and has sustained 50% completion in 2018 and continues to work towards a target of 65%.
- ✓ Ipswich has worked towards robust monthly data collection of end of life care plan use, time to discharge from request for fast track continuing health care and complaints. This helps align with Colchester having previously reported yearly.
- ✓ Survey of bereaved relatives at both sites to highlight any areas for specific improvement
- ✓ Staff changes and data collection issues have impaired robust assessment of complaints relating to end of life at Ipswich
- ✓ An Integrated system of end of life complaint assessment at ESNEFT has been developed enabling better recognition of complaints that have and end of life component. A cross site team assesses complaints, identifying if end of life is a component and changes to the Datix reporting system have also facilitated more robust data collection.

Did we achieve our intended target?

The Time Garden at Colchester has been completed, and prior to the merger there was development of end of life strategy for Colchester. Progress has been made against other key targets with a comprehensive system wide project to facilitate rapid discharge in the Ipswich area, improved Trust wide data collection regarding time to discharge, end of life care plan use and complaints but there are continued Trust, and wider local system issues, which have impaired more significant progress on such areas as discharge from hospital. Revised local systems and greater engagement with the wider health care teams via the regional end of life care groups may enable greater progress from this point.

How and where was progress reported?

To the ESNEFT EOL board monthly meetings, QPS, Time matters Board and also to the Regional End of life programme board

Our key achievements

- ✓ The merge of the two sites EOL meetings into the ESNEFT EOL Board with cross site representation
- ✓ Recruitment of a Trust lead for EOLC
- ✓ Opening of the Time Garden at Colchester
- ✓ Both sites contributed to the National Audit for Care at End of Life (NACEL)
- ✓ Commencement of CHUFT Blanketeers and now the start of the Ipswich Blanketeers providing knitted blankets for dying patients.
- ✓ Increased number of EOL champions/ambassadors with training to support their role
- ✓ Participation in the quality improvement project and reporting to the Time Matters Board.
- ✓ Combined ESNEFT EOL eLearning
- ✓ Commencement of aligning EOL processes and procedures.

Our priorities for improvement in 2019/20

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

Medical Director 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
- ✓ Compliance with Sepsis 6 in ED >90% at end of 12 months

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:

- ✓ Time Matters
- ✓ Patient Safety,
- ✓ Quality and Patient Safety Committee
- ✓ Deteriorating Patient Group.

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 based on the national best practice and benchmarking completed in quarter 1.

What will we do to improve our performance?

- ✓ A review of the current best practice, benchmarking and current number and type of falls within the community to establish a trajectory for improvement in community falls
- ✓ A Trust-wide improvement plan for Falls will be developed
- ✓ An aggregated action plan will be implemented for falls incidents resulting in harm
- ✓ The Falls Prevention inpatient service will be developed within Corporate Nursing and Quality Divisions, with leadership provided by the Site Director of Nursing on

Our priorities for improvement in 2019/20

behalf of the Chief Nurse

How will we measure and monitor our performance?

- ✓ Incident reporting of all 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.
- ✓ All falls resulting in serious harm are investigated at the earliest opportunity and case were reviewed through the weekly Harm Free Forum chaired by the Site Director of Nursing. This identified immediate learning will inform quality improvement plans.
- ✓ 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:

- ✓ Matrons Meeting
- ✓ Patient Safety Group
- ✓ Harm Free Group
- ✓ Quality & Patient Safety Committee.

Clinical Effectiveness priority:

Getting it right first time (GIRFT) programme improvements

Why is this a priority?

GIRFT is a National programme working with frontline clinicians to identify and reduce unwarranted variations in service delivery and clinical practice. Clinical Specialty visits have taken place in some areas and others are currently underway or are planned.

Lead Director

Medical Director

What is our target?

Clinical Specialties will identify the top 3 areas for improvement during quarter 1 and develop the action plans required to achieve the improvements.

What will we do to improve our performance?

- ✓ Specialties to produce action plans and deliver against GIRFT Report recommendations, focussing on the top 3 areas requiring improvement
- ✓ The GIRFT Board will receive the specialty updates, agree milestones for improvement and support with identification and mitigation against risks identified.

How will we measure and monitor our performance?

- ✓ Agree key milestones and monitor performance against the milestones at GIRFT Board
- ✓ Ensure the improvements are included within the Quality Improvement Faculty within ESNEFT to support clinicians to develop and sustain improvements.
- ✓ Identify a key person from the Transformation Team to support the clinical teams with planning and improvements.

How and where will progress be reported?

Regular reports and updates to:

- ✓ Time Matters Board
- ✓ Clinical Effectiveness Group
- ✓ Quality & Patient Safety Committee.

Our priorities for improvement in 2019/20

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 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 is this a priority?

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

Lead Director

Chief Nurse & Medical Director

What is 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 will we do to improve our performance?

- ✓ Recognise timely identification of patients in the last year of life by increasing use of end of life support tools
- ✓ Discuss with patients and their families their wishes and document on My Care Choices Register (MCCR) and develop this across ESNEFT
- ✓ Access patient's MCCR on every emergency admission
- ✓ Work with system partners to improve end of life care at home provision
- ✓ Use national and locally recognised tools, i.e. the regional DNACPR form, the yellow folder , treatment options form and the Individual Care Record for the last days of life, SPICT and MCCR
- ✓ Promote co-ordinated care for discharge planning, enabling patients to die in their preferred surroundings, be that at home, hospital or hospice
- ✓ Facilitate palliative and end of life care training and education for staff using innovative and creative approaches to learning
- ✓ Continued access to specialist palliative care assessments, seven days a week.

How will we measure and monitor our performance?

- ✓ Monitored themes from complaints relating to end of life care and share these complaints with clinical staff
- ✓ Monitored results from DNACPR and national end of life audits to highlight themes for improvement
- ✓ Audited use of individualised care Individual Care Record for the Last Days of Life plans to ensure best possible practice
- ✓ Expanded post bereavement follow up service with families.

How and where will progress be reported?

Regular reports and updates to:

- ✓ Time Matters Board
- ✓ Patient Experience Group
- ✓ Quality & Patient Safety Committee

Our priorities for improvement in 2019/20

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 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 Director

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 Emergency Department (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:

- ✓ Time Matters Board
- ✓ Clinical Effectiveness Group
- ✓ Patient Experience Group
- ✓ Personal and Organisational Development Group (POD).

Provided and sub-contracted services

Provided and sub-contracted services

During 2018/19, and with the transaction to East Suffolk & North Essex Foundation Trust on 1st July 2018, the Trust has continued to be contracted for and provide 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 co-commissioners of the Trust services are North East Essex Clinical Commissioning Group (CCG) & Ipswich & East Suffolk Clinical Commissioning Group (CCG) & Associate commissioners; NHS England (specialised, local area and armed forces healthcare commissioning). Additional services being provided in relationships with other organisations, including, West Suffolk Hospitals NHS Trust, Essex Partnership University NHS Foundation Trust, Norfolk & Suffolk Foundation Trust, Anglian Community Enterprise CIC, and Ramsay Healthcare Ltd.

The East Suffolk & North Essex Foundation Trust has reviewed all the data available to them on the quality of care in 90 of these relevant health services.

The income generated by the relevant health services (NHS clinical income) reviewed in 2018/19, represents 89% of the total income generated for the Trust for 2018/19.

The data reviewed covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience. All relevant data has been reviewed.

Takeover Challenge Day at Colchester and Ipswich hospitals

The day gave young people from schools in north Essex and east Suffolk a chance to get a glimpse of hospital life.

Participation in clinical audit

During 2018/19, 46 National Clinical Audits and 2 National Confidential Enquiries covered relevant health services that East Suffolk and North Essex NHS Foundation Trust (ESNEFT) provides.

During that period ESNEFT participated in 97.87% National Clinical Audits and 100% 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 2018/19 are as follows:

National Clinical Audits Table 1	
Heart and Circulatory System	
1	Myocardial Ischaemia National Audit Project (MINAP)
2	National Cardiac Arrest Audit (NCAA)
3	Cardiac Rhythm Management (CRM)
4	National Audit of Percutaneous Coronary Interventions (PCI)
5	National Heart Failure Audit
6	National Vascular Registry
7	National Audit of Cardiac Rehabilitation
Acute	
8	Case Mix Programme (CMP)
9	Falls and Fragility Fractures Audit Programme (FFFAP)*
10	Major Trauma Audit
11	National Joint Registry (NJR)
12	National Emergency Laparotomy Audit (NELA)
13	Feverish Children (care in emergency departments)
14	Vital Signs in Adults (care in emergency departments)
15	VTE risk in lower limb immobilisation (care in emergency departments)
16	Adult Community Acquired Pneumonia
Women and Children	
17	National Maternity and Perinatal Audit (NMPA)
18	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
19	National Paediatric Diabetes Audit (NPDA)
20	Neonatal Intensive and Special Care Audit (NNAP)
Older People	
21	National Audit of Dementia
22	Sentinel Stroke National Audit programme (SSNAP)
23	National Audit of Intermediate Care
	Long Term Conditions
24	BAUS Urology Audit - Cystectomy
25	BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)
26	BAUS Urology Audit - Nephrectomy
27	BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)
28	BAUS Urology Audit – Radical Prostatectomy
29	Inflammatory Bowel Disease programme / IBD Registry
30	National Asthma and COPD Audit Programme
31	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)

Participation in clinical audit

Cancer	
32	National Bowel Cancer (NBOCA)
33	National Audit of Breast Cancer in Older People
34	National Prostate Cancer Audit
35	National Oesophago-gastric Cancer (NAOGC)
36	National Lung Cancer Audit (NLCA)
	Haematology
37	National Comparative Audit of Blood Transfusion programme*
38	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance
Other	
39	Seven Day Hospital Services
40	Elective Surgery (National PROMs Programme)
41	Surgical Site Infection Surveillance Service
42	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection
43	National Ophthalmology Audit
44	Medical and Surgical Clinical Outcome Review Programme
45	Learning Disability Mortality Review Programme (LeDeR)
46	National Audit of Care at the End of Life (NACEL)

National Confidential Enquiries	
1	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)
2	Medical and Surgical Clinical Outcome Review Programme

Participation in clinical audit

The National Clinical Audits and National Confidential Enquiries that East Suffolk and North Essex Foundation Trust participated in during 2018/19 are as follows:

National Clinical Audits Table 2		Ipswich Hospital	Colchester Hospital
Heart and Circulatory System			
1	Myocardial Ischaemia National Audit Project (MINAP)	Y	Y
2	National Cardiac Arrest Audit (NCAA)	Y	Y
3	Cardiac Rhythm Management (CRM)	Y	Y
4	National Audit of Percutaneous Coronary Interventions (PCI)	Y	
5	National Heart Failure Audit	Y	Y
6	National Vascular Registry	N/A	Y
7	National Audit of Cardiac Rehabilitation	N/A	Y
Acute			
8	Case Mix Programme (CMP)	Y	Y
9	Falls and Fragility Fractures Audit Programme (FFFAP)*	Y	Y
10	Major Trauma Audit	Y	Y
11	National Joint Registry (NJR)	Y	Y
12	National Emergency Laparotomy Audit (NELA)	Y	Y
13	Feverish Children (care in emergency departments)	Y	Y
14	Vital Signs in Adults (care in emergency departments)	Y	y
15	VTE risk in lower limb immobilisation (care in emergency Departments)	N/A	Y
16	Adult Community Acquired Pneumonia	Y	Y
Women and Children			
17	Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y
18	National Maternity and Perinatal Audit (NMPA)	Y	Y
19	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Y	Y
20	National Paediatric Diabetes Audit (NPDA)	Y	Y
21	Neonatal Intensive and Special Care Audit (NNAP)	Y	Y

Older People			
22	National Audit of Dementia	Y	Y
23	Sentinel Stroke National Audit programme (SSNAP)	Y	Y
24	National Audit of Intermediate Care	N/A	Y

Participation in clinical audit

Long Term Conditions			
25	BAUS Urology Audit - Cystectomy	N/A	Y
26	BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	Y	N/A
27	BAUS Urology Audit - Nephrectomy	Y	Y
28	BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Y	Y
29	BAUS Urology Audit – Radical Prostatectomy	N/A	Y
30	Inflammatory Bowel Disease programme / IBD Registry*	N	N
31	National Asthma and COPD Audit Programme*	Y	Y
32	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Y	Y
Cancer			
33	National Bowel Cancer (NBOCA)	Y	Y
34	National Audit of Breast Cancer in Older People	Y	Y
35	National Prostate Cancer Audit	Y	Y
36	National Oesophago-gastric Cancer (NAOGC)	Y	Y
37	National Lung Cancer Audit (NLCA)	Y	Y
	Haematology		
38	National Comparative Audit of Blood Transfusion programme	Y	Y
39	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Y	Y
Other			
40	Seven Day Hospital Services	Y	Y
41	Elective Surgery (National PROMs Programme)	Y	Y
42	Surgical Site Infection Surveillance Service	Y	Y
43	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Y	Y
44	National Ophthalmology Audit**	Y	N
45	Medical and Surgical Clinical Outcome Review Programme	Y	Y
46	Learning Disability Mortality Review Programme (LeDeR)	Y	Y
47	National Audit of Care at the End of Life (NACEL)	Y	Y

*__Inflammatory Bowel disease (IBD) Programme Registry__ Trust did not have sufficient internal resources to enable participation with this National Audit

Participation in clinical audit

National Confidential Enquiries			
		Ipswich	Colchester
1	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Y	Y
2	Medical and Surgical Clinical Outcome Review Programme	Y	Y

The national clinical audits and national enquiries that East Suffolk and North Essex Foundation NHS Trust participated in, and for which data collection was completed during 2018/19, are listed blow 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		Ipswich Hospital			Colchester Hospital		
		Cases Submitted	Cases Expected	%	Cases Submitted	Cases Expected	%
Heart and Circulatory System							
1	Myocardial Ischaemia National Audit Project (MINAP)				219	219	100 %
2	National Cardiac Arrest Audit (NCAA)	45	45	100 %	70	70	100 %
3	Cardiac Rhythm Management (CRM)						
4	National Audit of Percutaneous Coronary Interventions (PCI)						
5	National Heart Failure Audit	656	656	100 %	412	412	100 %
6	National Vascular Registry	N/A	N/A	N/A	575	575	100 %
7	National Audit of Cardiac Rehabilitation				375	375	100 %

Participation in clinical audit

National Clinical Audits		Ipswich Hospital			Colchester Hospital		
		Cases Submitted	Cases Expected	%	Cases Submitted	Cases Expected	%
Acute							
8	Case Mix Programme (CMP)	811	811	100%	648	648	100%
9	Falls and Fragility Fractures Audit Programme (FFFAP) Data to September 2018	243	243	100%	250	250	100%
10	Major Trauma Audit Data from Jan to July 2018	81	81	100%	125	125	100%
11	National Joint Registry (NJR)	626	626	100%	721	721	100%
12	National Emergency Laparotomy Audit (NELA)	153	153	100%	146	146	100%
13	Feverish Children (care in emergency departments)	120	120	100%	60	60	100%
14	Vital Signs in Adults (care in emergency departments)	112	112	100%	65	65	100%
15	VTE risk in lower limb immobilisation (care in emergency Departments)	N/A	N/A	N/A	75	75	100%
16	Adult Community Acquired Pneumonia	Pneumonia audit data collection ongoing					
Women and Children							
17	National Maternity and Perinatal Audit (NMPA)	3523	3523	100%	3436	3436	100%
18	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) Organisational Data	1	1	100%	1	1	100%
19	National Paediatric Diabetes Audit (NPDA)	221	221	100%	221	221	100%
20	Neonatal Intensive and Special Care (NNAP)	500	500	100%	558	558	100%
Older People							
21	National Audit of Dementia	115	115	100%	115	115	100%
22	Sentinel Stroke National Audit programme (SSNAP)	489 Figures to Feb 2019	548	89%	574 Figures to 5th March 2019	574	100%
23	National Audit of Intermediate Care	144	150	96%			
Long Term Conditions							
24	BAUS Urology Audit - Cystectomy				36	36	100 %
25	BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	2	2	100%			
26	BAUS Urology Audit - Nephrectomy	28	28	100%	75	75	100 %

Participation in clinical audit

27	BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	13	13	100 %	6	6	100 %
28	BAUS Urology Audit – Radical Prostatectomy				149	149	100 %
29	Inflammatory Bowel Disease programme / IBD Registry*	0	0	0	0	0	0
30	National Asthma and COPD Audit Programme				1359	1359	100 %
31	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	44	100	44%	18	100	18%
Cancer							
32	National Bowel Cancer (NBOCA)	131	131	100 %	136	136	100 %
33	National Audit of Breast Cancer in Older People	281	281	100 %	292	292	100 %
34	National Prostate Cancer Audit	226	226	100 %	351	351	100 %
35	National Audit Oesophago-Gastric Cancer (NAOGC)	162	162	100 %	151	151	100 %
36	National Lung Cancer Audit (NLCA)	203	203	100 %	284	284	100 %
Haematology							
37	National Comparative Audit of Blood Transfusion programme	4	4	100 %	4	4	100 %
38	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	17	17	100 %	12	12	100 %
Other							
39	Seven Day Hospital Services	202	202	100 %	216	216	100 %
40	Surgical Site Infection Surveillance Service						
41	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	66	66	100 %			
42	National Ophthalmology Audit	1754	1754	100 %	0	0	0
43	National Mortality Case Record Review Programme						
44	Learning Disability Mortality Review Programme (LeDeR) National	11	11	100 %	25	25	100 %
45	Audit of Care at the End of Life (NACEL)	73	80	91.25%	79	80	98.75%
46	Elective Surgery (National PROMs Programme)***	769	769	100 %			

** Colchester data to September 2018, awaiting validation of Q3 data before release

*** Elective Surgery (National PROMs Programme) – Data collated under ESNEFT and not individual sites

Participation in clinical audit

National Confidential Enquiries		Ipswich Hospital			Colchester Hospital		
	Medical and Surgical Clinical Outcome Review Programme	**Cases Submitted**	**Cases Expected**	**%**	**Cases Submitted**	**Cases Expected**	**%**
	NCEPOD – Perioperative Diabetes **Surgical Questionnaire** **Anaesthetic questionnaire** **Set of case notes returned**	 **8** **8** **8**	 **8** **8** **8**	 **100** **100** **100**	 **0** **0** **0**	 **5** **5** **5**	 **0** **0** **0**
	NCEPOD – Pulmonary Embolism **Clinical Questionnaires** **Sets of care notes returned**	 **2** **4**	 **4** **4**	 **50** **100**	 **1** **1**	 **4** **4**	 **25** **25**
	NCEPOD – Bowel Obstruction **Study still open deadline 12 March 2019**						
	NCEPOD – Long Term Ventilation **Study still open** **Case note request deadline 25th February 2019** **Clinical and organisation questionnaires not been sent out**	**4**	**4**	**100%**			
	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)						

The reports of 31 National Clinical Audits were reviewed by the provider in 2018/19 and ESNEFT intends to take the following actions to improve the quality of the healthcare provided.

Pain in Children (moderate to severe) – Clinical Audit 2017-18

The purpose of the audit is to monitor documented care against the standards published in July 2017. The audit is designed to improve clinical care by helping clinicians examine the work they do day-to-day, benchmark against their peers, and to recognise clinical excellence.

Sample and method

Cases were submitted who met the inclusion criteria (aged 5-15, presenting in moderate to severe pain with specified fractures and attending between 1 January 2017 and 31 December 2017.

Findings for the Trust: Areas of good practice

Good practice

- ✓ Ipswich Hospital achieved standards 2a (50% with severe pain receive analgesia within 20 mins of arrival/triage)
- ✓ Ipswich Hospital achieved standard 3a (50% with moderate pain received analgesia within 20 mins of arrival/triage)
- ✓ Ipswich Hospital nearly achieved Standards 2b & 2c and performed better than the national median (75% of patients with severe pain receive analgesia within 30 mins of arrival/ triage, 100% of patients with severe pain receive analgesia within 60 mins of arrival/ triage).

Areas for Improvement

- ✓ Ipswich Hospital did not achieve Standards 1 or 3b, but did perform better than the national median
- ✓ Standard 4, a standard recently included in the audit, was not achieved – staff to be reminded,

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to re-evaluate pain if the patient remains in the department longer than 60 minutes

- ✓ Standard 5 was not achieved, staff need to be reminded or a prompt given to document the reason for not providing analgesia.

The area for improvement detailed in table xx has now moved to a Quality Improvement project to drive the action forward within ESNEFT.

Table 4- Area for Improvement Pain in Children audit

Recommendations relevant to the Trust	Action required	By whom
Needs to improve documentation of pain scoring and re-evaluation	Current initiative in Paediatrics to empower patient to request for analgesia. Once implemented, roll out to adults.	Dr Darlow & ED colleagues

National Oesophago-Gastric Cancer Audit 2018

The 2018 Annual Report from the National Oesophago-Gastric (OG) Cancer Audit provides up-to-date information on the quality of OG cancer care provided by NHS organisations in England and Wales. The aim of this report is to give an overall picture of the care provided by NHS services to adult patients with OG cancer or oesophageal HGD.

The Audit is run by the Association of Upper Gastrointestinal Surgeons of Great Britain & Ireland (AUGIS), the Royal College of Radiologists (RCR), the British Society of Gastroenterology (BSG), NHS Digital and the Clinical Effectiveness Unit of the Royal College of Surgeons of England. The delivery of the Audit was overseen by a Project Board whose role was to ensure the Audit was well managed. Advice on the clinical direction of the Audit, the interpretation of its findings and their dissemination was provided by a Clinical Reference Group (CRG), of members representing professional medical associations as well as the Oesophageal Patients Organisation (see report for further details www.nogca.org.uk).

The Audit evaluated the care pathway followed by patients once they have been diagnosed with either OG cancer or HGD, and to answer questions related to:

- ✓ The pathway of care that patients took to diagnosis
- ✓ Whether clinical (pre-treatment) staging is performed to the standards specified in national clinical guidelines
- ✓ Whether decisions about planned treatments are supported by the necessary clinical data (staging, patient fitness, etc.)
- ✓ Access to curative treatments for suitable patients, such as neoadjuvant chemotherapy prior to surgical resection
- ✓ The use of palliative services
- ✓ Outcomes of care for patients receiving curative and palliative therapies.

Data collection

All NHS trusts in England involved in the care of both curative and palliative OG cancer patients were required to upload patient information into the Clinical Audit Platform (CAP) managed by NHS Digital. Data was anonymised by NHS Digital then collated and analysed by the Clinical Effectiveness Unit (CEU), Royal College of Surgeons. Information on the proforma for data collection and the data dictionary are available from www.nogca.org.uk

Participation in clinical audit

National Audits

Table 5 Levels of case ascertainment:

	England	Wales	Ipswich Hospital
Records Recorded	19,769	1.263	>90
% case ascertainment	79.8	75.6	162

Audit findings

Nationally:

Patients diagnosed with OG cancer are recommended to have a CT scan to identify metastatic disease

90% of patients diagnosed in 2015-17 had an initial CT scan

This proportion rose from 86% in 2012-13 to 90% in 2016-17

Locally:

Ipswich Hospital NHS Trust 91.7%

Nationally:

Among patients diagnosed with OG cancer in 2015-17, 13% were diagnosed following an emergency admission. There was substantial variation in emergency diagnoses by Cancer Alliance / Welsh region.

Locally:

Ipswich Hospital NHS Trust 13.9%

Action Plan

Awaiting Divisional Governance approval.

National Diabetes Inpatient Audit 2017

Background and Aim

✓ The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

✓ Anonymised data is collected and submitted by hospital staff in England and Wales. *Source: NaDIA slides – slide 3 Introduction – Overview*

The Audit sets out to measure the quality of inpatient care provided to people with diabetes by answering the following questions:

✓ Did diabetes management minimise the risk of avoidable complications?

✓ Did harm result from the inpatient stay?

✓ Was patient experience of the inpatient stay favourable?

✓ Has the quality of care and patient feedback changed since the previous audit years.

✓ Source: NaDIA slides – slide 4 Introduction – Audit Questions.

Findings for the Trust: Areas of good practice and Areas for Improvement

Ipswich Hospital has higher proportion of emergency admissions (92.8% Ipswich vs 87.0% England). Also, the Ipswich Hospital has a higher proportion of patients admitted for the management of diabetes (10.8% Ipswich vs 8.3% England).

Areas of good practice

Patient being visited by a member of the diabetes specialist team is much higher at Ipswich (77.1% vs 34.7%).

Patients admitted with active foot disease that were seen by the MDFT within 24 hours is higher than average (100% vs 59.3%).

Medication errors and glucose management errors are below average, as are mild hypoglycaemic episodes.

Patients report meal timing suitable as slightly above average (65.1% vs 62.6).

Areas for improvement

There were slightly higher prescription errors and severe hypoglycaemic episodes in 2017, both worse than in 2016.

Patients reported that all or most staff caring for them were aware that they had diabetes. However, Ipswich patients reported below average for staff looking after them knew enough about diabetes to meet their needs, or staff being

Participation in clinical audit

National Audits

able to answer their questions.

This is rather surprising as the diabetes inpatient nurses are very active in supporting patients and as the audit shows twice as many patients are visited by the diabetes team than the national average.

Patients at Ipswich reported slightly lower than average overall satisfaction (81.0% vs 83.4%)

The patient responses for both meal choice and timing of meals were lower than in 2016.

Table 6- Areas for improvement/ development and local action required

Recommendations relevant to the trust	Action required	By whom	Target date
Some wards are poor at delivering diabetes care and despite input from the Diabetes Inpatient Specialist Nurses there has been little or no improvement	Diabetes Champions on Wards	Diabetes Specialist Nurses	Ongoing 2019
Insulin safety and diabetes related patient harms should be represented on the hospital's safety committee and on the related dashboard	This may benefit from intervention by the Director of Nursing and or Medical Director.	Diabetes Specialist Nurse's	Completed 2018
Seek to develop educational Diabetes service through the Trust	A business case is being developed for a Diabetes Lead Nurse	Clinical and Operational leads	Summer 2019

Trainee doctors have voted Colchester Hospital as Orthopaedic Training Hospital of the Year for the east of England.

Orthopaedic trainees in the region marked the hospital for several aspects of their training, including operating lists and how much operating they get to do, formal teaching and educational value of clinics and meetings..

Participation in clinical audit
Local Audits

The reports of the 162 local clinical audits were reviewed by the provider in 2018/19 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). For the period 1/4/2018 to 31/01/2019, 98.2% of inpatients did not experience a new-harm event - the national average for acute organisations was 97.8%.
0.3% patients had had a fall resulting in harm in the 3 days prior to the audit
0.4% patients had developed a new pressure ulcer
0.5% patients had started treatment for a new DVT or PE
1.8% patients had a urethral catheter and had started treatment for a new UTI

Participation in clinical audit

Table 7—Local Audits

Group 1	
Medicine	
Audit	Description of Actions
Diagnostic pathways in RACPC: A review consideration of changes to NICE guidelines	1. Cardiology team to consider reducing certain investigations as per NICE
ICRLDL Audit (part of QS)	1. Junior doctor teaching to be adapted to incorporate learning points (esp. individualising prescribing) 2. Proforma's available in EAU & A&E at the point of admission when often DNACPR is discussed 3. Wider availability of Palliative Care communications skills sessions (all FYs from sept 18 4. Promoting End of Life Champion scheme
Use of urinary catheters in Medical wards	1. Posters 2. Information sessions
Assessment of Cognitive impairment in older people	1. CAS card to be altered to include prompt/section for AMTS in patients >75 / confused patients
Triage of paediatric patients from ED to GP	1. Audit out of hours admission that may be suitable for Primary care. In view of extending Primary care provision
Procedural Sedation in adults	1. Update Emergency Department staff on audit results, especially areas of improvement 2. Include eGFR box into the ED procedural sedation proforma 3. Include flushing the line after drug administration box into the ED procedural proforma
Impact of palliative care CNS in the EAU/A&E	No Actions
Survey-Quality of teaching in EOLC by measuring confidence of students pre and post training	No Actions
Appropriate use of D- Dimer in the Emergency Medicine Department	1. Results shared and education given at teaching meeting. Poster sent to a conference
Audit of assessing NRT in smoker patients at Ipswich Hospital	1. Action - dr teaching and posters after first audit, improvement made but need to amend admission proforma recommended
Confirmation of safe nasogastric tube placement (REAUDIT)	1. Educate was staff about appropriate justification of x-ray as a means of confirming NG tube placement. Standard safety phrases for insertion into x-ray reports to ensure continuity within Radiology. Provide teaching and discuss at next audit meeting.
Door to Needle Time in Acute Ischaemic Stroke Thrombolysis	1. 1. Ensure reasons for a delay past the 60min standard are documented. Use a monitoring tool to track and prevent delays in real time. Inform the relevant departments to raise awareness of delay points. Monitor the performance against other UK institutions 2. Tool devised, re-audit planned
Heart failure clinic health improvement project	1. Action was taken by introducing HF alert cards in HF NS-led clinics

Participation in clinical audit

Indications for Plain Abdominal films from the ED	1. 88 of 98 requests net the iRefer criteria. Further education to be provided in ED
Stroke prevention in AF (SPAF)	1. Case finding. Keep the quality of anticoagulation under close review by regularly checking the individuals Time in Therapeutic Range of those on Warfarin is greater than 65%.
Use of Cardiac monitoring in patients admitted to medicine	1. 16 did not receive daily medical review, but 11 of these received daily nursing review. Results shared.
Follow-up of Consolidation on Chest X-ray done for Pneumonia	1. Email to the junior doctors advising them to adhere to the guidelines 2. Considering to re institute the pneumonia bundle 3. Presentation in the audit meeting
ILD Care in Ipswich	1. Using Quality of life QUESTIONNAIRE FOR Palliative care AND Pulmonary Rehab referral. Assessment for necessity of 6MWT (assessment through questionnaire and informal test for exertional desaturation and lung function test). Further investigation whether
Infective endocarditis audit	1. Checklist to be implemented and re-audit in March 2019 in time. In cases where a patient is unwell and require urgent antibiotics, 2 separate samples can be taken at the same time from 2 venepuncture sites

Cancer & Diagnostics	
Audit	**Description of Actions**
Neutropenic Sepsis - Audit of 'door to needle time' - antibiotic administration for patients with NS (one hour standard) - Oncology & Haem-Onc Patients	1. Datix to be raised for all patients going over the DTN 1 hour standard
Audit of Deaths within 30 days of last Systemic Ante-cancer therapy (National NCEPOD recommendation 2008) – Clinical oncology and Haemo-oncology patients	No Actions
Evidence of peer discussion at patients receiving palliative SACT with PS 2,3 or 4 - CQUIN Quality Standard	1. A change in Trust Policy will be required to include peer discussion for patients with a performance status of 2
Use of EPO in Haematology patients 2014-2016	1. Complete revision of methods of EPO monitoring, Documentation needs to be improved by all
Audit of outcomes for Diffuse Large B cell Lymphomas	1. To repeat this audit in 2 years time to ensure that patient outcomes are recorded
Audit of use of Bisphosphonates in Multiple Myeloma	1. Write a bisphosphonate standard/ guideline for CHUFT /ESNEFT, review and update the dental letters with the Oral Surgeons, Review the information given to patients about bisphosphonates and ONJ,
Intended day case procedures for the breast surgery department	1. The nursing staff on the ward and the on-call surgical teams to be reminded to complete discharge letters on ICE system the same day as discharge. Bilateral mastectomies not to be listed as day-cases. Suitable patients at pre-operative assessment to be listed for overnight stay depending on comorbidities and social support.

Participation in clinical audit

Audit to Determine the Proportion of WIC Minor Injury X-Rays Showing Abnormality Requiring A&E Referral	1. Local levels fall uniformly slightly below anticipated literature outcomes regarding R/A rate. Consideration for further training may be raised. Literature is slightly outdated
Obtaining Consent for Systematic Anti Cancer Therapy	1. Late effects to be added to generic consent form and signed when discussed, clinician to record in their letters that leaflets given PRIOR, clinicians to record if pt offered copy of consent
Radiotherapy Palliative and Emergency Referrals	1. Numbers consistent with previous audits, re-audit planned
CT KUB adherence to standards and incidence of Pathology	1. New pathway agreed to be implemented and re-audited
Assessment of the Diagnostic Image Quality of Plain Abdominal Radiographs in Adult Patients	No Actions
Radiological investigation of renal colic following the introduction of CT KUB	No Actions
Lung Cancer Patient Support and Information Giving	1. Annual review of patient information, Ensure CNS is introduced by name and job title, Clarification of diagnosis and treatment options with the patient to ensure understanding.
Lymphedema service - patient evaluation	1. Speed up the process of clinic letters reaching the GP within a few days if a prescription is due (correct prescription compression sleeves from the GP/ Chemist)
Information and support Radiographers survey	No Actions
Cancer survivorship exercise class – a patient evaluation survey	1. Ensure all patients are issued with home exercise advice and information on continuing exercise in the community – this will require the development of a leaflet regarding such information, which will be given to each patient on completion of the 10-week exercise programme.
Oncology Pleural Procedures Audit 2017	1. Feedback results to involved clinicians, re-audit similar period in 2018 with focus on pain, plan for larger recurrent effusion, exp of practitioner, asepsis doc, adm avoidance. Consider formalising referral process
Audit of Radiology Patient Safety Checklist for Interventional Procedures (Major and Minor)	1. Regular 6 monthly audit to monitor compliance 2. Make minor modification to signature box of Minor checklist similar to Major checklist.
Audit to identify the cause of inadequate or unreliable results of lung and EBUS samples sent for molecular testing.	1. Implement change to current protocol and re-audit in 12 months to determine number of inadequate /unreliable molecular results and if the number due to histology technical issues has reduced since the introduction of the change in procedure.
Audit of histological reporting of large loop excisions of the transformation zone (LLETZ)	1. Action – Remind histopathologists to use report template and comment on all margins. SMILE to be added as a Proforma item. Locums to be made aware of Proforma during induction. Re-audit planned

Participation in clinical audit

Adequate Contrast Enhancement of CT Pulmonary Angiograms	No Actions
Diagnostic Quality of PA Erect Chest Radiographs based on Anatomical Image Criteria	No Actions
Patients undergoing Chemotherapy treatment in the Mary Barron Suite	No Actions
Audit of Safety Checklist 2017	1. Make minor modification to signature box of Minor checklist similar to Major checklist
CT KUB audit of GP requests	1. Continue to manage CP CT KUB requests as effectively as possible
Neck lump in children. US request by a general practitioner	1. Discuss the issue of non compliance within department.
LENS exclusion in CT head	1. Reduce inclusion of LENS in CT head with teaching of radiographer
The Use of P16 Immunohistochemistry in Cervical Biopsies	1. Current practice meets the newly published BAGP guidelines. No action required
Intrathecal Chemotherapy Audit	1. Compliant in all areas, re-audit next year
LENS exclusion in CT head (re-audit)	1. There has been improvement in the practice after the initial Audit and presentation. Now another reminder email should be sent to all the radiographers to improve the practice even further.
Audit of Mulitparametric prostate imaging prior to biopsy in suspected prostate cancer; adherence to referral criteria and reporting standards	1. Results shared, education and encouragement to keep to pathway standards
Group 2	
T&O and Specialist Surgery	
Audit	Description of Actions
Audit of Orthopaedic Surgical-Site Marking (Chaos-sm)	1. Educate responsible on call doctors and consultants, vial weekly metal work meeting, poster in trauma meeting room and mail.
Response to Major Incident Survey	1. Re-education program planned 2. Plan for 2 consultants to attend a Major Trauma course
Clinical Assessment & Management of Acute Dislocation of the Knee Study (CAMADoK): Audit of National Practice	1. Present final results whenever the national data is released
Service Evaluation of Information Provided to Orthopaedic Day Surgery Patients	1. Develop the “Patient Portal” and include day case procedural based information (including animations, anaesthetic/day case walk through videos, and patient experience videos)
Radiographic Justification and Reporting For Orthopantograms (OPGs) in Maxillofacial Surgery Outpatient Department	1. Discuss in audit meeting that radiograph must be checked systematically 2. Re-audit in April-May 2019 to review any progress of further development needed.
Audit on whether smoking status is recorded and whether advice and action is offered to smokers in OMFS clinics	1. Posters of VBA with easy instructions in each surgery 2. Show clinicians the Very Brief Advice videos from the online module provided by the National Centre of Smoking Cessation and Training (NCSCT).

Participation in clinical audit

Argon Laser Peripheral Iridoplasty (ALPI) - safety and efficacy	No Actions
2 week wait referrals for skin cancer patients	Results to be discussed more widely in audit meetings.
Record Keeping & Blood Request Details in Oral Surgery	No Actions
Audit on BOAST guidelines (December 2017) - Management of distal radius fractures	No Actions
Spondylodiscitis antimicrobial guidelines	1. Create new antimicrobial guidelines on the treatment of spondylodiscitis
ATILLA Study (Administration of Tranexamic Acid (TXA) in Lower Limb Arthroplasty)	No Actions
Audit of Hip Fracture Time to Theatre 2015-2017	1. Hospital audits requested to determine reasons for delays
Audit on the uptake of influenza and pneumococcal vaccination in patients with autoimmune inflammatory rheumatic diseases in the Rheumatology Clinic	No Actions
Patients' experience and expectations of the rheumatology telephone advice line	No Actions
Pulsed Radiofrequency treatment for Trigeminal Neuralgia	No Actions
The BAHNO National head and neck Cancer surveillance audit	No Actions
MUA fracture nose audit	No Actions
Tonsillectomy haemorrhage audit	No Actions
MRI IAM, CPA Requesting for Screening of Vestibular Schwannoma	No Actions
BAHNO National Head and Neck Surveillance Audit 2018	No Actions
Skin Prick Tests 2009 to 2018	No Actions
DRAFFT Impact Study	No Actions
Ponsetti treatment of CTEV	1. Re-audit in 12 months.
Knee aspirates – do the gram stain and culture result correlate and are they actioned appropriately	No Actions
Evaluation of the awareness of major incident protocols in the orthopaedic department	1. Results shared within T & O Department, education given and follow-up survey planned
A re-audit into compliance with the acute pain guidelines in the orthopaedic department.	1. Not documented, closed the loop.
Vitrectomy Audit	No Actions
Audit of surgical outcome of cases operated by Mr G Ghosh	No Actions
Audit of virtual service for suspected new wet AMD patients. Time from referral registered to appointment	1. Increase virtual clinic to 14 slots per week or its equivalent. Outcome: clinic not been increased as the new referral numbers has dropped. To be picked up again only if the numbers increase.
Patient Satisfaction Survey	No Actions
Audit of orthoptist / optometrist led new referral paediatric clinic	1. Discuss and implement minimum age from referrals 2. Set prescribing guidelines to be followed

Participation in clinical audit

Internal QA audit of management of diabetic retinopathy April 2016-March 2017	1. G8 tool did not add benefit over the current pre-assessment process
Eye Care in the Intensive Care Unit	Conclusion: video was helpful, ITU nurse management asked to include in future ITU nurse induction
Audit of Outcomes in Paediatric Patients Undergoing Syringing and Probing for Nasolacrimal Duct Obstruction	No Actions
Audit on timeless of treatment initiation for 'WET-Age related macular degeneration'	No Actions
Efficacy of Selective Laser trabeculoplasty (SLT)	No Actions
Psychosocial effects of squint surgery in the adult population of Ipswich by using the AS-20 questionnaire	No Actions
Record Keeping Audit in Ophthalmology	No Actions
Effectiveness of 'Treat & Extend' regimen of Aflibercept treatment in Wet AMD : Year 2014 cohort (THREE year results)	1. To continue best practice and aim to audit different aspects of the AMD service in the future
Skin Excision Margins Audit	No Actions

Surgery & Anaesthetics	
Audit	Description of Actions
Documentation of daily plans in the critical care ward round	1. Ensure daily documentation 2. Re-audit and presentation
Paediatrics Fasting Time Re-audit	No Actions
Consent of anaesthesia re-audit	No Actions
Evaluating professional standards regarding CCU ward admission	No Actions
Diagnostic yield and clinical outcome of emergency CT Head scans in elderly patients	Results shared within hospital and at the European Congress of Emergency Medicine at Glasgow 2018
Effectiveness of the current Trust fluid balance chart and its compliance across the Trust	No Actions
Perioperative Management of Hypothermia	1. To re-audit
Recognition of patients with red or amber flags and the Compliance with the Sepsis 6 bundle within the emergency department	No Actions
Identification and management of AKI inpatients	No Actions
Re-admission rates post Appendectomy	No Actions
Re-audit Completeness of information sent with referrals to HPB MDT	Results presented to HPB MDT and Dr Mohsen, re-audit planned
Oxygen Delivery Audit - ADA	No Actions
Review of the outcomes of EUS in 2017	No Actions
Oesophageal Stent Audit 2017-2018	Results shared within hospital
ERCP Audit 2018	No Actions
Outcome and Patient Satisfaction After Radio Frequency Ablation for Varicose Veins Under Local Anaesthetic	No Actions

Participation in clinical audit

A multi-centre study investigating the knowledge of post-operative complications following Transurethral Resection of Prostate (TURP) amongst junior doctors	Results shared at urology conference and with urologists in the department
Performing urine dip before Flexible Cystoscopy; are we cancelling patients unnecessarily	No Actions
ICM sedation hold	1. Doctors on the Critical care need to improve documentation
Opioid use in #NOF	No Actions
Microbiological investigations in patients admitted to critical care with sepsis	1. Creation of an order set in Medway Portal 2. Liaising with microbiology department about samples received time
Measurement of CRP in elective surgical patients	1. Creation of an investigation proforma for elective surgical patients
Emergency Laparotomy and CCU - Analysis of 2017 NELA data	1. Ask anaesthetists and surgeons to discuss their cases pre-op so CCU can prioritise CCU beds for their cases
Re-audit of Handover in Recovery	No Actions
Recognition of patients with red or amber flags and the Sepsis Six bundle compliance within the emergency department	No Actions
Recognition of patients with red or amber flags and the Sepsis Six bundle compliance within the adult ward settings	No Actions
Perioperative Management of Hypothermia (re-audit B0341)	No Actions
Readmissions after colorectal cancer resections: a single centre experience	No Actions
Readmission of surgical patients to SAU	No Actions
Appropriate imaging in acute pancreatitis Re-Audit	No Actions
Management of severe acute pancreatitis in ITU in a DGH	No Actions
Readmissions following diagnosis of symptomatic gallbladder disease	1. Introduce a half day theatre list to cover biliary colic and acute cholecystitis or one acute slot on all upper GI lists every week
Elective colorectal cancer resections: Are there modifiable factors to reduce readmission rate and costs following hospital discharge?	No Actions

Women's & Children's	
Audit	Description of Actions
Shoulder Dystocia	1. A designated, specific coloured folder in every delivery room for obstetric emergencies 2. Colour code our existing proforma's 3. Education, theme of the week about using proforma's 4. Theme of the week handed over at every shift change to all maternity staff, obstetric, midwives and support staff 5. Re-audit and review in 12 months

Participation in clinical audit

To Review the use of Actim Partus for the Prediction of Pre-term Births	1. To explore the data available about alternative tests available on the market for predicting preterm labour - 6 months 2. Introduce another test to help predict preterm labour in the maternity triage at CHUFT - 6 months
TVT Stress Incontinence 2017	1. Start new Uro-Gynae MDT to adhere to NICE guidance on offering surgery Mr Sanderson & Mr Alfhaily - Already implemented 2. Use decision aid document to aid giving informed consent to the patients before they choose a surgical procedure Mr Sanderson & Mr Alfhaily already implemented
Paediatric Bronchiolitis Audit	1. Importance of extended viral screen – data for future audits to see if other viruses are more likely to cause longer admissions or more severe disease and how can this help with predicting treatment 2. Repeat audit data collection to assess if further changes patient population given the variability of RSV season
Paediatric Fasting Times	1. Re-write SOP for paediatric fasting 2. Change existing perioperative leaflet in line with national guidance on fasting 3. Introduce welcome drinks on the paediatric unit to reduce fasting times
Impact of SALT in ASD Pathway	1. Complete re-audit on an annual basis 2. Explore possibility of increasing SALT time / new post 3. Explore what else SALT can offer and create business plans as appropriate 4. Create space with effective facilities for SALT within the community paediatrician team office 5. Increase compliance with ASD pathway re: feedback post SALT input within 6 weeks 6. Increase SALT profile within ESNEFT and increase understanding of SALT job role
Assurance Review of Patient Safety- Safeguarding Children - Chaperoning	1. Staff to be reminded of the documentation requirements of the Chaperoning policy. Processes to obtain regular information on compliance with the chaperoning guideline be put in place and regular information provided to the Safeguarding Operational Group
Potentially avoidable admissions to NNU April 2017-March 2018	1. Guidelines to be updated for evidence of best practice and disseminated to all staff. (Audit of compliance with Red group allocation / management completed by LP) 2. Selected Midwives to complete competencies for NGT insertion 3. New resuscitation record
Paediatric Mental Health Provision	1. Re-audit once new psychiatry liaison service is rolled out 2. Consider user satisfaction feedback forms (+/- parental satisfaction feedback)

Participation in clinical audit

Audit on new fertility patients	1. A new referral Proforma for GP's 2. Teaching the GPs re the new referral forms
Parent communication on neonatal unit	1. Education, re-audit to include parental presence at consultant
First Hour of care audit	1. Re-audit, advice and training given on presentation of results, email reminders sent, note on computers
Effectiveness of Thyroid Function & Urine MCS IN Jaundice Screen	1. We can improve care by looking at the Guthrie reports which is noted on the day 5 screening bloods.
Colposcopy Patient Survey 2018	1. Shared the results with colleagues in the unit and department and emphasised importance of attention to detail in all communication with patients.
Emergency Care Pathway for Gynaecology theatre cases	1. Re-audit prospectively once agreed pathway and timeline finalised for emergency cases.
Disclosure of results from Invasive cervical cancer audit to affected individual - audit of offer and acceptance rates	1. Need to do better at offering disclosure. Education to be given at Colposcopy MDT. Annual re-audit planned
Carbon Monoxide monitoring in pregnancy	1. Results shared, staff to monitor CO at every contact, book smoking cessation trainer for SBL education session
Re-audit of Annual Paediatric Asthma Audit 2017 – Up to April 2018	1. Reinforce advice for doctors/nurses to ALWAYS use, follow and COMPLETE Asthma focused care pathway for all wheezy children attending acutely with a wheezy illness 2. Always request Asthma Specialist Nurse review for all children with acute wheeze. However Specialist Nurse not always available and children seen and discharged from ED/CAU may miss out on nurse assessment 3. Senior doctor or nurse should review child before discharge and go through basic asthma education and management 4. Ensure inhaler techniques checked and good 5. Review recent asthma control and need for prophylaxis 6. Provide PAMP and advise GP review within 2 days (and organise follow up on hospital asthma clinic if necessary) 7. Record all these in notes
Early Pregnancy Unit: Management of Miscarriage	1. Interrogate scans quoted as "complete" as to what prior management they had as may have underestimated No. of SMM - 6 months 2. Examine scans regarding size of RPOC for incomplete miscarriages who have SMM if fit criteria for SMM/MVA - 6 months 3. Draft business plan regarding cost/saving based on number of SMM per year - 6 months 4. Questionnaire to women weather they would consider MVA under LA - 6 months

Participation in clinical audit

Colposcopy MDT Audit II	1. Results were satisfactory, they were fed back to the team and department
G8 screening tool: assessing the diagnostic accuracy in the geriatric breast oncology population	1. G8 screening tool to be used in early treatment planning for patients aged over 70 undergoing breast cancer surgery under a general anaesthetic.
CGIN Audit	1. Reminder email sent to all Colposcopists and further full discussion at next Gynae Audit meeting
Colposcopy MDT Audit	1. Results shared with Colposcopists
Vaginal Pack Recording	1. Results acceptable, no further action required
Management of Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum following implementation of Patient Pathway and Ambulatory Daycare	No Actions
Management of Hypoglycaemia on the Postnatal ward	1. To review training needs of staff (with PDM's and ward leads) re: completion of observation charts. Observation chart audit to be repeated.
Category 1 Decision to Delivery Times April 2017 - March 2018	1. Ongoing audit with 6 mthly results presentation, include average time of LSCS decision to del, dissemination of results
Category 2 Decision to Delivery Time Jan-Feb 2018	1. Continue auditing and present results 6-mthly including consistency of allocation of category. Datix triggers being considered, results disseminated
Do labour ward staff know the location of equipment and necessary contact numbers in an obstetric emergency	1. Education via meeting/presentation and email reminders to all staff
Macrosomia Re-audit	1. Standard patient leaflet to be devised for community and hospital
Skin to Skin in Theatre Re-audit	1. Continue to promote skin to skin in theatres by sharing results with staff and encouraging consideration even in busy clinical times
Correct use of Aspirin in Pregnancy	1. Amend personal maternity record to include Family History - full re-write of maternity notes is in progress

Group 3	
Integrated Pathways	
Audit	Description of Actions
QI project to assess frequency and documentation of DNAR discussions with family on a COTE ward	1. Proforma's available on Birch ward. Proforma's available in EAU & A&E at the point of admission when often DNACPR is discussed
Diabetes	No Actions
Do tailored medication reviews of the severely frail in primary care impact on falls and admission rates	1. Carrying out medication reviews impacted positively, but GP QOF payments have changed. Results to be shared with CCG
Screening for delirium in elderly acute admissions II	No Actions
Pre-Diabetes Audit - A Window for intervention	1. The practice is performing well at treating pre-diabetes with lifestyle interventions, but not as effective at ensuring appropriate follow-up

Participation in clinical research

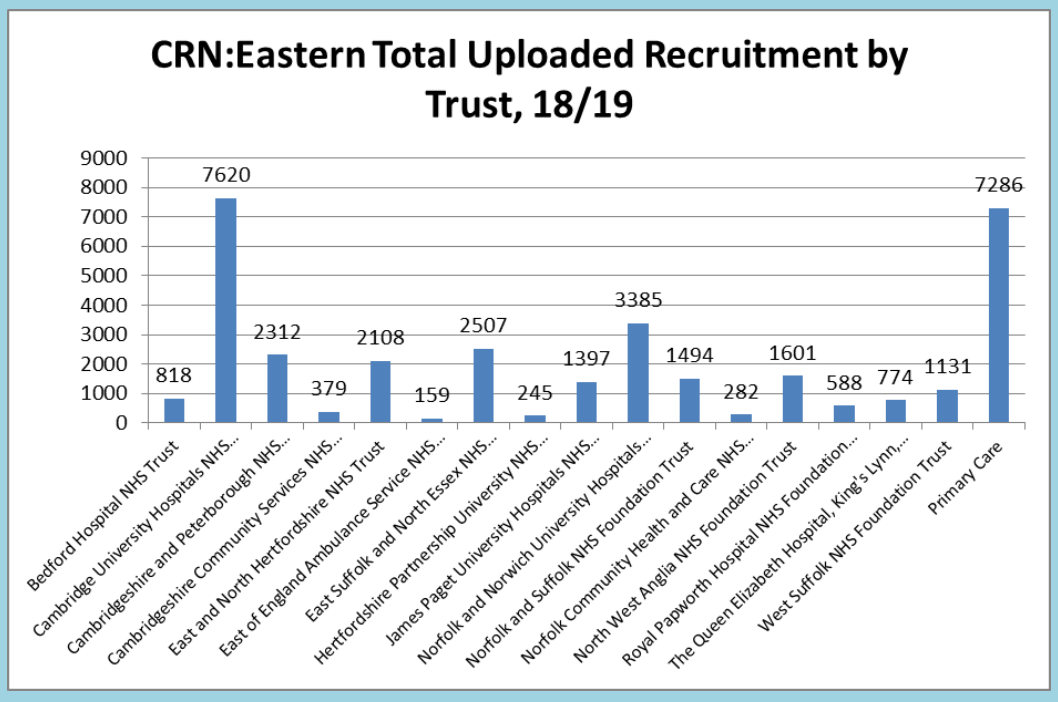
Commitment to research as a driver for improving the quality of care and patient experience.

The merger has enabled us to increase the range of research active areas within a single organisation.

The number of patients receiving relevant health services provided or sub-contracted by our Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 2,645. Of these 2,615 were recruited to NIHR portfolio studies. This ranks the Trust as the third highest recruiting organisation in the East of England in 2018/2019 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 103 recruiting clinical research studies during 2018/2019, across 28 clinical units. The number of staff involved within the research fixed workforce equates to 35.5 WTE while the number of staff involved and supporting the research has increased year on year; currently there are over 129 Principal Investigators listed as leads in our research studies examples of which include:

- ✓ UrgoStart for treating diabetic foot ulcers and leg ulcers – our patients took part in this international study which gathered evidence to support the case for adopting UrgoStart dressings to treat diabetic foot ulcers and venous leg ulcers in the NHS. The dressings are associated with increased wound healing compared with non-interactive dressings . In January 2019 NICE recommended that UrgoStart dressings should be considered as an option for people with diabetic foot ulcers or venous leg ulcers after any modifiable factors such as infection have been treated.

Chart 1



Participation in clinical research

Pictured: The JuxtaCuresTM device

- ✓ RESONATE – our patients were involved in a two pivotal studies which brought ibrutinib to the market to treat Chronic Lymphocytic Leukaemia (CLL) /Small Lymphocytic Lymphoma (SLL). We were one of only a handful of sites in the UK to have the opportunity to participate in both studies enabling access to ibrutinib before approval.

Readers wishing to learn more about the participation of acute Trusts in clinical research and development can access reports on the website of the National Institute for Health Research, at the following address: https://www.nihr.ac.uk/research-and-impact/making-a-difference/

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. (TBA) articles and abstracts were produced. **These examples demonstrate that a commitment to clinical research leads to better treatments for patients.**

Part of our strategy for the coming year is to increase our activity in developing our own in-house research studies by creating opportunities for our researchers to grow ideas whilst increasing our research culture within our new organisation. To help us achieve this increase we will develop our academic and clinical partnerships with universities. At present the majority of research undertaken by the Trust originates at other organisations and we host the research study as a participating site. Our plan is to grow and to establish our own in house research which we will act as the sponsor at our Trust and across the NHS therefore creating greater opportunities for patients to take part in research.

An example of our own Trust sponsored study is an interventional study called MAVEN (Management of People with Venous Ulceration: Feasibility Study), This interventional study compares the effectiveness of bandaging compared to the JuxtaCuresTM device in the management of people with venous ulceration. We have now closed the study after recruiting our 40th patient. We will be informing those that took part of the results later this year.

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 2018/19 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 2018/19 are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/. The monetary income total for 2018/19, based on plan and conditional upon achieving quality improvement and innovation goals, was c. £10.85m. The CQUIN schemes following the schema of the national CQUIN formats, available at the web link above, and were supplemented with locally defined schemes. The listing of schemes being:

Preventing ill health by risky behaviours – alcohol & tobacco

- ✓ Improving Staff Health and Wellbeing
- ✓ Reducing the impact of serious infections (Antimicrobial and Sepsis)
- ✓ Improving Services for people with mental health needs who present to A&E
- ✓ Offering Advice and Guidance
- ✓ Preventing ill health by risky behaviours – alcohol & tobacco
- ✓ Full provider engagement and commitment to the STP process
- ✓ Risk reserve as part of a more collaborative and system-wide approach

- ✓ Dose Banding
- ✓ Optimising Palliative Chemotherapy Decision Making
- ✓ Hospital Medicines Optimisation
- ✓ Spinal Surgery Network
- ✓ Improving AAA Screening uptake in GP Practices with poor uptake
- ✓ Increased Access to breast screening
- ✓ Armed forces policy
- ✓ Dental dashboard.

The table on the following page details the outcomes. These CQUINs all being two year based, aligning with the national contract timeframes, with the exception of the scheme for NHS e-Referrals which is to be replaced by a scheme for Preventing ill health by risky behaviours (alcohol and tobacco). Table 1 demonstrates the actual performance for the CQUIN indicators for 2018/19 for East Suffolk and North Essex NHS Foundation Trust

Table 1 overleaf demonstrates the actual performance for the CQUIN indicators for 2018/19 for East Suffolk and North Essex NHS Foundation Trust.

Monitoring quality

Table 8– Actual performance for the CQUIN indicators for 2018/19

CCG Scheme		Sub-scheme		Q1	Q2	Q3	Q4
	Improving Staff health and wellbeing		Improvement of Health and well Being of NHS Staff				Annual CQUIN/Data not available
			Healthy food for NHS staff, visitors and patients				Annual CQUIN/Data not available
			Improving the uptake of flu vaccinations for front line staff within Providers				Annual CQUIN/Data not available
	Reducing the impact of serious infections (Antimicrobial and Sepsis)		Timely identification of Patients with Sepsis in EDs and Acute Inpatient Settings				Data N/A
			Timely treatment of Sepsis in EDs and Acute Inpatient Settings				Data N/A
			Antibiotic Review				Data N/A
			Reduction in antibiotic consumption per 1,000 admissions				Annual CQUIN/Data not available
	Improving Services for people with MH needs who present at A&E		Improving Services for people with MH needs who present at A&E				Data N/A
	Offering Advice and Guidance		Offering Advice and Guidance				Data N/A
	Preventing Ill Health by risky behaviours		Tobacco screening				Plan to implement for 19/20
			Tobacco brief advice				
			Tobacco referral & medication				
			Alcohol screening				
			Alcohol brief or referral				
	Provider engagement & commitment to STP		Provider engagement & commitment to STP				Data N/A
	Risk reserve (collaborative and system-wide approach)		Risk reserve (collaborative and system-wide approach)				Data N/A

Specialist Commissioning Scheme

Scheme	Sub-scheme		Q1	Q2	Q3	Q4
Dose Banding		Dose Banding				Data N/A
Optimising Palliative Chemotherapy Decision Making		Optimising Palliative Chemotherapy Decision Making				Data N/A
Hospital Medicines Optimisation		Hospital Medicines Optimisation				Data N/A
Improving AAA Screening in GP Practices with poor uptake		Improving AAA Screening in GP Practices with poor uptake			Data N/A	Data N/A
Armed forces policy		Armed forces policy				Data N/A
Dental Quality dashboard		Dental Quality dashboard				Data N/A

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

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) was formed on the 1 July 2018 following the acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust.

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 not taken enforcement action against ESNEFT Trust during 2018/19.

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 will always be 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
Inadequate

On an annual basis the CQC request and receive a set 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 both community and acute services and includes the following:

- ✓ 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.
ESNEFT services have not been inspected by the CQC in 2018/19.

How healthcare is regulated

Medical Staffing

Rota Gaps

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

For doctors in training, HEEoE and Foundation Schools provide us with the doctors that are due to rotate or commence with ESNEFT. When vacancies arise, we appoint Locum Appointment for Service to back fill these gaps. We are also working in partnership with the ICENI Centre to offer fellowship posts and are working with a hospital in China where a MOU has been signed.

Our current vacancies across ESNEFT are as follows:

- ✓ 6 Training Grade vacancies
- ✓ 14 Non-training Grade vacancies.

This is a 14% reduction against the last reporting year.

All vacancies are advertised on a rolling basis on NHS Jobs and in specialist journals when required. Agency doctors are also used to fill gaps. In January 2019, the Hospital Bank rates were uplifted which has resulted in an increase in the number of doctors joining the bank which also helps us fill any rota gaps.

Information around vacancies and rota gaps are provided and discussed at the following committees:

- ✓ Divisional Accountability Meetings
- ✓ Safer Working Forum
- ✓ Joint Local Negotiations Committee (JLNC)
- ✓ People, Organisation and Development (POD).

Neurology care focus

Staff at Colchester Hospital have reduced neurology waiting times by three weeks after completing a 100-day challenge to improve patient care.

The team worked with NHS England to identify actions which could be taken within 100 days.

Modified food tasting for hospital team

The team at Aldeburgh Hospital has been getting to grips with changes to the way we describe food and fluid thicknesses, as part of the International Dysphagia Diet Standardisation Initiative (IDDSI). IDDSI is improving safety for patients with modified diets. A taster session helped staff put themselves into patients' shoes

Extra helping hand for patients

Helping people stay safe at home is at the heart of a new partnership programme called Halfway to Home. The innovative project aims to help patients maintain or regain the skills they need for independent living so they do not need to be admitted to a nursing or residential care home. The eight week long pilot project is funded by Suffolk County Council and managed by the Trust.

Time Matters

TIME MATTERS

Our ESNEFT philosophy is that 'time matters' to everyone. Too often, our current systems and ways of working add unnecessary stress and frustration. Throughout ESNEFT, we will concentrate on removing or improving the things we do, that do not work for our patients and staff, the things which cause time delays throughout our every day-to-day business.

From 5th to 11th November 2018 we had a week-long series of engagement events to share our philosophy, ambition and objectives, listening and working with our patients and staff to see what it means to them and how they can contribute.

The aim of Time Matters Week was to:

· 'Time Matters, let's start the conversation', creating a social movement for all staff across the organisation to personally contribute to 'Time Matters'.

· 'Time Matters' to everyone in the organisation, whoever and wherever they are. Hence all staff were involved and asked to play their part in contributing to the vision and every contribution was valued.

· The primary focus of the directors during the week 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.

o To enable innovation, encouragement of ideas, empowerment and support to release 'non value-added time' and improve time to care

o To build 'interconnectedness' – i.e. what affects one of us affects us all

The Diary Room: A place to spend a few minutes sharing thoughts on how we can make time matter, an inflatable diary room that was based at Colchester Hospital's Outpatients Department

Time matters

Table 9- The volume and source of feedback received.

Data Source	Data Collected
Managers Survey	475 Responses
Staff & Patient Survey	649 responses
'Inflatapod' video comments	176 videos
Ideas Panel	66 Ideas
Corporate Fix-It Sessions	C200 drop-ins

o To build 'ingenuity' – i.e. there's nothing we can't achieve if we set our minds to it

Senior managers and service leads were asked to work across their teams, providing focused face-to-face support to learn, observe, advise and empower staff to contribute to Time Matters. Teams were encouraged to talk about what 'Time Matters' means to them and how/where they can release time in their day to make life easier; whether it's for themselves, their team or their patients/ customers. Managers were encouraged to link with the areas they cover throughout the week, whether it's directly managing or supporting in everyday work, to learn and collectively work towards improvements in accordance with our Time Matters philosophy. This was a fully inclusive event and covered all teams across ESNEFT, both clinical and non-clinical teams, together with seeking patients' views via surveys and 'inflatapod' (message diary room) communications.

The outcome of the week was a raft of feedback which when analysed highlighted that:

- We need to 'Get the Basics Right'
- Staff want basic business processes that work.
- Be able to contact each other.
- Have IT equipment that works and assists and doesn't hinder doing the job!
- We frustrate our patients by:
- Inviting them to multiple appointments, often for 2minutes to then be told they need to have another appointment for a diagnostic test.
- Cancelling clinics as last minute and not informing them.
- Not being able to contact department to change a booking.
- Our patients put up with delays as grateful to be seen and the wonderful treatment being received by themselves and their loved ones.
- Our clinical processes often work against staff and patients, requiring duplicate data, not clear as to the value / purpose of some process steps, consultations occurring before diagnostics.
- Car Parking was the most frequent frustration for both patients and staff.
- Reluctance of staff to raise issues or ideas, and give their names

The Trust has taken forward a number of actions as a result of the feedback from patients and staff, many of which are being led by individual clinical services to make improvements in their own services. Where actions cut-across many services or affect corporate business processes these actions have been incorporated into the programmes of work that are overseen by the Time Matters Board, which consists of the following transformation programmes:

· TMB1: Logistics & Corporate Transformation
· TMB2: e.Health
· TMB3: Informatics
· TMB4: Trust Strategy De-

Time Matters

velopment

· TMB5: Use of Resources

· TMB6: Quality Improvement

· TMB7: Emergency Care

· TMB8: Elective Care

· TMB9: Estates Strategic Development

In addition the trust:

- Is bringing Time Matters to life each day, all staff to think about the impact their actions have on others time.
- Continues to encourage an environment where ALL staff feel empowered to speak up about ideas they have without judgement and give them confidence to take responsibility for things they can change themselves.
- Is following-up on the data we received through all the channels as actions distributed amongst the respective divisions and build these into business plans for fixes that will take more planning.
- Directors and Senior Managers continue to make time to listen and engage with teams.
- Plans to schedule another Time Matters Week in summer of 2019

Peter and Pauline, below, are part of the Red Cross volunteer team at Ipswich Hospital's Emergency Department. They help patients and visitors by serving refreshments, keeping them company and providing support to families in distress. This saves time for staff who can focus on care and treatment.

Time matters

Chasing referral letters and patient notes, as well as slow IT systems, are common frustrations at Essex County Hospital. Colleagues are hopeful improvements will follow when services move to the primary care centre.

The Merger

The merger of Colchester and Ipswich Trusts was completed as planned in July 2018. This has created the largest NHS organisation in East Anglia, serving 760 thousand people in Suffolk and north east Essex. We employ nearly 10,000 staff and some of our services are now among the largest in England including orthopaedics, general surgery and cancer services. This puts the Trust in a good position to offer the best care and experience for patients into the future.

Our clinical and operational leadership teams now have responsibility for their services across the whole Trust. This is helping our teams to work more closely together and to share learning, ideas and good practice. Our services have developed Trust-wide clinical integration plans and have contributed to the development of the Trust's new strategy which will set the priorities for the next five years. This will be finalised in April 2019.

Among the early benefits of the merger are the increased range of subspecialty services which are now available to patients within the Trust, for example in cardiology, paediatrics and cancer. This is possible due to the different mix of subspecialist skills in teams at the two hospitals, which are now working as a single specialty.

Our integrated community services in Suffolk are showing the benefit of close working between community and hospital services, with sustained reductions in the number of people requiring hospital treatment.

Trust wide operational planning of services has identified new efficiencies, leading to opportunities for faster treatment and better use of resources. Investment in technology is increasing our ability to share information across the Trust both for clinical care and planning. The Trust is working with partners in the Suffolk and north east Essex Integrated Care System to extend this information sharing (compliant with data security requirements) across other organisations involved in caring for our patients, including other hospitals, GP practice and community services.

The new Trust has attracted significant investment to improve our clinical services, including £69.3m of capital funding. This will be used to create new urgent treatment centres at both hospitals, improve emergency departments and elective care services over the next few years.

Quality Improvement

Quality Improvement faculty

Quality Improvement Faculty Information

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

There have been intrinsic and extrinsic drivers for Quality Improvement (QI) within healthcare. Nationally poor safety and poor patient experience has been seen in some trusts e.g. Morecombe bay. At CHUFT quality issues have been raised by the CQC and other regulators, in addition to horizon programmes such as GIRFT which will have significant positive impact on supporting QI by providing peer and benchmarking data.

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 within the Trust has been in existence for a year now and we are building 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 reports to and is governed by the Portfolio Board which has an improvement focus. The benefit to the Trust is that QI will become embedded as a part of everyone's daily routine and that the culture of QI seen as 'normal'. This will undoubtedly lead to proactive improvement and innovation in care from staff of all disciplines and levels.

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, coordination 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

Sleep well in hospital campaign

Companies back Colchester Hospital's "Sleep Well in Hospital" campaign.

Patients are getting a better night's sleep after a delivery of ear plugs and eye masks at Colchester Hospital.

British Airways have provided the hospital's "Sleep Well in Hospital" campaign with eye masks – often used by customers on their flights – while Arco, who provide and sell safety wear and equipment, have donated the earplugs.

Noise and light on a ward can disturb a patient's sleep, slowing down their recovery and potentially extending their hospital stay.

Campaign lead Stephanie Ellis, from the hospital's patient experience team, acted after reviewing survey results where more than a third of patients complained about noise coming from fellow patients and staff during the night.

The campaign is part of Colchester Hospital's quality improvement programme which makes small changes to improve care.

Lead quality improvement nurse Karen Lake, said: "This is about making changes for our patients by listening to them and learning from their experiences.

"Staff from all disciplines are encouraged to get involved in making small changes to benefit the patients, their carers, staff and visitors.

The first eye masks and ear plugs were donated to Aldham Ward. Ward sister Lucy Crimmin said: "As well as the eye masks and ear plugs we also make sure our night shift staff switch off the lights in the patient bays by 10.30pm, while the corridor lights go out at 11pm.

"Only the patient safety lights in the bays, reception area, and the clean and dirty utility area are kept on overnight."

British Airways customer service manager Scott Coglan, said: "We are delighted to support this campaign and contribute towards improving the patient experience.

"We always try to go the extra mile for our customers and the eye masks are very popular in aiding a peaceful night's sleep.

"We hope the patients reap the benefits that many of our customers do, as part of their ongoing recovery."

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 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data (April – October 2018).

The percentage of records in the published data including a valid NHS number for patients seen:
· 98.4% for admitted patient care;
· 99.7% for outpatient care; and
· 98.4% for accident and emergency care.

The percentage of records in the published data including a valid General Medical Practice Code for patients seen:
· 100% for admitted patient care;
· 100% for outpatient care; and
· 100% for accident and emergency care.

Source: NHS and Social Care Information Centre data quality dashboards March 2019

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 was graded satisfactory (Green).

Clinical coding

East Suffolk and North Essex NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period..

The National PbR Clinical Coding audits were last required in 2013/14 for Colchester site and 2014/15 for Ipswich site. The audits now link to Data Protection and Security Toolkit (DP&ST) standards. National PbR audits have ceased. PbR audits were specialty based and requested by local Commissioner , DP&ST standards are randomly selected cross-specialty, and this information is readily available on request from the Head of Clinical Coding. The DP&ST Audit report looks across the department's coding standards, with specific link to randomly selected specialty and as such this it is made available annually to the Information Governance Lead/Data Protection Officer and should be recorded within the their datasets.

Data Quality

East Suffolk and North Essex NHS Foundation Trust will be taking the following actions to improve data quality:

Table 10

Data Quality Indicator	Data Quality or Data Flow	When	Update
Data Quality Maturity Index	Data Quality	2019/20	Plan to achieve greater than 98% for A&E, APC and OP. And work in year to improve MSDS score.
Post merger – looking to maintain current levels of data quality.	Data Quality	On-going	Core metrics will be monitored through reports to the Information Governance & Records Committee.

Learning from Deaths

During 2018/19, 2744 of East Suffolk and North Essex NHS Foundation Trust patients died** (of which 1 was a neonatal death, 16 were still births, 35 were people with learning disabilities and no patients had a severe mental illness).

This comprised the following number of deaths which occurred in each quarter of that reporting period:

For Ipswich Hospital Trust, 300 in the first quarter (of which v number were neonatal death, x number were still births, y number were people with learning disabilities and no patients had a severe mental illness).

For Colchester Hospital NHS Foundation Trust, 448 in the first quarter (of which 1 was a neonatal death, 5 were still births, 4 were people with learning disabilities and no patients had a severe mental illness)

Following the formation of ESNEFT 1st July 2019 this comprised the following number of deaths which occurred in each quarter of that reporting period:

682 in the second quarter (of which none were neonatal deaths, 5 were still births, 14 were people with learning disabilities and no patients had a severe mental illness).

824 in the third quarter (of which none were neonatal deaths, 5 were still births, 13 were people with learning disabilities and no patients had a severe mental illness).

490 in the fourth quarter (of which none were neonatal deaths, 1 was a still birth, 4 were people with learning disabilities and none had a severe mental illness).

Case Record Reviews and Investigations

The Trust has developed 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 pre-defined 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.

A review is conducted using the (adapted) Royal College of Physicians' Structured Judgement Review (SJR) form, which breaks down care into stages in the patient's pathway, for example, care on admission and in first 24 hours, care after first 24 hours, etc. The form requires the clinician to review care in its entirety, placing a value judgement on the care at each stage of delivery. Where issues or learning is recognized this is collated and fed back to the clinical teams in addition to being escalated via the trust internal governance system if required.

From April 2018, all patient deaths will be additionally screened through the introduction of Medical Examiners (MEs), a new role to the NHS, consisting of a group of experienced doctors who will be able to discuss the care of the patient with those close to them. They will also review the health record highlighting any case where there are concerns about the quality of care. Any concerns raised will be investigated in full.

By 28/02/2019, 646 case record reviews using the Structured Judgement Review methodology have been carried out in relation to 2744 of the deaths as reported above.

The number of deaths in each quarter for which a case record review or an investigation was carried out was: 252 in the first quarter; 229 in the second quarter; 146 in the third quarter; 19 in the fourth quarter (partial data).

0.3% 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.

In relation to each quarter, this consisted of: 0.4% for the first quarter; 0% for the second quarter; 0.7% for the third quarter; 0% for the fourth quarter. These numbers have been estimated using the summary of care information from the Structured Judgement Review forms.

Previous Reporting Period for Colchester Hospital

In relation to 2017/18, an additional 471 case record reviews using the Structured Judgement Review methodology were completed after 28/2/2018 which related to deaths which took place before the start of 2018/19.

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. These numbers have been estimated using the summary of care information from the Structured Judgement Review forms.

0.9% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Lessons Learned from Case Record Reviews and Investigations

An external alert for acute cere-

Learning from Deaths

brovascular disease led to a detailed audit of the care of patients with that admitting diagnosis.

The staff reviewers identified occasions where there was poor use of fluid balance charts for patients needing additional monitoring. Secondly, although patients are closely monitored using a track and trigger system called the National Early Warning Score (NEWS), there were sometimes issues with miscalculation of the results which meant that some patients experienced delays in receiving timely care.

Monitoring of fluid input, review of fluid charts and improved use of the NEWS tool is part of the trust quality improvement programme led by the deteriorating patient group as detailed below.

Since September 2017, the Trust has participated in the LeDeR (Learning Disabilities Mortality Review) programme, which reviews the deaths of patients with a diagnosed learning disability. The Trust has not as yet received any peer-reviewed information from partner organisations, however, all patient deaths in this group have been subject to hospital reviews and these have identified some issues in community and hospital care that echo national findings such as: ensuring good nutrition where the patient has swallowing problems, communicating effectively with the patient and with those who know them best, diagnostic overshadowing (where behaviour may be misinterpreted as being part of the patient's disability rather than symptomatic of a physical cause, e.g. pain), establishing what is 'normal' for the patient so that any variance to that is a signal that something may be wrong, setting appropriate ceilings of care in consultation with families and carers, and ensuring prompt diagnosis of constipation on admission that has gone unrecognised for a period of time.

The Trust participates in national mortality audits relating to pregnancy (MBRRACE Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) and also deaths of babies (Perinatal Mortality Review Tool) and children (Safeguarding Children Boards).

Recently released results from MBRRACE for activity in 2016 indicated that perinatal mortality at Ipswich Hospital was lower than national and was slightly higher at Colchester Hospital.

Actions taken following Care Record Review and Investigation

- ✓ Acute cerebrovascular disease - the audit resulted in an action plan designed to improve the use of repeat diagnostics where there is uncertainty, improve seizure control, optimise blood sugar control and ensure that patients at end of life receive specialist palliative support.
- ✓ Acute kidney injury - Renal consultants, supported by Deteriorating Patient Nurse Specialists, are working towards the standardisation of fluid balance charts which, in conjunction with teaching packages, will be used to ensure more detailed monitoring of patients who may be deteriorating.
- ✓ Vital signs monitoring - the Trust has developed its own electronic observations system, due for roll-out in the financial year 2019/20. This system will calculate the track and trigger score based on NEWS (2) criteria and will, in the second stage of development, contact nursing and medical staff based on patient need. The benefits of this system is that it can be tailored to suit the hospital population and going forwards, will include other key elements of hospital care such as screening patients for sepsis.
- ✓ Learning Disabilities - the Learning Disability Hospital Liaison Nurse Specialists are working with the Clinical Commissioners to ensure that patients in residential care are supported by staff trained to recognise when their clients become unwell. Following the outcome of national findings which have identified that what may seem like minor conditions, such as constipation, can often remain undiagnosed in the community, and can have a severe impact on the health of patients, the LDHLNSs have designed a teaching package to help ensure that staff identify this and act swiftly.
- ✓ The team has also launched a new document called the 'Reasonable Adjustment Tool' which addresses all elements of patient care including likes and dislikes, clinical information, pain scoring and contact details for the patient's carers. This, in conjunction with the Hospital Passport which travels with the patient and the communication books on the wards help to ensure that needs can be met and that the patient's stay is as safe and comfortable as possible.
- ✓ Standardised processes are being established including monitoring compliance with GROW (a foetal growth monitoring tool), development and implementation of a robust Antenatal Screening database to reduce manual data entry and collection.

In 2018, the Trust participated in the 7 Day Services Audit, a review that looks at time to first consultant review, access to diagnostic tests, access to consultant-directed interventions and ongoing

Learning from Deaths

review by a consultant. The results of this are being used to inform future work to improve patient care.

The Trust has also signed up to GIRFT (Getting it Right First Time), a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. The surgical specialities have been visited by the National teams and the programme is now extending to medical specialties. Clinical teams are using the recommendations from the visits as a basis for quality improvement.

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

Previous Reporting Period

Deteriorating Patients

In the Quality Report 2017/18, a target was set for 95% of patients to have their early warning scores completed fully and calculated correctly, with patients escalated according to trust guide-lines when appropriate.

- ✓ Peer audits four times a month have indicated compliance with accurate early warning scores of 92% for the financial year.
- ✓ Compliance with the timely escalation of patients to the right grade of staff has improved from 53% in April to an average for the last three months of 76%.

End of Life and Palliative Care

Aims for 2017/18 included the need for earlier recognition of patients who may be in the last days/weeks of life, compliance with use of the last days of life record to ensure that patient needs are met, the need to improve communication between the community and acute hospital setting about patient choice and ensuring that more than 90% of patients achieve their preferred place of death.

- ✓ Mortality reviews have indicated that the end of life record is being used fairly consistently but the quality of completion is still variable.

Sepsis

A key priority was the need for early diagnosis and treatment for red flag sepsis.

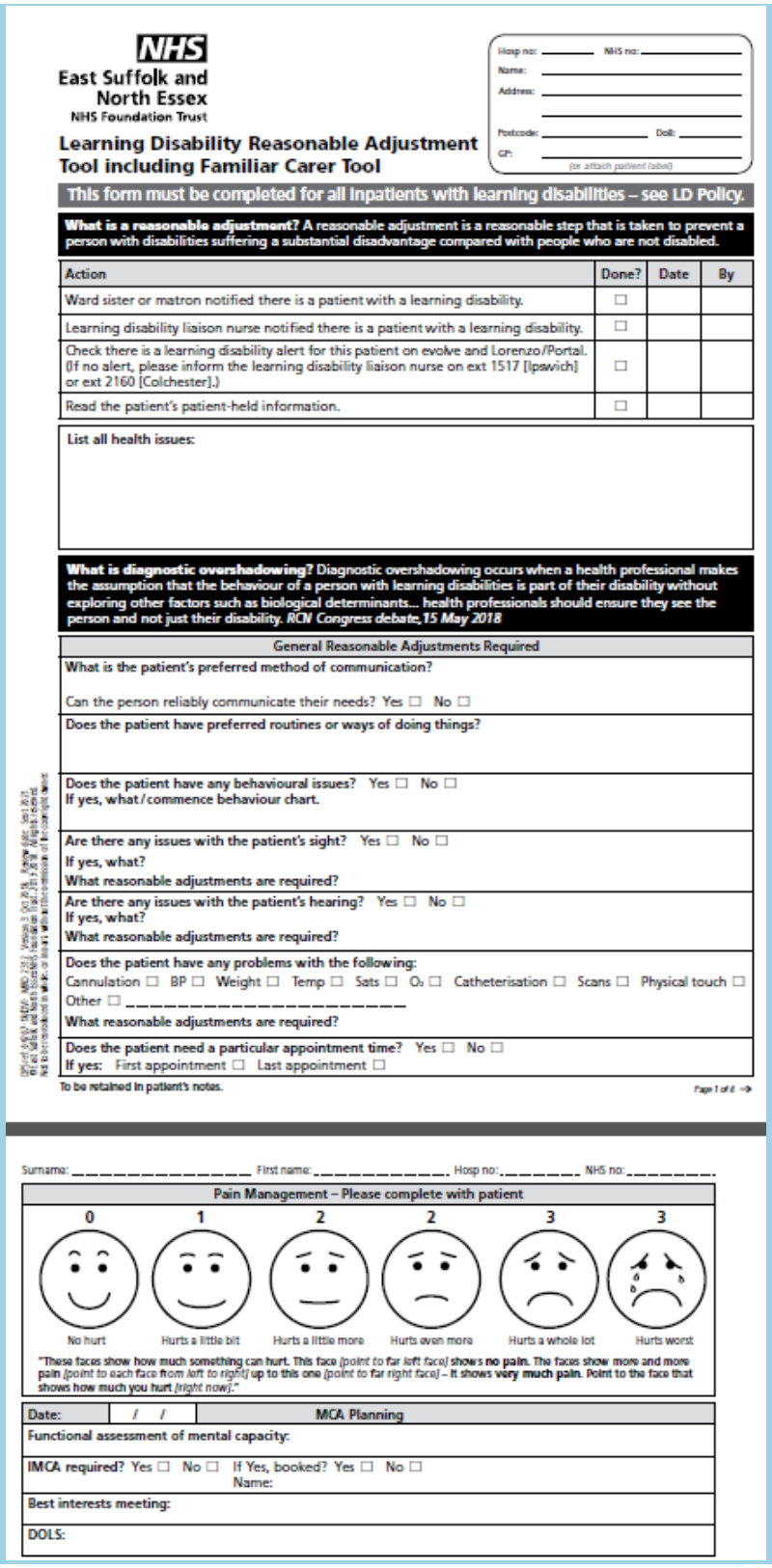
- ✓ Significant improvements have been made overall to sepsis screening and treatment, both in the Emergency Department and on wards, although there is still a lot of work to do. Please see the Sepsis section for more information.

Hyperglycaemia

There has been only one reported incident following a mortality review in 2018/19, however, there were three Datix incident forms raised in the year where hyperglycaemia required treatment, these issues were addressed

Learning from Deaths

The 'Reasonable Adjustment Tool'



NHS
East Suffolk and North Essex NHS Foundation Trust

Hosp no: _____ NHS no: _____
Name: _____
Address: _____
Postcode: _____ DoB: _____
GP: _____
(or attach patient label)

Learning Disability Reasonable Adjustment Tool including Familiar Carer Tool

This form must be completed for all inpatients with learning disabilities – see LD Policy.

What is a reasonable adjustment? A reasonable adjustment is a reasonable step that is taken to prevent a person with disabilities suffering a substantial disadvantage compared with people who are not disabled.

Action	Done?	Date	By
Ward sister or matron notified there is a patient with a learning disability.	☐		
Learning disability liaison nurse notified there is a patient with a learning disability.	☐		
Check there is a learning disability alert for this patient on evolve and Lorenzo/Portal. (If no alert, please inform the learning disability liaison nurse on ext 1517 [Ipswich] or ext 2160 [Colchester].)	☐		
Read the patient's patient-held information.	☐		

List all health issues:

What is diagnostic overshadowing? Diagnostic overshadowing occurs when a health professional makes the assumption that the behaviour of a person with learning disabilities is part of their disability without exploring other factors such as biological determinants... health professionals should ensure they see the person and not just their disability. *RCN Congress debate, 15 May 2018*

General Reasonable Adjustments Required
What is the patient's preferred method of communication? Can the person reliably communicate their needs? Yes ☐ No ☐
Does the patient have preferred routines or ways of doing things?
Does the patient have any behavioural issues? Yes ☐ No ☐ If yes, what / commence behaviour chart.
Are there any issues with the patient's sight? Yes ☐ No ☐ If yes, what? What reasonable adjustments are required?
Are there any issues with the patient's hearing? Yes ☐ No ☐ If yes, what? What reasonable adjustments are required?
Does the patient have any problems with the following: Cannulation ☐ BP ☐ Weight ☐ Temp ☐ Sats ☐ O_2 ☐ Catheterisation ☐ Scans ☐ Physical touch ☐ Other ☐ _____ What reasonable adjustments are required?
Does the patient need a particular appointment time? Yes ☐ No ☐ If yes: First appointment ☐ Last appointment ☐

To be retained in patient's notes.

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Surname: _____ First name: _____ Hosp no: _____ NHS no: _____

Pain Management – Please complete with patient

"These faces show how much something can hurt. This face *[point to far left face]* shows **no pain**. The faces show more and more pain *[point to each face from left to right]* up to this one *[point to far right face]* – it shows **very much pain**. Point to the face that shows how much you hurt *[right now]*."

Date: / /	MCA Planning
Functional assessment of mental capacity:	
IMCA required? Yes ☐ No ☐ If Yes, booked? Yes ☐ No ☐ Name:	
Best interests meeting:	
DOLS:	

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	Apr 17—Mar 18	1.109	1.0	1.232	0.699	2
	Jul 17—Jun 18	1.133	1.0	1.257	0.698	1
	Oct 17—Sep 18	1.141	1.0	1.268	0.692	1
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)	Apr 17—Mar 18	25.5%	32.5%	59.0%	12.6%	
	Jul 17—Jun 18	28.9%	33.1%	58.7%	13.4%	
	Oct 17—Sep 18	29.0%	33.6%	59.5%	14.3%	

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

The Trust is banded as '1' which is 'higher than expected' owing to the fact that the value exceeds the 95% confidence limit (with over-dispersion), i.e. more patients are dying in hospital and within 30 days of discharge than statistical modelling predicts.

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 in-hospital deaths are reviewed in line with national guidance for Learning from Deaths and discussed at specialty Mortality and Morbidity meetings.
- ✓ The appointment of Medical Examiners who will provide additional scrutiny by assessing the quality of care as described in the health record and through discussion with the bereaved.
- ✓ Ensuring that issues identified through mortality reviews and the following systems are investigated and that any learning identified is shared with the relevant team and trust-wide if appropriate:
  - ✓ The Trust incident-reporting system
  - ✓ Complaints
  - ✓ Responses to the Chief Executive's letter to the bereaved
  - ✓ Responses to letters sent to GPs for deaths after discharge
- ✓ The Learning from Deaths meeting where divisions are required to present their mortality data and alerts provided by external groups such as Dr Foster Intelligence are discussed.
- ✓ Ensuring that health records and the resulting Clinical Coding accurately identifies the admitting diagnoses and comorbidities for patients so that external agencies can use the information to correctly identify performance at variance to national benchmarking.
- ✓ Monitoring compliance with the use of track and trigger systems and pathways such as the Sepsis 6, COPD, pneumonia and acute kidney injury.
- ✓ Working with community partners to promote symptom control for patients in the last months/weeks of life, thereby avoiding hospital admission if that is not the patient's preferred place of care

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	2015-16				
	Colchester	2016-17				
	Colchester	2017-18				
	Ipswich	2015-16				
	Ipswich	2016-17				
	Ipswich	2017-18				
The Trust's patient reported outcome measures scores for varicose vein surgery during the reporting period	Colchester	2015-16	0.097	0.096		
	Colchester	2016-17				
	Colchester	2017-18				
	Ipswich	2015-16	0.116	**0.096**		
	Ipswich	2016-17				
	Ipswich	2017-18				
The Trust's patient reported outcome measures scores for hip replacement surgery during the reporting period	Colchester	2015-16	0.474	0.438		
	Colchester	2016-17	No Data	0.437		
	Colchester	2017-18	0.478	0.458		
	Ipswich	2015-16	0.496	0.438		
	Ipswich	2016-17	0.534	0.437		
	Ipswich	2017-18	0.538	0.458		
The Trust's patient reported outcome measures scores for knee replacement surgery during the reporting period	Colchester	2015-16	0.300	0.320		
	Colchester	2016-17	No Data	0.325		
	Colchester	2017-18	0.386	0.337		
	Ipswich	2015-16	0.385	**0.320**		
	Ipswich	2016-17	0.378	**0.325**		
	Ipswich	2017-18	0.387	0.337		

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	CHUFT score	National average	Highest score	Lowest score
The Trust's responsiveness to the personal needs of its patients during the reporting period	2014/15	63.9	68.9	86.1	59.1
	2015/16	64.9	69.6	86.2	58.9
	2016/17*	66.9	68.1	85.2	60.0

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 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:

✓ 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 Q1	82%	81%	100%	55%
	2017/18 Q2	73%	80%	100%	46%
	2017/18 Q3**	62%	71%		
	2017/18 Q4	60%	80%	100%	36%
	2018/19 Q1	75%	81%	98%	53%
	2018/19 Q2	72%	81%	100%	39%
	2018/19 Q3**	68%	70%	90%	49%

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:
During the 2018/19 reporting period, the Full Business Case articulated that the newly merged organisation, 'East Suffolk & North Essex NHS Foundation Trust' would be able to take advantage of increased scale and shared resources by:

- ✓ Improving the recruitment and retention of highly skilled staff through improved training, education and career development
- ✓ Creating larger clinical services which are more able to meet service standards, offer 24/7 services, sustain and improve the range of services to meet the needs of patients
- ✓ Creating sustainable partnerships with community services to support more self- and community-based care
- ✓ Investing in innovation, research and technology to transform the services for patients and staff
- ✓ Adapting flexibly and attract investment to meet the changing needs of the population

This will in turn give our workforce the confidence to recommend the Trust as a provider of care to their family and friends.

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)*	94.5%	95.4%	100%	82%
	2017/18 (Inpatients)*	97.6%	95.6%	100%	81%
* Highest & Lowest Score is based on the position in March in each year	2018/19 (Inpatients) **	97.3%	95.6%	100%	80%
** 2017/18 YTD (April 2018 - November 2018) with Highest & Lowest Score being based on November 2018 (Latest Report)	2016/17 (A&E)*	81.7%	86.2%	100%	46%
	2017/18 (A&E)*	84.1%	86.4%	100%	64%
	2018/19 (A&E) **	84.3%	87.%%	100%	63%

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

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.

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:

- ✓ Reviewing results within the relevant CDG and Divisional 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.

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	2016/17	90.65%	96.73%	100%	67.04%
	2017/18	90.55%	95.53%	100%	63.02%
* Q1-Q3 2018-19 High/Low scores at last reported period	2018/19*	92.07%	96.74%	100%	54.86%

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:

Education and training for doctors and nurses by the VTE nurse team;

✓ 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	41.14	36.73	147.23	0
	Apr 17-Mar 18	35.58	38.28	157.51	0
	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													
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)	October 14 - March 15	3,326	31.97	2,664	26.67	NA	NA	621,776	36.24	3,225	82.21	443	3.57
	April 15 - September 15	3,798	39.55	2,954	32.9	NA	NA	632,050	38.11	3,948	74.67	4,078	18.07
	October 15- March 16	3,969	40.94	3,331	38.68	NA	NA	655,193	38.58	3,426	75.91	1,499	14.77
	April 16 - September 17	3,789	39.79	3,486	35.44	NA	NA	673,865	39.89	3,620	71.81	2,305	21.15
	October 17 - March 18	3,667	36.77	4,049	36.77	NA	NA	696,643	40.52	3,300	68.97	3,219	23.13
	April 18 - September 18	NA	NA	NA	NA	4,870	40.7	731,348	NA	13,692	51.9	374	66.1
	October 18- March 19	Data not available at time of publishing.											
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	%
	October 14 - March 15	10	0.1	12		NA	NA	3,089	0.18				
	April 15 - September 15	16	0.17	21		NA	NA	2,717	0.16				
	October 15 - March 16	32	0.33	19		NA	NA	2,642	0.16				
	April 16 - September 16	16	0.40%	27		NA	NA	2,516	0.40%	98	1.40%	1	0.02%
	October 16 - March 17	16	0.40%	22		NA	NA	2,623	0.40%	92	1.10%	1	0.03%
	October 17 - March 18	15	0.40%	19	0.40%	NA	NA	2,522	0.30%	99	1.50%	0	0.00%
	April 18 - September 18	NA	NA	NA	NA	47	0.50%	2,441	0.30%	105	0.30%	0	0.00%
	April 17 - March 18	Data not available at time of publishing.											

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; ESNEFT continued to report as Ipswich Hospital & Community and Colchester Hospital to the end of the financial year. The last data set reported from the NRLS shows the both hospital sites to be slightly below average reporters of incidents, however both show an increase (Colchester from 36.77 per 1000 bed days to 39.2 and Ipswich from 36.77 incidents per 1000 bed days to 38.44.. 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 2017 – March 2018 is 0.03% (Colchester) and 0.04% (Ipswich) and therefore just above the 0.03% average for all medium acute Trusts. This shows an improvement for both former Hospital Trusts, (0.05% for both) and provides a baseline for future reports. 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.
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. ✓ Training at Trust Induction has been implemented to encourage reporting of incidents and near misses as well as give guidance for risk assessment and escalation of incidents. ✓ The Trusts Procedure for the Management of Incidents and Serious Incidents gives staff clear guidance on how to report and escalate and also details the SI process ✓ Key performance indicators for the management of incidents and SI's have been developed and are included within our Accountability Framework.

Part 3 - Other information
Patient safety
Infection prevention and control

Methicillin resistant Staphylococcus aureus (MRSA)

Achieve Trust Target of zero for MRSA cases in 2018/19

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.

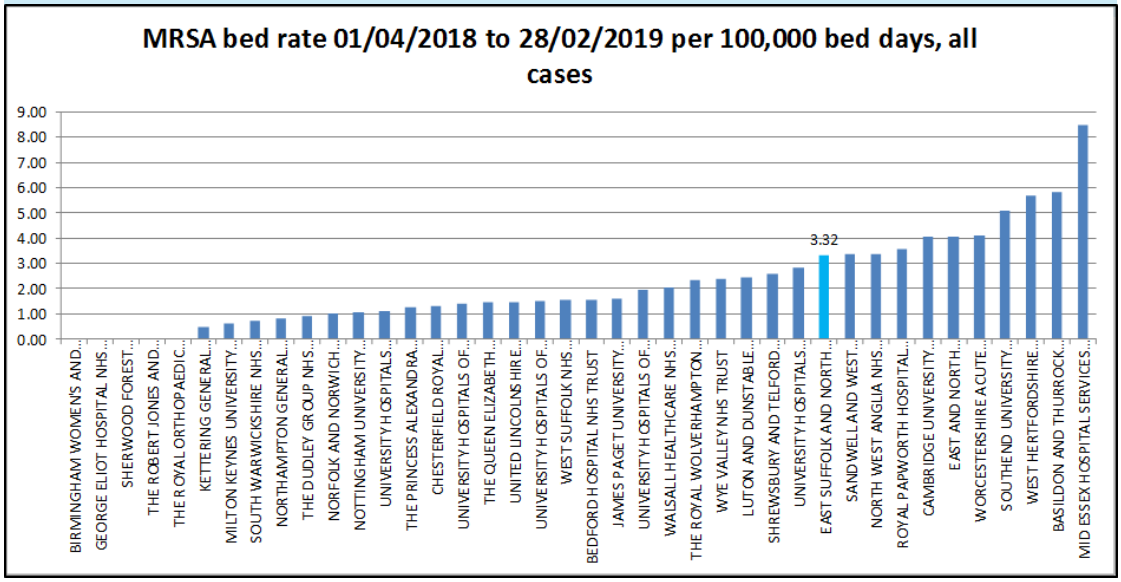
Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin resistant Staphylococcus aureus (MRSA) and often require different 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 11— Number of cases of MRSA bacteraemia apportioned to ESNEFT

Year	Number of cases of MRSA bacteraemia cases apportioned to ESNEFT	Target
2014/15	0	0
2015/16	2	0
2016/17	2 (1 of which was a contaminant)	0
2017/18 to date	2	0
2018/19 to date	1	0

There was 1 case of MRSA bacteraemia identified across ESNEFT in 2018/19 it is recognised that there is some learning related to the timely identification and MRSA screening and management of high risk patients together with looking at intravenous device management in patients whom may require longer term lines inserted.

Chart 2– The performance of ESNEFT in rates of MRSA bacteraemia, compared with the other hospitals in the East of England region for 2017/18



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.

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).

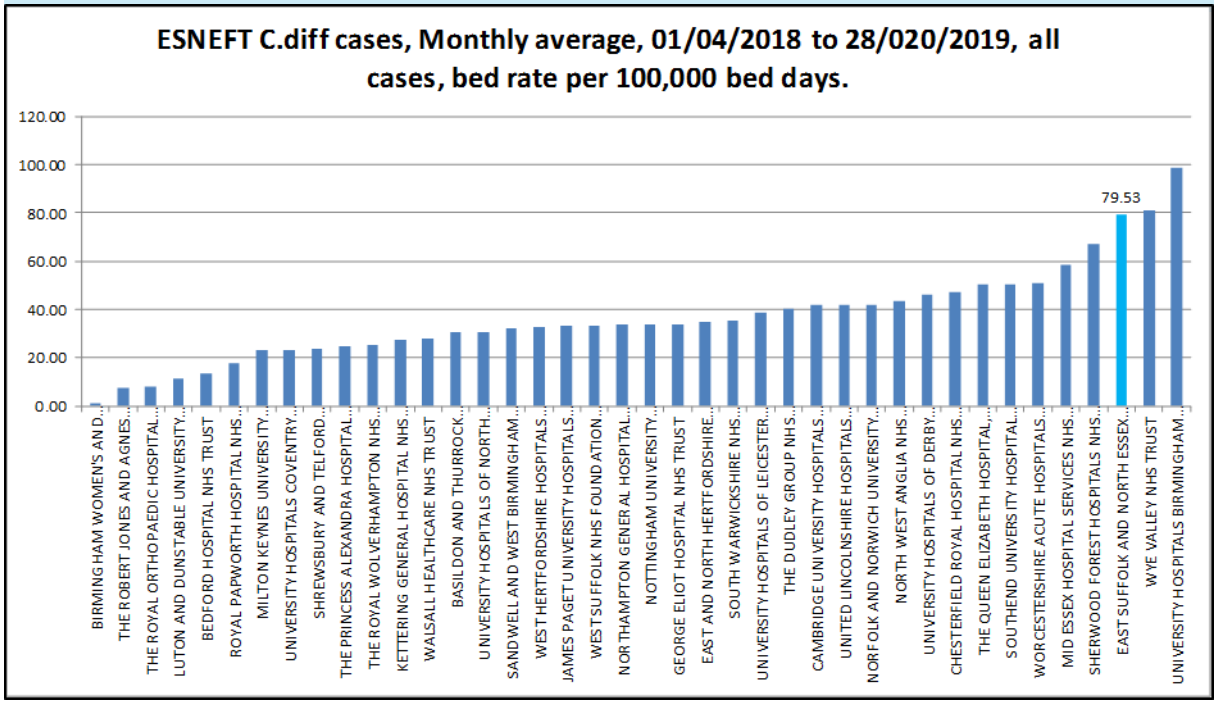
Each case Identified in the Trust is subject to post infection review. If all care and treatment is managed within nationally and locally recognised policy the Clinical Commissioning Group (CCG) scrutiny panel may agree that it is deemed as 'Non trajectory' (2015/16 onwards).

37 (of 52) C difficile cases for Colchester have been agreed as non-trajectory 2018/19.

- ✓ 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 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

NB: For 2019/20 the criteria for what constitutes a case which will be deemed as Trust case will change from less than or equal to 3 days post admission to less than or equal to 2 days post admission There will be additional information collected relating to prior healthcare interventions within the 4 weeks prior to identification.

Chart 3– The performance of ESNEFT in rates of Clostridium difficile, compared with the other hospitals in the East of England region for 2018/19



Patient safety
Infection prevention and control

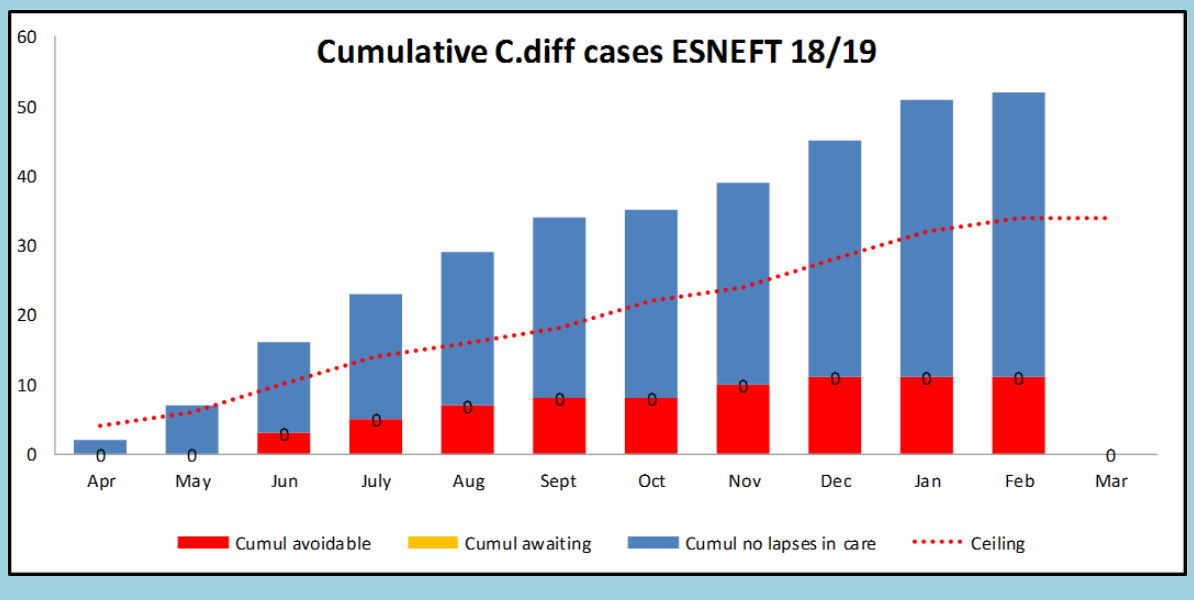
Table 11- Number of C.Diff cases apportioned to Colchester Hospital

Year	Number of cases of *Clostridium difficile apportioned to Colchester Hospital*	Target No more than
2014/15	32 cases	20 cases
2015/16	10 trajectory cases – 14 non - trajectory	18 trajectory cases
2016/17	9 trajectory cases - 26 non-trajectory	18 trajectory cases
2017/18 to date	1 trajectory case – 17 non- trajectory	18 trajectory cases
2018/19 to date	10 trajectory cases – 16 non-trajectory – 2 awaiting decision	17 trajectory cases

Table 12- Number of C.Diff cases apportioned to Ipswich Hospital

Year	Number of cases of *Clostridium difficile apportioned to Ipswich Hospital*	Target No more than
2017/18 to date	9 trajectory, 14 non trajectory,	17 trajectory cases
2018/19 to date	1 trajectory case – 21 non-trajectory – 2 awaiting decision	17 trajectory cases

Chart 4- Clostridium difficile cases 2018/19



Patient safety
Prevention of inpatient falls Colchester Site

We wanted to reduce the number of falls that occurred during inpatient stays as falling has both a physical and psychological impact on the rehabilitation and recovery process for patients during their stay.

A fall can lead to an increased length of stay and can alter the plans for discharge including the post inpatient stay discharge destination. Nationally reducing falls has shown to reduce length of stay in the older population and reduce the discharge to alternative care facilities. We also wished to reduce the severity of harm that was suffered by those who did experience a fall as this has significant consequences for the patient in the immediate increase in stay and long term health implications.

What was our target?

We set ourselves a target of not more than 5 falls per 1000 inpatient bed days.

What did we do to improve our performance?

The ward areas reviewed some key elements such as bathroom layouts and some refurbishment was undertaken to improve the safety of patients in these areas. Bay tagging was introduced to increase the staff visibility and proximity to those who were at increased risk of falling. This allowed for staff to be available to patients when they needed to mobilise as staff were immediately on hand to supervise and support those patients. An unintended consequence is that in these areas the ward environment has improved as it has come quieter and so is a calmer environment for our patients who have dementia thereby reducing their anxiety and distress.

How did we measure and monitor our performance?

This is measured monthly by the number of falls reported and the level of harm. This is monitored by ward areas and by those who have more than one fall. The monthly data is then collated into a figure per 1000 inpatient bed days.

Did we achieve our intended target?

The target was consistently met with an average figure of 4.99 for 2018/19.

How and where was progress reported?

Progress was monitored and reported monthly to the Patient Safety Committee in the Patient Safety Report. This was then amalgamated into the Board reports.

Our key achievements

We successfully reduced our number of falls consistently this year meeting the no more than 5 falls per 1000 bed days target each month and the number of falls where the patient suffered high harm this year were only 17.

Patient safety

Prevention of inpatient falls Ipswich Site

We wanted to reduce the number of falls with significant harm that occurred during inpatient stays as falling has both a physical and psychological impact on the rehabilitation and recovery process for patients.

A fall can lead to an increased length of stay and can alter the plans for discharge including the post inpatient stay discharge destination. Nationally reducing falls has shown to reduce length of stay in the older population and reduce the discharge to alternative care facilities.

What was our target?

Our aim was to reduce the number of falls with harm and increase the learning from falls to reduce the number of overall falls.

What did we do to improve our performance?

A Multidisciplinary Falls working Group was set up with a Lead Geriatrician and representation from Allied Health Professionals, Pharmacy, Matrons and Frailty Assessment Base. The group looked at the current assessment process with the aim of supporting staff to identify those at high risk on admission, this included both the admission pack and the allied health professional's assessment. Education of junior doctors included specific training around falls and of medication impact.

Purchase of new ward based equipment to support falls assessment and identification of key factors of falls, such as postural hypotension was undertaken to allow for better management. Falls training was re-introduced for new staff at induction and an e-learning package is due to be introduced for staff as part of Mandatory Training. Ward areas with a high proportion of patients at high risk used bay cohorting to reduce the falls risk whilst supporting patients to mobilise and continue with rehabilitation.

How did we measure and monitor our performance?

This is measured monthly by the number of falls reported and the level of harm suffered across all the inpatient areas.

Did we achieve our intended target?

There was a reduction in falls with high harm this year with only 21 falls classed as high harm. The falls per 1000 bed days was 7.38 for 2018/19.

How and where was progress reported?

Progress was monitored and reported monthly to the Patient Safety Committee in the Patient Safety Report. This was then amalgamated into the Board reports.

Our key achievements

We have reduced the number of falls where the patient has suffered high harm across all inpatient area. This has been particularly challenging for the community hospitals who have changed model of care to be focused on rehabilitation and mobilising. This has seen an increase in the rehabilitation of inpatients in the community hospitals, thereby successfully supporting them to return to their pre-admission place of care and reducing admissions into care homes.

Patient safety

Prevention of pressure ulcers which develop in hospital

Colchester Site

The reduction of inpatient acquired pressure ulcers remains a national priority and is a key element in keeping patients safe and harm free during their admission. Colchester had the aim to reduce the number of pressure ulcers to heels as this had been the highest proportion of damage the previous year.

What was our target?

The Trust's aim was to ensure that assessments, care and actions were taken with every patient to ensure that the risk of developing pressure damage during an inpatient stay was reduced. There were no specific numerical targets set. Nationally the guidance was that the levels of harm and full investigation of incidents to learn lessons was the priority and to ensure that all care was carried out to high standards and needs of the patient.

What did we do to improve our performance?

Specific education around pressure area care and prevention to all wards was supported by the Tissue Viability and Harm Free care Team, with a focus on elevating heels and correct moving and handling with the "Heels Up" Campaign. Early reporting of damage and support from both of these teams continued this year to reduce the risk of development of damage to those at very high risk of deterioration of those who had been admitted with pressure damage.

How did we measure and monitor our performance?

This data is collated, monitored and verified daily by the relevant clinical teams. The monthly data was collected and analysed for reporting, with weekly peer review panels for lessons learnt and Trust wide knowledge improvements.

Did we achieve our intended target?

Overall the number of patients who developed damage reduced not only to heels but to other body areas, on all wards this year, and when collated into the number of pressure ulcers per 1000 inpatient bed days supported a decrease and nationally sits in the higher performance against similar sized hospitals. The average pressure ulcer incidence was 0.4 per 1000 bed days for 2018/19.

How and where was progress reported?

Monthly reports were provided to the Patient Safety Board with reporting up to the executive level. This allowed for reports to be seen across divisions and heads of quality to support ongoing work at ward level.

Our key achievements

Reduction in pressure damage acquired during admission with a significant reduction in those who suffered heel damage. Consistent use of documentation supporting pressure area care and early support to wards to reduce the risk of damage occurring or deterioration of those admitted with pressure damage.

Patient safety

Prevention of pressure ulcers which develop in hospital Ipswich and Community Hospitals

The reduction of inpatient acquired pressure ulcers remains a national priority and is a key element in keeping patients safe and harm free during their admission.

What was our target?

The Trust's aim was to ensure that assessments, care and actions were taken with every patient to ensure that the risk of developing pressure damage during an inpatient stay was reduced. There were no specific numerical targets set. Nationally the guidance was that the levels of harm and full investigation of incidents to learn lessons, was the priority and to ensure that all care was carried out to high standards and needs of the patient.

What did we do to improve our performance?

Purchase of new equipment such as mattresses and heel protectors to increase the availability of these to our highest risk patients. There was a change in the investigation and reporting process to include a panel peer review to support lessons learned and wider trust learning. Specific education around pressure area care and prevention was supported by the Tissue Viability and Harm Free care Team, this included a specific training session on induction for all new staff. Early reporting of damage and support from both of these teams continued this year to reduce the risk of development of damage to those at very high risk of deterioration of those who had been admitted with pressure damage.

How did we measure and monitor our performance?

This data is collated, monitored and verified daily by the relevant clinical teams. The monthly data was collected and analysed for reporting, with weekly peer review panels for lessons learnt and Trust wide knowledge improvements. There was a change in reporting and increase in pressure ulcer categories from October 2018 and this has increased the incidence per 1000 bed days but the actual numbers have not increased when reviewed per patient.

Did we achieve our intended target?

Overall the number of patients who developed damage did not significantly increase this year and when collated into the number of pressure ulcers per 1000 inpatient bed days was 0.9 per 1000 bed days for 2018/19 and nationally reflects the numbers for similar sized hospitals. The change in reporting has impacted in this figure seeing an increase in the last quarter

How and where was progress reported?

Monthly reports were provided to the Patient Safety Board with reporting up to the executive level. This allowed for reports to be seen across divisions and heads of quality to support ongoing work at ward level.

Our key achievements

Increase in availability of equipment for our inpatients who are most at risk of developing pressure damage. Increase in wider staff knowledge and understanding. Increase in internal reporting of Category 1 levels of pressure ulcer (pre-ulcer damage) which has seen a positive impact in reversal of pre-damage and so prevention of damage becoming a pressure ulcer. Increase in staff supporting patient choice during stay with pressure area care and prevention by using a wider variety of resources and equipment.

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 Governance & Quality meetings, and via email for hospital areas outside the scope of the Division involved in the incident.

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. 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 xx

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

- ✓ The embedding of 'Baywatch' to ensure the safe care for patient's who are at risk of falling
- ✓ A review of the risk assessment in ED for patients presenting with Mental Health Needs
- ✓ Review of the training and provision of the PICC line service to ensure all patients have a safe insertion and all ward areas have PICC line champions to support the safer care of patients with PICC lines
- ✓ Changes to Maternity Sepsis recognition and escalation guidelines and enhanced training for all midwifery staff.

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.

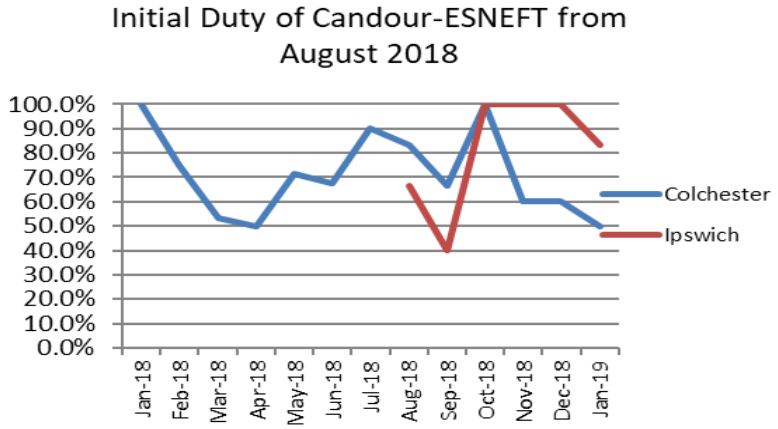
Duty of Candour ensures healthcare professionals are open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested.

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 training for Incidents, SI's and Duty of Candour;
- ✓ Root Cause Analysis Training for Serious Incident Investigators;
- ✓ 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 5— Duty of Candour compliance during 2018/19



Patient safety
Learning from incidents, SIRIs and Never Events

Table 13– Adverse events and SIRIs reported

For the year 2018,/19 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
Access, Appointment, Admission, Transfer, Discharge	1533
Abusive, violent, disruptive or self-harming behaviour	146
Accident that may result in personal injury	2342
Anaesthesia	76
Clinical assessment (investigations, images and lab tests)	1098
Consent, Confidentiality or Communication	1499
Diagnosis, failed or delayed	203
Financial loss	0
Patient Information (records, documents, test results, scans)	1200
Infrastructure or resources (staffing, facilities, environment)	586
Labour or Delivery	714
Medical device/equipment	406
Medication	1487
Implementation of care or ongoing monitoring/review	1077
Other - please specify in description	443
Security	1
Treatment, procedure	806
Totals:	**13617**

Of these, 186 were reported as Serious Incidents Requiring Investigation (SIRIs):

Type of adverse event	No. of SIRIs
Abuse/alleged abuse	1
Adverse Media Coverage/Public Concern about Organisation	1
Screening Issues Meeting SI Criteria	5
Diagnostic incident including delay meeting SI criteria	26
Infection control incident meeting SI criteria	4
Maternity/Obstetric incident meeting SI criteria (mother/baby)	9
Maternity/Obstetric incident meeting SI Criteria: Baby Only	12
Maternity/Obstetric incident meeting SI Criteria: Mother Only	2
Medication incident meeting SI criteria	7
Pressure ulcers meeting SI criteria	46
Slip/trip/fall meeting SI criteria	25
Suboptimal care of the deteriorating patient meeting SI criteria	16
Surgical/Invasive procedure incident meeting SI criteria	17
Treatment delay meeting SI criteria	15
Totals:	**186**

Patient safety
Learning from incidents, SIRIs and Never Events

Never Events at East Suffolk & North Essex NHS Foundation Trust

2016/17	2017/18	2018/19
3	3	7

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

In 2018/19 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.

- Wrong site surgery (2)
- Wrong Implant/prosthesis (2)
- Wrong site local anaesthetic block
- Wrong route administration of medication
- Retained foreign object post-procedure

The following actions have been taken to prevent recurrence:

A Never Event showcase day was held for all clinical and non-clinical staff to increase staff awareness of potential for never events and to highlight areas for improvement.

The operating list schedules have been reviewed to ensure that there is adequate time for safe effective care to be delivered by all staff involved at each stage.

The theatre management guidance and allocation of staff to cases and theatre lists have been reviewed to ensure that any changeovers to staff occur at the beginning of a case or end of a case unless there is a prolonged case or urgent situation.

The existing theatre staffing policy is under review to ensure AfPP recommendations are met as a standard

Rolling programme of theatre peer reviews across both sites (4 per month, 2 per site). Further analyses of these is requires to identify actions

Adoption of the QI methodology, identifying small changes and monitor improvements

The WHO Surgical Safety Checklist is under review to standardise and bring back to basics

Patient Safety Culture Survey is being undertaken to ascertain the underlying safety culture in theatre

Human Factors Training continues to be rolled out across all theatres.

A review of the current policies and procedures is underway to ensure staff are easily signposted to the correct policy as required.

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 2018/19 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.

Colchester Hospital's neonatal unit was one of eight in the country to achieve a high score of 88% following a national review of neonatal critical care services, while Ipswich Hospital's unit scored 81%.

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.

In addition we have established a review 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.

A priority for the medication safety agenda 18/19 was to continue the programme of work from 17/18 to decrease the potential risk of patient harm as a result of an omitted prescribed critical medicine:

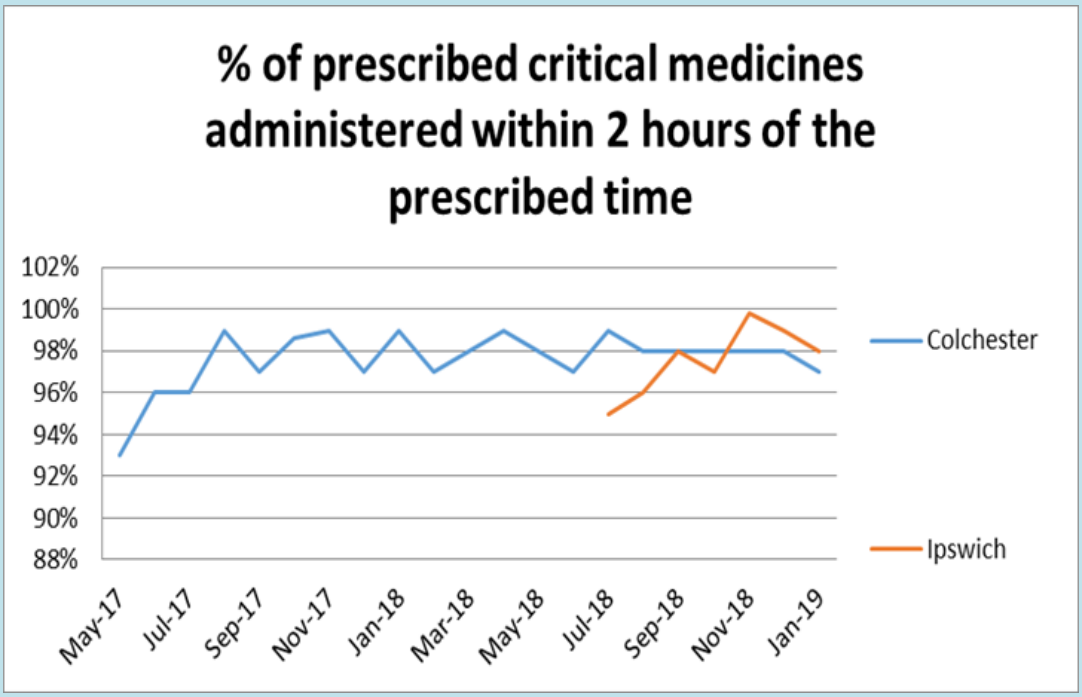
Why was this chosen as a priority?: Risks associated with the omission of medication administration are significant and have been known to cause significant harm or death in other organisations. Omitted critical medicine rates are an important metric to assess medication safety within an organisation.

How did we measure success?: A focus was put on the timely administration of prescribed critical medicines. A critical medicine is one which is known to have a high risk of harm if delayed or omitted. The pharmacy department conducts a monthly snap shot audit of 10 patients per in-patient ward area to establish the percentage of prescribed critical medicines that were administered within 2 hours of the prescribed time (unless omitted for a clinically appropriate reason).

What was our target?: The trust aims to have 100% of prescribed critical medicines administered in a timely fashion.

What actions were taken to promote timely administration of

Chart 6



Medication safety

Prevention of harm from medication

The Pharmacy team is leading a campaign from Monday, 4 March 2019 at Ipswich Hospital to promote the earlier writing of patient prescriptions, or Tablets to Take Away (TTAs).

medicines?: Audit practice was shared between the two sites to ensure a consistent methodology for monitoring adherence to standards and improvements. The Colchester site has been collecting monthly data from April 17 and the Ipswich site from July 18. The Medication Safety Committee oversaw all actions related to this priority and the action plan was discussed monthly. Communication between Sisters and Matrons and pharmacy staff has been strong with senior nursing staff regularly use the audit results to feedback to their frontline staff.

2018/19 saw both sites continue to work closely together producing joint publications which included a joint Critical Medicines List which was heavily published to frontline staff. To prevent omissions as a result of a drug being unavailable a flowchart for nursing staff on 'how to obtain medicines' was printed and placed in each clinical area with local training provided. Access to the Emergency Drug Cupboard at the Colchester site was reviewed and additional out of hours staff have been provided access to ensure timely medication retrieval. A "no blank challenge" is to be launched at the end of February to promote a zero tolerance to blank boxes against prescribed medication doses.

What was our performance: A baseline audit in May 17 at the Colchester site showed that 93% of prescribed critical medicines were administered within 2 hours of the prescribed time (unless there was a clinically appropriate reason). In July the baseline audit at Ipswich gave 95% Adherence. Colchester site remains within 97-99% adherence throughout 18/19 with Ipswich maintaining adherence within 97 – 99% since September 17.

Other key achievements in the Medicines Optimisation agenda include:

Cross site harmonisation of Pharmacy and medicines audits including the safe use of opioids and quality of prescribing.

ESNEFT Antimicrobial Stewardship has developed significant 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.

Clinical effectiveness
Stroke care Colchester Site

Specialist stroke care - the impact on recovery

By working together, using new ways of thinking and working, pooling our expertise, experience and learning, the multi-disciplinary team on the Stroke Unit has been successful in performing to high standards.

The following is a summary of some of our recent achievements.

SSNAP performance:

Since April 2016, Colchester Stroke Unit has consistently achieved the highest banding of "A" in the national stroke audit (SSNAP).

Currently the Colchester Stroke Unit holds 6th place in the National Stroke Specific National Audit Program (SSNAP) rankings. This national audit aims to improve the quality of stroke services and patient care by reviewing care against set standards. The unit held 1st place nationally in 2014; a decline in some areas of performance was noted in the winters quarters of 2014 –15 and 2015 –16. In response to this the Stroke Unit introduced a SSNAP improvement plan and since then there has been a consistent performance since 2016-2017 across the standards.

Since the introduction of SSNAP audit (July 2013), Colchester Stroke Unit has achieved the best average score in the East of England across each quarter.

SSNAP mortality:

With regard to the outcomes, stroke specific mortality for Colchester Stroke Unit as per SSNAP remains the lowest in East of England at 0.82 based on the last available data.

Falls, pressure ulcers and other metrics:

Despite the high levels of dependency post stroke and highest premorbid frailty rate in East of England, Colchester Stroke Unit has performed well in falls reduction, pressure ulcers etc. Analysis and learning from previous incidents and close working with the Falls Prevention Practitioner have identified a number of themes, enabling us to take practical actions that make a difference to patients. By embracing the practice of cohorting, actively discussing falls risks at board rounds and daily team briefs, new ways of working have become embedded in day to day activity. This has resulted in an increased awareness of falls prevention and a sustained reduction in the number of falls.

Table 14- The national stroke audit (SSNAP)

P1 16-17	P2 16-17	P3 16 -17	P1 17-18	P2 17-18	P3 17-18	Q1 18 -19	Q2 18-19
84	87	85	84	88	88	86	91

The Stroke Unit team are proud that no patients have developed a hospital acquired pressure ulcer of grade 3 or 4 in over three years. Commitment to regular checking of skin condition, position changes and good communication of patients at risk has led to this achievement.

The senior nurses on the Colchester Stroke Unit have worked hard to improve compliance with two particular metrics over the past year which had been previously consistently rated 'amber'. Dementia screening and in-patient MRSA screening have now been compliant at 100% for many months indicating embedded practice.

The Friends and Family test for Colchester Stroke Unit achieves near to a 100% positive responses each month and our Ward Clerks have ensured excellent compliant with response rates.

Training and education:

The Colchester Stroke Nursing Team is actively working with the nursing team at Ipswich Hospital Stroke Unit and have recently jointly produced a Standard Operating Procedure where Acute Stroke Nurse telephone support will be offered to the Ipswich Stroke Unit overnight whilst they have a junior workforce in place.

There is an on on-going programme of team days facilitated by our Advanced Nurse Practitioner and Clinical Skills Nurse which runs twice a year. These days are focused on improving specialist stroke knowledge and skills and completion of stroke specific competencies.

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.

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. One member of staff is being supported through her Apprentice Associate Practitioner work based learning training.

Innovation:

At Colchester Stroke Unit we have successfully created an Advanced Stroke Nurse Practitioner Role and recently recruited to the thirty hour post. The new post holder manages the Acute Stroke Nurses team and will be involved with improving specialist stroke knowledge and skills as well and learning how to facilitate clinics as a future job responsibility.

The Colchester Stroke Unit has developed and produced a bespoke mouth care assessment tool and protocol which has been adopted across the East of England with the support of the Eastern Academic Health Science Network. An e-module acts as a learning resource for new starters and is available for all the stroke unit staff in East of England.

The unit actively takes part in research trials and the stroke research nurse is based on the unit to facilitate prompt recruitment. The team also aims to implement research evidence and national guidelines promptly. Our unit

Clinical effectiveness
Stroke care Colchester Site

has an excellent track record of implementation of evidence based practices such as early mobilisation and intermittent pneumatic compression.

Research evidence shows a strong correlation between adequate hydration and nutrition and optimal recovery from stroke. As a result patients on the Stroke Unit routinely receive oral or enteral nutrition within 24 hours of admission, with nurses, dieticians and speech therapy colleagues working together to achieve this important standard. An increase in the frequency of MUST audit and an analysis of themes has allowed us to focus on this issue to ensure that MUST assessment continues to improve.

Stroke Initial Continence Assessment is consistently 100% but we need to improve compliance of Stroke Continence Integrated Care Pathway.

A Consultant/Ward Sister led daily MDT has been in place since 2010 and this has shown to improve patient flow and decrease length of stay.

The team have also focused on the environment as this has an impact on delivery and experience of care for patients and their families. We have refurbished the dining room area on the unit to give additional space for patients to socialise with families and also provide another area for group therapy sessions or self-directed therapy on most days of the week, enhancing the recovery of patients. Our OT team has developed a cognitive stimulation room and this innovative practice has been presented in the National OT conference. Our therapy team has also expanded the provision of group therapy which was also presented as brag and steal poster in National stroke conference. Other Therapy innovations and improvements have been made with the introduction of the electronic Joint Care Plan, Speech and Language Therapy using Apps on an iPads and Improvements in psychology staffing support. All the projects outlined in this report would have had a positive major impact for our patients.

The Unit has successfully implemented 7 day therapy from occupational and physiotherapy. Assessment within 72 hours of admission has consistently met a very high standard over the last three years.

We have made numerous interventions to improve direct admission of stroke patients to stroke unit within 4 hours such as enhanced presence of acute stroke nurse in the Emergency Department, direct clerking in the unit, running the stroke unit at 85% occupancy levels, identifying and transferring stroke mimics to alternative appropriate wards and reducing the length of stay. We have been achieving around 80% and continue to strive towards achieving the 90% target though the national average is only around 60% for this target.

The senior 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.

In Summary, key areas of quality improvement are:

- ✓ Focus on education and training of staff – in house sessions and regional e-module
- ✓ Implementation of advances in clinical care for e.g. mouth care, IPC, cognitive stimulation, speech therapy through IPad and improved continence management.
- ✓ Sustained SSNAP performance in top banding of A and remaining the highest performing stroke unit in East of England.
- ✓ Lowest mortality(0.82) in East of England

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.

- ✓ 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 now averages 15% across both sites.
- ✓ Ipswich have implemented a new Sepsis screening tool, and information being shared with the wider ED team to ensure learning.
- ✓ Ipswich have standardised 6 key roles to ensure effective communication between key individuals to ensure effective communication and early escalation to improve patient pathways and journeys. The roles are (ED Nurse in Charge, ED command and control consultant, Hospital Coordinator, EAU coordinator, Silver and Divisional Bed Manager
- ✓ Both sites have introduced the Floor Manager role, this is to proactively manage issues to support performance of the ED 4-hr standard by providing support to the CIC (Consultant in Charge) and NIC (Nurse in Charge) in supporting and monitoring patient flow through the A&E, escalating issues as appropriate with follow up on required actions, to ensure safe and timely provision of care.
- ✓ 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.

Clinical effectiveness
Emergency care

Table 16– Our performance over the last three years: 4 hours to discharge from Emergency Department

		201718		2018/19	
	Target	ESNEFT Performance	National Average	ESNEFT Performance	National Average
April	95.00%	89.7%	85.7%	92.8%	82.3%
May	95.00%	89.4%	84.6%	95.3%	85.1%
June	95.00%	89.7%	86.1%	94.6%	85.6%
July	95.00%	86.3%	85.5%	94.8%	83.5%
August	95.00%	89.2%	85.4%	93.7%	84.0%
September	95.00%	88.7%	84.6%	95.5%	83.0%
October	95.00%	89.3%	84.8%	95.0%	83.1%
November	95.00%	92.4%	83.0%	92.8%	81.1%
December	95.00%	87.6%	77.3%	91.2%	79.3%
January	95.00%	91.6%	77.2%	89.2%	84.4%
February	95.00%	90.9%	76.9%	90.2%	84.2%
March	95.00%	92.6%	76.4%	92.7%	86.6%
YTD	**95.00%**	89.8%	88.3%	93.5%	88.5%

Table 17– Our performance over the last three years: Emergency Department activity

Financial Year	ESNEFT Number of Attendances	ESNEFT 4 hr Performance	National 4 hr Performance
2016/17	192313	88.7%	89.1%
2017/18	240160	89.8%	88.3%
2018/19	260273	93.1%	88.0%

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?

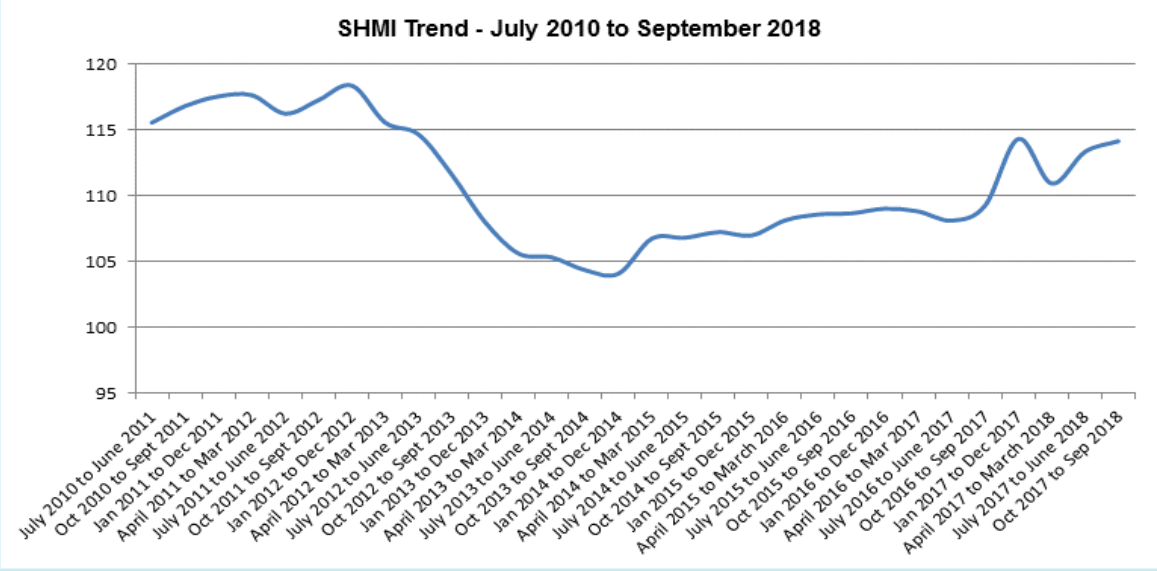
Mortality indicators show whether the number of deaths linked to a particular hospital or diagnosis group is more or less than expected, and whether that difference is statistically significant.

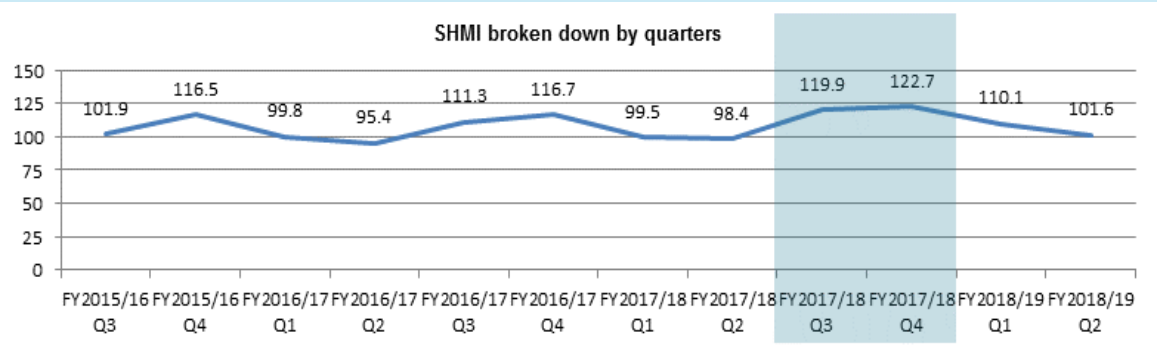
Why are mortality ratios/indicators important?

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 xx** - Mortality: SHMI trend July 2010 – September 2018*





Clinical effectiveness

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

The national benchmark for HSMR and SHMI is set at 100 - 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 2018 was 114.1, in the 'higher than 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.

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

- ✓ The data period includes one of the worst winters the Trust has experienced in terms of patient mortality, where a much larger number of patients than were statistically expected to die passed away.
- ✓ The Trust is aware that many patients with long term conditions such as lung cancer and COPD are admitted for symptom control rather than being treated in their preferred place of care.
- ✓ The Trust serves a large community of quite frail older people who are more susceptible to acute problems (e.g. infections, falls) which, when added to a host of chronic diseases results 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 can have their symptoms managed at home 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 will be 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 18- *Results summary for December 2017 - November 2018*

In-hospital mortality, for all in-patient admissions to ESNEFT for the period December 2017 to November 2018 has been reviewed. The SHMI is updated and rebased quarterly.

Metric	Result
HSMR	109.2 12 months to November within the 'higher than expected' range
HSMR position vs. East of England peers	The Trust is 1 of 5 in the peer group of 15 that sit within the 'higher than expected' range.
HSMR diagnosis groups attracting higher than expected deaths	There are 4 outlying groups attracting significantly higher than expected deaths: Acute bronchitis Relative risk 156.4 - 84 deaths, 54 expected Other gastrointestinal disorders Relative risk 151.5 - 40 deaths, 26 expected Pneumonia Relative risk 113 - 528 deaths, 466 expected Acute Cerebrovascular disease Relative risk 115.8 - 210 deaths, 181 expected
HSMR Weekday/Weekend Analysis	There is no significant difference between the weekday HSMR and weekend HSMR for emergency admissions. Both are statistically 'higher than expected'
Patient Safety Indicators (mortality metrics)	There is 1 mortality outlier for deaths in low risk groups.
SHMI (October 2017 to September 2018)	Published SHMI = 114.1 'higher than expected' (band 1) The percentage of patient deaths with palliative care coded during their admission was 2.2%

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 Frame-work.

***Chart 7**- Percentage of patients waiting over 6 weeks for a diagnostic test at month end*

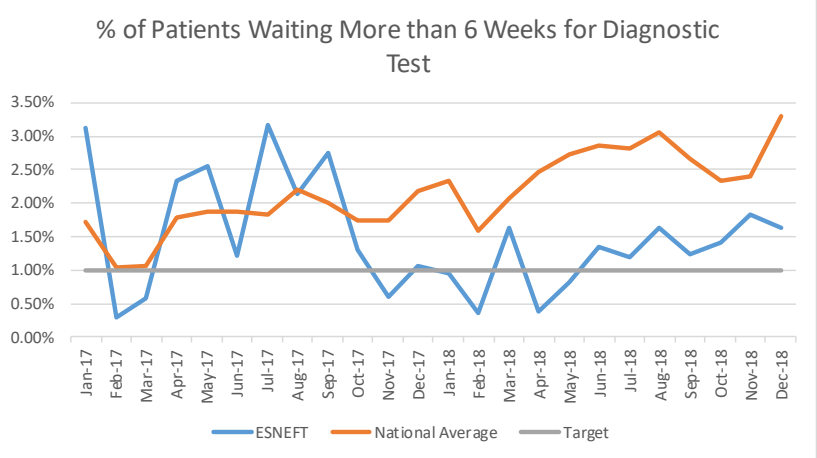


***Table 19**- Percentage of patients currently waiting under 18 weeks on an incomplete path-way*

		2017		2018	
% of Patients Waiting More than 6 Weeks for Diag-nostic Test	Target	ESNEFT Performance	National Average	ESNEFT Performance	National Average
January	1.00%	3.12%	1.73%	0.95%	2.33%
February	1.00%	0.29%	1.04%	0.36%	1.58%
March	1.00%	0.59%	1.06%	1.63%	2.07%
April	1.00%	2.34%	1.78%	0.39%	2.47%
May	1.00%	2.54%	1.87%	0.83%	2.72%
June	1.00%	1.21%	1.87%	1.36%	2.87%
July	1.00%	3.17%	1.84%	1.18%	2.83%
August	1.00%	2.14%	2.21%	1.64%	3.06%
September	1.00%	2.74%	1.99%	1.23%	2.67%
October	1.00%	1.30%	1.74%	1.42%	2.34%
November	1.00%	0.61%	1.74%	1.84%	2.41%
December	1.00%	1.07%	2.18%	1.64%	3.30%
End of Year posi-	**<1%**	**1.07%**	**2.18%**	**1.64%**	**3.30%**

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?

The process for assessing the performance against the standards has changed and the new process has used data from previous rounds of audit.

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
- ✓ Both Hospitals were below the required standard of 90% for consultant reviews within 14 hours in the last audit round. However job plans are in place to enable the target to be met.
- ✓ **Standard 5** access to diagnostic tests
- ✓ ✓The Trust achieved the overall standard required. Ipswich achieved all six standards at during both weekday and the weekends .Colchester achieved 5/6 of the targets at the weekend with only out of hours provision for echocardiography not being achieved
- ✓ **Standard 6** consultant-directed interventions
- ✓ The Trust met the overall standard achieving 9/9 of the standards at Ipswich in both weekdays and weekends. Colchester achieved 8/9 standards with interventional endoscopy only available by informal arrangement at weekends
- ✓ **Standard 8** ongoing review by a consultant
  - The trust achieved the standard of more than 90% of High dependency patients receiving twice daily at both Hospitals both during the weekday and the weekend.
  - For those patients requiring a once daily review The trust was just below the national target of 90% achieving 89% for weekdays. However at weekends Colchester achieved 59% and Ipswich 69%.

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.

Table 20- Self Assessment

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	No the intervention is only available on or off site via informal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Interventional Endoscopy is avialable on site at Ipswich Hospital, with 24/7 on call gastroenterlogy. There is interventional endoscopy available during the weekdays and weekends at Colchester but no formal out of hours rota with emergency cases being completed on informal arrangement. Extension of a formal 24/7 interventional rota across the trust is a priority for the service in the next year.Cardiac pacing is available 24/7 on site at Ipswich and with on and off site arrangements for Colchester	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

Patient experience
Improving the patient and carer experience

Patient Experience Collaborative

Ahead of the merger Colchester and Ipswich hospitals had already begun to work together to understand and improve the patient experience. As part of this joint working the hospitals joined the Patient Experience Collaborative:

What is the Collaborative?

12 trusts across the UK have come together to work with Northumbria Healthcare NHS Foundation Trust and the Patient Experience Network (PEN) for 12 months to trial the use of the Northumbria model for gathering patient experience feedback and applying quality improvement ideas and methodology.

The focus of the collaborative is to identify, develop, share and embed ideas and processes for improving patient experience, sustaining that improvement and providing a measurement framework to evidence improvement.

What is the Northumbria Model?

Real time surveying of at least 50% of patients on a ward using a set survey covering key aspects of care and experience which are considered to have the strongest relationship to patients' overall satisfaction (Picker Institute 2009).

The following are recognised as the priority areas for assessing patient experience of acute hospital inpatient care:

- ✓ Consistency and coordination of care;
- ✓ Treatment with respect and dignity;
- ✓ Involvement in decisions;
- ✓ Doctors;
- ✓ Nurses;
- ✓ Cleanliness; and
- ✓ Pain control.

Surveys, covering these areas are undertaken and reported on as close to real time as possible enabling immediate action to improve. This is then monitored over time to map and show the improvements.

A steering group oversaw the programme with a team of volunteers and members of the clinical audit team undertaking the surveys.

Six wards (3 per site) were involved:

Martlesham, Needham and Saxmundham – Ipswich

Layer Marney, Brightlingsea and Aldham – Colchester

Suffolk New College hairdressing students visit to provide hair treatments

Patient experience
Improving the patient and carer experience

Kissing it Better (KiB)

Ipswich hospital continued its partnership with KiB during 2018/19.

Kissing it Better is recognised nationally and their vision of constantly exceeding a patient's expectation of their care environment - simple ideas, small acts of kindness, harnessing the energy and goodwill of the community, mirrors the Trust's own values.

The aim is to provide a range of compassionate caring services over and above traditional healthcare. For example; music, art, theatre, reminiscence, social visiting, hairdressing, manicures, make-up etc. The services are provided in partnership with organisations such as local colleges, charities and societies. Kissing it Better allows the Trust to create a programme which sets it apart from others - with a focus on the patient as a person and the hospital being truly a part of the community.

All students conduct themselves with charm, grace and dignity. Patients respond and, time and again we see patients that had looked withdrawn, open up in their company. The students not only provide a treatment but also a welcome distraction from other worries, and it is a confidence boost for the students, many of whom are nervous about working in a hospital. Students are always accompanied by their tutors and hospital staff.

- ✓ **Better patient experience** Addresses patient needs, including emotional needs, in a holistic way, and responds to patient feedback that it is the small things which matter and make a difference. Visitors and family carers can also take part.

Ipswich Hospital Community Choir take part in supportive singing on the wards.

- ✓ **Better staff experience** Improves staff morale by enabling staff to do something with and alongside patients over and above the traditional healthcare interaction which facilitates a shared experience; enhancing empathy and compassion.
- ✓ **Better quality of care** Enhances the whole patient experience.

Who has been involved this year?

- ✓ Suffolk New College beauty therapy students visit to provide hand massage and manicures.
- ✓ Ipswich High School drama and music students sing, act and read poetry.
- ✓ Ipswich Hospital Community Choir take part in supportive singing on the wards. #suppertimesinging
- ✓ Suffolk New College hairdressing students visit to provide hair treatments.

Patient experience
Improving the patient and carer experience

Sleep well in Hospital Campaign

Patients are getting a better night's sleep after a delivery of ear plugs and eye masks at Colchester Hospital.

British Airways have provided the hospital's "Sleep Well in Hospital" campaign with eye masks – often used by customers on their flights – while Arco, who provide and sell safety wear and equipment, have donated the earplugs.

Noise and light on a ward can disturb a patient's sleep, slowing down their recovery and potentially extending their hospital stay.

Campaign lead Stephanie Ellis, from the hospital's patient experience team, acted after reviewing survey results where more than a third of patients complained about noise coming from fellow patients and staff during the night.

The campaign is part of Colchester Hospital's quality improvement programme which makes small changes to improve care.

Lead quality improvement nurse Karen Lake, said: "This is about making changes for our patients by listening to them and learning from their experiences.

"Staff from all disciplines are encouraged to get involved in making small changes to benefit the patients, their carers, staff and visitors.

The first eye masks and ear plugs were donated to Aldham Ward. Ward sister Lucy Crimmin said: "As well as the eye masks and ear plugs we also make sure our night shift staff switch off the lights in the patient bays by 10.30pm, while the corridor lights go out at 11pm.

"Only the patient safety lights in the bays, reception area, and the clean and dirty utility area are kept on overnight."

British Airways customer service manager Scott Coglan, said:

"We are delighted to support this campaign and contribute towards improving the patient experience.

"We always try to go the extra mile for our customers and the eye masks are very popular in aiding a peaceful night's sleep.

"We hope the patients reap the benefits that many of our customers do, as part of their ongoing recovery."

Mental health

People facing a mental health crisis can now receive the help and support they need in more calming surroundings at Colchester Hospital.

The new £150,000 mental health suite, within the hospital's Emergency Department, will help to make sure the patient's visit to hospital is less stressful and they are safe.

Natasha Tuck, Emergency Department matron, said

"This suite will provide calming, comfortable surroundings in which people who are facing a mental health crisis can receive the support they need."

The suite has been fitted out with specific features and furniture to keep patients and staff safe, including a video intercom and anti-ligature fittings throughout, as well as a separate discrete entrance. It also has adjustable heating, lighting and airflow to help patients to feel comfortable so incidents can be scaled down, and has been decorated in calming colours to make it relaxing.

Suites like this are a safe place where police officers can take vulnerable people who are facing a mental health crisis, or have been sectioned under the Mental Health Act. They can be assessed and given tailored help and support from mental health professionals working for North Essex Partnership NHS Trust, as well as any treatment they may need for physical health issues.

Natasha said

"It has been carefully designed to make it easy for staff to monitor patients, while also giving us the option to control the lighting, air flow and temperature to help them to relax and de-escalate.

We hope that the investment we have made will make a real difference by providing a

Patient experience
Improving the patient and carer experience

safe, calming and engaging environment for people when they are at their most vulnerable."

Although Colchester Hospital previously had an isolation room for mental health patients, it is the first time a purpose-built suite has been available at the Turner Road site.

Robots

Robots have arrived at ESNEFT and they are giving back hundreds of hours to medical secretaries so they can spend more time helping patients.

Robots have arrived at ESNEFT and they are giving back hundreds of hours to medical secretaries so they can spend more time helping patients.

The Trust is the first in the UK to use Robotic Process Automation (RPA) to support staff in their everyday roles.

Five virtual workers are now handling admin-style tasks at Ipswich Hospital, including GP referrals in Neurology. The robot monitors the electronic referral system and when a new one arrives, it gathers key clinical data and downloads several documents which it then records in Evolve ready for clinical review.

This was previously carried out by medical secretaries who had to print out all the documents, before scanning each one into Evolve – a process which could take between 10 and 20 minutes per referral.

Those secretaries now have more time to talk to patients and deal with their queries and it is a 24/7 process for the first time so referrals are also dealt with at weekends.

Deputy Director of ICT Darren Atkins said: "It's giving time back to people to allow them to do the job they are here to do, leaving the mundane work to the robots."

RPA is now being used in Cardiology, Urology, Neurology, Nephrology and Haematology – currently at Ipswich only.

Since July 23 the robots have processed 442 referrals releasing 110 hours of secretarial time, but these benefits will continue to increase as other areas of specialty, which could include Clinical Coding, HR Processes, and Service Desks, are added to the programme.

Tasks or processes suited for automation are:

Repetitive
Involve a high number of transactions
Time consuming
Require very little decision making
Require no human interaction
Remember, automation can be applied to a part of a larger end-to-end process to make time matter.

The robotics team will be happy to run an interactive automation opportunity workshop for your team to introduce you to the technology and help you identify automation opportunities.

Nutrition

Consultant gastroenterologist Dr Louise Scovell and nutrition nurse specialist Dawn Bromley held a community nutrition education session in the Post Graduate Lecture Theatre in Ipswich on Tuesday.

Consultant gastroenterologist Dr Louise Scovell and nutrition nurse specialist Dawn Bromley held a community nutrition education session in the Post Graduate Lecture Theatre in Ipswich on Tuesday.

Targeted at clinical staff from community nursing homes and care homes, the event focused on Percutaneous endoscopic gastrostomy (PEG) feeding tubes, PEG management and Buried Bumper Syndrome (BBS).

This was the first time such a holistic-based event had been held for community staff and was designed to educate and help to reduce the risk of problems and preventable hospital admissions – keeping patients in their own home.

Neonates

Neonatal Unit teams at East Suffolk and North Essex NHS **Foundation Trust (ESNEFT) have been praised in new reports* for the care they give to babies.**

Colchester Hospital's neonatal unit was one of eight to achieve the highest score of 88% following a national review of neonatal critical care services, while Ipswich Hospital scored 81%.

Inspectors visited the units to assess whether the teams

Patient experience
Improving the patient and carer experience

were meeting clinical indicators and guidelines, which include adequate staffing levels, ensuring correct referral pathways are in place and specific, key roles such as lead neonatologist, pharmacist, lead sister and dietician are filled, to make sure they are providing the right level of care for patients and their families.

Dr Andrea Turner, clinical director for Children's Services at ESNEFT, said:

"Though both neonatal units are performing extremely well, our teams continue to work hard to improve our services and further improve the outcomes for babies requiring neonatal critical care."

Colchester and Ipswich are level two local neonatal units. They treat, manage and stabilise the sick newborn baby. They work within the East of England Neonatal Network and transfer extreme preterm babies, or very unwell full term babies, to the level three neonatal intensive care units at Addenbrookes and Norfolk and Norwich hospitals.

Karen Moss, Neonatal Unit sister at Colchester Hospital, said:

"We're overjoyed to achieve this status and credit to all the team for that. We're a progressive team and we are looking towards continuing to help parents and improve the patient experience."

Environment

Somersham Ward refurbishment

Somersham Ward nurses at Ipswich Hospital were on hand to cut the ribbon at the unit after an extensive refurbishment. The new ward, where patients with cancer are cared for, includes sky lighting and features to make the environment dementia friendly.

Cancer Centre development

Gainsborough Wing.

Patients can now experience a brighter outlook while they wait for appointments on Gainsborough Wing.

Artwork which previously hung in the corridors of Essex County Hospital for about 20 years has been given a new home at Colchester Hospital.

Lorraine Presland, ward clerk for Gainsborough Clinics, remembered the work was at the Lexden Road site as she knows the artists who put the collection together and didn't want it to be lost when the hospital closed its doors in November.

Lorraine spoke to Gainsborough Wing sister Sue Warner who was keen for the work to be moved to the Turner Road site to brighten up the walls and take patients' minds off why they are in hospital.

Lorraine, who was on a ceramics course at Colchester Institute while the artists were doing an art foundation course in the late nineties, said: "I thought I better rescue it before it disappeared.

"It's nice for the girls to keep it (the collection) together and that it's here brightening it up."

Sue said: "Although we have been in our new setting for over a year now, the corridors and waiting room walls remained bare. The kind donation and relocation of the artwork from Essex County Hospital has enhanced our working environment and we have received positive comments from patients and visitors to the department as well."

ICU group

People recovering from time spent in intensive care at Ipswich Hospital can share their experiences, thoughts and fears at a new, monthly support group.

ICU (Intensive Care Unit) Steps is held on the first Wednesday of every month at Bluebird Lodge in Ipswich, between 6pm and 8pm, and brings together patients from all walks of life.

Led by nurses Claire Gray and Tamasin King, the informal, confidential group is open for people to come and go as they please and share as much or as little information as they like.

Jonathan Jenkyn, 42, from Ipswich, who spent time in intensive care three years ago after suffering a cardiac arrest in his sleep, said: "It is comforting to hear that other people have gone through similar experiences and to understand how their life has changed as a result of being in intensive care.

"We are part of an eco-system so listening to how other people's families have recovered

Patient experience
Improving the patient and carer experience

from such trauma too and being able to impart some of those stories and lessons on to my family is really valuable.

“You don’t have to say much, just listen. I am happy to talk about my entire experience but other people just like to listen and that is OK and can be part of the healing process as well.

“You can share as much or as little as you want with the group, everything is completely confidential, and we are happy to talk about things in a very candid, sympathetic way.”

Fellow member Ian Mackay, 62, from Stowmarket, who spent time in intensive care after collapsing in March last year, said: “I have found ICU steps very interesting, it has helped me along the way and has allowed me to understand more what was happening to me in hospital by listening to other people’s experiences.

“If you have spent time in intensive care please come along for a free cup of tea and a biscuit. It will start to make your life an awful lot easier by understanding what other people have gone through. You are not on your own.”

Tamasin King said: “Up to a couple of years ago there was no real follow-up for people after they had been discharged from intensive care and many patients can leave with ongoing psychological issues, so we looked at how we could help them post-discharge.

“I would like people to have more access to rehabilitation psychologically – it’s a huge problem among survivors of a critical illness and hopefully attending ICU Steps can lessen the burden that some people may have long-term.”

Claire Gray said: “I don’t think there is any better way to get support than from listening to someone who has gone through a similar experience.”

Following the group's success at Colchester, a Blanketeers group has been set up at Ipswich Hospital.

The newly established group met for the first time on Saturday, 16 February.

Members knit and crochet blankets for patients who are receiving end of life care and their families.

Michelle Biggins, deputy head of Infection Prevention and Control at ESNEFT, is a member of Colchester's Blanketeers and helped to set up the Ipswich group.

She said: "These blankets will be used for comfort when patients are at the end of their lives. The offer of a homemade blanket 'knitted with love' at a time of great sadness, can make all the difference for a family.

LD & Autism

East Suffolk and North Essex NHS Foundation Trust's (ESNEFT) Reasonable Adjustment Tool

Launched at Colchester & re-launched at Ipswich

Patient experience
Improving the patient and carer experience

In 2018 IHUG underwent a process of restructure. One of the big changes is the way people join IHUG; going from a system where the chair or a rep from each user group automatically takes a place on IHUG, to a recruitment process where by people can apply to join IHUG as long as they are a patient or carer. This will allow IHUG to take on people with particular skill sets and expertise in areas we don't currently have.

IHUG hosted two celebration of user groups events, the first time that members of all the user groups had been invited to attend an event together. On April 20th our guest speaker was Neill Maloney, who spoke about the merger and alliance working and took questions from the floor.

The second workshop was held in October. Our guest speaker was Lucy Watts MBE, who gave an incredibly uplifting, passionate and thought provoking presentation of her work. Lucy works tirelessly on behalf of patients who have disabilities, young people's services, improving palliative care and many more but one of Lucy's biggest passions is helping to improve the transition from children to adult services.

Members continue to sit on a variety of committees and groups, including End of Life, PEG, Commendations awards panel, Medication Safety Committee, SPACE, buggy group, transport group, nutrition & hydration, infection control, PLACE and caring for carers.

Members take part in Adopt a Ward, where we chat to patients, relatives and carers on some of the wards and departments. We spend as much time as we need chatting to find out how the patient experience has been and by weaving certain questions into the conversation, we gain lots of 'soft intelligence' which is given via a report to the ward sister, matron and the patient experience team.

One area where IHUG has been particularly busy has been in the Sim Centre, we have taken part in Human Factors, REACT and GP training courses and Bleep Week where 100 scenarios took place in 4 days.

Several members took part in the annual PLACE audit, one member sat on the Local Clinical Excellence awards panel, the UOS and UOE have contacted IHUG to see how we can work together, members have either already completed or are signed up to undertake the QI silver level training and carried out surveys as and when required.

IHUG celebration of user groups event April 2018

Patient experience
Improving the patient and carer experience

The second IHUG workshop held in October. Guest speaker Lucy Watts MBE

Colchester hospital now has its own Hospital User Group; formed in the late summer of 2018 the group now comprises 11 members and have recently elected their first Chair and Vice Chair. The group have already had the privilege to be involved in reviewing plans for the 'front door' of Colchester hospital as planning gained approval to move forward with enhancing the environment for all visitors, patients and staff.

The group will mirror IHUG in terms of getting involved with ward visits, QI projects and ensuring the patient and carer voice is represented on key committees and groups across Colchester and the whole of ESNEFT.

Young People's Takeover Day

About 100 pupils from schools in North Essex and East Suffolk took part in Takeover Challenge Day at Colchester and Ipswich hospitals in November 2018.

The day is a chance for the youngsters to get a glimpse of hospital life, allowing them access to different departments such as the pathology lab and the operations centre.

They were also encouraged to be innovative – using their experience of modern technology to come up with ideas that could improve the way we work, while embracing ESNEFT's Time

Caring for Carers
Ipswich

Suffolk Family Carers were able to increase the number of support workers at Ipswich during the year - Debbie Reeve and Mandy King were joined by Jacqui Cawkwell East. They walk the wards each day in search of family carers or patients themselves who may be family carers, who might need help. The team provide awareness raising and education opportunities for staff both 1:1 and on the wards.

SFC also provided a young carers information stand along with a visit from their bus for Carers' Rights Day in November 2017 and for Young Carers Day in January 2018.

497 family carers have been supported directly by Debbie and Mandy during the year.

708 people have visited the Carers Cabin over the year.
Carer Friendly Awards
Suffolk family Carers were again able to award Ipswich Hospital with a 'silver' award for its carer friendly policies, processes and support. Individual areas also received awards:
Brantham, Capel, Constable Suite, Lavenham, Outpatients, Somersham, Stowupland, Stradbroke

HSJ Awards

Ipswich Hospital Caring for Carers work was recognised at a national level as finalists in the prestigious HSJ Awards.

Colchester

A Caring for Carers Group was formed bringing together key staff and partner organisations to work together to improve the experience for family carers using Colchester hospital.

During the year the organisation delivering on site support and signposting services for carers changed from Action for Family Carers Essex to Carers First Essex. This meant that there was a brief period where a support worker was unavailable however Carers' First were successful in appointing to the role and Pippa Richard has been in post for the last few months; she has seen over 70 people since starting. The group has worked on a Carers' Handbook and badge to mirror that at Ipswich hospital and it is planned to create a Carers' Cabin facility on the hospital site in the coming year.

Carers Week

Carers Week is an annual campaign held in June to raise awareness of caring, highlight the challenges carers face, and recognise the contribution they make to families and communities throughout the UK. The campaign is brought to life by thousands of individuals and organisations who come together to organise activities and events throughout the UK, drawing attention to just how important caring is.
This year there were activities across ESNEFT

Patient experience
Caring for people with dementia

There are currently 850,000 people in the UK living with dementia, and the number is set to double in the next 25 years. There are 40,000 people under 65 years of age. At the end of 2017 the National Office of Statistics reported that dementia had become the UK's biggest killer, overtaking heart disease, and the cost of dementia to the UK economy is 26bn/year.
Episodes of hospitalisation can be very frightening and distressing for a person with dementia or a cognitive impairment particularly if they are unable to understand where they are and why they have been admitted. This can lead to increased confusion, disorientation, high levels of anxiety and deconditioning all of which can reduce confidence, well -being and independence. All of these things also impact on those closest to the patient and add to carer stress. The dementia friendly refurbishments that have been undertaken in areas on both sites have helped to reduce some of the negative impacts that a hospital environment might have on a person with dementia.
Colchester Hospital has been implementing a 3 year Dementia Strategy, and Ipswich Hospital have been working under their Dementia Care Policy. All of this work aligns to the National Strategies for the improvement of dementia care across care sectors e.g. . The Prime Minister's Challenge on Dementia 2020 and Dementia: Applying All Our Health. Both hospitals partner with other key stakeholders using patient centred approaches to care planning and delivery through multi-disciplinary working and the Admiral Nurses on both sites are working to support staff on the frontline by delivering quality training that aligns to Health Education England recommendations.
The Admiral Nurses recognise that dementia affects the whole family, so support is offered not just to the patient but to those who care for that person. This might include signposting to other support services, palliative or end of life support, advice about difficult situations, advice about looking after the carer's own well-being, and giving information about all aspects of dementia. Support is also offered to any member of staff experiencing dementia in their own family.
Colchester Hospital has a care support and assessment coordinator from Carer's First, based on site from Monday to Friday. She can offer support and advice to any carers, and can then make onward referrals for continued support in the community.
Ipswich Hospital works closely with Suffolk Family Carers. There is an office on site and staff can make referrals for any carer who needs support, advice and help. The support can then be ongoing in the community once the patient has been discharged. There is a Carer's Cabin manned by volunteers and supplied with tea and coffee by the Co-operative Society where a person can access a free cuppa, advice, helpful literature, a listening ear or just a place to get away from it all.
Both hospital sites are fully committed to supporting John's Campaign, supporting named carers to be as involved in the care of their relative as they wish. This includes facilitating staying with their loved one overnight, and both sites have recently invested in recliner chairs/ beds to allow for this.
ESNEFT can now boast that it has 3 Admiral Nurses , two working at Colchester Hospital and one at Ipswich following the role conversion of the Practice Development Nurse for Dementia at Ipswich to Admiral Nurse in December 2018. At the time of writing there are only 21 Admiral Nurses working in the NHS acute sector so this is something to be really proud of. Admiral nurses offer specialist care and support, building therapeutic relationships with patients and families experiencing dementia.
Governance and reporting
Quarterly reports are prepared and submitted to the Dementia Management Group which is chaired by the clinical lead and the deputy chair is the Head of Safeguarding.

ESNEFT meets its responsibility under national reporting requirements for dementia and is consistently above the targets set for the FAIR (Find/Assess/ Investigate/Refer) pathway. All people over 75 years of age coming into hospital as emergency admissions and without an existing diagnosis of dementia are assessed to see if they have any problems with their memory, or other symptoms of cognitive decline. If there are concerns, the person will be offered the opportunity of further investigation and referred for follow-up appropriately.

Having completed the role conversion from practice development nurse to Admiral Nurse at Ipswich Hospital, there are now 3 ESNEFT Admiral Nurses bringing specialist support and care to patients and families living with dementia. They are in turn supported by Dementia UK (a leading dementia charity) to develop within this role, and they work to raise the profile of dementia across the Trust and beyond. They engage with other local dementia initiatives, such as the Dementia Action Alliances, EPUT (Col) and Dementia Together (Ips). The ANs attend regular professional development days hosted by Dementia UK and have opportunities to engage with ANs across the region to learn together in order to deliver up-to-date, evidence based care and to share best practice innovations.

Training: supporting staff in the organisation

Investing in staff training is a key priority and the Admiral Nurses provide a range of training to support staff at all levels. From advanced dementia workshops to bespoke training in a given clinical area, supporting best practice is one of the 6 competencies that ANs work to. Apart from formal training (aligned to HEE recommendations) the ANs take opportunities to teach as they arise

Patient experience
Caring for people with dementia

on when they are out and about in the hospitals. Training always emphasises the importance of a biopsychosocial, person-centred, multi-disciplinary approach to care and care planning whilst seeing the person with dementia in the wider social context of their family and underlining the importance of empathy to give insight into the impact that dementia can have on everyone involved.
Evaluation of the training has been extremely positive on both sites and feedback demonstrates that learners feel more confident and equipped to deliver quality dementia care.
In addition to Tier One and Tier Two training for all staff, the Admiral Nurses at Colchester Hospital currently provide bespoke sessions of dementia and delirium for medical staff, overseas nurses, preceptors and volunteers at the hospital.

At Ipswich Hospital, in addition to workshops the AN delivers Alzheimer Society Dementia Friends (DF) sessions to all students coming in from local schools/colleges under the Kissing it Better or work experience programmes. DF sessions are also available for non-clinical staff and support teams, for example Red Cross workers and our volunteer fidget quilters. Working alongside the education team, training is given at forums for Suffolk University students currently on placements, and to all new overseas nurses taking up employment.

Whilst Admiral Nursing is now established and proving to be invaluable at Colchester Hospital, work is underway with a Dementia UK Consultant Admiral Nurse to develop the role on the Ipswich site and to

Whether standing in a classroom teaching, holding the hand of a person who is dying, giving advice to a carer who is struggling, or working alongside the multi-disciplinary team to bring about best outcomes, the ESNEFT Admiral Nurses are passionate about supporting the patient, the family and the teams who deliver care within the Trust.

Lara's knitting squad goals

Therapeutic radiographer Lara Burgess, pictured, has enlisted the help of radiotherapy patients and their loved-ones to help her knit fidget quilts for people living with dementia.

Patient experience
Measuring and reporting the patient experience

Care Quality Commission National Patient Surveys

Care Quality Commission National Patient Surveys Patients are asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS Trust is given a score out of 10 for each question (the higher the score the better). The question scores presented here have been rounded up or down to a whole number.

Each Trust also receives a rating of 'Above', 'Average' or 'Below'. Above (Better): the Trust is better for that particular question than most other trusts that took part in the survey. Average (About the same): the trust is performing about the same for that particular question as most other trusts that took part in the survey. Below (Worse): the trust did not perform as well for that particular question as most other trusts that took part in the survey.

Where there is no section score ('overall score unavailable'), this is because one or more questions are missing from that section ('score unavailable'). This means that no section score can be given.

There is no single overall rating for each NHS trust. This would be misleading as the survey assesses a number of different aspects of people's experiences (such as care received from doctors and nurses, tests, views on the hospital environment e.g. cleanliness) and performance varies across these different aspects.

The structure of the questionnaires mean that there are a different number of questions in each section. This means that it is not possible to compare trusts overall. Full reports can be found at www.cqc.org.uk/provider/RGQ/surveys

Maternity Survey 2018

From the Picker, November 2018, Maternity Survey, 295 women were invited and eligible to complete the survey.

Response rate was 32%, which was the same as last year.

From the Colchester site, we had 2 areas which were recorded as requiring improvement:

B4. 77% for the Colchester site, against an average of 86%, of those Trusts who were surveyed: 'That women were offered choice of where to have their baby' – on the action plan, we are currently registering amber, on this but aim to blue by 31.10.19. The Local Maternity System Board has just purchased 'Baby and Me' app, where women will be shown in detail the choices available to them across all 3 sites within the LMS, and within each site the choices i.e. home, MLU, Consultant Unit or Standalone Midwifery Unit where available.

B12. 84% for the Colchester site, against the average of 92% of those Trusts which were surveyed: 'That the woman has been asked about her emotional wellbeing during the antenatal period'. This is recorded as blue, as this a mandatory field in the Medway Maternity System which must be completed at the booking history. Reports are available from the Medway system.

Patient experience
Measuring and reporting the patient experience

Table 21 *– Based on patients' responses to the National Maternity Survey, this is how* ***Ipswich Hospital*** *compares with other Trusts*

Labour and birth	9.0 /10	
Staff during labour and birth	8.8 /10	
Care in hospital after birth	7.9 /10	

Table 22*– Based on patients' responses to the National Maternity Survey, this is how* ***Colchester Hospital*** *compares with other Trusts*

Labour and birth	8.8 /10	
Staff during labour and birth	9.0 /10	
Care in hospital after birth	8.2 /10	

Patient experience
Measuring and reporting the patient experience

The results from the Care Quality Commission Survey of inpatient experiences of acute trusts 2018 are due to be published in June 2019

The full report can be found at

www.cqc.org.uk/provider/RGQ/surveys

Table 23– *Based on patients' responses to the National Inpatient Survey, this is how ESNEFT compares with other Trusts* (Not yet published)

The Emergency/A&E Department (answered by emergency patients only)	/ 10	WORSE ABOUT THE SAME BETTER
Waiting lists and planned admissions (answered by patients referred to hospital)	/ 10	WORSE ABOUT THE SAME BETTER
Waiting to get a bed on a ward	/ 10	WORSE ABOUT THE SAME BETTER
The hospital and ward	/ 10	WORSE ABOUT THE SAME BETTER
Doctors	/ 10	WORSE ABOUT THE SAME BETTER
Nurses	/ 10	WORSE ABOUT THE SAME BETTER
Care and treatment	/ 10	WORSE ABOUT THE SAME BETTER
Operations and procedures (answered by patients who had an operation or procedure)	/ 10	WORSE ABOUT THE SAME BETTER
Leaving hospital	/ 10	WORSE ABOUT THE SAME BETTER
Overall views of care and services	/ 10	WORSE ABOUT THE SAME BETTER
Overall experience	/ 10	WORSE ABOUT THE SAME BETTER

Patient experience
Measuring and reporting the patient experience

Friends and Family Test (Patient)

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 Divisional 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 24– *Friends and Family Test Data April 2018 to March 2019*

		Merged Internal Da-			Taken from NHS FFT Archive								
		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
A&E	Recommender	85.82%	87.58%	86.48%	84.04%	82.49%	82.98%	84.19%	80.47%	82.61%	85.04%	79.70%	81.00%
	Responder	16.65%	15.87%	16.40%	17.20%	15.27%	13.95%	14.91%	16.51%	13.70%	13.40%	14.00%	N/A
Inpatient	Recommender	97.78%	97.54%	97.88%	97.51%	96.96%	96.98%	96.92%	97.12%	97.04%	96.70%	97.92%	97.26%
	Responder	31.26%	39.33%	43.05%	37.64%	34.14%	36.34%	35.58%	35.45%	33.10%	32.00%	27.40%	N/A
Outpatient	Recommender	97.89%	97.65%	96.61%	97.94%	96.95%	97.44%	96.96%	96.64%	97.00%	96.57%	97.17%	98.26%
Birth	Recommender	98.65%	95.92%	99.19%	100.00%	98.24%	98.12%	98.70%	98.40%	98.50%	99.39%	99.09%	99.30%
	Responder	51.37%	44.09%	37.91%	41.71%	33.33%	26.75%	40.95%	32.00%	31.10%	55.30%	21.00%	N/A
Antena-	Recom-	96.7	98.0	95.3	96.38	96.8	95.4	97.0	97.4	96.29	99.24	100.0	98.3
Post	Recom-	98.2	95.9	97.0	96.87	95.5	96.8	98.1	96.3	95.80	97.88	96.09	95.1
Post Com	Recommender	96.81%	98.85%	99.25%	96.89%	94.26%	96.12%	98.59%	99.41%	100.00%	100.00%	100.00%	100.00%

Patient experience
Patient and public involvement, community engagement and patient feedback

Plaudits

Plaudits are patient/carers/ family members way of expressing their praise for either individuals 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)
- ✓ comments boxes within the hospitals and listening events.

Ipswich only started to record plaudits after the merger in July 2018.

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 led assessments of the care environment (PLACE)
- ✓ patient advice and liaison service (PALS)
- ✓ Inspections
- ✓ Learning from complaints.

User groups support staff in the trust will not only bringing the patient, carer relative voice but also 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 both sites, Colchester and Ipswich

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

Table 25 *— Number of plaudits received by East Suffolk and North Essex NHS Foundation Trust during 2018//2019*

Month	Plaudits received	Additional Info
Apr-18	938	Colchester Only
May-18	1103	Colchester Only
Jun-18	1189	Colchester Only
Jul-18	989	Colchester Only
Aug-18	958	Colchester Only
Sep-18	1416	ESNEFT
Oct-18	1616	ESNEFT
Nov-18	2160	ESNEFT
Dec-18	4575	ESNEFT
Jan-19	1726	ESNEFT
Feb-19	1490	ESNEFT
Mar-19	1426	ESNEFT
Total Plaudits for 2018/2019	19586	

Patient experience
Patient and public involvement, community engagement and patient feedback

A patient 'You said, We did' poster

You Said	We Did
It is difficult to move around in the bathrooms, could handrails be installed to make this easier	Handrails will be included in the refurbishment program for Somersham ward
It would be really good to put lockers in the changing area in the hydrotherapy pool	We have put new lockers into the changing cubicles.
Toilets in Outpatients are looking very tired	Some of the toilets have been refurbished with colours to aid visually impaired.
Seats in A&E are split and don't give much privacy	We have purchased new chairs with higher backs and arms which allow for more privacy and for patients to get out of easier.
Public Toilets are not very dementia friendly	Were possible we have changed seats and other fittings to be more dementia friendly.
Examination couches are in need of repair	Some new couches have been ordered.

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, telephone call or a face to face meeting.

This year 90% 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 2018/19 59 (8.8%) of the complaints received were 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.

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

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)

During 2018/19 9 complaints were investigated by the PHSO as the complainant was unhappy with the response received from the Trust.

During this reporting period 9 cases are still being investigated. 2 cases were not upheld, 1 case was partially upheld and no 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.

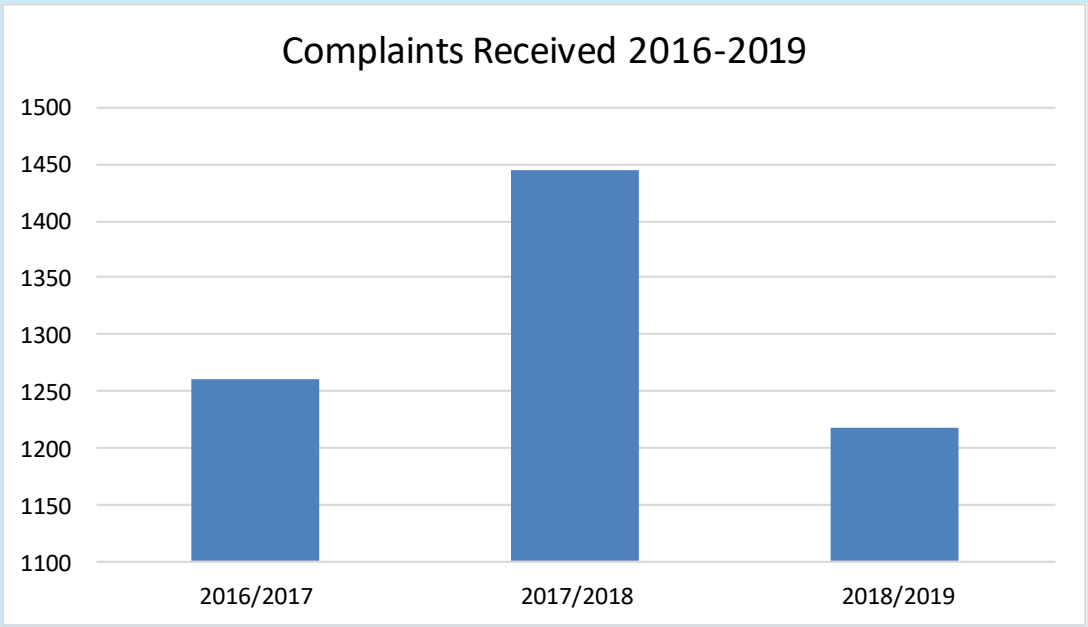
It is acknowledged that there needs to be further Trust wide improvement in identifying, reporting and sharing lessons learned and actions taken from complaints.

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,

Chart 8 *– Our performance over the last three years:*



Patient experience
Learning from complaints

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

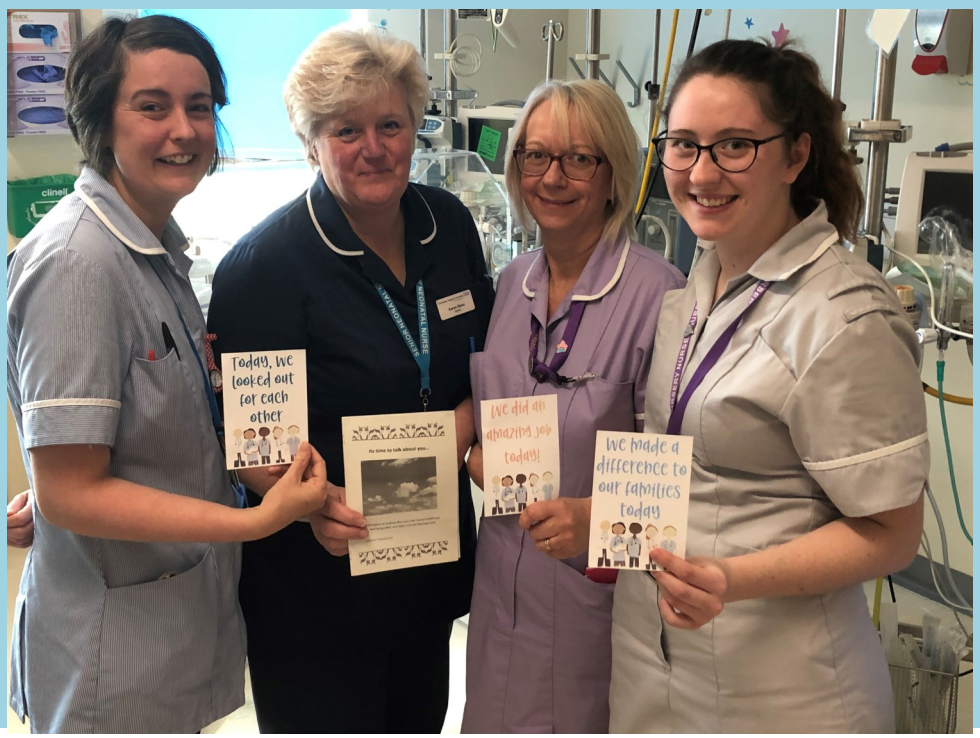
for inpatients and their families, waiting list enquiries and appointment enquiries.

Table xx—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		
2016/17	**2017/18**	**2018/19**
Attitude of staff/ Elements of Treatment	Attitude of staff/ Elements of Treatment	Elements of treatment
Elements of treatment/ Aspects of Care	Elements of treatment/ Attitude of Staff	Communication
Discharge/Attitude of Staff	**Discharge/Aspects of Care**	Aspects of Care

ESNEFT colleagues are giving extra mental health support to parents that have a baby on our Neonatal Units (NNUs) at Colchester and Ipswich hospitals.

As part of Neonatal Mental Health Awareness Week, staff at Colchester, led by Neonatal nurse Charlotte Younger, have launched a weekly coffee morning for parents to discuss their worries. Staff will also sit down individually with parents to check their state of mind.



Patient experience
Learning from complaints

***Chart 9**- PALS Queries April 2018 until March 2019*

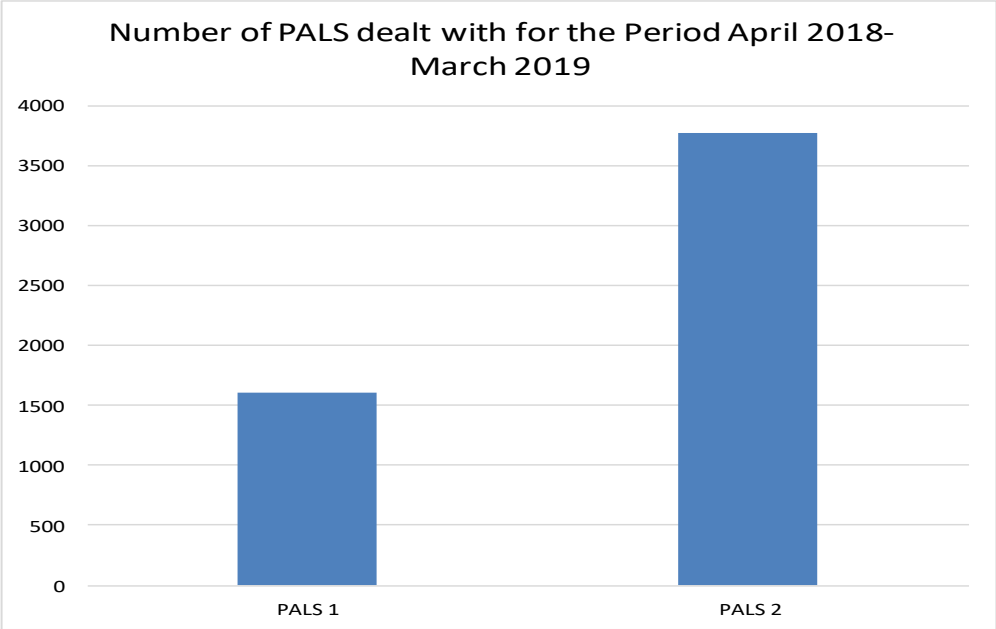
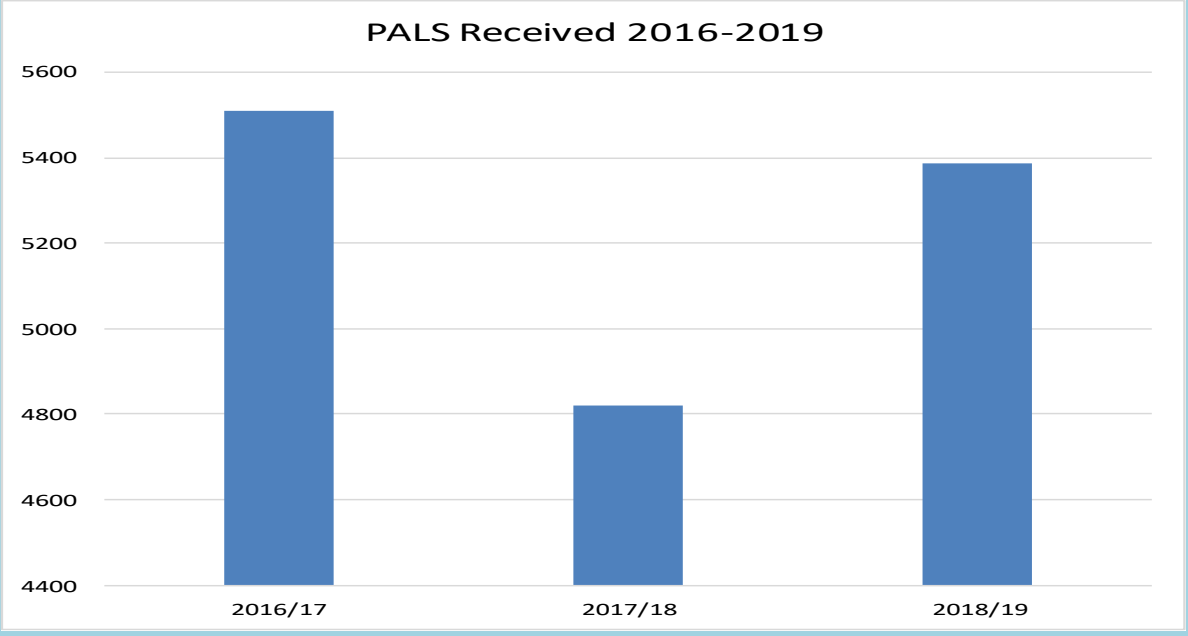


***Chart 10**- PALS Queries received for the last 3 years*



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) assessments which were carried out between 2000- 2012, and were also a self-assessment. The difference between PLACE and PEAT is that PLACE assessments are 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.

N.B. It should be noted that PLACE assessments do not focus on clinical care.

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 2018 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 as well as 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 2018 assessments the teams were usually made up of two or three patients assessors, a 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 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

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

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.

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 weeks notice by the Health and Social Care Information Centre (HSCIC) of the specified timeframe during which their PLACE assessment must occur. In 2018, this changed and Trusts were able to decide when the assessments would be carried out between February and the end of May. As the regime previously used at Colchester (assessing over a two week period with two assessments taking place in the morning, taking in food audits at lunchtime, and two assessments in the afternoon/early evening to take in supper service) was considered to be more 'user friendly' for Patient Assessors, , a decision was made to adopt this format at Ipswich, as it was felt that as the merger of the two Trust was imminent, joint working was a pragmatic route to take, however it should be noted that no cross site assessing occurred.

Following on from the assessments, the PLACE process requires organisations to respond formally to their assessments and develop plans for improvement. Going forward ESNEFT will have a single PLACE action plan which will be reviewed on a quarterly basis.

Areas assessed in 2018
The following areas were assessed in 2018:

Colchester:
- ✓ Wards - Aldham, Darcy, Children, Peldon, Birch, Langham, Brightlingsea, Layer Marney, Wivenhoe, Stanway, Lexdon, Acute Cardiac Unit, West Bergholt
- ✓ Departments - Gainsborough Clinics, Breast Clinics, X-Ray Department, Surgical Assessment Unit, Turner Diagnostic Centre, Main Outpatients Department,
- ✓ Food - Peldon, Darcy, Childrens, Aldham

Ipswich:
- ✓ Wards - Bergholt, Brantham, Deben, Grundisburgh, Kirton, Lavenham, Needham, Saxmundam, Somersham, Stowupland
- ✓ Departments - Ante natal/ Gynae, Childrens Outpatients, Clinic E, Diagnostic Imaging, Endoscopy, Frailty Assessment Unit, Heart centre, Oncology Day Unit, Raedwald Day Surgery, Urology
- ✓ Food - Brantham, Deben, Kirton, Saxmundham, Somersham

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

General areas (compulsory assessment every year for acute hospital)

- ✓ Emergency Department
- ✓ Communal areas inside the hospital building, i.e. corridors, public toilets, reception
- ✓ External grounds

Results of the PLACE assessments

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

- ✓ Continue to refurbish wards/departments/sites to ensure that the environment is bright and welcoming for patients and hospital visitors
- ✓ Provide day rooms/social space on wards that are appropriately furnished
- ✓ Extend the 'dementia friendly' ward and department programme
- ✓ Ensure that internal and external signage is relevant and correctly placed
- ✓ Make finger foods available for specific groups of patients
- ✓ Ensure patients have access to a lockable storage space

The results of the PLACE assessments were submitted in May 2018 and published in August 2018. 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 comparison in the scores achieved by the various sites in 2017 and 2018.

Table 26 - PLACE Overall Scores with the 2018 national average and the overall score achieved by ESNEFT hospital sites in 2018

PLACE CRITERIA	Cleanliness	Food and Hydration	Privacy and Dignity	Condition, Appearance & Maintenance	Dementia	Disability
National Average	98.5%	90.2%	84.2%	94.3%	78.9%	84.2%
Colchester Hospital	99.9%	90.5%	87.6%	97.3%	82.2%	89.4%
Ipswich Hospital	97.0%	86.7%	77.3%	82.3%	67.4%	78.0%
Bluebird Lodge	93.3%	91.0%	64.7%	72.1%	66.1%	69.8%
Felixstowe	96.8%	82.4%	65.5%	80.0%	77.0%	79.3%
Aldeburgh	96.8%	90.8%	77.5%	76.6%	83.1%	86.5%

Patient experience

Patient-Led Assessment of the Care Environment (PLACE)

Chart 11

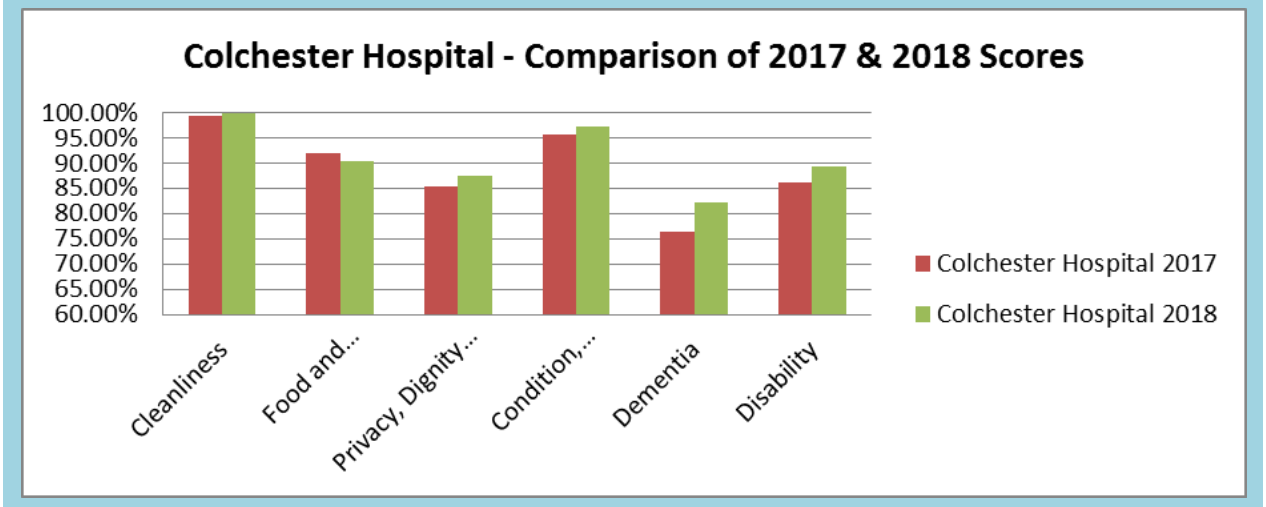
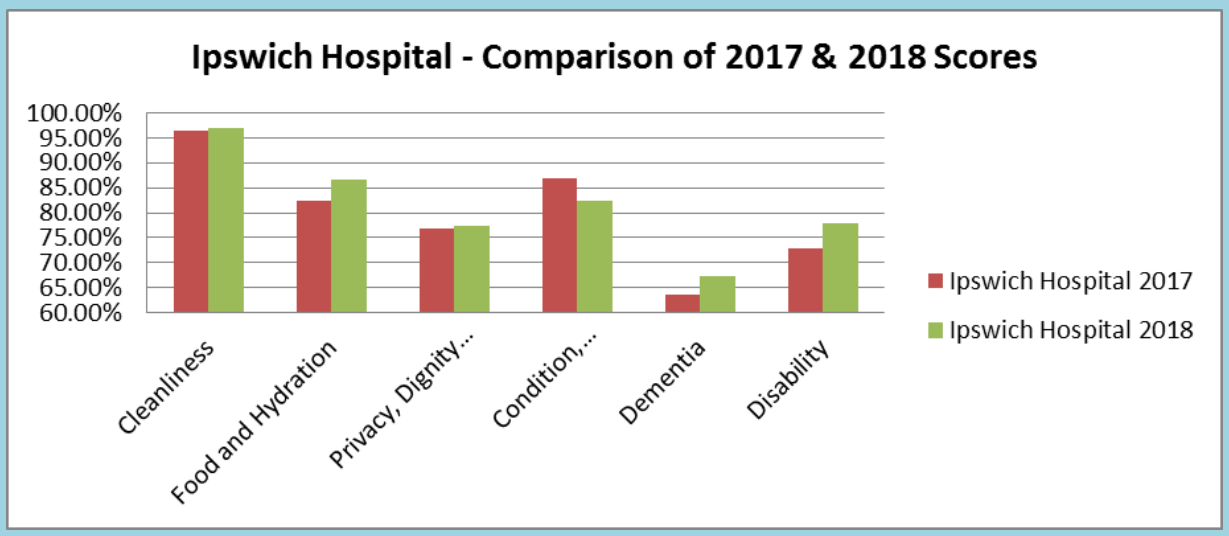


Chart 12



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

Chart 13

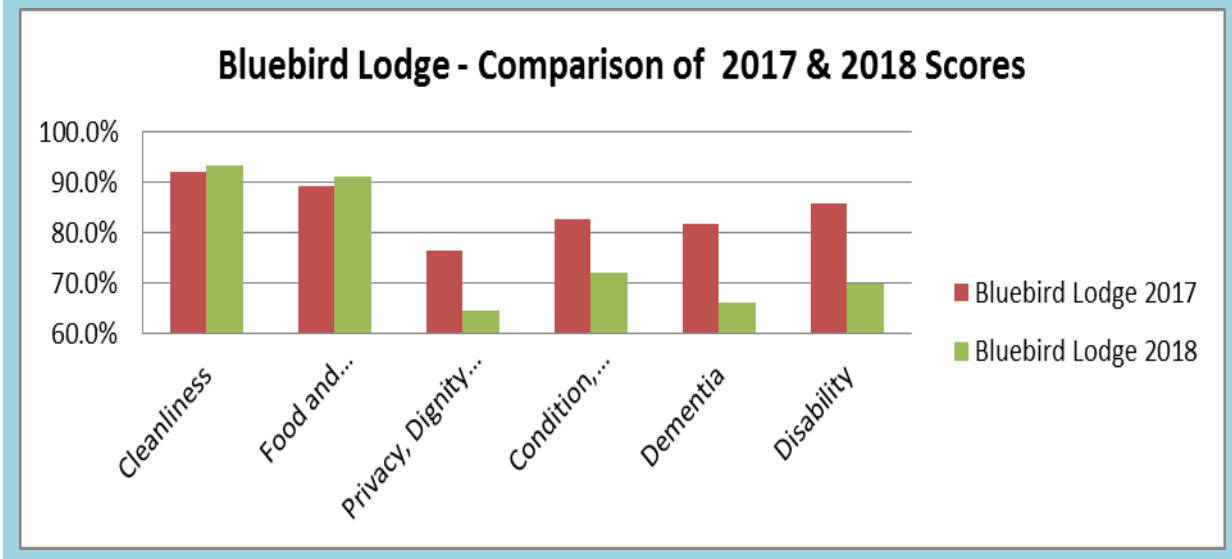
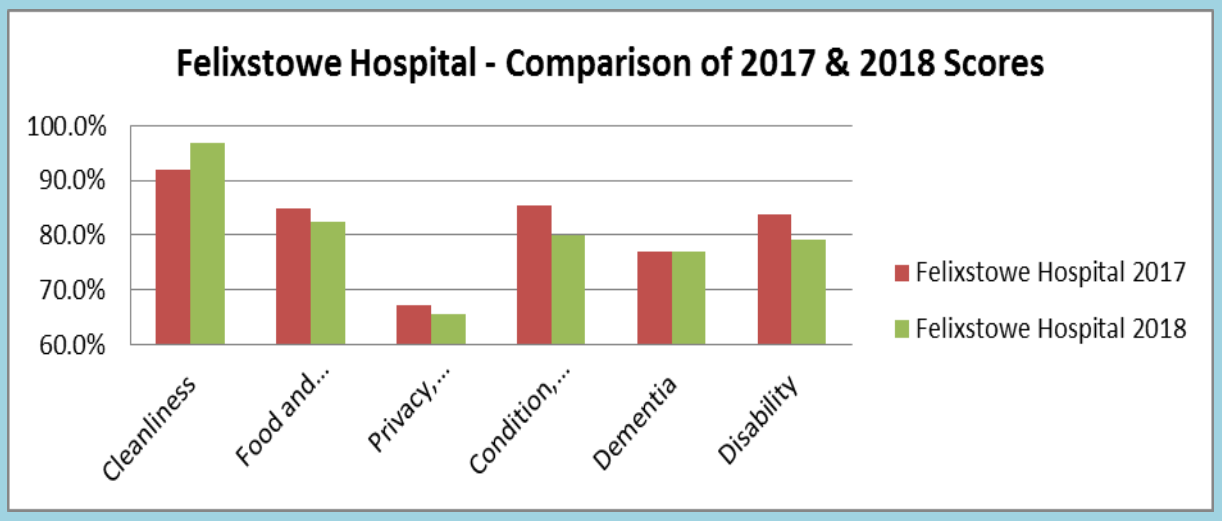
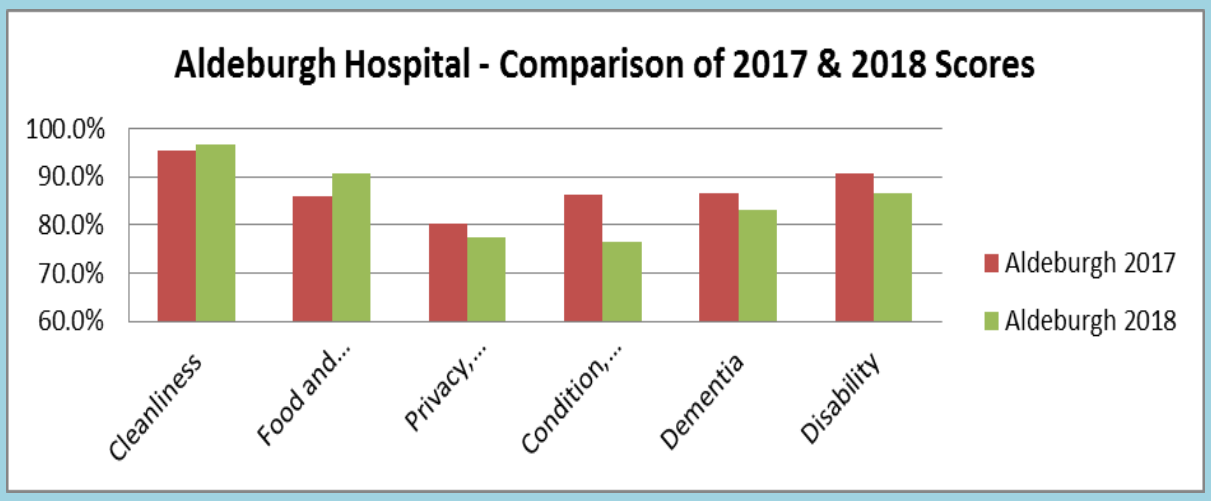


Chart 14



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

Chart 15



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 information against scores from previous years, 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. The process for PLACE will also need to be harmonised and standardised for ESNEFT and take into account best practice from the old Colchester and Ipswich Trusts.

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

Ensuring that patients with either a suspected cancer are diagnosed quickly and receive effective treatment is a key priority for all staff at Colchester and Ipswich Hospitals

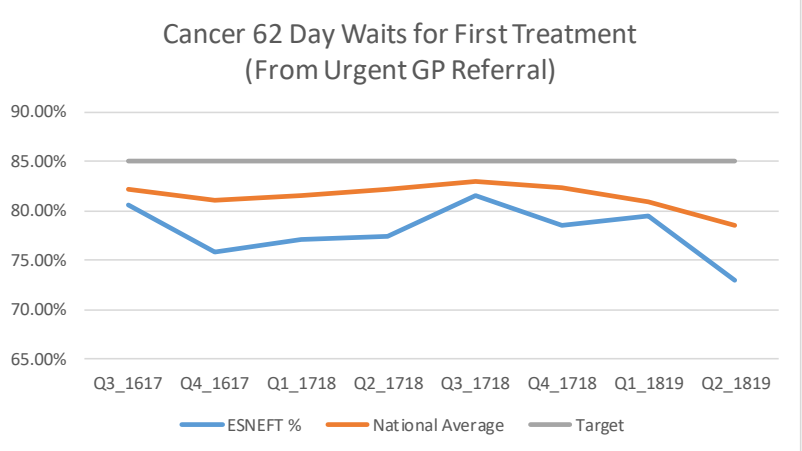
Improving the experience of patients referred in on a cancer pathway by ensuring timely diagnostics and where cancer has been diagnosed, that treatment occurs within 62 days (and 31 days of decision to treat) , remains a priority for our newly merged organisation.

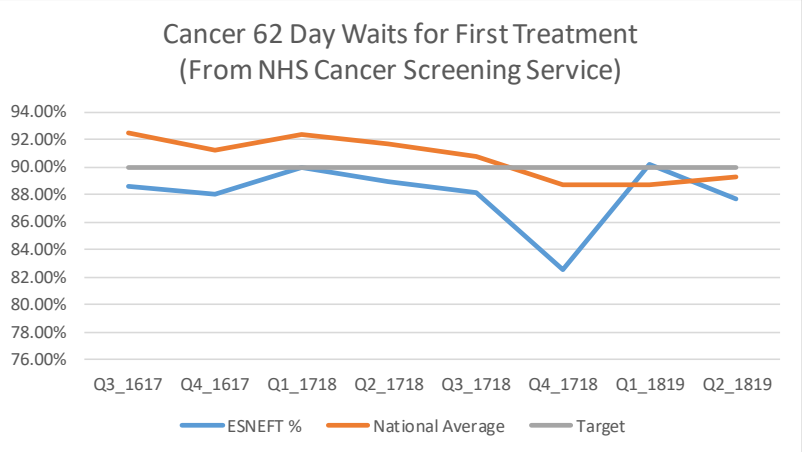
Performance against 62 day first standard is currently below the 85% national performance target however some improvement has been achieved in recent months with many individual tumour sites now compliant with the 85% target. Sustainable delivery remains an area of challenge for our new organisation but there are robust plans in place which are supported by both NHSI and the CCG's.

Initial challenges post-merger:

- ✓ Cancer timed pathways differ slightly on each hospital site i.e. some clinicians follow national timed pathways whilst others follow locally agreed pathways making an immediate merger of specialty level pathways unrealistic without first working through process.
- ✓ Patient flow for onward tertiary referrals; Ipswich referrals are towards Norfolk and Cambridge whilst Colchester's are towards the south of Essex and into London. Currently the only shared pathway between the Colchester and Ipswich sites is for Gynae-Oncology.

***Charts 16**—Cancer 62 Day Waits*





- ✓ Cancer data capture systems used to track their cancer waiting lists are different - Colchester use the Somerset system and Ipswich use Infoflex. Somerset and Infoflex cancer systems do not 'talk' to each other so this has created a number of issues for our business informatics colleagues as data for each site has to be validated before being merged prior to national submission.
- ✓ Time constraints for the operational teams who now have to cover both hospital sites, both use different waiting list and diagnostics systems and there is limited access to 'real time' data.

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

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.
- ✓ Focus on understanding the barriers faced within radiology and histology and what prevents those areas turning around a cancer diagnostic within the locally agreed Standard Operating Policy (SOP) and changes that can be made to ensure that both services are futureproofed in terms of achieving a sustainable cancer diagnostic pathway.
- ✓ Increased understanding of cancer waiting time rules amongst the admin staff and generally raising the profile of the importance of cancer waits within the trust.
- ✓ Working Differently in Q4 (WDQ4) initiative – Focused project looking at specific blocks in our most challenged tumour sites: Gynaecology, Lower and Upper GI and Urology. Weekly face to face calls with service teams to discuss recovery against plan, what's going well and where the issues remain.
- ✓ Prioritisation of Cancer throughout the Trust – Cancer performance and recovery named as one of top 3 Trust level priorities.
- ✓ Escalation of issues that are not able to be resolved at operational level, highlighted to Executive Management team as part of WDQ4 call.

Planned Improvements

- ✓ STT (Straight to Test) Colchester site already has in place STT for endoscopy (colonoscopy and OGD) and MRI Prostate. Ipswich to commence STT colonoscopy (they already provide OGD) by June 2019 and MRI prostate by early summer 2019.
- ✓ STT CT for lung cancer pathway on both sites no later than Q4 (2019/20) The aim of all STT diagnostics is to significantly improve the waiting time to diagnosis, thus improving the patient experience as well as potentially improving outcomes by treating those diagnosed with cancer sooner.
- ✓ Revised escalation processes on both sites to support the Cancer Recovery Plan to enable us to identify potential issues or blocks to a patient's cancer pathway.
- ✓ Communication and face to face engagement with all departments, in particular radiology and histology, building on relationships and increasing the understanding of cancer waiting time rules amongst the admin staff.

Business as Usual – Cancer delivery

- ✓ Mandatory weekly Cancer PTL meetings, chaired by the COO and supported by the Lead Cancer Manager, are attended by the General Manager and Service Manager for each tumour site.
- ✓ Weekly cancer reporting – Submitted to NHSI/NHSE/CCG
- ✓ Weekly cancer Red to Green - Service manager review of cancer PTL with cancer performance team to identify any blocks in the patient's timed pathway of care and plan to resolve.
- ✓ 104 day breaches: A weekly 104 day report is also sent to NHSI/CCG. All 104 day breaches (confirmed cancers) also reported as part of the trusts Datix (risk assessment) system
- ✓ 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. Attended by the lead clinician for each tumour site, the Divisional Lead and the Head of Operations. Each Division is required to produce a performance report which they are asked to present at the meeting.

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

✓ The Board is also attended by the CCG, a representative from the trust's Cancer User Group (CUG), the Lead Cancer Nurse and the Lead Cancer Manager.

Chart 17—*Percentage of patients currently waiting under 18 weeks on incomplete pathway*

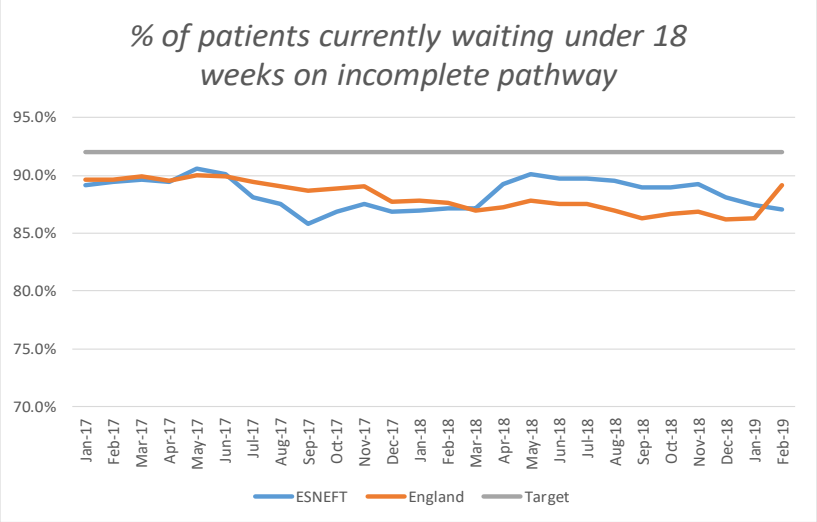


Table 27—Percentage of patients currently waiting under 18 weeks on incomplete pathway

		2017		2018		2019	
% of patients currently waiting under 18 weeks on Incomplete Path-	**Target**	**ESNEFT Performance**	**National Average**	**ESNEFT Performance**	**National Average**	**ESNEFT Performance**	**National Average**
January	92%	89.16%	89.59%	86.92%	87.85%	87.4%	86.3%
February	92%	89.40%	89.59%	87.13%	87.62%	87.1%	89.2%
March	92%	89.66%	89.93%	87.18%	86.92%		
April	92%	89.42%	89.55%	89.20%	87.21%		
May	92%	90.56%	89.96%	90.11%	87.84%		
June	92%	90.07%	89.86%	89.70%	87.50%		
July	92%	88.14%	89.46%	89.67%	87.49%		
August	92%	87.52%	89.02%	89.51%	86.91%		
September	92%	85.77%	88.67%	88.92%	86.28%		
October	92%	86.83%	88.85%	88.98%	86.62%		
November	92%	87.51%	89.05%	89.28%	86.84%		
December	92%	86.82%	87.71%	88.1%	86.15%		
End of Year posi-	**92%**	**86.82%**	**87.71%**	**88.14%**	**86.15%**	**87.1%**	**89.2%**

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 patients 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 2018 captured the experience of cancer patients who experienced care at the Trust in April, May and June 2017.

The results

The results for ESNEFT in 2018 were positive.

National Cancer Patient Experience Survey (NCPES), Aug 2018

Table 28- Performance in areas monitored by PHE

Question	Colchester	Ipswich
Involved with decisions re care & treatment	80%	79%
Given name of CNS to support them	96%	95%
Easy / very easy to contact the CNS	85%	84%
Treated with dignity & respect while in hospital	89%	92%
Told who to contact if worried / had concerns after discharge from hospital	96%	96%
GPs & nurses at GP Practice did everything they could to support them while they were having cancer treatment	56%	68%

Table 29- MDT level performance

	Colchester	Ipswich	National Average
Brain / CNS	N/A	N/A	8.5
Breast	9.1	9.2	8.9
Colorectal	9.0	9.2	8.8
Gynae	8.4	N/A	8.8
Haematology	9.0	8.8	8.9
H&N	N/A	N/A	8.7
Lung	8.9	9.0	8.7
Prostate	8.9	N/A	8.8
Sarcoma	N/A	N/A	8.6
Skin	N/A	N/A	8.9
UGI	N/A	N/A	8.7
Urology	8.7	8.9	8.7

Cancer Care Delivery
Patient Experience

NCPES : Areas of good practice – better than National Average Colchester	
Topic	**% greater than NA**
Easy to understand written info re cancer diagnosis	7%
Practical advice given re managing S/E of treatment	9%
Patients given care plan	7%
Ipswich	
Topic	**% greater than NA**
Given advice re financial help	14%
Confidence & trust in ward nurses	10%
Asked what name wish to be called by	12%
Given info re Radiotherapy	13%
Provided with social support post treatment	9%

Key achievements:

- ✓ Increased use of treatment & care via the chemotherapy bus so patients are having care nearer to their own homes (in line with the national cancer strategy)
- ✓ Launch of the chemotherapy alert card with pre prescribed Intravenous antibiotics – ensures that >90% of patients with potential neutropenic sepsis are treated within the nationally recommended period of 1 hour. This is important from a safety perspective, but also improves the patient experience during any sos admission via A&E
- ✓ Trial of a novel outreach Clinical nurse specialist role for lung caner patients at Ipswich – this has ensured that patients with symptoms of advanced lung cancer can remain in their own homes whilst receiving specialist care.

Cancer Care Delivery
Patient Experience

NCPES : Areas for improvement (lower than National Average)

Colchester

Topic	% worse than National Average
Treated with dignity & respect whilst in-patient	14%
Enough nurses on duty	24%
Told had cancer in sensitive way (Lung)	24%
Able to contact Gynae CNS	28%
Treatment options explained well (Urology)	13%
Give info / results in understandable way (Gynae)	13%

Ipswich

Topic	% lower than National Average
Told re treatment S/E in understandable way (Urology)	14%
Given practical advice re S/E (Urology)	10%
Told re potential S/E – Lung	13%
Given name of CNS (Urology)	21%
Research d/w pt (Breast & Colorectal)	16%

Key actions:

- ✓ CNS workforce review to be undertaken to maximise the potential of the workforce, and to ensure that CNS to patient ratios are optimised
- ✓ Introduce a cancer family support worker role at the Colchester site
- ✓ Wellness centre being developed at Colchester & align at Ipswich
- ✓ Blossom appeal at Ipswich to develop a designated new Breast Centre
- ✓ Recovery package & survivorship roll out
- ✓ Greater roll out of the Open Access Follow Up programme – Empowerment of patients
- ✓ Work with local Clinical Commissioning Groups (CCG's) and Public Health England to improve early diagnosis – In particular to focus on Lung pathways

Patient Experience Survey and data collection

National: NCPES is repeated annually. Patients now being surveyed for 2019 survey which will be published Aug 2019.

Local: ESNEFT Real time patient experience is captured via FFT, informal interviews in OPD areas, complaints, PALS, local level surveys.

Safeguarding

Adult, Dementia & Learning Disability Teams

ESNEFT is committed to the protection of all adults at risk from abuse

Safeguarding individuals is an integral part of patient care. 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 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 Head of Safeguarding leads on the safeguarding of all adults at risk within the safeguarding teams based in Ipswich and Colchester acute hospitals the community of Suffolk

Governance: The safeguarding team supported by the head of Safeguarding and which includes an additional newly appointed Admiral Nurses for Dementia taking ESNEFT to three full time Admiral nurses and two Learning Disability nurse specialists.

The adult safeguarding team work in partnership with the safeguarding children's & maternity team, living the values of a safeguarding family approach, this working in partnership and co-delivery of training is setting the expectations to staff of Think Families, this approach had been part of the Colchester hospital philosophy and has been adopted at Ipswich hospital following the formation of ESNEFT.

The safeguarding team attend the serious incident review panel when specific safeguarding concerns are agented and the patient and carer experience committee to ensure that safeguarding is considered throughout the organisation.

Reporting: providing assurance Quarterly reports and updates are provided at the Safeguarding Adults Operational Group and Safeguarding Committee, the operational group is chaired by the Head of Safeguarding Adults and has multi-disciplinary and relevant divisional and safeguarding, dementia and LD are represented and provide updates. The group members work together with 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: supporting staff in the organisation There has been a significant increase in safeguarding training across all levels over the past 3 months as we are focusing on adapting training provision in preparation to meet L3 training requirements as set out in the new Intercollegiate Roles & Competencies for health care staff (August 2018). This has seen the recent development of training on gang crime working in partnership with the police. L3 FGM and Domestic Abuse training plan has been developed.

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 monthly monitoring of training to maintain training levels, any concerns will be escalated to the Safeguarding Committee and Quality and Patient Safety (QPS). The safeguarding team will continue to adapt training to make L3 the core standard for the majority of staff.

The formation of ESNEFT continues to develop and aligning its working practices it has also brought together the opportunity for the larger team to be creative with training and to increase skills by sharing knowledge and experience. This has been demonstrated in the introduction across ESNEFT of the Reasonable Adjustment Tool for people with a learning disability

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 is a member of the NHS England Midlands and East (EAST) Safeguarding Adults Forum this role enable the sharing of best practice regionally and also an opportunity to shape the safeguarding service the development of the NHS

Safeguarding and Learning Disability

Safeguarding App used nationally and updated in 2018 was the work of the forum, this provides staff instant access to safeguarding information and guidance.

The learning disability nurses across both sites of ESNEFT have developed a number of services for people with learning disabilities and Autism.

We will shortly have a shared LD and Autism policy across both sites to insure parity of service.

We have a unified reasonable adjustment tool over both sites and working in the community hospitals, this paperwork is also in policy and ensures equitable treatment for people with learning disabilities as inpatients. We also have a quick reasonable adjustment tool for the emergency dept. and maternity, which assists in making quick reasonable adjustments.

We have a specific paediatric reasonable adjustment tool in development and the community hospitals in Suffolk are using the reasonable adjustment tool.

We are regularly auditing the reasonable adjustment tools use.

The LD team has started user groups across the trust for people with Learning disabilities and Autism. In Ipswich there are two user groups, the learning disability action group (LDAG) and the parents and carers for people with LD (PCPLD) these two groups meet regularly and co-produce all aspects of care for people with LD.

The LDAG group has consulted upon the easy read leaflets for the service, the reasonable adjustment tool on the intranet and the public internet. In Colchester the service user groups are in their infancy but will be completing similar work as Ipswich.

The public internet site, has been put together in conjunction with the user groups to have the most important information available publically. The site is currently under construction but it will have links to hospital passports, contact details as well as user experience videos.

We are currently working towards making the trust compliant with the reasonable adjustment standard.

The hospital passport is given to all patients with a learning disability and assists in getting the best information available on the patient notes electronically so clinicians that have never met the person will get a sense for what kind of reasonable adjustment may be required.

As well as paperwork and user groups the LD nurses over both sites in ESNEFT write bespoke day care plans for people with profound disabilities that may otherwise be unable to access the hospital these are used in conjunction with a one stop clinic in some cases to assist patients who find it difficult to come to hospital get the best quality health care.

The nurses over both sites have L2 and 3 face to face training as well as mandatory LD training for all clinical staff. We also have a n eLearning package that trains L1 and 2.

LD nurses over both sites have extensive links in the local community in other clinical teams and the CCG to ensure seamless delivery and the best quality.

The LD nurses have been involved in notifying deaths of people with a learning disability to the LeDeR programme and also providing support to the LeDeR reviewers. Deaths of people with a learning disability and / or Autism are reviewed monthly at the ESNEFT mortality review meetings.

Communication tools, easy read resources and videos of procedures are available to support people to understand their own health care and therefore improve engagement in treatment plans.

Speaking Up

The Board of ESNEFT recently endorsed the following vision statement, in accordance with the CQC Self Review Tool, which required Senior leaders to readily articulate the trust's FTSU vision, and to act upon key learning from issues that workers have spoken up about.

"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."

There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement and the Trust has developed this jointly with staff side colleagues and has included input from Health and wellbeing, Governors NEDs and the Equality and Diversity steering group. Staff are encouraged through induction, posters and the intranet to raise concerns, the first paragraph of which states:

"Freedom To Speak Up (Raising Concerns) is a cultural shift within our hospital intended to encourage all staff to raise concerns and issues no matter how big or small. The Freedom to Speak Up policy outlines the process. If you are unsure about the nature of your concern then have a look at the examples below. If you are still unsure, in any way, then raise the matter with Tom Fleetwood, our Freedom to Speak up Guardian, by email: raising.concerns@esneft.nhs.uk or by phone on 07919 298 635." Feedback is given to those who raise concerns by a senior individual within the Trust such as a member of the Executive Team or when appropriate by the Freedom to Speak Guardian.

The Trust replies quarterly to the National Guardians data collection and the FTSU reports quarterly to POD and annually to the Main Board of ESNEFT.

Tom Fleetwood is our Freedom to Speak Up Guardian, a role designed to encourage staff to raise concerns and issues, no matter how big or small, with a trusted and well-respected person in the organisation.

Speaking Up


Raise a concern
Tell your line manager
Call Health & Wellbeing ext 5284
Call Human Resources department ext 5952
Discuss with your trade union rep
Talk to the Freedom to Speak Up Guardian 07919 298635
Call the confidential helpline ext 5300

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.

The Trust aims to ensure that the highest quality of care is consistently delivered to our patients. To enable that, we will support and develop our staff. We will:

- ✓ Be a great place to work with fulfilling roles and exciting opportunities
- ✓ Value and embrace diversity in our workforce
- ✓ Engage, listen and develop all our staff
- ✓ Create a healthy and positive working environment.

We will know when we have succeeded when:

- ✓ Our staff satisfaction is among the best in England
- ✓ Our vacancy rate is among the lowest in England
- ✓ We are able to award higher qualifications in our own right

National NHS Staff Survey

The Trust takes part in the quarterly friends and family test as well as the annual NHS Staff Survey.

The full reports for East Suffolk & North Essex NHS Foundation Trust are available at www.nhsstaffsurveys.com

In 2017, the Staff Survey Co-ordination Centre undertook a review of the reporting outputs for the National NHS Staff Survey to establish what worked well and what needed improvement. The findings of the review has resulted in a number of significant changes being implemented prior to the implementation of the 2018 Staff Survey.

Ten new key themes have been applied to the survey (which replace the previous 'Key Findings') and are scored consistently on a 0-10 point scale (a higher score will always indicate a better result). These 10 themes are as follows:

- ✓ Equality, diversity and inclusion
- ✓ Health and wellbeing
- ✓ Immediate managers
- ✓ Morale
- ✓ Quality of appraisals
- ✓ Quality of care
- ✓ Safe environment – bullying and harassment
- ✓ Safe environment – violence
- ✓ Safety culture
- ✓ Staff engagement (calculated using the same questions as in previous years, but adjusted to a 0-10 point scale).

The key headlines from the first NHS Staff Survey for East Suffolk & North Essex NHS Foundation Trust are as follows:

- ✓ Our organisation was benchmarked against 43 Combined Acute and Community Trusts.
- ✓ 39% of staff (3,620) responded compared to a 41% average response rate for similar trusts.
- ✓ 90 questions were asked in the survey. The responses to 50 questions showed no significant difference compared to the average from other combined acute community trusts, whilst the answers from our staff to the other 40 questions were significantly worse than the average response rate.
- ✓ 55% of staff said they would recommend ESNEFT as a place to work.
- ✓ 68% of staff said they would be happy with the standard of care provided if a friend or relative needed treatment.
- ✓ 74% of staff agreed that care of service users is the organisation's top priority.
- ✓ We score significantly lower than average in questions relating to leadership and communication.

Our core strengths are outlined in table 30. It's very reassuring to know that our staff are very clear about how to report unsafe clinical practices and near misses and this is what keeps patients in our care safe.

Our key issues to address are outlined in table 31.

Staff Survey
Equality and Diversity

Table 30

	Top 5 scores (compared to average)
96%	Q18a. Know how to report unsafe clinical practice
95%	Q16c. Last error/near miss/incident seen that could hurt staff and/or patients/service users reported
92%	Q15b. Not experienced discrimination from manager/team leader or other colleagues
99%	Q12c. Not experienced physical violence from other colleagues
100%	Q12b. Not experienced physical violence from managers

Table 31

	Bottom 5 scores (compared to average)
73%	Q9a. I know who senior managers are
30%	Q9b. Communication between senior management and staff is effective
24%	Q9d. Senior managers act on staff feedback
46%	Q19g. Supported by manager to receive training, learning or development definitely identified in appraisal
27%	Q19e. Appraisal/performance review: organisational values definitely discussed

Staff Survey

The responses to the three key 'recommendation' questions that indicate our overall staff engagement position are outlined below.

	Q21a Care of patients/ service users is my organisation's top priority	Q21c I would recommend my organisation as a place to work	Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation
Best	88.7%	77.3%	90.3%
Our Organisation	**74.4%**	**55.3%**	**68.3%**
Average	76.5%	61.1%	69.9%
Worst	59.9%	47.2%	49.2%

Staff Friends and Family Test

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).

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	Reporting	CHUFT	IH Score	ESNEFT	National
	2018/19 Q1	75%	81%	-	81%
	2018/19 Q2	-	-	72%	81%
	2018/19 Q3	National NHS Staff Survey Period			
	2018/19 Q4	-	-	TBA*	TBA*

The % of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a place to work	Reporting	CHUFT	IH Score	ESNEFT	National
	2018/19 Q1		49%	-	66%
	2018/19 Q2	-	-	33%	64%
	2018/19 Q3	National NHS Staff Survey Period			
	2018/19 Q4	-	-	TBA*	TBA*

*Data not available at the time of production.

Staff Survey
Equality and Diversity

Equality, Diversity & Inclusion

Equality is about fair and inclusive treatment. It is protected in law with the aim that we can all live and work in a society where everyone can participate, have opportunity to fulfil potential and fair access to services and employment.

Diversity supports equality, recognising and understanding the broad range of differences which makes someone unique such as their culture, belief, gender, age, physical or mental abilities, and also their experiences, needs, expectations and responsibilities.

Being **fair and inclusive** means valuing and respecting a person's diverse requirements, thoughts and contributions. Equality and diversity work in unison to achieve all of this.

The people we serve and employ are becoming increasingly diverse with varied needs, but everyone needs to feel valued and included and treated fairly and respectfully. The Trust, our patients, staff and stakeholders have all identified and made a commitment to this within our shared values and our expectations of conduct. Everyone is responsible for supporting this agenda.

To ensure we meet our responsibilities and ensure deliver, the Trust has established an Equality, Diversity and Inclusion Steering Group. This group provides oversight of this agenda and provides assurance to Trust committees and the Trust Board. During the last meeting, members agreed to focus on the following 6 priorities over the course of the next 12-18 months:

- ✓ Accessible Information Standard (AIS)
- ✓ EDI Induction / Training
- ✓ Equality Impact Assessments
- ✓ LGBT+ Programme
- ✓ Workforce Race Equality Scheme
- ✓ Workforce Disability Equality Scheme
- ✓ Compliance.

Accessible Information Standard

The AIS helps to meet needs in relation to a disability, impairment or sensory loss which affects the ability to communicate. The AIS applies to patients, carers or parents.

This ongoing programme of work is being led by Mike Meers, Director of ICT. Workshops have been held to review the Trust's compliance with the AIS and relevant required activities have been identified.

Equality Delivery System 2

Like all NHS organisations, the Trust uses the Equality Delivery System (EDS2) to implement equality and diversity strategies and the Public Sector Equality Duty. There are four overarching goals:

- ✓ Better health outcomes
- ✓ Improved patient access and experience
- ✓ A representative and supported workforce
- ✓ Inclusive leadership

A key part of EDS2 is identification of stakeholders from patients, staff or local interest groups, to secure meaningful engagement to help assess and evaluate where we are and how to progress. It is acknowledge that a review and refresh of ESNEFT's EDS2 is now required and it is intended that this review will be carried out during 2019/20.

Gender Pay Gap Reporting (GPGR)

NHS employers are required by law to publish statutory calculations each year showing how large the pay gap is between their male and female employees. We will continue to analyse the information and will consider appropriate action to address any gaps identified.

Workforce Race Equality Standard (WRES)

The NHS WRES was introduced to the NHS on 1 April 2015. It aims to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The Trust measures progress against 9 indicators of workforce race equality which focus on any differences between the experience and treatment of White and BME staff. This also marks the level of BME representation at senior management and board level, and helps to plan evidence based action.

The WRES priorities for the year ahead will include a focus on:

- ✓ Data collection from our existing processes and systems
- ✓ Enabling and empowering our internal experts
- ✓ Reverse mentoring
- ✓ Recruitment

Staff Survey
Equality and Diversity

✓ External benchmarking and networking

Development sessions on the WRES were delivered at a senior leadership conference during quarter 2 and these sessions were very well received. Plans are in place to roll these out as 'bite-size' development sessions for all staff during 2019/20.

Workforce Disability Equality Standard (WDES)

Results of the annual NHS Staff Survey show that disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities. The purpose of WDES is to improve the experience of disabled staff working in, and seeking employment in, the NHS.

The WDES, which is mandated by the NHS Standard Contract, is a data-based standard that uses a series of measures to help improve the experiences of disabled staff in the NHS. The ten evidence-based metrics will enable NHS organisations to compare the reported outcomes and experiences of disabled staff with non-disabled staff. First reports are to be published on 1 August 2019 and based on date from the 2018/19 financial year.

LGBT+ Network

The LGBT+ Network has gone from strength to strength this year, which was acknowledged following the team winning January's commendation award. Nick Hulme, Chief Executive, presented this to the team during their meeting in January 2019.

The LGBT+ Network, which was set up by staff volunteers, represents the interests of LTBT+ staff and service users at ESNEFT. The network aims to:

Nick Hulme, Chief Executive, presenting the commendation to the LGBT + Network team in January 2019.

✓ Engage in positive change in the workplace, which will allow all LGBT+ staff to excel in a supportive and non-discriminatory work environment.

✓ Ensure that patient services are welcoming, non-judgemental and meet the healthcare needs of the LGBT+ community.

Staff Survey
Equality and Diversity

2018 NHS Staff Survey Results – Theme results - Equality, Diversity & Inclusion

	Q14 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?		Q15a In the last 12 months, have you personally experienced discrimination at work from patients/service users, their relatives or other members of the public?
Best	91.5%	Worst	13.5%
ESNEFT	**80.0%**	**ESNEFT**	**6.6%**
Average	85.5%	Average	5.2%
Worst	70.5%	Best	2.1%

	Q15b In the last 12 months, have you personally experienced discrimination at work from manager/team		Q28b Has your employer made adequate adjustment(s) to enable you to carry out your work?
Worst	14.5%	Best	82.2%
ESNEFT	**8.1%**	**ESNEFT**	**71.4%**
Average	7.0%	Average	73.3%
Best	4.5%	Worst	52.3%

Workforce
Health and Well-being

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

During the latter part of 2018/19, it was agreed that the priority for health and wellbeing at ESNEFT would be placed on the mental wellbeing of our staff. To that end, the Trust has worked in partnership with Suffolk MIND to agree a programme of work for the immediate 12 to 18 months. This will include delivering 'Your Needs Met' training to all of our divisional senior leadership teams, and also includes the continuation of the Emotional Needs Audit (ENA). ESNEFT's first ENA was undertaking during December 2018 and the results have been shared with the organisation.

ESNEFT were delighted to support

Suffolk Mind's RED January campaign this year. RED January is a community initiative that encourages people to support their mental health by doing something active every single day, during a characteristically tough month. Many staff joined in this year and we hope to attract even more interest before January 2020.

Over the past 12 months, our Health & Wellbeing team have enjoyed working in partnership with Public Health England and various alliance partners, which has included a review and refresh of The Healthy Workplace Award. The Award is built around 8 standards based on the following headings:

- ✓ Leadership
- ✓ Attendance Management
- ✓ Health & Safety
- ✓ Mental Health
- ✓ Physical Activity
- ✓ Healthy Eating
- ✓ Smoking and Tobacco-Related Ill health
- ✓ Alcohol and Substance Misuse

Schwartz Rounds

Schwartz Rounds are structured monthly one-hour meetings available to all staff, volunteers and those who work on our hospital 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 2018/19 have included the following topics:

- ✓ The view from the other side
- ✓ My proudest moment
- ✓ No stigma, no shame … breaking the silence of mental health illness
- ✓ Giving people back their lives
- ✓ Love is …

During quarter 3, representatives from the ESNEFT Schwartz team were delighted to be invited to talk to colleagues from James Paget University Hospitals NHS Foundation Trust about their experiences of facilitating Schwartz Rounds over the past few years.

A Schwartz Round panellist

Workforce
Health and Well-being

Some of our Schwartz Round panellists

Workforce

Volunteering

Volunteers

Our volunteers service is co-ordinated in house at Ipswich Hospital and in partnership with Community 360 at Colchester Hospital (formally known as Colchester Community Volunteers Services or CCVS) and have gone from strength to strength over the past 12 months.

Highlights from our volunteers are summarised below:-

- ✓ Over 710 active volunteers across the Trust providing more than 6,650 hours a month of voluntary services.
- ✓ 42 young volunteers between the ages of 16-18 delivering Ward Support in Surgery and Gastro, Children's Wards, Maternity and Critical Care
- ✓ 12 new volunteers roles identified (Activity Co-ordinators, Patient Buggy Drivers, Discharge Lounge Support, End of life support, Falls & Bone Health Admin, Myeloma Clinic Support, Stour Centre Support, Maternity Ward Support, Activity Support Volunteer, Child Development Centre Volunteer, Wayfinders and Dementia Support), all providing direct benefit to our patients
- ✓ We now have 15 visiting therapy dogs across the sites which are very popular on our children's, adults and older people wards.
- ✓ All our volunteers attend induction training and are carefully vetted and subject to DBS checks before contact with patients can take place.
- ✓ One of our volunteers celebrated her 50th year of volunteering 2 x volunteers completed their 45th year volunteering
- ✓ We have 31 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, 34 breast feeding support volunteers and many more providing fantastic support to our patients, their families and our staff.
- ✓ We have increased the number of volunteers in the maternity wards from 1 to 5, and 9 new volunteers were placed in Children's ward and outpatients area covering Monday – Friday.
- ✓ Our volunteers supported the Christmas Fair with a Santa's Grotto complete with Mother Christmas.
- ✓ We held a summer tea party for all our Colchester based volunteers and a Christmas Party for our Ipswich based volunteers to thank them for their contribution to the Hospitals and our patients

We are planning to restructure the voluntary services department in April 2019 to bring together the voluntary services functions with funding secured from the Colchester & Ipswich Hospitals Charity and look forward to our volunteers delivering further benefits to our patients during 2019 and beyond.

Aldeburgh Hospital staff and members of the volunteer garden team join Darren, James and Jason from Gladwells to celebrate an award.

Roger Gladwell Landscape, Design and Construction were awarded the gold medal in the ‘Community Garden’ category at the National Landscaping Awards in London.

The sensory garden which is also open to the wider community, is a peaceful setting designed to stimulate the senses of patients, including those with anxiety or depression.

Aldeburgh Hospital matron, Michelle Fletcher, said: “Our patients’ time matters and the garden is a focal point of the hospital which creates conversation and stimulation, helping them in their recovery and rehabilitation so they can return to the comfort of their own home as soon as possible."

Anne Parsons, volunteer garden team leader at Aldeburgh Hospital, said: The garden is coming to life again as spring bulbs burst into flower. There are plenty of seats to sit and enjoy the view in the peaceful surroundings and the gardens are wheelchair and buggy friendly.”

The garden, which also features a yellow spiral listening bench, can be prescribed by GPs to patients during their rehabilitation and recovery, for activities such as art, music and drama.

Workforce

Education and training of staff

Workforce – education and training of staff

The Trust is committed to providing a multifaceted learning environment for all staff and trainees to ensure it has a high quality workforce which is committed, engaged, trained and supported to deliver safe, effective, dignified and respectful care.

Medical Education - Undergraduate Education

The Trust currently hosts students from the following universities:-
Barts and the London School of Medicine and Dentistry
University of East Anglia
Anglian Ruskin University (new for 2018)
University of Cambridge

Medical Training

During 2018/19 the Trust received a visit from the Health Education England on behalf of the General Medical Council (GMC) at the Ipswich site to further explore concerns originating from the GMC National Training Survey 2018.

The visit concentrated on Surgery and Obstetrics and Gynaecology. Both educational supervisors and training grade doctors gave feedback as part of the visit.

On the Colchester site in November 2018 the Trust was advised that the GMC had removed the status of enhanced monitoring following a previous quality visits, robust action plans and the results of the 2018 GMC survey.

Education and Workforce

Pre-registration

Number of pre-registration students supported in the Trust During 2018/2019:

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 as well as supporting our local community we support students from:
University of Hertfordshire
University of Essex
Anglia Ruskin University
University of East Anglia
University of Suffolk
University of Sheffield

Practice Education Facilitators (PEF)

Continued investment has been made in employing Practice Education Facilitators to provide support and training to both our mentors and pre-registration students from all programmes. We are working to standardise the support and learning opportunities across all of our sites for the benefit of all. Our PEFs promote active learning and application of theory to practice utilising skills of experts within the Trust and community where required.
Specific focus of work over the last year has included:
Standardising processes following merger
Improving teaching and assessing
Implementation of Hub and Spoke placements
Continued roll out of Collaborative Learning and Assessment model
Preparation for the new NMC education standards
Increasing inter-professional learning

Education programmes have been developed to engage varying disciplines of pre-registration students, to improve both the educational experience and understanding of differing roles.

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.

With the approval of the new NMC education standards earlier this year, we have worked collaboratively with our partner universities to plan and prepare to implement these and support preparation of new programme curriculums.

Some of the Key pieces of work have included:

Preparation for new NMC education standards

In order to ensure that education standards are fit for purpose and that nurses, midwives and nursing associates are equipped with the skills and knowledge they need to deliver high quality and safe care now and in the future, the NMC have published a suite of new standards. To implement these, we have worked closely with our partner universities to interpret and plan for the changes required. This has included identifying new roles and providing a programme of training for our current nurses and allied healthcare professionals as well as reviewing current practice to ensure we are able to support the new learning requirements across the organisation

Hub and Spoke

As part of our work to improve the learning environment for students, we have been implementing a Hub and Spoke model at Colchester for the last year and aim to have full implementation in all of our sites by end of 2020. Hub and Spoke model provides the students with a main base for the majority of their clinical placement with short ‘spoke’ placements, to related areas to enable students to follow the patient journey. This also allows us to work together more closely with specialist areas with shared responsibility and interest in student learning to benefit; skills and knowledge, the quality of our practice delivery and learning achieved. This will allow all healthcare professionals to benefit one another’s practice through supporting learning of others as well as increasing the inter-professional learning.

Collaborative Assessment Learning Model (CALM)

Last year we introduced a new model of supporting learners in practice; CALM. This did not replace the existing model, but compliments and develops it, in preparation for changes to the nursing education standards which were under consultation at the time. This approach, moves away from a

Workforce

Education and training of staff

Table 32 Number of Students

Student Programme	Colchester April – June 18 Number of students	ESNEFT July – March 19 Number of students
Return to Practice	0	12
Child	35	63
Adult Nursing	227	562
Midwifery	46	86
Operating Department Practitioner	7	27
Physiotherapy	10	50
Speech and Language therapy	3	14
Occupational Therapy	4	17
Dietetics	3	9
Paramedic	96	139
Diagnostic radiography	12	45
Therapeutic radiography	9	19

traditional mentoring role to a more collaborative team approach to supporting learning in practice. Students will be coached daily by 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. Nurses must work across professional boundaries to deliver high quality care therefore, our initiative has championed interprofessional education (IPE). We are continuing to roll this out across the Colchester sites and have developed a plan to roll out across out Ipswich and community areas. Extra learning resources have been provided to support the learning in the clinical area.

Non-registered nursing career pathway

As part of the trust's commitment to "growing our own" staff a non-registered nurse career pathway has been developed that provides the structure through which non-registered nursing staff can progress and develop a career whilst also being paid through the apprenticeship scheme. Details on the clinical apprenticeships are as below:

Education and Training Opportunities

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

Advanced Clinical Practitioners (ACP)

Responding to the changing landscape of healthcare and workforce demands the organisation has supported further implementation and development of Advanced Clinical Practitioner role and supporting the associate training required. Advanced clinical practice embodies the ability to manage clinical care in partnership with

Workforce

Education and training of staff

individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes.

Continuing development

The organisation has supported our multidisciplinary healthcare staff to attend a wide variety of courses and workshops. To enhance skills to be able to safely care for the more diverse and complex health issues which patients are admitted with the training has been particularly focused around:

- ✓ Urgent and emergency care – providing increased skills in identifying and caring for the acutely ill patients, i.e. caring for the critically unwell woman (maternity), non-medical prescribing, consultation and assessment, tracheostomy care, Intensive Neonatal Nursing.
- ✓ Long term conditions – Specialist education of long term conditions i.e. Management of the individual with long term conditions, ophthalmic nursing, therapeutic handling of patients, physiotherapy updates, diabetes management.
- ✓ Mental health awareness – to improve awareness of mental health conditions and support recovery with a patient centred focus, i.e. mental health workshops, mental health awareness in young people
- ✓ Cancer Care – Specialist education to support the delivery of care to patients with cancer to improved services and patient experience i.e. Palliative care course, Brachytherapy Principles in practice, Technical Advances in Radiotherapy
- ✓ Leadership - developing the leadership and communication skills of staff across the Trust to help move forward with innovation and initiative, supporting staff to drive change and continually improve the services we offer i.e. Leadership in Healthcare, Learning, Teaching and Assessment, coaching conversations
- ✓ Patient Safety – providing training to support patient safety and learning from incidents as well as shared working, i.e. Human factors training

Risk and Quality Governance Framework

The risk and quality governance framework is a process used to measure, identify and improve quality in education and training environments and for all learners in health and care. As a Trust we are undertake continuous self-assessment against standards identified by Health Education England, this allows an opportunity to constantly review and improve our learning environment and share good practice across the organisation.

Post Registration

The trust has continued to invest in post-registration education and training following the merger, establishing a new team of Practice Educators at Ipswich hospital as well as embracing community education staff into the post-registration team to encourage collaborative working across acute and community.
The focus of work has included:

- ✓ Roll out of OSCE preparation programme at Ipswich site. The overall pass rate across ESNEFT is currently 91% compared to 81% nationally.
- ✓ Commencement of a new ESNEFT clinical induction programme for all non-medical clinical staff starting employment in the trust.
- ✓ New 12 month ESNEFT multidisciplinary Preceptorship programme for newly registered professionals.
- ✓ Practice Educators delivering education and training at the bedside in clinical areas.
- ✓ Development of skills training and education across both sites to ensure fair opportunities for all non-medical clinical staff
- ✓ Clinical Leadership Programme for Band 6 and 7 Registered Nurses to commence at Ipswich site in April 2019.
- ✓ New medical device and clinical competency policies and processes to support skills training, improve patient safety and compliance
- ✓ Clinical Skills passport to be launched for Registered Nurses across ESNEFT in Spring 2019.

Workforce

Corporate Learning, Organisational Development

Corporate Learning and Organisational Development and effectiveness

Following the merger in July 2018, it was identified by the Trust that some immediate Organisational Development input and support was needed in the short term; specifically for the clinical divisions. It was understood that the merger had been successful, but as would always be the case after such significant change, leaders and managers in particular were finding things difficult and new teams were trying to form and develop with no specific developmental support, against a backdrop of growing day to day demands.

A broad range of individuals and teams were engaged in discussion, and team meetings were observed in relation to outputs and behaviours.

Based on these findings, an action plan has been developed as a way of prompting immediate action to support leaders and staff post-merger.

The objectives of the plan include:

-To provide some stability to leaders post- merger.

-To identify barriers to success and introduce initiatives which will help to overcome obstacles.

-To provide support and investment from a morale and engagement perspective.

Delivery of the plan commenced towards the end of 2018 and work will continue during 2019/20.

Other initiatives have continued and have been delivered across the organisation including the community which commenced in March 2019. These include stand-alone leadership development modules, a consultant development programme, operational leads programme and Mary Secole local.

Leadership

Leadership events have continued in 2018/19 involving leaders from across the organisation. As well as two senior leadership conferences the Trust also ran two very successful middle managers conferences in November 2018. The conferences concentrated on what was expected of leaders within the organisation and will help inform the Trusts leadership behaviour framework.

Library development

The libraries on both Ipswich and Colchester Hospital sites has to submit their Library Quality Assurance framework in 2018 with the Ipswich site attaining 92% and the Colchester site 97%.

Mandatory Training

During 2018/19 significant work has taken place to harmonise mandatory training. There were differences between the requirements across both the Colchester and Ipswich sites as well as the community including role requirements, renewal periods and delivery methods. The Trust now has one suite of mandatory training requirements and every role within the organisation has been mapped to its specific needs. Delivery has been reviewed and access to e-learning is now via a platform that allows staff to access their training anywhere. The training portal that allows any member of staff with access to the ESNEFT intranet to view their own records, managers to look at their teams performs and also for subject specialists to see where any intensive work may be required. There has been an expected decease in compliance as new subjects have been introduced to staff working on the Ipswich site and in the community. With the launch of the new e-learning platform and the training portal it is expected that compliance will increase during 2019/20.

Organisational Development - Valuing our staff

During 2018/19 the Trust has continued to recognise staff and volunteers through the Trust commendation scheme. Commendations are a chance for colleagues, patients and the public to nominate the people they feel have made outstanding contributions at our Trust .

Every nominated person gets a letter from the chief executive with the citation included. Winners are visited by a member of the executive team who present them with their certificate.

Over leaf are examples of some winners.

Workforce

Valuing Our Staff

Commendation award for Lyndsey

Lyndsey Walker is a nurse who cares for children with cancer.

We have given Lyndsey one of our Team ESNEFT Commendation awards for her commitment and kindness to families going through the toughest of times.

Workforce

Valuing Our Staff

Gennine Pelayo winner of Commendation award

Moving to a new country to start a new job is a daunting prospect for anyone, but Gennine Pelayo, a resourcing officer in the Recruitment team at Colchester Hospital, goes above and beyond to make the process a smooth and happy one for our international recruits.

She is said to “go the extra mile” to ensure the new starters who are relocating thousands of miles from home are given a warm welcome, not only to the Trust, but to the Colchester community.

Vascular Surgeon Adhip Mandal Commendation award winner

Adhip cares for patients with conditions affecting their circulation, including artery and vein diseases and won the award for his compassion and teamwork.

Statements from key stakeholders

healthwatch Essex

Response to ESNFT Account 2018-19 from Healthwatch Essex

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

We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by 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 ESNFT Quality Account.

What has been very encouraging has been the way ESNFT has remained focused on its delivery of high quality care, financial control and improvement of services, whilst also being part of the STP transformation process taking place in this part of Essex.

HWE is assured that this is a solid first year of a merger strategy with some quite difficulty changes & challenges from the health & social care landscape.

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. Highlights include the Sleep Well campaign, the Dementia work and the user groups.

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 ESNFT.

Dr David Sollis

Chief Executive Officer, Healthwatch Essex

Statements from key stakeholders

Healthwatch Suffolk response to the East Suffolk & North Essex Foundation Trust Quality Account 2018/2019

Healthwatch Suffolk (HWS) thank the Trust for the opportunity to comment on the Quality Accounts for 2018/19. We recognise the Trust has been dealing with a massive integration agenda and that it has been a challenging year merging two hospitals, their staff, services and cultures. It is, therefore, pleasing to report that HWS feedback indicates local people are highly positive about the treatment andcare they receive.

There is still some way to go to achieve the targets set against quality improvement priorities (particularly sepsis and mental health) but they appear to be moving in the right direction. Clinical audit and research is key to improving quality of care and thereby patient experience, so it is encouraging to see the Trust has participated in a wide range of national and local clinical audits and is ranked as the third-highest recruiting organisation in the East of England for clinical research and trials. This will help to attract a wider range of skilled professionals contributing to future development and ensuring continued improvements in patient care.

The report highlights a number of initiatives during the past year, such as “Time Matters” — a staff and patient engagement activity, which has provided valuable data to inform future business plans. The ongoing process of harmonising practice across Ipswich and Colchester is a huge task, and the Trust is to be commended for its achievements in this area so far. The section on cancer care is helpful with valuable user feedback from the National Cancer Patient Experience Survey. However, it would be useful if there was an explanation or discussion, for instance, of performances significantly at variance from the national average.

It is positive to see the Trust embracing a speaking-up policy, the adoption of the Accessible Information Standard, and the efforts to develop approaches in equality and staff support. “PLACE” comes across as a helpful approach which we would like to see extended to clinical areas, providing valid viewpoints in these areas too. It would also be useful if there was a commentary about the ratings, particularly in relation to those areas with below average scores such as privacy in Felixstowe and Bluebird, and dementia care in Bluebird and Ipswich.

The data and intelligence that informed the priorities for improvement set for 2019/20 was collected from a variety of sources, including patient users and user groups at “a community engagement event”. It would be useful to see greater engagement than one event and further explanation of how the Trust is ensuring it is reaching and collecting views from all parts of the community. Generally, the report lacked detail about public and patient engagement and partnerships, and without this detail there is a sense that patient feedback is not central to the Trust’s approach to quality. At HWS, we have considered feedback received about Ipswich Hospital between April 2018 and April 2019. Overall, positive feedback has remained at a similar level to the previous year whilst negative feedback has reduced. By far the largest number of reviews that we received were about treatment and care (213), and 80% of these were positive. In addition, 88% of the (91) comments about experience of care were positive. We were struck, for instance, by remarks made about the quality of cancer care. More critical reviews were posted about communication, discharge experiences, access to services, and diagnosis. Communication continues to receive the heaviest criticism, and while addressing this may be implicit in some of the targets, it would be useful to see his perennial complaint explicitly addressed.

We do think that the Quality Account could be improved by adopting a focus on analysis and outcomes rather than description and inputs. We would like to see greater clarity about priorities, and more reference to the contribution of partnership working. Overall, the document is very long, and we think that greater succinctness might enhance its impact.

Statements from key stakeholders

NHS
Ipswich and East Suffolk
Clinical Commissioning Group

Ipswich and East Suffolk Clinical Commissioning Group, as the joint lead commissioning group for East Suffolk and North East Essex Foundation Trust, confirm that the Trust has consulted and invited comment regarding the Quality Report for 2018/2019. This has occurred within the agreed timeframe and the CCG is satisfied that the Quality Report incorporates all the mandated elements required.

The CCG has reviewed the Quality Report data to assess reliability and validity and to the best of our knowledge consider that the data is accurate. The information contained within the Quality Report is reflective of both the challenges and achievements within the Trust over the previous 12 month period. The priorities identified within the account for the year ahead reflect and support local priorities.

Ipswich and East Suffolk Clinical Commissioning Group is currently working with clinicians and managers from the Trust and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and good patient experience is delivered across the organisation.

This Quality Report demonstrates the commitment of the Trust to improve services. The Clinical Commissioning Group endorses the publication of this account.

Lisa Nobes
Chief Nursing Officer
10th May 2019

Statements from key stakeholders

North East Essex
Clinical Commissioning Group

North East Essex and Ipswich and East Suffolk Clinical Commissioning Groups' response to

East Suffolk and North Essex NHS Foundation Trust Quality Report 2018-19

North East Essex CCG and Ipswich and East Suffolk CCG welcomes this first Quality Report of the newly merged Trust, which is a commitment to an open and honest dialogue with patients and the public regarding the quality of care provided by East Suffolk and North Essex NHS Foundation Trust (ESNEFT).

Though the CCGs are commenting on the final draft version of the Quality Report, we are pleased to be able to assure the accuracy of the content in general, recognising that some of the elements are yet to be addressed.

Part 1 of the report, provides a statement from the Chief Executive summarising the key achievements throughout 2018-19 assuring the quality of the health services provided by the organisation.

Part 2 demonstrates the Trust's achievements against the priorities for improvement for 2018-19; to improve the physical health of patients with mental health problems; to continue the improvements in care and support to those patients at the end of their life and their carers; and to continue the excellent work undertaken in the management of sepsis. The document identifies areas of success as well as areas which continue to be improved. The document demonstrates good organisational governance.

The priorities for improvement for 2019-20 are welcomed as a Trust wide programme of improvement facilitated through the 'getting it right first time' methodology following the merger in July 2018, as well as further improvements in sepsis 6 care bundle and a reduction in patient falls.

As a public facing document, the 3 column presentation is not easy to review electronically; and summarising more of the information in a pictorial format would be helpful to the public.

The performance report against the 2018-19 national CQUINs would have benefited from quarter 4 data however, the CCGs acknowledges the challenges in collating data across the newly merged organisation to demonstrate performance.

The CCGs note and recognise the Trust performance against the core quality indicator standards required by the regulatory framework. There are clear improvement plans in place with system partners to improve the SHMI position.

Our conclusion is that ESNEFT's Quality Report 2018-19 provides an accurate overview of the Trust's quality improvements for the year; clearly identifying better patient outcomes and future ambitions for improving quality and safety in the services it provides; and agrees with the priorities identified for 2019-20.

Both North East Essex and Ipswich and East Suffolk CCGs look forward to continue working collaboratively with the Trust, to ensure services remain safe and of a high quality to our patients and local population.

Lisa Llewelyn

Lisa Llewelyn
Director of Nursing & Clinical Quality
On behalf of NHS North East Essex; and Ipswich and East Suffolk Clinical Commissioning Groups.

Statements from key stakeholders

The Trust has worked regularly with both the Essex HOSC and the Joint HOSC (established with Suffolk County Council) updating members on the merger and development of a corporate strategy and as a key partner of STP plans. In addition, it has supported the Essex HOSC in its recent review of A&E and seasonal pressures. Both the Essex HOSC and JHOSC expect to continue working closely with the Trust in the coming year.

With regard to the Quality Accounts, we liked the way you presented your priority areas and actions being taken. Some commentary on how those priorities may change over time, with the processes followed for management review, and anticipated future priorities would be helpful.

Some of the scores from the Staff Survey recommending services to family and friends, and about recommending the organisation as a good place to work, seemed low and we would have expected a more robust statement of intent on what steps would be taken to address this.

The section on Volunteering system was informative. As it seems that there may be circumstances where some volunteers could have access to confidential patient information some commentary providing reassurance about data security protection and safeguarding might help the disclosure.

Thank you for the opportunity to comment.

Cllr Jill Reeves

Chairman

Essex HOSC

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 2018/19 Quality Report.

Statement from the Council of Governors on the Quality Report 2018/19

The Governors of East Suffolk and North Essex NHS Foundation Trust are pleased to have the opportunity to comment on the draft Quality Report for 2019/20.

We continue to support the Trust's focus on patient safety, experience and quality and take this opportunity to reinforce our view that safety of patients is paramount. We believe that putting the patients and their carers first is the key to achieving consistent and high quality care. We look forward to progress being made on the Trust Strategy bringing improvements to patient care.

Governors have been actively involved with the new creation of ESNEFT and the appointment of the new Non-Executive Directors to the Board. We have been attending many patient and strategic meetings with internal and external stakeholders across our constituencies.

The Governors continue to hold the Non-Executive Directors to account, who in turn will hold the Executive Team to account. We are confident that by continuing to maintain our role we will be in the best possible position to provide assurance to our members that we represent.

Statement of assurance from the Board of Directors

Statement of directors' responsibilities in respect of the Quality Report

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 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*

• 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 2018 to [the date of this statement]

– papers relating to quality reported to the board over the period April 2018 to [the date of this statement]

– feedback from commissioners dated 17/05/2019

– feedback from governors dated 26/04/2019

– feedback from local Healthwatch organisations dated 10/05/2019

– feedback from overview and scrutiny committee dated XX/XX/20XX (awaited)

– the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated (not completed as yet)

– the [latest] national patient survey (not yet nationally published)

– the [latest] national staff survey 2018

– the Head of Internal Audit's annual opinion of the trust's control environment dated XX/XX/2019 (awaited)

– CQC inspection report dated (there was no CQC inspection report within the reporting period)

• 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

• [this point is only required where the foundation trust is not reporting performance against an indicator that otherwise would have been subject to assurance] as the trust is currently not reporting performance against the indicator [xxx] due to [xxx], the directors have a plan in place to remedy this and return to full reporting by [xxx]

• 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

.....Date.....
.....Chairman

.....Date.....
.....Chief Executive

Glossary

Bed days The measurement of a day that a patient occupies a hospital bed as part of their treatment.
Care Quality Commission (CQC) The regulatory body for all health and social care organisations in England. The CQC regulates care provided by the NHS, local authorities, private companies, 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.
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.

Appendix A

Independent Auditors' Limited Assurance Report to the Council of Governors of East Suffolk & North Essex NHS Foundation Trust on the Annual Quality Account

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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@colchesterhospital.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.colchesterhospital.nhs.uk

Colchester Hospital University NHS Foundation Trust
Turner Road, Colchester, Essex CO4 5JL
Tel: 01473 712233

This report is available online in this format and as an easy-read document at
www.colchesterhospital.nhs.uk/qualityaccount