Annual Report, Annual Accounts and Quality Report

1 April 2018 – 31 March 2019

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East Suffolk and North Essex NHS Foundation Trust

Annual Report
Annual Accounts
and
Quality Report

1 April 2018 – 31 March 2019

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

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Useful contact information

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Patient Advice and Liaison Service (PALS)

Our Patient Advice and Liaison Service (PALS) offers confidential, on-the-spot advice and support to help patients, relatives and other visitors to sort out any concerns they may have about their care.

You can contact PALS on Freephone 0800 783 7328 or by emailing pals@esneft.nhs.uk. Please state whether your email is about Ipswich, Colchester Hospital or our community services.

We care, do you?

Becoming a member of our foundation trust gives you the opportunity to get involved in decisions that affect the services that we provide to you and your family. Membership is open to anyone over the age of 16 who lives in our area.

To find out more, email ft.membership@esneft.nhs.uk, phone 01206 742347 or visit www.esneft.nhs.uk and click on “get involved”.

General information and inquiries

Email: communications@esneft.nhs.uk

Full contact details and more contact information is available at www.esneft.nhs.uk

For a copy of this Annual Report in Braille, large print or foreign language formats, please call 01473 704770

Welcome

Message from the Chair

I would like to begin by expressing my sincere thanks to every member of staff from Ipswich and Colchester hospitals, as well as those based in our community services, who worked so hard to make our merger during the summer a success. I've been hugely impressed with their positivity and the way in which everyone has worked together to create East Suffolk and North Essex NHS Foundation Trust (ESNEFT), and look forward to building on these strong foundations to further improve the services we provide in the future.

We have made significant progress during our first months, including appointing a new Board of Directors, as well as Executive and Non-Executive Directors and a Council of Governors. We have also started to offer some treatments closer to home, while creating ESNEFT and becoming the largest NHS trust in East Anglia has also seen us improve staff recruitment and retention.

We are ambitious and want to provide the very best care for the 800,000 people who rely on our services. We want to be a sustainable and stable organisation which, along with our partners, plays a full role in the development of our emerging integrated care system. We also have great ambitions for our 10,000 staff, and want to give them the chance to develop their careers, enhance their skills and have the opportunity to take part in research, innovation and the development of cutting-edge technology.

In January, we published a draft strategy which sets out what we need to do to help us achieve these ambitions and establishes a clear and exciting direction for our services over the next five years. The strategy was developed with our staff, partner organisations and representatives of the communities we serve, and was approved by the Board in April 2019. More information about the strategy, along with the five strategic objectives which underpin it, is available on page 13.

There has been much to celebrate over the past year. National recognition of the major step forward we have made in joining our two trusts came when we were awarded nearly £70m in capital funding to redesign and improve the facilities from which we work, include emergency and urgent treatment and diagnostic facilities at both Colchester and Ipswich hospitals. There were also plenty of other highlights:

- Work began on the £3.25m Collingwood Centre at Colchester Hospital. Once complete, the centre will vastly improve the experience which cancer patients and their families and carers have when coming into hospital by providing them with more modern, comfortable and welcoming facilities. The project has been made possible thanks to fantastic support from the local community, who have gone above and beyond to raise money for the building.

- Former surgeon Dame Clare Marx, who is now part of our leadership team, made history by becoming the first woman to be appointed chair of the General Medical Council.

- A dementia-friendly sensory garden featuring an exercise area, pavilion and listening bench, opened at Aldeburgh Hospital to help patients to recover so they can return home more quickly.

- Robots arrived at Ipswich Hospital to handle admin tasks, such as some GP referrals, in turn freeing up hundreds of hours of medical secretaries' time to spend helping patients.

- New technology was introduced at Colchester Hospital which cancels appointments automatically in our patient record systems, in turn helping reduce the number of wasted outpatient appointments.

- Ipswich Hospital's cardiology department began offering a new 'rotoblation' procedure which allows patients to receive treatment for extremely calcified coronary arteries without having to travel to Papworth Hospital.

- Nienke Warnaar, a consultant surgeon at Colchester Hospital, became one of just a handful of clinicians from across Europe to be awarded the prestigious European Association for Endoscopic Surgery fellowship.

- Our community midwifery teams in east Suffolk were given new devices which test for jaundice in newborn babies, allowing them to carry out the test during a home visit or in the community rather than asking the family to come to hospital.

- Plans to create a £7m combined interventional radiology and cardiac angiography unit at Colchester Hospital were unveiled in January, allowing ESNEFT patients to be diagnosed more quickly and receive care in a specialist suite.

- Colchester patient Gerald Brown became the first person to be fitted with a heart monitor which sits under the skin and talks to a smartphone, meaning he can be monitored at home and no longer needs to go into hospital for check-ups.

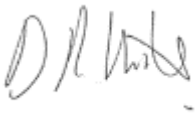
- Fordham Ward at Colchester Hospital was refurbished to provide brighter, more modern surroundings to make patients' stays less stressful.

- Energy-saving LED lights, dementia-friendly flooring, wet rooms, a children's playroom and streamlined nurse stations were installed during a six-week transformation of Ipswich Hospital's Somersham cancer ward.

- Plans to build a new drugs manufacturing facility worth more than £3million at Colchester Hospital were unveiled, giving patients the chance to continue benefitting from tailor-made medication, including chemotherapy drugs.

- Work on a multi-million pound transformation of the main entrance at Colchester Hospital began. The project will see the building extended, providing additional space for the emergency department, while new visitor facilities will also be added to provide a welcoming, safe and comfortable environment for people arriving at the hospital.

None of these achievements would be possible without the invaluable support of our staff, volunteers, supporters, stakeholders, partners and the people we serve. My thanks go to you all.



David White
Chairman

Chief Executive's overview and plans for the year ahead

Four days before the NHS celebrated its 70th birthday last July, East Suffolk and North Essex NHS Foundation Trust (ESNEFT) was created. It brought together Colchester and Ipswich hospitals and a range of community services in east Suffolk, along with around 10,000 staff who work together to deliver care to 800,000 people from eight sites.

A huge amount of work went into making the merger a success and ensuring that patients could continue to receive high quality, kind and compassionate care while it took place. My thanks go to all of our colleagues, volunteers, partners and the community for their support during this time. Their hard work has given us a strong foundation from which to build our organisation and develop our ambitions for the future.

At the heart of all our work in preparing for and becoming a new Trust was our philosophy that 'Time Matters'. Dealing with ill health is stressful, both for the patient and for those caring for them. However, too often the complexity of the health and care systems adds unnecessary stress. At the heart of this is time, which is important to everyone, whether they are patients, family or carers or staff delivering care. Our Time Matters philosophy was born from this concept – we will reduce the things we do which create unnecessary stress for patients and families and which waste their valuable time. We want to improve services to make every moment count so that we can offer the best care and experience.

We are also changing the way we think about providing care, concentrating on what patients need instead of how hospitals work. We know that people do best when they're at home, so our aim is to provide support that keeps them close to home for as much of the time as possible, using hospitals only when there is no alternative. This means working closely with the other parts of the health and care system, such as GPs, mental health and community services providers, social care and voluntary services, to break down the barriers which exist between organisations so that patients can receive truly joined-up care. We will also give our colleagues in the community quicker access to advice and guidance from specialists to reduce unnecessary admissions to hospital and allow better planning of longer-term care once patients have been discharged.

All of this relies on us sharing information about patients. Significant work will go into linking our technology together so that we can access patient information more easily, in turn meaning they only need to tell their story once. Our online 'patient portal' will also allow patients to see the information we hold about them, make and change appointments and provide a way of communicating directly with their doctor to monitor ongoing conditions and reduce unnecessary journeys to hospital.

We will work to help people stay in control of their health through increased support for self-care and physical and mental wellbeing. Our aim is also to provide direct access to our consulting and diagnostic services so that people with suspected cancer, for example, don't have to go through their GP.

When people do have to come to our hospitals, we will provide high quality care with the right level of clinical expertise, improved buildings and facilities and safe systems and processes. We will reduce waiting times for planned care and use technology to coordinate care more effectively. We will also modernise our diagnostic and consulting services to provide care as efficiently and consistently as possible, for example through providing more one-stop clinics.

To achieve all of these goals, it will be vital for us to support and develop our staff. Our aim is to do just that by creating an environment which allows our people to thrive while helping us to retain and attract the best staff.

It is going to be an exciting year.

Nick Hulme
Chief Executive

About this Annual Report

This is East Suffolk and North Essex NHS Foundation Trust's first Annual Report and Accounts since the Trust came into existence on 1 July 2018. As such, there is no comparative 2017/18 data available. These figures will be included for the first time in our 2019/20 report.

The 2017/18 Annual Reports for our legacy organisations – Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust – are available on our website, at www.esneft.nhs.uk/about-us/annual-report-and-accounts/

A report for The Ipswich Hospital NHS Trust, which covers the first quarter of 2018/19 until the merger in July, has also been prepared and will be available on the Trust's website.

About us

History of the Trust

East Suffolk and North Essex NHS Foundation Trust (ESNEFT) was established in July 2018 and brought together the two trusts which previously ran Colchester (Colchester Hospital University NHS Foundation Trust) and Ipswich (Ipswich Hospital NHS Foundation Trust) hospitals and Ipswich East Suffolk Community health Services.

As the two organisations had shared a leadership team since 2016, the next logical step was to fully merge the trusts, in turn improving efficiency and reducing overheads and duplication. Bringing our teams and resources together would also allow us focus on seeing patients at the right time, attracting and keeping the best staff and providing the latest treatments locally.

The merger process took around two years to complete, during which we engaged with staff, patients and partners and spent time assuring our regulators and stakeholders that we could deliver our aims. We initially produced a strategic outline case in January 2017, followed by an outline business case in August 2017 and the final business case, which was approved at the end of March 2018. All three documents are available on our website, at www.esneft.nhs.uk/about-us/merger-of-colchester-and-ipswich-hospitals/

We are excited about the possibilities that ESNEFT will offer our local residents and staff, and will continue to engage with local people as the Trust develops over the months and years ahead.

The people we serve

We provide hospital and community health services to around 800,000 people living across a wide geographical area. We deliver care from two main hospitals in Colchester and Ipswich, six community hospitals, high street clinics and in patients' own homes. We also provide a range of specialised services, such as spinal surgery and prosthetics.

Our pathology services are provided by North East Essex and Suffolk Pathology Services (NEESPS) which is a partnership of Ipswich, Colchester and West Suffolk hospitals and is hosted by our Trust.

We are the largest NHS organisation in the region and have an annual budget of more than £650 million.

We are also one of the biggest employers in East Anglia, and employed 10,045 people as 31 March 2019.

Time Matters

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

During November, we arranged a week-long series of engagement events to share our philosophy, ambitions and objectives, listening and working with our patients and staff to see what it meant to them and how they could contribute.

The aim of Time Matters week was to:

- start the conversation and create a social movement for all staff across the Trust to personally contribute to Time Matters; and
- involve all staff, asking them to play their part in contributing to the vision and making sure every contribution was valued.

The primary focus of the Directors during the week was to:

- be visible in supporting areas across the organisation;
- have face-to-face contact with teams to gain knowledge of areas outside of their day-to-day responsibilities;
- to listen, observe, gently enquire, share expertise and to lead the ambition for the organisation around Time Matters;
- to enable innovation, encourage ideas and empower and support people to release 'non value-added time' and improve time to care;
- to build interconnectedness – i.e. what affects one of us affects us all; and
- to build ingenuity by telling people 'there's nothing we can't achieve if we set our minds to it', for example.

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 meant to them and how/where they could release time in their day to make life easier for themselves, their teams or their patients. Managers were encouraged to link with the areas they cover throughout the week 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. We also sought our patients' views via surveys and an interactive diary room.

Feedback

During the week, we collected feedback from a variety of sources, as detailed in the table below:

Method	Data collected
Manager's survey	475 responses
Staff and patient survey	649 responses
'Inflatapod' video comments	176 videos
Ideas panel	66 ideas
Corporate fix-it sessions	Around 200 drop-ins

When analysed, this feedback highlighted that:

- we need to 'get the basics right';
- staff want basic business processes that work;
- staff want to be able to contact each other;
- staff want IT equipment that works and assists and doesn't hinder doing the job;
- patients put up with delays as they are grateful to be seen and appreciate the wonderful treatment they are receiving;
- our clinical processes often work against staff and patients, requiring duplicate data. The value/purpose of some process steps is also not clear;
- car parking was the most frequent frustration for both patients and staff; and
- there is a reluctance from staff to raise issues or ideas, and give their names.

The feedback also showed that we frustrate our patients when:

- we invite them to multiple appointments, often for two minutes for them to be then told they need to book another appointment for a diagnostic test; and

- cancel clinics at the last minute and don't inform them; they are not able to contact department to change a booking.

Action taken

We have taken several actions after listening to this feedback, many of which are being driven by individual services to make improvements within their own area. This includes investing in new PCs and tablets to speed up IT for staff, creating additional car parking spaces for people using our sites and giving colleagues the opportunity to keep their own contact details up-to-date on our intranet directory so that they can get in touch with each other more easily.

Actions which cut across many services or affect corporate business processes have been incorporated into a programme of work that is overseen by the Time Matters Board and fall into categories such as use of resources, logistics and corporate transformation and elective care.

In addition, we are:

- bringing Time Matters to life each day by asking all staff to think about the impact their actions have on others' time;
- continuing to encourage an environment where all staff feel empowered to speak up about ideas they have without judgement, giving them confidence to take responsibility for things they can change themselves;
- following-up on the data received as actions distributed amongst the respective divisions. These will be built into business plans for fixes that will take more planning;
- seeing Directors and senior managers continue to make time to listen and engage with teams; and
- planning to schedule another Time Matters week in the summer of 2019.

Performance Report

The Performance Report helps readers to assess how the Directors performed in their duty to promote the success of the Trust. The report has been prepared in accordance with the relevant sections of the Companies Act 2006, as interpreted in the Government Financial Reporting Manual. We have also taken account of Monitor guidance and the Financial Reporting Council guidance on the Strategic Report (November 2015) to ensure that the report is fair, balanced, understandable, comprehensive but concise and forward-looking.

Statement of purpose and activities

Our vision and strategy

Since ESNEFT was created, we have developed a new strategy, which was published in January and approved by our Board in April 2019. It was developed with our staff, partner organisations and representatives of the communities we serve, and sets out a clear and exciting direction for our services over the next five years.

Our ambition is to offer the best care and experience, and is supported by five strategic objectives which will guide planning and investment:

- Keep people in control of their health
- Lead the integration of care
- Develop our centres of excellence
- Support and develop our staff
- Drive technology enabled care

The document is aligned with national and local strategies, and recognises that we are part of a complex system of health, care and wellbeing services and have key role to play in making sure that service users can receive joined-up care. At its heart is our philosophy that time matters, and our drive to reduce the unnecessary stress of navigating the system and free up time to focus on what matters most.

The challenges for our services, and the health and care system as a whole, are significant. This is due to the growing and ageing population combined with shortages in some parts of the workforce.

To meet this challenge, we have to adopt new ways of working and achieve better coordination with other parts of the system. Developing our staff by giving the chance to learn new skills lies at the heart of this, along with introducing new roles at the Trust. Technology will also be key in helping us use information well while making our services more accessible. Innovation in treatments and diagnostic services are also needed to ensure we can continue to provide the highest quality services for local people.

Our services

The Trust provides a range of patient services:

	2018/19
Outpatient attendances*⅄	1,020,435
Emergency Department (A&E) patients*	201,747
Inpatient and day case admissions*†	190,435
Babies born	6,948

*Source: figures taken from Trust commissioned activity
⅄ Outpatient attendances include first, follow-up appointments and procedures carried out on an outpatient basis

† Inpatient and day case admissions include day cases, electives, non-electives and regular day attenders

Key issues and risks

Key issues

The merger of Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust to create East Suffolk and North Essex NHS Foundation Trust took place on 1 July 2018. This has created the largest Trust in the region, bringing opportunities to develop economies of scale and improve organisational resilience.

Risks

The causes of the risks and the mitigating actions are described in more detail in the Annual Governance Statement, which begins on page 91. In brief, the principal risks to the Trust's strategic objectives are:

- Ineffective organisational management may not be able to fully mitigate the variance and volatility in performance against the plan.
- Identifying, measuring and delivering cost improvement opportunities and leveraging transformational change, impact on delivery of control total, cash flow and long-term sustainability as a going concern.
- Ineffective engagement of our staff on the improvement journey, which may limit the sustainability of improvements made.
- Poor processes for recording activity, which may lead to information gaps
- Delay in transformation of pathology services, leading to suboptimal service impacting on patient care and relationship with our partners.
- Insufficient nursing staff may lead to delayed or rushed care for patients and a poor patient experience.
- Failure to transform through our strategy and its delivery so that we are unable to achieve long term sustainability.
- If activity growth exceeds capacity assumptions based on the 2018/19 contract and legacy issues are not addressed, then we may not have sufficient capacity to assess and treat people in a timely manner.

Going concern disclosure

These accounts have been prepared on a going concern basis. In accordance with IAS 1, management has made an assessment of the Trust's ability to continue as a going concern. For the financial year commencing 1 April 2019 the Trust has forecast a deficit of £8.6million. Within this forecast is a cost improvement programme requiring £31.9million of efficiencies and savings. In order to fund this deficit, the Directors are seeking interim financial support for 2019/20 of £8.5million from the Department of Health and Social Care. At the time of writing, an interim working capital loan facility of £170million has been provided to the Trust and discussions are ongoing with regard to the further support required.

The Directors, having made appropriate enquiries, have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Department of Health and Social Care Group Accounting Manual 2018/19, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Performance analysis

This section provides more detail about the Trust's performance and information on our most important performance metrics, including finance, activity, quality and our future plans, including plans relating to regulatory compliance.

Care Quality Commission (CQC) registration

For the period before the merger (1 April to 30 June 2018), Colchester Hospital University NHS Foundation Trust (CHUFT) had in place registration with the CQC with no enforcement action.

On 1 July 2018, we successfully registered all ESNEFT regulated activities with the CQC by:

- registering The Ipswich Hospital NHS Trust regulated activities to CHUFT registration;
- completing statutory notification to change the name of our organisation to East Suffolk and North Essex NHS Foundation Trust;
- completing statutory notification to change the statement of purpose; and
- submitting statutory notification to cancel The Ipswich Hospital NHS Trust registration to provide all regulated activities;
- The CQC has subsequently archived The Ipswich Hospital NHS Trust's registration. Those regulated activities which were acquired by CHUFT are currently stated as 'not inspected' and therefore have no rating assigned by the CQC;
- Deregistered Essex County Hospital following closure in 2018;

Following the CQC's last inspection of CHUFT in 2017, the Trust was rated as 'requires improvement'. In 2018/19, we continued to progress priority actions from the CQC requirement notices from both predecessor organisations.

East Suffolk and North Essex NHS Foundation Trust has unconditional registration with the CQC with no enforcement action. In line with the CQC inspection framework, we anticipate an inspection of our core services, use of resources and well-led in 2019/20.

Further detail on the quality of care can be found in the Quality Report (section C).

NHSI enforcement undertakings

The S106 improvement notice issued to Colchester Hospital University NHS Foundation Trust by NHSI in January 2018 remained in force throughout 2018/19. This recognised that the Trust had not yet achieved sustainable improvements in its operational performance against the cancer 62-day standard, ED and referral to treatment time targets. Throughout the year, we have continued to focus on improving our performance in these areas against the agreed trajectories, with regular reporting to NHSI.

We plan to carry out a self-assessment during 2019 to assess East Suffolk and North Essex NHS Foundation Trust's leadership against the NHSI Well-Led Framework. This will include a review of risk management and Board to ward effectiveness.

Financial outlook

2018/19 was a significant year regarding the scale of the Trust's accountability for NHS resources. The turnover of our newly-formed Trust grew from £344m as Colchester Hospital University NHS Foundation

Trust to £624.3m as ESNEFT at the end of the financial year. Both legacy Trusts were deficit organisations and the establishment of ESNEFT was expected to initially maintain this deficit position, before the full benefits of the merger were realised. During the year it was also necessary for us to instigate a significant financial recovery programme as ESNEFT was not performing in-line with the financial plans agreed at the start of the year, which would have resulted in a substantial unplanned deficit.

Before financial adjustments related to the merger ('transfers by absorption'), ESNEFT incurred a deficit of £8.4m which was better than plan. This includes £31.3m of support from the Provider Sustainability Fund (PSF), which was set up in 2017/18 by NHS Improvement to support providers to move to a sustainable financial footing based on their financial and operational performance. This non-recurrent funding was awarded to the Trust for first achieving our agreed financial plan and then for ED performance. Under the 2019/20 guidance, the maximum PSF support our Trust can achieve in the coming financial year is £11.4m.

After financial adjustments related to the acquisition, the Trust is reporting a surplus for the year of £33m. This incorporates £41.4m of gains arising from the transfer by absorption of The Ipswich Hospital NHS Trust. The value of this transfer represents the value of the net assets and liabilities transferred from the date of acquisition.

Cost improvement programme

During 2018/19, our ambition was to deliver a cost improvement programme (CIP) of £40.5m. The scale of this target was unprecedented, but was necessary for the Trust to gain support from the Provider Sustainability Fund. Although we successfully achieved savings of £30.2m during the financial year, only £16m of these were recurrent, which leaves us with an underlying cost improvement challenge in 2019/20.

A CIP target of £31.9m is required to meet our planning requirements during 2019/20. This represents 4.5% of turnover. It is higher than planned in the merger business case (2.6%) because of the low level of recurrent savings delivered in 2018/19 and a number of financial pressures not planned for within the approved merger business case.

A range of measures have been implemented using the Model Hospital and outputs from the 'Getting it Right First Time' programme. Following financial recovery measures during 2018/19, we are maintaining financial grip and controls, with a particular focus on agency staffing expenditure and a financial improvement regime.

Looking ahead to 2019/20

During the coming year, we will continue to develop our clinical strategy while retaining a focus on the financial implications of strategic changes. We are continuing to progress our detailed financial modelling, particularly in relation to the capital investment approved as part of the national Wave Two investment programme during 2018/19.

The requirements of the NHS Long Term Plan, which was published in January 2019, set out the need for trusts which are in deficit to be back in balance by 2023/24. To help us achieve this, we will develop a sustainable financial recovery plan and expect to receive £14.8m of Financial Recovery Funding as a result.

Cash funding

Due to the scale of the deficit from previous years, the Trust continues to be reliant on Department of Health and Social Care funding through a government loan arrangement. For 2019/20, we will seek external cash financing of £8.5m via the Department of Health and Social Care.

NHS Improvement will review our plans to ensure that financial support is provided only for the necessary costs of running a safe organisation. Discretionary spending and investments will be reviewed as part of the conditions of accessing funding from the Department of Health and Social Care.

The Trust will also need to abide by other conditions, such as the use of capital, which means we will be under increased scrutiny financially and will face constraints in our ability to incur significant costs or capital commitments.

Long term planning

Longer term, the Trust will need to do more than deliver cost improvement plans and efficiency savings to return to a financially sustainable position and improve standards of care.

We are currently producing a pre-consultation business case setting out the options for ESNEFT to develop sustainable clinical services in the long term, and expect to consult with the public on this document during 2019/20. This clinical strategy will consider ways to address increased demand and pressure on services caused by a growing population, changes in demographics and increasing prevalence of long-term conditions.

The Suffolk and North East Essex Integrated Care System (ICS) was established during 2018/19. The King's Fund have been supporting the ICS to consider future governance arrangements which will allow it to take forward planning at a neighbourhood, alliance and system level.

Financial accountability is expected to be held at an alliance level. ESNEFT straddles the North East Essex Alliance and the Ipswich and East Suffolk Alliance.

Financial performance

The Trust's accounts for 2018/19 have recorded a surplus of £33million. This includes £41.4m gains arising from transfers by absorption resulting from the acquisition of The Ipswich Hospital NHS Trust on 1 July, when ESNEFT was formed. As such, the assets, liabilities and ongoing operational income and expenditure form part of these accounts from this date.

Acknowledging that the growth in income and expenditure significantly increased due to the in-year transaction, all of the comparisons represent a material change.

As a result of its overall performance in 2018/19, the Trust received £31.3m from the Sustainability and Transformation Fund (an increase of £11m compared to 2017/18). The Sustainability and Transformation Fund is to be distributed to providers to support movement to a sustainable financial footing.

	2018/19 £m	2017/18 £m
Total Operating Income (included in EBITDA)	623.6	343.5
Total Operating Expenses (included in EBITDA)	-610.7	-336.9
EBITDA*	**12.9**	**6.6**
Depreciation and amortisation	-16.9	-8.2
Non-operating costs	-4.4	-2.7
Surplus/(deficit) for the year BEFORE gains arising from transfers by absorption	**-8.4**	**-4.3**
Gains arising from transfers by absorption	41.4	n/a
Surplus/(deficit) for the year	**33.0**	**n/a**

*EBITDA is Earnings Before Interest, Taxation, Depreciation and Amortisation

Consolidated accounts

Colchester Hospital Charity was merged with the Ipswich Hospital Charity with a single registration under the Charity Commission to form Colchester and Ipswich Hospitals Charity. The Trust has not consolidated the activities of the charity, whose activities are not considered to be material.

Innovation and excellence

We support a wide range of advanced skills training, innovation and industry collaboration to improve the quality of the services we provide and the experience our patients have of receiving care.

In July we established a new innovation team which supports staff who have innovative ideas with advice and funding applications, as well as linking up with external support networks. We have also established an innovation network to provide a community which nurtures budding entrepreneurs.

Our clinical services continue to develop new and better ways to serve our local communities, such as:

- **Stroke telemedicine** – equipping ambulances with video equipment to allow our specialists to assess people at home, speeding up diagnosis.

- **Stroke ambulance** – trials of a special ambulance equipped with a mini CT scanner, which will allow strokes to be diagnosed and even treated before the patient reaches hospital.

- **Diabetes service** – which won two National Quality in Care awards for their innovations in care and patient education.

- **Hospital at night** – which has seen a smartphone app called WatchPoint developed to ensure patients receive safe care at night and the weekends. Developed by our in-house software team, the app helps to identify patients at risk and improves the handover of important information.

- **Intensive care** – which is using a new system called CareVue which allows all the information about intensive care treatment to be recorded electronically, including automatic collection of data from monitors, ventilators and syringe pumps. This increases the quality of care and makes the records accessible instantly.

- **Outpatients** – we are now using 'virtual workers' to speed up some of the administrative processes around managing outpatient appointments. This frees up our staff to give more time to patients.

- **Children's services** – we have introduced the 'Little Journey' app to help children prepare for a stay in hospital. It allows them to take a virtual tour of the department and meet the staff, while explaining what they can expect to happen in a child-friendly way.

We are also continuing to expand education and training for staff and people who may want a career in healthcare, and have dedicated simulation facilities at both Colchester and Ipswich hospitals which allow our staff to practice their skills in a realistic but completely safe environment. Other innovations to take place within education include:

- offering drop-in laparoscopic simulation training for surgical trainees;
- providing international courses and conferences in advanced surgical techniques, including video-casts of eminent surgeons operating from around the world and from our hospitals to surgeons across the globe;
- offering a highly successful course to help pre-registration nurses prepare for the Objective Structured Clinical Examination (OSCE);
- Running schools' engagement programmes and intensive courses in our hospitals; and
- increasing the number and range of apprenticeships available at ESNEFT, including new opportunities in IT and communications.

In addition, the Iceni Centre at Colchester Hospital remains one of only five across the world to be accredited by the Royal College of Surgeons as an Advanced Surgical Skills Centre.

Operational service standards

Emergency department (A&E) four-hour standard

The Trust recorded a performance of 91.3% against the national standard of 95%.

National access standards

Our performance against the challenging national access standards between April 2018 and 31 March 2019 was:

	Standard	Performance
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	93%	91.7%
Two-week wait for symptomatic breast patients (cancer not initially suspected)	93%	79.1%
All cancers: 62-day wait for the first treatment from national screening service referral	90%	88.0%
All cancers: 62-day wait for the first treatment from urgent GP referral to treatment	85%	75.3%
All cancers: 31-day wait from diagnosis to first treatment	96%	96.1%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	100%	93.3%
Percentage of patients on an incomplete pathway with a maximum of 18 weeks waiting time	92%	88.5%
MRSA	0	1
Incidence of Clostridium difficile infection	18	56

Research and development/ innovation

We are fully committed to research which improves the quality and experience of care for local people. Since our merger, we have increased the range of clinical specialties carrying out active research, and saw 28 departments taking place during 2018/19, with 129 principal investigators leading the projects.

We meet our NHS Constitution duty to offer patients the opportunity to be involved in research and now involved the third highest number of patients in research of any organisation in the east of England. This has been reinforced by our new Trust strategy, developed after the merger, which places research and innovation at the heart of our ambition to offer the best care and experience.

A new leadership team has been appointed this year, while the governance arrangements for research have been refreshed for the new, multi-hospital organisation. Representation at the Trust Board is through the Director of Strategy, Research and Innovation.

Our Trust is a member of the NIHR Clinical Research Network: Eastern (CRNE), which is responsible for effectively delivering research in the east of England. The majority of funding for our research activity flows through CRNE, with just over £1.6m allocated for research staff and supporting activity during 2018/19. This funding supports 35.5 WTE research posts.

We are also actively building links with academic institutions in the region and internationally. Over time, this will increase the opportunities for people to be involved in basic science research.

The Trust is a member of the University of Suffolk's Centre for Health and Wellbeing's research board and of the Eastern Academic Health Science Network (EAHSN), which promotes and supports the application of research into practice. Through the Suffolk and North Essex Sustainability and Transformation Partnership, we also participate in the University College London Partner's Academic Health Science Network, which is based in north London.

In addition, we have joined the University of East Anglia's Health and Care Partnership (UEAHCP), which is a local collaboration for research and innovation, and signed collaborative agreements with two hospitals in China, which include research.

Our staff also regularly produce conference abstracts and papers for academic journals which demonstrate the importance of research across our Trust.

Maximising engagement in research

This year we have involved 2,645 new people in ethics committee-approved research. Of these, 2,615 were recruited into NIHR portfolio studies. This means that we involved the third highest number of people in research of any organisation in CRNE, with only teaching hospitals recruiting more.

Involvement in research offers significant benefits, including improved outcomes. It is also part of our commitment to improving the quality of care we provide while making a wider contribution to health improvement. Examples of projects our patients have taken part in this year include an international study which evaluated the effectiveness of using UrgoStart dressings to treat diabetic foot and leg ulcers. The dressings, which are associated with faster wound healing, were subsequently recommended by NICE as an option for treating patients.

Our patients were also involved in a two pivotal studies which brought ibrutinib into practice to treat chronic lymphocytic leukaemia and small lymphocytic lymphoma. We were one of only a handful of sites in the UK to be given the opportunity to participate in both studies, which gave our patients the chance to access ibrutinib before its general approval.

We are also keen to initiate research at our Trust. One example of this is an interventional study called MAVEN (Management of People with Venous Ulceration: Feasibility Study). This study compares the

effectiveness of standard bandaging compared to a device called Juxta-Cures in managing people with venous ulceration. We have now closed the study after recruiting our 40th patient and will be informing everyone who took part of the results later this year.

Research governance

All research is delivered in accordance with the Research Governance Framework for Health and Social Care (2005). This sets out the research governance standards which all organisations should apply to work managed in a formal research context.

We ensure that all of our research has undergone robust governance, and Trust assurance is required before any research can start at the organisation. All studies on the NIHR portfolio have been through quality assurance processes to ensure compliance with good practice.

Staff undertaking research activity should be trained in International Conference Harmonisation – Good Clinical Practice (ICH-GCP), which is valid for two years, to make sure that best practice is maintained.

The Medicines and Healthcare products Regulatory Agency (MHRA) also regulate research practice and undertake periodic site inspections, with the last taking place at our Trust during 2017/18.

Performance metrics

The CRN Eastern high level objectives (HLOs) for research in 2018/19 were:

- HLO1: Number of participants recruited into NIHR CRN portfolio studies
- HLO2a: Commercial sites recruiting to time and target (RTT)
- HLO2b: Non-commercial studies achieving RTT
- Value for money: Activity-based funding model using a study complexity weighted score to determine budget setting.

The NIHR continues to publish outcomes against national benchmarks. The Trust holds one of these contracts – NIHR: Performance in Initiating and Delivering (PID) Clinical Research. These outcomes include an initial benchmark of 70 days or less from the time a provider of NHS services receives a valid research application to the time when that provider recruits the first patient for that study (performance in initiating clinical research). It also includes the NHS provider's performance in recruiting to time and target for commercial contract clinical trials (performance in delivery of clinical research).

These reports are available by visiting
www.nihr.ac.uk/research-and-impact/nhs-research-performance/crn-performance/key-statistics.htm

Life sciences industry

The NIHR promotes industry studies, which are adopted onto its portfolio via an expression of interests system. The Trust receives expressions of interest from CRN Eastern which are reviewed locally to determine their feasibility. Additionally, through clinicians and research associations with industry, the Trust has been pre-selected for industry studies.

Income received from life sciences industry research contributes to our research infrastructure and is reinvested into research activities. We are also able to offer early access to new medicines as a result of industry sponsors supplying trial drugs free of charge.

Collaborations with life sciences partners during the past year include manufacturing NutLife, a peanut protein immunotherapy treatment, and the Iceni Centre, which is our advanced surgical skills centre.

Environmental sustainability

We take our responsibility as a major employer and consumer of energy and resources seriously, and are committed to continuous improvement in reducing the adverse effects of our operations on the wider environment and the health of local people. We recognise the impact of our operations on the local and global environment and are committed to demonstrating leadership in sustainable development.

Sustainable development can be achieved only in conjunction with the wider community. As such, we have joined Colchester Travel Plan Club and are actively exploring how we can work more effectively with other local organisations. We also regularly promote sustainable modes of transport to staff at all of our sites.

The Director of Estates and Facilities is the Trust's Executive lead for sustainable development and carbon reduction.

Sustainability strategy

Following our merger, ESNEFT has two Board-approved Sustainable Development Management Plans (SDMPs) in place which are broadly consistent with the NHS Sustainable Development Strategy 2014-2020.

The plans identify the ways in which the Trust's activities impact on the environment and look to provide a framework for measuring improvement in each area. Work is currently taking place to combine these two documents into a single Trust-wide plan.

Activities in 2018/19

We have carried out a number of activities to address specific objectives in the SDMPs over the past 12 months. In particular, we invested additional funds in replacing fluorescent lighting with LED fittings, which will continue into 2019/20. We are planning to equip this lighting with automatic controls to further improve the carbon savings.

We have implemented our Travel Planning and Car Parking Management Strategy at Colchester Hospital, and plans to roll the strategy out to Ipswich Hospital during the coming year.

Work to replace old inefficient chillers at Colchester Hospital has begun, and has also given us the opportunity to revise plant layouts, remove historic system inefficiencies and replace ancillary equipment in order to make the new systems as efficient as possible. Improvements are also planned at Ipswich Hospital, where we will displace the electric chillers through the use of absorption chillers connected to the steam network.

Energy

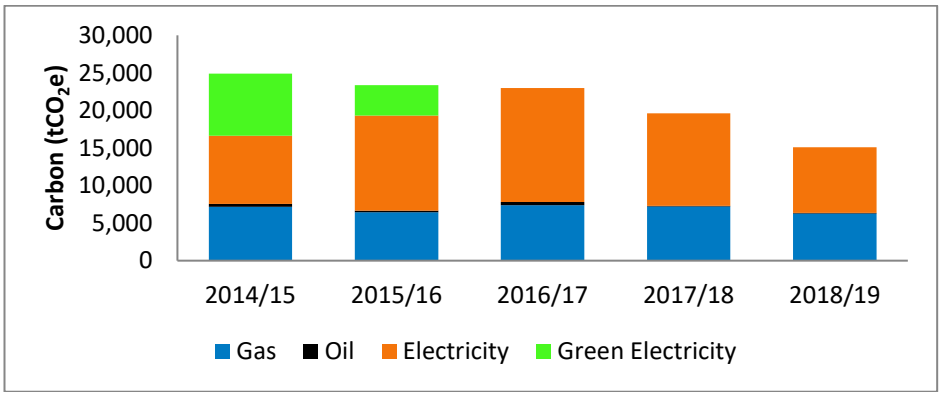
The Trust's carbon emissions decreased in 2018/19, driven by the work to change in light fittings to LED and the review of operating plant and associated equipment.

In 2015, the Colchester site moved away from its 'green' electricity tariff as these tariffs are regarded as having no impact on overall carbon emissions under modern environmental reporting principles. Instead, the Trust has chosen to focus its efforts on energy efficiency to achieve carbon reductions.

Resource		2014/15	2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	34,188,424	30,808,829	35,334,914	34,605,401	33,995,271
	tCO_2e	7,173	6,448	7,385	7,207	6,255
Oil	Use (kWh)	1,161,491	644,657	1,406,948	474,999	334,617
	tCO_2e	372	206	446	109	93
Electricity	Use (kWh)	14,707,497	22,006,469	29,353,175	27,598,731	28,549,523
	tCO_2e	9,109	12,652	15,170	12,301	8,770
Green electricity	Use (kWh)	13,345,551	7,078,886	441,766	1,267,547	200,774
	tCO_2e	8,265	4,070	0	0	0
Total energy CO_2e		**24,919**	**23,375**	**23,000**	**19,618**	**15,118**

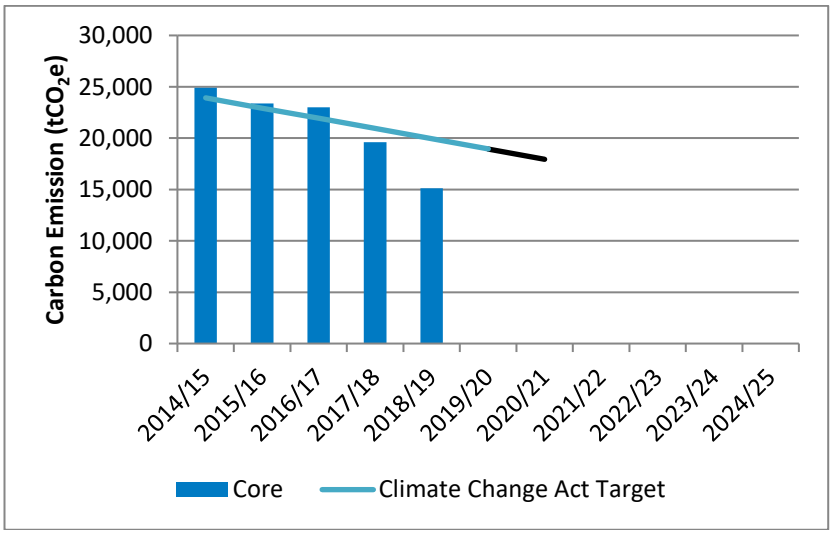
We will invest further in energy-saving measures in 2019/20, and will continue to replace fluorescent lighting with LED lights and fans and pumps with modern energy-efficient models. The boiler plant will also be optimised.

Carbon emissions – energy use



Carbon reduction target

Through the various schemes implemented to date, together with the steady closure of our historic buildings, we have achieved the 2020 carbon reduction target ahead of schedule and will now begin plans for achieving the 2025 target.



Water consumption

Water consumption has decreased to its lowest level to date, however additional buildings at both Colchester and Ipswich over the next two to three years will see this figure rise again.

Water		2014/15	2015/16	2016/17	2017/18	2018/19
Mains Water	m^3	250,807	251,358	270,605	248,286	220,691
	tCO_2e	228	229	246	226	217

Renewable energy

Colchester Hospital has two sets of solar photovoltaic (PV) panels, which generated a total of 29,061kWh during 2018/19, reducing the amount of grid-supplied electricity used by the Trust and generating income.

Ipswich Hospital made use of its biofuel plant during the winter to generate 171,713kWh of electricity from a renewable source.

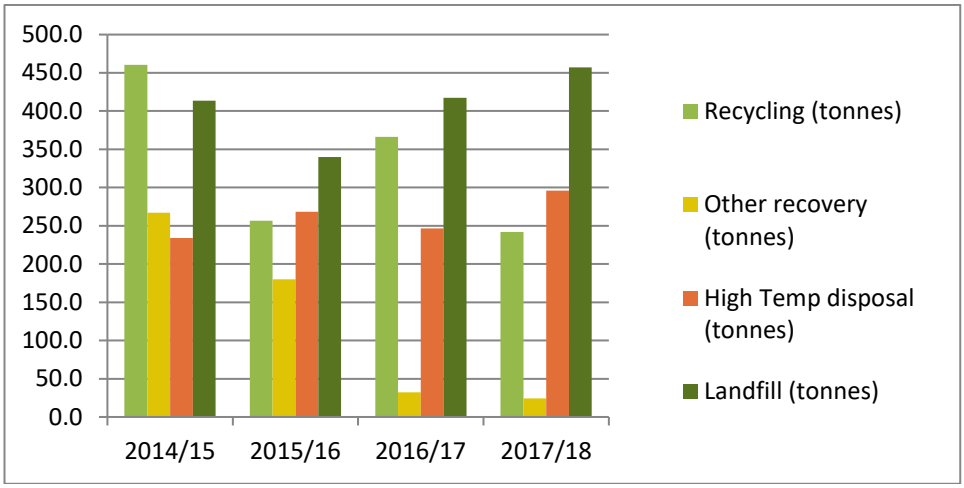
Clinical waste from both hospitals is incinerated on site at Ipswich, with the heat recovered used to provide heating and hot water, meaning much less gas is used than at other equivalent hospitals. This reduces our carbon emissions by more than 3,500 tonnes. Plans are underway to make use of this heat during the summer, when it is normally discharged into the atmosphere, to provide cooling in place of electric chillers.

Waste

Waste proportions have changed in recent years in line with the transfer of services from Essex County Hospital to Colchester Hospital and into the community.

Waste		2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	460.36	256.61	366.12	242.07
	tCO_2e	**9.67**	**5.13**	**7.69**	**5.27**
Other recovery	(tonnes)	266.94	179.83	32.26	24.28
	tCO_2e	**5.61**	**3.60**	**0.68**	**0.53**
High temp disposal	(tonnes)	233.94	268.52	246.60	295.78
	tCO_2e	**51.47**	**58.81**	**54.25**	**65.07**
Landfill	(tonnes)	413.50	339.92	417.22	457.15
	tCO_2e	**101.07**	**83.08**	**129.34**	**157.48**
Total waste (tonnes)		1374.74	1044.88	1062.20	1019.28
% Recycled or re-used		33%	25%	34%	24%
Total waste tCO_2e		**167.81**	**150.62**	**191.96**	**228.35**

Waste breakdown



Travel

The Trust has formed a travel, access and parking group which will discuss and set targets, as well as reviewing and monitoring the progress we make towards increasing sustainable travel. This will include our drive to decrease single car occupancy and offer more sustainable forms of transport for all ESNEFT staff and visitors.

During the year, we have offered subsidies on bus and rail fares, and plan to build new cycle storage facilities and staff showers at both acute hospital sites and a new dedicated travel centre for staff and patients at Colchester.

Procurement

We also look to reduce our energy consumption through careful equipment purchasing, such as by installing new pedestrian crossings which are solar powered. Our estates department continually reviews and adds to our standard materials list, which includes energy efficiency is one of its key criteria.

The sustainability of all of our planned new builds and refurbishments is considered during the business case approval process.

Social, community and human rights issues

Our place in the community

As an NHS provider and employer, the Trust operates within the requirements of UK and European law, including its responsibilities for equity of access to services, employment and opportunities.

We also operate within the NHS Constitution and have employment and service policies in place which address equality and human rights issues.

Information to, and consultation with, employees

The Trust has consulted with staff to implement organisational change, including mergers and where services have been redesigned or are being transferred either to or from an external service provider. Where formal consultation is necessary, the Trust is very careful to ensure that communication takes

place before the formal consultation period. Once that period is closed, informal communication and consultation continue while any change is introduced.

Throughout any period of consultation and change, staff are given the opportunity for both individual and group communication in a variety of forums with the aim of supporting harmonious change for the staff affected and, ultimately, the service provided to patients. This is supported by our recognised unions.

The intranet and email system are also used as rapid methods of communication, while screensavers are also to share simple messages.

There is an established regular briefing by the Chief Executive and members of the Executive team which is cascaded through the organisational management structure. The Board encourages managers to engage with staff members in changing and improving the way in which services are provided.

Equality, diversity and inclusion (EDI)

Our Trust is committed to making sure that our staff and patients feel valued and included and are treated fairly and respectfully. This commitment is included within our stared values and expectations of conduct, which all of our staff have a responsibility to support.

To ensure we meet our responsibilities, we have set up an Equality, Diversity and Inclusion Steering Group to provide assurance to committees and the Trust Board. The group has set its agenda for the coming 12 to 18 months, and will focus on:

- accessible information standard
- EDI induction / training
- equality impact assessments
- LGBT+ programme
- workforce race equality scheme
- workforce disability equality scheme
- compliance

Equality Delivery System 2

The Equality Delivery System2 (EDS2) is the national framework which supports NHS trusts to deliver better outcomes for patients and communities and better working environments for staff which are personal, fair and diverse. Like all NHS organisations, ESNEFT uses the Equality Delivery System (EDS2) to implement its equality and diversity strategies and deliver its Public Sector Equality Duty.

At the heart of the EDS2 are four goals, which are:

- better health outcomes
- improved patient access and experience
- a representative and supported workforce
- inclusive leadership

A key part of EDS2 includes recruiting patients, staff and representatives from local interest groups to help evaluate our current position and identify ways to progress.

We plan to review and refresh our EDS2 during 2019/20.

LGBT+ Network

Our LGBT+ Network was set up by staff volunteers, who represents the interests of LGBT+ staff and service users at ESNEFT. Its aims are to:

- Engage in positive change in the workplace, which will allow all LGBT+ staff to excel in a supportive and non-discriminatory work environment; and
- Ensure that patient services are welcoming, non-judgemental and meet the healthcare needs of the LGBT+ community.

Our LGBT+ Network has gone from strength to strength this year, with the progress it has made acknowledged in January when the team were presented with an ESNEFT commendation by Chief Executive Nick Hulme.

Workforce race equality standard

The NHS workforce race equality standard (WRES) was introduced 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 nine 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 overall performance on the WRES is of a mixed picture, with both improvements and some deterioration.

WRES indicators			2016	2017	2018
1. Percentage of staff in each of the AFC bands 1-9 and VSM (including Board members) compared with the percentage of staff in the overall workforce	IHT	BME	8.91%	8.50%	10.85%
		White	77.97%	74.61%	75.33%
		Unknown	13.12%	16.89%	13.81%
	CHUFT	BME	14.70%	15.40%	16.80%
		White	82.40%	82.00%	80.80%
		Unknown	2.90%	2.60%	2.50%
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	IHT	BME	13.74%	13.74%	18.15%
		White	24.62%	24.62%	26.14%
		Unknown	0.00%	0.00%	19.30%
	CHUFT	BME	15.00%	15.08%	Not known
		White	19.00%	19.15%	Not known
		Unknown	0.00%	0.00%	Not known
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	IHT	BME	0.88%	0.82%	0.84%
		White	0.81%	0.74%	0.68%
		Unknown	0.00%	0.00%	0.13%
	CHUFT	BME	0.90%	1.35%	Not known
		White	0.70%	1.14%	Not known
		Unknown	0.00%	0.00%	Not know
4. Relative likelihood of BME staff accessing non-mandatory training and CPD	IHT	BME	0.00%	0.00%	4.40%
		White	0.00%	0.00%	4.35%
		Unknown	0.00%	0.00%	4.34%
	CHUFT	BME	10.50%	10.01%	0.00%
		White	5.80%	5.90%	0.00%
		Unknown	0.00%	0.00%	0.00%
5. Percentage of BME staff experiencing harassment bullying or abuse from patients, relatives or the public in the last 12 months*	IHT	BME	39.13%	33.33%	22.73%
		White	30.22%	30.43%	25.28%
	CHUFT	BME	33.00%	30.00%	29.57%

		White	36.00%	27.81%	28.21%
6. Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months*	IHT	BME	43.48%	25.64%	31.25%
		White	23.08%	27.67%	21.27%
	CHUFT	BME	16.67%	26.32%	30.85%
		White	26.00%	27.16%	28.42%
7. Percentage of BME staff believing that the trust provides equal opportunities for career progression or promotion*	IHT	BME	66.67%	61.5%	81.9%
		White	92.11%	90.9%	87.90%
	CHUFT	BME	69.57%	73.1%	66.96%
		White	82.86%	77.88%	80.72%
8. Percentage of BME staff personally experiencing discrimination at work from a manager/team leader or other colleagues*	IHT	BME	13.04%	12.82%	11.43%
		White	4.11%	6.18%	4.37%
	CHUFT	BME	11.43%	13.16%	12.23%
		White	5.80%	7.94%	6.05%
9. BME board membership	IHT	BME	0.00%	0.00%	0.00%
		White	70.60%	100.00%	100.00%
		Unknown	29.40%	0.00%	0.00%
	CHUFT	BME	7.70%	6.70%	15.40%
		White	85.60%	86.70%	76.90%
		Unknown	6.70%	6.70%	7.70%

* The results marked with an asterix have been taken from the 2017 NHS Staff Survey.

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

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
- external benchmarking and networking

Gender pay gap reporting

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced gender pay reporting legislation, which requires organisations with 250 or more employees to publish statutory calculations every year identifying the pay gap between male and female employees.

There are six gender pay gap indicators, which all NHS trusts report upon:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay

The gender pay gap is different to equal pay. Equal pay relates to the differences between individuals or groups performing the same or similar work. It is unlawful to pay people unequally because of their gender.

Gender pay gap has a focus on the differences between the average earnings for all men and all women within the workforce, regardless of their level or role within the organisation.

Local findings

As the snapshot date for analysis is 31 March 2018, the following sections provide a breakdown of the information reported by the separate NHS organisations pre-merger.

Data must be submitted to 1 decimal point. For differences in rates of pay and bonuses, a positive percentage indicates that men in the Trust receive a higher rate than women.

Bonus pay for this purpose relates to clinical excellence awards for medical staff.

Each part time worker counts as one employee for gender pay gap reporting purposes.

The Ipswich Hospital NHS Trust

Gender	Average hourly rate	Median hourly rate
Male	21.8298	16.2237
Female	15.1195	14.0563
Difference	6.7103	2.1674
2018 pay gap %	30.7393	13.3595
2017 pay gap %	32.3424	17.2895

Bonus pay

Gender	Average pay	Median pay
Male	12,294.04	9,040.50
Female	5,252.53	2,862.81
Difference	7,041.51	6,177.69
2018 pay gap %	57.28	68.33
2017 pay gap %	21.53	0.00

The reason for the high % rate for the pay gap for 2018 is due to the number of female staff who received a bonus this year, which increased from nine in 2017 to 14 at 31 March 2018. These five additional female colleagues are in the first year of receiving their Clinical Excellence Awards and are therefore at the lower end of the bonus scale, in turn lowering the average pay value:

The Trust appoints a Local Awards Committee (LAC) to oversee the awards process and following appointment to the panel, training is provided on how to score applications following set guidance by NHS Employer/BMA. All applications are reviewed independently and confidentially by the panel members using the guidance documentation, once the scores are received by the Coordinator these are collated and ranked to provide a view of the initial application rankings; the aggregate scores for each domain and ranked total scores are available to all members at the formal award panel meeting.

In advance of the LAC meeting, a pre-meet is held with the Medical Director, HRD, Head of Medical Staffing and LCEA Coordinator to review the final application scores and highlight any outlying scores for further review at the LAC. As a benchmark of excellence, applications are required to achieve a minimum average score of 22 to be considered for a value award. Therefore at this pre-meet, applications that are currently placed plus or minus one point from an overall average score of 22 for 1 value award and plus or minus a point of 32 for 2 value award points. Once value award points are agreed at the LAC meeting, letters are generated the following day to both the successful and unsuccessful applications. Feedback meetings are offered to all unsuccessful applications.

Gender	Employees paid bonus	Total relevant employees	% 2018	% 2017
Female	14.00	4590.00	0.31	0.22
Male	73.00	1207.00	6.05	7.06

Employees by pay quartile

The figures in brackets relate to the 2017 data period and are for comparison purposes only.

Quartile	Female	Male	Female %	Male %
Lower quartile 1	1048.00 (940.00)	204.00 (197.00)	83.71 (82.67)	16.29 (17.33)
Lower middle quartile 2	1046.00 (962.00)	205.00 (175.00)	83.61 (84.61)	16.39 (15.39)
Upper middle quartile 3	1098.00 (1002.00)	157.00 (137.00)	87.49 (87.97)	12.51 (12.03)
Upper quartile 4	847.00 (736.00)	407.00 (403.00)	67.54 (64.62)	32.46 (35.38)

Colchester Hospital University NHS Foundation Trust

Gender	Average hourly rate	Median hourly rate
Male	20.6006	14.8226
Female	15.2391	13.5855
Difference	5.3615	1.2372
2018 pay gap %	26.0261	8.3466
2017 pay gap %	27.4404	7.2123

Bonus pay

Gender	Average pay	Median pay

Male	12,346.76	9,040.50
Female	7,187.07	6,027.04
Difference	5,159.68	3,013.46
2018 pay gap %	41.79	33.33

2017 pay gap %	36.05	0.00

Gender	Employees paid bonus	Total relevant employees	% 2018	% 2017
Female	13.00	3654.00	0.36	0.44
Male	58.00	1176.00	4.93	5.62

Employees by pay quartile

The figures in brackets relate to the 2017 data period and are for comparison purposes only.

Quartile	Female	Male	Female %	Male %
Lower quartile 1	897.00 (807.00)	219.00 (209.00)	80.38 (79.43)	19.62 (20.57)
Lower middle quartile 2	849.00 (784.00)	263.00 (232.00)	76.35 (77.17)	23.65 (22.83)
Upper middle quartile 3	924.00 (862.00)	202.00 (154.00)	82.06 (84.84)	17.94 (15.16)
Upper quartile 4	724.00 (639.00)	395.00 (378.00)	64.70 (62.83)	35.30 (37.17)

Summary

It is acknowledged that further analysis is required to understand the reasons why the pay gap exists in certain areas and how we benchmark against other local NHS organisations and alliance partners. This review will take place during 2019/20 and will include recommendations as to the approaches our organisation should take in the future.

The Trust has a policy that all substantive staff are paid through the payroll. No Board member or senior officials with significant financial responsibility were engaged on an off-payroll basis in 2018/19. The procedure for engaging contractors and limits are set out in the Trust SFIs. The Trust has needed to engage a number of contractors to support fixed-term assignments in areas such as information technology, financial services and corporate transformation on an off-payroll basis.
The number of contractors engaged is shown in the tables where daily rates exceed £245 per day and the engagement has lasted longer than six months.

Gender profile

Our workforce is similar to the overall NHS workforce gender profile as shown below. In the coming year, work will continue to ensure staff are not disadvantaged due to their gender.

Gender	England average (NHS Employers May 2018)	ESNEFT (ESR March 2019)
Male	23%	23.06%
Female	77%	76.94%

Age profile

The age profile of the Trust is similar to that of the national average.

Age	England average (NHS Employers May 2018)	ESNEFT (ESR March 2019)
Under 25	6%	4.77%
25 to 34	23%	26.48%
35 to 44	24%	23.63%
45 to 54	28%	24.97%
55 to 65	17%	17.45%
65 and over	2%	2.70%

Ethnicity profile

The ethnicity profile of the workforce is broadly similar to the national profile of the NHS workforce, although is a greater ethnic mix than the population we serve.

Ethnicity	England average * (NHS Employers May 2018)	ESNEFT (ESR March 2019)
White	77%	74.45%
Back or Black British	5%	2.14%
Asian or Asian British	9%	10.55%
Mixed	2%	1.63%
Chinese	1%	0.56%
Any other ethnic group	2%	0.92%
Not stated/ unknown	5%	9.75%

* Figures are rounded to the nearest percentage point, therefore may not add to 100

Armed Forces

The Trust is a positive champion of the Armed Forces, and signed the Armed Forces Covenant in 2016. In 2017, the Trust received the revalidation of the silver award, highlighting its continued commitment to defence personnel since 2014. Our HR colleagues will continue to work in partnership with the Ministry of Defence towards achievement of the gold award.

Health and safety

The risk and governance team continue to lead Trust-wide health and safety governance structures, which allows us to provide a robust and well-developed health and safety management system as part of ESNEFT's risk management strategy.

The health and safety policy has been approved by the Board and complies with Section 3 (2) of the Health and Safety at Work Act 1974. In addition, all ward/departments have access to:

- A health and safety folder which contains the policy along with ward/department risk assessments; and
- COSHH (Control of Substances Hazardous to Health) manuals which contain risk assessments and guidelines for the safe use of substances.

All incidents relating to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) have been reported to the Health and Safety Executive (HSE) and investigated by the risk and governance team. The health and safety team have completed investigations where staff or visitors have been injured due to a health and safety concern, which are then uploaded onto Datix, our electronic local incident reporting and management system.

All departments, including our community sites, have been audited in compliance with HSG 65. Any safety failures which were identified were addressed immediately with departments or escalated to line managers.

The health and safety team have also continued to deliver health and safety mandatory training which is at 87% compliance. Annual manual handling audits have taken place in clinical areas and time-bound action plans issued to areas where the need for improvement has been identified. Areas of concern included documenting competency assessments, provision of consistent basic equipment levels and progress with action plans from 2018/19.

Trust-wide compliance with manual handling part one (non-clinical) stands at 87% compliance, with part two (clinical) at 86% compliance.

Health and wellbeing

The Trust is committed to providing an effective health and wellbeing service to which all staff have access. The service provide rapid access to physiotherapy to enable staff to receive speedy advice and treatment, as well as an employee assistance programme.

Towards the end of 2018/19, we identified the mental wellbeing of our staff as a priority for the Trust, and have since worked in partnership with Suffolk Mind to agree a 12 to 18 month work programme to help staff protect their emotional wellbeing and mental health. This included delivering training called 'Your Needs Met' to all of our divisional senior leadership teams, along with the continuation of our emotional needs audit (ENA), which first took place during December 2018.

We were delighted to support Suffolk Mind's RED January campaign this year. The initiative encourages people to support their mental health by doing something active every single day. Many staff joined in during 2019, and we hope to attract even more interest before January 2020.

Over the past 12 months, our health and wellbeing team have also enjoyed working with Public Health England and various alliance partners to review and refresh of the Healthy Workplace Award, which is based on eight standards including leadership, health and safety, healthy eating and mental health.

Schwartz Rounds

During the year, we have continued to facilitate Schwartz Rounds, which are structured one-hour meetings open to anyone who works on our hospital sites. Taking place monthly, their aim is to give people the chance to reflect on the emotional experience of working in healthcare, rather than finding solutions to problems. Evidence shows that staff who attend the meetings feel more supported, valued and connected with others.

Topics explored during the Schwartz Rounds this year have included:

- 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 the autumn, representatives from ESNEFT 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.

Employee assistance

Staff continue to have access to an employee assistance programme for psychological support and a database for non-psychological problems. A helpline is available to support managers with work issues.

Zero tolerance policy against violence and abuse

The Trust will not hesitate to seek the prosecution of anybody who attacks members of staff while at work. The vast majority of assaults are verbal, and on rare occasions staff have been subject to assault which we take very seriously and will involve the police if required.

The safety of our workforce is paramount and a number of procedures are in place to minimise any potential risk to staff. The Trust has an accredited security adviser who runs in-house training courses on how to deal with violent and aggressive situations and how to manage conflict successfully. These courses are mandatory for all frontline staff.

Fraud and corruption

The Trust supports the continued establishment and maintenance of a strong anti-fraud, bribery and corruption culture among all staff, contractors, the public and patients. Fraud is taken seriously and staff are made aware of how to identify and report fraud correctly.

The Trust endorses the right and duty of individual staff to raise any matters of concern they may have with the delivery of care or services to a patient of the Trust, or about financial malpractice, unlawful conduct, dangers to health and safety or the environment.

In 2018/19 we published an anti-fraud and bribery statement, which supplements our existing anti-fraud work by setting out our position to all staff, contractors, the public and patients.

We are committed to abiding by the NHS Counter Fraud Authority's Standards for Providers and believe that a culture of openness and dialogue is in the best interests of patient care. However, this must be set in the context of our duty of confidentiality to patients. Our Freedom to Speak Up Policy sets out the procedures put in place for staff if they wish to raise concerns, and the responsibilities managers at all levels have to ensure these are dealt with thoroughly and fairly.

Overview and scrutiny

Both Essex County Council and Suffolk County Council's Health Overview and Scrutiny Committees (HOSCs) considered aspects of the Trust's work during the year.

Shane Gordon, Director of Strategy, Research and Innovation, appeared before both committees to present an update on the development of ESNEFT's strategy while the Trust's Directors of Operations –

Alison Power, Simon Hallion and Alison Smith – attended to discuss specific operational issues relating to the emergency department, effective discharge of patients and community care.

Public consultations

There were no public consultations during 2018/19 under section 242 of the NHS Act 2006. However the Trust did undertake preliminary engagement relating to the development of its strategy.

Other patient and public involvement activities

The head of patient experience maintained contact with Healthwatch Essex and Healthwatch Suffolk, providing feedback on any issues which were raised. They also attended the Colchester and Ipswich hospital patient advisory groups pre-merger, which became a joint group following the creation of ESNEFT.

Our patient user groups, which aim to make sure patients are involved in the new Trust, have agreed their terms of reference. A new Colchester Hospital User Group is being formed, while the Ipswich Hospital User Group, which has been established for a number of years, is making changes to its responsibilities to reflect the role of Governors after becoming part of a foundation trust. Both groups are aligning their processes and working together to support ESNEFT.

Principal risks and uncertainties

The Trust is able to demonstrate compliance with the corporate governance principle that the Board of Directors maintains a sound system of internal control to safeguard public and private investment, ESNEFT assets, service quality through its board assurance framework (BAF).

Board Assurance Framework (BAF)

The BAF was regularly reviewed during 2018/19 to ensure that it provided an adequate evidence base to support the effectiveness and focused management of the principle risks to meeting strategic objectives. The BAF illustrates the escalation process to the Board of Directors and its committees when risk to quality, performance and finance arise which require corrective action.

The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified on the BAF. It also identifies the key controls in place to manage each of the principle risks and explains how the Board is assured that those controls are in place and operating effectively.

Its principal aim is to provide a mechanism for the Trust's Board of Directors to regularly assess the level of risk against the controls in place to mitigate the risks, and to also consider the adequacy of the assurance. A summary of the principle risks within the BAF is provided within the Annual Governance Statement, which begins on page 91.

Effective Risk and Performance Management

The Trust's risk management policy ensures effective governance and compliance with best practice. The Board maintains a framework which ensures timely escalation of risk to the Board by committees and specialist groups.

The risk management policy which sets out the principles to ensure performance and quality improvement is connected through a two-way communication between the Board and service delivery areas across ESNEFT, such as wards, clinics and patients' homes. This is underpinned by a clear risk appetite statement, which was approved by the Board of Directors in October 2018.

A governance structure was established as defined by the post-transaction implementation plan. A monthly integrated performance report to the Board provides an organisational dashboard which is underpinned and informed by reviews of service level dashboards, with action planning at these levels. Improvements at an operational level is managed through divisional quality and performance meetings and is tested through divisional accountability meetings with Executive Directors. A programme of patient presentations and patient stories relating to quality priorities and service risks is also delivered to the Board and its committees.

The Quality and Patient Safety Committee oversees and routinely receives information on all serious incidents and the lessons we have learnt from them.

The Trust has continued to build and strengthen the arrangements for managing serious incidents requiring investigation (SIRIs). During 2018/19, we continued to report patient safety incidents and investigate to establish their root cause to enable risks to be addressed in a timely manner.

ESNEFT is a member of the NHS Resolution's Clinical Negligence Scheme for Trusts.

Effectiveness of systems of internal control

The Board's arrangements for its review and evaluation of the effectiveness of its systems of internal control to manage its principal risks and meet regulatory requirements are also explained in the Annual Governance Statement.

Contractual or other arrangements

This section gives information about organisations with whom we had contractual or other arrangements which were essential to the business of the Trust (unless disclosure would, in the opinion of the Directors, be seriously prejudicial to that organisation and contrary to public interest):

- North East Essex Clinical Commissioning Group (CCG) and associate commissioners (healthcare commissioning)
- Ipswich and East Suffolk Clinical Commissioning Group and associate commissioners (healthcare commissioning)
- NHS England (specialised, local area and armed forces healthcare commissioning)
- West Suffolk NHS Foundation Trust (clinical services)
- Essex Partnership University NHS Foundation Trust (mental health services)
- Norfolk and Suffolk NHS Foundation Trust (mental health services)
- Anglian Community Enterprise (clinical services)
- Ramsay Healthcare Ltd (clinical services)

Overview of other procurement arrangements

The Trust had a number of other procurement arrangements, including:

- National Blood Service (blood products)
- Alliance Medical (MRI services)
- Diaverum UK (renal services)
- Opcare (orthotic and prosthetic services)
- GE Capital (equipment leasing)
- Suffolk GP Federation

Joint ventures and partnership arrangements

The Trust has always worked in partnership with a number of organisations for the delivery of services. The most significant of these are:

- A section 31 partnership under the Health Act 1999 with Essex County Council, Mid Essex Hospital Services NHS Trust, NHS Mid Essex, NHS North East Essex, NHS South East Essex, NHS South West Essex and Thurrock Council for an integrated community equipment service.
- Partnership arrangements with other NHS Trusts, such as Mid Essex Hospital Services NHS Trust and West Suffolk NHS Foundation Trust for a range of clinical services

Trust business model

ESNEFT operates a devolved management structure comprising six clinical divisions within three groups and one corporate division. The groups and divisions have delegated authority for governance, performance and expenditure/income and are accountable through the accountability framework to the Executive team, led by the Chief Executive.

Post year-end events

The S106 improvement notice issued by NHSI in January 2018 remained in force throughout 2018/19. On 24 April 2019, NHSE and the NHSI Regional Support Group agreed that all undertakings should be removed from ESNEFT and that the Trust move from Single Operating Framework segment three to segment two.

On 24 April 2019, David White, Trust Chair, announced his appointment as the Chair of the Norfolk and Norwich University Hospital NHS Foundation Trust. As a result, he will be stepping down as Chair of ESNEFT at the end of May 2019.

Helen Taylor, Deputy Chair, will act up in the interim period as the trust seeks to recruit to the position.

Accountability Report

The Accountability Report pulls together all of the statutory disclosures relating to NHS foundation trusts and comprises the Directors' Report, Remuneration Report, Staff Report, FT Code of Governance Disclosures, regulatory ratings, Statement of Accounting Officer's Responsibilities and the Annual Governance Statement.

Directors' Report

The Directors' Report comprises the details of the individuals undertaking the role of director during 2018/19 and the statutory disclosures required to be part of that report and information relating to quality governance. It is presented in the name of the following directors who occupied Board positions during the year (it also incorporates the operating and financial review):

Name	Title
Susan Aylen-Peacock	Non-Executive Director (to 31 October)
Eddie Bloomfield	Non-Executive Director (from 1 November)
Barbara Buckley	Director of Clinical Integration (1 April to 30 June) Chief Medical Officer (1 July to 31 January)
Jude Chin	Deputy Chair/Non-Executive Director (to 30 June)
Laurence Collins	Non-Executive Director (from 1 July)
Tim Fenton	Non-Executive Director (to 31 October)
Shane Gordon	Director of Integration (1 April to 30 June) Director of Strategy, Research and Innovation (from 1 July)
Nick Hulme	Chief Executive
Richard Kearton	Non-Executive Director (1 July to 31 October)
Diane Leacock	Non-Executive Director (to 30 November)
Mike Meers	Director of IM&T
Neill Moloney	Managing Director/Deputy Chief Executive
Catherine Morgan	Chief Nurse
Elaine Noske	Non-Executive Director (1 July to 31 October)
Julie Parker	Non-Executive Director
Dawn Scrafield	Director of Finance
Jan Smith	Non-Executive Director (to 30 June)
Richard Spencer	Non-Executive Director (from 1 November)
Carole Taylor-Brown	Non-Executive Director (from 1 November)
Helen Taylor	Non-Executive Director (from 1 July)
Dr Angela Tillett	Interim Chief Medical Officer (from 1 February)
David White	Chair
Richard Youngs	Non-Executive Director (from 1 November)

Statement as to disclosure to auditors

So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken all of the steps that they ought to have taken as Directors in order to be aware of any relevant audit information and to establish that the auditors are aware of that information.

Planned developments at the Trust

The Trust agreed its Annual Plan for 2019/20 at its Finance Committee and Board of Directors meeting during March 2019. The final plan was submitted to NHS Improvement in April.

The key points to note from the 2019/20 Annual Plan and budget are:

- planned income and expenditure deficit of £8.6m, requiring a CIP delivery of £31.9m. This CIP target represents 4.5% of all pay and non-pay budgets and will be stretching; and
- capital programme of £32.2m, funded through internal resources, third parties and government loans.

Overall, the Trust will require £8.5m of revenue cash support for 2019/20.

Statutory income disclosures

Non-NHS income

Under the requirements of section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Trust can confirm that income from the provision of goods and services for the purpose of health services in England is greater than the income generated from the provision of goods and services for any other purpose.

Income to the Trust from non-NHS sources has a positive impact on the provision of goods and services for the purposes of the health service, as all income to the Trust is used for the benefits of NHS care.

HM Treasury requires disclosure of fees and income from charges to service users where income from that service exceeds £1 million. For 2018/19 and for 2017/18 this is nil.

Other public interest disclosures

Better Payment Practice Code

The Trust is required to pay trade creditors in accordance with the Better Payment Practice Code. This simple code sets out the following obligations of a business to its suppliers:

- bills are paid within 30 days, unless covered by other agreed payment terms
- disputes and complaints are handled by a nominated officer
- payment terms are agreed with all traders before the start of contracts
- payment terms are not varied without prior agreement with traders
- a clear policy exists of paying bills in accordance with contract.

We aim to pay at least 95% of our invoices in accordance with these obligations. However, cash constraints caused by our in-year deficit necessitated that we increase payment terms to 35 days wherever possible without causing a detrimental impact on the supply of goods and services it receives.

The trust's performance with the better payment practice code is set out in note 15 in the annual accounts.

HM Treasury cost allocation compliance

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Fixed assets

Although there is no predetermined frequency at which property, plant and equipment assets must be revalued, accounting standards require that asset values should be kept up-to-date. Therefore, the frequency of revaluation needs to reflect the volatility of asset values and, in NHS Improvement's view, property assets are likely to require revaluation at least every five years.

The last full valuation of the Trust's land and building assets was carried out at 31 March 2019 by the DVS (the commercial arm of the Valuation Office Agency). Both sites will be revalued on the same basis of alternative site with alternative build.

Political or charitable donations

The Trust made no political or charitable donations.

Interest rate or exchange rate risks

The Trust does not have any significant exposure to interest rate or exchange rate risks and therefore does not hold any complicated financial instruments to hedge against such risks. Details of the Trust's financial instruments are shown in the Annual Accounts.

Accounting policy for pensions and details of senior employees' remuneration

The accounting policy for pensions can be found in the Annual Accounts, which are in section B of this report. Details of senior employees' remuneration can be found in the remuneration report, which begins on page 62.

Quality Governance

The clinical governance structure supporting the quality agenda has been established across ESNEFT. Three executive groups (the Clinical Effectiveness Group, Patient Safety Group and Patient Experience Group) report through to the Quality and Patient Safety Committee, a sub-committee of the Board of Directors.

Well-Led framework

Quality, which encompasses patient safety, clinical effectiveness and patient experience, is at the heart of the Board and organisation's agenda.

As part of the preparation for the merger, the Board reviewed the arrangements in place to deliver against the NHSI Well-Led Framework, which included a review of risk management and Board to ward effectiveness. As a result of this review, Board memorandums for quality governance, financial reporting procedures and a post transaction implementation plan will be developed to show how we will deliver safe and high quality services and implement a vision for the future.

We plan to carry out a self-assessment during 2019 against the NHSI Well Led Framework, along with an external evaluation of the Board and governance of the Trust during 2019/20.

Consistency of evaluation

The Trust has reviewed the consistency of its Annual Governance Statement against other disclosure statements made during the year as required by the Risk Assessment Framework, the disclosure statements required as part of this report, the Quality Report and the Annual Plan and against the

reports arising from the CQC planned and responsive reviews of the Trust. We have identified no material inconsistencies to report.

Patient safety

Our ultimate aim is to deliver the highest quality healthcare services to every patient, every day. Each area is responsible for setting and delivering Trust-approved improvement targets. Performance against internal and external quality indicators is monitored by the Patient Safety Group. Assurance is provided to the Quality and Patient Safety Assurance Committee on a monthly basis.

Patient safety walkabouts

Following the induction and training period for our new elected Council of Governors (July 2018) and newly appointed Non-Executive Directors (November 2018), the Non-Executive Directors and the Governors have commenced walkabouts from February 2019 on our wards, clinics and other service areas in the Trust, speaking with patients and staff. These walkabouts are reported through to the Council of Governors, with immediate actions reported back to service area leads for completion. A scheduled programme of walkabouts has been established for 2019/20.

Peer reviews

The methodology used during CQC and Monitor reviews, which focus on the five key domains of safe, effective, caring, responsive and well-led, has been recognised as best practice. Subsequent peer reviews and 'deep dives' into concerns raised internally and externally continue to be led by the Risk and Compliance Team.

Mortality

The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) give an indication of whether the mortality ratio of an organisation is higher or lower than expected when compared to the national (England) baseline.

The following show the HSMR by Trust and period for 12 months to the date shown:

- Ipswich Hospital NHS Trust to March 2018 – 108.6, 'higher than expected'
- Colchester Hospital University NHS Foundation Trust to March 2018 – 109.4, 'higher than expected'
- East Suffolk and North Essex NHS Foundation Trust to December 2018 – 108.1, 'higher than expected'

For the period ending December 2018, ESNEFT was one of six acute non-specialist trusts of 15 in the East of England with a 'higher than expected' HSMR.

The SHMI results include deaths within 30 days of discharge. For the 12 months to the date shown, they are:

- Ipswich Hospital NHS Trust to March 2018 – 107.35, 'as expected'
- Colchester Hospital University NHS Foundation Trust to March 2018 – 113.76, 'as expected'
- East Suffolk and North Essex NHS Foundation Trust to September 2018 – 114.1, 'higher than expected'

A report from the Office for National Statistics showed that excess winter deaths in England and Wales were the highest recorded since 1975/76, with a 45% increase on 2016/7. These winter deaths have had a marked impact on both the SHMI and HSMR (statistical) relative risks.

ESNEFT serves a large elderly population, and records 8% more attendances for patients aged 64 and above than the national average. As a result, Colchester Hospital has seen year-on-year increases in in-hospital deaths for the last five years.

Mortality rates follow the national seasonal trend for acute trusts, which is amplified during the winter due to multiple chronic comorbidities such as heart failure, renal failure, diabetes and COPD.
Work is ongoing to make sure that patients arriving at ED are rapidly assessed and treated according to national protocols and that, following admission, they are closely monitored and escalated. We are working with community partners to reduce unnecessary admissions for patients in the last months of life by improving symptom control in the community, introducing services such as the COPD HOT clinic and allowing patients to be treated in their preferred place of care.

We have developed a robust mortality review process for in-hospital deaths in line with national guidance published March 2017. Deaths are reviewed in line with national mandatory requirements for learning from deaths using pre-defined criteria and multiple data sources. In addition, staff review any death where they feel that death was not 'expected' or where there were care concerns. From April 2019, medical examiners will provide additional scrutiny by assessing the quality of care as described in the health record and through discussion with the bereaved.

Where learning or issues are recognised these are collated and fed back to the clinical teams, and are also escalated via the Trust's internal governance system if required.

Falls prevention

There were 876 inpatient falls at Colchester Hospital in 2018/19, which is a 2.7% reduction on the previous year. Of these falls, 18 resulting in serious harm, which is the equivalent of a 42% decrease on the previous year (24).

Ipswich Hospital had 1,288 inpatient falls in 2018/19, which is a reduction of 15.5% on the previous year. Of these, 17 resulted in serious harm, which is an increase of 30% on the previous year's figure of 13.

Our community hospitals recoded a total of 406 falls in 2018/19. Data prior to 2018 is not available.

Since the merger, ESNEFT has continued its focus on delivering safe care for all patients. Cohort nursing has been effective and is rolling out across all hospital sites. Our aim is to maximise patient safety by identifying patients at risk of falls on admission and continually monitoring them until their discharge, while placing a focus on rehabilitation and mobilisation in our community hospitals.

Pressure ulcers

Pressure ulcers remain an unwanted complication associated with healthcare and it is widely acknowledged that they are largely preventable. They are costly in terms of human suffering, treatment and rising litigation costs due to them being regarded as an indicator of clinical negligence. Despite many national prevention campaigns in recent years, pressure ulcer incidence rates continue to rise.

Wounds are graded in accordance with European Pressure Ulcer Advisory Panel guidelines from stage one to stage four, with stage four being the most severe due to the extent of tissue damage that occurs.

The number of pressure ulcers at Colchester Hospital classified in stages two to four was 78, a decrease of 29.7% on the previous year. At Ipswich, there was a total of 171, which is an increase of 2% from the previous year. Our community hospitals recorded 19 stage two to four pressure ulcers this year. Data prior to 2018 is not available.

Our Trust continues to promote the use of the ASKIN (assessment, surface, keep moving, incontinence/ moisture, nutrition/ hydration) care bundle as an effective model of pressure ulcer prevention by ensuring staff embed the model principles into their everyday nursing care. Assessment ensures that patients who are at risk of developing pressure ulcer damage are identified early and appropriate care interventions are implemented to prevent pressure ulcers.

Improvements in patient information

Our patient information strategy continued to ensure healthcare professionals were able to deliver accurate, up-to-date, easy-to-understand, informative and timely information to patients. More than 1,000 different leaflets were available, which were compliant with Department of Health guidelines.

Infection control

We have continued to perform well with regard to controlling and preventing hospital-acquired infections. Rigorous clinical and environmental hygiene measures, controls on prescribing antibiotics, isolation of infected patients and root cause analysis of cases, supported by learning and implementing changes, continue to have a significant impact. We will continue this vigilant approach in 2019/20 with education, monitoring and reporting.

Clostridium difficile

Clostridium difficile incidence is assessed as cases detected more than 72 hours after admission (these are considered to be attributable to an infection acquired in hospital). A new system of reviewing cases was introduced to determine whether cases were associated with or without breaches of local protocols, the latter being deemed unavoidable. The agreed maximum ceiling of cases with breaches for ESNEFT was 34.

Of the 52 cases reported, there were 11 cases with breaches and 41 cases with no breaches across all sites. Continuing with a low number of cases is testament to the vigilance of clinical teams and their compliance with best practice. However, we still have further work to do relating to antimicrobial prescribing and timely isolation.

From April 2019, the way figures are reported will change, with the focus moving to a system-wide approach and giving CCGs responsibility and accountability for reducing in the total number of cases.

MRSA bacteraemia

MRSA incidence is assessed as cases detected more than 48 hours after admission, which are considered to be attributable to an infection acquired in hospital, or cases where MRSA is considered to be a contaminant in blood cultures. Although our target was to have zero cases of MRSA bacteraemia, one inpatient case was identified. The case was reviewed by a panel and learning relating to peripheral line management shared as a result.

Gram negative blood stream infections

There is a national ambition to reduce the number of cases of E-coli bacteraemia by 50% by 2021. As three-quarters of these cases occur before patients are admitted to hospital, we are contributing to a system-wide plan to support improvements across the health economy.

Surgical site infection

Orthopaedic surgical site infection data reporting has been mandatory since 2005. The Trust also participates in non-mandatory reporting, including continual vascular surgical site infection surveillance, and continues to achieve rates well below the national benchmark in all modules covered.

Hand hygiene monitoring

We monitor compliance with best practice for hand hygiene in all clinical areas every month. Compliance overall remained above 95%.

Improving our patients' experience

Your experience is our responsibility

We remain fully committed to improving patient experience and providing high quality, safe and effective services, while putting patients, relatives and carers at the heart of everything we do.

We continue to welcome complaints as a tool for learning and making improvements. As a result of the merger, our Patient Advice and Liaison Service (PALS) and the complaints team were aligned to ensure anyone contacting them would receive a consistent and high standard of support, although the teams also continue to provide local support to each hospital as enquiries remain site-based.

We are committed to learning from incidents and ensure our teams are aware of all lessons to be learnt for their areas in order to minimise the risk of serious incidents, never events and serious complaints.

We collect patient feedback from many sources and use this information to inform service development and improvement programmes.

Privacy and dignity

Maintaining patients' privacy and dignity is fundamental to providing a high standard of care. According to the 2018 national adult inpatient survey, 99% of Trust patients said they were treated with dignity and respect and 96% stated there was always enough privacy when being examined or treated.

Treating patients with privacy and dignity is included on the extended clinical induction for our nurses and allied health professionals.

Delivering same sex accommodation

The NHS Constitution confirms a patient's right to dignity and respect. The Trust is committed to treating all patients with privacy and dignity in a safe, clean and comfortable environment.

We are compliant with the government requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will share only the room where they sleep with members of the same sex, and that same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will happen only when clinically necessary, for example, where patients need specialist equipment such as in intensive care or the high observations unit.

If our performance falls short of the required standard, this is reported to North East Essex CCG or Ipswich and East Suffolk CCG. We also have an audit mechanism to make sure we do not misclassify any of our reports. We record the results of that audit as part of our patient experience audits.

Patient and public involvement

As an NHS foundation trust, we are committed to the principle of public, patient and staff involvement. Public and staff members have elected Governors to represent their views and to work with the Trust to ensure patients' views are taken into consideration at all times.

The Council of Governors were represented at a number of public engagement events held between April 2018 and March 2019, and listened to feedback around the merger, the new strategy and the quality of care across ESNEFT. They were pleased to note that at these engagement events, new public members were recruited in all constituencies including Colchester (42), Ipswich (18), the rest of Essex (23) and the rest of Suffolk (53). This shows the level of interest which our communities have in the future of their local hospitals.

How the Trust monitors patient experience

We value the feedback we receive from patients about their experiences of receiving care and gather it in several different ways.

The NHS Friends and Family Test (FFT) is well-established across the adult inpatient, maternity and emergency department (A&E) pathways. Responses are largely collected by leaflet, as well as via SMS and the phone for patients using the ED. FFT reports are sent to the Trust's divisions and wards both weekly and monthly, while the results are also reported to the Quality and Patient Safety Assurance Committee and shared with commissioners.

Compliments and commendations are recorded and reported on a monthly basis. Feedback which is posted on online via forums such as NHS Choices, Care Opinion and Healthwatch is collected and shared via the patient experience team. Complaints and PALS also remain a rich source of feedback for learning and improvement and, where necessary, may also look into issues which have been raised online.

The well-established Ipswich Hospital User Group gives all of the hospital's local user groups the chance to meet and identify Trust-wide trends, themes and areas for improvement. A user group for Colchester Hospital is currently being set up. Representatives from both of these groups also make sure the patient's voice is heard by sitting on our Patient Experience Group.

Using online and social media to engage and communicate

The Trust's communications team uses social media, such as Facebook and Twitter, and websites such as NHS Choices and Patient Opinion, to further engage and communicate with service users.

New ESNEFT Facebook and Twitter pages were launched following the merger, with traffic directed to our new sites. As of 31 March 2019, our ESNEFT Twitter page had 1,971 followers and our Facebook page had 6,350. In addition, our ESNEFT Facebook page also had 6,181 likes, which is the number of unique people who have liked our page. Facebook encourages people to recommend and review services based on personal experience. As of 31 March 2019, our Trust had been recommended 37 times and had received 118 ratings, scoring and average of 4.3 out of 5.

The communications team responds to reviews on its Facebook pages, positive or negative, escalating any issues as appropriate.

NHS Choices

The NHS Choices website (www.nhs.uk) allows people to leave compliments or feedback about our hospitals and services. These comments can be seen by anyone who visits the website and aids people to make decisions about where they chose to receive their treatment.

ESNEFT has been reviewed 27 times so far, and has scored an overall rating of 4.5 out of 5 stars.

Our patient experience team responds to the reviews on NHS Choices, signposting patients to relevant services and departments as appropriate, along with escalating any issues as required.

Patient-led Assessments of the Care Environment (PLACE)

Patient-led Assessments of the Care Environment, or PLACE, are an assessment of non-clinical services and factors which contribute to the hospital environment. They take into consideration:

- cleanliness
- the condition of the environment
- how well the organisation meets the food and hydration needs of patients
- how well the organisation and environment support patients' privacy and dignity
- how dementia-friendly the environment is
- how accessible the environment is for those people who may, for example, have to use wheelchairs or have sight impairment.

The assessments are carried out by teams made up of patient assessors (members of the public), in conjunction with staff from the Trust's facilities management service and representatives from infection control and nursing. Patient assessors must make up at least 50% of the membership of the teams carrying out the assessments.

In 2018, the PLACE assessments at Colchester and Ipswich hospitals were spread over a number of days, while assessments at our community hospitals were completed in a day. In line with the instructions issued by NHS Digital, the assessments were completed before the merger.

The results showed that Colchester performed well in comparison with the scores it achieved in 2017 and against other local acute hospitals and the national average. Ipswich also performed well in comparison with its 2017 scores, but not as well as other local acute hospitals or the national average.

Our community hospitals – Aldeburgh, Felixstowe and Bluebird Lodge – generally failed to perform well against other local community hospitals and the national average, but achieved better scores for cleanliness than in 2017.

Over the coming months, we will review our current PLACE-lite arrangements, which give us the chance to carry out optional interim assessments throughout the year.

Engaging our staff in developing a patient experience approach

We continued to engage staff in developing a personal approach which improves the patient experience. In recruitment, all job descriptions, person specifications, adverts and questions at interview reflected the attitudes, behaviours and standards we expect of employees.

All new staff attended a corporate induction where a half-day was dedicated to patient experience and what all staff must do in terms of behaviours to ensure the Trust is consistently at its best.

Spiritual care and chaplaincy

We have a caring and responsive trust chaplaincy team and approximately 60 chaplaincy multi-faith volunteers, as well as faith/belief visitors whom we are able to call upon to provide appropriate rites and rituals to patients, carers, and staff who request them.

Our Trust chaplains have seen a substantial increase in referrals and contacts from staff, clergy, family members and volunteers. These cover different facets of care from cradle to grave and include spiritual, religious, emotional, and pastoral care, Holy Communion, prayers, naming and blessings, baptisms and funerals and end of life support. Our team was also privileged to work with patients and their partners to arrange emergency marriages in the past year. We were honoured to work with the staff to make each wedding a very special event for the couple involved.

Patient advice and liaison service (PALS)

Our Patient Advice and Liaison Service (PALS) aims to help patients, carers, relatives and families resolve problems as quickly and easily as possible by investigating their concerns or putting them in touch with the appropriate member of staff. A total of 5,396 PALS contacts were recorded in 2018/19.

Compliments

The Trust received 903 compliments in 2018/19. Compliments were received in several forms, including letters, cards, gifts, emails and through the local press. Where staff are named they are, where possible, informed and this aids morale and improves staff experience.

Complaints

We are committed to learning from all patient feedback to improve the services we provide. We encourage patients and visitors to help by telling us what they think of their experience.

A total of 1,281 complaints were received by the Trust in 2018/19. The Trust views the receipt of complaints positively, as each offers an opportunity to learn lessons and improve patient experience.

We responded to 65% of complaints within the agreed timeframe. We re-opened 61 complaints because the complainants were not satisfied by the first response they received.

We have worked extremely hard to improve the quality of complaint responses. However, in some cases the complainant has remained dissatisfied, either because not all their concerns were addressed or they challenged some aspects of the response. In such cases the complaint has been re-opened for further investigation. Re-opened complaints are generally resolved with either a face to face meeting or a further letter of response.

Referrals to the Parliamentary and Health Service Ombudsman (PHSO)

A total of 28 complaints were referred to the PHSO, with nine investigated. During the reporting period, one case was partially upheld and no cases were fully upheld.

Acting to improve our complaints process

Every effort is made to ensure a senior manager calls a complainant within 24 hours of the complaint being logged to gain clarity on their concerns and offer apologies for the poor experience. A formal acknowledgement letter is also sent within three working days.

Service improvements following complaints

The Trust ensures that complaints are reviewed at Divisional Clinical Governance meetings so that lessons can be learnt and changes made to practice.

For example, staff now use reusable boxes kept in bags which are clearly marked with the patient's name to store personal belongings such as glasses, dentures and hearing aids during surgery. These are kept on the patient's bed during their procedure so that they can use them as soon as they get to recovery. This change was introduced after several patients complained that their possessions had been lost while they were in surgery.

Our Board of Directors

The Board of Directors functions as a corporate decision-making body. The duty of the Board and of each Director individually is to ensure the long-term success of the Trust in delivering high quality health care. As a Board, all Directors have the same status and as Non-Executive and Executives sitting on a single Board, operate on the principle of a “unitary board”.

All the powers of the Trust shall be exercised by the Board of Directors on behalf of the organisation. The rules and regulations within which the Board is expected to operate are captured in the Trust’s corporate governance documents, which include the organisation’s constitution (which contains the standing orders for the Board of Directors), its schedule of matters reserved for Board decision, standing financial instructions and scheme of delegation. These documents explain the respective roles and responsibilities of the Board of Directors and Council of Governors, the matters which require board and/or council approval and matters which are delegated to committees or executive management.

Disagreements between the Board of Directors and Council of Governors are resolved through a process which aims to achieve informal resolution in the first instance, following which a formal process will be taken which involves a resolution for discussion at a Board meeting.

The limitations set on the delegation to executive management require that any Executive action taken in the course of business does not compromise the integrity and reputation of the Trust and takes account of any potential risk, health and safety, patient experience, finance and working with partner organisations.

Appointment and composition of the Board of Directors

The Board of Directors is made up of full-time Executive Directors and part-time Non-Executive Directors (NEDs), all of whom are appointed because of their experience, business acumen and/or links with the local community. The Trust considers all of its Non-Executive Directors to be independent.

The Board comprises a Chair, seven further NEDs and seven voting Executive Directors. The Council of Governors appointed the Chair and other NEDs in accordance with the constitution and in line with paragraphs 19(2) and 19(3) respectively of Schedule 7 of the National Health Service Act 2006. The NEDs were appointed by the Council of Governors following national recruitment. In line with the Trust’s constitution, these appointments and reappointments were approved by the Council of Governors.

Disclosures of the remuneration paid to the Chair, Non-Executive Directors and Executive Directors are given in the Remuneration Report (page 62 onwards).

The Board is content that its balance, completeness and effectiveness meet the requirements of an NHS foundation trust.

Register of interests

All Directors are asked to declare any interests on the register of directors’ interests at the time of their appointment. This register is reviewed and maintained by the Company Secretary, and is available for inspection by the public. Anyone who wishes to see the register should contact the Trust’s offices at the address on page 5.

None of the Executive Directors were released by the Trust to serve as Non-Executive Directors elsewhere during the year.

About the Non-Executive Directors

David White
Appointed: 6 May 2016
Term of office: Expires 5 May 2019

Chair of the Board of Directors, the Council of Governors, the Remuneration and Nomination Committee and Appointments and Performance Committee.

David has extensive leadership experience as both a Chief Executive and Non-Executive Director in the public sector. He moved to Suffolk in 1994 as Chief Executive of Suffolk Health Authority, a post he held until 2002. He was then Chief Executive of Thurrock Council for four years, before joining Norfolk County Council as Chief Executive in 2006. He retired in April 2013. He has been Chair of Ipswich Hospital since November 2015 and Colchester since 2106.

Eddie Bloomfield
Appointed: 1 November 2018
Term of office: Expires 31 October 2021

Member of Finance and Performance Committee, Charitable Funds Committee, Remuneration and Nomination Committee

Eddie has held four Chief Executive roles at the Ministry of Justice, which have included Head of the Court Funds Office and Head of the Office of the Accountant General Public Trustee and as HM Chief Inspector of Court Administration for England and Wales. He is involved with several charities in and around Colchester in trustee and other voluntary positions, and brings extensive experience in political, financial management and change management. He was previously a non-executive director at Colchester PCT.

Laurence Collins
Appointed: 1 July 2018 (former non-executive director of Ipswich Hospital since 1 April 2013)
Term of office: To 4 April 2019

Senior Independent Director, Chair of People and Organisational Development committee (to 31 October 2018), member of People and Organisational Development committee, Remuneration and Nomination Committee, Quality and Patient Safety committee

Laurence has had a long career in planning in the public sector. He is a former Director of Ipswich Borough Council, and was lead Director for health strategies and improvements. Laurence has extensive

	experience of leading change, corporate restructures and transformation programmes, including setting up multi-agency customer service and contact centres. During his time at the borough council, he led complex multi-agency partnership projects such as the Ravenswood development, East West rail and key Ipswich Waterfront regeneration schemes including Felaw Maltings.
	**Julie Parker** **Appointed:** 1 April 2014 **Term of office:** Expires 31 March 2020 Chair of the Finance and Performance Committee, member of Audit and Risk Committee (from 1 November), Quality and Patient Safety Committee (to 31 October) and Remuneration and Nomination Committee. Julie, who has lived all her life in the area served by the Trust, is a qualified accountant. She has significant experience working as a Director of Resources and Finance at three London councils over a period of 10 years. She is currently a Board member at Colchester Borough Homes and a trustee for the Queen's Theatre, Hornchurch. Julie is a member of the Joint Audit Committee of the Police and Crime Commissioner and Essex Police. She also serves on the audit committees of the Health and Care Professions Council and Essex Fire and Rescue Service.
	**Richard Spencer** **Appointed:** 1 November 2018 **Term of office:** Expires 31 October 2021 Chair of Charitable Funds Committee, member of People and Organisational Development Committee and Remuneration and Nomination Committee. Richard Spencer is a former Director of Culture and Policy and Director of Corporate Social Responsibility at BT, and also worked as the company's Head of Strategy and Partnerships. Since taking early retirement in 2017, he has been appointed to the Communication Consumer Panel by the Department of Digital, Culture, Media and Sport and continues to act as an executive coach. He is also trustee of a homeless charity based in Colchester.

	**Carole Taylor-Brown** **Appointed:** 1 November 2018 **Term of office:** Expires 31 October 2021 Chair of People and Organisational Development Committee (from 1 November 2018), member of Quality Committee and Remuneration and Nomination Committee. Carole has significant experience in the NHS and as a NED in the charity and housing sectors. An HR professional by background, she went on to become Chief Executive of NHS Suffolk until her retirement in 2010. Since then, she has been working with the NHS supporting a range of governance reviews and coaching senior leaders and clinicians. She was formerly Chair of Trustees for Suffolk Mind and is currently Chair of Suffolk Housing and a Visiting Fellow at University Suffolk.
	**Helen Taylor** **Appointed:** 1 July 2018 (formerly NED of Ipswich Hospital NHS Trust from April 2016) **Term of office:** Expires 31 October 2021 Chair of Quality and Patient Safety Committee, member of the Audit & Risk Committee and the Remuneration and Nomination Committee. Having trained as a nurse, Helen has held a number of senior positions in health and social care, including Director of Integrated Commissioning and Vulnerable People with Essex County Council and Interim CEO with Suffolk Age UK. She has also held director-level positions in social care with the London Borough of Tower Hamlets and North Yorkshire County Council, and was previously National Policy Lead for Adult Social Care and Older People with the Audit Commission.
	**Richard Youngs** **Appointed:** 1 November 2018 **Term of office:** Expires 31 October 2021 Chair of Audit & Risk Committee, member of People and OD Committee, Charitable Funds Committee and Remuneration and Nomination Committee. Richard is a former RAF wing commander, a role comparable to Chief Executive. He has held a number of roles at a senior level, including Officer Commanding Support Wing at RAF Honington, and Head of Future Pay Structure for the 170,000 members of the armed forces. He is also a NED with the East of England Cooperative Society, a membership organisation with a model not dissimilar to that of foundation trusts. He has a wide-ranging skills set covering HR and Finance.

Former Non-Executive Directors

Susan Aylen-Peacock	**Appointed:** 9 November 2015	Susan was a transitional NED from Colchester Hospital until she stepped down on 31 October 2018
Jude Chin	**Appointed:** 13 September 2011	Jude stepped down on 30 June 2018
Tim Fenton	**Appointed:** 8 December 2016	Tim was a transitional NED from Colchester Hospital until he stepped down on 31 October 2018
Richard Kearton	**Appointed:** 1 July 2018 (formerly non-executive of Ipswich Hospital NHS Trust)	Richard was a transitional NED from Ipswich Hospital until he stepped down on 31 October 2018
Diane Leacock	**Appointed:** 1 April 2014	Diane was a transitional NED from Colchester Hospital until she stepped down on 30 November 2018
Elaine Noske	**Appointed: 1 July 2018** (formerly non-executive of Ipswich Hospital NHS Trust)	Elaine was a transitional NED from Ipswich Hospital until she stepped down on 31 October 2018
Jan Smith	**Appointed:** 9 November 2015	Jan stepped down on 30 June 2018

About the Executive Directors

Nick Hulme
Chief Executive
Appointed: 17 May 2016
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Trust Accounting Officer. Responsible for corporate strategy, external relations, transformation plan, regulation and compliance, leadership.
Twitter: @Nickhulme61

Nick has worked in the NHS for more than 30 years. He was appointed Chief Executive of Ipswich Hospital in January 2013, and also became Chief Executive of Colchester in May 2016.

Shane Gordon
Director of Strategy, Research and Innovation
Appointed: 2 March 2015
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Twitter: @DrShaneGordon

Shane was previously Clinical Chief Officer of North East Essex Clinical Commissioning Group. He was Associate Medical Director of the East of England Strategic Health Authority and is a member of the Royal College of General Practitioners and the Royal College of Surgeons.

Mike Meers
Director of ICT
Appointed: 1 January 2018
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Mike has worked within local NHS services for more than 27 years managing information technology services and their transformation.

Neill Moloney
Managing Director/Deputy CEO
Appointed: 1 January 2018
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Twitter: @NeillMoloney

Neill has worked in the NHS for more than 26 years, 11 of which have been as an Executive Director. He has extensive experience and expertise in operational management, planning and performance, as well as leadership in commissioning and information.

Catherine Morgan
Chief Nurse
Appointed: 23 January 2017
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Catherine has over 25 years' experience in the NHS in both senior clinical and leadership roles. She has significant experience in leading quality improvement and previously worked at Queen Elizabeth Hospital, King's Lynn, where she was Director of Nursing for three years. Prior to this, she held Deputy Director of Nursing roles at both The Ipswich Hospital and Mid Essex Hospitals.

Dawn Scrafield
Director of Finance
Appointed: 2 February 2015
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Twitter: @DawnScrafield

Dawn has more than 22 years' experience in the NHS, as an accountant and predominantly as Director of Finance. She spent two years at NHS England's Essex Area Team as Director of Finance and Deputy Area Director. Prior to that, she was Director of Finance at NHS South West Essex and Director at South East Essex PCT from 2006 to 2009.

Dr Angela Tillett
Interim Chief Medical Officer
Appointed: 9 March 2015
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Twitter: @angela_tillett

Angela trained at University College London and started as a Paediatric Consultant in Colchester in 2001. Her roles have included Lead Clinician for Paediatric Services, Divisional Director for Women's and Children's Services and subsequently Divisional Director for Surgery before appointment to the Chief Medical Officer role.

At the time of their appointment, all Directors are asked to declare any interests on the register of directors' interests. They are asked to register any changes to their declarations and to confirm, in writing, on an annual basis that the declarations made are accurate. The register is maintained by the Trust's company secretary and is available to anyone who wishes to see it. Inquiries should be made to the company secretary at the address on page 5.

Former Executive Directors

Barbara Buckley, Chief Medical Officer, was appointed in December 2016 and left the Trust on 31 January 2019.

Evaluation of the Board of Directors' performance

The Board of Directors met monthly. There were 11 meetings of the Board, five of which were held in public. They took place on 24 April, 29 May, 22 June, 5 July, 2 August, 30 August, 4 October, 1 November, 29 November, 31 January and 7 March.

Name	Title	Attended
Susan Aylen-Peacock	Non-Executive Director	6/7
Eddie Bloomfield	Non-Executive Director	4/4
Barbara Buckley	Chief Medical Officer	8/10
Laurence Collins	Non-Executive Director	6/7
Jude Chin	Non-Executive Director	3/3
Tim Fenton	Non-Executive Director	6/7
Shane Gordon	Director of Strategy, Research and Innovation	11/11
Nick Hulme	Chief Executive	10/11
Richard Kearton	Non-Executive Director	3/4
Diane Leacock	Non-Executive Director	9/9
Mike Meers	Director of ICT	11/11
Neill Moloney	Deputy Chief Executive	9/11
Catherine Morgan	Chief Nurse	11/11
Elaine Noske	Non-Executive Director	1/4
Julie Parker	Non-Executive Director	11/11
Dawn Scrafield	Director of Finance	8/11
Jan Smith	Non-Executive Director	1/3
Richard Spencer	Non-Executive Director	4/4
Carole Taylor-Brown	Non-Executive Director	3/4
Helen Taylor	Non-Executive Director	6/8
Angela Tillett	Medical Director/Interim Chief Medical Officer	3/4
David White	Chair	9/11
Richard Youngs	Non-Executive Director	4/4

Board development

Board development takes place in workshops and seminars on the days when the Board meets. During the year, the Board had sessions on developing ESNEFT's strategy, the Sustainability and Transformation Programme, risk management and developing the Trust's risk appetite.

Following the appointment of six substantive NEDs, four of whom were new members of the Board, an induction programme took place for all of the NEDs. Among other things, this development session covered the regulatory and financial framework in the NHS, the patient pathway and the context for healthcare in Suffolk and North Essex.

Ongoing development

The Chair holds team and one-to-one meetings with the Chief Executive and Non-Executive Directors as required.

Appraisal process for the Chair and Non-Executive Directors

The Chair and company secretary worked with the Council of Governors to maintain the appraisal process for the Chair and Non-Executive Directors.

The Chair is formally appraised by the senior independent director in conjunction with the Council of Governors via its Appointments and Performance Committee.

Appraisal of Non-Executive Directors is carried out by the Chair, advised by the Lead Governor, and reported in the Council of Governors via the Appointments and Performance Committee. The new Non-Executive Directors who joined the Board on 1 November 2018 will not receive an appraisal in 2018/19, but will receive a six-month review in April 2019.

Appraisal process for Executive Directors

An appraisal process is in place for the Chief Executive and other Executive Directors. The Chair appraises the Chief Executive and the Chief Executive appraises the Executive Directors, reporting to the Remuneration and Nomination Committee on the process and outcome of the appraisals.

Board and committee effectiveness

Before the merger, all of the Board committees completed self-assessment surveys of their own effectiveness. Areas for potential improvement were identified and actioned with immediate effect through reviews of administration procedures and updates to the committees' terms of reference.
Due to new committee chairing and membership arrangements following the appointment of substantive Non-Executive Directors, a limited committee effectiveness review has taken place in the final quarter of 2018/19.

NHSI observed the Finance and Performance Committee and the Quality and Patient Safety committee during Q4 and will complete their review in 2019/20 with an observation of the Trust Board. Feedback from these observations and the 'Well-Led Framework review', along with the results of a follow-up of the committee self-assessment surveys, will be reported back to the Board in the first quarter of 2019.

Governance arrangements

The Board's governance arrangements are described in more detail in the Annual Governance Statement. The Board finished the year with six committees. All are chaired by a Non-Executive Director and meet regularly, based on an agreed business cycle, and report to the Board of Directors. Governors have been assigned as observers to these committees and provide their feedback to the Council of Governors on their effectiveness.

The committees of the Trust Board are:

- Audit and Risk Assurance Committee
- Quality and Patient Safety Assurance Committee
- Finance and Performance Assurance Committee
- People and Organisational Development Assurance Committee
- Charitable Funds and Sponsorship Committee
- Remuneration and Nomination Committee

Audit and Risk Assurance Committee

This committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) which support the achievement of the organisation's objectives.

It also ensures there is an effective internal audit function, established by management, which meets mandatory NHS internal audit standards and provides independent assurance to the Audit and Risk Assurance Committee, Chief Executive and Board of Directors.

The committee also reviews the work and findings of the external auditors appointed by the Council of Governors and considers the implications of their findings and recommendations and related management responses.

The Audit and Risk Assurance Committee held five meetings: 11 May, 24 May, 24 July, 6 November and 26 February.

Members and meetings attended in brackets: Jude Chin, Committee Chair (to 30 June) (2/2), Diane Leacock, Committee Chair (1 July to 30 November) (4/4), Jan Smith (1/1), Richard Kearton (1/1), Richard Youngs, Committee Chair (from 1 December) (2/2), Helen Taylor (2/3), Julie Parker (1/2).

Executive Directors (voting and non-voting) in attendance: Dawn Scrafield, Barbara Buckley, Mike Meers, Neill Moloney, Ann Alderton, Denver Greenhalgh

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Internal auditors

Internal audit was provided by Mazars Public Sector Internal Audit Ltd and TIAA Ltd. Their role is to provide independent assurance that our risk management, governance and internal control processes are operating effectively

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External auditors

The Council of Governors appointed BDO UK LLP as the Trust's external auditors from 1 April 2017 for three years.

The responsibility of the Trust's external auditors is to independently audit the financial statements and part of the remuneration report in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland). They also provide independent assurance on the Quality Report.

The Trust ensures that the external auditors' independence is not compromised by work outside the Audit Code by having an agreed protocol for non-audit work. Non-audit work may be performed by the Trust's external auditors where the Audit and Risk Assurance Committee's approved procedure is followed, which ensures all such work is properly considered and the auditors' objectivity and independence are safeguarded.

Quality and Patient Safety Assurance Committee

This committee's main duties are to:

- Oversee the development and implementation of a quality strategy with a clear focus on improvement, drawing on and benchmarking against ideas and best practice from external organisations.
- Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance against key quality performance indicators and undertake "deep dives" as appropriate.
- Receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address them. These should include mortality outlier alerts.
- Oversee the implementation of improvement plans relating to reports of regulators and other external review bodies with responsibility for quality and safety.
- Oversee the development and implementation of action plans arising from both inpatient and other care related surveys with recommendations to the Board as appropriate.

- Consider the impact of quality impact assessments of cost improvement programmes on quality, patient safety and wider health and safety requirements.
- Oversee the effectiveness of the clinical systems established by the Trust to ensure they maintain compliance with the CQC's Essential Standards of Quality and Safety.
- Monitor and review the systems and processes in place at the Trust in relation to infection control and to review progress against identified risks to reducing hospital-acquired infections.
- Review aggregated analyses of adverse events (including serious incidents), complaints, claims and litigation to identify common themes and trends and gain assurance that appropriate actions are being taken to address them.
- Advise the Board of key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate.

The Quality and Patient Safety Assurance Committee held 11 meetings:19 April, 25 May, 18 June, 24 July, 25 September, 23 October, 22 November, 18 December, 22 January, 26 February and 26 March.

Members and meetings attended in brackets: Susan Aylen-Peacock, Committee Chair (to 30 June 2018) (6/6), Julie Parker (4/6), Tim Fenton (1/3), Helen Taylor, Committee Chair (from 1 July 2018) (9/9), Laurence Collins (5/5) and Carole Taylor-Brown (5/5).

Executive Directors in attendance: Catherine Morgan, Dr Angela Tillett, Dr Barbara Buckley, Neill Moloney.

Finance and Performance Assurance Committee

This committee's remit is to:

- Oversee the development and implementation of the Trust's financial and performance strategy to deliver the service objectives as set out in the Forward Plan and to ensure delivery of financial and performance targets.
- Monitor delivery of the Trust's cost improvement programme and the development of efficiency and productivity processes.
- Oversee the investment and borrowing strategy and policy, reviewing performance against Treasury management benchmarks and targets and ensuring compliance with Trust policies and procedures in respect of limits, approved counterparties and types of investment.
- Receive monthly reports on financial and operational performance, including cost improvement programmes, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and undertaking "deep dives" as appropriate.
- Under direction from the Board, oversee and scrutinise the investment appraisal of business cases and wider business development opportunities.
- Oversee the contracting and planning mechanisms in place with commissioners of healthcare to agree annual or longer term contracts as may be appropriate, seeking to ensure that any financial or operational risks arising from those contracts are identified and mitigated as appropriate.
- Oversee the rolling capital programme, including scrutiny of the prioritisation process, and monitor its delivery.
- Advise the Board of key strategic risks relating to financial and operational performance and consider plans for mitigation as appropriate.

The Finance and Performance Assurance Committee held 12 meetings: 18 April, 23 May, 20 June, 26 July, 23 August, 27 September, 25 October, 22 November, 20 December, 24 January, 28 February and 28 March.

Members and meetings attended in brackets: Julie Parker, Committee Chair (10/10), Jude Chin (3/3), Jan Smith (2/3), Richard Kearton (3/4), Elaine Noske (2/4), Eddie Bloomfield (5/5) and Laurence Collins (5/5).

Executive Directors in attendance: Dawn Scrafield, Catherine Morgan, Neill Moloney, Dr Barbara Buckley.

People and Organisational Development Assurance Committee

This committee's main duties are to:

- Oversee the Trust's strategy and plans on workforce issues, including the efficient deployment of staff to meet service requirements, advising the Board on strategic and operational risks and opportunities relating to workforce, staff engagement and employment practice.
- Oversee the Trust's strategy and plans for workforce education, learning and development, and provide assurance to the Board that individual training and development approaches are fit for purpose.
- Receive details of workforce planning priorities that arise from the annual business planning process and to receive exception reports on any significant issues/risks.
- Ensure that effective workforce enablers are put in place to drive high performance and quality improvement.
- Review performance indicators relevant to the remit of the committee.
- Monitor and evaluate the Trust's compliance with the Public Sector Equality Duty.
- Mandate the scope of negotiations on changes to reward systems within the Trust and to keep oversight and impact of benefits management.
- Receive and review regular reports on organisational development, including leadership capability, workforce planning, cost management, regulation of the workforce and its health and wellbeing.
- Receive and review reports on the NHS Staff Survey and other staff engagement data and ensure that action plans support improvement in staff experience and services to patients.
- Advise the Board of key strategic risks relating to workforce and employment practice and consider plans for mitigation as appropriate.

The People and Organisational Development Assurance Committee met 10 times: 18 April, 23 May, 22 June, 26 July, 27 September, 25 October, 22 November, 24 January, 28 February and 28 March.

Members and meetings attended in brackets: Members and meetings attended in brackets: Diane Leacock, Committee Chair (to 31 October) (6/6), Susan Aylen-Peacock (3/3), Tim Fenton (5/6), Laurence Collins (2/3), Carole Taylor-Brown, Committee Chair (from 1 November) (3/3), Richard Spencer (3/3) and Richard Youngs (3/3).

Executive Directors in attendance: Dawn Scrafield, Catherine Morgan, Dr Barbara Buckley, Dr Angela Tillett

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Charitable Funds and Sponsorship Committee

The Charitable Funds and Sponsorship Committee has delegated responsibility from the Board of Directors to adhere to the principles and responsibilities of trusteeship as defined by the Charity Commission and the Trustee Act 2000, Section 11. In the main, the committee reviews the policies and procedures for fundraising, acceptance and expenditure, including the internal control arrangements operating within the Trust for charitable funds.

The committee includes representation from operational senior managers from across the Trust. Eight formal meetings of the committee were held: 21 May, 25 July, 23 October, 20 November, 18 December, 23 January, 26 February and 26 March.

Members and meetings attended in brackets: Susan Aylen-Peacock, Committee Chair (to 31 October 2018) (3/3), Jan Smith (1/1), Tim Fenton (1/2), Laurence Collins (0/2), Richard Spencer, Committee Chair (from 1 November) (5/5), Eddie Bloomfield (5/5), Richard Youngs (4/5)

Executive Directors in attendance: Dawn Scrafield, Barbara Buckley, Catherine Morgan, Shane Gordon

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Remuneration and Nomination Committee

The Remuneration and Nomination Committee also fulfils the role of a nomination committee and reviews the structure, size and composition of the Board of Directors and makes recommendations for changes where and when appropriate. It also considers succession planning arrangements, taking into account the challenges and opportunities facing the Trust and the skills and expertise required on the Board of Directors. This committee is responsible for advising on the appointment and/or dismissal of Executive Directors. It is also responsible for the approval of their remuneration and terms of service and the monitoring of their performance against delivery of organisational objectives.

The Trust Chair is the Chair of the committee and the membership comprises all the Non-Executive Directors. The Chief Executive, Director of Human Resources and Organisational Development and the company secretary are routinely invited to attend these meetings except when their own terms and conditions are under discussion. An appointments panel of the Remuneration and Nomination Committee is convened when permanent executive appointments are to be made. All appointments are by public advertisement. External assessors are part of the recruitment process.

The Remuneration and Nomination Committee held four meetings: 10 May, 29 May, 4 October and 31 January. An appointments panel was convened to appoint to the post of Director of Communications.

Members and meetings attended in brackets: David White, Chair (4/4), Susan Aylen-Peacock (3/3), Jude Chin (2/3), Tim Fenton (2/3), Jan Smith (1/2), Julie Parker (3/4), Diane Leacock (1/3), Helen Taylor (2/2), Laurence Collins (2/2), Richard Kearton (0/1), Elaine Noske (0/1), Eddie Bloomfield (1/1), Carole Taylor-Brown (1/1), Richard Spencer (1/1), Richard Youngs (1/1)

The committee did not commission any advice or assistance during the year.

Remuneration Report (unaudited)

The purpose of the Remuneration Report is to provide a statement to stakeholders on the decisions of the Remuneration and Nomination Committee relating to the Executive Directors of the Board of Directors. In preparing this report, the Trust has ensured it complies with the relevant sections of the Companies Act 2006 and related regulations and elements of the NHS Foundation Trust Code of Governance.

Annual Statement on Remuneration

Statement of the Chair of the Remuneration and Nomination Committee

The shadow board for East Suffolk and North Essex NHS Foundation Trust was in place from 1 April 2018, with appointees undertaking their shared responsibilities for Colchester Hospital University NHS Foundation Trust and Ipswich Hospital NHS Trust concurrently. Executive appointments to the ESNEFT Board were confirmed by the committee in May 2018 and came into effect from 1 July 2018.

Decisions on Executive remuneration were based on available benchmarking information from a NHS Providers survey, the advice of the executive search firm supporting the appointments and other market intelligence. Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust.

Following publication of NHS Improvement's Guidance on Pay for Very Senior Managers, all new appointments to the Trust where the salary is over £150,000 are subject to an element of earn-back pay. This means that a percentage of base pay (normally at least 10%) is placed at risk, subject to the individual meeting agreed performance objectives.

Remuneration and performance conditions

With the exception of those individuals subject to earn-back pay, the remuneration of the Directors and Non-Executive Directors does not include any individual performance-related component. Their remuneration is subject to an annual review which takes into account a benchmarking comparison with other similar organisations, general labour market conditions and the Board's collective achievement of organisational objectives.

The Remuneration and Nomination Committee reviewed benchmarked data at its meeting on 29 May when it confirmed the executive appointments to the ESNEFT Board. Where there were increases in remuneration, they came into effect on 1 July 2018, which was the date of the merger. Service contracts for Directors do not contain any obligations which could give rise to or impact on remuneration payments or payments for loss of office.

The remuneration of the Chair and Non-Executive Directors is decided by the Council of Governors following advice from the Appointments and Performance Committee. To determine the remuneration, the committee uses the data from an annual survey undertaken by NHS Providers. The level of remuneration for Non-Executive Directors is based on an average expected workload of a minimum of four days a month and a minimum of three days a week for the Chair.

To determine Executive Directors' salary levels, the Remuneration and Nomination Committee uses mainly the data from the annual NHS Providers survey along with the benchmarking information provided by external search organisations supporting executive director recruitment.

Decisions relating to salary levels in the rest of the organisation are factored into the Remuneration and Nomination Committee's discussion of Executive Director salaries and the Appointments and

Performance Committee's discussion of Non-Executive Director salaries. The committee does not consult with employees when considering its policy on senior managers' remuneration.

Other than the Trust's Medical Director, amendments to annual salary are decided by the Remuneration and Nomination Committee. The annual salary of the Executive Directors is inclusive of all cash benefits other than business mileage. The Medical Director's salary is in accordance with the medical and dental consultants' terms and conditions of service. The special allowance for undertaking the role of Medical Director is approved by the Remuneration and Nomination Committee.

Five of the Trust's eight Executive Directors in post during the year were on remuneration packages of more than £150,000, which is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury, as set out in guidance issued by the Cabinet Office. This currently equates to the Prime Minister's ministerial and parliamentary salary.

Only two of these – the Chief Executive and Managing Director – were appointed by the Trust following the introduction of the requirement to seek approval, via NHS Improvement, from the Chief Secretary to the Treasury for the remuneration package.

There were no new applications to the Treasury during 2018/19 following the benchmarked review of remuneration for the appointments to the Board. No payments were made during the year for loss of office or to past senior managers.

Salary is set at a level appropriate to secure and retain the high calibre individuals needed to deliver the Trust's strategic priorities, without paying more than is necessary.

When determining salary levels, an individual's role, experience and performance, and independently sourced data for relevant comparator groups are considered. Salary increases typically take effect from 1 April each year.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Senior managers' remuneration policy

Contractual compensation provisions for early termination of Executive Directors' contracts

There are no special contractual compensation provisions for early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the Agenda for Change: NHS Terms and Conditions of Service Handbook (Section 16); or, for those above the minimum retirement age, early termination by reason of redundancy is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Principles on which the determination of payments for loss of office, an indication of how each component will be calculated and whether, and if so how, the circumstances of the loss of office and the senior manager's performance are relevant to any exercise of discretion are considered on a case by case basis by the Remuneration and Nomination Committee.

Annual report on remuneration

Duration of contracts, notice periods and termination payments

Details of Directors' contracts and notice periods are summarised in the Board of Directors' profiles section (page 54). With the exception of the Medical Director, Executive Directors are appointed to substantive contracts.

There was one interim Board appointment during the year. Dr Angela Tillett was appointed as Interim Chief Medical Officer following Dr Barbara Buckley's resignation on 31 January 2019.

Remuneration and Nomination Committee

Details on the meetings of the Remuneration and Nomination Committee are provided on page 61. The committee has a clear policy on the remuneration ranges for every Executive Director position. Any decisions that fall outside the parameters of the policy, which are due to exceptional circumstances for example, are subject to further discussion and approval by the committee.

Median salary as a multiple of highest paid director salary (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in ESNEFT in the financial year 2018/19 was £212,100 (2017/18: £212,500). This was 7.9 times (2017/18: 8.99) the median remuneration of the workforce, which was £26,963 (2017/18: £23,597).

In 2018/19, seven (2017/18, 0) employees received remuneration in excess of the highest paid director. Remuneration ranged from £7,215 to £306,776 (2017/18: £6,844 – £212,500). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Salaries for senior managers are established and maintained taking the following elements into consideration: the individual's role, experience and performance and independently sourced data for relevant comparable organisations. This includes consideration of salary levels at other members of ESNEFT. Salaries for senior managers are formally reviewed every three years with annual interim reviews.

When setting remuneration levels for the executive directors, the committee considers the prevailing market conditions, the competitive environment (in particular through comparison with the remuneration of executives at other leading NHS healthcare organisations of similar size and complexity) and the positioning and relativities of pay and employment conditions across the broader Trust workforce.

The remuneration committee has responsibility for authorising the engagement of any staff member on a non-agenda for change contract or salary.

Salary and pension entitlement of the Board of Directors

The Chief Executive has determined that "senior managers", being those staff in senior positions who have authority or responsibility for directing or controlling the major activities of the Trust, are the Executive and Non-Executive Directors. The remuneration, salary and pension entitlements of the Board of Directors are detailed on pages 65 to 67. These disclosures have been audited.

Directors and Governors expenses

Information on the expenses of Directors and Governors is required by the Health and Social Care Act 2012.

There were 23 Directors eligible to claim expenses during 2018/19. Of these, 18 made claims totalling £20,683.

A total of 38 Governors were eligible to claim expenses. Of these, 11 made claims totalling £2,020.69.

Signed

Nick Hulme
Chief Executive

Salary and allowances of senior managers (subject to audit)

Name	Title	Salary (bands of £5,000) £000	Expenses payments (rounded to nearest £100) £00	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Nick Hulme	Chief Executive	190 – 195	0	0	0	5 – 7.5	195 – 200
Neill Moloney	Chief Operating Officer/ Managing Director	150 – 155	1	0	0	127.5 – 130	280 – 285
Michael Meers	Director of Information Communication and Technology	90 – 95	0	0	0	87.5 – 90	180 – 185
David White	Chairman	50 – 55	6	0	0	0	50 – 55
Tony Thompson (Left 30/06/2018)	Non-Executive Director	0	0	0	0	0	0
Andrew George (Left 30/06/2018)	Non-Executive Director	0	1	0	0 – 5	0	0 – 5
Laurence Collins	Non-Executive Director	5 – 10	0	0	0	0	5 – 10
Elaine Noske (Left 31/10/2018)	Non-Executive Director	0 – 5	0	0	0	0	0 – 5
Helen Taylor	Non-Executive Director	5 – 10	5	0	0	0	5 – 10
Richard Kearton (Left 31/10/2018)	Non-Executive Director	0 – 5	2	0	0	0	0 – 5
Barbara Buckley (Left 31/01/2019)	Chief Medical Officer	155 – 160	0	0	0 – 5	0	160 – 165
Catherine Morgan	Chief Nurse	135 – 140	0	0	0	77.5 – 80	215 – 220
Angela Tillett	Medical Director (from 01/07/2019) Chief Medical Officer (from 01/02/2019)	25 – 30	0	0	10 – 15	67.5 – 70	105 – 110
Shane Gordon	Director of Integration	185 – 190	0	0	10 – 15	0	195 – 200

Dawn Scrafield	Director of Finance	150 – 155	0	0	0	115 – 117.5	265 – 270
Jude Chin (Left 30/06/2018)	Non-Executive Director	0 – 5	0	0	0	0	0 – 5
Tim Fenton (Left 31/10/2018)	Non-Executive Director	5 – 10	0	0	0	0	5 – 10
Diane Leacock (Left 30/11/2018)	Non-Executive Director	5 – 10	0	0	0	0	5 – 10
Julie Parker	Non-Executive Director	10 – 15	0	0	0	0	10 – 15
Jan Smith (Left 30/06/2018)	Non-Executive Director	0 – 5	0	0	0	0	0 – 5
Edward Bloomfield (From 01/11/2018)	Non-Executive Director	5 – 10	2	0	0	0	5 – 10
Richard Spencer (From 01/11/2018)	Non-Executive Director	5 – 10	2	0	0	0	5 – 10
Carole Taylor-Brown (From 01/11/2018)	Non-Executive Director	5 – 10	3	0	0	0	5 – 10
Richard Youngs (From 01/11/2018)	Non-Executive Director	5 – 10	5	0	0	0	5 – 10
Susan Aylen-Peacock (Left 01/11/2018)	Non-Executive Director	5 – 10	0	0	0	0	5 – 10

Comparative table showing salary and allowances of senior managers in 2017/18

Name	Title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	All pension-related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Susan Aylen-Peacock	Non-Executive Director	10 – 15	–	–	10 – 15
Barbara Buckley from 1 December 2016	Managing Director and Deputy Chief Executive	200 – 205	–	237.5 – 240	440 – 445

Jude Chin	Non-Executive Director and Deputy Chair	15 – 20	–	–	15 – 20
Tim Fenton from 8 December 2016	Non-Executive Director	10 – 15	–	–	10 – 15
Julie Fryatt to 21 August 2017	Director of Workforce and Organisational Development	45 – 50	–	5 – 7.5	50 – 55
Nick Hulme [1] from 17 May 2016	Chief Executive	115 – 120	–	15 – 17.5	135 – 140
Diane Leacock	Non-Executive Director	10 – 15	–	–	10 – 15
Roy Miller [2] from 1 April 2017 to 1 October 2017	Acting Medical Director	60 – 65	–	10 – 12.5	70 – 75
Catherine Morgan from 23 January 2017	Director of Nursing	130 – 135	–	137.5 – 140	265 – 270
Julie Parker	Non-Executive Director	10 – 15	–	–	10 – 15
Dawn Scrafield	Director of Finance	130 – 135	–	22.5 – 25	155 – 160
Jan Smith	Non–Executive Director	10 – 15	–	–	10 – 15
Angela Tillett [3]	Medical Director	75 – 80	–	7.5 – 10	85 – 90
David White [4] from 6 May 2016	Chair	35 – 40	–	–	35 – 40

1. N Hulme is also the Chief Executive of The Ipswich Hospital NHS Trust. The salary he received for that appointment in this period in bands of £5,000 was £90,000 - £95,000.
2. R Miller receives a salary for his role as a medical consultant. The salary for working as a medical consultant in this period in bands of £5,000 was £45,000 - £50,000.
3. A Tillett receives a salary for her role as a medical consultant. In 2017/18, Dr Tillett took a period of special leave due to ill health from 1 April to 30 September and during this time she received her full salary and allowances in accordance with the terms and conditions of her NHS employment contract. The salary shown for 2017/18 therefore only reflects the period 1 October 2017 to 31 March 2018 when she returned to her Board duties as Medical Director. The salary for working as a medical consultant in this period in bands of £5,000 was £25,000 - £30,000.
4. D White is also the Chair of The Ipswich Hospital NHS Trust. The salary he received for that appointment in this period in bands of £5,000 was £25,000 - £30,000.

Pension benefits (subject to audit)

Name	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at age 60 at 31 March 2019 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2019 £000	Cash equivalent transfer value at 31 March 2018 £000	Real increase in cash equivalent transfer value £000	Employers contributions to stakeholder pension £000
Nick Hulme	0 – 2.5	0 – 2.5	55 – 60	165- 170	1296	1143	82	0
Neill Moloney	5 – 7.5	10 – 12.5	55 – 60	135 – 140	1012	752	160	0
Michael Meers	2.5 – 5	5 – 7.5	45 – 50	110 – 115	818	623	121	0
Barbara Buckley (left 31/01/2019)	0 – 2.5	0 – 2.5	90 – 95	270 – 275	2192	1990	110	0
Catherine Morgan	2.5 – 5	2.5 – 5	45 – 50	125 – 130	889	716	131	0
Angela Tillett	2.5 – 5	7.5 – 10	50 – 55	150 – 155	1150	954	147	0
Shane Gordon	0	0	0	0	0	0	0	0
Dawn Scrafield	5 – 7.5	7.5 – 10	45 – 50	100 – 105	672	502	132	0

The financial information in the table above is derived from information provided to the Trust from the NHS Pensions Agency. Whilst the Trust accepts responsibility for the disclosed values, the Trust is reliant upon NHS Pensions Agency for the accuracy of the information provided to it, and has no way of auditing these figures. The figures are therefore shown in good faith as an accurate reflection of the senior managers' pensions' information.

There will be no entries in respect of pensions for Non-Executive Directors as they do not receive pensionable remuneration.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures

and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual had transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Accounting policy for pensions can be found in the notes of the accounts.

Key management compensation can be found in the accounts.

Staff report

On 31 March 2018, the Trust directly employed 10,045 staff (8,374 full time equivalents (FTE).

The Trust also reviewed its acuity staffing levels on the wards, resulting in an increase in the establishment required to meet patient need safely.

	Number of Trust staff		
	Headcount	Establishment (FTE)	Staff in post (FTE)
31 March 2019	10,045	9,224	8,374

Staff costs (subject to audit)

	2018/19		
	Permanent (£000)	Other(£000)	Total (£000)
Salaries and wages	260,557	1,664	**262,221**
Social security costs	26,888	0	**26,888**
Apprenticeship levy	1,302	0	**1,302**
Employer contributions to NHS Pension Scheme	32,154	0	**32,154**
NEST pension contributions	21	0	**21**
Termination benefits	0	0	**0**
Agency/ bank staff	0	49,469	**49,469**
Total	**320,922**	**51,133**	**372,055**

Average staff numbers (subject to audit)

The average staff numbers by staff group is shown below. This calculation is based on the whole time equivalent (FTE) number of employees in each week in the financial year, divided by the number of weeks in the financial year.

Average number of employees (FTE basis)	2018/19		
	Total	Permanent	Other
Medical and dental	951	886	65
Administration and estates	1,992	1,830	162
Healthcare assistants and other support staff	1,598	1,409	189
Nursing, midwifery and health visiting staff	2,400	2,116	284
Scientific, therapeutic and technical staff	640	597	43
Healthcare science staff	333	290	43
Total average numbers	**7,914**	**7,128**	**786**

Membership of the Trust

The data in the table below is sourced from the Trust's membership database and therefore analyses staff members, not just employees. “Staff” includes any qualifying Trust employee and hospital volunteers so the number in the table below is greater than the number of staff employed by the Trust.

Age	Staff members 2018/19	Public members 2018/19
0 to 16 years	0	4
17 to 21 years	95	20
22+ years	10,627	9,707
Not specified	101	1,207
Total	**10,823**	**11,005**
Ethnicity		
Not specified	1,773	1,890
White	7,520	8,545
Mixed	168	105
Asian or Asian British	1,080	269
Black or Black British	209	135
Other ethnic group	73	61
Other	0	0
Total	**10,823**	**11,005**
Gender		
Male	2,498	4,233
Female	8,325	6,437
Transgender	0	0
Not specified/ prefer not to say	0	335
Total	**10,823**	**11,005**

Sickness absence

Staff sickness absence	2018/19
Total WTE calendar days lost	105,951
Total WTE days available	3,045,523
Total staff years lost (days lost/365)	289.48
Total staff years available	10,045
Total staff employed in period*	12,399
Total staff employed in period with absence*	6,076
Total staff employed in period with no absence*	6,323
Average working days lost per employee	10.55

* headcount, including starters and leavers. Source: Electronic Staff Record

Gender equality

The table below shows the breakdown of male and female Directors, other senior managers and employees. The Non-Executive Directors and Directors who were on interim off-payroll contracts as at 31 March are not classed as employees and are not therefore covered in the total number of staff employed by the Trust figure of 10,045.

Role	Female	Male	Notes
Non-Executive Directors	3	5	Includes Chair
Executive Directors	9	7	Includes Chief Executive
Other senior managers	19	13	Bands 8d and above
Employees	7,698	2,291	
Total	**7,729**	**2,316**	

Employment of disabled people

We are committed to eliminating discrimination, both within the workforce and in the provision of services. The Trust has a legal responsibility under the Equality Act 2010 to:

- eliminate discrimination, harassment and victimisation;
- advance equality of opportunity; and
- foster good relations between persons who share a relevant characteristic and those who do not.

Recruitment

The Trust makes sure that disabled applicants are always fully and fairly considered on their merits, as with any individual. Any applicant who meets the minimum criteria for selection is invited for interview.

Via our recruitment policy, we make sure that the implementation of the recruitment and selection practices will not discriminate directly or indirectly on the grounds of gender, sexual orientation, marriage or civil partnership, pregnancy and maternity, caring responsibility, ethnic or national origin, religion, culture, disability, age or trade union membership.

Number of employees who were trade union officials	Whole time equivalent
21	18.03
Percentage of time spent on facility time	**Number of employees**
0%	12
1%-50%	9
51% - 99%	0
100%	0
Total cost of facility time	**Costs**
Total pay bill	372,055,000
Percentage of pay bill spent on facility time	0.01%
Time spent on trade union activities as percentage of total facilities time	**Percentage**
2040 Hours Activity (statutory and Trust meetings only)	76%

The workplace

The Trust provides an occupational health service which can be accessed by all staff. It is provided by a multidisciplinary team, and as well as specialist practitioners in occupational health also includes clinical nurses, technicians and a consultant.

If an employee becomes disabled, the Trust will, via line managers and the health and wellbeing department, maintain regular contact with them to monitor progress, give support and, at an agreed and appropriate stage, consider possible courses of action. This can include a phased return to work and consideration of the effect any disability might have on future employment.

The Trust seeks to offer terms and conditions of service which will enable suitably qualified person with a disability to seek and maintain employment with the organisation wherever practicable.

Policies

We carry out equality impact assessments for equality analysis when reviewing policies or when planning changes to services as part of organisational change processes to ensure our functions and services are not discriminatory.

Training

It is important for all staff to have equal opportunities with others to develop new skills and advance their careers. This includes mandatory training, clinical skills and personal development.

All staff with additional needs should have those needs addressed wherever possible by the Trust in terms of induction. This includes staff who:

- qualified abroad (EC and overseas)
- are returning to work after a prolonged absence
- are training part-time
- are under the age of 18
- have a disability

Ultimately, it is the responsibility of the line manager to ensure that staff with additional needs are treated equitably during their employment with the Trust.

All staff are required to undertake equality and diversity training, with compliance currently standing at 91.73%. Training is also provided and is tailored to role requirements in the following areas:

- dementia
- deprivation of liberties
- learning disability
- Mental Capacity Act
- recognising and safeguarding the adult at risk
- mental health awareness

In terms of mental health awareness, the Trust continues to work in partnership with Suffolk MIND to roll out ‘Your Needs Met’ training to all leaders. This will help to:

- Undo misconceptions about mental health and raise awareness of people’s emotional needs.
- Address the causes of low morale which will help to improve staff engagement.
- Begin to reduce the cost of sickness absence.

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 Workforce Disability Equality Standard (WDES) will be introduced to the NHS from 1 April 2019 to improve the experience of disabled staff who a seeking to work in the NHS or already do so.

The WDES is mandated by the NHS standard contract and is a data-based standard which uses a series of measures to help improve the experiences of disabled staff in the NHS. The 10 evidence-based

metrics will enable NHS organisations to compare the reported outcomes and experiences of disabled staff with non-disabled staff.

The first reports will be published on 1 August 2019 and based on data from the 2018/19 financial year.

Staff engagement

Organisational development

Following the merger, we identified that some immediate short-term organisational development input and support would be needed within our clinical divisions. As with any significant change, leaders and managers were facing fresh challenges while new teams were trying to form without any specific development support. This took place against a backdrop of growing day-to-day demands.

We involved a range of individuals and teams in our discussions, and also observed team meetings. An action plan based on this work was developed with the aim of providing leaders and staff with immediate support following the merger.

Its objectives included:

- providing some stability to leaders post-merger
- identifying barriers to success and introducing initiatives to overcome obstacles
- providing support and investment to improve morale and engagement

Work began to deliver the plan at the end of 2018 and will continue during 2019/20.

Other initiatives have continued to be delivered across all areas of the Trust, including stand-alone leadership development modules, a consultant development programme, operational leads programme and Mary Seacole local.

Leadership

Leadership events have continued in 2018/19 and involved leaders from across the Trust. As well as two senior leadership conferences, we also ran two very successful middle managers conferences in November which focused on what was expected of leaders. Outcomes from these conferences will help to inform our leadership behaviour framework.

Valuing our staff

During 2018/19, we continued to recognise staff and volunteers through our Trust commendation scheme, which gives colleagues, patients and the public the chance to nominate the people they feel have made outstanding contributions.

Everyone who is nominated receives 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.

Staff Partnership Forum

The Staff Partnership Forum is made up of management and staff side union representatives. It meets bi-monthly and its agenda includes business updates, future strategy and a review of key performance indicators. The agenda is agreed jointly between staff side and management.

A partnership agreement is in place to outline the role the forum plays in supporting staff management and organisational development, along with the organisational and financial support the Trust provides to recognised union representatives.

The Trust funds 5.65 days a month of dedicated facility time, which enables the release of the staff side Chair, branch secretary and senior stewards to attend meetings, undertake specific union activity and support HR case work. Additional support from shop floor union stewards is funded by releasing staff from their substantive post. Secretarial support is provided by the HR team.

Freedom to Speak Up

In January, our Board approved a new 'speaking up' vision for the Trust, which is:

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.

This reinforces the intent of the Trusts leadership to fully support the Freedom to Speak Up guardian in his business. Tom Fleetwood remains in post having been appointed in December 2017 as one of ESNEFT's first joint appointments.

The Trust Board, as senior leaders, are fully aware of their responsibilities to support this role:

- They can readily articulate the Trust's Freedom to Speak Up vision, as well as key learning from issues which workers raised previously. They also regularly communicate the value of speaking up.
- They can provide evidence that a leadership strategy and development programme are in place which emphasises the importance of learning from issues raised by people who speak up.
- They take an interest in the Trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.
- They are visible, approachable and use a variety of methods to seek and act on feedback from workers.

We recognise that cultural change cannot happen without leaders being open and responsive to staff when they speak up. This needs to become a feature of our organisation, normal practice to all and applicable at every level.

We remain committed to embedding a Freedom to Speak Up culture across all Trust sites which:

- supports staff in raising concerns
- reacts to and actions those concerns
- feeds back and learns
- does not victimise or hold to account those who speak up

We continue to encourage our staff to raise concerns in whichever way they feel most comfortable. This can be via their line manager, trade union representative, our health and wellbeing department or the human resources department. We also encourage the use of a confidential helpline and email, available at raising.concerns@esneft.nhs.uk

We recognised that there is scope for improvement. Leaders at every level must remind and encourage those with concerns to raise them, while we will continue to advertise the role of the guardian and highlight the support which is available.

NHS Staff Survey

In 2017, a national review took place of the NHS Staff Survey to establish what worked well and what needed improvement. As a result, a number of changes were made to the way the 2018 survey was carried out.

Ten new key themes have been applied to the survey, replacing the previous 'key findings'. These are scored on a 0 to 10 point scale, with a higher score indicating a better result.

These 10 themes are:

- 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 (which is calculated using the same questions as in previous years, but adjusted to a 0-10 point scale)

Results

The key headlines from ESNEFT's first NHS Staff Survey are:

- 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 below, and show that our staff are very clear about how to report unsafe clinical practices and near misses, which keeps our patients safe.

	Top five 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

Our key issues to address are as follows:

	Bottom five 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%	Q9g. Supported by manager to receive training, learning or development definitely identified in appraisal
27%	Q19e. Appraisal/performance review: organisational values definitely discussed

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 Trust	**74.4%**	**55.3%**	**68.3%**
Average	76.5%	61.1%	69.9%
Worst	59.9%	47.2%	49.2%

The full report of the 2018 NHS Staff Survey for ESNEFT is available at www.nhsstaffsurveys.com

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. It aims to give staff the opportunity to feed back their views on their organisation at least once a year, in turn helping to change the culture of the NHS and make sure the views of staff are heard and 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; as well as safety measures such as infection rates. The more engaged staff members are, the better the outcomes for patients and the organisation generally. It is therefore important to strengthen the voices of staff as well as patients.

The results of the FFT are as follows:

	Reporting period	CHUFT score	IHT score	ESNEFT score	National average
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	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 period	CHUFT score	IHT score	ESNEFT score	National average
	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.

Review of tax arrangements of public sector appointees

The Trust now publishes information in relation to the number of off-payroll engagements following the review of tax arrangements of public sector appointees published by the Chief Secretary to the Treasury on 23 May 2012.

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2019	3
Number that have existed for less than one year at time of reporting	3
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	2
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	2
Number for whom assurance has been requested	2*
Of which:	
Number for whom assurance has been received	2
Number for whom assurance has not been received	0
Number terminated as a result of assurance not being received	0

* The figure of 2 reflects only those individuals who are contracting directly with the Trust and have been in post for six months or more. It includes individuals sourced through an agency (NHS procurement contracts require agencies to seek assurance as to individuals' tax obligations) and individuals who have not yet been in post for six months.

Off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed "Board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements	6

Expenditure on consultancy

Trust expenditure on consultancy in 2018/19 was £1.621m, down from £4.636m last year.

Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project. The total was significantly less than during 2017/18, during which consultancy advice on the full business case for the proposed merger with the Ipswich Hospital NHS Trust and support for the new North Essex and East Suffolk Pathology Service was required.

Staff exit packages (subject to audit)

Compulsory redundancies

Exit package cost band	2018/19		2017/18 (Colchester Hospital University NHS Foundation Trust)	
	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of compulsory redundancies	Cost of compulsory redundancies £000
<£10,000	0	0	0	0
£10,001 - £25,000	0	0	0	0
£25,001 - £50,000	3	114	0	0
£50,001 - £100,000	0	0	1	58
£100,001 - £150,000	0	0	1	131
Total	**3**	**114**	**2**	**189**

This disclosure reports the number and value of exit packages agreed in the year.

Note: The expense associated with these departures may have been recognised in part or full in a previous period.

Non-compulsory departure payments

	2018/19		2017/18 (CHUFT)	
	Number	Cost (£000)	Number	Cost (£000)
Contractual payments in lieu of notice	16	25	2	3
Exit payments following employment tribunals or court orders	0	0	2	55
Total	**16**	**25**	**4**	**58**

Foundation Trust code of governance

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The code, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Board considers that it has complied with the provisions of the NHS Foundation Trust Code of Governance with the exception of the requirements relating to evaluation (Code B.6).

Although the Board has continued to undertake a formal and rigorous evaluation of the performance of Board committees (including external observation by NHS Improvement of its Finance and Performance Committee and Quality and Patient Safety Committee), it has not evaluated the performance of the Audit and Risk Committee or the Board of Directors since the merger of Ipswich Hospital NHS Trust and Colchester Hospital University NHS Foundation Trust.

Due to the merger, there was a transitional board in place until November, when the Council of Governors confirmed the Non-Executive appointments. The Board agreed to give the new Board and committee members' time to settle in, and to focus on the development of the new ESNEFT strategy, before commissioning any evaluation. The Board is, however, assured by the positive feedback from NHSI on the committee observations and looks forward to their observation of its May meeting.

Similarly, the Trust has not fully complied with the requirement that the Council of Governors, led by the Chair, should periodically assess its own performance.
The merger resulted in the Council of Governors having a new composition and membership. It, too will also undertake its first evaluation in 2019/20.

The Council has continued, however, to report at all of its public meetings on how it has discharged its responsibilities in holding the Non-Executive Directors to account and engaging with members.

Board of Directors and Council of Governors

Other disclosures relating to the Board of Directors and its committees are in the report into our Board of Directors, which begins on page 50. Disclosures relating to the Council of Governors and its committees from page 83 onwards.

Our membership

Eligibility requirements for joining different membership constituencies

Our Trust has two types of member: public and staff. Public members are people aged 16 years or over who live in Essex or Suffolk and have registered to become a member. Staff members are automatically registered when they join the Trust and include any employee and volunteers.

Public membership and staff membership significantly increased following the merger, as Ipswich's sleeper membership merged with Colchester's membership. Since then, a membership and engagement officer has been appointed and has boosted membership recruitment. At the same time, a data cleanse was carried out by the external organisation which manages the Trust's membership database.

At March 2019, ESNEFT had 11,019 public members and 10,823 staff members.

The public members are spread across the geographical area as follows:

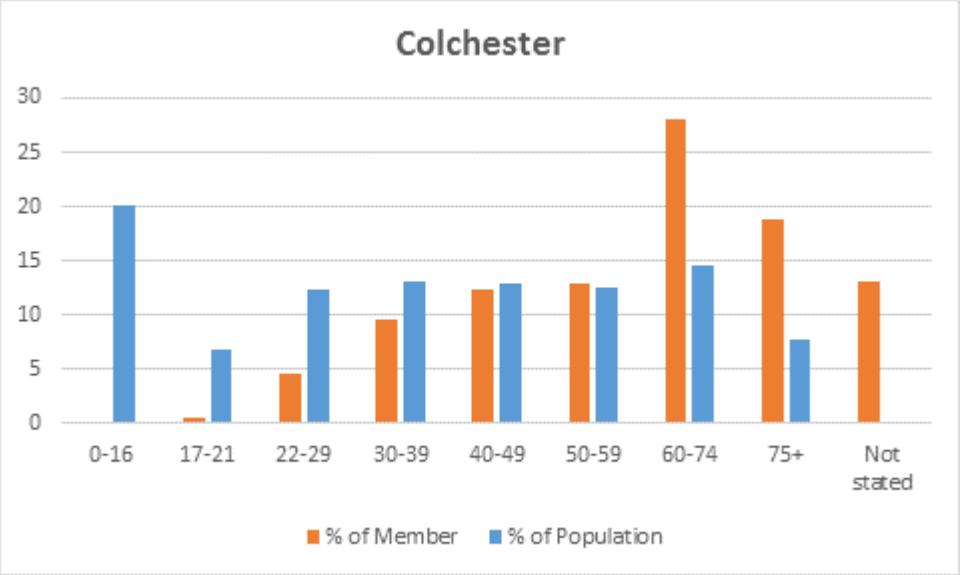
Public membership	Number

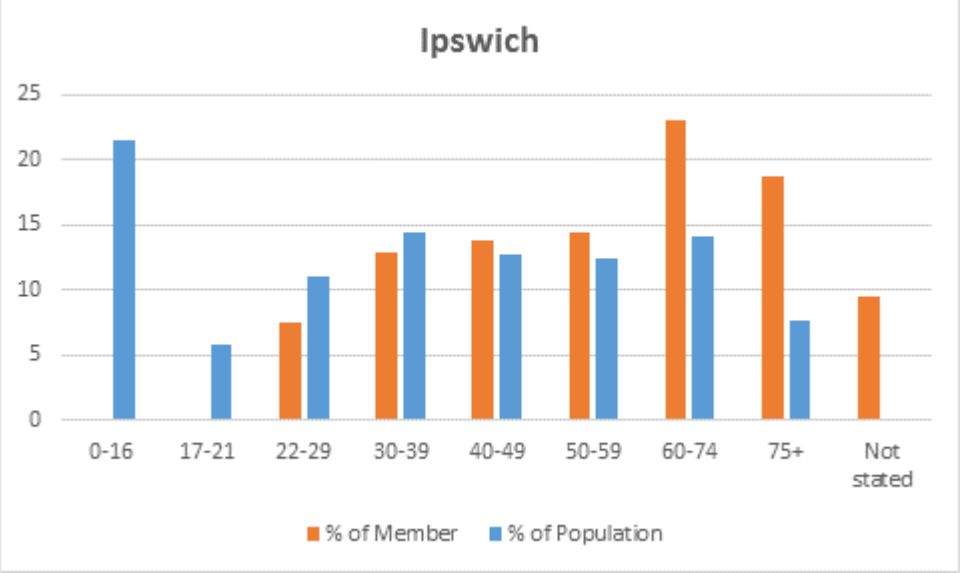
Colchester	2,574
Ipswich	2,278
Rest of Essex	2,689
Rest of Suffolk	3,300
Out of area (including Suffolk)	N/A

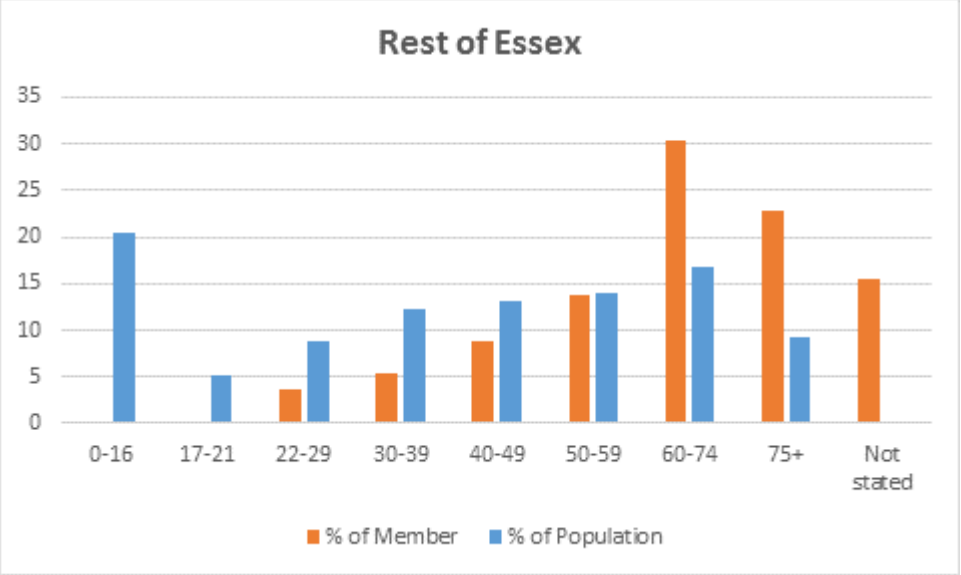
Age profile of our public members

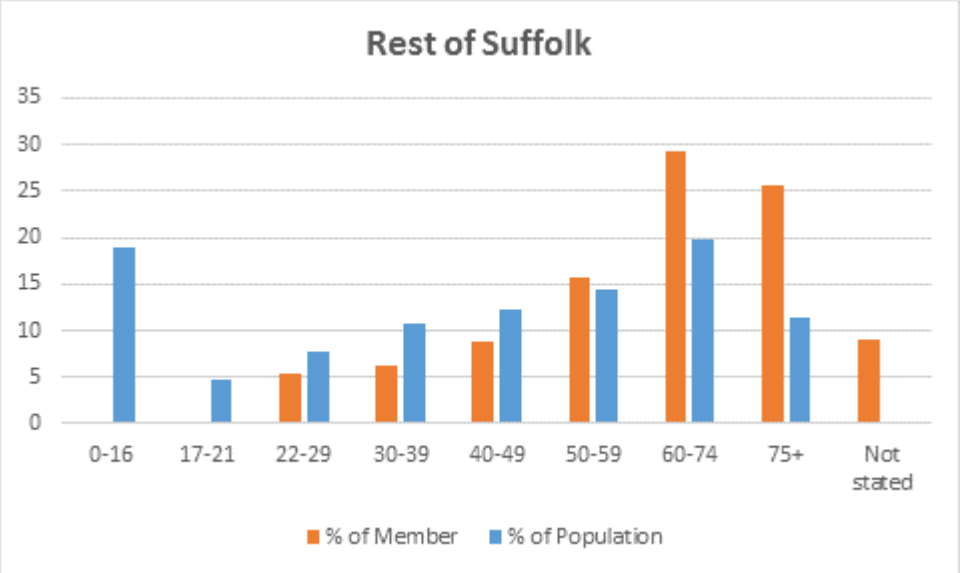
As with many NHS foundation trusts, there is under-representation of public members between the ages of 16 and 49 years, although efforts have been made to start rectifying this by making links with local academic institutions.

We have more public members aged 60 years and above than is representative of the geographical area we serve. Ideally, each pair of columns in the chart would be the same height to be truly representative of our population. Please note that people aged under 16 are not eligible to be members.









Over representation starts at the age of 40 in Colchester and Ipswich and at the age of 50 for the rest of Essex and Suffolk regions. However, efforts have been made below these age groups to close the under-represented age gaps.

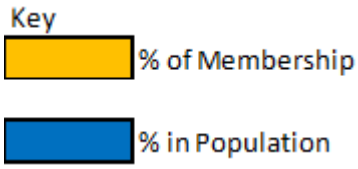
Public membership demography

According to population data, we have far more public members than is representative in the middle class categories. In the semi and skilled labourers group, we are almost proportionately represented across all areas, while there are slight variations in the other categories across all four regions. Ideally, each pair of columns in the chart would be the same height to be truly representative of our population.

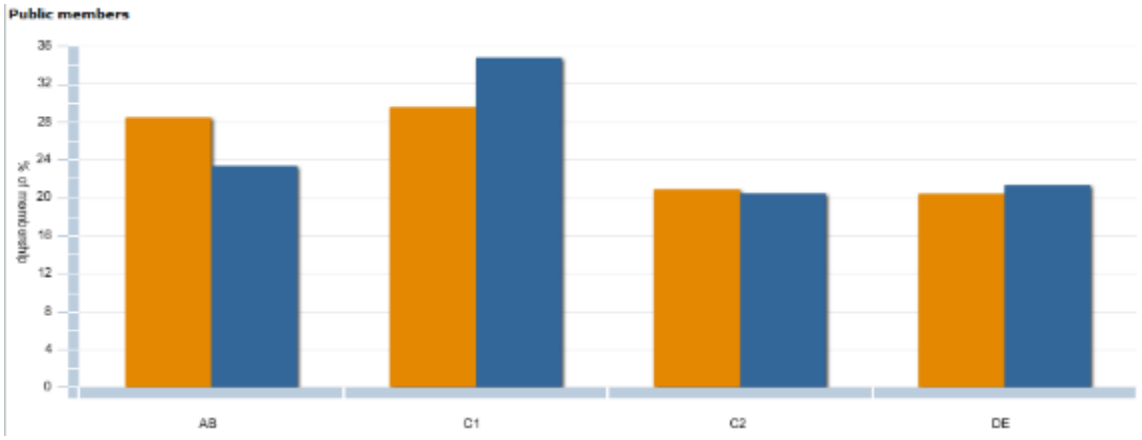
The National Readership Survey social grades are a system of demographic classification:

A = Higher managerial, administrative or professional
B = Intermediate managerial, administrative or professional
C1 = Supervisory or clerical and junior managerial, administrative or professional
C2 = Skilled manual workers
D = Semi-skilled and unskilled manual workers

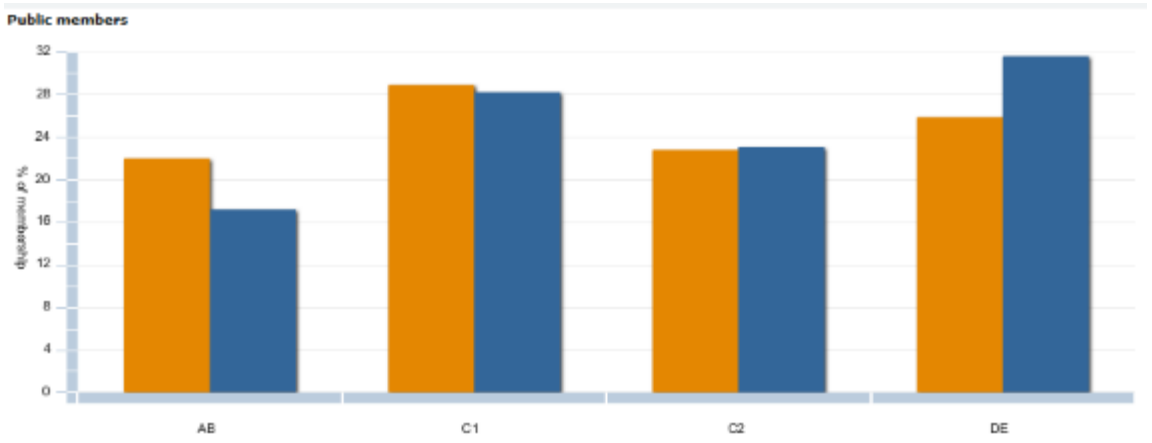
E = Casual or lowest grade workers or those who depend on the welfare state



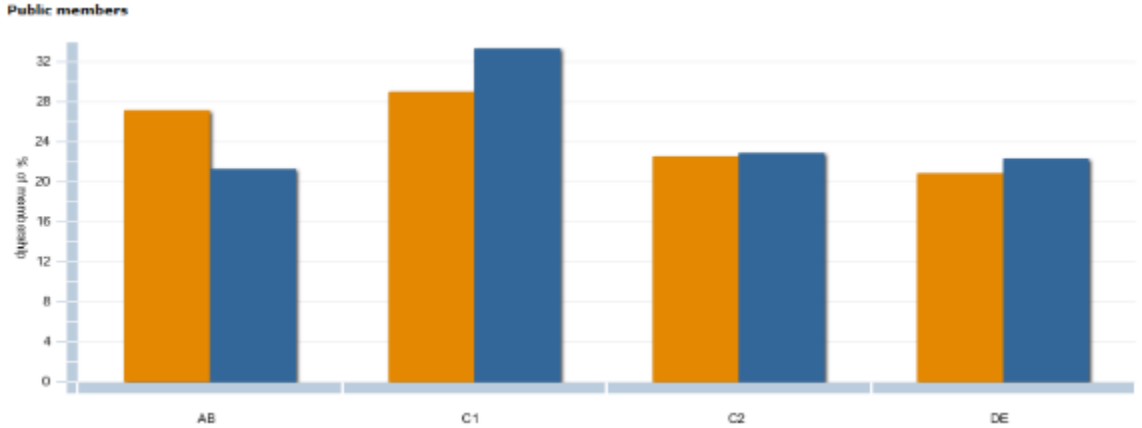
Colchester



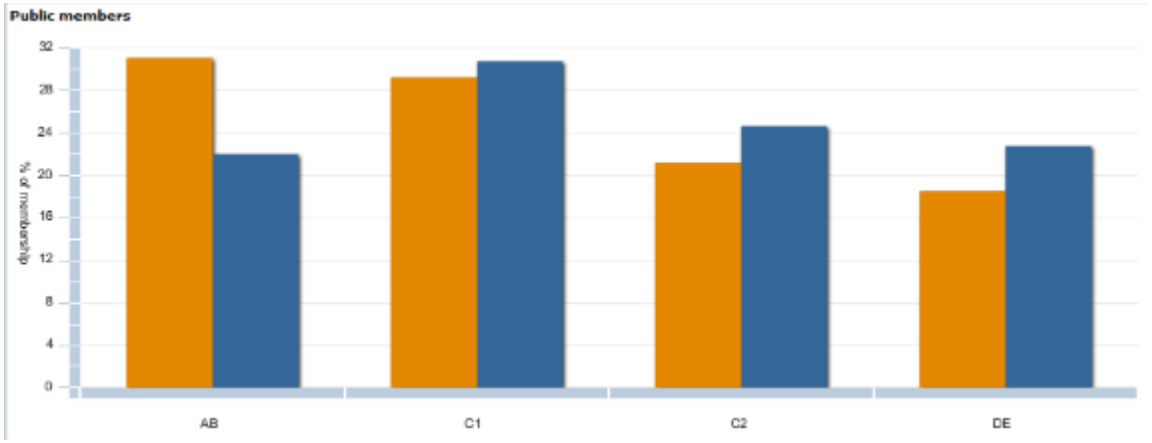
Ipswich



Rest of Essex



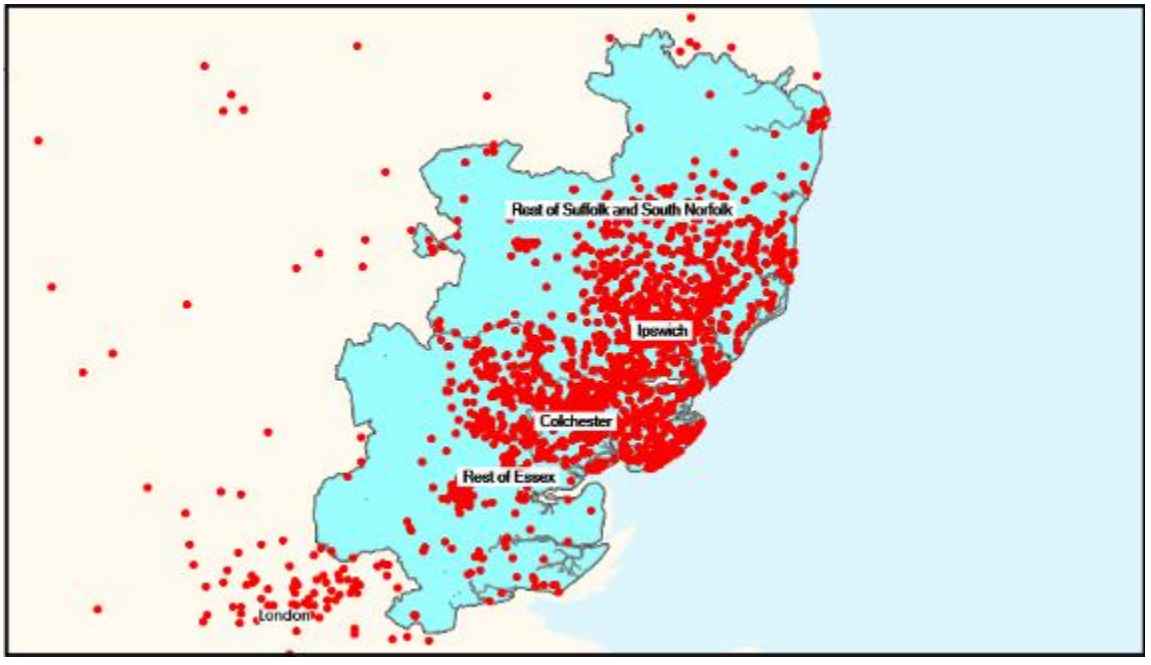
Rest of Suffolk



Location of public members

As the map below shows, there are densely populated centres of membership at our main hospitals and community bases, including Colchester, Clacton, Harwich, Halstead, Ipswich, Felixstowe and Aldeburgh.

Although some of members live outside of the blue area, which is where our external membership database team consider our boundaries to be, they are not be able to vote or stand for election to the Council of Governors.



Contacting our membership office

Members and the public can contact Governors through the membership office by calling 01206 742347 or emailing ft.membership@esneft.nhs.uk

Council of Governors

The Council of Governors represents the interests of the public and employees through its elected Governors and appointed stakeholder Governors.

Directors and Governors working together

The Council of Governors continues to provide an effective local accountability role for the Trust, ensuring that patients, service users, staff and stakeholders are linked in to the Trust's strategic direction. It has proved to be an effective and highly-valued critical friend of the organisation, working with the Board of Directors to develop plans for the Trust.

The Council of Governors acts as a consultative and advisory forum to the Board. It provides a steer on how the Trust can carry out its business and helps it develop long-term strategic plans consistent with the needs of the community it serves. The council also acts as guardian to ensure that the Trust operates in a way that fits with its statement of purpose and is expected to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors.

The other statutory duties of the Council of Governors are:

- the appointment and, if appropriate, removal of the Chair and other Non-Executive Directors
- the remuneration and allowances and other terms and conditions of office of the Chair and the other Non-Executive Directors
- the approval of the appointment of the Chief Executive
- the appointment and, if appropriate, removal of the auditor
- the receiving of the Trust's Annual Accounts, any report of the auditors on them and the Annual Report at a general meeting of the Council of Governors
- the approval of a significant transaction as defined in the Trust's constitution, or an application by the Trust to enter into a merger, acquisition, separation or dissolution
- a decision on whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the Health Service in England, or performing its other functions
- approval of amendments to the Trust's constitution

Membership engagement

Council of Governors elections were held in June 2018 for the newly constituted membership areas of the Trust which came into being on 1 July as a result of the merger. The previous Council of Governors had been in place since January 2018. The main focus of the council to June 2018 was the approval of the merger and the related constitutional changes.

Governors are encouraged to engage with members by taking part in local health forums and patient groups. Within the Trust, they participate in a programme of activities which includes ward walkabouts, task and finish groups and links to staff engagement initiatives.

The main engagement priority up to June 2018 was the merger. Governors were encouraged to take part in the engagement events with the public to discuss the proposals and consider their views. Governors also engaged with local patient participation groups and have continued to undertake walkabouts of the hospital, talking to patients, carers and families.

As more than 70% of the newly-elected Council of Governors were new to the Trust, the main focus since June 2018 has been on induction and orientation.

Governors have been actively involved in the development of ESNEFT's strategy. They will continue to support staff, public and membership engagement activities following its approval by the Trust Board and the implementation of its delivery plans.

Committees and panels

There are two sub-committees of the Council of Governors: the Appointments and Performance Committee and the Standards Committee. Governors are invited to regular informal meetings with the Chair to discuss a wide range of issues, from planning and operations, through to governance and accountability arrangements relating to the Board of Directors.

Governors and Directors are actively encouraged to attend each other's public meetings to gain insight into each other's activities and responsibilities. In addition, a joint confidential meeting also took place to give the Council of Governors and Board the opportunity to discuss ESNEFT's strategy and give governors the opportunity to feed back their views and those of members and stakeholders

Governor representatives also attended the following Board committees as observers:

- Quality and Patient Safety Assurance Committee
- Audit and Risk Assurance Committee
- Finance and Performance Assurance Committee
- People and Organisational Development Assurance Committee
- Charitable Funds and Sponsorship Committee.

Governors also met regularly at the following working groups:

- Transaction Working Group (a task and finish group from February to June 2018)
- Strategy and Membership Group

Standards Committee

The Standards Committee is responsible for reviewing the Governors' Code of Conduct and enforcing it through:

- receiving and reviewing complaints and grievances against individual or groups of Governors
- considering any allegations of failure by a governor to comply with the Trust's constitution or guidance issued by any regulatory authority
- assessing allegations that Governors have breached the Governors' Code of Conduct.

There were no referrals made to the Standards Committee during 2018/19 and therefore the committee did not meet.

Appointments and Performance Committee

The Appointments and Performance Committee is responsible for advising the Council of Governors on the appointment, termination, performance and remuneration of the Non-Executive Directors (including the Chair).

The committee met on five occasions during 2018/19 and convened two appointment panels for the appointment of seven Non-Executive Directors to the Board. Six were appointed from 1 November 2018, with the final NED appointed in March 2019, with a start date of 4 April 2019.

Members and meetings attended in brackets:
David White (2/2), Michael Horley (4/5), Janet Brazier (3/4), Elizabeth Smith (1/1), James Cheung (0/1), Chris Hall (1/1), Donna Booton (2/4), Helen Vanstone (2/2), Michael Loveridge (4/4), Gordon Scopes (4/4), Jennifer Rivett (3/3), Ralph Nation (0/1), Lynda McWilliams (0/1), Gordon Jones (2/4), Anthony Rollo (0/4), Isaac Ferneyhough (1/4) and Sharmila Gupta (0/2).

About the Governors

Elected public Governors (1 April to 30 June)

There were two Councils of Governors in place during 2018/19. From 1 April to 30 June, the council represented the constituencies of Colchester Hospital NHS Foundation Trust. Following the merger on 1 July, a new council was appointed representing the new constituencies of East Suffolk and North Essex NHS Foundation Trust.

Colchester	Tendring	Halstead and Colne Valley
Michael Horley (Lead Governor)	Elizabeth Smith	Janet Brazier
Andrew May	Peter Jackson	David Gronland
Chris Hall	Roy Raby	
Yaa Dankwa Ampadu-Sackey		
Eric Prince		
Rest of Essex	**Suffolk and South Norfolk**	
Vacancy	Jane Young	

Elected staff Governors (1 April to 30 June)

Medical and dental	Nursing and midwifery	Allied health professionals/ healthcare scientists	Support staff
Sharmila Gupta	Donna Booton Anna Swan	Richard Allen	Ralph Nation

Appointed stakeholder Governors (1 April to 30 June)

Under the constitution for Colchester Hospital University NHS Foundation Trust, appointed governors did not have a fixed term.

- Colchester Borough Council: Cllr Helen Chuah was appointed in August 2015
- Tendring District Council: Cllr Lynda McWilliams was appointed in September 2010
- Essex County Council: Cllr Carlo Guglielmi was appointed in August 2017
- Colchester Garrison: Major Gareth Mason was appointed in November 2016; Major Royston Dove was appointed in June 2018
- University of Essex and Anglia Ruskin University: Professor Jo Jackson was appointed in August 2016 to represent both universities

Elected public Governors (from 1 July)

Colchester	Ipswich
Chris Hall	Susan Hayes
Joanna Kirchner	Joanne Thain
Michael Horley	Ian Marsh
Paul Ellis	Jenny Rivett
Rest of Essex	**Rest of Suffolk**
Elizabeth Smith	Helen Vanstone (resigned February 2019)
Jane Young	Gillian Orves
Janet Brazier	David Welbourn
Michael Loveridge	John Alborough
John Price	Gordon Scopes

Elected staff Governors (from 1 July)

Colchester and Essex	Ipswich and Suffolk
Isaac Ferneyhough	Tonia Evans
Donna Booton	Louise Palmer
Sharmila Gupta	Joanne Garnham

Appointed stakeholder governors (from 1 July)

Under the ESNEFT constitution, appointed governors have a fixed term of three years and a maximum of nine consecutive years.

- Colchester Borough Council and Tendring District Council: Cllr Helen Chuah was appointed in July 2018 for a second term of office to represent both councils
- Essex County Council: Cllr Carlo Guglielmi was appointed in July 2018 for a second term of office
- Colchester Garrison: Major Royston Dove was appointed in June 2018
- University of Essex and Anglia Ruskin University: Vikki-Jo Scott was appointed in July 2018 to represent both universities
- Essex Healthwatch: David Sollis was appointed in October 2018
- Ipswich Borough Council and Suffolk Coastal District Council: Cllr Neil Macdonald was appointed in February 2019
- Suffolk County Council: Cllr Gordon Jones was appointed in July 2018
- University of Suffolk: this position is vacant
- Suffolk Healthwatch: Anthony Rollo was appointed in July 2018

Register of interests

All Governors are asked to declare any interests on the register of governors' interests at the time of their appointment or election. This register is reviewed and maintained by the foundation trust office, and is available for inspection by members of the public. Anyone who wishes to see the register or get in touch with a Governor should contact the foundation trust office by calling 01206 747474.

Council of Governor meetings

There were five meetings of the Council of Governors: 14 June, 22 June, 4 October, 29 November and 7 March. The meetings were chaired by David White (4/5) and Jude Chin (1/1).

Governor attendance at Council of Governors meetings

Name	Attended	Name	Attended
Janet Brazier	5/5	Vikki-Jo Scott	2/2
Michael Horley	5/5	Michael Loveridge	3/3
David Gronland	2/2	Gordon Scopes	3/3
Yaa Dankwa Ampadu-Sankey	2/2	Gordon Jones	1/3
Andrew May	2/2	Helen Vanstone	2/2
Eric Prince	2/2	Isaac Ferneyhough	2/3
Elizabeth Smith	5/5	John Price	2/3
Roy Raby	2/2	Tony Rollo	2/3
Jane Young	2/5	Sue Hayes	1/3
Richard Allen	1/2	Jenny Rivett	3/3
Ralph Nation	2/2	Paul Ellis	2/3
Anna Swan	2/2	John Alborough	3/3
Sharmila Gupta	3/5	David Welbourn	3/3
Donna Booton	3/5	Gillian Orves	3/3
Helen Chuah	3/5	Ian Marsh	2/3
Jo Jackson	2/2	Joanne Thain	0/3
Lynda McWilliams	2/2	Joanne Garnham	0/3
Peter Jackson	0/2	Tonia Evans	0/3
Chris Hall	3/5	Louise Palmer	1/3
Joanna Kirchner	1/3		

The Council of Governors did not exercise its power under the Health and Social Care Act to require one or more of the Directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the Directors' performance of their duties.

Regulatory ratings

NHSI Single Oversight Framework for NHS providers

Since 1 April 2013, all NHS foundation trusts need a licence from NHS Improvement (NHSI) stipulating specific conditions they must meet to operate, including financial sustainability and governance requirements.

Since October 2016, NHSI has overseen compliance with these arrangements through the Single Oversight Framework for NHS providers. The framework is used to assess the Trust's compliance across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

Using this approach, NHS segments individual trusts according to the level of support each trust needs. ESNEFT has been placed in segment three, which reflects that the Trust is receiving mandated support due to significant concerns and has agreed enforcement undertakings with NHSI.

The aim of an NHSI assessment under the Single Oversight Framework is to ensure that the regulator identifies the level of support each trust needs across the five themes. This, in turn, will provide the Trust and NHSI with the information it needs to help attain and maintain CQC ratings of "good" or "outstanding".

Risk of any other non-compliance with terms of authorisation

The Trust was issued with a Section 106 letter in January 2018 on the basis that NHSI had reasonable grounds to suspect that the licensee has provided and is providing healthcare services for the purposes of the NHS in breach of the following conditions of its licence: FT4(5)(b),(c),(e) and (f).

These terms are detailed in the licence which can be found at:
www.gov.uk/government/groups/colchester-hospital-university-nhs-foundation-trust

There is an improvement programme in place to ensure that the Trust meets the undertakings agreed with NHSI on the publication of the Section 106 letter. The ongoing review of risks did not identify any further significant risks to compliance with the Trust's terms of authorisation.

Mandatory service risk

The Trust's Board of Directors is satisfied that:

- all assets needed for the provision of mandatory goods and services are protected from disposal,
- plans are in place to maintain and improve existing performance,
- the Trust has adopted organisational objectives and is now measuring performance in line with these objectives, and
- the Trust is investing in change and capital estate programmes which will improve clinical processes, efficiency and, where required, release additional capacity to ensure it meets the needs of patients.

CQC compliance

East Suffolk and North Essex NHS Foundation Trust has not been inspected by the Care Quality Commission since it was formed.

Colchester Hospital University NHS Foundation Trust (CHUFT) was last inspected in July 2017 and received a “requires improvement” rating. The Ipswich Hospital NHS Trust (IHT) was last inspected between August and October 2017 and received a rating of “good”.

Individual services were rated as follows:

Service	CHUFT	IHT
Maternity and gynaecology	Good	Good
Medical care (including older people’s care)	Good	Good
Urgent and emergency services (A&E)	Requires improvement	Good
Surgery	Good	Good
Intensive/ critical care	Good	Good
Services for children and young people	Good	Good
End of life care	Good	Good
Outpatients	Requires improvement	Good

Statement of the Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of East Suffolk and North Essex NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

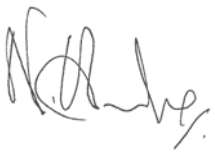
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require East Suffolk and North Essex NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of East Suffolk and North Essex NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance.
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable him to ensure that the accounts comply with requirements outlined in the above-mentioned act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Nick Hulme
Chief Executive

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore provide only reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Suffolk and North Essex NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place at ESNEFT for the year ended 31 March 2019 and up to the date of approval of the Annual Report and Annual Accounts.

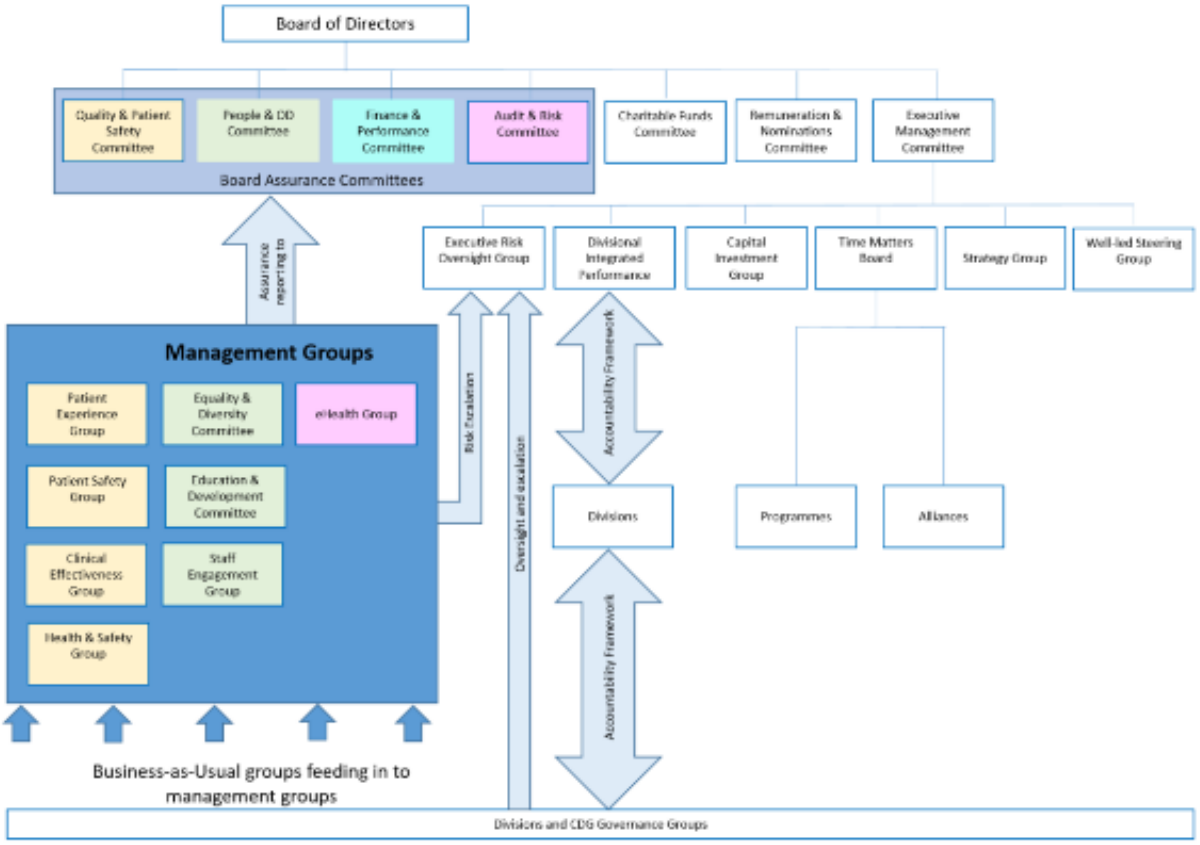
Capacity to handle risk

The overall responsibility for risk management within the Trust rests with me and the Executive Management Team, along with requirements to meet all statutory requirements and adhere to the guidance issued by NHSI and the Department of Health in respect of governance.

The Trust has established an Executive Risk Oversight Committee with a remit to ensure the adequacy of structures, processes and responsibilities for identifying and managing key risks facing the organisation prior to discussion at the Board. This includes oversight of the Board Assurance Framework (BAF), the Trust-wide risk register and divisional risk registers. This committee is chaired by the Deputy Chief Executive and supported by the Director of Governance, who is the Board lead for risk management.

The Trust's principal and strategic risks are captured in the BAF, which is used to inform the risk priorities of the Board and the four main assurance committees (the Audit and Risk Assurance Committee, the Finance and Performance Assurance Committee, the People and Organisational Development Assurance Committee and the Quality and Patient Safety Assurance Committee). The Audit and Risk Assurance Committee has a further duty to review the Trust's internal financial controls and the Trust's internal control and risk management systems.

Day-to-day management of risks is undertaken by operational management, who are charged with ensuring that risk assessments are undertaken proactively throughout their area of responsibility, and remedial action carried out where problems are identified and incidents reported indicating a potential weakness in internal control. These are captured in divisional risk registers, which are discussed in divisional governance meetings and the Executive Risk Oversight Committee, ensuring that the issues facing the divisions are being recognised and captured corporately. Trust-wide issues are captured in the Trust-wide risk register which, when discussed concurrently with the divisional risk registers in Executive Risk Oversight Committee meetings, ensure that there is appropriate escalation to the BAF, ensuring that it remains an up-to-date tool to inform the Board of Directors and its assurance committees for risks where there are difficulties in implementing mitigations.



All staff members are trained in risk management at a level relevant to their role and responsibilities. Staff also have access to additional support and education to ensure they have the necessary skills and knowledge and are competent to identify, control and manage risk within their work environment. All newly-appointed staff receive training at the compulsory corporate induction day, which includes their personal responsibilities as well as the necessary information and training to enable them to work safely and to recognise risk.

All policies relating to risk management are available on the intranet in the policy section, with support available from the Risk and Compliance Team. The BAF and Corporate Risk Register are in the public domain as part of the papers discussed during public Board meetings, which enables public stakeholders to be aware of potential risks which may impact on them.

The Risk and Control Framework

The risk management policy (see page 36) sets out the Trust's approach to managing risk, describes the structures for the management and ownership of risk and explains its risk management processes. Leadership for risk is driven by the Board of Directors through the BAF, which keeps the Board informed of the key strategic risks affecting the Trust.

Following the acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust in July 2018, a transitional BAF was established to cover the new Trust. The structure of the transitional BAF is consistent with those of the previous Trusts as it covers the principal risks, key controls, gaps in control, gaps in assurance, movements in the risk profile and actions to reduce risks to an acceptable level. There is clear ownership over who is the senior Board-level risk owner and over which assurance committee oversees the assurance process for each risk.

The Board has considered and agreed the principles regarding the risk that the Trust is prepared to seek, accept or tolerate in the pursuit of its objectives and has captured these in its Risk Appetite Statement.

Financial

The Trust has a flexible view of financial risk when making medium to long-term business decisions with transformative potential and is prepared to make bold, but not reckless, decisions, minimising the potential for financial loss by managing risks to a tolerable level.

For other financial decisions, the Trust takes a cautious position, with value for money as the primary concern. However, the Trust is willing to consider other benefits or constraints and will consider value and benefits, not just the cheapest price. Resources are allocated in order to capitalise on opportunities.

Compliance/Regulatory

The Board has a minimal to cautious risk appetite when it comes to compliance and regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, it will make every effort to meet regulator expectations and comply with them and will only challenge them if there is strong evidence or argument to do so and the gain will outweigh the adverse consequences.

Innovation

The Board has a flexible view of innovation that supports quality, patient safety and operational effectiveness. Its strategic objective to embrace new ideas to deliver new, technology enabled, financial viable ways of working leads it to pursue innovation and challenge current working practices. It is willing to devolve responsibility for non-critical decisions on the basis of earned autonomy.

Quality

The Board has a cautious view of risk when it comes to patient safety, patient experience or clinical outcomes and places the principle of “no harm” at the heart of every decision it takes. It is prepared to accept some risk if, on balance, the benefits are justifiable and the potential for mitigation is strong. When taking decisions involving choices between a wide range of outcomes, it will prioritise the option resulting in the greatest benefit for the most patients.

Infrastructure

The Board will take a measured approach when investing in building and equipment maintenance and replacement, based on informed analysis and assessment of risk, but may take informed risks if there are identifiable mitigations that can provide reasonable alternative protection.

Workforce

The Board is prepared to take decisions that would have an effect on staff morale if there are compelling arguments supporting change, including some decisions with a high inherent risk if there is a potential higher reward.

Reputation

The Board's view over the management of the Trust's reputation is that it is willing to take high to significant risks and is willing to take decisions that are likely to bring scrutiny to the organisation where the potential benefits outweigh the risks and sees new ideas as potentially enhancing the reputation of the organisation.

Commercial

The Board has a flexible view of commercial risk. It is willing to pursue business opportunities with the potential for high returns alongside commercial activities of a more established nature, taking a balanced view of risk and reward and on the basis of earned autonomy.

The Risk Appetite Statement was agreed at a public meeting of the Board in November 2018 and is incorporated in the Trust's Risk Strategy.

During 2018/19, the Trust saw its principal risks as follows:

- If we do not have in place effective organisational management, then we may not be able to fully mitigate the variance and volatility in financial performance against the plan, leading to failure to deliver the control total and impacting on cash flow and long-term sustainability as a going concern.
- If we do not establish systematic processes for identifying, measuring and delivering cost improvement opportunities and leveraging transformational change, then we will not deliver the cost improvement programme in the financial year or create long-term opportunities for sustainability, which may lead to failure to deliver the control total and impact on cashflow and long-term sustainability as a going concern.
- If we do not fully engage our staff on the improvement journey, then they may fail to make a positive contribution to change, which may limit the sustainability of improvements made.
- If we do not have in place robust processes for recording activity, then we may have inaccuracies for clinical use and reported activity, which may lead to information gaps regarding patient diagnosis, care and treatments, tracking of patient pathways and coding inaccuracies. This would impact on our external data submissions, such as contract reporting, HSMR and regulatory submission.
- If we do not transform pathology services, then we may fail to achieve quality and cost improvements leading to suboptimal service impacting on patient care and our relationship with our partners.
- If we do not have sufficient nursing staff on duty, then there may be delayed or rushed care for patients that may lead to poor patient experience, potential clinical harm, delays in patient flow and poor job satisfaction.
- If we do not transform through our strategy and its delivery, then we will be unable to achieve long term sustainability leading to further regulatory intervention.
- If activity growth exceeds capacity assumptions based on the 2018/19 contract and legacy issues are not addressed, then we may not have sufficient capacity to assess and treat people in a timely manner affecting system resilience and internal efficiencies, patient safety and delivery of contractual performance (four hour standard, RTT 18 weeks, cancer and diagnostics within six weeks.

These risk issues, the key controls in place to manage them and the actions in hand to further reduce their likelihood and impact were discussed at the Trust's Executive Risk Oversight Group meetings, meetings of the Board's assurance committees and at Board meetings.

Risks are identified through many sources such as risk assessments, clinical benchmarking, audit data, clinical and non-clinical incident reporting, complaints, claims, patient and public feedback, stakeholder and partnership feedback and internal/external assessment, including CQC inspection reports.

At East Suffolk and North Essex NHS Foundation Trust, we believe that every incident offers an opportunity to learn. The reporting of incidents is a fundamental building block in achieving an open, transparent and fear-free way of fulfilling this aim. Our structures and frameworks promote learning, escalation, treatment and mitigation of, or from, risk.

East Suffolk and North Essex NHS Foundation Trust is fully compliant with the registration requirements of the CQC.

The Trust has in place effective systems and processes which assure the Board that staffing is safe, sustainable and effective, ensures provision of a quality service and that care and treatment needs are met. The Trust reviews it staffing establishments in line with NQB guidance, assessing that the right number and skill mix of staff are available to meet the needs of people using the service. This review includes use of evidence-based tools where available, such as SNCT, national guidance, reviews of quality measure and outcomes and professional judgement.

We have an electronic roster system in place for nursing staff which details the type and number of staff that are required to ensure there are suitably qualified, competent, skilled and experienced staff to meet patients' care and treatment needs effectively. We work in partnership with bank and agency providers to fill gaps in our rotas.

Professional teams carry out daily staffing reviews (risk assessments) in line with standard operating procedure. These take into account staff numbers, skill mix and competencies, patient acuity and dependency and activity. Where indicated, staff are used flexibly to provide cover and any risks are formally escalated for action to the staffing co-ordinator, while the senior manager on call is also informed.

The Trust has an agreed set of workforce performance metrics which are RAG rated against expected performance. These are reported to the Board of Directors within the monthly integrated performance report. Where a metric is below target, remedial actions are included in the report and, where necessary, overseen by a Board assurance committee. Where such mitigations are insufficient to address the gap, business continuity plans are enacted with escalation to the Director on call.

ESNEFT will present its first nursing and midwifery establishment and skill mix review to the Board of Directors in June 2019, which will include recommendations from the Chief Nurse to ensure safe and effective staffing. We are also reviewing medical staffing levels as part of our clinical strategy work, and some service areas have developed Trust-wide posts to improve the sustainability of medical cover. Rotas for trainee doctors across the Trust are monitored for compliance, with oversight from the Guardian of Safe Working whose work is overseen by the People and Organisational Development Committee. With any review of staffing, the Chief Nurse and Chief Medical Officer will present their assessment to the Board on whether staffing governance processes are safe and sustainable. Updates on safe staffing will be presented bi-yearly thereafter. All changes to skill mix and introduction of new roles undergo a quality impact assessment which is signed off by the Chief Nurse and Chief Medical Officer.

ESNEFT has an annual workforce plan which is submitted to the Board of Directors and NHSI on an annual basis, in line with guidance. The Trust is currently developing it medium and long term workforce strategy.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. The trust continues to strengthen the process and embed within the organisation.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme

are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. This includes carrying out equality impact assessments to provide assurance that consultations relating to changes to any of our functions and services are not discriminatory. Where any remedial action is identified by the assessment, we develop and implement an action plan to address this.

The Trust has carried out risk assessments and put carbon reduction delivery plans in place in accordance with emergency preparedness and civil contingency requirements, as based on UK Climate Projections 2018 (UKCIP18). The Trust ensures that its obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Corporate Governance Statement

The Trust's risk and governance frameworks as described in this statement ensure that the organisation can confirm the validity of its corporate governance statement as required under NHS foundation trust condition 4(8)(b). The Trust Executive Team carries out regular risk assessments of its compliance with these conditions and flags for the Board's attention those areas where action is required. The corporate governance statement itself, with a summary of the evidence supporting it, is reviewed by the Board of Directors. This was last reviewed by the Board at its meeting on 29 May 2018.

Never events

Never events are "serious, largely preventable patient safety incidents which should not occur if the available preventative measures have been implemented by the healthcare provider".

The Trust reported seven serious incident never events in 2019/20. They were:

- wrong site surgery (2)
- wrong implant / prosthesis (2)
- wrong site local anaesthetic block
- wrong route administration of medication
- retained foreign object post-procedure

We continue to proactively report our never events and compliance against the WHO Safer Surgery Checklist to the Board and the Quality and Patient Safety Committee every month.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has a range of processes in place to ensure that resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff, regular reporting to the Board on quality, operational performance and finance, with further review and scrutiny on a monthly basis at meetings of the Quality and Patient Safety Assurance Committee, the Finance and Performance Assurance Committee and the People and Organisational Development Assurance Committee.

The Trust has an agreed risk-based annual audit programme with its internal auditors. These audit reports are aimed at evaluating the Trust's effectiveness in operating in an efficient and effective manner and are focused on reviewing its operational arrangements for securing best value and optimum use of resources in respect of the services the organisation provides.

For 2018/19, the Trust delivered a surplus of £33m. The plan for 2019/20 is a deficit of £8.6m, with a requirement of £8.5m in revenue cash support from the Department of Health and Social Care. During 2019/20, the Trust's financial control total will be £8.6m. To deliver this control total, a cost improvement programme of £31.9m needs to be delivered which may be in the form of planned cost reductions, as set out at the start of the financial year, or through cost avoidance, which may be necessary to mitigate any underachievement of the plan during the year. Recognising the size of the cost reductions, the Trust is gearing up robust measures for monitoring and in particular escalation and recovery arrangements to mitigate slippage of deliver, particularly during the transition phase.

Following the merger of Colchester and Ipswich hospitals, the Trust has continued to seek economy, efficiency and effectiveness in the use of resources, particularly with regard to its decision-making processes and sustainable resource deployment. The merger and the immediate post-merger implementation programme, along with the implementation of tighter management and control over quality, operational efficiency and finance has strengthened the Board's confidence in the Trust's strategy and operational delivery.

Information governance

The Trust has a designated SIRO (the Director of ICT) who has responsibility for data security as the champion for information risk. The SIRO aims to mirror the model prescribed by central Government's Cabinet Office. Following this best practice approach allows for uniformity across the public sector as it strives to meet the competing demands of further transparency and public/private engagement in contrast to increased cybersecurity threats and the need to prevent data leakage. By treating information as a business priority and not as an ICT or technical issue, the Trust can ensure that risks are addressed, managed and capitalised upon.

The Trust currently reports key IT controls relating to data and cyber security to the Audit and Risk Committee and is planning for Cyber Essentials Plus accreditation in 2021. We also act on any advice from the NHS Digital CareCert Information Sharing Portal on Cyber Security, and have increased our cyber security precautions by appointing a dedicated IT security manager who is a certified information systems security professional. We have reported no significant cyber security incidents in the past year.

The Trust submitted the Data Protection and Security Toolkit in March 2019 for 2018/19 and complied with all mandatory assertions.

The Data Protection Officer has investigated 196 potential personal data breaches, four of which were reportable to the Information Commissioner's Office. No further action was taken in any of the cases.

Data Protection Act subject access requests are managed in accordance with GDPR. We received substantial assurance in 2019/20 on an internal audit following the change in the law during 2018, which recognises that the process of capturing and reporting any breaches is operating effectively.

Training is aligned with General Data Protection Act. Information Governance Freedom of Information Act training has been redesigned to take account of changes in the law during the year, while mandatory awareness training for all employees has and will continue to take place.

The Trust carried out an assessment of its compliance with the data security and protection toolkit, the outcome of which was a compliance score of satisfactory.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Reports for each financial year. NHSI has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

ESNEFT places high priority on the quality of its clinical outcomes, patient safety and patient experience and strives to deliver the principles outlines in NHSI's well-led framework.

Indicators relating to the Quality Report were identified following a process which included consultation with its Council of Governors and Board of Directors, and appropriate internal and external audit arrangements were put in place to ensure the accuracy of the data. The Chief Nursing Officer is the Executive Director responsible for patient safety and patient experience, and the Chief Medical Officer is responsible for clinical effectiveness. The Associate Director of Clinical Governance provides further leadership and support for the quality and governance agenda.

The executive governance structure supporting the quality agenda was reviewed in advance of forming ESNEFT and set out in the Post-Transaction Implementation Programme. To support the executive team, all aspects of quality governance report through the Patient Safety Group, Patient Experience Group and the Clinical Effectiveness Group, with escalation through to the Executive Risk Oversight Committee and the Executive Management Committee.

These indicators have been incorporated into the key performance indicators reported regularly to the Board as part of the performance monitoring arrangements. Scrutiny of the information contained within these indicators and its implication as regards to clinical outcomes, patient safety and patient experience takes place at the Quality and Patient Safety Committee.

The inter-relationship between the indicators in the Quality Report and other measures of the Trust's performance (financial and operational) is reviewed monthly by the board of directors. Reviews of data quality and the accuracy, validity and completeness of Trust information fall within the remit of the Audit and Risk Committee, which is informed by the reviews of internal and external audit and internal management assurances. The Board takes further assurance from the external auditor's review of the quality report, including the testing of data provided within the report.

As reported in the Quality Report, other plans to improve quality have included the following:

- setting up a quality improvement faculty to support quality improvement development in the new Trust
- making plans to deliver the key performance indicators (KPIs) in the CQUINs agreed with commissioners
- taking action to deliver improvements in the key national performance indicators, including RTT, cancer targets and the A&E waiting time.

The Trust reported an end-of-year position of 87.07% of patients waiting under 18 weeks on incomplete pathways against a target of 92%.

The Trust assures the quality and accuracy of its elective waiting time data through a regular validation process internally, with additional checks by the business informatics team to ensure the data reported is accurate. This includes ensuring all 52 week breaches have been confirmed by the service, with large movements checked and triangulated with other recording systems. Further independent assurances are made through internal audits of data quality, national validation programmes and third party support from specialist organisations with validation expertise.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I

have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Assurance Committee and other assurance committees of the Board, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- assessment of financial reports submitted to NHSI;
- opinions and reports made by external auditors;
- reports made by internal auditors, including specific audit reports on governance and risk management;
- the Head of Internal Audit opinion;
- clinical audit reports, as detailed in the Quality Report, used to change and improve clinical practice;
- accreditations held for designated services;
- the Infection Control Annual Report and associated monthly reporting;
- other annual reports relating to statutory reporting requirements, which include radiation safety, safeguarding and health and safety;
- investigation reports and action plans following serious and significant incidents;
- departmental and clinical risk assessments and action plans;
- results of national patient surveys;
- results of the national NHS Staff Survey;
- results of peer reviews and external quality assurance visits (including CQC activities);
- Data Security and Protection Toolkit; and
- Patient-Led Assessment of the Care Environment (PLACE) inspections.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been reviewed by:

- the Board; through consideration of key objectives and the management of principal risks to those objectives within the BAF, and by reviewing all policies relating to governance and risk management and monitoring the implementation of arrangements within the Trust;
- the Audit and Risk Assurance Committee; by reviewing and monitoring the opinions and reports provided by both internal and external audit;
- the Quality and Patient Safety Assurance Committee; by implementing and reviewing clinical governance arrangements and receiving reports from all operational clinical governance related committees; and
- external assessments and peer review of services.

Head of internal audit opinion

In accordance with the Public Sector Internal Audit Standards (PSIAS), internal audit provides the Trust with an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit and Risk Committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

Internal audit issued 17 reports during 2018/19:

- one has been given a 'substantial' level of assurance – General Data Protection Regulations
- 14 have been given a 'satisfactory' level of assurance – agency control, complaints, patient and staff safety (including serious incidents, pharmacy stock control, assurance framework and risk management), governance (including engagement with third parties, SSCM post-implementation, budgetary control, creditors, debtors, financial ledger, fixed assets, treasury management and payroll)
- one was given a 'limited' level of assurance – reference costs – cost transformation

The final audit (Data Protection Security (DSP) Toolkit), was not provided with an opinion due to the nature of the work undertaken.

The framework for monitoring and review action in response to internal audit reports is established and is status is reported at each Audit and Risk Committee meeting.

For the 12 months ended 31 March 2019, the head of internal audit's opinion for ESNEFT is that: "satisfactory assurance can be given that there is a generally sound system of internal control, designed to meet the Trust's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls puts the achievement of particular objectives at risk."

The audit work undertaken during 2018/19 has been completed as part of a collaboration between Mazars LLP and TIAA. TIAA have undertaken seven audits in the year, of which six have been finalised. One of those finalised has been given a 'substantial' level of assurance (Estates Premises Assurance Model), two were given a 'reasonable' level of assurance (E-Rostering and policy review), and three a 'limited' level of assurance (theatre utilisation – data quality – Colchester, CIPs – deep dive and ward visits). One audit is currently in draft (outpatient's cancellations – Colchester site).

Conclusion

In considering any significant control issues, the following have been recognised:

- **Long term financial sustainability** – Whilst the Trust reported a surplus in 2018/19, this resulted from an accounting transaction relating to the acquisition of net assets from The Ipswich Hospital NHS Trust. Without this adjustment, the Trust reported an adjusted deficit in 2018/19 and has submitted a deficit plan for 2019/20. We are not expected to achieve financial balance in the medium term, which may impact on the expectation on us to achieve financial balance / surplus by 2023/24. We continue to develop transformation plans to deliver patient / service benefits whilst reducing cost.

- **Access targets** – Whilst we benchmark well against peers, we have yet to consistently deliver the national access targets. We continue to work to improve performance against national indicators, including RTT, cancer targets and the A&E waiting time.

- **Pathology services** – The pathology service provided by the Trust (as host for the North East Essex and Suffolk Pathology Services) has been a cause for concern in 2018/19. This primarily relates to quality assurance in the laboratory management processes and computer system, staff recruitment, equipment upgrades, service accreditation and improvement in legacy logistics functions. We have worked with West Suffolk NHS Foundation Trust to put in place a plan to address the immediate priorities and, through clinical engagement, have drafted a vision and strategy for the services to be approved in 2019/20. The resourcing of the plan to address immediate priorities and transform the service to deliver the strategy has and will require additional resources.

I am confident that our internal control systems are operating well and that the work we have done to maintain and develop our risk management system will help us to consolidate this position in the future. The Trust is committed to the continuous improvement of processes of internal control and assurance.

Nick Hulme
Chief Executive

The Directors consider that this Annual Report, Annual Accounts and Quality Report taken as a whole are fair, balanced and understandable and provide the information necessary for our patients, regulators and stakeholders to assess East Suffolk and North Essex NHS Foundation Trust's performance, business model and strategy.

Nick Hulme
Chief Executive

Independent auditor's report to the Council of Governors

Independent auditor's report to the Council of Governors of East Suffolk and North Essex NHS Foundation Trust

Opinion on financial statements

We have audited the financial statements of East Suffolk and North Essex NHS Foundation Trust (the Trust) for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and as interpreted and adapted by the 2018-19 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2018-19, and the NHS Foundation Trust Annual Reporting Manual 2018-19 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key Audit Matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Matter	How we addressed the matter in the audit
Acquisition of The Ipswich Hospital Trust (IHT) • The Trust acquired Ipswich Hospital on 1 July 2018. The acquisition brought challenges to the Trust in terms of the merger of balances on the ledger from a financial perspective. • The presentation of the acquisition and related disclosures also needed to be properly considered to ensure compliance with the requirements of the Group Accounting Manual (GAM). • The details of the assets and liabilities transferred from Ipswich Hospital are disclosed in Note 38 of the financial statements	We reviewed the Trust's method for compiling accounts from multiple systems and controls operating to mitigate associated risk. We also considered whether the control environment was appropriate across the two hospital sites following the acquisition. We also reviewed the process in place to merge the two ledger systems and confirmed that the opening balances as at 1 July were accurate. We also ensured that the balances from the three-month period prior to the acquisition were correctly reflected in the newly merged ledger. We confirmed that the disclosures and accounting entries made by the Trust regarding the acquisition complied with the requirements of the GAM.
Valuation of Property, Plant and Equipment (PPE) • The calculation of the fair value of land and buildings requires the use of judgement in determining the appropriate assumptions underlying the valuation and this is susceptible to bias or error. • The PPE disclosure is in Note 8 of the financial statements • Small changes in the underlying assumptions can have a significant impact on the movements in valuation recognised in the financial statements.	We reviewed the instructions provided to the valuer and considered the valuer's skills and expertise in order to determine the extent to which we could rely on the Management's expert. We assessed Management's review of the alternative site basis for both Hospital sites to ensure that it remained a valid judgement within the financial statements during 2018/19. We reviewed indices of price movements for similar classes of assets to determine whether any updated valuation was required, and to ensure that fair value of land and buildings was not materially different from their carrying value at the balance sheet date. We confirmed that the basis of valuation for assets valued in year was appropriate based on their usage, and valuation movements were in line with indices of price movements.

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements. We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonable users that are taken on the basis of the financial statements.

Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

The materiality for the financial statements as a whole was set at £9.4 million (2018 £5.1 million). This was determined with reference to the benchmark of gross expenditure (of which it represents 1.5%) (2018 – 1.5%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance and position of the Trust.

We agreed with the Audit Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of £200,000 (2018- £128,000) in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

Overview of the scope of our audit

The Trust operates as a single entity with no significant subsidiary bodies or other controlled undertakings. Accordingly our audit was conducted as a full scope audit of the Trust.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on the Remuneration Report and Staff Report

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes ;
- the tables of exit packages and related notes;
- the analysis of staff numbers and related notes; and
- the table of pay multiples and related narrative notes.

In our opinion the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2018-19.

Matters on which we are required to report by exception

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, with the exception of the matter reported in the Basis for qualified conclusion on use of resources section of our report, we are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion on use of resources

The Trust has a general duty under paragraph 63 of Chapter 5 of the National Service Act 2006 to exercise the functions of the Trust effectively, efficiently and economically.

For the year ended 31 March 2019 the Trust has reported a surplus of £33m. This was largely due to the gain arising from the transfer by absorption from the acquisition of Ipswich Hospital of £41.4m. When this is removed, the Trust's 'real' deficit is £8.4m.

Although the Trust delivered £26.6m of cost improvement plan savings, the 2019/20 agreed control total of a deficit of £8.6m is dependent upon delivery of cost improvement plan savings of £31.8m in the year. This represents a significant challenge for the Trust.

The Trust does not yet have plans to secure a return to a breakeven position in the medium term.

These matters are evidence of weakness in proper arrangements regarding sustainable resource deployment.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice we report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not misleading or inconsistent with other information that is forthcoming from the audit; or
- the Quality Report has been prepared in accordance with the detailed guidance issued by NHS Improvement.

We also report to you if:

- we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006; or

We have nothing to report in these respects.

Responsibilities the Accounting Officer

As explained more fully in the Statement of Accounting Officer's Responsibilities in respect of the Accounts, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors either intends to liquidate the Trust or to cease operations, or has no realistic alternative but to do so.

The Accounting Officer is also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's other responsibilities

We are also required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of East Suffolk and North Essex NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Council of Governors of East Suffolk and North Essex NHS Foundation Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Council of Governors of East Suffolk and North Essex NHS Foundation Trust those matters we are required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the NHS Foundation Trust and the Council of Governors as a body, for our audit work, for this report or for the opinions we have formed.

David Eagles
For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK

28 May 2019

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

East Suffolk and North Essex NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

FOREWORD TO THE ACCOUNTS

East Suffolk and North Essex NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by East Suffolk and North Essex NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

The Trust's accounts for 2018/19 have recorded a surplus of £33.0 million (excluding the consolidation of charitable funds). This includes £41.4m gains arising from transfers by absorption resulting from the acquisition of The Ipswich Hospital NHS Trust (IHT).

On the 1st July 2018 Colchester Hospital University NHS Foundation Trust (CHUFT) acquired The Ipswich Hospital NHS Trust, forming East Suffolk and North Essex Foundation Trust (ESNEFT), and as such the assets, liabilities and ongoing operational income and expenditure form part of these accounts from this date.

Acknowledging that the growth in income and expenditure significantly increased due to the in-year transaction, all of the comparisons represent a material change.

In accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, management have assessed the organisation's ability to continue as a going concern for the foreseeable future. Significant work is ongoing with NHS Improvement, local commissioners and stakeholders to provide safe and sustainable services across the East Suffolk and North East Essex area and no decision has been made to transfer services or significantly amend the structure of the organisation. The clinical strategy for the future has started to be developed for public consultation during 2019/20, with a commitment that there remains a need for A&E, maternity and acute medical services at both Colchester and Ipswich sites in the future.

The Trust has developed a plan for 2019/20 which is a deficit of £8.6m, with a requirement of £8.5m in revenue cash support from the Department of Health and Social Care. The receipt of unplanned Provider Sustainability Funding will mitigate the short term need for revenue cash support.

Contracts for 2019/20 have been signed with commissioners, and whilst the Trust has not yet received formal confirmation in respect of the interim financial support it requires at the time of signing the accounts, there is a presumption that additional working capital support will again be provided to the Trust in 2019/20. However, the Trust has made no decision to request dissolution from the Secretary of State and has no reason to believe that financial support will not be provided.

Whilst the Trust is facing some significant challenges, the Directors, having made appropriate enquiries, still have reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis for preparing the accounts.

Nick Hulme, Chief Executive

28 May 2019

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	539,013	296,878
Other operating income	4	85,307	46,625
Operating expenses	7, 9	(627,561)	(345,058)
Operating deficit from continuing operations		**(3,241)**	**(1,555)**
Finance income	12	224	46
Finance expenses	13	(4,415)	(1,558)
PDC dividends payable		(779)	(1,107)
Net finance costs		**(4,970)**	**(2,619)**
Other losses	14	(161)	(71)
Gains arising from transfers by absorption	38	41,369	-
Surplus /(deficit) for the year		**32,997**	**(4,245)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	19	(13,246)	5,346
Total comprehensive income / (expense) for the period		**19,751**	**1,101**

The notes on pages 8 to 47 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	16	9,942	5,749
Property, plant and equipment	17	284,393	157,272
Receivables	23	1,691	-
Total non-current assets		**296,026**	**163,021**
Current assets			
Inventories	22	9,889	4,838
Receivables	23	67,746	31,701
Non-current assets held for sale	24	4,100	4,100
Cash and cash equivalents	25	15,855	9,233
Total current assets		**97,590**	**49,872**
Current liabilities			
Trade and other payables	26	(71,447)	(38,923)
Borrowings	28	(94,303)	(1,304)
Provisions	30	(705)	(2,210)
Other liabilities	27	(3,743)	(1,842)
Total current liabilities		**(170,198)**	**(44,279)**
Total assets less current liabilities		**223,418**	**168,614**
Non-current liabilities			
Borrowings	28	(132,692)	(100,637)
Provisions	30	(1,642)	(815)
Other liabilities	27	(1,954)	(2,280)
Total non-current liabilities		**(136,288)**	**(103,732)**
Total assets employed		**87,130**	**64,882**
Financed by			
Public dividend capital		121,860	77,994
Revaluation reserve		38,554	26,423
Other reserves		754	754
Income and expenditure reserve		(74,038)	(40,289)
Total taxpayers' equity		**87,130**	**64,882**

The financial statements on pages 2 to 47 were approved by the Board and signed by:

Nick Hulme, Chief Executive

28 May 2019

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**77,994**	**26,423**	**754**	**(40,289)**	**64,882**
Surplus/(deficit) for the year	-	-	-	32,997	**32,997**
Revaluations	-	(13,246)	-	-	**(13,246)**
Transfers by absorption: transfers between reserves	41,369	25,575	-	(66,944)	**-**
Transfer to retained earnings on disposal of assets	-	(198)	-	198	**-**
Public dividend capital received	2,497	-	-	-	**2,497**
Taxpayers' equity at 31 March 2019	**121,860**	**38,554**	**754**	**(74,038)**	**87,130**

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2018

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**76,764**	**21,132**	**754**	**(36,099)**	**62,551**
Surplus/(deficit) for the year	-	-	-	(4,245)	**(4,245)**
Revaluations	-	5,346	-	-	**5,346**
Transfer to retained earnings on disposal of assets	-	(55)	-	55	**-**
Public dividend capital received	1,230	-	-	-	**1,230**
Taxpayers' equity at 31 March 2018	**77,994**	**26,423**	**754**	**(40,289)**	**64,882**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(3,241)	(1,555)
Non-cash income and expense:			
Depreciation and amortisation	7.1	16,922	8,243
Income recognised in respect of capital donations	4	(762)	(52)
Amortisation of PFI deferred credit		(326)	(326)
(Increase) / decrease in receivables and other assets		(8,034)	(2,394)
(Increase) / decrease in inventories		299	36
Increase / (decrease) in payables and other liabilities		(431)	7,819
Increase / (decrease) in provisions		(2,007)	1,208
Net cash generated from / (used in) operating activities		**2,420**	**12,979**
Cash flows from investing activities			
Interest received		224	46
Purchase of intangible assets		(1,171)	(381)
Purchase of property, plant, equipment and investment property		(8,206)	(11,483)
Sales of property, plant, equipment and investment property		54	44
Receipt of cash donations to purchase capital assets		498	-
Net cash generated from / (used in) investing activities		**(8,601)**	**(11,774)**
Cash flows from financing activities			
Public dividend capital received		2,497	1,230
Interim capital support loans - Received		2,063	-
Interim capital support loans - Repaid		(182)	(80)
Normal capital investment loan - Repaid		(1,188)	(1,188)
Interim revenue support loans - Received		22,329	13,338
Interim revenue support loans - Repaid		(4,618)	(9,022)
Movement on other loans		97	-
Capital element of finance lease rental payments		(1,351)	(97)
Capital element of PFI and other service concession payments		(622)	-
Interest on loans		(2,454)	(1,499)
Other interest		2	-
Interest paid on finance lease liabilities		(1,058)	(24)
Interest paid on PFI and other service concession obligations		(1,231)	-
PDC dividend (paid) / refunded		(2,347)	(72)
Net cash generated from / (used in) financing activities		**11,937**	**2,586**
Increase / (decrease) in cash and cash equivalents		**5,756**	**3,791**
Cash and cash equivalents at 1 April - brought forward		**9,233**	**5,442**
Cash and cash equivalents transferred under absorption accounting	38	866	-
Cash and cash equivalents at 31 March	25.1	**15,855**	**9,233**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
Other reserves represent the balance of working capital, inventories, and plant and equipment assets transferred to the Trust as part of the disaggregation and dissolution of Essex and Herts Community NHS Trust in 2001. The reserve is held in perpetuity and cannot be released to the Statement of Comprehensive Income.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. In accordance with IAS 1, management has made an assessment of the Trust's ability to continue as a going concern. For the financial year commencing 1st April 2019 the Trust has forecast a deficit of £8.6 million and within this forecast is a cost improvement programme requiring £31.9 million of efficiencies and savings. In order to fund this deficit, the Directors are seeking interim financial support for 2019/20 of £8.5 million from the Department of Health and Social Care. At the time of writing, this interim working capital support has not been provided to the Trust and discussions are on-going with regard to this, although there is a presumption that working capital support will once again be provided to the Trust in 2019/20 as required.

The Directors, having made appropriate enquiries, have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the Department of Health and Social Care Group Accounting Manual 2018/19, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Note 1.3 Interests in other entities

Colchester Hospital Charity was merged with the Ipswich Hospital Charity under a single registration under the Charity Commission to form Colchester and Ipswich Hospitals Charity. The Trust has not consolidated the activities of the Charity, whose activities are not considered to be material.

ESNEFT is the host provider of Pathology services for West Suffolk Hospital and community as well as for ESNEFT and community.

The Trust holds no investments in associates or joint ventures.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred. The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are:

	Min life Years	Max life Years
Buildings, excluding dwellings	10	65
Plant & machinery	5	15
Information technology	3	10
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are:

	Min life Years	Max life Years
Software licences	2	15

Note 1.9 Inventories

Inventories are valued at current cost. Current cost is considered to be a reasonable approximation to the lower of cost and net realisable value due to the high turnover of stocks..

Note 1.10 Investment properties
Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)
The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The Trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 31.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 32 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

Foundation Trusts have a statutory exemption from corporation tax on all of their core healthcare activities. No significant commercial activity on which corporation tax would be applicable is undertaken.

Note 1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM* .

Note 1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Tust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.23 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities. An equivalent entry is recorded against Public Dividend Capital to reflect this net gain / loss in the Trust's taxpayers equity.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Note 1.24 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, IAS 1 requires management to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.24.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The Trust considers that the valuation of property, plant and equipment assets poses a significant risk relating to estimates and assumptions about their carrying value. To mitigate the risk of material misstatement, the Trust engages the professional services and advice of the Valuation Office Agency (VOA) to provide estimated values for these assets. The VOA is recognised as a suitable provider of a range of valuation and surveying services to public sector bodies and their estimates can be relied upon in respect of these services, including estimates of the remaining useful economic lives of property assets.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

The following list of recently issued International Financial Reporting Standards and amendments have not yet been adopted within the FReM, and are therefore not applicable to Department of Health and Social Care group accounts in 2018/19. Other than IFRS16 (see below), none of these are expected to impact upon the Trust financial statements.

IFRS 14 Regulatory Deferral Accounts: Not EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applcable to DHSC group bodies.

IFRS 16 Leases: Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is therefore not permitted. The Trust is aware that this standard will have an impact, the extent of which is still to be quantified.

IFRS 17 Insurance Contracts: Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 23 Uncertainty over Income Tax Treatments: Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

The Trust has determined that the Chief Operating Decision Maker is the Board of Directors, on the basis that all strategic decisions are made by the Board. Segmental information is not provided to the Board of Directors and therefore it has been determined that there is only one business segment, that of Healthcare.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
Acute services		
Elective income	85,648	40,880
Non elective income	151,579	89,862
First outpatient income	28,627	16,160
Follow up outpatient income	50,284	26,396
A & E income	22,371	12,711
High cost drugs income from commissioners (excluding pass-through costs)	44,506	-
Other NHS clinical income	112,269	105,778
Community services		
Community services income from CCGs and NHS England*	29,051	-
All services		
Private patient income	1,775	735
Agenda for Change pay award central funding	7,194	-
Other clinical income	5,709	4,356
Total income from activities	**539,013**	**296,878**

* Community services income is recognised for services which were transferred to the Trust as part of the acquisition of The Ipswich Hospital NHS Trust.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	77,013	43,351
Clinical commissioning groups	438,597	235,169
Department of Health and Social Care	7,194	-
Other NHS providers	8,654	13,048
NHS other	92	196
Local authorities	24	-
Non-NHS: private patients	1,611	637
Non-NHS: overseas patients (chargeable to patient)	164	98
Injury cost recovery scheme	1,349	1,074
Non NHS: other	4,315	3,305
Total income from activities	**539,013**	**296,878**
Of which:		
Related to continuing operations	539,013	296,878

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	164	98
Cash payments received in-year	91	50
Amounts added to provision for impairment of receivables	199	47
Amounts written off in-year	18	25

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	775	1,017
Education and training (excluding notional apprenticeship levy income)	16,305	7,794
Non-patient care services to other bodies	15,834	5,003
Provider sustainability / sustainability and transformation fund income (PSF / STF)	31,297	20,336
Income in respect of employee benefits accounted on a gross basis	2,434	1,932
Car Parking income	2,559	1,237
Pharmacy sales	2,791	1,385
IT recharges (external)	1,024	12
Staff contribution to employee benefit schemes	421	405
Crèche services	466	-
Other contract income	9,003	6,734
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	468	36
Receipt of capital grants and donations	762	52
Charitable and other contributions to expenditure	367	241
Rental revenue from operating leases	475	115
Amortisation of PFI deferred income / credits	326	326
Total other operating income	**85,307**	**46,625**
Of which:		
Related to continuing operations	85,307	46,625

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

Revenue recognised in the reporting period that was included within contract liabilities at the previous period end is nil

Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods is nil.

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is nil.

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	524,335	291,787
Income from services not designated as commissioner requested services	14,678	5,091
Total	**539,013**	**296,878**

Note 5.4 Profits and losses on disposal of property, plant and equipment

There were no material disposals of property, plant and equipment in the year.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and income from charges to service users where income from that service exceeds £1 million. For 2018/19 and for 2017/18 this is nil.

Note 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,935	-
Purchase of healthcare from non-NHS and non-DHSC bodies	25,850	6,130
Staff and executive directors costs	372,055	206,473
Remuneration of non-executive directors	162	137
Supplies and services - clinical (excluding drugs costs)	63,836	40,728
Supplies and services - general	15,770	4,004
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	56,219	27,602
Inventories written down	103	138
Consultancy costs	1,621	4,636
Establishment	6,908	7,403
Premises	19,692	6,047
Transport (including patient travel)	1,635	1,042
Depreciation on property, plant and equipment	14,799	7,203
Amortisation on intangible assets	2,123	1,040
Movement in credit loss allowance: contract receivables / contract assets	834	-
Movement in credit loss allowance: all other receivables and investments	-	148
Increase/(decrease) in other provisions	-	1,391
Change in provisions discount rate(s)	(21)	8
Audit fees payable to the external auditor		
Audit fees in respect of the statutory audit *	86	55
Audit fees in respect of the quality report *	7	5
Internal audit costs	95	59
Clinical negligence	18,631	13,585
Legal fees	250	303
Insurance	440	324
Education and training	1,592	866
Rentals under operating leases	6,926	2,996
Redundancy	79	166
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	704	-
Car parking & security	93	160
Hospitality	38	(3)
Losses, ex gratia & special payments	65	126
Other services, eg external payroll	426	3,620
Other	13,608	8,666
Total	**627,561**	**345,058**
Of which:		
Related to continuing operations	627,561	345,058

* Audit fees are disclosed inclusive of VAT.

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 8 Impairment of assets

No impairments were charged to the operating deficit during the year

Note 9 Employee benefits

	Total	Total
	£000	£000
Salaries and wages	262,221	143,932
Social security costs	26,888	13,505
Apprenticeship levy	1,302	689
Employer's contributions to NHS pensions	32,154	17,041
Pension cost - other	21	10
Termination benefits	-	32
Temporary staff (including agency)	49,469	31,264
Total staff costs	**372,055**	**206,473**
Of which		
Costs capitalised as part of assets	-	-

Note 9.1 Retirements due to ill-health

During 2018/19 there were 6 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £410k (£86k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018, Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

National Employment Savings Scheme (NEST)

NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008.

Note 11 Operating leases

Note 11.1 East Suffolk and North Essex NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where East Suffolk and North Essex NHS Foundation Trust is the lessor.

The Trust's operating lease income is from the annual rents charged by the Trust for the use of its premises. Lease income from operating leases is recognised in income on a straight-line basis over the lease term, irrespective of when the payments are due.

	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	475	115
Total	**475**	**115**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due on land leases:		
- not later than one year;	209	35
- later than one year and not later than five years;	548	85
- later than five years.	4,431	-
Total	**5,188**	**120**
Future minimum lease receipts due on building leases:		
- not later than one year;	233	55
- later than one year and not later than five years;	632	50
- later than five years.	6,274	-
Total	**7,139**	**105**
Total future minimum lease receipts due:		
- not later than one year;	442	90
- later than one year and not later than five years;	1,180	135
- later than five years.	10,705	-
Total	**12,327**	**225**

Note 11.2 East Suffolk and North Essex NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where East Suffolk and North Essex NHS Foundation Trust is the lessee.

The Trust's operating leases include rentals for the use of NHS premises, lease car contracts and the hire of medical and laboratory equipment. The leases have been reviewed and classified as operating leases in accordance with IAS 17.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	6,926	2,996
Total	**6,926**	**2,996**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due on building leases:		
- not later than one year;	4,574	1,396
- later than one year and not later than five years;	5,632	1,745
- later than five years.	606	703
Total	**10,812**	**3,844**
Future minimum lease payments due on other leases:		
- not later than one year;	812	506
- later than one year and not later than five years;	860	244
- later than five years.	-	-
Total	**1,672**	**750**
Total future minimum lease payments due:		
- not later than one year;	5,386	1,902
- later than one year and not later than five years;	6,492	1,989
- later than five years.	606	703
Total	**12,484**	**4,594**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	224	46
Total finance income	**224**	**46**

Note 13.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,497	1,529
Finance leases	664	24
Interest on late payment of commercial debt	20	3
Main finance costs on PFI scheme obligations	577	-
Contingent finance costs on PFI scheme obligations	654	-
Total interest expense	**4,412**	**1,556**
Unwinding of discount on provisions	3	2
Total finance costs	**4,415**	**1,558**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	20	3

Note 14 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	35	15
Losses on disposal of assets	(196)	(86)
Total gains / (losses) on disposal of assets	**(161)**	**(71)**

Note 15 Better Payment Practice Code - Measure of Compliance

	2018/19		2017/18	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	123,928	355,756	77,165	190,354
Total non-NHS trade invoices paid within target	62,885	237,361	36,502	123,297
Percentage of non-NHS trade invoices paid within target	0.51	0.67	0.47	0.65
Total NHS trade invoices paid in the year	2,849	63,616	1,838	58,768
Total NHS trade invoices paid within target	1,309	38,140	806	42,223
Percentage of NHS trade invoices paid within target	0.46	0.60	0.44	0.72

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Note 16.1 Intangible assets - 2018/19

	Software licences £000
Valuation / gross cost at 1 April 2018 - brought forward	**11,750**
Transfers by absorption	10,003
Additions	1,707
Reclassifications	117
Disposals / derecognition	(669)
Valuation / gross cost at 31 March 2019	**22,908**
Amortisation at 1 April 2018 - brought forward	**6,001**
Transfers by absorption	5,394
Provided during the year	2,123
Reclassifications	117
Disposals / derecognition	(669)
Amortisation at 31 March 2019	**12,966**
Net book value at 31 March 2019	**9,942**
Net book value at 1 April 2018	**5,749**

Note 16.2 Intangible assets - 2017/18

	Software licences £000
Valuation / gross cost at 1 April 2017 - as previously stated	**12,063**
Prior period adjustments	-
Valuation / gross cost at 1 April 2017 - restated	**12,063**
Additions	501
Disposals / derecognition	(814)
Valuation / gross cost at 31 March 2018	**11,750**
Amortisation at 1 April 2017 - as previously stated	**5,775**
Prior period adjustments	-
Amortisation at 1 April 2017 - restated	**5,775**
Provided during the year	1,040
Disposals / derecognition	(814)
Amortisation at 31 March 2018	**6,001**
Net book value at 31 March 2018	**5,749**
Net book value at 1 April 2017	**6,288**

Note 17.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**12,375**	**124,851**	**3,228**	**38,678**	**6,112**	**175**	**185,419**
Transfers by absorption	6,380	108,292	1,225	41,858	4,986	2,480	**165,221**
Additions	-	661	7,015	11,222	282	-	**19,180**
Revaluations	(205)	(21,150)	-	-	-	-	**(21,355)**
Reclassifications	-	6,733	(7,823)	115	858	-	**(117)**
Disposals / derecognition	-	-	(20)	(3,762)	(1,552)	-	**(5,334)**
Valuation/gross cost at 31 March 2019	**18,550**	**219,387**	**3,625**	**88,111**	**10,686**	**2,655**	**343,014**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**23,482**	**4,542**	**123**	**28,147**
Transfers by absorption	-	1,081	-	23,601	2,524	1,814	**29,020**
Provided during the year	-	7,028	-	6,173	1,442	156	**14,799**
Revaluations	-	(8,109)	-	-	-	-	**(8,109)**
Reclassifications	-	-	-	(211)	94	-	**(117)**
Disposals / derecognition	-	-	-	(3,567)	(1,552)	-	**(5,119)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**49,478**	**7,050**	**2,093**	**58,621**
Net book value at 31 March 2019	**18,550**	**219,387**	**3,625**	**38,633**	**3,636**	**562**	**284,393**
Net book value at 1 April 2018	**12,375**	**124,851**	**3,228**	**15,196**	**1,570**	**52**	**157,272**

Note 17.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017	**12,375**	**114,404**	**2,594**	**36,862**	**6,075**	**175**	**172,485**
Additions	-	29	9,564	2,519	84	-	**12,196**
Revaluations	-	1,942	-	-	-	-	**1,942**
Reclassifications	-	8,476	(8,930)	313	141	-	**-**
Disposals / derecognition	-	-	-	(1,016)	(188)	-	**(1,204)**
Valuation/gross cost at 31 March 2018	**12,375**	**124,851**	**3,228**	**38,678**	**6,112**	**175**	**185,419**
Accumulated depreciation at 1 April 2017	**-**	**-**	**-**	**21,382**	**3,948**	**106**	**25,436**
Provided during the year	-	3,404	-	3,091	691	17	**7,203**
Revaluations	-	(3,404)	-	-	-	-	**(3,404)**
Disposals / derecognition	-	-	-	(991)	(97)	-	**(1,088)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**23,482**	**4,542**	**123**	**28,147**
Net book value at 31 March 2018	**12,375**	**124,851**	**3,228**	**15,196**	**1,570**	**52**	**157,272**
Net book value at 1 April 2017	**12,375**	**114,404**	**2,594**	**15,480**	**2,127**	**69**	**147,049**

Note 17.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019							
Owned - purchased	18,550	184,832	3,127	26,129	3,589	512	**236,739**
Finance leased	-	2,671	-	11,387	-	-	**14,058**
On-SoFP PFI contracts and other service concession arrangements	-	31,494	-	-	-	-	**31,494**
Owned - donated	-	390	498	1,117	47	50	**2,102**
NBV total at 31 March 2019	**18,550**	**219,387**	**3,625**	**38,633**	**3,636**	**562**	**284,393**

Note 17.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018							
Owned - purchased	12,375	117,721	3,201	15,070	1,553	52	**149,972**
Finance leased	-	1,651	-	-	-	-	**1,651**
On-SoFP PFI contracts and other service concession arrangements	-	5,479	-	-	-	-	**5,479**
Owned - donated	-	-	27	126	17	-	**170**
NBV total at 31 March 2018	**12,375**	**124,851**	**3,228**	**15,196**	**1,570**	**52**	**157,272**

Note 18 Donations of property, plant and equipment

The Trust received donations of assets in the year valued at £763k. These were for the Colchester Cancer Centre and other medical equipment.

Note 19 Revaluations of property, plant and equipment

In accordance with IAS 16, all property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

IFRS 13 Fair Value is adopted in full; however, IAS 16 and IAS 38 have been adapted and interpreted for the public sector context which limits the circumstances in which a valuation is prepared under IFRS 13. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13 if it does not meet the requirements of IAS 40 of IFRS 5.

All assets are measured subsequently at current value. All land and buildings are restated to current value using professional valuations at least every five years, with an interim valuation at 3 years. All plant and equipment is valued using a depreciated historical costs basis as a proxy for current value.

For land and building assets, professional valuations are carried out by the District Valuer Service of the Valuation Office Agency. The valuations accord with the requirements of the professional standards of the Royal Institution of Chartered Surveyors: RICS Valuation – Global Standards 2017 and the RICS Valuation - Professional Standards UK (January 2014, revised April 2015), commonly known together as the Red Book, including the International Valuation Standards, in so far as these are consistent with IFRS, HM Treasury the National Health Service and the above mentioned guidance; RICS UKVS 1.14 refers.

The valuation basis for the Trust's land and building assets is that of an alternative site basis. In selecting the alternative site on which the modern equivalent asset would be situated, the Valuer considers whether the actual site remains appropriate for use by the Trust, in accordance with section 7 of UKGN 2. For public sector bodies, HM Treasury guidance is that the choice of whether to value an alternative site will normally hinge on whether the proposed alternative site will meet the locational requirements of the service that is being provided (Treasury Guidance Note paragraphs 1.14 to 1.16).

A valuation of land and buildings was prepared by the District Valuer Service as at 31 March 2019 based on his site visits to Colchester and Ipswich. This resulted in a downward revaluation of building by £13.2m.

Following discussions with the District Valuer Service, it was determined that alternative sites would be appropriate for certain assets, and these instances the land has been valued assuming the benefit of planning permission for development for a use, or a range of uses, prevailing in the vicinity of the selected site.

In 2018/19 the Trust has applied its valuation basis consistently to the land and building assets acquired from The Ipswich Hospital NHS Trust.

Valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value. In accordance with Treasury guidance, all revaluations undertaken since 1 May 2008 have been based on "modern equivalent assets".

The fixed assets include bio-fuel plant and equipment with a closing value of £5.1m. Following a review of options, the Trust is proposing to take the bio-fuel plant and equipment out-of-use during 2019/20 and, subject to approval, will seek to impair its asset value accordingly.

Note 20 Investment Property

The Trust holds no investment property.

Note 21 Disclosure of interests in other entities

Colchester Hospital Charity was merged with the Ipswich Hospital Charity under a single registration under the Charity Commission to form Colchester and Ipswich Hospitals Charity. The Trust has not consolidated the activities of the Charity, whose activities are not considered to be material.

The Trust holds no other unconsolidated interests in subsidiaries, joint ventures or associates.

Note 22 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	3,791	2,047
Consumables	6,012	2,550
Energy	86	38
Other	-	203
Total inventories	**9,889**	**4,838**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £52,037k (2017/18: £45,900k). Write-down of inventories recognised as expenses for the year were £103k (2017/18: £138k).

Note 23.1 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	62,350	
Trade receivables*		11,302
Accrued income*		19,685
Allowance for impaired contract receivables / assets*	(3,505)	
Allowance for other impaired receivables	-	(1,463)
Prepayments (non-PFI)	2,934	1,663
PFI lifecycle prepayments	2,051	-
PDC dividend receivable	1,325	-
VAT receivable	2,511	514
Corporation and other taxes receivable	28	-
Other receivables	52	-
Total current trade and other receivables	**67,746**	**31,701**
Non-current		
Contract receivables*	2,062	
Allowance for impaired contract receivables / assets*	(371)	
Total non-current trade and other receivables	**1,691**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	49,942	22,824

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 23.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	**-**	**1,463**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,463	(1,463)
Transfers by absorption	1,803	-
New allowances arising	1,877	-
Reversals of allowances	(1,043)	-
Utilisation of allowances (write offs)	(224)	-
Allowances as at 31 Mar 2019	**3,876**	**-**

Note 23.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017	**1,369**
Increase in provision	252
Amounts utilised	(54)
Unused amounts reversed	(104)
Allowances as at 31 Mar 2018	**1,463**

Note 23.4 Exposure to credit risk

Due to the fact that the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2018 is in receivables from customers, as disclosed in the receivables note.

Note 24 Non-current assets held for sale

	2018/19	2017/18
	£000	£000
NBV of non-current assets for sale at 1 April	4,100	4,100
NBV of non-current assets for sale at 31 March	4,100	4,100

Note 25.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**9,233**	**5,442**
Transfers by absorption	866	-
Net change in year	5,756	3,791
At 31 March	**15,855**	**9,233**
Broken down into:		
Cash at commercial banks and in hand	156	280
Cash with the Government Banking Service	15,699	8,953
Total cash and cash equivalents as in SoFP	**15,855**	**9,233**

Note 25.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Monies on deposit	90	-
Total third party assets	**90**	**-**

Note 26.1 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	32,135	19,586
Capital payables	4,344	2,351
Accruals	26,875	12,854
Other taxes payable	8,003	3,858
PDC dividend payable	-	92
Accrued interest on loans*		182
Other payables	90	-
Total current trade and other payables	**71,447**	**38,923**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	12,079	5,794

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 26.2 Early retirements in NHS payables above

The payables note above includes no amounts in relation to early retirements.

Note 27 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	3,371	1,516
PFI deferred income / credits	372	326
Total other current liabilities	**3,743**	**1,842**
Non-current		
PFI deferred income / credits	1,954	2,280
Total other non-current liabilities	**1,954**	**2,280**

Note 28 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	91,744	1,267
Obligations under finance leases	1,475	37
Obligations under PFI or other service concession contracts (excl. lifecycle)	1,084	-
Total current borrowings	**94,303**	**1,304**
Non-current		
Loans from the Department of Health and Social Care	102,348	99,858
Other loans	97	-
Obligations under finance leases	10,722	779
Obligations under PFI or other service concession contracts	19,525	-
Total non-current borrowings	**132,692**	**100,637**

Further details of the movements in borrowings are shown in Note 28.1

Note 28.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**101,125**	**-**	**816**	**-**	**101,941**
Cash movements:					
Financing cash flows - payments and receipts of principal	18,404	97	(1,351)	(622)	**16,528**
Financing cash flows - payments of interest	(2,454)	-	(1,058)	(576)	**(4,088)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	182	-	-	-	**182**
Transfers by absorption	74,338	-	5,869	21,230	**101,437**
Additions	-	-	7,257	-	**7,257**
Application of effective interest rate	2,497	-	664	577	**3,738**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2019	**194,092**	**97**	**12,197**	**20,609**	**226,995**

Note 29 Finance leases

Obligations under finance leases where East Suffolk and North Essex NHS Foundation Trust is the lessee.

	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**16,515**	**1,030**
of which liabilities are due:		
- not later than one year;	2,199	60
- later than one year and not later than five years;	7,804	240
- later than five years.	6,512	730
Finance charges allocated to future periods	(4,318)	(214)
Net lease liabilities	**12,197**	**816**
of which payable:		
- not later than one year;	1,475	37
- later than one year and not later than five years;	5,540	157
- later than five years.	5,182	622

Finance lease obligations at 31 March 2019 include the values transferred as part of the acquisition of The Ipswich Hospital NHS Trust during the year.

Note 30.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Re-structuring	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	**364**	**554**	**72**	**1,146**	**672**	**217**	**3,025**
Transfers by absorption	185	871	44	-	-	226	**1,326**
Change in the discount rate	(2)	(19)	-	-	-	-	**(21)**
Arising during the year	17	85	53	-	-	-	**155**
Utilised during the year	(115)	(96)	(44)	(1,122)	(67)	(226)	**(1,670)**
Reversed unused	-	-	(32)	(24)	(415)	-	**(471)**
Unwinding of discount	-	3	-	-	-	-	**3**
At 31 March 2019	**449**	**1,398**	**93**	**-**	**190**	**217**	**2,347**
Expected timing of cash flows:							
- not later than one year;	109	96	93	-	190	217	**705**
- later than one year and not later than five years;	269	382	-	-	-	-	**651**
- later than five years.	71	920	-	-	-	-	**991**
Total	**449**	**1,398**	**93**	**-**	**190**	**217**	**2,347**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

Note 30.2 Clinical negligence liabilities

At 31 March 2019, £185,972k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East Suffolk and North Essex NHS Foundation Trust (31 March 2018: £153,853k).

Note 31 Contingent assets and liabilities

	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(37)	(55)
Other	-	(10)
Net value of contingent liabilities	**(37)**	**(65)**
Net value of contingent assets	**-**	**-**

Note 32 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	3,365	274
Intangible assets	368	314
Total	**3,733**	**588**

Note 33 On-SoFP PFI or other service concession arrangements

The Trust has two PFI schemes recognised on-SoFP:
The values below relate to a building transferred as part of the acquisition of IHT during the year.
The Trust's other PFI arrangement for staff accommodation is accounted for as a service concession in accordance with IFRIC 12. The operator receives all of its income from individual users rather than in the form of unitary payments from the Trust. As such there is no service charge but the asset is recognised under non-current assets on the balance sheet with a corresponding deferred income liability.

Note 33.1 Imputed finance lease obligations

East Suffolk and North Essex NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	31 March 2019	31 March 2018
	£000	£000
Gross PFI or other service concession liabilities	**27,842**	**-**
Of which liabilities are due		
- not later than one year;	1,823	-
- later than one year and not later than five years;	7,293	-
- later than five years.	18,726	-
Finance charges allocated to future periods	(7,233)	-
Net PFI or other service concession arrangement obligation	**20,609**	**-**
- not later than one year;	1,084	-
- later than one year and not later than five years;	4,740	-
- later than five years.	14,785	-

Note 33.2 Total on-SoFP PFI and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019	31 March 2018
	£000	£000
Total future payments committed in respect of the PFI or other service concession arrangements	**45,237**	**-**
Of which liabilities are due:		
- not later than one year;	2,663	-
- later than one year and not later than five years;	10,653	-
- later than five years.	31,921	-

Note 33.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**3,065**	**-**
Consisting of:		
- Interest charge	577	-
- Repayment of finance lease liability	622	-
- Service element and other charges to operating expenditure	618	-
- Contingent rent	654	-
- Addition to lifecycle prepayment	594	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	86	-
Total amount paid to service concession operator	**3,151**	**-**

Note 34 Financial instruments

Note 34.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local clinical commissioning groups and the way those clinical commissioning groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Financial risk management

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is routinely reported and is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. As such, the Trust does not undertake transactions in currencies other than sterling and is therefore not exposed to movements in exchange rates over time. The Trust has no overseas operations.

Credit risk

Due to the fact that the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2019 is in receivables from customers, as disclosed in the receivables note.

Liquidity risk

The NHS Trust's net operating costs are incurred under annual service contracts with local clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

The Trust borrows from Government for capital expenditure subject to affordability. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Alternatively, the Trust can borrow on a commercial basis and would only take such loans on a fixed rate basis. The Trust therefore has low exposure to interest rate fluctuations.

Note 34.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	60,588	**60,588**
Cash and cash equivalents at bank and in hand	15,855	**15,855**
Total at 31 March 2019	**76,443**	**76,443**

	Loans and receivables	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39		
Trade and other receivables excluding non financial assets	27,373	**27,373**
Cash and cash equivalents at bank and in hand	9,233	**9,233**
Total at 31 March 2018	**36,606**	**36,606**

Note 34.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	194,092	**194,092**
Obligations under finance leases	12,197	**12,197**
Obligations under PFI and other service concession contracts	20,609	**20,609**
Other borrowings	97	**97**
Trade and other payables excluding non financial liabilities	58,464	**58,464**
Total at 31 March 2019	**285,459**	**285,459**

	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	101,125	**101,125**
Obligations under finance leases	816	**816**
Trade and other payables excluding non financial liabilities	32,538	**32,538**
Provisions under contract	2,034	**2,034**
Total at 31 March 2018	**136,513**	**136,513**

Note 34.4 Fair values of financial assets and liabilities

As at 31 March 2019 there are no significant differences between fair value and carrying value of any of the Trust's financial instruments.

Note 34.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	152,786	35,875
In more than one year but not more than two years	55,792	1,305
In more than two years but not more than five years	44,633	85,621
In more than five years	32,248	13,712
Total	**285,459**	**136,513**

Note 35 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	41	44	33	42
Bad debts and claims abandoned	114	57	139	41
Stores losses and damage to property	2	107	6	138
Total losses	**157**	**208**	**178**	**221**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	35
Ex-gratia payments	84	142	83	78
Total special payments	**84**	**142**	**84**	**113**
Total losses and special payments	**241**	**350**	**262**	**334**
Compensation payments received		-		-

Note 36.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £182k, and trade payables correspondingly reduced.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,210k.

Note 36.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. Consequently notes 24.1 and 24.2 disclose contract receivables values at 31 March 2019. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 37 Related parties

NHS foundation trusts are deemed to be under the control of the Secretary of State, in common with other NHS trusts. The Department of Health and Social Care is considered to be the Trust's parent organisation and other NHS bodies are therefore classed as related parties. During the financial period, the Trust had a number of material transactions with NHS bodies, all of which were at arms length. None of the Trust's balances with related parties are held under security or guarantee.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies during the year.

Related Party Transactions (over £5m)	**2018/19**	**2018/19**	**2018/19**	**2018/19**	**2017/18**	**2017/18**	**2017/18**	**2017/18**
	Income	**Expenditure**	**Receivables**	**Payables**	**Income**	**Expenditure**	**Receivables**	**Payables**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cambridge University Hospitals NHS Foundation Trust	1,438	5,559	1,301	1,983	264	5,471	150	1,195
West Suffolk NHS Foundation Trust	6,464	9,802	1,986	896	5,611	1,423	550	222
Ipswich Hospital NHS Trust	2,216	403	-	-	8,190	5,963	1,899	2,473
NHS Ipswich and East Suffolk CCG	194,909	-	2,615	1,688	11,122	-	72	-
NHS Mid Essex CCG	22,409	-	432	98	21,045	-	109	132
NHS North East Essex CCG	221,561	259	4,819	1,885	197,794	161	1,910	1,434
NHS West Suffolk CCG	8,582	406	94	319	5,090	18	40	26
NHS England	92,736	-	17,021	3,120	65,074	3	16,026	1
Public Health England (PHE)	572	6,805	293	628	886	6,697	197	46
Health Education England	14,282	3	961	-	7,489	5	51	47
NHS Resolution (formerly NHS Litigation Authority)	152	18,991	-	118	-	13,783	-	-
Department of Health and Social Care	7,218	-	6	-	39	3	-	-
HM Revenue & Customs inc VAT	-	28,190	2,540	8,003	-	14,194	514	3,858
NHS Pension Scheme	-	32,154	59	5,432	-	17,041	-	2,396
NHS Professionals	-	31,659	4	5,034	-	15,774	-	2,669

During the period, none of the members of the Board of Directors, Board of Governors or members of the key management staff, or parties related to them, have undertaken any material transactions with the Trust.

The Trust is the Corporate Trustee of Colchester and Ipswich Hospitals Charity. The Trust receives grants to purchase items to benefit patient and staff welfare which are above and beyond those that would be considered as part of the nornal operating activities of the Trust. The Charity had no material transactions with the Trust.

Note 38 Transfers by absorption

The Trust acquired The Ipswich Hospital NHS Trust on 1 July 2018, whose assets and liabilities as at 30 June 2018 were transferred to the Trust's Statement of Financial Position. In line with the requirements of the DH GAM 2018/19, these were transferred at book value and were not adjusted to fair value prior to recognition.

A gain on transfer by absorption of £41,369k is recognised in the SOCI and is equal to the book value of the net assets transferred on the date of acquisition.

The value of assets and liabilities acquired is below.

	£000
Assets	
Property, plant and equipment	136,201
Intangible assets	4,609
Contract receivables and other assets	30,438
Inventories	5,350
Cash	866
Total assets transferred	177,464
Liabilities	
Current trade and other payables	(33,332)
Borrowings	(101,437)
Provisions	(1,326)
Total liabilities transferred	(136,095)
Total net assets transferred	**41,369**

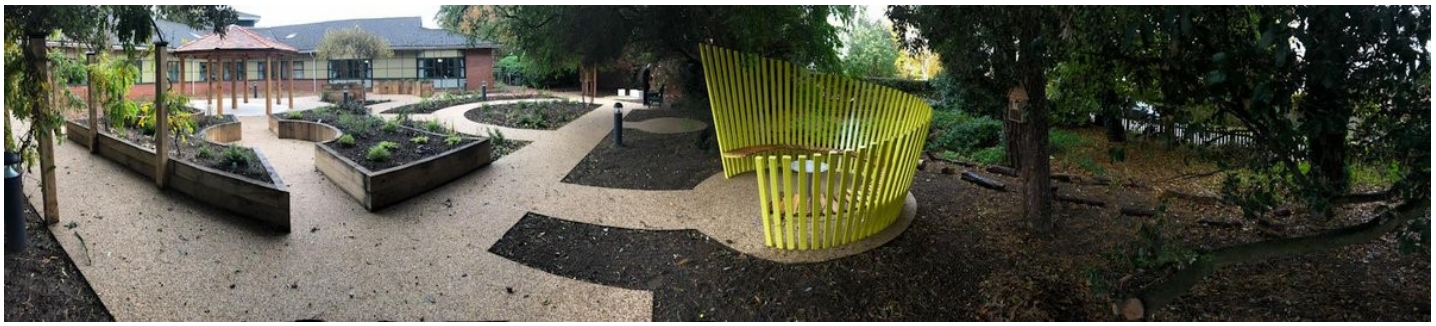
Note 39 Events after the reporting date

There are no events after the reporting period.

NHS

East Suffolk and North Essex

NHS Foundation Trust



Quality Report 2018/19

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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

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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

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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

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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

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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

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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).

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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

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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 depart-	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

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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

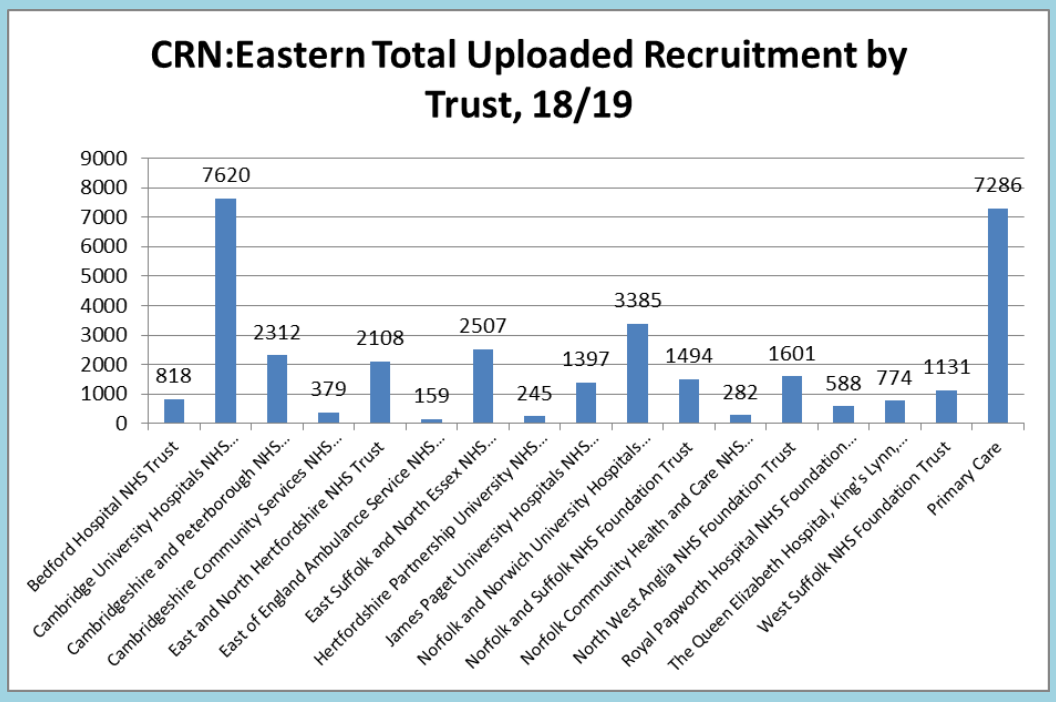
Commitment to research as a driver for improving the quality of care and patient experience.

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				
			Healthy food for NHS staff, visitors and patients				
			Improving the uptake of flu vaccinations for front line staff within Providers				
	Reducing the impact of serious infections (Antimicrobial and Sepsis)		Timely identification of Patients with Sepsis in EDs and Acute Inpatient Settings				
			Timely treatment of Sepsis in EDs and Acute Inpatient Settings				
			Antibiotic Review				
			Reduction in antibiotic consumption per 1,000 admissions				
	Improving Services for people with MH needs who present at A&E		Improving Services for people with MH needs who present at A&E				
	Offering Advice and Guidance		Offering Advice and Guidance				
	Preventing Ill Health by risky behaviours		Tobacco screening				
			Tobacco brief advice				
			Tobacco referral & medication				
			Alcohol screening				
			Alcohol brief or referral				
	Provider engagement & commitment to STP		Provider engagement & commitment to STP				
	Risk reserve (collaborative and system-wide approach)		Risk reserve (collaborative and system-wide approach)				

Specialist Commissioning Scheme

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

Key

Green Standard achieved Red Standard not achieved

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

How healthcare is regulated

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

Colchester Hospital University NHS
NHS Foundation Trust

The Ipswich Hospital NHS
NHS Trust

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.

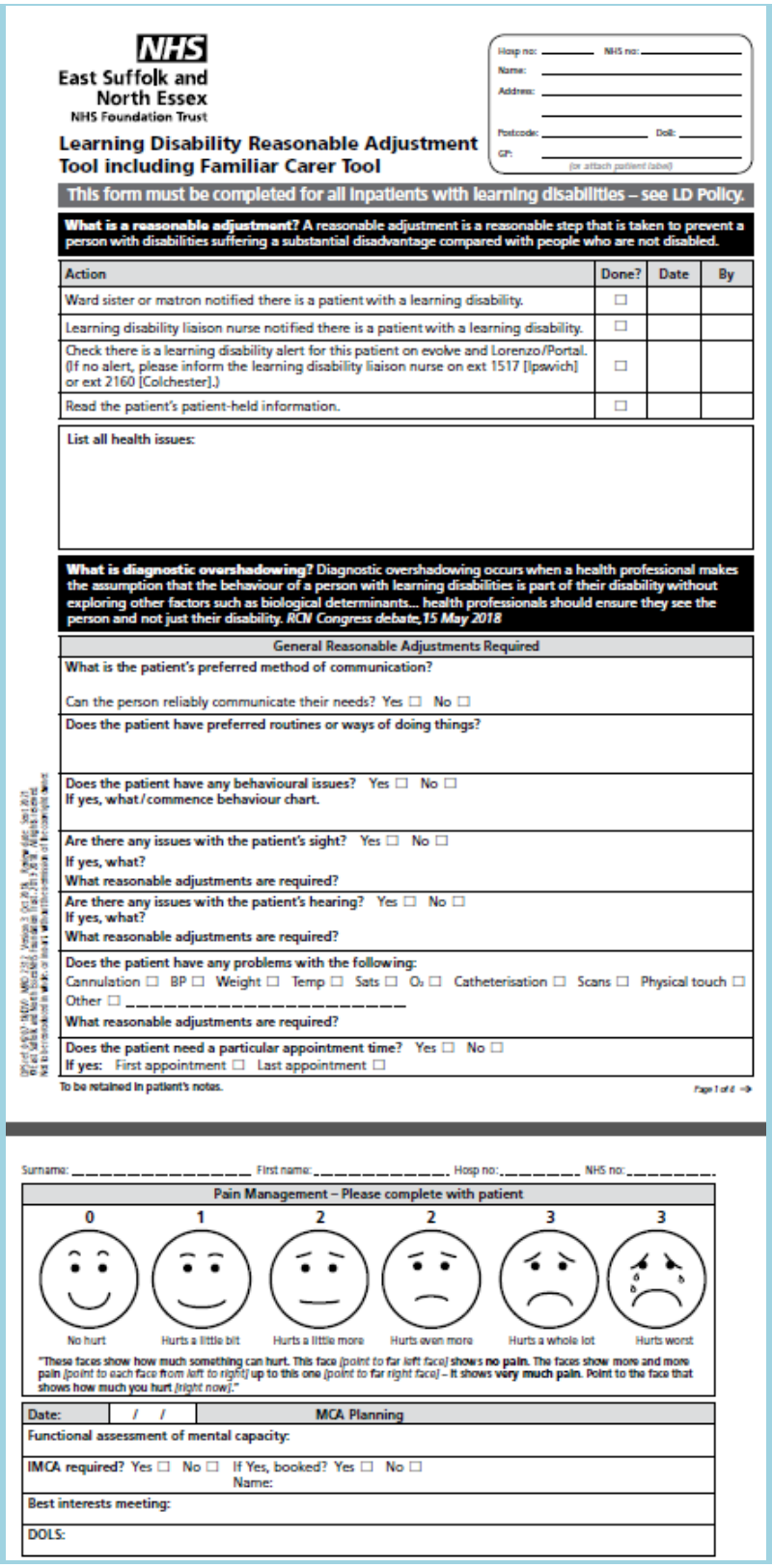
- ✓ Significant improvements have been made overall to sepsis screening and treatment, both in the Emergency Department and on wards, although there is still a lot of work to do. Please see the Sepsis section for more information.

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.

Page 1 of 4 →

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.											
		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
the number and percentage of such patient safety incidents that resulted in severe harm or death during the reporting period	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.

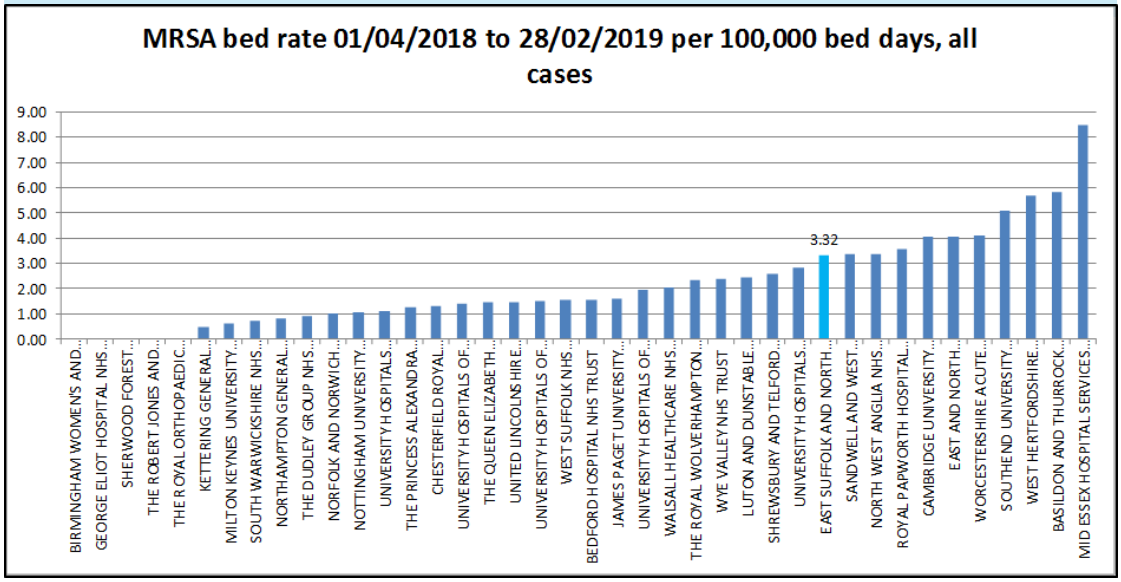
Most strains of S. aureus are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some S. aureus bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin resistant Staphylococcus aureus (MRSA) and often require different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

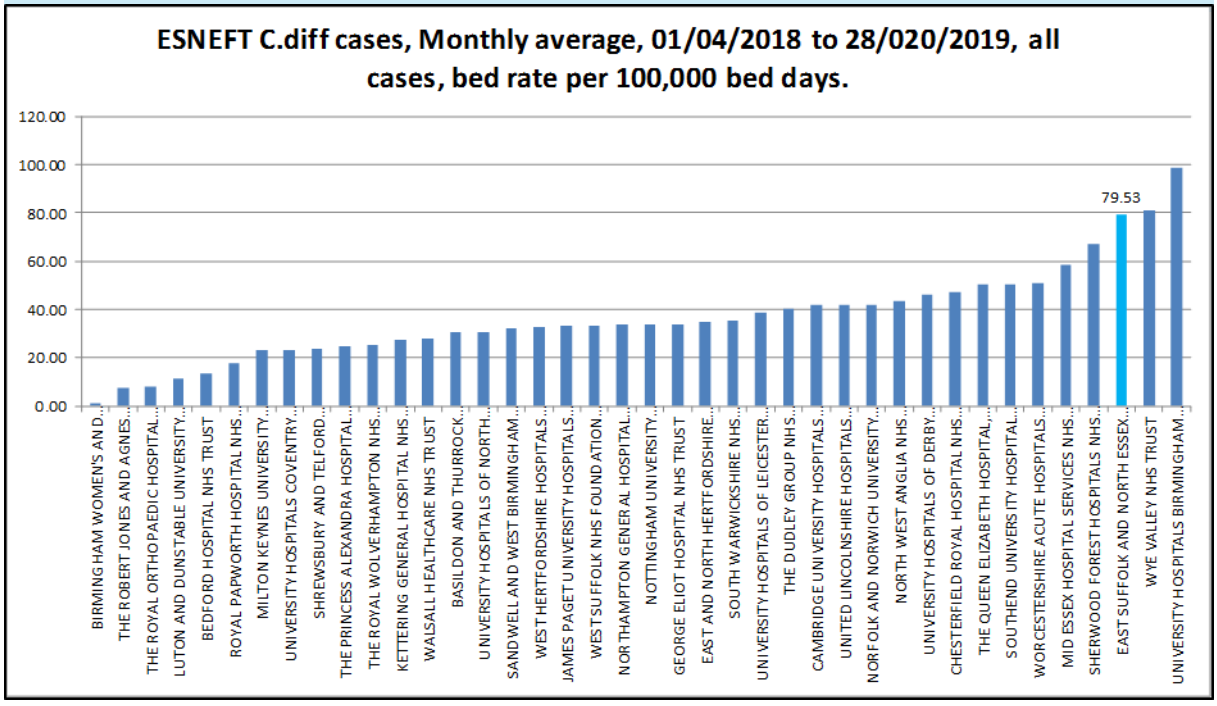
Each case Identified in the Trust is subject to post infection review. If all care and treatment is managed within nationally and locally recognised policy the Clinical Commissioning Group (CCG) scrutiny panel may agree that it is deemed as 'Non trajectory' (2015/16 onwards).

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

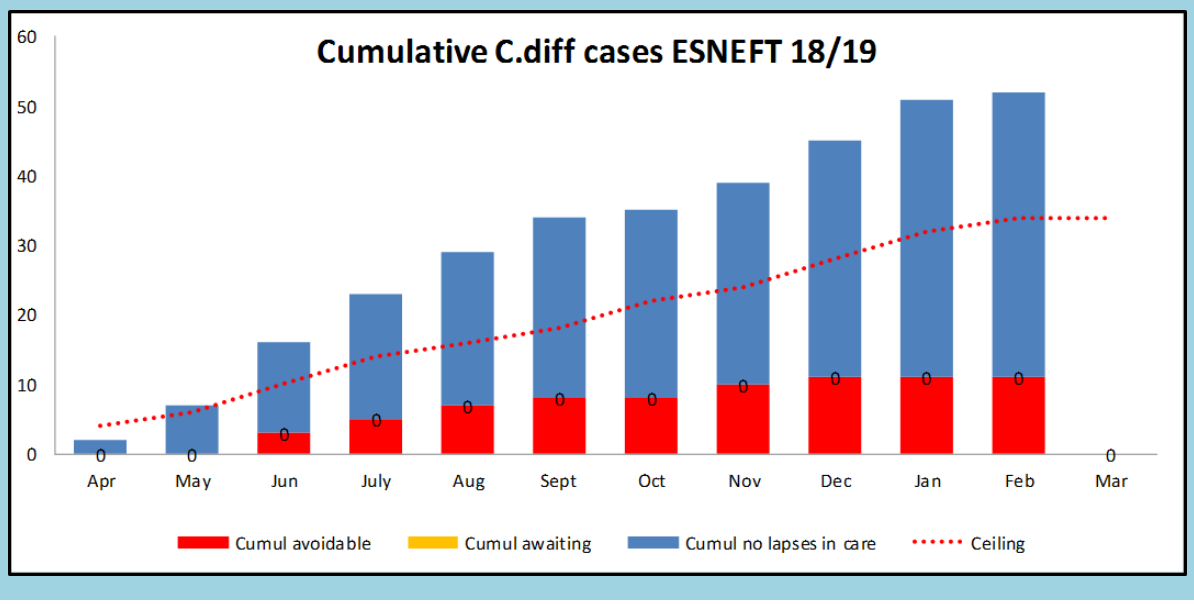
Table 11- Number of C.Diff cases apportioned to Colchester Hospital

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.

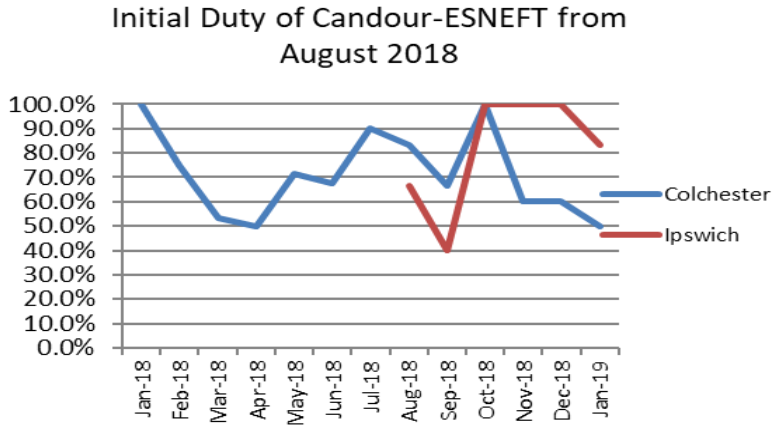
Duty of Candour ensures healthcare professionals are open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested.

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:

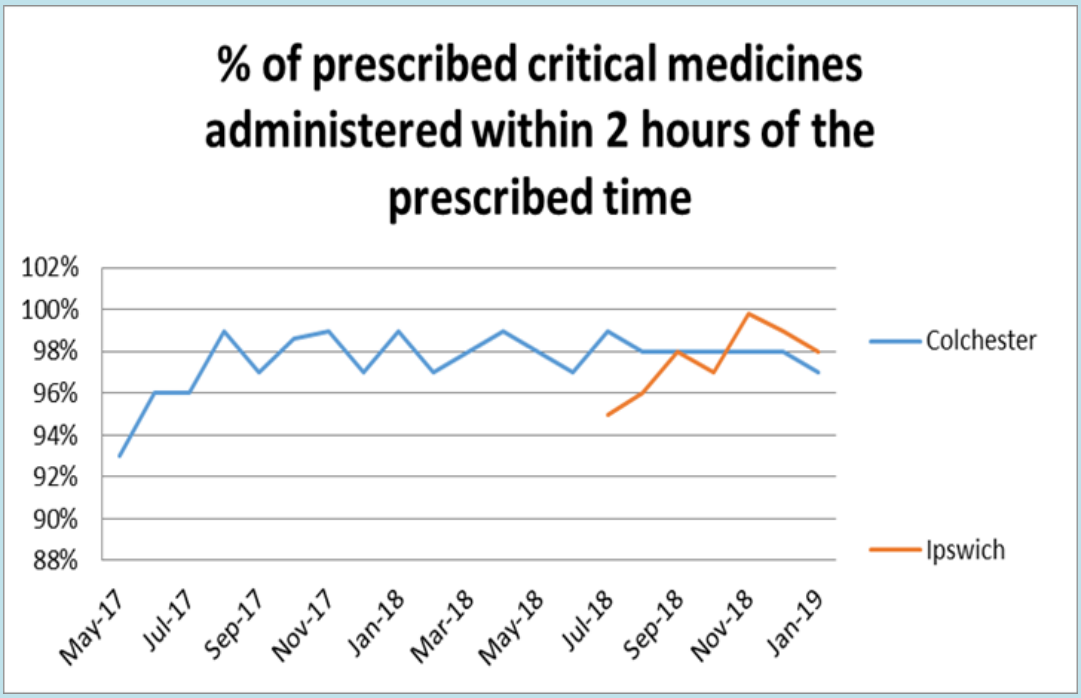
Why was this chosen as a priority?: Risks associated with the omission of medication administration are significant and have been known to cause significant harm or death in other organisations. Omitted critical medicine rates are an important metric to assess medication safety within an organisation.

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?

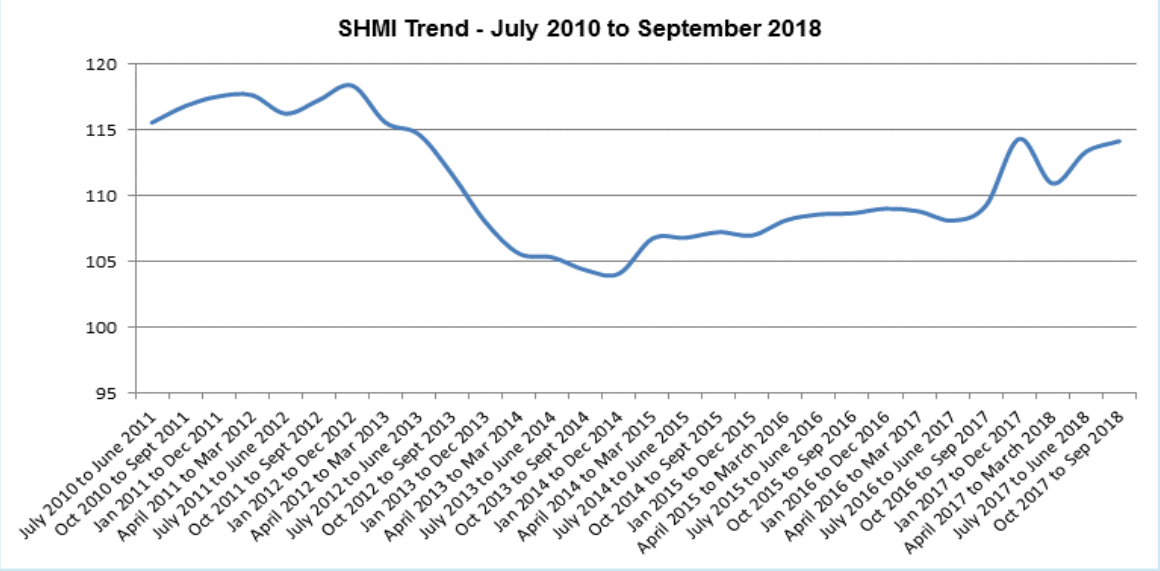
Mortality indicators show whether the number of deaths linked to a particular hospital or diagnosis group is more or less than expected, and whether that difference is statistically significant.

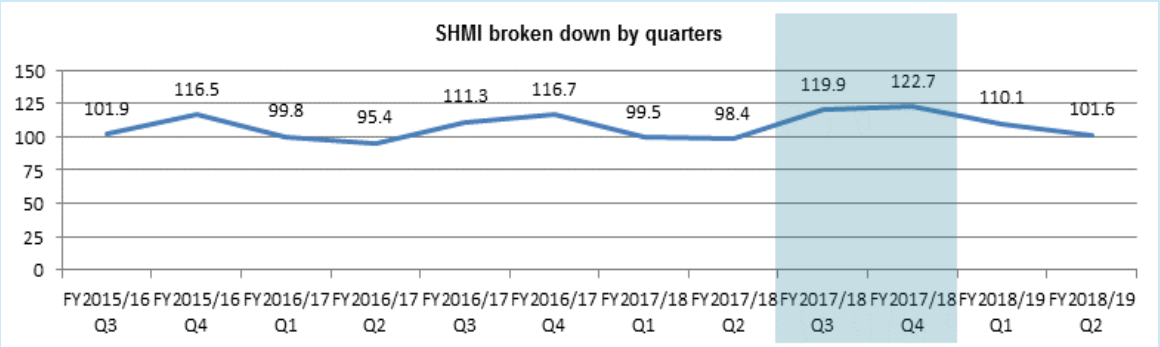
Why are mortality ratios/indicators important?

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 Framework.

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

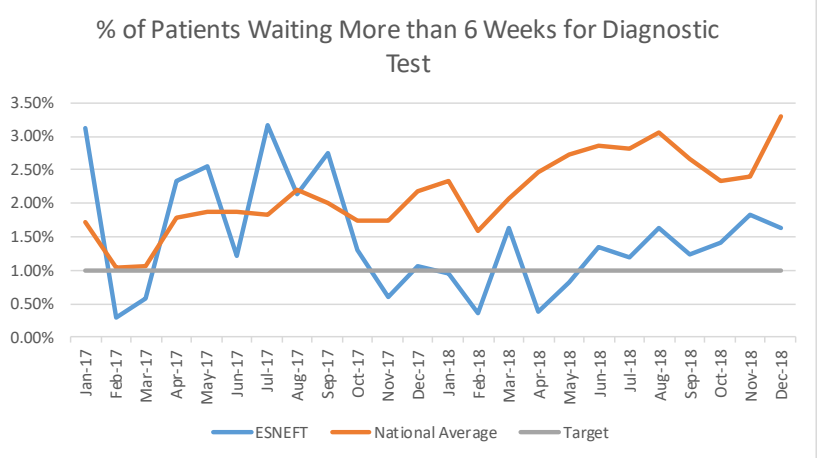


***Table 19**- Percentage of patients currently waiting under 18 weeks on an incomplete pathway*

		2017		2018	
% of Patients Waiting More than 6 Weeks for Diagnostic 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 Data			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
Antenatal	Recommender	96.79%	98.04%	95.30%	96.38%	96.85%	95.47%	97.04%	97.45%	96.29%	99.24%	100.00%	98.37%
Post Ward	Recommender	98.28%	95.98%	97.08%	96.87%	95.57%	96.89%	98.13%	96.39%	95.80%	97.88%	96.09%	95.12%
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

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.

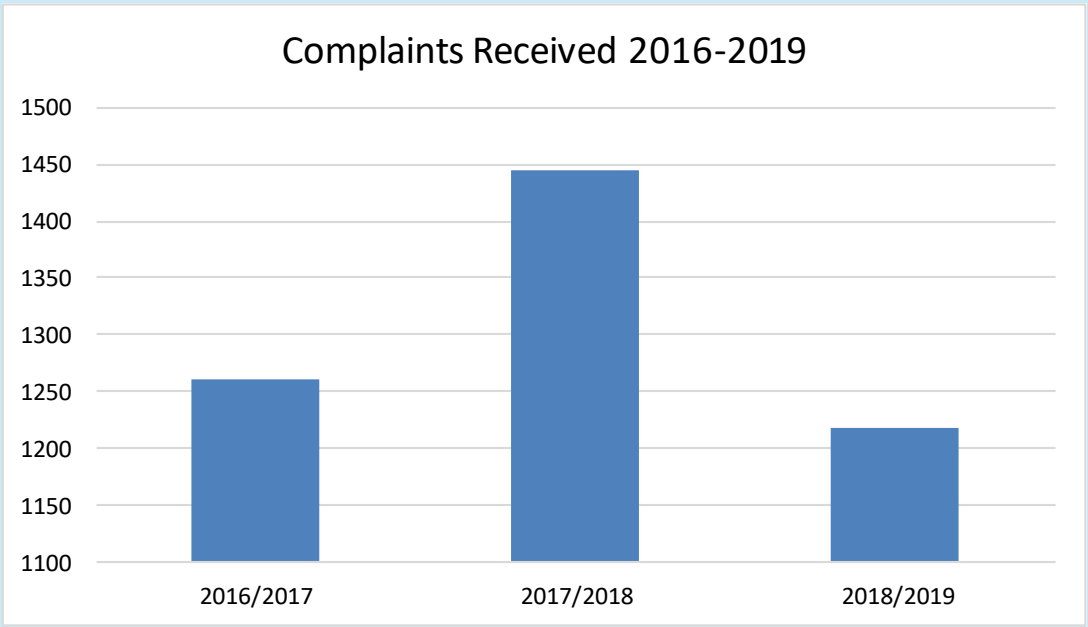
It is acknowledged that there needs to be further Trust wide improvement in identifying, reporting and sharing lessons learned and actions taken from complaints.

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

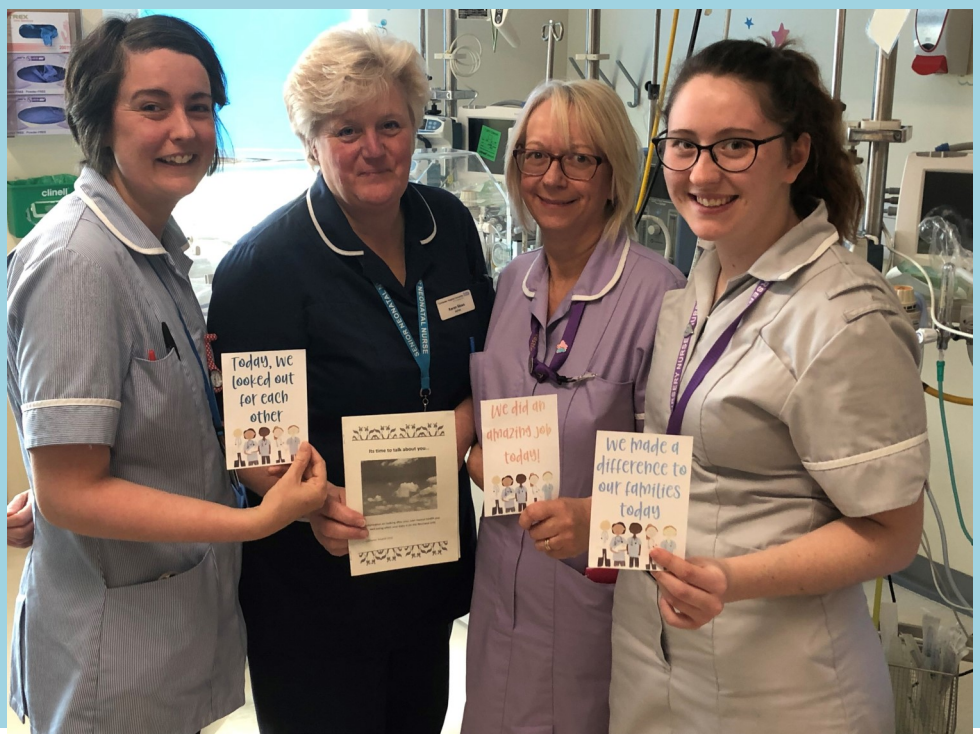
for inpatients and their families, waiting list enquiries and appointment enquiries.

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*

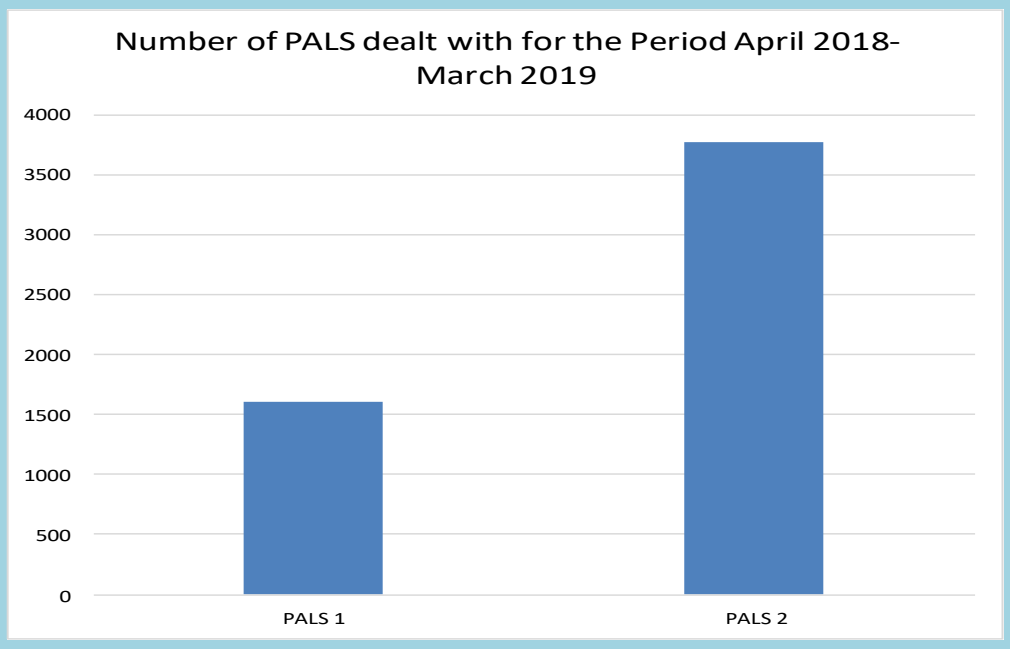
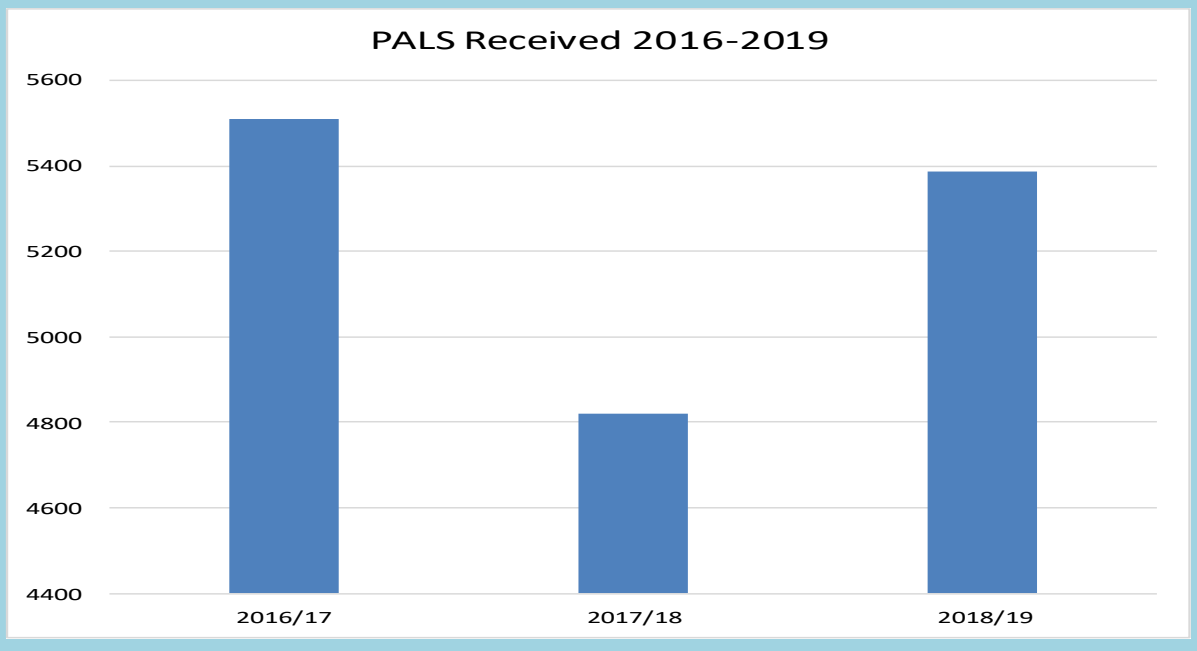


***Chart 10**- PALS Queries received for the last 3 years*



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

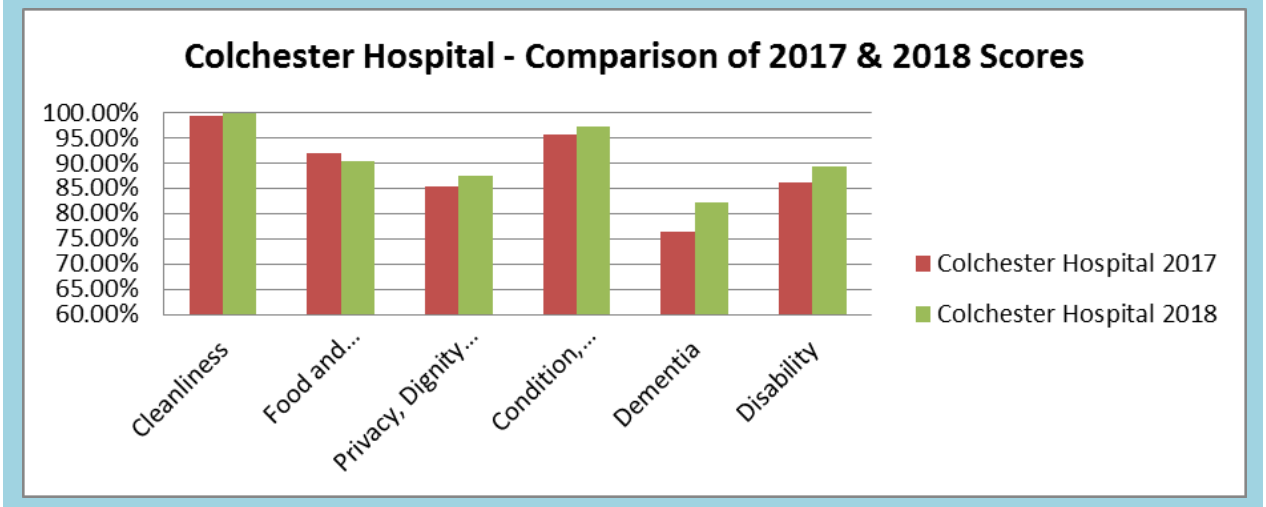
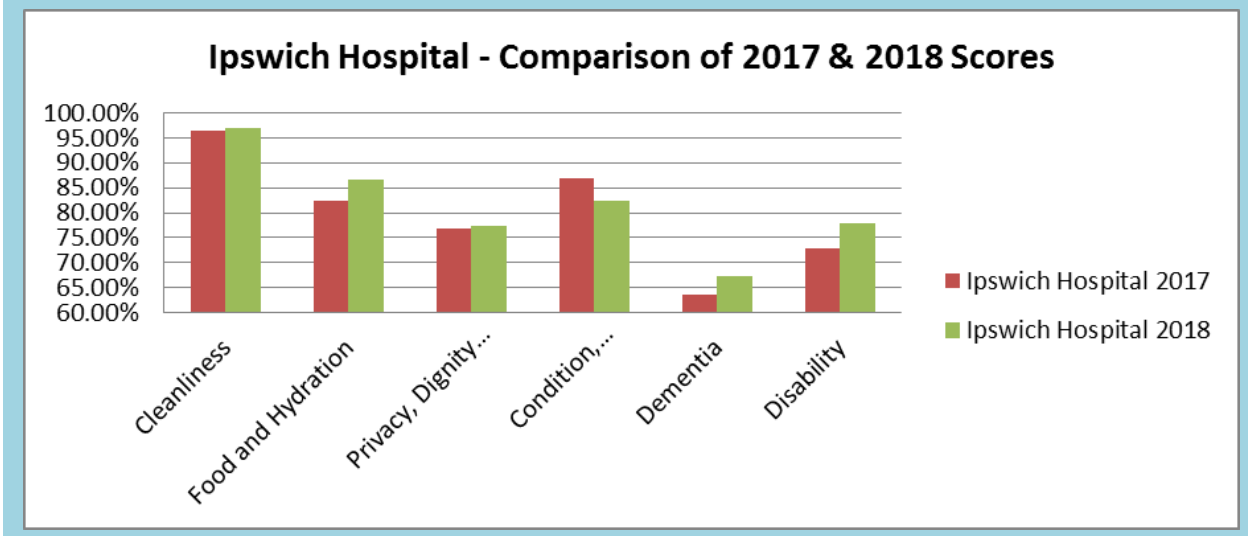


Chart 12



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

Chart 13

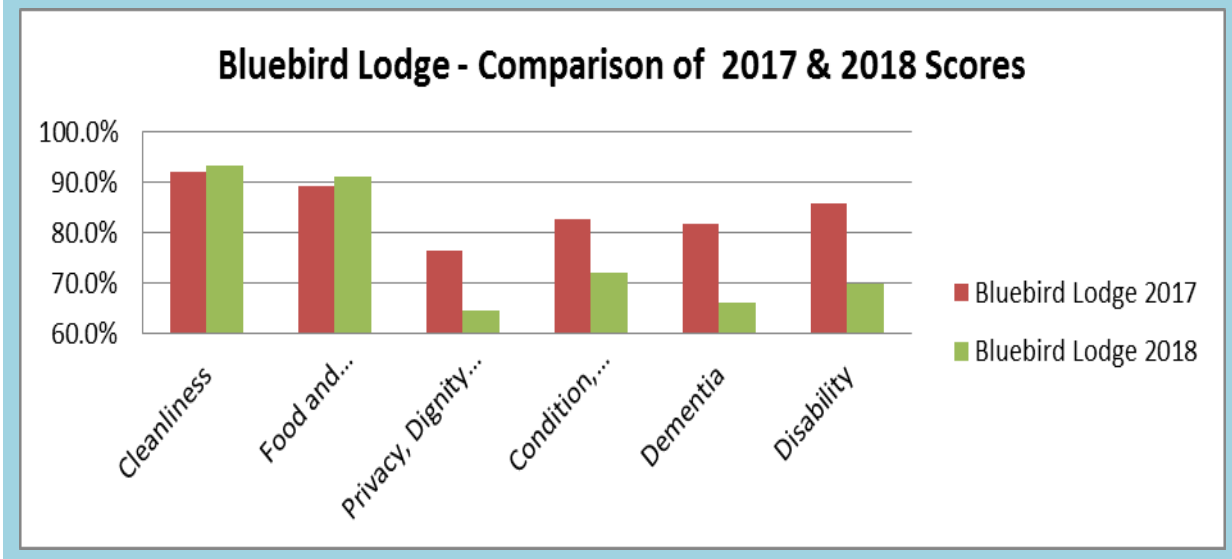
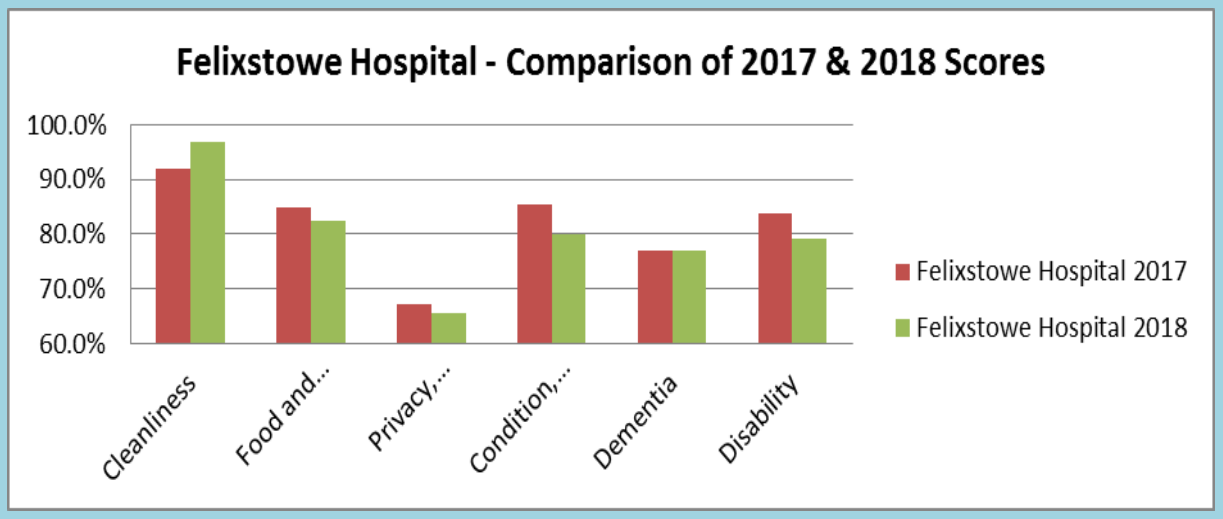
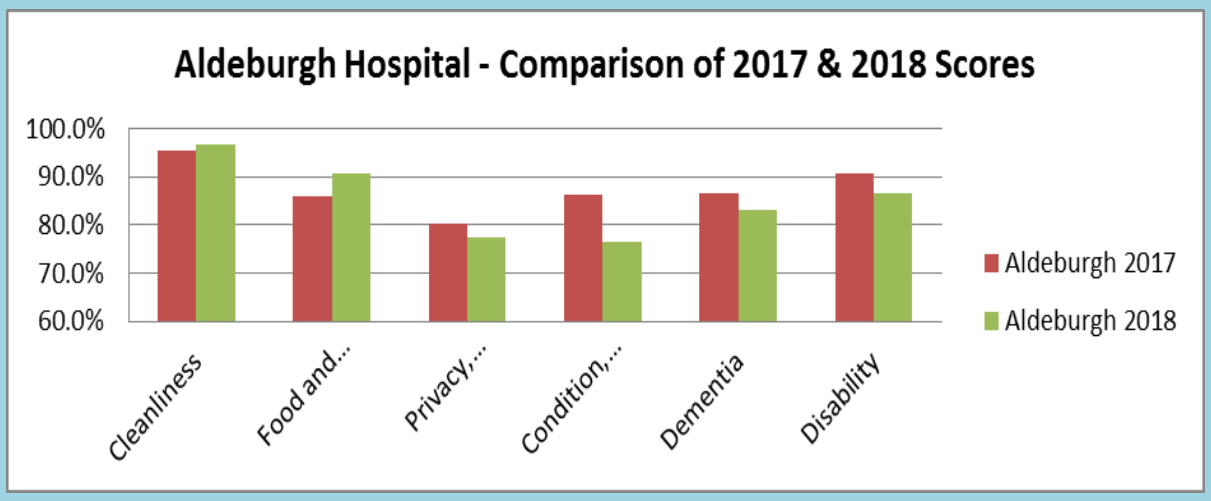


Chart 14



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

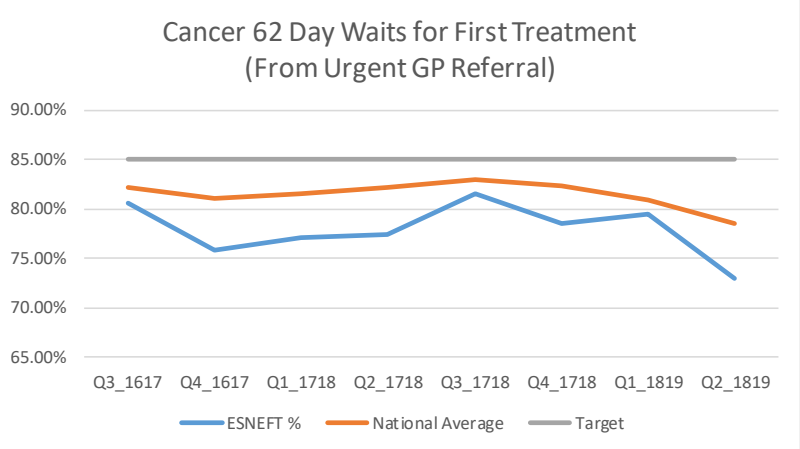
Improving the experience of patients referred in on a cancer pathway by ensuring timely diagnostics and where cancer has been diagnosed, that treatment occurs within 62 days (and 31 days of decision to treat) , remains a priority for our newly merged organisation.

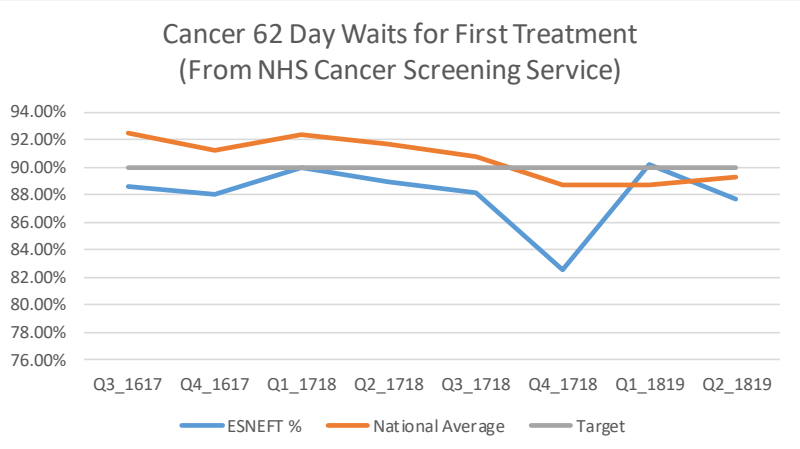
Performance against 62 day first standard is currently below the 85% national performance target however some improvement has been achieved in recent months with many individual tumour sites now compliant with the 85% target. Sustainable delivery remains an area of challenge for our new organisation 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*

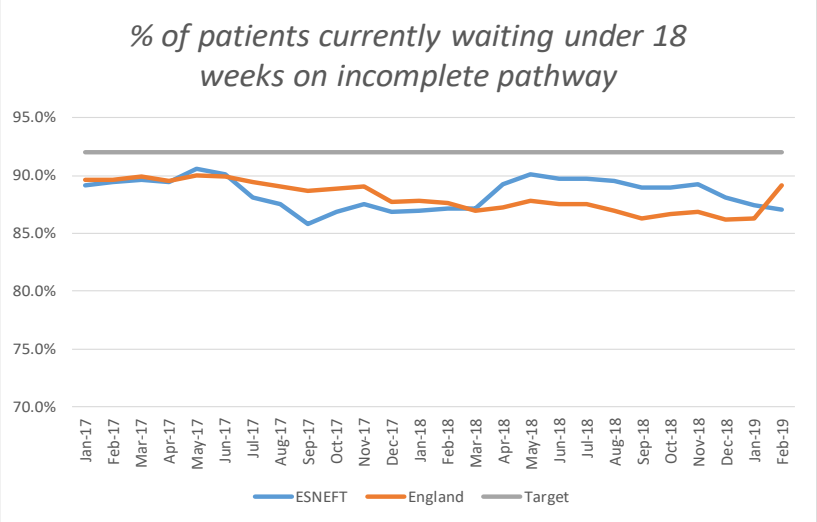


Table 27—Percentage of patients currently waiting under 18 weeks on incomplete pathway

		2017		2018		2019	
% of patients currently waiting under 18 weeks on Incomplete Pathway	**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 position	**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 period	CHUFT Score	IH Score	ESNEFT Score	National average
	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 period	CHUFT Score	IH Score	ESNEFT Score	National average
	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

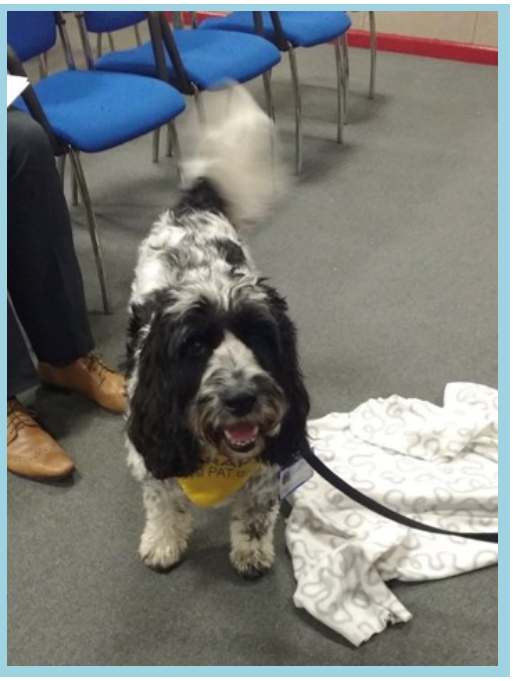
Schwartz Rounds are structured monthly one-hour meetings available to all staff, volunteers and those who work on our hospital sites. The purpose is to reflect on the emotional experience of working in healthcare, rather than finding solutions to problems. Evidence shows that staff who attend Rounds 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

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

NHS

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

NHS
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 2018/19.

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 [2018)] national patient survey 2018 (not yet nationally published)

– the [l2018] national staff survey 2018 dated 26/02/2019

– 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

David White

Chairman

28 May 2019

Nick Hulme

Chief Executive

28 May 2019

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

We have been engaged by the Council of Governors of East Suffolk and North Essex NHS Foundation Trust to perform an independent assurance engagement in respect of East Suffolk and North Essex NHS Foundation Trust's Quality Report for the year ended 31 March 2019 ("the Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

We refer to these national priority indicators collectively as "the indicators".

Directors' responsibilities

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibilities

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Requirements for External Assurance for Quality Reports 2018/19 issued by NHS Improvement in December 2018 ("the Guidance"); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2018 to May 2019;
- papers relating to quality reported to the Board over the period April 2018 to May 2019;
- feedback from commissioners, dated 10/05/2019 and 17/05/2019;
- feedback from governors, dated 29/04/2019;
- feedback from Healthwatch Essex, dated 29/04/2019;
- feedback from Healthwatch Suffolk, dated 10/05/19
- the latest national patient survey, dated 29/01/2019;
- the latest national staff survey, dated XX/XX/2018;
- Care Quality Commission inspection, dated 02/11/2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated 21/05/2019;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of East Suffolk and North Essex NHS Foundation Trust as a body, in reporting East Suffolk and North Essex NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and East Suffolk and North Essex NHS Foundation Trust for our

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

work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) Assurance Engagements other than Audits or Reviews of Historical Financial Information, issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator against supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by East Suffolk and North Essex NHS Foundation Trust.

Basis for qualified conclusion

The Trust was unable to provide sufficient evidence to support the accuracy of two of our sample tested in respect of the "percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator. We also have concerns over the data capture arrangements in place at the Ipswich Site for recording the discharge time onto the patient activity system. We have therefore concluded that the indicator has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in Detailed Requirements for External Assurance for Quality Reports 2018/19 issued by NHS Improvement in December 2018; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

BDO LLP
Chartered Accountants

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.