Colchester Hospital University
NHS Foundation Trust

Annual Report, Annual Accounts and Quality Report

1 April 2017 – 31 March 2018

The reverse of the front cover must be kept blank

Colchester Hospital University NHS Foundation Trust

Annual Report
Annual Accounts
and
Quality Report

1 April 2017 – 31 March 2018

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

Contents

Section A – Annual Report

Section B – Annual Accounts

Section C – Quality Report

Useful contact information

If you would like to make any comments about this Annual Report, please contact:

Nick Hulme
Chief Executive
Trust Offices
Colchester Hospital University NHS Foundation Trust
Colchester General Hospital
Turner Road
Colchester CO4 5JL

01206 746433
communications@colchesterhospital.nhs.uk
Facebook: www.facebook.com/ColchesterGeneralHospital
Twitter: @ColchesterNHSFT

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 sort out any concerns they may have about their care.

You can contact PALS on freephone 0800 783 7328 or by emailing pals@colchesterhospital.nhs.uk

We care, do you?

It's easy to show you care about the services we provide. Complete an application form and register to become a public member of the Trust. Visit our website or phone 01206 747474 during office hours.

General information and inquiries

Email: info@colchesterhospital.nhs.uk

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

For a copy of this Annual Report in Braille, large print or foreign language formats, please call 01206 745338.

Welcome from the Chair

It has been a tremendous year for Colchester Hospital University NHS Foundation Trust. During 2017/18, our staff worked incredibly hard to improve the quality of the care we provide, with those efforts rewarded in November when we were lifted out of 'special measures' and given a Care Quality Commission (CQC) rating of 'requires improvement'. After a number of years under significant external scrutiny, this indeed was a major achievement.

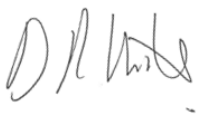
The CQC's latest report showed we have made huge steps forward since their 2016 visit, with three quarters of the 40 areas they inspected now graded as 'good', and none rated as 'inadequate'. While we appreciate that there is still work to do, it is also important for us to celebrate the progress we have made and thank our staff, whose dedication has played a huge part in this turnaround. Significantly, these latest results should also provide assurance to our patients that we have a bright future ahead of us.

From a personal perspective, I would like pay tribute to our Chief Executive Nick Hulme, former Managing Director Barbara Buckley and indeed the rest of our executive team for their leadership during this time. My thanks must also go to my non-executive colleagues and the Council of Governors for the support they have given during what has been a challenging period for our Trust. I truly believe we are now in a stronger position and are delivering much better services, with firm plans in place to improve still further over the coming months and years.

One of the key ways we will achieve this continued improvement is through our upcoming merger with Ipswich Hospital. This merger provides us with a real opportunity to further develop the range and quality of services available to patients, offer the best treatments locally and attract even more of the best and brightest staff to East Anglia. Everyone working on this exciting project is focused on the benefits it will bring to our patients, and shares a commitment to keep them truly at the heart of our partnership moving forwards.

Indeed, the coming 12 months promise to be just as important as the year which has just ended. Three major capital projects are set for completion – our new Breast Care Centre, Diagnostic Imaging Centre and the Primary Care Centre – and will make a huge difference to the experience our patients have when accessing care. The opening of these fantastic new facilities will also mark a significant point in the history of healthcare in Colchester, as for the first time all acute health services will be provided on the same site, increasing convenience for our patients.

I look forward to continuing to work with our staff, governors, volunteers, patients and the public as we strive to make even more improvements during the year ahead.



David White
Chairman

Performance Report

The Performance Report informs users and readers of the Annual Report and Annual Accounts and helps them 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.

Chief Executive's review of the year

Every day, 3,500 people come to our hospitals and services for care. Every day hundreds of colleagues work incredibly hard to improve those 3,500 lives. And every day, I am proud. When you multiply those daily figures by a week, a month, a year or a lifetime, the numbers are truly staggering.

Our progress in improving care has been considerable this year. We are much more stable and during this winter, we were the top performing emergency department in the region. This reflects the work we have been doing both within the organisation and with our partners. It is not the only marker of success but it is a significant.

With the 70th birthday of the NHS approaching this summer, there has been more discussion than ever on the future and sustainability of the health service. Coupled with questions about our nation's identity post-Brexit, I'm reminded that the NHS is probably the greatest thing about this country, and something we can all feel proud of together.

The question around the sustainability of the NHS is an important one. There is no doubt in my mind that with the challenges around finance and workforce, unless there is significant change, the NHS as we know it is under threat. As well as a long-term funding solution, we also need a long term strategy for NHS and social care services. With the merger of Ipswich and Colchester hospitals, we are starting to see how we can work together to sustain and develop our services.

It is also my privilege to lead the Sustainability Transformation Partnership (STP) which is partnership of health and social care, statutory and third sector providers in Suffolk and North East Essex. The STP is starting to think about the health of our population as a whole rather than just the patient or local resident in front of us.

I am greatly encouraged by the quality of the debate within the partnership and the ambition which is developing. The year ahead is going to be a fundamental one for us all. The most significant driver for the organisation is how we can continue to provide high quality, safe and compassionate care to the 3,500 who need us every day.

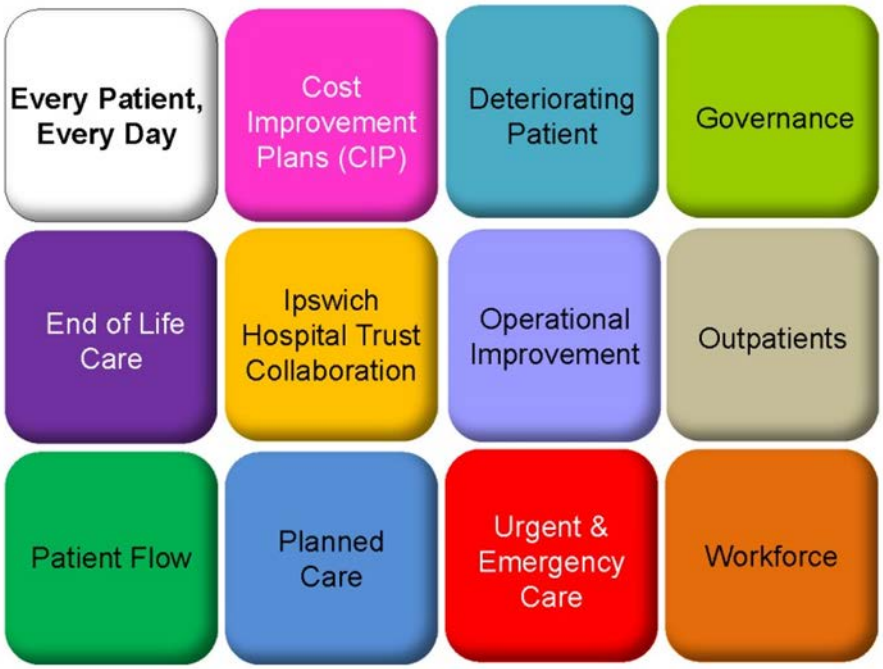
Nick Hulme
Chief Executive

Every Patient, Every Day

In 2017/18, our "Every Patient, Every Day" programme continued to drive improvement by focusing on 11 key areas, including urgent care, frail and elderly patients and planned care.

As a result, the Trust made good progress in reducing length of stay, while our Frailty Assessment Unit also opened.

The transformation work which is taking place in end of life care saw CHUFT achieve 'good' in every category for this area during the CQC visit this year.



Statement of purpose and activities

Our vision and strategy

Our vision was approved at a meeting of our Board of Directors on 27 October 2016. It is:

"Delivering great healthcare to every patient, every day"

The vision is aligned with 'Caring with Pride', our three-year-nursing and midwifery strategy which was launched in May 2015. It is also underpinned by three corporate objectives, which are:

Acting in the best interests of every patient, every day

- to deliver care in the right place at the right time in line with national best practice
- to ensure a positive patient experience at every contact by providing safe, effective, kind and compassionate care
- to achieve sustainable quality improvements in the delivery of care.

Supporting our workforce to look after every patient, every day

- to deliver a positive patient-centred culture of great care for patients
- to engage, support and develop staff to achieve their potential
- to train and support all staff to take personal responsibility and accountability for their actions and the actions of others to drive organisational success.

Achieving clinical, operational and financial resilience

- to develop constructive relationships with partner organisations to deliver sustainable and effective care for patients
- to deliver consistently and sustainably against national and local priorities
- to maximise value for money in delivering healthcare in our locality.

We use the Friends and Family Test to measure our progress towards delivering this vision.

The people we serve

We provide healthcare services to around 370,000 people from Colchester and the surrounding area. In addition, we provide radiotherapy and oncology services to a wider population of about 670,000 people across north and mid-Essex.

Colchester is the largest town in north east Essex. It is a largely affluent area with relatively low unemployment and above average life expectancy. The Tendring peninsula is more rural and has a much higher concentration of elderly and economically less well-off people. Colchester is also home to one of the largest UK garrisons. We value our relationship with the garrison and have developed a number of collaborative arrangements to provide services to service personnel and their families and to integrate garrison medical staff into service provision at the Trust.

Our services

The Trust provides a range of patient services:

	2017/18	2016/17
Outpatient attendances*⅄	404,768	428,221
Emergency Department (A&E) patients*	92,211	87,313
Inpatient and day case admissions*†	91,791	95,728
Babies born	3,751	3,628

*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

Our staff

We are one of the largest employers in north east Essex, employing 4,722 people on 31 March 2018.

History of the Trust

The Trust owns and manages Colchester General Hospital, which opened in 1984, and Essex County Hospital, which was established in 1820. It has long been the strategy of this Trust and our predecessor organisations to centralise acute services at Colchester General Hospital. The transfer of services from Essex County Hospital to Colchester General Hospital and into the community is scheduled to be complete in 2018.

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. Its vision is to deliver innovative high-performing pathology services that are clinically-led and responsive to the needs of our patients.

Although it is our strategy to centralise acute services at Colchester General Hospital, we also provide some services - such as outpatient and maternity services - at the community hospitals in Clacton and Harwich (run by Anglian Community Enterprise, or ACE) and Halstead Hospital (run by Provide, formerly Central Essex Community Services).

The Trust became an NHS foundation trust in May 2008 when the former Essex Rivers Healthcare NHS Trust, which had been in place since 1992, was authorised to become Colchester Hospital University NHS Foundation Trust.

Key issues and risks

Key issues

Achieving our strategic objective of long-term financial sustainability and organisational resilience has been challenging.

Following intervention by the Chief Inspector of Hospitals In April 2016, the Trust worked in partnership with NHS Improvement and Ipswich Hospital to develop a credible plan for a sustainable future for the services we provide to the 370,000 population we serve. The outcome of our improvement programme, called “Every Patient, Every Day”, resulted in the lifting of special measures in November. This followed a Care Quality Commission (CQC) visit, where the regulators reported significant improvement across all services.

The Trust is progressing its partnership with Ipswich Hospital and it is intended that the two organisations will merge during 2018/19 to create the largest NHS trust in the region and provide opportunities to develop economies of scale and improve resilience. The Board approved an outline business case for the merger in August 2017, and a full business case in March 2018.

Risks

The causes of the risks and the mitigating actions are described in more detail in the Annual Governance Statement on page 97. In brief, the principal risks to the Trust’s strategic objectives are:

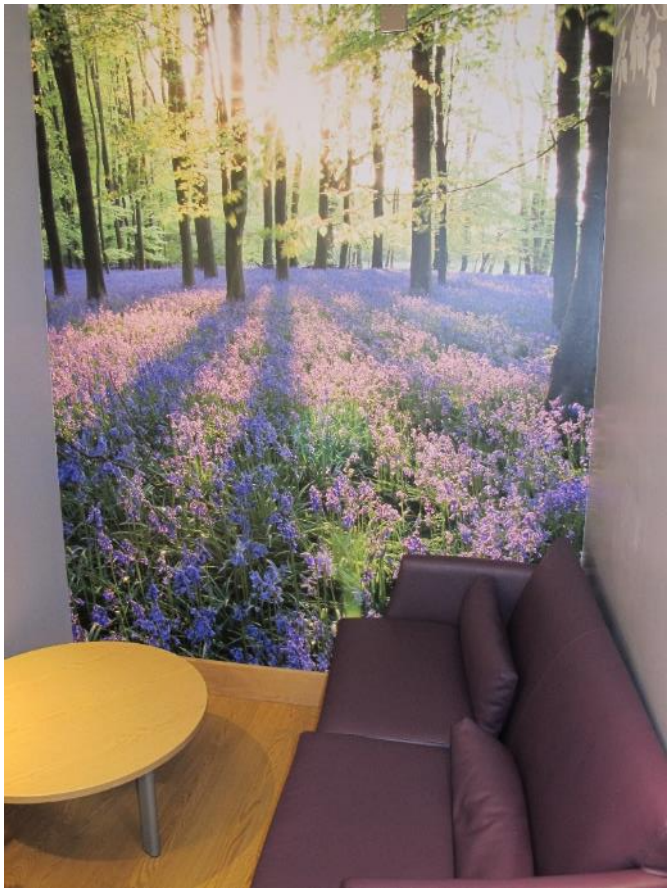
- growth in activity in excess of planned capacity, resulting in missed targets, breached standards and attendant fines;
- failure to mitigate the variance and volatility in financial performance against plan;
- failure to transform pathology services, resulting in a suboptimal service which impacts on patient care and partner organisations; and
- failure to ensure sufficient staff are recruited to meet the requirements of increased activity and acuity.

Going concern disclosure

The Directors have made an assessment of the Trust’s ability to continue as a going concern and have prepared the financial statements on a going concern basis. For the financial year beginning 1 April 2017, the Trust planned a deficit of £22.1m and within this forecast was a cost improvement programme requirement of £17m efficiencies and savings. In order to fund this deficit, the directors sought interim financial support for 2017/18 of £22.5m from the Department of Health through NHS Improvement. An interim working capital loan facility of £76.1m has been provided for the Trust and discussions are ongoing with regard to the further support required.

Although these factors represent material uncertainties that may cast significant doubt about the Trust’s ability to continue as a going concern, the Directors, having made appropriate inquiries, still have reasonable expectation that the Trust will have adequate resources to continue in operational existence for the foreseeable future. As directed by the NHS Foundation Trust Annual Reporting Manual 2017/18, 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 and has not included the adjustments that would result if it was unable to continue as a going concern.

In the news May 2017 – improving care for teenage patients

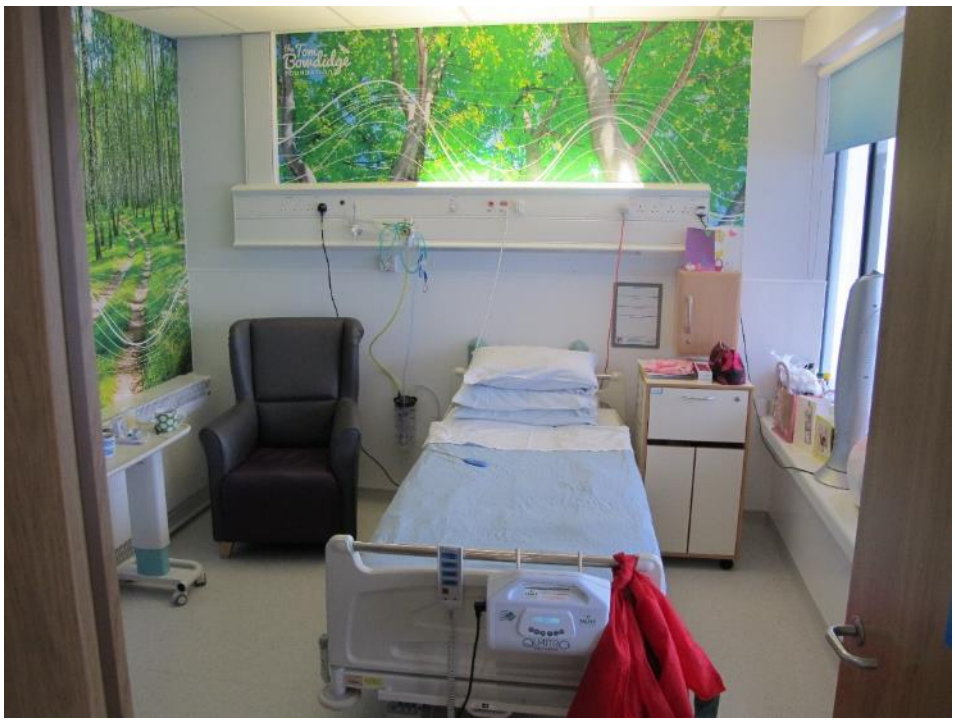


Three rooms designated for the exclusive use of young adults with cancer officially opened at the hospital thanks to a charity set up in memory of an inspirational Colchester teenager.

The Tom Bowdidge Foundation invested £25,000 in a quiet space for young adults in the outpatient department (pictured left).

An en-suite room for teenagers and young adults has also been created on the West Bergholt oncology ward (pictured below) and a dedicated clinic room, including equipment, for young patients with cancer has also been added.

The foundation has raised more than £500,000 to improve facilities for young people with cancer since it was set up in 2014 in memory of 19-year-old Tom, who passed away in 2013.



Performance analysis

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

CQC inspections

The CQC carried out a comprehensive inspection of the Trust in July and August and published its findings in November. The inspectors gave the Trust an overall rating of "requires improvement". They found significant improvements had been made across all services, and rated the Trust as "good" for the effective, caring and well-led domains, and "requires improvement" for the safe and responsive domains. The Section 31 letters issued to the Trust by the CQC in relation to A&E and the safer surgery checklist were in place until November. These were removed following the CQC inspection.

Looking ahead to 2018/19, we have identified priority actions arising from the CQC report which will enable us to maintain and improve standards of care and achieve the outcomes associated with such standards. Prioritising a culture of quality improvement and delivering further improvements in governance and leadership will ensure that all staff deliver on their responsibilities to deliver safe, effective, caring and responsive care and support the Trust to deliver a "good" or "outstanding" rating across all domains.

NHSI enforcement undertakings

The Monitor Enforcement Notices issued to the Trust in 2015/16 remained in force until December and were removed following the report of the comprehensive CQC inspection carried out in July and August. A new S106 improvement notice was issued by NHSI in January, recognising that the Trust had not yet achieved sustainable improvements in its operational performance against the cancer 62 day standard, A&E and RTT. The Trust has undertaken to improve its performance against trajectories agreed with NHSI and to carry out a well-led self-assessment within a reasonable timeframe following the merger with Ipswich Hospital.

Looking ahead, we have an improvement programme in place to support the achievement of its undertakings agreed with NHSI during 2018/19. This includes an assessment of the Trust's leadership against the NHSI Well Led Framework, and a deep dive into risk management and Board to ward effectiveness.

Financial outlook

The Trust incurred a deficit of £4.3m, which was significantly better than its planned deficit of £22.9m. This was mainly due to support from the Sustainability and Transformation Fund (STF). In 2017/18, the Department of Health introduced STF which was to be distributed to providers to support movement to a sustainable financial footing based on their financial and operational performance. As a result of our good financial and A&E performance, we received £20.3m. However, this funding is non-recurrent and under the current guidance, the maximum the Trust can achieve in 2018/19 is £12.4m.

Cost improvement plans

It is our ambition to deliver a control total of a deficit of £12.5m in 2018/19 and jointly with Ipswich for the new organisation a maximum deficit of £22.9m, although we recognise this will be extremely challenging. To reach this control total, it will be necessary for a combined cost improvement saving of £40.5m during 2018/19 (in 2017/18, £14.1m was saved in Colchester, while a combined total of £29m was achieved).

The Trusts are developing plans to achieve cost improvements of £109.6m over the five-year period set out in the business case for merger, equating to an average of 2.6% per annum. Given the historic level of CIP achieved by both Trusts, this is a challenging target; however, the merger will provide additional opportunities to identify schemes to deliver the target. A range of measures have already been implemented to ensure that financial grip is maintained during the transition period, with a particular focus on agency staffing expenditure.

Looking ahead to 2018/19

At the same time as aiming to deliver its financial targets, the Trust will remain under regulator and stakeholder scrutiny to deliver the quality, efficiency and transformation agenda. As we embrace these challenges, it will be important to achieve a balance of quality, access and the financial position. There continues to be workforce deficits and as the population demand grows, it is not expected that the Trust will return to a surplus financial position for several years. Therefore, we will continue to look at ways in which sustainable clinical services can be afforded and the drivers of the deficit reduced.

In March 2018, a full business case to merge Colchester and Ipswich hospitals to form the new East Suffolk and North Essex NHS Foundation Trust , with effect from July 2018, was approved by both Boards. The Boards of the two Trusts consider that a full merger will improve care for patients and create a more sustainable future for both organisations.

Cash funding

Due to the receipt of substantial Sustainability and Transformation Funding in 2017/18, and despite the planned deficit in 2018/19, the Trust is not planning to be reliant on Department of Health (DH) funding for cash financing. NHS Improvement will review the Trust's plans to ensure that financial support is provided only for necessary costs of running a safe organisation. Discretionary spending and investments will be reviewed as part of the conditions of accessing funding from the DH. There are other conditions, such as the use of capital, which the Trust is required to abide by. This means we are under increased scrutiny financially, and there are a number of constraints in our ability to incur significant costs or capital commitments.

Long term planning

Longer term, the current Trusts and new 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. A longer term view is needed to ensure plans are in place to address the pressure on services caused by an increasing population, especially as we are seeing particular growth in both younger and older patients – two of the groups who rely most heavily on health services. Increasing prevalence of long-term conditions are also causing service delivery and demand challenges, which we will need to work more closely with other health and care bodies to address.

Key to this is the establishment of Sustainability and Transformation Partnerships (STPs). On 15 March 2016, details were published of the 44 "footprint" areas which will bring health and care leaders, organisations and communities together to develop local blueprints for improved health, care and finances over the next five years, delivering the NHS Five Year Forward View. One of the footprints is Suffolk (with the exception of Waveney) and north east Essex, and the Trust is an active member of this group. Our STP is looking to progress as a wave two integrated care system later in 2018/19.

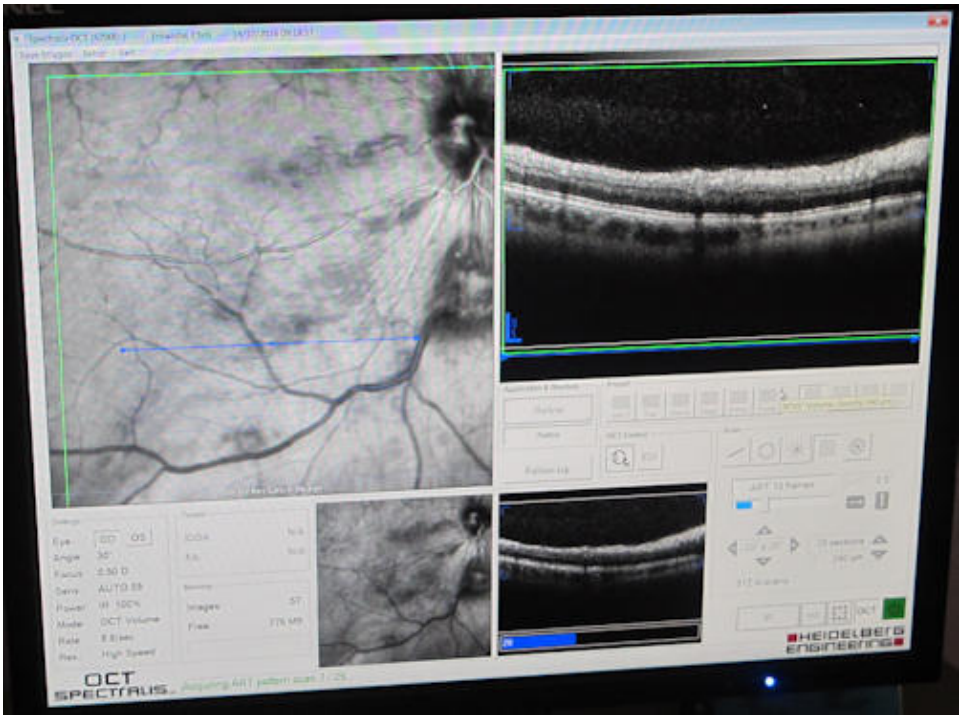
In the news June 2017 – faster care for eye patients

Eye patients are now spending less time in clinic and returning home sooner after healthcare company Bayer donated a second optical coherence tomography (OCT) machine to the retinal suite at Essex County Hospital.

The OCT machine, demonstrated by Ophthalmology Healthcare Assistant Rosemary Carter and patient Chris Entwistle (left) is used to examine the retina so that staff can diagnose serious conditions, such as glaucoma, and monitor the progress of treatment for diseases such as age-related macular degeneration (AMD).

The machine allows staff to show patients images of their retina on a monitor, which means they can see and understand what is going on in their eye.

Around 20 additional nurses, healthcare assistants and technicians received training to use the machine, in turn allowing the hospital to see more patients in each clinic and reducing appointment times for wet AMD patients from two hours to just 45 minutes.



Cost improvement programme

The Trust was set a target to deliver a deficit of no more than £22.1m in 2017/18. Our cost improvement programme (CIP) needed to achieve £17m of cost improvements, either in the form of planned cost reductions, as set out at the start of the year, or through cost avoidance, which may be necessary to mitigate any under achievement of the plan during the year.

The Trust achieved savings of £14.1m against this target.

Looking ahead to 2018/19, we need to achieve £17.3m of cost improvements, which may be in the form of planned cost reductions, as set out at the start of 2017/18, or through cost avoidance, which may be necessary to mitigate any under-achievement of the plan during the year. The challenge remains the scale of the programme and to sustain the cost reductions.

Innovation and excellence

A range of developments have taken place to improve care and clinical services at the Trust over the past year, including:

- Work began on the £6.4m primary care centre project, which will see all services transfer from Essex County Hospital in Lexden Road to the Colchester Hospital site. A variety of other major projects designed to improve facilities at the hospital, such as the new breast care centre and diagnostic imaging centre, continued to progress and are due to open to patients early in 2018/19.

- Seven mothers started in a new voluntary role to improve the service provided to new mums by supporting and encouraging them to breastfeed their babies.

- Staff wore their pyjamas to launch the #EndPJParalysis initiative, which aims to get patients up, out of bed, dressed and moving to speed up their recovery so they can leave hospital sooner.

- The Trust performed well in the 2017 Patient-Led Assessments of the Care Environment (PLACE) survey, scoring better than the national average in all of the six main categories, which include cleanliness, food and hydration and privacy, dignity and wellbeing.

- A short film featuring a physiotherapist, doctor, falls prevention practitioner, dietitian, pharmacist and occupational therapists was developed to minimise the risk of future falls in patients who have fallen or are at risk of falling.

- A state-of-the-art £1.2m decontamination unit opened to further improve patient safety by ensuring medical equipment continues to be disinfected to the highest standards. The Endoscope Decontamination Unit houses five state-of-the-art machines, which wash and disinfect the delicate scopes which are used to carry out around 9,000 endoscopies every year.

- A £24,000 refurbishment project took place in our plaster room to improve privacy and dignity for 1,000 patients each month who come to our hospital to have casts fitted or removed.

- The number of patients who suffer a cardiac arrest while an inpatient at the hospital fell by 24% after improvements were made to the way care is delivered to deteriorating patients. Data from the National Cardiac Arrest Audit 2016/17 showed that Colchester Hospital had one of the best records of any hospital in the UK and Ireland.

Financial performance

The Trust reported a deficit of £4.3m (excluding charitable funds). Compared with the previous year, income increased by 13.9%, from £301.6m to £343.5m. Significantly, the Trust began hosting North East Essex Pathology Service (NEESPS) from May 2017. This increased income by a net £27.6m.

Income from commissioners has risen by a further £11.7m (4.6%). From 2017/18 a guaranteed income contract settlement was negotiated. This settlement was an agreed affordability value between the main commissioner and associates and Colchester Hospital. The settlement was based on a priced national tariff plan, with growth mainly related to the price impact of HRG4+ from April 2017.

Also, as a result of its overall performance in 2017/18, the Trust received £20.3m from the Sustainability and Transformation Fund (an increase of £3.5m compared to 2016/17), which helped drive the increase in income. The Sustainability and Transformation Fund is to be distributed to providers to support movement to a sustainable financial footing.

The Trust's operating expenditure rose by 9.7% from £307.2m in 2016/17 to £336.9m in 2017/18. This was mainly because we increased costs to match income received in relation to NEESPS (£27.5).

	2017/18 £m	2016/17 £m
Operating income	343.5	301.6
Operating costs	(336.9)	(307.2)
EBITDA*	6.6	(5.6)
Non-operating costs	(10.9)	(13.3)
Impairment of non-current assets	Nil	Nil
Surplus/(deficit) for the year	(4.3)	(18.9)

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

Consolidated accounts

In accordance with International Financial Reporting Standard 10, the Trust has included the Colchester Hospital University NHS Foundation Trust Charitable Funds as a subsidiary and has produced a set of consolidated accounts. Further details of the consolidation and the impact on the Trust's reported financial position can be found in note 1.3 of the Annual Accounts.

Colchester Hospital University NHS Foundation Trust Charitable Funds (Colchester Hospitals Charity, or CoHoC) raises funds to provide additional equipment and amenities to enhance the care and treatment of patients.

The charity was created by the declaration of the Trust on 1 November 1995 and is an NHS umbrella charity. It includes funds in respect of Colchester General Hospital, Essex County Hospital and Clacton Hospital, and is registered with the Charity Commission under charity number 1051504.

The corporate trustee is the Trust. The charitable funds are administered by the Charitable Funds and Sponsorship Committee, which is a sub-committee of the Board of Directors.

Further details of the charity's annual report and accounts can be found on the Charity Commission's website at www.charitycommission.gov.uk

---

Operational service standards

Emergency department (A&E) four-hour standard

The emergency department has faced some challenges in meeting performance targets due to various issues across the Trust, especially during the winter. We were required to meet the target of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. We achieved 82.57% (84.13% in 2016/17).

National access standards

Our performance against the challenging national access standards between April 2017 and 31 March 2018 was:

	Standard	Performance
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	93%	95.4%
Two-week wait for symptomatic breast patients (cancer not initially suspected)	93%	92.2%
All cancers: 62-day wait for the first treatment from national screening service referral	90%	84.9%
All cancers: 62-day wait for the first treatment from urgent GP referral to treatment	85%	75%
All cancers: 31-day wait from diagnosis to first treatment	96%	96.3%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	100%	95.1%
Percentage of patients on an incomplete pathway with a maximum of 18 weeks waiting time	92%	83.9%
MRSA	0	2
Incidence of Clostridium difficile infection	18	18

*Source: Accountability Framework

Research and development/ innovation

Research and Innovation (R&I) promotes, supports and develops research and innovation projects for patients at Colchester Hospital and the surrounding areas.

Research in the NHS is largely funded through the National Institute for Health Research (NIHR) via the Comprehensive Research Networks (CRN). CHUFT is a member of the Eastern CRN, currently hosted by the Norfolk and Norwich University NHS Foundation Trust. The Academic Health Science Networks (AHSN) are also responsible for primary and translational research and for piloting of new developments. CHUFT is a member of the Eastern AHSN, which is hosted by Addenbrooke's Hospital in Cambridge.

In 2017/18 there was a reduction of 25% from the 2016/17 CRN funding to the Trust. This research budget is supplemented by CHUFT substantive funding, income derived from clinical trials and DH Research Capability Funding. The budget reduction this year has resulted in a reduction in the current workforce, which has translated into an approximately 40% drop in the number of participants recruited into research trials. The CRN budget itself is determined by activity, performance and recruitment to trials in the previous financial year.

The research staff consist of 15 nurses, one allied health professional, clinical support staff, administrative staff and a pharmacy position. The research staff recruit and support patients in NIHR clinical trials and ensure that the research is being conducted within the recommended frameworks and conducted to International Conference Harmonisation – Good Clinical Practice (ICH-GCP) standards. The research service also includes governance reviews, assurance and risk assessment, specialist advice, clinical feasibility, patient recruitment, patient follow-up, research specific training, performance and financial management.

The Trust has an established research infrastructure which supports the clinical divisions to participate in research. However, research integration varies amongst clinical specialities. Research active specialities are led by research engaged clinicians (called 'principle investigators') who incorporate research into their routine clinical practice to offer more choice and opportunities to their patients. Research and Innovation continues to promote research for patient benefit with an aspiration for all patients to have an opportunity to have treatment within a clinical trial.

In the current environment, funding streams from the CRN are very much matched to performance rather than historical levels. Looking at opportunities from other streams of funding is essential to maintain future investment, provide stability and expand the service to meet the needs of the population. As well as being part of the NHS Constitution, it is widely recognised that research-active trusts have better outcomes for their patients and attract higher quality staff and improves standard of care.

The current merger with Ipswich Hospital will increase the range of areas of research in clinical services within a single organisation. This gives us the potential to be the third largest recruiting trust in the eastern network. Commitment, leadership and drive will be required for harmonisation of workforce, policies and procedures to work towards delivering top quality research and innovative technologies within the required value for money.

Maximise engagement in research

The Trust sponsors two NIHR projects within vascular and cancer and a non-portfolio haematology project, as well as supporting students with MSc and PhD projects. R&I aims to further develop Trust sponsored research and collaborations with other pharma and academia onto the national portfolio.

We are now in the second year of the Trust-sponsored study called MAVEN (Management of People with Venous Ulceration: Feasibility Study). This interventional study compares the effectiveness of bandaging compared to the Juxta-Cures™ device in the management of people with venous ulceration. A funding award of £125,000 was secured from the healthcare company. This includes the budget for a research nurse, consumables and supply of the Juxta-Cures™ device. To date, 20 patients have been

recruited into this trial, with a target of 50. Depending on the study results, the Trust hopes to run a multicentre trial and would need to apply for an NIHR Research for Patient Benefit grant to do so.

Research at the Trust takes place in anaesthetics and intensive care, the breast unit, vascular surgery, general and colorectal surgery, gastroenterology, haematology, obstetrics, oncology, ophthalmology, paediatrics, renal, rheumatology, stroke and urology. There are a number of clinical areas which are not research active, and is an area to explore further with the ongoing merger to help R&I meet performance and financial targets.

Research activities are further supported by the Mary Barron chemotherapy suite, the electro-biomedical engineering department, cardio-respiratory department, nuclear medicine department, radiotherapy centre, pathology, pharmacy and radiology departments. Activities within the Trust and engagement with the public to advertise research takes place by specialty meetings, through internal communications and articles in the local press. The Head of R&I is a committee member of the CRNE Communications Steering Group and the Patient and Public Involvement Steering Group, and also attends regional research managers' meetings and regional network events. The clinical research nurse manager is a regional Good Clinical Practice (GCP) facilitator and delivers GCP training in the Trust; is lead for the regional informed consent in research course working group; a member of the steering group of the Advance Research in Practice (ARIP); chair of the research team leaders group and a member of the regional workforce development steering group.

We are currently involved in 173 studies on the NIHR portfolio which are recorded on the local portfolio management system (EDGE). 67 are open to participant recruitment and 107 studies closed to recruitment and are in follow-up status. Clinical research team managers overseeing the three research teams (cancer, haematology and clinical studies) are required to identify NIHR portfolio studies. They engage with potential principal investigators and perform detailed site feasibility and the set-up of research studies alongside the R&I department.

The Essex Biomedical Sciences Centre highlights successful ongoing collaborations between academics and clinicians and showcases emerging research areas where future collaborations can be formed. The next bi-annual conference will be held at Trust in April 2018. An area needing further exploration and collaboration are the links with the University of Essex and Anglia Ruskin University alongside the previously established relationships with the ICENI centre at CHUFT.

The Trust's R&I team works with Health Enterprise East to explore potential commercialisation of intellectual property and the research design service to develop innovation and support staff with design, methodology, grant applications, statistics and research.

Other opportunities for innovation include programs such as the Dragons' Den style innovation scheme. A previous winner, 'Falls prevention education and support group for inpatients and their relatives', was developed by staff with R&I guidance, and is now an in-house training tool for patients and carers on hospital wards. Staff are also encouraged to submit applications for innovation funding programmes such as the Medtech Accelerator programme. This has been set up to facilitate the early stage development of medical technology and software innovations from within the NHS.

Research governance

All patients should have the right to access to research trials, as legislated by the NHS Constitution. The R&I department is committed to the integration of research in clinical practice.

All research is delivered in accordance with the UK Policy Framework for Health and Social Care Research. This outlines the principles of good practice in healthcare to ensure research governance is one of the core standards that all organisations must apply. The R&I department ensures that all research has undergone a local governance review to provide the appropriate assurances before it can commence. R&I ensures all appropriate communications with the Health Research Authority, encompassing research ethics committees, occur on each study. This provides assurance that costs and contracts are negotiated and signed, capacity modelling is performed, risks addressed and appropriate authorisations have been received from clinical and support departments.

The Medicines and Healthcare products Regulatory Agency (MHRA) remain responsible for providing authorisations for medicinal products trials. All researchers at this Trust undertake ICH-GCP, a legal requirement for medicines trials and standard for all research at this hospital.

Training for clinicians and research staff is available through network-funded staff to ensure standards and best practices are maintained. The Trust ran three ICH-GCP refresher courses and will maintain a training schedule in future years. ICH-GCP training is valid for two years, with 97 staff holding a current certificate. 56 updated their training in 2017/18 and 43 currently need recertification.

The R&I department has recorded the following:

- 20 studies receiving confirmation of capacity and capability
- 160 studies require amendment confirmations
- 16 reported SAEs to study teams, 75% compliance for reporting to R&I with 24 hours.

The key policies for R&I at this Trust are the R&I Policy, Intellectual Property Policy, Procedure for Reporting Adverse Events and Reactions during a Research Study. Teams are responsible for producing local standard operating procedures to support with service delivery and training of new staff.

Performance metrics

The NIHR CRN high level objectives (HLOs) for research, applicable to this Trust for 2017/18 are:

- 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
- HLO4: Reduce the time taken for eligible studies to achieve set up
- HLO5: Reduce the time taken to recruit first participant
- Value for money: Activity-based funding model using a study complexity weighted score to determine budget setting.

The NIHR continues to publish outcomes against contract NIHR 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 on the R&I page of the Trust website.

Life sciences industry

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

Research income generated £320,000.00 from contracted clinical trials which contribute to staff costs, Trust overheads, research infrastructure and investment into research associated activities. Pharmacy drug-saving costs as a result of pharmaceuticals supplying trial drugs free of charge provide savings to the Trust.

Patient involvement

The NIHR open data platform reports the Trust has recruited 695 participants into NIHR portfolio studies. This compares to 930 participants recruited the previous year, a decrease of just over 25%, and as

documented above reflects the reduction in funding to replace staff vacancies in the service. The merger brings new opportunities to offset the changes in the funding going forward.

We continue to involve our patient research ambassadors (PRA) to help promote research within the local community and at Trust events. We meet quarterly to explore what initiatives can be focused on. The PRAs contribute locally to research, including the design of business cards to promote research within the community, and also attend regional meetings with partner NHS trusts involved in the PRA programme

---

Environmental sustainability

The Trust takes its responsibility as a major employer and consumer of energy and resources seriously and is committed to continuous improvement in reducing the adverse effects of its operations on the wider environment and the health of the population it serves. The Trust recognises that sustainable development can be achieved only in conjunction with the wider Colchester community. The Trust is a member of Colchester Travel Plan Club and is actively exploring how it can work more effectively with other local organisations.

Sustainability strategy

The Trust has a Board-approved Sustainable Development Management Plan (SDMP) in place which is broadly consistent with the NHS Sustainable Development Strategy 2014-2020. The plan identifies the ways in which the Trust's activities impact on the environment and seeks to provide a framework for measurable improvement in each area. The Trust will need to revise the SDMP in 2018/19 in order to capture and incorporate the vision of the new trust which will be created through the merger with the Ipswich Hospital.

The Trust has recruited a new Energy and Sustainability Manager to drive the sustainability agenda forward. The Good Corporate Citizen model, which the Trust has previously used to measure performance, will be brought up-to-date and used to set up a framework for improvement.

Activities in 2017/18

The Trust carried out a number of activities which addressed specific objectives in the SDMP. In particular, additional funds were invested into replacing fluorescent lighting with LED fittings.

We have also revisited our Travel Planning and Car Parking Management Strategy, outlining a number of elements which will improve travel, access and parking at the Colchester General Hospital site. The Trust has completed and approved a full business case for their plans to install 12 electric car charging points at the hospital to reduce carbon emissions and improve local air quality, as well as providing infrastructure to encourage the uptake of electric vehicles in the Colchester area.

The SDMP will be fully updated in conjunction with Ipswich Hospital to define new measurable targets and metrics for the new combined Trust.

Governance to support sustainability

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

Energy

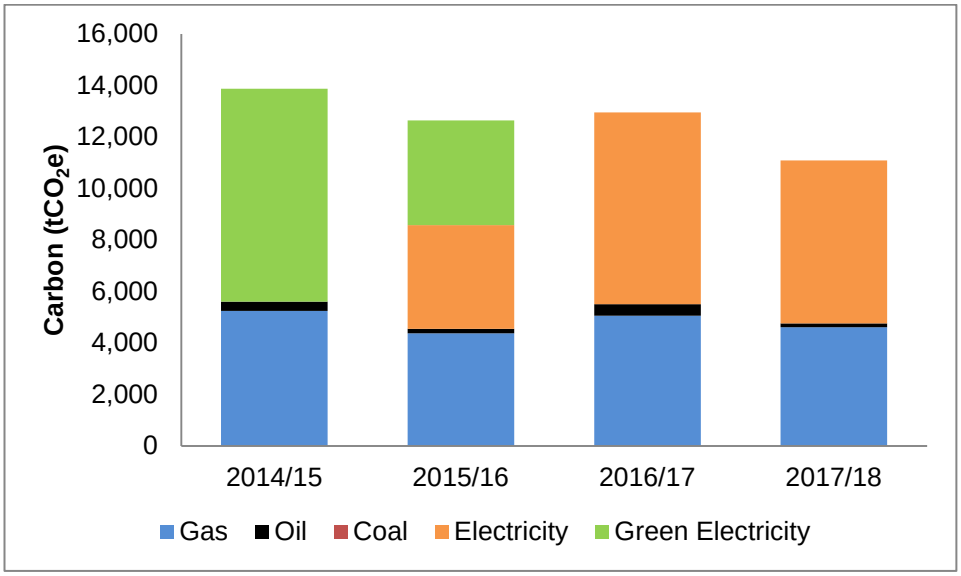
The Trust's energy consumption decreased in 2017/18, driven by a continued change in light fittings to LED and a review of operating plant and associated equipment.

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

Resource		2014/15	2015/16	2016/17	2017/18
Gas	**Use (kWh)**	**24,971,134**	**20,913,996**	**24,180,661**	**21,742,267**
	tCO_2e	5,239	4,377	5,053	4,610
Oil	**Use (kWh)**	**1,161,491**	**523,657**	**1,406,948**	**474,999**
	tCO_2e	372	167	446	155
Coal	**Use (kWh)**	**0**	**0**	**0**	**0**
	tCO_2e	0	0	0	0
Electricity	**Use (kWh)**	**0**	**7,008,472**	**14,406,026**	**14,186,142**
	tCO_2e	0	4,029	7,445	6,323
Green electricity	**Use (kWh)**	**13,345,551**	**7,078,886**	**0**	**26,953**
	tCO_2e	8,265	4,070	0	0
Total energy CO_2e		**13,876**	**12,643**	**12,945**	**11,088**

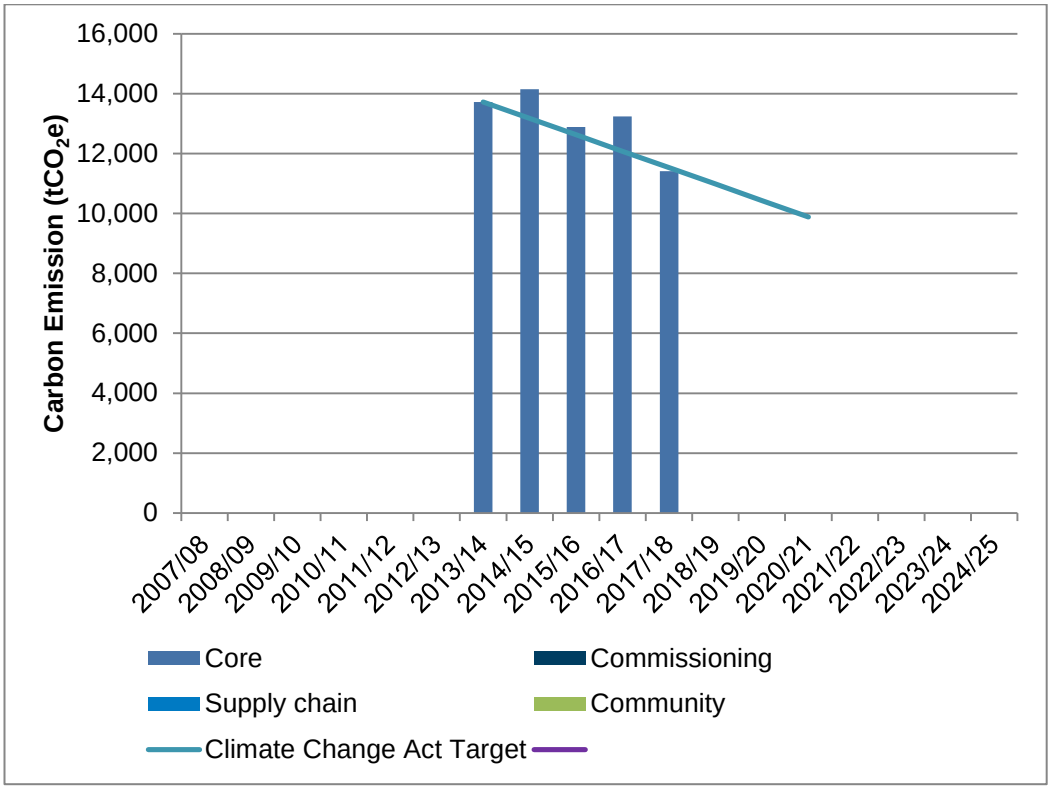
The Trust will invest further in energy-saving measures in 2018/19, and will replace fluorescent lighting with LED lights and fans and pumps with modern energy-efficient models, while the boiler plant will also be optimised.

Carbon emissions – energy use



Carbon reduction target

Through the various schemes implemented to date, together with the steady closure of historic building stock, the Trust is on track to achieve the 2020 carbon reduction target.



Water

Water consumption increased above 2015/16 levels but was still lower than 2014/15 and 2016/17.

Water		2014/15	2015/16	2016/17	2017/18
Mains water	m^3	114,602	96,899	109,771	108,687
	tCO_2e	104	88	100	99

Renewable energy

Colchester General Hospital has two sets of solar photovoltaic panels. These generated a total of 26,953 kWh, reducing the amount of grid-supplied electricity used by the Trust and generating income.

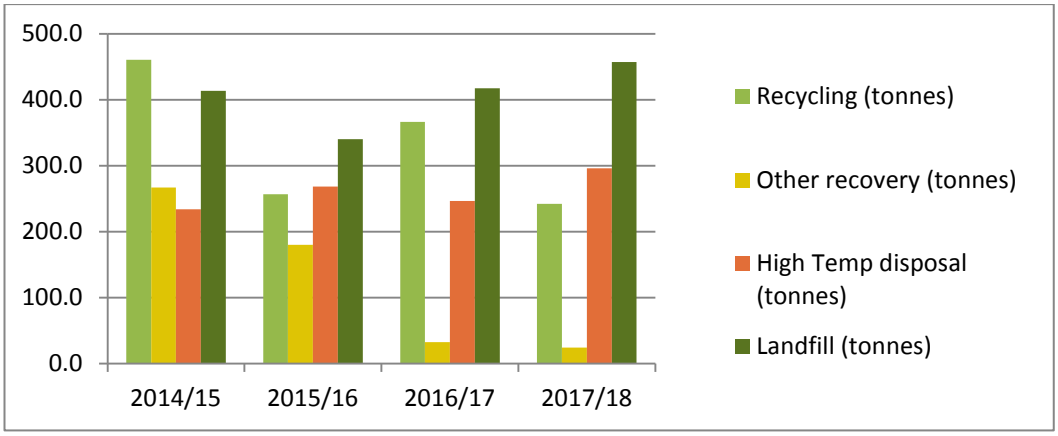
Waste

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	**(tonnes)**	**233.94**	**268.52**	**246.60**	**295.78**

temp disposal	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)		**1,374.74**	**1,044.88**	**1,062.20**	**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

In June 2016, the Trust carried out a survey of staff about the different ways they travelled to work. The results showed the majority travel by car:

Mode of travel	Percentage
Drive alone	83.0%
Walk	5.8%
Car share	3.7%
Bus	3.2%
Cycle	2.6%
Train	1.2%

The Trust has introduced a number of initiatives to promote sustainable travel, with a view to reducing the proportion of staff who drive alone. The survey will be repeated annually to measure changes over time.

A new car parking partnership has been agreed and is due to launch in April 2018. This will improve parking arrangements and produce revenue which will allow investment in improved sustainable transport initiatives. These include offering further subsidies on bus and rail fares, building new cycle storage facilities and staff showers and creating a new, dedicated travel centre for staff and patients.

Procurement

The Trust seeks to reduce its energy consumption through careful equipment purchasing, such as by installing new pedestrian crossings which are solar powered. The estates department continues adding and reviewing to the standard materials list in which energy efficiency is a key criterion for all new equipment.

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 continues to consult with staff to implement organisational change where services have been re-designed 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 engagement takes place before the onset of any formal consultation period. Once that period is closed, engagement continues through to the implementation of change. Throughout any period of change, staff have an opportunity for both individual and group communication in a variety of forums. This methodology enhances and supports harmonious change for the staff affected and, ultimately, the service provided to patients.

In partnership with the Trust and its trade unions, a fortnightly consultation sub-group meets to progress formal consultations. Trust staff have access to the organisation's intranet and email system which are used as rapid methods of communication. Screensavers provide a simple method of communication.

There is an established regular briefing by the Chief Executive and members of the executive team which is cascaded through the organisational management structure. A Staff Involvement Group also meets monthly to discuss current issues and how relationships and services can improve.

The Board encourages managers to engage with staff members in changing and improving the way in which services are provided.

Equality and diversity

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.

At the heart of the EDS2 are four goals, which the Trust has adopted as our equality objectives:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well supported staff
- Inclusive leadership

To support delivery of this work the trust has a dedicated committee structure and governance. These are the:

- Equality and Diversity Steering Group, which is chaired by the Director of Nursing and meets quarterly. The group's purpose is to give assurance to the Trust Board, via the People and Organisational Development Committee, that the Trust is fulfilling its responsibilities to comply with equality legislation for both service provision and employment in line with the legislation, national guidance and regulations.

- Equality and Diversity Operational Group, which is chaired by the Assistant Director of Human Resources. This group ensures operational delivery of the action plans and provides support to the Trust-wide champions. It meets bimonthly and has focussed this year on progressing the Workforce Race Equality Action Plan and the LGBT agenda.

Diversity champions

Diversity champions are members of staff who volunteer to support the Trust and colleagues to make positive improvements and drive the development of a culture which values equality and diversity. The role was introduced in 2016, and champions are invited to the operational group meeting.

The number of champions has not increased greatly over the previous year, and the role will be re-launched following the merger with Ipswich Hospital as part of the revised equality and diversity activity.

Stonewall diversity champion

As one of Stonewall's diversity champions, Colchester Hospital has continued to work with Stonewall to provide support and guidance on Lesbian, Gay, Bisexual and Transgender matters. An online survey asking staff if they wished to have an LGBT network received overwhelming support, and Stonewall colleagues are working with the Trust to launch the network early in 2018/19. Although the group is in early stages of development, its formation has been well received and a number of champions have come forward. The group will continue to receive support from Stonewall to ensure momentum is not lost and the group incorporates colleagues from Ipswich post-merger.

Workforce race equality standard

The workforce race equality standard comprises of nine metrics, three of which are workforce data and four relate to the national staff survey indicators. There is also an indicator which requires Boards to be representative of the communities they serve. In the third year of reporting, the Trust has an action plan to improve the indicator outcomes and improve the experience of our BME employees which is monitored by the People and Organisational Development Committee.

Gender pay gap reporting

This was the first year that gender pay gap reporting took place within the NHS. It differs from equal pay, which 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.

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 results from 31 March 2017 are:

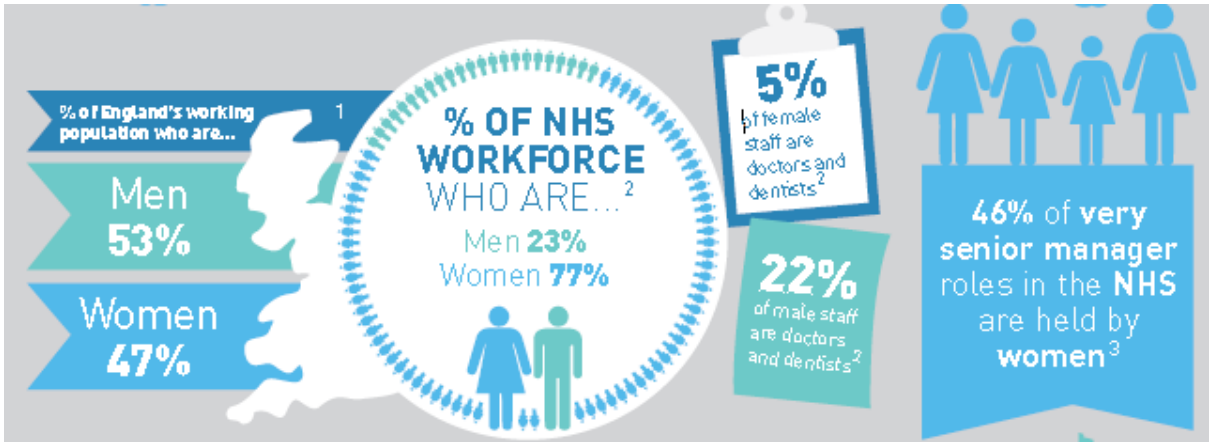
	Average hourly rate	Median hourly rate	Average pay	Median pay	Employees paid bonus	Total relevant employees
Male	20.9958	14.7967	12,585.02	8,950.75	59	1050
Female	15.2345	13.7296	8,048.51	8,950.75	15	3376
Difference	5.7613	1.0672	4,536.51	0		
Pay gap %	27.4404	7.2123	36.05	0	0.44	5.62

Number of employees | Q1 = Low, Q4 = High				
Quartile	**Female**	**Male**	**Female %**	**Male %**
Lower quartile 1	807.00	209.00	79.43	20.57
Lower middle quartile 2	784.00	232.00	77.17	22.83
Upper middle quartile 3	862.00	154.00	84.84	15.16
Upper quartile 4	639.00	378.00	62.83	37.17

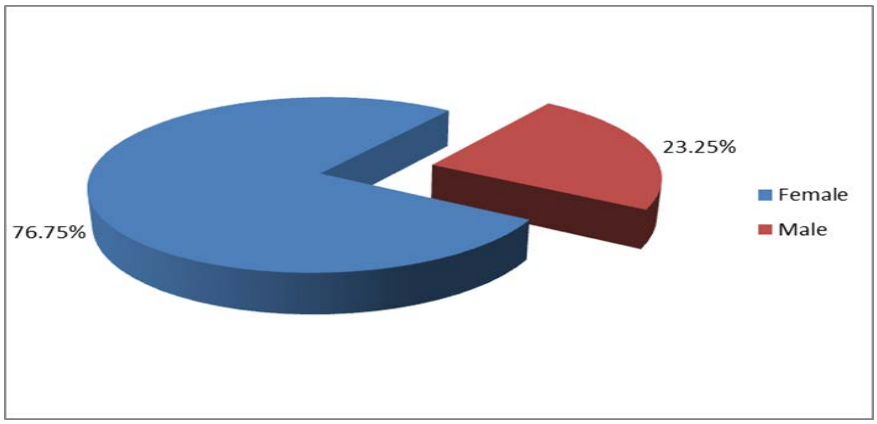
Gender profile

The workforce at CHUFT 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.

England average:



Colchester Hospital:

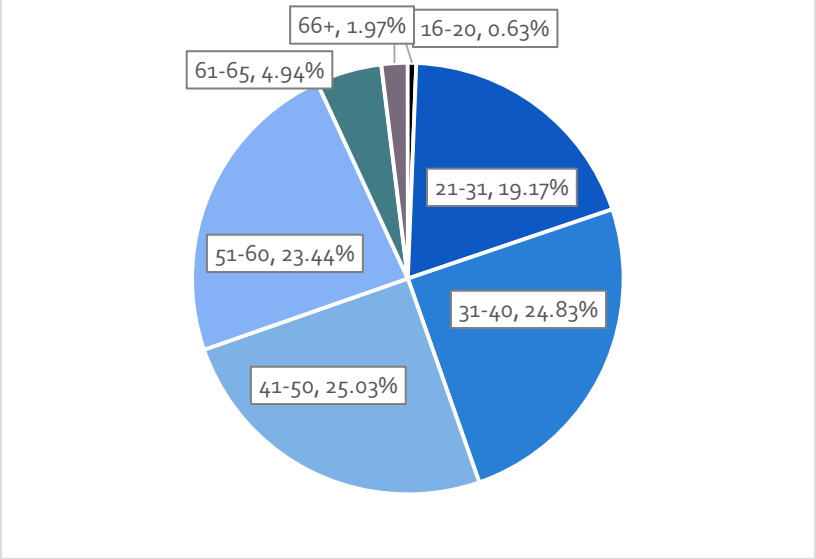


Age profile

The age profile across the Trust and by staff group highlights that 50% of the workforce is over the age of 40 and that we currently attract very few of the younger workforce, as shown in the diagrams below. A focus for the new Trust will be making careers within the NHS attractive to all age groups.

England average:

Colchester Hospital:



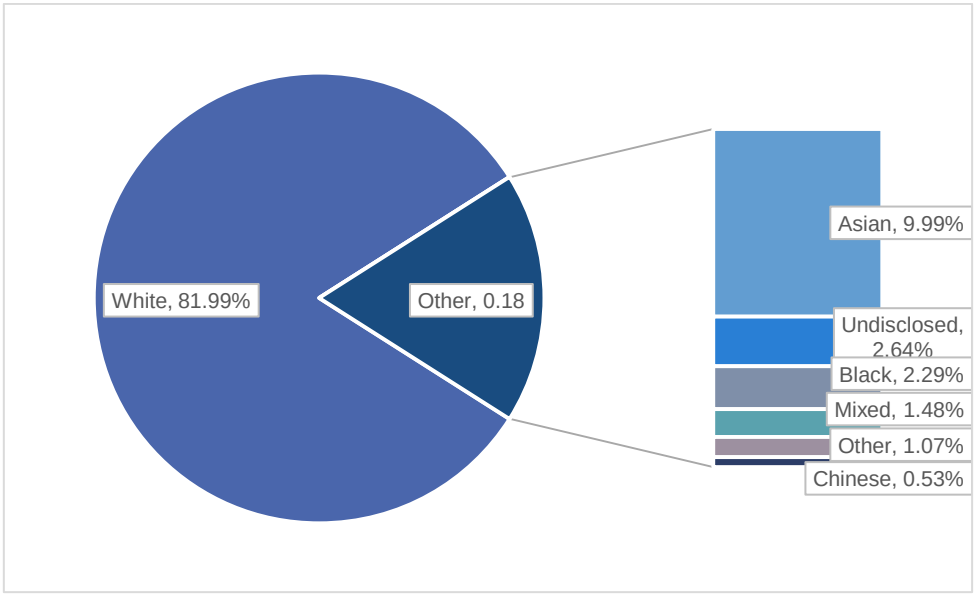
Ethnicity profile

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. A recurrent theme for the staff survey is that staff from an ethnic background do not routinely feel supported to progress their careers and move into management posts.

We have a programme of work which includes embracing differences, celebrating all of our staff and providing support such as dedicated group meetings for our international new joiners. While progress has been made, it is recognised that further work is required.

England average:

Colchester Hospital:



Protected characteristics

Recognising that there is a need to treat everyone fairly, an Executive lead, supported by human resources, has been identified as a champion for the protected characteristics. These are:

Age	Managing Director
Disability	Director of Estates and Facilities
Gender reassignment	Medical Director
Marriage and civil partnership	Director of Finance
Pregnancy and maternity	Director of Nursing
Race	Director of Communications and Engagement
Religion or belief	Trust Secretary
Sex	Director of Integration
Sexual orientation	Director of Workforce

Actions and outcomes for the coming year

While the forthcoming merger will necessitate change to the plans as we move into a larger Trust, the following outlines what the equality and diversity steering group has agreed as the plan for next year. This will be incorporated into the revised plan for the new East Suffolk and North East Essex NHS Foundation Trust.

What we will do	How we will do it	Outcome measures
A representative and supported workforce	• Wide-ranging recruitment campaigns • Training and development opportunities available to all • Increase diversity champion programme	• Benchmarking against national dataset • Opportunities are taken up and positively evaluated by all staff • Staff survey results
When at work, ensure that staff are free from abuse, harassment, bullying and violence from any source	• Trained officers investigate allegations and present findings to the appropriate manager	• Staff survey
Promote the Workforce Race Equality Standard	• Publicise the action plan arising from the WRES • Actively involve the diversity champions in this work	• Workforce Race Equality Standard national benchmarking
Preparation for the new equality standards	• Plan for the Disability Equality Standard • Include within local research: Support for Sight • Reporting preparedness for gender pay	• Disability Equality Standard national benchmarking • Outcome of research and benchmarking data • Gender pay national benchmarking
Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond the Trust	• A clear equality and diversity programme of work • Board leads for the protected characteristics report to the Trust Board on progress • Papers presented to Board and other major committees identify equality related impacts, including risks and how these risks are to be managed	• Programme of work for E&D • Benchmarking against national dataset • Complaints and complements data
Inclusive leadership, with middle and other line managers supporting their staff to work in culturally competent ways within a work environment free from discrimination	• Leadership development training for managers • Talent management	• Staff survey • Equality data from employee relations casework
Flexible working arrangements are available to all staff consistent with the needs of the service and the way people lead their lives	• Annual review of flexible working arrangements	• Vacancy factor of 10%

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. In September 2017, the Trust was represented at 254 Medical Regiment's training camp in Croatia, and in November, the Trust welcomed our first Step Into Health work placement. There is continued involvement in the Injured, Wounded and Sick Programme, supporting soldiers who are being discharged on medical grounds**.**

Health and safety

The Trust has well-developed health and safety arrangements as part of its overall risk management strategy. The Health and Safety Policy has been inspected previously by the Health and Safety Executive and is compliant with Section 3 (2) of the Health and Safety at Work Act 1974.

In addition, all ward/departments have:

- access to a hard copy of the Health and Safety Policy within their Health and Safety Folder. All ward/department risk assessments can also be found within this folder
- COSHH (Control of Substances Hazardous to Health) manuals which contain clear risk assessments of how to use substances safely

All reportable incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) have been controlled by the Patient Safety and Quality Team (PSQ). PSQ members have completed investigations where staff or visitors have been injured due to a health and safety issue. All reports have been uploaded onto the Trust's electronic incident reporting system.

All departments, including all satellite sites, have been audited in compliance with HSG 65. Any safety failures were addressed immediately with departments or escalated to line managers. PSQ members have continued to deliver mandatory training which is at 92% compliance.

All annual manual handling audits have taken place in clinical areas and time-bound action plans have been issued to areas where improvement is required. Areas of concern included documenting competency assessments, provision of consistent basic equipment levels and progress with action plans from 2015/16. Follow-up audits take place every April.

Trust-wide compliance with manual handling part one stands at 87%, and part two at 82%.

Health and wellbeing

The Trust provides a health and wellbeing (H&W) service to which all staff have access. The service is staffed by a multidisciplinary team, including specialist practitioners in occupational health, a registered mental health nurse, an occupational therapist, clinical nurses, technicians and a part time consultant.

All staff have direct rapid access to physiotherapy to enable them to receive speedy advice and treatment. In addition, the occupational therapist undertakes home and work assessments and provides aids to staff to enable them to manage chronic health conditions more effectively and reduce sickness.

Staff also have access to an employee assistance programme for psychological support, access to citizen's advice database for non-psychological problems and a managers' helpline to support mangers with work issues.

The Trust has achieved the Staying Healthy at Work award. This focusses on supporting staff with mental health issues. To this end the Trust has also signed up to being a "mindful employer".

The H&W service facilitates mental health first aid, providing managers with the skills to recognise and support staff with mental health issues. In addition, anxiety management workshops are being developed to support staff and provide them with the tools to manage their anxiety.

Emotional resilience sessions are provided for all staff, enabling them to identify their stressors and how they react to stress before using cognitive behavioural techniques to manage their stress.

External trainers attend to provide yoga, mindfulness and relaxation sessions for staff.

During the year, we arrange several wellbeing events which tie in with the national wellbeing agenda, including:

- Dry January
- Stop smoking
- World mental health week
- Men's health
- Health and wellbeing day

Schwartz Rounds

The Trust continues facilitate Schwartz Rounds, and saw 356 staff attending during 2017/18.

The Schwartz Rounds provide a confidential environment and an opportunity for staff to talk about the emotional challenges they experience when caring for patients. They are held monthly with a panel of three or four, who provide a synopsis of an event in how they felt about that event. Once all panellists have told their story, the facilitators open the discussion to the floor enabling others to resonate with what they have heard and how they have felt in similar situations.

Studies have shown that Schwartz Rounds leads to an increase in confidence in dealing with both clinical and non-clinical difficult and sensitive issues, as well as changes in practice. Attendance at them also reduces stress.

Schwartz Rounds in 2017/18 have included the following topics:

- Palliative care
- Making a difference
- Life as an SAS doctor
- Complaints
- Discharge planning
- Supporting families through challenging times

Pop-up Schwartz Rounds have also been facilitated in areas where staff such as students and junior doctors have found it hard to leave their clinical areas.

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 the Trust's 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 culture among all staff, contractors 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 members of staff to raise any matters of concern they may have with the delivery of care or services to a patient or client of the Trust, or about financial malpractice, unlawful conduct, dangers to health and safety or the environment. It believes that a culture of openness and dialogue is in the best interests of patient care. However, this must be set in the context of the Trust's duty of confidentiality to patients. Our Freedom to Speak Up or "whistleblowing" policy sets out the procedures put in place for staff if they wish to raise their concerns, and the responsibilities managers at all levels have to ensure these are dealt with thoroughly and fairly.

Overview and scrutiny

Essex County Council's Health Overview and Scrutiny Committee (HOSC) took a keen interest in the Trust throughout the year. Several senior staff, including the Chair, David White; Chief Executive, Nick Hulme; and Shane Gordon, Director of Integration; appeared before councillors. The HOSC took a particular interest in the long-term partnership with Ipswich Hospital as well as the Suffolk and North East Essex Sustainability and Transformation Partnership (STP).

Public consultations

There were no public consultations during 2017/18 under section 242 of the NHS Act 2006. The Trust did carry out extensive engagement, however, relating to the proposed merger with Ipswich Hospital.

Other patient and public involvement activities

The Head of Patient Experience maintained contact with the North East Essex Health Forum, providing feedback on issues raised. In addition, the Head of Patient Experience attended the CHUFT Patient Advisory Group and the joint CHUFT/IHT Patient Advisory Group as part of the partnership/merger discussions.

The Head of Patient Experience and the Deputy Director of Nursing attended an annual general meeting of the Frinton Residents' Association to raise awareness of key patient experience initiatives and hear feedback.

The Patient User Group did not become established due to role changes in the organisation. However, discussions have begun with a view to developing a robust user involvement programme for the new organisation.

Principal risks and uncertainties

Managing risk

The Trust is committed to providing high quality patient services in an environment that is safe and secure. The Board of Directors monitors the key risks to the Trust through its review of the Board Assurance Framework, which maps the high-level risks associated with the achievement of our corporate objectives. 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.

Risk Management Strategy

The Trust is committed to delivering continuous improvement to its risk management arrangements. The Trust has in place a risk management strategy which is underpinned by the following:

- an assurance and escalation policy and framework. This sets out the principles to ensure there are effective communication lines from the frontline of service delivery right through to divisional leadership teams, the senior executive team and the Board of Directors itself to improve organisational risk management from ward to board
- a clear Risk Appetite Statement, which was agreed by the Board following a risk workshop in January 2017, where it considered its tolerance for risk and its risk appetite. This was later drafted into a Risk Appetite Statement that was incorporated into the Risk Management Strategy agreed by the Board at its February 2017 meeting, and was used as the basis for its risk discussions in 2017/18
- a clear governance structure which was redesigned as part of the Every Patient, Every Day programme, resulting in a review of the content and structure of the Board Assurance Framework to ensure it is an effective tool for board assurance on the principal risks to the Trust's strategic objectives
- an accountability framework which holds clinical divisions and corporate directorates to account against a set of indicators and supports them to deliver the Trust's strategic objectives, manage risks to those objectives and to ensure effective identification and escalation of risks at service level.

The Quality and Patient Safety Assurance Committee routinely receives information on all Serious Incidents and the lessons learnt from them. This reinforces the Trust's approach to developing a safety and risk management culture across the organisation. Staff are encouraged to report any incidents that occur so we learn from them and improve practice. All incidents identified as moderate, major or extreme undergo detailed investigation to establish their root cause and are written into a formal report with an action plan, which is reviewed by the Quality and Patient Safety Assurance Committee.

Principal risks as at 31 March 2018

The Trust's principal risks are summarised on page 11, with further detail in the Annual Governance Statement on page 97.

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 the public interest):

- North East Essex Clinical Commissioning Group (CCG) (healthcare commissioning)
- NHS England (specialised healthcare commissioning)
- Essex Partnership University NHS Foundation Trust (mental health services)
- Anglian Community Enterprise (clinical services)
- Ramsay Healthcare Ltd (clinical services)

- Diaverum UK (renal services)

Overview of other procurement arrangements

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

- National Blood Service (blood products)
- Serco (payroll)
- Alliance Medical (MRI 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 The Ipswich Hospital NHS Trust and Mid Essex Hospital Services NHS Trust for a range of clinical services

Long-term partnership with Ipswich Hospital

In April, NHS Improvement and the CQC recommended a long-term partnership between the Trust and Ipswich Hospital. In March 2018, a full business case was approved by both Boards, with the aim of merging to form the new East Suffolk and North Essex NHS Foundation Trust from July 2018. The Boards of the two trusts consider that a full merger will be bring improved care for patients and create a more sustainable future for both organisations.

Trust business model

The Trust operates a devolved management structure comprising four clinical divisions and one corporate division. The 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

Following the approval by the Board on 29 March of the full business case for a merger with Ipswich Hospital NHS Trust, the main post-year end event involves the preparations for the implementation of the merger.

In the news July 2017 – bringing care closer to home

Around 100 patients each year have been saved a journey to London for specialist tests on pelvic floor disorders following the introduction of a new service in Colchester.

The anorectal physiology laboratory opened in July after Mr Subash Vasudevan (pictured right), a colorectal surgeon, suggested setting up the facility during a Dragon's Den-style innovation competition.

The service can carry out investigations for symptoms associated with childbirth, radiotherapy and some pelvic operations, including constipation, rectal prolapse and faecal incontinence.

It means that patients who may be experiencing these distressing symptoms no longer need to travel and can access care closer to home, as well as treatments such as targeted pelvic floor physiotherapy, biofeedback therapy and surgery.

Pictured above, former Managing Director (now Medical Director) Dr Barbara Buckley cuts a ribbon to mark the opening of the laboratory.

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 2017/18 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
Ali Bailey	Director of Communications (from 22 May)
Barbara Buckley	Managing Director (1 April to 31 December) Medical Director (from 1 January)
Jude Chin	Deputy Chair/Non-Executive Director
Clare Edmondson	Director of Human Resources (from 1 January)
Paul Fenton	Director of Estates and Facilities (from 1 March)
Tim Fenton	Non-Executive Director
Julie Fryatt	Director of Human Resources and Organisational Development (until 21 August)
Shane Gordon	Director of Integration
Chris Howlett	Director of Estates and Facilities (to 28 February)
Nick Hulme	Chief Executive
Diane Leacock	Non-Executive Director
Mike Meers	Director of ICT (from 1 January)
Neill Moloney	Managing Director (from 1 January)
Catherine Morgan	Director of Nursing
Julie Parker	Non-Executive Director
Alison Power	Director of Operations
Dawn Scrafield	Director of Finance
Jan Smith	Non-Executive Director
Dr Angela Tillett	Medical Director
David White	Chair

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 and 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 2018/19 at its February 2017 Board of Directors' meeting and submitted it to NHS Improvement in March (draft) and April (final).

The key points to note from the 2018/19 Annual Plan are:

- Planned income and expenditure deficit of £12.1m, requiring a CIP delivery of £17.3m. This CIP target represents 4.7% of all pay and non-pay budgets and will be stretching.
- Capital programme of £13m, funded through internal resources, third parties and brought forward planned support.

Overall, the Trust will require no revenue cash support for 2018/19 due to the favourable financial performance in 2017/18.

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.

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.

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

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 pre-determined frequency at which property, plant and equipment (PPE) 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 undertaken as at 31 March 2015 by the DVS (the commercial arm of the Valuation Office Agency).

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 notes 1.5 and 4.1 of the accounts. Details of senior employees' remuneration can be found in the remuneration report, which begins on page 65.

Quality Governance

The Trust's approach to quality governance is outlined in the Annual Governance Statement (page 97) and its performance against its quality priorities and key quality metrics are shown in the Quality Report.

The executive governance structure supporting the quality agenda was reviewed and two executive groups (Clinical Effectiveness and Patient Safety and Experience) report through to the Quality and Risk Executive Team and the Quality and Patient Safety Assurance Committee, a sub-committee of the Board of Directors. Further details on the responsibilities of the Quality and Patient Safety Assurance Committee are shown on pages 60 and 61.

Well-led framework

The Board carried out a self-assessment of the Trust's performance against the Monitor Well-led Framework in June 2017. This was reviewed by the CQC during their comprehensive inspection in July and August, who concluded that the Trust could now be rated as "good" for this domain due to the clarity and direction provided by the new executive team, the levels of risk awareness among the senior executive team and a clear vision and strategy focussing the Trust on improving patient care.

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.

In the news September 2017 – families benefit from maternity ward upgrade

Our maternity ward reopened in September following the completion of a seven-week refurbishment programme costing £438,000.

The refurbishment was designed to make the Lexden Ward more welcoming and homely.

As part of the project, 12 reclining chairs were purchased with a £11,355 donation from Colchester League of Hospital and Community Friends. The chairs are making it more comfortable for partners to stay on the ward overnight and share the experience of becoming a new family (as demonstrated by new dad Jordan McCarthy, pictured right with partner Rachael Coombs and one-day-old baby Ewan).

Previously, partners had to try to sleep in an upright chair.

In addition, new showers, toilets and basins were installed, a new reception and base for midwives created and new flooring and ceilings added. The ward was also redecorated and new toilet facilities added for visitors.

Staff, friends and family members also held fundraising events to help towards the cost, including a 10km sponsored walk and an open garden and vintage tea party.

The refurbishment comes two years after £1.2m was spent upgrading the delivery suite and Juno suite midwife-led birthing unit, which are both on the ground floor of Constable Wing.

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

The Non-Executive Directors and Governors undertake regular walkabouts on our wards, speaking with patients and staff. These walkabouts are reported through to the Patient Safety and Quality Committee, with immediate actions being reported back to service area leads for completion.

Peer reviews

It was accepted that the methodology used during previous CQC and Monitor reviews, with a focus on the five key domains (safe, effective, caring, responsive and well-Led), was recognised best practice. Subsequent peer reviews and “deep dives” into concerns raised internally and externally continue to be led by the Quality Assurance 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. Statistical models indicate that the Trust is one of eight trusts in the East of England peer group of 16 with an ‘as expected’ HSMR.

- the HSMR for the 12 months to November 2017 was 105.3
- the latest SHMI (which includes deaths within 30 days of discharge) for the 12 months ending June 2017 was 108.06, placing the Trust 109th out of 134 acute trusts. Statistical models indicate that the result is “as expected band 2”.

Recognition of the deteriorating inpatient has been a focus in the Every Patient, Every Day programme, with increased monitoring of the accuracy and frequency of patient observations producing early warning scores and the prompt identification and escalation of the deteriorating patient. The work to date continues to show improvement. As part of the Trust’s commitment to ensuring that sepsis is identified and treated in line with the Sepsis Six programme, the Sepsis Nurse Specialist undertakes regular audits which indicate where medical and nursing staff may need additional training, advice and support in the identification and treatment of septic patients.

Falls prevention

There were 901 inpatient falls in 2017/18, 147 fewer than the previous year (a 14% reduction). There were 29 falls resulting in serious harm, a 6% decrease on the previous year (31).

The Trust continues to implement cohort nursing which, through the commitment of staff, has demonstrated a reduction of falls as much as 60% in one ward. We are continuing to deliver care often at maximum capacity, and care for an increased number of frail and elderly patients, often with complex needs. Confusion in such patients often leads to unpredictable behaviour which can be challenging to manage. The Trust strives to promote and maximise patient safety through early identification of risk of falls on admission and continual monitoring until discharge.

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 (EPUAP) 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 graded at stages two to four was 115, an increase on the previous year (111). There was an increase (6%) in pressure ulcers noted on admission, which is indicative of the increasing frailty of patients and contributing factors such as reduced funding in the social care sector. There has been a reduction of 30% of total pressure ulcer figures (all grades) compared to 2016/2017.

The 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

The Trust 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. The Trust will continue this vigilant approach in 2018/19.

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 the Trust was 18. Of the 18 cases reported, we had one case with breaches and 17 cases with no breaches. Continuing with a low number of cases is testament to the vigilance of clinical teams and their compliance with best practice.

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. The Trust's target was to have 0 cases of MRSA bacteraemia. There were two cases in inpatients. The cases were subject to investigation and panel review, and there was learning related to the sub-optimal care of one patient's intravenous line and the other patient related to MRSA screening.

Surgical site infection

Orthopaedic surgical site infection data reporting has been mandatory since 2005. The Trust 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. Additional staff were recruited into the Patient Advice and Liaison Service (PALS) and the complaints team to support local resolution of concerns and issues. In addition, the Trust is committed to learning from incidents and ensures 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.

The Patient User Group did not become established due to role changes in the organisation. However, discussions have commenced with a view to developing a robust user involvement programme for the new organisation.

Privacy and dignity

Maintaining patients' privacy and dignity is fundamental to providing a high standard of care. According to the 2017 national adult inpatient survey, 85% of Trust patients said they were treated with dignity and respect and 91% stated there was always enough privacy when being examined or treated.

Dignity training designed by the Royal College of Nursing is included on the extended Trust induction for nurses, midwives, healthcare assistants 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. The Trust is 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 when patients actively choose to share, such as the renal unit).

If our performance falls short of the required standard, this is reported to North East Essex 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. There were no breaches during the year and the Trust has declared full compliance with delivering same-sex accommodation. The Trust undertakes continuous monitoring.

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 was represented at a number of public engagement events held in February and March 2018 to listen to feedback around the quality of care at Colchester Hospital which was, in the main, very positive. Governors were pleased to note that at these engagement events, more than 40 new public members were recruited which signified an interest within the local community in their local hospitals.

How the Trust monitors patient experience

Patient experience feedback is gathered in many ways.

The NHS Friends and Family Test (FFT) is well established across the adult inpatient, maternity and Emergency Department (A&E) pathways. Leaflets are the main collection method but the FFT question is asked via SMS and phone contacts for the Emergency Department.

FFT reports are sent to the Trust's divisions and wards on a weekly and monthly basis. The information is reported to the Quality and Patient Safety Assurance Committee in the patient experience report which is also shared with the Trust's commissioners.

Compliments and commendations are recorded and reported on a monthly basis and feedback that is shared via online feedback forums such as NHS Choices, Care Opinion and Healthwatch Essex is collected and shared via the Patient Experience Team. Where necessary PALS or complaints may look into an issue raised on line also.

The Patient User Group did not become established due to role changes in the organisation. However, discussions have commenced with a view to developing a robust user involvement programme for the new organisation.

Complaints and PALS remained a rich source of feedback for learning and improvement. The Patient safety and Experience Group has Public Governor representation which enables the patient voice to be represented.

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. You can read more about how we use social media in the news section of our website.

Our Trust Twitter page had 4,872 followers on 31 March, compared with 3,951 on 31 March 2017.

At 31 March, our Facebook page for Colchester General Hospital had 6561 likes – the number of unique people who have liked our page – compared with 5,063 on 31 March 2017. Our Facebook page for Essex County Hospital had 565 likes (505).

Facebook encourages people to rate and review services based on personal experience. At 31 March, of the 1,200 ratings for Colchester General Hospital, 690 gave five stars (the highest) and 204 gave one star (the lowest), giving an overall score of 3.8 out of 5.

A year ago there were 1,000 reviews: 535 five star reviews and 191 one star reviews, with the overall score coming out as 3.7.

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.

Based on 236 ratings on NHS Choices, the Trust's overall rating is 4.5 out of 5 stars. This rating includes cleanliness, staff co-operation, dignity and respect, involvement in decisions and same sex accommodation.

Our patient experience team responds to the reviews on NHS Choices, signposting patients to relevant services and department 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 who are 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.

The PLACE assessments took place over four days in April 2017. The Trust generally performed well from a number of perspectives – against the national average, against other local Trusts, and compared with its performance the previous year.

The Trust also carries out PLACE-lite assessments six times throughout the year, and has a PLACE steering group which meets quarterly and oversees the implementation of the recommendations which arise from the assessments which have taken place.

Engaging our staff in developing a patient experience approach

The Trust continued to engage staff in developing a personal approach that improves the patient experience. In recruitment, all job descriptions, person specifications, adverts and questions at interview reflected the attitudes, behaviours and standards the Trust expects 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 40 chaplaincy 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.

We have been fortunate to commission five new ward chaplains this year, and have also had the privilege of assisting in the training of two new clergy and two new pastoral assistants for the Diocese of Chelmsford. Our Trust chaplains have seen a substantial increase in referrals and contacts from staff, clergy, family members, and volunteers covering different facets of care from cradle to grave, including 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 in arranging four emergency marriages in the past year, with three taking place at Colchester General and one at Clacton Hospital. 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 2,264 PALS contacts were recorded in 2017/18, compared with 2,930 in 2016/17 and 1,857 in 2015/16.

Compliments

The Trust received 13,300 compliments in 2017/18 (compared with 18,814 in 2016/17). Compliments were received in several forms, including letters, cards, gifts, emails and through the local press. Of the compliments received by the Trust, 31% were general praise and thank you messages; 27% related to care and time with patient and the remainder gave general praise for staff. Where staff are named they are, where possible, informed and this aids morale and improves staff experience.

Complaints

The Trust is committed to learning from all patient experience feedback to improve the service offered to patients and visitors. We encourage patients and visitors to help by telling us what they think of their experience.

A total of 801 complaints were received by the Trust in 2017/18 compared with 693 in 2016/17, which represents a 14% increase. The Trust views the receipt of complaints positively, as each offers an opportunity to learn lessons and improve patient experience.

The Trust responded to 90% of complaints within the agreed timeframe. We re-opened 59 complaints because the complainants were not satisfied by the first response they received.

We have worked extremely hard on improving 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 PHSO

During 2017/18, nine Colchester Hospital complaints were subject to independent investigation by the Parliamentary and Health Service Ombudsman (PHSO) compared with 20 in 2016/17. Of the nine 2017/18 cases, two complaints were partially upheld following investigation by the Ombudsman. One complaint was not upheld and two complaint investigations were discontinued by the PHSO. Four cases are still under investigation and the PHSO will advise the Trust of their findings in due course.

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 in order to gain clarity on the matters of concern 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 local clinical governance meetings so that learning and changes in practice can be made. An example of this follows a family complaining that they had wrongly received a phone call from a ward stating that their relative had passed away. It was established that this error had occurred because the ward in question had two patients with very similar names. As a result of this complaint, wards use clearly identifiable markers to highlight when patients have the same or similar names.

In the news October 2017 – tackling boredom with activity boxes

Activity boxes containing colouring books, games, craft materials and dominoes have been distributed to virtually all wards and departments at the hospital to help patients alleviate boredom during their admission.

The boxes were introduced to help patients who may not have friends or family to visit, and may otherwise struggle to fill their time. They also include sensory bands, also known as “twiddle muffs”, which are knitted hand muffs, sometimes decorated with zips, buttons, beads, ribbons or tassles, which can help provide comfort and distraction in patients with dementia.

Much of the material for the boxes was donated by the Community Learning Disability Health Team run by Hertfordshire Partnership University NHS Foundation Trust.

The Colchester Hospitals Charity also donated to the boxes, as did the friends and family of Steph Baker, Learning Disability Hospital Liaison Nurse Specialist, who came up with the idea.

(L – R) Steph Baker, Learning Disability Hospital Liaison Nurse Specialist, patient Charlotte Buckland-Harriss and hospital volunteer William Westbrooke show off the contents of the activity boxes.

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, 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, six further Non-Executive Directors and five voting Executive Directors. The Council of Governors appointed the Chair and other Non-Executive Directors 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 Non-Executive Directors 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 65 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 members of the public. Anyone who wishes to see the register should contact the Trust’s offices at the address on page 6.

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

About the Non-Executive Directors

David White
Non-Executive Director
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.

Susan Aylen-Peacock
Non-Executive Director
Appointed: 9 November 2015
Term of office: Expires 8 November 2018

Chair of the Charitable Funds and Sponsorship Committee and Quality and Patient Safety Assurance Committee; member of the People and Organisational Development Assurance Committee, and the Remuneration and Nomination Committee.

Susan lives in Great Bromley and has worked for the NHS for the past 14 years in project management, service improvement and various corporate governance roles. She is a qualified company secretary with 30 years' experience as a governance and risk professional, spanning health, local government and the third sector.

Jude Chin
Non-Executive Director
Appointed: 13 September 2011
Reappointed: 13 September 2014 and 1 February 2018
Term of office: Expires on the date of the transaction with Ipswich Hospital or 12 September 2018 (whichever is earlier)

Chair of the Audit and Risk Assurance Committee; member of the Finance and Performance Assurance Committee and the Remuneration and Nomination Committee.

Jude has extensive commercial and international experience gained from a 30-year career with the professional services firm KPMG, auditing and advising on mergers and acquisitions.

He also has extensive experience of the education sector as Chair of SSAT (The Schools, Students and Teachers network) and a number of voluntary roles on school governing bodies.

Jude is a Fellow of the Institute of Chartered Accountants in England and Wales and a biochemistry graduate of the University of Bristol.

Tim Fenton
Non-Executive Director
Appointed: 8 December 2016
Term of office: Expires 7 December 2019

Member of the People and Organisational Development Assurance Committee, the Quality and Patient Safety Assurance Committee and the Remuneration and Nomination Committee.

Tim enjoyed a 19-year career at the BBC, starting in Colchester as a reporter, producer and newsreader for BBC Essex. His other roles at the corporation included being a political and parliamentary correspondent (1988-1995) and Managing Editor of BBC News Online (2000-2004).

Since September 2006, Tim has worked as an independent news industry consultant and interim manager. The son of a GP and a nurse, he was Chair of Governors at Holbrook Academy between 2013 and 2015.

Diane Leacock
Non-Executive Director/Senior Independent Director
Appointed: 1 April 2014. Reappointed for a second term of office in February 2018
Term of office: Expires 31 March 2020

Trust Non-Executive Director lead for safeguarding and children. Chair of the People and Organisational Development Assurance Committee and member of the Audit and Risk Assurance Committee and Remuneration and Nomination Committee.

Diane lives locally, and served as a Non-Executive Director at NHS North East Essex from July 2009 to November 2011. She is a Fellow of the Association of Chartered Certified Accountants.

Currently the Director of Finance of a regional law firm, she has considerable experience in senior finance roles within commercial organisations, most recently as Finance Director within the professional services and publishing arenas. In addition, Diane served as a school governor for over 10 years, retiring as Vice Chair in 2015.

Julie Parker
Non-Executive Director
Appointed: 1 April 2014. Reappointed for a second term of office in February 2018
Term of office: Expires 31 March 2020

Trust Non-Executive Director lead for eProcurement. Chair of the Finance and Performance Assurance Committee; member of the Quality and Patient Safety Assurance Committee 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; a member of the Joint Audit Committee of the Police and Crime Commissioner and Essex Police. Julie also serves on the audit committees of two national bodies (the Health and Care Professions Council and the Housing Ombudsman).

Jan Smith
Non-Executive Director
Appointed: 9 November 2015
Term of office: Expires 8 November 2018

Member of the Audit and Risk Assurance Committee, Finance and Performance Assurance Committee and the Remuneration and Nomination Committee.

Jan lives near Coggeshall and has run her own marketing consultancy and service provider company since 1998, working either as a consultant or interim board director with a focus on strategy development, marketing and communication, sales and customer experience.

She has been a Non-Executive Director on a number of Boards during the past 18 years in both the public and private sectors. Between 2009 and 2011, she was a Non-Executive Director of Mid Essex Hospital Services NHS Trust.

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. In addition, he leads the Suffolk and North East Essex STP.

Barbara Buckley
Managing Director (to 31 December)
Medical Director – Clinical Integration (from 1 January)
Started at the Trust: 17 May 2016
Appointed Board Director: 1 December 2016
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Formerly the Medical Director of Ipswich Hospital, Barbara has over 15 years' experience of board leadership as Medical Director in three previous organisations. She has a wealth of knowledge in leading change and transformation through clinical engagement.

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

Catherine previously worked at Queen Elizabeth Hospital, King's Lynn, where she was Director of Nursing for three years. Before that, she was Deputy Director of Nursing at Ipswich Hospital.

Dr Angela Tillett
Medical Director
Appointed Medical Director: 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 qualified in 1987. She trained as a GP but went on to complete paediatric training, starting as a consultant in Colchester in 2001. Roles include Lead Clinician for Paediatric Oncology Services and, from March 2011 to December 2013, Divisional Director for Women's and Children's Services. She is an instructor for Resuscitation UK courses and supports life support training and the paediatric critical care group at the Trust.

As well as her Medical Director role, Angela continues with her specialty clinical work in paediatric oncology and paediatric cardiology.

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 18 years' experience in the NHS, predominately as an accountant and ultimately a Finance Director. 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 worked at South East Essex PCT from 2006 to 2009.

Alison Power
Director of Operations*
Appointed: 23 January 2017
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Alison was previously the Deputy Chief Operating Officer and Head of Operations at Ipswich Hospital.

Shane Gordon
Director of Integration
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.

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 20 years. He has extensive experience and expertise in operational management, planning and performance, as well as leadership in commissioning and information.

Neill is also Managing Director and Deputy CEO at Ipswich Hospital.

Clare Edmondson
Director of HR*
Appointed: 1 January 2018
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Clare has more than 30 years' experience in human resource management and organisational and leadership development in both the private and public sectors. She is also Director of HR at Ipswich Hospital.

Clare joined Ipswich from Luton and Dunstable Hospital where she was Director of Human Resources then held a number of interim programme roles.

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. He works across both Colchester and Ipswich hospitals.

Before taking up his current role, Mike led the delivery of major infrastructure, corporate and clinical IT systems at Ipswich from procurement through to implementation.

Paul Fenton
Director of Estates and Facilities*
Appointed: 27 February 2018 (Shadow Board member)
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Paul was appointed to the shadow board on 27 February 2018 and will be Director of Estates and Facilities when the Trust merges with Ipswich Hospital.

Paul is a Chartered Engineer and has built up extensive experience over the last 25 years within the building services and facilities industry in both the public and private sectors. Commencing his career in the NHS in 2002, Paul has held senior positions in four acute hospitals and joined Ipswich from North Essex Partnership NHS Foundation Trust.

Chris Howlett
Director of Estates and Facilities*
Appointed: June 2015
Term of office: Permanent
Notice period: Trust: six months; employee: three months

Chris started in the NHS as an engineering apprentice over 30 years ago and has worked in estates management roles in mental health and community services in Dorset and East Sussex.

He attained his first director role at South Essex Partnership NHS Trust in 2010, and has a track record of delivering high quality estates and facilities services and capital developments.

Ann Alderton
Company Secretary*
Appointed: June 2015
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Twitter: @Tredaran

Ann was previously Company Secretary at Cambridge University Hospitals NHS Foundation Trust and Director of Audit Services of an NHS internal audit consortium.

She is a qualified accountant and chartered secretary. She is responsible for the corporate governance of the Trust and advising the Board of Directors and Council of Governors about their duties and responsibilities.

Ali Bailey
Director of Communications* (Joint role with Ipswich Hospital)
Appointed: May 2017
Term of office: Permanent
Notice period: Trust: six months; employee: three months
Twitter: @Ali_Bailey_

Ali worked for the Department of Health and a London teaching hospital before being appointed as Director of Communications at University Hospital Southampton NHS Foundation Trust, where she remained for ten years.

After relocating to East Anglia in 2016, Ali worked as head of communications at West Suffolk NHS Foundation Trust before taking up the joint role of Director of Communications for both Colchester Hospital University NHS Foundation Trust and The Ipswich Hospital NHS Trust.

* = non-voting member of the Board of Directors

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 6.

Former executive directors

Julie Fryatt, Director of Human Resources and Organisational Development, was appointed in November 2015 and left the Trust on 21 August.

In the news November 2017 – £6.4m redevelopment begins

Work has begun on a £6.4m development which will bring all acute hospital services in Colchester onto the same site for the first time.

The nine-month programme to transfer clinical services currently provided at Essex County Hospital to Colchester Primary Care Centre (PCC), next to the main hospital, began in November.

During the project, the first and second floors are being converted into clinical space and will house eye services, including two operating theatres, the retinal suite and outpatient services.

Ear, nose and throat and audiology services, including clinic rooms, treatment rooms and audiology booths, will be located on the second floor.

Essex County Hospital, which has provided services from Lexden Road for nearly 200 years, will close permanently once work is complete later in 2018.

Evaluation of the Board of Directors' performance

The Board of Directors met monthly. There were 13 general meetings of the Board, seven of which were held in public (each with a private session to discuss confidential matters) on 25 April, 30 May, 27 June, 1 August, 24 August, 26 September, 31 October, 28 November, 30 January, 27 February, 14 March, 27 March and 29 March.

Name	Title	Attended
Ann Alderton	Company Secretary	11/13
Susan Aylen-Peacock	Non-Executive Director	10/13
Alison Bailey	Director of Communications (from May 2017)	11/12
Barbara Buckley	Medical Director Clinical Strategy	12/13
Jude Chin	Non-Executive Director	12/13
Clare Edmondson	Director of Workforce (from January 2018)	3/5
Tim Fenton	Non-Executive Director	10/13
Shane Gordon	Director of Integration	12/13
Chris Howlett	Director of Estates & Facilities	9/13
Nick Hulme	Chief Executive	11/13
Diane Leacock	Non-Executive Director	12/13
Mike Meers	Director of ICT (from September 2018)	6/8
Neill Moloney	Managing Director (from 1 January 2018)	4/5
Catherine Morgan	Director of Nursing	9/13
Julie Parker	Non-Executive Director	9/13
Alison Power	Director of Operations	8/13
Dawn Scrafield	Director of Finance	10/13
Jan Smith	Non-Executive Director	7/13
Dr Angela Tillett	Medical Director	8/13
David White	Chair	11/13

Board development

Board development takes place in workshops and seminars on the days when the Board meets. During the year, the Board had workshops and seminars on mortality, the Accountability Framework, counter-fraud awareness, commissioning intentions, the winter plan, service improvement and 18 weeks.

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 to the Council of Governors via the Appointments and Performance Committee.

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

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. The committees were observed by EY as part of the governance workstream of the Every Patient, Every Day programme in March 2017, and by NHS Improvement the next month. Feedback from these observations and the 'Well-led Framework' review, along with the results of a follow-up of the committee self-assessment surveys, were reported back to the Board in June 2017.

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. With the exception of the Remuneration and Nomination Committee, 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) that 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: 10 May, 25 May, 28 July, 6 November and 19 February.

Members and meetings attended in brackets: Jude Chin, Committee Chair (5/5), Diane Leacock (5/5), Jan Smith (4/5).

Executive Directors (voting and non-voting) in attendance: Dawn Scrafield, Catherine Morgan, Barbara Buckley, Ann Alderton.

Internal auditors

The Trust's internal auditors are Mazars Public Sector Internal Audit Ltd. Their role is to provide independent assurance that our risk management, governance and internal control processes are operating effectively.

External auditors

Following a joint procurement with Ipswich Hospital NHS Trust, 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 12 meetings: 21 April, 26 May, 26 June, 21 July, 25 August, 22 September, 27 October, 24 November, 21 December, 26 January, 23 February and 23 March.

Members and meetings attended in brackets: Susan Aylen-Peacock, Committee Chair (10/12); Julie Parker (9/12), Tim Fenton (9/12).

Executive Directors (voting and non-voting) in attendance: Catherine Morgan, Chris Howlett, Dr Angela Tillett and Barbara Buckley.

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 health
- care 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 13 meetings: 19 April, 24 May, 21 June, 19 July, 23 August, 20 September, 25 October, 22 November, 20 December, 24 January, 21 February, 9 March and 21 March

Members and meetings attended in brackets: Julie Parker, Committee Chair (11/13), Jude Chin (11/13), Jan Smith (11/13).

Executive Directors (voting and non-voting) in attendance: Dawn Scrafield, Alison Power and 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, including 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 12 times: 19 April, 24 May, 26 June, 19 July, 23 August, 20 September, 25 October, 22 November, 20 December, 24 January, 21 February and 21 March.

Members and meetings attended in brackets: Diane Leacock, Committee Chair (12/12), Susan Aylen-Peacock (10/12), Tim Fenton (7/12)

Executive Directors in attendance (voting and non-voting): Julie Fryatt (until July 2017), Ann Alderton, Dr Angela Tillett, Catherine Morgan, Dawn Scrafield and Clare Edmondson (from January 2018).

Charitable Funds and Sponsorship Committee

The Board of Directors is the corporate trustee of the charities that are together registered with the Charity Commission under number 1051504.

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. Four formal meetings of the committee were held: 11 May 10 August, 9 November and 8 February.

Members and meetings attended in brackets: Susan Aylen-Peacock, Committee Chairman (4/4). Jan Smith (1/2) Ms Smith took over the vacant NED seat on the committee following the August meeting.

Executive Directors in attendance (voting and non-voting): Dawn Scrafield and Ann Alderton.

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 is a member when appointing to the Board of Directors. At other times, he attends along with the Director of Human Resources and Organisational Development and the Company Secretary. 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 on 8 June, 21 December, 27 February and 14 March.

There were no appointment panels convened during the year.

Members and meetings attended in brackets: David White, Chair (4/4), Tim Fenton (2/4), Susan Aylen-Peacock (3/4), Jude Chin (3/4), Julie Parker (3/4), Diane Leacock (2/4), Jan Smith (1/4) and Nick Hulme (4/4).

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

In the news December 2017 – faster relief from prostate problems

Patients with prostate problems can now receive fast, effective treatment which allows them to return quickly to normal life after Colchester Hospital began offering a new, less-invasive alternative to major surgery.

The procedure, called a UroLift®, is being used to treat patients with benign prostatic hyperplasia, which is a common condition affecting one in three men which causes the prostate to enlarge and press on the bladder, causing difficulties with urination.

Minimally invasive and straightforward, it sees a urologist place tiny implants in the body to hold the prostate lobes apart and relieve compression, allowing urine to flow normally again. Performed using local anaesthetic, the procedure takes just 10 minutes to complete and can be carried out in either an operating theatre or outpatient setting. Patients get almost instant results and able to return home the same day.

(L – R) Consultant Urologist Sam Datta, Associate Specialist in Urology Nihal Jayasooriya, Mark Rochester, Consultant Urological Surgeon at the Norfolk and Norwich University Hospital, Consultant Urological Surgeon Rajiv Pillai and Consultant Urologist Zaf Maan

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 committee appointed the Managing Director and Director of HR of Ipswich Hospital NHS Trust to the Colchester Board in January to reflect the move towards a shadow board for East Suffolk and North Essex NHS Foundation Trust. The committee also appointed the former Managing Director to a new Board position of Medical Director – Clinical Integration.

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 relating to trusts in special measures.

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 was over £142,500 (to 31 December) or £150,000 (from 1 January) 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 8 June.

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 its 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.

Three of the Trust's six Executive Directors are currently paid more than £142,500, only one of whom (Managing Director) was 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. The Trust followed the approval procedure for the remuneration of Barbara Buckley on her appointment to the role of Managing Director. The remuneration was benchmarked with all trusts of similar size and complexity and reflected that as an organisation in special measures, there was a need to set a competitive salary to attract candidates of sufficient calibre. Nick Hulme is also on a remuneration package which is greater than £142,500 but as his contract is held by Ipswich Hospital, the application to the Treasury was made by that Trust.

There have been no changes to report relating to other senior managers' remuneration. No payments were made during the year for loss of office or to past senior managers, but the committee did approve a redundancy payment which will be payable in 2018/19. This relates to the Trust's Director of Estates and Facilities who has not been appointed to the same role at East Suffolk and North Essex NHS Foundation Trust when the merger takes effect. The redundancy payment accorded with statutory and contractual provisions.

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 50 onwards). With the exception of the Medical Director, Executive Directors are appointed to substantive contracts. There were no interim board appointments during 2017/18.

Remuneration and Nomination Committee

Details on the workings of the Remuneration and Nomination Committee are provided on page 63. 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, e.g. due to exceptional circumstances, are subject to further discussion and approval by the committee.

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

The Trust is required to disclose the ratio of the highest paid senior manager to the median remuneration of its staff. This disclosure is based on the requirement to annualise the data, which means that this figure is higher than what was actually paid to the post holder.

The median salary paid in the Trust was £23,597, and the maximum was £212,100. This is a multiple of 8.99 the median.

Salary and pension entitlement of the Board of Directors

The Chief Executive has determined that “senior managers”, being those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust, are the Executive and Non-Executive Directors. Detailed on pages 68 to 70 are the remuneration, salary and pension entitlements of the Board of Directors. 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.

The Trust had a total of 16 Directors eligible to claim expenses, compared with 19 in 2016/17.

Year	Number of Directors claiming expenses	Total claimed £
2016/17	14	11,526
2017/18	13	12,129

The Trust had a total of 34 Governors eligible to claim expenses, compared with 27 in 2016/17.

Year	Number of Governors claiming expenses	Total claimed £
2016/17	6	2,198.86
2017/18	7	1,131.37

Signed

Nick Hulme
Chief Executive
29 May 2018

Salary and allowances of senior managers (subject to audit)

The Financial Reporting Manual requires NHS foundation trusts to prepare a Remuneration Report in their Annual Report and Accounts which complies with:

- Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3), section 421(3) and (4) and section 422(2) and (3) do not apply to NHS foundation trusts);
- Regulation 11 and parts 3 and 5 of schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations");
- Parts 2 and 4 of schedule 8 of the Regulations as adopted by the Manual; and,
- Elements of the NHS Foundation Trust Code of Governance.

Name	Title	2017/18				2016/17			
		Salary (bands of £000	Expense payments (taxable) total to nearest £00	All pension related benefits (bands of £2.500) £000	Total (bands of £000	Salary (bands of £5.000) £000	Expense payments (taxable) total to £00	All pension related benefits (bands of £2.500) £000	Total (bands of £000
Aylen-Peacock, S	Non-Executive Director	10 – 15	–	–	10 – 15	10 – 15	–	–	10 – 15
Buckley, B from 1 December 2016	Managing Director and Deputy Chief Executive	200 – 205	–	237.5 – 240	440 – 445	65 – 70	–	105 – 107.5	170 – 175
Chin, J	Non-Executive Director and Deputy Chair	15 – 20	–	–	15 – 20	15 – 20	–	–	15 – 20
Fenton, T from 8 December 2016	Non-Executive Director	10 – 15	–	–	10 – 15	0 – 5	–	–	0 – 5
Fryatt, J to 21 August 2017	Director of Workforce and Organisational Development	45 – 50	–	5 – 7.5	50 – 55	125 – 130	–	60 – 62.5	185 – 190

Hulme, N [1] from 17 May 2016	Chief Executive	115 – 120	–	15 – 17.5	135 – 140	100 – 105	–	25 – 27.5	125 – 130
Leacock, D	Non-Executive Director	10 – 15	–	–	10 – 15	10 – 15	–	–	10 – 15
Miller, R [2] from 1 April 2017 to 1 October 2017	Acting Medical Director	60 – 65	–	10 – 12.5	70 – 75	–	–	–	–
Morgan, C from 23 January 2017	Director of Nursing	130 – 135	–	137.5 – 140	265 – 270	20 – 25	–	5 – 7.5	30 – 35
Parker, J	Non-Executive Director	10 – 15	–	–	10 – 15	10 – 15	–	–	10 – 15
Scrafield, D	Director of Finance	130 – 135	–	22.5 – 25	155 – 160	130 – 135	–	30 – 32.5	165 – 170
Smith, J	Non–Executive Director	10 – 15	–	–	10 – 15	10 – 15	–	–	10 – 15
Tillett, A [3]	Medical Director	75 – 80	–	7.5 – 10	85 – 90	205 – 210	–	117.5 – 120	325 – 330
White, D [4] from 6 May 2016	Chair	35 – 40	–	–	35 – 40	30 – 35	22	–	30 – 35

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 (2016/17, £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 (2016/17, £65,000 - £70,000).

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 (2016/17, £25,000 to £30,000).

Pension benefits (subject to audit)

Name	Real increase in pension at pension age* (bands of £2,500) £000	Lump sum at pension age related to real increase in pension* (bands of £2,500) £000	Total accrued pension at 31 March 2018* (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018* (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2017* £000	Cash equivalent transfer value at 31 March 2018* £000	Real increase in cash equivalent transfer value* £000
Buckley, B	10 – 12.5	35 –37.5	90 – 95	270 – 275	1634	1990	340
Fryatt, J	0 – 2.5	–	15 – 20	–	228	263	13
Hulme, N	0 – 2.5	5 – 7.5	50 – 55	155 – 160	1053	1144	80
Miller, R	0 – 2.5	–	35 – 40	85 – 90	517	556	17
Morgan, C	5 – 7.5	15 – 17.5	40 – 45	120 –125	563	716	147
Scrafield, D	0 – 2.5	–	35 – 40	90 – 95	442	499	53
Tillett, A	0 –2.5	0 – 2.5	45 – 50	140 – 145	862	954	42

*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.

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

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 notes 1.5 and 4.1 of the accounts.

Key management compensation can be found in note 4.2 of the accounts.

In the news January 2018 – extra support for people affected by dementia

The families of people with dementia who are being treated at Colchester Hospital are now receiving dedicated support to overcome difficulties and stay connected to their loved one following the launch of a new specialist service.

Former dementia care nurse specialists Maisey Dear and Vanessa Mclean have converted to Admiral Nurses to further improve care offered to people with dementia and their families or carers. They receive referrals from colleagues when a patient has been admitted to the hospital and their family is experiencing difficulties or struggling to cope, and offer one-to-one support and expert guidance, as well as techniques to help with areas such as communication or managing behaviour changes.

They can also help with discharge planning, give information about different types of dementia and its progression, and signpost people to sources of further support, such as carers' groups.

The pair are among just 12 Admiral Nurses working in acute hospitals across the country, and a total of 217 working in different settings across the UK.

(L – R) Admiral Nurse Vanessa McLean, CHUFT director of nursing Catherine Morgan, Victoria Lyons, senior consultant Admiral Nurse (Dementia UK) and Admiral Nurse Maisey Dear

Staff report

On 31 March 2018, the Trust directly employed 4,722 staff (4,119 full time equivalents). The number of full time equivalent (FTE) staff in post was 385 more than 12 months earlier.

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 2017	4,314	4,346	3,734
31 March 2018	4,722	4,606	4,119

Staff costs (subject to audit)

	2017/18			2016/17		
	Permanent	Other	Total	Permanent	Other	Total
Salaries and wages	141,625	2,307	**143,932**	135,153	672	**135,825**
Social security costs	13,505	-	**13,505**	12,737	-	**12,737**
Apprenticeship levy	689	-	**689**	-	-	**-**
Employer contributions to NHS Pension Scheme	17,041	-	**17,041**	15,657	-	**15,657**
NEST pension contributions	10	-	**10**	7	-	**7**
Termination benefits	253	-	**253**	296	-	**296**
Agency/ bank staff	-	31,264	**31,264**	-	28,044	**28,044**
	173,123	33,571	**206,694**	163,850	28,716	**192,566**

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)	2017/18			2016/17		
	Total	Perman-ent	Other	Total	Perman-ent	Other
Medical and dental	518	465	53	510	462	48
Administration and estates	908	804	104	900	789	111
Healthcare assistants and other support staff	799	799	0	890	822	68
Nursing, midwifery and health visiting staff	1,382	1,122	260	1,303	1,102	201
Scientific, therapeutic and technical staff	582	546	36	356	337	19
Healthcare science staff	260	220	40	228	220	8
Total average numbers	**4,449**	**3,956**	**493**	**4,187**	**3,732**	**455**

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 2016/17	Staff members 2017/18	Public members 2016/17	Public members 2017/18
0 to 16 years	1	0	0	0
17 to 21 years	41	59	5	3
22+ years	4,846	5,318	5,155	4795
Not specified	1	1	938	838
Total	**4,889**	**5,378**	**6,098**	**5,636**
Ethnicity				
Not specified	293	311	2,065	1,879
White	3,892	4,188	3,781	3,514
Mixed	59	76	41	38
Asian or Asian British	470	598	126	121
Black or Black British	129	153	58	58
Other ethnic group	46	52	27	26
Other	0	0	0	0
Total	**4,889**	**5,378**	**6,098**	**5,636**
Gender				
Male	1,172	1,330	2,157	1,985
Female	3,717	4,048	3,704	3,407
Transgender	0	0	0	0
Not specified/ prefer not to say	0	0	237	244
Total	**4,889**	**5,378**	**6,098**	**5,636**

Sickness absence

The health of our staff is important, and providing support through what may be difficult times due to ill health is another way in which we demonstrate the ‘at our best’ values to our staff.

The Trust’s rolling 12 month sickness rate is 3.67% (12 months to 31 March 2018). This compares to 3.64% in March 2017 and is comparable with neighbouring acute trusts. During the rolling period, at its highest it rose to 3.75% and at its lowest was at 3.66%.

Increased absence monitoring aims to reduce absence levels to an acceptable minimum consistent with genuine illness. The Trust has successfully implemented robust systems and processes to manage sickness absence at divisional and manager level with support from the HR and health and wellbeing teams.

Staff sickness absence	2017/18	2016/17
Total WTE calendar days lost	52,986	49,687
Total WTE days available	1,445,692	1,366,388
Total staff years lost (days lost/365)	144.77	135.76
Total staff years available	4,722	4,314
Total staff employed in period*	5,566	5,108
Total staff employed in period with absence*	3,031	2,829
Total staff employed in period with no absence*	2,535	2,279
Average working days lost per employee	11.22	11.52

* 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 4,722

Role	Female	Male	Notes
Non-Executive Directors	4	3	Includes Chair
Executive Directors	4	1	Includes Chief Executive
Other senior managers	8	5	Bands 8d and above
Employees	3,606	1,091	
Total	**3,622**	**1,100**	

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 the recruitment policy, the Trust ensures 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.

The workplace

The Trust provides a health and wellbeing 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 part-time 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 undertake 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.

The Trust has developed its policy on disabled people in employment in order to maintain a working environment which is supportive and inclusive of current and prospective employees, whether they are currently disabled or may become disabled in the future.

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 stands at 97.85%. 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
- work-related stress risk assessment training
- emotional resilience training

Managers have access to the “Mindful Employers” line manager’s resource, which assists in supporting staff who experience stress, anxiety, depression and other mental health conditions. The health and wellbeing service facilitates mental health first aid, providing mangers with the skills to recognise and support staff with mental health issues. In addition, emotional resilience sessions are provided for all staff, enabling them to identify their stressors and how they react to stress and employing cognitive behavioural techniques to manage their stress.

Staff engagement

Organisational development

The renewed organisational effectiveness plan has been used to continue and implement a number of interventions. The ‘Licence to Lead’ programme has continued and expanded to contain new modules,

such as sickness absence and coaching conversation. The Trust also launched' Licence to Learn', which gives staff the chance to develop in areas such as customer service skills. Further development programmes include a clinical leadership development programme and the Mary Seacole Leadership programme, which is delivered on a local basis.

Staff involvement

The staff involvement group has continued to meet with a focus on the merger between Colchester and Ipswich hospitals.

Leadership

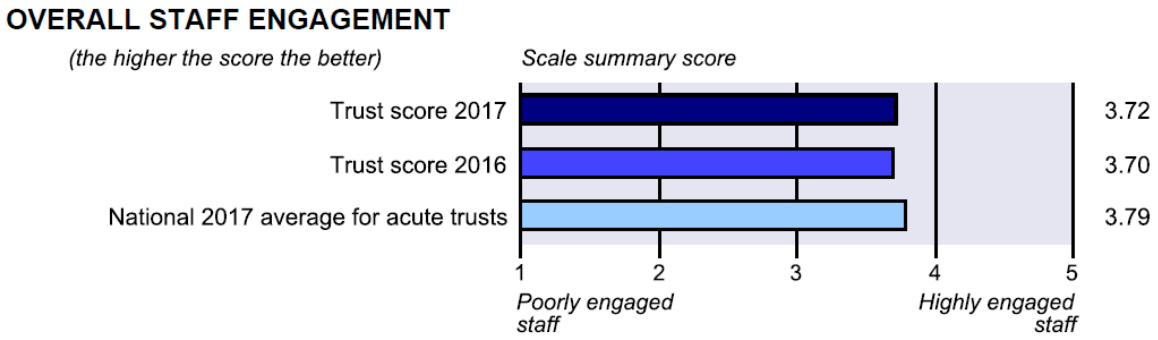
Leadership events have continued and in November 2017 the first joint programme took place involving top leaders from both Colchester and Ipswich hospitals. The event focused on the alignment of clinical service and was very well attended. The feedback that was given and outputs from group work have been used to inform the final proposed clinical structure.

2017 NHS Staff Survey

The overall indicator for staff engagement comprises three key findings in the NHS Staff Survey:

- staff members' perceived ability to contribute to improvements at work (KF7)
- their willingness to recommend the Trust as a place to work or receive treatment (KF1)
- staff motivation at work (KF4)

The Trust is still in the bottom 20% when compared to other trusts of a similar size. Our score for 2017 was 3.72, which compares to 3.70 in 2016 and a national average of 3.79.



It is disappointing that there has not been a significant improvement in the results and feedback in the 2017 survey as the Trust revisited and revitalised its communications and briefing process during the year to ensure all staff receive key messages in a timely manner. In addition, the aforementioned leadership conferences gave many staff chance to shape and influence the way forward for the Trust and to share learning.

More information about the NHS Staff Survey is on page 79.

Principles when developing plans to improve organisational effectiveness

The Trust has a set of underpinning principles it uses when developing plans to improve organisational effectiveness. These include:

- Multi-professional – all professions are required to deliver together to achieve our objectives. In order to build relationships and learning across the Trust, our plans will include access for all staff groups.
- Centrally organised – we will invest time, money and resources into developing individuals and teams to create a sense of one organisation/one team. This means that we will not invest resources in activities which are outside of this plan.
- We recognise that leadership takes place at many levels within the Trust and our plans will include a broad cross section of staff at a range of levels.
- Organisations do not exist in a vacuum and we will work with others in our health economy to support system effectiveness and development. When considering training and development, a 70/20/10 principle will be adopted. This model calls for 70% of development to consist of on-the-job learning, supported by 20% coaching and mentoring and 10% classroom training.

Multi-professional learning has increased with the launch of the Licence to Lead programme.

Staff Partnership Forum

The Staff Partnership Forum is made up of management and staff side union representatives. It meets every six weeks with an agenda that includes business updates, future strategy and a review of key performance indicators. The agenda is agreed jointly between staff side and management.

Freedom to Speak Up

A key recommendation from Sir Robert Francis' 'Freedom to Speak Up' report into the culture of raising concerns within the NHS, published in February 2015, was the introduction of Freedom to Speak Up Guardians, who are responsible for ensuring staff feel confident about raising concerns.

Tom Fleetwood has now been the Freedom to Speak Up Guardian for the Colchester and Ipswich Hospital trusts for a year. He is firmly embedded within both organisations and is available to help and assist any member of staff who might wish to raise a concern. The issue of speaking up is now included within both Colchester and Ipswich induction sessions, while Tom also regularly talks to other groups of staff and student bodies.

It is good practice to encourage staff to raise concerns as it creates a safer and better working environment which gives staff the opportunity to look after our patients more effectively.

The intention at both Colchester and Ipswich is to create an environment where speaking up is business as usual for all. This will be a long-term process but is already showing dividends.

It is recognised that this 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 for all and

applicable at every level. As such, the Freedom to Speak Guardian is responsible to the Board and regularly reports to the Board through the People Organisation and Development Assurance Committee.

We aspire to embed a Freedom to Speak Up culture within both Trusts 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 know that we have already made a difference, but that there is more that we need to do to support our staff when they wish to raise a concern, while we must also reinforce success and keep pushing our message.

NHS Staff Survey

Since 2003, the Trust has surveyed staff as part of the annual national NHS Staff Survey. On 6 March 2018, the results of the 2017 survey for all Trusts in England were published.

Questionnaires were sent to all staff and 1577 people participated, giving a response rate of 35% compared to 33% the previous year. The national average response rate was 44%.

The results from the 2017 survey showed a slight rise in overall staff engagement compared to 2016, although we remain in the bottom 20% for acute Trusts.

Results

We increased our score in one of the 32 key finding indicators. For the remaining 31, there were no statistically significant changes from 2016. Due to changes between the 2016 and 2017 surveys, not all key findings are comparable to the previous year, but those where the change can be measured are shown below.

The overall indicator of staff engagement was calculated using the questions that make up key findings (KF) 1, 4 and 7. These key findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (KF7); their willingness to recommend the Trust as a place to work or receive treatment (KF1) and the extent to which they feel motivated and engaged with their work (KF4).

The table below shows how the Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Changes since 2016 survey	Ranking compared with acute trusts
Overall staff engagement	No change	Lowest (worst) 20%
KF1. Staff recommendation of the trust as a place to work or receive treatment (The extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)	No change	Below (worse than) average

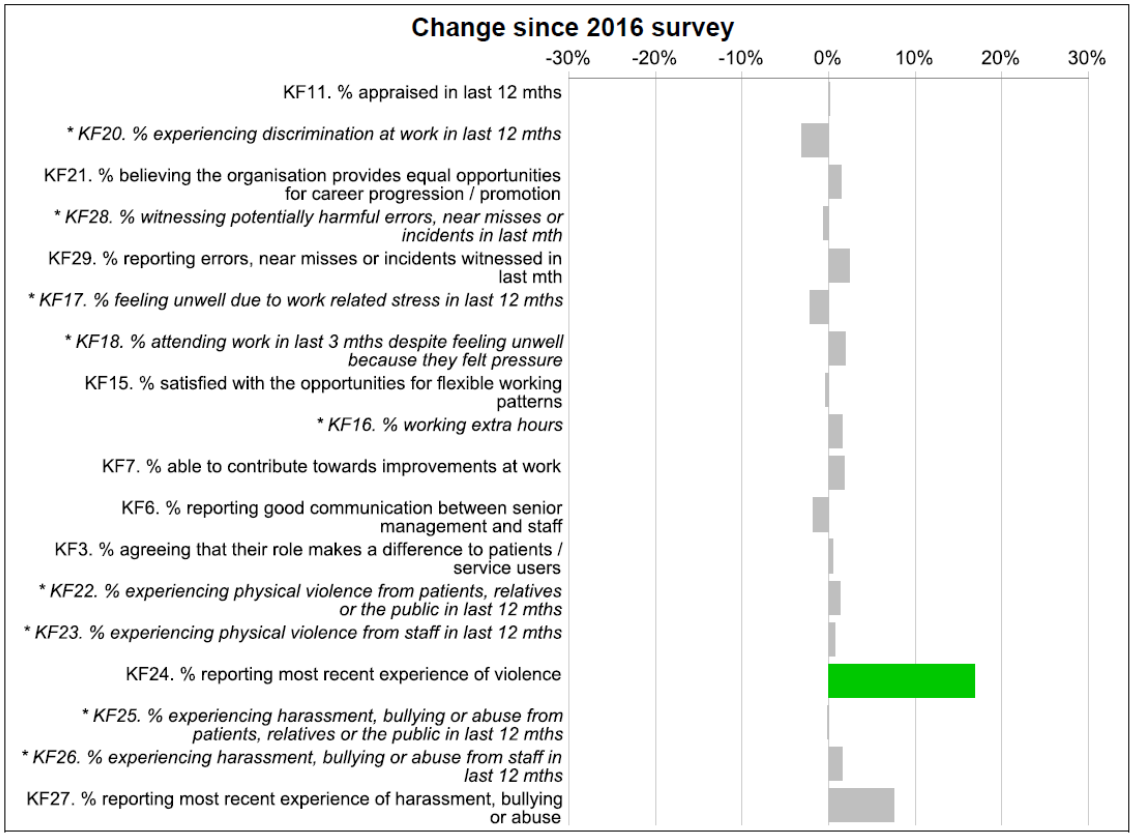
KF4. Staff motivation at work (The extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)	No change	Below (worse than) average
KF7. Staff ability to contribute towards improvements at work (The extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)	No change	Lowest (worst) 20%

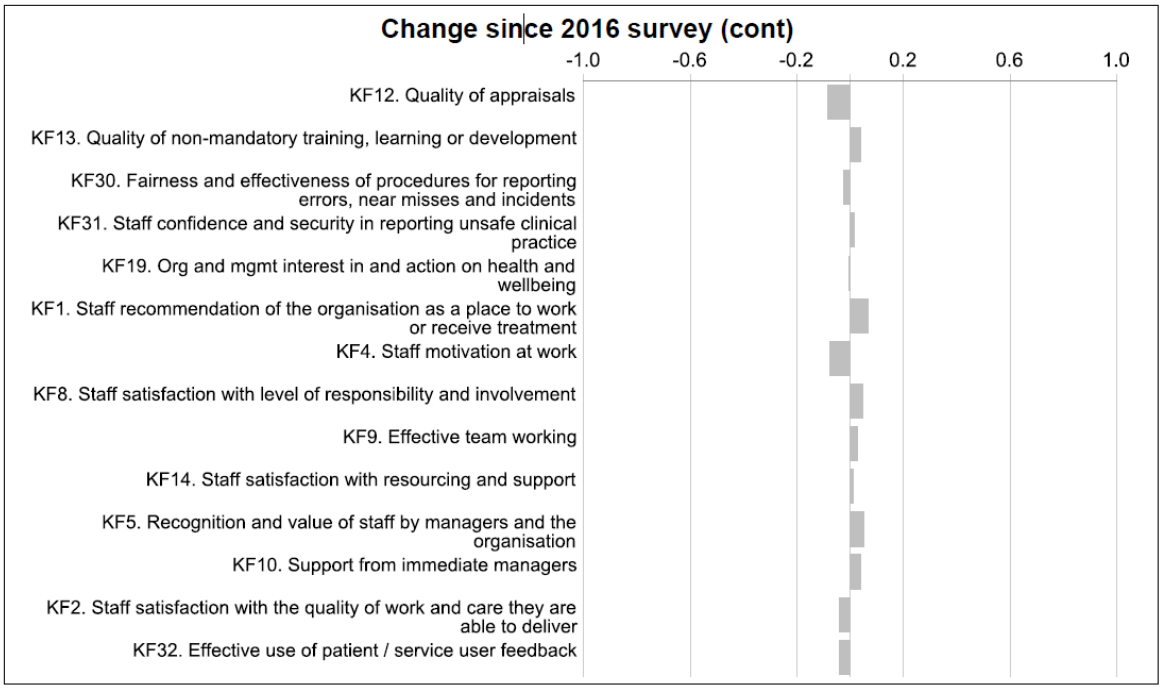
Comparison between 2016 and 2017 – key findings

Key:

- Green = positive finding (eg there has been a statistically significant positive change in the key finding since the 2016 survey)
- Red = negative finding (eg statistically significant negative change since the 2016 survey)
- Grey = no statistically significant change since the 2016 survey

For most of the key findings, the higher the score the better. However there are some scores for which a higher score would represent a negative finding. These are marked with an asterisk and in italics to highlight that the lower the score, the better.





Staff survey key findings	2016 survey		2017 survey		Trust change from 2016 results
	Trust	National average	Trust	National average	
Top five ranking scores					
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	89%	90%	91%	90%	No statistically significant change
KF20. Percentage of staff experiencing discrimination at work in the last 12 months (the lower the score the better)	13%	11%	10%	12%	No statistically significant change
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users (the higher the score the better)	90%	90%	91%	90%	No statistically significant change
KF11. Percentage of staff appraised in last 12 months (the higher the score the better)	88%	87%	87%	86%	No statistically significant change
KF32. Effective use of patient / service user feedback (the higher the score the better)	3.75	3.72	3.72	3.71	No statistically significant change
Staff survey key findings	**2016 survey**		**2017 survey**		**Trust change from 2016 results**
	Trust	**National average**	**Trust**	**National average**	
Bottom five ranking scores					
KF12. Quality of appraisals (the higher the score the better)	2.93	3.11	2.85	3.11	No statistically significant change
KF6. Percentage of staff reporting good communication between senior management and staff (the higher the score the better)	25%	33%	24%	33%	No statistically significant change

KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (the higher the score the better)	78%	87%	79%	85%	No statistically significant change
KF5. Recognition and value of staff by managers and the organisation (the higher the score the better)	3.29	3.45	3.34	3.45	No statistically significant change
KF8. Staff satisfaction with level of responsibility and involvement (the higher the score the better)	3.79	3.92	3.84	3.91	No statistically significant change

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 2018, for more than £220 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2018	7
Number that have existed for less than one year at time of reporting	6
Number that have existed for between one and two years at time of reporting	1
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 2017 and 31 March 2018, for more than £220 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 2017 and 31 March 2018	5
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	7
Number for whom assurance has been requested	7
Of which:	
Number for whom assurance has been received	7
Number for whom assurance has not been received	0
Number terminated as a result of assurance not being received	0

Off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017:

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 during 2017/18 was £4.636m, up from £4.317m the previous 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. During the year, this included expenditure on the full business case for the proposed merger with the Ipswich Hospital NHS Trust, support for the new North Essex and East Suffolk Pathology Service and advice and support regarding the delivery of cost improvement plans and financial recovery.

Staff exit packages (subject to audit)

Compulsory redundancies

Exit package cost band	2017/18		2016/17	
	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of compulsory redundancies	Cost of compulsory redundancies £000
<£10,000	0	0	11	50
£10,001 - £25,000	0	0	6	102
£25,001 - £50,000	0	0	1	43
£50,001 - £100,000	1	58	0	0
£100,001 - £150,000	1	131	1	101
Total	**2**	**189**	**19**	**296**

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

	2017/18		2016/17	
	Number	Cost (£000)	Number	Cost (£000)
Contractual payments in lieu of notice	2	3	5	24
Exit payments following employment tribunals or court orders	2	55	0	0
Total	**4**	**58**	**5**	**24**

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 two exceptions.

Between 1 April and 1 February, the Trust did not comply with the requirement that at least half the Board, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent. This was due to the reappointment of Non-Executive Directors Julie Parker and Diane Leacock in April 2017, and the extension of Jude Chin's term of office until the date of the transaction with Ipswich Hospital not having been approved at a general meeting of the Council of Governors until 1 February 2018. This did not affect the legitimacy of any of the decisions taken by the Board of Directors during this period.

The Trust has not fully complied with the requirement that the Governors, led by the Chair, should periodically assess its own performance. However, it does 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

Disclosures relating to the Board of Directors and its committees are in the Directors' Report on page 38. Disclosures relating to the Council of Governors and its committees from page 88 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. They include any employee and volunteers. Public membership is falling and staff membership rising. See also the Staff Report, which begins on page 73).

	2017	2018	New members	Leavers
Public	6,098	5,636	54	516
Staff	4,889	5,378	1,115	626

Information on the number of members and the number of members in each constituency

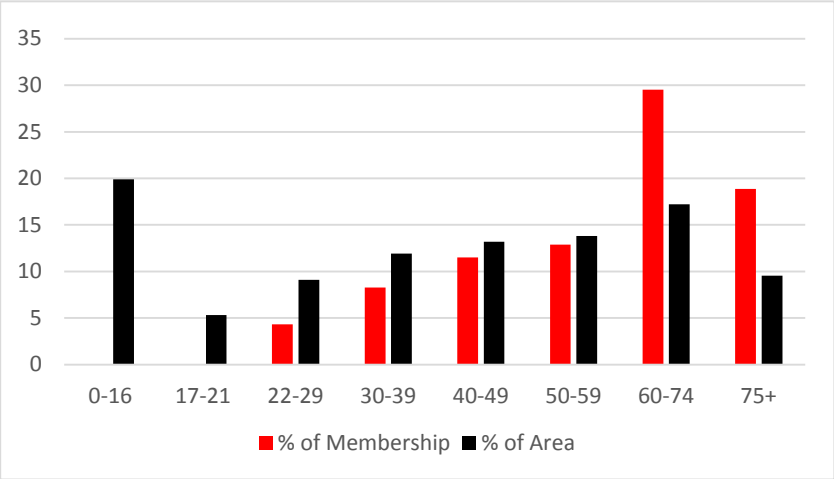
Public constituency	31 March 2017	31 March 2018
Colchester	2,708	2,530
Halstead and Colne Valley	667	589
Rest of Essex	325	291

Suffolk and South Norfolk	255	250
Tendring	1,951	1,794
Catchment not found	192	182
Total	**6,098**	**5,636**
Staff constituency	**31 March 2017**	**31 March 2018**
Allied health professionals/healthcare scientists	1,004	1,044
Medical or dental practitioners	590	680
Not known	7	7
Nurses/midwives	1,354	1,411
Support staff	1,934	2,236
Total	**4,889**	**5,378**

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.

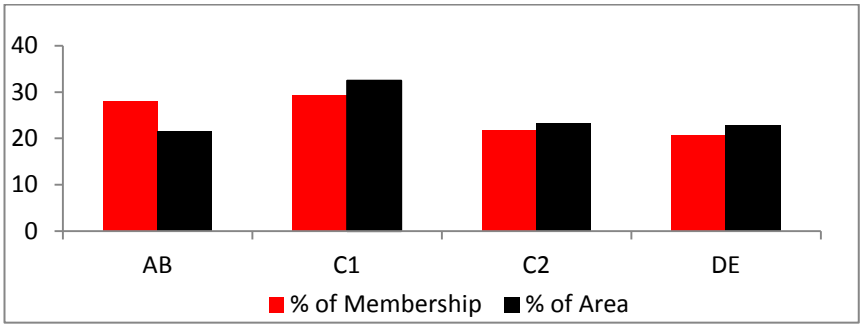
We have more public members aged 60 years and above than is representative of the geographical area we serve. Ideally, each pair columns in the chart would be the same height to be truly representative of our population. Please note that people aged under 16 are not eligible to be members.



of

Public membership demography

According to population data, we have far more public members than is representative in the middle class categories, and too few in other classification groups. Ideally, each pair of columns in the chart would be the same height to be truly representative of our population.

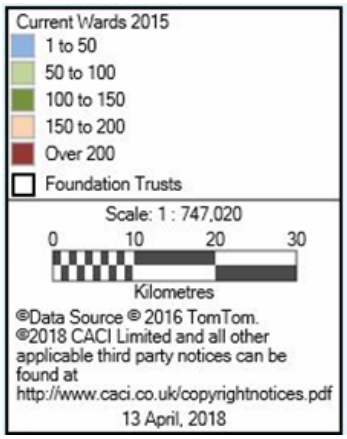


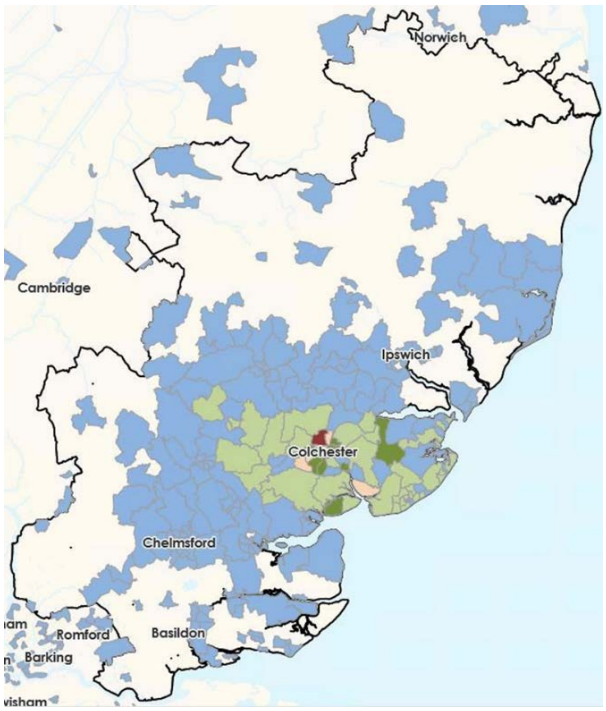
The National Readership Survey social grades are a system of demographic classification:

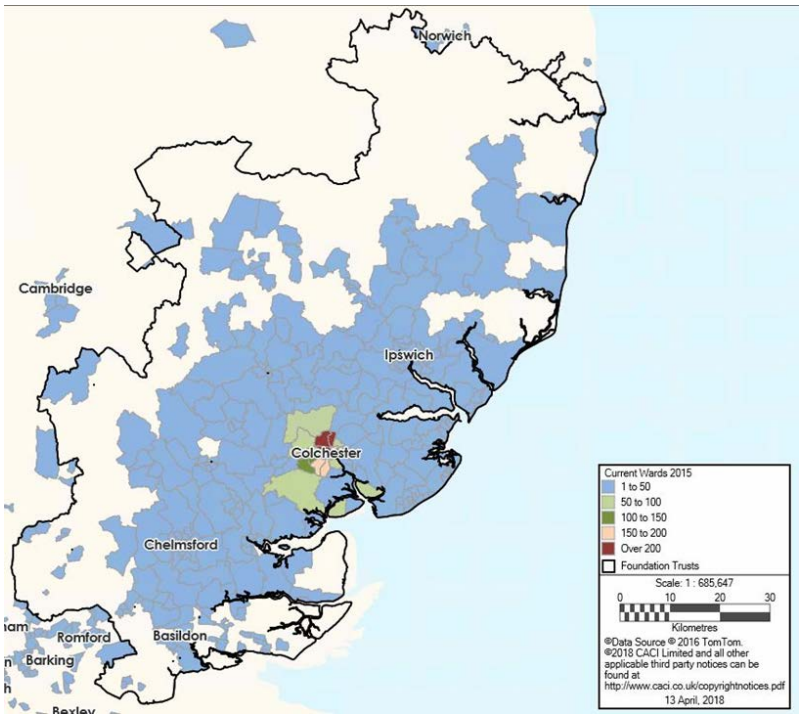
A = Higher managerial, administrative or professional
B = Intermediate managerial, administrative or professional
C1 = Supervisory or clerical and junior managerial, administrative or professional
C2 = Skilled manual workers
D = Semi-skilled and unskilled manual workers
E = Casual or lowest grade workers or those who depend on the welfare state

Location of our members

More of our public members are in north east Essex – see the next page – with a decline towards the boundaries of the catchment area of Essex, Suffolk and south Norfolk.







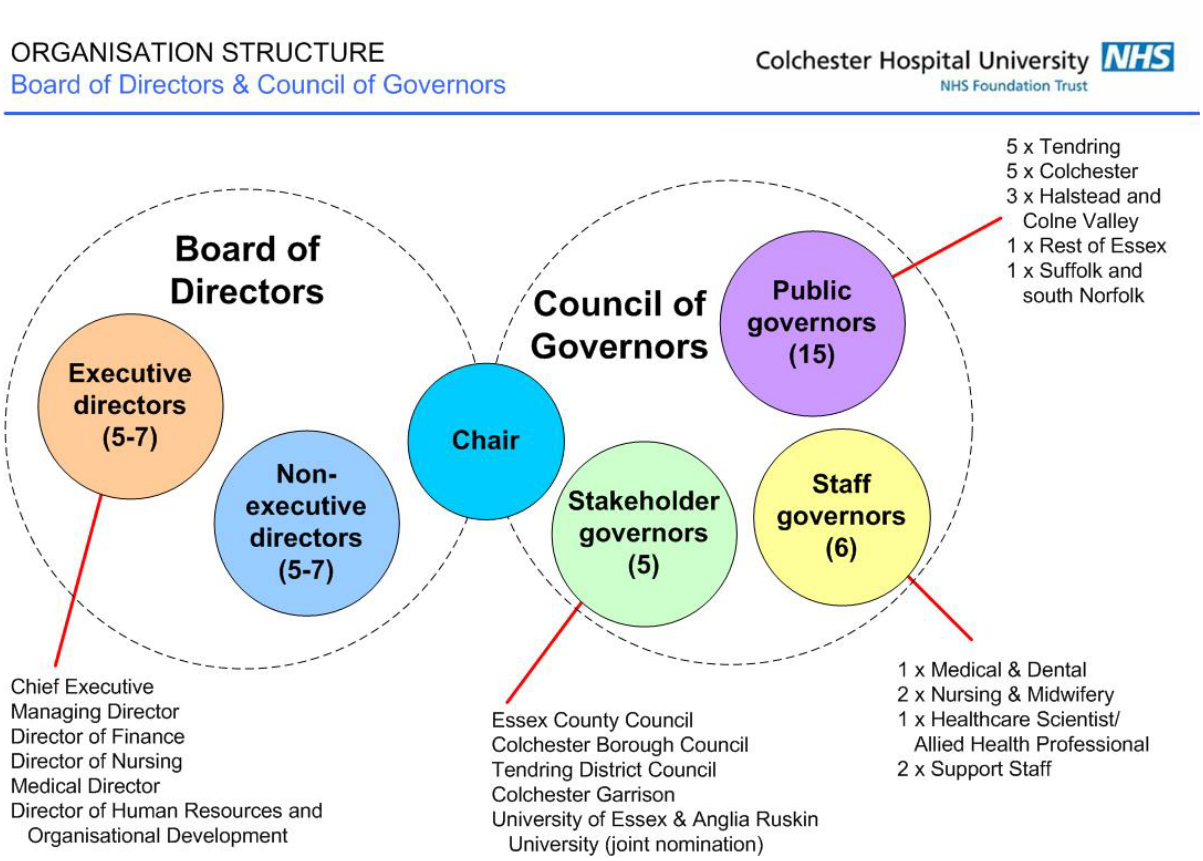
Our staff members are more evenly spread across the catchment area (and beyond), but with a high concentration in the Colchester area, as show in the map to the left.

Contacting our members

People can contact Governors or Directors via the Membership Office on 01206 742347 during office hours, or by emailing ft.membership@colchesterhospital.nhs.uk We also have a membership helpline, which is available between 9.30am and 5pm on weekdays on 0800 051 51 43.

Council of Governors

The Council of Governors represents the interests of the public and employees through its elected governors and its 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 of Directors. 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
- 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 January 2018. The previous Council of Governors had been in place since April 2014. During its tenure, the Trust's forward planning process was driven by improvement notices from the regulators, providing minimal opportunity for governors to canvass the opinion of the Trust's members and the public on its objectives, priorities and strategy. Regulatory input continues to inform forward plans for quality improvement.

Governors are encouraged to engage with the membership through participation in local health forums and patient groups and internally within the Trust through a programme of activities which includes ward walkabouts, assisting with the collection of NHS Friends and Family Test surveys, task and finish groups, the Patient User Group and links to staff engagement initiatives.

From December 2017, the main engagement priority for the council has been the long-term partnership with Ipswich Hospital NHS Trust. Governors were encouraged to participate in the engagement events organised across the geography of both sites to talk to the public about the proposals and consider their views. Governors have also been engaged with local patient participation groups and have continued to undertake walkabouts of the hospital, talking to patients, carers and family members.

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 informal meetings with the Chair and Chief Executive to discuss planning and operational issues, and with the Chair and Non-Executive Directors to discuss governance and accountability arrangements relating to the Board of Directors.

Along with attendance at Council of Governor meetings, this helps members of the Board develop an understanding of the views of Governors and members. The lead Governor or, in his absence, his designated deputies, have an open invitation to attend the private as well as the public meetings of the Board of Directors, reporting back to the Council of Governors.

In addition, Governor representatives 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 Committee
- Charitable Funds and Sponsorship Committee.

Governors also meet regularly at the following working groups:

- Membership Engagement Panel
- End of Life Steering Group

A new working group was established in February 2017 to oversee the Governors' fulfilment of their statutory duties in relation to the merger with Ipswich Hospital. This is called the Transaction Working Group and is a task and finish group which met weekly from February until the end of the year. The group will continue to meet weekly until the first day of the new organisation.

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 two meetings of the Standards Committee, held on 17 October and 7 December.

Members and meetings attended in brackets: David White (2/2), Janet Brazier (1/2), Ralph Nation (1/2), Andrew May (1/2), Barry Wheatcroft (1/2), Lynda McWilliams (1/2), Jane Young (1/1), Elizabeth Smith (1/1) Carlo Guglielmi (1/1) and Gareth Mason (1/1).

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).

Julie Parker and Diane Leacock were reappointed as Non-Executive Directors for a second term of office in February. Jude Chin's appointment was extended until the date of the merger with Ipswich Hospital NHS Trust.

There were two meetings of the Appointments and Performance Committee on 4 April and 15 June.

Members and meetings attended in brackets: David White (2/2), Michael Horley (2/2), James Chung (2/2), Barry Wheatcroft (2/2), Lynda McWilliams (2/2) and Ralph Nation (1/2).

There was no activity during the year for which the Trust required assistance from any external party.

About the governors

Elected public Governors

Public Governors: representing and elected by public members of the Trust for a period of three years plus 12 months*, effective from 10 April 2014:

Colchester	Tendring	Halstead and Colne Valley
Janet Brazier	James Chung	Pauline Aldridge
Michael Horley (lead governor)	Lesley Clancy	David Gronland
Andrew May	Ken Guyton	Rosemary Hunt
Robin Rennie	Barry Wheatcroft	
	Elizabeth Smith (from June 2017)	
Rest of Essex	**Suffolk and south Norfolk**	
David Linghorn-Baker	Jane Young	

Elected staff Governors

Staff Governors: representing and elected by staff members of the Trust for a period of three years plus 12 months, effective from 10 April 2014:

Medical and dental	Nursing and midwifery	Allied health professionals/ healthcare scientists	Support staff
Sharmila Gupta (from June 2017)	Jenny Edwards Anna Swan	Andy Nash	Ralph Nation Nick Bailey

* The last full elections were held in April 2014, so were due again in April 2017. Due to the announcement in May 2016 of a long-term partnership between our Trust and Ipswich Hospital, the council considered it would be beneficial to have the same Governors present for the duration of this process and agreed to extend its members' term of office for 12 months and to run a by-election where there were vacancies. This decision was subsequently found to be unlawful and an election was run during December 2017 and January 2018 to correct the error.

A by-election took place in spring 2017 to fill three public Governor posts and one staff Governor vacancy on the council. An election of the remaining public and staff Governor posts took place in January 2018:

Public Governors:

Colchester	Tendring	Halstead and Colne Valley
Michael Horley (lead governor) (re-elected February 2018)	Elizabeth Smith (from June 2017)	Janet Brazier (re-elected February 2018)
Andrew May (re-elected February 2018)	Peter Jackson (from February 2018)	David Gronland (re-elected February 2018)
Chris Hall (from February 2018)	Roy Raby (from February 2018)	
Yaa Dankwa Ampadu-Sackey (from February 2018)		
Eric Prince (from February 2018)		
Rest of Essex	**Suffolk and south Norfolk**	
	Jane Young	

Staff Governors:

Medical and dental	Nursing and midwifery	Allied health professionals/ healthcare scientists	Support staff
Sharmila Gupta (from June 2017)	Donna Booton (from February 2018) Anna Swan (re-elected February 2018)	Richard Allen (from February 2018)	Ralph Nation (re-elected February 2018)

Appointed stakeholder Governors

Appointed Governors do 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.
- University of Essex and Anglia Ruskin University: Professor Jo Jackson was appointed in August 2016 to represent both universities.

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 six formal meetings of the Council of Governors: 16 February, 15 June, 14 September, 16 November, 1 February and 27 March.

The meetings were chaired by David White (5/6) and Jude Chin (1/1).

Governor attendance at Council of Governors meetings

Name	Attended	Name	Attended
Pauline Aldridge	1/1	Eric Prince	1/2
Nick Bailey	3/4	Elizabeth Smith	5/5
Jane Young	2/6	David Linghorn-Baker	1/4
Janet Brazier	6/6	Andrew May	4/6
Rosemary Hunt	1/4	Lynda McWilliams	4/6
Cllr Helen Chuah	5/6	Jo Jackson	3/6
James Chung	4/4	Andy Nash	1/4
Lesley Clancy	1/4	Ralph Nation	3/6
Michael Horley	5/6	Robin Rennie	3/4
Jenny Edwards	1/4	Major Gareth Mason	2/6
Ken Guyton	2/4	Peter Jackson	0/2
David Gronland	3/6	Roy Raby	1/2
Anna Swan	4/6	Donna Booton	1/2
Barry Wheatcroft	4/4	Richard Allen	2/2

Yaa Dankwa Ampadu-Sackey	2/2	Sharmila Gupta	3/5

Directors are not required to attend Council of Governors' meetings routinely, but do attend by invitation. During the year, Council of Governors' meetings were attended by the following directors: Shane Gordon, Dawn Scrafield, Barbara Buckley, Ann Alderton, Nick Hulme, Jude Chin, Julie Parker, Jan Smith and Susan Aylen-Peacock.

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 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, NHSI segments individual trusts according to the level of support each trust needs. The Trust was placed in segment four during the period that it was in special measures, with breach of licence and very serious and complex issues. When the Trust was removed from special measures in November 2017, the Trust was moved to segment three. This is an improvement on segment four and 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".

Section 106 enforcement undertaking

The former Section 106 undertaking issued by Monitor in February 2015 was removed following the CQC visit and a new undertaking agreed in January 2018. This reflected that the Trust was still not meeting the national targets and that as special measures had only just been lifted, there was limited evidence that the improvements recognised by the CQC were sustainable.

There are plans in place to deliver the required undertakings during the remaining lifespan of Colchester Hospital University NHS Foundation Trust and its successor, East Suffolk and North Essex NHS Foundation Trust.

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 NHS Improvement 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 this website:
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 that 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

Following a comprehensive inspection during July and August 2017, the CQC gave the Trust a "requires improvement" rating overall, with individual services at Colchester General Hospital being rated as follows:

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

Statement of the Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Colchester Hospital University 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 Colchester Hospital University 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 the 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
- 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
29 May 2018

Annual Governance Statement

Scope of responsibility

The Board is accountable for internal control. 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 Colchester Hospital University 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 Colchester Hospital University NHS Foundation Trust for the year ended 31 March 2018 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 adhering to the guidance issued by NHSI and the Department of Health in respect of governance.

The Trust has established a Quality and Risk Executive Management 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 Director of Nursing 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 is 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 Quality and Risk Executive Management 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 Quality and Risk Executive Management 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. Members of staff have had 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. This 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 accessible and available to staff on the Trust intranet policy section with supporting information available under the risk management department section. The BAF and Corporate Risk Register (CRR) are in the public domain as part of the papers discussed in public Board meetings, enabling public stakeholders to be sighted on potential risks which impact on them.

The Risk and Control Framework

The risk management strategy (see page 35) 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. The BAF was reviewed in terms of its content and the way it is used in order to provide greater clarity to the Board and the Board's committees over the Trust's 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 risk 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 a Risk Appetite Statement.

Financial: The Trust is keen to ensure a sustainable future for its services and is mainly cautious in its approach to financial risk. It is, however, prepared to invest for return where the case for investment is strong and will minimise the possibility of financial loss by managing risks to a tolerable level through prudent financial control measures and optimising the use of resources.

Compliance/regulatory: The Board has a 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, it will make every effort to meet regulator expectations and comply with them and will challenge them only if there is strong evidence or argument to do so.

Innovation: The Board has a flexible view of innovation that supports quality, patient safety and operational effectiveness. This means that it is eager to pursue innovation and challenge current working practices, and views new technologies as a key enabler of operational delivery. However, decision making authority will be carefully managed to ensure that prioritisation and focus is on the identification and delivery of innovations with transformative potential and will be devolved only 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 actions are 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.

Reputation: The Board has a flexible view over the management of the Trust's reputation. The Board is willing to take decisions that are likely to bring scrutiny of the organisation in those circumstances where potential cost, efficiency and quality benefits to the widest group of stakeholders outweigh the risk consequences of making an unpopular decision.

Commercial: The Board has a predominantly cautious view of commercial risk. It will support low-risk opportunities in established business areas and markets and in areas where it has significant commercial strength over its competitors and/or wishes to secure continuity to the benefits and outcomes to the Trust's patients and the wider community it operates in. It is prepared to be ambitious when opportunity presents itself, but will not actively pursue business and commercial opportunities in new areas as part of its strategy.

The Risk Appetite Statement was agreed in a public meeting of the Board in April 2017 and is incorporated in the Trust's Risk Strategy.

During 2017/18, the Trust saw its principal risks as follows:

- If activity growth exceeds the 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. This has an effect on system resilience and internal efficiencies and a potential impact on patient safety and delivery of contractual performance such as the four hour standard, referral to treatment within 18 weeks, cancer performance standards and diagnostics within six weeks.

- If we do not have in place effective organisational financial 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, impact on cash flow and long term sustainability as a going concern.

- If we do not transform pathology services, then we may fail to achieve quality and cost improvements, leading to suboptimal service which impacts on patient care and relationship with our partners.

- If we do not resource our nurse staffing rotas at ward / department level, then we will not meet patient needs consistently, with the potential for reduced quality and coordination of care provision, negative impact on patient flow and access targets and a long term impact on staff resilience and poor retention of staff.

- If we do not resource our medical staffing rotas at ward / department level then we will not meet patient needs consistently, with the potential for reduced quality and coordination of care provision, negative impact on patient flow and access targets and a long term impact on staff resilience, poor retention of staff and failure to meet the educational needs of junior doctors in training.

- 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 reporting of activity, which may lead to information gaps regarding patient diagnosis, care and treatments, tracking of patient pathways and coding inaccuracies (impacting on our external data submissions e.g. contract reporting, HSMR and regulatory submissions).

- If we do not improve the quality of care to patients sustainably and consistently as a result of gaps in key roles and poor engagement, leadership, capacity and capability, we will fail to provide good care, fail to achieve regulatory compliance and will suffer reputational damage.

- If we do not transform through strategy and its delivery, then we will be unable to achieve long term sustainability leading to further regulatory intervention.

- If we do not have in place a suitably qualified and experienced leadership team (across sub Board levels, including Divisional and Clinical Delivery Group (CDG leadership), then we may fail to deliver the required improvement at pace – with the potential for continued or escalated regulatory enforcement action.

- If we do not resource our AHP staffing rotas at ward / department level then we will not meet patient needs consistently, with the potential for reduced quality and coordination of care provision, negative impact on patient flow and access targets and a long term impact on staff resilience and poor retention of staff.

- If we do not have effective accountability and escalation arrangements, the executive team and Board may be unaware of important risk issues, significant control weaknesses and patient safety concerns in the rest of the organisation. This may lead to failure to act to protect patient safety, failure to learn as an organisation and potential regulatory intervention.

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 Quality and Risk Executive Management Committee meetings, monthly Board meetings and at meetings of the Board's assurance committees.

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 the CQC inspection reports.

At Colchester Hospital University 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.

Regulatory action

The foundation trust was not fully compliant with the registration requirements of the CQC and was in breach of conditions of its licence with NHSI, the foundation trust regulator, until November 2017, when NHSI removed the Trust from special measures following a positive report following an inspection by the CQC. The discretionary requirements imposed under section 105 of the Health and Social Care Act 2012 ("the Act") to address concerns raised following an inspection of cancer services by the CQC, the additional licence condition under section 111 of the Act to ensure that it established an effectively functioning Board and Board committees and sufficient and effective Board, management and clinical leadership capacity and capability to enable it to successfully meet those discretionary requirements and the Section 106 enforcement undertakings that were imposed in August 2014 and February 2015 were removed in December 2017.

A further section 106 enforcement undertakings letter was agreed in January 2018 to ensure that the Trust addresses the regulator's concerns about its performance against the national targets for A&E, RTT and cancer, and will keep its governance arrangements under review through a well led self-assessment following the transaction with Ipswich Hospital during 2018/19. The regulator has also requested undertakings from the Trust relating to the progressing of its Quality Improvement Plan, undertaking a Quality Data Review and a deep dive into risk management and Board to ward effectiveness.

Following the July 2017 inspection of the Trust, the CQC removed all of the outstanding section 31 notices in place.

Throughout the year, there were regular meetings between the Chair, Chief Executive and other members of the executive team with public stakeholders, which included North East Essex CCG, Healthwatch Essex, committees of the district, borough and county councils and with partners in the

local health care economy. Discussions in these meetings included the long-term partnership with Ipswich Hospital as well as the Sustainability and Transformation Partnership (STP) for Suffolk and north east Essex.

Our governors are also informed about the regulatory challenges and those risks which impact upon the public and members through regular meetings at which the Trust's performance is presented and discussed. Governors are also involved in the development of our Quality Report and Annual Plan.

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 organisation's obligations under equality, diversity and human rights legislation are complied with. This includes undertaking 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 foundation trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's 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 27 June 2017. All remedial actions are incorporated in the Every Patient, Every Day programme and the CQC improvement plan.

Never events

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

The Trust reported three serious incident never events in 2017/18. They were:

- SI 2017/074 – surgical invasive procedure – misplaced NG tube, medicine including emergency care
- SI2017/030 – treatment delay – breast screening, women and children
- SS2017/056 – wrong site surgery, surgery

The Trust continues to report proactively on a monthly basis to the Board and the Quality and Patient Safety Assurance Committee on its never events and compliance rates against the WHO Safer Surgery Checklist. There is also a never event framework used by the consultant body and divisions for review and training.

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 was assessed as “requires improvement” by the CQC in 2017/18. The inspectors reported significant improvement across all services at the Trust and observed more structured disciplines being embedded around executive and performance behaviours and responsibilities. However, there was recognition that much more needed to be done to achieve a “good” rating, with a particular emphasis on safety, responsiveness and governance. Their recommendations have been incorporated into an action plan which is overseen by the Quality and Patient Safety committee on behalf of the Board. The action plan for regulatory compliance is overseen by the Executive Management Committee quarterly.

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 2017/18, the Trust incurred a financial deficit of £4.3m. The plan for 2018/19 is a deficit of £12.6m, with a requirement of £12.6m in revenue cash support from the Department of Health. During 2018/19, it is expected that Colchester Hospital will merge with Ipswich Hospital and the combined financial control total will be £22.9m. To deliver this control total, a cost improvement programme of £40m needs to be delivered across the old and new organisations 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.

The Trust has used the learning opportunity from its period in special measures and the support provided through the Every Patient Every Day programme to continue to address the underlying weaknesses in its arrangements to secure economy, efficiency and effectiveness in the use of resources, particularly with regard to its decision-making processes and sustainable resource deployment. The progression of a long-term partnership with Ipswich Hospital is a key component of this solution. This progressed at pace during 2017/18, with the outline business case for the two organisations to merge approved at a meeting of both Boards in public during August 2017 and a full business case approved at a further meeting of both Boards in public during March 2018. This, as a long-term solution, 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

As part of NHS information governance rules, details of serious incidents involving data loss or a breach of confidentiality have to be reported. Patients and the public can be reassured that the Trust takes security and patient confidentiality very seriously. In 2017/18, the Trust reported 85 level 1 incidents and two level 2 incidents relating to breaches of patient confidentiality, compared with 90 level 1 incidents and 11 level 2 incidents in 2016/17.

Information governance training and awareness have increased to prevent level 2 incidents, which are reportable to the Information Commissioner’s Office (ICO).

Both of the level 2 incidents were reported to the ICO. One related to inappropriate access to patient data by a staff member. This case is pending with the ICO. The other related to a patient letter sent to the incorrect patient. This was due to human error but training was redesigned to highlight the importance of paying attention to detail when handling patient information.

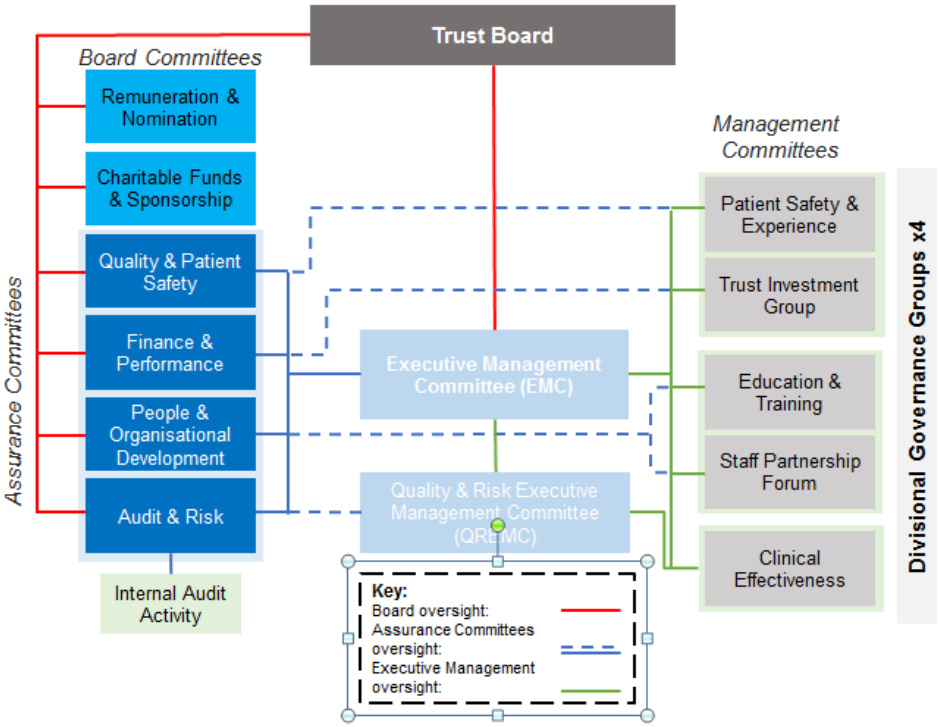
The Trust carried out an assessment of its compliance with the Department of Health information governance toolkit, the outcome of which was a compliance score of 90% (compared with 88% in 2016/17).

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. The Trust set three quality priorities for 2017/18, identifying one high priority for each of the areas of patient safety, clinical effectiveness and patient experience. The delivery of these priorities was monitored monthly by the Board of Directors. Details on the Trust's performance against these priorities is analysed and reported in the Quality Report.

In setting its priorities, the Trust consulted 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 Director of Nursing is the Executive Director responsible for patient safety and patient experience and the Medical Director is responsible for clinical effectiveness. The Associate Director of Clinical Governance provides further leadership and support for the quality and governance agenda. The Associate Director of Clinical Governance reports to the Director of Nursing and is responsible for quality and clinical and non-clinical risk management across the Trust.

The executive governance structure supporting the quality agenda was reviewed as part of the governance workstream of Every Patient, Every Day, ensuring that all aspects of quality governance report through the Patient Safety and Experience Group and the Clinical Effectiveness Group through to the Executive Management Committee, the Quality and Risk Executive Management Committee, the Quality and Patient Safety Assurance Committee and the Board. This was in place by February 2017 and remained the same throughout 2017/18.



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

- Every Patient, Every Day, details of which are summarised in the Quality Report;
- plans to deliver the key performance indicators (KPIs) in the CQUINs agreed with commissioners;
- initiatives to reduce errors in surgery through improving compliance with the World Health Organisation Safer Surgery Checklist; and
- actions 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 84.64% 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, which includes ensuring all 52 week breaches have been confirmed by the service, checks on large movements and triangulation 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:

- the report of the CQC's inspection of the Trust in July 2017 and reported in November 2017, the associated improvement plans and the reports on their delivery status
- 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
- Clinical Pathology Accreditation (CPA) held for designated pathology services
- Infection Control Annual Report and associated monthly reporting
- other annual reports relating to statutory reporting requirements, which include radiation safety, safeguarding, health and safety etc
- 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
- information governance toolkit
- Patient-Led Assessment of the Care Environment (PLACE) inspections

- the work undertaken by the Trust and supported by investment from NHSI as part of the Every Patient, Every Day programme
- due diligence undertaken by the Trust and supported by Deloitte and Hempsons as part of the preparations for the long-term partnership with the Ipswich Hospital NHS Trust.

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 of services, including the reports of the CQC following its inspections.

Head of Internal Audit Opinion

The Trust received a significant assurance statement in the Head of Internal Audit opinion on the basis of an assessment of the design and operation of the underpinning assurance framework and supporting processes and of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year.

In particular, the auditors raised concerns regarding the following operational processes:

- Data quality – doctor details on electronic discharge summaries. This related to differences between the details held on the clinical notes and the electronic discharge summary regarding the discharging consultant.
- Emergency and contingency planning. This related to contingency arrangements following the resignation of the Emergency Planning Manager, low attendance of gold command responders at organised training sessions and the removal of emergency preparedness, resilience and response training from the list of mandatory courses.
- Infection control. This related to a backlog in the infection control team audit programme and failure to hold regular meetings of the infection control team.
- Medicines management. This related to a high incidence of delays in undertaking medicine reconciliations and a failure to monitor performance against this target.
- Ward visits. This related to poor completion of patient property register forms on three wards and poor staff awareness of procedures over the management of patient property.

An internal audit review of the Trust's readiness for GDPR reached a limited assurance conclusion and identified four high priority recommendations. These related to the lack of a project group to manage and monitor the implementation of GDPR by May 2018, the lack of a comprehensive and accurate record of the location and origin of all personal data held in-house and shared with third parties, weaknesses in the way the Trust seeks, records and manages consent and the lack of a framework to allow the Trust to identify instances where a privacy impact assessment would be required and how it would be undertaken.

The Trust has already taken action to address the weaknesses identified and this will be closely monitored by the Audit and Risk Committee during 2018/19 to ensure that the risk of non-compliance is mitigated.

Conclusion

The foregoing statement identifies a number of incidences of control weakness, identified both through internal reviews and through external scrutiny from NHSI, the CQC and other sources. In terms of significant control issues, the Trust would highlight its deficit position, readiness for GDPR and the vulnerabilities exposed by the cyber attack in May 2017, as summarised below.

The Trust reported a deficit in 2017/18 and has submitted a deficit plan for 2018/19. As it is not expected to achieve financial balance in the medium term, the Trust's external auditors are unable to conclude that there is sufficient evidence that the Trust's arrangements support, in all significant respects, its ability to achieve planned and sustainable financial stability, and have issued a modified opinion in that respect.

The Trust also concluded that its lack of readiness for GDPR is a significant control issue.

The disruption caused by the cyber attack on the Trust's IT systems on 12 May 2017 exposed vulnerabilities in both the Trust's preventative information security controls and in its business continuity arrangements. A root cause analysis was undertaken to understand those vulnerabilities. There were no incidences identified of any harm to patients as a result of the attack and there was minimal disruption to Trust business, with no outpatient cancellations and only six clinical procedures cancelled.

Immediate work was undertaken to minimise further risk to the organisation and to enhance IT security, which included the implementation of additional cyber security controls, revision of business continuity plans and a review of planning and local procedures. In August 2017, the Trust received the industry-supported, Government-backed Cyber Essentials Plus accreditation. This required the Trust to demonstrate a high level of information security and cyber security control.

Nick Hulme
Chief Executive
29 May 2018

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 Colchester Hospital University NHS Foundation Trust's performance, business model and strategy.

Nick Hulme
Chief Executive
29 May 2018

In the news February 2018 – Refurbished Gainsborough Wing opens

Patients using the hospital are receiving care in brighter, more modern surroundings following an extensive £1.6m refurbishment of the Gainsborough Wing.

The project has seen the area reconfigured to more than double the amount of clinic rooms which are available, whilst the environment is now lighter and more welcoming. Improvements have also been made to ensure the department meets the latest dementia-friendly standards.

The general physiotherapy, prosthetic and neuro-rehabilitation gyms have been redeveloped so that they better meet the needs of patients, with additional storage space created for specialist equipment. In addition, the outpatient department has been completely refurbished, the number of day beds increased, a purpose-built area has been created for patients receiving infusions and automatic check-in kiosks installed.

Independent auditor's report to the Council of Governors of Colchester Hospital University NHS Foundation Trust

Opinion on financial statements

We have audited the financial statements of Colchester Hospital University NHS Foundation Trust (the Trust) for the year ended 31 March 2018 which comprise the group and Trust Statement of Comprehensive Income, the group and Trust Statement of Financial Position, the group and Trust Statement of Changes in Taxpayers' Equity, the group and Trust 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 2017/18 Government Financial Reporting Manual as contained in the Department of Health and Social Care Group Accounting Manual 2017-18, and the NHS Foundation Trust Annual Reporting Manual 2017/18 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 and group as at 31 March 2018 and the Trust's and group's expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; 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 and the group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC'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
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 assessed management's review of the alternative site basis to ensure that it remained a valid judgement within the financial statements during 2017/18. 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 assessed whether 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. Management's consideration of fair values for land and buildings was based on a report provided by an external valuer. We reviewed the instructions provided to the valuer and considered the valuer's skills and expertise to determine the extent to which we could rely on the work performed by the valuer.

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 group financial statements as a whole was set at £5.1 million (2017 £6.3 million). This was determined with reference to the benchmark of gross expenditure (of which it represents 1.5%) (2017 – 2.0%) which we consider one of the principal considerations for the Council of Governors in assessing the financial performance and position of the group and the Trust.

We agreed with the Audit and Risk Assurance Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of £128,000 (2017- £250,000) 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 group operates with two subsidiary bodies, the Trust and the Charitable Fund. Our audit was conducted as a full scope audit of the Trust, performance of targeted audit procedures on the financial records of the Colchester Hospital University NHS Foundation Trust Charitable Fund, focusing on investments and cash balances and performance of audit procedures and evaluation of the consolidation process by which the components were consolidated into the group financial statements.

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 and Staff Report

We have also audited the information in the Remuneration 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 pay multiples and related narrative notes.

In our opinion the parts of the Remuneration Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2017/18.

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 put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion on use of resources

For the year ended 31 March 2018 the Trust reported a deficit of £4.2m (2016/17: deficit of £18.9m). This represents a considerable improvement on the original control total set for 2017/18 by NHS Improvement of £22.1m. The financial position has stabilised in a number of areas, although challenges remain in others.

Although the Trust delivered £14.1m cost improvement plan savings, the 2018/19 agreed control total of a deficit of £24.9m is dependent upon delivery of cost improvement plan savings of £17.3m in the year.

The Trust does not yet have plans to secure a return to a breakeven position in the medium term, whether as a standalone trust or through the proposed merger with Ipswich Hospital Trust.

These matters are evidence of weaknesses in arrangements to ensure that the Trust has deployed its resources to achieve sustainable outcomes for taxpayers and local people.

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.

We have nothing to report in these respects.

Responsibilities the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting Officer, 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 resources of the Trust are used economically, 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 section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 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.

As set out in the Matters on which we report by exception section of our report there are certain matters which we are required to report by exception.

Certificate

We certify that we have completed the audit of the accounts of Colchester Hospital University 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 Colchester Hospital University 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 Colchester Hospital University 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
29 May 2018

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

In the news February 2018 – neonatal unit highly commended for its care

The care provided by our Trust's neonatal unit (NNU) and the steps which staff take to give new babies the best possible start in life have been highly commended following a national review.

A team from NHS England visited the hospital in November to interview staff, tour the NNU and examine evidence about the way it is run. They praised the innovations which staff have introduced to further improve care for newborns and their families and commended their teamwork, the strong leadership of senior staff and the "exemplary" career progression offered to those at the beginning of their working lives.

The results come after the NNU was given an 'outstanding' rating by the Care Quality Commission.

Karen Moss, neonatal ward manager (right) and Michaela Gray, neonatal nurse, cradle newborn Ernest Rowe.

FOREWORD TO THE ACCOUNTS

Colchester Hospital University NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Colchester Hospital University NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

The Trust's accounts for 2017/18 have recorded a deficit of £4.3 million (before the consolidation of charitable funds). The deficit represents an improvement in the Trust's financial position compared to the prior reporting period (2016/17 deficit, £18.9 million). Significant variances contributing to this deficit include:

- Compared with the previous year, income increased by 13.9%, from £301.6m to £343.5m. Significantly, the Trust began hosting North East Essex Pathology Service (NEESPS) from May 2017. This increased the Trust's income by a net £27.6m. Income from commissioners has risen by a further £11.7m (4.6%). From 2017/18 a guaranteed income contract settlement was negotiated. This settlement was an agreed affordability value between the main commissioner and associates and Colchester Hospital. The settlement was based on a priced national tariff plan with growth mainly related to the price impact of HRG4+ from April 2017. Also, as a result of its overall performance in 2017/18 the Trust received £20.3m of Sustainability and Transformation Fund (an increase of £3.5m compared to 2016/17) which helped drive the increase in income. The Sustainability and Transformation Fund is to be distributed to providers to support movement to a sustainable financial footing.

- The Trust's expenditure rose by 9.1% from £316.3m in 2016/17 to £345.1m in 2017/18. This was mainly because The Trust increased costs to match income received in relation to NEESPS (£27.5).

In accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, 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 North East Essex area and no decision has been made to transfer services or significantly amend the structure of the organisation.

The Trust has developed a plan for 2018/19 which is a deficit of £12.6m, with a requirement of £12.6m in revenue cash support from the Department of Health and Social Care.

During 2018/19, it is expected that Colchester Hospital will formally join with Ipswich Hospital to form a joint Trust to be known as East Suffolk and North Essex NHS Foundation Trust. The combined financial deficit of this Trust is forecast to be £22.4m, with a revenue cash support requirement of £22.8m.

Whilst to all intents and purposes this will be a merger of equal standing between the two Trusts, the formal legal and accounting basis of the transaction will constitute an acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust.

Following the necessary due diligence and regulatory scrutiny processes, it is expected that the merger will take place in July, at which point the Trust is planning to publish a set of accounts for the first quarter of the financial year. Although it is not anticipated that the transaction will not progress in full, should this eventuality occur, the Trusts will continue in their current form as separate organisations. In respect of that outcome, the Trust has submitted a financial plan to NHS Improvement for 2018/19 in its own right. This plan was approved by the Trust Board and identifies the Trust's deficit and reliance on working capital support from the Department of Health and Social Care for the period.

Contracts for 2018/19 have been signed with commissioners, although the Trust has not yet received formal confirmation in respect of the interim financial support at the time of signing the accounts. This represents a material uncertainty for the Trust and there is a presumption that additional working capital support will again be required in 2018/19. 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

29 May 2018

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

	Note		2017/18 £000		2016/17 £000
Operating Income					
Operating income from patient care activities	2		296,878		257,699
Other operating income	2		46,625		43,947
Operating Expense	3		(345,058)		(316,265)
Operating Deficit			**(1,555)**		**(14,619)**
Finance Costs					
Finance income	6	46		24	
Finance expense - financial liabilities	6.1	(1,556)		(1,662)	
Finance expense - unwinding of discount on provisions	16	(2)		(13)	
PDC dividends payable		(1,107)		(2,680)	
Net Finance Costs			**(2,619)**		**(4,331)**
Gains/(losses) of disposal of assets	6.2		**(71)**		**8**
Deficit from continuing operations			**(4,245)**		**(18,942)**
DEFICIT FOR THE YEAR			**(4,245)**		**(18,942)**
Other Comprehensive Income:					
Revaluation gains/(losses) and impairment losses property, plant and equipment *	1.7		5,346		(45,192)
Other reserve movements			-		-
TOTAL COMPREHENSIVE INCOME FOR THE YEAR			**1,101**		**(64,134)**

* In 2016/17 the Trust undertook a revlaution of its land and building assets using the alternative site valuation methodology. Further information regarding this change in valuation basis can be found in note 1.7.

The notes on pages 11 to 47 form part of these accounts.
All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	Note	31 March 2018 £000	31 March 2017 £000
NON-CURRENT ASSETS			
Intangible assets	7	5,749	6,288
Property, plant and equipment	8.1	157,272	147,049
Total Non-Current Assets		**163,021**	**153,337**
CURRENT ASSETS			
Non-current assets held for sale	8.2	4,100	4,100
Inventories	10	4,838	4,874
Trade and other receivables	11.1	31,701	30,250
Cash and cash equivalents	17.1	9,233	5,442
Total Current Assets		**49,872**	**44,666**
CURRENT LIABILITIES			
Trade and other payables	12.1	(38,923)	(30,178)
Borrowings	15	(1,304)	(5,364)
Provisions	16	(2,210)	(910)
Other liabilities	13	(1,842)	(1,864)
Total Current Liabilities		**(44,279)**	**(38,316)**
Total Assets less Current Liabilities		**168,614**	**159,687**
NON-CURRENT LIABILITIES			
Borrowings	15	(100,637)	(93,626)
Provisions	16	(815)	(905)
Other liabilities	13	(2,280)	(2,605)
Total Non-Current Liabilities		**(103,732)**	**(97,136)**
TOTAL ASSETS EMPLOYED		**64,882**	**62,551**
TAXPAYERS' EQUITY			
Public Dividend Capital		77,994	76,764
Revaluation Reserve		26,423	21,132
Other Reserves		754	754
Income and Expenditure Reserve		(40,289)	(36,099)
TOTAL TAXPAYER'S EQUITY		**64,882**	**62,551**

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

Nick Hulme, Chief Executive

29 May 2018

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	2017/18	2016/17
	£000	£000
Cash flows from operating activities		
Operating deficit from continuing operations	(1,555)	(14,619)
Operating deficit	**(1,555)**	**(14,619)**
Non-cash income and expense:		
Depreciation and amortisation	8,243	9,048
Impairments	-	-
Non-cash donations credited to income	(52)	(29)
Amortisation of PFI credit	(326)	(326)
Increase in trade and other receivables	(2,394)	(16,625)
Decrease in inventories	36	145
Increase in trade and other payables	7,840	234
Decrease in other liabilities	(21)	(289)
Increase in provisions	1,208	440
Net cash generated from/(used in) operations	**12,979**	**(22,021)**
Cash flows from investing activities		
Interest received	46	24
Purchase of intangible assets	(381)	(1,650)
Purchase of property, plant and equipment	(11,483)	(7,897)
Sales of property, plant and equipment	44	15
Net cash used in investing activities	**(11,774)**	**(9,508)**
Cash flows from financing activities		
Public dividend capital received	1,230	1,750
Public dividend capital repaid	-	(1,750)
Loans received from the Department of Health	13,338	41,765
Loans repaid to the Department of Health	(10,290)	(1,264)
Capital element of finance lease rental payments	(97)	(408)
Interest paid	(1,499)	(1,510)
Interest element of finance lease	(24)	(28)
PDC dividend paid	(72)	(3,609)
Net cash generated from financing activities	**2,586**	**34,946**
Increase in cash and cash equivalents	**3,791**	**3,417**
Cash and Cash equivalents at 1 April	**5,442**	**2,025**
Cash and Cash equivalents at 31 March	**9,233**	**5,442**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2018

	Total	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2016	**126,685**	**76,764**	**66,485**	**754**	**(17,318)**
Deficit for the year	**(18,942)**	-	-	-	(18,942)
Revaluation gains and impairment losses property, plant and equipment	**(45,192)**	-	(45,192)	-	-
Transfers to the income and expenditure account in respect of assets disposed of	**-**	-	(161)	-	161
Public Dividend Capital received	**1,750**	1,750	-	-	-
Public Dividend Capital repaid	**(1,750)**	(1,750)	-	-	-
Taxpayers' Equity at 31 March 2017	**62,551**	**76,764**	**21,132**	**754**	**(36,099)**
Deficit for the year	**(4,245)**	-	-	-	(4,245)
Revaluation gains and impairment losses property, plant and equipment	**5,346**	-	5,346	-	-
Transfers to the income and expenditure account in respect of assets disposed of	**-**	-	(55)	-	55
Public Dividend Capital received	**1,230**	1,230	-	-	-
Taxpayers' Equity at 31 March 2018	**64,882**	**77,994**	**26,423**	**754**	**(40,289)**

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018
CONSOLIDATED FOR CHARITABLE FUNDS *

	Note		2017/18 £000		2016/17 £000 Restated
Operating Income					
Operating income from patient care activities	2		296,878		257,548
Other operating income	2		47,351		44,730
Operating Expense	3		(345,346)		(316,466)
Operating Deficit			**(1,117)**		**(14,188)**
Finance Costs					
Finance income	6	50		28	
Finance expense - financial liabilities	6.1	(1,556)		(1,662)	
Finance expense - unwinding of discount on provisions	16	(2)		(13)	
PDC dividends payable		(1,107)		(2,680)	
Net Finance Costs			**(2,615)**		**(4,327)**
Gains of disposal of assets	6.2		(71)		8
Deficit from continuing operations			**(3,803)**		**(18,507)**
DEFICIT FOR THE YEAR			**(3,803)**		**(18,507)**
Other Comprehensive Income:					
Revaluation gains/(losses) and impairment losses property, plant and equipment			5,346		(45,192)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR			**1,543**		**(63,699)**

* The Trust is a corporate trustee of Colchester Hospital University NHS Foundation Trust Charitable Fund. In accordance with International Financial Reporting Standard (IFRS) 10 and the requirements of Monitor's Annual Reporting Manual, the Trust has consolidated the financial statements of the Charity with those of the Foundation Trust for the reporting period ending 31st March 2018.

A reconciliation of the impact of this consolidation on the Trust's surplus/(deficit) can be seen in note 1.3.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018 CONSOLIDATED FOR CHARITABLE FUNDS

	Note	31 March 2018 £000	31 March 2017 £000 Restated
NON-CURRENT ASSETS			
Intangible assets	7	5,749	6,288
Property, plant and equipment	8.1	157,272	147,049
Total Non-Current Assets		**163,021**	**153,337**
CURRENT ASSETS			
Non-current assets held for sale	8.2	4,100	4,100
Inventories	10	4,838	4,874
Trade and other receivables	11.2	31,701	30,369
Cash and cash equivalents	17.1	11,733	7,333
Total Current Assets		**52,372**	**46,676**
CURRENT LIABILITIES			
Trade and other payables	12.2	(39,064)	(30,271)
Borrowings	15	(1,304)	(5,364)
Provisions	16	(2,210)	(910)
Other liabilities	13	(1,842)	(1,864)
Total Current Liabilities		**(44,420)**	**(38,409)**
Total Assets less Current Liabilities		**170,973**	**161,604**
NON-CURRENT LIABILITIES			
Borrowings	15	(100,637)	(93,626)
Provisions	16	(815)	(905)
Other liabilities	13	(2,280)	(2,605)
Total Non-Current Liabilities		**(103,732)**	**(97,136)**
TOTAL ASSETS EMPLOYED		**67,241**	**64,468**
TAXPAYERS' EQUITY			
Public Dividend Capital		77,994	76,764
Revaluation Reserve		26,423	21,132
Other Reserves		754	754
Income and Expenditure Reserve		(40,289)	(36,099)
Charitable Funds Reserve		2,359	1,917
TOTAL TAXPAYER'S EQUITY		**67,241**	**64,468**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018 CONSOLIDATED FOR CHARITABLE FUNDS

	2017/18	2016/17
	£000	£000
		Restated
Cash flows from operating activities		
Operating deficit from continuing operations	(1,117)	(14,188)
Operating deficit	**(1,117)**	**(14,188)**
Non-cash income and expense:		
Depreciation and amortisation	8,243	9,048
Impairments	-	-
Income recognised in respect of capital donations (cash and non-cash)	-	(15)
Amortisation of PFI credit	(326)	(326)
Increase in trade and other receivables	(2,424)	(16,593)
Decrease in inventories	36	145
Increase in trade and other payables	7,840	234
Decrease in other liabilities	(21)	(289)
Increase in provisions	1,208	440
NHS charitable funds - net working capital movements	197	94
NHS charitable funds - other movements in operating cash flows	(52)	(14)
Net cash generated from/(used in) operations	**13,584**	**(21,464)**
Cash flows from investing activities		
Interest received	46	24
Purchase of intangible assets	(381)	(1,650)
Purchase of property, plant and equipment	(11,483)	(7,897)
Sales of property, plant and equipment	44	15
NHS charitable funds - investment income	4	4
Net cash used in investing activities	**(11,770)**	**(9,504)**
Cash flows from financing activities		
Public dividend capital received	1,230	1,750
Public dividend capital repaid	-	(1,750)
Loans received from the Department of Health	13,338	41,765
Loans repaid to the Department of Health	(10,290)	(1,264)
Capital element of finance lease rental payments	(97)	(408)
Interest paid	(1,499)	(1,510)
Interest element of finance lease	(24)	(28)
PDC dividend paid	(72)	(3,609)
Net cash generated from financing activities	**2,586**	**34,946**
Increase in cash and cash equivalents	**4,400**	**3,978**
Cash and Cash equivalents at 1 April	**7,333**	**3,355**
Cash and Cash equivalents at 31 March	**11,733**	**7,333**

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2018
CONSOLIDATED FOR CHARITABLE FUNDS

	Total	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve	Charitable Funds Reserve
	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2016	**128,167**	**76,764**	**66,485**	**754**	**(17,318)**	**1,482**
Surplus/(Deficit) for the year	**(18,507)**	-	-	-	(19,111)	604
Revaluation gains and impairment losses property, plant and equipment	**(45,192)**	-	(45,192)	-	-	-
Transfers to the income and expenditure account in respect of assets disposed of	**-**	-	(161)	-	161	-
Public Dividend Capital received	**1,750**	1,750	-	-	-	-
Public Dividend Capital repaid	**(1,750)**	(1,750)	-	-	-	-
Other reserve movements in respect of charitable funds	**-**	-	-	-	169	(169)
Taxpayers' Equity at 31 March 2017	**64,468**	**76,764**	**21,132**	**754**	**(36,099)**	**1,917**
Surplus/(Deficit) for the year	**(3,803)**	-	-	-	(4,536)	733
Revaluation gains and impairment losses property, plant and equipment	**5,346**	-	5,346	-	-	-
Transfers to the income and expenditure account in respect of assets disposed of	**-**	-	(55)	-	55	-
Public Dividend Capital received	**1,230**	1,230	-	-	-	-
Other reserve movements in respect of charitable funds	**-**	-	-	-	291	(291)
Taxpayers' Equity at 31 March 2018	**67,241**	**77,994**	**26,423**	**754**	**(40,289)**	**2,359**

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 trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation 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 income and expenditure reserve is the accumulated surpluses and deficits of the NHS foundation trust. It is held in perpetuity and cannot be released to the Statement of Comprehensive Income.

Charitable Funds Reserve

The charitable funds reserve represents those funds which are available to the Charity to be spent at the Trustees' discretion in furtherance of the Charity's objectives and which are not yet spent or committed.

NOTES TO THE ACCOUNTS

1. Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

In accordance with IAS 8, the most suitable accounting policies have been selected which provide the most relevant and reliable information in respect of the Trust's activities.

1.1 Accounting Convention and Going Concern

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 liabilities.

The financial statements have been prepared on a going concern basis. In accordance with IAS 1, management have made an assessment of the Trust's ability to continue as a going concern. For the financial year commencing 1st April 2018 the Trust has forecast a deficit of £12.6 million and within this forecast is a cost improvement programme requiring £17.3 million of efficiencies and savings. In order to fund this deficit, the Directors are seeking interim financial support for 2018/19 of £12.6 million from the Department of Health and Social Care. At the time of writing, an interim working capital loan facility of £77.7 million has been provided to the Trust and discussions are on-going with regard to the further support required.

Although contracts for 2018/19 have been signed with commissioners, the Trust has not yet received formal confirmation in respect of the interim financial support at the time of signing the accounts. This represents a material uncertainty for the Trust and there is a presumption that additional working capital support will again be required 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.

In January 2017, both Colchester Hospital University NHS Foundation Trust (CHUFT) and The Ipswich Hospital NHS Trust (IHT) identified that a Long-Term Partnership (LTP) was essential to their sustainability. In March 2018 a Full Business Case was approved by both Boards, with the aim or merging to form the new East Suffolk and North Essex Foundation Trust with effect from July 2018. The Boards of the two Trusts consider that a full merger will be for the benefit of improved care for patients and create a more sustainable future for both organisations.

Whilst to all intents and purposes this will be a merger of equal standing between the two Trusts, the formal legal and accounting basis of the transaction will constitute an acquisition of The Ipswich Hospital NHS Trust by Colchester Hospital University NHS Foundation Trust.

The clinical strategy for the future has started to be developed for future public consultation post organisational merger, but the Trust Boards have committed last year that there will need to be A&E, maternity and acute medical services at both Colchester and Ipswich hospital sites in the future.

Although it is not anticipated that the transaction will not progress in full, should this eventuality occur, the Trusts will continue in their current form as separate organisations. In respect of that outcome, the Trust has submitted a financial plan to NHS Improvement for 2018/19 in its own right. This plan was approved by the Trust Board and identifies the Trust's deficit and reliance on working capital support from the Department of Health and Social Care for the period.

Although these factors represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still 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 2017/18, 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 and has not included the adjustments that would result if it was unable to continue as a going concern.

1.2 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

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.

The Trust considers that the valuation of property, plant and equipment assets poses the largest 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.

There are no other sources of estimation uncertainty that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.3 Consolidation

Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Consolidated Accounts - NHS Charitable Funds

Where a foundation trust is a corporate trustee of an NHS charity, the foundation trust needs to consider whether that fund represents a subsidiary. This is likely to be the case where the NHS foundation trust both:

- has control of the NHS charitable fund (as determined by IFRS 10); and
- benefits from the NHS charitable fund.

The Trust is a corporate trustee of Colchester Hospital University NHS Foundation Trust Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

Reconciliation of Trust deficit to pre-consolidated accounts:

	2017/18 £000	2016/17 £000 Restated
Trust deficit for year	**(4,245)**	**(18,942)**
Less:		
Charitable contributions previously credited to Trust income	**(239)**	**(155)**
Receipt of donated assets previously credited to Trust income	**(52)**	**(14)**
Plus:		
NHS charitable funds income	**1,017**	**801**
NHS charitable funds investment income	**4**	**4**
Less:		
NHS charitable funds expenditure	**(283)**	**(198)**
NHS charitable funds audit fee	**(5)**	**(3)**
Consolidated deficit for year	**(3,803)**	**(18,507)**

1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Partially completed clinical spells are valued using a methodology based on the estimated value of the proportion of the spell completed as a proportion of the total estimated spell value. These are recorded under income.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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.

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.

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, e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments 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 Pensions Schemes. These Schemes are unfunded, defined benefit schemes that covers NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The Schemes are not deigned to be run in a way that would enable NHS bodies to identify their share of the underlying scheme liabilities. Therefore, the Schemes are accounted for as though they were defined contribution schemes: the cost to the Trust of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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.

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.

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.

1.7 Property, Plant and Equipment

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; and
- the cost of the item can be measured reliably.

Property, Plant and Equipment is capitalised if it is capable of being used for a period which exceeds one year and it:

- individually has a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

The finance costs of bringing fixed assets into use are not capitalised.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Capital expenditure on strategic schemes, i.e. those schemes which are of a longer-term nature such as building or large infrastructure projects, is initially charged to assets in the course of construction during the construction phase. Capital schemes are regularly assessed for progress, and once completed, costs are transferred from assets in the course of construction to the appropriate asset category and are recognised as coming into full use.

Measurement

Valuation

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 are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation - Professional Standards 2014 UK edition, in so far as these terms are consistent with the agreed requirements of HM Treasury, Monitor and the National Health Service.

A desktop valuation of land and buildings was prepared by the District Valuer Service as at 31 March 2018.

In 2016/17 the valuation basis for the Trust's land and building assets was changed to that of an alternative site basis, and this has been continued in 2017/18. In selecting the alternative site on which the modern equivalent asset would be situated, the Valuer has considered 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).

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.

The significant reduction in the valuation of land and buildings has been driven by two main factors:

- The reduction in land price values in relocating to a commercial development from a prime residential location
- A reduction in gross internal area of approximately 15% which arises through the rationalisation of the Trust's existing properties into a single, purpose-built, hospital facility

The 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".

Assets in the course of construction are valued at current cost. These assets include any existing land or buildings under the control of a contractor.

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 economic 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. Equipment is depreciated on current cost evenly over the estimated life of the asset.

Assets in the course of construction are not depreciated until the asset is brought into use.

Economic life of property, plant and equipment:

- Buildings	22 to 57 years
- Medical Equipment and Engineering Plant and Equipment	5 to 15 years
- Furniture & Fittings	10 years
- Set-up Costs in New Buildings	10 years
- Information Technology	5 to 10 years

Finance-leased assets are depreciated over the shorter of the useful economic life or the lease term, unless the FT 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.

Revaluation gains and losses

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments 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 DH GAM, impairments that are due to a loss of economic benefits or 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 arising from a loss of economic benefit or 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 income 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.

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, i.e.:
  - 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 dropped 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, Government Grant and Other 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.

Private Finance Initiative (PFI) Transactions

PFI transactions which meet the International Financial Reporting Interpretations Committee (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. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The Trust's 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 balance.

The deferred income balance is released to operating income over the life of the concession.

1.8 Intangible Assets

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.

Intangible assets are capitalised when they are capable of being used in the Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as 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 where expenditure of at least £5,000 is incurred, and are amortised over the shorter of the term of the licence and their useful economic lives.

Measurement

Intangible fixed assets held for operational use are valued at historical cost and are amortised over the estimated life of the asset on a straight-line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

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. Revaluation 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 economic lives in a manner consistent with the consumption of economic or service delivery benefits.

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.

1.10 Financial Instruments and Financial Liabilities

Financial Assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Classification and Measurement

The Trust's financial assets are categorised as loans and receivables.

Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost less any impairment.

The Trust's loans and receivables comprise cash and cash equivalents, NHS receivables, accrued income and other receivables.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Other Financial Liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly the estimated future cash payments through the expected life of the financial liability, or when appropriate a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of Financial Assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

The Trust holds a bad debt provision for potentially irrecoverable debts but does not write off amounts to the Statement of Comprehensive Income until there is reasonable certainty that the debt is irrecoverable.

1.11 Leases

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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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. Leased land is treated as an operating lease.

1.12 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 (NHSR), formerly the NHS Litigation Authority, operates a risk pooling scheme under which the Trust pays an annual contribution to NHSR, which, in return, settles all clinical negligence claims. Although NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHSR on behalf of the Trust is disclosed at note 16 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.

1.13 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 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 20, 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 control of the Trust; 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.

1.14 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 trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care 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, (ii) average daily cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. 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.

1.15 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.

1.16 Corporation Tax

Foundation Trusts currently 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.

1.17 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.18 Cash at Bank, Overdrafts and Cash Equivalents

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash books. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within borrowings. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

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.

1.19 Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. Where NHS foundation trusts are registered with the CRC scheme, they are required to surrender to the Government an allowance for every tonne of CO2 they emit during the financial year. Therefore, registered NHS foundation trusts should recognise a liability and related expense in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at 31 March will, therefore, reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances/tonnes required to settle the obligation.

1.20 Accounting Standards that have been Issued but have not yet been Adopted in the FReM

The following changes to standards issued by the International Accounting Standards Board (IASB) have not yet been adopted within the FReM, and are therefore not applicable to Department of Health and Social Care group accounts in 2017/18. None of these are expected to impact upon the Trust financial statements with the exception of IFRS 16 Leases. Under IFRS 16 the Trust will be required to recognise additional right of use assets on its statement of financial position for leased assets which are currently charged to operating expenses. The monetary value of the impact of this change in accounting standard has not yet been estimated.

IFRS 9 Financial Instruments: Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is therefore not permitted.

IFRS 14 Regulatory Deferral Accounts: Not yet European Union-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 15 Revenue from Contracts with Customers: Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

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.

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 22 Foreign Currency Transactions and Advance Consideration: Application required for accounting periods beginning on or after 1 January 2018.

IFRIC 23 Uncertainty over Income Tax Treatments: Application required for accounting periods beginning on or after 1 January 2019.

1.21 Early Adoption of Accounting Standards, Amendments and Interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

1.22 Segmental Reporting

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.

Further information on segmental reporting is presented at note 26 "segmental analysis".

2. Operating Income

2.1 Operating Income (by classification)	Foundation Trust		Consolidated	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
2.1.1 Income from Activities				
Elective income	**40,880**	**42,861**	**40,880**	**42,861**
Non-elective income	**89,862**	**81,669**	**89,962**	**81,669**
Outpatient income	**42,556**	**43,482**	**42,556**	**43,482**
A&E income	**12,711**	**11,362**	**12,711**	**11,362**
Other activity income	**105,778**	**73,518**	**105,778**	**73,518**
Private patient income	**735**	**836**	**735**	**836**
Other non-protected clinical income	**4,356**	**3,971**	**4,256**	**3,971**
Total Income from Activities	**296,878**	**257,699**	**296,878**	**257,699**

2.1.2 Commissioner Requested Services and Continuity of Services

Commissioner Requested Services are defined in the provider licence and are the services that commissioners believe must continue to be delivered to local patients should the provider be unable to carry on as a going concern.

	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Commissioner Requested Services	**291,787**	**252,892**	**291,887**	**252,892**
Other services	**5,091**	**4,807**	**4,991**	**4,807**
	296,878	**257,699**	**296,878**	**257,699**

2.1.3 Other Operating Income

	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
				Restated
Research and development	**1,017**	**1,158**	**1,017**	**1,158**
Education and training	**7,794**	**6,891**	**7,794**	**6,891**
Notional income from apprenticeship levy	**36**	**-**	**36**	**-**
Charitable and other contributions to expenditure	**241**	**157**	**2**	**2**
Receipt of donated assets	**52**	**29**	**-**	**15**
Non-patient care services to other bodies	**5,003**	**4,071**	**5,003**	**4,071**
Sustainability and Transformation Fund Income	**20,336**	**16,538**	**20,336**	**16,538**
Car parking	**1,237**	**1,133**	**1,237**	**1,133**
Staff recharges	**1,932**	**3,358**	**1,932**	**3,358**
Drug sales	**1,385**	**1,565**	**1,385**	**1,565**
Other *	**7,151**	**8,610**	**7,151**	**8,610**
Rental revenue from operating leases	**115**	**111**	**115**	**111**
Amortisation of PFI deferred credits	**326**	**326**	**326**	**326**
NHS charitable funds	**-**	**-**	**1,017**	**801**
Total Other Operating Income	**46,625**	**43,947**	**47,351**	**44,579**

* Other income includes funding to support the merger with Ipswich Hospital, room hire, occupational health services, transport service contracts and winter support funding.

2.1.4 Total Operating Income

	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000 Restated
Income from activities	**296,878**	**257,699**	**296,878**	**257,699**
Other operating income	**46,625**	**43,947**	**47,351**	**44,579**
Total Operating Income	**343,503**	**301,646**	**344,229**	**302,278**

2.1.5 Impact of North Essex and East Suffolk Pathology Service

In May 2017, pathology services which were previously provided by The Pathology Partnership under a consortium arrangement, were transferred back to the Trust. The Trust now provides pathology services to The Ipswich Hospital NHS Trust and West Suffolk Hospital NHS Foundation Trust along with direct access to GP practices and other healthcare providers.

The impact of the Pathology Service on the 2017/18 financial position is identified below:

	2017/18 £000
Income	
- Clinical income	28,029
- Non-clinical income	897
- Other operating income	816
- Colchester Hospital contribution to income	6,640
Total Income	**36,382**
Expenditure	
- Pay	(12,013)
- Non-pay	(22,951)
- Colchester Hospital recharges	(1,389)
Total Expenditure	**(36,353)**
Net surplus contributed to Trust operating deficit	**29**

2.2 Private Patient Income

	2017/18 £000	2016/17 £000
Private and overseas patient income	**735**	**836**
Total patient related income	**296,878**	**257,699**

2.3 Operating Lease Income

	2017/18 £000	2016/17 £000
Rents recognised as income in the period	**115**	**111**
Total	**115**	**111**

Future Minimum Lease Payments Due

-not later than 1 year	**90**	**86**
-later than 1 year and not later than 5 years	**135**	**217**
Total	**225**	**303**

The Trust's operating lease income is from the annual rents charged by the Trust for the use of its premises.

2.4 Income from Activities (by type)

	2017/18 £000	2016/17 £000
NHS Foundation Trusts	**5,641**	**24**
NHS Trusts	**7,407**	**160**
NHS England	**43,351**	**36,948**
Clinical Commissioning Groups	**235,169**	**215,417**
Local Authorities	**-**	**(22)**
Private patients	**637**	**715**
Overseas patients (non-reciprocal)	**98**	**121**
Injury Cost Recovery *	**1,074**	**1,027**
Other	**3,501**	**3,309**
	296,878	**257,699**

* Injury cost recovery income is subject to a provision for doubtful debts to reflect expected rates of collection.

2.5 Overseas Visitors (relating to patients charged directly by the Trust)

	2017/18 £000	2016/17 £000
Income recognised this year	**98**	**121**
Cash payments received in-year	**50**	**64**
Amounts added to provision for impairment of receivables	**47**	**25**
Amounts written off in-year	**25**	**49**

3. Operating Expenses

3.1 Operating Expenses (by type)	Foundation Trust		Consolidated	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Services from NHS trusts	-	(74)	-	(74)
Purchase of healthcare from non-NHS bodies	6,130	10,613	6,130	10,613
Non-Executive Directors' costs	137	148	137	148
Staff and executive director costs	206,473	192,294	206,473	192,294
Drug costs	27,602	28,004	27,602	28,004
Supplies and services - clinical	40,728	32,973	40,728	32,973
Supplies and services - general	4,004	3,954	4,004	3,954
Establishment	7,403	1,807	7,403	1,807
Transport	1,042	868	1,042	868
Premises	6,047	8,470	6,047	8,470
Increase/(decrease) in bad debt provision	148	539	148	539
Increase in other provisions	1,391	424	1,391	424
Change in provisions discount rate	8	70	8	70
Inventories written down	138	140	138	140
Depreciation	8,243	9,048	8,243	9,048
Rentals under operating leases	2,996	3,326	2,996	3,326
Audit fees in respect of the statutory audit *	55	46	55	46
Audit fees in respect of the quality report *	5	18	5	18
Audit fees in respect of the charitable funds audit *	-	-	5	3
Clinical negligence	13,585	12,350	13,585	12,350
Legal fees	303	169	303	169
Consultancy costs	4,636	4,317	4,636	4,317
Professional Services	3,393	3,162	3,393	3,162
Internal audit costs	59	54	59	54
Training, courses & conferences	830	811	830	811
Notional expenditure funded from the apprenticeship levy	36	-	36	-
Car parking & security	160	451	160	451
Redundancy	166	296	166	296
Insurance	324	317	324	317
Other services, e.g. external payroll	227	822	227	822
Losses, ex gratia & special payments	126	44	126	44
Other	6,163	804	6,163	804
Grant funding **	2,500	-	2,500	-
NHS charitable funds	-	-	283	198
Total	345,058	316,265	345,346	316,466

* Audit fees are disclosed inclusive of VAT.

** In 2017/18 the Trust used its grant-making freedoms to provide a grant to The Ipswich Hospital NHS Trust. This grant was provided on the basis that it allowed the Trusts to meet their respective Control Totals as set by NHS Improvement, gain access to Sustainability and Transformation Funding and progress the merging of the two organisations. The grant is only repayable should the merging of the Trusts not progress.

3.2 Arrangements Containing an Operating Lease

	2017/18 £000	2016/17 £000
Minimum lease payments	**2,996**	**3,326**
Total	**2,996**	**3,326**
Future Minimum Lease Payments Due		
-not later than 1 year	**1,902**	**1,744**
-later than 1 year and not later than 5 years	**1,989**	**600**
-later than 5 years	**703**	**367**
Total	**4,594**	**2,711**
Total of future minimum sublease lease payments to be received as at 31 March 2018	-	-

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.

3.3 Limitation on Auditor's Liability

The limitation on auditor's liability is £1,000,000 (£2,000,000 in 2016/17).

4. Staff Costs

4.1 Employee Benefits

	2017/18 £000	2016/17 £000
Salaries and wages	**143,932**	**135,849**
Social Security costs	**13,505**	**12,737**
Apprenticeship levy	**689**	**-**
Employer contributions to NHS Pension Scheme*	**17,041**	**15,657**
NEST pension contributions	**10**	**7**
Termination benefits	**253**	**296**
Agency/bank staff	**31,264**	**28,044**
Total	**206,694**	**192,590**

*** 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) 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 recent demographic experience), and to recommend contribution rates payable by employees and employers.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

b) 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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.

4.2 Key Management Compensation

The key management of the Trust are the Executive and Non-Executive Directors. The compensation paid or payable to key management for employee services is shown below:

	2017/18 £000	2016/17 £000
Salaries and other short-term employee benefits	811	1,015
Employer contributions to NHS Pension Scheme	100	110
Total	911	1,125

4.3 Staff Benefits in Kind

	2017/18 £000	2016/17 £000
Subsidised travel permits	48	50
Total	48	50

4.4 Retirements Due to Ill-health

During 2017/18 there was 1 early retirement from the Trust on the grounds of ill-health (4 in 2016/17). The estimated additional pension liabilities of these ill-health retirements is £86,528 (2016/17, £207,907). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

5. Better Payment Practice Code

5.1 Better Payment Practice Code - Measure of Compliance

	2017/18		2016/17	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	77,165	190,354	75,143	178,087
Total non-NHS trade invoices paid within target	36,502	123,297	9,739	88,521
Percentage of non-NHS trade invoices paid within target	47%	65%	13%	50%
Total NHS trade invoices paid in the year	1,838	58,768	1,401	36,519
Total NHS trade invoices paid within target	806	42,223	311	27,646
Percentage of NHS trade invoices paid within target	44%	72%	22%	76%

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.

5.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2017/18	2016/17
	£000	£000
Amounts included within interest payable (note 6.1) arising from claims made under this legislation	3	-
Total	3	-

6. Finance Income

	2017/18	2016/17
	£000	£000
Interest income on short-term bank deposits	46	24
NHS charitable funds - investment income	4	4
	50	28

6.1 Finance Costs

	2017/18	2016/17
	£000	£000
Finance Leases	24	28
Loans from the Department of Health	1,529	1,634
Other interest payable	3	-
	1,556	1,662

6.2 Gains/Losses on Disposal/De-recognition of Non-Current Assets

	2017/18	2016/17
	£000	£000
Profit on disposal of non-current assets	15	15
Loss on disposal of non-current assets	(86)	(7)
Net profit/(loss) on disposal of non-current assets	(71)	8

7. Intangible Assets

	Software Licences £000
Gross cost at 1 April 2016	10,377
Additions purchased	1,689
Disposals	(3)
Gross cost at 31 March 2017	**12,063**
Amortisation at 1 April 2016	4,843
Charged during the year	935
Disposals	(3)
Amortisation at 31 March 2017	**5,775**
Net book value	
- Purchased at 31 March 2017	6,288
- Total at 31 March 2017	**6,288**
Gross cost at 1 April 2017	12,063
Additions purchased	501
Disposals	(814)
Gross cost at 31 March 2018	**11,750**
Amortisation at 1 April 2017	5,775
Charged during the year	1,040
Disposals	(814)
Amortisation at 31 March 2018	**6,001**
Net book value	
- Purchased at 31 March 2018	5,749
- Total at 31 March 2018	**5,749**

8. Property, Plant and Equipment

8.1 Property, Plant and Equipment at the Statement of Financial Position Date Comprise the Following Elements:

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	28,470	141,524	296	38,291	7,104	223	215,908
Additions purchased	-	670	6,095	959	138	-	7,862
Additions donated	-	-	-	22	7	-	29
Transfers from assets under construction	-	3,418	(3,797)	-	379	-	-
Revaluations	(16,095)	(31,208)	-	-	-	-	(47,303)
Disposals	-	-	-	(2,410)	(1,553)	(48)	(4,011)
Cost or Valuation at 31 March 2017	**12,375**	**114,404**	**2,594**	**36,862**	**6,075**	**175**	**172,485**
Depreciation and impairments at 1 April 2016	-	-	-	20,641	4,671	133	25,445
Provided during the year	-	4,118	-	3,144	830	21	8,113
Revaluations	-	(4,118)	-	-	-	-	(4,118)
Disposals	-	-	-	(2,403)	(1,553)	(48)	(4,004)
Depreciation and Impairments at 31 March 2017	**-**	**-**	**-**	**21,382**	**3,948**	**106**	**25,436**
Net Book Value							
Owned at 31 March 2017	12,375	107,724	2,594	15,342	2,037	69	140,141
Finance Lease at 31 March 2017	-	1,542	-	-	64	-	1,606
On-balance-sheet service concession contracts	-	5,138	-	-	-	-	5,138
Donated at 31 March 2017	-	-	-	138	26	-	164
Total at 31 March 2017	**12,375**	**114,404**	**2,594**	**15,480**	**2,127**	**69**	**147,049**

8.1 Property, Plant and Equipment at the Statement of Financial Position Date Comprise the Following Elements (continued):

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	12,375	114,404	2,594	36,862	6,075	175	172,485
Additions purchased	-	29	9,537	2,494	84	-	12,144
Additions donated	-	-	27	25	-	-	52
Transfers from assets under construction	-	8,476	(8,930)	313	141	-	-
Revaluations	-	1,942	-	-	-	-	1,942
Disposals	-	-	-	(1,016)	(188)	-	(1,204)
Cost or Valuation at 31 March 2018	**12,375**	**124,851**	**3,228**	**38,678**	**6,112**	**175**	**185,419**
Depreciation and impairments 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	-	-	-	(991)	(97)	-	(1,088)
Depreciation and Impairments at 31 March 2018	**-**	**-**	**-**	**23,482**	**4,542**	**123**	**28,147**
Net Book Value							
Owned at 31 March 2018	12,375	117,721	3,201	15,070	1,553	52	149,972
Finance Lease at 31 March 2018	-	1,651	-	-	-	-	1,651
On-balance-sheet service concession contracts	-	5,479	-	-	-	-	5,479
Donated at 31 March 2018	-	-	27	126	17	-	170
Total at 31 March 2018	**12,375**	**124,851**	**3,228**	**15,196**	**1,570**	**52**	**157,272**

Of the totals at 31 March 2018, no land or buildings were valued at open market value.

8.2 Net Book Value of Non-Current Assets Held for Sale

	Land £000
Non-current assets held for sale at 1 April 2016	6,107
Revaluation of non-current assets held for sale	(2,007)
Non-current assets held for sale at 31 March 2017	**4,100**
Non-current assets held for sale at 1 April 2017	4,100
Non-current assets held for sale at 1 April 2018	**4,100**

9.1 The Total Amount of Depreciation Charged to the Income and Expenditure Account in Respect of Assets Held Under Finance Leases:

	2017/18 £000	2016/17 £000
Buildings	**41**	**41**
Plant & equipment	**63**	**191**
Total	**104**	**232**

9.2 The Net Book Value of Assets Held Under Finance Leases Comprises:

	31 March 2018 £000	31 March 2017 £000
Buildings	**1,651**	**1,542**
Information technology	**-**	**64**
Total	**1,651**	**1,606**

9.3 The Net Book Value of Land and Buildings:

	31 March 2018 £000	31 March 2017 £000
Freehold	**134,196**	**124,199**
Total	**134,196**	**124,199**

9.4 Impairment of Assets

In 2017/18 a desktop valuation exercise of the Trust's land and buildings was undertaken by the District Valuer Service, having regard to International Financial Reporting Standards (IFRS) as interpreted and applied by the DH Group Accounting Manual, which is compliant with HM Treasury Financial Reporting Manual (FReM) guidance for the United Kingdom public sector.

The valuations also accord with the requirements of the RICS Valuation - Professional Standards 2014 UK edition (known as "the Red Book"), including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.14 refers.

The valuation assumes that the properties valued will continue to be held for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

In accordance with IAS 16, the valuation of the Trust's land and buildings has been undertaken on a fair value basis, where fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction.

9.5 Donated Assets

	2017/18 £000	2016/17 £000
Donations of property, plant and equipment received	52	29
Total	**52**	**29**

10. Inventories

10.1 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	**2,047**	**2,143**
Consumables	**2,550**	**2,480**
Energy	**38**	**47**
Other	**203**	**204**
Total	**4,838**	**4,874**

10.2 Inventories Recognised in Expenses

	2017/18 £000	2016/17 £000
Inventories recognised in expenses	**45,900**	**42,086**
Write-down of inventories recognised as an expense	**138**	**140**
Total	**46,038**	**42,226**

11. Receivables

11.1 Trade Receivables and Other Receivables

	Total 31 March 2018 £000	Financial Assets 31 March 2018 £000	Non-Financial 31 March 2018 £000	Total 31 March 2017 £000	Financial Assets 31 March 2017 £000	Non-Financial 31 March 2017 £000
Current Trade and Other Receivables						
Receivables from NHS and DHSC group bodies	**22,824**	22,801	23	**23,500**	22,434	1,066
Trade receivables	**5,600**	5,600	-	**2,558**	2,558	**-**
Provision for impaired receivables	**(1,463)**	(809)	(654)	**(1,369)**	(777)	(592)
Prepayments	**1,640**	-	1,640	**1,787**	-	1,787
Accrued income	**2,586**	(278)	2,864	**3,050**	469	2,581
VAT receivable	**514**	-	514	**724**	-	724
Total	**31,701**	**27,314**	**4,387**	**30,250**	**24,684**	**5,566**

11.2 Trade Receivables and Other Receivables (consolidated)

	Total 31 March 2018 £000	Financial Assets 31 March 2018 £000	Non-Financial 31 March 2018 £000	Total 31 March 2017 £000	Financial Assets 31 March 2017 £000	Non-Financial 31 March 2017 £000
Current Trade and Other Receivables				**Restated**	**Restated**	
Receivables from NHS and DHSC group bodies	**22,824**	22,801	23	**23,500**	22,434	1,066
Trade receivables	**5,600**	5,600	-	**2,524**	2,524	-
Provision for impaired receivables	**(1,463)**	(809)	(654)	**(1,369)**	(777)	(592)
Prepayments	**1,640**	-	1,640	**1,787**	-	1,787
Accrued income	**2,582**	(282)	2,864	**3,050**	469	2,581
VAT receivable	**514**	-	514	**724**	-	724
NHS charitable funds: trade and other receivables	**4**	4	-	**153**	153	-
Total	**31,701**	**27,314**	**4,387**	**30,369**	**24,803**	**5,566**

11.3 Provision for Impairment of Receivables

	Total 31 March 2018 £000	Total 31 March 2017 £000
At 1 April	**1,369**	**894**
Increase in provision	**252**	**724**
Amounts utilised	**(54)**	**(64)**
Unused amounts reversed	**(104)**	**(185)**
At 31 March	**1,463**	**1,369**

11.4 Analysis of Impaired Receivables

	Total 31 March 2018 £000	Total 31 March 2017 £000
Aging of Impaired Receivables		
Up to 1 month	-	44
In 1 to 2 months	15	38
In 2 to 3 months	25	4
In 3 to 6 months	51	430
Over 6 months	1,372	853
Total	**1,463**	**1,369**

	Total 31 March 2018 £000	Total 31 March 2017 £000
Aging of Non-Impaired Receivables Past their Due Date		
Up to 1 month	5,193	2,515
In 1 to 2 months	1,831	910
In 2 to 3 months	1,021	263
In 3 to 6 months	1,278	689
Over 6 months	1,347	546
Total	**10,670**	**4,923**

12. Trade and Other Payables

12.1 Trade and Other Payables comprise the following:

	Total 31 March 2018 £000	Financial Liabilities 31 March 2018 £000	Non-Financial Liabilities 31 March 2018 £000	Total 31 March 2017 £000	Financial Liabilities 31 March 2017 £000	Non-Financial Liabilities 31 March 2017 £000
Current Trade and Other Payables						
Payables to NHS and DHSC group bodies	**5,794**	5,702	92	**3,901**	3,901	-
Trade payables	**15,058**	12,622	2,436	**9,901**	7,670	2,231
Trade payables - capital	**2,351**	2,351	-	**1,570**	1,570	-
Other taxes payable	**3,858**	-	3,858	**3,489**	-	3,489
Accruals	**11,862**	11,862	-	**11,317**	11,317	-
Total	**38,923**	**32,537**	**6,386**	**30,178**	**24,458**	**5,720**

12.2 Trade and Other Payables (consolidated) comprise the following:

	Total 31 March 2018 £000	Financial Liabilities 31 March 2018 £000	Non-Financial Liabilities 31 March 2018 £000	Total 31 March 2017 £000	Financial Liabilities 31 March 2017 £000	Non-Financial Liabilities 31 March 2017 £000
Current Trade and Other Payables						
Payables to NHS and DHSC group bodies	**5,794**	5,702	92	**3,901**	3,901	-
Trade payables	**15,058**	12,622	2,436	**9,901**	7,670	2,231
Trade payables - capital	**2,351**	2,351	-	**1,570**	1,570	-
Other taxes payable	**3,858**	-	3,858	**3,489**	-	3,489
Accruals	**11,862**	11,862	-	**11,317**	11,317	-
NHS charitable funds: trade and other payables	**141**	141	-	**93**	93	-
Total	**39,064**	**32,678**	**6,386**	**30,271**	**24,551**	**5,720**

13. Other Liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,516	1,538
Deferred PFI credits	326	326
Sub Total	**1,842**	**1,864**
Non-Current		
Deferred PFI credits	2,280	2,605
Sub Total	**2,280**	**2,605**
Total	**4,122**	**4,469**

14. Finance Lease Obligations

14.1 Future Finance Lease Obligations

The Trust has future finance lease obligations for which the minimum payments at 31 March 2018 are £1,030k over a 18 year period of commitment (£1,151k over 19 years at 31 March 2017). The lease relates to the Iceni training facility.

14.2 Finance Lease Obligations

			Present Value of Minimum Lease Payments	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Gross Lease Liabilities	**1,030**	**1,151**	**816**	**914**
of which liabilities are due				
not later than 1 year	60	121	37	97
later than 1 year and not later than 5 years	240	240	157	157
later than 5 years	730	790	622	660
Finance charges allocated to future periods	(214)	(237)	-	-
Net Lease Liabilities	**816**	**914**	**816**	**914**

14.3 PFI Obligations

The Trust's 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 (see note 13).

The deferred income is released to operating income over the life of the concession.

15. Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Capital loans from Department of Health and Social Care	1,267	5,267
Obligations under finance leases	37	97
Total Current Borrowings	**1,304**	**5,364**
Non-current		
Capital loans from Department of Health and Social Care*	22,157	19,424
Working capital loans from Department of Health and Social Care	77,701	73,385
Obligations under finance leases	779	817
Total Other Non-Current Liabilities	**100,637**	**93,626**

*In 2014/15 the Trust received a £4.0 million capital loan to assist with the relocation of services from Essex County Hospital. The loan provided working capital to allow replacement infrastructure to be built ahead of the sale. The loan period has been extended to accommodate the timing of the sale of Essex County Hospital and is now repayable in April 2022.

Borrowings include four single currency term loans from the Secretary of State for Health.

The interest rate on the first loan (amount outstanding at 31 March 2018, £17,842k (31 March 2017, £19,030k) is 2.18% per annum, and the loan will be repaid in full by March 2033.

The interest rate on the second loan (amount outstanding at 31 March 2018, £4,000k (31 March 2017, £4,000k) is 0% per annum, and the loan will be repaid in full in April 2022.

The interest rate on the third loan (amount outstanding at 31 March 2018, £1,582k (31 March 2017, £1,661k) is 1.61% per annum, and the loan will be repaid in full by February 2038.

The interest rate on the fourth loan (amount outstanding at 31 March 2018, £77,701k (31 March 2017, £73,385k) is 1.5% per annum. This loan represents the combined working capital advances provided by the Department of Health to the Trust. These loans will be repaid in full by April 2021.

16. Provisions for Liabilities and Charges

	Current 31 March 2018 £000	Current 31 March 2017 £000	Non-Current 31 March 2018 £000	Non-Current 31 March 2017 £000
Pensions - early departure costs	103	105	815	905
Other legal claims	72	60	-	-
Restructuring	1,146	-	-	-
Redundancy	672	391	-	-
Other	217	354	-	-
Total	**2,210**	**910**	**815**	**905**

	Pensions - early departure costs	Legal claims	Restructuring	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2016	1,070	33	-	-	259	**1,362**
Change in the discount rate	70	-	-	-	-	**70**
Arising during the year	112	52	-	391	248	**803**
Utilised during the year	(117)	(14)	-	-	(78)	**(209)**
Reversed unused	(138)	(11)	-	-	(75)	**(224)**
Unwinding of discount	13	-	-	-	-	**13**
At 31 March 2017	**1,010**	**60**	**-**	**391**	**354**	**1,815**
At 1 April 2017	1,010	60	-	391	354	**1,815**
Change in the discount rate	8	-	-	-	-	**8**
Arising during the year	10	42	1,146	672	36	**1,906**
Utilised during the year	(105)	(8)	-	-	-	**(113)**
Reversed unused	(7)	(22)	-	(391)	(173)	**(593)**
Unwinding of discount	2	-	-	-	-	**2**
At 31 March 2018	**918**	**72**	**1,146**	**672**	**217**	**3,025**
Expected timing of cash flows:						
Within one year	103	72	1,146	672	217	**2,210**
Between one and five years	327	-	-	-	-	**327**
After five years	488	-	-	-	-	**488**
	918	**72**	**1,146**	**672**	**217**	**3,025**

Other provisions relate to the new Staff and Associate Specialists contract. The provision was calculated on a person-by-person basis. Legal claims represent a number of miscellaneous legal claims. The Trust is defending these claims and expects agreement to be reached within the coming year based on the timing of court and other negotiation arrangements.

16.1. Clinical Negligence Provisions

£153,853k is included in the provisions of NHS Resolution at 31 March 2018 in respect of clinical negligence liabilities of the Trust (£135,349k, 31 March 2017).

17. Notes to the Statement of Cash Flows

17.1. Cash and Cash Equivalents

	At 1 April 2017	Other changes in year	**At 31 March 2018**
	£000	£000	**£000**
Cash with the Government Banking Service	5,210	3,743	**8,953**
Commercial cash at bank and in hand	232	48	**280**
NHS charitable funds cash and cash equivalents	1,891	609	**2,500**
	7,333	**4,400**	**11,733**

18. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2018 were £588k (£1,386k, 31 March 2017).

19. Events After the Reporting Period

There are no events after the reporting period.

20. Contingencies

	31 March 2017	**31 March 2016**
	£000	**£000**
Contingent liabilities	**(65)**	**(68)**

Contingent liabilities relate solely to claims for personal injury and property expenses which are being handled by the NHS Resolution (formerly the NHS Litigation Authority).

21. Movement in Public Dividend Capital

	£000
Public Dividend Capital as at 1 April 2016	76,764
Public Dividend Capital received	1,750
Public Dividend Capital repaid	(1,750)
Public Dividend Capital as at 31 March 2017	**76,764**
Public Dividend Capital as at 1 April 2017	76,764
Public Dividend Capital received	1,230
Public Dividend Capital as at 31 March 2018	**77,994**

22. Related Party Transactions and Balances

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, Colchester Hospital University NHS Foundation trust has had a number of material transactions (balances greater than £5m) with other government departments and other central and local government bodies during the year:

	2017/18 Income £000	2017/18 Expenditure £000	2017/18 Receivables £000	2017/18 Payables £000	2016/17 Income £000	2016/17 Expenditure £000	2016/17 Receivables £000	2016/17 Payables £000
Cambridge University Hospitals NHS Foundation Trust	264	5,471	150	1,195	1,815	8,786	1,145	1,821
Ipswich Hospital NHS Trust	8,190	5,963	1,899	2,473	283	812	261	533
West Suffolk NHS Foundation Trust	5,611	1,423	550	222	26	13	16	4
Health Education England	7,489	5	51	47	6,520	23	57	29
NHS England	65,074	3	16,026	1	53,689	3	11,515	63
NHS Ipswich and East Suffolk CCG	11,122	-	72	-	4,073	-	576	-
NHS Mid Essex CCG	21,045	-	109	132	20,186	-	899	91
NHS North East Essex CCG	197,794	161	1,910	1,434	187,007	5	2,585	1,330
NHS Resolution (formerly NHS Litigation Authority)	-	13,783	-	-	-	12,555	-	2
NHS West Suffolk CCG	5,090	18	40	26	1,626	-	146	7
Public Health England (PHE)	886	6,697	197	46	238	8	56	-
HM Revenue & Customs	-	14,194	-	3,858	-	12,737	-	3,489
NHS Pension Scheme	-	17,041	-	2,396	-	15,657	-	2,194
NHS Professionals	-	15,774	-	2,669	-	13,485	17	2,188

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

The disclosure required by IAS 24 in relation to the compensation of key management can be found at note 4.2.

The Ipswich Hospital NHS Trust is considered a related party due to the shared appointments of the Trust's Chief Executive and Chairman between both Trusts. In addition, a number of other senior clinical, managerial and operational staff are now shared between both Trusts for which appropriate recharges of salary costs are made.

None of these associations has resulted in transactions outside of the normal business of the Trust.

23. Financial Instruments

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 2018 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.

23.1a Financial Assets by Category

	Loans and receivables	
	31 March 2018	31 March 2017
Assets as per Statement of Financial Position	**£000**	**£000**
Trade and other receivables	27,369	24,650
Cash at bank and in hand	9,233	5,442
NHS charitable funds: financial assets	2,504	1,893
Total	**39,106**	**31,985**

23.1b Financial Liabilities by Category

	Other financial liabilities	
	31 March 2018	31 March 2017
Liabilities as per Statement of Financial Position	**£000**	**£000**
Obligations under finance leases	816	914
Borrowings	101,125	98,076
Trade and other payables	32,597	24,457
Provisions under contract	2,034	745
NHS charitable funds: financial liabilities	141	93
Total	**136,713**	**124,285**

24. Fair values

As at 31 March 2018 there are no significant differences between fair value and carrying value of any of the Trust's financial instruments.

The fair value for provisions is not significantly different from book value since in the calculation of book value the expected cash flows have been discounted by the Treasury discount rate of 0.1% in real terms.

25. Losses and Special Payments

Losses and special payments are transactions 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 loses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums being included as normal revenue expenditure).

However, the losses and special payments note is complied directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

	2017/18		2016/17	
Losses	**Number**	**Value £000**	**Number**	**Value £000**
Cash losses	33	42	9	3
Fruitless payments	-	-	3	9
Bad debts	139	41	52	70
Stores losses	6	138	5	140
Total Losses	**178**	**221**	**69**	**222**
Special Payments				
Compensation under legal obligation	1	35	1	38
Loss of personal effects	21	4	24	16
Clinical negligence with advice	1	2	-	-
Other employment payments	2	55	-	-
Personal injury claims	2	15	5	13
Ex gratia payments	57	2	86	11
Total Special Payments	**84**	**113**	**116**	**78**
Total Losses and Special Payments	**262**	**334**	**185**	**300**

26. Segmental Analysis

IFRS 8 prescribes the accounting and disclosures required for an entity's operating segments, products and services, and the geographical areas in which it operates and its major customers. It requires an entity to report financial and descriptive information about its reportable segments. Reportable segments are operating segments or aggregations of operating segments that meet specified criteria. Operating segments are components of an entity about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance.

IFRS 8 defines the term chief operating decision maker as a group or individual whose 'function is to allocate resources to, and assess the performance of, the operating elements of the entity'. For the Trust, the most appropriate interpretation is that the Board of Directors represents the chief operating decision maker.

The Trust has only one segment - the provision of healthcare. The Trust Board of Directors only receives information on this segment. Whilst the Trust has a number of divisions and departments, information on the financial performance of these individual elements is not received by the Trust Board. Financial information reported to the Board is compliant with IFRS.

A reconciliation between the published accounts and the information presented to the Board of Directors is shown below.

There is one major income stream for the Trust's activities: NHS funding for healthcare provision. This comprises 98% of the Trust's total income from activities, and 86% of its total operating income. Only two customers of the Trust, NHS North East Essex CCG and NHS England - East of England Specialist Commissioning Hub, make up more than 10% of the Trust's income from activities (67%, £197,794k and 12%, £35,398k respectively).

Revenues from countries outside of England are small (£25k received from Welsh and Scottish Commissioners). The Trust received £98k in relation to overseas visitors.

		2017/18 £000		2016/17 £000
Income		**343,451**		**301,617**
Expenditure				
Pay	**(206,610)**		**(192,455)**	
Non-pay	**(130,205)**		**(114,775)**	
Total Expenditure		**(336,815)**		**(307,230)**
EBITDA		**6,636**		**(5,613)**
Depreciation, PDC dividend, etc.		**(10,881)**		**(13,329)**
Deficit before non-current asset impairments		**(4,245)**		**(18,942)**
Non-current asset impairments		**-**		**-**
Deficit after non-current asset impairments		**(4,245)**		**(18,942)**

Colchester Hospital University
NHS Foundation Trust

Quality Report 2017/18

Contents

Who was involved in the development of our Quality Account?

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

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

Colchester Hospital University NHS Foundation Trust would like to thank those who contributed to the development and publication of this Quality Account.

Our front cover shows

The Dementia Care Pledge Tree and members of staff holding their pledges.

The Dementia Care Pledge Tree is located within the Hosptial main corridors.

Part 1 - Statement on quality

Chief Executive's commentary

This is our account to you about the quality of services provided by Colchester Hospital University NHS Foundation Trust in 2017/18. It looks back at our performance over the last year and gives details of our priorities for improvement in 2018/19.

The challenges faced by Colchester have been well documented over the years. I began as Chief Executive in May 2016 to support the staff to address the concerns raised by our regulators and others.

As Chief Executive, my prime focus is the safety of patient services, ensuring they are consistently accessible, consistently of high quality and continually meeting the operational standards expected.

One of my priorities has been the merger of the trusts that run Colchester and Ipswich hospitals to create a new organisation that will be the biggest in East Anglia; working together to improve care for patients and create a more sustainable future. Of course, there is a financial element to it but, fundamentally, the merged organisations will be an opportunity to improve care for patients and drive up quality. Merging means we will spend less money on overheads and duplication, releasing more money for our services, leading to improved care for our patients.
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.
The merger is not a silver bullet for these problems but provides opportunities to address them more successfully by working together as a single organisation.

In 2017-18 our *"Every Patient, Every Day"* programme continued to drive improvement in a systematic and caring way.

This focused on 11 key work streams, including Urgent Care, Frail & Elderly Patients and Planned Care. I'm delighted with the progress we've made in reducing length of stay and in particular the opening of the Frailty Assessment Unit.

The transformation with End of Life care saw the Trust achieve 'Good' in every category for this area during the CQC visit this year.

Another project we implemented was Project Ivy, Ivy is one patients story driving change, the story of a lady who waited too long……She spent 9 hours lying on her kitchen floor in pain, cold and frightened while the ambulance service tried to get to her. They took the best part of a day because they were tied up at Colchester Hospital waiting to drop off other patients at our Emergency Department.

The flow of patients through our Emergency Department, Assessment Units, Wards and back home again is the most important issue we face. At its heart are the stories of people just like Ivy who need our care but aren't able to access it quickly enough.

Project Ivy was launched in August 2017 with the goal that no patient would spend a moment longer in hospital than was needed, to progress their care. It is being led by a small team of staff-clinical and non-clinical who are committed to making multiple rapid improvements on an incremental basis.

Areas of focus have included:

- ✓ Effective board rounds
- ✓ Creating an excellent discharge lounge
- ✓ Gaining some insight why some patients are in hospital for more than seven days
- ✓ Bringing energy to the Red to Green process
- ✓ Introducing non-clinical staff volunteers to help with peaks in demand

The CQC completed a full inspection of the hospital in July 2017, published in November 2017 and I am pleased with the progress recognised in the inspection; but aware of the significant work yet to be undertaken. The CQC found that significant improvement had been made across all services at the Trust. The team in place now worked together with more structured disciplines being embedded around executive and performance behaviours and responsibilities. With the Every Patient, Every Day programme (EPED), the responsibility, accountability and ownership of service improvement had been given back to the local leaders.

The boards of both Colchester Hospital and Ipswich Hospital are continuing to work together to merge the organisations to improve care for patients and create a more sustainable future.

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 Account is accurate.

Nick Hulme
Chief Executive

Part 2 - Priorities for improvement and statements of assurance

2017/18 quality improvement priorities

Progress against the priorities we set as a Trust

Patient safety priority 1 (a):

To reduce the numbers of inpatient falls

Why was this a priority?

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

The Trust is committed to ensuring that, wherever possible, no patient suffers from harm whilst receiving care, and therefore, this was identified as the key patient safety priority for 2017/18.

Lead Director

Director of Nursing

What was our target?

A reduction of inpatient falls per 1000 bed days to below 5.

What did we do to improve our performance?

- ✓ A Trust-wide improvement plan for Falls has been developed
- ✓ An aggregated action plan was implemented for falls incidents resulting in harm
- ✓ The Falls Prevention inpatient service has been developed within Corporate Nursing and Quality Divisions, with leadership provided by the Deputy Director of Nursing on behalf of the Director of Nursing

How did we measure and monitor our performance?

- ✓ Incident reporting of all inpatient falls were monitored through Patient Safety & Quality Team and reported upon via Ward Safety Dashboard to Matrons Group, chaired by Director of Nursing.
- ✓ All falls resulting in serious harm were investigated at the earliest opportunity and case were reviewed through the weekly Harm Free Forum chaired by Deputy Director of Nursing. This identified immediate learning and informed quality improvement plans.
- ✓ Monthly review of falls activity and trends has formed part of the Patient Safety and Experience Report.
- ✓ Inpatient falls incidents have been triangulated with PALS complaints and Safeguarding information to identify any emerging themes and trends to any specific areas of the Trust. This has identified 'early warning' signals which enabled quality improvement actions to be undertaken.

Did we achieve our intended target?

- ✓ Overall, the Trust has demonstrated a reduction of inpatient falls by 14%
- ✓ There has been a reduction in the number of falls resulting in serious harm by 6%.

How and where was progress reported?

Regular reports and updates were provided to:

- ✓ Matrons Meeting
- ✓ Patient Safety and Experience Group
- ✓ Quality & Patient Safety Committee.

Our key achievements

- ✓ Achieving a reduction in the overall number of inpatient falls and consistency in <5 falls per 1,000 bed days
- ✓ A reduction in the number of falls resulting in serious harm
- ✓ Development of a weekly Harm Free Forum Group to discuss inpatients falls incidents resulting in serious harm in order to identify areas for learning and to target support.

2017/18 quality improvement priorities
Progress against the priorities we set as a Trust

Patient safety priority 1 (b):

A reduction in hospital acquired pressure ulcers

Why was this a priority?

To reduce the burden on patients living with them

To reduce resources spent by the Trust on treating them.

To ensure that clinical care supports best practise in pressure ulcer prevention.

To reduce incidence of patient harm .

Lead Director

Director of Nursing

What was our target?

A reduction by 30% of hospital acquired pressure ulcers (total numbers) compared to 2016/17.

What did we do to improve our performance?

- ✓ Delivered 1:1 training on pressure ulcer prevention across the Trust
- ✓ Engaged with NHSI Pressure Ulcer Collaborative 2017/2018
- ✓ Increase staffing within the Tissue Viability (TV) team allowing for increased face to face support across the Trust
- ✓ Reviewed current pressure ulcer prevention practises and implemented improvements in line with best practise
- ✓ Delivered education on pressure ulcers to enhance skills and knowledge for Trust staff
- ✓ Provided monthly training to all new staff on pressure ulcers via clinical induction
- ✓ Implemented pressure redistribution surfaces within A&E to protect at risk patients.
- ✓ Audited use of pressure redistribution surfaces to ensure correct selection
- ✓ Harm Free panel setup revised focusing on lessons learnt and shared learning.

How did we measure and monitor our performance?

- ✓ Monitored via Datix system
- ✓ Against national Patient Safety Thermometer data
- ✓ Completion of Root Cause Analysis into PU incidences.

Did we achieve our intended target?

Yes—reduction of total pressure ulcer numbers by 30%.

How and where was progress reported?

Matrons meetings

Harm Free Panel

Monthly patient safety report

Quarterly reports to Patient Safety & Experience Group and Quality & Patient Safety Committee.

Our key achievements

- ✓ Reduction of 30% of total PU figures (all grades) compared to 2016/2017
- ✓ Involvement in the NHSI PU Collaborative 2017/2018
- ✓ An increase in staffing within the Tissue Viability Service enhancing Ward support and patient education
- ✓ Raising awareness of appropriate use of dynamic support surfaces to aid PU prevention/management
- ✓ Introduction of pressure reducing mattresses in A & E to ensure ‘at risk’ patients receive preventative care
- ✓ 1:1 individual training with Ward staff on PU prevention
- ✓ Patients that require Tissue Viability support are identified on inpatient whiteboards
- ✓ Implementation of a recognised tool to aid staff in differentiating between different types of skin damage
- ✓ Improved resources to support Heel elevation as a tool to aid PU prevention
- ✓ User friendly Wound Care Formulary to guide staff on appropriate choice of dressings.

Part 2 - Priorities for improvement and statements of assurance

2017/18 quality improvement priorities

Progress against the priorities we set as a Trust

Clinical Effectiveness priority:

To ensure the Trust has completed its requirements in relation to NatSSIPS

Why was this a priority?

The National Safety Standards for Invasive Procedures (NatSSIPs) were published in September 2015 to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur.

The principle behind the NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. This will be done by organisations working in collaboration with staff to develop their own set of 'Local Safety Standards for Invasive Procedures' (LocSSIPs). The NatSSIPs cover all invasive procedures, including those performed outside of the operating department. The Trust will use the key elements of safe care as a basis for the development of Local Standards for Invasive Procedures (LocSSIPs).

Lead Director

Medical Director

What was our target?

Ensure the Trust has completed its requirements in relation to NatSIPPS in 80% of settings.

What did we do to improve our performance?

The Trust identified a lead clinician with administrative support to coordinate and assure the Board the required work is being undertaken, to provide regular updates on progress and to support the clinical teams in identifying the required procedures and undertake the requirements.
The Trust has compiled a centralised database of procedures across all clinical settings where NatSSIPs are applicable. The database will continue to be monitored centrally as further procedures continue to be identified and logged or where there are changes to the guidance;
Intervention teams have been identified within the clinical specialties and the clinical lead and administrator meet to support them to complete their LocSSIPs for the relevant procedures.

How did we measure and monitor our performance?

The performance was monitored on a monthly basis at the Clinical Delivery Group and Divisional Governance and Quality meetings.

Progress has been measured against the identified number of LocSSIPs required as well as identifying and completing more Trust wide Policy and Procedure based on the NatSSIPs requirements.

Did we achieve our intended target?

There have been 123 interventions requiring a LocSSIPs identified as at 31st March 2018. 7 of these are in progress and 99 are now complete, which shows a 88.61% completion target against the 80% identified.

How and where was progress reported?

The performance was monitored on a monthly basis at the Clinical Delivery Group and Divisional Governance and Quality meetings. Monthly updates have been provided to the Clinical Effectiveness Group and to the Quality and Patient Safety Committee which reports to the Trust Board. Updates have also been presented monthly to the Trust's Quality & Risk Executive Meeting to provide assurance that risks to the workplan have been identified and are being mitigated or to request support where needed.

Our key achievements

A Safer Surgery Policy has been developed and was launched in August 2017. The policy ensures staff use the safest practice in minimising risks to patients during the perioperative patient episode. The policy focuses on key patient safety processes including Patient consent and identification, surgical site marking, Pregnancy check before surgery, surgical safety checklist, Stop before you block (regional Anaesthesia) and focuses on the World Health Organisation core standards for safer surgery.

The Policy for the checking of pregnancy before surgery, x-ray/ diagnostics and chemotherapy was approved in August 2017. This was a key document which the Trust did not have in place at the time despite a historic NPSA Rapid Response Alert. The policy is one of the necessary safety mechanisms to support NatSSIPs.

2017/18 quality improvement priorities
Progress against the priorities we set as a Trust

Patient experience priority:
Improved Friends and Family Test (FTT) performance across all required domains to upper quartile in response rate whilst maintaining >95% positive recommendation

Why was this a priority?

The Friends and Family Test provides real-time feedback on the true experience of patients, relatives and carers and provides healthcare providers with the opportunity to improve services and respond immediately to any emerging concerns. The FFT supports the Trust in achieving its goal to be the most caring healthcare provider.

Lead Director
Director of Nursing

What was our target?

Improved Friends and Family Test (FTT) performance across all required domains to upper quartile in response rate whilst maintaining >95% positive recommendation.

What did we do to improve our performance?
- ✓ FFT compliance was tracked as part of the senior nursing accountability programme.
- ✓ FFT metrics were utilised within the Trust's Accountability Framework
- ✓ The process to move to an electronic FFT collection process was commenced with the closing of the tender happening in April 2018.

How did we measure and monitor our performance?

- ✓ FFT weekly, monthly tracking through Patient Safety and Experience Group and assured through Quality and Patient Safety Committee
- ✓ Programme oversight for new FFT system implementation to be tracked through the Projects Management office.

Did we achieve our intended target?

The Trust achieved its target for recommender being at or above 95% for Inpatients with a score of 97.9% (national average 95.7%) ; the score for ED was 87.7% - this was, however, higher than the national average.

How and where was progress reported?

Regular reports and updates to:
- ✓ Divisional Governance meetings
- ✓ Patient Safety and Experience Group
- ✓ Quality and Patient Safety Committee
- ✓ Weekly Matrons Meetings
- ✓ Divisional Integrated Performance Meetings
- ✓ Trust Board through Integrated Performance Report Accountability Framework.

Our key achievements

- ✓ Improved response rates for ED, becoming one of the better performing trusts nationally for response rates and recommender rate above the national average.
- ✓ Listening to patient feedback and making improvements

Our priorities for improvement in 2018/19

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 2018/19.

Patient safety priority:

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 Director of Nursing

2017/18 performance

- Identification of sepsis in the Emergency Department Was 58% and acute inpatient settings was 40%.
- Timely treatment of sepsis within 60 minutes is 52% and inpatient areas 24.92%

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
- ✓ Bespoke training sessions for ward-based staff.

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: Patient Safety & Experience Group, Quality and Patient Safety Committee and Deteriorating Patient Group

Clinical effectiveness priority:

To improve access to psychiatric liaison services for hospital inpatients

Why is this a priority?

This is a national priority to ensure patients receive prompt access to ensure parity of both mental health and physical health care.

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.

This will support the hospital to meet NICE guidance criteria for managing mental health and psychological conditions and those co-morbid with long-term conditions and ensure patients are treated appropriately.

Lead Director

Director of Operations

2017/18 performance

The Trust reported a reduction of 44.75%, meeting the expectation of a 20% reduction in the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.

What is our target?

Our priorities for improvement in 2018/19

- Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions.
- Reduce total number of attendances to A&E by 10% for all people with primary mental health needs.

What will we do to improve our performance?

✓ Work with our partners, both education providers and staff to provide education and training for all staff to increase confidence

✓ Monitor the ED breaches for patients requiring mental health support.

✓ Monitor the length of stay for patients who have a mental health co-morbidity.

How will we measure and monitor our performance?

✓ Monitor the ED breaches for patients requiring mental health support.

✓ Monitor the length of stay for patients who have a mental health co-morbidity

✓ Reporting on Outcomes Framework to the Operational Board.

How and where will progress be reported?

Regular reports and updates to:

✓ A&E Operational Board

✓ Executive Management Committee

✓ Quality & Contract Performance Meeting with the Commissioners

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
Director of Nursing & Medical Director

2016/17 performance

✓ >75% of admitted emergency patients who are on My Care Choices Register being accessed during their hospital stay, achieved 76%

✓ <17 Complaints related to end of life care. Performance was 21

✓ 50% Use of the Individual Care Record End of Life documentation, 58% achieved

✓ 90% of Patients who are rapidly deteriorating (last weeks of life) and discharged to their Preferred Place of Death ("PPD"), 87% achieved

✓ <=24hrsTime taken to discharge rapidly deteriorating patients (last weeks of life) to their preferred place of discharge from time of referral to complex discharge team, achieved 192hrs (average)

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 SPICT
- Discuss with patients and their families their wishes and document on My Care Choices Register (MCCR).
- 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, ie 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,

Our priorities for improvement in 2018/19

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.
- Improve bereavement support for families of patients who have died by promoting and/or referring to NEE Bereavement services

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:

✓ Patient Safety & Experience

✓ Quality & Patient Safety Committee

✓ End of Life Steering Group.

Our priorities for improvement in 2018/19

Karen Magill, Sepsis and Deteriorating Patient Nurse Specialist and the Children's Emergency Department Team following the short listing for the improvements made to the Care of a Child with Sepsis in the Emergency Department, for the National Patient Safety Awards.

Provided and sub-contracted services

Provided and sub-contracted services

During 2017/18 Colchester Hospital University NHS Foundation Trust provided and/ or sub-contracted 68 relevant health services.

Colchester Hospital University NHS Foundation Trust has reviewed all the data available to them on the quality of care in 68 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18, represents 100% of the total income generated from the provision of relevant health services by Colchester Hospital University NHS Foundation Trust for 2017/18.

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

.

Colchester Hospital now offers a new service , 'brachytherapy with needles' for advanced cervical cancer. Pictured below the Brachytherapy Team with the equipment

Participation in clinical audit

During 2017/18, 36 national clinical audits and 5 national confidential enquiries covered relevant health services that Colchester Hospital University NHS Foundation Trust provides.

During 2017/18 Colchester Hospital University NHS Foundation Trust participated in 81% of the national clinical audits and 100% of the 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 Colchester Hospital University NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

Table 1.—National Audits

National Audits 2017/18
Heart
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Cardiac Rhythm Management (CRM)
National Cardiac Arrest Audit (NCAA)
National Heart Failure Audit
National Vascular Registry
Acute
Case Mix Programme (CMP)
Falls and Fragility Fractures Audit programme (FFFAP)
Major Trauma Audit
National Emergency Laparotomy Audit (NELA)
National Joint Registry (NJR)
Fractured Neck of Femur (care in emergency departments)
Procedural Sedation in Adults (care in emergency departments)
BAUS Urology Audits
Women's & Children
Diabetes (Paediatric) (NPDA)
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)
Child Health Clinical Outcome Review Programme
Maternal, Newborn and Infant Clinical Outcome Review Programme
National Maternity and Perinatal Audit (NMPA)
Pain in Children (care in emergency departments)
Older People
National Audit of Dementia
Sentinel Stroke National Audit programme (SSNAP)
Long Term Conditions
Endocrine and Thyroid National Audit
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
National Diabetes Audit - Adults
UK Parkinson's Audit
Cancer
Bowel Cancer (NBOCAP)
National Lung Cancer Audit (NLCA)
National Prostate Cancer Audit
Oesophago-gastric Cancer (NAOGC)
National Audit of Breast Cancer in Older People (NABCOP)
Haematology
National Comparative Audit of Blood Transfusion programme
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
Other
Elective Surgery (National PROMs Programme)
Learning Disability Mortality Review Programme (LeDeR)
National Ophthalmology Audit
Medical and Surgical Clinical Outcome Review Programme
National Confidentional Enquiries 2017/18
Chronic Neurodisability
Young People's Mental Health
Cancer in Children, Teens and Young Adults
Acute Heart Failure
Perioperative Diabetes

Participation in clinical audit

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust participated in during 2017/18 are as follows:

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Audits 2017/18	Cases Sub-mitted	Cases Ex-pected	%
Heart			
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	294	294	100 %
Cardiac Rhythm Management (CRM)	279	279	100 %
National Cardiac Arrest Audit (NCAA)	59	59	100 %
National Heart Failure Audit	631	631	100 %
National Vascular Registry	201	201	100 %
Acute			
Case Mix Programme (CMP)			NA
Falls and Fragility Fractures Audit programme (FFFAP)	30	30	100 %
Major Trauma Audit	364	364	100 %
National Emergency Laparotomy Audit (NELA)	176	176	100 %
National Joint Registry (NJR)	908	908	100 %
Fractured Neck of Femur (care in emergency departments)	41	41	100 %
Procedural Sedation in Adults (care in emergency departments)	51	51	100 %
BAUS Urology Audits			NA
Women's & Children			
Diabetes (Paediatric) (NPDA)	211	211	100 %
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)			NA
Child Health Clinical Outcome Review Programme			NA
Maternal, Newborn and Infant Clinical Outcome Review Programme	44	44	100 %
National Maternity and Perinatal Audit (NMPA)	NA	NA	100 %
Pain in Children (care in emergency departments)	51	51	100 %
Older People			
National Audit of Dementia	56	50	100 %
Sentinel Stroke National Audit programme (SSNAP)	653	653	100 %
Long Term Conditions			
Endocrine and Thyroid National Audit			NA
National Chronic Obstructive Pulmonary Disease (COPD) Audit pro-gramme	616	616	100 %
National Diabetes Audit - Adults	47	47	100 %
UK Parkinson's Audit			NA

Participation in clinical audit

Cancer			
Bowel Cancer (NBOCAP)	339	339	100%
National Lung Cancer Audit (NLCA)			NA
National Prostate Cancer Audit			NA
Oesophago-gastric Cancer (NAOGC)	52	52	100%
National Audit of Breast Cancer in Older People (NABCOP)			
Haematology			
National Comparative Audit of Blood Transfusion programme	135	135	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	NA	NA	NA
Other			
Elective Surgery (National PROMs Programme)	98	98	100%
Learning Disability Mortality Review Programme (LeDeR)	20	0	0%
National Ophthalmology Audit	***	***	***
Medical and Surgical Clinical Outcome Review Programme			NA

***Studies still open

National Confidentional Enquiries 2017/18	Cases Submitted	Cases Expected	%
Chronic Neurodisability	2	2	100%
Young People's Mental Health	1	4	25%
Cancer in Children, Teens and Young Adults	N/A (Ongoing)	N/A (Ongoing)	N/A (Ongoing)
Acute Heart Failure	1	3	33%
Perioperative Diabetes	N/A (Ongoing)	N/A (Ongoing)	N/A (Ongoing)

Participation in clinical audit

The reports of 5 national clinical audits were reviewed by the provider in 2017/18 and Colchester Hospital University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Confidential Enquiry and Patient Outcome Data (NCEPOD) - Acute Pancreatitis 2016 Report.

The report demonstrated that the Trust is fully compliant with 11 of the 18 recommendations, partially compliant with 6, and 1 recommendation was not relevant to the trust. Of those 6, work related to achieving full compliance includes; improving the quality and accuracy of clinical coding has occurred through education of clinicians and weekly monitoring of MUST compliance to support improvement work.

National Cardiac Arrest Audit

Cumulative reports are received quarterly and are reviewed at the Resuscitation Group. Results demonstrate that our rate of cardiac arrests per 1000 admissions is 1.1 the same as the national average rate of 1.1. The ratio of observed to predicted survivors to hospital discharge remains stable at 1.06.

National Emergency Laparotomy Audit

Trust: 5 areas good. 5 areas amber. 1 area red – assessment by elderly medicine specialist in patients aged 70 years and over. Local audits being carried out to assess the quality of the data being submitted.

National Joint Registry

We constantly review our performance on the NJR both as individual surgeons and as a trust. In the past this has identified issues with prostheses and techniques which have been addressed and our implant revision rate improved. We now have a weekly lower limb arthroplasty MDT where registry data is analysed and discussed and problems identified and actions discussed to improve performance. These meetings are attended by surgeons performing lower limb arthroplasty and are minuted.
The current report has flagged consent rate for the registry, quality of trainee operations and individual revision rates for surgeons. We are instituting changes to our practise and documentation to improve them.

National Bowel Cancer Report 2016

This report covers patient diagnosed with bowel cancer. In 91% of cases the patient is seen by a Clinical Nurse Specialist. Mortality outcomes and readmission rates are within limits.

MINAP

In general, we are better or similar to national standards (eg patients seeing a Cardiologist, being admitted to a cardiology ward, having angiography if appropriate and receiving the full package of secondary prevention therapies). We are worse for our length of stay for NSTEMI and our ability to provide angiography/PCI within 72 hours of admission (the NICE QS). Both these areas are due to the inability of the tertiary centre to accept patients for angiography/ PCI in an appropriate timescale. Further improvements will come from moving to a 7/7 Consultant service (which will be achieved with 2 additional Consultant appointments, currently out to advert). A 7/7 Clinical Nurse Specialist service will also improve our NICE QS in NSTEMI and heart failure.

The reports of the 85 local clinical audits were reviewed by the provider in 2017/18 and Colchester Hospital University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Participation in clinical audit

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 85% 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 1/4/2017 to 28/2/2018, 98.5% of inpatients did not experience a new-harm event - the national average for acute organisations was 97.9%.

0.1% patients had had a fall resulting in harm in the 3 days prior to the audit
0.3% patients had developed a new pressure ulcer
0.4% patients had started treatment for a new DVT or PE
0.8% patients had a urethral catheter and had started treatment for a new UTI
(Some patients had more than 1 new harm event.)

Participation in clinical audit

Table 2—Local Audits

Division 1 - Surgery	
Audit	Description of Actions
Think ABCD on emergency admission	Introduce new proforma and re-audit
General Surgery VTE audit on compression stockings	No Actions
Notes & Record Keeping in General Surgery	No Actions
Antibiotic prescribing and compliance with local guidelines	No Actions
Are ventilation strategies on the critical care unit complying with evidence based guidance on tidal volume targets?	Education Sessions
Appropriate Imaging in Acute Pancreatitis	Education of junior staff about the importance of avoiding early CECT and performing an early USS examination in acute pancreatitis
Evaluation of Surgical Drains in General Surgery	Provide information on appropriate handling and positioning of surgical drains to nursing colleagues on the ward Design, produce and introduce patient information leaflet on care of surgical drains
Evaluation of Pre-Operative Surgical Site Marking	No Actions
General surgery antibiotic Re-audit	Update guideline in collaboration with microbiology department Include guideline in induction for junior/locum doctors Encourage frequent guideline/App review
Can inpatient access to angioplasty be improved?	No Actions
Major Lower Limb Amputations: an audit of patient selection, management and postoperative care	Implement local pathway
Thromboprophylaxis and Anticoagulation on the Vascular Ward	To add an extra section in handover sheet that records the anticoagulation of each patient. To implement teaching on renal failure and anticoagulation.
Radiograph reporting in fracture clinic: are we meeting IRMER standards?	No Actions
Operation notes audit for Orthopaedic Trauma	Consider whether consultants would like to make computer templates for operations Doctors reminded of post-op instructions, incision, blood loss documentation Nurses reminded re: elective/emergency documentation
Thromboprophylaxis in Neck of Femur Fractures	No Actions
The Essex Monopost Efficiency and Safety Study (EMESS)	No Actions
Pilot of Optometrist Led Cataract clinic	Clinic to increase capacity Referral pathway for other pathology to be refined

Participation in clinical audit

Are ENT clinics follow-up appointments being allocated appropriately?	Clinicians check outcomes on clinic forms Clinicians to consider discharging patients from clinic if for procedure only +/- stipulate this on clinic coding form Administrative staff to check all patients with final discharge letters are not listed as awaiting appointment from ENT
Pre-operative fasting in elective surgical patients	No Actions
Central Venous Catheters (CVC) and CVC related bloodstream infections in critical care	Encourage the use of gained blood cultures if CVC infection suspected Encourage IN team to chase results of CVC tips Promote clear documentation in the notes Encourage nursing staff to send CVC tips to microbiology Continue recording and collecting data after adjusting date collection proforma
Humidification of breathing circuits in critical care	Draft guidance for nursing staff regarding humidification of circuits in critical care
Anaesthetic Chart Review	Feedback to Anaesthetists with poor performance
Re-Audit of Acute Kidney Injury in Lower Limb Arthroplasties	Preoperative airway assessment for patients undergoing general anaesthetic
Preoperative airway assessment for patients undergoing general anaesthetic	No Actions
ITU magnificent 7 – nutrition	No Actions
Noise Level in Adult Critical Care Unit and Achieving a Better Sleeping Pattern for Patients	Reduce the volume of discussions around patients; use the handover room especially in the evening; have discussions away from the patient when possible Adjust alarm parameters to patient physiological state Non-work related conversations should happen away from patients; keep mobiles on silent mode; small number of visits/patient Introduce earplugs to reduce the amount of noise perceived by the patient
Central Venous Catheter Project – revisiting practice following recent intervention	Continue careful CVC monitoring and meticulous care Encourage higher standards for documentation in clinical notes re: CVC insertion and CXR Acknowledge teams' efforts in sending the CVC tips to microbiology – to be continued

Participation in clinical audit

Division 1 - Cancer Services and Haematology (including Breast and Radiology)	
Audit	Description of Actions
Open Access Follow Up (OAFU) service for breast Cancer Patients - a patient evaluation	1. Recruitment of OAFU co-ordinator, 2. Recruitment of Breast Care Nurse Secretary, 3. Ensure all topics are covered in nurse led consultation (as per holistic needs assessment), 4. Assess patient's understanding of treatment and risk, 5. Ward staff to plan appropriate dressing removal, suitable to patients needs
Chelmsford & Colchester Breast Screening Service Assessment - Client Satisfaction Survey	1. Remove landline line from assessment letter and information so screening nurse is more available to contact, 2. Try to speak with client's pre assessment to ensure they have read info pre assessment, 3. Feedback to Linda Kearton assessment letter invites not be sent to arrive on Fridays and put on letter that there is no one to contact over the weekends, 4. Review assessment leaflet
Audit of Level 2 High Intensity chemotherapy for Hodgkin's/High grade Non –Hodgkin's Lymphomas	1. To continue to monitor patients receiving salvage closely, 2. To continue selecting appropriate patients to receive these regimens.
Enteral feed audit - Head & Neck Oncology	Now developed a Head and Neck flow chart for the placement of enteral feeding tubes in patients admitted to West Bergholt ward. The flow chart ensures optimisation of analgesia, optimal times of the day for tube placement, confirmation from the oncology consultant that they are happy for a nurse, or if they ned a medic to place the NG tube
Patients attending the Head & Neck Cancer Clinics - a patient evaluation	1. Add financial support information into the patient information pack, 2. Bring back all CHUFT patients from MEHT (this was completed in June 2017), 3. Work with the Network to streamline the MDT clinic process.
Re-audit of Documentation Procedure compliance for 'administration of Intrathecal Chemotherapy'	1. ITC folders and registers need to be checked for completeness as new guidelines and registers are produced. Now a standing item on the Chemo Quality Group Agenda, 2. 2. Clerical staff should make every effort to ensure notes are available prior to the procedure being carried out, and failing that details of the visit should be documented separately and filed at a later date, 3. 3. Annual training sessions to highlight and enforce the need for all doctors and nurses involved in the administration of ITC need to formally document all the 12 steps on the ITC proforma, every time including patient participation, most recent FBC and that proforma's are being faxed back to pharmacy

Participation in clinical audit

Lung Cancer Support and Information Giving for newly diagnosed patients - Patient Satisfaction Survey	1. Business case for additional Band 5/6 Lung Cancer Nurse, 2. Ensure to question patient's understanding and follow up phone call, 3. Review the printed patient information
Patient Satisfaction Survey for Lymphoma Patients (support and information giving)	1. To make sure booklets are available in the day unit, clinic rooms and CNS office. Haematology support nurse will be available when CNS is not to offer written information, 2. The CNS to make sure they make clear to the patient that a holistic assessment has been carried out.
Patients Undergoing Chemotherapy treatment in the Mary Barron Suite - a patient evaluation	1. Formalise roles & responsibilities of the Co-coordinator role, 2. 2. Feedback back Audit during monthly Meeting
An audit comparing the survival benefit between Pertuzumzb-Herceptin and T-DM1 in HER2 positive metastatic breast cancer patients at Colchester Hospital Oncology Department	1. Convey the findings to chemotherapy funding association for efficacy and toxicity monitoring, 2. Plan to re-audit in 3 years' time to have more convincing data with the ongoing regimen, 3. Implication of the result after 3 years data analysis
CT Pneumocolon Service - a patient evaluation	1. To review the leaflets again to ensure they are kept up to date with any change in our current practise, 2. To keep up in-house training to ensure maintenance of good patient care
Radiology Service - annual Trust wide service evaluation	1. Restructure Appointment Letters, 2. Improve Signage, 3. Create platform of information about pathways (simplistic), 4. Recondition Waiting areas
Quality Improvement Project Aiming to Improve Teaching and Support for Junior Doctors on West Bergholt Ward (Re-audit following changes made in December 2016)	1. Haematology/oncology teaching to be re-introduced, 2. 1 hour communication skills training session introduced to the West Bergholt junior doctors induction programme should continue, 3. Breakout sessions once a month to openly discuss difficult cases
External user evaluation for the Renal Surveillance Clinic	1. Additional clinic set up in Clacton, 2.
Patient Satisfaction Survey - Information & Support Radiographer (ISR)	1. Continue to audit Radiotherapy leaflets (the service is audited in this survey), 2. Continue to give out ISR's business cards, 3. Provide information that is relevant to patients tailored for their needs, 4. Continue to address patients' needs using the Concerns Assessment
Patient satisfaction survey for the Uro-oncology Clinical Nurse Specialist service across the Essex Cancer Network	1. With regards to negative feedback received about the department regarding surgical secretaries and admissions, these comments have been brought to the attention of our management, the team are working together to make improvements.
External user evaluation for the Urology Advanced Nurse Practitioner Led – Active Surveillance Programme	1. Review patient literature regarding active surveillance, 2. Review current literature/consider new literature regarding the need for reimaging/re-biopsy during active surveillance

Participation in clinical audit

Division 2 - Medicine	
Audit	Description of Actions
Use of the Rapid Access Chest Pain Clinic to facilitate A+E discharges	All RACPC forms to be printed and attached to criteria – Administrative staff and clinicians. Time Scale- From 14/6/17 New clear RACPC posters to be printed and displayed in department- Auditor– Time Scale- 14/6/17 This report to be circulated to the department - Dr Koshonko- Time Scale- 14/6/17 Plans for Re-Audit- Actions implemented 14/06/17. Dr. Selwyn-Gotha to re-audit 30 days of data from this date to complete audit cycle.
Trauma team activation in the ED - An assessment of documentation and radiological response time	Meet with management to discuss Qlikview + poor data storage A&E education- A&E consultants- Deadline: Next teaching day Audit into radiological response time- Deadline: ASAP
Re-audit of Use of Rapid Access Chest Pain Clinic to facilitate A&E discharges	No Actions
Management of Head injury in A&E	No Actions
Thrombo prophylaxis in lower limb fracture	No Actions
Process of diagnosing SAH in patients presenting with headache	No Actions
Variation of MUSt scores between COTE and general medical wards	Add to the bottom of ASKIN chart as a prompt to calculate MUST Laminated print out of how to calculate MUST score at the start of nursing notes/at each nurses station Writing the weight on admission and the weight on last booklet on each next nursing booklet Documenting rationale when MUST score changes
Are referrals for NIV (non-invasive ventilation) in patients with MND (Motor neurone disease) compliant with NICE guidelines	Audit project results to be discussed at Neurology Governance meeting Dr Roebuck to meet Dr P. Hawkins & Dr F. Kapsimalis to explore ways of improving the service
Hypoglycaemia Audit	Ongoing education to trust staff Continuous review of blood glucose levels <3mmols
Completion of stool charts on COTE	All patients to have stool charts in bedside notes All patients to have bowel motions completed daily in nursing notes
Inpatient Catheter Audit	Presentation Informative Sessions: Grand Round Informative Sessions: Infection Control Possible Interventions Catheter Tags Posters

Participation in clinical audit

A retrospective audit into IBD care and IBD pathways	To be discussed at IBD meeting
Audit to investigate the uptake os spict screening and TREC forms	Email ward team to inform them of audit findings Present audit to ward and emphasise benefits of SPICT and TREC completion Compile SPICT and TREC pack with guidance on using both and place this on ward to aid and encourage uptake Present in clinical audit half day

Participation in clinical audit

Division 3 - Women & Children	
Audit	Description of Actions
Talley Mattress Audit	Reduce number of dynamic mattresses used within the Trust by increasing staff awareness of Policy/ Guidance on the use of pressure reducing/relieving mattresses and their role in PU prevention. Re-audit Talley mattress usage in 3 months' time. To renegotiate the dynamic mattress contract.
Impact of Pathology Services on Colposcopy Treatment	R/V process of receiving reports from pathology lab. To provide data gathered to share with pathology partnership to ensure optimal work force planning.
Assessing communication regarding shoulder dystocia within DGH following Montgomery report	To check to see if NIPE's have been done by a paediatrician. To add a compulsory field for anterior shoulder on Medway.
Neonatal sepsis	The development of a lumbar puncture guideline specific to neonates. Re-audit results.
Thyrotoxicosis in pregnancy – controlling the storm	No Actions
Management of coeliac disease in children	Dedicated multidisciplinary Coeliac clinic has now been established (from April 2017) 6 clinics a year. New local guidelines.
IRMER Regulations: Compliance Rate of Image Reporting by Non-Radiology Clinicians	Re-audit.
Claustrophobia and MRI-an audit to ascertain the number of failed MRI scans due claustrophobia	No Actions
Abnormal Chest X-Ray Urgent Referral Pathway Vs Straight to Test Lung Pathway	No Actions
Audit to Optimize CT KUB Imaging in Investigation of Renal Colic	No Actions
An audit into the quality of ADOS referrals	Design new referral from. Information about module selection and significant information shared with team. Clerical team informed of new referral process.

Participation in clinical research

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

The number of patients receiving relevant health services provided or sub-contracted by Colchester Hospital University NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 695

Participation in clinical research demonstrates Colchester Hospital University NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Colchester Hospital University NHS Foundation Trust was involved in conducting 53 clinical research studies during 2017/18, examples of which include:

The Maven Study – Trust spooned nationally adopted. This is a randomised controlled clinical trial comparing the effectiveness of bandaging compared to the Juxta Cures™ device in the MAnagement of people with VEnous ulceratioN: Feasibility Study;

PrEP Impact Trial: A pragmatic health technology assessment of PREP and implementation. This trial aims to determine what proportion of people who attend sexual health clinics in England will be eligible for PrEP according to the eligibility criteria set out for PrEP use and how long they are eligible for. Through the trial it will be able to measure how many attendees at sexual health clinics meet eligibility criteria for PrEP, how many of these take up the offer of PrEP and how long they remain on PrEP for;

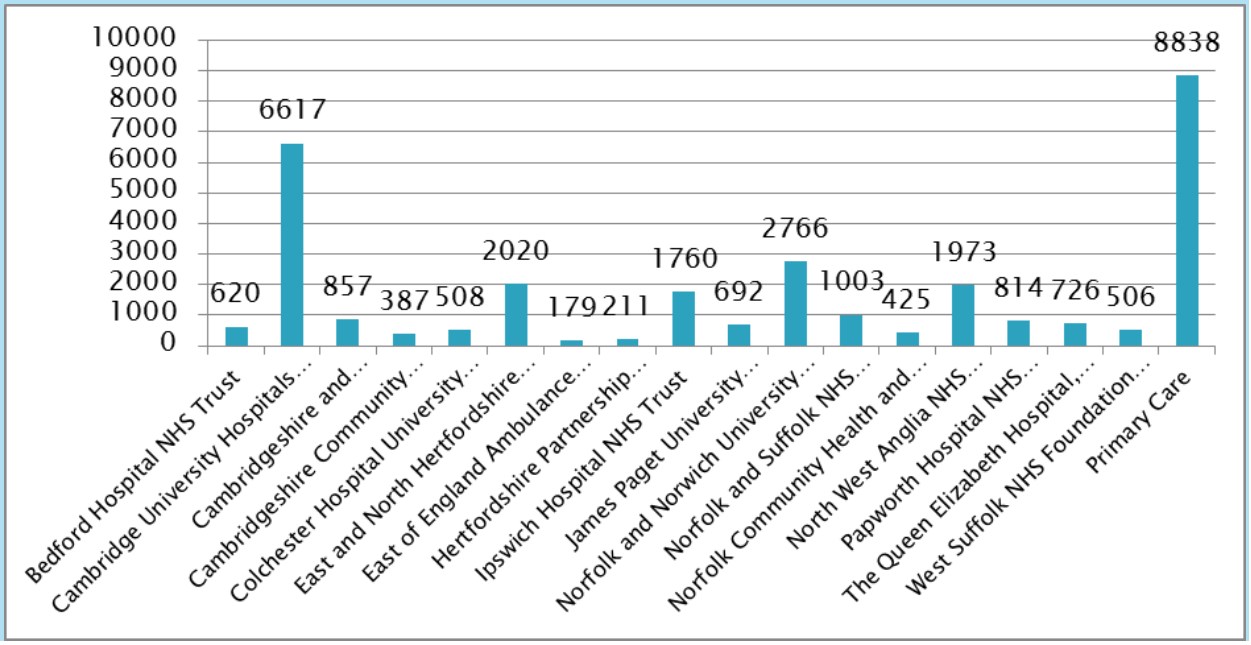
Molecular Profiling for Lymphoma Study (MaPLe Study) - To aid the identification of patients with lymphoma that may be suitable for specific targeted therapies.
To test whether molecular characterisation of lymphoma can be carried out as a standardised, routine practice during the treatment of patients in the NHS;

RAPPER Study (Radiogenomics: Assessment of Polymorphisms Predicting the Effects of Radiotherapy) The purpose of the study is to understand why some patients who receive radiotherapy are more likely to experience side effects than others.

Research & Innovation (R&I) promotes, supports and develops Research and Innovation projects for patients in Colchester Hospital and the surrounding areas.

Research in the NHS is largely funded through the National Institute for Health Research (NIHR) via the Comprehensive Research Networks (CRN). CHUFT is a member of the Eastern CRN, currently hosted by the Norfolk and Norwich Trust. The Academic Health Science Networks (AHSN) are also responsible for primary and translational research and for piloting of new developments. CHUFT is a member of the Eastern AHSN, which is hosted by Addenbrookes.

Chart 1 -Recruitment 17/18 – CRN Eastern Comparison:



Participation in clinical research

In 2017/18 there was a reduction of 25% from the 2016/17 CRN funding to CHUFT. This research budget is supplemented by CHUFT substantive funding, income derived from clinical trials and DH Research Capability Funding. The budget reduction this year has resulted in a reduction in the current workforce, which has translated into an approximately 40% drop in the number of participants recruited into research trials in the current year. The CRN budget itself is determined by activity, performance and recruitment to trials in the previous financial year.

The research staff consist of 15 nurses, 1 AHP, clinical support staff, administrative staff and a pharmacy position. The research staff recruit and support patients in NIHR clinical trials and ensure that the research is being conducted within the recommended frameworks and conducted to International Conference Harmonisation – Good Clinical Practice (ICH-GCP) standards. The research service also includes governance reviews, assurance and risk assessment, specialist advice, clinical feasibility, patient recruitment, patient follow-up, research specific training, performance and financial management.

CHUFT has an established research infrastructure that supports the clinical divisions to participate in research. However, research integration varies amongst clinical specialities. Research active specialities are led by research engaged clinicians (Principle Investigators) who incorporate research into their routine clinical practice to offer more choice and opportunities to their patients. R&I continues to promote research for patient benefit with an aspiration for all patients to have an opportunity to have treatment within a clinical trial.

In the current environment funding streams from the CRN are very much matched to performance rather than historical levels. Looking at opportunities from other streams of funding are essential to maintain future investment, provide stability and expand the service to meet the needs of the population. As well as being part of the NHS Constitution it is widely recognised that research active trusts have better outcomes for their patients and attract higher quality staff and improves standard of care.

The current merger with Ipswich Hospital will increase the range of availability of areas of research in clinical services within a single organisation. This gives the potential to be the 3rd largest recruiting Trust in the eastern network. Commitment, leadership and drive will be required for harmonisation of workforce, policies and procedures to work towards delivering top quality research and innovative technologies within the required value for money.

Maximise engagement in research

The Trust sponsors two NIHR projects within Vascular and Cancer; a non-portfolio Haematology project, and also supports students with MSc and PhD projects. R&I aims to further develop Trust sponsored research and collaborations with other pharma and academia onto the national portfolio.

We are now into Year 2 of the Trust sponsored study called MAVEN (Management of People with Venous Ulceration: Feasibility Study). This interventional study compares the effectiveness of bandaging compared to the Juxta-CuresTM device in the management of people with venous ulceration. A funding award of £125,000 was secured from the healthcare company. This includes the budget for a research nurse, consumables and supply of the juxta-cures device. To date, a total of 20 patients have been recruited into this trial, with a target of 50. Depending on the study results, the Trust hopes to run a multicentre trial and would need to apply for an NIHR Research for Patient Benefit grant.

Research at the Trust takes place in anaesthetics and intensive care, the breast unit, vascular surgery, general and colorectal surgery, gastroenterology, haematology, obstetrics, oncology, ophthalmology, paediatrics, renal, rheumatology, stroke and urology. There are a number of clinical areas which are not research active, and is an area to explore further with the ongoing merger to help R&I meet performance and financial targets.

Research activities are further supported by the Mary Barron chemotherapy suite, the Electro-Biomedical Engineering Department (EBME), Cardio-Respiratory Department, Nuclear Medicine Department, Radiotherapy Centre, pathology, pharmacy and radiology departments. Activities within the Trust and engagement with the public to advertise research takes place by specialty meetings, through internal communications and also articles in the local press. The Head of R&I is a committee member of the CRNE Communications Steering Group, the Patient and Public Involvement Steering Group, attends regional Research managers' meetings and regional network events. The Clinical Research Nurse Manager is a regional Good Clinical Practice (GCP) facilitator and delivers GCP training in the Trust; is lead for the regional informed consent in research course working group; a member of the steering group of the Advance Research in Practice (ARIP); chair of the research team leaders group and a member of the regional workforce development steering group.

The Trust is currently involved in 173 studies on the NIHR portfolio which are recorded on the Local Portfolio Management System (EDGE). 67 are open to participant recruitment and 107 studies closed to recruitment and are in follow-up status. Clinical research team managers overseeing the three research teams (cancer, haematology and clinical studies) are required to identify NIHR portfolio studies. They engage with potential principal investigators and perform detailed site feasibility and the set-up of research studies alongside the R&I Department.

Participation in clinical research

The Essex Biomedical Sciences Centre (EBSC) highlights successful ongoing collaborations between academics and clinicians and showcases emerging research areas where future collaborations can be formed and the next bi-annual conference will be held at Trust in April 2018. An area needing further exploration and collaboration are the links with the University of Essex and Anglia Ruskin University alongside the previously established relationships with the ICENI centre at CHUFT.

The Trust's R&I team works with Health Enterprise East in the exploration of potential commercialisation of intellectual property and the Research Design Service to develop innovation and support staff with design, methodology, grant applications, statistics and research.

Other opportunities for innovation include programs such as the Dragons' Den style innovation scheme. A previous winner: "Falls Prevention Education & Support Group for Inpatients and their Relatives" was developed by staff with R&I guidance and has now been developed as an in-house training tool for patients and carers on hospital wards. Staff are also encouraged to submit application for innovation funding programmes such as the Medtech Accelerator programme. This has been set up to facilitate the early stage development of medical technology and software innovations from within the NHS.

Research governance

All patients should have the right to access to research trials, as legislated by the NHS Constitution, and the R&I Department is committed to the integration of research in clinical practice.

All research is delivered in accordance with the UK Policy Framework for Health and Social Care Research. This outlines the principles of good practice in healthcare to ensure research governance is one of the core standards that all organisations must apply. The R&I Department ensures that all research has undergone a local governance review and to provide the appropriate assurances before any research can commence at CHUFT. R&I ensures all appropriate communications with the Health Research Authority, encompassing research ethics committees, occur. This provides assurance on each study, that costs and contracts are negotiated and signed, capacity modelling is performed, risks addressed and also to ensure appropriate authorisations have been received from clinical and support departments.

The Medicines & Healthcare products Regulatory Agency (MHRA) remain responsible for providing authorisations for medicinal products trials. All researchers at this Trust undertake ICH-GCP, a legal requirement for medicines trials and standard for all research at this hospital.

Training for clinicians and research staff is made available through network funded staff to ensure standards and best practices are maintained. The Trust ran three ICH -GCP refresher courses and will maintain a training schedule in future years. ICH-GCP training is valid for two years with 97 staff holding a current certificate, 56 updating their training in 2017/18 and 43 who currently need recertification.

The R&I department has recorded the following:

20 number of studies receiving confirmation of capacity and capability

160 number of studies require amendment confirmations

16 reported SAEs to study teams, 75% compliance for reporting to R&I with 24 Hours.

The key policies for R&I at this Trust are in place as follows: R&I policy, Intellectual Property Policy, Procedure for Reporting Adverse Events and Reactions during a Research Study.

Teams are responsible for producing local Standard Operating Procedures to support with service delivery and training of new staff.

Performance metrics

The NIHR CRN High Level Objectives (HLOs) for research, applicable to this Trust for 2017/18 are:

- 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
- HLO4: Reduce the time taken for eligible studies to achieve set up
- HLO5: Reduce the time taken to recruit first participant
- Value for Money: Activity based funding model using a study complexity weighted score to determine budget setting.

The NIHR continues to publish outcomes against contract NIHR 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 on the R&I page of the Trust website.

Participation in clinical research

Life sciences industry

The NIHR promotes industry studies adopted onto its portfolio via an Expression of Interests (EOIs) system and through consultant collaborations with pharmaceuticals. The Trust receives expressions of interest from CRN Eastern which are reviewed locally to determine feasibility. Additionally, through clinicians and research associations with industry, the Trust has been pre -selected for industry studies.

Research income generated approximately £200,000 to contribute to Trust overheads, research infrastructure and re-investment into research activities.

Pharmacy drug-saving costs as a result of pharmaceuticals supplying trial drugs free of charge provide savings to the Trust.

Patient involvement

Based upon the national submissions, there were 550 participants recruited into NIHR portfolio studies compared to 930 participants the previous year. This is a decrease of 40% from the previous year and as documented above reflects the reduction in funding from the CRN this year with resultant staff reductions. The current merger brings new opportunities to offset the changes in the funding going forward and openings for the future.

We continue to involve our Patient Research Ambassadors (PRA) to help promote research within the local community and at Trust events. We meet quarterly to explore what initiatives can be focused on. They contribute locally to research, including the design of business cards to promote research within the community, and they also attend regional meetings with partner NHS trusts involved in the PRA programme.

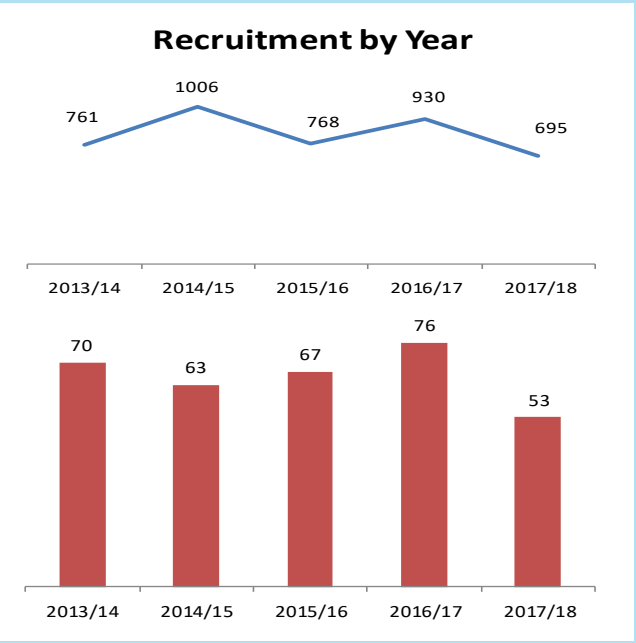
The Trust Research Team

Participation in clinical research

Chart 2—Five-year Performance *Data Source:CRN Eastern, Performance, Recruitment and VFM tables.*

Recruitment	2013/14	2017/18
	761	695

Recruiting Studies	2013/14	2017/18
	70	53



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 locally-agreed quality improvement goals. A proportion of Colchester Hospital University NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Colchester Hospital University NHS Foundation 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 2017/18 are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/.

The monetary income total for 2017/18, based on plan and conditional upon achieving quality improvement and innovation goals, was c. £5.6m. 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:

- ✓ 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
- ✓ NHS e-Referrals
- ✓ Supporting proactive and safe discharge (8a)
- ✓ 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
- ✓ Armed forces policy
- ✓ Improving AAA Screening uptake in GP Practices with poor uptake
- ✓ Increased Access to breast screening
- ✓ 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 overleaf demonstrates the actual performance for the CQUIN indicators for 2017/18 for Colchester Hospital University NHS Foundation Trust.

Monitoring quality

***Table 3** – Actual performance for the CQUIN indicators for 2017/18*

The total payment represents 2% of Actual Outturn Value of Contract.

CCG	Scheme	Sub-scheme		Q1	Q2	Q3	Q4
	Improving Staff health and wellbeing		Improvement of Health and well Being of NHS Staff				Data not available
			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				
	NHS e-Referrals		NHS e-Referrals				
	Supporting proactive and safe discharge		Supporting proactive and safe discharge				
	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				No data available
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				
Increase Access to Breast screening		Increase Access to Breast screening				
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

Table 4 *- Care Quality Commission (CQC) ratings published 2nd November 2017*

	Safe	Effective	Caring	Respon-sive	Well-led		Overall
Urgent and Emer-gency Services	Requires Improve-ment	Good	Good	Good	Requires Improve-ment		Requires Improve-ment
Medical Care	Requires Improve-ment	Good	Good	Good	Good		Good
Surgery	Good	Good	Good	Requires Improve-ment	Good		Good
Critical Care	Good	Good	Good	Good	Requires Improve-ment		Good
Maternity and Gy-naecology	Good	Good	Good	Good	Good		Good
Services for Chil-dren and Young People	Requires Improve-ment	Good	Good	Good	Good		Good
End of Life Care	Good	Good	Good	Good	Good		Good
Outpatients and Diagnostic Imaging	Requires Improve-ment	N/A	Good	Requires Improve-ment	Requires Improve-ment		Requires Improve-ment
Overall	Requires Improve-ment	Good	Good	Requires Improve-ment	Requires Improve-ment		Requires Improve-ment

How healthcare is regulated

Colchester Hospital University NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is full registration. Colchester Hospital University NHS Foundation Trust has the following conditions on registration: None.

The Care Quality Commission has not taken enforcement action against Colchester Hospital University NHS Foundation Trust

Colchester Hospital University NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC monitoring and inspection process

Inspections by the Care Quality Commission

The CQC regularly inspects Trusts and continues to re-inspect those services which fail to meet the Fundamental Standards of Quality and Safety, and inspect any service at any time if there are concerns raised.

On 30 December 2015, the Trust was served with a Section 29A letter relating to the findings of the September inspection requesting significant improvements by 18 February 2016.
A CQC follow-up visit in April 2016, focusing on A&E, Surgery, Medical Care and End of Life Care, concluded that the Trust had not made sufficient progress in a number of key areas. The CQC continued to have significant concerns about the completion of the Five Steps to Safer Surgery checklist, a continuing lack of awareness over when to place a patient on the individual care plan for the last days of their life and leadership in A&E. Two Section 31 letters were issued, in relation to A&E and the safer surgery checklist. These were removed after the CQC report was published in November 2017.

The CQC carried out a comprehensive inspection of the Trust in July 2017 and published its findings in November 2017

The inspection assigned an overall rating of "Requires Improvement" for the Trust. During this inspection the CQC found that significant improvement had been made across all services at the Trust. The Chief Executive and Managing Director had created stability in the senior executive team that had not been previously in place. The executive team understood the challenges to good quality care and the wider challenges faced by the NHS, and could see the importance of exploring solutions such as the long-term partnership with Ipswich Hospital.

The team in place now worked together with more structured disciplines being embedded around executive and performance behaviours and responsibilities. Within the every patient, every day programme (EPED), the responsibility, accountability and ownership of service improvement had been given back to the local leaders. They saw many examples of local leaders and senior staff being highly motivated, engaged in seeking solutions to drive improvements locally.
Their key findings were as follows:
They saw several areas of outstanding practice including:

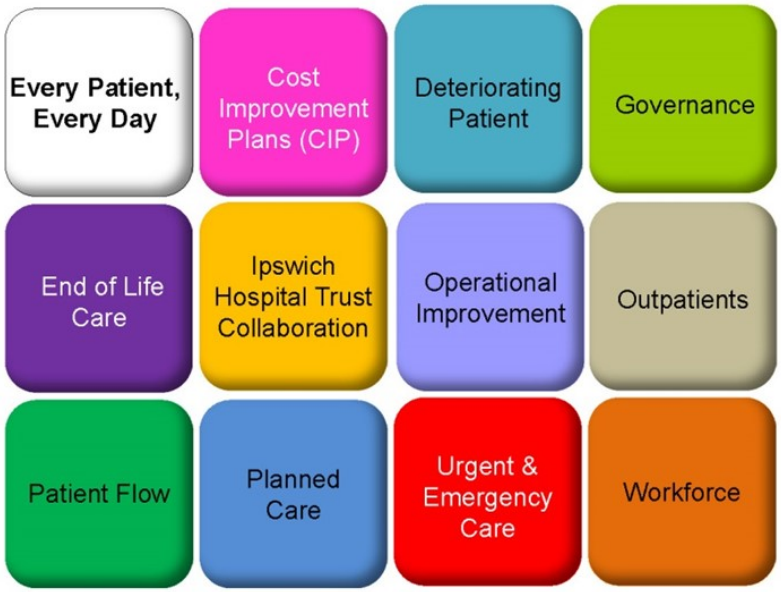
- ✓ The service's dedicated children's transition team was the only one in the region and other trusts sought advice from them. The transition team worked with other teams to meet the more complex individual needs of patients at the age of transitioning to other services. For example, they ran a joint clinic with the epilepsy specialist nurse three to four times a year.
- ✓ The neonatal unit (NNU) was piloting a 'discharge passport' to empower parent involvement in ensuring a timely discharge for babies.

However, there were also areas of poor practice where the trust needs to make improvements and these were categorised in the form of must dos and should dos. These actions are currently being managed by the Director of Nursing.

How we addressed the issues raised by the CQC:

- ✓ The Trust's Every Patient, Every Day programme continues with the aim of establishing and maintaining consistent standards of care across the Trust and achieving the outcomes associated with such standards. This will ensure safe staffing levels, further improvements in governance and leadership, and the continuing implementation of measures to ensure all staff are aware .

Every Patient Every Day



"Every Patient, Every Day" is the name of the transformation programme that the Trust established to provide safe, compassionate care to patients each and every day.

It was launched in September 2016 as a programme of clinical, operational and financial improvement to improve the quality of care, increase efficiency and deliver financial sustainability. The Chief Executive notes: *'It has started to address our many challenges – for example, I'm pleased with the progress we've made on end of life care and there has been significant improvements with the booking processes including moving towards 'paper free' in March.*

'The programme has centred on three key modules of work:

- ✓ quality and governance
- ✓ operational turnaround and Cost Improvement Plan (CIP) delivery
- ✓ cross-cutting improvements

CIP Workstream

The Trust has a target of delivering £16.7m of cost reductions (known as CIP) in 2017/18. The CIP EPED Workstream is tasked with ensuring this is on track. This is achieved through regular meetings with each Division, chaired by the DoF (SRO) for the project and actions taken as appropriate. So far, £13.7m has been delivered.

Urgent Care Workstream

2017 saw the launch of the ED streaming service with the aim of utilising primary care services to ease pressure on A&E and reduce patient waiting times. The newly built GP room co-located in ED was set up specifically for the service.

Frailty Workstream

The Frailty Assessment Unit (FAU) opened October 2017 providing a Monday to Friday service with 5 bays for patients with expected same day discharge. Rapid identification of newly arrived frailty patients across ED and EAU is in place now and early comprehensive geriatric assessment involving a multi-discipline team now follows.

Outpatients Workstream

The main focus of this Workstream has been to improve patient experience by improving the Outpatient environments and ensuring the patient is seen in the right place at the right time.

Measures Introduced:

- ✓ Self-service check-in kiosks in Outpatient areas to increase patient check-in choice, reduce queues at the reception desk and help clinicians manage their clinics more effectively
- ✓ Increased utilisation of Outpatient clinic slots to ensure the optimum number of patients are seen in each session – reducing waiting times for patients
- ✓ Improved signage in Outpatient areas to optimise the flow of patients on their journey through Outpatients
- ✓ Improved appointment reminder service to reduce number of clinic DNAs
- ✓ Re-launch of the electronic booking service to provide patients with greater choice of where and when they are seen

The aim for 18/19 is to increase patient electronic access to appointment systems and clinic information and further reduction of paper processes.

Advice & Guidance Workstream

The aim of the Advice & Guidance development was to set up and operate a system allowing GPs to access consultant advice prior to referring patients in to secondary care, for non-urgent GP referrals. The intended benefits being assisting clinical decision making and patient pathways, enhanced clinical communication, and looking to assist

Every Patient Every Day

reducing GP referral demand on the Trust. This by enabling (at the point of GP / patient consultation) a call to a Consultant for an expert clinical opinion for advice and considering if a patient referral would be needed, and if so, urgently or routine.

During 17/18 the service has been established in c.11 live specialities, covering c.40% of speciality referral areas (target being 35%), with further flexibility remaining for additional specialities to be introduced in 18/19. Certain specialities that have triage service inclusion within the established patient pathways (such as Ophthalmology and Orthopaedic specialities) are agreed to not be implementing A&G in the near future.

Additionally to the above, the Trust has established stretch targets of 65% of calls answered (achieved 80% of the weeks) and 80% of calls answered having feedback recorded. Currently in 17/18 the Trust is slightly below these measures at c. 54% and 66% respectively.

The aim in 18/19 is to achieve coverage of more than 75% of appropriate speciality referral areas and to continue to enhance the call answer and feedback recording rates.

Planned Care Workstream

The Planned Care Workstream has been focussing on maximising the utilisation of theatre slots and lists to ensure that patients are treated within the appropriate timeframes.

Measures Introduced:

- ✓ Check and challenge processes in place to ensure that theatre lists start on time
- ✓ Profiling of lists to ensure lists run in the most efficient way possible
- ✓ Increase of number of cases per list to accommodate a greater throughput of patients
- ✓ Robust root cause analysis procedures in place to review preventable on-the-day cancellations and DNAs - to identify recurring themes and measures to be put in place to prevent further occurrences.

The aim for 18/19 is to review the pre-admission processes to increase efficiency and capacity and continued improvement in theatre utilisation and scheduling.

Deteriorating Patient Workstream

The Deteriorating Patient Workstream predominantly focuses on improving Sepsis compliance Trust-wide and escalation processes of the deteriorating patient.

Achievements in 17/18:

- ✓ Improved Sepsis Compliance within ED as explained in detail within the section Key Priorities for 2018/19.
- ✓ Completed a Trust-wide NEWS escalation Audit to identify areas for focussed work
- ✓ Rolled out Treatment Escalation Form (TEP) Trust wide following trialling and feedback from Clinical Teams
- ✓ Established cohort of Sepsis Champions Trust wide

Aims for 18/19:

- ✓ Further improve Sepsis Compliance in ED towards target of 90%
- ✓ Improve Sepsis compliance on the Wards
- ✓ Implement monthly Sepsis and Escalation auditing on all Wards
- ✓ Monitor usage and quality of completion of Treatment Escalation Plans
- ✓ Work with Ambulance Service on redesigning sepsis pathway.

End of Life Workstream

The End of Life Workstream has now exited the EPED programme due to reaching target and delivering on milestones of the project.

Achievements in 17/18:

Every Patient Every Day

End of Life Care

- ✓ Achieved green in all domains for End of Life Care in CQC report improving from 5 red 'inadequate'
- ✓ Increased usage of Individual Care Record Last Days of Life (ICRLDL) to over 60% increase use of Wathcpoint last days of life data base, allowing staff to see where the dying patients are across the hospital;
- ✓ Reduced number of complaints pertaining to End of Life Care with continued work to improve EOL complaints
- ✓ Increased usage of My Care Choices Register (MCCR)
- ✓ Developed business case for x2 Rapid Discharge Nurse Assessors and recruited to posts, to unlock delays of discharge for our rapidly deteriorating patients
- ✓ End of Life Care Champions established on Wards with quarterly training. Also non-clinical champions recruited
- ✓ Education Strategy and teaching programme in place including communication skills for Band 6/7 and CMT doctors and above; 1 hour intensive role play for junior doctors; education on recognising dying and sensitive communication to all band 2-6 offered every month for half day; all newly qualified nurses receive 1 day of EOL training in their preceptor training package.
- ✓ New End of Life Care Strategy 2018-2020 developed
- ✓ Recruited EOL volunteers to support dying patients and their families in the wards with a plan to increase numbers and to offer a more robust service
- ✓ Complete fund raising for the Time Garden with a proposed opening date of May 14th 2018 to coincide with Dying Matters Week 2018
- ✓ Yearly Memorial Services set up for family/friends of patients who died at CHUFT
- ✓ 230 staff trained in 3 hour workshop on Communication skills with joint working with St Helena Hospice
- ✓ Improved communication with complaints team so that the EOL team see all complaints immediately and these complaint are shared across the clinical teams as part of the 2 at the top process
- ✓ 'CHUFT Blanketeers' set up by Sister Sarah Sands and supported by the End of Life Steering Group so that dying patients are offered a blanket if dying to reduce clinical feel for the family and then given as a gift after death if the family would like it. This is now being discussed at other hospitals who are interested in the idea
- ✓ Improvements in the bereavement suite with soft furnishings and pictures; tea/coffee; quarterly bereavement survey given out from there and results fed back through the EOL steering group. Continues work planned regarding the property bags and jewellery boxes. 3 bereavement walkthroughs have been completed; from A&E; paediatrics and neonates and then from the wards with associated work from these that is still ongoing.

Every Patient Every Day

Project Ivy

Project Ivy

One patient's story driving change. Ivy spent nine hours lying on her kitchen floor in pain, cold and frightened while the ambulance service tried to get to her.

They took the best part of a day because they were tied up at Colchester Hospital waiting to drop other patients off at our Emergency Department (ED).

The flow of patients through our ED, assessment units, wards and back home again is the most important issue we face. At its heart are the stories of people just like Ivy who need our care but aren't able to access it quickly enough. We launched Project Ivy in August 2017 with the goal that no patient will spend a moment longer in hospital than is needed, to progress their care.

It is being led by a small team of staff – clinical and non-clinical – who are committed to making multiple rapid improvements on an incremental basis.

Areas of focus have included:

- ✓ Effective board rounds
- ✓ Creating an discharge lounge
- ✓ Creating and auditing clinical standards of care we expect for our patients
- ✓ Developed a standard operating procedure for patients with regard to admission, transfer and discharge.
- ✓ Gaining new insights into why some patients are in hospital for more than seven days
- ✓ Bringing energy to the Red to Green process
- ✓ Introducing staff volunteers to help with peaks in demand
- ✓ Reviewing processes in ED and EAU
- ✓ More of our patients are getting 'home for lunch' as part of our focus on the discharge process
- ✓ Peldon ward is now supported by a senior physiotherapist on nurse-led ward rounds
- ✓ Physios and OTs are now able to refer directly to Swan and reablement solutions, rather than having to go through the discharge hub
- ✓ Computers on wheels have been ordered for Emergency Assessment Unit (EAU) following observations of delays in EAU processes, so that medication and Electronic Discharge Summaries (EDS) are being ordered more promptly.

Next Steps include:

- ✓ Auditing polypharmacy in order to reduce the burden of taking many tablets for patients which in turn will support prompter turnaround in pharmacy
- ✓ Allocating wards mobile telephones in order that the nurse in charge can be contacted promptly with regard to patient admissions
- ✓ Rolling out the "Community Navigators" a joint project with Essex County Council, North Essex CCG and the Rural Community Council of Essex which has been developed following the length of stay work undertaken. We are actively working together to improve the way in which people leave hospital, return home and live well in the community.

Every Patient Every Day

Quality Improvement Faculty

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

- ✓ Safety-doing no harm to patients
- ✓ Experience of Care-this should be characterised by compassion, dignity and respect.

Effectiveness of Care-including preventing people from dying prematurely, enhancing quality of life and helping people to recover following episodes of ill health.

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

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

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.

Within the Trust there is currently no QI Faculty function. QI training or support for individuals or teams to help development and monitoring of QI projects is limited. The current route for reporting is through clinical audit and Divisional Governance. Currently, in some cases audit outcomes are not recorded, reported or disseminated to the wider trust. There is a lack of cross specialty working and trust wide learning. The QIF will provide 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 Every Patient Every Day Improvement 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 proposal is to establish a QI faculty in order to place a support structure for QI development within the new organisation from ward to board and in all staff groups. Training, coaching, spreading learning, co-ordination and monitoring will be the key roles of the QIF. This will help to develop a QI ethos and expertise across the trust initially within Colchester and once the team is established they will work to develop the team at Ipswich and in the new trust.

Statements relating to the quality of relevant health services provided

NHS number and General Medical Practice Code validity

Colchester Hospital University NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.2% for admitted patient care;
- 99.6% for outpatient care; and
- 97.7% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 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 January 2018

.

Information Governance Toolkit attainment levels

Colchester Hospital University NHS Foundation Trust (including community services) Information Governance Assessment Report overall score for 2017/18 was 90% and was graded satisfactory (Green).

Clinical coding

Colchester Hospital University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period..

Data Quality

Colchester Hospital University NHS Foundation Trust will be taking the follow-

Data Quality Indicator	Data Quality or Data Flow	When	Update
IG Toolkit – Data Quality Output Standards	Data Quality	2018/19	Plan to retain current level of attainment – Trust currently achieved scores of 9.8 for Outpatients and 9.4 for Inpatients.
Improved reporting, from a centrally accessible dashboard. Change being taken forward as part of merger plans with Ipswich Hospital	Data Quality and Data Flow	Between May 2018 and December 2018	Plan to have dashboards fully operational by the end of 2018. Dashboards will give oversight of the new organisations data quality, and individual site level detail – as quality will need to be maintained on two separate PAS systems as part of this change.
Merger of Colchester and Ipswich Hospitals – looking to maintain current levels of data quality. Given the complexity of working with two separate PAS system, this will be challenging.	Data Quality	On-going	Core metrics will be monitored on the Accountability Framework.

Learning from Deaths

During 2017/18, 1369* of Colchester Hospital University NHS Foundation Trust patients died**. This comprised the following number of deaths which occurred in each quarter of that reporting period:

421 in the first quarter;
396 in the second quarter;
552 in the third quarter;
(365 in January & February*)
* full quarter four data not available at time of reporting
** all hospital deaths included, both in-patient and A&E

Case Record Reviews and Investigations

By 05/03/17, 828* case record reviews and 18 investigations have been carried out in relation to 1369 of deaths included in item 27.1

In 11 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

327 in the first quarter;
247 in the second quarter;
254 in the third quarter;
* quarter four data not available at time of reporting

19 representing 1.39% 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:
4 representing 0.95% for the first quarter
7 representing 1.77% for the second quarter
8 representing 1.45% for the third quarter
* quarter four data not available at time of reporting

These numbers have been estimated using the judgement score methodology as requested by the Learning From Deaths Dashboard, or, where that judgment score is not available, by meeting Serious Incident or Internal Incident criteria.

Lessons Learned from Case Record Reviews and Investigations

Deteriorating Patients:

- The need for timely observations and accurate NEWS Scores
- The need for early recognition of deteriorating patients
- The need to correctly follow escalation procedures

End of Life and Palliative Care:

- The need for earlier recognition of patients who may be in the last days / weeks of life
- Earlier consideration for the individual care record of the last days of life pathway (ICR LDL), a document that supports best practice with a person-centred approach, focusing on food, drink, symptom control and psychological, social and spiritual support
- The need to communicate between hospital and community about deterioration and patient choice

Sepsis:

- The need for early diagnosis and treatment for red flag sepsis
- The importance of a thorough ED clinical assessment that considers all possible diagnoses including sepsis
- The reminder that the protocol states that all patients with a NEWS of 5 or more, 3 in 1 parameter, or a suspicion of infection need to be screened for sepsis

Hyperglycaemia:

- Importance of recognising and treating hyperglycaemia

Actions taken following Care Record Review and Investigation

Deteriorating Patients:

✓ Targets set for greater than 95% of Early Warning Scores to be completed fully and calculated correctly, with patients escalated according to trust guidelines when appropriate.

✓ NEWS Scoring to be monitored twice monthly during an independent point prevalence audit and at least monthly by the senior ward nursing staff.

✓ Additional observation training for HCAs, AHPs and registered nurses

✓ Relevant staff to attend RED training (Recognition and Escalation of the Deteriorating patient)

✓ Commence development of electronic vital signs monitoring (Sentinel)

✓ The roll out across the Trust of the new Treatment and Escalation Plan (TEP), which prompts staff to consider the patient's progno-

Learning from Deaths

sis regularly with consideration for the completion of a DNACPR form. Medical staff can also document the level of escalation appropriate for that patient, the frequency of observations required, and revise parameters within allowed ranges

- ✓ All agency staff to be trained on NEWS and escalation procedure before being employed by the trust.
- ✓ Changes to board rounds so that sick patients are identified and reviewed immediately after the board round.

End of Life and Palliative Care:

- ✓ Targets set for >90% of patients to achieve preferred place of death and for >50% of patients who die to have a completed ICR LDL
- ✓ Earlier consideration for rapid discharge for patients to die in their preferred place of care, with the aim of reducing the time taken to get people home
- ✓ Increased audits into the completion of the ICR LDL
- ✓ Increased awareness across the Trust of the role of and support offered 24/7 by the Palliative Care Team
- ✓ Increasing Advance Care Planning and communicating this to our Primary Care colleagues. Also increased use of the locality End of Life Register (My Care Choices Register) to view and record patient wishes
- ✓ Launch of Project Ivy – with the goal that no patient will spend a moment longer in hospital than is needed.

Sepsis:

- ✓ The introduction of new sepsis screening paperwork
- ✓ The introduction of Sepsis Nurse Champions who conduct peer reviews and deliver training where required
- ✓ A weekly randomised audit of all patients through the Emergency Department for compliance with sepsis screening and use of the Sepsis 6 pathway
- ✓ Implementation of Code Sepsis calls in the Emergency Department to ensure the prompt treatment of patients with possible sepsis.
- ✓ Work with the Ambulance Service to pre-alert any patients with Red Flag Sepsis
- ✓ The development of a PGD allowing the outreach team to prescribe and deliver first dose antibiotics for patients with a red flag sepsis marker
- ✓ Local initiatives within ED, EAU, SAU and ED paediatrics to assist with increasing compliance with sepsis management are now underway, with monthly regular auditing in each area and reporting back to the Every Patient Every Day Deteriorating Patient Workstream and the Sepsis and Deteriorating Patient Group

Hyperglycaemia:

The senior diabetologist is:

- ✓ Revising the blood glucose charts so that the ranges reflect lab results
- ✓ Revising the chart to provide better signposting to staff as to what actions are required, who should be contacted, when, and what to do if there is no improvement after delivering treatment
- ✓ In light of the increasing number of patients with diabetes, looking at including the blood glucose chart with the drug chart to increase visibility
- ✓ Reviewing the number of patients with very high blood glucose to see if the diabetes nurse specialists should be undertaking ward visits for patients with very high blood glucose values.

Learning from Deaths

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

Deteriorating Patients:

- ✓ An increase in the number of escalation to doctors and the use of Watchpoint – an in hospital developed web based tool for patients requiring review, additional support or are end of life, bringing them to the attention of the site team and doctors.
- ✓ A reduction in the number of avoidable in hospital cardiac arrests due to a failure to escalate – from 20 for the rolling 12 months in March 2016, to 3 in the rolling 12 months in January 2018.

End of Life:

- ✓ Better end of life care provided to patients and their family
- ✓ Better use of the Independent Care Record Last Days of Life and the prescribing of anticipatory medication (use of the ICR LDL in hospital deaths up from 45% April 2017, to 63% in January 2018)
- ✓ Increased uptake on the My Care Choices Register (EPaCCs- Electronic Palliative Care Coordination System or end of life register), which records patients' wishes in the last 12 month of life, giving healthcare professionals information about the type of care the patient would like to receive, cultural or religious wishes and preferred place of care in the last days / weeks of life (number of patients on the My Care Choices Register admitted to hospital up from 0.9% in January 2017 to 2.0% in January 2018)

Sepsis:

- ✓ Improvement in the identification of patients who potentially have sepsis to ensure they receive the Sepsis 6 pathway within 1 hour of presentation
- ✓ Areas for improvement highlighted and targeted regarding the recognition and treatment of sepsis
- ✓ Increased general awareness of sepsis across the Trust
- ✓ National ranking for HSMR Septicaemia has increased from 123rd to 70th out of 136 Trusts.

Hyperglycaemia:

- ✓ Impact to be seen once the actions have been carried out.

Previous Reporting Period

0 case record reviews and 0 investigations completed after 1st April 2017 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the the judgement score methodology as requested by the Learning From Deaths Dashboard, or, where that judgment score is not available, by meeting Serious Incident or Internal Incident criteria

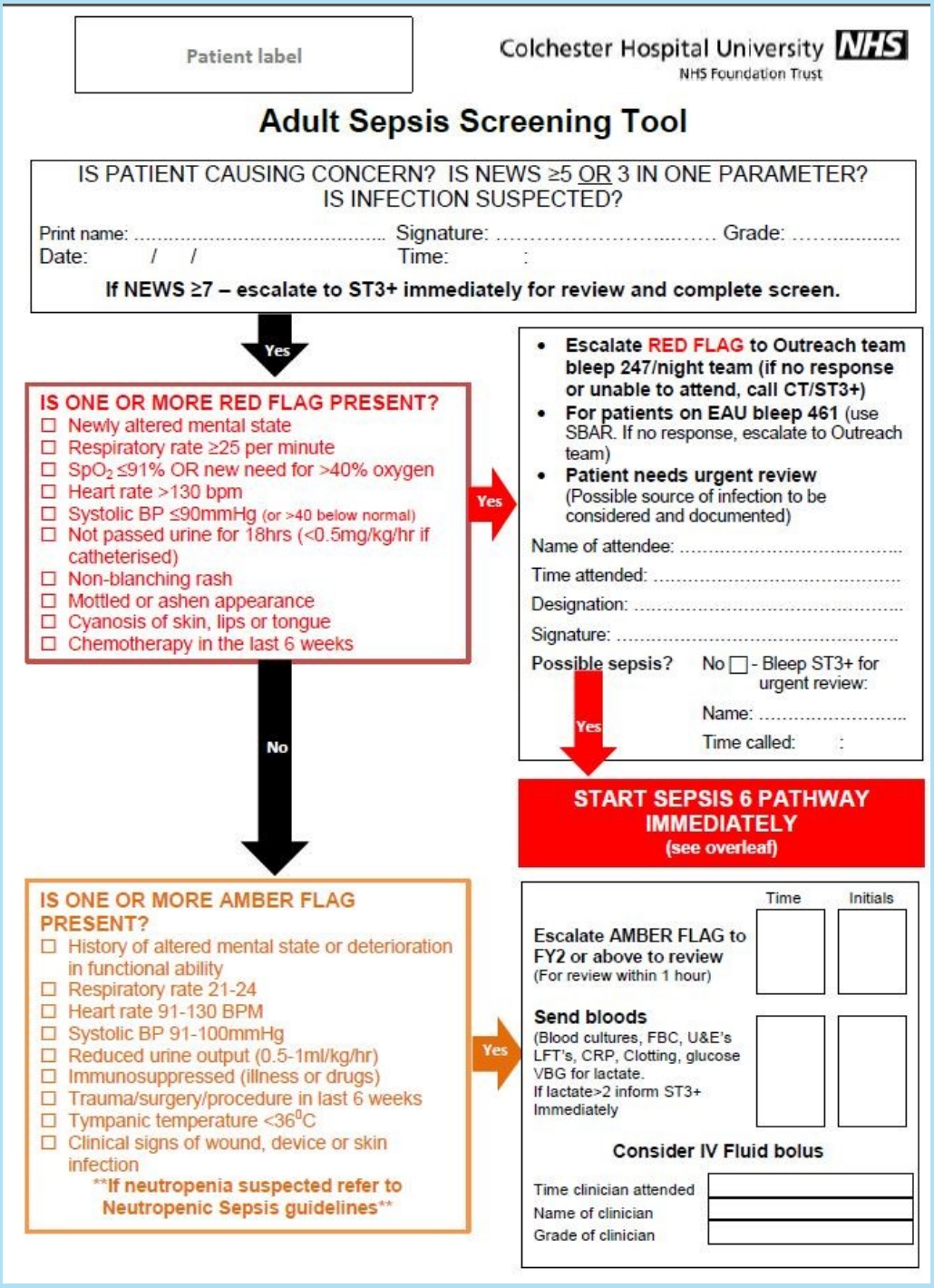
0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient. "

Although reviews were undertaken, there was no statutory requirement to submit this information.

From April 2017, Trusts were required to collect and publish on a quarterly basis specified information on deaths. Information prior to this time is not available to report.

Learning from Deaths

The Adult Sepsis Screening Tool that was rolled out throughout the Trust during January 2018



Patient label

Colchester Hospital University NHS
NHS Foundation Trust

Adult Sepsis Screening Tool

IS PATIENT CAUSING CONCERN? IS NEWS ≥5 OR 3 IN ONE PARAMETER?
IS INFECTION SUSPECTED?

Print name: ..... Signature: ..... Grade: .....
Date: / / Time: :

If NEWS ≥7 – escalate to ST3+ immediately for review and complete screen.

Yes

IS ONE OR MORE RED FLAG PRESENT?
- ☐ Newly altered mental state
- ☐ Respiratory rate ≥25 per minute
- ☐ SpO_2 ≤91% OR new need for >40% oxygen
- ☐ Heart rate >130 bpm
- ☐ Systolic BP ≤90mmHg (or >40 below normal)
- ☐ Not passed urine for 18hrs (<0.5mg/kg/hr if catheterised)
- ☐ Non-blanching rash
- ☐ Mottled or ashen appearance
- ☐ Cyanosis of skin, lips or tongue
- ☐ Chemotherapy in the last 6 weeks

Yes

- **Escalate RED FLAG to Outreach team bleep 247/night team (if no response or unable to attend, call CT/ST3+)**
- **For patients on EAU bleep 461** (use SBAR. If no response, escalate to Outreach team)
- **Patient needs urgent review** (Possible source of infection to be considered and documented)

Name of attendee: .....
Time attended: .....
Designation: .....
Signature: .....

Possible sepsis? No ☐ - Bleep ST3+ for urgent review:

Yes

Name: .....
Time called: :

START SEPSIS 6 PATHWAY IMMEDIATELY
(see overleaf)

No

IS ONE OR MORE AMBER FLAG PRESENT?
- ☐ History of altered mental state or deterioration in functional ability
- ☐ Respiratory rate 21-24
- ☐ Heart rate 91-130 BPM
- ☐ Systolic BP 91-100mmHg
- ☐ Reduced urine output (0.5-1ml/kg/hr)
- ☐ Immunosuppressed (illness or drugs)
- ☐ Trauma/surgery/procedure in last 6 weeks
- ☐ Tympanic temperature <36^{0}C
- ☐ Clinical signs of wound, device or skin infection

****If neutropenia suspected refer to Neutropenic Sepsis guidelines****

Yes

	Time	Initials
Escalate AMBER FLAG to FY2 or above to review (For review within 1 hour)		
Send bloods (Blood cultures, FBC, U&E's LFT's, CRP, Clotting, glucose VBG for lactate. If lactate>2 inform ST3+ Immediately		

Consider IV Fluid bolus

Time clinician attended
Name of clinician
Grade of clinician

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	CHUFT score	National average	Highest score	Lowest score	Banding
The value and banding of the SHMI for the Trust for the reporting period	Jan 16 - Dec 16	1.090	1.0			2
	Apr 16 - Mar 17	1.088	1.0			2
	Jul 16 - Jun 17	1.081	1.0			2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)	Jan 16 - Dec 16	25.2%	30.1%	55.9%	7.3%	
	Apr 16 - Mar 17	25.8%	30.7%	56.88%	11.1%	
	Jul 16 - Jun 17	27.1%	31.1%	58.59%	11.2%	

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- Trust is banded as a '2' which is 'as expected' mortality. This correlates with the information gained from local morbidity & mortality meetings.

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Using mortality indicators in conjunction with patient/family/carer feedback, incident reporting and summaries from mortality reviews to identify both good practice and any potential areas of concern.
- Dealing with individual issues according to severity in line with Trust governance processes and aggregating incidents to form part of the Trust's Quality Improvement Project.
- Appointing specialist staff to lead projects, auditing, teaching and monitoring processes and outcomes so that we know the changes made have benefited patient care and experience, with reporting from ward to Trust Board. An example of this would be the screening and treatment of patients admitted with sepsis. In 16 months, the Trust's ranking for mortality ratio for septicaemia has improved from 123rd out of 136 acute trusts to 70th. There has also been continued focus on the recognition and escalation of the deteriorating patient through staff training, process audits and mortality reviews.

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:	Reporting period	CHUFT score	National average	Highest score	Lowest score
The Trust's patient reported outcome measures scores for groin hernia surgery during the reporting period	2015/16	0.057	0.084	0.154	0.027
	2016/17		**0.087**	**0.135**	**0.019**
	2017/18*		**0.089**	**0.140**	**0.055**
The Trust's patient reported outcome measures scores for varicose vein surgery during the reporting period	2015/16		0.094	0.154	0.009
	2016/17		**0.092**	**0.155**	**0.010**
	2017/18*		**0.096**	**0.134**	**0.068**
The Trust's patient reported outcome measures scores for hip replacement surgery during the reporting period	2015/16	0.430	0.438	0.510	0.320
	2016/17	0.449	**0.437**	**0.533**	**0.329**
	2017/18**				
The Trust's patient reported outcome measures scores for knee replacement surgery during the reporting period	2015/16	0.292	0.320	0.398	0.198
	2016/17	0.336	**0.324**	**0.404**	**0.242**
	2017/18**				

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- A disparity in process for patient questionnaires between day case and inpatient has led to totally inadequate sampling for day case procedures which covers varicose vein and groin hernia surgery. This arose due to changes in personnel and has now been rectified with a clear process for questionnaire handout and patient information regarding questionnaire return. This is beginning to show in significant improvement in sampling for the day case procedures which is not apparent in this period of the dataset.
- Inpatient procedures for hip and knee replacement have shown a gradual improvement during this period and again improvement in patient information has led to this benefit.

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Improved patient information has led to better sample size which is anticipated will be seen in the next years data set.

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

Colchester Hospital University 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).
Local data sets have provided the following data for readmission rates:

- These figures are generated using live data as at 23/04/2018
- Showing data for Elective to Non Elective readmissions
- Age as at parent (elective) admission

Reporting period	0-15 years	16+ years
2015/16	9.8%	4.5%
2016/17	10.2%	4.0%
2017/18*	11.2%	4.0%

Colchester Hospital University 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

Colchester Hospital University 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).

Colchester Hospital University 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	CHUFT 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.“	2016/17 Q1	82.4%	81.7%	92.3%	23.1%
	2016/17 Q2	63.9%	81.9%	100.0%	43.8%
	2016/17 Q3	-	-	-	-
	2016/17 Q4	65.7%	81.5%	81.7%	60.0%
	2017/18 Q1	82.4%	83.4%	98.6%	54.9%
	2017/18 Q2	73.4%	81.5%	100.0%	41.1%
	2017/18 Q3	-	-	-	-
	2017/18 Q4	-	-	-	-

Colchester Hospital University 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

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

✓ By working with the Essex Leadership group the Trust has been delivering and giving access to the Mary Secole

✓ Programme which has a specific module on line of sight to the patient

✓ Developing and delivering further modules within the Licence to Lead Programme such as coaching conversations

✓ Developing joint programmes with Ipswich Hospital for new consultants, clinical leads and operation leads to equip them with the skills to be compassionate, inclusive and effective leaders

Indicator: Patient recommendation (Friends and Family Test)					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT 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)	2015/16 (Inpatients)	97.1%	95.4%	100.0%	83.3%
	2016/17 (Inpatients)*	97.8%	95.4%	100.0%	82.2%
* 2016/17 Highest & Lowest Score is based on March 2017 ** 2017/18 YTD (April 2017 - February 2018) with Highest & Lowest Score being based on February 2018 (Latest Report)	2017/18 (Inpatients) **	97.9%	95.7%	100.0%	45.9%
	2015/16 (A&E)	82.1%	87.7%	98.9%	49.3%
	2016/17 (A&E)*	88.1%	86.2%	100.0%	45.9%
	2017/18 (A&E) **	87.7%	86.6%	100.0%	67.3%

Colchester Hospital University 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 andTrust Board using the Integrated Performance Report; and any outlying scores trigger a review.

Colchester Hospital University 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	CHUFT 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	2015/16	94.70%	95.64%	100%	61.47%
	2016/17	96.10%	95.53%	100%	63.02%
	2017/18*	95.56%	95.20%	100%	51.38%

Colchester Hospital University 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

Colchester Hospital University 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 individuals responsible.

Indicator: Clostridium difficile infection rate					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT 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 14-Mar 15	15.5	15.0	62.6	0.0
	Apr 15-Mar 16	12.4	14.9	67.2	0.0
	Apr 16-Mar 17	18.0	13.2	82.7	0.0

Colchester Hospital University 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

Colchester Hospital University 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, where they are symptomatic.

✓ 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.

✓ 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 3 years with a plan for the final COTE Ward to be refurbished in the coming financial year. This supports the appropriate positioning of patients in an environment which allows for better isolation with an ability to clean effectively.

✓ Continue to investigate and invest in new cleaning technologies to support best practice and efficiency including the use of HPV fogging, micro-fibre implemented in June 2017. Trials of UV technology to support enhanced, timely deep cleaning is being investigated.

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		National average		Highest score		Lowest score	
		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	621,776	36.24	3,225	82.21	443	3.57
	April 15 - September 15	3,798	39.55	632,050	38.11	3,948	74.67	4,078	18.07
	October 15- March 16	3,969	40.94	655,193	38.58	3,426	75.91	1,499	14.77
	April 16 - September 16	3,789	39.79	673,865	39.89	3,620	71.81	2,305	21.15
	October 16 - March 17	3,667	36.77	696,643	40.52	3,300	68.97	3,219	23.13
	April 17 - March 18	Data not available at time of publishing.							
		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	0.10	3,089	0.18				
	April 15 - September 15	16	0.17	2,717	0.16				
	October 15 - March 16	32	0.33	2,642	0.16				
	April 16 - September 16	16	0.4%	2,516	0.4%	98	1.4%	1	0.02%
	October 16 - March 17	16	0.4%	2,623	0.4%	92	1.1%	1	0.03%
	April 17 - March 18	Data not available at time of publishing.							

Core Quality Indicators

Indicator: Patient safety incident rate
Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons: • All incidents are reviewed by the Patient Safety & Quality Team to assess and validate the level of harm reported and ensure those reported as no and low harm are accurately graded. There is also clinical judgement in the classification of an incident as moderate and above harm as it requires moderation and judgement against subjective criteria and processes. All incidents are investigated to ensure that lessons are learned to safeguard future patient care. All patient safety incidents (irrespective of level of harm) are uploaded to the NRLS within one month of reporting; and those initially considered to have caused severe harm or above are reported within 72 hours; • The last data set reported from the NRLS shows the Trust to be slightly below average reporters of incidents, this is the first dip in trend since 2013. 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 awareness weeks and it is anticipated the trend will once again improve. • The percentage of high harm and death incidents taken from the NRLS report (as mandated by the Quality Account Guidance) for April 2016 – September 2017 is 0.4% for the Trust, which is equivalent to the national average for medium acute Trusts and an improvement from the previous dataset. The Trust 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 24 hour review is requested. The 24 hour report is presented at SI Panel, held twice weekly and chaired by either the Medical Director or Director of Nursing; 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.
Colchester Hospital University 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. An E-learning training package 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

Healthcare Associated Infections (HCAIs)

Achieve Trust Target of zero for MRSA cases in 2017/18

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 meticillin are termed meticillin resistant Staphylococcus aureus (MRSA) and often require different types of antibiotic to treat them. Those that are sensitive to meticillin are termed meticillin 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) ;

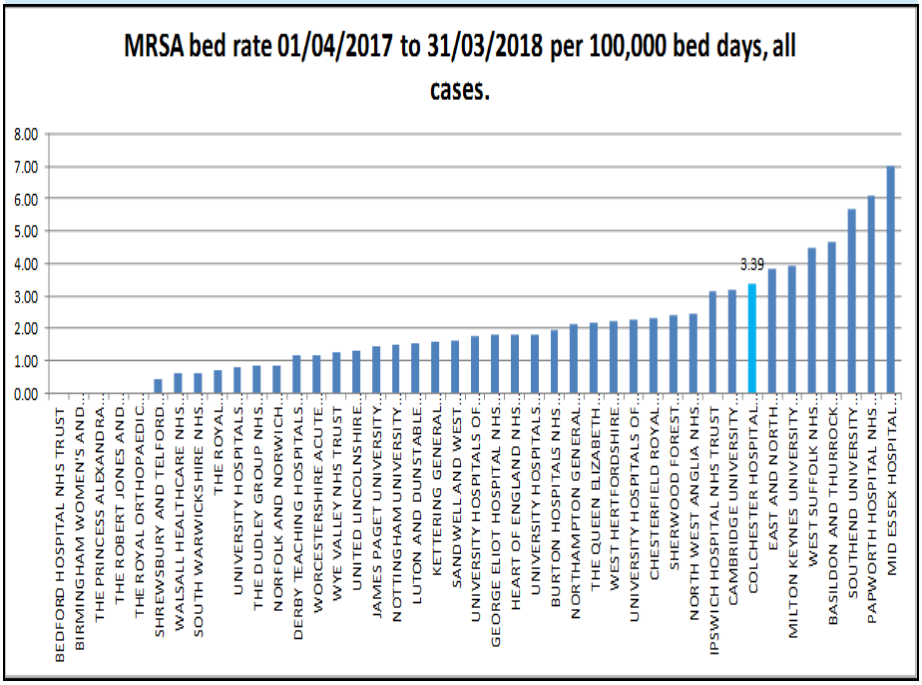
All Acute Trusts have participated in PHE mandatory enhanced surveillance of MRSA bacteraemia since October 2005:

- ✓ The root cause of the MRSA bacteraemia cases in 2017/18; one patient was previously known to be MRSA positive and was not screened in a timely way on admission, this did not allow the patient to undergo decolonisation treatment in a timely way.
- ✓ Continued education and support in promoting appropriate MRSA screening continues with an active process of highlighting to Wards/ Departments patients whom are previously positive.

Table 5— *Number of cases of MRSA bacteraemia apportioned to Colchester Hospital*

Year	Number of cases of MRSA bacteraemia cases apportioned to Colchester Hospital	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

Chart 3 –
The performance of Colchester Hospital 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

Clostridium difficile infection (CDI) remains an unpleasant, 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). NHS improvement carried over the objectives for 2016/17 into 2017/18, with CHUFT objective trajectory was set at no more than 18 cases in which there had been breaches in policy. 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).

18c *difficile* cases identified of which 17 cases for Colchester have been agreed as non- trajectory 2017/18 and therefore not attributed to the Trust.

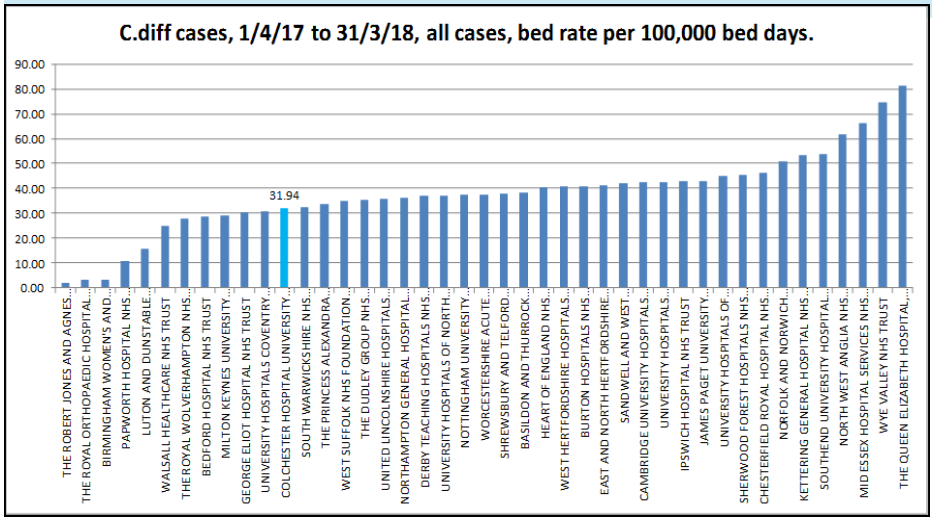
- ✓ Patients identified as carriers are monitored closely and managed in much the same way as patients with CDI.
- ✓ Work continues through scrutiny panel reviews with Clinical Commissioning Group to identify areas which may impact on further reduction of cases.
- ✓ Including looking at antimicrobial prescribing in the local health care economy.
- ✓ Patients whom are identified with CDI are given a credit card size information card to show to other healthcare professionals who may be involved in their care in the future to highlight the need for prudence in antibiotic prescribing for those individuals
- ✓ Antimicrobial auditing and awareness training continues to be a priority
- ✓ There have been challenges nationally with the availability of certain groups of antibiotics which then pushes clinical teams to the groups of antibiotics which can drive the risk of c difficile acquisition up

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 with a plan for the final COTE Ward to be refurbished in 2017/18.

***Table 6** — Number of C.Diff cases apportioned to Colchester*

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

***Chart 4** – The performance of Colchester Hospital in rates of Clostridium difficile, compared with the other hospitals in the East of England region for 2017/18*



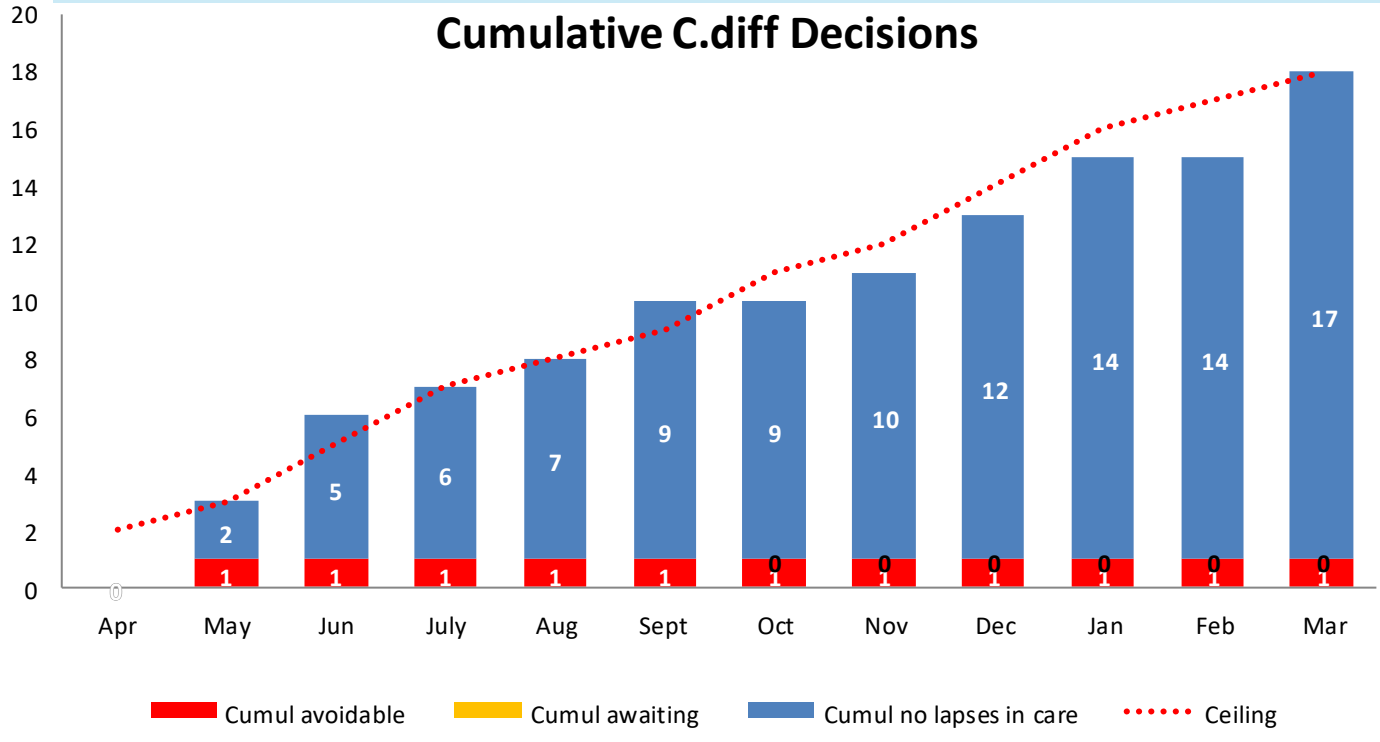
Patient safety
Infection prevention and control

Achieve Trust Target of 18 cases of Clostridium difficile in 2017/18.

The Trust has seen a decrease in cases identified as Trust apportioned 18 in total compared to total of 35 cases in the last financial year this equates to a 48.57% reduction in cases.

The Infection Control Conference held at Colchester Hospital during 2017

***Chart 5 -** Clostridium difficile cases 2017/18 to date, with areas of responsibility (Hospital, Community, yet to be decided)*



Patient safety
Prevention of inpatient falls

What is a fall?

A fall is defined as ".. *an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level..*"

Inpatient falls are commonly reported patient safety incidents and result in loss of confidence, slower recovery even when physical harm is minimal. The estimated overall cost to hospital Trusts due to inpatient falls is £630 million per year.

Who is most at risk?

The National Institute for Clinical Excellence (NICE) identifies that people aged 65 or over present the highest risk of falling. People aged 50—64 who are admitted to hospital and are judged by a clinician to be at a higher risk of falling because of an underlying condition may also present as a higher falls risk. Acute illness, particularly in frail older people or those recovering from serious injury or surgery can increase the risk of sustaining a fall whilst in hospital. Patients can be vulnerable to delirium, dehydration and become deconditioned, all of which can affect balance and mobility especially in unfamiliar surroundings. A high proportion of falls occur during the first few days of admission.

Assessing risk

On admission, patients are assessed for their risk of falls and if appropriate are commenced on the Falls Prevention Integrated Care Pathway. Completion of a series of preventative actions will help to ensure the optimum care plan is in place and reduce the risk of falls. The Trust has a Falls Prevention Practitioner who supports members of the multi-professional team in a wide variety of aspects in the safe management of patients identified at risk of falling.

Our key achievements:

- ✓ Achieving a reduction in the overall number of inpatient falls and consistency in <5 falls per 1,000 bed days
- ✓ A reduction in the number of falls resulting in serious harm
- ✓ Widespread implementation of 'Bay Watch' cohort nursing for those patients deemed at highest risk of falls and which has aided the reduction in falls incidents
- ✓ Implementation of a revised and improved Falls Prevention Integrated Care Pathway
- ✓ Introduction of a short educational film produced by a multidisciplinary team to help educate inpatients and their family members or carers about all aspects of falls and falls prevention;
- ✓ Implementation of a new and improved falls prevention educational booklet for patients
- ✓ Development of a weekly Harm Free Forum Group to discuss inpatients falls incidents resulting in serious harm in order to identify areas for learning and to target support;
- ✓ Purchase of new low-rise bed frames and roll-out mats for those patients at highest risk
- ✓ Purchase of an age simulator kit and training mannequin for use as part of ward based scenario training.

Patient safety
Prevention of inpatient falls

Aims and goals for 2018/19

- ✓ Continue to reduce the number of inpatient falls including falls resulting in serious harm
- ✓ Continue to promote 'Harm Free' care as part of 'Every Patient, Every Day' and get the basics right for all patients
- ✓ Implement rolling programme of ward based theory and practical falls prevention training across Divisions
- ✓ Replacement and upgrade of falls prevention assistive technology.

Key challenges

- ✓ The Trust continues to experience operational pressures which can impact on the release of staff to attend training at ward level.

National Patient Safety Agency (NPSA) Definitions of Harm

No harm
No injury at the time of the assessment post fall

Low Harm

An injury which requires minor first aid. It does not prolong the patient's length of stay or require out-patient treatment following discharge

Moderate Harm

The patient will have an increased length of stay and /or require out-patient treatment as a result of their injury or the patient may require interventions that are considered more than minor first aid, such as surgery or a blood transfusion, but will make a full recovery

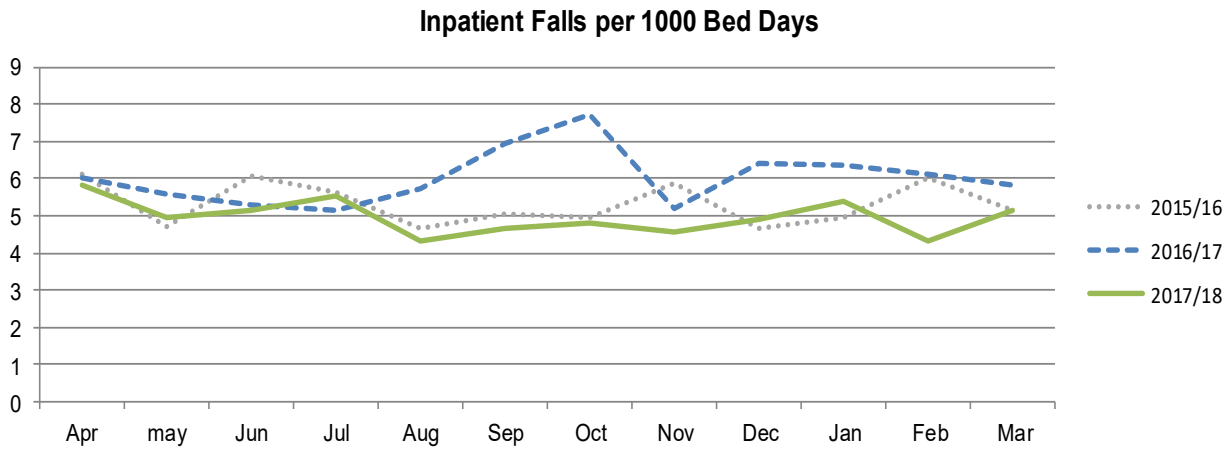
Severe Harm

This category of harm leaves the patient with a permanent injury or disability

Death

This is reported as a Serious Incident and follows the same process as a Moderate & Severe harm fall. This incident will be reported to the Coroner.

Chart 6 *– Our performance over the last three years: inpatient falls per 1,000 bed days*



Patient safety

Prevention of pressure ulcers which develop in hospital

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/management and rising litigation costs due them being seen as an indicator of clinical negligence. Despite many national prevention campaigns in recent years, pressure ulcer inci-dence rates continue to rise and this is reflected in Patient Safety Thermometer data.

In 2017/2018 the total number of CHUFT hospital acquired pressure ulcers graded at Stage 2-4 was 115 an increase of 4% on the previous year. It should be noted that there has been a 6% increase in Grade 3 & 4 pressure ulcers noted on admission (652 in 2017/2018 and 615 in 2016/17) which is indicative of increasing frailty of patients amongst other contributing fac-tors such as reduced funding in the social care sector and an increased burden on community resources.

The Trust continues to promote the use of the Midlands & East (2009) ASKIN care bundle as an effective 5 step model of pressure ulcer prevention. This ensures that patients who are at risk of developing pressure damage are identified early and actions can be taken to ensure appropriate care interventions are implemented to prevent pressure ulcer occurrence.

A = Assessment

S = Surface

K = Keep Moving

I = Incontinence/Moisture

N = Nutrition

Our key achievements

- ✓ Reduction of 30% of total PU figures (all grades) compared to 2016/2017
- ✓ Involvement in the NHSI PU Collaborative 2017/2018
- ✓ An increase in staffing within the Tissue Viability Service enhancing Ward support and patient education
- ✓ Raising awareness of appropriate use of dynamic support surfaces to aid PU prevention/management
- ✓ Introduction of pressure reducing mattresses in A & E to ensure 'at risk' patients receive preventative care
- ✓ 1:1 individual training with Ward staff on PU prevention
- ✓ Improved resources to support Heel elevation as a tool to aid PU prevention
- ✓ User friendly Wound Care Formulary to guide staff on appropriate choice of dressings.

NHS Improvements (NHSi) Pressure Ulcer Collaborative 2017/18

- ✓ Launched October 2017
- ✓ 25 Healthcare Trusts were enrolled nationwide.

Aims:

- ✓ A reduction in the number and severity of patient harm incidents
- ✓ Improve incident reporting
- ✓ Improve Quality Improvement skills
- ✓ Encourage a multidisciplinery focus on Pressure Ulcer care.

What we did as a Trust:

- ✓ Created and implemented an individual Trust action plan.

Patient safety

Prevention of pressure ulcers which develop in hospital

Aims and goals for 2018/19

- ✓ Review A.S.K.I.N assessment tool and identify where improvements could be made to enable improved completion
- ✓ Continue to support the improvements that have been identified as part of the NHSI PU Collaborative and escalate to all Wards across the Trust
- ✓ Improve engagement from Ward Link Nurses to drive for-ward changes and embed evi-dence based care
- ✓ Raise awareness of PU pre-vention via campaign days.

How will we measure and monitor our performance?

- ✓ Against national PST data
- ✓ Reduction of errors in reporting on Datix system
- ✓ Timely completion of Root Cause Analysis (RCA) investigations allowing for prompt review at Harm Free panel.
- ✓ Monitor trends/themes from RCA's to to identify learning that supports best practice.

How and where will progress be reported?

- ✓ Matrons meetings
- ✓ Harm Free Panel
- ✓ Monthly patient safety report
- ✓ 6/52 PSEG meetings
- ✓ Quarterly reports.

How pressure ulcers are graded European Pressure Advisory Panel (EPUAP) Classifications

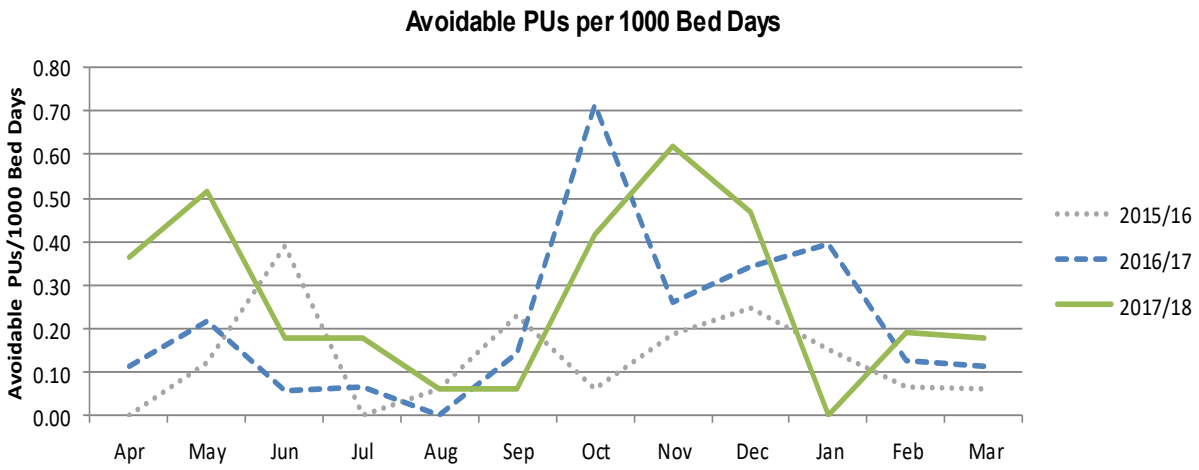
Grade 1
Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with

Grade 2
Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.

Grade 3
Full thickness of skin involving damage to, or necrosis of, subcutaneous tissue that may extend down to but not underlying fascia - the skin may be unbroken.

Grade 4
Extensive damage, tissue necrosis or damage to muscle, bone or supporting structures with or without full thickness skin loss.

Chart 7 – *Our performance over the last three years: Avoidable pressure ulcers per 1,000 bed days*



Patient safety
Learning from incidents, SIRIs and Never Events

Learning from incidents

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

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

The higher level incidents are categorised as Serious Incidents Requiring Investigation (SIRIs) and are reported to the North East Essex Clinical Commissioning Group. 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 introduction and embedding of 'Baywatch' to ensure the safe care for patient's who are at risk of falling
- ✓ A review of the medical examination proforma in the ED to enable Doctors to use a body map to document the clinical examination of patients who have attended following a fall at home.
- ✓ Review of the Extravasation Policy to include specific timescales for patients to re-attend for examination of extravasation as this is a common complication of chemo administration.
- ✓ Changes to the observation charts to aid staff to escalate the deteriorating patient quickly and to the correct

Duty of Candour

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

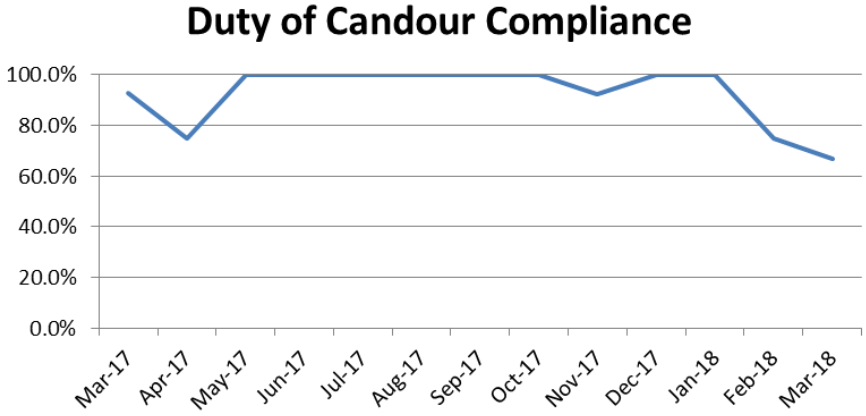
Healthcare professionals must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

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

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

- ✓ Face to face and E-Learning training for Incidents, SI's and Duty of Candour;
- ✓ Foot Cause Analysis Training for SI's;
- ✓ Introduction of the Trust's License to Lead Programme and the module 'Managing Governance'
- ✓ Review of process of sharing SI's and lessons learned within the area affected and wider as a Trust.

***Chart 8** — Duty of Candour compliance during 2017/18*



Patient safety
Learning from incidents, SIRIs and Never Events

***Table 6** – Adverse events and SIRIs reported*

For the year 2017/18, 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	745
Abusive, violent, disruptive or self-harming behaviour	199
Accident that may result in personal injury	1369
Anaesthesia	49
Clinical assessment (investigations, images and lab tests)	1120
Consent, Confidentiality or Communication	904
Diagnosis, failed or delayed	195
Financial loss	0
Patient Information (records, documents, test results, scans)	596
Infrastructure or resources (staffing, facilities, environment)	606
Labour or Delivery	347
Medical device/equipment	206
Medication	857
Implementation of care or ongoing monitoring/review	825
Other - please specify in description	824
Security	58
Treatment, procedure	720
Totals:	**9620**

Of these, 84 were reported as Serious Incidents Requiring Investigation (SIRIs):

Type of adverse event	No. of SIRIs
Abuse/alleged abuse of child patient by third party	2
Apparent/actual/suspected self-inflicted harm meeting SI Criteria-Mental Health SI	1
Information Governance breach	1
Diagnostic incident including delay meeting SI criteria	19
Infection control incident meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria (mother/baby)	2
Maternity/Obstetric incident meeting SI Criteria: Baby Only	4
Maternity/Obstetric incident meeting SI Criteria: Mother Only	1
Medication incident meeting SI criteria	6
Pressure ulcers meeting SI criteria	1
Slip/trip/fall meeting SI criteria	8
Suboptimal care of the deteriorating patient meeting SI criteria	10
Surgical/Invasive procedure incident meeting SI criteria	10
Treatment delay meeting SI criteria	17
Totals:	**84**

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 2017/18 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.

Patient safety
Learning from incidents, SIRIs and Never Events

Never Events at Colchester Hospital University NHS Foundation Trust

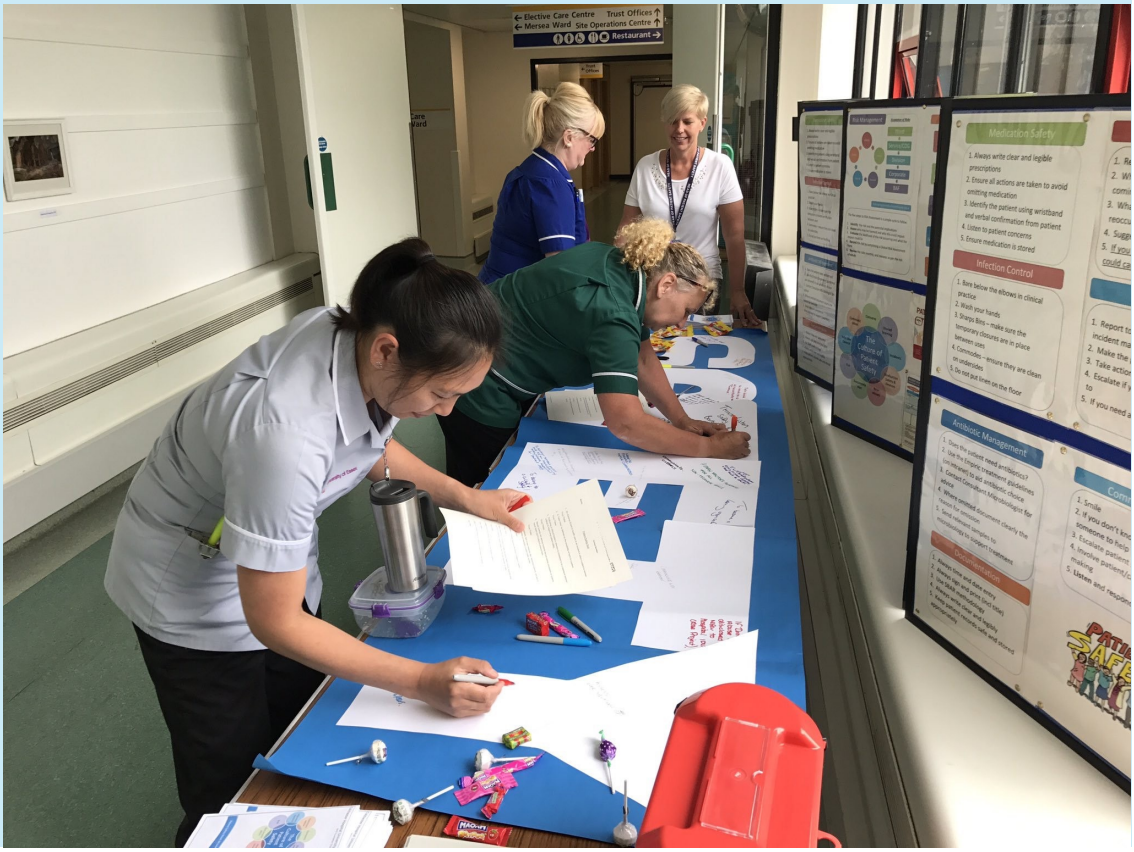
Whilst no patients had long-lasting

2015/16	2016/17	2017/18
4	3	3

or permanent damage, regrettably, three Never Events occurred in 2017/18:

- Wrong site surgery
- Misplaced naso- or oro-gastric tubes
- Wrong site local anaesthetic block

Staff writing Patient Safety pledges during Patient Safety Week, June 2017, at Colchester Hospital



Medication safety

Prevention of harm from medication

Medication Safety

The trust remains committed to the safe use of medicines. During 17/18 the Trust Medication Safety Group continued to effectively engage with representatives from all divisions and relevant clinical groups/staffing groups and the medication safety agenda was reinvigorated with a newly appointed Medication Safety Officer (MSO). Medicines Management Link Nurses also continued to meet bimonthly with the MSO to ensure medication safety work was highlighted at ward level and good practice shared.

A priority for the medication safety agenda 17/18 was to decrease the potential risk of patient harm as a result of an omitted prescribed critical medicine.

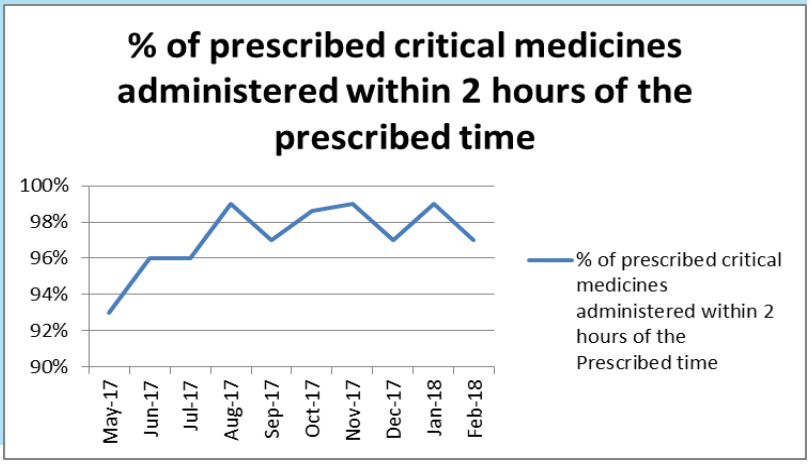
Why was this chosen as a priority:
Risks associated with the omission of medication administration are significant and have been known to cause significant harm or death in other organisations. Omitted critical medicine rates are an important metric to assess medication safety within an organisation.

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 conducted 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 medicines: The Medication Safety Group oversaw all actions related to this priority and the action plan was discussed monthly. The risk associated with omitted doses and the audit work was presented at the Sister and Matrons in June to engage with nursing staff and the response has been very positive. Communication between Sisters and Matrons and pharmacy staff has been strong and nursing staff regularly use the audit results to feedback to their frontline staff. Good documentation of administration has been targeted as an area for improvement. The trust 'Critical Medicines' list was updated in August 17 and posters were put up in all clinical areas to ensure all staff were aware of the high risk medicines. To prevent omissions as a result of a drug being unavailable a full review of the Trust Emergency Drug Cupboard has been undertaken and a flowchart for nursing staff on 'how to obtain medicines' was printed and placed in each clinical area.

Chart 9 *- Percentage of prescribed Critical Medicines administered within 2 hours of the prescribed time during 2017/18*



What was our performance:
A baseline audit in May 17 showed that 93% of prescribed critical medicines were administered within 2 hours of the prescribed time (unless there was a clinically appropriate reason). Following a focus on promoting the timely administration of medicines this increased to 99% in August 17. The trust remains within 97-99% adherence.

Other Key achievements in the Medicines Safety Agenda include:

- ✓ Regular 'Safe Storage of Medicines' audits including assessing medicines storage within the pharmacy department and theatres.
- ✓ Introduction of 'Grab Bags' for the safe administration of medicines during resuscitation events.
- ✓ Review of the Medicines Management Governance structure.

Clinical effectiveness
Stroke care

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 maintained a number of quality standards and stroke metrics over the last year. The following is a summary of some of our recent achievements.

The National Stroke Specific National Audit Program (SSNAP) audit aims to improve the quality of stroke services and patient care by reviewing care against set standards. Since the last report, Colchester Stroke Unit has maintained the top banding of "A" for Nov- Jan 16 -17 and April- July 17-18 in SSNAP national audit (within top 10% nationally).

CHUFT provides excellent stroke services across the whole pathway (hyperacute, acute and rehabilitation). It adopts evidence based practices and it is reflected in excellent clinical outcomes – lowest rates of new institutionalisation in East of England and lowest mortality in East of England (both below the national average). CHUFT's stroke specific Standardised mortality ratio was 0.82 for the year 2016-17 with the national average being 1. (source: SSNAP national database)

There is an active stroke research programme and CHUFT has recruited more than 40 patients for the year 2016-17. It is the top recruiter amongst the DGHs in the region.

MDT team is involved in an active clinical governance programme which regularly monitors the quality and performance: twice monthly performance meeting, monthly team at the top meeting and monthly mortality review meeting.

For two years running the Stroke Unit team are proud to report that no patients have developed a hospital acquired pressure ulcer of grade 2 and above since April 2016. This is a highly commendable achievement considering the high level of disability and dependency and level of care required for patients post stroke.

Physiotherapy and Occupational therapy have maintained the top banding of "A" for Nov- Jan 16 -17 and April- July 17-18 in SSNAP national audit and SLT have maintained "C" banding.

Close links have been established with the Emergency Department (ED) to facilitate sustaining and further improving direct admission within 4 hours and regular teaching sessions are being held for nurses and doctors in ED.

The Stroke unit has been involved in the Trust's piloting and improving End of Life (EOL) care for patients following a devastating stroke such as in-putting into the My Care Choices Register (MCCR) and Treatment Escalation Plan (TEP). The TEP form has enabled clear individualised parameters of care to be set for patients whilst they are in hospital. The MCCR helps improve EOL care by ensuring the patient has their choices respected, recorded and shared between hospital and community with the aim of improving the last days of life.

Some of the innovations listed below have been led by the Stroke Team members over the past year; they have included environmental and patient experience improvements.

The Stroke Unit is not immune to the national shortage of qualified nurses and has looked progressively and creatively at recruiting stroke specialist nursing staffing and focusing on growing our own team. Five of the unqualified staff on the stroke unit have developed their

Staff showing 'Poster Presentation' related to Cognition stimulation room

Clinical effectiveness
Stroke care

skills and knowledge on the nursing foundation degree course. This makes them uniquely qualified in nursing skills, stroke care and rehabilitation and enabled them to qualify and to be promoted to the assistant practitioners (AP) role within the stroke unit, enabling them to assist the qualified registered nurses provide nursing care. In addition to this two of the AP staff is continuing their training on a work based learning course and aim to become fully qualified registered nurses in the very near future.

The development of the Cognition stimulation room commenced in September 2017. Two of our senior Occupational Therapists produced a poster presentation about their innovative practice and presented at the RCOT Specialist Section Neurological Practice Conference. They developed an un-utilised space into the 'Cognitive Stimulation Room' and with funding from the non-medical tariff they invested in training and purchased resources to transform the room into a specific and meaningful environment to focus on cognition and cognitive rehabilitation.

***Chart 10** – Our performance over the last three years: % of people admitted to a Stroke Unit within 4 hours*

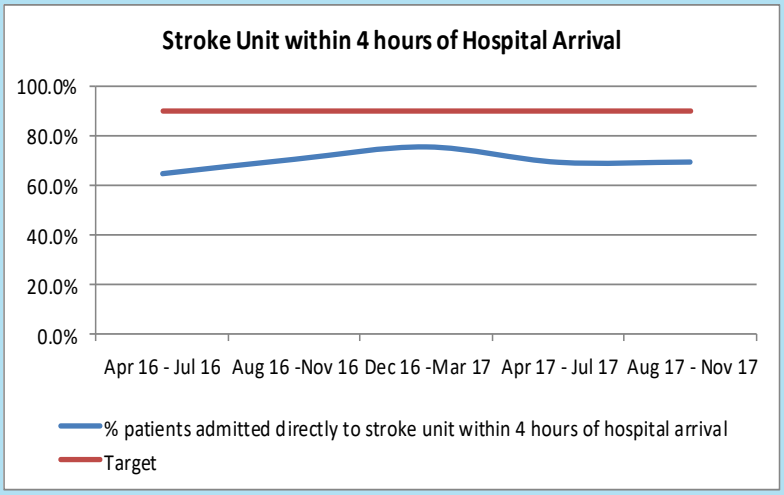
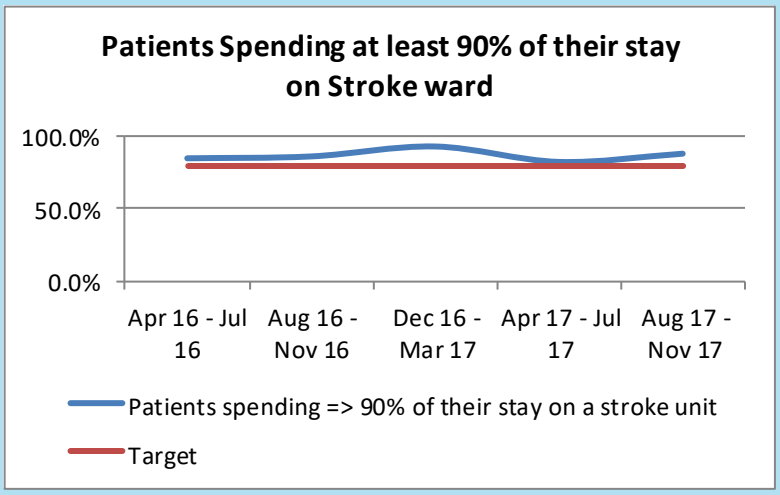


***Chart 11** – Our performance over the last three years: % of people treated on a Stroke Unit for >90% of the time*



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. These including sustained pressures on bed capacity, difficulties in establishing complete medical and nursing staff numbers and a 50% vacancy rate for Emergency Assessment Unit Consultants for which locum and agency staff are used to fill any gaps. There have been initiatives taken both locally within Emergency care and also in the wider Trust. These include:

A commitment to long term bookings of both Doctors and Nurses to ensure a higher fill rate.

Every Patient Every Day including The Emergency Department's Super Week during February. This aimed to:

- ✓ Standardise and embed ED processes so that these are adhered to 24 hours per day
- ✓ Embed the use of the Escalation and Whole Hospital Response policy and Action Cards
- ✓ Trial the use of the ED Trigger Tool in conjunction with the Escalation and Whole Hospital Response policy and Action Cards

Table 7 *– Our performance over the last three years: 4 hours to discharge from Emergency Department*

		2016/17		2017/18	
	Target	CHUFT Performance	National Average	CHUFT Performance	National Average
April	95.00%	73.7%	85.0%	78.9%	85.7%
May	95.00%	85.3%	85.4%	79.9%	84.6%
June	95.00%	86.2%	85.8%	82.3%	86.1%
July	95.00%	87.9%	85.4%	69.2%	85.5%
August	95.00%	81.6%	86.4%	82.3%	85.4%
September	95.00%	94.4%	86.0%	80.2%	84.6%
October	95.00%	85.7%	83.7%	78.8%	84.9%
November	95.00%	87.2%	82.7%	88.2%	83.0%
December	95.00%	70.6%	79.3%	81.4%	77.4%
January	95.00%	76.4%	77.6%	88.5%	77.1%
February	95.00%	87.8%	81.2%	87.5%	76.9%
March	95.00%	91.4%	85.1%	93.0%	76.4%
YTD	**95.00%**	**84.13%**	**83.68%**	82.6%	82.3%

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

Financial Year	CHUFT Number of Attendances	CHUFT 4 hr Performance	National 4 hr Performance
2015/16	68083	80.3%	87.4%
2016/17	85977	84.1%	83.7%
2017/18 *	91132	82.6%	82.3%

- ✓ Monitor breaches, identify breach reasons and hold people/areas to account for these.

Clinical effectiveness
Emergency care

Since the launch of Red to Green in September, we have seen improvements in patient flow, in bed capacity and in performance against the Emergency Department standards.

A Green day is a day when the patient has received an intervention in accordance with their care plan to support their journey through to discharge to meet the identified 'Earliest Discharge Date' (EDD). Therefore a Red day is when the patient 'does not' receive an intervention which was requested or planned, to support their journey through to discharge to meet the identified EDD.

From the time of admission clinicians should be concentrating on getting patients home from Colchester General Hospital as quickly as possible and with the right support.

Once a patient is medically fit, delaying their discharge results in deterioration of mobility and loss of independence. We ask all clinicians to think about what is really needed to support patients.

Sometimes the situation is made worse as medically fit patients end up being delayed and then end up needing more support.

The Trust continues to run these intensive Red to Green weeks in order to embed the processes into our systems. Red to Green aims to break the cycle of repeated escalation measures and end the continuing disruption to normal clinical business, which disadvantages patients.

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.

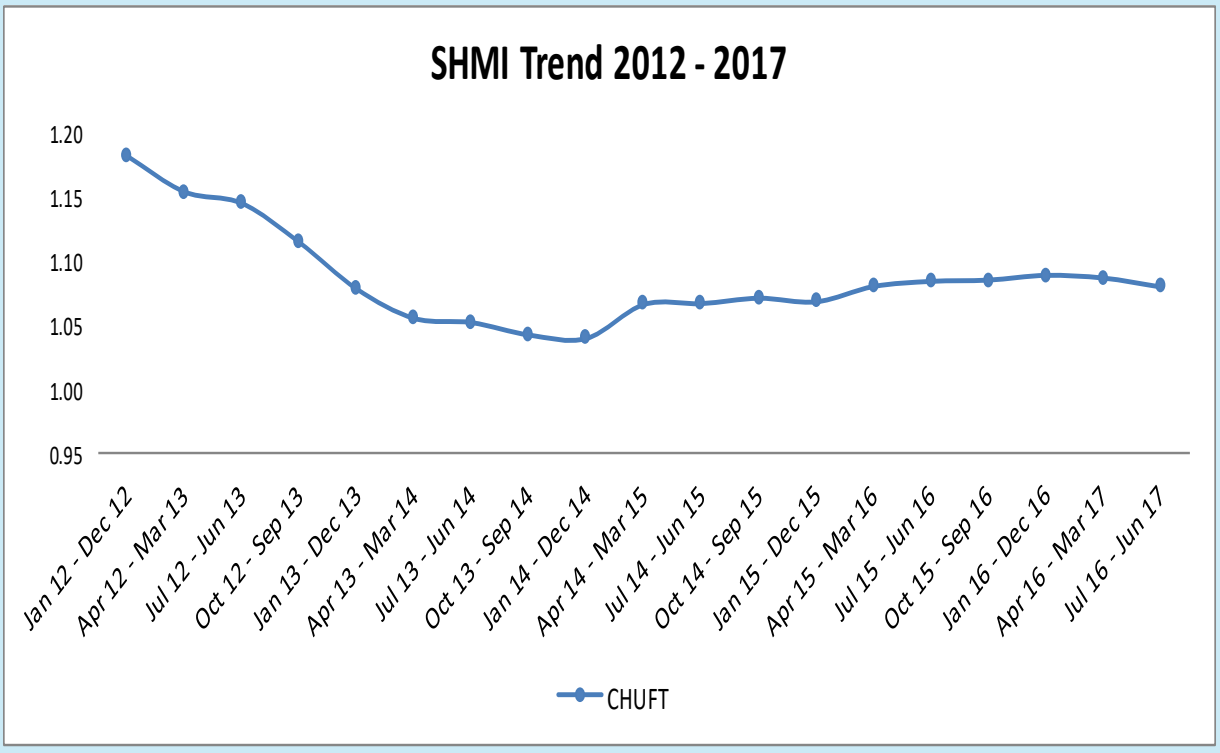
Why are mortality ratios/indicators important?

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.).

For more information about our performance with regard to SHMI, please see the SHMI Core Quality Indicator on page xx.

***Chart 12** - Mortality: SHMI trend January 2012 – July 2017*



Clinical effectiveness

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

The national benchmark for HSMR 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. For the period March to October 2017, the published monthly relative risk for the Trust was below 100, ranging from 85 to 95.

Mortality indicators are reviewed at the Mortality Review Group and are used, in combination with information from patient feedback, peer mortality reviews, incident-reporting and Divisional Morbidity and Mortality reports to identify potential issues which may require further investigation and action. In addition, where good care is identified, this is shared trust-wide.

From April 2017, the National Quality Board published guidance setting out the minimum standards for mortality reviews for NHS trusts. This Trust was already reviewing more than half of all deaths prior to these changes; however, the reviews are now being selected systematically according to recommendations and also where staff or families of patients have raised concerns.

The Chief Executive writes to the families/carers of every patient who has died in hospital. The response has been overwhelmingly positive, but any issues raised undergo thorough investigation by the team who looked after the patient. An additional review is completed by other medical staff not directly involved in their care to ensure a high level of objectivity and to ensure themes for improvement are captured

Following correlation of information from reviews and other sources, a number of key areas of focus have been identified including treatment of respiratory conditions such as pneumonia and COPD, sepsis screening and treatment and end of life care.

The HSMR relative risk for sepsis has improved the Trust's position from 123rd out of 136 trusts to 70th in 16 months.

Table 9 - *Results summary for January 2017 - December 2017*

In-hospital mortality, for all in-patient admissions to Colchester Hospital University NHS Foundation Trust for the period January to December 2016 has been reviewed. The SHMI is updated and rebased quarterly.

Metric	Result
HSMR	103.6 12 mth to Oct within the 'as expected' range
HSMR position vs. East of England peers	The Trust is 1 of 8 within the peer group of 16 that sit within the 'as expected' range.
HSMR diagnosis groups attracting higher than expected deaths	There are 5 outlying groups attracting significantly higher than expected deaths: Complication of device, implant or graft Relative risk 200 - 14 deaths, 7 expected COPD and bronchiectasis Relative risk 141 - 66 deaths, 47 expected Other lower respiratory disease Relative risk 194 - 14 deaths, 7 expected Senility and organic mental disorders Relative risk 162 - 23 deaths, 14 expected Pneumonia Relative risk 112 - 302 deaths, 269 expected
HSMR Weekday/Weekend Analysis	There is no significant difference between the weekday HSMR and weekend HSMR for emergency admissions. Both are statistically 'as expected'
Patient Safety Indicators (mortality metrics)	There are 0 mortality outliers
SHMI (April 2016 to March 2017)	Published SHMI = 108.06 'as expected' (band 2) 4 outlying SHMI groups What dates do you need for this Kerry? We have the 12 months to June 17 at the mo which is this figure. For March the figure was 108.76

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

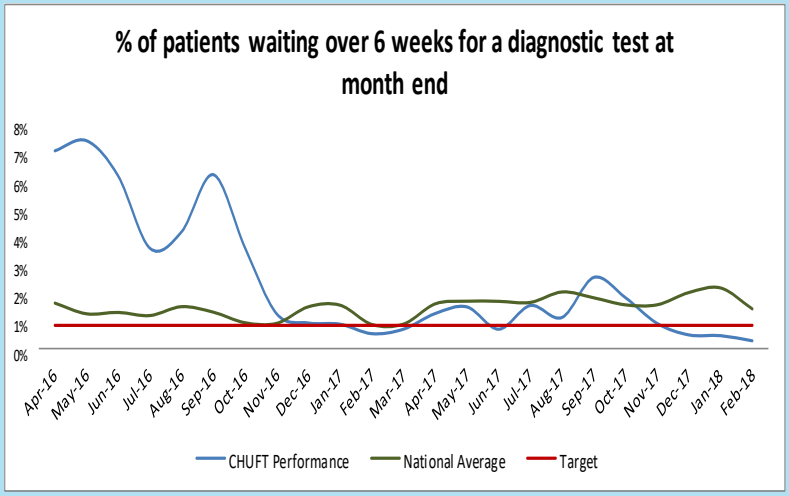


***Table 10** - Percentage of patients currently waiting under 18 weeks on an incomplete pathway*

		2016/17		2017/18	
% of patients currently waiting under 18 weeks on Incomplete Pathway	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
April	<1%	7.24%	1.81%	1.43%	1.78%
May	<1%	7.61%	1.42%	1.67%	1.87%
June	<1%	6.34%	1.47%	0.87%	1.87%
July	<1%	3.77%	1.36%	1.72%	1.83%
August	<1%	4.35%	1.68%	1.29%	2.20%
September	<1%	6.39%	1.48%	2.72%	1.99%
October	<1%	3.78%	1.10%	2.00%	1.74%
November	<1%	1.42%	1.08%	1.08%	1.74%
December	<1%	1.09%	1.67%	0.67%	2.18%
January	<1%	1.05%	1.73%	0.64%	2.35%
February	<1%	0.71%	1.04%	0.46%	1.60%
March	<1%	0.87%	1.06%		
End of Year position	**<1%**	**3.90%**	**1.40%**	**1.31%**	**1.92%**

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?

Two reviews were undertaken: a full review in March and a partial review in September 2017, as part of the national programme.

There is a national requirement that all Trusts meet the four priority standards for 7DS by March 2020. With this in mind, a number of key performance indicators (KPIs) have been set (please see the table below).

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

Standard 2 time to first consultant review

✓Although some way below the current KPI, the Trust's performance for March 2017 was above the national average. Job plans and protocols are under review to make sure that there is capacity within the system.

Standard 5 access to diagnostic tests

✓ The Trust achieved 6/6 for weekday services and 5/6 for weekend. (The service requiring improvement, echocardiography, is only provided by 56% of trusts at weekends.) The Trust is investigating the possibility of shared services following the merger with Ipswich Hospital NHS Trust and potential recruitment opportunities.

Standard 6 consultant-directed interventions

✓The trust provided 9 out of 9 consultant-directed interventions on-site or by formal arrangement.

Standard 8 ongoing review by a consultant

✓The trust achieved 100% in twice-daily reviews of high dependency (very unwell) patients .

✓For those patients requiring daily review, compliance was 84% overall (91% weekday compared to national average compliance of 90% and 63% weekend compared to a national average of 68%).

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. This standard will be a focus of the clinical strategy going forward. Progress will be reported to Clinical Effectiveness Group, Quality & Patient Safety and Trust Board as appropriate.

Table 11— Key performance Indicators relating to 7-day services

Key Performance Indicators – (Level 1)

KPI Ref	KPI Metric Description	Measurement Metric	Current KPI (as at dd/mm/yy)	KPI Target	Target KPI score		
					Green	Amber	Red
7DS-01	Time to first consultant review	- Percentage of patients seen by consultant within 14 hours of admission for weekends and weekdays	Weekday 76% Weekend 73%	90%	90%	75-89%	<75%
7DS-02	Access to diagnostic tests	- Number of six key diagnostics available at weekends and weekdays	Weekday 6/6 Weekend 5/6	6/6	6/6	4-5	<4
7DS-03	Access to consultant directed interventions	- Number of nine key consultant led interventions available at weekends and weekdays	Weekday 9/9 Weekend 9/9	9/9	9/9	7-8	<7
7DS-04	Ongoing review by consultant	- Percentage of patients who have twice daily review for high dependency patients and daily review for all other patients unless this would not affect the patient's care pathway	Weekday HDU 100% Weekend HDU 100% Weekday ward 91% Weekend ward 63%	90%	90%	75-89%	<75%

Patient experience
Improving the patient and carer experience

Key achievements
We aimed to ensure that we delivered first class care by continuing to demonstrate kindness, compassion, professionalism and skill, together with an ambition to do even better for our patients, relatives and carers.
Last year saw some innovative schemes to support our patients experience, this included as follows:

Enhancing the environment for our most vulnerable patients

- ✓ The Maternity ward (Lexden) was reopened following the completion of a seven-week refurbishment programme. The ward now feels less clinical and more spacious, and has a different ambience. League of Friends also provided comfortable chairs for the ward for partners staying overnight.
- ✓ Funding secured to help towards the Time Garden for terminally ill patients
- ✓ Grills fitted onto the French doors that open onto the balcony on West Bergholt ward (oncology ward) - this means that in the hot weather the doors can be opened to allow fresh air flow into the ward.
- ✓ Maternity garden developed by Tesco and Wyvale.
- ✓ Installation of a Changing Places toilet - the Changing Places toilet gives people with multiple physical and learning disabilities, such as spinal injuries, muscular dystrophy and multiple sclerosis, the extra space and equipment they need to ensure their safety and comfort. Available in the Gainsborough Wing and close to the new Outpatients Department (OPD), it includes a hoist, adult-sized changing table and shower, along with space for both the individual and their carer. It will be available 24 hours a day.

The Changing Places toilet

- A drab dining room has been transformed into a popular and well-used facility for stroke patients and their relatives, thanks to an initiative by Colchester hospital staff. What was previously simply the “Dining Room” on the Stroke Unit at Colchester General Hospital has been redesigned and upgraded into a “Day and Dining Room” where patients can relax with their visitors and work on their rehabilitation, as well as enjoy meals.

The Newly refurbished Maternity Ward

Patient experience
Improving the patient and carer experience

Reducing loneliness, isolation and anxiety or boredom for patients and carers:

- ✓ Activity boxes were distributed to virtually all wards and departments at Colchester General Hospital to give patients an opportunity to alleviate boredom. Each box contains a variety of activities, including colouring books, word search books, board games, pens, pencils, arts and crafts materials, playing cards and dominoes. They also include sensory bands – also called "twiddle muffs" which can provide visual and tactile stimulation, comfort and distraction.
- ✓ Pets as therapy (pat) dog visits are a huge hit and distract patients from feeling anxious.

Improving awareness of key issues for our patients, relatives and carers

- ✓ Members of staff joined patients who are currently undergoing medical trials, for a research showcase on the main corridor in January 2018. The hospital currently carries out research in the following areas: Neonates, renal, paediatrics, anaesthetics, surgery, haematology, oncology, vascular, stroke, ophthalmology, gastroenterology and maternity. The Trust is keen to raise awareness amongst staff, patients and visitors that trials and research are a big part of the work at Colchester Hospital.
- ✓ The "one-stop shop" information service at Colchester General Hospital celebrated its first anniversary. Birthday cake was handed out and balloons blown up when the weekly drop-in service for palliative and end of life care patients, their families and other carers reached the milestone. The sessions take place 2pm-3pm every Tuesday in the dayroom on West Bergholt Ward, which is located on the first floor of the main hospital building. In September the service was extended from palliative and end of life care patients currently in Colchester General Hospital and their families and other carers to include outpatients who are visiting the hospital and who may need support.

Activity boxes

- ✓ A New film to educate patients and carers about the risks of falling has been produced; so far, the feedback has been positive with patients reporting that the film has given them a greater understanding of what they can do to minimize the risk of falls and has made them feel more confident they will be able to manage when they return home.
- ✓ Education day with Essex schools by children's nurses
- ✓ Hypo Awareness Week activities took place
- ✓ Baby loss awareness week activities took place and remembrance service held.

Patient experience
Improving the patient and carer experience

Highlighting the importance of Carers in our community

- ✓ The Trust continued to work very closely with Essex Action for Family Carers. Family members can drop into the PALS Office during the week to seek support and guidance on what may be happening to their loved one. The team also visits wards daily speaking to carers to offer guidance and support. **Over 300 family carers have been supported during the year.**
- ✓ The dementia nurse specialists have signed up for John's Campaign to support family carers of patients with dementia to be able to stay and be more involved
- ✓ Carers Week, Carers' Rights Day and Young Carers' Awareness Days were all marked with an exhibition, stand and information workers providing advice and signposting to services.

Improving services for patients with learning disabilities:

- ✓ Learning Disability Good practice guide launched in July.
- ✓ Learning Disabilities Liaison worked with Essex County Council and Colchester Institute to provide films of having an MRI, blood test and attending A&E. These videos are available on you tube and also available in video brochures that can be loaned out to people to help reduce anxieties.

Supporting new mums:

- ✓ Seven mums have just started in a new voluntary role at Colchester General Hospital to support and encourage new mothers to breastfeed their babies. The "Colchester Volunteer Breastfeeding Supporters" currently help women on the hospital's maternity ward (Lexden Ward) but the plan is for them to also go onto the neonatal unit, delivery suite and midwife-led unit (the Juno Suite) as their numbers increase, as well as visiting mothers in their own homes. The seven volunteers who are currently supporting women range in age from a mother in her early 20s to a woman with grown-up children.

Making children and young people feel less scared or anxious:

- ✓ Colchester Children's Charity donated a saturation monitor to young patient, Renee Lewis-Driver (16), who is about to move to adult services for her continued care.
- ✓ The Starlight Children's Foundation sparkled some Christmas magic on our hospital when they performed their very special version of Cinderella for patients on the children's ward
- ✓ Ipswich Town & Colchester FC players took a break from their festive schedule to deliver some Christmas cheer to patients on our children's ward

The exhibition stand marking Carer's Week, Carer's Rights Day and Young Carer's Awareness Days

Patient experience
Improving the patient and carer experience

End of Life Care Focus:

Family care packs given to the patient's next of kin who stay as their relative is dying funded by Colchester Hospital League of Friends.

EOL volunteers available for hand holding, sitting with patients who are dying to allow family to go and get some food or to pop home. This is a new service and currently being trialled across a couple of ward areas with further 12 volunteers having some training next week. Plan for a 7 day service one day!

Memorial service set up last year for deceased adults where we held two small services last year and one bigger one this year when 48 next of kin attended. Plan to continue this for 2018

Bereavement walk-throughs – now completed four across paediatrics and adult services and have user and governor involvement. Bereavement suite improvements from this, funded by donations. Improvements to processes and policies made.

Quarterly bereavement survey given out from bereavement suite to help guide future service developments

Some ideas from wards include Acute Cardiac unit using **blankets** for dying patients which are then given to family if wanted or to cover patient when they go to the mortuary to reduce the clinical feel of dying in hospital. Critical care have **jewellery boxes** that they use for deceased patients.

Increase EOL champions across the hospital including clinical and non-clinical staff and the purchase of purple enamel pin badges to highlight who these staff are. Quarterly training days to share good practice and educate these staff.

Reviewing property bags for deceased patients to incorporate the purple butterfly as our EOL symbol

Ipswich Town & Colchester FC players deliver some Christmas cheer to patients on our children's ward

Blanketeers:

A Colchester ward sister has set up a group of volunteers to make blankets for patients who are nearing the end of their lives and also to reduce loneliness.

Sarah Sands from the Acute Cardiac Unit at Colchester General Hospital has been encouraged by the positive response from patients and their loved ones after blankets were donated by a knitting group in Norfolk led by her partner's mother.

She also believes that the group of volunteers, which will be called the "CHUFT Blanketeers", will bring together people who are often socially isolated, and give them a chance to get out of their home and meet other people. Ms Sands said: "When a patient is nearing the end of their life, we try to make their room less clinical by removing as much of the medical equipment as possible and make it more homely.

Each of their blankets has a handwritten tag giving the name of the person who knitted it and stating: "to bring you warmth and comfort at a difficult time". The other side of the tag is printed with the words "Knitted With Love" and has a motif comprising a ball of wool and two knitting needles.

Patient experience
Caring for people with dementia

Dementia Care

Each year the number of people living with dementia is growing and this number is expected to double during the next 30 years. Currently it is estimated that there are 850,000 people living with dementia in the UK, with numbers set to rise to over 1 million by 2025. 1 in 6 people over the age of 80 and over 40,000 people under the age of 65 have dementia in the UK. It is widely recognised that for patients who have a dementia diagnosis or a cognitive impairment who are admitted to hospital it can be very frightening and distressing experience and can reduce the person's level of independence. Last year CHUFT launched its 3 year Dementia Strategy to focus on improving the experience of patients, their families and carers when admitted. The Dementia strategy promotes a patient centered approach to care and includes improvements to the hospital environments, the use of distraction therapies, focused training for staff in supporting patients and increasing the support for families / carers.

It has been a key priority for the organisation over the past two years to create dementia friendly wards to reduce the anxiety of patients with dementia as part of the PLACE programme in the ward refurbishment plans at CHUFT. It is well known that reducing distress in patients can reduce length of stay, falls and other potential complications associated with admission to hospital. The Admiral Nurses have continued to be instrumental in advising the estates and facilities department regarding the creation of dementia friendly environments using evidence based practice. The Admiral Nurses are members of the Trusts refurbishment work stream and ensure that key areas of creating environments such as flooring, lighting, signage and quiet spaces are now incorporated into the ward and department plans as standard.

Governance and reporting:

Quarterly reports and updates are provided at the Dementia Management Group (DMG) Group which is chaired by the clinical lead and the deputy chair is the Head of Safeguarding. The DMG provides a forum for service leads to work together to address Dementia issues within the acute hospital setting and to ensure delivery of the 3 year Dementia strategy launched last year. The DMG provide a report to the quarterly Safeguarding Committee chaired by the Director of Nursing as Executive Lead and exception reports to the Quality and Patient Safety Committee and Trust Board. An annual Dementia activity report is produced and shared, stakeholders and the public.

The Dementia Care nurse specialists have undertaken further training to become Admiral nurses in partnership with Dementia UK (who are the charity that support them), and it is envisaged that the Admiral Nursing service will be an asset to our patients and families of people with dementia.

The Admiral Nurses regularly attend the dementia action alliance, the dementia partnership with EPT, the CHUFT end of life work-stream, the Essex Dementia Forum and the PLACE meetings to ensure that Dementia is considered throughout the organisation.

Training: supporting staff in the organisation

Ensuring a skilled and confident workforce to improve the experience of patient with dementia is a key priority. Along with mandatory training for all staff regarding Dementia, the Admiral Nurses run a two day advanced workshop. The workshop helps staff develop a person-centred approach to dementia care in an acute hospital setting. The programme is a multi-disciplinary approach to care in hospital including sessions which focus on communication, pain management, mobility and nutrition. Staff learn about the special needs of people with dementia and how to meet these needs by developing care practices, making the best possible use of time and resources available. Staff are encouraged to share their ideas, skills and experience and to give and receive feedback. The Admiral Nurses have increased the frequency of this workshop to monthly and will continue to provide training for staff to ensure they have coping strategies and the understanding to work confidently with patients with dementia.

In addition to this a volunteer Dementia day training programme has also been developed and feedback from the volunteers has been extremely positive. The volunteers have stated that the skills they have learnt during the training day has enabled them to feel more confident when communicating with patients in ward and community area.

In addition to the significant improvements to the hospital environment and appointment of the Admiral Nurses at CHUFT, work continues in supporting the individual with Dementia through distraction therapies such as the use of sensory bands to reduce distress and anxiety. Another Key priority for the team moving forward is to provide more support carers. The team have developed strong links with other Admiral Nurses at neighbouring acute hospitals and this will help in developing our Admiral Service further. A referral form has been developed for all staff to refer patients / families for advice and support. The Admiral Nurses and Dementia team can help with minimising distress that people with dementia may feel whilst they are in hospital; liaise with families, helping them cope with what is happening to their loved one, and ensuring they are equipped to continue with their caring role once their relative leaves hospital. This will hopefully reduce future crisis and unnecessary admissions.

Patient experience
Measuring and reporting the patient experience

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 eg 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

National Maternity Survey

The results from the CQC survey of maternity experiences of acute trusts 2017 was published on 30 January 2018. This survey looked at the experiences of 18,426 women who gave birth in February 2017.
During the summer of 2017, a questionnaire was sent to all women who gave birth in February 2017. Responses were received from 96 patients at CHUFT.

Colchester received an overall 'better rating (better compared to most other trusts that took part in the survey) for Labour and Birth.

We were the only Trust in the East of England that received a 'better rating' in any category.

Colchester did not receive a 'worse than' score in any area.

Colchester scored better than other trusts for mums being able to move around and choose the most comfortable position during labour, and for partners being involved as much as they wanted, for which the hospital recorded a maximum score of 10 out of 10.

Of the 36 questions that received an average response the percentage for the question concerning the amount of time taken for discharge had decreased from the previous survey.

This had already been identified as a concern from in-house patient feedback and the department has been working on improving the discharge process for our women.

Early discharges are a priority for midwives on Lexden and in times of increased workload the ward sister and/or the maternity bleep holder will complete discharges for women on the ward.

Currently each woman receives discharge information prior to discharge; this is undertaken by the maternity support staff. In order to both speed up the process and for the women to be able to revisit the information we will be changing to electronic information.

***Table 12** – Based on patients' responses to the National Maternity Survey, this is how Colchester Hospital compares with other Trusts*

Labour and birth	9.4/ 10	
Staff during labour and birth	9.1/ 10	
Care in hospital after birth	7.9/ 10	

Patient experience
Measuring and reporting the patient experience

National Inpatient Survey

The results from the Care Quality Commission Survey of inpatient experiences of acute trusts 2017 was published on (not yet published).
The final response rate for the Trust was xx% (national response rate xx%).

The sample size was xxx. People were eligible for the survey if they were aged 16 years or older and spent at least one night in hospital and were not admitted to maternity or psychiatric units. The survey took place for one month during the summer of 2017

The National Inpatient Survey 2017 results for Colchester Hospital show the hospital as being 'about the same' as all other hospitals overall, (add top and bottom answers)

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Table 13 *– Based on patients' responses to the National Inpatient Survey, this is how Colchester Hospital 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

National Accident and Emergency Survey

The results of the national Accident and Emergency Survey were published on 17th October 2017.

The final response rate for the Trust was 30% (national response rate 28%).

The survey sought the views of more than 45,000 people aged 16 years and older who attended emergency and urgent care departments at 137 acute and specialist NHS trusts during September 2016. At CHUFT the questionnaire was sent to 1,250people who had used emergency department services at the hospital, with responses received from 362 people.

The sample size was 362. People were eligible for the survey if they attended the Accident and Emergency Department during September 2016.

The National Accident and Emergency Survey 2017 results for Colchester Hospital show the hospital as being 'about the same'/ better/worse as all other hospitals overall,

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

***Table 14** – Based on patients' responses to the National Accident and Emergency Survey, this is how Colchester Hospital compares with other Trusts*

Arrival at Accident and Emergency	8.3/ 10	WORSE ABOUT THE SAME BETTER
Waiting times	6.1/ 10	WORSE ABOUT THE SAME BETTER
Doctors and Nurses	8.4/ 10	WORSE ABOUT THE SAME BETTER
Care and Treatment	8.1/ 10	WORSE ABOUT THE SAME BETTER
Tests	8.7 / 10	WORSE ABOUT THE SAME BETTER
Hospital Environment and Facilities	8.8 / 10	WORSE ABOUT THE SAME BETTER
Leaving Accident and Emergency	6.5/ 10	WORSE ABOUT THE SAME BETTER
Respect and Dignity	9.1/ 10	WORSE ABOUT THE SAME BETTER
Overall experience	8.3/ 10	WORSE ABOUT THE SAME BETTER

Patient experience
Measuring and reporting the patient experience

National Children and Young Peoples Survey

The results of the national Children and Young Peoples Survey was published on 28th November 2017.

The final response rate for the Trust was 24.9% (national response rate 26%).

The sample size was 1,250 with 306 responding. People were eligible for the survey if they were October, November and December 2016.

The survey looked at the experiences of 34,708 children and young people under the age of 16 who received inpatient or day case care during October, November and December 2016. Between February and June 2017, a questionnaire was sent to a maximum of 1,250 recent patients at each trust. Responses were received from 306 patients at Colchester Hospital University NHS Foundation Trust

The National Children and Young Peoples Survey 2017 results for Colchester Hospital show the hospital as being 'about the same'/better/worse as all other hospitals overall, for each section of the survey (there is no overall rating)
Top scoring question – 9.9 / 10 – for children spending most or all of their stay on a ward designed for children or adolescents, and not on an adult ward
Bottom scoring question – 2.1 / 10 – for parents and carers being given a choice of admission date

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Table 15 *– Based on patients' responses to the National Children and Young Peoples Survey, this is how Colchester Hospital compares with other Trusts*

Going to hospital		**No overall score available**
Choice of admission date	2.1/10	About the same
Change of admission date	9.1/10	About the same
The hospital ward		**No overall score available**
Things to do	6.9/10	About the same
Food	6.0/10	About the same
Sleep	6.1/10	About the same
Privacy	9.1/10	About the same
Play	4.9/10	About the same
Suitability of ward	8.710	About the same
Play for younger children	7.8/10	About the same
Enough things for younger children	8.2/10	About the same
Food for young children	5.4/10	About the same
Privacy for younger children	9.2/10	About the same
Type of ward stayed on	9.9/10	About the same
Appropriate equipment or adaptions	9.2/10	About the same
Cleanliness	9.1/10	About the same
Hospital staff		**No overall score available**
Speaking with staff	9.3/10	About the same
Understanding what staff say	8.1/10	About the same
Able to ask questions	9.3/10	About the same
Questions being answered	9.6/10	About the same
Involvement	6.3/10	About the same
Support when worried	8.5/10	About the same
Talking to a doctor or nurse alone	Not applicable	
Staff introducing themselves	8.9/10	About the same
Communicating with young children	7.8/10	About the same
Conflicting information	8.1/10	About the same
Parents and carers feeling listened to	8.7/10	About the same
Explanations parents and carers could understand	9.2/10	About the same
Keeping parents and carers informed	8.2/10	About the same
Parents and carers able to ask questions	8.8/10	About the same
Planning care	9.3/10	About the same
Parent and carer involvement	8.2/10	About the same
Information	8.6/10	About the same
Children's medical history	7.6/10	About the same
Individual or special needs	8.2/10	About the same
Help when needed	8.0/10	About the same
Staff working together	8.7/10	About the same
Confidence and trust	9.0/10	About the same
Facilities for parents and carers		**No overall score available**
Access to hot drinks	8.1/10	About the same
Food preparation	4.9/10	About the same
Facilities for staying overnight	7.9/10	About the same
Pain management		**No overall score available**
Pain management	8.5/10	About the same
Parent and carer's views on pain management	7.9/10	About the same

Continued

Patient experience
Measuring and reporting the patient experience

Continued

Operations and procedures	**No overall score available**	
Information before an operation or procedure	9.5/10	About the same
Information after an operation or procedure	8.9/10	About the same
Information for parents and carers before an operation or procedure	9.1/10	About the same
Answers to questions before an operation or procedure	9.1/10	About the same
Distracting a child during an operation or procedure	7.6/10	About the same
Information for parents and carers after an operation or procedure	8.3/10	About the same
Medicines	**No overall score available**	
Information about medicines	9.6/10	About the same
Leaving hospital	**No overall score available**	
What to do in case of further concerns	7.9/10	About the same
Information about next steps	8.2/10	About the same
Advice on self care	8.7/10	About the same
What to do if concerned about their child	8.2/10	About the same
Parents & carers being given information/next steps	8.1/10	About the same
Advice on caring for child	8.6/10	About the same
Information to take home	8.4/10	About the same
Overall experience	**No overall score available**	
Friendliness	9.1/10	About the same
Being well looked after	9.1/10	About the same
Parents and carers feeling staff were friendly	9.3/10	About the same
Parents view of child being well looked after	9.4/10	About the same
Dignity and respect	9.2/10	About the same
Parent and carer being well looked after	7.9/10	About the same
Parents view of child's overall experience	8.6/10	About the same

Friends and Families Test (FFT)

The Trust achieved its target for recommender being at or above 95% for Inpatients with a score of 97.9% (national average 95.7%); the return rate was consistently higher (over 30%) than the national average (24.5%)

The score for ED was 87.7% - this was higher than the national average (86.6%) with a return rate that exceeded the national average of 12% month on month at above 20% up to 28% in February 2018.

The scores for outpatients remained above 95% at 97% throughout the year. There is no national comparator for return rate.

Maternity return rates were variable throughout the year but scores for 'birth' touchpoint were above 95%; with post-natal ward scores being on average above 95%.

Table 16– *Friends and Family Test Data April 2017 to March 2018*

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient FFT return %	39	37	44	43	43	39	36	41	33	36	35	39
Inpatient recommenders %	97	96	96	98	96	97	98	96	96	98	97	97
ED FFT return %	19	19	19	19	23	23	24	26	25	26	25	28
ED recommenders %	81	80	82	85	87	84	87	89	89	90	89	85
Outpatient FFT return %	1	1	1	1	2	1	1	1	1	1	1	1
Outpatient recommenders%	96	98	97	97	96	98	97	96	97	99	97	98
Maternity FFT return %												
Antenatal return %	0	0	0	0	0	12	26	38	9	0	6	2
Antenatal recommenders %	-	-	100	-	-	90	85	88	81	-	95	100
Birth return %	15	11	10	13	14	20	11	22	14	7	19	17
Trust-wide Birth recommenders %	95	100	100	100	100	95	100	100	100	100	100	100
Postnatal ward %	33	28	24	16	22	25	48	35	41	42	49	31
Trust-wide Postnatal ward recommenders %	94	98	98	100	98	95	96	99	100	92	100	98
Postnatal community %	0	1	1	1	0	13	1	0	0	0	0	12.8
Trust-wide Postnatal community recommenders %	-	100	100	100	-	74	100	-	100	-	-	100

Patient experience
Measuring and reporting the patient experience

New Initiative - Patient Experience Collaborative

What is the Collaborative?

12 trusts across the UK coming together to work with Northumbria Healthcare and Patient Experience Network (PEN) for 12 months to trial use of the Northumbria model for gathering patient experience feedback and applying quality improvement ideas, 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?

Realtime surveying of at least 50% of patients on a ward utilising 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 'core domains' – 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
- Pain control

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

How are Colchester Hospital NHS Foundation Trust & Ipswich Hospital NHS Trust involved?

Working as one overall team from both hospitals, 6 core team members have been identified to take the project forward on both sites, which will involve up to 8 patient wards/departments across the sites.

The 6 core team members will attend 5 learning events during the year and there will be a real time measurement uploaded twice a month giving robust evidence on impact and change.

The core team will have additional membership to create a 'steering group' to guide and support the programme, including the wider multidisciplinary team

In addition several data collectors have been identified to undertake the surveys, upload and share the data with the wards/steering group.

Next steps

- ✓ 08/09 November - Visit from Northumbria team to train the data collectors and core team in the methodology.
- ✓ First, base-line data collection – during November and December.
- ✓ Monitoring of results and action plans until end of project in August 2018.

'Magic' the donated Giraffe to the Children's ward pictured with Nursing staff

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

The Trust has continued to involve patients and carers in a number of ways:

- ✓ Patient stories to public board
- ✓ Patient stories at corporate Induction
- ✓ Establishment of a patient advisory group to support the discussions around partnership working with Ipswich Hospital; development of a rolling action log to manage concerns and queries; establishment of a joint patient advisory group with Ipswich Hospital NHS Trust
- ✓ Supported user groups such as the Cancer Services User Group to develop further
- ✓ Collaborated with Ipswich Hospital User Group (IHUG) via key governors as the partnership discussions continued to review and build on existing good practice
- ✓ Attendance at Tendring Show
- ✓ Liaison with Healthwatch Essex and the Essex Health Forum

A patient 'You said, We did' poster

You said	We did
Patient explained by the time the food trolley reaches her bay on Nayland Ward there is no food left.	PALS visited ward and discussed the patients concern with Matron. Matron said she would raise this with the house keeper on the ward as rotation of bays should be made. The Matron has informed the patient of the action taken.
You said you could not hear the A&E receptionists and they could not hear you through the glass barrier in A&E Reception	We removed the glass barrier in the recent refurb' to make it easier for patients and staff to have confidential conversations in the A&E Reception
Several PALS contacts cover delays or problems in getting/making appointments	PALS proactively sort out the blockages and ensure the appointments are arranged appropriately
In the annual patient survey in Endoscopy one point of feedback was that on discharge only 80% of patients felt they were informed as to any necessary follow up appointments following their test.	We added a line to the ICP to ensure any follow up procedures or instructions are communicated to the patient and documented and signed
In the annual patient survey in Endoscopy one point of feedback was that a quarter of patients experienced a delay on the day of their procedure	This was recognised as a challenge funnelling three procedure rooms of patients through two admission rooms. A third admission room has been designed and fitted out – almost ready to go live with minimal snagging work left to do.
It gets hot and stuffy on the ward	Grills fitted onto the French doors that open onto the balcony on West Bergholt ward - this means that in the hot weather the doors can be opened to allow fresh air flow into the ward

Table 17 *— Number of plaudits received by Colchester Hospital during 2017/2018*

Month	Plaudits received
April 2017	1607
May 2017	1255
June 2017	1022
July 2017	1294
August 2017	1096
September 2017	995
October 2017	689
November 2017	687
December 2017	1351
January 2018	976
February 2018	1028
March 2018	1300
Total Plaudits for 2017-18	**13300**

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.

Colchester Hospital University NHS Foundation Trust 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 the hospital

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

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

Director to review and sign the letter of response.

Reopened complaints

During the year 2017/18 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.

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 2017/18, 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.

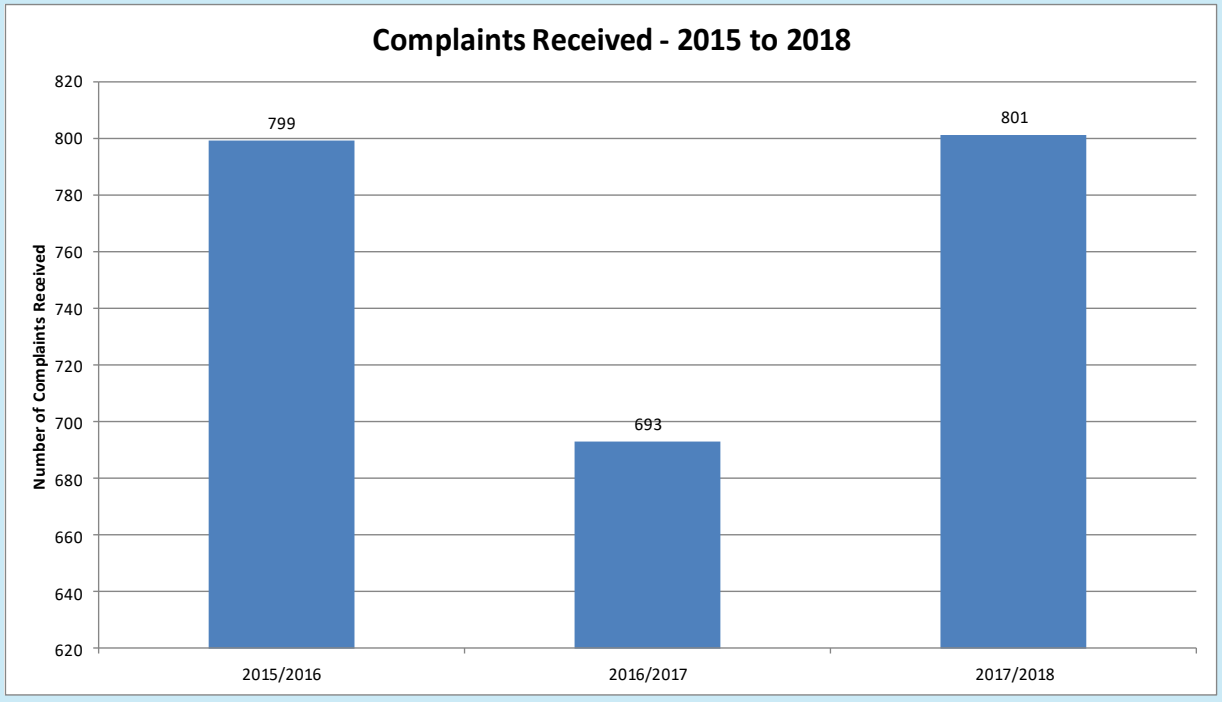
It is acknowledged that there needs to be further Trust wide improvement in identifying, reporting and sharing lessons learned and actions taken from complaints.

Through the new 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

***Chart 14** – Our performance over the last three years:*



Patient experience
Learning from complaints

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 non-complex issues informally, often preventing the need to raise a formal complaint.

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

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

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

Examples of PALS stories

✓ Patient's wife was unclear in relation to elements of the patient's care and did not know what treatment he should receive or what the discharge arrangements were. The patient suffers with Parkinson's and was admitted here after suffering a fall at the care home.

PALS arranged for the issues to be discussed with the patient's wife to enable her to understand what treatment plan was being put in place.

✓ Patient was concerned that he was told he needed a 2 week follow -up appointment after a minor operation in Oral Surgery but it was booked for 2 months.

PALS contacted the service area and arranged for the patient's appointment to be brought forward.

✓ Patient explained by the time the food trolley reaches her bay on Nayland Ward there is no food left.

PALS visited ward and discussed the patient's concern with Matron. Matron raised this with the house keeper on the ward to ensure rotation of bays was happening consistently.

✓ Patient was admitted on 29th December following clinic appointment for a scan. Scan did not occur until 2nd January. Patient was waiting to know when their chemotherapy would start.

PALS spoke to the Ward Sister who advised the patient that they would be seen by the doctor that morning and then would start chemotherapy the next day.

✓ Patient contacted PALS suggesting we install screen filters for self-service kiosks in outpatients.

Estates confirmed that we are aware of this issue and are looking into filter screens being fitted. PALS relayed this information to the

Table 18—*Colchester Hospital Top three subjects of complaints for the last 3 years*

Top three subjects of complaints		
2015/16	**2016/17**	**2017/18**
Attitude of staff	Attitude of Staff	Attitude of Staff
Elements of treatment	Elements of treatment	Elements of treatment
Clinical Communication and Co-ordination	Discharge	Discharge

Patient experience
Learning from complaints

patient and advised that she could report to the reception desk to be checked in for future appointments.

***Chart 15** - PALS Queries April 2017 until March 2018*

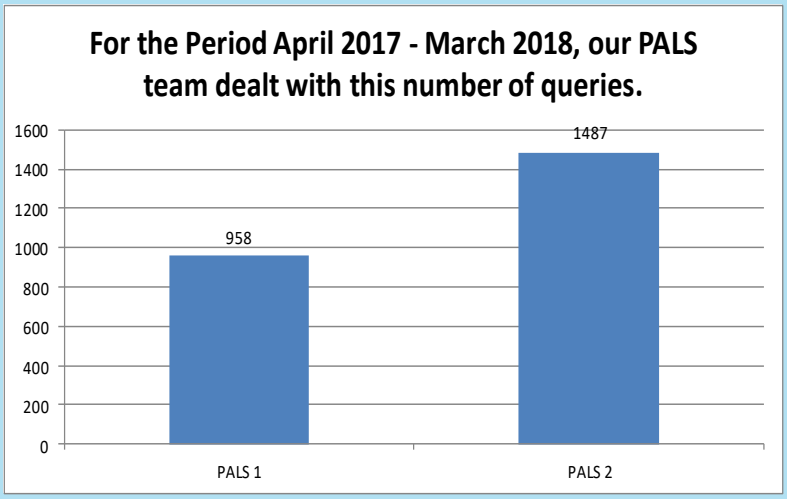
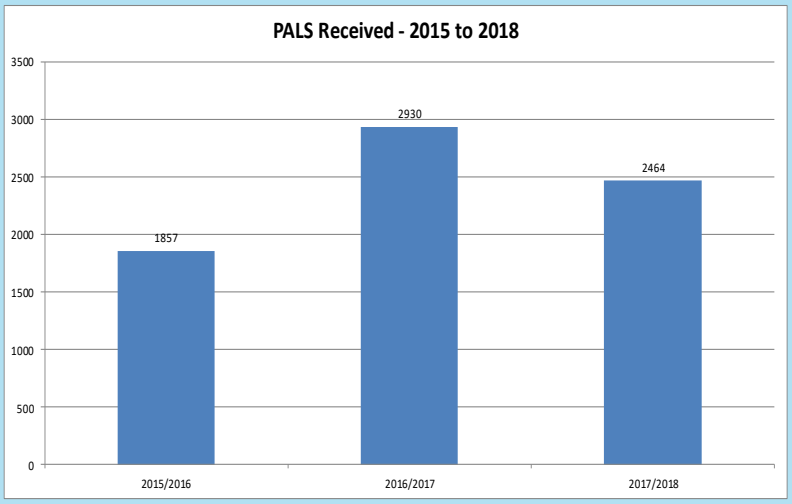


***Chart 16** - PALS Queries received for the last 3 years*



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

Patient-Led Assessment of the Care Environment or PLACE is a self-assessment of a range of non-clinical services 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 is a self-assessment of non-clinical services and replaced the Patient Environment Action Team (PEAT) assessments which ran from 2000- 2012 inclusive. PLACE assessments were introduced in April 2013 to and the scope of assessments is intended to focus on non-clinical areas which matter to patients, their families and carers. 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 inspections do not focus on clinical care.

The programme encourages the involvement of patients, the public and other stakeholders with an interest in Healthcare. Consequently the Patient Assessors who assisted with the 2017 annual PLACE inspection consisted of people from all walks of life with an interest in Colchester hospital and the Healthcare it provides.

The role of the patient assessor

The role of the assessors 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 at Colchester the teams are usually made up of two or three patients assessors, a member of the Facilities Team such as the Patient Environment manager, and 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 on an annual basis.

Scope of the assessment

A minimum of 25% of wards (or ten, whichever is the greater) and a similar number of non-ward areas must be assessed. Each area assessed must be sufficient to allow the PLACE team to make informed judgements about those parts of the hospital it does not visit;

- 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;
- include all buildings of different ages and conditions; and
- include departments/wards where a high proportion of patients have dementia or delirium.

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.

Scoring

Scores are based on what is observed at the time of the assessment. It is made clear to assessors that they must score the hospital 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

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

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.

Food audits

Teams must base their scoring on what is observed and said rather than rely on assertions of what usually happens. Assessors must:

- undertake the assessment on the ward, from the same food as provided to patients;
- if possible, assess both the lunchtime and evening meal services to obtain a rounded view and to improve the accuracy of the assessment;
- taste all food on offer to patients;
- taste food at the end of patient meal service to ensure that temperatures have been maintained at an acceptable level for the last patient to be served;
- watch how food is served to check for the care taken in presentation; and observe how staff are involved in the meal service and how they provide help for those patients who require it.

The assessments

Trusts are given six weeks' notice by the Health and Social Care Information Centre (HSCIC) of the specified timeframe during which the PLACE assessment must occur.

At Colchester, the assessments took place 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. This was to ensure that as many assessors who were available had an opportunity to take part in the assessment process and also to ensure that assessors did not have to spend overly long days at the hospital.

PLACE recognises that hospital buildings vary in age and design; which may impact on their ability to meet the criteria. However, it is important that the assessment is based on standard criteria and no allowances are made for such factors. The scores awarded reflect what was seen on the day. The assessments take place annually, and results are reported publicly by the Health and Social Care Information Centre (HSCIC) to drive improvement. Due to changes in the criteria to be scored it is not easy to draw comparisons between the scores achieved between 2013 and 2015 and those achieved in 2016 and 2017.

The PLACE process requires organisations to respond formally to their assessments and develop plans for improvement.

Areas assessed in 2017

The following areas were assessed in 2017:

Wards:
Tiptree, Layer Marney. Langham, Lexden, Wivenhoe, Nayland, Brightingsea, Mersea, Aldham, Stanway, Great Tey, Darcy, Peldon , Acute Cardiac Unit

Outpatient Clinics:
Physiotherapy, Hydrotherapy, X-Ray, Ante-natal, Mary Barron, Haematology, Elmstead Day Unit, Central Delivery Suite, Surgical Assessment Unit

Food audits were conducted on:
Layer Marney , Wivenhoe, Aldham, Stanway

General areas (these must be assessed every year)
Emergency Department
Communal areas inside the hospital building
External grounds

Results of the PLACE assessments

The assessments identify that the following action is required in order to improve the environment:

- Continue to refurbish bathrooms on wards identified in the relevant programme
- Provide day rooms/social spaces on wards when wards are refurbished
- Extend the 'dementia friendly' ward programme
- Make finger foods available for specific groups of patients
- Continue to improve signage and wayfinding around the site

The results of the PLACE assessments were submitted and published in August 2017. The scores achieved by Colchester hospital are detailed in Table 1 (see below). Table 2 details how Colchester performed against other local Hospital Trusts.

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

Next Steps

The Director of Estates & Facilities reports to the Trust Board on the findings from the Place assessments. The report also 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 PLACE Action Plan is updated and is then reviewed/discussed at the quarterly PLACE Steering Group meetings. The Group is attended by the Patient and Staff assessors who take part in the audit process.

The Trust will conduct six PLACE lite assessments throughout the year to audit the environment and monitor the impact of actions taken and improvements made.

***Table 19** - PLACE Overall Scores with the 2017 national average and the overall score achieved by CHUFT in (2016 & 2017)*

PLACE CRITERIA	National Average	Colchester General 2016	Colchester General 2017
Cleanliness	98.38%	99.43%	99.29%
Food and Hydration	89.68%	88.82%	91.88%
Privacy, Dignity and Wellbeing	83.68%	89.16%	85.41%
Condition, Appearance & Maintenance	94.02%	93.80%	95.62%
Dementia	76.71%	68.53%	76.39%
Disability	82.56%	71.58%	86.25%

***Table 20 -** PLACE Overall Organisational Scores against local Hospital Trusts*

Organisational Name	Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition, Appearance & Maintenance	Dementia	Disability
Colchester Hospital University NHS Foundation Trust	99.29%	91.88 %	85.41 %	95.62%	76.39 %	86.25%
Southend University Hospital NHS Foundation Trust	98.41%	91.01 %	75.18 %	90.28%	70.23 %	81.18%
Mid Essex Hospital	99.29%	89.00 %	84.68 %	94.59%	77.99 %	84.69%
Basildon & Thurrock University Hospitals NHS Foundation Trust	99.77%	92.00 %	86.43 %	98.82%	91.20 %	92.04%
Ipswich Hospital NHS Trust	96.50%	82.52 %	76.86 %	86.77%	63.70 %	72.87%
West Suffolk Hospitals NHS Foundation Trust	99.73%	93.99 %	83.96 %	96.14.%	78.39 %	84.07%
Cambridge University Hospitals NHS Foundation Trust	96.17%	82.81 %	80.48 %	91.66%	70.57 %	79.55%

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 Hospital

Cancer performance continues to improve across all standards. Although the focus from NHS Improvement (NHSI) and NHS England (NHSE) has been on the 62 day first standard, it has been acknowledged that by reviewing pathways and processes across every tumour site, overall performance across all standards has increased.

With perhaps the exception of the introduction of Straight to Test (MRI) for patients under the age of 75 referred in on a 2 week wait prostate pathway, there have not been any real changes to any of the cancer pathways. What has made the difference is the consistent approach to managing the cancer Patient Tracking List (PTL) and the focus not only to reduce the backlog (patients waiting longer than 62 days) but on a more robust escalation process which has enabled us to identify any potential issues or blocks to a patients cancer pathway. Communication and face to face engagement with all departments, in particular radiology, building on relationships and increasing the understanding of cancer waiting time rules amongst the admin staff, has enabled us to raise the profile of cancer within the trust. This in itself has almost, in a subliminal way, increased performance.

Cancer PTL meetings, chaired by the Director of Operations and supported by the Lead Cancer Manager, are attended by the General Manager for each tumour site. These meetings are mandatory and take place every Thursday afternoon. The trust has a set recovery trajectory, agreed by NHSI/NHSE and the CCG and weekly performance (actual and forecast) is recorded against this trajectory at each meeting. These reports are then submitted to all stakeholders with accompanying narrative which describes the discussions that have taken place at the meeting. The reports and some accompanying narrative (as well as ad hoc performance calls) provide an element of assurance to all concerned that recovery is on track and sustainable.

In addition to Cancer PTL Performance meeting, the Lead Cancer Manager (LCM) runs Cancer Red to Green every Tuesday afternoon. This is an opportunity for service managers to go through all patients on their PTL and identify where patients will be treated within the standard and more importantly, where there are any blocks in the patient's pathway of care. Following these meetings any unresolved issues are escalated by the LCM to senior managers within respective departments (this could be a tertiary issue, or internal radiology or histology) and where possible the issues are resolved before the Thursday performance meeting where a further update is given. Any issues still unresolved at this point are escalated to the Director of Operations.

62 day first standard has not been achieved at Colchester since December 2013. Although there have been a succession of recovery plans in place since then, it is only the trajectory agreed and set in September 2017 forecasting recovery in February 2018 that has been the most robust. The plan was based on each tumour site submitting their own recovery plan and being held to account to deliver against it. Previously the RAP's (Remedial Action Plans) had been 'trust' level documents that were never fully signed up to by either the service teams or the clinicians. The 'new' recovery plan is 'owned' by each Tumour Site Service Group and delivery in each tumour site has been facilitated and supported by Lead Cancer Manager and MDT Coordinator team. Colchester has also received external support from a NHS Elect 'coach' and a 6 month programme of collaborative events also hosted by NHS Elect.

104 day breaches: A weekly 104 day report is also sent to NHSI. The overall number of patients waiting over 104 days is at its lowest in over 3 years, with currently 8 patients waiting, all of which are either due to patient choice or require repeat diagnostic tests. For these patients, as there is still a suspicion of cancer, in line with Cancer Waiting Time rules they must remain on the PTL. The number of 104 day waits has reduced from over 40 patients 12 months ago.

The Root Cause Analysis (RCA) process has also changed and become more robust in recent months. All patients waiting longer than 62 days are now reported as incidents on Datix by the Cancer team.

The Divisional Governance Leads then request that a RCA is completed for each patient by the appropriate of the service managers. Where the delay has been caused by a failure of an internal process (clinical or administrative) a full RCA is required which included a clinical harm review. This will be recorded on DATIX and consideration

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

as to whether or not clinical harm has occurred an SI should be raised. Where the breach is due to a delay in removing patient from a pathway (tracking) meaning that the patient hasn't actually breached or patient choice to wait or defer, the DATIX is closed.

The incident RCA's are reported as part of the Divisional AF (Accountability Framework) process

Colchester has a Cancer Board that meet's bi-monthly which is chaired by the Trusts Lead Cancer Clinician, Mr Subash Vasudevan. There is a requirement for each tumour site lead clinician to attend along with 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.

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*

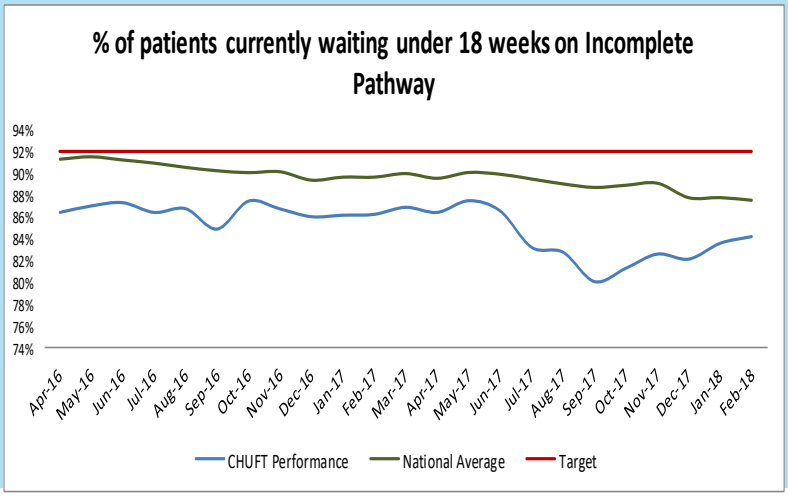
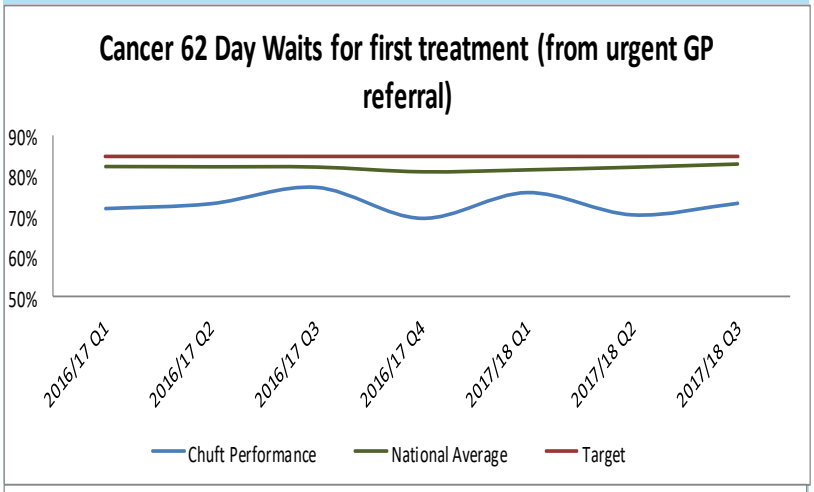


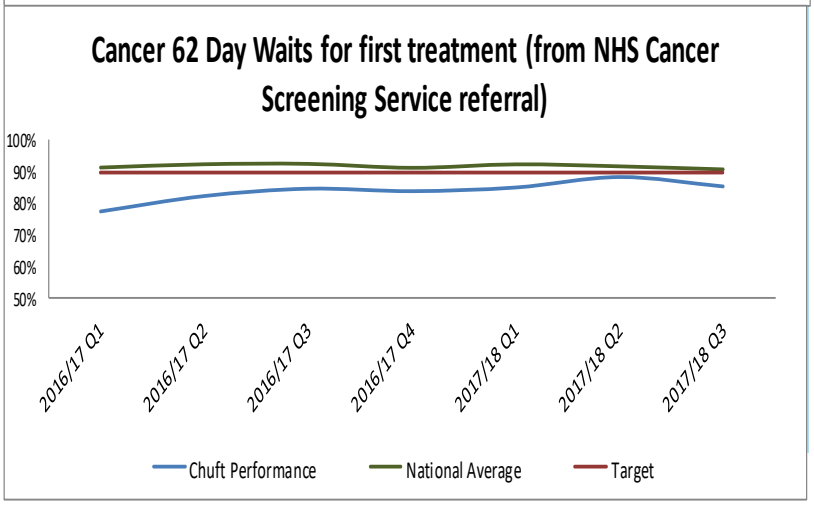
Table 21*—Percentage of patients currently waiting under 18 weeks on incomplete pathway*

		2016/17		2017/18	
% of patients currently waiting under 18 weeks on Incomplete Pathway	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
April	92%	86.45%	91.34%	86.46%	89.59%
May	92%	87.05%	91.56%	87.53%	90.12%
June	92%	87.35%	91.27%	86.59%	89.96%
July	92%	86.45%	90.98%	83.26%	89.52%
August	92%	86.80%	90.59%	82.81%	89.07%
September	92%	84.93%	90.28%	80.11%	88.75%
October	92%	87.49%	90.11%	81.33%	88.95%
November	92%	86.78%	90.19%	82.64%	89.13%
December	92%	86.06%	89.41%	82.17%	87.80%
January	92%	86.20%	89.69%	83.63%	87.81%
February	92%	86.28%	89.69%	84.24%	87.57%
March	92%	86.93%	90.02%	-	-
End of Year position	**92%**	**86.56%**	**90.42%**	**83.79%**	**88.94%**

Cancer Care Delivery
Patient Experience

Charts 18—*Cancer 62 Day Waits*





Patient Experience

The Trust Cancer User Group (CUG) underwent a recruitment drive and has welcomed new members and they have received informative talks about cancer patient pathways. They have designed and produced a patient information leaflet, poster and business card to be displayed and given out to patients who are visiting their GP and are being referred with a suspected cancer to the hospital. This will be officially launched at the GP afternoon event in April 2018. They have also been involved in the Cancer Unit plan to ensure that the cancer patient experience is listened to the design is for purpose. Finally the CUG have been seeking real time feedback from patients visiting the Outpatient department as well as the radiotherapy and chemotherapy units.

The Strategic Transformation Partnership (STP) Cancer Board has been meeting to discuss as a locality what our strategy should be to be able to deliver the NHS Five Year Forward View. The Colchester Hospital Cancer Strategy for 2017 – 2012 highlights key areas of work required including consistently complying with 2 week, 31 day and 62 day targets, continuing to plan the new cancer centre with an opening date of 2019 and including a wellness centre accessible to all cancer patients.

The Trust was successful in embarking on a Macmillan electronic holistic needs assessment (eHNA) as a pilot site with the use of a tablet device for patients to use. There have been some teething problems but there is ongoing work and further CNS are keen to trial. Macmillan have also been instrumental in developing the new roles of Survivorship Lead and Survivorship Support worker, along with a Programme Manager all as 2 year fixed term funded posts. These posts will enable further work on stratified follow up for some patients, and continued work on patient pathways as well as the planning and implementation of the Wellness Centre.

Continued work by the Macmillan Information Manager and Lead Cancer Nurse on the pre-treatment sessions for new patients and carers. These are currently being evaluated and are ready to recommence in April 2018 but with the aim of inviting all tumour sites to avoid repetition and provide a place where people with similar experiences can network.

The National Cancer Patient Experience Survey results were released late 2017 and even though Colchester was above average on 'Overall, how would you rate your care?', there were still some specific areas to work on and improve such as ensuring patients were aware they could bring a family/friend with them to their appointments, improving patients awareness of who their CNS is and the access to them, improve the trust and confidence in the nurses and Doctors by a more robust education plan.

Finally with Colchester Hospital joining with Ipswich hospital, the Lead Cancer Nurse has commenced work to look at the CNS service at CHUFT and in turn will arrange meetings with the IHT CNS team to ensure that patient pathways are similar and best practice is shared.

Safeguarding

Adult, Children, Maternity and Learning Disability Teams

Colchester Hospital University NHS Foundation Trust (CHUFT) is committed to the protection of all children, young people and adults at risk from abuse and has signed up to the guidelines agreed between the Southend, Essex and Thurrock (SET) local authorities and their respective strategic partners.

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 children, young people and 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 CHUFT 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 children, young people and adults at risk within the safeguarding team at CHUFT.

Governance: Safeguarding families
The safeguarding team supported by the head of Safeguarding and which includes the newly appointed Admiral Nurses for Dementia care continue to promote a "safeguarding families" approach to safeguarding within CHUFT. This approach was commended in the most recent NHSI and CQC visits to CHUFT. A Safeguarding families approach is achieved by joint working, procedure management, and attendance at the safeguarding management groups (SMG) and committee. It is envisaged that the safeguarding families approach will continue as CHUFT merges with Ipswich NHS Trust later this year.

The safeguarding team regularly attend the serious incident review panel, the harm free panel and patient experience committee to ensure that safeguarding is considered throughout the organisation.

Reporting: providing assurance
Quarterly reports and updates are provided at the Safeguarding of Adults at Risk Management Group (SAMG) and Safeguarding Children Management group (SCMG). Each management group is chaired by the named doctor and deputy chair is the Head of Safeguarding and Named Nurse Children Safeguarding. These groups have multi-disciplinary and relevant divisional and safeguarding agency representation. Within the SCMG the named midwife for safeguarding has commenced quarterly reporting and updates. Within SAMG Dementia and LD are represented and provide updates. The groups provide a forum for service leads to work together to address safeguarding issues within the acute setting and to lead the strategic direction of safeguarding within CHUFT.

The SMGs provide a report to the quarterly Safeguarding Committee chaired by the Director of Nursing as Executive Lead and exception reports to the Quality and Patient Safety Committee and Trust Board. An annual safeguarding adult and children report is produced and shared with local safeguarding boards, stakeholders and the public.

Training: supporting staff in the organisation
There has been a significant increase in safeguarding training across all levels over the past twelve months with continued focus on L3 and LAC child protection training. Trajectories for each quarter are set to achieve the targets agreed in the 2017/18 contract standards. The PREVENT (counter terrorism) target has been increased to 90% set by the Home Office (which the Trust has successfully met throughout the year).

The Trust has seen an increase in disclosures of domestic abuse in the community from patients who access services at CHUFT and a training package has been developed in partnership with Essex Domestic abuse Partnership Programme (EDAAP) to support staff in identifying domestic abuse, providing guidance for staff in how to respond to disclosures including seeking the support of Independent Domestic Violence Advisors for patients. And identifying risk to any children or young people that might also be affected.

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 promote the use of the domestic abuse training package across the organisation.

Learning Disabilities: supporting patients and staff in the organisation
The Learning Disabilities Liaison Nurse (LDLN) receives referrals from a number of sources for patients with a learning disability and/or autism and their carers / family as appropriate accessing the Acute Hospital. This is through both the emergency or elective pathways and includes a pre-alert system into A&E. There has been a significant increase in referrals over the last 12months. Referrals are from hospital staff, community learning disabilities team from HPFT (Hertfordshire Partnership Foundation Trust) and ACE (Anglian Community Enterprise), community care providers, social workers, GP's, family / carers and

Safeguarding

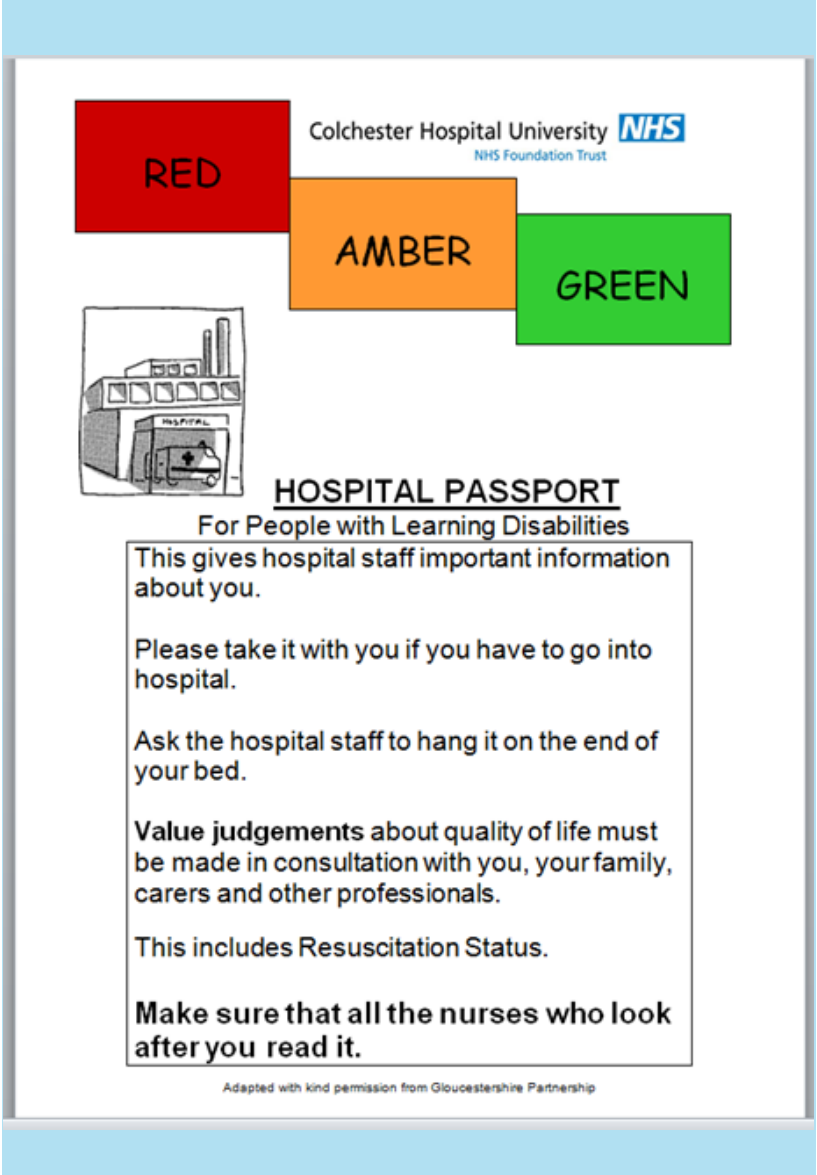
individuals with a learning disability. A number of referrals have been received from the transitions nurses at the hospital.

In addition to this the LDLN has made referrals to the community learning disabilities nurses, community AHP's, Independent Mental Capacity Advocate's and music therapy by the learning disabilities hospital liaison nurse to support patients on discharge. The LDLN provides valuable support for family / carers whilst the person accesses the hospital setting. Verbal feedback from carers has been very positive.

Learning disability training is provided for all staff and is mandatory to job role within the organisation and includes how to refer to the LDLN and to promote the use of the hospital communication book and hospital passport which are key for ensuring good quality care for people with learning disabilities or autism. The passports are discussed at each interaction with the LDLN. An electronic way of keeping these hospital passports is also being considered.

The importance of hospital passports has been a key theme discussed with care providers to try to increase their use. In addition to this a nurse practitioner from A&E and the LDLN visited one of the local care homes where we had a high number of visitors to the emergency department. This joint working approach has proved successful in reducing hospital attendances and this work will continue with other care providers.

CHUFT recognises that for patients with a learning disability and/or autism hospital can be a very new and often frightening place. To help reduce some anxiety often expressed by patients the LDLN launched the



"activity box" in November 2017. The activity boxes contain games, puzzles, colouring pages, activity books, craft supplies to provide distraction and copies of the communication book to assist staff. Ten wards have been provided with the boxes and feedback has been very positive. We have had a number of donations and so will be able to provide more boxes over the coming months.

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.

National NHS Staff Survey

The Trust aims to ensure that the highest quality of care is consistently delivered to our patients. To enable that we strive to ensure that all our staff have the training and support to deliver exceptional care. Our ambition is that our staff would recommend the Trust as a place to work and to be treated.

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

The full and summary survey reports for Colchester Hospital is available at www.nhsstaffsurveys.com

There is a key indicator which is the percentage of staff employed by, or under contract to, the Trust during 2016/17 who would recommend the Trust as a provider of care to their family or friends (staff survey question 21 d).

The scores presented below are unweighted question level scores for questions 21a – 21d and the unweighted score for Key Finding 1. The percentages for questions 21a – 21d are created by combining the responses for those who agree and strongly agree compared to the total number of staff who answered the question.

Questions 21a, 21c and 21d (shown below) feed into key finding 1 – staff recommendation of the organisation as a place to work or receive treatment.

Table 22—Data Source 2017 National Staff Survey

		2016	Average (median) for acute Trusts 2017	2017
Q21 a	"Care of patients / service users is my organisation's top priority"	75%	76%	74%
Q21 b	"My organisation acts on concerns raised by patients / service users"	69%	73%	73%
Q21 c	"I would recommend my organisation as a place to work"	50%	61%	50%
Q21 d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	59%	71%	62%
KF1	**Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)**	**3.56**	**3.75**	**3.63**

Table 23—shows the past 3 years results and the national comparison from the annual NHS staff survey.

Year	CHUFT % Recommended	Acute Trusts average
2015	62%	69%
2016	59%	70%
2017	62%	71%

Staff Survey
Equality and Diversity

Quarterly staff friends and family survey

Results from the annual and quarterly surveys are shown below. The indicator methodology used is as indicated on HSCIC – percentages are added for options “agree” and “strongly agree”.

National Staff Survey key findings and staff engagement

Overall indicator of staff engagement for Colchester Hospital University NHS Foundation Trust

The overall indicator for staff engagement comprises three key findings in the NHS Staff Survey:
• staff members perceived ability to contribute to improvements at work (KF7)
• their willingness to recommend the Trust as a place to work or receive treatment (KF1)
• staff motivation at work (KF4).

The Trust is still in the bottom 20% when compared to other trusts of a similar size and our score for 2017 was 3.72 compared to 3.70 in 2016 and a national average of 3.79.

Chart 19— Data source 2017 National Staff Survey

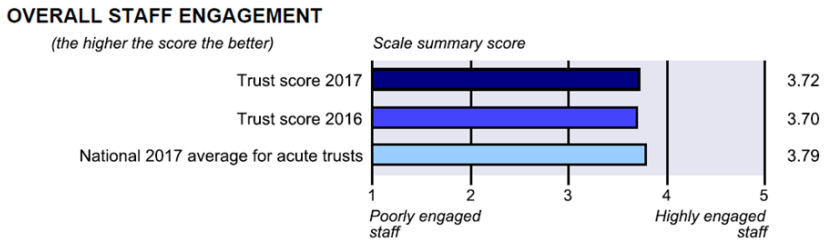


Table 24-Data source www.england.nhs.uk/data

Quarter	CHUFT % Recommended - WORK	England % Recommended - WORK	CHUFT % Recommended - CARE	England % Recommended - CARE
2014/15 Q2	88%	61%	88%	77%
2014/15 Q3	Results from National Staff Survey			
2014/15 Q4	43%	62%	58%	77%
2015/16 Q 1	49%	63%	68%	79%
2015/16 Q 2	47%	62%	66%	79%
2015/16 Q3	Results from National Staff Survey			
2015/16 Q4	60%	62%	70%	79%
2016/17 Q1	56%	64%	74%	80%
2016/17 Q2	48%	64%	64%	80%
2016/17 Q3	Results from National Staff Survey			
2016/17 Q4	43%	64%	66%	79%
2017/18 Q1	53%	64%	82%	81%
2017/18 Q2	61%	63%	73%	80%
2017/18 Q3	Results from National Staff Survey			

Staff Survey
Equality and Diversity

Equality and Diversity

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.

At the heart of the EDS2 are four goals, which the Trust has adopted as our equality objectives:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well supported staff
- Inclusive leadership

The Trust's Diversity Champions continue to work on the equality and diversity agenda and have been involved in progressing the Workforce Race Equality Action Plan and the LGBT agenda.

Stonewall Diversity Champion

As one of Stonewall's Diversity Champions, Colchester Hospital has continued to work with Stonewall to provide support and guidance on Lesbian, Gay, Bisexual and Transgender matters. An on-line survey asking staff if they wished to have an LGBT Network, received overwhelming support, and Stonewall colleagues are working with the Trust to launch the Network early in 2018/19.

Workforce Race Equality Standard

The workforce race equality standard comprises of nine metrics, three of which are workforce data and four relate to the national staff survey indicators. There is also an indicator which requires Boards to be representative of the communities they serve. In the third year of reporting, the Trust has an action plan to improve the indicator outcomes and improve the experience of our BME employees.

Gender Pay Gap Reporting

2017/18 was the first year for gender pay gap reporting to take place within the NHS for the year ending 31 March 2017. 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.

There are six gender pay gap indicators, which all NHS

Table 25—Sample of Staff Survey results

			Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	28%	27%	28%
		BME	30%	28%	30%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	28%	25%	27%
		BME	31%	27%	26%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	81%	87%	78%
		BME	67%	75%	73%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	6%	7%	8%
		BME	12%	15%	13%

Staff Survey
Equality and Diversity

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

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 continued commitment to Defence personnel since 2014. In September 2017, the Trust was represented at 254 Medical Regiment's training camp in Croatia, and In November, the Trust welcomed our first Step Into Health work placement. There is continued involvement in the Injured, Wounded and Sick Programme, supporting soldiers who are being discharged on medical grounds.

The outcomes for 31 March 2017 gender pay gap indicators are shown:

Tables 26—Gender pay gap indicators

Average & Median Hourly Rates

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	20.9958	14.7967
Female	15.2345	13.7296
Difference	5.7613	1.0672
Pay Gap %	27.4404	7.2123

Average & Median Hourly Rates

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	20.9958	14.7967
Female	15.2345	13.7296
Difference	5.7613	1.0672
Pay Gap %	27.4404	7.2123

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	15.00	3376.00	0.44
Male	59.00	1050.00	5.62

Number of employees | Q1 = Low, Q4 = High

Quartile	Female	Male	Female %	Male %
Lower Quartile 1	807.00	209.00	79.43	20.57
Lower Middle Quartile 2	784.00	232.00	77.17	22.83
Upper Middle Quartile 3	862.00	154.00	84.84	15.16
Upper Quartile 4	639.00	378.00	62.83	37.17

Workforce
Health and Well-being

The patient is at the centre of all we do.

In supporting our workforce e to uphold this principle, the Trust continues to embed the pledges to our staff within the NHS Constitution, providing a positive working environment, promoting an open culture, engaging staff in decisions, providing staff development and encouraging and sup-porting staff in raising concerns as soon as possible.
To enable staff to be more closely involved in decisions, a new organisational structure has been introduced, with senior clinicians forming part of the decision making Boards and Committees.
There has been close working with our partner Trust, the Ipswich Hospital NHS Trust, sharing good practice for both, and improving together.
All wards have an Executive Director as a senior "Buddy", and our Directors are often out in the clinical areas, being accessible to staff and patients.
We work in partnership with a number of Trade Unions, developing policies and procedures to provide a framework for supporting and developing our workforce.

Health and Wellbeing

The Trust provides a Health and Wellbeing (H&W) service which all staff have access to.

The H&W is staffed by a multidisciplinary team to include specialist practitioners in occupational health, a registered mental health nurse, and occupational therapist, clinical nurses, technicians and a part time consultant.

All Staff have direct rapid access to physiotherapy to enable them to receive treatment and advice speedily.

In addition the Occupational therapist undertakes home and work assessments providing aids to staff to enable them to manage their chronic health conditions more effectively and reducing sickness.

Staff also have access to an Employee Assistance Programme (EAP) for psychological support, The EAP and also access to citizen's advice database for non-psychological problems, and a managers helpline to support mangers with work issues.

The Trust has signed achieved the Staying Healthy at work award. This has a focus on supporting staff with mental health issues and to this end the Trust has also signed up to being a "mindful employer".

The H&W service facilitates mental health first aid providing managers with the skills to recognise and support staff with mental health issues.

In addition anxiety management workshops are being developed to support staff and provide them with the tools to manage there anxiety.

Emotional resilience sessions are provided for all staff, enabling them to identify their stressors and how they re-act to stress and by employing cognitive behavioural techniques to manage their stress.

External trainers attend to provide yoga, mindfulness and relaxation sessions for staff.

During the year the a number of wellbeing events are arranged and articles published on wellbeing that follows the national wellbeing agenda see calendar of activities below.

- ✓ Dry January
- ✓ Stop smoking
- ✓ World mental health week
- ✓ Men's health
- ✓ H&W day

Schwartz rounds

The Trust continues to facilitate Schwartz Rounds in September 2017/18 saw 356 staff attending.

The Schwartz Rounds provide a confidential environment and an opportunity for staff to talk about the emotional and challenges that they experience when caring for patients.

The Rounds are held monthly with a panel of three or four who provide a synopsis of an event in how they felt about that event. Once all panellists have told their story the facilitators open the discussion to the floor enabling others to resonate with what they have heard and how they have felt in similar situations.

Studies have shown that Schwartz rounds leads to an increase in confidence in dealing with difficult and sensitive issues both clinical and non-clinical, a change in practice and that attendance at them also reduces stress.

Schwartz Rounds in 2016/17 have included the following topics:

- ✓ Palliative Care
- ✓ Making a difference
- ✓ Life as an SAS doctor
- ✓ Complaints
- ✓ Discharge Planning
- ✓ Supporting families through challenging times

Pop up Schwartz Rounds have also been facilitated in areas where staff have found it hard to leave their clinical areas to include students and junior doctors

Workforce

Professional Practice and Volunteering

Appraisal & Revalidation (medical and nursing staff)

Nursing & Midwifery Revalidation

NMC Nurse Revalidation went live in April 2016, so far 760 Trust staff have successfully been through the process. Revalidation Workshops are run on a monthly basis, as well as regular one to one meetings with the Revalidation Officer.

To ensure that we are aware that people are on track with revalidating the Nursing & Midiwfery Revalidation Officer has requested to be sent copies of the confirmation forms. Ward Sisters, Matrons and Heads of Nursing are advised of staff who are due to revalidate and when, and staff are advised of the process via letter to home address in the first instance at least six months prior to revalidation date (ensuring we capture those on maternity leave). Staff are then advised via trust email address; when the application is open, when they have a month to submit and when they only have one week remaining. Also as the NMC do not advise us we are also asking staff to let us know if they are asked to provide further information for auditing purposes.

Medical Revalidation

Revalidation is the process by which a doctor's license to practice is renewed and is based on local organisational systems of annual medical appraisal and clinical governance. Licenced doctors are required to have a formal link known as a prescribed connection with a single organisation, identified as their Designated Body and headed up by a Responsible Officer, which will provide support with their appraisal and ultimately their revalidation. Following the launch of Medical Revalidation in 2012, the Trust has been committed to strengthening processes to ensure that all doctors with a prescribed connection are in the system to undertake annual appraisal and revalidation.

The Trust is required to provide assurance to the Board, our regulators and commissioners that we have effective systems in place to ensure we meet with nationally agreed standards for medical appraisal and revalidation.

The Annual Organisational Audit (AOA) is a tool used to achieve a robust, consistent system of revalidation compliant with the Responsible Officer Regulations. The mandatory audit contained within the AOA report provides a process by which every Responsible Officer, on behalf of their designated body, provides a standardised return to the higher level Responsible Officer. The collated audit then forms the basis of a report to Ministers and ultimately the public on the overall performance of revalidation across England.

The Trust currently has 318 doctors with a recognised prescribed connection and in the last five years has successfully revalidated 267 doctors.

Volunteers

Our volunteers services are coordinated in partnership with Community 360 (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 350 active volunteers (150 more than in 2016/17) providing more than 4000 hours a month of voluntary services.
- ✓ 30 new volunteers roles identified, mostly providing direct benefit to our patients.
- ✓ We now have 7 visiting therapy dogs which are very popular on our childrens, 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.
- ✓ Volunteers from NCS decorated our childrens ward garden area and a team of 40 volunteers from the local branch of Tesco transformed one of our courtyard gardens in the maternity unit.
- ✓ One of our volunteers celebrated her 50th year of volunteering
- ✓ We have 11 volunteers in our emergency department to provide extra support to our patients, 3 volunteers helping our pharmacy team, 6 "meet and greet-ers" , 10 who help with medical records scanning and other admin support, 6 dementia companions, 20 specially trained end of life care volunteers, breast feeding support volunteers and many more providing fantastic support to our patients, their families and our staff.
- ✓ We held a summer tea party for all our volunteers which was attended by the Chief Executive and Managing Director to thank them for their contribution to the Hospital and our patients followed by a winter coffee morning.

We have entered into a further one year partnership agreement with Community 360 and look forward to the relationship delivering further benefits to our patients during 2018 and beyond.

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.

One of the Trust's key aims is for people in training to recommend us as a place to train.

Medical Education

Undergraduate Education

The Trust currently hosts circa 250 students from Barts and the London School of Medicine and Dentistry and 24 from the University of East Anglia . During 2017/18 Anglia Ruskin University were confirmed as a new medical school and the Trust will host medical students from September 2018.

There was no site visit by Barts and the London in 2017/18; however one planned is for 20th April 2018.

Pre-registration nursing

Number of students, 2017/18:

In response to the changing landscape of pre-registration training we have now increased our partnership working with universities. We now support students from:

Return to Practice	7
Child	39
Adult Nursing	263
Midwifery	48
Operating Department Practitioner	9
Physiotherapy	63
Speech and Language Therapy	2
Occupational Therapy	19
Dietetics	5
Paramedic	81

University of Hertfordshire
University of Essex
Anglia Ruskin University
University of East Anglia
University of Suffolk
For various programmes of learning Practice Education Facilitators

Investment has been made in employing more Practice Education Facilitators to provide support and training to both our mentors and pre-registration students. Further developments have included:

- 4 distinct student learning opportunities available regularly to promote active learning and application of theory to practice utilising skills of experts within the Trust and community
- Clinical skills for student nurses programme – field & year specific
- Case studies for students – multi-professional
- Student forums – informal learning and networking
- Student Forum Extra's – invited speakers
- Increased mentor support resulting in student needs being identified earlier and more specifically, preventing student failure or resulting in students failing and being supported to address learning needs prior to further progression
- Specific programmes to support students from branches such as Mental Health or Radiology.
- Increased multidisciplinary involvement.

Education programmes have been developed to engage all 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.

The Health Education East of England Student Survey which invites all pre-registration learners to participate , has reflected the findings of our individual student evaluations. Whilst the audit indicated some areas where we could improve the learning environment , overall it was very positive.

All student evaluations are reviewed to see how we can continue to improve .

Collaborative Assessment Learning Model (CALM)

In January we introduced a new model of supporting learners in practice; CALM. This does not replace the existing model, but compliments and develops it. This approach however, moves away from a 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 patient 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.

Extra learning resources have been provided to support the learning in the clinical area.

Although still in its infancy we are already seeing fantastic results and positive feedback from learners, mentors and patients. Some of the feedback includes:

"*I personally like the CALM project, first day I was a bit nervous as was caring for 2 patients, involved in board round and handover. But by end of the shift I was confident enough to perform all care. I felt very positive." Student nurse – year 2*

"It (CALM) has made me question my knowledge more and pushed me to ask more questions. I am being more

Workforce

Education and training of staff

independent in my learning and have used the IPad to aid this." Student nurse – year 2

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. Commencing with the Trainee

Healthcare Assistant programme staff have the potential for career progression, to gain qualifications and potentially obtain nursing registration through our BSc Work based learning (WBL) and apprenticeship scheme.

Apprentice Assistant Practitioner

As part of our "grow your own" the Trust is also investing in developing new roles for our healthcare assistants by supporting them through an apprenticeship to become an Assistant practitioner. This allows us to have more skilled practitioners to care for our patients and be more responsive to the changing needs, ensuring we have the right staff in the right place at the right time

Work based learning

This year saw our second group of staff (5)complete their registered nurse training through the work-based learning programme, where they worked part time as either a healthcare assistant or associate practitioner whilst they studied for the BSc (Hons) Adult nursing. There are another 9 of our staff currently studying towards this.

Whilst this programme is coming to an end. We are commencing staff on the new apprenticeship nurse programme, which similarly allows staff to work and learn whilst they undertake a BSc (Hons) nursing.

Preceptorship

The trust recognises the importance of a period of Preceptorship which the Department of Health (DoH 2010) as "a period of structured transition for the Newly Qualified Practitioner (NQP) during which he or she will be supported by a Preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning".
The benefits of undertaking a period of Preceptorship include enhancement of quality care, improved recruitment and retention, developed understanding of the organisational objectives, supporting lifelong learning, making care the priority and enhancing the image of health care professionals (DoH 2009).
The trust delivers a multidisciplinary programme of monthly Preceptorship days over 12 months which enables new registrants to learn and support each other to improve their confidence and practice. A mixture of formal training education and skills training is incorporated into a programme that encourages peer support and sharing of good practice.

OSCE preparation for overseas nurses

As part of our overseas recruitment programme the trust has a very successful objective structured clinical examination (OSCE) preparation programme to prepare overseas nurses for part 2 of the NMC (Nursing & Midwifery Council) application process. This 3 hour practical examination assesses nursing knowledge and clinical practice. Newly recruited overseas nurses attend a 4 week programme to support them in preparing for this examination. The trust has a 94% overall pass rate in comparison to 55% nationally (NMC January 2018) and a number of other NHS trusts have been learning from our success.

Allied Health Professionals (AHPs)

Our AHPs have been busy this year undertaking a variety of courses to enhance their skills: This year some of the training funded includes:

✓ A Physiotherapist is undertaking courses in advanced practice, in order to develop the essential knowledge and skills required to provide the specialist care required to intensive care and patients with severe respiratory problems.

✓ An Occupational therapist is undertaking training to become an Advanced Care Practitioner, to provide greater specialist skills within the Emergency Department

✓ Dieticians are undertaking training in Paediatric dietetics, in response to challenges in recruitment of paediatric dieticians, so ensuring service provision

✓ A radiotherapist is undertaking a course in Cancer Care, in order to develop the essential knowledge and skills required to support and care for people with cancer and their family.

One of our Occupational Therapists is currently managing a project to role out a programme of training for coaching conversations across the organisation. The coaching conversations programme will have the ability to give large volumes of staff a basic understanding of coaching and essential conversational skills to enable them to use these, where appropriate, in their conversations on a daily basis. The programme was designed to be relevant for all staff groups, within health and Social Care; clinical and non-clinical.

Nursing and Midwifery

Across nursing and midwifery the Trust has supported additional training and education for staff within clinical practice, to ensure that we have suitably trained staff to be able to safely care for the more diverse and complex health issues which patients are admitted with.
Training has been particularly focused around:

· Specialist training i.e cardiac / respiratory care, non-medical prescribing, to enable more

Workforce

Education and training of staff

holistic treatment by practitioners and reduce delay to patient care

· Cancer care—Specialist education to support the delivery of care to patients with cancer to improved services and patient experience

· Mental health—to improve awareness of mental health conditions and support recovery with a patient centred focus

· Midwifery and Children training to support the development of these services to improve care and experience to patients.

· Emergency and urgent care—providing increased skills in identifying and caring for the acutely ill patients

· Leadership and Coaching – 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.

Healthcare Assistant training

All HCAs and Maternity Care Assistants now undertake the Care Certificate. This is seen as an indicator of quality by the Care Quality Commission. This has succeeded the Colchester Hospital Healthcare Assistant competency framework.

Support staff

Our hospital has signed up to a national pledge which helps widen access to working in the NHS and then provides support to develop through apprenticeships and employment opportunities.

Quality Improvement Performance Framework (QIPF)

In 2016 Health Education England (HEE) launched their new Quality Strategy, which outlined a new quality framework moving from a joint assessment and validation process previously known as Quality Improvement Performance Framework (QIPF) to organisational self-assessment. This framework is used to assess the quality of the organisation as a learning environment for students and trainees, to ensure we train a workforce with the right skills, values and behaviours to ensure high quality care for patients. The inaugural self-assessment was submitted to HEE as required and will be a dynamic document which will evolve over time to reflect changes within the learning environment. Whilst challenges were identified relating to vacancies and workload to adequately support and educate learners in practice, actions to improve this are in place.

Apprenticeships

Number of apprentices, 2017/18:

2017/18 has seen us further develop the opportunities for integrating apprenticeships across the health and social care sector and enabling all departments within the hospital to welcome apprentices to their teams.

Number of apprentices	55

Workforce

Corporate Learning, Organisational Development

Corporate Learning and Organisational Development and effectiveness

The renewed organisational effectiveness plan has been used to continue and implement a number of interventions. The Licence to Lead programme has continued and expanded to contain new modules such as sickness absence and coaching conversation. Licence to learn was launched which gives staff the chance to develop in areas such as customer service skills. Further development programmes include a clinical leadership development programme and the delivery of the Mary Secole Leadership programme on a local basis.

Staff Involvement

The staff involvement group have continued to meet with a focus on the merger between Colchester and Ipswich Hospitals.

Leadership

Leadership event have continued and in November 2017 the first joint programme took place involving top leaders from both Colchester and Ipswich hospitals. Focusing on the alignment of clinical service the event was very well attended and feedback given and outputs from group work have been used to inform the final proposed clinical structure.

Library development

Access to the library is now 24/7 ensuring that staff are able to use its facilities at a time that is convenient. The recent refurbishment includes new stock, more workstations and an area to hold meetings.

Mandatory Training

The Trust has continued to improve its compliance with mandatory training. In March 2017 compliance stood at 97.189% and this has decreased to 93.30% as at 20th February 2018. Measures to help staff increase their compliance in include the continuation of weekly e-mails to remind staff if they have a renewal due or if they have expired on any aspect. E-mails to managers have also been introduced reminding them they have staff who are on complaint. The training portal continues to be well received by staff allowing individuals to view their own compliance records and also assisting managers when planning for the release of staff to attend taught training session.

Organisational Development - Valuing our staff

During 2017/18 the Trust has continued to recognise staff and volunteers achievements through the Tryst 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 and to write 50 or so words about why they deserve to win - known as the citation.
Entries judged on the 50 or so words written where a person or team demonstrates the Trust behaviours standards and values.
Every nominated person gets a letter from the chief executive with the citation included. If the entry is for a team then the chief executive sends a letter with the citation to the team manager.
Winners and runners up are invited to attend the monthly core brief when they are presented with a certificate by a member of the executive team.

Workforce

Organisational Development, Valuing Our Staff

Winners of the Trust Commendation Scheme are pictured

Sarah Sands, Ward sister Acute Cardiac Unit
Winner in the Individual category

"Sarah has organised for volunteers to crochet/knit beautiful patchwork blankets for patients. These are being used for patients on the ward receiving end of life care. These blankets help create a more homely/ comforting less hospitalized environment. The ward staff also spray the blankets with patients perfume/sprays etc so when then patient dies they are given to the families as a special keepsake. This initiative is simple yet really enhances end of life care for our patients at CHUFT, and will also be of great comfort to the families who live on."

Workforce

Organisational Development, Valuing Our Staff

Stroke Unit

Winner in the Team category

"My mother was in the stroke ward at Colchester General hospital for six days recently. On arrival she was very ill with a serious stroke and the care and empathy she received was outstanding, particularly with the very specialist skills shown by your staff. On discharge back to her care home she was largely well again, thanks to your considerable efforts. We observed the ward staff working so very hard but always having time for each patient and of course some of the patients are very confused with stroke effects. Well done Colchester Hospital and generally we found everything connected with the establishment very satisfactory, and staff most helpful. I genuinely think you should be very proud of what you are achieving, and mother was also so very grateful to you all."

Statements from key stakeholders

North East Essex Clinical Commissioning Group response to Colchester Hospital University NHS Foundation Trust Quality Report 2017-2018

North East Essex Clinical Commissioning Group (CCG) welcomes this Quality Report as a commitment to an open and honest dialogue with patients and the public regarding the quality of care provided by Colchester Hospital University Foundation NHS Trust (CHUFT). The CCG is commenting on this provider's Quality Report for 2017-18.

Though the CCG is 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. We have relayed our comments on the previous draft report and can confirm the majority of the proposed changes and recommendations were taken under consideration.

In line with the NHSI Detailed Requirements for Quality Reports 2017/18 (January 2018), CHUFT have met the mandatory requirements within their report as well as reporting on the indicators identified in section 3 of the guidance.

Part 1 of the report provides a satisfactory statement summarising the key achievements throughout 2016-17 as a measure of the quality of the health services provided by the organisation.

Part 2 demonstrates the excellent achievements against the priorities for improvement for 2017-18 with regard to the reduction in falls; hospital acquired pressure ulcers; and the progress made in meeting the requirements in relation to NatSSIPs.

The priorities for improvement for 2018-19 are welcomed as a continuation of the economy wide programmes of work 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 CCG notes the information on the CQC full inspection in July 2017 and recognises the improved progress reported following the complete organisation inspection, particularly the end of life care provision.

The CCG notes that some of the reporting data is either missing or a previous year's data, for example quarter 4 Commissioning for Quality and Innovation Schemes (CQUIN) performance, some workforce data and the rate of patient safety incidents.

In 2017-18, The Trust signed-up to 8 national CQUINs and the report identifies the Trust performance against these. The CCG recognises the incremental improvement against the Sepsis CQUIN and supports the continued work being undertaken as a 2018-19 priority. The majority of the CQUIN work was achieved and the CCG acknowledges a continued improved position throughout the year.

The CCG notes the Trust performance against the core quality indicator standards required by the regulatory framework. There are clear improvement plans in place in the continued work in improving the SHMI position. It is however disappointing that the reporting issues in relation to PROMs have not been resolved. We acknowledge the difficulties in accessing national readmission figures and note the work that is being undertaken locally to ensure re-admissions are being reviewed and appropriate actions taken. There is limited data on Staff FFT, similar to last year, and the planned work on the EPED workforce work stream has not provided the improvements anticipated or has not identified the appropriate data capture systems to reflect the work undertaken.

The conclusion of NHS North East Essex CCG is that Colchester Hospital University NHS Foundation Trust's Quality Report 2017-18 provides an accurate overview of the Trust's performance for the year; clearly identifies improvements and future ambitions for improving quality and safety in the services it provides; and agrees with the priorities identified for 2018-19.

The CCG looks forward to continuing the collaborative working with the Trust and to providing support as the organisation merges with Ipswich Hospital, to ensure services remain safe and of a high quality to our patients and local population.

Lisa Llewelyn
Director of Nursing & Clinical Quality
NHS North East Essex Clinical Commissioning Group.

Response to Colchester Hospital University NHS Foundation Trust (CHUFT) Account 2017/18 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 CHUFT. We offer the following comments on the CHUFT Quality Account.

Statements from key stakeholders

HWE is encouraged by the way the boards of both Colchester Hospital and Ipswich Hospital are continuing to work together to merge the organisations to improve care for patients and create a more sustainable future.

HWE is impressed that CHUFT is actively using patient stories to drive change – for example, through Project Ivy, and involving patients in various groups and panels.

The number of innovative schemes implemented by CHUFT to improve the patient and carer experience, is a great achievement.

It is impressive that, based on patients response to national maternity survey, CHUFT was the only trust in the East of England that received a 'better rating' in any category.

HWE is reassured that the Trust acknowledges the need for improvement in identifying, reporting and sharing lessons learned and actions taken from complaints.

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 CHUFT.

Dr David Sollis
Chief Executive Officer, Healthwatch Essex

22/5/18

Statement from the Council of Governors on the Quality Report 2017/18

The governors of Colchester Hospital University NHS Foundation Trust are pleased to have the opportunity to comment on the draft Quality Account for 2017/18 and to provide input onto the quality improvement priorities on both 2017/18 and 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, relatives and carers first is the key to achieving consistent and high quality care and we look forward to progress being made on the 'Time Matters' philosophy bringing improvements to patient care in 2018 and beyond.

Governors have been actively involved with Ipswich Hospital and Colchester Hospital becoming one organisation and there was representation at a number of public engagement events in February and March 2018, where feedback has been heard around the quality of care at Colchester Hospital, in the main the feedback has been very positive. Governors were pleased to note that at these engagement events, over 40 new public members were recruited which signified an interest within the local community in their local hospitals.

Colchester Hospital University NHS
NHS Foundation Trust

Response to stakeholder comments

Colchester Hospital University NHS Foundation Trust thanks its stakeholders for their comments on the 2017/18 Quality Account.

Statement of assurance from the Board of Directors

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year.

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 2017/18 and supporting guidance

• 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 2017 to [the date of this statement]

• papers relating to quality reported to the board over the period April 2017 to [the date of this statement]

• feedback from commissioners dated 24/05/2018

• feedback from governors dated 09/05/2018

• feedback from local Healthwatch organisations dated 22/05/2018

• the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24/05/2018

• the [latest] national patient survey 06/2017

• the [latest] national staff survey 06/03/2018

• the Head of Internal Audit's annual opinion of the trust's control environment dated 29/05/2018

• CQC inspection report dated 02/11/2017

• the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

• the performance information reported in the Quality Report is reliable and accurate

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

• 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
Chair
29 May 2018

Nick Hulme
Chief Executive
29 May 2018

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 The main commissioner of services provided by Colchester Hospital University NHS Foundation Trust.
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 Meticillin 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 Colchester Hospital University NHS Foundation Trust on the Annual Quality Account

INDEPENDENT CHARTERED ACCOUNTANT'S LIMITED ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS OF COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Colchester Hospital University NHS Foundation Trust to perform an independent assurance engagement in respect of Colchester Hospital University NHS Foundation Trust's Quality Report for the year ended 31 March 2018 ("the Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 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;

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;

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 2017/18 issued by NHS Improvement in February 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 2017 to May 2018;
- papers relating to quality reported to the Board over the period April 2017 to May 2018;
- feedback from commissioners, dated 24/05/2018;
- feedback from governors, dated 09/05/2018;
- feedback from local Healthwatch organisations, dated 22/05/2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/03/2018;

Appendix A

Independent Auditors' Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Annual Quality Account

- the latest national patient survey, dated 2017;
- the latest national staff survey, dated 2017;
- Care Quality Commission inspection report, dated 02/11/2017; and
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2018.

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 Colchester Hospital University NHS Foundation Trust as a body, in reporting Colchester Hospital University 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 2018, 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 Colchester Hospital University NHS Foundation Trust for our 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.

Appendix A

Independent Auditors' Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Annual Quality Account

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 Colchester Hospital University NHS Foundation Trust.

Basis for qualified conclusion

Our testing completed over the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator has identified errors in relation to the accuracy and validity of the data recorded that lead us to conclude 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 2018:

- 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 2017/18 issued by NHS Improvement in February 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

Ipswich, UK

29 May 2018

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 "(a)ny 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 University NHS Foundation Trust,
Turner Road,
Colchester
Essex CO4 5JL

Thank you

We would like to take this opportunity to thank all those involved with Colchester Hospital University NHS Foundation Trust: our fantastic staff and volunteers, all of our patients and visitors, our valuable fundraisers, local media organisations, our local Members of Parliament and health colleagues across the East of England.

Thank you for all that you do to make this a hospital we can all be proud to be part of.

Find out more about the hospital by visiting
our website at www.colchesterhospital.nhs.uk

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

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