Colchester Hospital University NHS
NHS Foundation Trust

Annual Report
Annual Accounts
&
Quality Report

1 April 2014 – 31 March 2015

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Presented to Parliament pursuant to
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National Health Service Act 2006

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Useful contact information

Comments
We welcome comments about this publication.

Please contact:

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

Tel: 01206 742840

Email: info@colchesterhospital.nhs.uk

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Patient Advice and Liaison Service (PALS)
PALS offers confidential, on-the-spot advice and support, helping patients, relatives and other visitors to sort out any concerns they may have about their care.
Freephone: 0800 783 7328 Email: pals@colchesterhospital.nhs.uk

General information and inquiries
Email: info@colchesterhospital.nhs.uk

Full contact details and more information on our website:
www.colchesterhospital.nhs.uk

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Welcome from the Chairman and Chief Executive

Alan Rose
Chairman

Dr Lucy Moore
Chief Executive

As for many other hospital trusts and NHS organisations, 2014/15 was a tough year for Colchester Hospital University NHS Foundation Trust. As a trust in "special measures", we were under intense scrutiny throughout the entire 12 months. With the support of our partners, we made significant progress in some areas, such as our cancer services, and finished the year in a stronger position than we started it. However, in other areas, including our financial performance, there was significant deterioration. Further challenges have been identified and we will need to continue to drive forward improvement in the coming months and years.

Two of the year's constant features were the huge amount of goodwill from the community that it is our privilege to serve and unflinching commitment and loyalty from our staff. While sub-standard care and patient experience can never be acceptable, whatever the circumstances, it is satisfying to note that that for every complaint the Trust received, there were 23 plaudits. When the Care Quality Commission (CQC) published three quality reports in July, following a forensic Trust-wide inspection, they were full of compliments for staff working in all parts of the organisation, saying that the patients and relatives the CQC talked to described them as caring, kind, friendly and compassionate. This steadfast support from our community and workforce gives us good reason to be optimistic about the future.

We made significant progress on cancer services and our goal remains to have cancer services that are second to none. A significant date in the history of the Trust was 9 June 2014, which was when the radiotherapy centre at Colchester General Hospital treated its first patients, almost two years after the turf-cutting ceremony for the development took place. At £25m, it is the biggest single capital investment in the Health Service in Colchester since Colchester General Hospital was built in the mid-1980s, and is an outstanding facility of which we are extremely proud. Our progress on delivering the Trust's Cancer Action Plan was acknowledged by NHS England, which reported in July 2014 that five cancer pathways which were not deemed to be safe in December 2013 had been made safe.

Two reports published on 17 December 2014 examined concerns raised in a CQC report just over a year earlier about the alleged manipulation of cancer waiting lists at the Trust. Both the Trust's Retrospective Review of Cancer Care and an independent investigation by Carole Taylor-Brown and Professor Pat Troop concluded there was no evidence of systematic data manipulation. The latter report also found no evidence of a systemic culture of bullying. There were lessons to be learnt, however, regarding the need to establish an open and engaging culture that encourages staff to speak up and develop simple and accessible internal policies. The publication of these reports gave reassurance to our patients, their relatives and our local community and was an important step towards rebuilding public trust and confidence in our cancer services. We hope that Essex Police will soon be able to declare that its criminal investigation also found no evidence of waiting list manipulation.

As a result of the CQC quality reports published in July 2014, the Trust formed an "Improvement Board" with partner organisations, such as the North East Essex Clinical Commissioning Group (CCG), Monitor, Essex County Council, Healthwatch Essex and NHS England. At the same time, we developed an action plan which encompassed a number of existing action plans, against which we began to make progress in the second half of the year. Towards the end of 2014/15, following the CQC report published in January 2015 and the serving of the Trust with two Section 31 notices, we submitted to Monitor an "A&E Improvement Plan" following CQC visits in November and December to our Emergency Department (A&E) and Emergency Assessment Unit. At the centre of these improvement plans has been the focus on improving patient

safety and providing responsive, caring, effective and well-led services.

At the beginning of the year, the Trust announced its intention to transfer all services and departments off the Essex County Hospital site and to relocate them to Colchester General Hospital and community settings. This work begun and is scheduled to be completed in 2016. We look forward to recognising the significant role Essex County Hospital has played in the history of the organisation.

Another key milestone was the implementation of a new Patient Administration System (PAS), known as The Portal, which gives the Trust a platform to make further improvements, including the introduction of electronic patient records. Installing a new PAS is a hugely complex undertaking, which has caused major disruption at some hospital trusts. The fact that the transition from the old system to the new went relatively smoothly is testimony to the skill and planning of the implementation team, as well as the efforts of all our staff.

By the end of the year, the biggest priority for the Trust was the need to recruit to approximately 150 vacancies for registered nurses, which will be crucial to help us improve the quality of care. This will continue to be a priority in 2015/16 but, at the same time as employing many more healthcare professionals, we must do all that we can to become more efficient and reduce our expenditure, while maintaining the essential focus on improving quality.

In some ways, the Trust ended the year on a high note, including our relationship with our main commissioner, North East Essex CCG. At the start of 2014/15, this had been characterised a lack of trust, but by its end there had been a step-change and both organisations were well-aligned and intent on doing everything possible to do their best for the people of north east Essex.

By year-end, with the exception of the post of Chief Executive, all of the Trust's executive director posts had been filled on a substantive basis, including the key posts of Medical Director and Director of Nursing. The Board has also determined to involve more deeply the five Divisional Directors in steering the future of the organisation, emphasising the move to being a more clinically-led hospital trust. Along with the appointment of a new permanent Chairman from 1 April 2015 in succession to Dr Sally Irvine, who stood down after more than four years in the role, the Trust began 2015/16 with a strong Board of Directors, well-qualified and resolute about facing up to the many tough challenges of the year ahead.

Signed	Alan Rose Chairman	Dr Lucy Moore Chief Executive

Strategic Report

Introduction and purpose

The purpose of the Strategic Report is to inform users and readers of the Annual Report and Annual Accounts and to help 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 (June 2014) to ensure that the report is fair, balanced, understandable, comprehensive but concise, and forward-looking.

About our Trust – a summary

Our Trust was authorised as a Foundation Trust by Monitor in May 2008. The Trust provides healthcare services for people mainly in north east Essex and is an associate teaching hospital of the University of London.

Our new vision

Our vision was updated in August 2014 to be the Trust that patients, carers and staff would recommend 100% of the time to friends and family by:

- putting patients at the centre of all that we do
- providing high quality and safe care for our patients
- realising the potential of our workforce, empowering them to deliver
- delivering services “right, first time”, improving our patient pathways and reducing our waiting times
- achieving sustainable financial performance
- improving our infrastructure
- being a strong partner with health, social care, education and academic colleagues and other key stakeholders
- bringing our governance structures up to the standard of best practice.

These were revisited in March 2015 and summarised within three overarching strategic objectives:

- Acting in the best interests of our patients
- Valuing our workforce
- Achieving financial sustainability and organisational resilience.

The people we serve

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 home to one of the largest UK garrisons. The Trust values its relationship with the garrison and has developed a number of collaborative arrangements to provide services to service personnel and their families and to integrate garrison clinical staff into service provision at the Trust. The Trust has developed good relationships with members and officers at Essex County Council, Colchester Borough Council, Tendring District Council and MPs in the area it serves. The Trust serves a local population of about 370,000, predominantly from the local authority areas of Colchester, Tendring and part of Braintree.

Our services

The Trust provides a range of patient services:

	2014/15	2013/14
Outpatient attendances*^	495,238	498,994
Accident & Emergency patients*	78,877	77,757
Inpatient and day case admissions*†	91,511	95,819
Babies born	3,769	3,926

***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 (RDAs)*

Our sites

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.

Our pathology laboratory services transferred to the Pathology Partnership on 1 May. The Pathology Partnership is a network of six trusts, including our Trust, which provides pathology laboratory services. Our services continue to be based at the Severalls Hospital site and in the microbiology department near Colchester General Hospital.

The Trust also provides some services, such as outpatient and maternity services, at the community hospitals in Clacton, Harwich and Halstead, community midwifery services and a limited range of other community services.

Our staff

The Trust is one of the largest employers in north east Essex, employing 4229 people on 31 March 2015.

Performance in 2014/15

Review of the year

Despite remaining in “special measures” with the regulator Monitor, the Trust ended the year focused and determined in its goal of improving the quality of its services at pace, as it has been since 2013/14 in response to:

- the Keogh Review of July 2013
- the CQC investigation into cancer care published in November 2013
- the Trust being placed into special measures by Monitor in November 2013
- the Chief Inspector of Hospitals judging that the Trust “requires improvement” overall following an inspection in May 2014 and downgrading it further to “inadequate” in January 2015 following an unannounced inspection of A&E and EAU in November and December 2014
- further regulatory action by Monitor in the form of two enforcement notices. The first was issued in August 2014 and required the Trust to develop and implement an improvement plan to address the concerns of the CQC following its May inspection. The second was issued in February 2015. It required the Trust to develop an A&E improvement plan and a financial recovery plan for 2015/16.

The year has been focused on remedial action through the establishment of a comprehensive and far-reaching improvement plan to address the concerns of the CQC and Monitor on quality and safety, stabilising the leadership through the recruitment of a substantive and credible board of directors, reviewing ward staffing arrangements and introducing a recruitment and retention strategy to fill staff vacancies, especially in nursing.

The Trust’s financial position further deteriorated, with an increase in its deficit to

£22.3m, reflecting the challenging financial climate the NHS is operating in and specific local issues, which have included increased expenditure on nursing to address quality priorities, national tariff adjustments and turnaround costs.

A financial recovery plan and a five-year sustainability plan were developed to demonstrate how the Trust will return to financial balance and to plot the size of the financial challenge the Trust is facing.

These plans have left us in no doubt that delivering our objectives – both on quality and finance – will require transformational change. These changes are the foundation stones upon which the Trust will reinforce the highest possible standards of safety, effectiveness, caring and responsiveness in delivering care to its patients, rebuild the confidence and trust of its hard-working staff in its leadership, and restore staff morale and goodwill after a year of unprecedented external scrutiny.

CQC Inspections

Background

The Care Quality Commission (CQC) carried out a comprehensive inspection of the Trust in May and published its findings in July. The CQC visited the Trust again in November and December as part of an unannounced inspection of the Emergency Department (A&E) and Emergency Assessment Unit (EAU) at Colchester General Hospital after receiving information of concern about performance and care received by patients in those areas.

Findings

The first inspection assigned a rating of “requires improvement” on the Trust. There were concerns about the lack of stability and clear direction at board level due to the significant change in the leadership of the Trust and concerns about staffing levels overall. The inspection reports did, however, acknowledge the high regard patients held the Trust in, the good standards of caring and compassion, and the loyal and committed workforce the inspectors observed.

Following the unannounced inspection of A&E and EAU, the rating was downgraded to “inadequate” due to concerns about safe staffing levels, governance, leadership, safeguarding, the management of deteriorating patients, patient experience, infection control and the environment of care.

Action plan

The Trust took immediate action to address the concerns raised. These actions included closing 22 EAU beds to ensure there were adequate levels of staffing, a further review of nurse staffing levels in A&E and the EAU, deploying additional resources to support the assessment of the deteriorating patient and safeguarding assessments. A new and experienced leadership team was created and the appropriate governance arrangements put in place.

The Trust established a programme of spot checks, working with its partners and stakeholders. It worked with the Emergency Care Intensive Support Team (ECIST) to develop best practice models of care. This included opening a clinical decisions unit at the end of March and establishing a medical day unit in late spring 2015.

Section 31 letters

As a result of their concerns about A&E and EAU, the CQC served the Trust with two Section 31 notices, imposing legally binding conditions on the organisation relating to staffing, beds and patient pathways. The Trust reports to the CQC twice a week on its arrangements to ensure these conditions are being complied with.

* The Trust’s improvement plan is regularly updated and is published on the Trust website www.colchesterhospital.nhs.uk/cqc_review.shtml and NHS Choices

Looking ahead to 2015/16

The Trust’s priorities for 2015/16 are to ensure safe staffing levels, improve its governance and leadership, and implement measures to ensure all staff are aware of their responsibilities to deliver safe, effective, caring and responsive care.

Cancer Action Plan

Background

In 2013, information about alleged cancer waiting list manipulation at the Trust was passed to the CQC. On investigation, the CQC said that "hospital staff had reported they were pressured to change data relating to patients and their treatment to make it seem people were being treated in line with national guidelines and that as a result some patients may not have had the treatment they needed in time. Staff also reported having raised concerns about this but that this information was not acted upon by the Trust".

The CQC confirmed it had referred its findings to Essex Police. It also reported to NHS England, North East Essex Clinical Commissioning Group (CCG), Essex County Council and Monitor and asked that they provide the assurance that cancer services were safe and effective. Following investigation into whether the Trust had breached the conditions of its licence, Monitor issued a number of discretionary requirements and placed the organisation into special measures in November 2013.

Cancer action plan

In response to the CQC report and Monitor discretionary requirements. as reported in the 2013/14 Strategic Review, the Trust carried out a series of immediate actions to reinforce guidance and best practice in the management of cancer patients, reviewed reporting, monitoring and governance arrangements and engaged with its partner organisations, which included the Cancer Network, North East Essex CCG and Public Health England, to review practice in all tumour sites via external peer assessment teams and an assurance process of historical patient pathways.

The Royal Marsden NHS Foundation Trust was appointed to provide the Trust with support and expertise in delivering improvements to its cancer pathways.

The recommendations that emerged formed part of a comprehensive cancer action plan, progress against which was reported monthly to the Board of Directors and published on the NHS Choices website.

Retrospective review

The retrospective review, initiated in 2013/14, into the experience of approximately 1,500 patients treated at the Trust between 1 April 2010 and March 2014 who may have been affected by misreporting, reported its findings in December 2014. The objective was to investigate the extent of data inaccuracies and the impact on clinical care through a transparent audit process, take necessary remedial action to ensure accurate reporting and improved systems of care, and provide assurance to the public and stakeholders.

The review found a large number of minor discrepancies between recorded and actual patient data and considered that data manipulation or deliberate, inappropriate data entry was a possibility in a small number of patients (16). After carrying out a detailed review, the reviewers concluded that deliberate data manipulation was unlikely and that it was more likely due to a minor, but erroneous, interpretation of the cancer waiting times guidelines.

Other findings included poor documentation and record keeping with multiple causes, including data entry errors, misinterpretation of national guidance and operating process issues.

Troop Taylor-Brown Review

The *Report of the Independent Investigation into Management Response to Staff Concerns Relating to the Validation of the Cancer Waiting List 2011/12 at Colchester Hospital University NHS Foundation Trust* by Carole Taylor-Brown, former Chief Executive of NHS Suffolk and former Chair of Anglia Cancer Network, and Professor Pat Troop, a former Deputy Chief Medical Officer of England, also reported in December.

The investigation's remit included:

- establishing the facts relating to the investigation by management
- considering the appropriateness of the management response
- assessing the effectiveness of the Trust's whistleblowing policy
- considering any wider issues around bullying and harassment
- determining whether disciplinary action was appropriate for any employee remaining in the employment of the Trust.

The report concluded there was no evidence to support that there was at any time an instruction to junior staff (or others) to manipulate data or make inappropriate adjustments to cancer data, nor was there evidence to support the view that there was a systemic culture of bullying at the Trust. Furthermore, it stated categorically that the interview evidence of the individuals concerned, including those who raised specific concerns, clarified that at no time were individuals instructed or bullied to amend cancer or any other data inappropriately by any senior manager. It stated also that there was no case to answer for any individual in respect of alleged bullying and harassment.

There were, however, lessons to be learnt – for the Trust and other NHS organisations – including ensuring :

- NHS organisations establish an open and engaging working climate that encourages and supports staff to come forward with ideas and concerns
- key internal policies are simple and accessible
- managers provide an opportunity for concerns raised by staff to be openly and constructively explored
- the preliminary investigation of concerns raised by staff are undertaken by trained investigators and supported by people with relevant expertise.

Cancer outcomes 2014/15

By February 2015, all but 28 of the 331 actions in the cancer Action Plan had been implemented and all immediate and serious concerns resolved.

Looking ahead to 2015/16

The progress made in the implementation of the cancer action plan to address the concerns of the CQC and Monitor, the publication of the final investigations of the retrospective review and the Taylor-Brown/Troop report and the consequent improvements in the cancer pathway and resultant key performance indicators have enabled the Trust to move forward with greater insight than ever before. With the disbanding of the dedicated Programme Management Office for the cancer transformation by December 2014, the final remaining actions in the cancer action plan were incorporated into business as usual by the Cancer and Clinical Support Services Division by the end of 2014/15. The Trust anticipates that the discretionary requirements imposed by Monitor in its letter of November 2013 will be met in full by summer 2015, enabling the Trust to draw a line under its governance breaches relating to cancer services.

Monitor Enforcement Undertakings

Background Following publication of the CQC inspection reports in July and January, Monitor issued the Trust with two further letters specifying enforcement undertakings. This means the Trust will remain in special measures until such time as it can demonstrate it has met Monitor's requirements.

August In a letter in August, Monitor accepted the following undertakings from the Trust:

1. The submission of a CQC improvement plan to address the concerns of its inspection reports of 17 July and recommendations made in those reports
2. The implementation of all actions assigned to it in the improvement plan in accordance with the timescales specified in the improvement plan
3. The establishment of an Improvement Board for the purpose of overseeing the Trust's delivery of the improvement plan, the terms of reference, scope and membership of which must be agreed by Monitor
4. Attendance at meetings or conference calls at regular intervals, as stipulated by Monitor, to discuss the Trust's progress on delivering the improvement plan.

February Further enforcement undertakings were notified to the Trust in February. This notice reflected not only the CQC inspection report published the previous month, but Monitor's concerns about the Trust's forecast to finish the year (2014/15) with a deficit of £24m rather than its planned deficit of £15.9m, its Continuity of Service Risk Rating (CoSRR) of 2 from 2014/15 which is likely to remain at that level or lower until 2017/18 and its projection that it will require "distressed financing" from the Department of Health.

In a letter in February, Monitor accepted the following undertakings from the Trust:

A&E improvement plan

1. To take all reasonable steps to address the concerns raised in the CQC quality report and the governance failings which led to the provision of "inadequate" urgent and emergency services and medical care
2. To finalise and submit an A&E improvement plan to Monitor by 27 February, with key milestones, setting out the steps which it will take to comply with the CQC's requirements
3. The A&E improvement plan to include such actions to ensure the Trust can meet the conditions on its CQC registration imposed by the CQC on 23 January 2015 pursuant to Section 31 of the Health and Social Care Act 2008
4. To deliver the A&E improvement plan and meet the key milestones and the CQC conditions on registration
5. To obtain independent assurance over the strength, assumptions and likelihood of success of the A&E improvement plan from an independent expert appointed by the System Resilience Group and agreed with Monitor
6. If requested by Monitor, to commission an external review from the independent expert to provide assurance on the Trust's implementation of the A&E improvement plan
7. To co-operate and work with a partner organisation which may be appointed by Monitor to support and provide expertise to the Trust in addressing the CQC's concerns regarding A&E and EAU and in delivering the A&E improvement plan
8. To ensure it has sufficient capacity and capability to deliver the A&E improvement plan and, in particular, to take all reasonable steps to recruit additional nurses to A&E and EAU.

Quality improvement plan

1. To commission a multidisciplinary assurance review to assess the Trust's progress against delivering the CQC improvement plan of August 2014
2. To deliver the recommendations from the multidisciplinary assurance review

Financial recovery plan

1. To prepare and submit to Monitor a realistic and robust financial recovery plan for 2015/16
2. To include in the financial recovery plan key milestones and actions to address the Trust's financial decline and to take all reasonable steps to improve the organisation's recurrent financial position
3. If requested by Monitor, to commission and implement the findings of an external assurance review of the financial recovery plan
4. To deliver the financial recovery plan and meet key milestones
5. To ensure it has sufficient capacity and capability to deliver the financial recovery plan.

Long-term financial recovery plan

1. If requested by Monitor, to prepare and submit to Monitor a realistic and long-term strategy to secure the financial sustainability of the Trust
2. The long-term financial recovery plan will demonstrate how the Trust will return to at least a recurrent underlying breakeven position within five years or such other period as may be specified by Monitor.

Department of Health financing

1. Where interim support financing or planned support financing is provided to the Trust by the Secretary of State for Health pursuant to Section 40 of the NHS Act 2006, the Trust will comply with any terms and conditions which attach to the financing
2. To comply with any reporting requests made by Monitor in relation to any financing provided.

Meetings

1. To attend meetings or conference calls with Monitor during the currency of any of the compliance requirements in the enforcement notice at regular intervals as stipulated by Monitor.

Looking ahead to 2015/16

The Trust is aiming to complete the above undertakings and to demonstrate improvement against all the key performance indicators it sets for itself in its improvement and recovery plans. It is confident that, with an established leadership team, clarity of vision and strategy and the commitment, involvement and engagement of its staff, it will make significant steps forward to improve quality and to establish the foundations on which to build a sustainable financial future.

Financial Recovery and the Five Year Sustainability Plan

Background

Following three years of investment in staff and services, the Trust's financial position deteriorated so that, in addition to the £22.3m deficit confirmed for 2014/15, it faces a significant deficit in 2015/16. Based on current estimates of income and expenditure, if the Trust does not take any financial recovery measures, it will face a potential deficit of £44m in 2015/16.

Financial Recovery Plan

The Trust has budgeted for a planned deficit of £30m for 2015/16. To achieve this challenging target, it must, as a minimum, deliver a Cost Improvement Programme (CIP) of £13.7m and a further refinement of anticipated cost pressures of £2m. A governance and accountability framework for CIP delivery has been established and weekly outcomes-focused meetings are being held to monitor delivery against metrics and milestones and to address any issues causing initiatives to fall behind. A range of measures have been implemented to re-establish financial grip and financial controls over vacancies, establishment control, the use of interim and agency staff and business case approval have been strengthened.

Five Year Sustainability Plan 2014-2019

Longer term, the Trust will need to do more than deliver cost improvement plans and efficiency savings to return to a financially sustainable position and improve standards of care. A longer term view is needed to ensure it has the plans in place to address the demand pressure on services due to an increasing local population, with particular growth in the patient categories that rely most heavily on health services (such as young and old people) and service delivery and demand challenges due to increasing prevalence of long-term conditions.

During 2014/15, the Trust prepared a five year sustainability plan which has service transformation at its core. It has identified a number of key areas of focus to transform, expand or re-shape the Trust's involvement in – among other things – community care, elderly care and broader social care, end of life care and, potentially, primary care. It also plans to explore opportunities to repatriate elective care provided to local patients by other providers, and to exploit potential in its shared services.

The Trust will need to work closely with its commissioners and partners to ensure that service transformation objectives are aligned and take a whole system view, while at the same time are compliant with national and regional clinical and governance policy developments.

Looking ahead to 2015/16

There is no doubt that 2015/16 will be challenging for the Trust's financial position. The financial recovery plan is its first step back to sustainability and is essential to ensure that the Trust, in the long-term, is a financially sustainable and viable organisation which has:

- the ability to invest in safe patient care and facilities
- the ability to survive structural changes in the financial flows in the health economy
- the strength to be able to deliver efficiency savings on a medium to long term basis; and
- the capacity to cope with short term financial shocks

The Trust was last in surplus in 2012/13, with an reported surplus of £9.1m. In 2015/16, before the delivery of the cost improvement programme the Trust growth in spend over the 4 year period is estimated at £53.1m.

Areas	12/13 Final Spend	15/16 Gross before CIP	CAGR 12/13 to 15/16	Externally driven	Spend growth 12/13 to 15/16
NHS Clinical Income	220.5	220.1	-0.2%		(0.3)
Excluded Drugs	14.6	20.0	36.7%	5.4	5.4
Non NHS Clinical Income	2.5	1.8	-28.5%		(0.7)
Research & Training	7.4	6.7	-9.3%		(0.7)
Other	12.6	10.8	-14.4%		(1.8)
Total Income	**257.5**	**259.3**	**0.7%**	**5.4**	**1.8**
Consultants	(26.0)	(31.1)	19.5%		(5.1)
Junior Doctors	(20.9)	(22.3)	6.6%		(1.4)
Nursing & Midwifery	(54.8)	(70.7)	29.0%		(15.9)
S, T & T	(24.7)	(23.1)	-6.1%		1.5
Non Clinical Staff	(33.0)	(41.1)	24.7%		(8.1)
Total Pay	**(159.4)**	**(188.3)**	**18.2%**	**-**	**(29.0)**
Drugs	(5.3)	(7.6)	42.1%		(2.2)
Excluded Drugs	(14.6)	(19.0)	30.1%	(5.4)	(4.4)
Clinical Supplies	(25.4)	(26.1)	2.9%		(0.7)
Establishment & Transport	(3.3)	(3.7)	13.3%		(0.4)
Premises and Fixed Plant	(9.1)	(10.9)	19.6%		(1.8)
Secondary Commissioning	(3.6)	(4.4)	22.2%		(0.8)
CNST	(5.1)	(11.5)	125.5%	(6.4)	(6.4)
Other Non Pay	(10.3)	(15.8)	53.5%		(5.5)
Total Expenditure	**(76.6)**	**(98.9)**	**29.1%**	**(11.8)**	**(22.3)**
Non Operating	(12.4)	(16.1)	29.7%		(3.7)
Surplus / (Deficit)	**9.1**	**(44.0)**	**-583.4%**	**(6.4)**	**(53.1)**

The most significant areas of spending relate to investment in staffing, not only clinical staffing, but also non clinical staffing. The Trust is reviewing all aspects of expenditure through the use of tools such as the capacity modelling, to ensure that all expenditure is aligned to income from a commissioned activity. This will be a key principle that the Trust will focus on as part of the sustainability strategy.

Due to the sustained deficit over the last 3 years, it is necessary for the Trust to seek external cash financing via the Department of Health. For 2015/16 the value of this request is £26m. Monitor will review the plans of the Trust to ensure that financial support is provided only for necessary costs of running a safe hospital. Discretionary spending and investments will be reviewed as part of the conditions of the Trust accessing funding from the Department of Health. There are other conditions, such as the use of capital, which the Trust is required to abide by.

Turnaround Programme

Cost Improvement in 2014/15

The Trust set a Cost Improvement Programme (CIP) target of £8.9m for the year. Initiatives were identified to deliver this target through the introduction of a number of workstreams which were introduced following a benchmarking exercise that established potential cost-saving benefits across a range of areas. These workstreams were introduced to provide a clear focus and accountability for delivery. They are summarised as follows:

Workstream	Description	Planned value
Temporary staffing expenditure	Introduce controls on temporary expenditure	£2,650,000
Length of stay and patient flow	Identify improvements to length of stay/ patient flow, to reduce bed base	£190,000
Pharmacy	Realise benefits from pharmacy drug costs	£210,000
Outpatients productivity	Improve clinic utilisation and reduce the number of Did Not Attends (DNAs)	£200,000
Procurement and supply chain	Standardisation of clinical procurement items and contract negotiation	£510,000
Clinical productivity	Introduce job planning for clinical nurse specialists	£260,000
Operational support	Admin & Clerical (A&C) support to clinical areas re-set according to required ratios	£120,000
Facilities organisation	Realise savings through a review of some A&C roles, franking and teletracking	£270,000
Estates utilisation	Realise savings through energy procurement and other estates opportunities	£370,000
Theatres	Improve utilisation of theatre capacity and improvements to theatre processes	£420,000
Income	Ensure the Trust is accurately coding and counting the activity it provides	£1,060,000
Divisional specific schemes	Scheme identified within divisions not specific to the workstreams identified above	£2,610,000
		£8,870,000

Each of the above workstreams was supported by the Programme Management Office (PMO) and was led by an executive, operational and clinical lead. The leads met weekly to review tasks and to milestone progress against plan, and performance against the financial plan. In November, the projects supported by the workstreams were transitioned into 'business as usual', which saw the disbandment of the weekly meetings and the required tasks and activities led by the clinical divisions and corporate areas. The forecast outturn of the 2014/15 CIP was £7.6m, which was less than plan. This was largely due to the non-delivery of schemes relating to the controls

around temporary expenditure, theatre scheduling and utilisation, outpatient productivity and operational support. For 2015/16, the Trust is planning to re-introduce ten main programmes of work with improved governance and accountabilities to drive the identification and delivery of that year's CIP.

Looking Ahead to 2015/16

To deliver a deficit of no more than £30m in 2015/16 the Trust needs to achieve £14m of cost improvements 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 under achievement of the plan during the year. During 2014/15 cost avoidance of £1.2m was delivered in addition to the planned cost improvements of £6.4m, demonstrating a track record of taking recovering action in year. However the challenge for the Trust in the coming years is the scale of the programme and to sustain the cost reductions, which are twice the amount achieved in previous financial years.

Recognising the size of the cost reductions, the Trust has geared up robust measures for monitoring and in particular escalation and recovery arrangements to mitigate slippage of delivery. A comprehensive financial recovery plan was approved by the Board in March in private and shared in public in April 2015. The emphasis of plans during 2015/16 are less so in transformational change, although this is key to the longer term success of the hospital, but take a more transactional perspective.

A summary of the programme for the coming year is as follows:

	Corporate	Surgery	Medicine	W&C	C&SS	UC	Total Trust
Direct Costs (£m)	*46.3*	*68.5*	*41.6*	*27.9*	*58.8*	*20.0*	*263.1*
Corporate Restructure	3,817	-	-	-	-	-	**3,817**
E-Procurement Efficiencies	-	350	110	39	388	44	**930**
Estates & Facilities Optimisation	790	94	-	112	1	-	**996**
Outpatients Productivity	-	200	-	82	50	33	**365**
Patient Flow/ Length of Stay	-	730	1,199	551	94	321	**2,894**
Pharmacy/ Drugs Cost Reduction	-	-	-	-	133	-	**133**
Temporary Staffing Reduction	6	-	-	-	-	360	**366**
Theatre Productivity	-	707	-	-	-	-	**707**
Workforce Redesign	-	660	75	289	644	-	**1,668**
Risk Adjusted Identified Schemes	**4,613**	**2,741**	**1,384**	**1,072**	**1,309**	**758**	**11,876**
Unidentified against budget	331	-	927	-	893	-	**2,151**
Total Target	**4,944**	**2,741**	**2,311**	**1,072**	**2,202**	**758**	**14,027**
% of Income	**11%**	**4%**	**6%**	**4%**	**4%**	**4%**	**5%**

The most significant programme is the corporate restructure which will see up to 200 budgeted positions removed from the structure and a further 40 from other non-clinical teams. A consultation is expected to start from May 2015 to set out how the new structure will accommodate changes in corporate services.

This programme is the beginning of the road to recovery by the Trust and it will take several more years of challenging programmes to bring the Trust spending in line with the income achieved from commissioned activities.

Quality Governance

Quality Governance Reporting

The Trust's approach to quality governance is outlined in the following sections on patient safety and patient experience, in the Quality Report for 2014/15 and on pages 94-95 of the Annual Governance Statement

Patient Safety

Patient Safety

Our ultimate aim is to deliver the highest quality healthcare services to our patients. This is part of the Trust's commitment to be At Our Best for patients and colleagues and to be widely recognised as the Trust that patients, carers and staff would recommend 100% of the time to friends and family.

The Trust continued to work with the national High Impact Actions and Releasing Time to Care campaigns.

Each area is responsible for the setting and delivery of Trust-approved improvement targets. Performance against internal and external quality indicators is monitored by the Patient Safety Committee. Assurance is provided to the Quality and Patient Safety Assurance Committee on a monthly basis.

Patient safety walkabouts

This programme was launched in April 2011 as a new unannounced peer review inspection of wards. It uses a set of predetermined tools and its underlying objectives are to encourage areas to share good practice and to identify common themes and trends.

The Trust board widely recognised the benefits of this quality review programme, which is called the Clinical Area Assessment Programme (CAAP). However, the Board requested the programme was revised and aligned with recommendations from the Keogh Review. The CAAP was therefore restructured and moved away from a weighted audit and process review to one with an organisational development and assurance focus, which actively supports and involves staff and patients. The restructured process incorporated a planned staff engagement opportunity, highlighting leadership behaviours, cultures and values within the teams.

The CAAP visits were carried out monthly and were announced. This allowed both hard and soft data to be gathered as part of the intelligence information gathering stage, informing key lines of inquiry. Within five days of the announced visit, there was a short unannounced visit by two members of the CAAP Team.

The CAAP Review Team

The CAAP Team included wider representation to increase the scope of the review:

- Assistant Director of Nursing (later replaced by the Associate Director of Nursing (CAAP Lead) to ensure a consistent approach is followed
- peer review matron
- peer review divisional director
- one executive director
- one non-executive director
- a student nurse
- a patient/carer representative.

Each tool had been developed using national and local best practice and, where possible, the inclusion of objectives and standards set within the Trust's own policies and procedures documents. Each area was benchmarked against these standards and a RAG (Red, Amber, Green) rating applied. The assessment involves:

- a review of predetermined key specific indicators relevant to each specialty
- audit of record-keeping standards and identifying areas of poor/positive practice
- the area as a learning environment
- staff engagement opportunity and clinical leadership
- observations of care and identifying areas of poor/positive practice.

A walkabout and observations of both care and the environment included a review of patient safety, patient experience, governance, clinical effectiveness and risk

management and provided an opportunity for staff engagement.

A report, including detailed findings of the assessment, conclusions and key recommendations, was written and circulated.

Each service/division then ensures through its own governance group that any action and/or learning is highlighted from the recommendations. In order to provide assurance, it is essential that an action plan is created and developments of that action plan are reported to the divisional governance groups and the Quality and Patient Safety Assurance Committee.

Following the appointment of four Associate Directors of Nursing & Allied Health Professionals in July, there was an opportunity to build on the positive work and benefits of CAAP and of shared accountability for a quality review process. CAAP is a detailed programme of quality and safety assurance but its level of detail and preparatory work means that clinical areas are reviewed only on an annual basis. There is now an opportunity to streamline the process while maintaining the quality of the review and incorporating the five CQC domains of quality, safe, caring, effective, responsive and well-led. A CQC peer review process will replace CAAP in 2015/16, resulting in all wards and departments being reviewed quarterly.

Mortality

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

The Trust has had a high SHMI since the inception of the measure whilst the HSMR has been within the expected range since 2010/11. The high SHMI prompted the Keogh Review of the Trust in June 2013.

The latest available SHMI (October 2013 to September 2014) for the Trust is 104 which is “as expected.

The Trust has continued to work with primary care and St Helena Hospice to improve care for patients felt to be at the end of life.

There has been primary care representation at a monthly mortality review group. This has facilitated learning between primary and secondary care.

Recognition of the deteriorating inpatient remains a key concern for the Trust. There has been improved reporting of incidents. As a result, there has been a particular focus on encouraging escalation of patients with a high National Early Warning Score (NEWS).

Falls prevention

The previous year (2013/14) had been exceptional for falls prevention. It was accepted that it would be very difficult to maintain this momentum into 2014/15 owing to the increasing age and frailty of the patient population.

Falls reduction over the previous two-year period

In the two-year period from April 2012 to March 2014, the Trust achieved a 16% reduction in the total number of falls (201 fewer falls), and a 35% reduction in the number of serious harm falls (10 fewer serious harm falls).

More progress

In 2014/15, there were 1,124 inpatient falls, a 6% increase on the previous year (60 more falls) but slightly fewer than in 2012/13 (1,131 falls).

In 2013/14, the Trust made significant progress in reducing the number of serious harm falls; 18 patients fell and suffered serious harm compared with 26 in 2012/13.

In 2014/15, there were 32 serious harm falls. However, there has been a marked increase in the percentage of patients who were confused at the time of the fall, rising to 53% from 27% in 2013/14. Confusion in frail-elderly patients leads to unpredictable behaviour which is difficult to manage, with an increased risk of harm resulting from a fall. The Trust has committed to cohorting and 1:1 nursing to reduce the risk to patients.

Pressure ulcers

Pressure ulcers are an unwanted complication associated with healthcare. Estimates suggest they cost approximately 4% of the total annual NHS expenditure.

Prevention is our priority

They are costly in terms of prevention, management and human suffering.

The Trust's tissue viability clinical nurse specialist continued to develop a tailored suite of comprehensive training programmes for all staff that highlight the organisation's expectations and attitudes towards pressure ulcer assessment, prevention and management.

Work has concentrated on the SSKIN Care Bundle (a five step model for pressure ulcer prevention) and initial patient assessment, thereby ensuring patients at risk of developing pressure ulcer damage are identified early and appropriate care interventions are implemented, including:

- surface
- skin inspection
- keep patients moving
- incontinence and moisture
- nutrition and hydration.

Learning from any cases

Every hospital-acquired pressure ulcer incident is reviewed, using a detailed root cause analysis investigation. These are completed within 72 hours of the incident occurring and are followed by a panel review where a decision is made regarding the avoidable/unavoidable status. These decisions are ratified by the Tissue Viability Operational Group. An individual action plan is produced for each area where a pressure ulcer has been deemed avoidable, or if unavoidable, and issues and learning are highlighted from the panel review that require action.

Progress

In 2013/14, there was a reduction of 33% hospital acquired pressure ulcers grades 1-4, and a 44% reduction in grades 2-4 compared to 2012/13.

In 2014/15, although the number of hospital-acquired pressure ulcers dropped by 10%, the severity worsened, with an 18% increase in grades 2-4. Regrettably, root cause analysis identified an increase in avoidable hospital-acquired pressure ulcers. System weaknesses identified include failure to body map on admission and lack of evidence of skin care in the health record.

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. Almost 1,000 different leaflets were available, which were compliant with Department of Health guidelines. Regular audits were carried out to ensure standards were maintained.

Improving our Patients' Experience – *At our Best*

Your experience is our responsibility

The Trust experienced a tumultuous year but remains firmly committed to its responsibility to provide high quality, safe and effective services. The Trust has a duty of care to all its patients and carers and strives to make patient experience as positive as possible.

Positive patient experience is multi-factorial and includes, but is not limited to, achieving good clinical outcomes (making patients better), involving patients and carers in all levels of governance in the Trust, putting people first, making patients and their carers equal partners in care which should be patient-centred, respecting their privacy and dignity and keeping them informed.

The Trust advocates for the local resolution of concerns and issues through patients raising these with its Patient Advice and Liaison Service (PALS). Further information on PALs is provided on page 24 of this report. The Trust is equally committed to learning from incidents and complaints. It ensures that all team areas are aware of all learning lessons for their areas so that the possibility of recurrence of serious incidents, never events or serious complaints is minimised.

The Patient and Carer Experience Strategy was reviewed. It is envisaged that the Trust, in partnership with Healthwatch Essex and its commissioners, will solidify its work around service user involvement during 2015/16 following the re-launch of the Service User and Carer Experience Group. It is envisaged that complaints resolution will also improve following review of the complaints process and setup of the complaints group which has governor representatives.

The Trust continues to collect patient feedback and uses this information to inform service development and improvement programmes. The Trust retains its values and behaviours programme, called "At Our Best", which has been incorporated into the appraisal and recruitment system.

At Our Best

Continuous improvement

At Our Best remains an on-going programme of improvement to address concerns that have been expressed by patients and carers about staff attitude and behaviour. It aims to inspire, develop and support every Trust team by listening to the experiences of patients and carers. The Trust has strived to embrace the values of caring, communication and consistency to support the meaning and delivery of care At Our Best. These values continue to influence how the Trust sets leadership behaviours and recruit staff.

The Trust continues to hold its quarterly At Our Best Awards scheme for individual members of staff, teams and volunteers who have been nominated by colleagues,

patients, carers or members of the public for displaying behaviours that exemplify the At Our Best behaviours and standards.

The Trust plans to further this work with support from the company which helped launch At Our Best, so that:

- all staff are familiar with and share the Trust's vision
- the Trust fully embeds the drive for the delivery of high quality, seamless and responsive services at all times
- the Trust re-builds public confidence in the organisation and its staff.

Patient Experience and Carers Group

The Patient and Carer Experience Strategy has been reviewed with input from Healthwatch Essex and North East Essex Clinical Commissioning Group (CCG). The Patient Experience and Carer Strategy Group will be co-chaired by the Trust and a Healthwatch Essex representative in order to improve on the previous arrangements for ensuring the patient voice is heard. Work will also be undertaken to address service user representation at divisional and Trust-wide governance groups.

Privacy and dignity

Maintaining patients' privacy and dignity remains a Trust priority. The electronic survey that is used on the inpatient wards includes the following question:

"Overall, did you feel you were treated with respect and dignity while you were in the hospital?"

This allows areas to monitor their performance on a monthly basis. Between April and March, 92.2% of patients felt they were always treated with respect and dignity.

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 hospital 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 only share 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, eg 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.

How the Trust monitors the patient experience

Patient experience feedback is gathered in a variety of ways. The NHS friends and family test (FFT) is well established across the adult inpatient, maternity and A&E pathways. New guidance has been received which requires external reporting of the FFT for outpatients, day cases and children's services.

The FFT is already in use in children's services and day cases. External reporting began in April 2015. The paper leaflet that is currently in use with children is being revised to make it more appealing.

Paper leaflets are the main collection method, but the FFT question is also included on the electronic surveys that are used on the wards. Only the A&E Department uses a text messaging service run by an external company.

FFT reports are sent to divisions and wards on a weekly and monthly basis. The information is reported to the Patient Safety Group and is included in the integrated quality and safety report which is presented to the Quality and Patient Safety Assurance Committee the Trust's commissioners.

The electronic surveys that are used on the wards allow for more detailed feedback to be collected. Patient experience boards are on display in all clinical areas. These boards show the area's FFT results as well as "You said, We did" comments to demonstrate what actions have been taken in response to patient comments.

Patient experience formed part of the CAAP (Clinical Area Audit Programme). A review was undertaken of feedback that had been received, and surveys of current patients were completed. The new peer service review programme of internal inspections asks those carrying out audits to speak to a combination of staff, patients and carers so that patient experience is captured and any concerns raised are acted on.

Patient and public involvement

As an NHS Foundation Trust, we remain 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 service user views are taken into consideration at all times. Governors have remained involved in many aspects of Trust monitoring to ensure there are adequate standards in place for their communities. Governor representation continues on the Patient-led Assessments of the Care Environment (PLACE). Governors participated in a schedule of visits and all staff governors feed back areas of immediate concern directly to the Chief Executive and the Director of Nursing for their attention and action. Furthermore, feedback from governor walkabouts is included in the integrated quality and safety report to the Quality and Patient Safety Assurance Committee and to the Trust's commissioners who see this report at a monthly quality performance contract monitoring meeting, thereby ensuring services commissioned for the population the organisation serves are fit for purpose.

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 at its best consistently.

Patient-led Assessments of the Care Environment

Staff from the Trust's facilities management team, together with public governors and patient assessors (members of the public), held monthly mini Patient-led Assessments of the Care Environment (PLACE) walkabouts and an official Trust inspection to help monitor cleaning and environmental issues. This drove up standards and enabled the Trust to address concerns as soon as they arose. From April 2013 Patient Environment Action Team (PEAT) was replaced with these PLACE inspections. This assessment included local people going into hospitals as part of teams to see how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care or how well staff are doing their job.

"Got something to say?"

The Trust continues with its "Got something to say?" campaign, which highlights to patients how they can raise a concern with the Trust.

We want patients, relatives and carers to make sure they tell us if they have a comment, compliment or complaint.

Integrated PALS, Complaints and Litigation Services

The Trust is committed to learning from experience 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.

The Trust received 23,216 compliments between April 2014 and the end of March 2015. These are received in different ways including letters, cards, gifts, phone calls and through local press. During this period the ratio of compliments to complaints was 23:1.

Patient Advice and Liaison Service (PALS)

Our Patient Advice and Liaison Service (PALS) helps patients, carers, relatives and families resolve problems as quickly and easily as possible by putting them in touch with the appropriate member of staff. The Trust relocated the PALS service into the main hospital building at Colchester General Hospital to improve visibility and accessibility. Additional improvements in the location of the PALS office are planned to ensure even better accessibility by moving the team to the front of the hospital. Between April 2014 and the end of March 2015 a total of 1929 PALS contacts were recorded. This represents a 57% increase over the same period in 2013/14.

Information on complaints handling

A total of 1,022 complaints were received by the Trust, compared with 1,284 the previous year, representing a 20% reduction. The Trust views the receipt of complaints positively because it then seeks to learn lessons and improve the patient experience. The Trust re-opened 58 complaints because the complainants were not satisfied by the first response they received. This represents about 6% of all complaints.

Local resolution of complaints

Where complainants are not satisfied with the local resolution of issues and concerns, these are taken forward as formal complaints which receive a written response. The Trust sought to provide comprehensive complaint responses throughout the year so that complaints were not re-opened. The reason for complaints being re-opened was that complainants had concerns that were either not addressed completely the first time or because further questions were raised. The number of complaints that re-opened declined compared to the previous year, indicating an improvement in the information given to complainants.

Referrals to the Parliamentary Health Service Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) made contact with the Trust regarding 33 complaint cases. Of these, 24 required assessment or further investigation.

Acting to improve our complaints process

All complainants receive an acknowledgement of their complaint within 48 hours. This is followed up with a full acknowledgement detailing the concerns that are to be investigated and giving the complainant a time frame. The complaints process has been reviewed with a view to making it less onerous so that complainants can be assured they receive timely responses.

A high vacancy factor in the Trust sometimes meant that those tasked with investigating complaints had to focus on front-line care, thereby delaying responses. It is envisaged that as the staffing situation improves so will timely completion of complaint investigations.

The Trust has held money in reserve for additional resource in PALS which will enable the running of a seven-day service. Following the CQC visits in November and December, an action plan was developed to address some concerns in the Emergency Care Division.

As a result, the PALS Team now visits the A&E Department at least three times a week, thereby affording patients an opportunity to have their concerns addressed as they arise.

Service improvements following complaints

The Trust ensured that complaints were reviewed at local clinical governance meetings and that action plans were implemented and reviewed so that learning and changes in practice could be made.

Below are some examples:

- nursing staff and junior doctors on the care of the elderly wards can now access the duty patient safety review consultant on weekends and bank holidays
- the Trust's patient access policy has been updated to reflect what happens when a first treatment is not successful
- a target of 48 hours for non-urgent inpatient MRI scans was introduced.

Innovation and Excellence

Innovation in our portfolio of clinical services

Among the many developments, the following are of note:

- two laparoscopic (keyhole surgery) operating theatres at Colchester General Hospital were upgraded in a £788,000 project. The work included buying new scopes and fitting the theatres with HD (high-definition) equipment, with the capability to be upgraded for 3D technology
- an echocardiography service, which uses ultrasound to diagnose heart problems, was started at the Fryatt Hospital, Harwich. It was provided by Trust consultant cardiologist Dr Mark Scoote and colleagues from the cardio-respiratory department
- a new approach to supporting dying people in the last few days of life – as well as their families and carers – was implemented across north east Essex. The Individual Care Record For The Last Days Of Life was developed following the withdrawal of the Liverpool Care Pathway. It was designed by a cross-organisational group, which included the Trust, to ensure that the wishes of patients are respected and care is tailored to their needs
- surgeons at Colchester General Hospital became among the first in the UK to use laparoscopic (keyhole) surgery to operate on patients with bladder cancer. The main advantages for patients over traditional open surgery are a faster recovery time and less pain
- contraception and sexual health services were relocated from Essex County Hospital to the old Post Office building in Colchester High Street following a 15-week, £516,000 redevelopment
- the Growth Assisted Protocol (GAP) programme was introduced across north east Essex to help minimise the number of stillbirths. It involves giving each mother a customised growth chart that tells her how large her baby is expected to be for each week of her pregnancy. If the baby's growth falls outside the expected "norm" for that individual woman, the mother is offered extra ultrasound scans to check that the baby is thriving
- a new unit opened at Colchester General Hospital to speed up the assessment and treatment of patients who may need surgery. The £455,000 Surgical Assessment Unit (SAU) takes referrals directly from GPs from all over north east Essex and also stable surgical patients from the hospital's Emergency Department (A&E)
- a retinal suite was created at Essex County Hospital to provide a "one-stop shop" service for the growing number of patients with retinal disease, the most common of which is age-related macular degeneration (AMD)
- endobronchial ultrasound (EBUS) was introduced following an investment of £132,000. EBUS is a fairly new procedure to help diagnose some conditions of the airways (the tubes that carry air to the lungs) by taking tissue samples from the lungs and surrounding lymph glands. Previously, this service was not

available in north east Essex

- the Trust appointed an additional (sixth) consultant colorectal surgeon with a special interest in Pelvic Floor Disorders (PFD). Mr Subash Vasudevan's long-term aim is to set up a comprehensive pelvic floor service in Colchester which would mean that patients from north east Essex no longer having to go to London for assessment, investigation and treatment
- work began on the £375,000 first phase of a project to increase the size and improve the layout of the main outpatient department at Colchester General Hospital. It will enable the department to accommodate some of the additional patients resulting from the transfer of services from Essex County Hospital
- a Urology Day Unit was established at Colchester General Hospital following an investment of £250,000 in extra staff and equipment. It is located in the hospital's Elmstead Day Unit and means that more urology patients can have surgery on a day case basis.

Financial Performance

Our financial performance

The Trust reported a deficit of £22.3m (excluding charitable funds).

Compared with the previous year, income increased by 0.3%, from £266.7m to £267.6m. Expenditure rose by 11.2% from £255.7m to £284.3m. Pay costs made up the majority of this increase (£14.1m). The increase was partly planned investment in nursing staff but was also impacted by an increased expenditure on temporary staff which made up 12.7% of the total pay bill.

	2014/15 £m	2013/14 £m
Operating income*	267.6	266.7
Operating costs	(275.2)	(255.7)
EBITDA**	**(7.6)**	**11.0**
Non-operating costs	(14.6)	(12.5)
Impairment of non-current assets	(0.1)	(0.9)
Surplus/(deficit) for the year	**(22.3)**	**(2.4)**

*For the purpose of this analysis, the reversal of impairments of £2.0m in 2013/14 is reported under impairments rather than operating income

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

Consolidated accounts

In accordance with International Accounting Standard 27, 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 Colchester Hospital University NHS Foundation Trust. The charitable funds are administered by the Charitable Funds 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

A&E four-hour standard

A&E faced some challenges in meeting performance targets due to various issues across the Trust, especially during the winter. The Trust was required to meet the target of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. It achieved 87.4% compared with 94.75% the previous year.

Our performance against the challenging national access standards was as shown in the table on the right:

	Standard	Performance
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals *(Cancer submitted data: Apr 2014 – Feb 2015)*	93%	91.1%
Two-week wait for symptomatic breast patients (cancer not initially suspected) *(Cancer submitted data: Apr 2014 – Feb 2015)*	93%	93.3%
All cancers: 62-day wait for the first treatment from national screening service referral *(Cancer submitted data: Apr 2014 – Feb 2015)*	90%	91.%
All cancers: 62-day wait for the first treatment from urgent GP referral to treatment *(Cancer submitted data: Apr 2014 – Feb 2015)*	85%	75.5%
All cancers: 31-day wait from diagnosis to first treatment *(Cancer submitted data: Apr 2014 – Feb 2015)*	96%	93.6%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days *(Data Period: Apr 2014 – Feb 2015)*	95%	87.5%
18-week maximum wait – admitted patients *(RTT Submitted Data: Apr 2014 – Nov 2014)*	90%	80.1%
18-week maximum wait – non-admitted patients *(RTT Submitted Data: Apr 2014 – Nov 2014)*	95%	94.2%
Percentage of patients on an incomplete pathway with a maximum of 18 weeks waiting time *(RTT Submitted Data: Apr 2014 – Nov 2014)*	92%	93.5%
MRSA	0	0
Clostridium difficile	20	32

*Source: Performance Framework

Infection Control

Overview

The Trust continued to make good progress with controlling and preventing hospital-acquired infections. Rigorous clinical hygiene measures, controls on the prescribing of antibiotics, isolation of infected patients and root cause analysis of cases, supported by learning and implementing changes, had a significant impact. We will continue our vigilant approach to continue to drive down the incidence of hospital-acquired infections in 2015/16.

Clostridium difficile

Clostridium difficile incidence is assessed as cases detected more than 72 hours after admission which are considered to be attributable to an infection acquired in hospital. The agreed maximum ceiling (based on historic performance) for the Trust was 18 cases. We had 32 cases. Maintaining a low number of cases (there were 17 and 29 in each of the two previous years) was testament to the vigilance of staff and 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. The Trust's target was to have no cases of MRSA bacteraemia and there were none attributed to the organisation's care in 2014/15.

Surgical site infection

Orthopaedic surgical site infection data reporting has been mandatory since 2005. The Trust has consistently achieved rates well below the national benchmark.

Hand hygiene monitoring

The Trust monitored hand hygiene compliance with best practice in all clinical areas every month. Compliance overall remained at 96%-98%.

Our Staff

About our staff

On 31 March 2015 the Trust directly employed 4,229 staff (3,647 full-time equivalents (FTE)). The number of FTE staff in post was 116 fewer on 31 March 2015 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 2013	4,168	3,813	3,562
31 March 2014	4,380	3,964	3,763
31 March 2015	4,229	4,154	3,647

Summary of performance – NHS workforce statistics

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 2014/15	Staff members 2013/14	Public members 2014/15	Public members 2013/14
0 to 16 years	0	0	0	0
17 to 21 years	50	58	27	72
22+ years	4,492	4,452	5,384	5,585
Not specified	0	0	0	1,045
Total	4,542	4,510	6,421	6,702
Ethnicity				
Not specified	313	315	2,211	2,256
White	3,628	3,626	3,983	4,201
Mixed	51	44	36	38
Asian or Asian British	403	392	116	125
Black or Black British	105	94	51	58
Other Ethnic Group	42	39	24	24
Other	0	0	0	0
Total	4,542	4,510	6,421	6,702
Gender				
Male	1,075	1,055	2,284	2,393
Female	3,467	3,455	3,882	4,057
Transgender	0	0	0	0
Not specified/ Prefer not to say	0	0	255	252
Total	4,542	4,510	6,421	6,702

Staff Engagement

Staff engagement

Engaging with staff across the Trust at all levels remained a priority. There was continued scrutiny and challenge with many external quality visits which had an impact on staff morale.

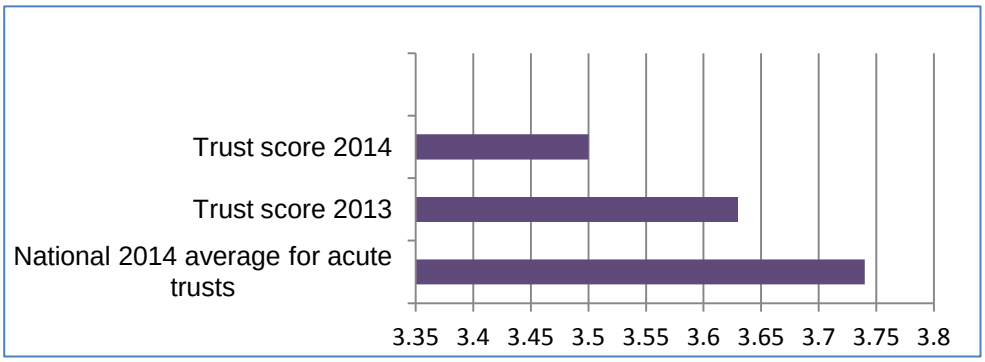
The human resources and health and wellbeing departments worked with the divisions to support engagement on both a local and Trust-wide level. Activities included listening sessions, departmental stress risk assessments, and various health and wellbeing initiatives, including open days. Surgeries were held in divisions to help interpret the data from the survey to provide a local focus.

However, despite these and the actions that are summarized in the NHS Staff Survey section of this report (see page 34), the overall engagement score in the 2014 staff survey, which was published in February 2015, fell from the previous year.

The overall indicator for staff engagement comprises three key findings in the Staff Survey, as follows:

- staff members perceived ability to contribute to improvements at work
- their willingness to recommend the Trust as a place to work or receive treatment
- the extent to which they feel motivated and engaged in their work.

The Trust was in the bottom 20% when compared to other trusts of a similar size.



Definitions of engagement have been summarised as being made up of four enablers that should be fundamental of any engagement strategy:

- leadership that gives a strong narrative about the organisation, where it has come from and where it is going
- line managers who motivate, empower and support their employees
- employee voice throughout the organisation, to challenge or reinforce the status quo and involve employees in decision making
- organisational integrity: stated values are embedded into organisational culture: “What we say is what we do”.

It is clear that there needs to be a concentrated focus on activities that are based on the areas of need as expressed in the survey data along with best practice highlighted in engagement literature. There is work to do to develop and encourage the kinds of conversations that will rebuild trust and engagement, such as appraisals and team meetings.

Priority outcomes

Our priority outcomes for further improvements in future staff surveys are to

Strengthen board commitment

Place staff engagement firmly on the board agenda.

Senior leaders need to treat staff engagement as an on-going priority alongside other strategic objectives, including patient experience, clinical outcomes and patient safety.

Strengthen the vision

Develop and communicate a compelling, shared vision.

Leaders who help their organisations to develop a clear vision and a compelling narrative about mission and priorities achieve higher levels of engagement.

Strengthen leadership visibility

To raise the profile of senior management and build trust and confidence in the stability and purpose of senior leaders within the Trust.

Strengthen culture

Establish a culture based on compassion, trust and integrity.

Strengthen staff involvement

Create Trust-wide and divisionally specific opportunities to involve and empower staff to lead service transformation.

Strengthen teamwork

Evidence shows that better team working is linked to better patient outcomes and lower mortality levels.

Suggested activities to underpin these priorities include:

- setting aspirational engagement targets at a divisional level and ensure progress is reported at board meetings
- involving staff in developing positive “stretch” goals for the Trust
- building the vision into staff objectives and other HR processes and all aspects of the employee life cycle
- engaging senior leaders to actively involve and lead on the forums, work streams and focus groups emanating from this programme of work
- creating a culture of acknowledgement, where praise and recognition are part of the fabric of the organisation
- building skills development in delivering authentic praise into all management and leadership development programmes
- setting up an engagement forum, consisting of staff at a variety of levels and disciplines. Use this as a think-tank to discuss and address the Trust-wide and local engagement challenges in a solution-focused way
- involving staff as facilitators and champions of “At Our Best together” working groups
- conducting appreciative exploration into high-performing Trust teams currently working well
- defining what “great teams” are at the Trust and creating a “team manifesto” (collectively) that resonates at a local and Trust level
- Including modules within management and leadership development offerings on building and developing high-performing teams.

Staff Partnership Forum

The Staff Partnership Forum, comprising management and staff side union representatives, met every month with an agenda that included business updates,

future strategy, a review of key performance indicators and Trust issues. The agenda was agreed jointly between staff side and management.

Specific joint working by the Partnership Forum included a review of the key employee relations policies, such as grievance, disciplinary, performance management, attendance and absence and organisational change policy. Due to close working with Staff Side, a remodelled grievance policy and performance management policy was agreed and implemented. The recruitment policy was also revised.

Staff Survey

Introduction

Since 2003, the Trust has surveyed staff as part of the annual national NHS Staff Survey. On 24 February 2015 the NHS published the results of the 2014 survey for all trusts in England. About two-fifths of the Trust's staff (1,684 people) took part, a response rate of 41.3% which was in line with the NHS average (41.6%).

The results from the 2014 survey were worse than those from its predecessor. Areas where performance deteriorated and also fell below the national average included communication between the senior team and staff, job satisfaction and engagement, the quality of work our staff feel they deliver and a lack of well-structured appraisal.

Fewer staff reported that they experienced violence from other staff. We are performing better than average for this key finding and have maintained our score since 2013.

We also improved locally compared with 2013 on the number of staff who experienced discrimination and who believed there were equal opportunities for career progression.

The questions in the survey are grouped into 29 key findings. There are two types:

- Percentage score – the percentage of staff giving a response to one or a series of questions that form the key findings.
- Scale summary scores – calculated by converting staff responses to questions into scores. Scores are always 1-5.

The Trust performed significantly worse than 2013 in five of the 29 key findings.

Compared to other acute trusts in the 2014 survey, Colchester was below average in 27 of the 29 key findings and was in the bottom 20%, which included staff engagement. Further explanation of what this comprises of and the Trust's actions to address the underlying causes is given on page 31 under Staff Engagement.

Details of the key findings from the 2014 NHS staff survey are shown on the next page.

NHS Staff Survey – Key Findings

	2013 survey (February 2014)		2014 survey (February 2015)		Trust Improvement/ Deterioration on 2013 results
	Trust	National average	Trust	National average	
Top 5 ranking scores (source Picker)					
KF17 Percentage of staff experiencing physical violence from staff in the last 12 months (the lower the score the better)	2%	3%	2%	3%	Same – 0% difference
KF12 Percentage of staff witnessing potentially harmful errors, near misses or incidents on the last month (the lower the score the better)	33%	29%	34%	34%	Deterioration – 1%
KF28 Percentage of staff experiencing discrimination at work in the last 12 months (the lower the score the better)	15%	11%	12%	11%	Improvement – 3%
KF7 Percentage of staff appraised in the past 12 months (the higher the score the better)	86%	84%	81%	86%	Deterioration – 5%
KF27Percentage of staff believing the Trust provides equal opportunities for career progression or promotion (the higher the score the better)	83%	88%	84%	87%	Improvement – 1%
Bottom 5 ranking scores (source Picker)					
KF21 Percentage of staff reporting good communication between senior management and staff (the higher the score the better)	22%	32%	15%	30%	Deterioration – 7%
KF23 Staff job satisfaction (the higher the score the better)	3.46	3.63	3.41	3.6	Deterioration – 0.05
KF14 Fairness and effectiveness of incident reporting procedures (the higher the score the better)	3.39	3.51	3.34	3.54	Deterioration – 0.05
KF1 Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (the higher the score the better)	77%	82%	69%	77%	Deterioration – 8%
KF8 Percentage of staff having well-structured appraisals in the past 12 months (the higher the score the better)	30%	39%	26%	38%	Deterioration – 4%

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.

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

Public constituency	31 March 2015	31 March 2014
Colchester	2,962	3,107
Halstead & Colne Valley	741	777
Rest of Essex	342	353
Suffolk	265	266
Tendring	2,110	2,197
Catchment not found	1	0
Total	**6,421**	**6,700**

Staff constituency	31 March 2015	31 March 2014
Allied Health Professionals/Healthcare scientists	802	723
Medical or dental practitioners	486	471
Not known	8	7
Nurses/midwives	1,266	1,322
Support staff	1,980	1,987
Total	**4,542**	**4,510**

Public membership is falling and staff membership rising. Public membership has fallen in all constituencies.

	2015	2014	New members	Leavers
Public	6,421	6,700	32	311
Staff	4,542	4,510	478	446

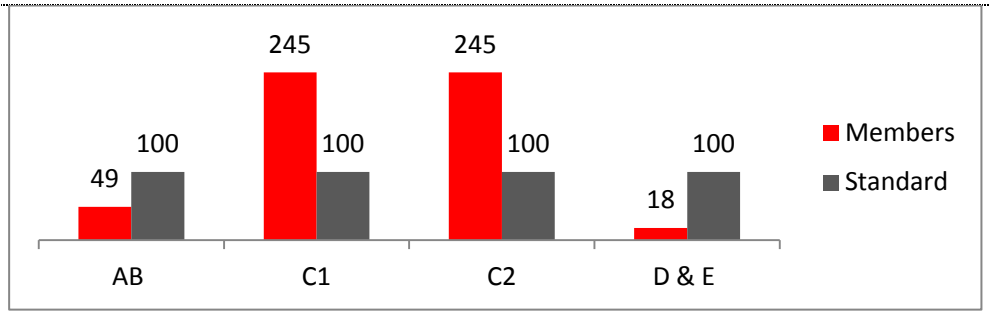
Public membership demography

There is a fairly uniform distribution of public members across the catchment area of Essex and Suffolk, including areas of deprivation and people from an ethnic minority background.

As with many NHS foundation trusts, there is under-representation of people between the ages of 16 and 59.

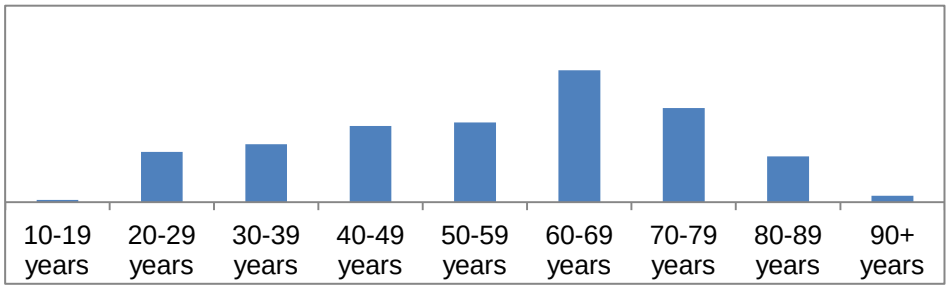
According to population data, we have far more public members than is representative in middle class and skilled working class categories, and far too few in other classification groups. Ideally, the columns on the next page would all be 100.

The National Readership Survey (NRS) 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

Age profile of our public members



Using social media to engage and communicate

The Trust's Communications Team uses social media, such as Facebook and Twitter, to further engage and communicate with users of the Trust's services.

The Trust's Twitter page had 1,854 followers on 31 March (1,024 on 31 March 2014) and the team had tweeted 3,029 times since its launch (1,465 on 31 March 2014).

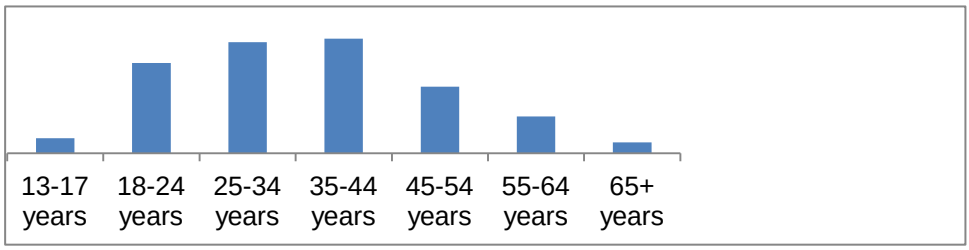
The Trust has a Facebook page for Colchester General Hospital and for Essex County Hospital.

At 31 March, our Facebook page for Colchester General Hospital had:

- 2,428 likes – the number of unique people who have liked our page. There were 1,386 on 31 March 2013

Facebook allows people to rate Colchester General Hospital. At 31 March there were 646 (549) ratings – with 218 (169) giving Colchester General Hospital five stars (the highest) and 159 (132) giving one star (the lowest).

Age profile of people who "liked" our Facebook Page



Contact procedures for members

People can contact governors or directors via the Membership Office on 01206 742733 during office hours or email ft.membership@colchesterhospital.nhs.uk

We also have a Membership Helpline, 0800 051 51 43, weekdays, 9.30am-5pm.

All of this information can be found on our website under About Us.

See also page 6 for more contact details.

Environmental Sustainability

Commitment to sustainability

The Trust takes its responsibility as a major employer and consumer of energy and resources seriously and is committed to helping reduce the adverse effects of its operations on the wider environment.

Sustainability strategy of the Trust

The Trust has a Board approved Sustainable Development Management Plan (SDMP) to provide the necessary tools to address and reduce its carbon footprint while at the same time improving the organisation's overall corporate social responsibility.

In 2014 the commitment of the Trust to sustainable energy was recognised at the Building Better Healthcare national awards; the Trust won in the category *Improving Sustainability and Reducing Energy* for work on energy recovery from more efficient steam traps. Also in 2014, as part of the new Radiotherapy Centre the Trust installed a photovoltaic electricity generation array designed to help increase the proportion of energy consumed that is generated from sustainable sources.

Governance to support sustainability

Tom Fleetwood is the non-executive director lead for sustainability issues.

Research & Development

Introduction

Research & Development (R&D) helps to increase the opportunities for patients to take part in clinical research, ensures that studies are carried out efficiently, and supports the Government's Strategy for UK Life Sciences by improving the environment for commercial contract clinical research in the NHS. The Trust's research teams continue to participate in national portfolio studies via the National Institute of Health Research (NIHR). Our contribution is included in the overall publication and to the body of evidence of a disease area through research critique and evaluation,

The Trust is committed to the integration of research in clinical practice to provide all patients access to research trials as legislated by the NHS Constitution.

All research is delivered in accordance within the Research Governance Framework for Health and Social Care (2005) to ensure research governance is one of the core standards that all organisations should apply to work managed in a formal research context.

The NIHR is the clinical research delivery arm of the NHS and operates nationally across England through a national co-ordinating centre and, from 1 April 2014, through 15 local Clinical Research Networks delivering research in the NHS across all disease areas with boundaries based on the geographical footprints of the Academic Health Science Networks.

The NIHR Clinical Research Network: Eastern is hosted by Norfolk and Norwich University Hospitals NHS Foundation Trust. The host is responsible for ensuring the effective delivery of research in the trusts, primary care organisations and other qualified NHS providers throughout the Eastern area.

This Trust is a member of CRN Eastern and receives a funding allocation of approximately £875,000 from the host. Additional funding is received from the Department of Health's Research Capability Funding stream (£20,000) which is based on NIHR criteria for achieving 500 participants recruited in the previous financial year.

Research funding has provided the Trust with an established research infrastructure that supports the clinical divisions to participate in research and through their contribution support research evidence in decision making about best practice, provide effective and novel treatments and potential cost savings.

Collaborations continue with the University of Essex and Anglia Ruskin University (ICENI Centre) through their links with the Trust.

R&D is also working with Healthwatch Essex for a major research project on hospital discharge.

The Essex Biomedical Sciences Institute (EBSI) Conference will be held at Colchester General Hospital on 1 July 2015 and will highlight successful on-going collaborations between academics and clinicians in EBSI and will showcase emerging research areas where future collaborations could be formed.

The Trust will also pursue opportunities for research and innovation through the Eastern Academic Health Sciences Network and the life sciences industry.

The Trust's R&D team works with Health Enterprise East in the exploration of potential commercialisation of intellectual property and the Research Design Service to develop research ideas and support researchers with design, methodology, grant applications, statistics and NIHR portfolio adoption status.

The R&D Steering Group oversees R&D activity within the Trust.

Maximise engagement in Research

Research at the Trust took place in anaesthetics, cardiovascular, gastroenterology, haematology, Intensive Therapy Unit (ITU), obstetrics, oncology, ophthalmology, paediatrics, rheumatology, renal, stroke and urology.

Research activities are also supported by the Electro-Biomedical Engineering

Department (EBME), information governance, the Mary Barron chemotherapy suite, nuclear medicine, pathology, pharmacy and radiology.

Engagement within the Trust and with the public to continue to profile research was communicated at the Tendring Show, via a "Research Changed my life" and "It's Ok to Ask" campaigns, at specialty public meetings and through internal communication and articles in the local press. As part of NIHR Patient and Public Involvement (PPI) initiatives, we have appointed Patient Research Ambassadors in March 2015 to develop a patient-focused approach to research services.

The NIHR publishes 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 providers' 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&D page of the Trust website: www.colchesterhospital.nhs.uk

The Operational Capability Statement is also available on the Trust website. It identifies the research activity and resources the Trust offers.

Raising the research profile in the Trust, encouraging clinical divisions to develop their research portfolio, embedding research in departments and highlighting patient engagement will continue to be a focus.

The Trust is currently involved in 257 studies, of which 136 were open to participant recruitment and 121 studies closed to recruitment and are in participant follow-up status. There were 65 new research studies and 130 study amendments approved through the R&D Office.

The balanced portfolio reports that the interventional/observation study split is 51/49, representing a more balanced portfolio on the previous year (54/46).

Clinical research team managers identify NIHR portfolio studies, engage with potential principal investigators and perform detailed site feasibility and the set-up of a research study.

Research governance

All research is delivered in accordance within the Research Governance Framework for Health and Social Care to ensure all research projects have been fully assessed to ensure compliance, capacity to deliver and address any risks and to ensure appropriate authorisations have been received from clinical and support departments.

The Trust has a trained facilitator to deliver International Conference Harmonisation - Good Clinical Practice (ICH-GCP) training for clinicians and research staff to ensure standards and best practices are maintained. The Trust ran four ICH-GCP refresher courses and intends to maintain this schedule in future years. ICH-GCP training is valid for two years with 87 researchers holding a current certificate and 40 updating their training in 2014/15.

NHS Permissions median time

From 1 April 2014, the NHS permission target was reduced to a 15-day target (from 30 days) to provide an extension for the research delivery teams to obtain the first patient recruited within an overall benchmark of 70 days to recruit the first participant. This was achieved by implementing robust changes in R&D local processes to avoid delays in issuing NHS permission and research teams working with R&D with regards to the submission and permission process.

Dashboard – Time to NHS Permission in median calendar days											
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
12	12	10	2	3	7	8	3	2	5	2	9

Life Sciences Industry	The NIHR promotes industry studies adopted onto its portfolio via an Expression of Interests (EOIs) system. The Trust receives expressions of interest from CRN Eastern which is reviewed locally to determine feasibility. Additionally, through clinicians and research association with industry, the Trust has been pre-selected for industry studies. The Trust approved and opened seven new industry studies adopted onto the NIHR portfolio. Research income generates approximately £130,000 to contribute to Trust overheads, research infrastructure and re-investment into research activities.
Patients recruited into NIHR CRN Portfolio studies	There were 927 participants into portfolio studies against a local target of 850 participants. From 1 April 2014, the Trust became a member of Clinical Research Network (CRN) Eastern and activity is reported across six divisions, compromising 30 clinical specialties.

Trust Strategy

Our objectives and priorities

In March 2015, the Board of Directors reviewed the Trust's strategic objectives and the key priorities for the organisation. Three overarching strategic objectives were agreed as being key to restoring the confidence of patients, staff, regulators, commissioners and the wider public.

- **Acting in the best interests of our patients**

  Immediate priority: Deliver the CQC improvement plan and remedial action plans for all areas of the Trust that are not meeting core standards. Develop a clinical strategy.

- **Valuing our workforce**

  Immediate priority: Develop and implement a workforce plan in keeping with the Trust's service and financial plan

- **Achieving financial sustainability and organisational resilience**

  Immediate priority: Develop and implement a financial recovery plan that achieves or betters the financial plan for 2015/16 and a strategy to achieve long-term sustainability

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 objective. Its principal aim is to provide a mechanism for the board 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 that is in place.

Risk Management Strategy

The Trust implemented a number of measures to strengthen its risk management arrangements. These followed the implementation of a new risk management strategy in February 2014 and an independent review of its risk management arrangements by Deloitte which was issued at the same time.

These measures included the following:

- The development and implementation of an assurance and escalation policy and framework in October 2014. This set out the principles to ensure there are effective communication lines from the front line of service delivery right through to divisional leadership teams, the senior executive team and the board itself to improve organisational risk management from ward to board.
- The executive governance structure from ward to board was reviewed and a new committee structure with reporting lines to the Executive Team and assurance committees of the Board clarified.
- A board risk workshop in November, to ensure the board had a shared understanding of the importance of effective risk management and was engaged in the development of and how to use the revised Board Assurance Framework. During this session, the board considered its tolerance for risk and, following a facilitated session, agreed its risk appetite. This was later drafted into a risk appetite statement that was agreed by the Board of Directors at its January meeting.
- A comprehensive review of the design and content of the Board Assurance Framework to ensure it is an effective tool for linking principal risks to the Trust's strategic objectives, identifying risk ownership and providing an overview of the key controls and sources of assurance

regarding those risks so as to inform the board's agenda

- The establishment of a monthly Executive Risk Management Group with oversight of divisional, directorate and corporate risks through to the Board Assurance Framework to ensure that risks identified at divisional or directorate level are aggregated and escalated as appropriate and appropriate mitigations and/or action plans are in place for risks that fall outside accepted tolerance levels.

The Board routinely receives information on all Serious Incidents and the lessons learned 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 2015

The Trust's principal risks identified in the Board Assurance Framework of March 2015 are as follows:

- inability to maintain safe ward staffing levels to meet increases in activity and acuity of patients, and ensure effective clinical supervision, due to staff shortages and difficulties recruiting suitably qualified clinicians, nurses and doctors
- financial unsustainability as a result of:
  - poor cost reduction controls
  - poor execution of cost improvements
  - weak recording of care provided and associated diagnoses
  - activities provided not being aligned with income and costs
  - failure to achieve income targets and CQUINs
  - not controlling capital spend
- insufficient bed and theatre capacity to deliver required clinical activity resulting in a poor environment of care for patients (for example, outliers), a poor patient experience, risks to patient safety, missed targets, lost income and potential penalties and regulatory intervention
- failure to develop and deliver a realistic and achievable clinical and financial strategy that persuades the Trust's regulators and stakeholders that the Trust has a plan which will return it to sustainability.

These risks will inform the board's agenda going into 2015/16. Consequently, the action plans and mitigations in place to reduce their likelihood and impact of these risks are under constant board monitoring to ensure that the risks are being managed to acceptable levels as stipulated in the Trust's risk appetite statement below.

Risk Appetite Statement

The Board of Directors 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. As a Trust currently in special measures with its regulators, the board has taken a cautious view regarding the risks that it is prepared to take in terms of risks to quality, patient safety and financial control, expressing a preference for safe delivery options that have a low degree of risk and which may only have a limited potential for reward. The board understands that there is a balance to be maintained between key risk areas and that sometimes risks in some areas will need to be taken to manage risks to an acceptable level in other areas. The key principles determining the Trust's risk appetite are as follows:

Quality: The quality of our services, measured by clinical outcomes, patient safety and patient experience is paramount. The Trust will seek to avoid taking risks that will compromise quality and patient safety.

Financial/VfM: The Trust is prepared to accept the possibility of some limited financial loss. Value for money is still the primary concern, but the board will consider other benefits or constraints.

Innovation: The Trust is supportive of innovation, with demonstration of commensurate improvements in management control. It supports the use of systems and technology developments being used to enable operational delivery, but priority will be given to improvements that protect current operations.

Commercial: Until such times as financial sustainability is re-established, the Trust's business development strategy will be based mainly on low-risk opportunities within well-established business areas and markets only and on a highly controlled basis.

Regulatory compliance: The Trust has been, and continues to be, under significant regulatory scrutiny due to concerns identified by the CQC and Monitor. The board is keen to return to regulatory compliance as soon as practicable as this is key to optimising quality and financial sustainability and will not take any risks that will compromise this.

Reputation: The board's tolerance for risks relating to its reputation is limited to those events where there is little or no chance of significant repercussion for the organisation.

Regulatory Ratings

Monitor Risk Assessment Framework

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

The Risk Assessment Framework constitutes Monitor's approach to overseeing NHS foundation trusts under these rules. The framework is used to assess individual NHS foundation trusts' compliance with two specific aspects of their work: the continuity of services and governance conditions in their provider licences. The Risk Assessment Framework for independent providers of NHS services is covered in a separate document available on Monitor's website.

The aim of a Monitor assessment under the Risk Assessment Framework is to show when there is:

- a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services and/or
- poor governance at an NHS foundation trust.

These will be assessed separately using the risk categories set out in this document; each NHS foundation trust will therefore be assigned two ratings.

The role of ratings is to indicate when there is a cause for concern at a provider. It is important to note that they will not automatically indicate a breach of its licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk.

Continuity of Services Risk Rating

The Continuity of Services Risk Rating (CoSRR) incorporates two common measures of financial robustness:

(i) liquidity – days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown; and

(ii) capital servicing capacity – the degree to which the organisation's generated income covers its financing obligations. The overall score will inform Monitor's

regulatory approach towards the Trust. The Trust finished the year with a CoSRR of 1, which is the lowest rating available under the Monitor scheme. For a CoSRR of 1, Monitor may:

- consider using its powers under the licence to initiate a contingency planning process, assessing the financial situation at the provider and the best options to address it in order to minimise disruption to patients; or
- maintain a closer degree of monitoring by collecting financial information on a monthly or more frequent basis. Where appropriate, Monitor may also consider formal enforcement action as well as specific requirements within the terms of the continuity of services licence conditions themselves, including co-operating with a Monitor appointed contingency planning team or other financial experts.

Looking ahead to 2015/16

The Trust is forecasting to remain within a CoSRR of 1 for 2015/16 but has in place a financial recovery plan which aims to show an improved position from 2016/17 onwards.

Governance Risk Rating

As a consequence of action taken in November 2013 to place the Trust in special measures, the governance risk rating for the Trust is "Red: subject to enforcement action". The Trust remains in special measures.

In August, Monitor took further action after an inspection by the Care Quality Commission rated the Trust as "requiring improvement" overall and "inadequate" against its "well-led" domain.

Looking ahead to 2015/16

The Trust will remain with a governance risk rating of "Red" until the actions in the improvement plans are showing sustainable delivery against its key performance indicators and the regulators are satisfied that it can come out of special measures.

Section 106 Enforcement Undertaking

On 5 February Monitor issued the Trust a Section 106 enforcement undertaking, stating quality, financial and governance breaches – "a failure of governance arrangements"; "a failure…to establish and effectively implement systems and/or processes for effective financial decision-making, management and control,… including to manage through forward plans, material risks…" In response to this the Trust was required to, and did provide in April 2015, a financial recovery plan, addressing the points raised in the Section 106 enforcement undertaking, to support its annual plan submission to Monitor for 2015/16.

Risk of any other non-compliance with terms of authorisation

The Trust has been found to be in breach of the following conditions of the Foundation Trust's licence: FT4(2); FT4(5)(a),(c) and (f); FT4(6)(a),(c), (d), (e) and (f); and FT4(7). These terms are detailed in the licence which can be found at www.monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register-licence-holders/colchester-hospital-university The recovery programme and related activity are designed to address the deficiencies which led to the Trust being put into special measures and to return the organisation to full regulatory compliance. The on-going 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
- 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 May and an unannounced inspection of the Emergency Department (A&E) and Emergency Assessment Unit (EAU) at Colchester General Hospital in November and December, the CQC gave the Trust an "inadequate rating" overall, with individual services being rated as follows:

Urgent and Emergency Services	Inadequate
Medical Care	Inadequate
Surgery	Good
Intensive/Critical Care	Good
Maternity/Gynaecology	Requires Improvement
Services for Children and Young People	Requires Improvement
End of Life Care	Requires Improvement
Outpatients	Requires Improvement

The Trust has developed a comprehensive CQC remedial action plan to address the concerns raised and to improve the standards of the service to "good" or better for future inspections.

Effectiveness of Systems of Internal Control

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

Contractual or Other Arrangements

Summary of contractual relationships

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)
- Mid Essex Hospital Services NHS Trust (plastic surgery services)
- North Essex Partnership NHS Foundation Trust (mental health services)
- Anglian Community Enterprise (clinical services).

Overview of other procurement arrangements

The Trust had a number of other procurement arrangements, some of which are listed below:

- National Blood Service (blood products)
- Serco (Payroll)
- Alliance Medical (MRI services)
- Opcare (orthotic and prosthetic services)
- GE Capital (equipment leasing)
- Fresenius (renal services)
- Concordia (dermatology)
- The Pathology Partnership.

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 Ipswich Hospital NHS Trust and Mid Essex Hospital Services NHS Trust for a range of clinical services
- partnership with Anglia Ruskin University for the development and management of The ICENI Centre for training and research and development in laparoscopic surgical techniques.

Trust Business Model

The Trust operates a devolved management structure with five clinical divisions, each led by an experienced senior clinician. The divisions have delegated authority for governance, performance and expenditure/income and are accountable through the divisional directors to the Chief Executive.

Divisions are supported by a number of Trust-wide corporate functions including human resources, finance, information technology, estates and facilities. Within the delegated structure, professional clinical leadership is maintained through the Medical Director and Director of Nursing.

For most of 2014/15, the Trust operated with four clinical divisions. Following the

CQC review of A&E and EAU, resulting in an "inadequate" rating, a fifth division – Urgent Care – was formed in January 2015.

Our place in the Community

Social, community and human rights issues.

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

The Trust operates within the NHS Constitution and has employment and service policies which address equality and human rights issues.

Gender Equality

As at 31 March 2015, the breakdown of the number of male and female directors, other senior managers and employees

The table below shows the breakdown of male and female staff. The non-executive directors and directors who were on interim off-payroll contracts as at 31 March 2015 are not classed as employees and are not therefore covered in the total number of staff employed by the Trust figure of 4,229.

Role	Female	Male	Notes
Non-executive directors	2	4	Includes Chair
Executive directors	5*	1	Includes Chief Executive
Other senior managers	9	7	Bands 8d and above
Employees	3,219	985	
Total	**3,232**	**997**	

* as at 31 March 2015, the Chief Executive and Director of Nursing were not on the payroll but were employed on interim contracts

Statement of the Directors

The strategic report must be approved by the directors and signed and dated by the Accounting Officer.

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.

Signed

Dr Lucy Moore

Chief Executive

Directors' Report

The Directors

The Directors' Report is presented in the name of the following directors who occupied Board positions since 1 April 2014 (it also incorporates the operating and financial review):

Name	Title
Roger Baker	Non-Executive Director (from 1 September)
Evelyn Barker	Chief Operating Officer (until 19 December)
Jude Chin	Non-Executive Director
Tom Fleetwood	Non-Executive Director
Kathy French	Acting Director of Nursing and Patient Experience (from 8 October until 4 November)
Shane Gordon	Chief Operating Officer (from 2 March)
Dee Hackett	Director of Nursing & Patient Experience (until 7 October)
Kim Hodgson	Chief Executive (until 22 May)
Dr Sally Irvine	Chair (until 30 September)
Lynn Lane	Director of Human Resources and Organisational Development (from 7 May)
Diane Leacock	Non-Executive Director
Andy Lehain	Acting Director of Finance (17 July until 30 September)
Dr Sean MacDonnell	Medical Director (until 8 March)
Dr Lucy Moore	Chief Executive (from 27 May)
Andy Morris	Director of Finance (from 1 October until 1 February)
Ian O'Connor	Director of Finance (until 16 July)
Julie Parker	Non-Executive Director
Helen Parr	Non-Executive Director (until 31 July)
Dawn Scrafield	Director of Finance (from 2 February)
Sandy Spencer	Chief Operating Officer (from 20 December until 1 March)
Barbara Stuttle	Director of Nursing and Quality (from 3 November)
Angela Tillett	Medical Director (from 9 March)
Melanie Whitfield	Director of Human Resources and Organisational Development (until 30 April)
Peter Wilson	Deputy Chair/Non-Executive Director until 30 September, Acting Chair 1 October until 31 March

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

When developing its plans for the coming year, the Trust took account of the impact of the NHS operating framework for England for 2015/16 and the prevailing economic and financial conditions.

In its Annual Plan for 2015/16, the Trust is identifying a programme to restore the

confidence in the Trust and to:

- improve and deliver excellent patient care and meet the performance expectations of the NHS
- transfer service from Essex County Hospital to the main Colchester General Hospital site.

The Annual Plan will be submitted to Monitor in May 2015.

Statutory Income Disclosures

Non NHS Income

Under the requirements of Section 43(2A) of the NHS Act 2006 (as amended by the Health & 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

Information to, and consultation with employees

Trust staff have access to the intranet and email which are used as rapid methods to communicate. The Trust publishes a monthly in-house magazine which is available to all staff and the public, both electronically and in hard copy. There is an established monthly briefing by the Chief Executive and other members of the Executive Team which is cascaded through the organisational management structure.

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

Where staff are affected by organisational change, for example, the transfer of a service or a significant change in working conditions, the Trust's policy on organisational change outlines the consultation process with staff and their representatives which will be applied.

Equality and diversity

The Trust is committed to a culture where those working for the Trust are valued and appreciated for the skills and talents they bring to the organisation, and where the needs of those using our services are understood and respected. The Trust is committed to treating everyone who visits or works in its services with respect and as individuals, taking into account individual differences, personal values and perspectives.

The NHS Equality Delivery Scheme2 (EDS2) is a toolkit for NHS organisations to support them in meeting the aims of the public sector duty. Following a review, the EDS has been refreshed and organisations are being asked to adapt to the EDS2. The four EDS2 goals are:

1. Better health outcomes
2. Improving patient access and experience
3. A representative and supportive workforce
4. Inclusive leadership

The chapel at Colchester General Hospital was replaced by the "Sacred Space", a new area for staff, patients and other visitors. It was set up for multi-faiths and/or a place for reflection and was completed and ready for use in the summer, but it was not officially opened by the Bishop of Colchester until October 2014.

Because of other challenges, such as the CQC inspections in 2014, the Trust has not identified equality and diversity as a priority. There is a need to re-establish the Equality and Diversity Steering Group and to re-energise the work programme for equality and diversity at all levels across the organisation. Tom Fleetwood, a non-executive director, was appointed Chair of the Equality and Diversity Steering Group which is meeting on 26 May 2015 It will update the action plan contained within the Single Equality Scheme in

line with the transfer to Equality Delivery Scheme2. The Equality and Diversity Steering Group will liaise with North East Essex CCG and other stakeholders in respect of community engagement work.

Disabled employees and equal opportunities

It can be difficult to dispense with preconceived ideas about the range or type of work disabled people can do, but it will be of mutual benefit to make sure that disabled applicants are always fully and fairly considered on their merits. All disabled applicants who meet the minimum criteria for selection will normally be invited for interview. If an employee becomes disabled, the Trust will maintain regular contact with the employee to monitor progress and at an appropriate stage consider possible courses of action and the effect any disability might have on future employment. It is important for disabled people to have equal opportunities with others to develop new skills and advance their careers. Therefore, judgement about an employee's potential to undertake more demanding work or to carry out greater responsibilities should be based on realistic assessment of their aptitudes and abilities, disregarding any preconceived ideas about the nature of the disability or the limitations imposed.

Recorded disability	2014/15	2013/14
Public members	472	503

The Electronic Staff Record (ESR) is used for storing staff payroll and other personal details. The Trust does not record staff disability on ESR.

Health and safety

The Trust has well-developed health and safety arrangements as part of its overall risk management strategy.

Health and wellbeing

The Health and Wellbeing Department continued to provide a full range of services to manage staff risks. It provided on-going support to staff experiencing both stress at work and personal stress.

Employee assistance

The employee assistance programme continued to offer a range of services to support staff and their family members on both work and private 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 members of 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 front-line staff.

Fraud and corruption

Information on policies and procedures with respect to countering 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 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.

Public consultations

From 15 October to 10 December 2014, the Trust carried out a joint public consultation with North East Essex CCG on the provision of maternity services at the community hospitals in Clacton and Harwich. In total, 233 people completed a questionnaire and an additional 16 narrative responses were received, for example, from charities, midwives, hospital consultants, GPs and unions/staff side representatives.

The outcome of the consultation was reported in February 2015 to a panel chaired by Healthwatch Essex and comprising members of a number of organisations and a service

user representative. The panel recommended to the boards of the Trust and CCG that Clacton and Harwich should remain as "on demand" midwife-led units, with antenatal and postnatal care to continue.

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 Chief Executive Dr Lucy Moore and Director of Nursing and Quality Barbara Stuttle, appeared before councillors. As well as wanting general updates about the Trust, the HOSC requested information about specific topics, including the project to transfer services off the Essex County Hospital site, maternity services, complaints handling, safeguarding and the CQC report published in January following its inspection of the Emergency Department (A&E) and Emergency Assessment Unit (EAU) in November and December.

Dr Moore also appeared once before Tendring District Council's Health and Wellbeing Board and, with Acting Chairman Peter Wilson and non-executive director Tom Fleetwood, once before Colchester Borough Council's Scrutiny Panel.

Other patient and public involvement activities

Five "patient ambassadors" were recruited to support the collection of feedback from patients and carers. These volunteers will support areas to collect the NHS friends and family test feedback. They will attend Patient Ambassador training that is provided by Healthwatch. Once they have completed this, they will support wards and divisions to collect more in-depth feedback utilising a national tool – KindaMagic.

The Trust will continue to build its relationship with Healthwatch Essex. Clinical nurse specialists have established a number of support groups for their patients, allowing them to gain peer support with specialist knowledge input if required.

As previously mentioned on page 39, the R&D Department has recruited a number of volunteer research ambassadors to support patients participating in clinical trials.

Sickness absence data

Sickness absence was 4.01%, up from 3.65% the previous year.

This is comparable with neighbouring acute hospital trusts. The aim of sickness absence monitoring is the reduction of absence levels to an acceptable minimum consistent with genuine illness. The Trust has successfully implemented more robust systems and processes to manage sickness absence at divisional and manager level with support from the Human Resources and Health and Wellbeing teams.

Staff sickness absence	2014/15	2013/14
Total WTE calendar days lost	53,282	49132
Total WTE days available		1,373,495
Total staff years lost (days lost/365)	145.98	134.61
Total staff years available	4,229	4,380
Total staff employed in period*	5143	5014
Total staff employed in period with absence*	2,628	2851
Total staff employed in period with no absence*	2,515	2,163
Average working days lost per employee	7.40	6.99

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

Annual Accounts

The accounts have been prepared under direction by Monitor in exercise of powers conferred on it by paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006. The direction requires that the keeping of accounts and the Annual Report of each NHS foundation trust shall be in the form as laid down in the annual reporting guidance for NHS foundation trusts within the NHS Foundation Trust Annual Reporting Manual that is in force for the relevant financial year.

Going concern statement

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 commencing 1 April 2015 the Trust has forecast a deficit of £30million and within this forecast is a cost improvement programme requiring £14million of efficiencies and savings. In order to fund this deficit, the Directors are seeking interim financial support for 2015/16 of at least £26m (plus a further £5.3m to May 2016) from the Department of Health through Monitor. At the time of writing, a working capital loan facility of £7.3million has been provided to the Trust and discussions are on-going 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 enquiries, 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 2014/15, 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.

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.

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.

Data loss and confidentiality breach

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.

The Trust reported 38 level 1 and 3 level 2 incidents relating to breaches of patient confidentiality, compared with 18 in 2013/14. The majority of these incidents were caused by staff not checking that they have the correct patient details when dealing with patient information.

Fixed assets

Although there is no pre-determined frequency at which property, plant and equipment (PPE) assets must be re-valued, 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 Monitor'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.

Events after the reporting period

There are no events after the reporting period.

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 on page 81 of the Remuneration Report.

NHS Foundation Trust Code of Governance

Colchester Hospital University NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The board considers that it has complied with the provisions of the NHS Foundation Trust Code of Governance with the exception of the provision that at least half the board excluding the Chair should comprise non-executive directors determined by the board to be independent (Code reference B.1.2). Following a failure to appoint to the role of Chair in October 2014, the role was filled by one of the existing NEDs, which meant that there were, from October 2014 until March 2015, five non-executive directors excluding the Chair. At the same time, there were six executive directors.

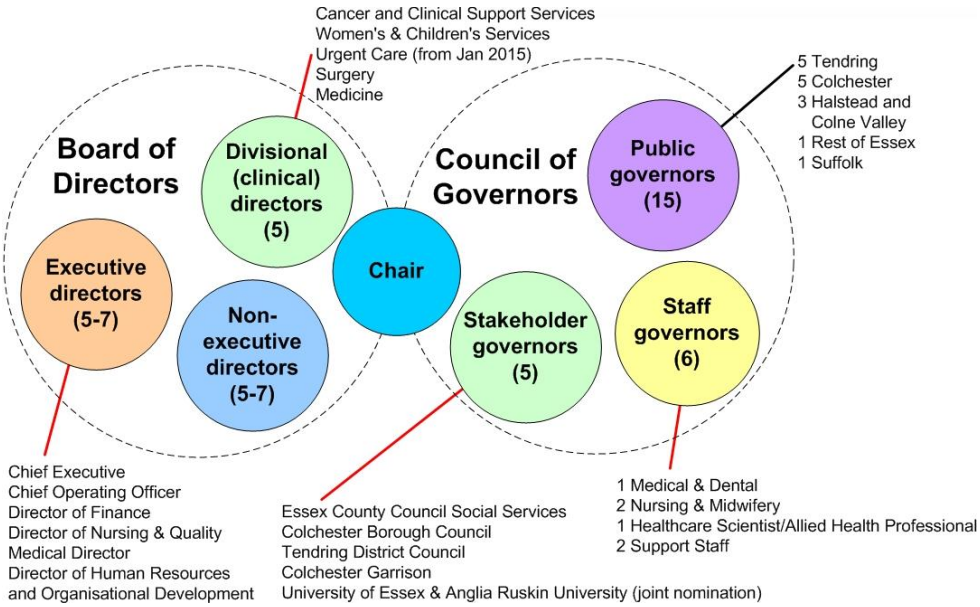
Council of Governors

Responsibility

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

Composition

The Council of Governors comprised 26 members:



Directors and Governors working together

The Council of Governors continues to provide an effective local accountability role for the Trust, ensuring that the patients, service users, staff and stakeholders of Colchester Hospital University NHS Foundation Trust 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 to 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 as follows:

- 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.

The programme of joint non-executive director and governor hospital walkabouts has continued to evolve. Individual non-executive directors and governors accompany one another on tours which give an insight into the operational issues facing the Trust. Feedback is then documented and reported in the integrated quality report to the Quality and Patient Safety Committee.

Membership Engagement

A new Council was appointed in April 2014. As the Trust's forward planning process during 2014/15 was driven by improvement notices from the regulators, there was minimal opportunity for governors to canvass the opinion of the trust's members and the public on its objectives, priorities and strategy. This has been addressed for 2015/16 with the publication of a Governor and Membership engagement strategy and the development of a work plan to ensure that appropriate public and member engagement takes place.

Committees and panels

The committees, sub-committees and joint committees established by the Council of Governors are:

(a) Council of Governor Standards Committee

(b) Appointments and Performance Committee (this was a joint committee with the Board of Directors until November 2014).

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.

The Lead Governor has 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, two individual 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 Committee.

Governors also meet regularly at the following working groups of the Council of

Governors:

- Membership Engagement Panel
- Annual Members Meeting Working Group
- Role and Effectiveness Task and Finish Group
- Patient Care and Assurance Panel.

Governors continued to be members of the At Our Best Awards judging panels and two governors took part in monthly Patient-led Assessments of the Care Environment (PLACE) inspections.

Standards Committee

The responsibilities of the Standards Committee are:

- to review annually the effectiveness and content of the governors' code of conduct and make recommendations of any required changes to the Council of Governors
- to examine any general and specific concerns about standards of conduct of elected governors, appointed governors or advisors to the Council of Governors
- to enforce the Council of Governors' code of conduct 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, Monitor guidance or guidance issued by any other regulatory authority
  - assessing allegations that governors have breached the Governors' code of conduct
- where necessary, conduct hearings and make recommendations following the process set out in the committee's terms of reference.

The committee met four times: 20 August, 23 September, 8 October, 5 November.

Members and meetings attended in brackets

Sally Irvine (1/2), Peter Wilson (2/2), David Linghorn-Baker (4/4), Barry Wheatcroft (4/4), Lynda McWilliams (4/4), Ralph Nation (3/4), Andrew May (3/4), Mark Aitken (1/1).

Appointments and Performance Committee

Until November, the Appointments and Performance Committee was a joint committee, with membership drawn from the Board of Directors and the Council of Governors. From November 2014 it became a Council of Governors committee. The committee is responsible for advising the Council of Governors on the appointment, performance and remuneration of the non-executive directors (including the Chair).

The committee met three times as a joint committee: 1 April, 5 June and 8 September. It met a further six times as a committee of the Council of Governors: 8 October, 23 October, 4 December, 22 December, 22 January, 30 March.

Non-executive director reappointments

During its time as a joint committee, it approved the reappointment of Peter Wilson and Jude Chin to second terms of office, following successful appraisals. These reappointments were subsequently approved by the Council of Governors.

Chair appointment

The committee's main priority during the year was the appointment of the Trust Chair. During its time as a joint committee, it oversaw the appointment process for the Chair during July and August. At its meeting of 8 September, the selection panel concluded that it could not recommend an appointment from the candidates who were interviewed. On reporting this recommendation to a meeting of the

Council of Governors on 9 September, the Council of Governors approved the appointment of Peter Wilson as Acting Chair and a return to the market for a new search and appointment process.

The new appointment process was launched under the remit of the committee as a committee of the Council of Governors. This took place from November and concluded in the appointment of Alan Rose at its meeting of 22 January.

Non-executive director reappointment

In its final meeting of the year, it approved the reappointment of Tom Fleetwood to a second term of office following a successful appraisal. This reappointment was subsequently approved by the Council of Governors on 12 May 2014.

Members and meetings attended in brackets

As a joint committee:

Dr Sally Irvine (3/3), Sir John Ashworth (1/1), Peter Wilson (3/3), Helen Parr (1/1), Julie Parker (2/2), Barry Wheatcroft (3/3), Andy Patrick (1/1), Lynda McWilliams (2/2), Mark Aitken (2/2), Janet Brazier (2/2), James Chung (1/2), David Linghorn-Baker (1/2), David Moore (1/2).

As a committee of the Council of Governors:

Peter Wilson (1/1), David Linghorn-Baker (5/6), James Chung (5/6), Barry Wheatcroft (4/6), Lynda McWilliams (6/6), Janet Brazier (6/6), David Moore (5/6).

Advice or services to the committee

The Trust commissioned Veredus to assist in the organisation and facilitation of the recruitment process for the Trust Chair. The appointment process that concluded in September 2014 used the services of David Edwards, former Chair of Cambridge and Peterborough NHS Foundation Trust as its external assessor, and Roger Quince, Chair of West Suffolk Hospital NHS Foundation Trust for the recruitment process that concluded in January 2015.

About the Governors

Elected public governors

Public governors: representing and elected by public members of the Trust for a period of three years, effective from 10 April 2014:

Colchester	Tendring	Halstead & Colne Valley
Janet Brazier	James Chung	Pauline Aldridge
Michael Horley	Lesley Clancy	David Gronland
Andrew May	Ken Guyton	Rosemary Hunt
Robin Rennie	David Rutson	
Elaine Smith	Barry Wheatcroft	
Rest of Essex	**Suffolk**	
David Linghorn-Baker	Mark Aitken (to 20 November)	

Elected staff governors

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

Medical & dental	Nursing & midwifery	Allied health professionals/ healthcare scientists	Support staff
Mr David Moore	Jenny Edwards Anna Swan	Andy Nash	Ralph Nation Nick Bailey

Appointed stakeholder governors

Appointed governors do not have a fixed term.

Colchester Borough Council: Cllr Annie Feltham was appointed in July 2013 (replacing Cllr Nigel Offen).

Tendring District Council: Cllr Lynda McWilliams was appointed in September 2010.

Essex County Council: Cllr Anne Brown was appointed in January 2010.

Colchester Garrison: Major Fiona Lankester was appointed in July 2013 (replacing Major Simon Rothwell).

University of Essex and Anglia Ruskin University: Professor Lesley Dobree was appointed in April 2011 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 communicate with a governor should contact the Foundation Trust Office at the address on page 6.

Council of Governors meetings

There were five formal meetings of the Council of Governors: 19 May, 24 July, 12 September, 20 November and 12 February, and one extraordinary meeting on 22 January to appoint the new Trust Chair.

Governor attendance at Council of Governors meetings

Name	Attended	Name	Attended
Mark Aitken	3/3	Peter Jackson	0/1
Pauline Aldridge	4/6	Major Fiona Lankaster	4/6
Nick Bailey	6/6	David Linghorn-Baker	6/6
Janet Brazier	6/6	Andrew May	5/6
Cllr Anne Brown	4/6	Lynda McWilliams	6/6
James Chung	4/6	David Moore	5/6
Lesley Clancy	4/6	Andy Nash	4/6
Prof Lesley Dobree	3/6	Ralph Nation	5/6
Jenny Edwards	5/6	Robin Rennie	4/6
Cllr Annie Feltham	6/6	David Rutson	3/6
David Gronland	6/6	Elaine Smith	4/6
Ken Guyton	4/6	Anna Swan	3/3
Michael Horley	6/6	Barry Wheatcroft	6/6
Rosemary Hunt	6/6		

Our Board of Directors

Board of Directors' responsibility

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 healthcare. 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 Trust'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 will involve 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 comprises 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-executives to be independent

The board comprises a Chair, six further non-executive directors and six voting executive directors. During 2014/15, the Trust had four non-voting divisional directors (see pages 66-67 for more details) and two non-voting directors who are members of the Executive Team and attend board meetings. 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 reappointments were approved by the Council of Governors. Three new non-executive directors took up appointments: Julie Parker and Diane Leacock joined on 1 April and Roger Baker on 1 September.

Disclosures of the remuneration paid to the Chair, non-executive directors and executive directors are given in the Remuneration Report (page 76).

The board is content that its balance, completeness and effectiveness meet the requirements of an NHS Foundation Trust. During 2014/15, however, it operated with one less non-executive director from 1 October until 31 March when Peter Wilson took on the role of Acting Chair following the resignation of Dr Sally Irvine.

Register of interests

All directors 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 should contact the Foundation Trust Office at the address on page 6.

About the Non-Executive Directors

Peter Wilson

Non-Executive Director/Deputy Chair (to 30 September) Acting Chair (from 1 October)

Appointed as Acting Chair: 1 October 2014

Appointed as NED: 11 May 2011

Reappointed as NED: 30 April 2014

Term of office: Peter stepped down as Acting Chair and NED on 31 March 2015

From 1 October 2014

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

Up to 30 September 2014

Trust non-executive lead for safeguarding. Chair of the Quality and Patient Safety Committee and member of the Audit and Risk Assurance Committee, and the Remuneration Committee and Appointments and Performance Committee.

Peter has extensive international experience gained from working in UK and US public companies covering a broad range of engineering and manufacturing. He is a former chief executive of Ransomes plc and following its acquisition by Textron became president of the enlarged Ransomes Jacobsen Business.

He was managing director of Crane Ltd for more than 10 years and on his retirement in December 2010 formed the PJW Partnership which provides consultancy services. He is also a director and part owner of Landguard Engineering Ltd and Harwich Supply Base Ltd and chairman of The Friends of Dedham Church.

Roger Baker

Non-Executive Director

Appointed: 1 September 2014

Term of office: Roger stepped down on 30 April 2015

Trust non-executive director lead for security; Chair of the Charitable Funds Committee; member of the Finance Assurance Committee, Audit and Risk Assurance Committee, People and Organisational Development Assurance Committee and the Remuneration Committee.

Roger, who lives in Sudbury, was Chief Constable of Essex Police for four years from July 2005 and then worked for Her Majesty's Inspectorate of Constabulary.

Jude Chin

Non-Executive Director

Appointed: 13 September 2011
Reappointed: 13 September 2014

Term of office:
Expires 12 September 2017

Chair of the Audit and Risk Assurance Committee; member of the Finance Assurance Committee, Charitable Funds Committee and the Remuneration Committee.

He 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 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 Bristol University.

Tom Fleetwood 	**Non-Executive Director** **Appointed:** 12 October 2012 **Reappointed:** 12 May 2015 **Term of office:** Expires 11 October 2018 *Trust non-executive director lead for sustainable development and fire safety; Chair of the People and Organisational Development Assurance Committee until 30 September; member of the Quality and Patient Safety Assurance Committee and its Chair from 1 October; member of the Charitable Funds Committee and the Remuneration Committee.*	His final appointment before retiring from the Army was as Commander of Colchester Garrison, his home town. As Garrison Commander he was responsible for the Colchester Garrison PFI scheme and facilities management, training, and the support and welfare of all the soldiers and their dependants in the Garrison area. His previous experience included responsibility as the Chief of Staff for one of the three regional Army Divisions in the UK as well as significant operational deployments working with NATO, the United States and the United Nations. He lives in West Mersea.
Diane Leacock 	**Non-Executive Director/Senior Independent Director** **Appointed:** 1 April 2014 **Term of office:** Expires 31 March 2017 *Trust non-executive director lead for safeguarding and children. Chair of the People & Organisational Development Assurance Committee from 1 October 2014 and member of the Audit & Risk Assurance Committee, Charitable Funds Committee and Remuneration Committee.*	Diane, who lives in Colchester, served as a non-executive director at NHS North East Essex from July 2009 to November 2011, and is a Fellow of the Association of Chartered Certified Accountants. She has considerable experience in senior finance roles within commercial organisations, most recently as Finance Director within the professional services and publishing fields. In addition, Diane has been a school governor for over 10 years, currently serving as Vice Chair of the Board of Governors of a local school.
Julie Parker 	**Non-Executive Director** **Appointed:** 1 April 2014 **Term of office:** Expires 31 March 2017 *Trust non-executive director lead for e-Procurement. Chair of Finance Assurance Committee. Member of Quality and Patient Safety Assurance Committee, Charitable Funds Committee and Remuneration Committee.*	Julie, who has lived all her life in the area served by the Trust, is an accountant by qualification. 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 & Care Professions Council and the Housing Ombudsman).
Dr Sally Irvine	**Chair** **Appointed:** 1 August 2010 **Reappointed:** 1 August 2013	Sally left the Trust on 30 September 2014
Helen Parr	**Non-Executive Director/Deputy Chair** **Appointed:** 1 December 2006 (appointed originally to Essex Rivers Healthcare NHS Trust) Reappointed 1 December 2010 Reappointed 1 December 2013	Helen left the Trust 31 July 2014

About the Executive Directors

Dr Lucy Moore

Chief Executive

Appointed Board Director

27 May 2014

Term of office: Interim

Trust Accounting Officer. Responsible for corporate strategy, external relations, transformation plan, regulation and compliance, leadership.

A doctor by training, Lucy has worked in public health, workforce development and education and has a track record and reputation of achieving significant and transformational change in difficult and complex circumstances.

Between November 2004 and September 2012, she was chief executive of Whipps Cross University Hospital Trust in East London.

Since then, she has worked with a range of acute trusts. In the first five months of 2014, she worked for the Trust by supporting the Medical Director and the four Divisional Directors.

Shane Gordon

Chief Operating Officer

Appointed Board Director

2 March 2015

Term of office: Permanent

Notice period:
Trust: six months
Employee: three months

Responsible for operational management, performance standards, financial and people management across all clinical services, emergency planning and business continuity, elective and emergency care standards, site teams, health records and clinical coding.

Shane has been a GP in Essex since 2002 and was Clinical Chief Officer of North East Essex Clinical Commissioning Group (CCG). He is vice-chairman of the East of England Clinical Senate. 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.

Lynn Lane

Director of Human Resources and Organisational Development

Appointed Board Director

7 May 2014

Term of office: Permanent

Notice period:
Trust: six months
Employee: three months

Oversees all aspects of the Trust's workforce, including leadership and management development, education, training and development, welfare and wellbeing, pay and reward, employee engagement, employee relations, workforce planning and corporate affairs.

An HR professional with over 25 years' experience in the public sector, Lynn previously held the position of interim Director of Workforce and Organisational Development at Royal Berkshire NHS Foundation Trust and spent seven years as Director of Human Resources at Royal Devon and Exeter NHS Foundation Trust.

Before joining the NHS in 2005, Lynn worked for the BBC in a number of senior HR executive positions.

About the Executive Directors

Dr Angela Tillett

Medical Director and Deputy Chief Executive

Appointed Medical Director
9 March 2015

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

Trust lead for quality and patient safety. Responsible for clinical strategy, Cancer Services Retrospective Review, medical workforce, medical appraisal and revalidation, job planning, clinical effectiveness and clinical audit, Caldicott Guardian, research, medical education, cancer action plan, relationships with primary care and other acute trusts.

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 - 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 Divisional Director role for Surgery, she continued 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

Responsible for finance, IT procurement, marketing/contracting, capital, estates, facilities, commissioning and charitable funds

With a reputation for problem solving and a track record of delivering effective Turnaround, Dawn joins the Trust with over 18 years NHS experience.

She is a Fellow of the Association of Chartered Certified Accountants and has significant senior NHS experience, including as Director of Finance and Deputy Chief Executive in her previous roles at the Essex Area Team (2013-2015) and in South Essex (2010-2013).

Barbara Stuttle

Director of Nursing and Quality

Appointed
3 November 2014

Term of office:
Permanent from 1 May 2015

Notice period:
Trust: six months
Employee: three months

Executive lead for risk, health and safety, child protection and infection control. Professional nursing adviser to the Board of Directors.

Responsible for nursing strategy and nurse management, clinical governance and quality improvement, integrated governance, complaints and litigation

Barbara has a nursing background spanning over 43 years working in the acute sector, community and primary care services. Before joining the Trust in November 2014, she was the Deputy Chief Executive/Chief Nurse at NHS South West Essex.

Barbara was awarded the CBE (Commander of the British Empire) by the Queen in October 2004 for her services to the NHS.

About the Executive Directors

Evelyn Barker	**Chief Operating Officer** **Appointed Board Director:** 13 January 2014	**Term of office:** Interim Evelyn stepped down on 19 December
Kathy French	**Acting Director of Nursing and Patient Safety** **Appointed Board Director:** 8 October until 30 October	**Term of office:** Temporary acting up arrangement
Dee Hackett	**Director of Nursing and Patient Experience** **Appointed Board Director:** 18 November 2013	**Term of office:** Permanent Dee stepped down on 7 October
Amanda Hallums	**Divisional Director, Women's and Children's Services** **Appointed Board Director:** January 2014	Amanda stepped down on 5 December
Kim Hodgson	**Chief Executive** **Appointed Board Director:** 13 January 2014	**Term of office:** Interim Kim stepped down on 22 May
Andy Lehain	**Acting Director of Finance** **Appointed Board Director:** 17 July 2014 until 30 September 2014	**Term of office:** Temporary acting up arrangement
Dr Sean MacDonnell	**Medical Director and Deputy Chief Executive** **Appointed Medical Director** 31 October 2011 **Appointed Deputy Chief Executive** 14 February 2014	**Term of office**: Permanent Sean stepped down on 8 March
Andy Morris	**Director of Finance** **Appointed Board Director:** 1 October	**Term of office:** Interim Andy stepped down on 1 February
Ian O'Connor	**Director of Finance** **Appointed Board Director:** 3 February 2014	**Term of office:** Interim Ian stepped down on 16 July
Sandy Spencer	**Chief Operating Officer** **Appointed Board Director:** 19 December	**Term of office:** Interim Sandy stepped down on 1 March
Melanie Whitfield	**Director of Human Resources and Organisational Development** **Appointed Board Director:** 6 January 2014	**Term of office:** Permanent Melanie stepped down on 30 April

About the Divisional Directors

Dr Charles Bodmer

Divisional Director Medicine

Appointed Divisional Director: December 2013

Charles trained in Liverpool and Cambridge. He was appointed as Consultant Physician and Diabetologist in north east Essex in 1996. He was the first specialty trained diabetologist in the district and was the clinical lead for diabetes until his appointment as Divisional Director. He has also been Clinical Director for General Medicine, Chair of the Medical Staff Committee and Local Negotiating Committee and chaired the District Diabetes Network. He continues with some of his specialty clinical work in endocrinology and diabetes.

Miss Jo Osborne

Divisional Director Women & Children's

Appointed Divisional Director: March 2015

Jo qualified from St Mary's Hospital Medical School, London, in 1990. She trained in Obstetrics and Gynaecology in London and Essex, completing her training at Colchester in 2001. She was appointed Consultant Obstetrician and Gynaecologist at Colchester in 2002. Jo has special interests in colposcopy, vulval disorders and HIV in pregnancy. She held the position of RCOG College Tutor from 2001 to 2006. Jo has been Lead Colposcopist at Colchester since 2002 and was appointed to the East of England Regional Colposcopy Quality Assurance (QA) team in 2006 where she was the QA Lead Colposcopist until 2012. She became Clinical Lead in Obstetrics and Gynaecology in 2012 and held this position until taking up the role of Divisional Clinical Director for Women's and Children's Services in April 2015. Jo completed an NHS Senior Leadership Modular training programme in May 2014. She continues her clinical work in Obstetrics and Gynaecology alongside her role as Divisional Clinical Director.

Mr Chris Backhouse

Divisional Director Surgery

Appointed Divisional Director: March 2015

Chris trained at Charing Cross Hospital qualifying in 1976. Having obtained the FRCS he returned to Charing Cross as a registrar then Lecturer in Surgery before a Senior Registrar rotation in the West Midlands. He was appointed Consultant General and Vascular Surgeon in Colchester in 1992. He has held various positions over the years including Surgical Tutor, chairman of Theatre Management Group, Vascular Lead Clinician and Associate Clinical Director in surgery, before his appointment as Divisional Director. He continues his clinical role as a Vascular and Endocrine surgeon.

Dr Gillian Urwin

Divisional Director Cancer and Clinical Support Services

Appointed Divisional Director: December 2013

Gillian trained in medicine at St Thomas' Hospital Medical School and qualified in 1986. She undertook her microbiology training at the Royal London Hospital and was appointed as a consultant microbiologist in Colchester in 1997. She is a member of the Infection Control Team and the lead for antimicrobial prescribing. Gillian acted as Associate Medical Director of Patient Safety for four years. After six months as interim Divisional Clinical Director, she was appointed to the substantive post of Divisional Director for Cancer and Clinical Support Services. She continues to work as a Consultant Microbiologist while she is the Divisional Director.

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.

Evaluation of the Board of Directors' performance

The Board of Directors' meetings

The Board of Directors met monthly.

There were 12 general meetings of the Board, 11 of which were held in public (each with a private session to discuss confidential matters): 10 April, 15 May, 12 June, 17 July, 14 August (private only), 17 September, 16 October, 13 November, 11 December, 29 January, 26 February, 26 March.

There were two extraordinary meetings of the Board, which were held in private: 25 September and 12 February.

Board of Directors' meeting attendance

Name	Title	Attended
Roger Baker	Non-Executive Director (from 1 September)	9/9
Evelyn Barker	Chief Operating Officer (until 19 December)	8/10
Jude Chin	Non-Executive Director	12/14
Tom Fleetwood	Non-Executive Director	13/14
Kathy French	Acting Director of Nursing and Patient Experience (from 8 October until 4 November)	1/1
Shane Gordon	Chief Operating Officer (from 2 March)	1/1
Dee Hackett	Director of Nursing and Patient Experience (until 7 October)	6/7
Kim Hodgson	Chief Executive (until 22 May)	2/2
Dr Sally Irvine	Chair (until 30 September)	7/7
Lynn Lane	Director of Human Resources and Organisational Development (from 7 May)	12/13
Diane Leacock	Non-Executive Director	12/14
Andy Lehain	Acting Director of Finance (17 July until 30 September)	1/2
Dr Sean MacDonnell	Medical Director (until 8 March)	12/13
Dr Lucy Moore	Chief Executive (from 27 May)	10/12
Andy Morris	Director of Finance (1 October 2014 to 1 February 2015)	4/4
Ian O'Connor	Director of Finance (until 16 July)	3/3
Julie Parker	Non-Executive Director	11/14
Helen Parr	Non-Executive Director (until 31 July 2014)	2/4
Dawn Scrafield	Director of Finance (from 2 February)	3/3
Sandy Spencer	Chief Operating Officer (20 December to 1 March)	1/3
Barbara Stuttle	Director of Nursing and Quality (from 3 November)	5/6
Angela Tillett	Medical Director (from 9 March)	1/1
Melanie Whitfield	Director of Human Resources and Organisational Development (until 30 April)	0/1
Peter Wilson	Deputy Chair/Non-Executive Director (until 30 September), Acting Chair (from 1 October to 31 March)	12/14

The Board of Directors' meetings

Board members also attended the Annual Members Meeting on 12 September, formal meetings of the Council of Governors (either as observers or to present reports) and workshops with the Council of Governors. These took place on 19 May, 24 July, 12 September, 20 November, 22 January and 12 February. Attendance at these workshops is not included in the table on the previous page.

Clinical Leaders

The Trust had in place a divisional structure with four divisional directors. This was later increased to five divisions (a fifth division for Urgent Care was established in January following the CQC inspection report into A&E and EAU but a Divisional

Director was not appointed until April 2015). Divisional directors are responsible for the delivery of all clinical services and performance in their division, as part of the Trust's strategy to become a predominantly clinically-led organisation. These roles are full members of the Executive Team and non-voting board members.

Board of Directors' meetings attended

Name	Title	Attended
Dr Charles Bodmer	Divisional Director – Medicine	6/12
Amanda Hallums	Divisional Director – Women & Children's (to 5 December)	7/8
Dr Angela Tillett	Divisional Director – Surgery (to 8 March)	8/11
Dr Gillian Urwin	Divisional Director – Cancer and Clinical Support Services	11/12
Dr Jo Osborne	Divisional Director – Women and Children's (from 25 March)	0/1
Mr Chris Backhouse	Divisional Director – Surgery (from 25 March)	1/1

Board development

The Board took part in one development session in a board workshop in November. This was facilitated internally by the Company Secretary and Assistant Director of Governance and Risk and covered Risk Management, the Board Assurance Framework and led to the development of the Trust's Risk Appetite Statement.

On-going development

The Chair holds team and one-to-one meetings with the non-executive directors and the Chief Executive and has frequent individual meetings with executive directors.

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 & 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 & Performance Committee. See details on page 56.

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 Committee on the process and outcome of the appraisals.

Board and committee effectiveness

The Board carries out periodic evaluation of its own effectiveness with an independent external review at least once every three years. The last independent evaluation of the board's effectiveness took place in September 2012, undertaken by the Foresight Partnership.

During 2014/15, the Board committees reviewed their terms of reference and will undertake an annual review of their effectiveness going forward.

Governance arrangements

Further review and development of the Trust's governance arrangements took place during 2014/15, with a view to strengthening assurance and escalation from the front-line to the Board of Directors and communication and accountability arrangements from the board back to the front-line. During the year, the board approved an assurance and escalation framework, undertook a root and branch review of its board assurance framework and established an executive committee structure reporting to the Executive Team with a strengthened focus on risk, clinical governance and transformation through the establishment of the following:

- a Risk Management Team comprising the Executive Team, Associate Directors of Operations and Associate Directors of Nursing, which meets monthly to review divisional, corporate and strategic risks
- a Transformation Board with responsibility for driving the delivery of Cost Improvement Programme workstreams
- a Clinical Governance Group, replacing the Clinical Quality Review Board, to oversee the processes and outcomes for delivering patient safety and quality throughout the Trust. Jointly chaired by the Director of Nursing and Medical Director, this group meets monthly and reports to the Executive Team where escalation of action is required and provides assurance to the Quality and Patient Safety Assurance Committee
- a clear line of reporting to the Executive Team and the board through a revised executive and committee structure.

Other arrangements have included a divisional board structure, where each division meets monthly to oversee the business of the division – focusing on ensuring the delivery of the corporate objectives. These meetings are chaired by the divisional directors. Core members include the associate directors of operations and nursing and human resource and finance business partners. The divisions also have a governance committee which focuses on the quality and safety agenda and provides assurance to both the divisional board and the Quality and Patient Safety Assurance Committee.

The Executive continues to formally review the performance of the clinical divisions and corporate directorates through monthly performance reviews chaired by the Chief Executive with appropriate Executive Team membership in attendance. Operational and financial performance and high risk issues highlighted at these meetings are reported to the Finance Assurance Committee.

Service lines hold monthly business meetings – chaired by the clinical lead with membership which includes the service manager and head of nursing. The agenda covers safety, quality, operational and financial performance and review of the risk register.

The board operated with six main committees throughout 2014/15. Chaired by a non-executive director, these meetings take place on a regular basis, based on an agreed business cycle, and report to the Board of Directors. With the exception of the Remuneration Committee, governors have been assigned as observers to these committees and provide their feedback to the Council of Governors on their effectiveness.

The Appointments and Performance Committee, previously a joint committee of the Board of Directors and Council of Governors, was changed into a committee of the Council of Governors from November 2014 to reflect that its core duties, the appointment of a Chair and non-executive directors, are matters for the Council of Governors to decide, not the Board of Directors.

The committees of the Trust Board are:

- Audit and Risk Assurance Committee
- Quality and Patient Safety Assurance Committee

- Finance Assurance Committee
- People and Organisational Development Assurance Committee
- Charitable Funds Committee
- Remuneration 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 that 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 and management's responses to its work.

The Audit and Risk Assurance Committee held five meetings: 9 May, 28 May, 31 July, 30 October, 6 February.

Members and meetings attended in brackets

Jude Chin, Committee Chair (5/5), Diane Leacock (5/5), Roger Baker (2/2), Helen Parr (0/2), Peter Wilson (1/3).

Executive directors in attendance: Ian O'Connor (up to June), Andy Morris (up to January), Dawn Scrafield (from February), Dr Lucy Moore, Lynn Lane, Barbara Stuttle (from November).

Internal auditors

In February, the Audit and Risk Assurance Committee approved the reappointment of Mazars Public Sector Internal Audit Ltd. Its role is to provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively.

External auditors

In March 2011 the Council of Governors approved the appointment of Grant Thornton UK LLP for a period of three years from 1 April 2012. The Council of Governors agreed a two year extension to that contract in May 2015 following a recommendation by the Audit Committee on the basis of the quality of the service they provide and a benchmarking of their costs.

The responsibility of the Trust's external auditors is to independently audit the financial statements and the part of the remuneration report to be audited in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

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 is 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 quality key 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 Care Quality Commission's Essential Standards of Safety and Quality

- monitor and review the systems and processes in place in 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 10 meetings: 29 April, 5 June, 30 June, 26 August, 29 September, 28 October, 24 November, 28 January, 23 February, 20 March.

Members and meetings attended in brackets

Peter Wilson, Committee Chair until 30 September (9/10), Tom Fleetwood, Committee Chair from 1 October (9/10), Julie Parker (10/10).

Executive directors in attendance: Kim Hodgson (up to May), Dr Lucy Moore (from late May), Evelyn Barker (up to December), Dee Hackett (up to September), Barbara Stuttle (from November), Dr Sean MacDonnell.

Finance Assurance Committee

This committee's remit is to:

- oversee the development and implementation of the Trust's financial and performance strategy to deliver the service objectives as set out in the Forward Plan and to ensure delivery of financial and performance targets

- monitor delivery of the Trust's Cost Improvement Programme and the development of efficiency and productivity processes

- oversee the investment and borrowing strategy and policy, reviewing performance against treasury management benchmarks and targets and ensuring compliance with Trust policies and procedures in respect of limits, approved counterparties and types of investment

- receive monthly reports on financial and operational performance, including Cost Improvement Programmes, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and undertaking "deep dives" as appropriate

- under direction from the board, oversee and scrutinise the investment appraisal of business cases and wider business development opportunities

- oversee the contracting and planning mechanisms in place with commissioners of healthcare to agree annual or longer term contracts as may be appropriate, seeking to ensure that any financial or operational risks arising from those contracts are identified and mitigated as appropriate
- oversee the rolling capital programme, including scrutiny of the prioritisation process, and monitor its delivery
- advise the board of key strategic risks relating to financial and operational performance and consider plans for mitigation as appropriate.

The Finance Assurance Committee held 14 meetings: 1 April, 29 April, 22 May, 19 June, 25 June, 22 July, 21 August, 23 September, 23 October, 25 November, 18 December, 21 January, 18 February, 18 March.

Members and meetings attended in brackets

Julie Parker, Committee Chair (12/13), Helen Parr (3/6), Peter Wilson (6/6), Jude Chin (10/14), Roger Baker (3/7).

Executive directors in attendance: Kim Hodgson (up to 22 May), Dr Lucy Moore (from 28 May), Ian O'Connor (up to June), Andy Morris (from October), Evelyn Barker (up to December), Sandy Spencer (from December), Dawn Scrafield (from February) and Shane Gordon (from March).

People and Organisational Development Assurance Committee

This committee's main duties are to ensure:

- oversee the Trust's strategy and plans on workforce issues, including the efficient deployment of staffing to meet services 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 their 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.

Members and meetings attended in brackets

The People and Organisational Development Assurance Committee met seven

	times: 25 April, 23 May, 20 June, 3 September, 6 November, 14 January, 4 March. Tom Fleetwood, Committee Chair to 30 September (7/7), Diane Leacock, Committee Chair from 1 October (6/7), Helen Parr (3/3), Roger Baker (3/3). Executive directors in attendance: Kim Hodgson (up to April), Dr Lucy Moore (from May), Melanie Whitfield (up to April), Lynn Lane (from May), Dr Sean MacDonnell, Dee Hackett (up to September), Barbara Stuttle (from November).
Board of Directors and Council of Governors Appointments & Performance Committee	Until November, the Appointments and Performance Committee was a joint committee, with membership drawn from the Board of Directors and the Council of Governors. It then became a Council of Governors committee. It fulfils the role of a nominations committee in respect of Chair and non-executive director appointments. The report of this committee is provided in the Council of Governors' section on page 56.
Charitable Funds 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 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. Two formal meetings of the committee were held during the year: 21 November, 27 March.
Members and meetings attended in brackets	Roger Baker (Chair) (2/2), Julie Parker (2/2). Executive directors in attendance: Andy Morris and Dawn Scrafield. The committee Chair also invited two nominated governors to attend.
Remuneration Committee	The Remuneration 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 the executive directors. It is also responsible for the approval of their remuneration and terms of service and the monitoring of their performance against delivery of organisational objectives. The Trust Chair is the chair of the committee and the membership comprises all the non-executive directors. The Chief Executive, Director of Human Resources and Organisational Development and the Company Secretary are routinely invited to attend these meetings except when their own terms and conditions are under discussion. An appointments panel of the Remuneration 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 Committee held seven meetings: 22 May, 28 May, 5 August, 3 October, 10 November, 29 January, 9 February. Appointments panels were convened to appoint to the posts of interim Chief Executive, Director of Human Resources and Organisational Development, Director of Finance, Chief Operating Officer and Medical Director.
Members and meetings attended in brackets	Dr Sally Irvine, Committee Chair until 30 September (3/3), Peter Wilson, Committee Chair from 1 October (7/7), Helen Parr (0/2), Jude Chin (7/7), Tom Fleetwood (6/7), Julie Parker (6/7), Diane Leacock (5/7), Roger Baker (4/4)
Advice or services to the committee	The Trust commissioned Veredus to assist in the organisation and facilitation of the recruitment process for the Chief Executive, Director of Finance, Chief Operating Officer. The total fee paid to Veredus for this support and for the recruitment of the Trust Chair (see page 58) was £94,764.07.

Remuneration Report (unaudited)

Introduction and Purpose

The purpose of the remuneration report is to provide a statement to stakeholders on the decisions of the remuneration committee relating to 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 Committee

During 2014/15, new appointments were made to the roles of Director of HR and OD, Director of Finance, Director of Nursing, Chief Operating Officer and Medical Director.

Decisions on their remuneration were based on available benchmarking information from the Foundation Trust Network 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.

There are no components within the remuneration relating to performance measures, bonuses or benefits in kind.

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.

Senior Managers' Remuneration Policy

Remuneration and performance conditions

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 Committee (see page 74) reviewed benchmarked data provided via an independent review process and determined that no pay awards would be approved with effect from April 2013.

A further review of benchmark data is planned for May 2015.

The remuneration of the Chair and non-executive directors is decided by the Council of Governors following advice from its Appointments & Performance Committee. To determine the remuneration, that committee uses the data from annual survey undertaken by the NHS Foundation Trust Network (now 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 Committee uses mainly the data from the annual survey undertaken by the Foundation Trust Network (now NHS Providers), 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 Committee's discussion of executive salaries and the Appointments and Performance Committee's discussion of non-executive 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 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 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 (from page 62). With the exception of the medical director, executive directors are appointed to substantive contracts. During 2014/15, interim appointments to the Board were made to cover the roles of Chief Executive, Director of Finance and Chief Operating Officer.

Remuneration Committee

Details on the workings of the Remuneration Committee are provided on page 74.

The Remuneration Committee has a clear policy on the remuneration ranges for every executive director position. Any decisions that fall outside the parameters of the policy eg. due to exceptional circumstances, are subject to further discussion and approval by the committee.

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 Committee,

Median salary as a multiple of highest paid director salary

The Trust is required to disclose the ratio of the highest paid senior manager to the median remuneration of the Trust staff. This disclosure is based on the requirement to annualise the data requirements of whether this applies to the actual arrangements for the post holder. The figure below is therefore higher than the actual remuneration shown in the tables on pages 80-82.

The median salary paid in the Trust is £21,692. This figure includes agency costs which cannot be separately identified.

The annualised pay for the highest paid officer for 2014/15 is £418,000 which is a multiple of 19.27 times 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 of the NHS Foundation Trust. Detailed on page 80 are the remuneration, salary and pension entitlements of the Board of Directors. These disclosures have been audited.

Review of Tax Arrangements of Public Sector Appointees

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.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than six months	
Number of existing engagements as of 31 March 2015	31*
Number that have existed for less than one year at time of reporting	26**
Number that have existed for between one and two years at time of reporting	3
Number that have existed for between two and three years at time of reporting	2
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

* 18 of the 31 are employed by recruitment agencies – including expressed obligation on agency to attest for tax and National Insurance (NI) obligations

** 16 less than six months

Note: Of the 31 off-payroll arrangements in place as at 31 March 2015, 18 are via recruitment agencies and formal contractual arrangements are in place which require the agency to confirm that NI and tax obligations are met. Eight new off payroll arrangements exceeded six months' duration.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, 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 2014 and 31 March 2015	35
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	35
Number for whom assurance has been requested	11*
Of which:	
Number for whom assurance has been received	6
Number for whom assurance has not been received	5
Number that have been terminated as a result of assurance not being received	0

* Reflects individuals who are contracting directly with the Trust and who have been in post for six months or more. It excludes individuals sourced through an agency (NHS Procurement contracts require agencies to seek assurance as to individuals' tax obligations) and individuals who have not yet been in post for six months.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	8
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	16

Details of the exceptional circumstances that led to each of these engagements

As a Trust subject to enforcement action by Monitor and the CQC, the explanation for the number of board members appointed on an off-payroll basis is twofold. Firstly, for most of the year, the Trust was in a position that required it to have a leadership team with a track record of delivering effective improvement strategies in the immediate term. These appointments are more commonly sourced on an interim basis. Secondly, the Trust's position with the regulators made it more difficult to appoint substantively to these roles, resulting in the extension of existing interim contracts or new interim appointments being made following a failure to appoint.

Details of the length of time each of these exceptional engagements lasted

Kim Hodgson – Chief Executive (13 January 2014 to 22 May 2014)

Lucy Moore – Chief Executive (27 May 2014 to 31 March 2015)

Barbara Stuttle – Director of Nursing (3 November 2014 to 31 March 2015)

Ian O'Connor – Director of Finance (3 February 2014 to 16 July 2014)

Andy Morris – Director of Finance (1 October to 1 February 2015)

Evelyn Barker – Chief Operating Officer (13 January 2014 to 18 December 2014)

Sandy Spencer – Chief Operating Officer (19 December 2014 to 1 March 2015)

Lynn Lane – Director of Human Resources and Organisational Development (7 May 2014 to 30 October 2014)

Information on the expenses of directors is required by the Health and Social Care Act 2012

The Trust had a total of 16 directors eligible to claim expenses during 2014/15. (The figure for 2013/14 was also 16)

Year	Number of Directors claiming expenses	Total claimed £
2013/14	11	13,106.60
2014/15	6	7,040.02

Information on the expenses of governors is required by the Health and Social Care Act 2012

The Trust had a total of 27 governors eligible to claim expenses during 2014/15. (The figure for 2013/14 was also 27)

Year	Number of Governors claiming expenses	Total claimed £
2013/14	8	2,347.40
2014/15	11	2,364.84

Signed

Dr Lucy Moore

Chief Executive

Salary and Pension Entitlements of Senior Managers (audited)

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")
- Elements of the NHS Foundation Trust Code of Governance.

		2014/15				2013/14			
Name	**Title**	**Salary & Fees** (bands of £5,000) £000	**Taxable Benefits** (taxable) total to nearest £100 £00	**All Pension Related Benefits** (bands of £2,500) £000	**Total** (bands of £5,000) £000	**Salary** (bands of £5,000) £000	**Expense Payments** (taxable) total to nearest £100 £00	**All Pension Related Benefits** (bands of £2,500) £000	**Total** (bands of £5,000) £000
Baker, R from 1 September 2014	Non-Executive Director	5 – 10	-	-	5 – 10	-	-	-	-
Barker, E[1] to 19 December 2014	Interim Chief Operating Officer	300 – 305	-	-	300 – 305	95 – 100	-	-	95 – 100
Chin, J	Non-Executive Director	10 – 15	-	-	10 – 15	10 – 15	-	-	10 – 15
Fleetwood, T	Non-Executive Director	10 – 15	-	-	10 – 15	10 – 15	-	-	10 – 15
French, K from 8 October 2014 to 2 November 2014 (prior year 23 April to 17 November)	Acting Director of Nursing and Patient Experience	5 – 10	-	-	5 – 10	60 – 65	100	207.5 – 210	270 – 275
Gordon, S from 2 March 2015	Chief Operating Officer/Deputy Chief Executive	10 – 15	-	42.5 – 45	55 – 60	-	-	-	-
Hackett, D to 7 October 2014	Director of Nursing and Patient Experience	55 – 60	-	105 – 107.5	160 – 165	40 – 45	-	217.5 – 220	255 – 260
Hodgson, K[2] to 22 May 2014	Interim Chief Executive	55 – 60	-	-	55 – 60	90 – 95	-	-	90 – 95

Irvine, S to 30 September 2014	Chair	15 – 20	-	-	15 – 20	35 – 40	-	-	35 – 40
Lane, L[3] Interim from 7 May 2014 to 31 October 2014 Permanent from 1 November 2014	Director of Human Resources and Organisational Development	210 – 215	-	82.5 – 85	295 – 300	-	-	-	-
Leacock, D from 1 April 2014	Non-Executive Director	10 – 15	-	-	10 –15	-	-	-	-
Lehain, A from 17 July 2014 to 30 September 2014	Acting Director of Finance	20 – 25	-	35 – 37.5	55 – 60	-	-	-	-
MacDonnell, S to 8 March 2015	Medical Director/Deputy Chief Executive	145 – 150	-	65 – 67.5	210 – 215	120 – 125	-	27.5 – 30	150 – 155
Moore, L[4] from 27 May 2014	Interim Chief Executive	285 – 290	-	-	285 – 290	-	-	-	-
Morris, A[5] from 1 October 2014 to 1 February 2015	Interim Director of Finance	105 – 110	-	-	105 – 110	-	-	-	-
O'Connor, I[6] to 16 July 2014	Interim Director of Finance	85 – 90	-	-	85 – 90	50 – 55	-	-	50 – 55
Parker, J from 1 April 2014	Non-Executive Director	10 – 15	-	-	10 – 15	-	-	-	-
Parr, H to 31 July 2014	Non-Executive Director	0 – 5	-	-	0 – 5	10 – 15	-	-	10 – 15
Spencer, S[7] from 20 December 2014 to 1 March 2015	Interim Chief Operating Officer	70 – 75	-	-	70 – 75	-	-	-	-
Stuttle, B[8] from 3 Nov 2014	Director of Nursing and Quality	110 – 115	-	-	110 – 115	-	-	-	-
Scrafield, D from 2 February 2015	Director of Finance	20 – 25	-	15 – 17.5	35 – 40	-	-	-	-
Tillett, A[9] from 9 March 2015	Medical Director	5 – 10	-	7.5 – 10	15 – 20	-	-	-	-
Whitfield, M to 30 April 2014	Director of Human Resources and Organisational Development	10 – 15	-	5 – 7.5	15 – 20	25 – 30	-	7.5 – 10	35 – 40
Wilson, P to 30 September 2014 from 1 October 2014	Non-Executive Director Acting Chair	25 – 30	-	-	25 – 30	10 – 15	-	-	10 – 15

1. E Barker, the amount disclosed represents payments in 2014/15 (including VAT) to Alium Partners Ltd for her services.

2. K Hodgson, the amount disclosed represents payments in 2014/15 (including VAT) to Morgan Law Partners LLP for her services.

3. L Lane, the amount disclosed for the period of 7 May 2014 to 31 October 2014 represents payments in 2014/15 (including VAT) of £154,623.60 to Morgan Law Partners LLP for her services.

4. L Moore, the amount disclosed represents payments in 2014/15 (including VAT) to Lucy Moore Health Care Consulting Limited for her services.

5. A Morris, the amount disclosed represents payments in 2014/15 (including VAT) to Integrity Addition Consulting Ltd for his services.

6. I O'Connor, the amount disclosed represents payments in 2014/15 (including VAT) to Morgan Law Partners LLP for his services.

7. S Spencer, the amount disclosed represents payments in 2014/15 (including VAT) to Spencers Associates Limited for her services.

8. B Stuttle, the amount disclosed represents payments in 2014/15 (including VAT) to BS Enterprise Ltd for her services.

9. A Tillett receives a salary for her role as Medical Director. Additional salary for working as a medical consultant from 9th March2015 – 31st March 2015 is not shown in the Remuneration Report.

Pension Benefits

Name	Real increase in pension at age 60* (bands of £2,500) £000	Lump sum at age 60 related to real increase in pension* (bands of £2,500) £000	Total accrued pension at 31 March 2015* (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015* (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2014* £000	Cash equivalent transfer value at 31 March 2015* £000	Real increase in cash equivalent transfer value* £000
Gordon, S	0 – 2.5	0 – 2.5	10 – 15	40 – 45	162	199	3
Hackett, D	0 – 2.5	5 – 7.5	35 – 40	110 – 115	607	732	56
Lane, L	0 – 2.5	2.5 – 5	15 – 20	50 – 55	249	327	29
Lehain, A	0 – 2.5	0 – 2.5	35 – 40	110 – 115	598	659	9
MacDonnell, S	2.5 – 5	7.5 – 10	50 – 55	155 – 160	862	963	73
Scrafield, D	0 – 2.5	0 – 2.5	25 – 30	80 – 85	322	350	3
Tillett, A	0 – 2.5	0 – 2.5	35 – 40	110 – 115	646	690	2
Whitfield, M	0 – 2.5	0 – 2.5	0 – 5	0 – 5	5	10	0

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

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 Cash Equivalent Transfer Values
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.

Key management compensation can be found in note 4.3 of the accounts.

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 Monitor.

Under the NHS Act 2006, Monitor has directed Colchester Hospital University NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. 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 NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 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 her 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, the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum have been properly discharged.

Signed

Dr Lucy Moore
Chief Executive

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 only provide 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 2015 and up to the date of approval of the Annual Report and Annual Accounts.
Capacity to handle risk	As Chief Executive, I have overall responsibility for risk management within the Trust, for meeting all statutory requirements and adhering to the guidance issued by Monitor and the Department of Health in respect of governance. The Executive Team, which I chair, has established a Risk Management Group, 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. 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 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 Risk Management Group, 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 Risk Management Group 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.
	Historically all staff members have been 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 that they have the necessary skills and knowledge and are competent to identify, control and manage risk within their

work environment. All newly-appointed staff have received training at the compulsory corporate induction day. This included their personal responsibilities as well as the necessary information and training to enable them to work safely and 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 Board Assurance Framework (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 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 BAF which keeps the board informed of the key strategic risks affecting the Trust. The BAF was reviewed in 2014/15 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. As a result of this review, there is now greater clarity over risk ownership, which assurance committee oversees each risk and the Trust's risk priorities. 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. As a Trust currently in special measures with its regulators, the Trust board has taken a cautious view of regarding the risks that it is prepared to take in terms of risks to quality, patient safety and financial control, expressing a preference for safe delivery options that have a low degree of risk and which may only have a limited potential for reward. The board understands that there is a balance to be maintained between key risk areas and that sometimes risks in some areas will need to be taken to manage risks to an acceptable level in other areas.

The key principles determining the Trust's risk appetite are as follows:

Quality: The quality of our services, measured by clinical outcomes, patient safety and patient experience is paramount. The Trust will seek to avoid taking risks that will compromise quality and patient safety.

Financial/VfM: The Trust is prepared to accept possibility of some limited financial loss. Value for money is still the primary concern, but the board will consider other benefits or constraints.

Innovation: The Trust is supportive of innovation, with demonstration of commensurate improvements in management control. It supports the use of systems and technology developments being used to enable operational delivery, but priority will be given to improvements that protect current operations.

Commercial: Until such times as financial sustainability is re-established, the Trust's business development strategy will be based mainly on low-risk opportunities within well-established business areas and markets only and on a highly controlled basis.

Regulatory compliance: The Trust has been, and continues to be under significant regulatory scrutiny due to concerns identified by the CQC and Monitor. The board is keen to return to regulatory compliance as soon as practicable as this is key to optimising quality and financial sustainability and will not take any risks that will compromise this.

Reputation: The board's tolerance for risks relating to its reputation is limited to those events where there is little or no chance of significant repercussion for the organisation.

The risk appetite statement was agreed in a public meeting of the board and is available on the Trust's website. During 2014/15 and going into 2015/16, the Trust sees its principal risks as follows:

- inability to maintain safe ward staffing levels to meet increases in activity and acuity of patients, and ensure effective clinical supervision, due to staff shortages and difficulties recruiting suitably qualified clinicians, nurses and doctors

- failure to achieve long-term financial viability through achieving a Cost Improvement Programme (CIP), failure to achieve income targets and CQUINs, poor cost control or not controlling capital spend

- insufficient bed and theatre capacity to deliver required clinical activity resulting in a poor environment of care for patients, a poor patient experience, risks to patient safety, missed targets, lost income, potential penalties and regulatory intervention

- failure to develop and deliver a realistic and achievable clinical and financial strategy that persuades the Trust's regulators and stakeholders that the Trust has a plan which will return it to financial viability.

These risk issues, the key controls in place to manage them and the actions in hand to further reduce the likelihood and impact of the risk are discussed at the Trust's twice weekly Executive Team meetings, monthly Board meetings and at every meeting of the assurance committees of the board.

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.

At Colchester Hospital University NHS Foundation Trust, we believe that every incident offers the opportunity to learn. The reporting incidents are then a fundamental building block in achieving an open, transparent and fear-free way of achieving this aim. Our structures and frameworks promote learning, escalation, treatment and mitigation of, or from risk.

Regulatory action

The foundation trust is not fully compliant with the registration requirements of the CQC and is in breach of conditions of the foundation trust's licence with Monitor, the FT regulator.

The Trust was first placed in special measures in November 2013 by Monitor as a result of alleged governance breaches relating to cancer services, Board effectiveness and governance. Monitor imposed discretionary requirements 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. Monitor also imposed an 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. The special measures have remained in force throughout 2014/15, with further regulatory action during the year by Monitor as follows:

- In August, Monitor accepted enforcement undertakings under Section 106 of the Act following a Trust inspection by the CQC in May 2014 which identified significant concerns with patients' experiences of care. The enforcement undertakings accepted from the Trust included the requirement to finalise, submit and implement an improvement plan to address the concerns of the CQC, set up an Improvement Board to oversee the delivery of the improvement plan and attend regular meetings with Monitor to discuss progress in delivering the improvement plan.

- In February 2014, Monitor accepted enforcement undertakings under Section 106 of the Act as a result of quality and governance breaches

and finance and governance breaches. The quality breaches were identified through an inspection by the CQC in November and December 2014 of the Trust's Accident and Emergency Department (A&E) and Emergency Assessment Unit (EAU), rating both areas and, as a consequence, the Trust overall with a provider level rating of "inadequate". The finance breaches were identified following a forecast to close 2014/15 with a deficit of £24m rather than its planned deficit of £15.9m. The undertakings accepted from the Trust included the requirement to develop an A&E improvement plan, commission a multidisciplinary assurance review to assess the August 2014 improvement plan, prepare a financial recovery plan for 2015/16, produce a long-term financial recovery plan on request and comply with the terms and conditions of any interim support financing or planned term support financing is provided by the Secretary of State for Health to the Trust pursuant to section 40 of the NHS Act 2006.

Following their inspection of A&E and EAU, the CQC also served the Trust with two section 31 notices in February 2015, imposing legally binding conditions on the Trust as follows:

EAU

- ensuring the EAU is staffed by a sufficient number of suitably qualified, skilled and experienced staff, assessed according to a nationally recognised acuity tool
- ensuring patients attending the GP triage referral area stay in that area for no more than 12 hours
- using some of the existing beds to cohort patients with a defined level of care of 2 in accordance with Intensive Care Society guidelines in an appropriately staffed area and ensuring those beds are staffed in accordance with Intensive Care Society guidelines to ensure that staffing levels in the cohorted area are safe
- allowing the use of these beds flexibly to meet demand in the EAU for patients with a lower acuity and dependency need whilst ensuring patients with level 2 needs are cohorted in this area as a priority
- ensuring only those beds remain open in respect of which the required level of staffing can be provided and no further beds opened if care at the appropriate level cannot be provided, so as to ensure the safety of patients
- to describe the system operated in EAU to comply with these conditions to the CQC and send twice weekly updates.

A&E

- ensuring patients attending A&E are streamed to appropriate patient pathways
- to undertake the "streaming" in such a manner as to comply with guidance issued by the College of Emergency Medicine or such other recognised professional processes or mechanisms as the Trust commits itself to
- ensuring a suitably qualified, skilled and experienced nurse is placed within the main area of the A&E department to support the streaming of patients into the pathways referred to above
- ensuring, for all patients being assessed in the streaming process, that a record is kept of the patient's arrival time, the time the clinical assessment is commenced and by whom and the pathway the patient will take and that patients who do not require A&E services are provided with information of alternative services before they leave A&E
- to describe the system operated in A&E to comply with these conditions to the CQC and send twice weekly updates.

Throughout the year, I and the Chair, as well as members of the Executive Team, met regularly 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 healthcare economy in discussions which included the

Trust's regulatory challenges and consideration of the risk to the Trust which impact on them and how to mitigate those risks, caused for example by lack of Trust capacity. 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 Trust 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 at a public meeting. This was last reviewed by the board at its meeting of 30 April 2015. All remedial actions are incorporated in the CQC improvement plans and responses to the Monitor enforcement notices.

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 nine never events during the year, involving nine patients, all of which related to surgery. A key cause was failure to follow checking and counting processes consistently. The Trust responded by putting preventive measures in place and increasing staff awareness and ensuring usage of the World Health Organisation (WHO) safer surgery checklist through compliance monitoring. The Trust continues to report proactively on a monthly basis to the board and the Quality and Patient Safety committee on its never events and compliance rates against the WHO safer surgery checklist. A never event framework has also been circulated to 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 and Finance Assurance Committee, and every other month at the People and Organisational Development Assurance Committee.

As the Trust during the year received two enforcement notices from Monitor and was assessed as "inadequate" by the CQC, the Trust cannot claim to have had in place for the full year adequate systems and standards of governance, board and

committee oversight, including those relating to quality and to ensure appropriate and efficient capacity. This resulted in a review of its governance and risk frameworks, the reporting and escalation arrangements from the organisation to the board and the terms of reference of the board's main assurance committees.

The Trust has an agreed risk-based annual audit programme with the Trust's 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 Trust provides.

In 2014/15 the Trust was in financial deficit of £22.3m. The plan for 2015/16 is a deficit of £30m, with a requirement of £26m in cash support from the Department of Health. To deliver the planned deficit a cost improvement programme of £14m needs to be delivered which may be in the form of planned cost reductions, as set out at the start of the financial year, or through cost avoidance, which may be necessary to mitigate any under achievement of the plan during the year. Recognising the size of the cost reductions, the Trust has geared up robust measures for monitoring and in particular escalation and recovery arrangements to mitigate slippage of delivery. A comprehensive financial recovery plan was approved by the Board in March in private and shared in public in April 2015.

Information governance

The Trust reported 38 level 1 and 3 level 2 incidents relating to breaches of patient confidentiality in 2014/15. The majority of these incidents were caused by staff not checking that they had the correct patient details when dealing with patient information.

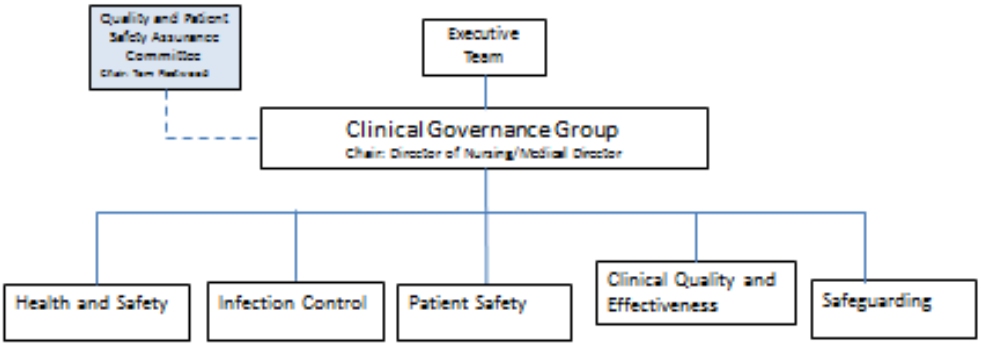
The Trust carried out an assessment of its compliance with the Department of Health Information Governance toolkit for 2014/15, the outcome of which was a compliance score of 84%.

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 Accounts for each financial year. Monitor 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 18 quality priorities for 2014/15 which were later rationalised to 11, reflecting the areas of high risk implications and the impact of regulatory pressures. The delivery of these priorities was monitored monthly by the Quality and Patient Safety committee of the Board of Directors and the Board. Details on the Trust's performance against these priorities is analysed and reported in its 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 and Quality is the Executive Director responsible for Patient Safety and Patient Experience and the Medical Director is responsible for Clinical Effectiveness. The new post of Director of Governance and Risk was established during the year to provide further leadership and support for the quality and governance agenda. They report to the Director of Nursing and Quality and are responsible for quality and clinical and non-clinical risk management across the organisation

The executive governance structure supporting the quality agenda was reviewed during 2014/15, ensuring that all aspects of quality governance report through to the Clinical Governance Group, the Executive Team, the Quality and Patient Safety committee and the board. This was not fully operational for the whole year but in place by March 2015.



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

- the CQC improvement plan, details of which are summarised above
- plans to deliver the KPIs in the CQUINs agreed with commissioners
- initiatives to reduce errors in surgery through improving compliance with the World Health Organisation (WHO) Safer Surgery Checklist
- Ward to Board leadership, staff engagement and communication programme

Due to data quality issues following the implementation of the clinical portal, the Trust was unable to report on its 18 weeks referral to treatment compliance from December 2014 to the end of the year. This was addressed by commissioning a review from the national validation team, who completed their programme of work on 28 February 2015 and produced a final assessment report in April 2015. The Trust will resume reporting at the end of Quarter 1 2015/16.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control 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 Committee and other assurance committees of the board, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- Assessment of financial reports submitted to Monitor
- 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
- The reports of the CQC in July 2014 and February 2015, the associated improvement plans and the reports on their delivery status
- Clinical Pathology Accreditation (CPA) held for designated pathology services

- Infection Control Annual Report and associated monthly reporting
- 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 Staff Survey
- Information Governance Toolkit
- Patient-Led Assessment of the Care Environment (PLACE) inspections

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

- The Board; through consideration of key objectives and the management of principal risks to those objectives within the Assurance Framework, 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
- External assessments of services including the reports of the CQC following its inspections, the Emergency Care Intensive Support Team (ECIST) to develop best practice models of care, the retrospective review of 1,500 cancer patients, the Troop Taylor-Brown review and Healthwatch Essex on patient and carer "lived experience" of cancer care and treatment at the Trust.

Conclusion

The foregoing statement identifies a number of significant internal control issues that have been identified both through internal reviews and through external scrutiny from Monitor and the CQC. The Trust received a limited assurance statement in the Head of Internal Audit opinion as processes to ensure an adequate and effective system of internal control to manage the significant risks identified by the Trust had not been fully embedded throughout the year.

The Board's priority since these issues emerged has been to put in place the sustainable systems and processes of internal control that will rebuild the confidence of patients, staff and commissioners, regulators and the wider public in the Trust and which will give assurance going forward.

The actions in the CQC improvement plan, the financial recovery plan and workforce strategy are addressing the underlying issues highlighted in this statement. This will be underpinned by the embedding of the Risk Management strategy and related assurance and escalation framework put in place to ensure all staff understand and fulfil their responsibilities for risk and internal control and that there are appropriate mechanisms in place for escalation and mitigation.

Signed

Dr Lucy Moore
Chief Executive

Independent auditor's report to the Trust's Council of Governors

Our opinion on the financial statements is modified

In our opinion the financial statements:

- give a true and fair view of the state of the financial position of the Group and Colchester Hospital University NHS Foundation Trust as at 31 March 2015 and of the Group and Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Emphasis of matter - Going concern

In forming our opinion on the financial statements, we have considered the adequacy of the disclosures made in note 1.1 to the financial statements concerning the Trust's ability to continue as a going concern.

The Trust incurred a deficit of £22.3 million during the year ended 31 March 2015 and has set a budgeted deficit of £30 million for 2015/16. This budgeted deficit also includes the requirement to achieve savings of £14 million. In order to fund this deficit, the Directors are seeking interim financial support for 2015/16 of at least £26 million from the Department of Health via Monitor. At the time of writing, a working capital loan facility of £7.3 million has been provided to the Trust and discussions are on-going with Monitor with regard to the further support required. As disclosed in note 1.1 to the financial statements, Monitor has not provided the Trust with assurance in respect of the additional support at the date of our report.

These conditions, along with the other matters explained in note 1.1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. As directed by the [NHS Foundation Trust Annual Reporting Manual 2014/15, 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. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Who are we reporting to:

This report is made solely to the Council of Governors of Colchester Hospital University NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them 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 Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Colchester Hospital University NHS Foundation Trust ('the Trust') for the year ended 31 March 2015 which comprise the Group and Trust statement of comprehensive income, the Group and Trust statement of financial position, the Group and Trust statement of cash flows, the Group and Trust statements of changes in taxpayers' equity and the related notes.

The Group financial statements include the financial transactions of Colchester Hospital University NHS Foundation Trust and Colchester Hospitals Charity for the year ended 31 March 2015.

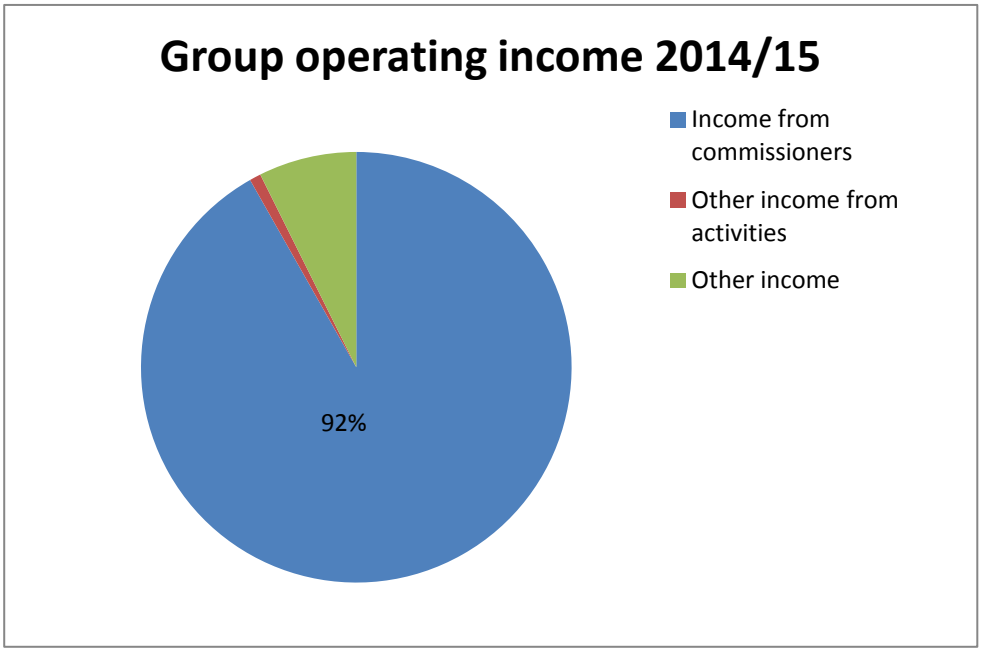
The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that are, in our judgement, likely to be most important to users' understanding of our audit.

Valuation of contract income from commissioning bodies and associated receivables

The risk: The Group receives a large proportion of its income from commissioners of healthcare services. It invoices its commissioners throughout the year for services provided, and at the year-end estimates and accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the year-end and after the deadline for the production of the financial statements. There is therefore a risk that the income from commissioners (and associated receivables) recognised in the financial statements may be misstated. We identified the accounting for the contract arrangements with commissioning bodies (in particular the consistency of the income with contract terms) as one of the risks that had the greatest impact on our audit strategy.



Our response: Our audit work included, but was not restricted to, assessing the Group's accounting policy for revenue recognition, understanding management's processes to recognise this income in accordance with the stated accounting policy, performing walk-throughs of management's key controls over income recognition (for example controls over contract billing, pricing and agreement of contract variations) to assess whether they were designed effectively and substantively testing the income and associated receivables.

Our substantive testing included:

- testing the reconciliation of the income figures in the financial statements for material contracts with commissioning bodies to signed contracts; and
- testing a sample of the contract variations to ensure they were accounted for appropriately and are not in dispute.

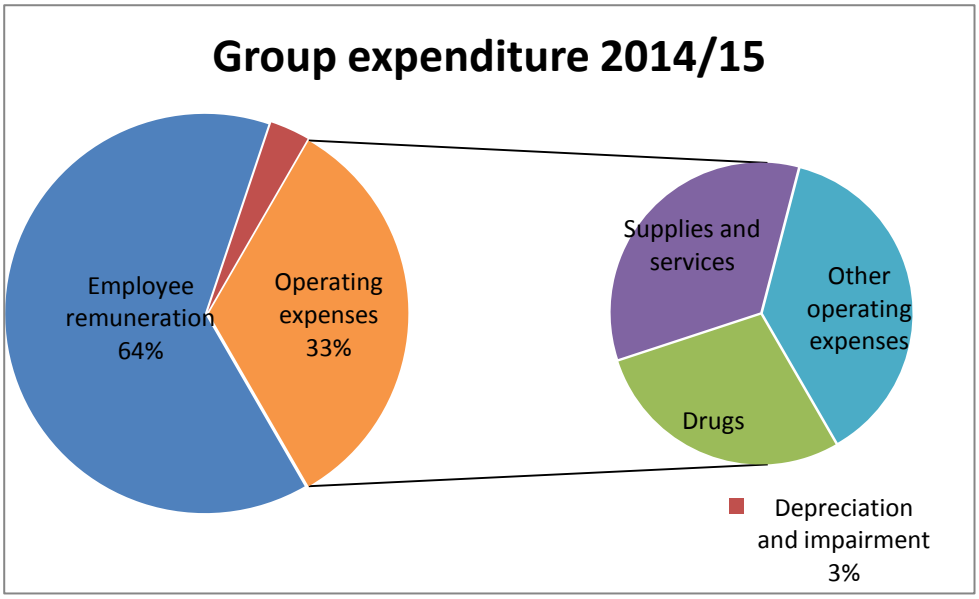
The Group's accounting policy on revenue recognition is shown in note 1.4 to the financial statements and its analysis of its total operating income is included in note 2.1.4.

Our findings:

We did not note any exceptions from our work on this income.

Completeness of employee remuneration and operating expenses and associated payables

The risk: The majority of the Group's expenditure relates to employee remuneration and operating expenses. Together they account for 97% of the Group's gross expenditure. The Group pays the majority of this expenditure through its payroll and accounts payable systems and at the year-end estimates and accrues for un-invoiced expenses. Invoices for the final weeks of the year are not received and processed until after the year-end and in many cases after the deadline for the production of the financial statements. There is therefore a risk that the expenses (and associated payables) recognised in the financial statements may be misstated. We identified the completeness of employee remuneration and operating expenses (in particular the understatement of accruals) as risks that had the greatest impact on our audit strategy .



Our response: Our audit work included, but was not restricted to, understanding management's processes to recognise payroll and accounts payable expenditure and year-end accruals for unprocessed invoices and expenditure incurred and not yet invoiced (GRNI), walking through management's key controls over recognition of expenditure (for example authorisation of expenditure subsystem interfaces, processing of adjustments and authorisation of payments) to assess whether they were designed effectively and substantively testing expenditure and associated payables.

Our substantive testing included:

- testing the reconciliation of employee remuneration expenditure in the financial statements to the general ledger and payroll subsystems;
- performing a trend analysis of payroll costs to identify any unusual cost variations for follow up;
- testing large or unusual payroll transactions;
- sample testing payroll expenditure to source documents;
- assessing whether the Group's processes for accruing for GRNIs were sufficiently robust to ensure that uninvoiced expenditure had been accrued for appropriately; and
- testing a sample of post year-end payments to confirm the completeness of accruals.

The Group's accounting policy for recognition of expenditure is shown in notes 1.5 and 1.6, its analysis of employee remuneration costs is included in note 4.1 and its analysis of operating costs is included in note 3.1 to the financial statements.

Our findings: We did not note any exceptions from our work on this expenditure.

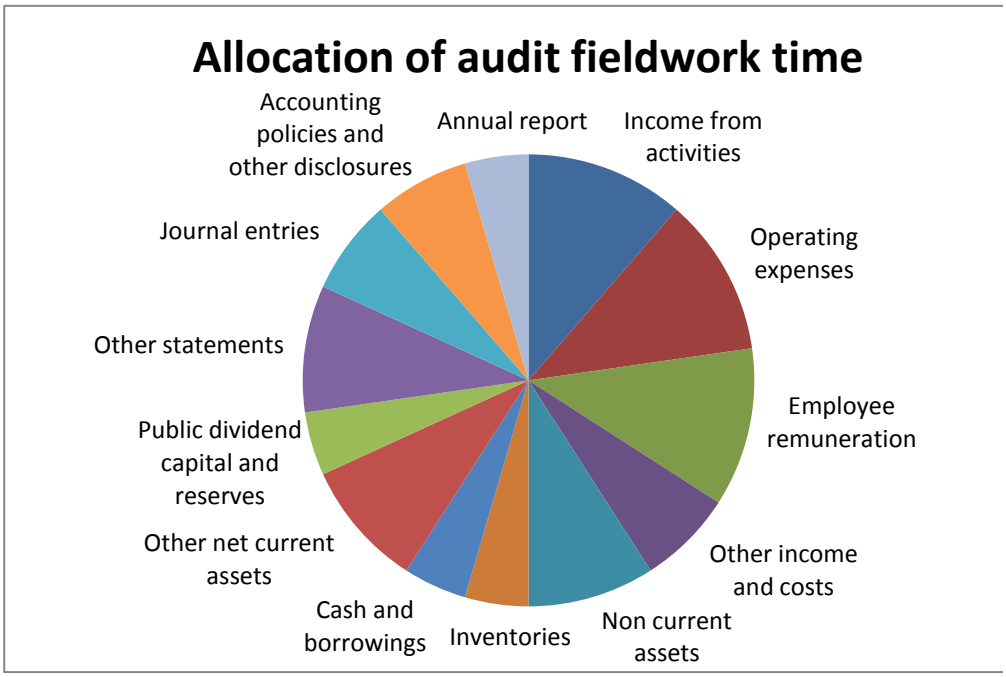
Our application of materiality and an overview of the scope of our audit

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the judgement of a reasonably knowledgeable person would be changed or influenced. We determined materiality for the audit of the Group financial statements as a whole to be £5,685,000, which is 2% of the Group's gross operating costs. This benchmark is considered the most appropriate because users of the financial statements are particularly interested in how healthcare funding has been spent. We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality for the audit of the Group financial statements. We also determine a lower level of specific materiality for certain areas such as related party transactions and senior officer remuneration. We determined the threshold at which we will communicate misstatements to the Trust's Audit Committee to be £250,000. In addition we communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Overview of the scope of our audit

We conducted our audit in accordance with International Standards on Auditing (ISAs) (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code and the ISAs (UK and Ireland) are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained from our audit is sufficient and appropriate to provide a basis for our opinion. We are independent of the Group in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards. Our audit approach was based on a thorough understanding of the Group's business and is risk based. Accordingly, our audit work was focused on obtaining an understanding of, and evaluating, relevant internal controls at the Group. In order to gain appropriate audit coverage of the risks described above and of the Trust's charity, we performed testing of the significant balances and transactions of the charity as part of our audit work on the Group financial statements. We undertook substantive testing on significant transactions, balances and disclosures in the Group financial statements, the extent of which was based on various factors such as our overall assessment of the Group's control environment, the design effectiveness of controls over significant financial systems and the management of risks.



Other reporting required by regulations

Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is modified
In our opinion:

- the part of the Directors' Remuneration Report subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014-15 issued by Monitor; and

the information given in the strategic report and directors' report for the financial year for which the financial statements are prepared is consistent with the Group financial statements.

Matters on which we are required to report by exception

Under the Code we are required to report to you if, in our opinion:

- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources;
- the Trust's Quality Report has not been prepared in line with the requirements set out in Monitor's published guidance or is inconsistent with other sources of evidence.

Under Section 62(1) of the National Health Service Act 2006 and Monitor's Audit Code for NHS Foundation Trusts, we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Audit Code requires us to report if we are not satisfied that the Trust has made proper arrangements.

The Trust was placed into special measures by Monitor in November 2013 to rectify failings in patient care and hospital governance. Further action was also taken by Monitor in August 2014 after an inspection by the Care Quality Commission (CQC) rated the Trust as 'requiring improvement' overall and 'inadequate' against its 'well led' standard.

Subsequent to this, in February 2015 an enforcement undertaking letter was issued by Monitor after an inspection of the Trust's A&E and Emergency Assessment Unit by the CQC rated the service as 'inadequate' and the Trust as 'inadequate' overall. Monitor also drew attention to the financial challenges at the Trust. In their letter Monitor stated that the Trust was breaching ten conditions of its licence due to quality, financial and governance breaches.

As a result of the above matters, we have not been able to satisfy ourselves that Colchester Hospital University NHS Foundation Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015. Under Section 62(1) of the National Health Service Act 2006 and Monitor's Audit Code for NHS Foundation Trusts, we have a duty to satisfy ourselves that the Trust's Quality Report has been prepared in line with the requirements set out in in Monitor's published guidance or is inconsistent with other sources of evidence.

The Trust has been unable to report on the Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways indicator since November 2014 because of issues with data reliability and completeness identified by the Trust following implementation of a new IT system. The Trust has been carrying out a process of data cleansing, with external assistance, but has so far not been able to resolve the data quality issues. It is therefore yet to agree when reporting of the indicator will recommence. Consequently, we have not be able to obtain sufficient assurance against the six dimensions of data quality for this indicator. In addition, at the time of our review, the Trust had not yet prepared the following documentation which we are required to consider for consistency with the quality account:

- the Trust's complaints report for 2014/15, published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009

As a result of this documentation being unavailable we are unable to confirm its consistency with the quality account.

As a result of the above matter, we have been unable to satisfy ourselves that Colchester Hospital University NHS Foundation Trust's Quality Report has been prepared in line with the requirements set out in Monitor's published guidance and is consistent with other sources of evidence.

We have nothing to report in respect of the following:

Under the Code we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with the information of which we are aware from our audit.

Under the ISAs (UK and Ireland), we are also required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to report to you if:

- we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable; or
- the annual report does not appropriately disclose those matters that were communicated to the Audit Committee which we consider should have been disclosed.

Responsibilities for the financial statements and the audit

What an audit of financial statements involves:

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Group's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially inconsistent with the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

What the Chief Executive is responsible for as accounting officer:

As explained more fully in the Chief Executive's Responsibilities Statement, the Chief Executive as Accounting Officer is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Direction issued by Monitor and for being satisfied that they give a true and fair view.

What are we responsible for:

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts issued by Monitor, and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Qualified Certificate

We certify that we have completed the audit of the financial statements 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 Audit Code for NHS Foundation Trusts issued by Monitor.

As set out above, we have been unable to satisfy ourselves that:

- Colchester Hospital University NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015;
- the Trust's Quality Report has been prepared in line with the requirements set out in the NHS Foundation Trust Annual Reporting Manual and is consistent with other sources of evidence.

Paul Dossett

Partner

for and on behalf of Grant Thornton UK LLP

Grant Thornton House

Melton Street

Euston Square

London

NW1 2EP

Date: 28 May 2015

Annual Accounts

FOREWORD TO THE ACCOUNTS

Colchester Hospital University NHS Foundation Trust

These accounts for the year ended 31 March 2015 have been prepared by the 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 2014/15 have recorded a deficit of £22.3 million (before the consolidation of charitable funds). The deficit represents a significant deterioration in the Trust's financial position compared to the prior reporting period. Significant variances contributing to this deficit include:

- NHS commissioned income rose only by £0.6m whilst the Trust's Market Forces Factor was unchanged, and there was a national tariff reduction of 1.5% in 14/15 relative to 13/14. The resultant reductions in income were in part offset by some growth in the volume of activity, including that allied to significant increases in PbR excluded drug spend and activity. In a year when contractual penalties incurred by the Trust have increased (such as those related to 18 weeks, cancer and ambulance handover), there have been other areas of income gains, such as service resilience and marginal rate monies to support the growth in emergency activity, as well as initiatives to support the delivery of improved 18 week access performance.

- The Trust's expenditure rose by £18.3m from £266.0m in 2013/14 to £284.3m in 2014/15. Staff costs increased by £7.0m driven by some pay inflation (£0.6m) and increased use of agency and interim staff over the previous year (£6.3m). Business rates increased by £1.3m and depreciation charges increased by a further £1.3m, both driven predominantly by the large capital investment into the radiotherapy building which opened at the start of the year. Clinical negligence insurance premium costs saw a significant increase of £1.7m over 2013/14 and high consultancy support costs (£1.3m) were incurred in response to the Keogh and CQC reviews. PbR excluded drugs contributed to an increased spend on drugs of £4m and supplies and services increased by a net £1.6m, driven in the most part by the first year of operation of the Pathology Partnership to which the Trust contributed to the operating loss (£0.9m).

In accordance with the NHS foundation trust Annual Reporting manual 2014/15, management have assessed the organisation's ability to continue as a going concern for the foreseeable future. Significant work is ongoing with Monitor, 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 financial strategy for 2014/15 which forecasts a deficit of £30 million. Within this forecast is £14 million of planned cost improvements and efficiency gains in addition to £26 million of interim working capital support from the Department of Health.

Although contracts for 2015/16 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. These factors all represent material uncertainties for the Trust and there is a presumption that additional working capital support will be required in 2016/17. 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.

The Auditor has issued an emphasis of matter paragraph in the course of his audit due to the absence of formal confirmation of interim financial support for 2015/16.

Dr Lucy Moore, Chief Executive

28th May 2015

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2015

	Note		2014/15 £000		2013/14 £000
Operating Income	2		267,576		268,745
Operating Expense	3		(284,258)		(266,004)
Operating Surplus			**(16,682)**		**2,741**
Finance Costs					
Finance income	6	50		84	
Finance expense - financial liabilities	6.1	(584)		(421)	
Finance expense - unwinding of discount on provisions		(21)		(28)	
PDC dividends payable		(5,081)		(4,744)	
Net Finance Costs			**(5,636)**		**(5,109)**
Surplus from continuing operations			**(22,318)**		**(2,368)**
SURPLUS/(DEFICIT) FOR THE YEAR			**(22,318)**		**(2,368)**
Other Comprehensive Income:					
Revaluation gains/(losses) and impairment losses property, plant and equipment			9,991		6,533
TOTAL COMPREHENSIVE INCOME FOR THE YEAR			**(12,327)**		**4,165**

The notes on pages 13 to 49 form part of these accounts.
All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

	Note	31 March 2015 £000	31 March 2014 £000
NON-CURRENT ASSETS			
Intangible assets	7	6,373	6,148
Property, plant and equipment	8.1	181,182	174,743
Total Non-Current Assets		**187,555**	**180,891**
CURRENT ASSETS			
Non-current assets held for sale	8.2	6,107	-
Inventories	10	4,984	5,523
Trade and other receivables	11.1	10,511	12,375
Cash and cash equivalents	18	9,774	28,674
Total Current Assets		**31,376**	**46,572**
CURRENT LIABILITIES			
Trade and other payables	12.1	(28,200)	(26,941)
Borrowings	15	(1,573)	(944)
Provisions	17	(286)	(288)
Other liabilities	13	(1,479)	(1,674)
Total Current Liabilities		**(31,538)**	**(29,847)**
Total Assets less Current Liabilities		**187,393**	**197,616**
NON-CURRENT LIABILITIES			
Borrowings	15	(25,540)	(23,096)
Provisions	17	(1,068)	(1,131)
Other liabilities	13	(3,257)	(3,582)
Total Non-Current Liabilities		**(29,865)**	**(27,809)**
TOTAL ASSETS EMPLOYED		**157,528**	**169,807**
TAXPAYERS' EQUITY			
Public Dividend Capital		76,820	76,772
Revaluation Reserve		59,188	49,639
Other Reserves		754	754
Income and Expenditure Reserve		20,766	42,642
TOTAL TAXPAYER'S EQUITY		**157,528**	**169,807**

The financial statements on pages 2 to 49 were approved by the Board and signed by:

Dr Lucy Moore, Chief Executive

28th May 2105

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015

	2014/15	2013/14
	£000	£000
Cash flows from operating activities		
Operating surplus from continuing operations	(16,682)	2,741
Operating surplus	**(16,682)**	**2,741**
Non-cash income and expense:		
Depreciation and amortisation	8,907	7,403
Impairments	144	2,930
Reversal of impairments	-	(2,040)
(Gain)/loss on disposal of property, plant and equipment	105	34
Non-cash donations credited to income	(17)	(49)
Amortisation of PFI credit	(326)	(326)
(Increase)/decrease in trade and other receivables	1,864	(4,440)
(Increase)/decrease in inventories	539	(328)
Increase/(decrease) in trade and other payables	3,692	3,868
Increase/(decrease) in other liabilities	(194)	1,062
Increase/(decrease) in provisions	(86)	(969)
Other movements in operating cash flows	(1)	-
Net cash generated from operations	**(2,055)**	**9,886**
Cash flows from investing activities		
Interest received	50	84
Purchase of intangible assets	(2,118)	(542)
Purchase of property, plant and equipment	(12,371)	(27,121)
Sales of property, plant and equipment	10	5
Net cash generated from/(used in) investing activities	**(14,429)**	**(27,574)**
Cash flows from financing activities		
Public dividend capital received	48	579
Loans received from the Independent Trust Financing Facility	-	16,500
Loans received from the Department of Health	4,000	-
Loans repaid to the Independent Trust Financing Facility	(594)	-
Capital element of finance lease rental payments	(333)	(302)
Interest paid	(479)	(271)
Interest element of finance lease	(104)	(135)
PDC dividend paid	(4,954)	(4,688)
Net cash generated from/(used in) financing activities	**(2,416)**	**11,683**
Increase/(decrease) in cash and cash equivalents	**(18,900)**	**(6,005)**
Cash and Cash equivalents at 1 April	**28,674**	**34,679**
Cash and Cash equivalents at 31 March	**9,774**	**28,674**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2015

	Total	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2013	**165,063**	**76,193**	**43,203**	**754**	**44,913**
Surplus/(deficit) for the year	**(2,368)**	-	-	-	(2,368)
Revaluation gains and impairment losses property, plant and equipment	**6,533**	-	6,533	-	-
Transfers to the income and expenditure account in respect of assets disposed of	**-**	-	(97)	-	97
Public Dividend Capital received	**579**	579	-	-	-
Taxpayers' Equity at 31 March 2014	**169,807**	**76,772**	**49,639**	**754**	**42,642**
Surplus/(deficit) for the year	**(22,318)**	-	-	-	(22,318)
Revaluation gains and impairment losses property, plant and equipment	**9,991**	-	9,991	-	-
Transfers to the income and expenditure account in respect of assets disposed of	**-**	-	(442)	-	442
Public Dividend Capital received	**48**	48	-	-	-
Taxpayers' Equity at 31 March 2015	**157,528**	**76,820**	**59,188**	**754**	**20,766**

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2015 CONSOLIDATED FOR CHARITABLE FUNDS *

	Note		2014/15 £000		2013/14 £000
Operating Income	2		267,714		268,897
Operating Expense	3		(284,670)		(266,442)
Operating Surplus			**(16,956)**		**2,455**
Finance Costs					
Finance income	6	55		88	
Finance expense - financial liabilities	6.1	(584)		(421)	
Finance expense - unwinding of discount on provisions		(21)		(28)	
PDC dividends payable		(5,081)		(4,744)	
Net Finance Costs			**(5,631)**		**(5,105)**
Surplus from continuing operations			**(22,587)**		**(2,650)**
SURPLUS/(DEFICIT) FOR THE YEAR			**(22,587)**		**(2,650)**
Other Comprehensive Income:					
Revaluation gains/(losses) and impairment losses property, plant and equipment			9,991		6,533
TOTAL COMPREHENSIVE INCOME FOR THE YEAR			**(12,596)**		**3,883**

* The Trust is a corporate trustee of Colchester Hospitals Charity. In accordance with International Accounting Standard (IAS) 27 (revised) and the requirments 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 2015.

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 2015 CONSOLIDATED FOR CHARITABLE FUNDS

	Note	31 March 2015 £000	31 March 2014 £000
NON-CURRENT ASSETS			
Intangible assets	7	6,373	6,148
Property, plant and equipment	8.1	181,182	174,743
Total Non-Current Assets		**187,555**	**180,891**
CURRENT ASSETS			
Non-current assets held for sale	8.2	6,107	-
Inventories	10	4,984	5,523
Trade and other receivables	11.2	10,504	12,347
Cash and cash equivalents	18	10,690	29,903
Total Current Assets		**32,285**	**47,773**
CURRENT LIABILITIES			
Trade and other payables	12.2	(28,226)	(26,990)
Borrowings	15	(1,573)	(944)
Provisions	17	(286)	(288)
Other liabilities	13	(1,479)	(1,674)
Total Current Liabilities		**(31,564)**	**(29,896)**
Total Assets less Current Liabilities		**188,276**	**198,768**
NON-CURRENT LIABILITIES			
Borrowings	15	(25,540)	(23,096)
Provisions	17	(1,068)	(1,131)
Other liabilities	13	(3,257)	(3,582)
Total Non-Current Liabilities		**(29,865)**	**(27,809)**
TOTAL ASSETS EMPLOYED		**158,411**	**170,959**
TAXPAYERS' EQUITY			
Public Dividend Capital		76,820	76,772
Revaluation Reserve		59,188	49,639
Other Reserves		754	754
Income and Expenditure Reserve		20,766	42,642
Charitable Funds Reserve		883	1,152
TOTAL TAXPAYER'S EQUITY		**158,411**	**170,959**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015 CONSOLIDATED FOR CHARITABLE FUNDS

	2014/15	2013/14
	£000	£000
Cash flows from operating activities		
Operating surplus from continuing operations	(16,956)	2,455
Operating surplus	**(16,956)**	**2,455**
Non-cash income and expense:		
Depreciation and amortisation	8,907	7,403
Impairments	144	2,930
Reversal of impairments	-	(2,040)
(Gain)/loss on disposal of property, plant and equipment	105	34
Amortisation of PFI credit	(326)	(326)
(Increase)/decrease in trade and other receivables	1,844	(4,415)
(Increase)/decrease in inventories	539	(328)
Increase/(decrease) in trade and other payables	3,701	3,859
Increase/(decrease) in other liabilities	(194)	1,062
Increase/(decrease) in provisions	(86)	(969)
NHS charitable funds - net working capital movements	(33)	82
Other movements in operating cash flows	(1)	-
Net cash generated from operations	**(2,356)**	**9,747**
Cash flows from investing activities		
Interest received	50	84
Purchase of intangible assets	(2,118)	(542)
Purchase of property, plant and equipment	(12,388)	(27,170)
Sales of property, plant and equipment	10	5
NHS charitable funds - investment income	5	4
Net cash generated from/(used in) investing activities	**(14,441)**	**(27,619)**
Cash flows from financing activities		
Public dividend capital received	48	579
Loans received from the Independent Trust Financing Facility	-	16,500
Loans received from the Department of Health	4,000	-
Loans repaid to the Independent Trust Financing Facility	(594)	-
Capital element of finance lease rental payments	(333)	(302)
Interest paid	(479)	(271)
Interest element of finance lease	(104)	(135)
PDC dividend paid	(4,954)	(4,688)
Net cash generated from/(used in) financing activities	**(2,416)**	**11,683**
Increase/(decrease) in cash and cash equivalents	**(19,213)**	**(6,189)**
Cash and Cash equivalents at 1 April	**29,903**	**36,092**
Cash and Cash equivalents at 31 March	**10,690**	**29,903**

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 MARCH 2015
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 2013	**166,497**	**76,193**	**43,203**	**754**	**44,913**	**1,434**
Surplus/(Deficit) for the year	**(2,650)**	-	-	-	(2,528)	(122)
Revaluation gains and impairment losses property, plant and equipment	**6,533**	-	6,533	-	-	-
Transfers to the income and expenditure account in respect of assets disposed of	**-**	-	(97)	-	97	-
Public Dividend Capital received	**579**	579	-	-	-	-
Other reserve movements in respect of charitable funds	**-**	-	-	-	160	(160)
Taxpayers' Equity at 31 March 2014	**170,959**	**76,772**	**49,639**	**754**	**42,642**	**1,152**
Surplus/(Deficit) for the year	**(22,587)**	-	-	-	(22,560)	(27)
Revaluation gains and impairment losses property, plant and equipment	**9,991**	-	9,991	-	-	-
Transfers to the income and expenditure account in respect of assets disposed of	**-**	-	(442)	-	442	-
Public Dividend Capital received	**48**	48	-	-	-	-
Other reserve movements in respect of charitable funds	**-**	-	-	-	242	(242)
Taxpayers' Equity at 31 March 2015	**158,411**	**76,820**	**59,188**	**754**	**20,766**	**883**

COLCHESTER HOSPITALS CHARITY

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2015

	2014/15	2013/14
	£000	£000
INCOMING RESOURCES		
Incoming resources from generated funds:		
Voluntary income:		
Donations	305	232
Legacies	37	2
Activities for generating funds:		
Fundraising events	32	28
Sponsorship and lotteries	4	4
Investment income	5	4
Incoming resources from charitable activities:		
Grants received	1	46
Other income	1	-
Total Incoming Resources	**385**	**316**
RESOURCES EXPENDED		
Cost of generating funds:		
Fundraising costs	198	218
Charitable activities:		
Patients - welfare and amenities	250	262
Staff - welfare and amenities	53	57
Contributions to NHS	114	22
Governance costs	39	39
Total Resources Expended	**654**	**598**
Net Incoming/(Outgoing) Resources	**(269)**	**(282)**
Reconciliation of Funds		
Opening funds brought forward	1,152	1,434
Total funds carried forward	**883**	**1,152**

COLCHESTER HOSPITALS CHARITY

BALANCE SHEET AS AT 31 MARCH 2015

	31 March 2015 £000	31 March 2014 £000
CURRENT ASSETS		
Debtors	7	15
Cash	916	1,229
Total Current Assets	**923**	**1,244**
CURRENT LIABILITIES		
Creditors	(40)	(92)
Total Current Liabilities	**(40)**	**(92)**
TOTAL ASSETS EMPLOYED	**883**	**1,152**
THE FUNDS OF THE CHARITY		
Restricted income funds	85	71
Unrestricted income funds	798	1,081
TOTAL CHARITY FUNDS	**883**	**1,152**

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.

Revaluation Reserve

The revaluation reserve reflects movements in the value of property, plant and equipment and intangible assets as set out in the accounting policy. The revaluation reserve balance relating to each asset is released to the income and expenditure reserve on disposal of that asset.

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 and Expenditure.

Income and Expenditure Reserve

The income and expenditure reserve is the cumulative surplus made by the Trust since its inception. It is held in perpetuity and cannot be released to the Statement of Comprehensive Income and Expenditure.

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

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. Where the NHS Foundation Trust Annual Reporting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular accounting policies adopted by the Trust are described below. They 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 2015 the Trust has forecast a deficit of £30million and within this forecast is a cost improvement programme requiring £14million of efficiencies and savings. In order to fund this deficit, the Directors are seeking interim financial support for 2015/16 of at least £26m (plus a further £5.3m to May 2016) from the Department of Health through Monitor. At the time of writing, a working capital loan facility of £7.3million has been provided to the Trust and discussions are on-going 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 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 NHS Foundation trust Annual Reporting Manual 2014/15, 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, management is required 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.

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 IAS 27 (revised)); and
- benefits from the NHS charitable fund.

The Trust is a corporate trustee of Colchester Hospitals Charity. 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.

Prior to 2013/14, the Annual Reporting Manual permitted the NHS foundation trust not to consolidate the charitable fund. Since 2013/14, the foundation trust has consolidated the charitable fund.

Reconciliation of Trust surplus/(deficit) to pre-consolidated accounts:

	2014/15 £000	**2013/14 £000**
Trust surplus/(deficit) for year	**(22,318)**	**(2,368)**
Less:		
Charitable contributions previously credited to Trust income	**(225)**	**(111)**
Receipt of donated assets previously credited to Trust income	**(17)**	**(49)**
Plus:		
NHS charitable funds income	**380**	**312**
NHS charitable funds investment income	**5**	**4**
Less:		
NHS charitable funds expenditure	**(409)**	**(435)**
NHS charitable funds audit fee	**(3)**	**(3)**
Consolidated surplus/(deficit) for year	**(22,587)**	**(2,650)**

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 Scheme.

Employers 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.

On 1st May 2014, the Trust entered into a consortium arrangement with six NHS trusts in the East of England that have come together to modernise delivery of pathology services for hospitals, GPs and patients. The arrangement was formed in response to changes driven by commissioners and NHS England to transform pathology services and follows the best practice recommendations set out in the Carter Report on Pathology 2008. There is no separate legal entity for the arrangement and the Trust does not exert significant power, control or influence over its management. All costs are therefore recognised in operating expenses as the purchase of pathology services.

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.

All assets are measured subsequently at fair value. All land and buildings are restated to fair 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 fair 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 full valuation of land and buildings was prepared by the District Valuer Service as at 31 March 2015.

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.

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

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

Medical Equipment and Engineering Plant and Equipment	5 to 15 years
Furniture & Fittings	10 years
Mainframe Information Technology Installations	8 years
Office and Information Technology Equipment	5 years
Software	5 to 10 years
Set-up Costs in New Buildings	10 years

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 FT ARM, 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 fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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.

At the end of the reporting period, the Trust assess 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 provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure 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 HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.30% (2013/14, 1.80%).

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 17 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 the NHS Litigation Authority 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

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote. Contingent liabilities are disclosed at note 21.

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 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 (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 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

The following changes to standards issued by the International Accounting Standards Board (IASB) have not yet been adopted in the NHS Foundation Trust Annual Reporting Manual. None of these are expected to impact upon the Trust financial statements.

IFRS 9 Financial Instruments

IFRS 13 Fair Value Measurement

IFRS 15 Revenue from Contracts with Customers

IAS 19 (amendment) - Employer contributions to Defined Benefit Pension Schemes

IAS 36 (amendment) - Recoverable Amount Disclosures

Annual Improvements 2012

Annual Improvements 2013

IFRIC 21 Levies

1.21 Accounting Standards Issued that have been Adopted Early

No accounting standards that have been issued have been adopted early.

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 27.

2. Operating Income

2.1 Operating Income (by classification)

	Foundation Trust		Consolidated	
	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
2.1.1 Income from Activities				
Elective income	39,584	43,769	39,584	43,769
Non-elective income	73,546	73,873	73,546	73,873
Outpatient income	46,959	45,921	46,959	45,921
A&E income	8,915	8,603	8,915	8,603
Other activity income	76,594	73,282	76,594	73,282
Private patient income	892	956	892	956
Other non-protected clinical income	1,394	883	1,394	883
Total Income from Activities	247,884	247,287	247,884	247,287

2.1.2 Commissioner Requested Services and Continuity of Services

Commissioner Requested Services replaced "mandatory services" on 1 April 2013. These are the services that local commissioners believe must continue to be delivered to local patients should the provider be unable to carry on as a going concern.

	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
Commissioner Requested Services	245,598	245,448	245,598	245,448
Other services	2,286	1,839	2,286	1,839
	247,884	247,287	247,884	247,287

2.1.3 Other Operating Income

	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
Research and development	1,020	975	1,020	975
Education and training	6,309	6,875	6,309	6,875
Charitable and other contributions to expenditure	285	164	60	53
Receipt of donated assets	17	49	-	-
Non-patient care services to other bodies	3,801	3,848	3,801	3,848
Reversal of impairments of property, plant and equipment	-	2,040	-	2,040
Car parking	862	890	862	890
Staff recharges	2,637	1,929	2,637	1,929
Drug sales	1,679	1,543	1,679	1,543
Clinical Excellence Awards	152	150	152	150
Other	2,513	2,582	2,513	2,582
Rental revenue from operating leases	89	87	89	87
Amortisation of PFI deferred credits	326	326	326	326
Profit on disposal of tangible fixed assets	2	-	2	-
NHS charitable funds	-	-	380	312
Total Other Operating Income	19,692	21,458	19,830	21,610

2.1.4 Total Operating Income

	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
Income from activities	247,884	247,287	247,884	247,287
Other operating income	19,692	21,458	19,830	21,610
Total Operating Income	267,576	268,745	267,714	268,897

2.2 Private Patient Income

	2014/15 £000	2013/14 £000
Private patient income	892	956
Total patient related income	247,884	247,287

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

2.3 Operating Lease Income

	2014/15 £000	2013/14 £000
Rents recognised as income in the period	89	87
Total	89	87

Future Minimum Lease Payments Due

-not later than 1 year	66	65
-later than 1 year and not later than 5 years	260	263
-later than 5 years	20	81
Total	346	409

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)

	2014/15 £000	2013/14 £000
Clinical Commissioning Groups	242,794	242,218
Local Authorities	2,849	2,818
Private patients	816	872
Overseas patients (non-reciprocal)	76	84
Injury Cost Recovery*	1,043	732
Other	306	563
	247,884	247,287

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

3. Operating Expenses

3.1 Operating Expenses (by type)

	Foundation Trust		Consolidated	
	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
Services from NHS	84	-	84	-
Purchase of healthcare from non-NHS bodies	4,559	2,825	4,559	2,825
Executive Directors' costs	1,870	1,328	1,870	1,328
Non-Executive Directors' costs	110	115	110	115
Staff costs	178,517	171,482	178,517	171,482
Drug costs	26,796	22,763	26,796	22,763
Supplies and services - clinical	24,451	25,450	24,451	25,450
Supplies and services - general	7,842	4,905	7,842	4,905
Establishment	1,924	1,977	1,924	1,977
Research and development	-	16	-	16
Transport	1,138	1,168	1,138	1,168
Premises	9,090	8,108	9,090	8,108
Increase/(decrease) in bad debt provision	(93)	24	(93)	24
Increase in other provisions	44	21	44	21
Change in provisions discount rate	36	42	36	42
Inventories write down	166	67	166	67
Depreciation	8,907	7,403	8,907	7,403
Fixed asset impairments	144	2,930	144	2,930
Rentals under operating leases	2,741	2,622	2,741	2,622
Audit fees in respect of the statutory audit	54	51	54	51
Audit services - regulatory reporting	-	64	-	64
Audit fees in respect of the charitable funds audit	-	-	3	3
Clinical negligence	8,253	6,603	8,253	6,603
Loss on disposal of other property, plant and equipment	107	39	107	39
Legal fees	123	82	123	82
Consultancy costs	4,728	3,457	4,728	3,457
Training, courses & conferences	733	587	733	587
Patient travel	38	41	38	41
Car parking & security	324	273	324	273
Redundancy	11	28	11	28
Insurance	272	339	272	339
Other services, e.g. external payroll	573	501	573	501
Losses, ex gratia & special payments	127	90	127	90
Other	589	603	589	603
NHS charitable funds	-	-	409	435
Total	284,258	266,004	284,670	266,442

3.2 Arrangements Containing an Operating Lease

	2014/15	2013/14
	£000	£000
Minimum lease payments	2,741	2,622
Total	2,741	2,622

Future Minimum Lease Payments Due

-not later than 1 year	1,669	1,621
-later than 1 year and not later than 5 years	1,262	1,104
-later than 5 years	466	-
Total	3,397	2,725

Total of future minimum sublease lease payments to be received as at 31 March 2015.	-	-

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 £2,000,000 (£2,000,000 in 2013/14).

4. Staff Costs and Numbers

4.1 Employee Expenses

	2014/15 £000	2013/14 £000
Salaries and wages	**128,624**	**128,755**
Social Security costs	**9,918**	**9,957**
Employer contributions to NHS Pension Scheme*	**14,425**	**14,609**
NEST pension contributions	**5**	**4**
Termination benefits	**11**	**28**
Agency/Contract Staff	**27,525**	**19,585**
Total	**180,508**	**172,938**

*** Pension Costs**
Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

b) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on the valuation data as at 31 March 2014, updated to 31 March 2015 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase Additional Voluntary Contributions (AVC's) run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

4.2 Exit Packages Agreed During 2014/15

	2014/15		2013/14	
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies £000**	**Number of compulsory redundancies**	**Cost of compulsory redundancies £000**
Less than £10,000	-	-	-	-
£10,001 - £25,000	1	11	-	-
£25,001 - £50,000	-	-	1	28
£50,001 - £100,000	-	-	-	-
£100,001 £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	-
>£200,001	-	-	-	-
Total	**1**	**11**	**1**	**28**

4.3 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:

	2014/15 £000	2013/14 £000
Salaries and other short-term employee benefits	1,431	995
Employer contributions to NHS Pension Scheme	48	84
Total	1,479	1,079

4.4 Average Number of Employees (WTE basis)

	2014/15 Total Number	2013/14 Total Number
Medical and dental	442	429
Administration and estates	744	727
Healthcare assistants and other support staff	805	789
Nursing, midwifery and health visiting staff	1,106	1,101
Scientific, therapeutic and technical staff	579	663
Bank and agency Staff	345	277
Total	4,021	3,986

4.5 Staff Benefits in Kind

	2014/15 £000	2013/14 £000
Subsidised travel permits	41	39
Total	41	39

4.6 Retirements Due to Ill-health

During 2014/15 there were 5 early retirements from the Trust on the grounds of ill-health (2 in 2013/14). The estimated additional pension liabilities of these ill-health retirements is £280,190 (2013/14, £255,080). 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

	2014/15		2013/14	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	78,061	128,993	73,972	126,372
Total non-NHS trade invoices paid within target	71,376	113,449	68,686	116,107
Percentage of non-NHS trade invoices paid within target	91%	88%	93%	92%
Total NHS trade invoices paid in the year	1,857	19,324	1,926	12,839
Total NHS trade invoices paid within target	1,592	16,662	1,724	11,929
Percentage of NHS trade invoices paid within target	86%	86%	90%	93%

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

	2014/15	2013/14
	£000	£000
Amounts included within interest payable (note 6.1) arising from claims made under this legislation	-	-
Total	-	-

6. Finance Income

	2014/15	2013/14
	£000	£000
Interest income on short-term bank deposits	50	84
NHS charitable funds - investment income	5	4
	55	88

6.1 Finance Costs - Interest Expense

	2014/15	2013/14
	£000	£000
Finance Leases	104	135
Loans from the Foundation Trust Financing Facility	480	286
	584	421

7. Intangible Assets

	Software Licences £000	Assets Under Construction £000	Total £000
Gross cost at 1 April 2013	4,298	3,266	7,564
Transfers from assets under construction	682	(682)	-
Additions purchased	-	1,529	1,529
Disposals	-	-	-
Gross cost at 31 March 2014	**4,980**	**4,113**	**9,093**
Amortisation at 1 April 2013	2,248	-	2,248
Charged during the year	697	-	697
Disposals	-	-	-
Amortisation at 31 March 2014	**2,945**	**-**	**2,945**
Net book value			
- Purchased at 31 March 2014	2,035	4,113	6,148
- Donated at 31 March 2014	-	-	-
- Total at 31 March 2014	**2,035**	**4,113**	**6,148**
Gross cost at 1 April 2014	4,980	4,113	9,093
Transfers from assets under construction	5,239	(5,239)	-
Additions purchased	9	1,126	1,135
Disposals	(105)	-	(105)
Gross cost at 31 March 2015	**10,123**	**-**	**10,123**
Amortisation at 1 April 2014	2,945	-	2,945
Charged during the year	910	-	910
Disposals	(105)	-	(105)
Amortisation at 31 March 2015	**3,750**	**-**	**3,750**
Net book value			
- Purchased at 31 March 2015	6,373	-	6,373
- Donated at 31 March 2015	-	-	-
- Total at 31 March 2015	**6,373**	**-**	**6,373**

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 2013	28,562	109,910	7,646	32,041	7,919	295	186,373
Additions purchased	-	-	25,417	1,954	13	-	27,384
Additions donated	-	-	-	49	-	-	49
Impairments charged to operating expenses	-	(2,930)	-	-	-	-	(2,930)
Transfers from assets under construction	-	20,705	(21,137)	178	254	-	-
Revaluation surpluses	1,695	(348)	-	-	-	-	1,347
Disposals	-	-	-	(1,139)	-	-	(1,139)
Cost or Valuation at 31 March 2014	**30,257**	**127,337**	**11,926**	**33,083**	**8,186**	**295**	**211,084**
Depreciation and impairments at 1 April 2013	147	11,721	-	21,058	4,890	145	37,961
Provided during the year	-	3,201	-	2,504	978	23	6,706
Reversal of impairments	(100)	(1,940)	-	-	-	-	(2,040)
Revaluation surpluses	-	(5,186)	-	-	-	-	(5,186)
Disposals	-	-	-	(1,100)	-	-	(1,100)
Depreciation and Impairments at 31 March 2014	**47**	**7,796**	**-**	**22,462**	**5,868**	**168**	**36,341**
Net Book Value							
Owned at 31 March 2014	30,210	112,032	11,926	10,430	1,650	127	166,375
Finance Lease at 31 March 2014	-	1,700	-	-	636	-	2,336
On-balance-sheet service concession contracts	-	5,766	-	-	-	-	5,766
Donated at 31 March 2014	-	43	-	191	32	-	266
Total at 31 March 2014	**30,210**	**119,541**	**11,926**	**10,621**	**2,318**	**127**	**174,743**

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 2014	30,257	127,337	11,926	33,083	8,186	295	211,084
Additions purchased	-	-	8,621	2,173	-	-	10,794
Additions donated	-	-	-	17	-	-	17
Impairments charged to operating expenses	-	(273)	-	-	-	-	(273)
Impairments charged to reserves	(47)	(7,795)	-	-	-	-	(7,842)
Transfers from assets under construction	-	9,901	(19,266)	8,221	1,144	-	-
Revaluation surpluses	4,981	1,031	-	-	-	-	6,012
Transfers to assets held for sale	(6,107)	-	-	-	-	-	(6,107)
Disposals	-	-	-	(4,647)	(2,964)	(77)	(7,688)
Cost or Valuation at 31 March 2015	**29,084**	**130,201**	**1,281**	**38,847**	**6,366**	**218**	**205,997**
Depreciation and impairments at 1 April 2013	47	7,796	-	22,462	5,868	168	36,341
Provided during the year	-	4,107	-	2,860	1,008	22	7,997
Impairments charged to operating costs	-	(129)	-	-	-	-	(129)
Reversal of impairments credited to reserves	(47)	(7,795)	-	-	-	-	(7,842)
Revaluation surpluses	-	(3,979)	-	-	-	-	(3,979)
Disposals	-	-	-	(4,533)	(2,963)	(77)	(7,573)
Depreciation and Impairments at 31 March 2014	**-**	**-**	**-**	**20,789**	**3,913**	**113**	**24,815**
Net Book Value							
Owned at 31 March 2015	29,084	122,382	1,281	17,905	1,986	105	172,743
Finance Lease at 31 March 2015	-	1,784	-	-	445	-	2,229
On-balance-sheet service concession contracts	-	6,035	-	-	-	-	6,035
Donated at 31 March 2015	-	-	-	153	22	-	175
Total at 31 March 2015	**29,084**	**130,201**	**1,281**	**18,058**	**2,453**	**105**	**181,182**

Of the totals at 31 March 2015, no land or buildings were valued at open market value.

8.2 Non-Current Assets Held for Sale

	Land £000	Total £000
NBV of non-current assets held for sale at 1 April 2013	-	-
NBV of non-current assets held for sale at 31 March 2014	**-**	**-**
NBV of non-current assets held for sale at 1 April 2014	-	-
Assets classified as available for sale in the year *	6,107	6,107
NBV of non-current assets held for sale at 1 April 2015	**6,107**	**6,107**

* In February 2010, the Board resolved to relocate services from Essex County Hospital to a new purpose-built radiotherapy centre on the site of Colchester General Hospital. The centre was completed in March 2014 and clinical services occupied the new facility shortly afterwards. As part of the Trust's overall exit strategy from the hospital site, Essex County Hospital was formally marketed for sale in the year. Accordingly, the land which forms part of the sale was revalued and reclassified as a non-current asset held for sale.

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

	2014/15 £000	2013/14 £000
Buildings	37	32
Plant & equipment	191	191
Total	228	223

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

	31 March 2015 £000	31 March 2014 £000
Buildings	1,784	1,700
Information technology	445	636
Total	2,229	2,336

9.3 The Net Book Value of Land and Buildings:

	31 March 2015 £000	31 March 2014 £000
Freehold	157,501	148,051
Total	157,501	148,051

9.4 Impairment of Assets

	2014/15 £000	2013/14 £000
Changes in market price	144	890
Total	**144**	**890**

In 2014/15 a full 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 NHS foundation trust Annual Reporting Manual, which is largely compliant with HM Treasury Financial Reporting Manual (FReM) guidance for the United Kingdom public sector.

The valuations also accord with the requirments 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.

10. Inventories

10.1 Inventories

	31 March 2015 £000	31 March 2014 £000
Drugs	2,434	2,380
Consumables	2,261	2,772
Energy	44	58
Other	245	313
Total	**4,984**	**5,523**

10.2 Inventories Recognised in Expenses

	2014/15 £000	2013/14 £000
Inventories recognised in expenses	40,762	39,551
Write-down of inventories recognised as an expense	166	67
Total	**40,928**	**39,618**

11. Receivables

11.1 Trade Receivables and Other Receivables

	Total 31 March 2015 £000	Financial Assets 31 March 2015 £000	Non-Financial Assets 31 March 2015 £000	Total 31 March 2014 £000	Financial Assets 31 March 2014 £000	Non-Financial Assets 31 March 2014 £000
Current Trade and Other Receivables						
NHS receivables	**1,818**	1,818	-	**5,343**	5,343	-
Other receivables with related parties	**187**	187	-	**431**	431	-
Provision for impaired receivables	**(845)**	(380)	(465)	**(944)**	(546)	(398)
Prepayments	**1,557**	-	1,557	**1,678**	-	1,678
Accrued income	**5,490**	3,035	2,455	**4,224**	2,021	2,203
Operating lease receivables	**4**	4	-	**4**	4	-
VAT receivable	**784**	-	784	**623**	-	623
Other receivables	**1,516**	1,516	-	**1,016**	1,016	-
Total	**10,511**	**6,180**	**4,331**	**12,375**	**8,269**	**4,106**

11.2 Trade Receivables and Other Receivables (consolidated)

	Total 31 March 2015 £000	Financial Assets 31 March 2015 £000	Non-Financial Assets 31 March 2015 £000	Total 31 March 2014 £000	Financial Assets 31 March 2014 £000	Non-Financial Assets 31 March 2014 £000
Current Trade and Other Receivables						
NHS receivables	**1,818**	1,818	-	**5,343**	5,343	-
Other receivables with related parties	**187**	187	-	**431**	431	-
Provision for impaired receivables	**(845)**	(380)	(465)	**(944)**	(546)	(398)
Prepayments	**1,557**	-	1,557	**1,678**	-	1,678
Accrued income	**5,490**	3,035	2,455	**4,224**	2,021	2,203
Operating lease receivables	**4**	4	-	**4**	4	-
VAT receivable	**784**	-	784	**623**	-	623
Other receivables	**1,502**	1,502	-	**982**	982	-
NHS charitable funds: trade and other receivables	**7**	7	-	**6**	2	4
Total	**10,504**	**6,173**	**4,331**	**12,347**	**8,237**	**4,110**

11.3 Provision for Impairment of Receivables

	Total 31 March 2015 £000	Total 31 March 2014 £000
At 1 April	**944**	**947**
Increase in provision	**389**	**98**
Amounts utilised	**(6)**	**(27)**
Unused amounts reversed	**(482)**	**(74)**
At 31 March	**845**	**944**

11.4 Analysis of Impaired Receivables

	Total 31 March 2015 £000	Total 31 March 2014 £000
Aging of Impaired Receivables		
Up to 1 month	199	-
In 1 to 2 months	2	-
In 2 to 3 months	13	8
In 3 to 6 months	68	8
Over 6 months	563	928
Total	**845**	**944**

	Total 31 March 2015 £000	Total 31 March 2014 £000
Aging of Non-Impaired Receivables Past their Due Date		
Up to 1 month	1,933	3,529
In 1 to 2 months	401	344
In 2 to 3 months	564	698
In 3 to 6 months	146	398
Over 6 months	95	669
Total	**3,139**	**5,638**

12. Trade and Other Payables

12.1 Trade and Other Payables comprise the following:

	Total 31 March 2015 £000	Financial Liabilities 31 March 2015 £000	Non-Financial Liabilities 31 March 2015 £000	Total 31 March 2014 £000	Financial Liabilities 31 March 2014 £000	Non-Financial Liabilities 31 March 2014 £000
Current Trade and Other Payables						
Receipts in advance	**6**	-	6	**6**	-	6
NHS payables	**1,541**	1,541	-	**2,891**	2,891	-
Amounts due to other related parties	**3,729**	1,650	2,079	**2,879**	745	2,134
Trade payables - capital	**1,770**	1,770	-	**4,330**	4,330	-
Other trade payables	**7,339**	7,339	-	**5,927**	5,927	-
Other taxes payable	**3,181**	-	3,181	**3,193**	-	3,193
Accruals	**10,478**	10,478	-	**7,686**	7,686	-
PDC payable	**156**	-	156	**29**	-	29
Total	**28,200**	**22,778**	**5,422**	**26,941**	**21,579**	**5,362**

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

	Total 31 March 2015 £000	Financial Liabilities 31 March 2015 £000	Non-Financial Liabilities 31 March 2015 £000	Total 31 March 2014 £000	Financial Liabilities 31 March 2014 £000	Non-Financial Liabilities 31 March 2014 £000
Current Trade and Other Payables						
Receipts in advance	**6**	-	6	**6**	-	6
NHS payables	**1,541**	1,541	-	**2,891**	2,891	-
Amounts due to other related parties	**3,729**	1,650	2,079	**2,879**	745	2,134
Trade payables - capital	**1,770**	1,770	-	**4,330**	4,330	-
Other trade payables	**7,339**	7,339	-	**5,918**	5,918	-
Other taxes payable	**3,181**	-	3,181	**3,193**	-	3,193
Accruals	**10,478**	10,478	-	**7,686**	7,686	-
PDC payable	**156**	-	156	**29**	-	29
NHS charitable funds: trade and other payables	**26**	26	-	**58**	58	-
Total	**28,226**	**22,804**	**5,422**	**26,990**	**21,628**	**5,362**

13. Other Liabilities

	31 March 2015 £000	31 March 2014 £000
Current		
Deferred income	1,150	1,348
Deferred PFI credits	329	326
Sub Total	**1,479**	**1,674**
Non-Current		
Deferred PFI credits	3,257	3,582
Sub Total	**3,257**	**3,582**
Total	**4,736**	**5,256**

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 2015 are £2,218k over a 21 year period of commitment (£2,461k over 22 years at 31 March 2014). These leases relate to the Trust's MRI Unit, the Iceni training facility and some network infrastructure equipment.

14.2 Finance Lease Obligations

			Present Value of Minimum Lease Payments	
	31 March 2015	**31 March 2014**	**31 March 2015**	**31 March 2014**
	£000	**£000**	**£000**	**£000**
Gross Lease Liabilities	**2,218**	**2,461**	**1,690**	**2,023**
of which liabilities are due				
not later than 1 year	437	437	368	333
later than 1 year and not later than 5 years	872	1,055	582	912
later than 5 years	909	969	740	778
Finance charges allocated to future periods	(528)	(438)	-	-
Net Lease Liabilities	**1,690**	**2,023**	**1,690**	**2,023**

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 2015 £000	31 March 2014 £000
Current		
Loan from Independent Trust Financing Facility	1,205	611
Obligations under finance leases	368	333
Total Current Borrowings	**1,573**	**944**
Non-current		
Loan from Independent Trust Financing Facility	20,218	21,406
Capital loan from Department of Health*	4,000	-
Obligations under finance leases	1,322	1,690
Total Other Non-Current Liabilities	**25,540**	**23,096**

*In 2014/15 the Trust received a capital loan to assist with the relocation of services from Essex County Hospital. The loan provides working capital to allow replacement infrastructure to be built ahead of the sale. The loan is repayable no later than October 2016, or sooner if the cash receipt for the Essex County Hospital is received earlier.

16. Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 were repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

17. Provisions for Liabilities and Charges

	Current 31 March 2015 £000	Current 31 March 2014 £000	Non-Current 31 March 2015 £000	Non-Current 31 March 2014 £000
Pensions relating to former directors	2	2	14	15
Pensions relating to other staff	131	128	1,054	1,116
Other legal claims	83	102	-	-
Redundancy	-	-	-	-
Other	70	56	-	-
Total	**286**	**288**	**1,068**	**1,131**

	Pensions relating to former directors £000	Pensions relating to former staff £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2013	18	1,268	122	93	859	**2,360**
Change in the discount rate	-	42	-	-	-	**42**
Arising during the year	-	28	53	-	14	**95**
Utilised during the year	(1)	(122)	(52)	(82)	(434)	**(691)**
Reversed unused	-	-	(21)	(11)	(383)	**(415)**
Unwinding of discount	-	28	-	-	-	**28**
At 31 March 2014	**17**	**1,244**	**102**	**-**	**56**	**1,419**
At 1 April 2014	17	1,244	102	-	56	**1,419**
Change in the discount rate	-	36	-	-	-	**36**
Arising during the year	1	24	51	-	14	**90**
Utilised during the year	(3)	(122)	(63)	-	-	**(188)**
Reversed unused	-	(17)	(7)	-	-	**(24)**
Unwinding of discount	1	20	-	-	-	**21**
At 31 March 2015	**16**	**1,185**	**83**	**-**	**70**	**1,354**
Expected timing of cash flows:						
Within one year	2	131	83	-	70	**286**
Between one and five years	7	432	-	-	-	**439**
After five years	7	622	-	-	-	**629**
	16	**1,185**	**83**	**-**	**70**	**1,354**

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.

£62,554,247 is included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities of the Trust (£54,494,704 as at 31 March 2014).

18. Notes to the Statement of Cash Flows

18.1. Cash and Cash Equivalents

	At 1 April 2014	Other changes in year	**At 31 March 2015**
	£000	£000	**£000**
Cash with the Government Banking Service	27,560	(18,088)	**9,472**
Commercial cash at bank and in hand	1,114	(812)	**302**
NHS charitable funds cash and cash equivalents	1,229	(313)	**916**
	29,903	**(19,213)**	**10,690**

19. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2015 were £3,441k (£2,954k, 31 March 2014).

20. Events After the Reporting Period

There are no events after the reporting period.

21. Contingencies

	31 March 2015	**31 March 2014**
	£000	**£000**
Contingent liabilities	**(70)**	**(50)**

Contingent assets and liabilities relate solely to claims for personal injury which are being handled by the NHS Litigation Authority.

22. Movement in Public Dividend Capital

	£000
Public Dividend Capital as at 1 April 2013	76,772
Public Dividend Capital as at 31 March 2014	**76,772**
Public Dividend Capital as at 1 April 2014	76,772
Public Dividend Capital received	48
Public Dividend Capital as at 31 March 2015	**76,820**

23. Related Party Transactions and Balances

Colchester Hospital University NHS Foundation Trust is a public benefit corporation authorised by the Independent Regulator for Foundation Trusts (Monitor) under the National Health Service Act 2006. 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 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.

During the period, none of the members of the Board of Directors, Board of Governors or members of the key management staff, or parties related to them, have undertaken any material transactions with the Trust.

The disclosure required by IAS 24 in relation to the compensation of key management can be found at note 4.3.

The Trust had significant transactions (>£0.5m) with the following bodies:

	Revenue		Expenditure		Payables		Receivables	
	2014/15	2013/14	2014/15	2013/14	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000	£000	£000	£000	£000
Barts Health NHS Trust	-	868	126	176	97	53	127	17
Cambridge University Hospitals NHS Foundation Trust	39	21	3,827	171	1,458	41	532	16
Colchester Borough Council	20	32	1,042	898	1	92	9	3
Community Health Partnerships	-	-	1,048	664	549	110	-	-
Department of Health	77	53	5,084	4,744	-	29	-	-
Derbyshire and Nottinghamshire Area Team	729	8	-	-	-	-	206	4
East Anglia Area Team	27,855	25,326	-	-	-	199	1,195	-
Essex Area Team	4,682	5,862	-	-	-	-	19	614
Essex County Council	2,946	2,930	797	697	208	112	104	393
Health Education England	5,982	6,744	3	3	-	-	87	565
HM Revenue & Customs	-	-	9,918	-	3,181	1,655	784	623
Ipswich Hospital NHS Trust	(37)	7	560	1,130	827	1,321	4	470
Leicestershire and Lincolnshire Area Team	2,950	1,515	-	-	-	-	327	423
Mid Essex Hospital Services NHS Trust	1,197	886	332	347	86	54	68	692
National Insurance Fund	-	-	-	9,957	-	1,572	-	-
NHS Blood and Transplant	24	27	1,481	1,551	127	-	-	22
NHS Ipswich And East Suffolk CCG	3,414	3,232	-	-	4	-	15	682
NHS Litigation Authority	-	-	8,429	6,791	-	-	26	-
NHS Mid Essex CCG	19,803	20,075	5	-	42	603	157	-
NHS North East Essex CCG	179,806	182,331	12	15	1,111	1,223	1,046	1,977
NHS Pension Scheme	-	-	14,425	14,609	2,044	2,101	-	-
NHS Professionals	-	-	7,964	5,189	2,375	1,239	-	-
NHS Property Services	-	166	765	773	30	80	-	17
NHS West Suffolk CCG	1,835	1,897	-	-	-	-	134	-
Norfolk and Norwich University Hospitals NHS Foundation Trust	847	1	38	19	8	2	1	-
Northumbria Healthcare NHS Foundation Trust	-	-	458	351	24	34	279	249
Public Health England (PHE)	505	509	39	105	-	12	23	3
West Suffolk NHS Foundation Trust	43	150	76	624	7	227	-	13

24. 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 2015 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.

24.1a Financial Assets by Category

	Loans and receivables	
	31 March 2015	31 March 2014
Assets as per Statement of Financial Position	**£000**	**£000**
Trade and other receivables	6,165	8,235
Cash at bank and in hand	9,774	28,674
NHS charitable funds: financial assets	919	1,231
Total	**16,858**	**38,140**

24.1b Financial Liabilities by Category

	Other financial liabilities	
	31 March 2015	31 March 2014
Liabilities as per Statement of Financial Position	**£000**	**£000**
Obligations under finance leases	1,690	2,023
Borrowings	25,423	22,017
Trade and other payables	22,840	21,570
Provisions under contract	70	56
NHS charitable funds: financial liabilities	26	58
Total	**50,049**	**45,724**

25. Fair values

As at 31 March 2015 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 1.30% in real terms.

26. 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, and special notation in the accounts to draw them to the attention of Parliament. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings on an accruals basis (excluding provisions for future payments), including losses 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).

	2014/15		2013/14	
Losses	**Number**	**Value £000**	**Number**	**Value £000**
Cash losses	8	1	4	1
Bad debts	44	12	36	31
Stores losses	3	166	2	67
Total Losses	**55**	**179**	**42**	**99**
Special Payments				
Compensation under legal obligation	-	-	1	61
Loss of personal effects	27	10	31	6
Personal injury claims	27	83	20	62
Ex gratia payments	22	14	18	15
Total Special Payments	**76**	**107**	**70**	**144**
Total Losses and Special Payments	**131**	**286**	**112**	**243**

27. 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: CCG funding for healthcare provision. This comprises 98% of the Trust's total income from activities, and 91% of its total operating income. Only one customer of the Trust, NHS North East Essex CCG, makes up more than 10% of the Trust's income from activities (73%, 179,806k).

Revenues from countries outside of England are small (£42k received from Welsh and Scottish Commissioners). The Trust received £76k in relation to overseas visitors.

		2014/15 £000		2013/14 £000
Income		**267,576**		**266,705**
Expenditure				
Pay	**(180,497)**		**(172,925)**	
Non-pay	**(94,710)**		**(82,746)**	
Total Expenditure		**(275,207)**		**(255,671)**
EBITDA		**(7,631)**		**11,034**
Depreciation, PDC dividend, etc.		**(14,543)**		**(12,512)**
Surplus before non-current asset impairments		**(22,174)**		**(1,478)**
Non-current asset impairments		**(144)**		**(890)**
Surplus after non-current asset impairments		**(22,318)**		**(2,368)**

Quality Report

Colchester Hospital University NHS Foundation Trust Quality Report 2014 – 15

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PART 1 – STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE OF COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST

a. Introduction

This Statement of Quality provides a comprehensive overview of what we have done and what we plan to do regarding quality improvements. Furthermore, it sets out our plans for 2015-16 taking account of the fact that the Trust is in Special Measures, has Care Quality Commission (CQC) enforcement notices and is trying to implement a rapid recovery programme following a tumultuous period of change and instability.

During 2014-15, the Trust developed an action plan following the CQC visits of May and June 2014. The CQC visited the Trust in November and December 2014 and issued the Trust with Section 31 notices in respect of the Emergency Assessment Unit (EAU) and Accident and Emergency (A&E). (Detail is provided at Section 2.2.6 Trust Registration Status on page 26). The Trust, therefore, developed its planning further to create a Trust wide Improvement Plan incorporating the Special Measures action plan, the CQC Section 31 Notices and the CQC final report of January 2015. This Improvement Plan has been monitored by stakeholders at the Improvement Board and System Resilience Group. The aim of this Improvement Plan is to address the quality concerns raised and, thereby, remove the condition of Special Measures. The Improvement Plan is described on page 8 of this Introduction.

The Trust Board is very clear that Patient Safety and Experience are of paramount importance and must, therefore, remain at the forefront of everything that we do. Whilst the Special Measures and enforcement notices have proved disheartening for Trust staff, the outcome is that we are paying greater attention to detail and the need to take remedial action and learn the lessons. External scrutiny has been beneficial in that it has prompted greater reflection and resulted in more self and peer assessment so that regulatory compliance can be achieved.

The Trust had set 18 quality priorities for 2014-15. These have since been rationalised and reduced to 11 in the light of the need to pay targeted attention to areas with high risk implications and the inevitable impact of the changes required to meet regulatory registration requirements.

As with most Trusts, urgent operational priorities have had an impact on the pace of developmental quality work. An increase in demand for services against a reduced capacity and flow have resulted in the Trust declaring two internal incidents for A&E, one on 13 November 2014 and the other on 7 January 2015. However, the end of the 2014-15 financial year has seen an increase in stability and capacity following a period of major change and key staff turnover. A substantive Executive Team and Chair are now in post with the expectation that a cohesive and united Board can take forward the work required to get the Trust out of Special Measures and to have the Section 31 Notices lifted.

The Trust has an on-going recruitment and retention programme which struggled to reap benefits during April to December 2014. January to March 2015, however, has seen an increase in the overall staffing and nurse fill rates, which in turn has resulted in some stability and therefore the capacity and stability to promote quality improvements.

Major re-organisation and recruitment has occurred in all areas and levels of the Trust, from Board to divisional roles. Turnover in key roles, however, has also been high thereby impacting the pace at which the Trust Improvement Plan can be delivered and the quality priorities fully implemented at the necessary pace.

A high priority has been cultural change. This was identified as a priority in the 2013-14 Quality Report and reinforced by implications of external inspections. Transformational change has occurred at Board level with its processes and ways of working being reviewed to support the cultural change and clinical leadership required. Key leadership roles have been stabilised, with the Chief Executive's role being extended for a longer duration and the appointment of substantive Executive Directors. Further leadership and impetus has been given to the quality and governance agenda with the development of a new Director of Governance and Risk role.

Work has been initiated to engage staff and clinicians, particularly in the development of service changes. A regular theme from our external reviews is the kindness, compassion and friendliness of many of our staff which is one of our main strengths. We have worked to promote openness and honesty in staff reporting incidents and concerns.

Although the Trust rationalised and reduced its quality priorities to 11 for the year, this is not to say that the remaining 7 were forgotten. These priorities centred on the monitoring and escalation of the deteriorating patient, ensuring nursing assessment and provision of information when transferring patients to residential homes, Friends and Family roll out, falls, pressure ulcers, End of Life and mental illness measures.

An amalgamated approach has been taken to develop a Maternity Services Integrated action plan, following a CQC visit in May 2014 and a review by the NHS England Area Team Essex, along with other improvements from peer reviews. Areas for improvement address the following: individual plans of care which would include mental health aspects, reviewing care pathways to support vulnerable women in pregnancy, regular documentation audits, complying with the WHO safe surgery checklist to reduce the risk of never events, increase staffing and opportunities for multi-professional learning and service development. A Maternity Improvement Board monitors the progress made in respect of this integrated action plan which is also monitored by the Clinical Commissioning Group.

b. Progress on Issues noted for attention in the 2013-14 Quality Account for the year ahead (not designated as Trust Quality Priorities)

Good progress has been made with falls prevention in the Trust. Improvements are continuing to be made in the area of End of Life care. We are aiming for further on-going improvement in the area of preventing pressure ulcers, led by our Tissue Viability Nurse. Working in liaison with the North Essex Partnership University NHS Foundation Trust, the Trust has introduced an on-site Crisis Mental Health team to assess and assist with any concerns with mental health issues.

In respect of monitoring and escalation of deteriorating patients, the Trust had implemented the National Early Warning Score tool and training, by October 2013 in all adult areas. The implementation of a Maternity Early Warning Score (MEWS) tool and training was delivered in 2014-15.

The Trust has not been able to introduce electronic monitoring and escalation to assist the recognition and response to patients with deteriorating vital signs in this reporting period. Although the option of VitalPak (a proprietary electronic system) was explored it was turned down in the light of the significant costs involved. Plans for this Trust wide improvement are under review. The existing Trust Improvement Plan describes a range of actions to develop and support an integrated care pathway for deteriorating patients. This will be enhanced by the next phase of Trust improvement planning, reflecting CQC requirements.

In terms of clinical effectiveness with respect to nursing transfers, appropriate assessment and provision of information when transferring patients to nursing/residential homes has

been introduced to the Trust's quarterly audit programme. This improved process was identified in response to the need for a retrospective audit of patient records in this area. Compliance with the assessment process has been low historically and little or no improvement has been shown during this reporting period. Improvement of compliance will be managed through senior nurse management during 2015-16.

The Trust continues to collect Friends and Family data from patients and on a positive note, progress has been sustained during the reporting period. A range of initiatives combined gathering the views of patients, responding to the feedback and taking actions to enhance patient experience. Innovative practice continues to be encouraged and of note is the creation of the practical admission packs. This means that patients who are admitted unexpectedly are provided with the essentials for a hospital stay. Additionally, a system of "You Said; We Did" boards has been introduced. This demonstrates our willingness to respond practically to patients' views and encourage more patients to give their feedback. Further details can be found on page 50 at Part 2.3 of this report. The next phase of Trust improvement planning will include training of staff in medical ethics and work to promote the culture and processes needed to reflect the "lived experience" and voice of patients and their representatives, reflecting the recommendations of Healthwatch Essex.

c. Progress with Trust Quality Priorities identified for 2014-15

The detail of the changes made to the priorities as part of rationalising them, and detailed reports are on page 62 at Part 3 "Other Information".

Out of Hours, EAU and A&E

In respect of Out of Hours, EAU and A&E, the report at Part 3 provides full details regarding the Trust quality priority "Reduce the time patients wait ensuring we meet the 95% 4 hour target by March 2015". We have not met our 4 hour target for the year 2014-15. Like other trusts, our performance has been affected significantly by increased numbers attending A&E combined with many patients tending to be more sick and dependent with multiple co-morbidities.

The Trust has introduced a number of improvements that support its work in waiting time reduction. These include improved data collection processes and accuracy, creating the separate Urgent Care division and Clinical Decisions Unit, recruitment and realignment of staff and new ambulatory care pathways.

Further work is planned to reduce waiting times. This includes meeting CQC requirements as described on page 28 in Section 2.2.7 a, b, where CQC conclusions and requirements from their inspection reports are detailed.

Other key actions to improve patient safety and effectiveness in A&E and EAU will include ensuring a Standard Operating Procedure for patients who are clinically assessed as safe to be "stepped down" from A&E to EAU, review of plans for escalation of high patient activity in A&E to ensure timely response to surges and additional support to managers and staff at very busy times. Review of patient flow from A&E has been on-going, to ensure patients are assessed to meet their needs and avoid unnecessary delay.

Mortality

Work on mortality has remained central to the Trust's quality improvement process and is reported upon in detail on page 41 at Section 2.3 and on page 67 at Part 3 of this report. The Trust Improvement Plan includes a range of actions that strengthen further our mortality processes.

In addition, latest available HSCIC data from October 2013 to August 2014 shows a Trust SHMI performance at 1.043, classified “as expected”. Although the Trust has not met its quality improvement objective of not exceeding the relative risk of 100, performance has improved from a SHMI of 1.146 in June 2013.

Venous Thromboembolism

In respect of Venous Thromboembolism, the Trust has experienced difficulty in meeting its target to improve the number of patients being risk assessed to 95% by March 2015. Although nationally produced data shows a performance of 94.35% up to November 2014, narrowly missing the Trust target, local data shows performance of at least 90% from January 2015 onwards but not meeting the 95% target. Details are given of this Core Indicator and Trust quality objective on page 56 in section 2.3 and on page 72 at Part 3.

World Health Organisation (WHO) Safer Surgery Checklist

The World Health Organisation (WHO) Safer Surgery Checklist is an international initiative to reduce errors in surgery. Pages 74-76 at Part 3 give details of a range of initiatives and actions to achieve 100% compliance with all elements of the WHO safety checklist.

The Trust has reported nine Never Events in the reporting period 2014-15, involving nine patients. All these incidents involved surgery. A key cause was failure to follow checking and counting processes consistently.

Never Events are a sub-set of the Serious Incidents that all hospitals have to report. They are defined as “serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by the healthcare provider”.

The Trust has responded to these incidents by putting preventive measures in place and increasing staff awareness. This has involved a combination of immediate practical steps to improve patient safety and longer term improvements. For example, banning the use of a particular type of gauze swab in one type of procedure is aimed at preventing recurrence through eliminating a key factor in the underlying cause of the incident.

The key learning changes being made are to foster a culture where all staff follow the WHO safety checklist consistently. This area has been identified for on-going improvement as a quality priority in the year ahead.

Additionally, work includes a combination of systems, process and communication improvements with training and cultural interventions. Datix incident reporting and investigation identify instances where surgical processes have not been fully compliant with the WHO safer surgery checklist. These incidents are not Never Events and some cause no harm to patients, but others have placed patients at some risk or caused some harm. The initiatives described on pages 74-76 at Part 3 under the Safer Surgery quality priority, are aimed at promoting 100% compliance with the WHO safe surgery checklist. Although a figure of 98% compliance is reported, it may be that further work on human factors will lead to increased rigor in reporting non-compliance. A lower compliance figure in future reports may indicate more accurate reporting rather than worsening performance.

Dementia

Regarding Dementia, the Trust has consistently achieved its target of achieving 90% compliance with each CQUIN measure by March 2015. Details of a range of significant and successful work in the area of dementia are given on page 85 at Part 3. These include a

strong emphasis on rigorous dementia assessment, screening and follow up, along with several training initiatives and, a drop-in service, and seeking patient views through new survey methods. The Trust is planning to build further on its work in this area through maintaining this target for the year to come, and through planned actions for adult safeguarding.

Ward to Board; leadership, staff engagement and communication programme

The Trust has continued to focus on Ward to Board; a staff leadership programme and initiatives to improve staff engagement and communication. This period of relative instability, alongside intense external scrutiny, at a time of increased demand for Trust services has resulted in a very demanding time for all our staff. This has been reflected in the 2014 staff survey. The Trust is planning to take steps to make lasting and real improvements and acknowledges that this will be a challenge. The report on the quality objective "Improve the way we communicate with each other from ward to Board" on page 88 at Part 3 describes Trust work in the area of two way communication between the Board and all staff. More detail is provided at Part 3 on actions taken and planned.

Considerable re-organisation and changes in senior roles along with a change in the appraisal process have affected the Trust's goal plan to increase the percentage of appraisals completed and avoid the gap between appraisals being more than one year. This important objective will be reviewed in the year ahead along with the appraisal process itself, aiming to improve the Trust's performance in the national indicator where it is currently placed relatively low. Nonetheless, the Trust increased the percentage of completed appraisals from 67.39% to 76.78%.

A wide range of communication initiatives have been undertaken and include extending the monthly Chief Executive briefing from senior managers only, to all staff who wish to attend, as well as the weekly Chief Executive email, and new staff suggestions boxes.

Progress has been made on encouraging staff reporting of both clinical and non-clinical concerns. Proactive poster campaigns regarding incident reporting and the new "You said, we did" process encouraged staff to raise concerns and make suggestions. Additional survey work has helped to understand staff views.

Significant structural changes have been aimed at increasing staff engagement and the quality of leadership. Divisional restructuring and new senior roles, particularly those of the Associate Directors of Nursing, Associate Directors of Operations and Clinical Divisional Directors, have laid the foundations for improving engagement and communication further. Additionally, reemphasis on standing agendas and monthly governance meetings at all levels in divisions have increased the opportunities for staff contribution and engagement.

As Chief Executive, I have directly encouraged openness and reporting. A review of ways of improving opportunities for staff to speak to Board members and raise Board members' visibility is underway also. A new post of Organisation Development and Staff Engagement Lead is being created.

Strengthening and simplification of Board Assurance Framework processes is aimed at improving engagement and contribution of Board members, whilst enhancing the quality of management of risk. The rigour and scrutiny of risk management processes has been improved, with more proactive use of the risk register. Monthly reports to divisions include feeding back on the management of each risk. The operation, senior membership and outcomes of the daily Serious Incidents (SI) panel have been considerably enhanced with complaints included twice weekly and encouragement of divisional ownership of SI investigation and learning.

A range of communications and engagement actions, including Ward to Board, are included in the existing Trust Improvement Plan, and reflected in the next phase of Trust improvement planning.

d. Main priorities of the Trust's Improvement Plan and Quality Priorities for 2015-16.

The more quantitative and specific Quality Priorities selected by the board for 2015-16 for achievement by March 2016 are given in full in the next section of this report. Highlights are summarised below.

The actions the Trust has planned to take following inspections and reviews from Monitor, CQC and Keogh are integrated into an overarching Improvement Plan. For detailed actions please see pages 28-35 at Section 2.2.7 of this report.

A brief summary of some important highlights of the actions already planned in the first phase of Trust improvement planning is given below, themed under patient safety, clinical effectiveness and patient experience.

Patient Safety highlights

A Nursing and Midwifery strategy launch is planned. This includes a proactive recruitment and retention plan, reducing temporary staff and displaying staffing skills and levels on each ward. Staffing numbers and skills mix will be reviewed twice yearly, combined with a measure of how ill our patients are. All staff achieving mandatory training is emphasised and some nursing roles in A&E will be clarified. In addition, action will be taken to ensure:

- Embedding of aggregated learning at service, divisional and Trust levels, including divisions having an organised updated plan for their complaints and incidents, sharing them with affected staff and holding post incident debriefings and providing evidence of implementation of learning. All lead clinicians will be trained in incident root cause analysis and how to report an incident or concern.

- All areas are monitoring and reporting on their mortality, identifying any preventable deaths and ensuring follow up and improvements are made.

- All areas are meeting cleanliness, decontamination and hand hygiene standards, with training, audits and a review of cleaning specifications and contingency plans in case of outbreaks.

- Every patient's nutritional need is assessed and planned, as required, on admission.

- Achievement of the Trust's targets for Healthcare Related Infections (HCAI) - zero for MRSA and no more than 18 cases for Clostridium difficile.

- Reduction of the incidence of medication missed doses by 50% by March 2016.

- Compliance with the 5 Steps for Safer Surgery, as per the 85% benchmark.

Clinical Effectiveness highlights

Work will continue to build upon good progress that has been made with increasing:

- Senior management leadership and visibility; senior members on Trust Groups and committees.

- Consistent structures and processes for 2 at the Top, service and divisional governance meetings monitoring performance.

An innovation panel will be launched and innovative ideas from staff encouraged so that a fresh approach to improvements can be made. In addition, action will be taken to ensure:

- Monthly peer reviewed compliance visits for each clinical service.

- Improvements in adult safeguarding, including structures, processes, communications and training, with a particular focus on vulnerable patients, care of the elderly and A&E admissions, ensuring on-going oversight and monitoring.

- Development of pathways for patients with complex care needs. This will include care of patients with multiple conditions, development of care bundles and review of the effectiveness of care through mortality and morbidity analysis and governance meetings.

- Improvements to A&E and EAU pathways and structures, including See and Treat, streaming of specific patient groups, establishment of GP referral triage arrangements and the development of the unit for Frail and Elderly patients in EAU.

- Structural, process and training improvements in the care of the deteriorating patient, including an integrated care pathway, high observation bays and increasing Critical Care Unit capacity to 14 beds.

- Improvement in discharge communication, including increasing the practice of explaining the discharge summary to patients/carers being discharged.

- Review of re-admission data, including increased quarterly review with follow up of agreed actions by all admitting specialties.

- Embedding of clinical governance from ward to Board level, ensuring 100% compliance with monthly meetings in all divisions and evidence of follow up actions.

Patient Experience highlights

The Trust has made plans to re-launch and reinforce its core At Our Best values and programme. This will include appraisals, induction and recruitment processes. In addition, action will be taken to ensure:

- Further work to develop action plans to respond to staff survey results and set up and develop a Patient Experience and Carer Strategy and Group.

- Further varied work to review complaints processes and learning and increase the annual percentage of complaint responses meeting agreed timescales by 10%.

- Implementation of learning from the Retrospective Review Audit of patients on cancer pathways, through establishing a Trust wide mechanism for real time feedback from cancer patients.

- For dementia, demonstration of continuing compliance with the 90% target for each CQUIN measure.

Healthwatch Essex report - Cancer Services in Colchester: A Study of Patient and Carer Experience October 2014

Following the CQC report into cancer care at Colchester Hospital University NHS Foundation Trust in autumn 2013, Healthwatch Essex undertook a detailed study of over 200 patients and carers to reveal valuable insights into the lived experiences of our patients undergoing cancer care.

Recommendations have informed our improvement plan and include making communication more effective and improving how we listen and respond to patients' and carers' views and experiences. Our quality improvement programmes should be informed by more qualitative types of research with on-going evaluation so we can understand better the experiences of our patients and their carers. Ethics training for staff at Colchester Hospital and in the Colchester area is also recommended. We are committed to making real improvements by using this report and are delighted to have Healthwatch facilitating our Board patient experience training on 30 April 2015, as a precursor to this process.

The Trust has been working closely with Essex County Council and other partners to reduce delayed discharges. Over the autumn and winter of 2014/15, the North East Essex health system has been working collaboratively through the local System Resilience Group (SRG). A number of collaborative work streams arising from the SRG are focused on supporting the discharge of patients with complex needs. These include the appointment of a community discharge coordinator to work in an in-reach role into the hospital and coordinate the placement of patients to a wide range of community settings including community hospitals, re-ablement services and social care placements. Essex County Council has also undertaken work to improve the responsiveness of social care providers to reduce the delay between referral for assessment and successful placement or start of domiciliary services.

In addition there is an on-going project group to redesign the complex discharge pathway and the integrated discharge team between the hospital and social care staff based in the hospital. This is supported by a specialist facilitator, and reports to the Chief Operating Officer for Colchester Hospital, and the Director of Adult Social Care.

e. Conclusion

The Trust has achieved significant progress in meeting its quality improvement targets and addressing a wide range of other areas that enhance its quality performance. The meeting of few quality improvement targets, at this stage in the Trust's development, is of concern but needs to be viewed in the context of the significant progress made to improve quality by a highly dedicated and caring workforce.

Operational challenges, cost constraints, increasing and changing demand patterns and the continuing effects of significant changes in senior roles remain important factors and constraints, limiting the pace of quality progress in some areas.

I am highly committed to promoting management ownership of the range of quality processes, as well as encouragement of staff involvement in all aspects of quality activities. The involvement of patients, relatives and carers will be another area of Trust development and work in this area has begun in consultation with Healthwatch Essex.

The scrutiny and inspection the Trust has received, and its being in Special Measures, have led to the identification of a wide range of areas for improvement. We are fully committed to

making these improvements. Achieving these will be a significant challenge, due to the demands of managing complex change.

The Trust ends this reporting period, however, in a stronger position than it has been previously. External scrutiny and inspection confirm that we are heading in the right direction, with the right people and the right values. We look forward to improving further in the year to come.

I can confirm that, to the best of my knowledge, the information in this document is accurate.

Dr Lucy Moore
Interim Chief Executive

28 May 2015

PART 2 – PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Detailed reports against specific indicators for quality improvement for 2014-2015 are to be found at Part 3 starting on page 62.

2.1 – PRIORITIES FOR IMPROVEMENT 2015-2016

The Trust plans to review the priorities for improvement identified below as part of the next phase of Trust improvement planning, in order to create greater integration and linkage between the overall Trust Improvement Plan and the more specific and quantitative quality priorities for improvement identified by the Board.

Colchester Hospital University NHS Foundation Trust has identified the following priorities for improvement in 2015-16, structured under the headings of safe care, effective care and patient experience:

<u>Safe Care</u>

1. Healthcare Related Infections (HCAI) – work continuously to reduce HCAIs, including:

    a. Achieve Trust financial year target of zero for Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia by 31 March 2016.

    b. Achieve Trust financial year target of no more than 18 cases for Clostridium difficile by 31 March 2016.

2. Medication and missed doses – to reduce the incidence of medication missed doses by 50% by March 2016.

3. World Health Organisation (WHO) Checklist – achieve compliance with all the Steps for Safer Surgery (briefing, sign in, timeout, sign out and debriefing) using the WHO checklist as per the 85% benchmark by March 2016.

<u>Effective Care</u>

4. Improve the process of discharging patients and engaging patients and carers fully in this process by:
    a. Discharge communication; increase the practice of explaining the discharge summary to patients/carers being discharged by 50% by March 2016.

5. Review re-admission data: increase quarterly review with follow up of agreed actions by all admitting specialties by March 2016.

6. Governance – embed clinical governance from ward to Board level ensuring 100% compliance with monthly meetings in all divisions and with evidence that actions arising have been followed up after meetings by March 2016.

<u>Patient Experience</u>

7. Cancer pathway – learn from Retrospective Review Audit; establish Trust wide mechanism for real time feedback from cancer patients by March 2016.

8. Dementia – to demonstrate continuing compliance with the 90% target for each CQUIN measure by March 2016.

9. Complaints – increase the annual % of complaint responses meeting agreed timescales by 10% by March 2016.

2.2 – STATEMENTS OF ASSURANCE FROM THE BOARD

2.2.1 - During 2014–15 Colchester Hospital University NHS Foundation Trust provided and/or sub-contracted 63 relevant health services.

Colchester Hospital University NHS Foundation Trust has reviewed all the data available to them on the quality of care in 63 of these relevant health services.

The income generated by the relevant health services reviewed in 2014–15 represents 100% of the total income generated from the provision of relevant health services by Colchester Hospital University NHS Foundation Trust for 2014–15.

2.2.2 - National Clinical Audits, National Confidential Enquiries

In this section, the full lists of data required by the mandatory Monitor structure for Quality Accounts are included. Although this reduces the readability of the report, the mandatory structure does not allow for this information to be placed in an annex.

National clinical audits and national confidential enquiries are tools that NHS organisations use to assess the quality of services provided, against the best available evidence based guidance and standards.

At Colchester Hospital University NHS Foundation Trust, we undertake many clinical audits. We participate in all national audits which are applicable to the organisation. This allows us to benchmark against other hospitals in England. We also have a programme of local clinical audits to improve local areas of care.

During 2014/15, 34 national clinical audits and 4 national confidential enquiries covered relevant health services that Colchester Hospital University NHS Foundation Trust provides.

During that period Colchester Hospital University NHS Foundation Trust participated in 88% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquires 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 2014/15 are as follows (see table 1):

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust participated in during 2014/15 are as follows:

Table 1: A list of the national clinical audits that the Trust was eligible to participate in and did participate in (2.2.2 & 2.2.3).

No.	National Clinical Audit	Eligible	Participated
1	Adult critical care (Case Mix Programme – ICNARC CMP)	Y	Y
2	Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (also known as Medical and Surgical Clinical Outcome Review Programme, or Patient Outcome and Death)	Y	Y
3	National emergency laparotomy audit (NELA)	Y	Y
4	National Joint Registry (NJR)	Y	Y
5	Severe trauma (Trauma Audit & Research Network, TARN)	Y	Y
6	National Comparative Audit of Blood Transfusion programme - 2014 Audit of patient information and consent	Y	Y
7	Bowel cancer (NBOCAP)	Y	Y
8	Head and neck oncology (DAHNO)	Y	Y
9	Lung cancer (NLCA)	Y	Y
10	Oesophago-gastric cancer (NAOGC)	Y	Y
11	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	Y
12	Cardiac Rhythm Management (CRM)	Y	Y
13	Heart failure (HF)	Y	Y
14	National Vascular Registry (elements will include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)	Y	Y
15	Chronic Obstructive Pulmonary Disease (COPD) Please note: this is NOT the COPD audit run by the British Thoracic Society)	Y	Y
16	Diabetes (Paediatric) (NPDA)	Y	Y

No.	National Clinical Audit	Eligible	Participated
17	Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services	Y	Y
18	Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)	Y	Y
19	Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13)	Y	Y
20	Elective surgery (National PROMs Programme) – See note below*	Y	Y
21	Epilepsy 12 audit (Childhood Epilepsy)	Y	Y
22	Maternal, infant and new born programme (MBRRACE-UK) (Also known as Maternal, New born and Infant Clinical Outcome Review Programme)	Y	Y
23	Neonatal intensive and special care (NNAP)	Y	Y
24	Rheumatoid and early inflammatory arthritis (new NCAPOP topic under development)	Y	Y
25	Pleural procedures	Y	Y
26	Prostate Cancer	Y	Y
27	Renal replacement therapy (Renal Registry)	Y	Y
28	Mental health (care in emergency departments)	Y	Y
29	Older people (care in emergency departments)	Y	Y
30	Fitting child (care in emergency departments)	Y	Y
31	*Adult community acquired pneumonia*	Y	N
32	*Non-invasive ventilation – adults*	Y	N
33	*National Cardiac Arrest Audit (NCAA)*	Y	N

No.	National Clinical Audit	Eligible	Participated
34	*National Audit of Dementia*	Y	N
No.	**National Confidential Enquiries**		
1	Sepsis	Y	Y
2	Gastrointestinal Haemorrhage	Y	Y
3	Lower Limb Amputation	Y	Y
4	Tracheostomy Care	Y	Y

The national clinical audits and national confidential enquires that Colchester Hospital University NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, 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.

*N.B.: Regarding PROMs programme below, the Trust submission figures are reliant on patients completing and returning questionnaires.

No.	National Clinical Audit	Percentage of cases submitted against the number of registered cases required by the terms of that audit or enquiry.
1	Adult critical care (Case Mix Programme – ICNARC CMP)	100%
2	Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (also known as Medical and Surgical Clinical Outcome Review Programme, or Patient Outcome and Death)	100%
3	National emergency laparotomy audit (NELA)	100%
4	National Joint Registry (NJR)	100%
5	Severe trauma (Trauma Audit & Research Network, TARN)	100%
6	National Comparative Audit of Blood Transfusion programme - 2014 Audit of patient information and consent	100%
7	Bowel cancer (NBOCAP)	100%

No.	National Clinical Audit	Percentage of cases submitted against the number of registered cases required by the terms of that audit or enquiry.
8	Head and neck oncology (DAHNO)	100%
9	Lung cancer (NLCA)	100%
10	Oesophago-gastric cancer (NAOGC)	100%
11	Acute coronary syndrome or Acute myocardial infarction (MINAP)	100%
12	Cardiac Rhythm Management (CRM)	100%
13	Heart failure (HF)	100%
14	National Vascular Registry (elements will include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)	100%
15	Chronic Obstructive Pulmonary Disease (COPD) Please note: this is NOT the COPD audit run by the British Thoracic Society)	100%
16	Diabetes (Paediatric) (NPDA)	100%
17	Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services.	100%
18	Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)	100%
19	Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13)	100%
20	Elective surgery (National PROMs Programme) – See note above*	56%
21	Epilepsy 12 audit (Childhood Epilepsy)	100%

No.	National Clinical Audit	Percentage of cases submitted against the number of registered cases required by the terms of that audit or enquiry.
22	Maternal, infant and new born programme (MBRRACE-UK)* (Also known as Maternal, New born and Infant Clinical Outcome Review Programme)	100%
23	Neonatal intensive and special care (NNAP)	100%
24	Rheumatoid and early inflammatory arthritis (new NCAPOP topic under development)	100%
25	Pleural procedures	100%
26	Prostate Cancer	100%
27	Renal replacement therapy (Renal Registry)	100%
28	Mental health (care in emergency departments)	100%
29	Cognitive Assessment in Older people (care in emergency departments)	100%
30	Fitting child (care in emergency departments)	100%
No.	**National Confidential Enquiries**	
1	Sepsis	60%
2	Gastrointestinal Haemorrhage	67%
3	Lower Limb Amputation	86%
4	Tracheostomy Care	100%

The reports of 15 national clinical audits were reviewed by the provider in 2014/15 and Colchester Hospital University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

No.	National Audit	Descriptions of actions
1	Adult critical care (Case Mix Programme – ICNARC CMP)	Discussed as an Agenda item at the Critical Care Governance monthly meeting
2	Severe trauma (Trauma Audit & Research Network, TARN)	Latest information extracted from the online reporting mechanism and discussed at the last Trauma Committee Meeting – January 2015
3	National Comparative Audit of Blood Transfusion programme - 2014 Audit of patient information and consent	Report discussed at the Hospital Transfusion Committee
4	Lung cancer (NLCA)	Discussed at the Lung Cancer Multi-Disciplinary team meeting
5	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Report disseminated
6	Cardiac Rhythm Management (CRM)	Report disseminated
7	National Vascular Registry (elements will include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)	Report disseminated to clinical leads
8	Diabetes (Paediatric) (NPDA)	Report disseminated
9	Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services.	Report disseminated
10	Renal replacement therapy (Renal Registry)	Annual presentation of the report at the medical governance meeting
11	Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)	Report disseminated
12	Elective surgery (National PROMs Programme)	Report disseminated
13	Epilepsy 12 audit (Childhood Epilepsy)	Report disseminated
14	Maternal, infant and new born programme (MBRRACE-UK)	Report disseminated
15	Neonatal intensive and special care (NNAP)	Report disseminated

2.2.3 - Local Audits

The reports of 37 local clinical audits were reviewed by the provider in 2014/15 and Colchester Hospital University NHS Foundation Trust University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

Medical Division		
No.	**Audit**	**Description of actions**
1	Review of the use of fundoparinox in acute coronary syndrome	Raise awareness of the findings of the audit in A&E and EAU
2	ACE AUDIT- Diabetic foot clinic patient satisfaction survey	Actions: None. Patients are very satisfied with the overall running of the clinic
3	Management of atrial fibrillation in a DGH	To be presented
4	An audit of the quality of two week referrals to Upper GI (OG and HPB) Cancer at Colchester Hospital	2 week referral system amended and updated in light of the audit findings. Discussion had with CCG for re-commission open access gastroscopy referral pathway. Education provided to GPs.
5	Surveillance and audit of management of bacteria due to resistant coliforms	Use of the urinary catheter passport to ensure catheters are managed appropriately
6	Deep Vein Thrombosis (DVT) in A&E	To train all A&E staff on the treatment pathway for DVT –in teaching sessions or at induction.
7	Re-audit - A retrospective process-audit examining the acute exacerbation of COPD care bundle at CGH	Creation of additional COPD code. Training re O_2 prescribing, COPD bundle awareness, liaison with COPD team, recording of venepuncture timing, repeat audit.
8	Re-audit Anaphylaxis / allergic reaction	Explore the possibility of splitting anaphylaxis and allergic reaction into separate codes, produce a set of intranet accessible guidelines re: anaphylaxis and allergic reaction, reinforce the importance of documenting observations to nursing and allied healthcare staff, reinforce the importance of oxygen prescribing to doctors and nursing staff.

Medical Division		
No.	**Audit**	**Description of actions**
9	Weekend handover project	Educate juniors on how to use handover system. Produce presentation for audit meeting. Produce guide poster for handover
10	Management of AF in the Accident and Emergency (A&E) Department	Leaflets/posters on stroke risk assessment. Re-audit in one year to check progress
11	Are we following the CEM guidelines for thromboprophylaxis in lower limb fractures	Email audit to A&E doctors, email guidelines to A&E doctors, make CEM thromboprophylaxis assessment tool available in A&E
12	Compliance with DNAR (Do not attempt resuscitation) guidelines	Increase staff awareness of the DNACPR decision making process through a departmental-level (grand round) presentation. Re-audit when local guidelines are updated to account for recent high-court ruling regarding discussing DNACPR decisions.
13	Trauma Team Activation	Display Trust guidelines by pre-alert phone in Resuscitation. Ensure location for storage of old pre-alert books is agreed upon, Re-iterate by e-mail trauma team activation guidelines
14	Ottawa rules ankle/knee	Design a pro forma with Ottawa Ankle rules picture to remind medical professional to follow strictly set guidelines. Re-audit in 3-6 months
15	Management of Asthma in children in ED	Create awareness and Educate all doctors and Nurses on use of ICP proforma To ensure that PEFR readings are taken on ALL patients To modify current proforma so it is inclusive
16	Cellulitis	Inform microbiology of differing guidance on intranet/microguide app. Design new guidelines for new CDU.

Medical Division		
No.	**Audit**	**Description of actions**
17	Time elapsed between first medical contact and ECG performance	Loose ECGs returned to notes or reception if separated. Scan ECGs carefully. Ensure all ECG machines do time/date stamps. Ensure adequate no. ECG machines & staff. Aim to do ECG before bloods. Ensure staff know how to change ECG times and are instructed to change after daylight savings.

Surgery Division		
No.	**Audit**	**Description of actions**
1	Audit of consent in trauma (re-audit)	Presented at July Governance Half Day Meeting
2	Anaesthetics drugs in A&E	Presented at Anaesthetics Governance meeting, September
3	Arterial line insertion on ITU	Presented at Anaesthetics Governance meeting, September
4	Documentation in ITU: Discussions with relatives	Presented at Anaesthetics and Medicine Governance meetings April

Cancer and Clinical Support Services		
No.	**Audit**	**Description of actions**
1	Audit of patients dying in 30 days of Systemic Anti-Cancer Treatment (SACT)	Learning presented at bi-monthly Chemo quality meetings
2	Audit of MRI Spine requests in CHUFT patients for suspected Metastatic Spinal Cord Compression (MSCC)	Presented at Oncology half day governance, November
3	Neutropenic sepsis audit of door to needle time	Presented at EoE cancer telecon 21/10/14
4	Cancer Arbiraterone in castrate resistant prostate cancers	Presented at Oncology half day 15/9/2014

Women's and Children Division		
No.	**Audit**	**Description of actions**
1	Management of children admitted with overdose	Findings will be conveyed to the CAMHS team for their information, no action required
2	Investigation and management of urinary tract infections in children under 16 years	Implementation of an integrated care pathway for all children with suspected UTI to enable better documentation and as a result better care.
3	Audit of the completion of a malnutrition screening tool for paediatrics on a children's ward by non-nutrition healthcare professionals	Train staff involved in patient care on the use of the tool and the importance of nutritional screening.
4	Re-audit (Bronchitis admissions and statistics) Respiratory Syncytial Virus (RSV) and Palivizumab	Continue present arrangement of providing Synagis immunisation, teaching parents in the Children's Ward, Children's Assessment Unit and Neonatal Unit. Modification of the information leaflet, Abstract of the presentation to the North East Essex CCG.
5	Investigation of post-menopausal bleeding	Review history proforma for the clinic
6	Recons form usage and documentation	Education of staff to promote the importance of completing the form. Supervision of staff to ensure forms are completed before discharge.
7	Medical Termination of pregnancy	Better record keeping for assessment of Service. Emphasis on follow up. Consideration of Medical TOP as an outpatient
8	Screening for Gestational Diabetes	Improvement of current risk scoring tool. Consideration of including those with a history of Polycystic Ovaries.
9	Management of Post-menopausal Ovarian Cysts	Implementation of Ovarian cyst proforma, outlining appropriate management.
10	Induction of labour after caesarean section	Aim for 100% documentation of risk counselling on proforma. Offer after 41 weeks gestation. Use Propess.
11	Category 1 Caesarean section	Achieved in less than 30 mins in 83%. Improve transfer time to theatre.
12	Code Blue Major Obstetric Haemorrhage	Look out for risk factors for Atony which is a component of most code blues. Actively

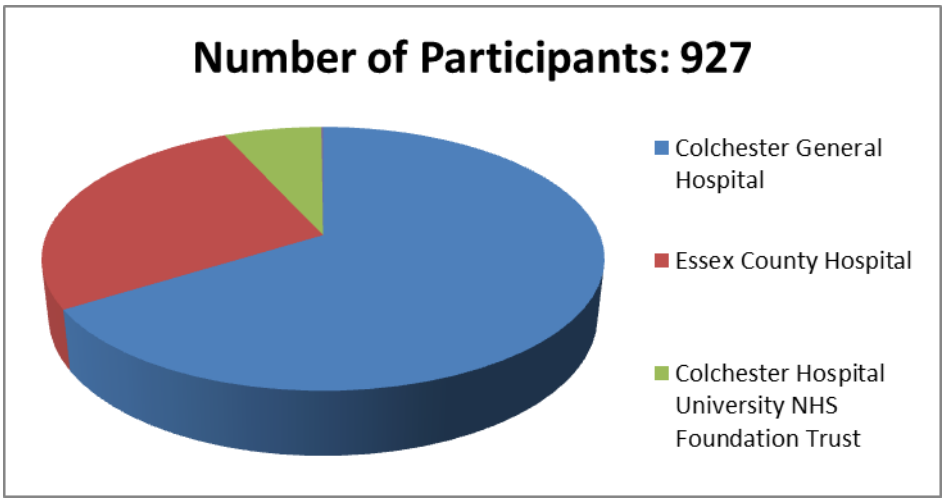
		manage the 3rd stage in rapid labours

2.2.4. - Numbers of patients recruited onto research programmes

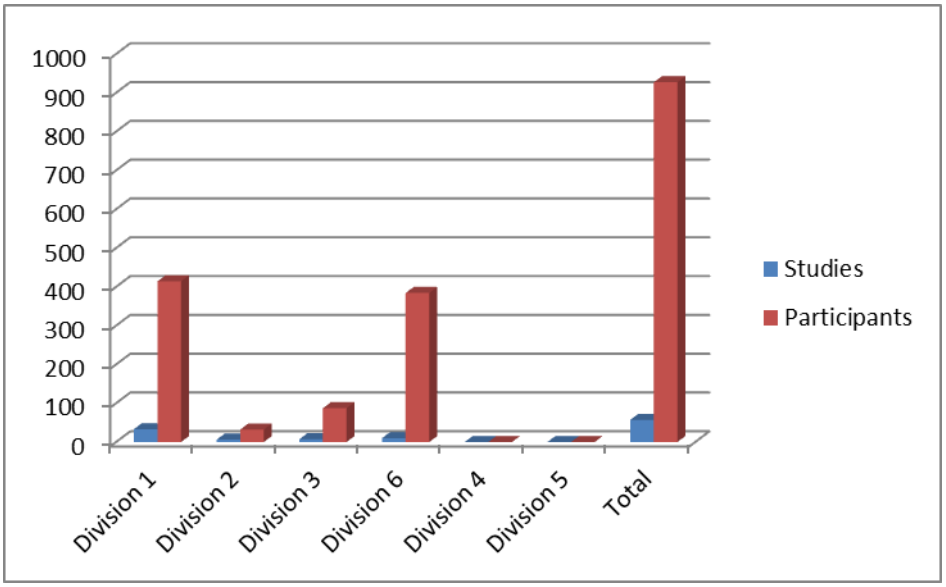
The number of patients receiving relevant health services provided or sub-contracted by Colchester Hospital University Foundation NHS Trust in 2014-15 that were recruited during that period to participate in research approved by a research ethics committee was 927. This represents an increase from the 760 patients recruited in 2013-14.

Number of patients recruited into NIHR CRN Portfolio studies

The trust was reported as recruiting 927 participants into portfolio studies for 2014/15 against a local target set at 850 participants. From 1st April 2014, the Trust became a member of Clinical Research Network (CRN) Eastern) and activity is reported across 6 divisions.



Participant recruitment by Speciality Divisions: 2014/15



156 Patients recruited to Haematology (Malignant Cancer) are included within Division 1

*Figures based on Open Data Platform as of 13th April 2015. Cut-off date for ODP FY14/15 total - End of April 2015.

NHS trust research activity league table

The Guardian publishes data received from the National Institute for Health Research, detailing the number of studies undertaken by each individual trust and the number of patients recruited

http://www.theguardian.com/healthcare-network-nihr-clinical-research-zone/table/nhs-trust-research-activity-league-table-2013-14

2.2.5. - CQUINS

A proportion of Colchester Hospital University NHS Foundation Trust's income in 2014-15 was conditional on achieving quality improvement and innovation goals agreed between Colchester Hospital University NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the commissioning of quality and innovation payment framework.

Further details of the agreed goals for 2014-15 and for the following 12 month period are available electronically at: http://www.england.nhs.uk/nhs-standard-contract/15-16/

The monetary total for income in 2014/15 conditional upon achieving quality improvement and innovation goals was £4,539,922. The monetary total for the associate payment for 2013/14 was £4,044,057.

The CQUINs for 2015-16 are according to the national CQUINs available at the weblink above and this will be supplemented with local defined schemes. At the writing of this report, local schemes are under discussion and for agreement with commissioners, but the list available includes:

- Acute Kidney Injury
- Sepsis screening
- Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)
- Reduction in A&E MH re-attendances
- Improving recording of diagnosis in A&E
- Workforce (leadership, management, recruitment, retention and reward, change and ability to adapt and work differently and engagement).
- The provision of specialist support for women with perinatal mental health concerns.
- Safer Patient Flow Bundle
- To enhance Clinical audit efficiency, effectiveness and capacity across the CCG and Trust
- Reduce separation of mothers and babies and reduce demand on neonatal services by improving learning from avoidable term admissions (≥ 37wk gestation) into neonatal units.
- Eligible patients receiving a NICE DG10 compliant test with provision of monitoring data
- Increasing home renal dialysis

2.2.6 – Trust Registration Status

Colchester Hospital University NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with conditions.

The Care Quality Commission has taken enforcement action against Colchester Hospital University NHS Foundation Trust during 2014-15.

Colchester Hospital University NHS Foundation Trust has the following conditions of registration:

The Trust has an overall rating of inadequate following a final report from the Care Quality Commission in January 2015. The hospital has two section 31 notices in respect of EAU and A&E services at Colchester General Hospital and has been in Special Measures since November 2013.

The EAU section 31 notice has 7 conditions and the A&E section 31 has 5 conditions. The conditions on the Trust's registration are in respect of triage in A&E and cohorting of patients within an appropriately staffed HDU area on EAU.

1. Colchester Hospital University Foundation NHS Trust must ensure that the Emergency Assessment Unit, which incorporates the GP triage referral area, is staffed by a sufficient number of suitably qualified, skilled and experienced staff. The Trust must carry out an assessment of the acuity of all patients using a nationally recognised acuity tool in order to determine the number of staff of the suitable qualification, skill and experience to meet the needs of all patients and that that assessment is undertaken at least once per shift.

2. Patients attending the GP triage referral area are to stay in the GP triage area for no more than 12 hours.

3. Colchester Hospital University Foundation NHS Trust may use some of the existing beds to cohort patients with a defined level of care of 2 in accordance with the Intensive Care Society's guideline 'Levels of Critical Care for Adult Patients (revised 2009)' in an appropriately staffed area.

4. Colchester Hospital University Foundation NHS Trust must ensure that the beds as outlined in Condition 3, are staffed in accordance with the Intensive Care Society's guideline 'Core Standards for ICU 2013' to ensure that staffing levels in this cohorted area are safe.

5. Colchester Hospital University Foundation NHS Trust is permitted to use these beds, as described in Condition 3, flexibly to meet demand in the EAU. Where the demand for level 2 beds is low the registered provider is permitted to use these beds for patients with a lower acuity and dependency need. However the provider must ensure that patients with level 2 needs are cohorted in this area as a priority.

6. Colchester Hospital University Foundation NHS Trust must ensure that only those beds remain open in respect of which the required level of staffing can be provided, and no further beds opened if care at the appropriate level could no longer be provided for patients on the Unit, so as to ensure the safety of patients.

7. Colchester Hospital University Foundation NHS Trust shall, as soon as is reasonably possible and in any event by 4pm on 28 January 2015, describe the system operated by the Trust is operating its Emergency Assessment Unit at Colchester Hospital so as to comply with these conditions. The trust must send the Care Quality Commission twice weekly updates in this respect from week commencing 26 January 2015.

The A&E Section 31 notice has 5 conditions as follows:

1. Colchester Hospital University Foundation NHS Trust must operate an effective system which will ensure that patients attending Accident and Emergency at Colchester General Hospital are streamed to appropriate patient pathways.

2. For the purpose of condition one, 'Streaming' will be undertaken in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011, a copy of which is attached to this condition ("the CEM standard") or such other recognised professional processes or mechanisms as the Registered Provider commits itself to.

3. Colchester Hospital University Foundation NHS Trust will ensure that a suitably qualified, skilled and experienced nurse is placed within the main area of the Accident and Emergency Department to support the streaming of patients into the pathways referred to in condition one.

4. For all patients being assessed in the streaming process referred to in condition one the Trust will ensure that:

   a) the patient's arrival time to the Accident and Emergency Department is recorded.
   b) they record the time at which an initial clinical assessment is commenced for each patient and by whom the assessment is being undertaken.
   c) they determine which pathway the patient will take and record this on the record.
   d) prior to leaving the Accident and Emergency department patients who do not require accident and emergency services must be provided with information of alternative services where they can receive their care.

5. Colchester Hospital University Foundation NHS Trust shall, as soon as is reasonably possible and in any event by 4pm on 28 January 2015, describe the system operated by the Trust within its A&E Department at Colchester Hospital so as to comply with the standards set out in conditions. The Trust must send the Care Quality Commission twice weekly updates in this respect from week commencing 26 January 2015.

2.2.7. - CQC Inspections

Mandatory Monitor numbers are in brackets after mandatory headings in italics.
Colchester Hospital University Foundation NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2014-15 (7.1.a. and b).
The Trust has been inspected by the CQC on the following occasions:

6 – 8 and 16-19 May and 18 June 2014 – the follow up inspection as part of the Keogh Mortality Review 2013.

The inspection covered A&E, medical care, Surgery, Critical Care Unit, maternity and family planning, children's and young people, End of Life care and Outpatients and covered both Colchester Hospital and Essex County Hospital.

The report found that patients and relatives spoke very highly of the service and that staff demonstrated caring and compassion in all clinical areas, commitment and loyalty. Good systems were noted for cleanliness and infection prevention and control.

Two services were found to be good (Surgery and Critical Care Unit), however, the remaining areas inspected had inconsistent and poor practice in general and resulted in an overall Trust rating of "requires improvement".

Key themes for improvement were:

- A need to recruit a substantive and credible Board of Directors
- Develop a clear strategy for leadership development and staff engagement at all levels
- Incorporate the patient voice in a systematic way into the workings of the Board

- Undertake an independent review of the management of elective waiting lists in all areas
- Improve systems and processes for storage and management of all medicines including Controlled Drugs.
- The Trust must assure itself that "5 Steps to Safer Surgery" (NHS Patient Safety First campaign and World Health Organisation (WHO) surgical safety checklist are consistently undertaken and compliance audited (including sign out and debrief)
- Nurse staffing levels need to meet safe staffing guidance recommendations
- Nursing handover, record keeping and assessment of clinical risk documentation needs to improve.
- Ensure a robust incident reporting system and that lessons learnt from investigations are shared with staff to include patient safety and experience.
- Ensure all areas including End of Life have a robust risk management process which enables the raising and addressing of issues and concerns with oversight from governance committees.
- Ensure consistent and adequate processes for Mental Capacity Assessment and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation
- Need to ensure that all staff have appropriate supervision and appraisal
- Review the complaints process ensuring how to complain is publicised in all patient areas
- Need to review the involvement of staff in Trust-wide issues, vision, strategies and objectives and contribution to service development
- Ensure appropriate procedures and implementation of waste disposal practices, sterile equipment and products, procedures are implemented particularly in outpatients department.

A Quality Summit was held at Colchester General Hospital on 15 July 2014 with senior leaders of the Trust and representatives of partner organisations. An Improvement Board with partner organisations was formed to oversee and review progress addressing the CQC reports' findings. An Improvement Plan was scheduled for 12 August 2014, encompassing all existing action plans such as the Keogh and cancer action plans.

17 July 2014 - CQC Progress Review of Five Cancer Services at Colchester Hospital University Foundation NHS Trust

This inspection was follow up to the CQC cancer visit report first published December 2013.

The report updated on the progress made with improvements to six cancer pathways identified as requiring enhanced or intensive CQC monitoring in the December 2013 report. These cancer services were Brain and Central Nervous System, Cancer of Unknown Primary origin, Radiology, Sarcoma, Urology and Dermatology.

A warning notice had been issued in 2013 because Colchester Hospital University NHS Foundation Trust had not ensured it effectively monitored the clinical management of cancer services to ensure treatment was provided as per national requirements. The Trust also failed to act on information raised by staff identifying alterations made to the Cancer Wait Times patient tracking system. This led to the Trust being placed in Special Measures by Monitor in November 2013.

In the CQC report of July 2014, the CQC was assured that the necessary changes had been made to ensure the service was safe for five of the cancer services. The Dermatology service remained under enhanced CQC monitoring with the Clinical Commissioning Group

and hospital reviewing capacity and demand management. A further CQC revisit was planned.
The Trust worked with specialists from the Royal Marsden on a comprehensive action plan to improve the cancer services. Improvements included:

- Recruitment of additional staff
- A programme of continuous and regular training
- The implementation of a new cancer information system; the nationally recognised Somerset Cancer Registry.
- The re-establishment of the Trust's Cancer Board.
- A comprehensive review of diagnosis, treatment and care to ensure full compliance with national standards.
- A £25 million purpose-built, state of the art Radiotherapy Centre opened on 9 June 2014 at Colchester Hospital.

12 and 27 November and 23 December 2014 - Accident and Emergency department (A&E) and Emergency Assessment Unit (EAU)

These unannounced visits were made following concerns, including a whistleblowing concern, about performance and care in A&E and EAU. The CQC had planned a revisit to monitor the effectiveness of actions after the first visit on 12 November; including the increased staffing, improved safeguarding and improved flow and capacity. After the 27 November visit, new information of concern was received relating to the care received in the A&E department and that, due to capacity issues, patients were staying in A&E with insufficient staff to care for them. This led to the inspection of 23 December. A further revisit is anticipated to see that improvements have been sustained. Key themes for improvement are:

- Ensure that patients' mental capacity is assessed appropriately and maintain records in accordance with the Mental Capacity Act 2005.
- Ensure that care provided in the patients' best interests complies with the Mental Capacity Act Deprivation of Liberty Safeguards so that any restraint is used appropriately.
- Ensure that treatment in A&E particularly around head injuries and chest pain accords with NICE guidelines.
- Ensure a Standard Operating Procedure is in place for patients who are clinically assessed as safe to be "stepped down" from A&E to EAU.
- Ensure effective use of the National Early Warning score system (NEWS) to respond to risks of patient deterioration in a timely way.
- Ensure there is a robust incident reporting system in place and ensure learning from incident investigations are shared with all staff.
- Ensure all staff complete their mandatory training and have access to necessary training such as safeguarding vulnerable adults and children , mental capacity and resuscitation and development to ensure they maintain appropriate skills for their role.
- Ensure up to date and maintained clinical records so that care can be provided appropriately and in a timely manner.
- Ensure sufficient qualified, skilled and experienced staff at all times, particularly in A&E and EAU.
- Review patient flow from A&E to ensure patients are assessed to meet their needs and there is no unnecessary delay.
- Review the complaints process to ensure learning can be identified and service improvements made.
- Ensure all staff adhere to infection prevention and control procedures; particularly with hand washing, cleaning procedures and curtain changes in A&E and EAU.

- Ensure Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) practice complies with national guidance, involves patients or their representatives and that decisions are recorded and communicated to all staff looking after the patient.
- Review plans for escalation of high patient activity in A&E to ensure the service responds to activity surges in a timely way.
- Review A&E and EAU staff involvement and engagement in Trust vision, strategies and objectives and contribution to service improvement.
- Maintain the EAU bed base at 45 inpatient beds and 17 GP triage beds where possible.
- Provide additional support to A&E and EAU managers and staff at very busy times.
- Review clinical audit findings and ensure actions and learning are shared with staff.
- Review training provision to staff for caring for people with dementia or a learning disability, ensuring staff have appropriate skills for their role.
- Review procedures for transferring and transporting deceased patients during busy periods to ensure the dignity of the deceased in respected.

Section 31 notices in respect of urgent care services were issued following the November and December inspections.

Colchester Hospital University Foundation NHS Trust intends to take the following action to address the conclusions or requirements by the CQC (7.1 (c))

Further to the CQC placing conditions of registration on the Trust, an action plan was submitted to the CQC on 27 February 2015. This strategic action plan brings together the Improvement Plan following the Trust's special measures and cancer investigation, the Section 31 notices and the recommendations from the CQC's Urgent Care Report from January 2015.

The Improvement Plan is designed to ensure that remedial action is taken in respect of all non-compliant areas of the Trust in preparation for a CQC re-inspection. Within the Trust, responsibility for implementation of improvement plan actions lies with executive and divisional directors. Underpinning this Improvement Plan, will be a local inspection regime comprising of peer service reviews led by matrons and sisters, governors and Healthwatch representatives.

It is envisaged that an internal inspection regime will ensure that the whole Trust becomes compliant with the Essential Standards for Quality and Safety. Non-compliant areas will be held to account by a compliance panel chaired by the Director of Nursing with a view to ensuring that areas of non-compliance are addressed so that patient safety, experience and clinical effectiveness remain at the forefront of the Trust's core business.

The Improvement Plan will be monitored by a multi-agency Improvement Board and System Resilience Group including representatives from Monitor, Healthwatch, NHS England and North East Essex Clinical Commissioning Group.

a. Actions planned and Improvement Plan Summary

A summary of the Trust Improvement Plan is given below. Actions to be taken have been grouped around patient safety, clinical effectiveness and patient experience. The CQC five domains are in brackets (safety, caring, effectiveness, well led and responsive).

Patient Safety

Nursing and midwifery strategy launch

- Develop Trust recruitment and retention plan. (Safe)
- Review Trust wide training Needs Analysis. (Safe)
- ED SOP – clarifying role of ENP (Emergency Nurse Practitioner) and ANP (Associate Nurse Practitioner) section 31 - CCG remedial action plan monitoring. (Safe)
- Display staff skills mix and levels templates on each ward board. (Safe)
- All staff to complete Fitness to Practice elements of training by April 2015. (Effective).
- Reduce temporary staffing – utilising NHS Professionals and the agency PERTEMPS to support deficiencies in templates. (Safe).
- Carry out bi-annual acuity review. (Safe)
- Review additional pharmacist support at ward level. (Safe)

Clinical documentation

- Audit and improve clinical documentation through monthly peer review visits and audits undertaken against the National Patient Safety standards (NPSA) audits. (Safe)

Mortality monitoring

- Embed mechanism for monitoring mortality to determine whether deaths are preventable. (Effective).
- Ensure bi monthly service level and divisional mortality review meetings. (Effective).
- Ensure mortality and morbidity learning is discussed at governance committees and minuted and that this is centrally monitored/reported. (Effective).

Learning

- Complaints discussed twice weekly in Trust wide SI/complaint SI Panel. (Responsive).
- Ensure complaints and SIs are shared with team involved - SI post incident debriefing (Safe)
- Develop open forum model across all divisions for sharing SI, complaint outcomes. (Safe)
- Embed aggregated learning at service/div levels. (Safe)
- Divisions to develop integrated complaints and SI action plan and evidence completion of LEAPs. (Safe)

Clinicians

- Ensure all lead clinicians are RCA/ Datix trained. (Safe)

Cleanliness, decontamination, hand hygiene

- Monthly managerial audits. (Safe)
- SSI audits to reflect care bundles. (Safe)
- Ensure all staff have IC training. (Safe)
- Focus on areas with poor practice. (Safe)
- Review cleaning specs and contingency plans for outbreaks. (Safe)
- Review compliance decontamination standards. (Safe)
- Review compliance and take action on hand hygiene audits. (Safe)

MUST

- Ensure patients have MUST assessment and nutrition care plan on admission. (Effective)
- Continue to protect meal times and develop a volunteer service to assist with patient meals. (Effective)

Clinical Effectiveness

Senior management leadership

- Increase Executive, NED and Governor visibility: Executive Lead and NED champion on each Trust Group and Board committee. (Well led)

Divisional and clinical leadership

- Clear divisional structure and supervision arrangements. (Well led)
- All divisional governance meetings to have an MDT representative. (Effective)
- '2 at the Top' will ensure the MDT are functioning; and develop service level outcome indicators across the Trust for reporting at governance and '2 at the Top' meetings. (Effective)
- Consistent governance meetings at each team, service area and division level with standing agendas that meet the requirements of Trust wide Clinical Governance meeting and generate innovative ideas from staff. (Well led)
- Launch innovation panel. (Well led)

Staff engagement/competence

- Relaunch Trust vision, strategy and objectives as part of operational plan 2015/16. (Well led)
- Review/relaunch Trust induction pack. (Well led)
- Permeate Trust vision in appraisals, meetings, recruitment. (Well led)
- Documented supervision and annual appraisal all staff. (Well led)

Aspiring Leaders programme (well led)

- Continue to encourage staff to raise concerns and undertake gap analysis on Whistleblowing report and plan. (Well led)
- Whistleblowing incidents to be reported to Board. (Well led)
- All out of date Human Resources policies updated with a schedule for all policies. (Well led)
- Conduct a Trust wide training needs analysis. (Well led)

Access

- 7 day services. (Responsive)
- Develop KPIs for same day diagnostics. (Responsive)

Monthly peer reviewed compliance visits for each clinical service

- Monthly documentation audit and peer compliance visits –accurate, complete, legible, up to date and stored securely. (Safe)

Clinical audit

- Ensure all mandatory and non-mandatory audits are completed – monitor via the Clinical Audit Group and Clinical Effectiveness Committee. (Effective)
- Review NICE/audit LEAPs at governance committees – and that changes have occurred (Effective)
- Continue new Clinical Effectiveness Committee. (Effective)

Adult safeguarding

- Nurses' routine assessment of patients on admission will include questions to check their mental capacity. If nurses are in doubt about a patient's capacity, a mental capacity assessment will be undertaken. (Safe)

- All patients who lack capacity or need to make a significant decision are to have MCA and DOLs. (Effective)
- All staff will have Managing Diversity training. (Responsive)
- Identify Trust Dementia Lead. (Responsive)
- Identify internal safeguarding lead and structure for strategic oversight. (Safe)
- Continue monthly Safeguarding Board with multi-agency input. (Safe)
- Review "Wandaguard" at each ward. (Wandguard is an electronic device to alert if patients who are prone to wander leave the ward). (Safe).
- Monitor safeguarding MCA and DOLs training for all staff. (Safe and effective)
- Include MCA and DoLS compliance in quality peer reviews and share learning at governance committees. (Effective)

Develop pathways for patients with complex care needs

- Include dementia and Learning Disability. (Responsive)
- Care bundles – Ensure effective care is implemented - review effectiveness of them through mortality and morbidity information at governance meetings. (Effective)
- Develop and evaluate care bundles in the light of Serious Incident, complaint and incident themes. (Effective)

Patient/carer- involvement

- Patient/carer sign off of care plans, on admission and discharge and DNACPR forms (audited). (Caring and effective).
- Informed consent – involvement/information to patients. (Caring)
- Ensure rounding occurs so all concerns/needs can be met. (Responsive)

A&E

- A&E streaming and See and Treat. (Responsive)
- Establish Clinical Decision Unit in A&E – Standard Operating Procedure compliance
- (s 31). (Responsive)
- Establish Frail Elderly Unit in A&E. (Responsive)
- Ensure compliance with fractured NOF pathway. (Responsive)
- Develop effective competencies for patient flow and capacity. (Responsive)
- Bed capacity modelling – elective and non-elective. (Responsive)
- Ensure compliance best practice stroke standards. (Responsive)
- Ensure compliance with acute MI pathway. (Responsive)

EAU

- Establish GP Referral triage EAU. (Responsive)
- Establish GP referral unit in Surgical Assessment Unit (SAU). (Responsive)
- Establish Medical Decision Unit and review ambulatory management EAU. (Responsive)
- Enhance dependent facilities in EAU. (Responsive)

Orthopaedics and General Surgery

- Implement enhanced recovery programmes. (Responsive)

Deteriorating patient

- Develop deteriorating patient integrated care pathway. (Safe)
- Develop Level 1 "High observation bays". (Safe)
- Cohort patients with high NEWS >5. (Safe)
- Audit compliance with deteriorating patient process and escalation. (Safe)
- Outreach support and ALERT (Acute Life Threatening Events Recognition and Treatment) training. (Safe)

- Develop Advanced Practitioner role across the Trust. (Safe)
- Ensure BLS/ALS/ILS(different levels of resuscitation expertise) training is up to date. (Safe)
- Training for HCAs for their role and observing the deteriorating patient. (Safe)
- Sepsis 6 to be rolled out to all clinical teams. (Safe)
- Increase Critical Care Unit capacity to 14 beds. (Safe)
- Develop electronic recording and escalation of physiological signs; review. (Safe)
- Ensure that CPR practice and DNACPR practice accords with best practice. (Safe)

Patient Experience

Staff support

- All staff to be informed of Health and Wellbeing confidential services. (Caring)
- At Our Best – reinforce and re-launch via appraisals, induction and interviews. (Caring)
- Trust to take follow up action on inappropriate behaviours. (Well led)
- Staffing levels to be reviewed to allow staff time to provide emotional support. (Caring)
- Local emotional support groups information to be provided. (Caring)
- Devise staff survey action plans and share at governance meetings all levels. (Well led)

Patient Experience and Carer Strategy and Group to be set up.

- Patient voice and lived experience in service re-design and governance groups and recruitment and selection processes. (Caring and well led)
- Develop complaints senior leadership review as part of SI panel. (Responsive)
- Complaints reports to be discussed as standing agenda items divisional meetings and patient stories at Board and divisional meetings (respond within agreed timescale; LEAPs. (Well led)
- PALS office to be re-sited to the front of hospital. (Responsive)
- Embed complaints learning in ward and division meetings. (Responsive)
- Establish peer review and compliance visits and review Friends and Family and feedback. (Responsive)
- Review visibility of “How to raise a complaint” in ward areas. (Responsive)
- Review display of patient waiting times in A&E. (Responsive)

b. Next Phase – Further Trust Improvement Initiatives

The Trust has taken a phased approach to its improvement planning. The next phase of Trust improvement planning will incorporate remaining CQC requirements and these are listed below under the three main themes: safety, clinical effectiveness and patient experience with the CQC five domains in brackets (safety, effectiveness, caring, responsive and well led):

Safety

Improve systems and processes for storage and management of all medicines including Controlled Drugs (*safety).*

- The Trust must assure itself that “5 Steps to Safer Surgery” (NHS Patient Safety First campaign and World Health Organisation (WHO) surgical safety checklist are consistently undertaken and compliance audited (including sign out and debrief) *(safety)*
- Completion of clinical documentation for the assessment of risk needs to improve *(safety).*

- Ensure all areas (including End of Life) have a robust risk management process and enable the raising and addressing of issues and concerns with oversight from governance committees *(safety)*
- Ensure appropriate procedures and implementation of waste disposal practices, sterile equipment and products, procedures are implemented particularly in outpatients department *(safety).*
- Ensure a Standard Operating Procedure is in place for patients who are clinically assessed as safe to be "stepped down" from A&E to EAU (*safety).*
- Ensure sufficient qualified, skilled and experienced staff at all times, particularly in A&E and EAU *(safety).*
- Ensure programme for changes of curtains in A&E and EAU *(safety)*
- Review plans for escalation of high patient activity in A&E to ensure the service responds to activity surges in a timely way (*safety).*
- Provide additional support to A&E and EAU managers and staff at very busy times *(safety).*

Clinical Effectiveness

- Undertake an independent review of the management of elective waiting lists in all areas (*effective)*
- Ensure that treatment in A&E particularly around head injuries and chest pain accords with NICE guidelines *(effective)*
- Ensure all staff complete their mandatory training (*effective)*
- Review patient flow from A&E to ensure patients are assessed to meet their needs and there is no unnecessary delay. *(effective)*
- Ensure up to date and maintained clinical records so that care can be provided appropriately and in a timely manner *(effective).*
- Review training provision to staff for caring for people with dementia or a learning disability, ensuring staff have appropriate skills for their role *(effective).*

Patient Experience

- Review the complaints process to ensure learning can be identified and service improvements made *(responsive).*
- Review procedures for transferring and transporting deceased patients during busy periods to ensure the dignity of the deceased is respected *(responsive).*
- Make plans to continue work with Healthwatch Essex, to ensure following of their recommendations to embrace the “lived experience” and voice of patients and carers. *(responsive).*
- Make plans to implement Healthwatch Essex recommendations on the training of staff in medical ethics. *(responsive).*
- Ensure Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) practice involves patients or their representatives and that decisions are recorded and communicated to all staff looking after the patient *(responsive).*

c. Progress made so far and Improvement Plan actions taken

Colchester Hospital University NHS Foundation Trust has made the following progress by 31 March in taking such action (7.1 (d))

Key progress has been made through the creation of the first phase of a comprehensive Trust Improvement Plan, reflecting CQC and other inspection requirements. The next phase of Trust improvement planning will reflect remaining CQC requirements.

A range of highlights of progress is identified below.

Patient Safety highlights

Substantial progress has been made in the CQC Safety domain with revision of internal governance arrangements. These ensure there are lessons learnt and risks are escalated from ward to Board.

A Nursing and Midwifery strategy is being completed and finalised, and will cover all the related actions of the Trust Improvement Plan. Varied actions to improve staffing and skill deployment have been undertaken, with significant recruitment work.

The efficiency and effectiveness of the SI Panel has been improved, along with its representation of divisional and senior management leadership. Analysis of outstanding Serious Incidents has been used to promote learning, leading to closure of incomplete investigations. Learning folders, reflecting learning from Serious Incidents and Never Events have been introduced to every ward and Department, for regular discussion and review.

Varied work to improve risk management has been undertaken, with review of the Board Assurance Framework and risk register processes.

Root cause analysis training has been revised and new training has been launched.

Planning has been undertaken to improve complaints processes, structures and learning. Reviews have been undertaken of the Quality Hub, with additional review work covering the complaints area and committee structures and processes. The use of quality related standard agendas has been re-launched.

Initial planning regarding improvements for monitoring and reporting on mortality has been undertaken.

Considerable work has been undertaken to promote safer surgery and use of the World Health Organisation (WHO) Surgical safety Checklist, described on pages 74-76 at Part 3. Further work is planned.

The medication safety group has been reviewed and a re-launch has been planned.

Clinical Effectiveness highlights

In respect of the Improvement Plan, the Trust has made considerable progress in the Well Led domain given the appointment of the majority of the Executive management team and senior managers. The Trust's governance structure was revised and approved by the Board and all internal agendas are now driven by a board assurance framework and Trust risk register.

Good progress has been made on senior management leadership and visibility, as well as senior members on Trust Groups and committees. Useful work has been undertaken to introduce consistent structures and processes for '2 at the Top', service and divisional governance meetings monitoring performance.

Initial planning for monthly peer reviewed compliance visits for each clinical service has been undertaken.

An action plan has been created for training of staff in adult safeguarding, in the areas of A&E and EAU. There has been an increase in Safeguarding Team presence in these areas.

A range of improvements in A&E and EAU pathways and structures have been undertaken, key highlights of which are described at pages 77-80 at Part 3.

The Trust has designed and established a Deteriorating Patient Group. Its work will include taking forward relevant actions in the Trust Improvement Plan.

The practice of patients signing off that they have seen their discharge summaries has been introduced.

The Trust has reviewed the terms of reference of the Clinical Effectiveness Committee, as well as other high-level committees.

Patient Experience highlights

Re-launch and reinforcement plans for the Trust's core At Our Best values and programme have been developed, for future implementation.

Initial plans have been made to respond to staff survey results.

The need for a Patient Experience and Carer Strategy and Group has been identified, initial drafts of key documents have been prepared and plans are being made for chairmanship and membership.

Work to review complaints processes and learning has been undertaken, and the need for further work identified. Complaints have now been included for twice weekly discussion by the SI Panel. A system has been designed for every division having a collated plan for all their complaints and Serious Incidents, with recorded follow-up actions and learning.

The Retrospective Review Audit of patients on cancer pathways has been completed, and the need for a Trust wide mechanism for real time feedback from cancer patients has been highlighted

Effective quality work has been done in the area of dementia, as described on pages 85-87 at Part 3.

Review work has been undertaken to identify suitable software to support Trust work on patient feedback, particularly Friends and Family and patient feedback surveys. Further work is needed in this area.

2.2.8 - Secondary Users Service Records

Colchester Hospital University NHS Foundation Trust submitted records during 2014-15 to the Secondary Users 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:

99.5% for admitted patient care;
99.7% for outpatient care and
98.2 % 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
99.9% for accident and emergency care.

2.2.9. – Information Governance Assessment

Colchester Hospital University NHS Foundation Trust Information Governance assessment report overall score for 2014-15 was 84% and was graded satisfactory (green).

The published score in March 2015 of 84% maintains a high score for the Information Governance Toolkit submission. The Trust scored a minimum of Level 2 on all 45 requirements. Our final position is: satisfactory (Green).

The Information Governance Toolkit is available on the HSCIC website. https://www.igt.hscic.gov.uk/

The Information/evidence is uploaded directly to the IG toolkit.

Colchester Hospital University NHS Foundation Trust intends to take/has taken the following actions to maintain this published score and therefore the quality of its services:

- An action plan is completed to maintain an evidenced level 2 submission against all 45 requirements
- This is monitored by the Information Governance Steering Group chaired by the Medical Director (Caldicott Guardian) or by the Director of Finance as Senior Information Risk Owner (SIRO).

2.2.10. – Payment by Results

Colchester Hospital University NHS Foundation Trust was not subject to the payment by results clinical coding audit during 2014-15 by the Audit Commission.

The Trust carried out an internal mandatory yearly IG audit for June and July 2014. The percentage of coding errors was 7% (national average 9%).

The results should not be extrapolated further than the actual sample audited and the service audited was endoscopy services.

Colchester Hospital University NHS Foundation Trust will be taking the following actions to improve data quality

An internal on-going training programme has been established and will run throughout the year. It covers all aspects of coding and will continue to re-enforce issues such as improving the extraction of data, coding of mandatory co-morbidities etc. Operations sheets, where available, will be used to support coding. In addition, the identification and coding of co-morbidities will be reviewed and new codes introduced. Practice will be audited and results fed back to staff so that improvements can be made.

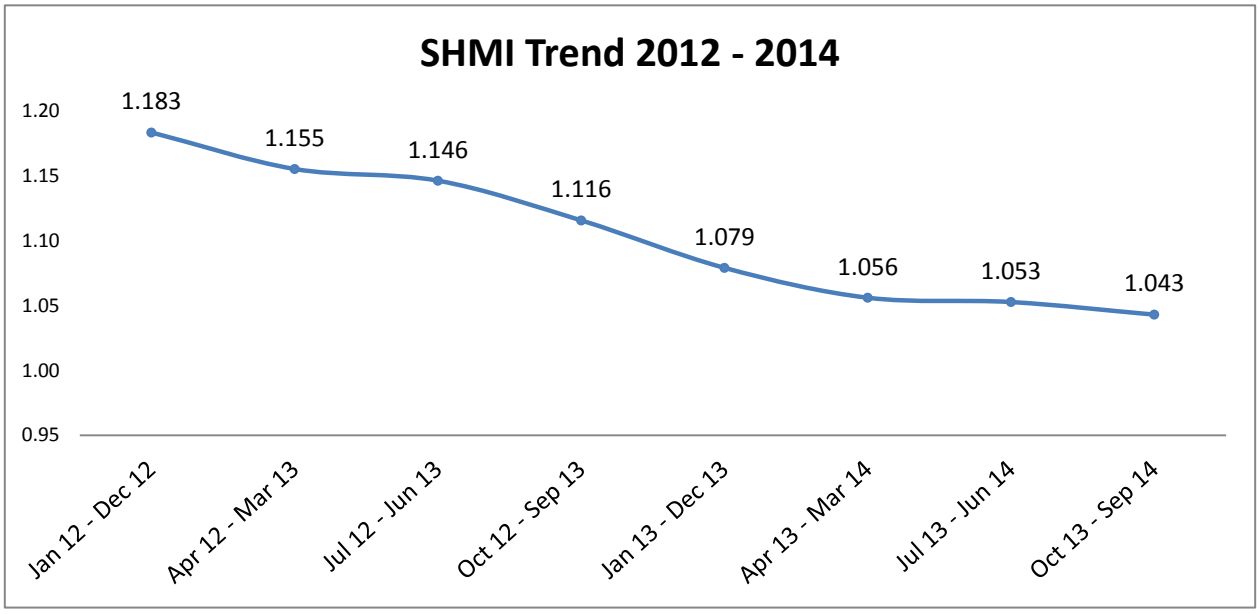
2.3 – REPORTING AGAINST CORE INDICATORS

In this section, mandatory Monitor numbering is used in brackets after mandatory Monitor headings in italics.

2.3.1 - SHMI

The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) for the Trust for 2014-15 (12 (a)) :

The following chart shows the trust's SHMI standardised values.



The table below shows the figures for the above graph

Period	SHMI value	Banding
Jan 12 - Dec 12	1.183	1
Apr 12 - Mar 13	1.155	1
Jul 12 - Jun 13	1.146	1
Oct 12 - Sep 13	1.116	2
Jan 13 - Dec 13	1.079	2
Apr 13 - Mar 14	1.056	2
Jul 13 - Jun 14	1.053	2
Oct 13 - Sep 14	1.043	2

* Please note that national average is not shown as this is a standardised indicator

For the latest period (Jul 13 – Jun 14)	Trust	Value
Trust(s) with lowest SHMI value	The Whittington Hospital NHS Trust	0.597
Trust(s) with highest SHMI value	Medway NHS Foundation Trust	1.198

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

The data has been sourced from HSCIC published data.

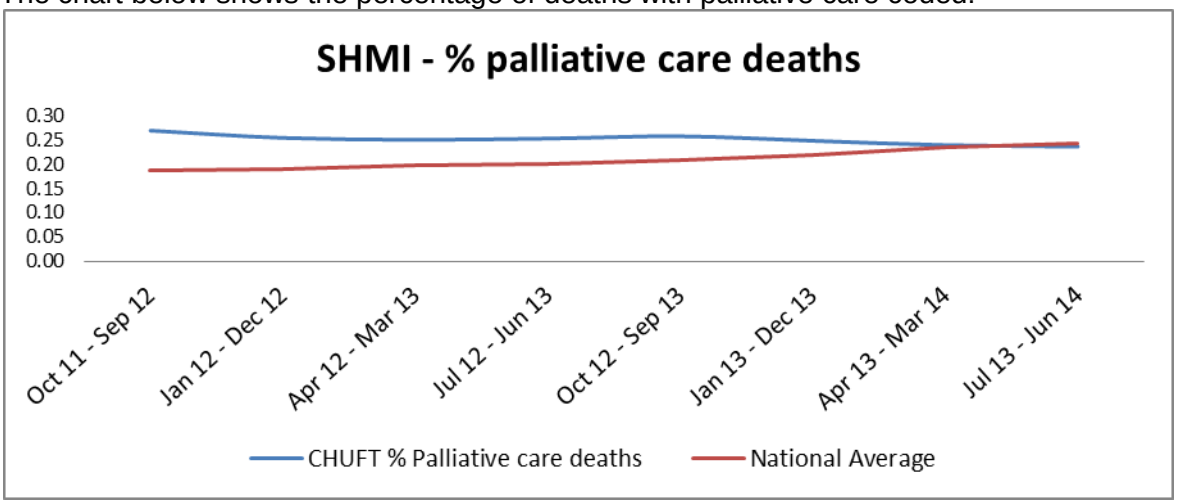
Colchester Hospital University NHS Foundation Trust intends to take and has taken the following actions to improve this performance, and so the quality of its services, by:

- Continuing to work with primary care and St Helena Hospice to improve care for those patients who are considered to be at the end of their life.
- Continuing to hold open house mortality review meetings with input from primary care and palliative care to facilitate learning across the patient pathway. Key learning is shared throughout the trust through the quality bulletin.
- Continuing the improved compliance with incident reporting.
- Keeping the particular focus on improved recognition of and response to the deteriorating patient.
- Developing a refined mechanism for regular review of deaths including those within 30 days of discharge.

2.3.2. – Patient Deaths with Palliative Care Code

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for 2014-15 (12 b)

The chart below shows the percentage of deaths with palliative care coded:



The chart below shows the figures for the above graph:

Period	CHUFT % Palliative care deaths	National Average
Oct 11 – Sep 12	27%	19%
Jan 12 – Dec 12	26%	19%
Apr 12 – Mar 13	25%	20%
Jul 12 – Jun 13	25%	20%
Oct 12 – Sep 13	26%	21%
Jan 13 – Dec 13	25%	22%
Apr 13 – Mar 14	24%	24%
Jul 13 – Jun 14	24%	25%

Trusts – least/most palliative care coded

For the latest period (Jul 13 – Jun 14)	Trust Name	Value
Trust(s) with least % palliative care deaths	The Whittington Hospital NHS Trust	0.0%
Trust(s) with most % palliative care deaths	Salford Royal NHS Foundation Trust	49.0%

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

The data has been sourced from HSCIC published data.

Colchester Hospital University NHS Foundation Trust intends to take and has taken the following actions to improve this performance, and so the quality of its services, by:

- The Individual Care Record for the Last Days of Life across the hospital and Locality was devised, written and launched.
- An in-house audit of care of the dying patient was completed.
- A training needs analysis was undertaken for 200 staff.
- Patient care was maintained as the focus although it was hard to promote, educate and audit in 2014 in a more formal way due to short staffing of the palliative care team.
- A formal action plan will be developed to integrate points from the National Care of the Dying Patient audit 2014, CQC July 2014 report, NICE Quality Standards and Keogh Action Plan.
- Participation will occur in the National Care of the Dying Audit 2015. Also, the coding of specialist palliative care will be audited and compared to the palliative care database to ensure quality and accuracy.

- A robust education plan will be developed for all staff who care for patients directly in end of life care including a larger training needs analysis of staff for baseline data.

- Referrals will be increased to the Specialist Palliative Care Team with increasing profile on wards and education, whilst maintaining quality and assessment within 24 hours.

- Referral and access to external support will be improved, e.g. to the North East Essex Bereavement Service and Health in Mind.

- Recognition of patients who are rapidly deteriorating will be increased. For those who wish to be discharged from hospital, the discharge process will be improved by working closely with the Complex Discharge team, key locality stakeholders and ensuring clear communication with the GP regarding the patient's deterioration.

- Awareness of the use of the 'My Care Choices' register will be increased e.g. by promoting the Dying Matters week 18 – 24 May 2015.

2.3.3 – Patient Reported Outcome Measures (PROMS)
(Please note Monitor's numbers 13 – 17 are not relevant)

During 2014-15, Colchester Hospital University NHS Foundation Trust's patient reported outcome measures for (18)

(i) groin hernia surgery;

(ii) varicose vein surgery;

(iii) hip replacement surgery and

(iv) knee replacement surgery.

There were 608 eligible hospital episodes and 583 pre-operative questionnaires returned – a headline participation rate of 95.9% (76.7% in England). Of the 258 post-operative questionnaires sent out, 64 were returned – a response rate of 24.8% (25.7% in England).

The nationally produced data in all the graphs below is for April to September 2014

Figure 1: Adjusted average health gain on the EQ-5D Index by procedure
(EQ-5D is a standardised instrument to measure health outcomes).

The following chart shows Trust performance with groin hernia

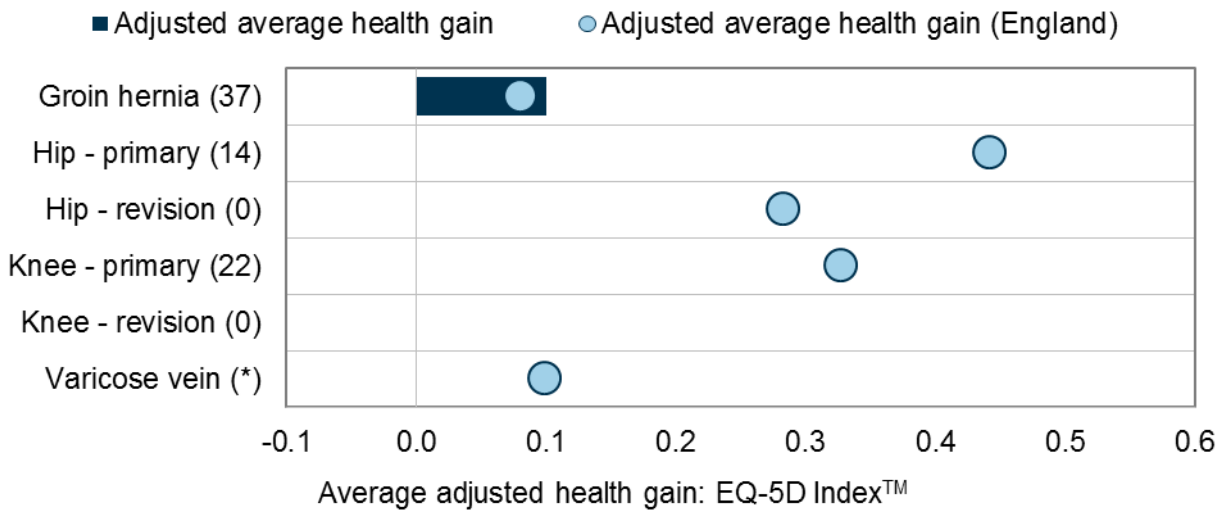
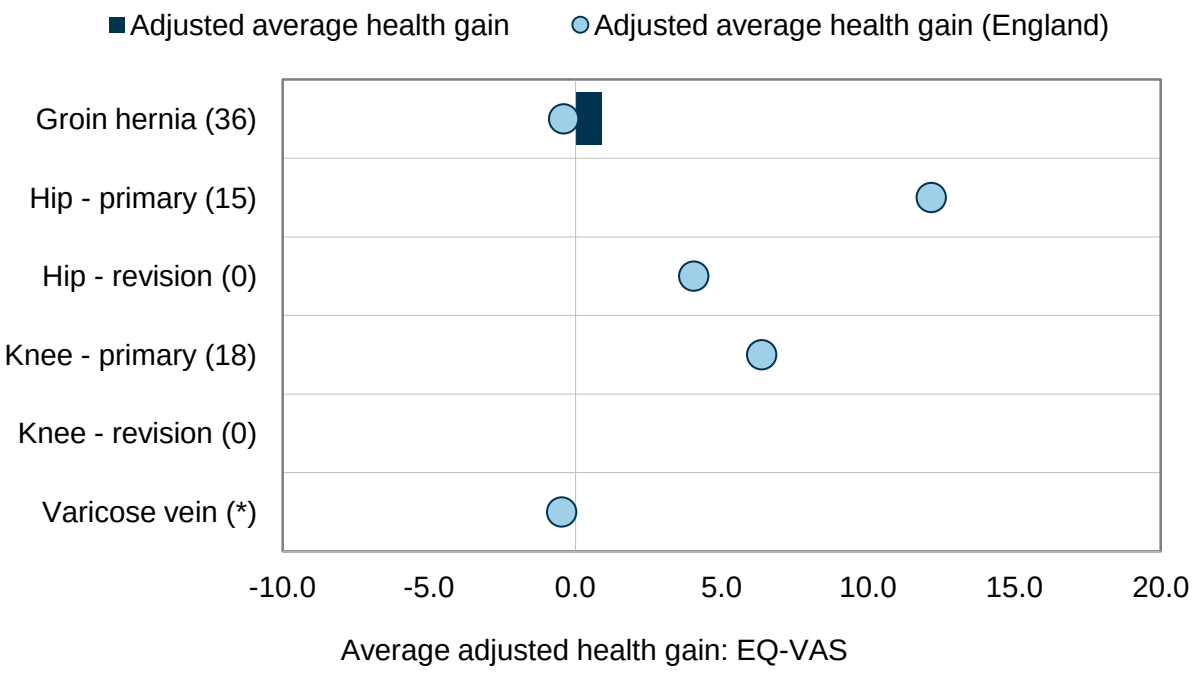


Figure 2: Adjusted average health gain on the EQ-VAS by procedure
(EQ –VAS is a health related quality of life questionnaire)



EQ VAS (current state of patient's general health marked on a visual analogue scale)
The adjusted average health gain on the EQ-VAS for groin hernia respondents following their operation as 0.901 (-0.4 in England).
The adjusted average health gain for hip replacement (primary) respondents could not be calculated as there were fewer than 30 modelled records. The average adjusted health gain for hip replacement (primary) respondents in England was 12.2.
No modelled records for hip replacement (revision) exist for this measure. The average adjusted health gain for hip replacement (revision) respondents in England was 4.
The adjusted average health gain for knee replacement (primary) respondents could not be calculated as there were fewer than 30 modelled records. The average adjusted health gain for knee replacement (primary) respondents in England was 6.4.
The England –level adjusted average health gain on the EQ VAS for knee replacement (revision) is not calculated as there are fewer than 200 modelled records.
The adjusted average health gain for varicose vein respondents could not be calculated as there were fewer than 30 modelled records. The average adjusted health gain for varicose vein respondents in England was -0.5

Adjusted average health gain for Colchester Hospital

NOTE: Table 1 and Table 2 only display data at England and Provider level – April to September 2014

Table 1: Pre-operative participation and linkage

The table below shows the number and % of pre-operative questionnaires completed and number and % of pre-operative questionnaires linked.

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	608	583	95.9%	406	69.6%
Groin Hernia	149	182	122.1%	104	57.1%
Hip Replacement	210	189	90.0%	147	77.8%
Knee Replacement	179	203	113.4%	146	71.9%
Varicose Vein	070	9	12.9%	9	100.0%

The table below shows the number and % of post -operative questionnaires completed and number and % of pre-operative questionnaires linked.

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	583	258	44.3%	64	24.8%
Groin Hernia	182	145	79.7%	42	29.0%
Hip Replacement	189	51	27.0%	*	*
Knee Replacement	203	53	26.1%	13	24.5%
Varicose Vein	9	9	100.0%	*	*

Condition Specific Measures (a series of questions specific to the patient's condition)

The adjusted average health gain for hip replacement (primary) respondents could not be calculated as there were fewer than 30 modelled records.

The average adjusted health gain for hip replacement (primary) respondents in England was 21.9. No modelled records for hip replacement (revision) exist for this measure. The average adjusted health gain for hip replacement (revision) respondents in England was 13.1.

The adjusted average health gain for knee replacement (primary) respondents could not be calculated as there were fewer than 30 modelled records. The average adjusted average health gain for knee replacement (primary) respondents in England was 16.7.

The England-level adjusted average health gain on the Oxford Knee Score for knee replacement (revision) is not calculated as there are fewer than 200 modelled records.

The adjusted average health gain for varicose vein respondents could not be calculated as there were fewer than 30 modelled records. The average adjusted health gain for varicose vein respondents in England was -9.5.

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

- The data has been sourced from HSCIC published data. (Please note, April to September 2014 is the latest nationally published data available).

Colchester Hospital University NHS Foundation Trust intends to take and has taken the following actions to improve this performance, and so the quality of its services, by:

- Explore with clinicians and others within the division, the best venue for review of PROMS data

- Explore the inclusion of the monthly number of offered and completed PROMS questionnaires onto the Divisional dashboard

2.3.4 – Readmissions within 28 Days of Discharge

The percentage of patients aged (19)

(i) 0 to 15 and

(ii) 16 or over

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 2014 – 15.

(i) Hospital Readmission in 28 days of Patients Under 16

Hospital readmission in 28 days Under 16	CHUFT rate	National Average
2010/11	8.79	Not available
2011/12	8.35	

For the latest period (2011/12)	Trust Name	Rate
Trust(s) with highest readmission rate	The Royal Wolverhampton Hospitals NHS Trust	14.94
Trust(s) with lowest readmission rate	The Princess Alexandra Hospital NHS Trust	5.1

* Please note that national average has not been published for readmissions under 16

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

- The data has been sourced from HSCIC published data (Please note 2011-12 is the latest nationally produced data available).

Colchester Hospital University NHS Foundation Trust intends to take/has taken the following actions to improve performance and quality of its services:

- Continuing the provision of 24-48 hour telephone advice to parents, as needed, following discharge. Continuing the additional arrangements for 24–48 hour telephone advice for diabetic children as part of the Regional Diabetes Network arrangements.

- Continuing the direct telephone access for parents to discuss concerns with a clinician in the speciality of oncology, asthma, allergy, cystic fibrosis, neurology, epilepsy, continence, transitional care, health visitor liaison and according to the Care of Next Infant initiative. (This is a scheme where any parent who has had a sudden infant death receives support and on-going management during any future pregnancy and birth of the next child).

- Continuing the neonatal outreach service provide support for post-discharge from the neonatal unit for up-to 6 months.

- Continuing - all parents of children who have had surgery, a post discharge phone call is made by an experienced Children's Nurse. Advice is given concerning pain relief, wound management and any concerns.

- The Children's Community Nursing team support children with long term conditions at home and undertake home visits, preventing unnecessary admissions.

- Regular monitoring and review of readmission data is undertaken and planned to continue for 2015–16.

(ii) Hospital Readmission in 28 days – Patients 16 and over
The table below shows indirectly age, sex, method of admission, diagnosis and procedure standardised percentage.

Hospital readmission in 28 days 16 and over	CHUFT rate	National Average
2010/11	9.89	10.35
2011/12	11.43	11.45

For the latest period (2011/12)	Trust Name	Rate
Trust(s) with highest readmission rate	Epsom and St Helier University Hospitals NHS Trust	13.8
Trust(s) with lowest readmission rate	Weston Area Health NHS Trust	8.73

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

- The data has been sourced from HSCIC published data. (Please note, 2011-2 is the latest nationally produced data available).

Colchester Hospital University NHS Foundation Trust intends to take/has taken the following actions to improve performance and quality of its services:

- All re-admissions are reviewed by the Trust to identify any underlying causes, issues and themes so that improvements can be made.
- Re-admissions occurring within 24 hours are viewed as "failed discharges" and the clinical teams involved in the patient's care reviews the details of the patient's care to identify improvements.
- Common themes identified include patients being discharged too quickly in their care, re-ablement packages not being arranged. Also, occasions occur when Social Services are not being informed about patients being admitted or discharged who already have care packages.

2.3.5 – Responsiveness to Personal Needs of Patients

The Trust's responsiveness to the personal needs of its patients during 2014-15 (20)

The chart below is based on data from the National Inpatient Survey. Average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (score out of 100).

Responsiveness to inpatients' personal needs	CHUFT Score	England Score
2012/2013	64.8	68.1
2013/2014	67.3	68.7

For the latest period (2013/2014)	Trust Name	Score
Trust(s) with highest score	Queen Victoria Hospital NHS Foundation Trust	85.0
Trust(s) with lowest score	Croydon Health Services NHS Trust	54.4

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

- The data has been sourced from HSCIC published data.

Colchester Hospital University NHS Foundation Trust intends to take and has taken the following actions to improve this performance and so the quality of its services, by:

- Elective and emergency patient packs to assist their experience of being admitted to hospital have been trialled. Funding will be explored to enable their provision as a routine ward consumable.

- New patient information leaflets have been designed to increase participation. Volunteers are being recruited to support the process of obtaining feedback from patients.

- All areas have displayed a "You Said, We Did" board which is updated monthly.

- A patient story has been presented to Board meetings on a monthly basis.

2.3.6 – Family or Friends Recommenders - Staff

The percentage of staff employed by, or under contract to, the Trust during 2014-15 who would recommend the Trust as a provider of care to their family or friends (21 a)

The indicator methodology used is as indicated on HSCIC – percentages are added for options "agree" and "strongly agree". Results for the Annual and Quarterly Staff surveys are shown below:

Annual Survey

Year	CHUFT % Recommended	Acute Trusts average
2013	58%	64%
2014	48%	65%

For latest period (2014)	Trust Name	% Recommended
Trust with highest staff recommendation	Frimley Park Hospital NHS Foundation Trust	89%
Trust with lowest staff recommendation	Royal Cornwall Hospitals NHS Trust	38%

Quarterly survey

Results for the quarterly staff survey are shown below

Quarter	CHUFT Percentage recommended - WORK	England Percentage recommended - WORK	CHUFT Percentage recommended - CARE	England Percentage recommended - CARE
2014/15 Q1	52%	62%	67%	76%
2014/15 Q2	88%	61%	88%	77%

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

- Data has been sourced from England.nhs.uk data.

2014/15 proved difficult for the Trust and this is reflected in the results of the Friends and Family staff survey. The Trust's responses fell below the national average and there was also a decrease in 2013/14.

Colchester Hospital University NHS Foundation Trust intends to take and has taken the following actions to improve this performance and so the quality of its services, by:

- A number of activities took place during 2014/15 which included increased training for staff in how to manage with care and manage in difficult times with around 540 staff attending these sessions.

- The annual staff survey for 2014 was sent to all staff as opposed to a sample percentage to allow us to get feedback from as many people as possible and to base actions to be taken in 2015/16.

- During the coming year there will be an increased focus on acting on what staff have told us in the NHS staff survey and well as the Staff Friends and Family Survey. An immediate action is the appointment of Lead for Organisational Development and Engagement. This allows for a full time focus on matters important to staff which is something the trust has not had for the past couple of years.

- We will be speaking with the trusts that performed well in the survey – particularly those in the top 5 – to learn from them. We will put particular emphasis on the need to listen to the concerns of our staff and then act on them.

- Another important action is to redouble our efforts to improve recruitment and retention among nursing staff with a number of new schemes including a 'refer a friend' initiative, relocation incentives and extended notice periods for nurses at certain levels.

- We will also be building on the improvements we've made in staff training. We have, for example, streamlined mandatory training so that it can be delivered more easily to the benefit of staff and patients.

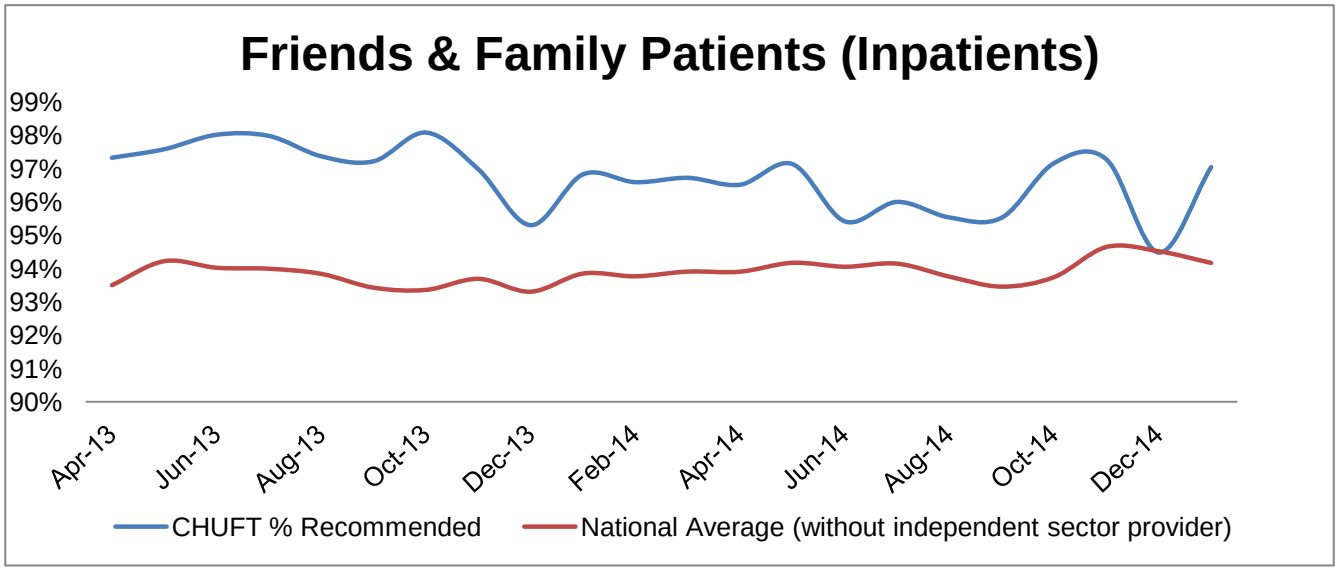
2.3.7 – Family or Friends Recommenders - Patients

The percentage of patients who would recommend the Trust as a provider of care to their family or friends (21 b).

This section shows data for Inpatients recommending the Trust to friends and family and likewise for A&E patients:

Inpatients

The chart shows the percentage of patients recommending the trust by month, compared to the national average:



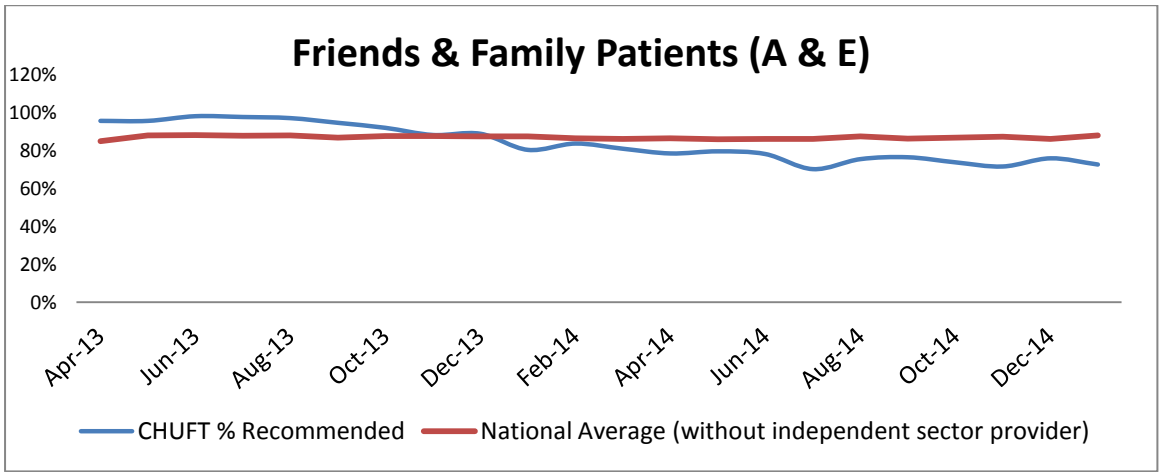
	2013/14		2014/15	
Friends & Family Patients (Inpatients)	CHUFT % Recommended	National Average (without independent sector provider)	CHUFT % Recommended	National Average (without independent sector provider)
April	97.33%	93.50%	96.52%	93.91%
May	97.58%	94.23%	97.14%	94.18%
June	98.02%	94.03%	95.42%	94.06%
July	97.98%	94.00%	96.00%	94.15%
August	97.37%	93.84%	95.53%	93.76%
September	97.22%	93.43%	95.53%	93.46%
October	98.08%	93.36%	97.17%	93.75%
November	96.98%	93.69%	97.28%	94.65%
December	95.30%	93.31%	94.48%	94.52%
January	96.83%	93.85%	97.04%	94.17%
February	96.59%	93.77%	-	0.00%
March	96.72%	93.91%	-	-
YTD	**97.19%**	**93.74%**	**96.25%**	**94.06%**

* % recommended calculated adding percentages for 'Extremely Likely' and 'Likely'

The table below shows the Trusts with the highest and lowest % patients recommending them as providers of care to their friends and family:

For the latest period (Jan 2014/15)	Trust Name	Value
Trust(s) with highest % recommended	Queen Victoria Hospital NHS Foundation Trust Birmingham Women's NHS Foundation Trust Moorfields Eye Hospital NHS Foundation Trust	100%
Trust(s) with lowest % recommended	North Middlesex University Hospital NHS Trust	51.17%

A&E patients



October 2014 saw a decline in the Friends and Family response rates for A&E and the decline continued to its lowest point in December 2014. The Trust investigated why this decline was occurring. Friends and Family is collected via a text message service supplied by an external company. Changes were made to improve the ability of patients to respond; with the message being checked for completeness and re-setting the timing for when the text is sent. Both actions saw improvements and further work is underway to raise awareness of Friends and Family.

	2013/14		2014/15	
Friends & Family Patients (A&E)	**CHUFT % Recommended**	**National Average (without independent sector provider)**	**CHUFT % Recommended**	**National Average (without independent sector provider)**
April	95.68%	85.00%	78.51%	86.54%
May	95.67%	88.04%	79.62%	86.05%
June	98.13%	88.22%	78.20%	86.11%
July	97.71%	87.81%	70.24%	86.22%
August	97.13%	88.00%	75.52%	87.48%
September	94.64%	86.80%	76.51%	86.37%
October	92.00%	87.66%	73.83%	86.87%
November	88.24%	87.75%	71.63%	87.43%
December	88.89%	87.57%	75.94%	86.19%
January	80.39%	87.53%	72.67%	88.12%
February	83.72%	86.45%	-	-
March	80.99%	86.23%	-	-
YTD	**90.18%**	**87.27%**	**75.50%**	**86.72%**

The table below shows the Trusts with the highest and lowest % of A&E patients recommending

* % recommended calculated adding percentages for 'Extremely Likely' and 'Likely'

For the latest period (Jan 2014/15)	**Trust Name**	**Value**
Trust(s) with highest % recommended	Royal United Hospitals Bath NHS Foundation Trust	98.15%
Trust(s) with lowest % recommended	North Middlesex University Hospital NHS Trust	55.19%

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

- Data has been sourced from England.nhs.uk data.

Colchester Hospital University NHS Foundation Trust intends to take and has taken the following actions to improve this performance and so the quality of its services:

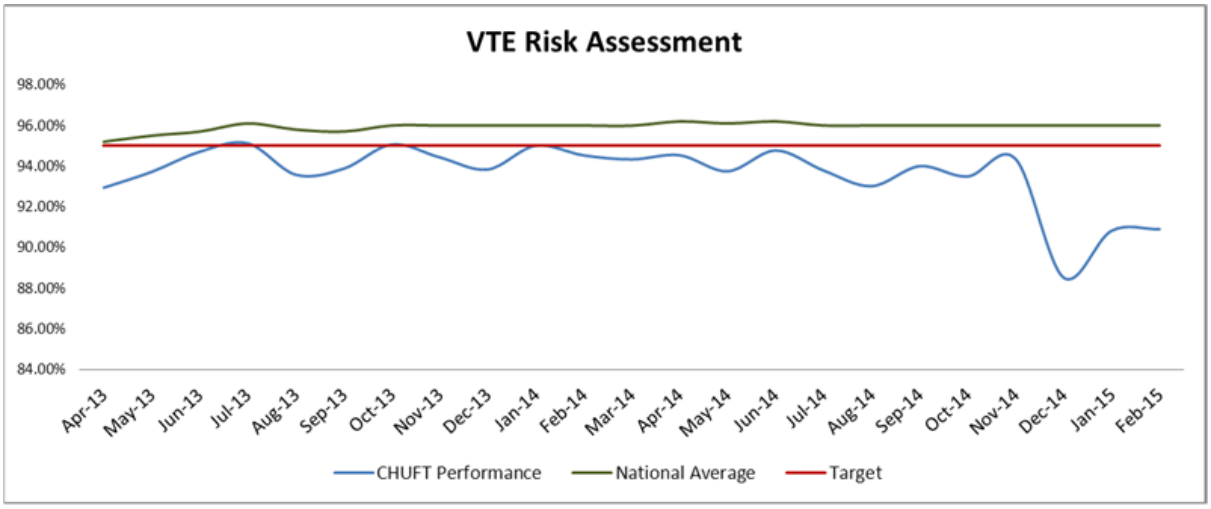
- Review has occurred of the methodology used for texting patients who have attended A&E to ensure the process of collecting feedback is as user friendly and effective as possible.

- Actions for the year ahead to improve our Friends and Family response rates as well as the quality of experience will be identified as part of a programme of improvements following review of the 2014-15 National Inpatient Survey.

2.3.8. – Venous Thromboembolism (VTE) Risk Assessment
(Please note Monitor number 22 is not relevant).

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during 2014-15 (23).

The chart below shows the % of admitted patients who were risk assessed for venous thromboembolism during 2014-15:



The figures are shown below:

		2013/14		2014/15
	Target	**CHUFT Performance**	**National Average**	**CHUFT Performance**
April	95.00%	92.94%	95.20%	94.54%
May	95.00%	93.72%	95.50%	93.75%
June	95.00%	94.71%	95.70%	94.77%
July	95.00%	95.12%	96.10%	93.78%
August	95.00%	93.58%	95.80%	93.02%
September	95.00%	93.88%	95.70%	94.00%
October	95.00%	95.07%	96.00%	93.49%
November	95.00%	94.43%	96.00%	94.35%
December	95.00%	93.84%	96.00%	88.52%
January	95.00%	95.01%	96.00%	90.82%
February	95.00%	94.53%	96.00%	90.90%
March	95.00%	94.33%	95.99%	-
YTD	**95.00%**	**94.27%**	**95.77%**	**92.99%**

Trusts with the Highest and Lowest Performance for 2014/15

Trust(s) with highest performance	South Warwickshire NHS Foundation Trust Royal National Orthopaedic Hospital NHS Trust Blackpool Teaching Hospitals NHS Foundation Trust Basildon and Thurrock University Hospitals NHS Foundation Trust Bridgewater Community Healthcare NHS Trust Derbyshire Community Health Services NHS Trust Queen Victoria Hospital NHS Foundation Trust Royal National Hospital For Rheumatic Diseases NHS Foundation Trust South Essex Partnership University NHS Foundation Trust The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	100%
Trust(s) with lowest performance	Cambridge University Hospitals NHS Foundation Trust	75%

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

- Data has been sourced from England.nhs.uk data.

Colchester Hospital University NHS Foundation Trust intends to take and has taken the following actions to improve this performance and so the quality of its services, by:

- Continuing the education programme on VTE prevention for all new junior medical staff and nursing staff.

- Continuing the use of the electronic risk assessment across the Trust and reviewing the system in 2015-16 to reduce the risk of transcription errors.

- Continuing to provide of regular feedback to wards and teams on their VTE risk assessments.

- Continuing to provide regular briefings to governance committees on cases of VTE as part of the learning from Serious Incidents.

- Identifying staff who are non-compliant with preparing risk assessments and arranging for individual follow up and support from their Divisional Clinical Director.

2.3.9. – Clostridium Difficile

The rate per 100,000 bed days of cases of C. Difficile infection reported within the Trust amongst patients aged 2 or over during 2014-15 (24).

The table below shows C.difficile cases per 100,000 bed days and the hospitals with the highest and lowest scores:

C.difficile cases / 100,000 Bed days	CHUFT Cases/100,000 bed days	National Average
2012/2013	14.98	17.40
2013/2014	8.58	14.70

For the latest period (2013/2014)	Trust Name	Value
Trust(s) with highest C.difficile rate	University College London Hospitals	37.1
Trust(s) with lowest C.difficile rate	Birmingham Women's Moorfields Eye Hospital Royal National Hospital for Rheumatic Diseases	0

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reason:

- Data has been sourced from gov.uk.statistics.

Colchester Hospital University NHS Foundation Trust intends to take and has taken the following actions to improve this performance and so the quality of its services, by:

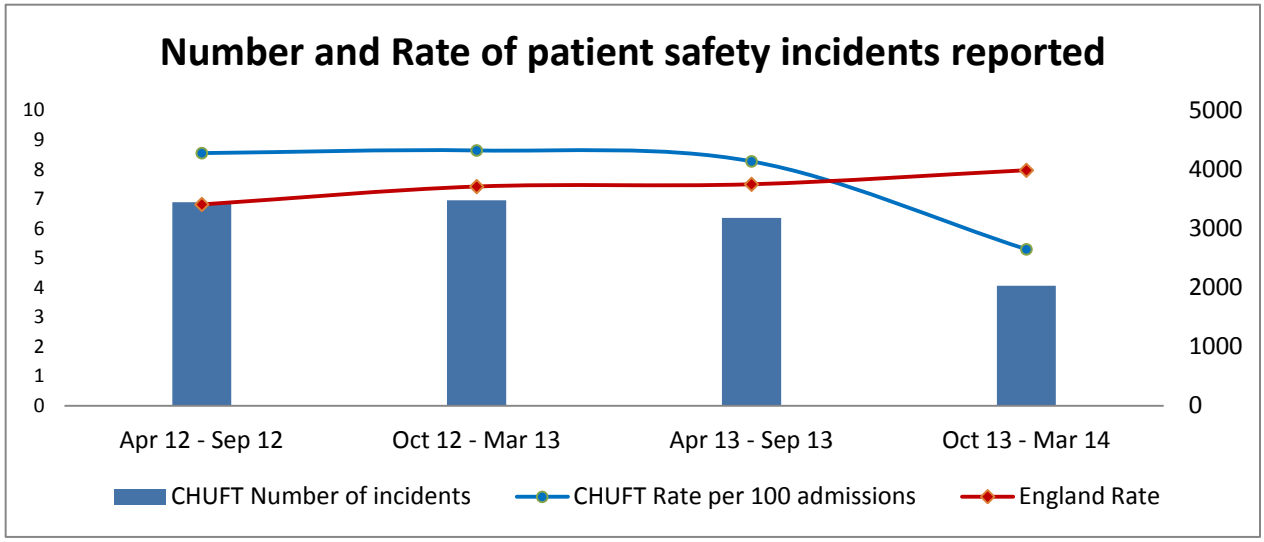
- Increasing the proportion of single rooms to c 25% of patient accommodation, making it easier to isolate infected patients earlier.
- Continued prompt isolation and management of patients identified with MRSA infections/colonisation *& Clostridium difficile* infections in the Isolation Unit.
- Continuing prioritisation of hydrogen peroxide vapour (HPV) decontamination for rooms where patients have *Clostridium difficile* infection.
- Continuing mandatory infection prevention and control training.
- Continuing the clinical link nurses roles for infection prevention and control for every ward and unit, with support and regular meetings with infection control specialists.
- Ensuring two yearly review of Trust Infection Prevention and Control policies and when new evidence/ guidance changes.
- Planned actions include ensuring infection prevention is factored into all refurbishments, new builds and service developments. Actions are also planned to build on the existing programme of inspections, audits, surgical site infection surveillance programme and feedback.

2.3.10. – Patient Safety Incidents: Severe Harm or Death

The number and , where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death (25).

In this section, the latest nationally published data (March 2014) is shown as well as the most recent hospital data reported via the electronic incident reporting system (Datix).

The charts below show the latest nationally published data on Colchester Hospitals' performance: - rate per 100 admissions

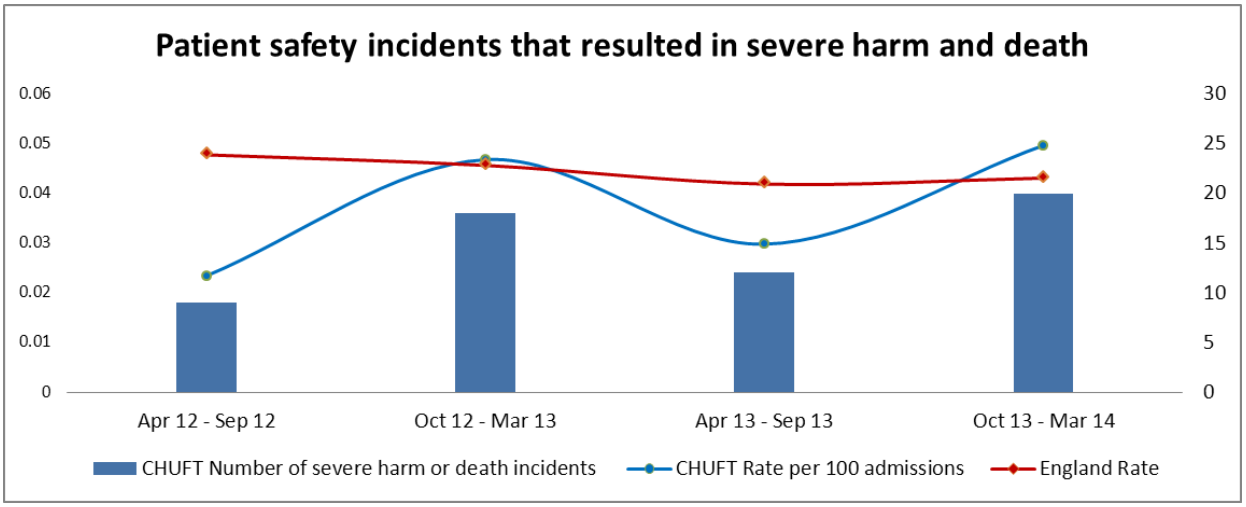


Rate of patient safety reported	CHUFT Number of incidents	CHUFT Rate per 100 admissions	England Rate
2012/2013	6924	8.6	7.1
2013/2014	5214	6.8	7.7

* England average calculated using data for Acute Trusts only

The Trusts with the highest and lowest incidents rates are shown below:

For the latest period (2013/2014)	Trust Name	Number of incidents	Rate
Trust(s) with highest incidents rate	Lewisham and Greenwich NHS Trust	4915	16.76
Trust(s) with lowest incidents rate	Dorset County Hospital NHS Foundation Trust	301	1.2



Rate of patient safety reported	CHUFT Number of severe harm or death incidents	CHUFT Rate per 100 admissions	England Rate
2012/2013	27	0.04	0.05
2013/2014	32	0.04	0.04

* England average calculated using data for Acute Trusts only

For the latest period (2013/2014)	Trust Name	Number	Rate
Trust(s) with highest incidents rate	Isle of Wight NHS Trust	50	0.37
Trust(s) with lowest incidents rate	Dorset County Hospital NHS Foundation Trust	0	0

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- The data has been sourced from HSCIC published data.

The chart below shows the number of patient safety incidents reported via the Trust's electronic incident reporting system reported from April 2014 – end March 2015:

Count of incidents reported by month 2014/15

Apr 2014	May 2014	Jun 2014	Jul 201	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Total
829	819	779	833	717	683	742	778	827	900	763	866	9536

There were 9,536 patient safety incidents for the year 2014/2015. The rate of severe and death incidents is less than 1% of these.

There were 31 severe harm or death incidents reported in 2014/15.

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- The data has been sourced from the Trust's electronic incident reporting system. New incidents reported each day are closely followed up to ensure appropriate recording and harm grading.

Colchester Hospital University NHS Foundation Trust intends to take/has taken the following actions to improve this performance and so the quality of its services, by:

- Continuing mandatory induction training for all new members of staff. The induction includes the importance of incident reporting. Information is provided on the support available when completing a Datix incident report form and immediately after induction training all members of staff receive Datix training on how to use the online reporting system to submit an incident.

- Continuing the checking of all patient incidents every working day by specialist governance staff. An audit trail is kept of any team comments and changes to the report. Checks are made on clarity, appropriate harm and investigator allocation and whether the incident requires escalation as a possible Serious Incident.

- Continuing the Serious Incident Panel which meets Monday – Friday and consists of senior risk, governance, clinical and executive team members.

- Continuing the focus on Trust wide initiatives to prevent patients from deteriorating. These include a wide range of strategies to improve timely diagnosis and treatment, for example:

    - the National Early Warning Score programme.
    - the sepsis pathway (included in Vital Signs Vital Action training).
    - the reduction of falls (e.g. through use of the falls integrated pathway and preventive measures such as sensor panels).

- Embedding the review of incidents, at least monthly, in all wards through the '2 at the Top' meetings (involving consultant leads and ward sisters) and team meetings with all staff.

- Embedding the emphasis on effective governance and learning in divisions.

- Embedding the review by divisions and service areas of all Serious Incident investigation reports to ensure actions to prevent recurrence have been implemented.

PART 3 – OTHER INFORMATION

3.1.- Rationale for selection and streamlining of priorities referred to in 2013-2014 Quality Report

Since the 2013-14 Quality Report in which 18 priorities for 2014-15 were identified, the Trust has undergone considerable scrutiny and been in Special Measures (due to concerns raised about cancer performance and records).

Work with the North East Essex Clinical Commissioning Group, Care Quality Commission and Monitor has resulted in the Trust streamlining its multiple priorities to select those that focus on the most important areas for improvement in this reporting period. The views of the board, governors, CCG, Healthwatch and other stakeholders were taken into account. The voice of patients and the public has been included via the stakeholder organisations at the hospital's Improvement Board.

The priorities were reduced from 18 to 11 and arrangements for assurance were confirmed for the 7 priorities removed. These arrangements included regular data collection and reporting to Trust committees and designated lead nurse roles for falls and tissue viability.

The 7 priorities removed include:

- 5 falls-related priorities (falls screening, following a protocol for serious harm falls, reducing falls in bathrooms, implementing falls audit and improving outcomes for patients with hip fractures).

- 1 tissue viability priority (risk assessment and body mapping).

- End of Life and mental illness measures have been removed from the priority to improve communication and the quality of relationship with service users and community providers, to enable a focus on dementia.

The care bundles priority was re-focused from a general approach of developing care bundles to a specific care bundle on chronic obstructive pulmonary disease.

Detail was removed from the Emergency Department priority to enable focus on the outcome of reduced time in the department, rather than aspects of assessment.

The 11 streamlined priorities are reported against in full below and structured according to the 3 main themes of Safe Care, Effective Care and Patient Experience.

3.2 - An overview of the quality of care offered by Colchester Hospital University NHS Foundation Trust based on performance in 2014/15

An overview of the quality of care offered by Colchester Hospital University NHS Foundation Trust based on performance in 2014/15 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason(s) for selection.

The quality indicators are reported against below under the headings safe care, clinical effectiveness and patient experience.

Safe Care

A. Healthcare related infections (HCAI) - work continuously to reduce HCAIs, including:

- **To reduce the number of *Clostridium difficile* Infections (CDI) to no more than 20 during 2014/15.**
- **To maintain a zero tolerance of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.**
- **To monitor and reduce the risk of infection from resistant gram negative organisms.**

Colchester Hospital University NHS Foundation Trust (CHUFT) serves a population with an increasingly elderly demographic. Infection prevention and control is seen as a key component of the patient safety and quality culture. These indicators were chosen because they are fundamental to good care for all our patients.

What did we do in 2014/15?

We have increased the proportion of single rooms, making it easier to isolate infected patients earlier. Approximately 25% of patient accommodation is single side rooms, many with en suite facilities.

The Isolation Unit has continued to support the reduction in the number of HCAIs through the prompt isolation and management of patients identified with MRSA infections/colonisation and Clostridium difficile infections. The Unit also supports the aim to reduce the incidence of multi resistant gram negative organisms within the Trust.

Hydrogen peroxide vapour (HPV) is used for the decontamination of patient rooms where the occupant has had an infection that may pose a risk to the next person to use the room. This service is available Trust wide. Priority is given to rooms that have been occupied by patients with symptomatic Clostridium difficile infection because HPV is the most effective way to destroy Clostridium difficile spores and therefore minimise the risk to other patients. Infection prevention and control is included in the mandatory induction programme for new staff. There is mandatory update training every two years, for all existing staff.

Each ward and unit has clinical link nurses for infection prevention and control, who act as clinical champions for Infection Control. The Infection Prevention and Control Team hold quarterly meetings for all 'link' staff. These meetings include an educational session and allow staff to discuss infection prevention and control issues.

All Trust Infection Prevention and Control policies are reviewed every two years and when new evidence/guidance changes with new policies added as required.

No MRSA bacteraemia cases were allocated to Colchester Hospitals during 2014/15.

Despite its hard work, the Trust team has not achieved the objective of fewer than 20 cases of hospital acquired Clostridium difficile infection during 2014/15; 32 cases of Clostridium difficile infection have been reported.

There is a process with the North East Essex Scrutiny Panel for assessing if a lapse in care has occurred. A lapse in care would be indicated by evidence that national guidance, policies and procedures have not been followed. Where no lapses in care are identified in conjunction within the scrutiny processes of the CCG some cases will not be included in terms of performance. Two cases from April to October 2014 were deemed not to be lapses in care. There are further cases currently in the process of being reviewed by the Scrutiny Panel.

The Trust remains committed to continue reducing the incidence of HCAIs in 2015/16.

What actions are we planning to improve our performance?

We aim to reduce the number of *C. difficile* and infections by antibiotic resistant organisms, including MRSA but particularly multi-resistant gram negative organisms.

We will aim to achieve the following:

1. Ensure that infection prevention is taken into account in all refurbishments, new builds and service developments across the Trust.

2. To build on the existing programme of inspections, audits and feedback; hand hygiene, Saving Lives, NPSA cleanliness audits, infection control audits; local daily checks and clinical indicators across the Trust.

3. Continue work with Facilities management to utilise effectively and efficiently existing environmental/ equipment decontamination technologies which will support the reduction of *Clostridium difficile* spores and other potentially harmful pathogenic organisms.

4. Continue with the surgical site infection surveillance programme.

5. Antimicrobial management – including education and audit with feedback.

6. Continuing with multidisciplinary team panel reviews for all MRSA, MSSA and *C.difficile* cases with feedback of themes for learning via the Infection Control hospital intranet page, newsletter, grand round and local feedback sessions.

7. Review teaching for all clinical and facilities staff on the importance of optimal infection prevention and control practices. Teaching will provide staff with the information, knowledge and skills necessary to minimise the risk of infection and will meet the requirements of the Hygiene Code.

8. Host the annual Infection Control Conference in 2015 on combating HCAIs, with the particular emphasis on the growing threat of multi-drug resistant gram negative organisms, aseptic non- touch technique and invasive device management including urinary catheters.

9. Continue to provide a proactive and responsive infection prevention service to all areas of the Trust, with particular emphasis on increasing awareness of the service in Therapies.

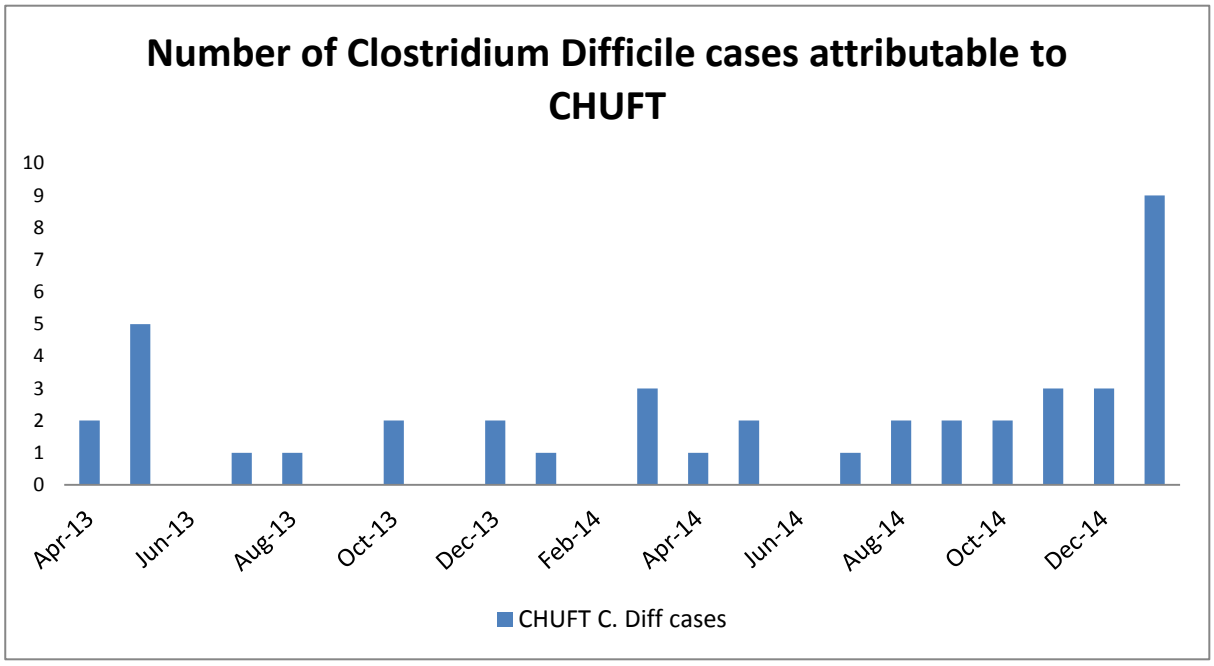
10. Continuing with regular awareness audits and feedback for MRSA screening with the aim to lift compliance from 87%.

How will improvement be measured and monitored?

Compliance and improvements will be monitored on a monthly basis by the Infection Prevention and Control Team. Assurance and feedback will be provided at the Hospital Infection Control Committee, held alternate months. This is a multidisciplinary meeting chaired by the Director of Infection Prevention and Control. Infection Control exception reports is a standing agenda item on all Divisional governance meeting agendas.

The table below shows the numbers of two important health care associated infections (HCAIs): meticillin resistant *Staphylococcus aureus* bacteraemia (MRSA) and *Clostridium difficile* (CDI) over recent years. These infections are monitored nationally through Public Health England with all hospitals submitting their information to the website monthly.

Infection	Number attributable 2010/11	Number attributable 2011/12	Number attributable 2012/13	Number attributable 2013/14	Number attributable 2014/15
MRSA bacteraemia	1	0	1	0	0
C. difficile	28	28	29	17	32



	2013/14		2014/15	
C Diff cases	**CHUFT C. Diff cases**	**National Average**	**CHUFT C. Diff cases**	**National Average**
April	2	3	1	2
May	5	3	2	3
June	0	3	0	3
July	1	3	1	3
August	1	3	2	3
September	0	3	2	3
October	2	3	2	3
November	0	3	3	3
December	2	3	3	3
January	1	2	9	3
February	0	2	0	-
March	3	3	7	-
YTD	**17**	**32**	**32**	**27**

B Standardised Hospital Mortality Indicator (SHMI) – maintain improvements to not exceed the expected relative risk of 100 as per the national benchmark by 31 March 2015.

This indicator was chosen as a Trust quality improvement priority because mortality is a key patient safety issue and because the inspection by Sir Bruce Keogh in 2013 highlighted mortality as an area for improvement by the Trust.

The Summary Hospital-level Mortality Indicator (SHMI) is reported in detail under the core indicators on page 41 at section 2.3; this includes the relevant data and graphs, performance actions taken and work remaining to be done. Other aspects of the Trust's work on this indicator described below.

The SHMI gives an indication of whether the mortality ratio of an organisation is higher or lower than expected when compared to the national baseline (England).

The Trust has had a high SHMI since the inception of the measure whilst the HSMR has been within expected range since 2010/11. This prompted the Keogh Review of the Trust in June 2013.

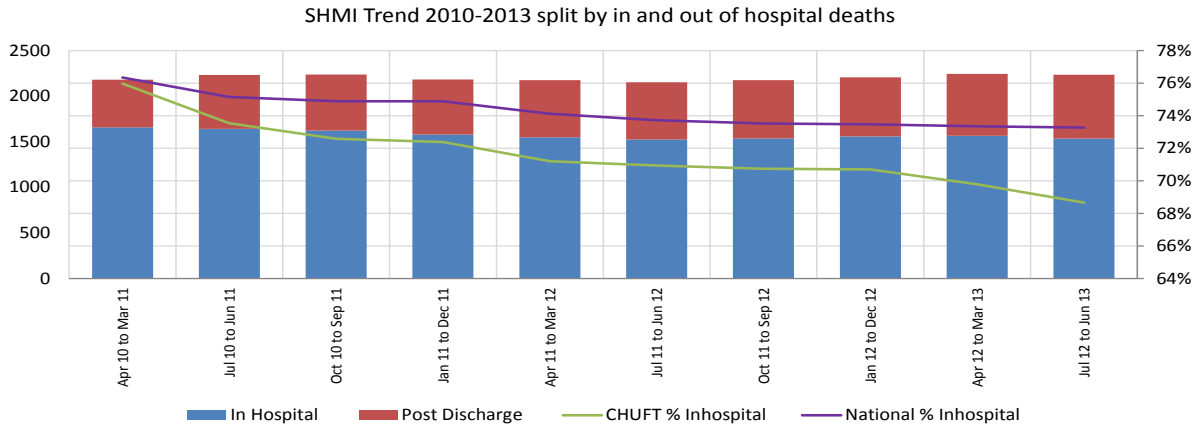
The latest available SHMI (October 2013 to August 2014) for the Trust is 1.043 which is 'as expected'.

The SHMI for the period April 2012 to March 2013 was 1.155. In January 2014 this figure was reported to have fallen to 1.146 for the period July 2012 to June 2013.

Healthcare Evaluation Data (HED), which provided information for the Keogh Review, also publishes monthly SHMI data which suggests that the Trust's SHMI rating has been within expected range every month since March 2013.

The Trust has continued to work with primary care and St Helena Hospice to improve care for patients felt to be at the end of life. Within the last 12 months, the My Care Choices Register has been developed and introduced. This identifies patients' preferred place of death for hospital consultants and GPs.

The Trust has a high proportion of deaths within 30 days of discharge. This is, in part, a result of the early supported discharge of patients to their preferred place of care. The following chart shows that fewer patients are now dying in hospital and more in their preferred place in a community setting.



The vast majority of deaths in hospital are patients who are admitted as emergencies. The Trust has continued to work on the reorganisation of emergency care to optimise outcomes for all patients. The National Intensive Support Team was invited in during January 2014 to advise the Trust on the progress since its previous visit in 2011.

Weekly mortality review meetings have continued, which are attended by Executive Team members. These meetings are regularly open to all staff who wish to attend. There is also regular representation from primary care to allow wider learning throughout local healthcare providers.

C – Staffing

Achieve the nursing staff fill rate monthly of equal to or greater than 95% By March 2015 and review every six months

This indicator was identified for reporting against because it has been an issue of national and local importance.

From May 2014, all trusts with inpatient areas were required to publish monthly staffing data on the NHS Choices website. There are currently 25 wards within the Trust that are included in this data collection. Data is collated from NHS Professionals and combined with data from the e-rostering system to produce the fill rates for each ward.

The chart below shows the current status: overall fill rate by month:

Nurse Staff Fill Rate	Av. Fill Rate - Day				Av. Fill Rate - Night			
	Colchester General		Essex County Hospital		Colchester General		Essex County Hospital	
	Reg. Nurses/Midwives	Care Staff	Reg. Nurses/Midwives	Care Staff	Reg. Nurses/Midwives	Care Staff	Reg. Nurses/Midwives	Care Staff
Apr-14	-	-	-	-	-	-	-	-
May-14	89.3%	97.9%	95.8%	86.5%	99.0%	101.4%	99.8%	102.4%
Jun-14	87.5%	80.5%	100.1%	69.6%	97.6%	77.8%	100.9%	68.3%
Jul-14	79.1%	89.3%	96.5%	103.2%	96.3%	101.8%	100.8%	132.8%
Aug-14	79.0%	91.5%	89.1%	102.5%	94.2%	100.6%	99.6%	126.8%
Sep-14	79.1%	88.3%	90.7%	96.3%	93.7%	103.6%	98.1%	113.5%
Oct-14	81.8%	88.2%	100.5%	93.0%	96.9%	101.1%	97.0%	98.8%
Nov-14	84.6%	97.0%	-	-	94.6%	103.0%	-	-
Dec-14	80.7%	82.9%	-	-	89.5%	88.8%	-	-
Jan-15	87.3%	92.2%	-	-	90.0%	89.5%	-	-
Feb-15	-	-	-	-	-	-	-	-
Mar-15	-	-	-	-	-	-	-	-
YTD	**83.1%**	**89.7%**	**95.4%**	**91.9%**	**94.5%**	**96.2%**	**99.4%**	**107.3%**

No national benchmarked data available.

The Trust has a high number of Registered Nurse vacancies which accounts for the poor fill rates in some areas.

Current vacancy figures for wards (UNIFY: data submitted via the NHS portal)

Band 2 Healthcare Assistant	22.26
Band 5 Registered Nurse	146.32

The above figures were provided by the Trust's Human Resources department and are for 13th February 2015. These vacancy figures do not reflect template changes from the acuity audit. This will be resolved when budgets are aligned to the new templates shortly.

What did we do in 2014/2015?

The Trust has been undertaking the following mitigating actions:

- Monitoring of nurse staffing levels on a shift by shift basis.
- Discussion of staffing at Bed Meetings (four times per day) and risk assessment throughout the day by the Speciality Matrons and Site Matrons.
- Moving of staff between departments and wards, as required, and according to risk assessment.

Registered Nurses (RNs)

A Recruitment Plan for Band 5 Registered Nurses (RNs) was developed and the following actions have been in progress:

- In conjunction with two recruitment agencies, the Trust has been intensively recruiting Registered Nurses from the UK as well as Europe and Overseas since October 2014.
- 16 Skype interview events have taken place since October 2014 and February 2015 to interview shortlisted candidates.
- 142 nurses started at the Trust from EU and non-EU countries during 2014/15.
- Number of nurses in the Human Resources recruitment process:
    - 77 Overseas (non EU)
    - 48 EU
    - Total 125
- European recruitment events took place In April and May 2015.
- The Return to Practice programme has recruited 2 nurses in 2014/15
- Commencement of the 18 month work-based learning RN (Adult) BSc programme, in conjunction with the University of Essex, in March 2015.
- A new recruitment website has been in development and its launch is planned shortly.
- Exploration of further marketing opportunities are underway by Human Resources.
- Incentive schemes for new starters are being planned.

Health Care Assistants

The Trust also has a Recruitment Plan for Band 2 Health Care Assistants and on-going Health Care Assistant recruitment has been in progress to help mitigate staffing risks.

Temporary Staffing

The Trust has been undertaking the following actions regarding temporary staffing:

- Joint working with National Health Service Professionals (NHSP) to improve the efficiency of NHSP usage and prevent waste and reduce costs. For example, a Trust project ensures cancelled NHSP staff are reassigned.

- There are plans for further incentive schemes in 2015.

- Tightening of controls for bank and agency bookings.

- Attendance of NHSP to a session on induction programmes to improve communication.

- Twice monthly recruitment walk rounds by NHSP recruitment staff.

- Participation in the Care Support Worker (CSW) Development Programme.

What actions are we planning to improve our performance 2015/2016?

- Continue the intensive EU recruitment programme to reduce vacancy factor and improve fill rate.

- Commence the Return to Practice course in June 2015 with Essex University.

- Hold further European events.

- Hold the nursing and midwifery recruitment open day 25 April.

- Gain agreement for the new process and programme for patient acuity audits on a 6 monthly basis to ensure staffing skill mix and numbers reflect patient needs.

D – Venous Thromboembolism (VTE)

Improve the number of patients being VTE risk assessed to achieve an internal target of equal to or greater than 95% By March 2015.

This indicator was identified for reporting against because of the vital importance of preventing thromboembolism as part of patient safety.

What did we do in 2014/15?

- Education was provided to all new junior medical staff starting at the trust. There are regular education and training sessions for nursing staff.

- The Trust has continued to use the Electronic risk assessment in all areas.

- Regular feedback has been provided to ward and clinical teams regarding their own performance on preventing thromboembolism. Any missing risk assessment forms are also highlighted for the ward/clinical team to complete.

- Work was undertaken with the Business Information team to identify and understand areas of apparent poor compliance with the risk assessment process. Sometimes this has been due to a change in process of recording patient activity. The introduction of the new Clinical Portal (Trust wide electronic patient administration system) in Quarter 3 posed some particular challenges regarding reviewing information and steps have been taken to overcome these.

- In all cases where patients have developed thromboembolism, the VTE (Venous Thromboembolism team) has highlighted the importance of root cause analysis.

- An agreed process was developed for cases of thromboembolism which were deemed to have been preventable; the cases are reported and investigated through the Serious Incident process.

How did we perform in 2014/15?

- We achieved greater than 90% performance for risk assessment, between April and November and from January onwards. There was a dip to 88.5% in December, linked to the introduction of the new clinical portal. This continues to fall short of the greater than 95% target set by our commissioners.

- The database for recording VTE root cause analysis outcomes is being used to set up a standard report for feedback to divisional governance groups.

- Engagement with the root cause analysis process has improved; but some difficulties remain with obtaining feedback from some clinicians. Assistance to improve this situation is being sought through the divisional directors.

- Review of root cause analyses has led to the introduction of extended prophylaxis by some surgical teams.

What actions are we planning to improve our performance?

- The Trust will continue to provide daily (which now includes weekends) feedback to ward staff regarding complete and missing risk assessment forms.

- Staff who are having difficulty in completing the risk assessment forms will be identified. The agreed approach is that the assistance of the Clinical Directors will be sought to identify solutions to remove any barriers to the completion of the forms.

- A standard report template will be produced for the root cause analysis outcomes, to enable discussion and review at divisional governance meetings.

- The possibility of a new electronic risk assessment form will be explored. The form will be linked to the Portal and this will minimise transcription errors and facilitate compliance with the risk assessment process.

How will improvement be measured and monitored?

- Monthly feedback to the Clinical Quality Review Group and commissioners.

- Feedback from Governance meetings to demonstrate learning and change of practice.

E –Safer Surgery Checklist

(World Health Organisation – WHO) – achieve compliance with all elements of the WHO Checklist as per the 100% target by 31 March 2015.

This indicator was identified for reporting against because it is fundamental to patient safety.

The Safer Surgery Checklist describes five methodical steps (elements) which are fundamental to patient safety.

The steps start with a Briefing at the beginning of every list. For each patient, a Sign In must occur prior to commencement of the anaesthetic. The Sign In involves a series of safety checks which include ensuring the correct patient, correct procedure and documentation. The next step is a Time Out which is a pause in activity immediately prior to skin incision, a Sign Out which involves checks made at the end of surgery and a De-brief which occurs at the end of the operating list.

These steps improve patient safety through enhancing team performance, increasing the reliability of key clinical processes and ensuring a process of deliberate planning for variations in expected care.

Communication between all members of the clinical team is improved by the checklist and, in particular, through the briefings before the surgical lists start and the de-briefings at the end of the surgical lists.

What did we do in 2014/15?

- There has been significant focus in the Trust on safer surgery training. In addition, there have been team simulation training sessions to explore the theatre environment and the impact of human factors on patient safety.

- Whilst audit of all steps has been embedded for a considerable time, with monthly compliance reports available trust-wide, there was less clarity regarding the actions required if non-compliance was recorded. Therefore, in June 2014, the theatres, anaesthetic and surgical teams further developed the joint Standard Operating Procedure. This procedure highlights the actions required at each stage and the documentation requirements. Details are given of how to escalate concerns and report non-compliance using the Trust incident reporting system. The procedure is that all incident reports are to be investigated by the senior theatre team.

- Following 2 Never Events in ophthalmology, a review of safer surgery was undertaken by the ADN surgery and Associate Divisional Director for surgery. This review consisted of visits to the Essex County Hospital (ECH) site to discuss the events directly with staff, review the actions taken and undertake direct observation of theatre practice. The summary report highlighted that immediate steps had been taken by the ophthalmology team to prevent recurrence and the ECH theatres were added to the monthly trust monitoring and reporting system for “WHO” compliance.

- The Medical Director and Divisional Director also sought assurance from all surgical teams undertaking procedures away from Colchester General Hospital to review their checks and processes. We are fortunate to have consultants and senior nurses who have a specific interest and experience in the process who were able to offer support and advice for these teams to ensure robust systems are in place.

- In terms of continuous monitoring and escalation of concerns, WHO checklist compliance is a standing agenda item on Divisional Governance agenda as are Serious Incidents and Never Events.

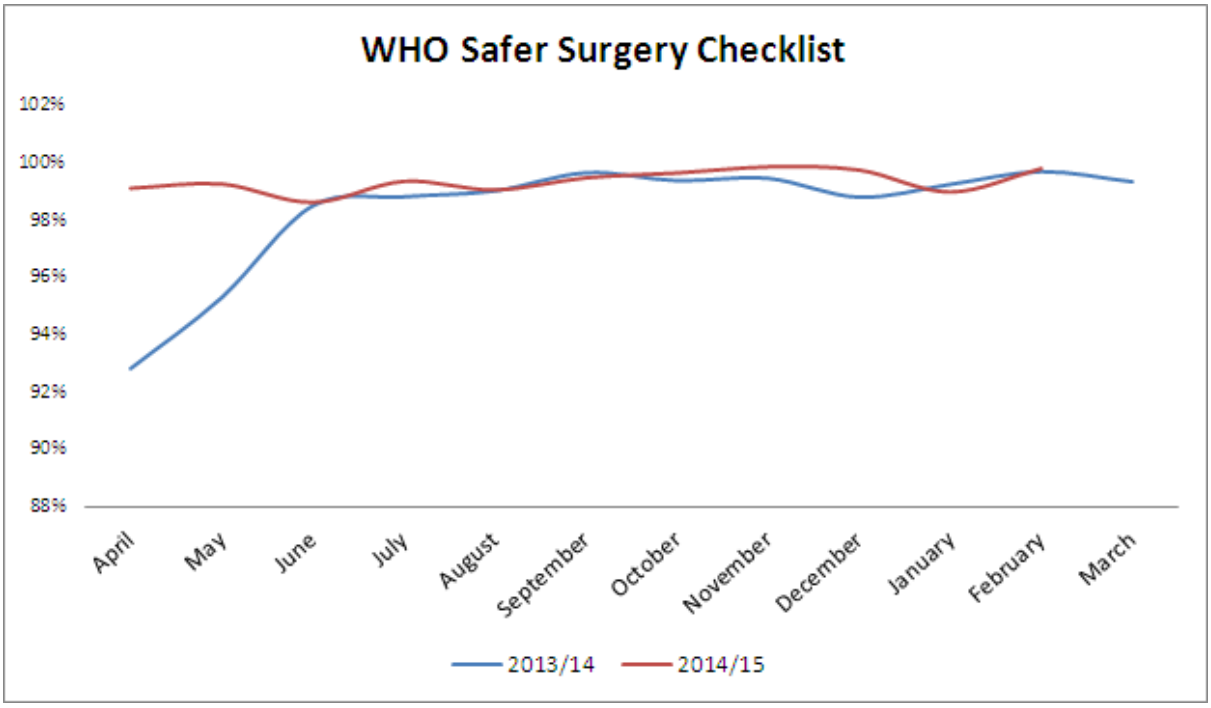
- All Never Events have been subject to an SI investigation. The incidents have been discussed in various groups to ensure the cascade of learning across different teams and Trust wide. An open invitation SI forum for all staff groups was commenced by the Associate Director of Nursing for Surgery in December 2014.

- Other methods have been deployed to highlight safe surgery practice issues in the division. For example, a monthly Clinical Leads meeting for medical, nursing and managerial service leads is led by the Divisional Director. Also, a Divisional newsletter has been developed to capture key learning points and cascade them to all staff groups. Trust risk and governance learning reports are also distributed.

- There are regular Surgical Site Infection meetings which are attended by multidisciplinary staff. Matters relating to the WHO checklist are also discussed and actioned if appropriate in this forum.

How did we perform in 2014/15?

- The Trust has, unfortunately, had 9 Never Events in 2014 – 15 due to a range of failings in the Safer Surgery checklist and other checking processes. (Please see the CE's Introduction for further information on the Never Events).



WHO Safer Surgery Checklist*	2013/14	2014/15
April	92.84%	99.13%
May	95.31%	99.28%
June	98.52%	98.64%
July	98.83%	99.37%
August	99.04%	99.07%
September	99.67%	99.49%
October	99.40%	99.66%
November	99.47%	99.87%
December	98.82%	99.77%
January	99.26%	99.00%
February	99.71%	99.82%
March	99.36%	-
YTD	**98.38%**	**99.31%**

What are we planning to do to improve our performance 2015/16?

- Extend the culture of 5 steps to safer surgery out to the wards with regard to pre-operative checks.
- Introduce a 1 day human factors/patient safety course in the Iceni centre to optimise team working.
- Include close monitoring routinely of the 5 steps to safer surgery at the Theatre Management Group.

Effective Care

F - Accident and Emergency (A&E) waits
Reduce the time patients wait ensuring we meet the 95% 4 hour standard by 31 March 2015.

What did we do in 2014/15?

Considerable work has been undertaken to review and improve the processes in the A&E department to reduce the time patients wait to be seen.

The Care Quality Commission (CQC) identified needed changes when they visited A&E and EAU in January 2015. The number of beds in EAU needed to be reduced and the ratio of staff to patients needed to increase. The hospital had to ensure that patients were assessed appropriately when they arrived and treated according to the appropriate clinical "stream" with dedicated services to meet their needs. In addition, highly dependent patients must be nursed safely in a dedicated area within EAU. The full CQC report identified a number of key areas for improvement including leadership, medical and nursing staffing, privacy and dignity. The CQC visit resulted in the Hospital reporting on its compliance with these improvements on a weekly basis to the CQC as part of the section 31 requirements (see 2.2.6 Trust Registration Status for further details on page 25).

A further driver for improvement has been the fact that patients attending A&E are generally sicker and more dependent than has been the case previously.

Following the CQC visit in January 2015, the Trust created a separate Urgent Care division; allowing for a dedicated experienced team to focus on the "front door" of the hospital (A&E and EAU). This has focused treatment on our emergency care patients; their immediate assessment, treatment and admission to an appropriate ward or discharge home, as required. This has given greater focus on these patients' pathways and helped patients to be assessed, treated, admitted or discharged within the four hour standard, where possible.
Key improvements have been made to the data collection process to ensure accurate measurement of performance. For example, tighter data controls and software improvements have been implemented in the Trust's new patient administration system (Portal).

The A&E department has been undertaking further recruitment of staff and realigning the service to improve the patient pathway. A Clinical Decisions Unit (CDU), within the A&E department, opened in early March 2015. This became a 24 hour service on 23 March 2015. This ensures that patients requiring extended stay but not requiring admission to a hospital in-patient bed can be assessed and treated safely. This has led to a reduced rate of patients being admitted and also a reduced length of stay.

The likely impact of this development is to see a reduction in admission to inpatient beds, increased patient satisfaction and the development of dedicated and robust patient pathways offering a high standard of treatment. Although this does not have a direct impact on the number of patients waiting in A&E, the ability to stream patients directly to the CDU on a dedicated pathway ensures that this cohort are receiving the right treatment in the right place at the right time. The hospital has an internal standard for patients who are converted to an inpatient stay which is that patients must not wait more than 12 hours for an inpatient bed. This prevents the unit becoming congested and allows for the rapid turnover of short stay patients.

Further developments have included the development of an Elderly Frail Unit which opened on 5 January 2015 in the existing EAU. This unit focuses on the care of frail elderly patients

who do not require lengthy admission but need short focused treatment, specialist input and social support to enable them to go home.

The Hospital Ambulance Liaison Officer based in A&E is critical to the management of the flow of patients in A&E e.g. by providing prior early information on the number of ambulances en route to the A&E department and the level of activity in the sector. This provides intelligence and allows for anticipation of surges and issues with other hospital trusts which could affect Colchester Hospital.

How did we perform in 2014/15?

4 hour wait performance

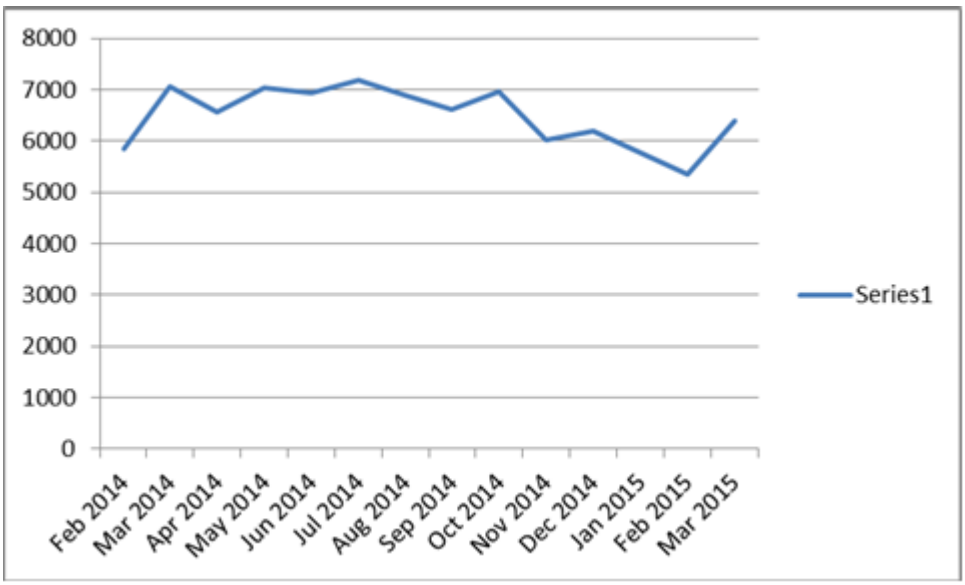
Performance for the year until the time of reporting from April 2014 is at 87.08% which is below the required 95% standard. There was a dip in performance with the four hour standard with 72.7% in January 2015, however February has seen a significant recovery to 82.62%. January to March 2015 had a significant increase in the number of 4 hour breaches which is in direct correlation to the fall in performance.

The significant dips in performance in November and December 2014 were partly attributable to the implementation of new computer software. Data quality was poor during this period. Data cleansing and rigorous control around data quality means that the Trust is now reporting accurate data in a timely fashion. Further improvements are being implemented with a view to having full system integrity by end of Q1 2015/16.

Admission rate

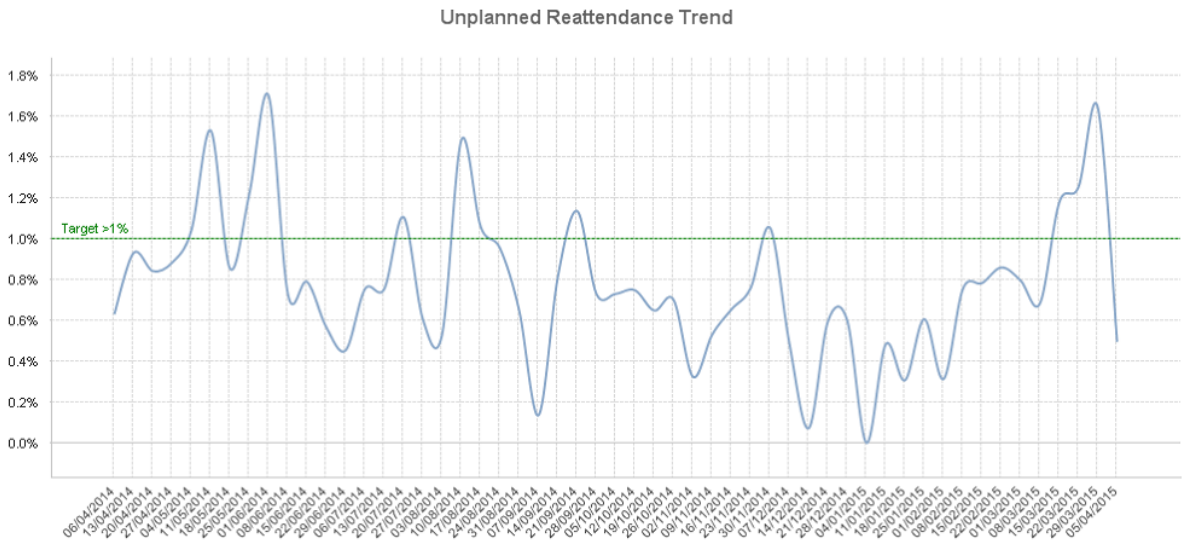
There was a high number of admissions October to December 2014 which impacted on the achievement of the 4 hour standard. Bottle necks occurred in A&E secondary to a lack of inpatient beds being available. This in turn further affected the performance of ambulances handing over and dropping off their patients. Also, the time for patients to be assessed was reduced due to reduced capacity in A&E.

The monthly attendance rate to A&E April 2014-March 2015 is shown in the chart. It shows a fall in attendances in February 2015; which also correlates with a fall in attendances in February 2014.



Unplanned re-attendance

There has also been a fall in the unplanned re-attendance of patients and patients waiting for treatment. For example, unplanned re-attendance was 4.86% in March 2015 as opposed to 5.25% in January 2015 and this is now below the 5% quality standard.



Leaving A&E without being seen

In addition to the 4 hour target, we also look at the percentage of patients who leave the A&E department before being seen. This is another indicator of the level of satisfaction patients have with their wait. The group of patients most frequently involved in this are walk-in patients who present themselves at A&E. The percentage of patients leaving before being seen has reduced over the year. The figure has fallen to 2.12% in 2014-15 compared to 2.64% in 2013-14.

This indicates that patient satisfaction with their treatment appears to be improving. There are still a small number of patients who return to A&E for review of minor complaints. The Hospital is working with the Walk-In Centre to ensure that patients receive dressing changes and reviews in the appropriate care venue.

Assessment waits

Assessment waits (i.e. time to meaningful contact in less than 60 minutes) peaked in October to December 2014. January to March 2015 performance, however, now is in line with the national standard. This represented a decline in patient experience with patients waiting longer to have a meaningful assessment in A&E after they arrive. This is a symptom of flow and capacity issues encountered in this period whereby lack of capacity in A&E causes a pinch point. Surging of ambulance patients that require assessment in the trolley areas are delayed as a result of patients remaining in the department for a period of time whilst awaiting a definitive destination.

What are we planning to do to improve our performance 2015/16?

The Trust Improvement Plan will result in continued change in the A&E department. (For details of the Improvement Plan please see section 2.2.7 Actions Planned and Improvement Plan Summary on page 30).

The Trust ran Operation Fresh Start for the week commencing 9 February 2015. The purpose of this exercise was to focus on patient pathways, how to improve them and ensuring that patients are being cared for in the right speciality. The results of this analysis work are being incorporated into the overarching improvement plan so that co-ordinated improvements across the whole hospital can occur.

The rapid initial assessment cell in the A&E department will continue and this seeks to address the patient safety aspect of the ambulance handover.

G - Chronic Obstructive Pulmonary Disease (COPD)

Demonstrate 75% compliance with chronic obstructive pulmonary disease (COPD) care bundles by 31 March 2015.

This indicator was identified for reporting against because this is a common cause of readmission and deterioration for patients with this long term condition.

What did we do 2014/2015?

The role of The COPD (Chronic Obstructive Pulmonary Disease) Clinical Nurse Specialist (CNS) identified this group of patients were not always getting the correct care pathway or discharge. After several trials of COPD Discharge Bundles, and working very closely with Respiratory, and Acute Medical Consultants, a new admission/discharge bundle was born. Introduced to recognise a COPD patient on admission, the aim was to provide the best management, ensuring that all education and information was given to enable safe discharge.

As a CQUIN (Commissioning for Quality and Innovation), patients with COPD exacerbation or an acute lower respiratory infection, on admission or as a secondary cause should have a care bundle.

How did we perform 2014/2015?

Due to the late start of the CQUIN, the bundle was not audited until Quarter 2. The bundle had only been launched in June 2014, and was still at an innovation stage. From the early figures collected, few were completed by staff other than the COPD CNS.

Out of a total of 216 patients coded with a COPD admission or secondary cause 37% had a care bundle present in the medical notes. Regular teaching sessions and presentations to clinical audit meetings, showed improvement for Quarter 3. We were above our target of 40%, obtaining 45.2% out of 241 patients admitted. This was an increase of 8.2%.

Quarter 4 performance data is not yet available so it is too early to predict the outcome, at the time of this report. The Trust audits the care bundle documentation in the health records to assess compliance. At the time of this report, 63% of care bundles are filed in patients' medical notes. This is an increase to date of 25% from the previous quarters.

What are we planning to improve our performance 2015/2016?

All COPD patients admitted to hospital will receive a follow up appointment with the Community COPD team. Integrating respiratory services should ensure the correct care and support is provided to aid their recovery and help prevent further admissions/readmissions. Readmission figures are being audited with the assistance of the Community COPD Team, which has identified a need for a seven day service. This would allow a continuation of expertise to be provided enabling quality and patient safety.

The Trust has commenced a pilot in the community to allow early supported discharges to be reviewed at home over the weekend. The intention is to obtain a further audit from patient analysis post discharge to see if improvements have been made in how confident they feel. The Trust believes it to be greatly beneficial for the care bundle to continue. Although improvements to care of COPD patients are slowly manifesting themselves there appear still

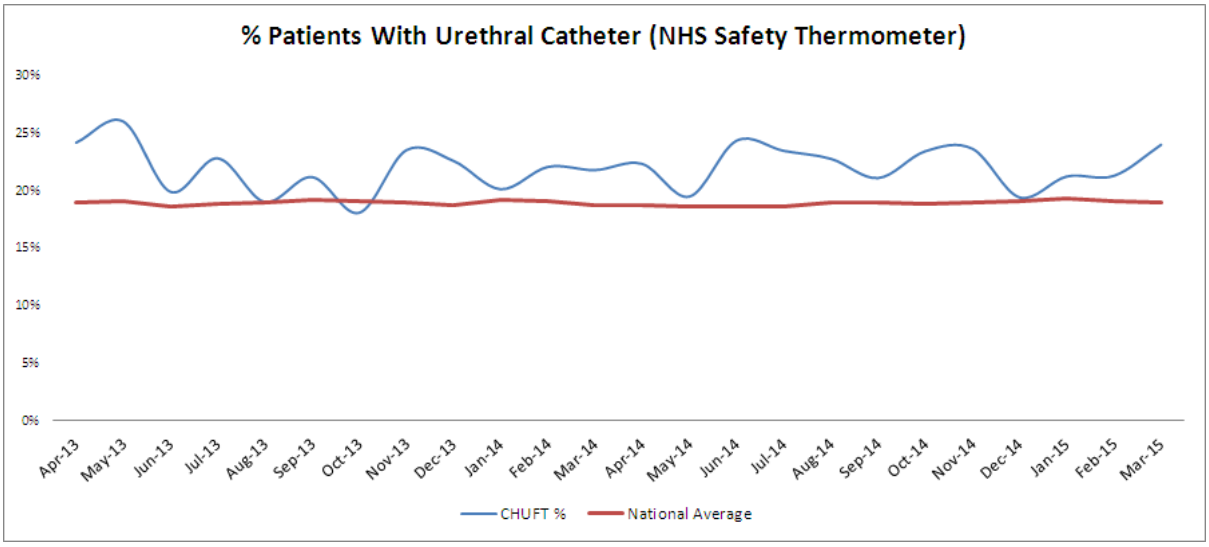
to be several barriers. Reshaping the attitudes of staff towards patients with long term conditions, will affect the care given in the future. The Trust aims to facilitate awareness to long term conditions and the subsequent care needed, making resources available for all. Supporting patients and understanding what is compromising the quality of their life will help prolong that life, reducing mortality rates.

H – Urinary Catheters

To reduce the percentage to below 19.8% by 31 March 2015 of inpatients with an indwelling urethral catheter, as recorded in the NHS Safety Thermometer, to minimise the risk of catheter related harm in our patients.

This indicator was identified for reporting against because the Trust has recognised it is an outlier on the National Safety Thermometer point prevalence audit data.

The key message aimed for through the staff education programme will be to review the need for a catheter before insertion. Following insertion, staff must continue to review regularly the need for a catheter and develop a plan for on-going management.



	2013/14		2014/15	
% Pts With Urethral Catheter (NHS ST)	CHUFT %	National Average	CHUFT %	National Average
April	24.13%	18.95%	22.29%	18.75%
May	25.97%	19.05%	19.45%	18.54%
June	19.87%	18.61%	24.31%	18.63%
July	22.78%	18.77%	23.42%	18.64%
August	18.98%	18.88%	22.74%	18.95%
September	21.15%	19.22%	21.06%	18.88%
October	18.05%	19.06%	23.39%	18.83%
November	23.48%	18.99%	23.61%	18.99%
December	22.55%	18.71%	19.39%	19.09%
January	20.09%	19.11%	21.20%	19.25%
February	22.03%	19.03%	21.25%	19.06%
March	21.75%	18.66%	23.95%	18.91%
YTD	**21.73%**		**22.15%**	

What did we do 2014/2015?

Progress has not been as advanced as planned, due to the non-approval of a business case to fund a specialist nurse. The nurse role was needed to support the necessary improvements in continence education and on-going catheter management and it remains a challenge to progress this priority until the role is in place.

Some developments, however, were taken forward by the Infection Control Team. A new urinary catheter insertion pack was introduced in January 2015 Trust wide to support best practice at the point of insertion of a urinary catheter. A staff education programme was commenced along with the introduction of the pack to remind staff to stop and think if there are alternatives to their patient being catheterised.

How did we perform 2014/2015?

The number of patients having a urinary catheter inserted by us is c 22% compared to a national average of c 19% (using NHS Safety Thermometer data). This makes the Trust an outlier in the monthly Safety Thermometer data collection tool.

What are we planning to improve our performance 2015/2016?

In 2015-16 the Trust will continue to work on this key development work to reduce the number of patients who have a urinary catheter inserted.

Key actions are as follows:

- Identify staffing options to implement this urinary catheter education and reduction programme.

- Continuing staff education to support and embed in clinical practice the use of Urinary Catheter Packs.

- Work with Clinical Skills Nurses to embed asceptic non touch technique practices relating to all invasive device insertion but with an emphasis on urinary catheters. This will be the focus in the first six months.

- Introduction of a new urinary pathway for in-patient short term catheterisation to support urinary catheter passport work.

Patient Experience

I - Dementia

Improve the way we communicate and ensure that respect, dignity and compassion are at the heart of our relationships with service users. This will be measured by:

Dementia; to achieve 90% target of compliance with each CQUIN measure by 31 March 2015.

This indicator was identified as a Trust quality indicator as part of the Trust's review and rationalisation of quality goals late in the reporting period. The target was selected because this vulnerable group of patients require particular communication, respect and dignity standards.

What did we do in 2014/15?

- The Trust has consistently achieved above 90% in dementia screening and the Dementia Nurses have trained senior ward staff to undertake screening in orthopaedics, Care of the Elderly and Medical wards.

- The Trust has implemented a delirium pathway and developed a delirium training package for staff.

- The Trust will continue to provide a Dementia Awareness training programme to improve the skills and understanding of clinical staff in the care and treatment of patients with Dementia or clinical signs of Dementia. The Acting Nurse Consultant for Older people and the Dementia Nurses have completed the Train the Trainer course in Jan 2014 and have established an advanced 2 day training workshop for staff focusing on caring for patients with dementia in an acute healthcare setting.

- All carers of patients who suffer with Dementia receive a questionnaire following discharge from hospital. The aim of the questionnaire is to seek the views and experiences of carers to establish if they feel supported. Findings from these returned questionnaires will help inform necessary changes to the delivery of Dementia care services.

- The Trust has worked with voluntary sectors (the Alzheimer's Society and Age UK) to establish weekly Dementia Carer 'drop-in' sessions based within the hospital to provide essential information and support.

- The Trust has developed a carers' leaflet, available Trustwide, which outlines what a carer can expect when a relative comes into hospital. The leaflet signposts carers to where they can obtain help and support on discharge

- The Trust has developed an "Information All About Me" patient information document which enables information to be shared on the needs of the patient.

How did we perform in 2014/15?

- 98.9% of all eligible patients over the age of 75 were asked the Dementia case finding questions
- 100% of all identified patients were screened for signs of Dementia
- 98.9% of all patients identified as requiring specialist referral for further diagnostic assessment and advice.

Month	CHUFT % patients asked Dementia case finding questions	National Average - % patients asked	CHUFT % patients with delirium or known dementia	National Average - % patients with delirium or known dementia	CHUFT % patients referred to GP	National Average - % patients referred to GP
Apr-13	97.19%	70.40%	100.00%	83.30%	100.00%	70.40%
May-13	98.44%	71.10%	100.00%	86.80%	100.00%	87.80%
Jun-13	99.35%	74.00%	100.00%	89.00%	100.00%	90.00%
Jul-13	98.08%	78.81%	100.00%	88.64%	100.00%	89.27%
Aug-13	99.34%	78.37%	100.00%	89.71%	100.00%	92.07%
Sep-13	97.94%	80.33%	100.00%	89.20%	100.00%	92.21%
Oct-13	98.44%	80.58%	100.00%	89.57%	100.00%	89.57%
Nov-13	99.22%	82.74%	100.00%	88.24%	100.00%	86.35%
Dec-13	99.44%	81.07%	100.00%	89.71%	100.00%	88.21%
Jan-14	99.48%	82.70%	100.00%	90.20%	99.06%	90.00%
Feb-14	99.36%	83.80%	100.00%	90.60%	100.00%	90.90%
Mar-14	99.64%	84.20%	100.00%	90.00%	100.00%	90.00%
2013/14	**98.84%**		**100.00%**		**99.90%**	
Apr-14	99.80%	85.50%	100.00%	91.60%	100.00%	90.50%
May-14	99.60%	86.10%	100.00%	92.70%	100.00%	93.80%
Jun-14	99.80%	87.10%	100.00%	92.90%	100.00%	96.20%
Jul-14	100.00%	88.20%	100.00%	93.60%	100.00%	97.10%
Aug-14	99.60%	88.20%	100.00%	92.80%	100.00%	95.40%
Sep-14	100.00%	88.70%	100.00%	93.20%	100.00%	96.50%
Oct-14	99.60%	89.10%	100.00%	93.60%	100.00%	96.80%
Nov-14	99.60%	89.70%	100.00%	93.40%	100.00%	95.80%
Dec-14	97.80%	88.20%	100.00%	93.50%	90.50%	95.70%
Jan-15	98.60%	89.40%	100.00%	94.40%	100.00%	96.60%
Feb-15	98.90%	90.20%	100.00%	94.70%	98.90%	96.40%
Mar-15	-	-	-	-	-	-
2014/15	**99.40%**		**100.00%**		**98.80%**	

All clinical roles have been aligned to the Dementia Awareness training and training has commenced through e-learning and classroom based sessions. Three members of nursing staff have completed an accredited national Dementia Train the Trainer course. These staff members have developed and provided a more in-depth training programme for staff to improve their skills and knowledge of caring for patients with Dementia.

Questionnaires are sent monthly to carers of patients discharged from the Trust within that month. The Trust currently identifies and sends out an average of 10 questionnaires a month and has a 30% response rate.

	Quarter 1				Quarter 2				Quarter 3				Quarter 4 (to date)			
Month	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total
Sent	15	16	8	39	5	8	5	18	4	12	10	26	17	12	18	47

The following learning themes were identified for the period July – December 2014:

- Carers felt confident in staff caring for their relative and ability to meet their needs whilst in hospital.
- Carers felt likely to recommend our hospital to friends and family, if their relative required similar care or treatment
- Carers were not always encouraged to share information with staff about their relative during the admission.
- Carers felt unsupported at times to care for their relative at home.

What actions are we planning to improve our performance?

- Work will continue to sustain the performance relating to the Dementia screening, assessment and referral process as part of this pathway of care
- Dementia Awareness Training will continue to be provided and monitored for 2015/16
- Delirium training will continue to be provided and monitored for 2015/16
- Themes and trends captured as part of the carers' questionnaire will be reviewed and local and Trust wide actions agreed Trust.
- The Trust wide implementation of 'information all about me" document to support person centred care within the hospital.

How will improvement be measured and monitored?

- To continue with the monthly review of performance outcomes for the screening, assessment and referral of patient with signs of dementia.
- Monthly reporting of training figures against agreed training trajectories.
- To continue to seek feedback from carers through a carer's questionnaire monthly and organise a further forum to ensure that as an organisation we are providing person-centred care initiatives to improving dementia care.

J – From ward to Board- communications and appraisal

Improve the way we communicate with each other from ward to Board

This indicator was identified for reporting against because it has been a Trust wide priority to transform the organisation into one where all staff are fully engaged and involved in Trust goals.

From ward to board: improve the way we communicate with each other from ward to board

Communication in any organisation as large as Colchester Hospital is always a challenge. To improve how we do this there have been many varied initiatives and work streams linked to increasing staff engagement and in turn effective two way communication. For the purpose of this report there will be a focus on how messages from the executive team reach our staff and also how our staff have a chance to feed back any concerns or ideas they may have.

What did we do in 2014/15?

For a number of years the Chief Executive Officer (CEO) has held monthly briefing sessions. In the past these have been aimed at the more senior members of the trust. In recent months this has been opened up to any member of staff who wishes to attend. Another change is the post board briefings which are again open to all staff and are held immediately after the monthly public board meeting. There is a weekly communication from the CEO to all staff where feedback from staff is always welcome.

Suggestions from staff as to how they can help improve the hospital are welcome through the use of suggestion boxes that have been placed around the hospital.

There has been substantial publicity in the past year as to how staff can raise concerns. Posters, surveys and the training of additional contact officers are a few of the actions that have been taken.

A “you said, we did” poster campaign was launched in May 2014 to feedback to staff actions that had been taken as a result of focus groups, the staff and engaging into action survey and other feedback methods.

On a more local level there has been a change to the divisional structures. Now led by an AD of Nursing, an AD of operation and the Divisional Director these structures allow for more cohesive leadership and bridges historical gaps in effective communication, now allowing for better alignment of clinical and strategic priorities.

There has also been an increase in the level of appraisal. The importance of this is that staff know what the organisational priorities are and how they contribute to achieving these. Recorded compliance with appraisal in January 2015 was 76.78% and this compares with 67.39% in January 2014 and 72.11% in January 2013.

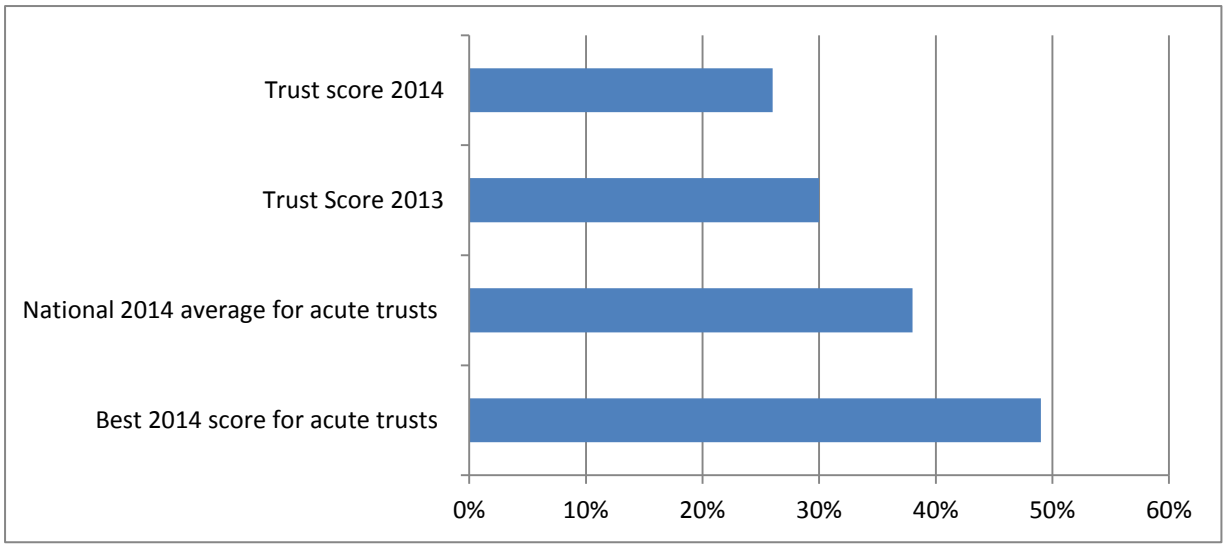
It needs to be noted that although records show appraisal rates increased, staff report a decrease in appraisal activity during 2014/15. This can be explained by a change in the process in 2014 which means that some staff had a period of 15 months between appraisals as opposed to 12 months.

How did we perform in 2014/15?

Whilst it is acknowledged there has been great commitment to improve board to ward communication across the trust it also need to be recognised that this is not reflected in the 2014 staff survey. Influencing factors include a number of changes to the top team during 2014/15 and the extreme business of the hospital.

A local increase in appraisal rates in the past year has been a positive move but the trust still lies below other Trusts in the key performance indicator relating to this in the 2014 staff survey. The quality of appraisal needs to be addressed as shown in the chart below. Whilst there has been an increase in staff having an appraisal throughout 2014-15 there has been a decrease in staff reporting that this was well structured, as can be seen from the graph below.

Key Finding 8: Percentage of staff having well-structured appraisal in the last 12 months (the higher the score the better).



What are we planning to improve our performance 2015/16?

The first improvement is already underway and that is to have a substantive trust board with most positions having been successfully recruited into. It is envisaged this will have the effect of a more consistent message coming through to staff from the Executive Leads.

The board are committed to increasing the number of “walk rounds”, giving staff the opportunity to talk to and feedback back to members of the Executive Team in their workplace.

There will be increased publicity around the monthly executive and board briefing to ensure as many staff as possible are able to attend and not only be aware of the key messages but have the opportunity to question and offer suggestions to the executive team.

A review of the appraisal process is already underway and will include changes to the paperwork and quality audits.

It is also recognised there needs to be an increased focus on the engagement of our staff, which is seen as a key component of effective two way communication. We will be focused on acting on what staff have told us in the recent survey. An immediate action is the appointment of Lead for Organisational Development and Engagement. This will allow for a full time focus on matters important to staff which is something the trust has not had for the past couple of years. We will be speaking with the trusts that performed well in the survey – particularly those in the top 5, to learn from them. We will put particular emphasis on the need to listen to the concerns of our staff and then act on them.

Also for 2015-16 the trust is investing in a refresh of the 'At Our Best' Programme. Initially launched in 2011, this has become part of the language at Colchester Hospital and as such is used in both the recruitment and appraisal process.

During the first quarter of 2015-16 there will be a focused piece of work that will include workshops for the executive team who in turn will facilitate sessions that all staff will have the opportunity to attend. These sessions will allow conversations around the vision for the Trust and how At Our Best is central to that. All staff who manage, supervise or have leadership responsibilities will also be invited to attend facilitated workshops to cascade how 'At Our Best' is an integral part of leadership and how the principle of At Our Best can be effectively used in their roles to lead, engage and motivate their teams.

K -Re-opened complaints

Reduce re-opened complaints by 20% from 2013-14 levels by 31 March 2015.

What did we do in 2014/15?

Complaints reopen when a complainant is dissatisfied with the response provided by the Trust, or the reply has raised new issues, or the complainant would like to organise a meeting to locally resolve their complaint.

- To ensure an improvement was achieved in relation to the numbers of complaints reopening, the Complaints Department looked at the entire complaints process and felt a greater emphasis should be placed on the start of the process. A new system of providing a basic acknowledgement (BAK), then a full acknowledgement (FAK) was introduced.
- The BAK is a communication sent in writing to the complainant within 24 hours of receiving concerns to verify receipt. The FAK follows within 7 days, and this period of time gives the Complaints Department and the complainant sufficient time to fully establish the items to be taken forward through the complaints process. This means that when the complaint reply is provided it matches the issues that the complainant wanted answered and reduces any ambiguity.
- In addition, the Complaints Department continued to monitor the number of reopened complaints and discuss these with service leads at weekly meetings and Divisional Governance meetings.
- A new 'Serious Incidents and Complaints' meeting was introduced that occurs twice a week and allows the Complaints Department to raise concerns with the executive team about the number, or types, of reopened complaints.

How did we perform in 2014/15?

In 2013/14 there were 155 complaints that needed to be reopened. The figure for 2014/15 was 73, representing a significant reduction by 53%, which exceeded the target of 20%.

The experience gained at the start of the complaints process, allowed the Complaints Department to return any insufficient responses to the teams investigating the complaint. The changes meant the Complaints Department had a much greater understanding of the outcomes required by the complainant, and could work with the investigating teams to achieve this.

What are we planning to improve our performance 2015/16?

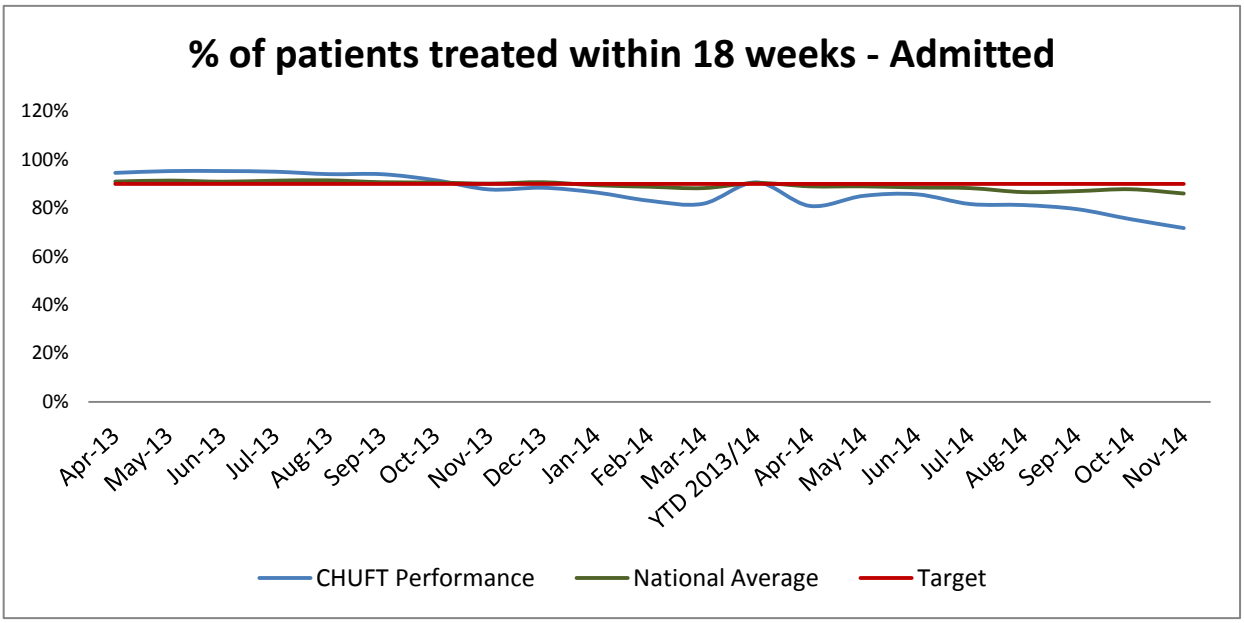
- The number of reopened complaints is normally reflective on the number of new complaints received and answered.
- To reduce the numbers of complaints being reopened the Trust intends to change its sign off procedure on first replies. From the 1st April all complaint replies will be signed by the Chief Executive, and it is hoped that this will give complainants greater trust in the reply provided and thus reduce the number that reopen.
- The Complaints Team will continue to meet regularly with service leads to discuss reopened complaints and identify trends.

3.3. – Monitor Risk Assessment Framework Reporting (reflecting Monitor's "Risk Assessment Framework" Appendix A)

Performance against the relevant indicators and performance thresholds set out in Appendix A of Monitor's "Risk Assessment Framework". Where any of the indicators have already been reported on in Part 2 of the Quality Report, they have not been repeated here.

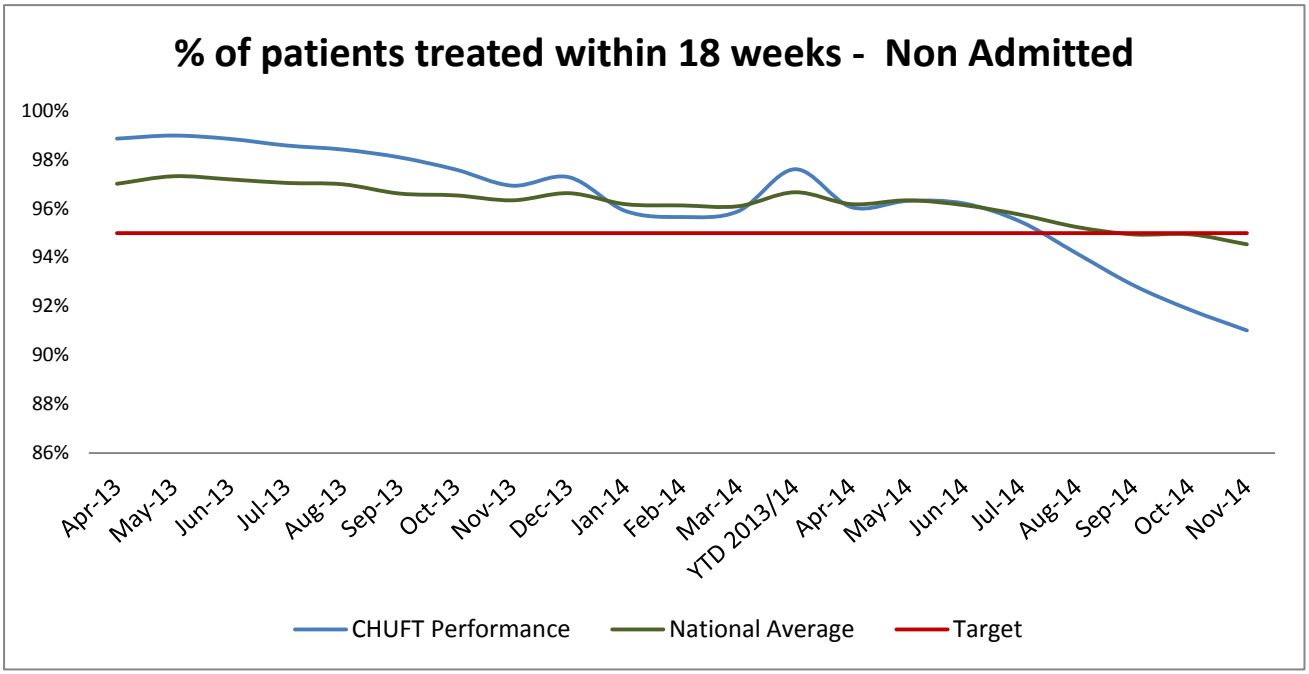
Three 18 week Referral to Treatment (RTT) indicators are reported below. The Trust has had significant issues with reporting data on this standard since November 2014. Please see page 95 for details on the situation and actions being taken.

1. **Maximum time of 18 weeks from point of referral to treatment in aggregate–admitted (C)**



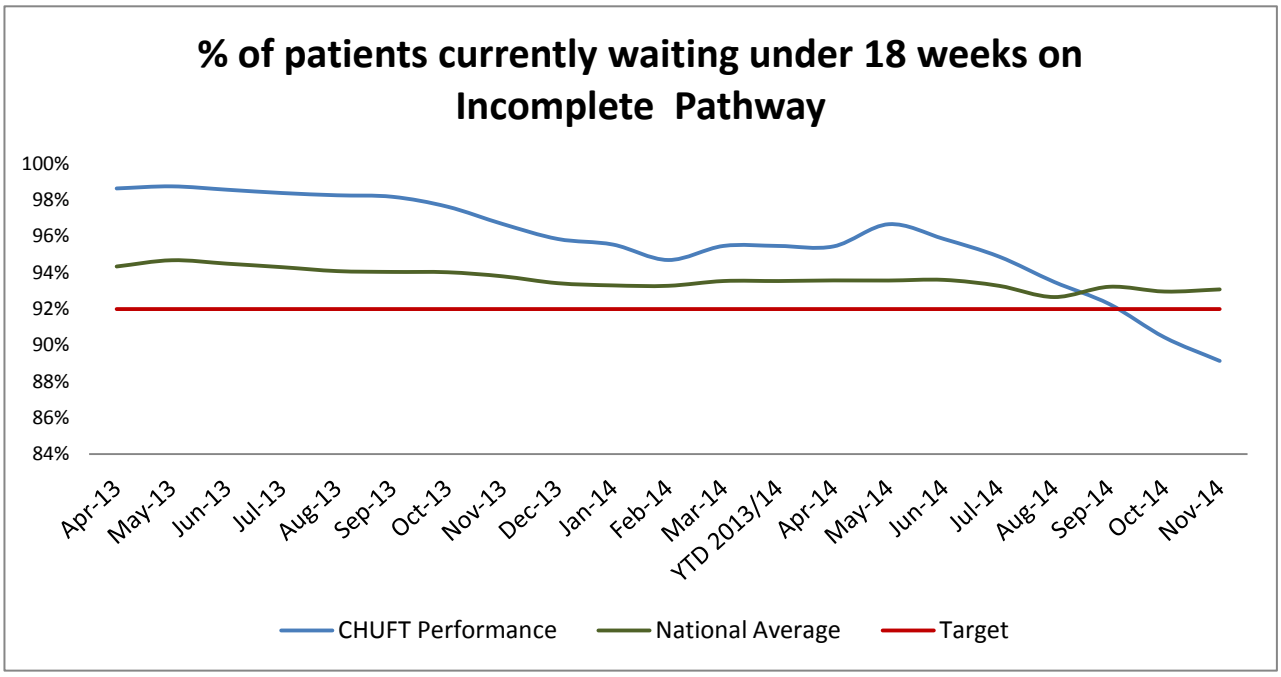
		2013/14		2014/15	
% of patients treated within 18 weeks - Admitted	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
April	90%	94.59%	91.04%	80.94%	89.07%
May	90%	95.33%	91.44%	85.08%	89.07%
June	90%	95.35%	90.99%	85.73%	88.61%
July	90%	95.07%	91.40%	81.72%	88.34%
August	90%	94.06%	91.54%	81.30%	86.70%
September	90%	94.04%	90.75%	79.61%	87.11%
October	90%	91.55%	90.64%	75.48%	87.88%
November	90%	87.75%	90.19%	71.78%	86.13%
December	90%	88.44%	90.74%	-	-
January	90%	86.49%	89.51%	-	-
February	90%	83.07%	88.91%	-	-
March	90%	81.84%	88.34%	-	-
YTD	**90%**	**90.69%**	**90.45%**	**93.96%**	**96.00%**

2. **Maximum time of 18 weeks from point of referral to treatment in aggregate–non-admitted (C)**



		2013/14		2014/15	
% of patients treated within 18 weeks - Non Admitted	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
April	95%	98.86%	97.02%	96.06%	96.18%
May	95%	98.99%	97.33%	96.32%	96.34%
June	95%	98.85%	97.20%	96.21%	96.14%
July	95%	98.58%	97.05%	95.46%	95.74%
August	95%	98.41%	96.99%	94.15%	95.24%
September	95%	98.09%	96.62%	92.86%	94.94%
October	95%	97.59%	96.54%	91.86%	94.94%
November	95%	96.94%	96.34%	91.02%	94.53%
December	95%	97.28%	96.63%	-	-
January	95%	95.90%	96.18%	-	-
February	95%	95.66%	96.13%	-	-
March	95%	95.90%	96.10%	-	-
YTD	**95%**	**97.61%**	**96.67%**	**94.21%**	**95.50%**

3. **Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway (C)**



		2013/14		2014/15	
% of patients currently waiting under 18 weeks on Incomplete Pathway	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
April	92%	98.64%	94.34%	95.45%	93.58%
May	92%	98.76%	94.68%	96.67%	93.57%
June	92%	98.57%	94.49%	95.85%	93.60%
July	92%	98.39%	94.30%	94.88%	93.28%
August	92%	98.26%	94.09%	93.48%	92.66%
September	92%	98.18%	94.04%	92.27%	93.23%
October	92%	97.63%	94.02%	90.43%	92.97%
November	92%	96.68%	93.80%	89.13%	93.08%
December	92%	95.85%	93.42%	-	-
January	92%	95.55%	93.30%	-	-
February	92%	94.70%	93.28%	-	-
March	92%	95.47%	93.54%	-	-
End of Year position	**92%**	**95.47%**	**93.54%**	**89.13%**	**93.08%**

Referral to Treatment (RTT) – issues affecting data and actions underway

Background

This year, the Trust has had data quality issues with its RTT data and this has resulted in a Quality Report qualification from the auditors. The Trust made the difficult decision in December 2014 to cease mandatory RTT reporting in the light of significant errors that were appearing on the waiting list as a result of the implementation of the new Clinical Portal system (a patient electronic administration system).

The Trust has undertaken significant work with the Clinical Portal electronic patient administration system to resolve the performance issues and log any data issues with them for future resolution. The Trust has been working with the National RTT Validation Team to establish its processes for validating the data. The National Validation Team completed their programme of work on 28th February 2015. From this validation work of 10,000 patients there were 608 patients identified for removal from the Clinical Portal due to inputting errors on the new system. The final assessment report commended the Trust for its co-operation during the validation exercise and made two recommendations;

- Review the Trust's Patient Access Policy (18 week RTT and Cancer Waiting Times) and apply recommendations accordingly
- Review the requirement for a dedicated RTT Training and Audit Compliance Officer resource.

The Trust noted a deterioration in its performance with a significant jump in backlog with the introduction of the Clinical Portal. The situation was further exacerbated by additional factors. These included capacity constraints in a number of specialities, emergency pressures (Trauma and Orthopaedics), clinical staff leaving (Dermatology) and 1 full time vacancy (Gastroenterology) and development of Open Access Referrals for primary care and the cancer awareness campaign (Endoscopy).

In January 2015, the Trust engaged the MBI Health Group to design and support a robust recovery programme. This programme addresses the whole pathway and also specific specialities. The Trust's approach has been to validate the waiting list whilst clearing the backlog in the specialties. To reduce the risk of harm to patients the programme has prioritised the specialities at greatest risk of not meeting the RTT standard (Trauma and Orthopaedics (T&O), Dermatology, Gastroenterology and Endoscopy). Other specialities deemed to be low risk have also been reviewed.

Governance arrangements and actions underway to improve the RTT performance

The progress against the Recovery Programme is reviewed in a weekly Reforming Elective Care (REC) meeting where performance and actions to meet compliance are reviewed. The meeting is chaired by the Chief Operating Officer. The REC reports on performance and progress and escalates any concerns to the Divisional Governance Boards. These Boards review the performance and provide assurance that the appropriate arrangements are in place. Onward reporting occurs directly to the Divisional Finance and Performance meetings, and to the Trust Finance and Assurance Committee.

Trust wide actions have included reviewing clinical staffing available to provide the needed service, undertaking demand and capacity modelling and, crucially, implementing a major training programme with standard operating procedures for administration and managerial staff.

Key points and actions are listed under the specific standards below:

RTT Admitted standard (i.e. the pathway for patients who are admitted)

- The problem is predominantly T&O related, with additional pressure from Dermatology
- T&O activity is being addressed via further internal capacity being put in place and the securing of additional outsourcing arrangements. Capacity is significantly constrained in the Essex region and beyond for T&O and hence, this speciality is one of the Trust's main areas of concern. This speciality is forecast to take the longest time to become compliant with the RTT standard.
- Dermatology activity is being addressed through the outsourcing of the service, through the agreed Community Outpatient Organisation (a company providing outpatient services). Additionally, the Trust is also outsourcing Dermatology activity to other agreed independent sector providers (IS) such as the Baddow and Medinet.
- Outsourcing capacity is being increased with other specialities with IS providers.

RTT Non-Admitted (i.e. the pathway for patients who are not admitted)

- This standard is now forecast to be nearing compliance following the actions agreed and put in place
- Main specialities affected are Dermatology and Gastroenterology related
- the Trust is looking to secure additional outsourced capacity for Gastroenterology activity, and will be do this in collaboration with the CCG
- this standard is forecast to be compliant following the end of quarter one

RTT Incompletes) (i.e. the pathway remains active; has not yet stopped)

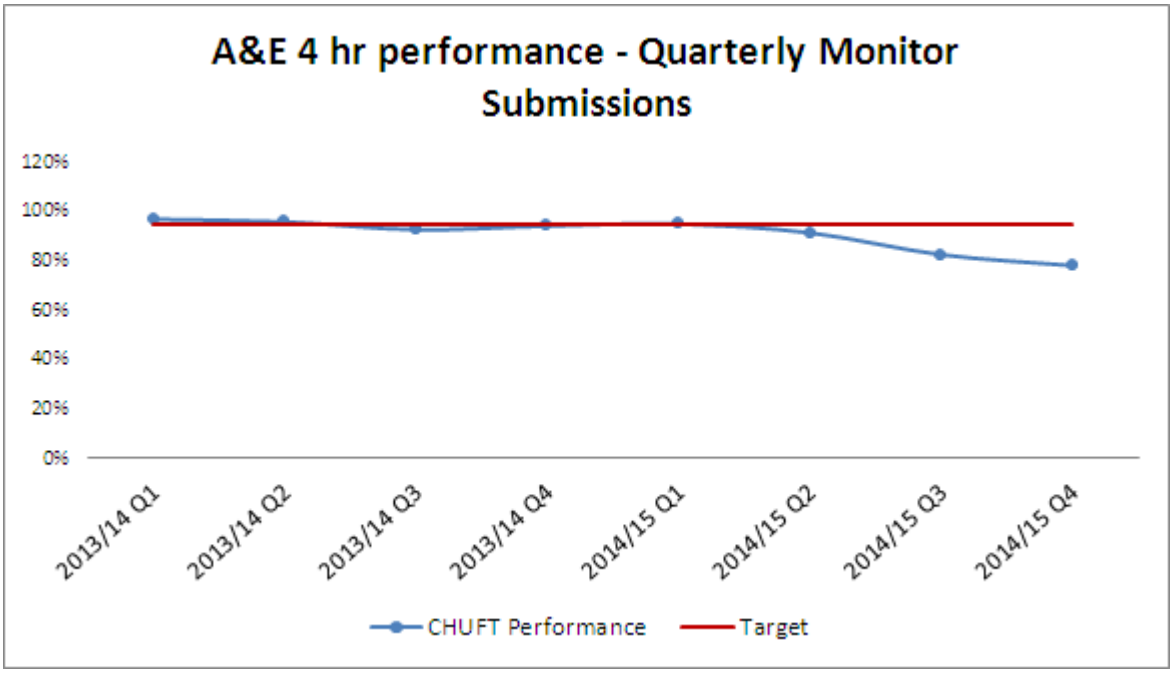
- This standard is forecast to be nearing compliance as a result of the local work being undertaken and planned in the Recovery Programme.
- Compliance is forecast for the end of August

Other actions in progress

- Theatre lists are reviewed in advance by staff to ensure capacity is maximised.
- The further employment of staff, and possible outsourcing options are being explored along with additional activity with extra Saturday working.
- The Trust validation team is being increased to 5 full time staff
- An outsourcing team is being planned to manage the process of transferring patients who choose to accept the option of treatment provided by a partner organisation.
- The outsourcing team was increased by 4 full time staff to improve the liaison with the IS providers to increase capacity.

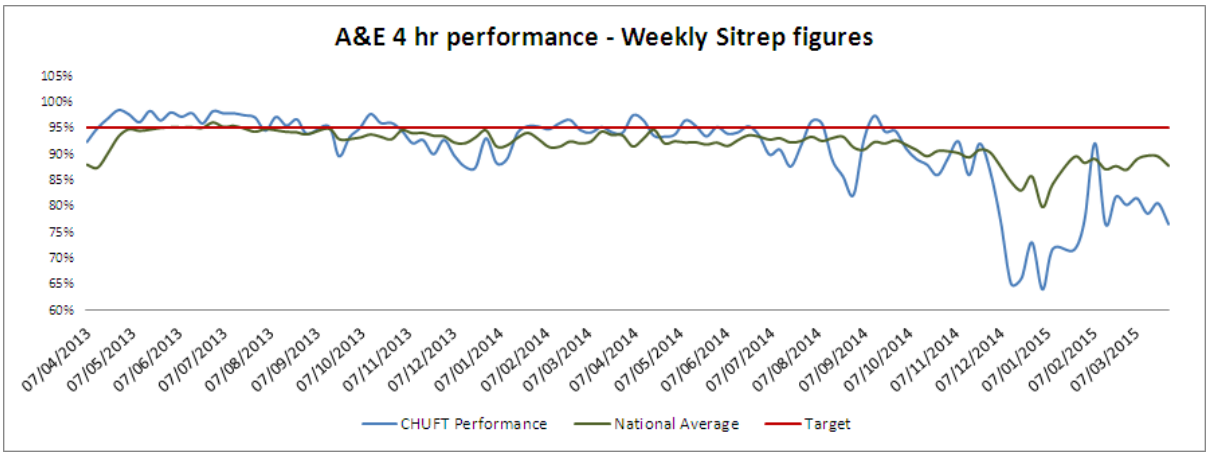
4. A&E: maximum waiting time of four hours from arrival to mission/transfer/ discharge (D)

The chart and the table below are sourced from Trust reported data



		2013/14	2014/15
A&E 4 hr performance - Quarterly Monitor Submissions	**Target**	**CHUFT Performance**	**CHUFT Performance**
Q1	95%	96.80%	94.91%
Q2	95%	95.70%	91.31%
Q3	95%	92.56%	82.40%
Q4	95%	94.06%	78.02%

The chart below is sourced from weekly published data from NHS England



62 Day Cancer Wait Times - issues affecting performance and actions underway

Four cancer indicators are reported on the next few pages. The Trust's 62 Day cancer wait data has been qualified in the Quality Report for last year.

Background

Some of the issues behind the cancer performance pressures are not unique to Colchester. They include a need to increase the capacity in diagnostics available in the hospital and also the growing number of cancer referrals being made. (The increased number of referrals has not resulted in an increased number of cancer diagnoses being made). The Trust's position regarding the cancer standards and the actions being taken through the Cancer Work Plan, are detailed below.

Governance arrangements and actions underway to improve the cancer performance

The Cancer Management team are addressing the current performance issues across the Trust as follows:

Cancer PTL meeting

The Cancer Management team meet with the Service managers and MDT coordinators for each Cancer speciality every Tuesday in timetabled slots to review each specialty's Cancer performance across all targets and at patient level detail. This meeting looks at the tracking of patients on the Somerset Cancer Registry (SCR) to ensure the patients are being tracked efficiently in the Cancer Pathway and that any actions that need to be escalated are actioned. Escalation can be to Service Manager, Diagnostics, treating consultant or CNS and includes escalation to the relevant ADO as needed.

This meeting also reviews capacity issues within individual specialities (using data from SCR and QlikView) to ensure that the service teams are aware of potential issues and have a plan to treat patients within the Cancer Waiting Time targets.

Reforming Cancer Care (RCC) meeting

The Assistant Director of Operations (ADO) for Cancer chairs a weekly meeting where the Service Management Teams for all specialities meet to present their cancer performance. The teams present a weekly report and any patients who have exceeded the Cancer waiting Times targets are discussed in detail with clear plans to treat the patients.

90 Day Plus patient review meeting

The Cancer Management team meet weekly to review all patients who are over 90 days on a cancer pathway (the information is updated each Thursday afternoon) and to collate the number of patients over 90 days who have either been treated, found not to have Cancer or have been added. The information from these meetings informs the discussion with speciality teams at both the Cancer PTL and RCC meetings for the following week.

Following the '90 Day Plus' the ADO for Cancer updates the COO with the weekly summary of patients and the range of reasons for the extended wait times.

Cancer Performance for the Trust is reported and discussed monthly at executive level at the divisional Finance and Performance reviews for all divisions with a responsibility for cancer pathways (Surgery, Medicine and Cancer Services). In addition Cancer Performance is discussed at the monthly Cancer Board.

Trust wide actions to improve performance

To improve the Trust's management systems, the Trust introduced, in Q4 2013/14, the Somerset Cancer Register (SCR). This is a dedicated software package designed to track patients on a cancer pathway from first referral to treatment. SCR is a nationally recognised electronic system which is used by a large number of NHS providers for tracking the management of cancer patients. The SCR system is well supported by the Trust's Information and Communications team and is updated as new software releases become available.

Each cancer speciality holds weekly multi-disciplinary team (MDT) meetings when they review the management and timing of their patients' treatments, using the SCR system to do so. SCR is also accessed by other Trust staff including the Cancer Referral team (referred to as the Hub) and relevant members of each speciality, such as the Clinical Nurse Specialists and the Service Managers.

Each speciality also has an MDT Co-ordinator who updates and enters information into the SCR and provides other administrative support to the cancer team. The MDT Coordinators received extensive training in the use of SCR and this training is regularly updated as new staff members join the Trust.

Further comments are made below, as required, under specific standards to provide further information on the actions underway to make improvements.

5. All cancers: 62-day wait for first treatment (E):

- **Urgent GP referral for suspected cancer**

		2013/14		2014/15	
Cancer 62 Day Waits for first treatment (from urgent GP referral)	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
Q1	85%	90.09%	84.10%	74.15%	86.92%
Q2	85%	83.43%	93.48%	76.12%	86.82%
Q3	85%	80.22%	83.80%	76.61%	85.76%
Q4	85%	78.52%	86.34%	-	-
YTD	**85%**	**82.70%**	**-**	**75.70%**	**-**

Please note– Q4 data for cancer was not available for inclusion in this Quality Account at time of external auditing and reporting.

Performance for the Trust has fallen in a number of specialities below the 85% target therefore impacting on the Trust's overall target. Some of these specialities (Gynaecology, Haematology and Head & Neck) treat small numbers of patients making it difficult to achieve the 85% target. The specialities that do have larger patient numbers (Lung, Upper GI, Urology and Lower GI) have experienced problems with capacity either at the beginning of the 62 Day Pathway (2 week wait capacity) or at the end of the 62 Day Pathway (surgical capacity). Work is on-going with Cancer Services and the Service Management teams to identify capacity and pathway improvements with those specialities in order to achieve the 62 Day Target. This work is being managed through the Cancer PTL, RCC and 90 Day Plus meetings described above

NHS Cancer Screening Service referral

		2013/14		2014/15	
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
Q1	90%	90.51%	93.84%	92.16%	95.21%
Q2	90%	97.95%	94.05%	93.04%	94.94%
Q3	90%	89.60%	93.53%	92.67%	94.53%
Q4	90%	95.33%	94.93%	-	-
YTD	**90%**	**93.40%**	**-**	**92.62%**	**-**

Please note– Q4 data was not available for inclusion in this Quality Account at time of external auditing and reporting.

In this specific standard, screening performance was above the target of 90% for the first three quarters of the year.

6. All cancers: 31 –day wait for second or subsequent treatment (F), comprising:

Surgery

31 Day for Second/Subsequent Activity (Surgery)	Target	2013/14 CHUFT Performance	2013/14 National Average	2014/15 CHUFT Performance	2014/15 National Average
Q1	94%	97.30%	96.25%	86.30%	97.71%
Q2	94%	95.06%	95.98%	70.59%	97.56%
Q3	94%	92.19%	95.77%	80.72%	97.01%
Q4	94%	85.42%	97.08%	-	-
YTD	**94%**	**93.26%**	**-**	**78.84%**	**-**

Please note– Q4 data was not available for inclusion in this Quality Account at time of external auditing and reporting.

The 31 Day target for Subsequent Surgery is affected by surgical capacity within Urology. The Cancer Management team are meeting with Urology to assist that team in their plan to improve surgical capacity and the Urology 31 Day pathway.

Anti-cancer drug treatments

Cancer 31 day wait for second or subsequent treatment - drug treatments	Target	2013/14 CHUFT Performance	2013/14 National Average	2014/15 CHUFT Performance	2014/15 National Average
Q1	98%	100.00%	99.72%	98.75%	99.72%
Q2	98%	100.00%	99.65%	97.96%	99.74%
Q3	98%	100.00%	99.64%	98.72%	99.78%
Q4	98%	98.54%	99.61%	-	-
YTD	**98%**	**99.74%**	**-**	**98.49%**	**-**

Please note– Q4 data was not available for inclusion in this Quality Account at time of external auditing and reporting.

Radiotherapy

Cancer 31 day wait for second or subsequent treatment - radiotherapy	Target	2013/14 CHUFT Performance	2013/14 National Average	2014/15 CHUFT Performance	2014/15 National Average
Q1	94%	98.40%	97.15%	99.73%	97.93%
Q2	94%	96.46%	97.28%	97.33%	98.12%
Q3	94%	98.45%	97.85%	94.99%	97.19%
Q4	94%	97.87%	98.08%	-	-
YTD	**94%**	**97.81%**	**-**	**97.38%**	**-**

Please note– Q4 data was not available for inclusion in this Quality Account at time of external auditing and reporting.

Radiotherapy performance in Q3 was affected by lower patient numbers and patient choice (i. e. some patients chose to defer Radiotherapy Treatment until after the Christmas period) in the month of December 2014.

7. All cancers: 31 –day wait from diagnosis to first treatment (G)

		2013/14		2014/15	
Cancer 31 day wait from diagnosis to first treatment	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
Q1	96%	95.90%	97.74%	94.85%	98.35%
Q2	96%	95.48%	97.78%	94.40%	98.46%
Q3	96%	92.23%	98.31%	93.53%	98.25%
Q4	96%	95.53%	-	-	-
YTD	**96%**	**90.00%**	**-**	**94.23%**	**-**

Please note– Q4 data was not available for inclusion in this Quality Account at time of external auditing and reporting.

The 31 Day target (Diagnosis to Treatment) has been affected by the Trust's surgical capacity (Urology). In addition, it has been affected by patients who are treated at tertiary centres (Lung and Upper GI). These are patients who receive specialist surgery at specific hospitals. For lung patients this would involve cardiothoracic surgery at the Basildon Cardiothoracic Centre or the Royal Brompton Hospital and for Upper GI patients this would be St Bartholomew's Health).

Cancer Services is working with the Service Management teams for Urology, Lung and Upper GI to improve the 31 Day target (Diagnosis to Treatment) both at the Trust and by developing closer working relationships with our partners at the tertiary centres.

8. Cancer: two week wait from referral to date first seen (H), comprising:

All urgent referrals (cancer suspected)

		2013/14		2014/15	
Cancer 2 week (all cancers)	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
Q1	93%	95.77%	93.53%	93.00%	95.50%
Q2	93%	98.40%	93.64%	89.54%	95.23%
Q3	93%	95.93%	94.74%	94.92%	95.59%
Q4	93%	94.46%	95.74%	-	-
YTD	**93%**	**96.16%**	**-**	**92.48%**	**-**

Please note– Q4 data was not available for inclusion in this Quality Account at time of external auditing and reporting.

The Two Week Wait (2WW) target was affected by poor Q2 performance.

Cancer Services continues to work with the Service Management teams and the Trusts Cancer Referral Centre (the Hub) to ensure that any issues with 2WW capacity are identified quickly and resolved.

Symptomatic breast patients (cancer not initially suspected)

		2013/14		2014/15	
Cancer 2 week (breast symptoms)	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
Q1	93%	96.14%	90.26%	94.70%	95.37%
Q2	93%	93.66%	93.54%	91.21%	94.44%
Q3	93%	91.85%	94.93%	94.69%	95.54%
Q4	93%	88.30%	95.70%	-	-
YTD	**93%**	**92.56%**	**-**	**93.62%**	**-**

Please note– Q4 data was not available for inclusion in this Quality Account at time of external auditing and reporting.

The Two Week Wait (2WW) target for Symptomatic Breast patients was affected by lower patient numbers seen in Q2 compared to the average quarterly figure and by patient choice in July and August 2014. (Some patients chose to defer treatment at CHUFT in July/August 2014).

14. Clostridium difficile – meeting the C difficile objective (M)

Clostridium difficile data is included at Part 2.3, 'Reporting against Core Indicators' on page 58. A detailed report on Trust performance is to be found at Part 3 under "Healthcare Related Infections (HCAI) – work continuously to reduce HCAIs" on page 63.

Annex 1 – Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Health and Overview and Scrutiny Committee (Statement received 12 May 2015)

The HOSC has sought to provide critical friend challenge whilst being supportive to the Trust. CHUFT representatives have appeared before the HOSC four times in the last 15 months as the Committee has sought assurances on quality of services, patient safety, leadership and culture and the robustness of the action plans to address continued regulatory issues. A representative from the local CCG was also in attendance for these sessions. The Trust is due to re-appear before the HOSC in September 2015 to give a further update on these regulatory concerns and the issues still requiring attention.

In addition to the above, a sub-group of the HOSC recently has also engaged with representatives from the Trust (and other Acute Trusts in Essex) as part of a review of complaints handling processes.

While reviewing the overall impression and messages given in the Quality Accounts, I am mindful of the collaborative and supportive partnership work that has been in place, particularly in relation to safeguarding and alleviating pressure on the Emergency Department and improving effective discharges. As part of presenting your review, I think it would be helpful in future to include commentary on some of the significant partnership working undertaken, how you think it has benefitted performance and assess its effectiveness and where it has most value and outline any plans for further joint working in future.

Finally, in reviewing the contents of the Accounts, I struggled to find any analysis of delayed discharges. I would suggest that this is important as part of understanding the capacity pressures facing the Trust.

On behalf of the HOSC, may I thank you for the opportunity to comment on these draft Accounts.

Jill Reeves
Chairman HOSC
Essex County Council

Response to CHUFT Quality Account 2014-15 from Healthwatch Essex
(Statement received 13 May 2015)
Healthwatch Essex is an independent organisation with a vision to be a voice for the people of Essex, helping to shape and improve local health and social care services. We believe that people who use health and social care services and their lived experience should be at the heart of the NHS and social care services.

We recognise that Quality Account reports are an important way for local NHS services to report on what services are working well, as well as where there may be scope for improvements. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient experience of care. We welcome the opportunity to provide a critical, but constructive, perspective on the Quality Accounts for CHUFT, 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.

In the Quality Account, CHUFT recognises that it has been difficult year as it remains in special measures, has been rated 'inadequate' by the CQC, and received enforcement notices for Accident and Emergency and EAU. In addition, work undertaken by Healthwatch Essex – such as our report 'Cancer services in Colchester: A study of patient and carer experience' has identified quality related issues in cancer services, and our routine monitoring of other sources of information have identified problems affecting patient experience elsewhere in the Trust.

However, the Trust is working towards an improvement plan and it is developing its engagement with patients, relatives and carers. Healthwatch Essex fully endorses and supports this approach, and recognises progress that has been made. We have worked, and will continue to work, with the Trust as a 'critical friend', ensuring patient experience is central to the Trust's improvement. For example, we have assisted the Trust by analysing qualitative data gathered as part of the National Cancer Patient Experience Survey, and have carried out a small survey of the 'lessons learnt' of those who participated in the Incident Management Team which led the NHS response to problems in cancer services. We continue to work with the Trust and the wider NHS and care system to assist them as they implement our recommendations and other changes.

In the priorities for 2015/16, CHUFT has identified patient experience as one of the focuses and has identified areas for improvement. These include – developing a patient experience and carer strategy group, reviewing complaint processes and response times, and implementing the learning from the Retrospective Review Audit of cancer pathways. The Trust also acknowledges the recommendations made within our report on Cancer services in Colchester.

Healthwatch Essex believes that lived experience should be heart of services, and believes that 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. We will continue to support the work of CHUFT in this regard.

Sarah Haines | Information and Policy Officer
Healthwatch Essex

North East Essex Clinical Commissioning Group response to Colchester Hospital University NHS Foundation Trust Quality Report 2014-15

North East Essex Clinical Commissioning Group (CCG) welcomes this Quality Report as a commitment to an open and honest dialogue with the public regarding the quality of care provided by Colchester Hospital University NHS Foundation Trust. Assurance from the CCG is required to ensure that the information in this Quality Report is accurate, fairly interpreted, and representative of the range of services delivered.

Though the CCG are aware that they are commenting on a draft version of this Quality Report, quarter 4 activity/performance figures are not available, therefore the overall success or otherwise cannot be fully appreciated. There is limited data reporting on the 2014/15 CQUINS and the CCG would have expected CQUINS for 2015/16 to be discussed in part 2 and linked directly with the identified priorities for improvement. The CCG is unable to assure all data reported, as some data will have been provided or updated prior to publication.

The CCG recognises that it have been a challenging year for the Trust following the Care Quality Commission visits and the review by Monitor. The CCG acknowledges the content of the Improvement Plan in addressing all areas of concern as well as the actions to address the two section 31 notices places on Accident and Emergency and the Emergency Admissions Unit. The report acknowledges the concerns raised by the CCG in January 2014 regarding maternity services at Colchester Hospital and the maternity action plan is now in place. The report acknowledges the need for embedded learning across the organisation which has been a major concern for the CCG.

Mindful that this report is a public facing document, the report in general is well presented with only a few technical acronyms and typing errors.

Part 1 of the report meets with the NHS Quality Accounts regulations and provides a statement summarising the provider's view of the quality of the services provided during the reporting period. Quality statements are contained throughout the document. Part 2 also meets with the regulation; however could be improved by the inclusion of a better description of services provided in order that the reader is able to better interpret the statistical information provided. Part 3 is well presented however, does not take into account some of the concerns highlighted recently in relation to an anticipated rise in HSMR/SHMI for quarter 4 or provide indicative timeframes for submission of serious incident data following the inability of the new clinical portal to provide accurate data. Annex 2 of part 3 acknowledges the need for the Trust to comply with Monitor's annual reporting regulation specific to foundation trust status, however this is incomplete. The final statements in part 3 sanctioning the internal controls for data collection and reporting and the robustness of data must be called into question given the lack of reporting by the Trust throughout the year on activity and quality standards.

The report demonstrates that there have been quality concerns raised during the year, identified by both Monitor and CQC. The report does not take into account the concerns raised locally by the CCG at monthly performance meetings and the 'Clinical Quality and performance concerns' formally raised in October 2014 outlining 8 key areas of concern directly relating to quality of care.

You have identified a comprehensive programme of remedial actions to remedy the quality challenges listed in the report, which the CCG has been working with you to support. The CCG recognises that 2015/16 will continue to be significantly challenging time as the Trust needs to continue to embed and provide assurance that quality and safety improvements are being delivered.

For 2014/15, the Trust identified 11 key priorities which can be mapped to the domains of quality, patient safety; patient experience and clinical effectiveness. These were;

- Healthcare Acquired Infections
- Improving standardised Hospital Mortality Index
- Safer Staffing
- Safer Surgery Checklist
- Venous thromboembolism
- Accident and emergency performance
- Chronic obstructive pulmonary disease
- Reduction in the percentage of urinary catheters
- Dementia
- Ward to Board
- Reduction in re-opened complaints

The report identifies progress in some of these areas as well as areas for further improvement in 2015/16. The improved performance reported against safer surgery checklist is worthy of noting. However, the report would benefit from triangulation with other elements of safety for example the improvement in safer surgery checklist but consideration to the number of never events specifically related to safer surgery checklist.

The CCG will continue to review the implementation of regulatory recommendation and seek assurances on the continued improvement on the delivery of safe and quality services. The CCG opinion is that the Quality Report demonstrates improvements in some areas of quality and safety and provides a comprehensive plan going forward. The CCG look forward to receiving clear time framed actions plans in the delivery of the Improvement Plan and Maternity action plan.

At the time of submission 5th May 2015, the CCG can confirm that the report is accurate, fairly interpreted, and representative of the range of services delivered. The CCG looks forward to continuing its work with Colchester Hospital in the coming year, and encourages the Trust to continue to implement the multiple and wide-ranging efforts and initiatives to improve the quality of its services.

Lisa Llewelyn
Director of Nursing and Clinical Quality
NHS North East Essex Clinical Commissioning Group

Annex 2 – Statement of directors' responsibilities for the quality report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) regulations to prepare Quality Accounts for each financial year.

Monitor 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 data quality for the preparation of the Quality Report.

In preparing this 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 2014/15 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 2014 to 21st May 2015
    - Feedback from North East Essex CCG dated 5th May 2015
    - Papers relating to quality reported to the Board over the period April 2014 to 21 May 2015.
    - Care Quality Commission reports published
        - 6 – 8 and 16-19 May and 18 June 2014 – the follow up inspection as part of the Keogh Mortality Review 2013.
        - 17 July 2014 - CQC Progress Review of Five Cancer Services at Colchester Hospital University Foundation NHS Trust.
        - 12 and 27 November and 23 December 2014 - Accident and Emergency department (A&E) and Emergency Assessment Unit (EAU).
    - Feedback from HOSC dated 12th May 2015
    - Feedback from Governors through the Council of Governors on 19 May 2015
    - Feedback from Healthwatch Essex dated 13 May 2015
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Regulations 2009. **Please note: The annual Complaints Report is not available at the time of completion of the Quality Account. The non-availability of the report has been noted by the external auditor.**
    - The 2014 national in-patient survey results dated 21 May 2015
    - The 2014 national staff survey dated February 2015
    - The Head of Internal Audit's annual opinion over the Trust's control

environment dated April 2015

- CQC Intelligent Monitoring Report dated May 2015

- The Quality Report presents a balanced picture of Colchester Hospital University 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 and is subject to appropriate scrutiny and review;

- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/ annual reporting manual).

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

Dr Lucy Moore	Mr Alan Rose
Interim Chief Executive	Chair

Independent auditor's limited assurance report to the Council of Governors and Board of Directors of Colchester Hospital University NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Directors and Council of Governors of Colchester Hospital University NHS Foundation Trust to perform an independent limited assurance engagement in respect of Colchester Hospital University NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditor
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 Monitor.

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',
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2014/15', 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 the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2014/15'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual', 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 1 April 2014 to 21 May 2015
- papers relating to quality reported to the board over the period 1 April 2014 to 21 May 2015
- feedback from Commissioners, dated 20/05/2015
- feedback from Governors, dated 19/05/2015
- feedback from local Healthwatch organisations, dated 14/05/2015
- feedback from Overview and Scrutiny Committee, dated 12/05/2015

- the national patient survey, dated February 2015
- the national staff survey, dated January 2015
- Care Quality Commission Intelligent Monitoring Report, dated December 2014
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated April 2014.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those 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 and the Board of Directors of the Trust as a body, to assist the Board of Directors and Council of Governors 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 2015, to enable the Board of Directors and 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 Board of Directors as a body, 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
- analytical procedures
- limited testing, on a selective basis, of the data used to calculate the indicator back to 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 which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'.

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

The Trust has been unable to report on the Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways indicator since November 2014 because of issues with data reliability and completeness identified by the Trust following implementation of a new IT system. The Trust has been carrying out a process of data cleansing, with external assistance, but has so far not been able to resolve the data quality issues. It is therefore yet to agree when reporting of the indicator will recommence. Consequently, we have not be able to obtain sufficient assurance against the six dimensions of data quality for this indicator.

In addition, at the time of our review, the Trust had not yet prepared the following documentation which we are required to consider for consistency with the quality account:

- the Trust's complaints report for 2014/15, published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009

As a result of this documentation being unavailable we are unable to confirm its consistency with the quality account.

Qualified conclusion

Based on the results of our procedures, with the exception of the matters 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 2015:

- 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';
- the Quality Report is not consistent in all material respects with the sources specified above; 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'.

Grant Thornton UK LLP

Grant Thornton UK LLP
London

Date: 28/5/2015