Colchester Hospital University **NHS**

NHS Foundation Trust

.Quality Report 2016/17

Contents

Who was involved in the development of our Quality Account?

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

- our commissioners, North East Essex Clinical Commissioning Group;

- Essex Health & Wellbeing Board;

- Healthwatch Essex; and

- staff, volunteers, carers and members of the public.

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

Our front cover shows:

Artwork produced to celebrate the 'Gift of Life' or organ donation at the hospital.

A patient receiving treatment on the Trust's new Mobile Chemotherapy Unit

Staff raising funds for the Trust's 'Time Garden' with CoHoC Charity support

Part 1 - Statement on quality
Chief Executive's commentary

This is our account to you about the quality of services provided by Colchester Hospital University NHS Foundation Trust in 2016/17. It looks back at our performance over the last year and gives details of our priorities for improvement in 2017/18.

The challenges faced by Colchester have been well documented over the past three years. I began as Chief Executive in May to support the staff to address the concerns raised by our regulators and others. Whilst some staff did not recognise the issues that had been raised, many expressed frustration that we have not been able to provide consistently high quality care to the people we serve.

After my appointment, the Trust carried out a very detailed review of our service which found challenges in terms of governance, access targets, quality, safety, finance and culture.

As Chief Executive, my prime focus is the safety of patient services, ensuring they are consistently accessible, consistently of high quality and continually meeting the operational standards expected. My first task was to assure the public by working with clinicians and all the staff to address some immediate concerns, such as concerns about safety and quality in theatres, about patient flow in our Emergency Department (A&E) and about the Emergency Assessment Unit (EAU).

When the CQC report was published in July, I publicly apologised to the people of north east Essex because the care we had been providing had not been good enough and we had been letting them down for years. For me, it was a watershed where we could draw a line under those areas at the Trust that delivered unacceptable levels of care. There is no doubt that every day people received great care at our Trust, but it is not consistent and we did not have the governance systems and processes in place to always know

where we got it wrong. It was time for a step change at the Trust, a time when we all had to step up to demonstrate that we could deliver on our promises and commitments to our patients and that we could consistently provide safe, high quality care with compassion. We had become over-reliant on external assessors to help identify safety and quality failings, and needed to take ownership and be held to account by the people we serve. I pledged to make the Trust truly patient-centred, which was a reference not only to those patients who were already here but also to those waiting to come in.

We developed a significant transformation approach of continuous improvement called "Every Patient, Every Day" which includes support from expert external advisers funded by NHS Improvement. It involves all staff and is about providing safe, compassionate care to patients, both as an organisation and as individual members of staff, each and every day, in a systematic and caring way.

"Every Patient, Every Day" has 11 workstreams, including End of Life Care, Deteriorating Patients, Governance, Workforce, and Urgent & Emergency Care. It has started to address our many challenges – for example, I'm pleased with the progress we've made on deteriorating patients and there has been significant improvement with end of life care. We have looked at our booking processes which have been described as chaotic by our patients and put in new systems. We have significantly reduced the waits for diagnostic tests and our cancer pathways have been reviewed.

One of my priorities has been to accelerate the long-term partnership with Ipswich Hospital. The boards of the two trusts are looking at different ways in which the organisations can work together to improve care for patients and create a more sustainable future. Of course, there is a financial element to it but, fundamentally, the partnership is about how we can improve care for patients and drive up quality.

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

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

Nick Hulme
Chief Executive

Part 2 - Priorities for improvement and statements of assurance

2016/17 quality improvement priorities

Progress against the priorities we set as a Trust

Patient safety priority 1:
To continue a reduction in healthcare-related infections

Why was this a priority?

The Trust is committed to reducing the number of avoidable infections and the harm they may cause, there is a focus on MRSA bacteraemia and C difficile in particular. Whilst, the main focus is in these areas they are not the sole focus given the increasing incidence nationally on gram negative resistant organisms.

In reducing the number of our patients affected by these infections, we decrease the length of hospital inpatient stay together with the potentially more complex care or surgery required as a result of infection.

Lead Director
Director of Nursing

What was our target?
0 cases of MRSA bacteraemia.

No more than 18 cases of Clostridium Difficile (C-Diff).

What did we do to improve our performance?

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

Patients whom are identified with CDI are given a credit card size information card to show to other healthcare professionals to highlight the need for prudence in antibiotic prescribing for these individuals.

The incidence of cases of Clostridium difficile is higher in Medicine and Care of the Elderly Wards, 7 of the 8 Wards have had a significant investment in refurbishments in the past 3 years with a plan for the final COTE Ward to be refurbished in 2017/18.

Antimicrobial management training was added as a mandatory element of the Trust Infection Control E-learning.

How did we measure and monitor our performance?

The performance was monitored at Bi monthly Hospital Infection Control Committee, Monthly Divisional Governance Meetings, reported on the monthly Trust Quality and patient safety dashboard.

Did we achieve our intended target?

We partially achieved our target with 33 C Difficile cases in year, 23 of which the CCG determined as non-trajectory (not avoidable) as care delivered had been to the best standard it could be. This leaves 10 cases as potentially avoidable against a ceiling of 18.

We did not achieve our target of 0 cases of MRSA bacteraemia as 2 cases were confirmed during 2016/17.

How and where was progress reported?

Bi-Monthly reporting through the Hospital Infection Control Committee, Monthly reporting through Patient Safety Group and Quality and Patient Safety Committee.

Our key achievements

✓ The Trust participated in the 5th UK and European Healthcare Associated Infection (HCAI) and Antimicrobial study which was completed during October 2016. The Trust has taken part in the four previous studies and have been able to utilise the local and comparative data to progress best practice. The Trust had an overall infection rate of 4.85% against a national infection rate of 7%. Antimicrobial usage Trust 36% and national rate 38%.

✓ Medicine and Care of the Elderly Wards, 7 of the 8 Wards have had a significant investment in refurbishments in the past 3 years with a plan for the final COTE Ward to be refurbished in 2017/18.

✓ The blood culture taking procedure was refreshed and new packs were introduced to reduce the risk of contamination of blood culture samples.

2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Patient Safety Priority 2

A reduction in missed doses of medication for non-clinical reasons by 50% by 31 March 2017

Why was this a priority?

The Trust ensures that patients receive the medications they require for pre-existing and new conditions. When patients miss medication doses this can impact upon their recovery.

In reducing the number of missed doses, we support patients in their journey through the hospital, without unnecessary delays, whilst ensuring their safety at all time.

Lead Director

Director of Nursing

2016/17 performance

For the Medication Safety Thermometer there was a **69% reduction** in missed doses excluding a valid clinical reason and patient refusal, from April to November 2016 (data currently available from the web based database).

What was our target?

A reduction in missed doses for non-clinical reasons by 50% by 31st March 2017.

What did we do to improve our performance?

Local improvement work focusing on education and professional standards for the safe administration of medicines.

How did we measure and monitor our performance?

The Medication Safety Thermometer monthly audit data is collected at ward level (4 wards) and uploaded onto a web-based system held nationally.

Reporting internally via the Patient Safety Report to the Quality and Patient Safety Committee to Board.

Did we achieve our intended target?

Yes for the period April to November (data has not been available to be uploaded from November due to changes in national software packages).

How and where was progress reported?

The medication safety audit data is reported back to the clinical teams directly for local review and action.

It is included in the Patient Safety report that escalates through the organisation to the Trust Board.

Our key achievements

✓ Local improvement work focusing on education about professional standards.

✓ Creation of medication link nurse roles for local ward issues.

Part 2 - Priorities for improvement and statements of assurance
2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Patient safety priority 3:

To achieve compliance with all steps for safer surgery using the WHO checklist as per the 100% benchmark by 31 March 2017

Why was this a priority?

Following an unannounced visit by the Care Quality Commission in April 2016 a Section 31 notice, which is a warning notice telling an organisation that they are not complying with a condition of their registration was issued to the Surgical Theatre department. The notice was issued to ensure the Trust operates effective audit and monitoring system that provides accurate assurance that the safer surgery checklist is being consistently carried out in accordance with the recommendations of the World Health Organisation Safer Surgery Checklist (2016), and the NHS Central Alert System (CAS) reference NPSA/2009/PSA002/U1 (Issue date 26 January 2009).

Lead Director
Medical Director

What was our target?
100% compliance with the surgical safety (WHO) checklist.

What did we do to improve our performance?

A more focused approach was introduced for the compliance of the 5 Steps to Safer Surgery.

These 5 steps are comprised of briefing, sign in, time out, sign out and de-briefing. This is a combination of the WHO Checklist (sign in, time out, Sign out) and the additional two steps which are briefing and debriefing.

An additional feedback monitoring process was introduced in which Recovery staff audit every patient attending theatre with compliance of the WHO checklist.

A retrospective weekly audit of 20 medical records which are randomly selected are reviewed to monitor the WHO checklist.

An observational audit to monitor the 'human factor's' element of the 5 steps to Safer Surgery conducted on a weekly basis.

Human Factors training has been introduced, which is a programme of change which has been designed to focus on the culture and behaviour within the Theatre environment.

Monthly analysis is reported at Divisional Governance meetings and the Integrated Performance meeting with the Executive team.

How did we measure and monitor our performance?

Reported Daily

Recording of Compliance

Theatre staff record completion of each element of the 5 steps to safer surgery. All steps are signed as soon as possible following completion of that step.

Recovery staff assess the Surgical Safety Checklist document for completion: The recovery staff monitor WHO compliance.

Reported Monthly

Environmental Audit within Theatres:

Each of the 17 theatres has been audited on a rotational basis.

An audit performed by the theatre manager and matron looks at the environment, staff behaviours,

safety measures and management of medications; encompassing the whole of theatres.

Reported every 6 weeks

Peer review:

Every 6 weeks a senior theatre nurse/ODP and clinician visits another theatre to directly observe procedures, practices and behaviours to ensure that this type of activity is owned and nurtured in all staff irrespective of grade. The objective is to enhance the cultural environment of theatres.
As a result of these audits 'in situ' training will be offered to teams felt in need of support by nurses and consultants trained in teaching human factors.

Human Factors training

A programme of change has been designed with a focus on culture and behaviour in the form of human factors training.

Did we achieve our intended target?

Yes, the Trust achieved its target of 100% regularly over a sustained period.

How and where was progress reported?

The evidence of compliance is reported to the hospital executives and CQC on a weekly basis.

Quality Patient Safety Committee (Board Assurance Committee).

Our key achievements

- ✓ Good quality Briefing and debriefings
- ✓ Good compliance rate with WHO Checklist
- ✓ Good Staff Engagement
- ✓ Good attendance rate for human factors training.

2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Patient safety priority 4:

To achieve greater than 95% of serious incident investigations within correct timescale and 100% compliance with the Duty of Candour

Why was this a priority?

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved.

Lead Director

Director of Nursing

What was our target?

95% compliance with serious incident investigation completion.

100% compliance with Duty of Candour.

What did we do to improve our performance?

✓ Root Cause Analysis training programme which includes Duty of Candour training implemented in 2016

✓ 40 day draft submission for Serious Incident Investigations as an internal KPI

✓ Initial Meeting offer to Investigating Officers with Patient Safety Managers for expert advice and guidance

✓ Duty of Candour E-Learning and face to ace training

How did we measure and monitor our performance?

✓ Performance tracked by the Patient Safety & Quality Team

✓ Monitored twice weekly through SI Panel, including 40 day draft compliance, 60 day compliance and Duty of Candour compliance

✓ Performance data is sent to the Divisions on a monthly basis

✓ Performance escalated through the monthly Patient Safety Report produced by the Corporate Team

✓ Performance is reported quarterly through the Complaints, Litigation, Incidents and Claims report (available on the Trust intranet).

Did we achieve our intended target?

60 day compliance has not been achieved consistently by the Trust however improvements have been made since June 2016 as a result of internal improvements to the process as identified.

Changes to Divisions in January and February 2017 as well as a more robust approval process has resulted in a drop in compliance over these months.

Key changes to Divisional Clinical Governance support structures will enable an increase in compliance in 2017/18.

Duty of Candour compliance at 100% was also not achieved consistently throughout the year, however internal improvements and training have resulted in an increase in compliance with recent evidence of sustainability since January 2017 at 100% and being sustained for the remainder of the year.

How and where was progress reported?

Regular reports to:

✓ Patient Safety & Experience Group
✓ Quality and Patient Safety Committee
✓ Divisional Integrated Performance Meetings
✓ Quality and Risk Executive Management Committee.

Our key achievements

✓ More than 130 RCA trained investigating officers

✓ A robust Procedure for the management of incidents and serious incidents

✓ A robust process for reviewing all incidents regardless of harm caused with resulting escalation

✓ Embedded SI Panel

✓ Harm Free Panel established for weekly review of Pressure Ulcers & Falls.

Part 2 - Priorities for improvement and statements of assurance

2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Patient experience priority 1:

Percentage of admitted patients where My Care Choices is accessed will be more than 85%.

Why was this a priority?

My Care Choices Register (MCCR) is the North East Essex Electronic Palliative Care Co-ordination System (EPaCCS).

It is a secure database that holds details of people's end of life preferences including any cultural or religious wishes, the choice of where they would like to receive end of life care as well as key information regarding the patient's diagnosis, their condition and the medical treatment they are receiving.

As part of the EOL improvements across CHUFT using MCCR was a priority to ensure patient's wishes were considered and to improve end of life care.

By accessing MCCR the information held can help facilitate discussions regarding the patient's care whilst at CHUFT and also their discharge planning and on-going admission avoidance.

Lead Director
Medical Director

What was our target?

Greater than 85% access to My Care Choices register for admitted patients.

What did we do to improve our performance?

My Care Choices access was made easily accessible for all ward sisters via the Trust's intranet.

Training was provided to all ward areas to ensure that staff were able to access MCCR on a daily basis, so that discussions could be held with the multidisciplinary team to identify any care decisions and conversations that would be required during the admission period.

How did we measure and monitor our performance?

Monitoring was undertaken on a daily basis by cross-checking those patients who were admitted to hospital that met the criteria for accessing the My Care Choices Register. Monitoring was undertaken by the Specialist Palliative Care Team and the End of Life Care Facilitator.

Did we achieve our intended target?

Our target of 85% was not always achieved and we have continued to work on this though there is evidence of increased access over 2016 (see Chart 1 below).

The priority now is training key staff to input onto MCCR so that the database has the most accurate information regarding key areas such as DNACPR and Preferred place of Death.

How and where was progress reported?

Progress was reported each month to the EOL Steering group as part of our internal KPI. We will continue to monitor the access to MCCR and to continue working with high use areas such as EAU and ED.

Our key achievements

- ✓ Following the CQUIN for 2016/2017 on using SPICT (Supportive and Palliative Care indicator tool) to identify patients who have the potential to be in the last year of life, Stroke have commenced adding their own patients to MCCR instead of the GP. This process will be rolled out to further specialist areas at CHUFT;

- ✓ We now have a dedicated Palliative nurse in EAU/ED to support the staff there to access and use the information held on MCCR.

Chart 1—Compliance with My Care Choices Register Access against patients identified—2016/17 YTD

Admission Ward	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Percentage Accessed												0.0%								
Total MCC Emergency Admissions	10	14	18	11	20	16	12	22	24	20	16	17	22	17	17	12	18	35	24	13
Total MCC records accessed	1	4	7	3	13	10	8	13	14	13	13	17	14	10	11	10	15	26	18	8
Total Percentage Accessed	10.0%	28.6%	38.9%	27.3%	65.0%	62.5%	66.7%	59.1%	58.3%	65.0%	81.3%	100.0%	63.6%	58.8%	64.7%	83.3%	83.3%	74.3%	75.0%	61.5%

2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Patient experience priority 2:

Achieve upper quartile results for the NHS Friends and Family Test across all services

Why was this a priority?

Receiving feedback from patients is a valuable tool in supporting and understanding what the patient is experiencing whilst using our hospital services. Achieving results in the upper quartile assists in validating the quality of care delivered by our organisation.

Lead Director
Director of Nursing

What was our target?
Upper quartile FFT results across all services (Inpatients, Outpatients, Emergency Department, Maternity).

What did we do to improve our performance?

Weekly reporting ensured clinical teams were aware and could locally act on their individual compliance, response rates and patient feedback comments. A Friends and Family champion was implemented within each area to assist in maintaining and increasing response rates.

The Head of Patient Experience worked with all wards and departments at utilising ways to support improvement. Displays in clinical areas of "you said, we did" boards demonstrated the local actions taken in response to patient feedback, to show patients, family members and visitors that we have listened and acted upon comments received.

Presentations at Sisters and Matrons meetings were delivered periodically to highlight patient feedback and improve response rates.

How did we measure and monitor our performance?

FFT responses are received within the Clinical Audit Team for data collation, thematic analysis and reporting. Weekly cumulative reports are circulated to all the clinical teams supplying FFT data. Information is represented in the Trust's performance framework.

Did we achieve our intended target?

Yes the Trust achieved upper quartile results for the NHS Friends and Family Test across all services (data validated externally).

How and where was progress reported?

The local governance process of "2 at the top" meetings have patient experience as an agenda item. Results are also discussed at Divisional Governance Meetings, the Patient Experience Group Meeting, Quality & Patient Safety Committee and Board of Directors.

Our key achievements

- ✓ Improved response rates being recognised nationally across the organisation

- ✓ Listening to patient feedback and making improvements

- ✓ Using and understanding patient comments to produce displays at ward level to inform patients, family members and visitors of local acknowledgement and actions.

Part 2 - Priorities for improvement and statements of assurance
2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Patient experience priority 3:

More than 90% of complaints will be responded to within time

Why was this a priority?

Complaints are seen as a valuable source of feedback about the services provided at Colchester Hospital.

Complaints are treated extremely seriously as they inform us when we have failed to provide the correct service to our patients, relatives and carers.

Every complaint is an opportunity to learn and improve services to meet our target of being the most caring healthcare provider.

Lead Director
Director of Nursing

What was our target?

90% of complaints to be responded to within agreed timescales.

What did we do to improve our performance?

Every complaint co-ordinator was brought back into a centralised area where they could be managed and supported appropriately.

The Divisions took responsibility for their complaints and met regularly with their complaints coordinator who updated them on potential breaches and required work for further improvement.

Complaints were welcomed by the Division to enable them to highlight areas of concern, any

themes or issues that they had in their areas.

Complaints were highlighted as a key quality concern and treated extremely seriously. Time was taken to read and digest the nature of the complaints.

A process by which initial telephone calls were made to complainants by the Divisional leadership teams within 24 hours of the complaint being received was introduced by the Trust, to ensure that no area was missed and that any immediate actions could be taken to support the complainant.

A process of 'Never Complaints' was introduced to the Trust, whereby specific complaint types were identified as something that does not wish to be seen in the Trust on any occasion. The categorisation of Never Complaints is made by an Executive Director, who will then seek assurance from the Divisional leadership team that appropriate actions has been taken to support the complainant and undertake immediate actions to prevent a similar occurrence from happening again.

The complainants are contacted regularly to ensure that they were kept informed throughout the process and that the central team understood the questions they actually wanted answering.

How did we measure and monitor our performance?

Weekly reports were provided to measure the performance and notify the Divisions of any gaps or areas of concern.

Did we achieve our intended target?

Yes— detailed evidence of our compliance with the standard is shown graphically on page **67.**

How and where was progress reported?

Divisional Governance Meetings

Patient Experience Group

Quality & Patient Safety Committee

Board of Directors.

Our key achievements

- ✓ Improved Compliance

- ✓ Patient kept informed of their complaints

- ✓ Patient, relative and carer concerns listened to and responded to appropriately

- ✓ A more improved response addressing the concerns of the patient and informing them of learning and outcomes

- ✓ Divisions taking responsibility for their own complaints

- ✓ Improved morale in the complaints service.

2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Patient experience priority 4:

More than 95% of patients will receive information about their condition when they are discharged from hospital

Why was this a priority?

Completion of Electronic Discharge Summery (EDS) is part of our normal clinical practice and part of our promise to patients in terms of providing high quality care.

Completing an EDS every time improves continuity of care on discharge so that patients, relatives and our clinical colleagues in primary care know what treatment has been given and what further treatment and investigation should be provided in the community.

A key activity of the discharge process is to ensure that patients are communicated with as part of the completion of the EDS. Patients are given a copy of their discharge letter, which enables staff an opportunity to provide clarity regarding patients' conditions either to patients directly or to identified next of kin/carers if patients do not have capacity, with on-going plans for follow up care either within the hospital outpatient system, or with community partners and local services.

Lead Director
Director of Operations

What was our target?
95% of patients receive information regarding their condition on discharge.

What did we do to improve our performance?

We worked with clinical teams, highlighting areas of good practice and targeting under-performing areas.

We used the quality bulletin published monthly to spread the message that all patients should go home with a copy of their competed discharge letter, alongside an explanation of their condition with additional information provided to them, where required.

How did we measure and monitor our performance?

Through daily, weekly and monthly reports circulated to all those involved in the discharge process and in monitoring performance.

Did we achieve our intended target?

Monthly performance currently varies between 92-94% of discharge letters sent within 24 hours of hospital discharge.

Our aim is to be consistently above 95% of letters sent within 24 hours of discharge.

How and where was progress reported?

EDS performance is reported as part of the quality scorecard.

Results from each division are presented at the Trust's Risk and Compliance (now Clinical Effectiveness) group monthly.

Reports are included in papers presented to Quality and Patient Safety Committee and the Trust Board.

Our key achievements

✓ Consistent performance maintained throughout doctor handover period

✓ Excellent clinical engagement both in timeliness and in improving quality of EDS

✓ Offer of support from CCG to guide junior doctors in writing discharge letters in a way that best informs primary care.

Part 2 - Priorities for improvement and statements of assurance
2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Clinical effectiveness priority 1:

Reduce Hospital Standardised Mortality Ratio to below 100

Why was this a priority?

Monitoring HSMR allows us to identify areas of clinical care that may require further attention in terms of quality and patient safety. It provides a benchmark to compare us with other Trusts both nationally and regionally.

While the headline figure gives us an overall indicator of the Trust's performance, the breakdown into individual diagnostic groups allows us to target the mortality review work more effectively.

Lead Director
Medical Director

What was our target?
HSMR of less than 100.

What did we do to improve our performance?

We are currently working on a number of areas highlighted as requiring further attention.

Respiratory conditions frequently trigger as alerts and we are working with the respiratory team to develop clear clinical pathways, in particular for COPD as part of the national COPD audit and for pneumonia. In the past heart failure has been an areas of concern and we are again developing local guidelines based on NICE guidance.

We investigate all CUSUM alerts received and have been working in particular on an alert for

'intestinal obstruction without hernia'. We have been linking this with the work on the National

Emergency Laparotomy Audit (NELA) and the surgical team have developed guidelines for the management of small bowel obstruction. We are currently focusing on how we can improve medical input to elderly patients admitted with an emergency surgical condition.

We hold weekly mortality review meetings where clinical teams present cases of patients who have died in the hospital. We look at how care could be improved and feedback the learning to clinical teams. We also have a monthly peer review meeting in medicine where clinicians review the notes of other teams.

Deaths are also reviewed within clinical teams as part of the governance process.

How did we measure and monitor our performance?

We hold a monthly mortality review group where all the information from across the divisions and from Dr Foster and other sources is brought together and the processes for investigation of deaths and any alerts or statistical outliers are reviewed.

The meeting, chaired by the medical director, has input from divisional representatives, clinicians, business informatics, the clinical audit and effectiveness team and coding. It informs the on-going workplan for mortality review.

Data is regularly reviewed from a number of sources to pro-actively highlight any areas of concern which require further investigation.

Did we achieve our intended target?

HSMR for December 2015 to November 2016 was 108.2 'higher than expected.

While HSMR peaked in March and June 2016, over recent months it has been falling and for November 2016 stood at 93.3.

How and where was progress reported?

Progress with HSMR is monitored monthly at the mortality review group. Result are reported to QPS and to the Trust Board.

Our key achievements

✓ Progress with clinical pathways, especially for emergency surgical patients where audit data (NELA) has shown dramatic improvements in clinical care over recent years. Following the CUSUM alert and implementation of the new small bowel obstruction pathway we have seen a significant improvement in the HSMR statistics in this area;

✓ Dynamic mortality review meetings which are clinically led and provide a focus for on-going work, identifying areas of concern and bringing together key themes across the divisions;

✓ Joined up working by linking in different areas across the Trust such as NEWS escalation, management of sepsis, provision of 7 day services, end of life care, use of My Care Choices register.

2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Clinical effectiveness priority 2:
Mortality case review of all deaths will be undertaken by clinical teams

Why was this a priority?

By reviewing all our deaths we can make sure we learn the lessons which help us provide safe, high quality care for all our patients.

Lead Director

Medical Director

What was our target?

100% of deaths will have mortality case reviews undertaken.

What did we do to improve our performance?

We asked all clinical areas to review all their deaths. A lead clinician in each area is responsible for co-ordinating the review of deaths.

The majority of deaths occur in the medical specialties, particularly Care of the Elderly and there is comprehensive process in place led by a consultant to co-ordinate the reviews and to disseminate the learning points that arise.

As a result over the last year we have dramatically increased the number of reviews to 80% of deaths across medicine.

How did we measure and monitor our performance?

Monitoring of performance is led by the clinical audit team who receives all the completed mortality review forms and collates the responses and key themes.

As well as the feedback to the divisions, the key themes are presented each month at the mortality review group.

Did we achieve our intended target?

Although we didn't achieve the target of 100% of deaths reviews, the 80% we achieved compares very favourably with other Trusts.

How and where was progress reported?

Results from mortality review are reported each month to the mortality review group chaired by the medical director.

More generally mortality data is shared with the Quality and Patient Safety Committee and also in the monthly Board report.

Our key achievements

- ✓ Sustained improvement in the percentage of deaths reviewed in the Trust
- ✓ Widespread engagement in learning lessons from hospital deaths
- ✓ Robust system across medical specialties to disseminate lessons across the division
- ✓ Development of new mortality review app which will allow online review of deaths, linking in with rollout of electronic patient records
- ✓ Preparations well advanced for implementation of national mortality review programme from April 2017.

Part 2 - Priorities for improvement and statements of assurance
2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Clinical effectiveness priority 3:

Venous Thromboembolism (VTE) assessments will be above 95% compliance

Why was this a priority?

Venous Thromboembolism (VTE) is a leading cause of mortality.

Carrying out VTE Risk Assessments (RA) is a priority for patient's safety in preventing VTE events. VTE RA assesses a patient's individual VTE risk and bleeding risk. This assists with making safe clinical decisions with regards to safest treatment options for the patient.

Lead Director
Medical Director

What was our target?
Greater than 95% of patients will have a VTE assessment completed.

What did we do to improve our performance?

The on-going provision of education and training for doctors and nurses by the VTE nurse team.

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

The divisions also receive a weekly and monthly VTE RA report which identifies their performance looking at elective and non-elective admissions, they can then deal with any performance issues in their area.

How did we measure and monitor our performance?

Performance Calculation:

VTE assessment details for patients admitted are entered on the online VTE assessment Tool which includes key assessment details as well as Patient Identifier and assessment dates and times.

For reporting, admission data is extracted from Medway Clinical Portal for the respective period. This is then matched with the corresponding VTE assessment using Patient Identifier and dates of admission against date of assessment as per the rules.

Further rules are applied flagging agreed cohorts where an assessment is not required. Using this data, performance is calculated and presented at various levels such as Consultant/Ward/Specialty/Division etc.

Did we achieve our intended target?

Yes, to date the performance for VTE RA has been continuously above 95%.

How and where was progress reported?

External reporting:

Trust level VTE assessment figures are submitted to DoH via UNIFY2 website Quarterly (showing monthly breakdown).

Internal reporting:

Performance reports are distributed weekly and monthly from Business Informatics team showing detailed breakdown VTE performance is also included on various Trust reports such as

Accountability Framework, Performance Framework as well as on Division reports.

A daily list is also made available via an online self-service report showing patients who have not been VTE assessed for the previous day.

Quarterly reports to QCPM.

Weekly and monthly VTE RA reports to the Divisions.

Our key achievements

✓ Attaining greater than 95% compliance in undertaking VTE RA on all admitted patients 18 years and above for 2016/17 year to date

✓ Redesign of bespoke VTE RCA template for any cases that require review

✓ Ongoing Trust-wide communication to engage staff with VTE RA compliance, evidenced through improved performance.

2016/17 quality improvement priorities
Progress against the priorities we set as a Trust

Clinical effectiveness priority 4:
Quarterly review of re-admissions by each specialty

Why was this a priority?

The Trust is committed to ensure that patients are not re-admitted to hospital unnecessarily.

It is important that patients receive full treatment pathways, and a safe discharge process to their place of discharge, be that their home, community care services or to another hospital environment.

Therefore, key services within the Trust have focussed on reviewing all re-admissions that have not been due to new or worsening existing clinical conditions.

Lead Director
Director of Operations

What was our target?
All re-admissions will be reviewed at specialty level on a quarterly basis.

What did we do to improve our performance?

Within the Division of Surgery all weekly consultant and managerial meetings are held to review all re-admissions from the previous week.

How did we measure and monitor our performance?

All readmissions are reported via the Datix system for peer review. The outcome of the peer review data are then fed quarterly to the Speciality and Divisional Governance meetings.

Did we achieve our intended target?

There is clear evidence of this being embedded within General Surgery.

The governance processes are not fully embedded within other specialties, and this will be tracked through newly formed Clinical Delivery Group (CDG) and Divisional Governance meetings.

How and where was progress reported?

Progress within General Surgery is tracked through Speciality meetings, Divisional Governance, with exceptions being reported through reports to the Risk and Compliance Group (now Clinical Effectiveness Group).

Our key achievements

✓ Consolidated systems in place across General Surgery Speciality

✓ Developments in re-admission reviews within gynaecology and maternity speciality.

The Trust is committed in continuing to work on its previous quality priorities, particularly focussing on any that were not achieved.

In order to continue to drive quality improvements across the Trust, the 2016/17 quality priorities will either be incorporated into a work stream already identified as part of the Every Patient Every Day programme of quality improvement (page 36) or will be considered for inclusion into operational delivery group activities with appropriate governance processes supporting it.

We aim to assure both internal and external stakeholders, patients and the public that we have clear oversight of our responsibilities to provide safe, effective and high quality care to all.

Our priorities for improvement in 2017/18

Qualitative information from a number of sources including patient surveys, staff surveys, complaints, compliments and the views or staff and public governors has helped inform the Trust's priorities for 2017/18.

Patient safety priority:

Reduction of inpatient falls per 1000 bed days to below 5 and a reduction by >30% of hospital acquired pressure ulcers (total numbers) compared to 2016/17 (identified through incident reporting)

Why is this a priority?

Ensuring that our patients come to 'no harm' during their admissions is a key priority for any healthcare provider. The impact on patients when suffering from pressure damage or an injury following a fall are wide ranging and complex.

The Trust is committed to ensuring that, wherever possible, no patient suffers from harm whilst receiving care, and therefore, this has been identified as the key patient safety priority for 2017/18.

Lead Director
Director of Nursing

2016/17 performance

The Trust had 5.9 falls per 1000 bed days in March 2017, and 111 hospital acquired pressure ulcers for the financial year.

What is our target?
- Patient falls reduction to below 5 per 1000 bed days
- Reduction by >30% of hospital acquired pressure ulcers (total numbers).

What will we do to improve our performance?
- Development of Trust-wide improvement plans for Falls and Pressure Ulcers
- Aggregated action plans for all pressure ulcer and falls incidents resulting in harm
- Development of tissue viability and falls service within Corporate Nursing and Quality

Divisions, with strategic leadership provided by the Deputy Director of Nursing on behalf of the Director of Nursing
- Engagement with national programmes for quality improvements, including the National Falls Collaborative and Pressure Ulcer campaign.

How will we measure and monitor our performance?
- Incident reporting of all pressure ulcers and falls will be monitored weekly through Patient Safety and Quality team and reported through Ward Safety Dashboard to Matrons Group, chaired by Director of Nursing;
- Early investigation of all pressure ulcers and falls resulting in harm to be reviewed through weekly Harm Free Panel, chaired by Deputy Director of Nursing, to identify immediate learning and quality improvement plans;
- Monthly review of pressure ulcers and falls activity will form part of the Patient Safety and Experience report;
- Triangulation of all falls and pressure ulcers with PALs, Complaints and Safeguarding information will inform any emerging themes and trends in specific areas of the Trust, to provide 'early warning' signals for immediate QI action to be undertaken.

How and where will progress be reported?

Regular reports and updates to:

✓ Matrons Meeting
✓ Patient Safety and Experience Group
✓ Nursing, Midwifery and Therapies Board
✓ Quality and Patient Safety Committee.

Clinical effectiveness priority:

Ensure that the Trust has completed its requirements relation to NatSSIPs in >80% of settings

Why is this a priority?

The National Safety Standards for Invasive Procedures (NatSSIPs) were published in September 2015 to support NHS organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events can occur.

The principle behind the NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. This will be done by organisations working in collaboration with staff to develop their own set of 'Local Safety Standards for Invasive Procedures' (LocSSIPs). The NatSSIPs cover all invasive procedures, including those performed outside of the operating department. The Trust will use the key elements of safe care as a basis for the development of Local Standards for Invasive Procedures (LocSSIPs).

Lead Director
Medical Director

2016/17 performance

A Patient Safety Alert (PSA) was published by NHS England on 14 September 2015 asking all NHS organisations to undertaken a series of actions—the Trust has complied with the following:

✓ The Medical Director has been identified as the responsible lead;

Our priorities for improvement in 2017/18

The quality priorities set out below for 2017/18 are three key areas for improvement which are not included in our 'Every Patient Every Day' programme

✓ The Trust has compiled a centralised database of procedures across all clinical settings where NatSSIPs are applicable, further procedures continue to be identified and logged;

✓ Work has commenced for the identified clinical procedures, to develop and test LocSSIPs based on the relevant NatSSIPs. Where a policy/procedure/guideline already exists, specialty areas have been asked to review the current document and benchmark them against both the national standards and LocSSIPs;

✓ Links have been made with Ipswich Hospital to work collaboratively and to share good practice.

What is our target?
- To identify all invasive procedures which are identified by NatSSIPs as requiring LocSSIPs
- To ensure >80% of all identified invasive procedures have LocSSIPs as required.

What will we do to improve our performance?
- Project management by the transformation team
- Project team enlisted to drive improvements and ensure deadlines are met.

How will we measure and monitor our performance?
- Development of LocSSIPs will be reported monthly through Clinical Effectiveness Group.

How and where will progress be reported?
✓ Clinical Effectiveness Group
✓ Patient Safety & Quality Committee.

Patient experience priority:

Improved Friends and Family Test (FFT) performance across all required domains to upper quartile in response rate whilst maintaining >95% positive recommendation

Why is this a priority?

The Friends and Family Test provides real-time feedback on the true experience of patients, relatives and carers and provides healthcare providers with the opportunity to improve services and respond immediately to any emerging concerns. The FFT supports the Trust in achieving its goal to be the most caring healthcare provider.

Lead Director
Director of Nursing

2016/17 performance

Inpatient return	**38.9%**
Inpatient recommend	**97.8%**
A&E return	**21.1%**
A&E recommend	**87.8%**
Maternity (inpatient) return	**35.1%**
Maternity (inpatient) recommend	**96.9%**

What is our target?
- Upper quartile response rate in all areas, which includes inpatients, outpatients, accident and emergency and maternity (all four areas)
- To maintain or improve to greater than 95% positive recommendation in all areas.

What will we do to improve our performance?
- Project plan to change FFT to electronic system as a joint working project with Ipswich Hospital NHS Trust
- Ward champions to be further developed to ensure every opportunity for FFT completion is exploited to ensure the voice of the patient is heard
- FFT compliance to be tracked as part of the senior nursing accountability programme.
- FFT metrics to be utilised within the Trust's Accountability Framework..

How will we measure and monitor our performance?
- FFT weekly, monthly tracking through Patient Safety and Experience Group and assured through Quality and Patient Safety Committee
- Benchmark comparison to be sought through Model Hospital Portal and NHS England Patient Experience Highlight Metrics Report
- Programme oversight for new FFT system implementation to be tracked through PMO office.

How and where will progress be reported?

Regular reports and updates to:

✓ Divisional Governance meetings
✓ Patient Safety and Experience Group
✓ Quality and Patient Safety Committee
✓ Weekly Matrons Meetings
✓ Divisional Integrated Performance Meetings
✓ Trust Board through Integrated Performance Report.

Provided and sub-contracted services

Provided and sub-contracted services

During 2016/17 Colchester Hospital University NHS Foundation Trust provided and/ or sub-contracted 64 relevant health services.

Colchester Hospital University NHS Foundation Trust has reviewed all the data available to them on the quality of care in 64 of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17, represents 100% of the total income generated from the provision of relevant health services by Colchester Hospital University NHS Foundation Trust for 2016/17.

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

"The staff make you feel so relaxed. The whole place is very relaxing and it really is very good here."

William, in the Radiotherapy Centre at Colchester General Hospital , March 2017.

Colchester 'At Our Best' Award winners

Colchester Hospital 'At Our Best' Award is a staff recognition scheme which says thank you to colleagues who live the hospital values. The nominations are judged by a panel of colleagues and patients.

'This individual is consistently named in complimentary feedback from patients. One patient stated "The cleaner would come in every morning and would be cheery, speaking to patients as they cleaned the ward and stopping to help them reach for a drink, or just chatting about the news outside of the hospital." Another patient described this individual as "a quiet ambassador of the ward". Always cheerful, as well as being supportive to both staff and patients. They go out of their way to ensure our patients have a positive experience with us, at what can be a very difficult time for them. If you were to ask me what At Our Best looked like, she would be the example that I would show you. Her pride and passion for her work shines through

Participation in clinical audit

During 2016/17, 37 national clinical audits and 5 national confidential enquiries covered relevant health services that Colchester Hospital University NHS Foundation Trust provides.

During 2016/17 Colchester Hospital University NHS Foundation Trust participated in 81% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust was eligible to participate in during 2016/17 are as follows:

Clinical Audits	
Heart	
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
2	Cardiac Rhythm Management (CRM)
3	National Cardiac Arrest Audit (NCAA)
4	National Heart Failure Audit
5	National Vascular Registry
Acute	
6	Asthma (paediatric and adult) care in emergency departments
7	Case Mix programme (CMP) (ICNARC)
8	Falls and Fragility Fractures Audit Programme (FFFAP)
9	Major Trauma Audit (TARN)
10	National Emergency Laparotomy Audit (NELA)
11	National Joint Registry (NJR)
12	Severe Sepsis and Septic Shock - care in emergency departments
Women and Children	
13	Diabetes (Paediatric) (NPDA)
14	Neonatal Intensive and Special Care (NNAP)
15	Paediatric Pneumonia
16	Child Health Clinical Outcome Review Programme
17	Maternal, Newborn and Infant Clinical Outcome Review Programme
Older People	
18	National Audit of Dementia
19	Sentinel Stroke National Audit Programme (SSNAP)
Long Term Conditions	
20	Adult Asthma
21	Endocrine and Thyroid National Audit
22	Inflammatory Bowel Disease (IBD) programme
23	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
24	National Diabetes Audit - Adults
25	Radical Prostatectomy Audit
26	Rheumatoid and Early Inflammatory Arthritis
27	Stress Urinary Incontinence Audit
Cancer	
28	Bowel Cancer (NBOCAP)
29	Head and Neck Cancer Audit
30	National Lung Cancer Audit (NLCA)
31	National Prostate Cancer Audit
32	Oesophago-gastric Cancer (NAOGC)
Haematology	
33	National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery
Other	
34	Elective Surgery (National PROMs Programme)
35	Learning Disability Mortality Review Programme (LeDeR Programme)
36	National Ophthalmology Audit
37	Medical & Surgical Clinical Outcome Review Programme

National Confidential Enquiries	
1	Cancer in Children, Teens and Young Adults Study
2	Chronic Neurodisability
3	Non Invasive Ventilation Study
4	Young People's Mental Health
5	Mental Health

Participation in clinical audit

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust participated in during 2016/17 are as follows:

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, 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:

*no submissions required in 16/17

**audit in progress at time of reporting

***data correct up to time of report

	Clinical Audits	Cases	Cases	%
	Heart			
1	Acute Coronary Syndrome or Acute Myocardial	227	227	100%
2	Cardiac Rhythm Management (CRM)	321	321	100%
3	National Cardiac Arrest Audit (NCAA)	78	78	100%
4	National Heart Failure Audit	404	404	100%
5	National Vascular Registry	146	308	47%
	Acute			
6	Asthma (paediatric and adult) care in	69	69	100%
7	Case Mix programme (CMP) (ICNARC)	503	503	100%
8	Falls and Fragility Fractures Audit Programme	614	614	100%
9	Major Trauma Audit (TARN)	397	397	100%
10	National Emergency Laparotomy Audit (NELA)	179	179	100%
11	National Joint Registry (NJR)	845	845	100%
12	Severe Sepsis and Septic Shock - care in	50	50	100%
	Women and Children			
13	Diabetes (Paediatric) (NPDA)	0*	NA	NA
14	Neonatal Intensive and Special Care (NNAP)	1356***	1356	100%
15	Paediatric Pneumonia	0**	NA	NA
16	Child Health Clinical Outcome Review Programme	0*	NA	NA
17	Maternal, Newborn and Infant Clinical Outcome Review Programme	31	31	100%
	Older People			
18	National Audit of Dementia	61	61	100%
19	Sentinel Stroke National Audit Programme	379	379	100%
	Long Term Conditions			
20	Adult Asthma	27	27	100%
21	Inflammatory Bowel Disease (IBD) programme	14	14	100%
22	National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	673***	673	100%
23	National Diabetes Audit - Adults	40	40	100%

Continued...

Participation in clinical audit

Clinical Audits		Cases submitted	Cases expected	%
	Cancer			
24	Bowel Cancer (NBOCAP)	339****	339	100%
25	Head and Neck Cancer Audit	0*	NA	NA
26	National Lung Cancer Audit (NLCA)	408****	408	100%
27	Oesophago-gastric Cancer (NAOGC)	64***	64	0%
	Haematology			
28	National Comparative Audit of Blood Transfusion - Audit of Patient Blood	94	94	100%
	Other			
29	Elective Surgery (National PROMs Programme)	219	1511	14%
30	Medical & Surgical Clinical Outcome Review	4	4	100%

National Confidential Enquiries		Cases submitted	Cases expected	%
1	Cancer in Children, Teens and Young Adults Study*	0	0	NA
2	Chronic Neurodisability	2	2	100%
3	Non Invasive Ventilation Study**	1	1	100%
4	Young People's Mental Health*	0	3	NA
5	Mental Health	4	5	80%
	*Studies still open. **Organisational questionnaire required only.			

'The River of Life' artwork launch at Colchester Hospital in 2017 to recognise the amazing Gift of Life that organ donation represents—the work was commissioned by the Trust's Organ Donation Committee.

Materials were donated by local people including staff, donor families and organ recipients.

Colchester Hospital University NHS Foundation Trust is incredibly proud to dedicate the artwork to local donors and their families.

Participation in clinical audit

The reports of 5 national clinical audits were reviewed by the provider in 2016/17 and Colchester Hospital University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Confidential Enquiry and Patient Outcome Data (NCEPOD) - Acute Pancreatitis 2016 Report.

The report demonstrated that the Trust is fully compliant with 11 of the 18 recommendations, partially compliant with 6, and 1 recommendation was not relevant to the trust. Of those 6, work related to achieving full compliance includes; improving the quality and accuracy of clinical coding has occurred through education of clinicians and weekly monitoring of MUST compliance to support improvement work.

National Cardiac Arrest Audit

The trust has re-commenced submitting data to this national audit in 2016 after a period of non-submission. Cumulative reports are received quarterly and are reviewed at the Resuscitation Group. Results demonstrate that our rate of cardiac arrests per 1000 admissions is 0.75 and less than the national average rate of 1.2. The ratio of observed to predicted

survivors to hospital discharge remains stable at 0.99.

National Emergency Laparotomy Audit

Trust: 5 areas good. 5 areas amber. 1 area red – assessment by elderly medicine specialist in patients aged 70 years and over.

Local audits being carried out to assess the quality of the data being submitted.

National Joint Registry

We constantly review our performance on the NJR both as individual surgeons and as a trust. In the past this has identified issues with prostheses and techniques which have been addressed and our implant revision rate improved. We now have a weekly lower limb arthroplasty MDT where registry data is analysed and discussed and problems identified and actions discussed to improve performance. These meetings are attended by surgeons performing lower limb arthroplasty and are minuted.

The current report has flagged consent rate for the registry, quality of trainee operations and individual revision rates for surgeons. We are instituting changes to our practise and documentation to improve them.

National Bowel Cancer Report 2016

This report covers patient diagnosed with bowel cancer. In 91% of cases the patient is seen by a Clinical Nurse Specialist. Mortality outcomes and readmission rates are within limits.

MINAP

In general, we are better or similar to national standards (eg patients seeing a Cardiologist, being admitted to a cardiology ward, having angiography if appropriate and receiving the full package of secondary prevention therapies).

We are worse for our length of stay for NSTEMI and our ability to provide angiography/PCI within 72 hours of admission (the NICE QS). Both these areas are due to the inability of the tertiary centre to accept patients for angiography/PCI in an appropriate timescale.

Further improvements will come from moving to a 7/7 Consultant service (which will be achieved with 2 additional Consultant appointments, currently out to advert). A 7/7 Clinical Nurse Specialist service will also improve our NICE QS in NSTEMI and heart failure.

Participation in clinical audit

The reports of the 85 local clinical audits were reviewed by the provider in 2016/17 and Colchester Hospital University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Trust wide large scale NEWS & Sepsis audit

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

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

Monthly audits of 50 patient deaths are sampled to examine compliance with the completion of the DNACPR tool. Compliance has remained static around the 85% mark. Feedback is provided to the relevant clinical teams to improve the completion of the documentation. This is in addition to the work surrounding DNACPR decision making by the End of Life Steering Group and the EOL work stream as part of the Every Patient, Every Day improvement programme.

Last Days of Life Audit

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

Classic Safety Thermometer Audit

This audit focuses on the provision of harm free care. Overall the Trust is slightly above the national median of 97.86% at 98.7% due to the incidence of urinary catheters and new UTIs. A catheter passport is commenced when a patient is catheterised for the first time to facilitate the monitoring of patients with catheters both in the acute and community settings.

Medication Safety Thermometer audit

Four wards participate in this audit . Compliance has been variable across the year. Where poor compliance has been recognised the ward nursing staff have received reminders, intense teaching sessions and where appropriate performance monitoring . Improvements have subsequently occurred.

Participation in clinical audit

Medical Division		
No.	Audit	Description of actions
1	Thrombo-lysis - Door to Needle Time	Key Findings • No real statistically significant difference between specialty and DtN – Stroke consultant • Mean time = 54.9 mins, Median time = 50 mins, Breaching = 29.6% – Non-stroke consultant • Mean time = 51.1 mins, Median time = 49 mins, Breaching = 28.1% • Stroke consultants thrombolysed 71.9% more cases than non-stroke consultants overall • Out of Hours (5pm – 9am) – statistically significant difference in DtN (increase in time) – 35% chance of breach compared with 16.9% (more than double chance) – Median • Within time = 41 mins • OOH time = 55 mins – Slight increase of DtN OOH for Stroke compared to Non-stroke Consultants Key Learning Points No significant difference in door to needle time between stroke and non-stroke consult-ants Out of Hours effect noted (increased time) Actions: Further audit of reasons for time delay in Out of Hours (e.g. if Night Hawk sys-tem, time for consultant to come in, presence of Acute Stroke Nurse)
2	Off-line neu-rophysiology data analy-sis (ulnar nerve response) in frequency domain	Key Findings The Matlab transformation produced a number of frequency values through FFT (Fast Fourier Transform) and PSD (Power Spectrum Density). Result: After the statistically analysis, it was concluded that the data is not normally dis-tributed. Man Whitney test revealed that there is no difference between symptomatic and asymptomatic hands when compared through frequency and power spectrum. One can-not reject the null hypothesis. Key Learning Points ☐ Dominant frequency of the signal ☐ Secondary frequency ☐ Power of a signl (max) & (mean) ☐ Frequency peak power ☐ FFT (Fast fourier Transformation) ☐ PSD (Power Spectral Density) Actions: None
3	Evaluation and manage-ment of stroke in young adults presenting to CHUFT	Key Findings • All young stroke patients presenting to CGH were managed by the stroke service team. • All young stroke patients have access to all basic and extended investigations but not all patients had the investigations.. • Majority of patients were discharged home with minimum support. • Advanced rehabilitation was offered to all young stroke patients when required. Key Learning Points 1) All young adult patients presenting with ischaemic stroke should basic investigations including Homocysteine, Patent foramen ovale, CT angiogram and thrombophilia screen 2) Emotional support should be readily available to all young stroke patients 3) There should be easier access to phone consultation 4) Continuity of care after discharge should always be in place when required 5) There is no local register for all young stroke patient presenting to CHUFT, this should be available to enable easy access to data Actions: None

Continued...

Participation in clinical audit

4	Positive predictive rate performance of angiography via rapid access chest pain clinic	Key Findings • Total 1212 patients referred to RAPC; Mean age = 61 years old; Female patients referred = 618; Male patients referred = 594 • Majority of referrals are from GPs (81.4%) • Majority of referrals are discharged home with no change in management (49.3%) • 40.9% of referrals underwent further investigations; 28% of these patients referred for angiograms • 6.6% of referrals discharged on medical management Of all OP angiogram referrals in 1 year period: • 73.9% were following initial referral from RAPC, remaining were after f/u • 9.2% were cancelled • 23.2% were normal • 15.7% showed mild CAD • 15.1% showed moderate CAD • 36.8% showed severe CAD. Key Learning Points • Majority of referrals were from the GP, and almost 50% of referrals were discharged without any interventions. Do GPs abuse the clinic in order to get patients seen faster e.g. for breathlessness? • Out of the angiograms that were done, the majority required some kind of intervention We have a very good hit rate for triaging patients at high risk of cardiac events. Actions: None.
5	Diagnostic pleural aspiration	Key Findings • 67 patients over a 4 month period underwent a pleural aspiration • 64% male and 36% female with a mean age of 73.2 years • 89.5% of samples were sent for pleural fluid protein and 86.6% sent for pleural fluid LDH • 31% of patients had a paired serum protein sample and only 4.5% had a paired serum LDH sample • 100% of samples sent to microbiology for MC&S analysis • 91% of samples sent for cytological analysis • 26.9% of pleural samples were sent for pH Key Learning Points • Pleural aspiration and subsequent analysis is a common procedure within the hospital • Key areas of good practice: 100% of samples obtained were sent for microbiological analysis with 91% of samples sent to cytology (only a small area of improvement required) • Key areas for improvement: - paired serum samples to be sent for both protein and LDH - all samples to be sent for pleural fluid protein and LDH Actions: Implementation of a pleural diseases algorithm for investigating pleural effusions. Implementation of a checklist for all pleural procedures.
6	Accuracy of drug chart transcription and requested outpatient investigations recorded in discharge summary for hip fracture patients	Key Findings 40 out of 100 patients (40%) had at least one regular medications stopped or dose changed. Only 14 out of 40 discharge summaries (35%) contained information/ explanation to GP regarding the change. 82 out of 100 patients (88%) had at least one new medication initiated. 63 out of 82 discharge summaries (77%) contained information/ explanation for initiating a new medication. 11out of 100 patients (11%) were to have DEXA scans as out-patient. 2 out of 11 discharge summaries (21%) contained information to GPs regarding the planned DEXA scan. Only 29 out of 100 discharge summaries (29%) were checked by a pharmacist. Key Learning Points Although large numbers of our patients have their medications changed or stopped, there were documentation errors in discharge summaries and not enough information is given to GPs in the discharge summaries regarding stopping or dose changing. Better results were noted in discharge summaries where new medications were initiated. Not enough information was given to GPs regarding the planned DEXA scans. The number of discharge summaries checked by pharmacy was poor. Actions: More pharmacy check is needed

Participation in clinical audit

Surgery Division		
No.	Audit	Description of actions
1	Critical Care emergency drug preparation and storage	Each new trainee now receives an induction with regards to the preparation and storage of drugs with guidelines being available on the local intranet.
2	Peripheral insertion of central catheter (PICC) lines	Proposed the development of a PICC/Vascular access service to enable safe insertion of appropriate vascular access devices on the right environment, by a suitably qualified practitioner.
3	Surgical versus percutaneous tracheostomies on ITU - Re-audit 2015-16	1. Use of the percutaneous tracheostomy safety checklist must become standard practice. 2. Consideration should be given to increasing the number of trained percutaneous tracheostomy inserters to further reduce waiting times and perhaps bring the ratio of percutaneous vs. surgical tracheostomy insertions in line with the national average. This may be done through a local training program. 3. Consent, especially regarding surgical tracheostomy insertion, needs to be better recorded and then filed in the notes. This should be the responsibility of the person taking consent. 4. In line with NCEPOD guidance, the use of variable length or extended length tracheostomy flanges should be considered more often especially in the obese
4	Compliance of surgical site marking with National Guidance	* A new checklist will need to be fixed to patient notes and completed for each new surgical procedure * Therefore, CHUFT will need to ensure that copies of the checklist are reproduced and made available. * Additional safeguards are needed where patients refuse pre-operative skin marking.
5	NELA data entries in a District General Hospital: An audit looking at completeness and accuracy of entries	Further education is required to emphasise the importance of complete and accurate data entries.
6	Missed drug doses	Critical/High risk medications should not be omitted and measures should be taken to ensure these are found and given, and in the event this is not possible to escalate the issue. Ensure that any omission should have the correct clinical codes documented Document in nursing and medical notes when omitting medications Avoid having blank boxes in the drug cards – blank boxes should be investigated and placed on Datix When medications are not available, to follow local protocol of ordering medications on intranet and in clinical preparation areas Findings should be relayed to doctors, pharmacists and nurses through regular team meetings to emphasise the need for improvement
7	Outcome After 'decision not to Operate' on acutely unwell High risk Surgical Patients	To do a prospective study with a well-designed proforma for all such patient for decision not to operate is taken

Participation in clinical audit

Surgery Division		
No.	Audit	Description of actions
8	Audit of diabetic retinopathy service consultation time for screen positive patients	*Continue as now to maintain 100% of urgent referrals meeting National Standard *To improve the non-urgent referral wait for appointments to meet minimum 95% seen in time frame.
9	Evaluation of Clinical Utility of Humphrey Standard Automated Static Perimetry for Non-Glaucoma Patients at ECH	* Build-up of new service entitled Glaucoma Monitoring Service * Neurological visual field defects to be evaluated with Goldmann kinetic perimetry
10	Orthoptics - Patient Satisfaction Survey	Continue with current practice
11	Tonsillectomy Haemorrhage Audit	Introduction of local policy for cold steel to be the preferred tonsillectomy technique Ensure that patients are aware of the local rates of tonsillar haemorrhages with the different techniques when consenting Provide patients with the NICE "Information for the public" guidance prior to the procedure
12	Nasal fracture manipulation & success related to timing	* We believe that it is reasonable to offer patients (with appropriate informed consent) trial of manipulation, even beyond the traditional 2 week window. * This work has been presented at several national and regional meetings.
13	Recognition and treatment of button battery ingestion audit	To design and implement button battery management flowchart for the Trust Re-audit

14	ENT inpatient notes - documentation standards (audit and re-audit)	Areas for improvement:
		  *Full name and ID no on EVERY page
		  *PRINTED name AND designation on every entry
		  *All errors to be countersigned, with date and time
		  *Contact numbers to be left in all entries

15	Analysis of admissions data across ENT/orthopaedics departments following implementation of a 'hospital at night' model	Orthopaedic rota coordinator to be sent the ENT handover pack to disseminate to orthopaedic trainees to help them with their assessment and management of ENT patients.
16	Patient Satisfaction following manipulation of fractured nose	It is reasonable to offer patients, with appropriate consent, trial of manipulation beyond the traditional 2 week window.
17	Assessment and documentation of Neurovascular status in upper and lower limb trauma patients	A pro-forma that shows how to perform a neurovascular examination as well as help improve its documentation. Will also improve overall documentation and continuity of care. We hope to implement the pro-forma over a 1 week period and re-audit. We will also produce an educational poster to circulate amongst staff
18	Outcomes of total elbow replacement	Disseminated to teams. Re-audit in 1 yr

Participation in clinical audit

Surgery Division		
No.	Audit	Description of actions
19	Timely Evaluation - Management of Ankle Fracture Dislocations	*Documentation of Neurovascular/Skin status in all cases *Rapid assessment and reduction should take priority however if this can be achieved with incorporation of a pre-reduction radiograph it may help operative * Try to perform operative fixation within the first 24hrs days to avoid swelling and long delays Timely Evaluation - Management of Ankle Fracture Dislocations Re-audit in a year.
20	Thromboprophylaxis and Complications in Ankle Fracture Dislocations	Better guidelines needed to help health care professionals make decisions on Clexane.
21	Thromboprophylaxis in neck of femur fractures	SHO on call to consider kidney status of patient by checking eGFR on admission before prescribing Clexane To be re-audited.

22	Timely evaluation of surgical management of neck of femur fractures	Recommendations to SHOs:
		    SHO on-call to treat all the correctable medical conditions during admission and seek medical SpR input in A&E where necessary
		    Not to prescribe blood thinners on the drug chart
		    SHO on-call to see to that 2 group & save samples are done
		    SHO on-call to prescribe all the necessary medications (eg. Insulin/inhalers) during admission

23	Evaluation of calcium and iron prescription in orthopaedic wards	*To prescribe calcium and Iron at different times of the day (Minimum 2 Hours apart) *When patients are being clerked, SHO on-call to prescribe them at different times on the drug chart even if the patient already comes in with them administering at same times.
24	Assessment of the efficacy of Colchester General's Stone Pathway	*Greater access to CEPOD would improve pathway *Ensure all patient are added to stent register
25	Segmental Ureterectomy in Ureteric TCC	Segmental ureterectomy offers good oncological outcome
26	Assessing the role of X Ray KUB in the Haematuria work up	Continue with X ray KUB for now To be re-audited with a larger sample size.
27	Routine Post-operative Bloods Check in TURP Patients (REAUDIT)	Outcome of audit to be disseminated to all clinical staff Laminated signs to be put up on the ward, doctors office and theatres (Th 3 and Th 12)
28	Recognition and treatment of button battery ingestion audit (REAUDIT)	Second cycle re-audit post-intervention of management leaflets, departmental teaching session and protocol flowchart demonstrated an improvement on all domains of management between 89%-100%.

Participation in clinical audit

Cancer and Clinical Support Services		
No.	Audit	Description of actions
1	Open Access Follow Up service for Breast Cancer Patients	Ensure all topics are covered in nurse led consultation, as per holistic needs assessment (HNA), Re-profile clinic to allow additional 15min per patient to cover all topics based on HNA following recruitment as per business case/ identification of clinical space, Re-develop workshop with Breast Care Care (BCC) facilitation and invite all suitable patients on OAFU, Streamline pathway for DEXA results, Improve timeliness of mammogram results
2	Breast Screening Assessment Clinic	Review audit questions to focus on anxiety of attending assessment clinic, Change contact details to mobile only
3	Lung Cancer Patient Satisfaction Survey	Review of existing service, Review current questionnaire and update accordingly.
4	Urology Advanced Nurse Practitioner Led Post Radical Prostatectomy clinic	The consultant responsible for penile rehab has now returned from a period of sabbatical leave. He will be running a penile rehab clinic regularly every 6 weeks moving forward. Waiting list to be monitored on a fortnightly basis
5	Comparative audit of local and teaching hospital's interpretation of Lymphoma Cases	Reopen discussions re IOG guidance regarding SIHMDS facilities with finance department
6	Positive predictive values for colonic lesions in CT pneumocolon studies at Colchester General Hospital	Collect data from CT pneumocolon scans over 3 years, Present findings to National Bowel Screening Programme Inspection
7	Deep Inspiration Breath Hold (DIBH) technique used in the Radiotherapy Department	For the patient information sheet to be made into a departmental leaflet, To implement the technique for all left sided breast cancer patients who can tolerate the technique, Notify clinical effectiveness committee, To be agreed and included into the breast radiotherapy clinical protocol, To present findings of audit and update of DIBH to the radiotherapy department.

Participation in clinical audit

	Womens and Children Division	
No.	Audit	Description of actions
1	Management of Epilepsy in Pregnancy	Write leaflet for women regarding epilepsy in pregnancy. Updating epilepsy guideline. •There are still some improvements needed: •All women should be booked into the maternal medicine ALYNE as soon as possible in pregnancy (some were MLC and not referred until late in pregnancy) •Documentation of seizure history and management plans could improve •Documentation of counselling can improve •An information leaflet has been designed for pregnant women with epilepsy which can also cover basic information around SUDEP, UK epilepsy register, medication, postnatal advice, contraception etc. •Our guideline conflicts with RCOG and have been reviewed.
2	Management of Cardiac Disease in Pregnancy	☐The clinic is a mixture (at the moment) of ladies with known cardiac disease and those with symptoms that may turn out to be due to cardiac disease but usually aren't ☐If referring for symptoms please follow guideline of organising relevant investigations (24 hr tape/ ecg/echo) then refer if these are abnormal ☐Most women have mild/corrected disease and have good outcomes ☐All women with congenital heart disease need to be discussed with fetal med for fetal echo ☐All women should have clear plans in the notes using appendix 2 and 3 in the guidelines ☐All women with cardiac disease should be reviewed by a registrar and anaesthetist in labour and the plans reviewed ☐Monitoring postnatally is important as are discussions about contraception/ prenatal counselling and cardiology review
3	Failed Instrumental Deliveries	Local practice appears to be in line with national guidelines. Failure rates are low. Complication rates are low and the only case involving questionable practice (no harm done) was subject to a swift and detailed investigation.
4	Endometriosis centre audit 2016	Re-Audit in 2-3 years Comply with all international standards in terms of outcome and more financially beneficial to the trust than routine gynaecological work. Waiting times for Outpatients and theatres comparable to other
5	Maternal O2 Usage on Delivery Suite	All staff should be aware that following an emergency event that O2 usage should be documented and relevant prescriptions and O2 therapy should be planned and prescribed.
6	Analysis of Appropriate use and Implementation of the Developmental Dysplasia of the Hip Screening and Investigation Pathway	To retrain midwives. To chase all babies lost to follow up. New and clearer DDH pathway to be introduced. •To refresh and emphasize guidelines to all health care professionals doing baby checks – ie posters •Healthcare professionals should use the NIPE smart system to record their actions and finding in detail – i.e radiology request and specific examination findings •To check if NIPE can include differentiation between simple and extended breech

Participation in clinical audit

	Womens and Children Division	
No.	Audit	Description of actions
7	Regional Gastrostomy Study	More liaisons with the dieticians pre and post the procedure. More close follow up to the growth and development of children with gastrostomy tubes. •To refresh and emphasize guidelines to all health care professionals taking care of children who are in need for gastrostomy. •Healthcare professionals in the region of East of England should be close to the criteria and guidelines of gastrostomy to provide the best service for these children. •More strict follow ups and good data recording to be sure those children with gastrostomy are growing well.
8	Prolonged Jaundice Workup According to NICE Guidelines	More training on samples extractions to avoid rejections or haemolysis. Additional support to the clinic by the phlebotomist to increase the efficiency of the samples and decrease the recall rate. •To refresh and emphasize guidelines to all health care professionals doing prolonged jaundice clinic – i.e. posters •Healthcare professionals should use the NICE guidelines to provide the best service for the babies. •More strict follow ups and good data recording to be sure not to miss a diagnosis.

Participation in clinical research

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

The number of patients receiving relevant health services provided or sub-contracted by the Colchester Hospital University NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee is 576. .

The Trust is a member of Clinical Research Network CRN Eastern and is required to deliver research across the 6 clinical divisions as defined by the NIHR local clinical research network structure, comprising 30 specialities.

The trust should commit to research activity in all specialties that have access to in-patients and an increase in recruitment activity can only be achieved, once all clinical services and workforce embed research into their everyday clinical practice. Research not only improves the quality of patient care but also attracts new staff.

Participation in clinical research demonstrates Colchester Hospital University NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Colchester Hospital University NHS

Foundation Trust was involved in conducting **61** clinical research studies during 2016/17, examples of which include:

1. The Maven study – A randomised controlled clinical trial comparing the effectiveness of bandaging compared to the Juxta CuresTM device in the MAnagement of people with VEnous ulceratioN: Feasibility Study.

   This is a Trust sponsored, led by a consultant vascular surgeon and Colchester is the only site in UK. The study is open to recruitment and has a study target of 50. Since fully opening in February, the team have already recruited 3 patients into this trial.

2. A commercial ophthalmology trial, to determine the efficacy and durability (treatment interval) of 2 mg IVT aflibercept in a T&E regimen over a treatment period of 76 weeks using protocol-defined visual and anatomic criteria in subjects with macular oedema secondary to central retinal vein occlusion The Trust was the first site open in the UK, recruited within one week of opening and has recruited 50% of its target of 4 patients.

3. National Studies of Rare Kidney Diseases. known as RaDaR collects information from patients who have certain kidney diseases. This will allow a much better understanding of how the condition affects people. It will also speed up research. If the research leads to benefits, such as better diagnosis, treatments or general advice, the registry is set up to feedback results to patients themselves.

   This an observational registry study and although a recruitment target was set at 15, the team have 97 patients recruited into this trial.

Chart 2—number of recruited research participants within region

CRN:Eastern Total Uploaded Recruitment by Trust, 16/17
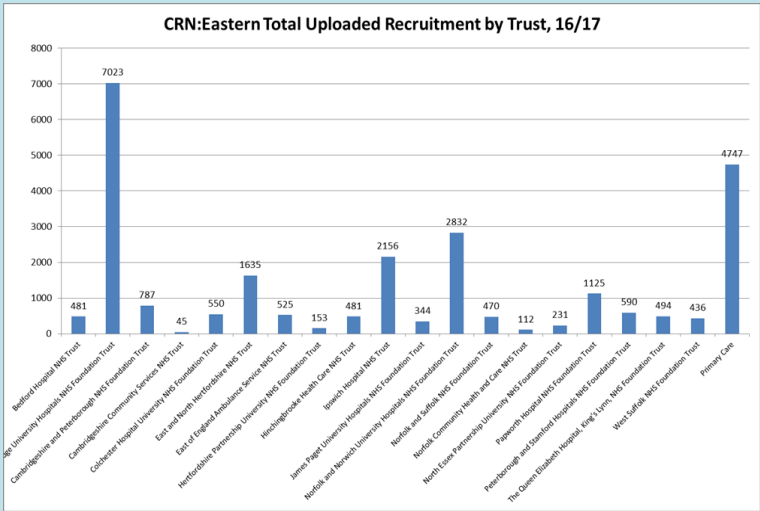
Monitoring quality

When we talk about quality care we mean care that is safe, responsive to people's needs and contributes to a positive patient experience.

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN payment framework enables our commissioners to reward excellence and innovation, by linking a proportion of the Trust's income to the achievement of locally-agreed quality improvement goals.

A proportion of Colchester Hospital University NHS Foundation Trust's income in 2016/17 was conditional upon 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 for Quality and InnovatioN payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at:
https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/
The monetary total for income in 2016-17, based on plan and conditional upon achieving quality improvement and innovation goals, was c. £4.2m. The monetary total for income in 2015-16, based on plan and conditional upon achieving quality improvement and innovation goals, was c. £5.7m. The CQUINs for 2016-17 are according to the national CQUINs available at the web link above and were supplemented with locally defined schemes. The listing of schemes being:

- NHS Staff Health & Well-being
- Timely identification & treatment of Sepsis
- Antimicrobial Resistance and Antimicrobial Stewardship
- End of Life
- Perinatal Mental Health
- Consultant / Urgent connect
- Dose banding
- NICU – hypothermia
- NICU – two year follow up
- Armed forces policy
- Dental dashboard.

For 2017-18, the agreed schemes are a combination of the national schemes and local schemes (schemes to be agreed):

- NHS staff health and wellbeing (all providers)
- Proactive and safe discharge (acute and community providers)
- Reducing the impact of serious infections (acute providers);
- Improving services for people with mental health needs who present to A&E (acute and mental health providers);
- R-referrals (acute providers, 2017/18 only). This linked to the requirement for all referrals to the Trust to be made electronically from April 17;
- Preventing ill health by risky behaviours – alcohol and tobacco (acute providers, 2018/19 only);
- Advice and guidance services (acute providers);

- STP - Provider engagement and commitment to the STP process;
- STP - Risk reserve, to complement the introduction of system control totals at STP level;
- Dose banding;
- Optimising Palliative Chemotherapy Decision Making;
- Hospital Pharmacy Transformation and Medicines Optimisation;
- AAA screening;
- Breast screening;
- Dental dashboard;
- Enhanced Armed Forces covenant.

Table 1 overleaf demonstrates the actual performance for the CQUIN indicators for 2016/17 for Colchester Hospital University NHS Foundation Trust.

Monitoring quality

Table 1 – Actual performance for the CQUIN indicators for 2016/17

The total payment represents 2% of Actual Outturn Value of Contract.

CCG	Scheme	Sub-scheme	Q1	Q2	Q3	Q4
1a	NHS Staff health and wellbeing	Introduction of health and wellbeing initiatives (option B)	Green	Grey	Grey	Green
1b		Healthy food for NHS Staff, visitors and patients	Green	Grey	Grey	Green
1c		Improving the uptake of flu vaccinations for front line staff within Providers	Grey	Grey	Green	Grey
2a	Timely identification and treatment of sepsis	Timely identification and treatment for sepsis in emergency departments	Green	Amber	Amber	Red
2b		Timely identification and treatment for sepsis in acute inpatient settings	Green	Green	Amber	Amber
3a	Antimicrobial Resistance and Antimicrobial	Reduction in antibiotic consumption per 1000 admissions	Green	Green	Green	Amber
3b		Empiric review of antibiotic prescriptions	Green	Green	Green	Red
4a	End of Life	EOL education about the sPICT delivered to each adult inpatient ward by end of Q4	Green	Green	Green	Green
4bi		After an unplanned admission or a decline in health status, the Consultant in charge of the patient should consider SPICT initial trigger statements 1-3 for adult inpatients	Green	Green	Green	Green
4bii		Patients who have been identified from SPICT trigger statements 1-3 have the 4 interventions been implementation and documented	Green	Green	Green	Green
4c		Feedback to clinical teams to enable action for improvement	Grey	Green	Green	Green
5a	Perinatal Mental Health	Evidence of 10 CHUFT midwives attending the approved course	Grey	Green	Green	Green
5b		Pathways to be shared with commissioner	Grey	Green	Green	Grey
5c		Minutes of quarterly perinatal mental health network meetings	Grey	Green	Green	Green
5d		Date and time for perinatal mental health network event	Grey	Green	Green	Green
6a	Consultant/ Urgent Connect	Number of additional specialties implementing Consultant Connect	Green	Green	Red	Grey
6b		% of calls that are answered by CHUFT consultants/clinicians	Red	Red	Red	Red
6c		% of calls where feedback is given after the call by CHUFT consultants/clinicians	Grey	Red	Amber	Amber

Specialist Commissioning Scheme

Scheme		Sub-scheme	Q1	Q2	Q3	Q4
7	Dose banding	Dose Banding	Green	Green	Green	Green
8	NICU—Hypothermia	NICU—Hypothermia	Green	Green	Green	Green
9	NICU—2 year follow up	NICU – 2 year follow up	Green	Green	Green	Green
10a	NHS Staff health and well-being	Introduction of health and wellbeing initiatives (option b)	Green	Grey	Grey	Green
10b		Healthy food for NHS staff, visitors and patients	Green	Grey	Grey	Green
10c		Improving the uptake of flu vaccinations for frontline staff within providers	Grey	Grey	Green	Grey
11	Armed forces policy	Armed forces policy	Grey	Green	Green	White
12	Dental quality dashboard	Dental Quality dashboard	Green	Green	Green	Green

Key

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

How healthcare is regulated

Colchester Hospital University NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is full registration. Colchester Hospital University NHS Foundation Trust has the following conditions on its registration:

Following an unannounced inspection in July 2015 a Section 31 notice was issued in relation to induction of staff in clinical areas. The Trust responded robustly in undertaking a new practice to ensure patient safety and the notice was lifted on 6th October 2015.

Two further Section 31 notices were issued in July 2015. One of the notices was issued to the Emergency Department (ED) to ensure that patients attending ED are streamed to the appropriate pathways. In addition there was to be a sufficient number of suitably qualified skilled and experienced nurses to support the streaming of patients into these pathways.

The second notice was issued to the Surgical Theatre department to ensure the Trust operates effective audit and monitoring system that provides accurate assurance that the safer surgery checklist is being consistently carried out in accordance with the recommendations of the World Health Organisation Safer Surgery Checklist (2016). The Trust continues to provide weekly evidence and updates to CQC on compliance.

A section 29a Warning Notice was served on the Trust in December 2015, giving the Trust 90 days to significantly improve the quality of services delivered by the Trust.

The Care Quality Commission has not taken further enforcement action against Colchester Hospital University NHS Foundation Trust during 2016/17.

Colchester Hospital University NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Ratings	
Overall rating for this trust	Inadequate ●
Are services at this trust safe?	Inadequate ●
Are services at this trust effective?	Inadequate ●
Are services at this trust caring?	Requires improvement ●
Are services at this trust responsive?	Inadequate ●
Are services at this trust well-led?	Inadequate ●

CQC monitoring and inspection process
Inspections by the Care Quality Commission
The CQC regularly inspects Trusts and continues to re-inspect those services which fail to meet the Fundamental Standards of Quality and Safety, and inspect any service at any time if there are concerns raised.

Colchester Hospital University NHS Foundation Trust in September 2015 received a rating of 'Inadequate'. The full report can be viewed on the CQC website. The following table indicates that areas that were deemed inadequate, requires improvement or good.

How we addressed the issues raised by the CQC:

✓ The CQC revisited the Trust in September 2015 and the resulting report was published on 19 January 2016.;

✓ Following an unannounced inspection by CQC on 4 and 5 April 2016, on 13 April 2016 the Chairman, the executives, the Non-Executive Directors and the Divisional Directors were interviewed to gain an understanding of the progress made at Board level to date. While senior staff had been able to describe improvements made in response to CQC's previous inspection, it was deemed by the CQC that the Trust had not taken a sufficiently proactive approach to addressing wider issues in the Trust;

✓ A long term partnership between Colchester General Hospital and Ipswich Hospital NHS Trust was recommended jointly by the CQC Chief Inspector of Hospitals, Professor Sir Mike Richards, and the Chief Executive of NHS Improvement, Jim Mackey as the only way of securing services for patients long into the future;

✓ Mr Nick Hulme was appointed as Chief Executive and Mr David White as Chair of the Trust Board on 17 May 2016 and diagnostic phase commenced to best determine the urgent priorities to be addressed. A plan for improvement has been developed which superseded the Quality Improvement Programme and drive forward quality of care across the Trust;

✓ The trusts are working together to establish a long-term partnership. Areas of opportunities/efficiency have already been found, for example, the sharing of on call Doctors across both Trusts as where previously these were hard to fill, given the vacancy levels at the Trust at this time;

✓ The Trust started the implementation of embedding a new programme of continuous improvement. The programme is called "Every Patient, Every Day". In summary this programme plans to touch every aspect of working life; ensuring staff provide the quality of care the NHS aspires to and which patients expect and deserve.

Every Patient Every Day

Every Patient, Every Day

is about providing safe, compassionate care to patients both as an organisation and as individual members of staff, each and every day, in a systematic and caring way. Discussions last summer led to a commitment from NHS Improvement (NHSI) to fund this programme so that the Trust could continue to focus its existing resources on direct patient care.

The programme is centred on three key modules of work:

1. Quality & Governance, End of Life Care and the Deteriorating Patient;

2. Operational Grip & Cost Improvement Plans (CIP) delivery;

3. Cross-cutting themes such as patient flow and planned care.

There are 11 key work streams within the programme, which are:

✓ Cost Improvement Plans (CIP)

✓ Deteriorating Patient

✓ End of Life Care

✓ Governance

✓ Ipswich Hospital Trust Collaboration

✓ Operational Improvement

✓ Outpatients

✓ Patient Flow

✓ Planned Care

✓ Urgent & Emergency Care

✓ Workforce.

Each of the workstreams is led by an Executive **Senior Responsible Officer ("SRO")** and an **Operational Lead** who drives the day to day activities.

There are activities in each work stream that involves divisions, departments, teams and individuals across the Trust. This complements the current work being done and helps unblock issues, increasing the rate of improvement.

Establishing genuine clinical and team leadership is essential and it is recognised that critical to the success of this programme is the importance of bringing every member of our staff with us to change the way the Trust does things.

More than 10 Briefing newsletters have been designed and circulated to all Trust Staff. Each edition focusses on a couple of different work streams from the programme. Each provides a reference point for anyone to see what is happening in each workstream.
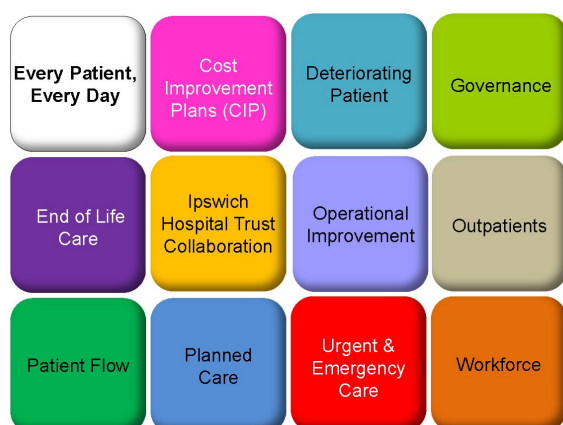
Statements relating to the quality of relevant health services provided

NHS number and General Medical Practice Code validity

Colchester Hospital University NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.3% for admitted patient care;
- 99.8% for outpatient care; and
- 98.0% 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;
- 99.9% for outpatient care; and
- 99.9% for accident and emergency care.

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

Information Governance Toolkit attainment levels

Colchester Hospital University NHS Foundation Trust's Information Governance Assessment Report overall score for 2016/17 was 87% and was graded satisfactory (green).

The published score in March 2017 of **88%** maintains a high score for the Information Governance Toolkit. The Trust scored a minimum of Level 2 on all 45 requirements. Our final position was satisfactory (Green).

The Information Governance Toolkit is available on the HSCIC website: www.igt.hscic.gov.uk
The information/evidence is uploaded directly to the Information Governance Toolkit.

Clinical coding

Colchester Hospital University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

However, there is a yearly departmental audit (last one January 2017) to comply with Information Governance Toolkit 505. The aim of this Clinical Coding Audit is to improve the data quality of the coded clinical record which underpins organizational management and planning, commissioning of services for the population, clinical research and financial flows.

The objectives are to evaluate the accuracy and completeness of coded clinical data against the source document, which in this audit, is the patient case note and the impact of data collection procedures which underpin the coding process, to help sustain high standards of reliable clinical information and inform and effect improvements where required.

Summary of errors 16/17 as follows;

Primary diagnosis correct %	Secondary diagnoses correct %	Primary procedure correct %	Secondary procedures correct %	Unsafe to Audit	Total % FCEs resulting in HRG change
91%	89.6%	91.4%	94%	0	14 (7%)

Data Quality

Colchester Hospital University NHS Foundation Trust will be taking the following actions to improve data quality as follows:

Data Quality Indicator	Data Quality or Data Flow	When	Update
Information Governance Toolkit attainment levels	Data Quality	On-going	The Trust will continue to maintain an action plan to evidence Level 2 submission against all 45 requirements, monitored through the Information Governance Steering Group, chaired by the Medical Director (Caldicott Guardian) or by the Director of Finance (Senior Information Risk Owner).
Clinical coding	Data Quality	On-going	An internal on-going training programme has been established and will run throughout the year covering all aspects of coding and will continue to re-enforce quality issues.

Operations sheets, where available, will be used to support coding.

The identification and coding of comorbidities will be reviewed and new codes introduced.

Practice will be audited and results fed back to staff so that improvements can be made. |

Core Quality Indicators

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

Indicator: Summary Hospital-Level Mortality Indicator (SHMI)						
SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality, however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period.						
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score	Banding
The value and banding of the SHMI for the Trust for the reporting period	Apr 15—Mar 16	1.081	1	1.171	0.694	2
	Jul 15—Jun 16	1.085	1	1.171	0.694	2
	Oct15—Sep 16	1.086	1	1.163	0.6897	2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)	Apr 15—Mar 16	24.0%	27.0%	54.83%	0.6%	
	Jul 15—Jun 16	24.0%	27.0%	54.83%	0.6%	
	Oct 15—Sep 16	24.9%	29.7%	56.3%	0.4%	
Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons: • Trust is banded as a '2' which is 'as expected' mortality. This correlates with the information gained from local morbidity & mortality meetings.						
Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by: ✓ The Palliative care team and coders continue to work cohesively to ensure correct coding of palliative patients across the trust; ✓ The Watchpoint list for last days of life patients has been formulated and is becoming embedded to ensure that as a trust we are recognising the patients who are deteriorating and potentially in the last days of their lives so that supportive assessment and care can be provided timely and appropriately. This early recognition then facilitates the use of the Individualised Care Record for the Last Days of life to support a patients and family's end of life care needs. The development of a Band 6 Palliative and End of Life Clinical Skills nurse has been fundamental in deepening the awareness and education of peers across the organisation in providing best supportive end of life care; ✓ The use of My Care Choices register in the support of accessing the patient's wishes and preferences are known and facilitated as early as possible after their admission into hospital continues to be embedded into practice; ✓ Improved communication to GP's on discharge through greater clinical information sharing on the patients electronic discharge summary continues.						

Core Quality Indicators

Indicator: Patient Reported Outcome Measures (PROMs) scores					

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

The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
The Trust's patient reported outcome measures scores for groin hernia surgery during the reporting period	2014/15	0.096	0.085	0.108	0.053
	2015/16	0.057	0.084	0.154	0.027
	2016/17		0.089	0.119	0.021
The Trust's patient reported outcome measures scores for varicose vein surgery during the reporting period	2014/15		0.094	0.154	0.009
	2015/16		0.095	0.149	0.018
	2016/17		0.099	0.125	0.083
The Trust's patient reported outcome measures scores for hip replacement surgery during the reporting period	2014/15	0.42	0.436	0.524	0.331
	2015/16	0.43	0.438	0.510	0.320
	2016/17		0.449	0.508	0.431
The Trust's patient reported outcome measures scores for knee replacement surgery during the reporting period	2014/15	0.33	0.315	0418	0.204
	2015/16	0.292	0.320	0.398	0.198
	2016/17		0.337	0.430	0.261

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- Insufficient sample size data has been supplied by the Trust to provide PROMs scores to date via the national database;

- There were 690 eligible hospital episodes and 120 pre-operative questionnaires returned - a headline participation rate of 17.4% (76.2% in England);

- Of the 27 post-operative questionnaires sent out, 6 have been returned - a response rate of 22.2% (41.1% in England).

Colchester Hospital University NHS Foundation Trust has taken and intends to take the following actions to improve this score, and so the quality of its services, by:

- ✓ Improving patient information on returning questionnaires to ensure that the Trust improves its return rate to be included within the national data set, led by ward based clinicians.

Core Quality Indicators

Indicator: Readmission rates					
The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
% of patients aged 0-15 years readmitted within 28 days	2010/11	8.79	10.42	14.11	0
	2011/12	8.35	10.44	14.94	0
% of patients aged 16 years or over readmitted within 28 days	2010/11	9.89	11.43	14.06	0
	2011/12	10.35	11.45	13.8	0

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

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

- Local data sets have provided the following data for readmission rates

Reporting Period	0-15 years	16+ years
2014/15	9.2%	4.11%
2015/16	9.84%	4.49%
2016/17	10.04%	3.97%

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

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

Indicator: Responsiveness to the personal needs of patients during the reporting period					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
The Trust's responsiveness to the personal needs of its patients during the reporting period	2013/14	67.3	68.7	84.2	54.4
	2014/15	63.9	68.9	86.1	59.1
	2015/16	64.9	69.6	86.2	58.9

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- National data sets are not available for readmission rates as provided by NHS Digital (HSCIC)

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

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

✓ Colchester Hospital implemented a new patient user group providing a forum for patient experience including external stakeholders of Public Governors, local health forum committee members and Healthwatch members.

Core Quality Indicators

Indicator: Staff recommendation (Friends and Family Test) Taken from Question 21d of the NHS staff survey					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
The % of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends."	2015/16	62%	69%	89%	46%
	2016/17	59%	70%	91%	48%

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- Indicator methodology used as published on HSCIC - Percentages added for options 'agree' and 'strongly agree'.

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

✓ The Organisational Development strategy that was approved in 15/16 has commenced delivery. It has been used to supported organisational change and the commencement of a leadership development suite of interventions which launched in December 2016;

✓ During 2016/17 there has been the continuation of the monthly staff involvement groups. Led by the Director of Finance the Staff involvement Groups seeks to find solutions to issues that affect staff and patients. One suggestion from the group was to have minutes and note taking courses for staff. This has been developed and delivery commenced in February 2017;

✓ In September 2016 a leadership event took place where circa 100 leaders came together to review and discuss progress with the "Every Patient Every Day" workstreams, the progress made during the "Red to Green" weeks and to look at and learn from a series of patient complaints.

Indicator: Patient recommendation (Friends and Family Test)					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
All acute providers of adult NHS funded care, covering services for inpatients and patients discharged from A&E (type 1—inpatients and type 2—A&E patients)	2014/15 (type 1)	96.29%	94.01%	100%	78.18%
	2015/16 (type 1)	97.01%	95.40%	100%	83.3%
	2016/17* (type 1)	97.84%	95.39%	100%	75.55%
	2014/15 (type 2)	75.19%	86.84%	98.61%	57.78%
	2015/16 (type 2)	82.08%	87.69%	98.9%	49.3%
* 2016/17 YTD (Apr 2016—Feb 2017)	2016/17* (type 2)	87.88%	86.16%	100%	47.80%

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:
- Indicator methodology used as per NHS Digital (HSCIC) guidelines.

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:
- Identifying both response rates and recommender rates as a key quality priority for 2017/18.

Core Quality Indicators

Indicator: Risk assessment for venous thromboembolism (VTE)					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
% of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	2014/15	92.7%	96.07%	100&	70.32%
	2015/16	94.7%	95.73%	100%	77.55%
	Apr 2016-Dec2016	96.1%	96.00%	100%	71.3%

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:
- The indicator as reported nationally is the national data set and confirms local data analysed and reported internally

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

✓ Education of doctors;

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

✓ Support from the VTE nurse team in capturing any outstanding VTE RAs in ward areas.

Indicator: Clostridium difficile infection rate					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
the rate for 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	Apr 13—Mar 14	8.6	14.7	37.1	0
	Apr 14—Mar 15	15.5	15	62.6	0
	Apr 15—Mar 16	12.3	14.9	66	0

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- There is a rigorous checking process in place before data is submitted;
- The data is cross-checked with laboratory data and is subject to external assurance.

Colchester Hospital University NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

✓ Improving mandatory IPC education compliance rates across the organisation;
✓ IPC e-learning including regular updates best practice in relation to C difficile best practice management;
✓ Increased IPC face to face sessions with staff through the winter months regarding C difficile and Norovirus management in particular;
✓ Ribotyping of all positive cases of C difficile to identify trends and cases of cross infection;
✓ Antimicrobial and C difficile ward rounds to assist in the promotion and review of antimicrobial use and thereby optimal use.

Core Quality Indicators

Indicator: Patient safety incident rate									
The data made available to the Trust by the HSCIC with regard to:	Reporting period	Colchester Score		National average		Highest score		Lowest score	
		Number	Rate	Number	Rate	Number	Rate	Number	Rate
the number and rate of patient safety incidents reported within the Trust during the reporting period	October 15- March 16	3969	40.94	655193	75.5	11998	40.89	1499	14.77
	April 16- September 16	3789	39.79	673865	76	11627	86.2	851	53.9
(please note that the reporting period changed to 'per 1,000 bed days' in April 2014)	October 16- March 17	Data not available at time of publishing.							
the number and percentage of such patient safety incidents that resulted in severe harm or death during the reporting period		Number	%	Number	%	Number	%	Number	%
	October 15- March 16	32	0.8	2642	0.4	91	1.7	0	0
	April 16- September 16	16	0.4	2516	0.4	98	1.4	1	0.01
	October 16- March 17	Data not available at time of publishing.							

"The care here has been brilliant for me, my sister and my dad."

Harvey, aged 10, MRI appointment, March 2017."

Core Quality Indicators

Indicator: Patient safety incident rate

Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- All incidents are reviewed by the Patient Safety & Quality Team to assess and validate the level of harm reported and ensure those reported as no and low harm are accurately graded. There is also clinical judgement in the classification of an incident as moderate and above harm as it requires moderation and judgement against subjective criteria and processes. All incidents are investigated to ensure that lessons are learned to safeguard future patient care. All patient safety incidents (irrespective of level of harm) are uploaded to the NRLS within one month of reporting; and those initially considered to have caused severe harm or above are reported within 72 hours;

- The last data set reported from the NRLS shows the Trust to be slightly above average reporters of incidents, and this trend has steadily increased since 2013. Trusts which are high reporters of incidents are very good indicators of a strong reporting culture. We have robust processes in place to capture incidents. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. We have provided training to staff and there are various policies in place relating to incident reporting but this does not provide full assurance that all incidents are reported. We believe this is in line with all other trusts;

- The percentage of high harm and death incidents taken from the NRLS report (as mandated by the Quality Account Guidance) for October 2015 – March 2016 is 0.8% for the Trust, slightly above the national average for medium acute Trusts which is 0.5%. The Trust has implemented a robust process for the investigation of all potential serious incidents despite the initial grading chosen by the reporter. All incidents are reviewed by the Patient Safety & Quality Team and where there is a suspicion of harm or a near miss further information or a 24 hour review is requested. The 24 hour report is presented at SI Panel, held twice weekly and chaired by either the Medical Director or Director of Nursing; and a decision made as to level of harm caused and whether or not the incident fits SI criteria. Within the open reporting culture of the Trust, staff are encouraged to identify and escalate any Serious Incidents (SIs) and as with any other incident the Trust reviews SIs for trends and themes to look for opportunities for improvement.

Colchester Hospital University NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by:

- Continue to build our culture for reporting patient safety incidents at all levels of harm. An E-learning training package has been designed and implemented to encourage reporting of incidents and near misses as well as give guidance for risk assessment and escalation of incidents. The Trusts Procedure for the Management of Incidents and Serious Incidents gives staff clear guidance on how to report and escalate and also details the SI process;

- Develop key performance indicators for the management of incidents and SI's and include these within our Accountability Framework.

Part 3 - Other information
Patient safety
Infection prevention and control

Achieve Trust Target of zero for MRSA cases in 2016/17

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

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

All Acute Trusts have participated in PHE mandatory enhanced surveillance of MRSA bacteraemia since October 2005:

✓ The root cause of the MRSA bacteraemia case in 2016/17, related to peripheral intravenous line management. There has been
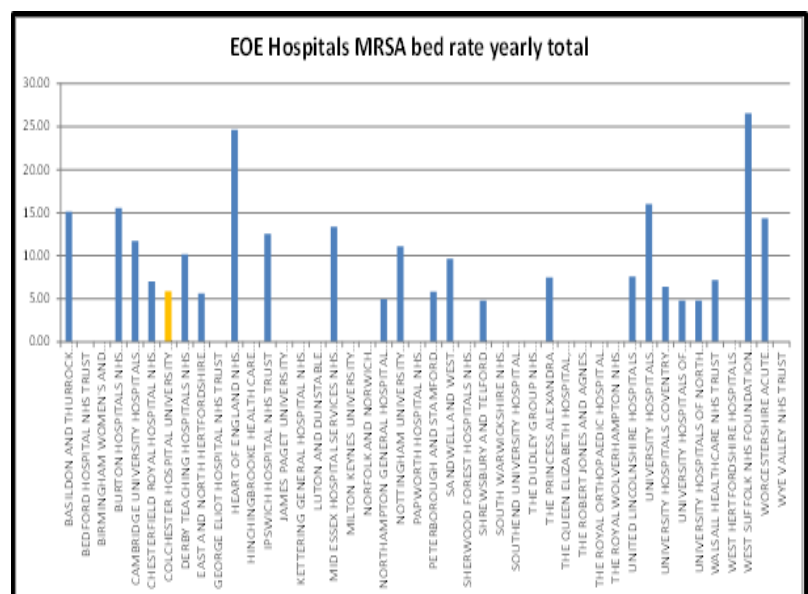
Chart 3 –
The performance of Colchester Hospital in rates of MRSA bacteraemia, compared with the other hospitals in the East of England region for 2016/17

further training locally and across the Trust relating to intravenous line management, the policy was updated and promoted. There was a Grand Round and Infection Control conference with the affected patient involvement which was extremely powerful in supporting improvement in practice;

✓ There was a blood sample which was a contaminant and was not an infection in a patient. However, the opportunity was taken to review the blood culture taking procedure with new packs introduced to reduce the risk of contamination of samples.

Year	Number of cases of MRSA bacteraemia apportioned to Colchester Hospital	Target
2014/15	0	Zero cases
2015/16	2	Zero cases
2016/17	2 (1 of which was a contaminant)	Zero cases

Chart 3—number of MRSA bed rates per year compared with regional Trusts

EOE Hospitals MRSA bed rate yearly total

Patient safety
Infection prevention and control

Clostridium difficile infection (C-Diff) remains an unpleasant, and potentially severe or fatal infection which occurs mainly in the elderly or other vulnerable groups especially those who have been exposed to antibiotic treatments.

The Trust has made great strides in reducing the number of people affected by CDI, however, the rate of improvement has slowed over recent years and it is recognised that some infections are a consequence of factors outside of the control of the NHS organisation that detected the infection. (NHS England 2016/17). Each case

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

23 c difficile cases for Colchester have been agreed as non- trajectory 2016/17.

✓ There had been an increased incidence in cases with 3 cases linked on the Stroke Unit December 2015 – March 2016. An investigation took place

with a comprehensive action plan drawn up and implemented which included two deep cleaning episodes for this area a few months apart with some environmental refurbishment taking place. Targeted education and intensive support from the infection control team.

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

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

Year	Number of cases of Clostridium difficile apportioned to Colchester Hospital	Target
2014/15	32 cases	20 cases
2015/16	24 cases – 14 non-trajectory	18 cases
2016/17	33 cases – 23 non-trajectory	18 cases

Chart 4a – The performance of Colchester Hospital in rates of *Clostridium difficile*, compared with the other hospitals in the East of England region for 2016/17
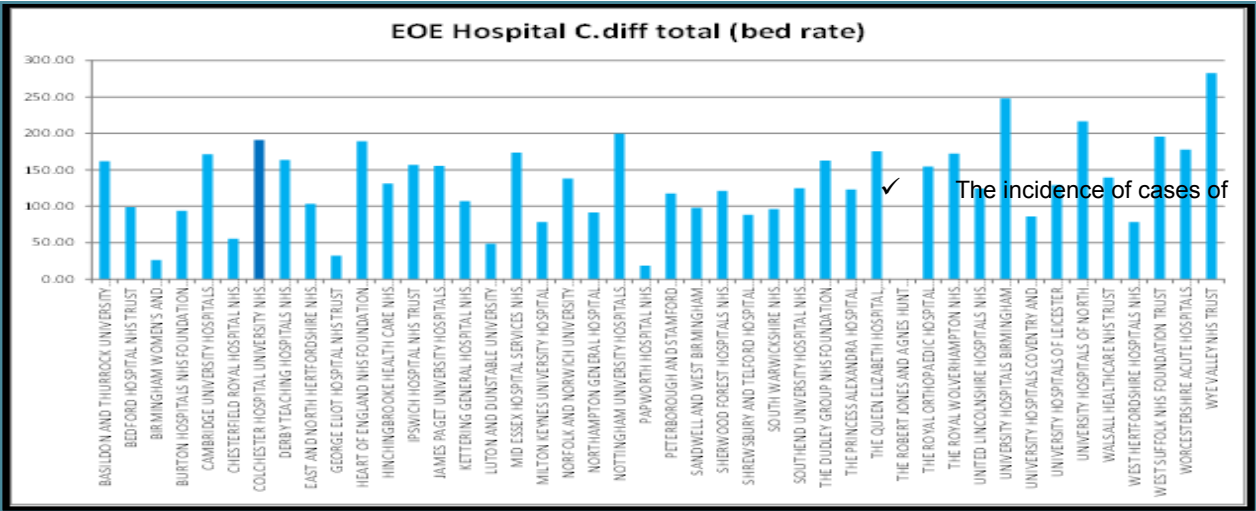
✓ The incidence of cases of

Patient safety
Infection prevention and control

Clostridium difficile is higher in Medicine and Care of the Elderly Wards, 7 of the 8 Wards have had a significant investment in refurbishments in the past 3 years with a plan for the final COTE Ward to be refurbished in the coming financial year. This supports the appropriate positioning of patients in an environment which allows for better isolation with an ability to clean effectively.

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

Healthcare Associated Infections (HCAIs)

The Trust participated in the 5th UK and European Healthcare Associated Infection (HCAI) and Antimicrobial study which was completed during October 2016. The Trust has taken part in the 4 previous studies and have been able to utilise the local and comparative data to progress best practice.

The complete comparative data for this study will be available in its entirety later in 2017. However, we are able to report the findings as below.

	Health Care Associated Infection Prevalence		Antimicrobial Usage	
	2016	**2011**	**2016**	**2011**
CHUFT	4.85%	4.8%	36%	31.9%
All participating Hospitals	7%	6%	38%	35%

Chart 4b – The performance of Colchester Hospital in rates of avoidable and no identified lapses of care *Clostridium difficile* cases following independent review for 2016/17
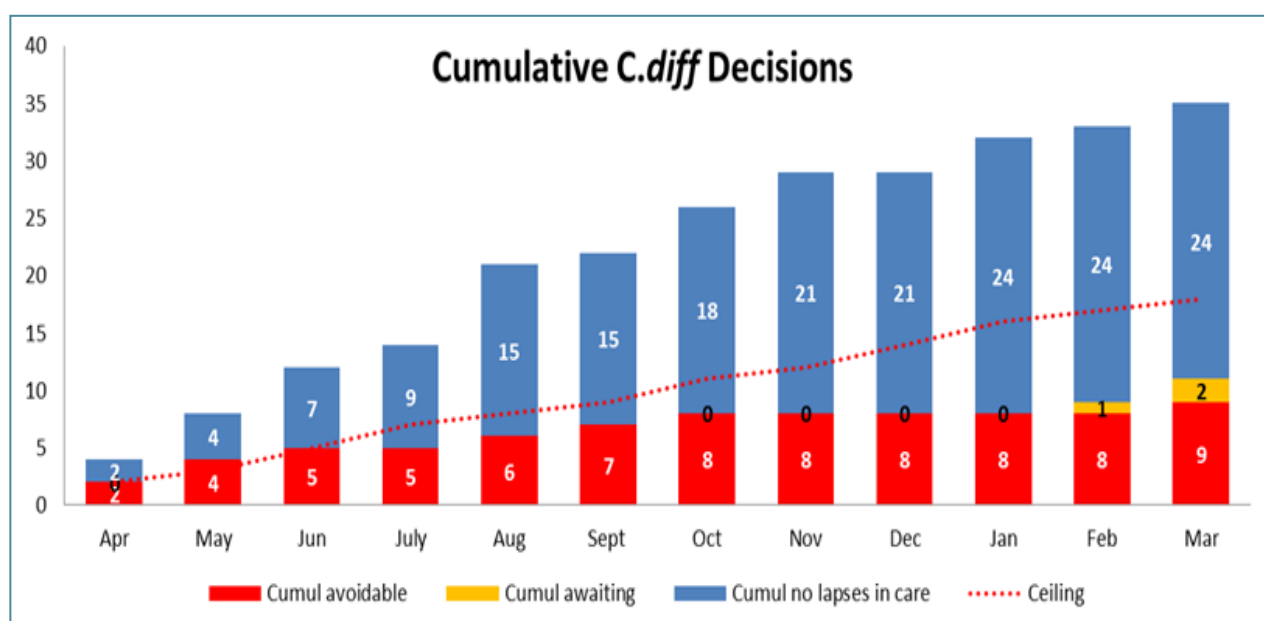
Patient safety
Prevention of pressure ulcers which develop in hospital

What is a pressure ulcer?

A pressure ulcer is damage that occurs to the skin and or underlying tissues over a bony prominence or area in contact with direct pressure.

Pressure ulcers are caused by extrinsic factors, including:

* Pressure

* friction and shearing

* moisture (causes the skin integrity to deteriorate)

Where do they occur?

The most common places for pressure ulcer to develop are the bony prominences such as heels, sacrum, spine, elbows, back of head however any area in contact with direct pressure is at risk.

Inpatient support

On admission a full skin inspection and risk assessments relating to pressure ulcers, nutrition and moving and handling will be completed on admission. Daily skin inspections, 3x daily heel checks, nutrition advice, assistance with repositioning and continence support will be provided by ward staff.

CHUFT have a specialist Tissue viability nurse who provides support to patients and wards with individual care plans, dressing advice and review of complex wounds.

Identifying risk

Some acute or chronic conditions can predispose patient's to pressure damage such as diabetes, peripheral vascular disease, heart failure, respiratory conditions, impaired mobility, stroke and reduced appetite, this list in not exhaustive. It is important patient's are risk assessed on admission and at regular intervals to ensure all preventative measures are in place and care plans reflect the patient's needs,. Braden tool is the pressure ulcer risk assessment used at CHUFT.

Our key achievements

✓ Reduction in avoidable hospital acquired pressure ulcers.

✓ Implementation of ASKIN within surgery, medicine and COTE to focus on daily re-assessment, highlighting risk and individual care planning (see below).

✓ Ad hoc update teaching on wards where education needs highlighted

✓ Pressure ulcer prevention teaching on induction for all new starters

✓ Link nurse meetings held monthly with new topics for staff to take back to ward areas.

✓ Twice yearly full study days arranged and open to all ward staff, both well attended with positive feedback and support from senior mangers. Education provided by internal and external speakers.

✓ An increased focus on heel checks with wards continuing a sustained improvement.

✓ Development of an MDT harm free panel which meets weekly to discuss the root cause of all grade 3 and 4 hospital acquired pressure ulcer incidences to discuss learning and required actions.

✓ Piloting outpatient tissue viability service to reduce length of stay and improve patient experience.

Patient safety
Prevention of pressure ulcers which develop in hospital

Aims and goals for 2017/18

1. Continue to reduce all inpatient hospital-acquired pressure ulcers.

2. Review all pressure relieving equipment within Quarter 1 2017/18 to ensure it is both beneficial to patients and cost effective.

   3. Review of Tissue viability service to enhance ward support, staff and patient education.

   4. Re–launch Tissue viability outpatient service to reduce length of stay, waiting times and improve patient experience.

Key challenges

We have not achieved the rate of improvement that we set ourselves for 2016/17, which is disappointing.

By focussing on 'Harm Free' care rather than the separation of Tissue Viability and Falls, we are confident that a re-energised corporate resource, with a clear focus on delivery for harm free care, will help the Trust deliver the standard of care that any of patients should expect to receive.

This is the rationale for the Trust Board deciding that 'Harm Free' care will be the patient safety quality priority for 2017/18, with stretch but achievable targets for the year ahead.

How pressure ulcers are graded
European Pressure Advisory Panel (EPUAP) Classifications

Grade 1
Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

Grade 2
Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.

Grade 3
Full thickness of skin involving damage to, or necrosis of, subcutaneous tissue that may extend down to but not underlying fascia - the skin may be unbroken.

Grade 4
Extensive damage, tissue necrosis or damage to muscle, bone or supporting structures with or without full thickness skin loss.

Chart 5 – Our performance over the last three years: Avoidable pressure ulcers per 1,000 bed days

Avoidable Pressure Ulcers Grades 2 to 4			
	Avoidable incidents	Bed days	Avoidable PUs per 1000 bed days
2014/15	39	207884	0.19
2015/16	24	200493	0.12
2016/17 to Jan 17	34	169432	0.20

NB: the bed day activity is an adaption of the standard KH03 report: it excludes day case, but includes critical care and maternity services where there is overnight bed occupancy so that incidents are reflective of activity.

Patient safety
Learning from incidents, SIRIs and Never Events

Learning from incidents

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

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

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

The percentage of patient safety incidents resulting in severe harm or death is subject to external assurance. The detailed definition for this performance indicator is presented on page 43.

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

✓ An electronic solution to requesting and receiving the reports for diagnostic tests which introduces a system to ensure the report is read by the requesting clinician;

✓ A safer process for the insertion and management of NG Tubes;

✓ Introduction of 'Credit Card' information for the safe use of antibiotics in patients with a known allergy to penicillin for all staff. Red, Green and Amber lists to ensure safe prescribing and administration;

✓ A safer policy and procedure for the management of chest drains within the Trust.

Duty of Candour

Open and honest communication with patients is essential to collaborative working and directly impacts the experience and outcomes for the patient as well as for staff in the delivery of safe care. Healthcare professionals must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

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

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

What are we doing to make improvements:

✓ Face to face and E-Learning training for Incidents, SI's and Duty of Candour;
✓ Root Cause Analysis Training for SI's;
✓ Incident investigation introduced as part of Health & Safety Managers course to target key staff;
✓ Review of process of sharing SI's and lessons learned within the area affected and wider as a Trust;
✓ Revised VTE RCA and process to facilitate learning from possible hospital acquired DVT's or PE's.

Chart 6—Duty of Candour Compliance 2016/17
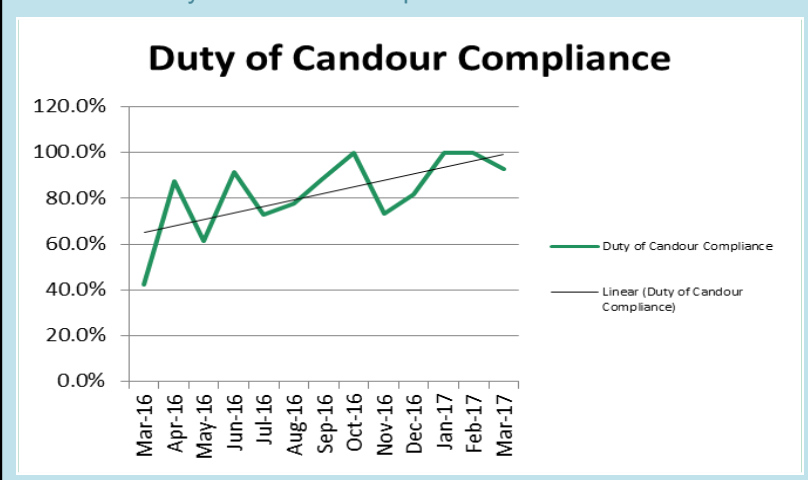
Patient safety
Learning from incidents, Serious Incidents and Never Events

Table 2 – Adverse events and SIRIs reported

For the year 2016/17, there have been the following adverse events (categorised as no harm to severe harm)

	Total
Advice & Information (pt)	174
Anaesthetics Clinical Management	48
Appointments/ Clinics	244
Blood & Blood Products (Transfusion) - Other blood products (old)	57
Cardiac Arrest / Cardiac Call	152
Communication - Electronic e.g. phones (non pt) (old)	814
Delays in Care/ Waiting Times	750
Diagnosis/Treatment - all	852
Environment (non pt)	118
Equipment/ Electrical	479
Slip, Trip, Falls (all)	1099
Gynaecology	11
Healthcare Records/ Xrays/ Scans (documentation) - all	266
Infection related - all	133
Information Security & Confidentiality (all)	194
IT & Clinical Systems (all)	61
Laboratory Specimens	113
Maternity (all)	609
Medication (all)	907
Patient Actions	141
Patient Injuries including Near Misses	426
Privacy & Dignity	49
Radiation (all)	169
Safeguarding - all	1363
Security (all)	375
Sharps (all)	176
Staff Injuries at work & well being (all)	287
Staffing Levels	347
Tissue Viability	1747
Transport	112
Unacceptable Behaviour (staff/ Visitors)	71
Unescorted Patients	28
Venous Access - all	54
Visitors/ Contractors Injuries & Well Being - all	28
Total	**12454**

Patient safety
Learning from incidents, Serious Incidents and Never Events

Table 3—Number of Serious Incidents declared 2016/17

Type of Adverse Event meeting SI criteria	No. of SIs
Alleged/Actual Abuse	1
Confidential Information leak	5
Diagnostic Incident	24
HCA/Infection Control Incidents	1
Hospital acquired (g3) pressure ulcer	10
Maternity/Obstetric Incident: Baby only	1
Maternity/Obstetric Incident: mother and baby	3
Medication Incident	7
Operation/Treatment Without Consent	2
Pending Review	1
Screening Issues	1
Slip/Trip/Falls	17
Sub-optimal care of deteriorating patient	17
Surgical Invasive Procedure Incident	13
Treatment Delay	26
VTE	2
Maternity/Obstetric Incident: mother only	1
Blood Product/Transfusion Incident	1
Specimen Issues	1
	134

Chart 7—60 day Serious Incident investigations compliance

Serious Incident KPIs to Date
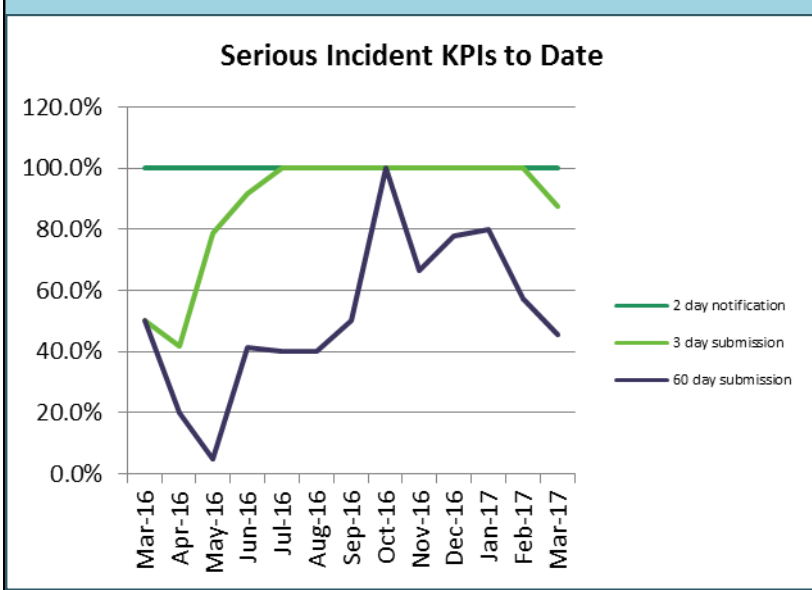
Never Events

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

The list of Never Events for 2016/17 are:

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

There are exclusions to each Never Event category as set by NHS Improvement.

The Trust reported three Never Events occurred in 2016/17:

- Wrong site surgery
- Misplaced naso- or oro-gastric tubes
- Wrong implant/prosthesis.

2014/15	2015/16	2016/17
9	4	3

Sign Up to Safety

Sign Up to Safety is a national patient safety campaign with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. Its ambition is to halve avoidable harm in the NHS over the next three years, and save 6000 lives as a result. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient safety helping to ensure patients get harm free care every time, everywhere.

Organisations who Sign Up to Safety commit to strengthen patient safety by:

- Setting out the actions they will undertake in response to the five Sign up to Safety pledges and agree to publish this on their website for staff, patient and the public to see; and

- Committing to turn these actions into a safety improvement plan which will show how organisations intend to save lives and reduce harm for patients over the next 3 years.

The five Sign up to Safety pledges:

1. **Putting safety first**
   Commit to reduce avoidable harm in the NHS by half and publicise locally developed goals and plans;

2. **Continually learn**
   Make organisations more resilient to risks, by acting on the feedback from patients and staff and constantly measuring and monitoring how safe services are;

3. **Being honest**
   Be transparent with people about progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong;

4. **Collaborating**
   Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use;

5. **Being supportive**
   Helping people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

We intend for the Safety Improvement Plan to be a living document, with the express wish to improve safety for all patients who come into contact with Colchester Hospital University NHS Foundation Trust services. The plan will be reviewed quarterly by the Quality and Patient Safety Committee.
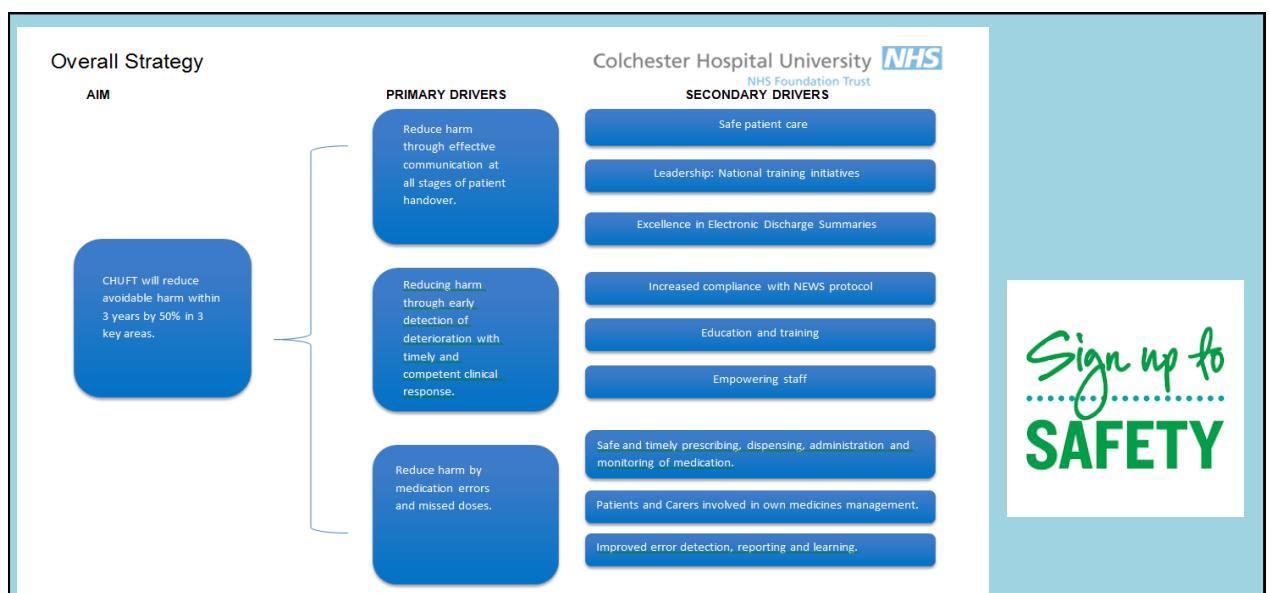
Clinical effectiveness
Stroke care

Specialist stroke care - the impact on recovery

By working together, using new ways of thinking and working, pooling our expertise, experience and learning, the multi-disciplinary team on the Stroke Unit has improved on a number of quality standards and stroke metrics over the last year. The following is a summary of some of our recent achievements.

All the projects outlined in this report have a major impact on our patient's recovery and standards of care provided, many of them are elements of the National Stroke Specific National Audit Program (SSNAP) audit, therefore improvement in these areas resulted in improved SSNAP scores.

Currently the Colchester Stroke Unit holds 9th place in the SSNAP rankings. This national audit aims to improve the quality of stroke services and patient care by reviewing care against set standards. The unit held 1st place nationally in 2014, a decline in some areas of performance was noted in the winters quarters of 2014 –15 and 2015 –16. In response to this the Stroke Unit introduced a SSNAP improvement plan; this has seen a consistent sustainable improvement in 2016-2017 performance across the standards.

Analysis and learning from previous incidents and close working with the Falls Prevention Practitioner have identified a number of themes, enabling us to take practical actions that make a difference to patients.

By embracing the practice of cohorting, actively discussing falls risks at board rounds and daily team briefs, new ways of working have become embedded in day to day activity. This has resulted in an increased awareness of falls prevention and a sustained reduction in the number of falls since September 2016.

The Stroke Unit team are proud that no patients have developed a hospital acquired pressure ulcer of grade 2 and above since April 2016. This is an especially worthy achievement considering the high level of disability and dependency of patients post stroke.

Commitment to regular checking of skin condition, position changes and good communication of patients at risk has led to this achievement.

An on-going programme of multidisciplinary team days are planned and run throughout the year, each team member attends three days per year and there is a strong focus on improving specialist stroke knowledge and skills and completion of stroke specific competencies. The Stroke Competency Toolkit (SCoT) is a set of multidisciplinary competencies that have been locally applied and launched on the unit at the end of 2016 and have replaced the East of England Stroke Competencies that required updating and lacked a multidisciplinary approach.

Development of staff and their commitment to the unit is evident by the number continuing with their education and their desire to remain on the unit when qualified. Six nursing rehabilitation staff have undertaken or are working toward their foundation degree. Two staff progressed to work based learning for their qualification as Registered Nurses (RN) and two nurses have just qualified through this program and are working on the unit as a qualified RNs.

The CHUFT Stroke Unit has developed and produced a bespoke mouth care assessment tool and protocol which has been adopted across the East of England and is supported by the Eastern Academic Health Science Network.

An e-module acts as a learning resource for new starters. Research is embedded within the unit with all Consultants GCP trained and acting as Principal Investigators supported by a dedicated research nurse currently recruiting to 4 interventional studies with 3 more in the pipeline. The team also aims to implement research evidence and national guidelines promptly.

For example implementation of a Very Early Mobilisation programme was facilitated by the therapy team in 2013 and is currently being updated based on new evidence.

A program to implement a standard operating procedure for Intermittent Pneumatic Compression (IPC) for prevention of venous thromboembolism was implemented in 2015. Both projects aimed at preventing stroke complications.

Research evidence shows a strong correlation between adequate hydration and nutrition and optimal recovery from stroke. As a result patients on the Stroke Unit routinely receive oral or enteral nutrition within 24 hours of admission, with nurses, dieticians and speech therapy colleagues working together to achieve this important standard.

An increase in the frequency of auditing the MUST tool with an analysis of themes has allowed us to focus on this issue to ensure that MUST assessment has improved over the past quarter.

The CHUFT Stroke Unit has developed and produced a Stroke Continence Assessment this has recently been developed into a

Clinical effectiveness
Stroke care

Stroke Continence Integrated Care Pathway. Currently 100% of appropriate patients have a continence assessment on admission. The new ICP will provide a structured approach to continue assessment and implementation of a continence plan, ensuring optimum opportunity for patients return to continence following their stroke.

The team have also focused on the environment as this has an impact on delivery and experience of care for patients and their families. A project led by the rehabilitation assistant team has led to refurbishment of the dining room area on the unit. This now gives additional space for patients to socialise with families and also provides another area for group therapy sessions or self-directed therapy to run on most days of the week, enhancing patients rehabilitation.

The unit has successfully implemented 7 day therapy from occupational and physiotherapy. Assessment within 72 hours of admission has consistently met a high average standard over the last 12 months of 2016 -2017, with physiotherapy achieving 97% and occupational therapy 96%. Other Therapy innovations and improvements have been made with the introduction of the electronic Joint Care Plan, Speech and Language Therapy using Apps on an ipads and Improvements in psychology staffing support. A team focus on

meeting the 4 hour admission, direct to stroke unit standard (ASI 2), has seen steady progress within a challenging hospital environment where availability of beds has been at a premium. The unit's performance this winter has improved to 77% in Quarter 4 2016 see Chart 8.

Chart 9 shows the unit's performance to the 90% of stay on the Stroke unit (ASI 3) achieving 88% in quarter 4 of 2016.

Maintaining a higher performance in the 4 hour target and the 90% of stay on the unit has an impact on the quality of stroke care the patient receives and their outcome.

The senior members of the multidisciplinary team are dedicated to maintaining the stroke unit performance, sustained clinical engagement, supervision within the clinical environment, supporting junior and new team members, listening to concerns and creating a positive working environment.

Chart 8 – Our performance over the last three years: % of people admitted to a Stroke Unit within 4 hours

Year	2014	2015	2016			
Quarter			Q1	Q2	Q3	Q4
	64.20	58.20	67.20%	74.40%	70.80%	77.10%

Chart 9 – Our performance over the last three years: % of people treated on a Stroke Unit for >90% of the time

Year	2014	2015	2016			
Quarter			Q1	Q2	Q3	Q4
	81.00	76.00	80.70%	81.60%	75.20%	88.00%
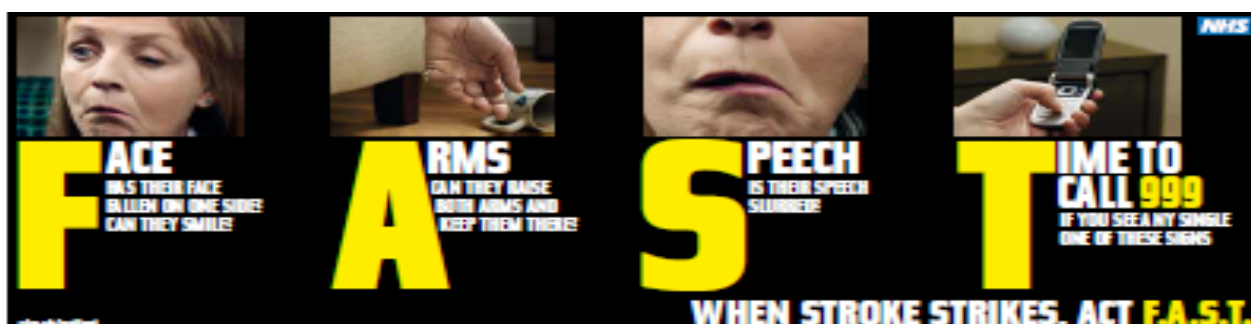
Clinical effectiveness
Emergency care

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

The Emergency Department has faced challenges in achieving the 95% target of patients spending four hours or less from arrival to admission, transfer or discharge. These including sustained pressures on bed capacity, difficulties in establishing complete medical and nursing staff numbers and a 50% vacancy rate for Emergency Assessment Unit Consultants. There have been initiatives taken both locally within Emergency care and also in the wider Trust. These include:

A commitment to long term bookings of both Doctors and Nurses to ensure a higher fill rate.

Every Patient Every Day including The Emergency Department's Super Week during February. This aimed to:

✓ Standardise and embed ED processes so that these are adhered to 24 hours per day

✓ Embed the use of the Escalation and Whole Hospital Response policy and Action Cards

✓ Trial the use of the ED Trigger Tool in conjunction with the Escalation and Whole Hospital Response policy and Action Cards

✓ Monitor breaches, identify breach reasons and hold people/areas to account for these.

Chart 10 – Our performance over the last two years: 4 hours to discharge from Emergency Department**

	Target	2015/16		2016/17	
		CHUFT Perfor-mance	National Average	CHUFT Perfor-mance	National Average
Apr	95.00%	89.6%	89.84%	73.7%	85.0%
May	95.00%	92.7%	91.27%	85.3%	85.4%
Jun	95.00%	85.6%	92.26%	86.2%	85.8%
Jul	95.00%	81.9%	92.52%	87.9%	85.4%
Aug	95.00%	84.5%	91.41%	81.6%	86.4%
Sept	95.00%	77.3%	90.16%	94.4%	86.0%
Oct	95.00%	81.2%	88.57%	85.7%	83.7%
Nov	95.00%	80.9%	87.02%	87.2%	82.7%
Dec	95.00%	80.8%	86.56%	70.6%	79.3%
Jan	95.00%	83.1%	83.03%	76.4%	77.6%
Feb	95.00%	76.66%	81.62%	87.8%	81.2%
Mar	95.00%	71.62%	80.86%	91.8%	-
YTD	**95.00%**	**80.30%**	**87.36%**	**84.1%**	**84.42%**

** Type 1 A&E department = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

Chart 11– Our performance over the last three years: Emergency Department activity

Financial Year	Total number of attendances	4hr Perfor-mance
2014-15	78,878	87.4%
2015-16	82,189	80.3%
2016-17	87,313	84.1%

✓ Throughout 2016/17 the Emergency Department have ensured that shifts are mapped to activity on a daily basis.

Clinical effectiveness
Emergency care

Red to Green

Since the launch of Red to Green in September, we have seen improvements in patient flow, in bed capacity and in performance against the Emergency Department standards.

A Green day is a day when the patient has received an intervention in accordance with their care plan to support their journey through to discharge to meet the identified 'Earliest Discharge Date' (EDD). Therefore a Red day is when the patient 'does not' receive an intervention which was requested or planned, to support their journey through to discharge to meet the identified EDD.

From the time of admission clinicians should be concentrating on getting patients home from Colchester General Hospital as quickly as possible and with the right support.

Once a patient is medically fit, delaying their discharge results in deterioration of mobility and loss of independence. We ask all clinicians to think about what is really needed to support patients.

Sometimes the situation is made worse as medically fit patients end up being delayed and then end up needing more support.

The Trust continues to run these intensive Red to Green weeks in order to embed the processes into our systems. Red to Green aims to break the cycle of repeated escalation measures and end the continuing disruption to normal clinical business, which disadvantages patients.
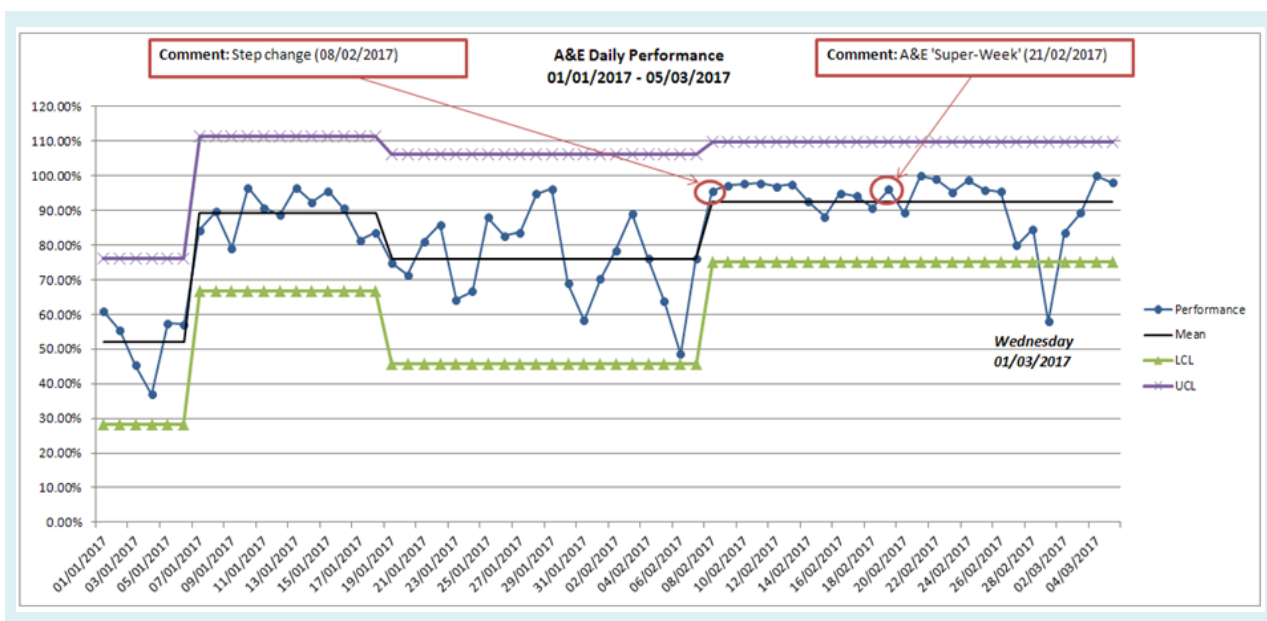
Clinical effectiveness
Summary Hospital-level Mortality Indicator (SHMI)

What is SHMI?

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

Why is SHMI important?

We need to know what our ratio of actual deaths against expected deaths is, in order to assess and measure how good the care and treatment is.

How does SHMI work?

SHMI, like the HSMR, is a ratio of the observed number of deaths to the expected number of deaths. The calculation is the total number of patient admissions to hospital which result in a death either in hospital or within 30 days of discharge. Like all mortality indicators, the SHMI shows whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant.

What is HSMR?

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in-hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

Chart 12 - Mortality: SHMI trend June 2012 – July 2016

For more information about our performance with regard to SHMI, please see the SHMI Core Quality Indicator on page **38**.

SHMI Trend 2012 - 2016
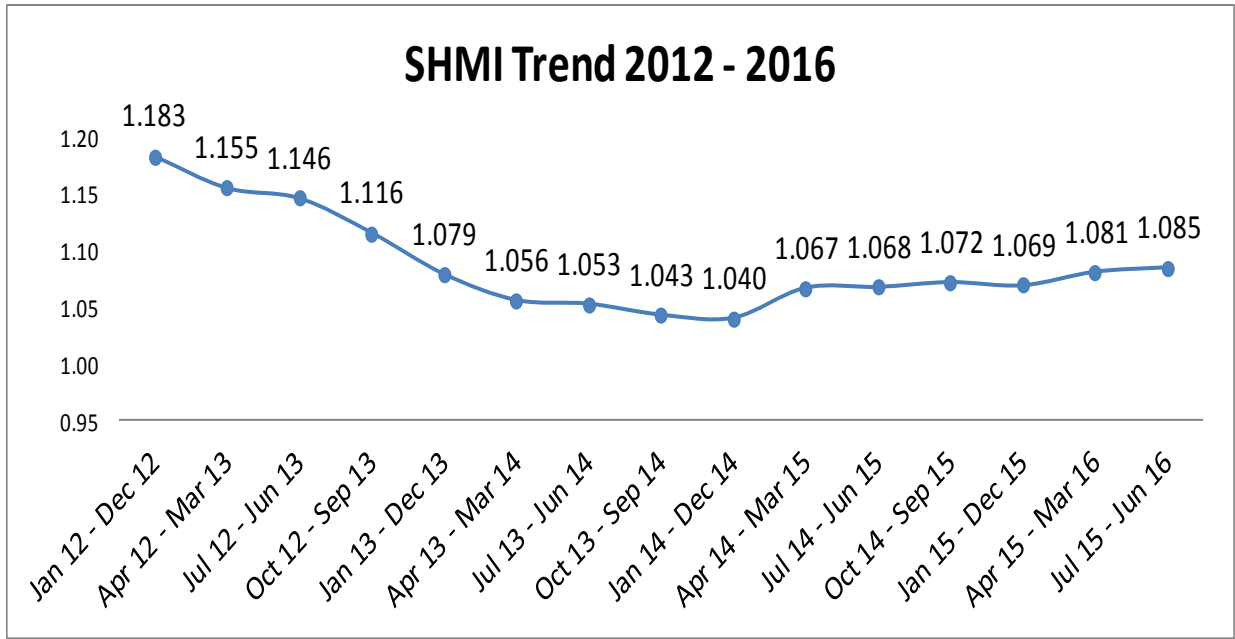
Clinical effectiveness
Summary Hospital-level Mortality Indicator (SHMI)

SHMI for the 12 months to June 2016 was **108.53** (within the 'as expected' range placing the Trust 109/136).

Quarterly trend data indicates that over the last 12 reporting periods, the Trust has been an outlier on 4 occasions.

SHMI alongside HSMR is reviewed at the Mortality Review Group with divisional representation.

Nationally there has been an increased number of deaths in January and February (the latter saw a 12% increase) which will affect both mortality indicators for this fiscal year.

There were 207 deaths in January (20 ED/187 IP) – the highest number of deaths in one month for the last 6 years (January average for the last 5 years was 164). The Trust undertook a full review of the deaths to ensure that care was effectively delivered. The Office for National Statistics has reported significant increases in registered deaths in England and Wales in calendar weeks 2 (+8%) and 3 (+16%) based on an average of the last 5 years.

Table 4 - Results summary for January 2016 - December 2016

In-hospital mortality, for all in-patient admissions to Colchester Hospital University NHS Foundation Trust for the period January to December 2016 has been reviewed. The SHMI is updated and rebased quarterly.

Metric	Result
HSMR	108.2 'higher than expected' range
HSMR position vs. East of England peers	The Trust is 1 of 6 within the peer group of 17 that sit within the 'higher than expected'
HSMR diagnosis groups attracting higher than expected deaths	There are 4 outlying groups attracting significantly higher than expected deaths. COPD and bronchiectasis RR = **144.7** (63 deaths vs. 43.5 expected) – continues to alert Septicaemia (except in labour) RR = **122.4** (125 deaths vs. 102.1 expected) – continues to alert Other lower respiratory disease RR = **165.5** (20 deaths vs. 12.1 expected) – continues to alert Cancer of bronchus, lung RR = **136.8** (48 deaths vs. 35.1 expected)
HSMR Weekday/ Weekend Analysis	There is a difference between weekday and weekend mortality. Weekday HSMR is higher than expected, weekend HSMR is as expected. For one period in the year there was a significant mortality risk if admitted on a Wednesday.
SHMI (April 2015 to March 2016)	108.53 'as expected' (band 2) 7 outlying SHMI groups

Patient experience
Improving the patient and carer experience

Key achievements

We aimed to ensure that we delivered first class care by continuing to demonstrate kindness, compassion, professionalism and skill, together with an ambition to do even better for our patients, relatives and carers.

We strongly believe that care should be delivered in partnership and we will continue to ensure the patient, relative and carer is heard and they are at the heart of everything we do.

Last year saw some innovative schemes to support our patients experience, this included as follows:

Improved Estate and Facilities for our most vulnerable patients

✓ The Estates and Facilities team worked with our clinical teams to really ensure that Colchester Hospital met the needs of the service users to make their stay in hospital as comfortable as possible. For our elderly patients it can be a very scary experience being away from their loved ones or carers, so by working with the experts, they were able to come up with designs that supported exactly what they need.

✓ This has included ensuring that floors are not blue, trying to stay away from carpet or mats at entrances and designing comfortable day rooms with memorabilia. A lot of work also took place with signage to support the patients along with wet room bathrooms and grab rails for their own safety. Better lighting was

facilitated over the beds so that patients could have their lights on at night and would not disturb sleeping patients.

Making care less scary for our paediatric patients

✓ Colourful clown doctors (pictured below) continue to visit the children's ward two to three times a month. They support our young patients stay being more fun, especially when they are on their own. The clown doctors arrive with puppets, balloons, ukuleles and other props to support their fun making experience. Doctors and

nurses can be very busy and this allows the clown doctors to spend some real quality time with our young patients at what can be a very scary time for them and their family.

Improving awareness of key issues for our patients, relatives and carers

✓ The patient experience team have held many awareness days to educate patients, relatives and carers.

✓ Working collaboratively with the Clinical Commissioning Group and Health Forum Committee and Action for Family Carers to raise awareness

"Clown Doctors" preparing to make our paediatric patients smile while delivering care on the ward

Patient experience
Improving the patient and carer experience

of the help that is available to everyone at the hospital and other providers.

✓ It can also educate people to self-care, not to come to A&E unless it is an emergency and offering advice for local GP practices.

Highlighting the importance of Carers in our community (picture attached)

✓ It is so very important to recognise that carers need support too when their loved ones are in hospital.

✓ Colchester Hospital works very closely with Action for Family Carers. Family members can drop into the PALS Office during the week to seek support and guidance on what may be happening to their loved one. The team also visits

wards daily speaking to carers to offer guidance and support. Family Action Carers days are regularly held throughout the hospital to raise awareness and educate not only carers but staff of the role they undertake.

Improving access for our patients with physical disabilities

✓ Mr O'Connell kindly (pictured below) gave up his time for him and his dog to spend some quality time with the Head of Patient Experience and Head of Estates and Facilities, where he educated both of them what we as a hospital, should be considering when opening up new PALS hubs that would allow access for his wheelchair and dog.

✓ We all visited clinic rooms within the Outpatients Department to ensure there was sufficient amount of room for his wheelchair and dog to be able to manoeuvre appropriately to ensure the least amount of stress when attending for hospital appointments.

Comments from patients

'The care and treatment he received was above and beyond all expectations. The A&E department was exceptionally busy, however we was extremely well looked after'

'The NHS comes in for a lot of stick in the media but I felt I must advise that my treatment was first class yesterday. Many thanks'

'The staff worked to the highest level, administrating the upmost care and support. Thank you to all involved in my sons care'

Our Action for Family Carers team available to support our patients, their carers and families

Mr O'Connell and his working Labrador meeting our Head of Facilities to improve services for our patient with disabilities

Patient experience
Caring for people with dementia

Why was this a priority?

Each year the number of people living with dementia is growing and this number is expected to double during the next 30 years. It is estimated that over 40% of people aged over 65 in general hospitals have a dementia diagnosis or a cognitive impairment. Being in an unfamiliar environment such as a hospital can be very frightening and distressing and can reduce the person's level of independence. Creating Patient dementia friendly wards to reduce the anxiety of patients with dementia was identified as a key priority through the PLACE programme (detail found on page **69**) in the ward refurbishment plans at CHUFT. It is well known that reducing distress in patients can reduce length of stay, falls and other potential complications associated with admission to hospital.

What was our target?

As part of the Trust's continued refurbishment plans a further four in patient wards have been fully refurbished; two care of the elderly and two medical wards. Plans are

underway to complete refurbishment of wheelchair services and Gainsborough outpatients department.

What did we do to improve our performance?

The Dementia care nurse specialists have been instrumental in advising the estates and facilities department regarding the creation of dementia friendly environments using evidence based practice. The Dementia care nurse specialists are members of the Trusts refurbishment work stream and ensure that key areas of creating environments such as flooring, lighting, signage and quiet spaces are now incorporated into the ward and department plans as standard.

We have continued to expand our distraction therapy initiatives across wards and departments at CHUFT. In addition to the very successful pet therapy the Trust has introduced sensory bands across all wards and departments and an electronic distraction unit within orthopaedics to enable photographs, films and music

personal to the patient can be viewed.

We have implemented the All about me document to enable carers and patients to inform staff about the person living with dementia.

We have initiated Dementia champions within all ward areas who receive additional training to support patients, carers and their colleagues in improving patient experience.

The Trust's thanks go to our charity CoHoC who have supported many interventions in improving the experience for patients with dementia.

How did we measure and monitor our performance? / How and where was progress reported?

Feedback from staff, patients and carers is reviewed and reported through the Dementia Management group which meets quarterly and shared at the patient experience group. The feedback helps to further improve environments within the hospital.

Patient experience
Measuring and reporting the patient experience

Care Quality Commission National Patient Surveys

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

Each Trust also receives a rating of 'Above', 'Average' or 'Below'.

- Above (Better): the Trust is better for that particular question than most other trusts that took part in the survey.

- Average (About the same): the trust is performing about the same for that particular question as most other trusts that took part in the survey.

- Below (Worse): the trust did not perform as well for that particular question as most other trusts that took part in the survey.

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

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

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

National Inpatient Survey

The Inpatient Survey was carried out by Picker on behalf of Colchester Hospital. The survey is part of a series of annual surveys required by the Care Quality Commission for all NHS Acute trusts in England. The survey was based on a sample of discharged patients who attended the Trust in July 2016. The purpose of the survey is to understand what patients think of healthcare services provided by Colchester Hospital. A total of 1250 patients was sent a questionnaire, 1144 were eligible for the survey of which 523 returned a completed questionnaire giving the Trust a response rate of **46%** . The Trust was **about the same** in all categories.

The survey highlighted many positive aspects of the patient experience:

- ✓ 85% rated care 7+ out of 10
- ✓ 81% was treated with dignity and respect
- ✓ 79% had confidence and trust in Doctors
- ✓ 99% thought the room or ward was fairly clean
- ✓ 96% thought toilets and bathrooms was fairly clean
- ✓ 90% thought there was always enough privacy when being examined or treated.

Table 5 – Based on patients' responses to the National Inpatient Survey, this is how Colchester Hospital

	Score	Rating
The Emergency/A&E Department (answered by emergency patients only)	8.3/10	ABOUT THE SAME
Waiting lists and planned admissions (answered by patients referred to hospital)	8.5/10	ABOUT THE SAME
Waiting to get a bed on a ward	7.6/10	ABOUT THE SAME
The hospital and ward	8.0/10	ABOUT THE SAME
Doctors	8.3/10	ABOUT THE SAME
Nurses	8.1/10	ABOUT THE SAME
Care and treatment	7.6/10	ABOUT THE SAME
Operations and procedures (answered by patients who had an operation or procedure)	8.5/10	ABOUT THE SAME
Leaving hospital	6.8/10	ABOUT THE SAME
Overall views of care and services	5.7/10	ABOUT THE SAME
Overall experience	7.8/10	ABOUT THE SAME

Patient experience
Measuring and reporting the patient experience

Friends and Families Test (FFT)
.

Inpatients FFT

Response rates have met the 30% level throughout the year. There is an expectation to keep levels at 30% in accordance with our general contract obligations.

The 'recommender rate' has been consistently above 97%.

Emergency Department FFT

There is an expectation to keep levels at 20% in accordance with our general contract obligations. This has mostly been achieved except for 2 months at 19.5% and

19.8% respectively.

'Recommender rates' fluctuate within a ~5% range.

Outpatients FFT

'Recommender rates' have been consistency excellent above 96.9%. There is no national target for response rates.

Maternity FFT - antenatal, birth ward, post birth ward and post birth community

The FFT question is asked at four 'contact points' along the mother's maternity journey - antenatal,

birth, postnatal ward and postnatal community.

The Trust scores are on a par with the national FFT % recommending scores for each.

Antenatel recommendations have remained at 100% this year. Birth recommendations varied between 95-100%.

Postnatal ward rates are not consistent due to the variability in response ratesfrom 69 to 149 a month.

Table 6—Friends and Family Test performance year to date

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient FFT return %	31.4%	45.4%	43%	47.3%	41.2%	41.3%	41.4%	37.8%	30.6%	35.8%	33.2%	Data not validated at time of publication
Inpatient recommenders %	98.1%	97.3%	98.1%	97.6%	97.6%	98.3%	97.6%	97.8%	97.5%	98.2%	98.1%	
ED FFT return %	22.7%	20.4%	19.5%	20.1%	20.5%	21.5%	23%	22.8%	19.8%	21.7%	20.8%	
ED recommenders %	84.2%	87.2%	88.5%	86%	87.7%	89.9%	88.4%	89.5%	87.3%	89.6%	88.4%	
Outpatient FFT return %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Outpatient recommenders%	97.7%	96.9%	99.1%	98.6%	99.6%	99.7%	97.1%	98.6%	99.6%	96.9%	97%	
Maternity FFT return %	40.6%	34%	37.6%	41.6%	38.8%	30%	35.4%	30%	35.3%	28.4%	34.5%	
Antenatal return %	Not Reported by Unify											Data not validated
Antenatal recommenders %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Birth return %	14%	11%	10.8%	8.7%	15.2%	11.7%	13.4%	16.7%	14.5%	12.4%	21.7%	
Trust-wide Birth recommenders %	97%	100%	100%	100%	95%	97%	100%	98%	100%	100%	100%	
Postnatal ward %	Not Reported by Unify											
Trust-wide Postnatal ward recommenders %	94%	90%	93%	87%	91%	93%	100%	85%	95%	97%	87%	
Postnatal community %	Not Reported by Unify											
Trust-wide Postnatal community recommenders %	100%	100%	0 Returns	100%	0 Returns	100%	100%	100%	0 Returns	100%	100%	

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

Community Engagement — Tendring Show

Every July since 2010, our Trust brings together 25+ stands and 100+ staff in a 100ft marquee to show people at the Tendring Show that the future of their health is in their hands. Over 25,000 people from across Essex and Suffolk – the Trust's catchment area for public members – came to the county's premier agricultural event. Thousands of people venture into the 100ft NHS marquee and many positive comments are made about the Trust.

Last summer, our 100ft NHS marquee won "best of breed" for the sixth time in a row! The NHS won the "Most Informative & Educational Trade-Stand" for, as the judge commented, "*its innovative stands and for its interactivity with the public*".

There were 27 stands in 2016 and more than 100 staff from CHUFT and other organisations in the marquee. Visitors could find out about a wide range of health issues from Stroke Awareness to diabetes, as well as about advances in health treatments and more. Eleven stands were new for 2016. Highlights included:

- ✓ 27ft long walk-through inflatable colon highlighting bowel cancer screening
- ✓ Midwives and their birthing pool
- ✓ Free fruit (from ACE)
- ✓ Health check corner (from ACE)
- ✓ Recruitment stand for Colchester Proud
- ✓ Emergency ambulance first responders
- ✓ Fun competitions
- ✓ An Occupational Therapy zone
- ✓ The League of Friends kindly supplied free tea and coffee to staff and visitors.

Mobile Chemotherapy Unit 'Maureen' launched in Colchester

Cancer charity Hope for Tomorrow has provided Colchester Hospital University NHS Foundation Trust with a state-of-the-art Mobile Chemotherapy Unit (MCU), named 'Maureen' after Maureen Dore, a Colchester nurse and long-term supporter of the charity. On Tuesday, 19th July 2016, in a special ceremony at Colchester General Hospital, Maureen's sister, Liz Burton, cut the ribbon at the official launch of the MCU. Christine Mills, MBE, Founder and Trustee of Hope for Tomorrow, said: "I'm delighted to name this MCU after Maureen Dore. She was a wonderful supporter of the charity."

The East Essex MCU is the eleventh Unit to be put into operation. The Unit visits Tiptree, Clacton, Halstead and Stanway, with further locations to be added. 10 to 15 patients a day benefit from the new mobile service.

The CHUFT health stand at the Tendring Show in summer 2016.

CHUFT staff demonstrating how the human body works to young and old in the community

Liz Burton, opening the MCU 'Maureen' to help deliver services to patients in out local community

Patient experience
Learning from complaints

What are complaints?

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

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

Complaints Service

Complaints are taken extremely seriously as they are a tool to identify when we have let our patients and their families down. Each and every complaint is used as an opportunity to improve the services that we offer and enable us to achieve our goal of being the most caring healthcare provider. Every complaint is treated with respect, dignity and every complainant is treated as an individual. Complaints are never held on the patients' medical notes and will never harm or prejudice the care provided to them. Complaints are welcomed into Colchester Hospital to ensure that we continue on our journey of improvement.

How complaints are managed within the hospital

Every complaint should be responded to within 28 working days from receipt. The complainant is kept abreast of the progress of their complaint to ensure they are involved and understand the process.

The Trust has been aiming to ensure that a senior manager within the appropriate service area contacts the complainant with 24 Hours to talk through their complaint, gain clarity on the concerns raised, apologise in the first instance and offer any support or guidance that may be required. This then aids the service area to gain an understanding of the key issues to be investigated, to ensure a more meaningful and thorough investigation and response.

Reopened complaints

During the reporting period 36 complaints were reopened. The main reasons identified for complaints being reopened are poor investigation, responses that do not address all the concerns raised and responses that do not address the concerns raised with empathy or evidence of understanding the patient's experience.

Complaints to the Parliamentary and Health Service Ombudsman (PHSO) handling process.

During the reporting period 11 cases were referred to the PHSO, these remain under investigation.

What are we doing to make improvements to complaints handling?

To give Trust staff a greater understanding of the complaints handling process a series of Complaint Training Workshops

Complaints are categorised in three ways, depending on their severity:

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

Patient experience
Learning from complaints

are being provided by the Complaint Service Manager. This training is linked to the Trust's Licence to Lead programme and in addition to explaining the complaints process, the workshop explores what can cause patients to complain, how the Trust strives to learn from complaints and the Trust's expectations of how to write a letter of response.

An effective escalation process has been implemented to ensure that Lead Investigators discuss complaint investigations with a member of the Executive Team in cases where a first extension to the agreed timeframes is likely to be breached.

Learning from complaints

It has been identified that there needs to be Trust wide improvement in identifying and reporting on lessons learned and actions taken from complaints.

Through the new divisional accountability and performance framework we expect to be able to see clear evidence of learning from complaints and this is very ad hoc at present. With this in mind the Complaints Service Manager is working closely with the complaints team and colleagues across the Trust to ensure measures are put in place to improve performance in this area.

Some examples of lessons learned and actions taken following complaints:

Concern – *Failure to have a biopsy performed in the appropriate timeframe*

Action – *Fault in the newly installed electronic radiology system rectified*

Concern - *Staff in the General Office and Welcome Desk caused offence when trying to advise a patient*

Action – *Staff training has been reviewed to ensure that staff have a better understanding of how to manage difficult situations without causing offence*

Concern – *Staff failed to give their nursing PIN when asked*

Action – *Staff have been reminded that they should provide their PIN number if requested*

Concern – *Poor communication between Theatres, ECC and the TWOC clinic*

Action – *Case discussed at the audit meeting and within the teams to ensure better communication.*

Chart 13 – Our performance over the last three years:

Complaints 3 Day Acknowledgement Target of 100% Achieved - Monthly - 2014 - 2017

Legend:
- 2014 - 2015
- 2015 - 2016
- 2016 - 2017
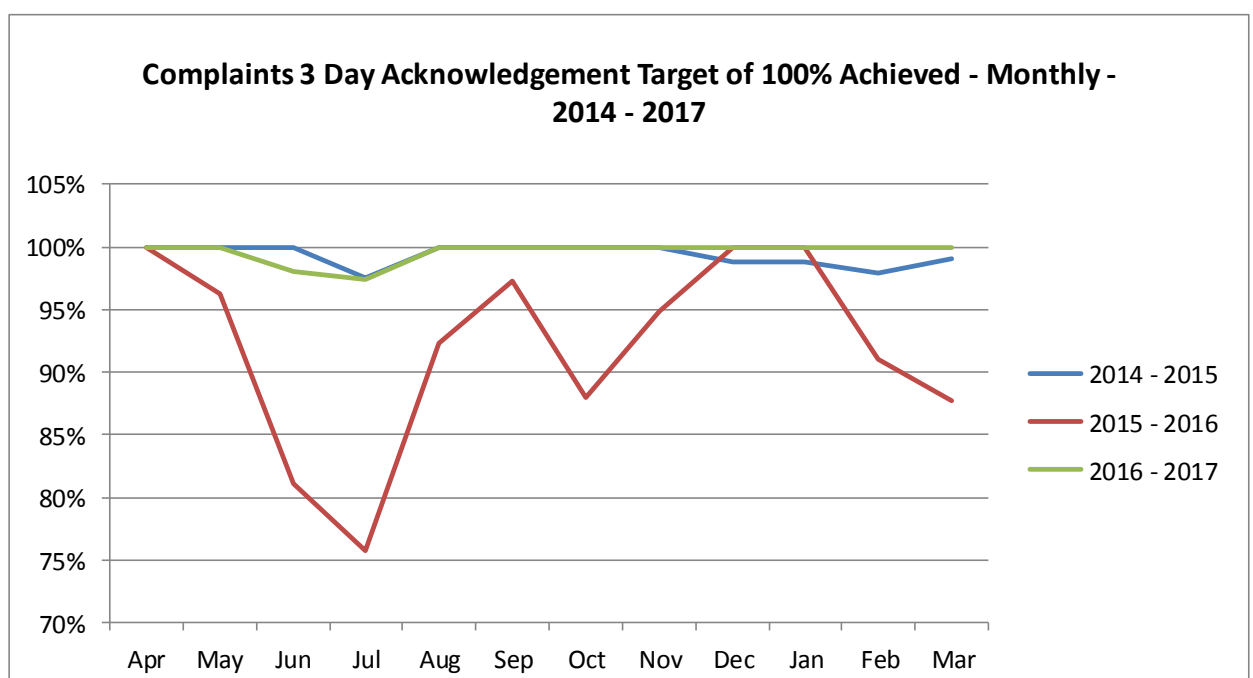
Patient experience
Learning from complaints/PALS

Top three subjects of complaints		
2014/15	**2015/16**	**2016/17**
Treatment Plan	Attitude	Attitude
Attitude	Treatment Plan	Treatment Plan
Booking Clinical Service	Clinical Communication & Co-ordination	Discharge

PALS (Patient Advice and Liaison Service)

The PALS team handle enquiries and concerns in a practical way, resolving and addressing issues at source to avoid matters escalating. This is seen as a really positive step towards taking more responsibility for issues as they arise. In line with National guidance PALS address non-complex concerns aiming to resolve problems quickly thus improving patient experience and avoiding the need to raise a complaint.

Following a review of the PALS service PALS have been graded and logged as either PALS 1 or PALS 2.

PALS 1 contacts relate to matters that require the team to provide straightforward information or signposting.

PALS 2 contacts relate matters that are non-complex but do need to be resolved or addressed.

Typical matters raised with PALS include:-

♦ Problems booking Clinical Services
♦ Enquiries about treatment plans
♦ Patients chasing test results
♦ Problems with access to Clinical Services
♦ Ward related concerns.

Some examples of matters raised with PALS and actions taken as a result:-

✓ Concern raised by a patient and his daughter as they were concerned about side effects the patient was having following various treatments and medications for his bladder and prostate cancer.

✓ PALS liaised with the Urology nurse who then spoke with the patient and his family to address their concerns.

✓ Concerns raised by a patient on the ward as she had not been seen by a doctor or a Neurologist.

✓ PALS liaised with ward staff to ensure the appropriate doctors reviewed the patient.

Never Complaints

As part of the Every Patient Every Day Programme the Trust launched the concept of "Never Complaints".

A Never Complaint is a complaint for which the Trust has decided to adopt a 'zero tolerance' approach, by focusing on issues which are within its control, and which is believed can be completely eliminated.

The Trust has defined a Never Complaint as one which relates to either:

⇒ unacceptable staff behaviour in the form of verbal aggression,

⇒ an active disregard of compassion to patients and their relatives, or

⇒ a situation where a patient's privacy or dignity has been neglected

Never Complaints will be reported and managed in the same way as Never Events, and the process has been outlined in an update to the Complaints Policy and Procedure.

The ability to completely eliminate this type of complaint lies with each and every member of staff; the way staff conduct themselves has a huge impact on the people they meet and care for. Learning opportunities associated with Never Complaints will be hosted so staff can work more closely with patients and their families, allowing everyone the opportunity to learn and improve the way they work, making sure that every patient receives the best possible experience. Everyone at the Trust can make every patient contact count. It's up to us to be the change we want to see and deliver the care we would expect to receive.

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

Patient-Led Assessment of the Care Environment (PLACE) is a self-assessment of a range of assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent/private healthcare sector in England.

The self-assessments are carried out voluntarily and were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments which ran from 2000- 2012 inclusive.

Through focusing on the non-clinical areas which matter to patients, their families and carers, the PLACE programme considers:

- how clean the environment is;
- what the condition of the environment is – both inside and outside the hospital;
- how well the buildings meet the needs of the people who use it;
- the quality and availability of food and drinks;
- how well the environment protects people's privacy and dignity;
- whether the hospital buildings are equipped to meet the needs of dementia sufferers;
- whether the hospital is able to meet the needs of people with disabilities. (New in 2016).

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

The programme encourages the involvement of patients, the public and other stakeholders with an interest in Healthcare. Consequently the Patient Assessors who assisted with the 2016 annual PLACE inspection consisted of people from all walks of life with an interest in Colchester hospital and the Healthcare it provides.

The role of the patient assessor

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

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

The assessment teams must always consist of at least 50% Patient assessors and at Colchester the teams are usually made up of two or three patients assessors, a member of the Facilities Team such as the Patient Environment manager, and a Matron or Infection Control nurse. Teams are always accompanied by a 'scribe' who records observations and scores throughout the day.

Anyone who takes part in the assessments is offered training on an annual basis.

Scope of the assessment

A minimum of 25% of wards (or ten, whichever is the greater) and a similar number of non-ward areas must be assessed. Each area assessed must be: sufficient to allow the PLACE team to make informed judgements about those parts of the hospital it does not visit;

- where possible, focus on areas of the hospital not included in recent PLACE assessments so that over a period of time all areas will be assessed;
- include all buildings of different ages and conditions; and
- include departments/wards where a high proportion of patients have dementia or delirium.

Each team makes the final decision on which patient areas they will inspect, but they must ensure that the wards and areas chosen are reflective of the range of services and buildings across the hospital.

Scoring

Scores are based on what is observed at the time of the assessment. It is made clear to assessors that they must score the hospital on how it delivers against the defined criteria and guidance.

To achieve a pass, all aspects of all items must meet the definition/guidance as set out in the assessment criteria. When the definition criteria are not met, the score will either be a fail or a qualified pass.

A qualified pass is awarded when the criteria are generally met, but there may be a minor exception, i.e. the walls on a ward are mostly in a good state of repair, but one wall may not be up to the required standard. This is detailed and a qualified pass is awarded/scored.

Assessment teams therefore need to be able to exercise judgement, and will discuss and agree which score to apply.

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

Food audits

Teams must base their scoring on what is observed and said rather than rely on assertions of what usually happens. Assessors must:

- undertake the assessment on the ward, from the same food as provided to patients;
- if possible, assess both the lunchtime and evening meal services to obtain a rounded view and to improve the accuracy of the assessment;
- taste all food on offer to patients;
- taste food at the end of patient meal service to ensure that temperatures have been maintained at an acceptable level for the last patient to be served;
- watch how food is served to check for the care taken in presentation; and
- observe how staff are involved in the meal service and how they provide help for those patients who require it.

The assessments

Trusts are given six weeks' notice by the Health and Social Care Information Centre (HSCIC) of the specified timeframe during which the PLACE assessment must occur.

At Colchester, the assessments took place over a week and at different time of the day. This was to ensure that as many assessors who were available had an opportunity to take part in the assessment process, that assessors were able to observe breakfast, lunch and supper service, and finally to ensure that assessors did not have to spend overly long days at the hospital.

PLACE recognises that hospital buildings vary in age and design; which may impact on their ability to meet the criteria. However, it is important that the assessment is based on standard criteria and no allowances are made for such factors.

The scores awarded reflect what was seen on the day.

The assessments take place annually, and results are reported publicly by the Health and Social Care Information Centre (HSCIC) to drive improvement. Due to changes in methodology, comparison between 2015, 2014 and 2013 is difficult.

The PLACE process requires organisations to respond formally to their assessments and develop plans for improvement.

Areas assessed in 2016

The following areas were assessed in 2016:

Wards:

Layer Marney	Birch
Great Tey	Lexden
Peldon	Copford
Langham	Wivenhoe
Children's	Dedham
Mersea	Aldham

Outpatient Clinics:

Haematology	Ante-Natal
X-Ray	CDU
Main Outpatients	SAU
Hydrotherapy	

Food audits were conducted on:

- Children's Ward
- Mersea Ward
- Peldon Ward
- Layer Marney Ward.

General areas (these must be assessed every year):

- Emergency Department
- Communal areas inside the hospital building
- External grounds
- Main Reception.

Next steps

Trusts are required to formally respond to the findings of a PLACE assessment and develop an action plan for improvement.

The action plan is monitored through the PLACE Steering Group. This is a group which meets quarterly and which is attended by the Patient assessors who take part in the inspection process.

The Director of Estates & Facilities reports to the Trust Board on the findings from the Place assessments. The report also includes information relating to not only how well the Trust performed, but also considers the information against scores from previous years, the national average and performance against other local Trusts.

What are we doing to make improvements?

- Improving bathrooms on some wards
- providing day rooms/social spaces on wards
- improving how dementia friendly our wards are
- improving the availability of finger foods for specific groups of patients
- agreeing a standard specification for various items of furniture on wards and departments
- improve signage and wayfinding around the site.

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

Chart 14 – CHUFT Site PLACE scores, 2015/16 and comparators

PLACE CRITERIA	National Average	Colchester General 2016	Colchester General 2015
Cleanliness	98.10%	99.43%	99.13%
Food and Hydration	88.20%	88.82%	90.61%
Privacy, Dignity and Wellbeing	84.20%	89.16%	89.33%
Condition, Appearance & Maintenance	93.40%	93.80%	93.00%
Dementia	75.30%	68.53%	66.09%
Disability	78.80%	71.58%	

Organisational Name	Cleanliness	Food and Hydration	Privacy, Dignity and Well-	Condition, Appearance & Mainte-	Dementia	Disability
Colchester Hospital University NHS Foundation Trust	99.43%	88.82%	89.16%	93.80%	68.53%	71.58%
Southend University Hospital NHS Foundation Trust	95.60%	89.33%	87.60%	86.46%	72.60%	82.28%
Mid Essex Hospital	99.48%	88.80%	88.80%	93.58%	69.33%	74.83%
Basildon & Thurrock University Hospitals NHS Foundation Trust	99.94%	92.57%	91.44%	99.59%	93.68%	94.35%
Ipswich Hospital NHS Trust	96.18%	79.39%	77.90%	85.27%	58.26%	59.61%
Norfolk & Norwich University Hospitals NHS Foundation Trust	99.39%	85.33%	90.23%	92.94%	82.55%	78.91%
Cambridge University Hospitals NHS Foundation Trust	98.33%	78.56%	87.11%	92.98%	81.25%	84.16%

Cancer Care Delivery
Improving performance

Cancer 62 Day Waits for first treatment (from urgent GP referral)

Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)

Chart 15—Cancer performance to date
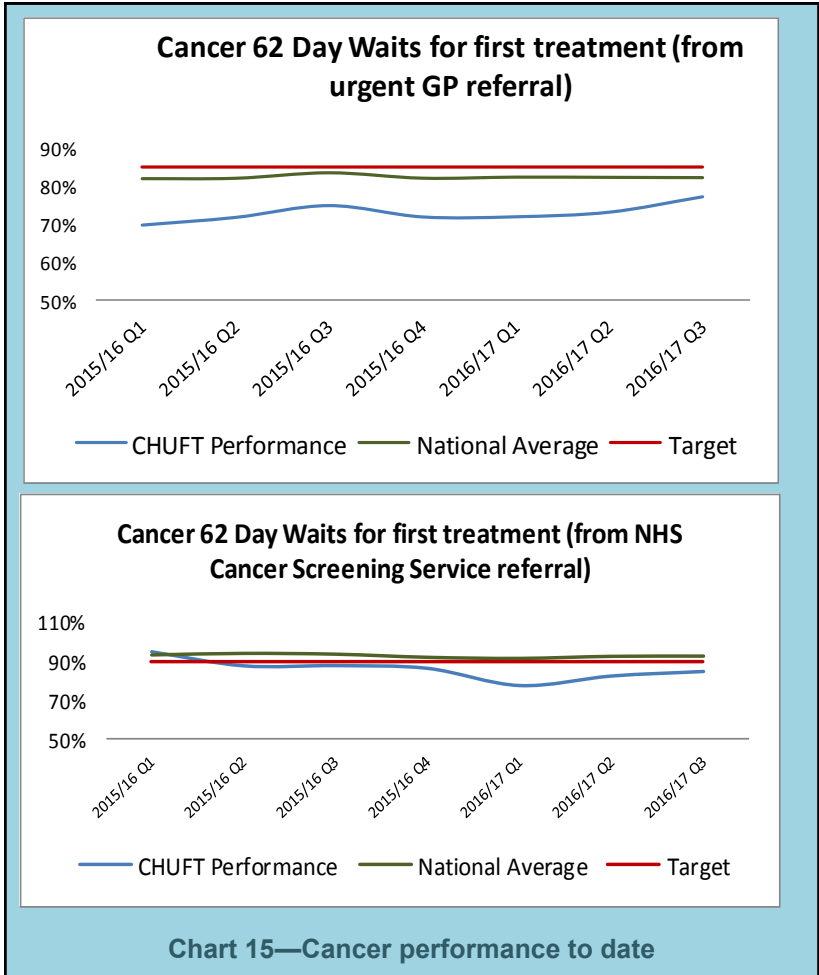
Ensuring that patients with either a suspected cancer are diagnosed quickly and receive effective treatment is a key priority for all staff at Colchester Hospital.

Cancer performance is managed by a weekly cancer Red to Green meeting every Tuesday where Cancer management meet with all services to go through issues and blocks within their PTLs and discuss escalations, where required.

This is followed later in the week by a Cancer PTL meeting every Thursday chaired by the Director of Operations, where long waiters, overall performance and cancer TSSG Remedial Action Plans (RAP) discussed. Each RAP has been agreed and signed up to by the Service lead, the head of division and the clinical lead for that service is terms of trajectory and outcomes. These RAPs have been shared directly with NHSI.

In addition to this, the Root Cause Analysis process has been agreed for both 62 and 104 day delays.

104 day waiting numbers are reducing significantly and the Trust has a Standard Operating Procedure (SOP) in place which each specialty is working to. Weekly 104 day breach panel meetings are in place (the full report of which goes directly to NHS Improvement). The panels also ascertain whether any clinical harm has come to the patient (if known) and whether the delay was avoidable or non-avoidable. All patients that have breached 104 days are presented to the panel regardless of whether they are a confirmed cancer or not.

A 62 day breach panel is in place monthly. These are for all patients with a confirmed cancer that have been treated within the previous month. Clinical harm is established and whether the breach was avoidable or non-avoidable. There is a separate SOP in place for these panels.

There is also the cancer RAP and every specialty has signed up (lead clinician as well as service lead and divisional director) to deliver the 62 day standard. Some specialties are already achieving but work continues for a Trust-wide consistent improvement. Some specialties The RAPS contain actions and trajectories for all specialties and each service presents its update at the weekly Cancer PTL meeting.

In addition, there is also the weekly Cancer Red to Green meeting and the Every Patient Every Day cancer work stream.

Cancer Care Delivery
Cancer Patient's Experience

The Healthwatch Essex (2014) document entitled 'Cancer Services in Colchester: A Study of Patient and Carer Experience highlighted the importance of listening to patient stories and utilising them to identify areas in which may need changing or improving.

The Trust was successful in becoming a pilot site to embed the MacMillan Values Based Standards (VBS) project. This is a project where by clinical areas work together with their patients/carers to improve cancer patient experience. This is now underway on Tiptree and Layer Marney Wards. An observational study was undertaken by a Macmillan Volunteer and has successfully fed back the findings to the ward teams including Heads of Nursing.

As a result of this feedback the wards expressed a wish to have 'ward companions' to be an integral part of the team whereby we have recruited 10 volunteers to undertake this role.

The volunteers on Tiptree Ward are now in place with final preparation for the latter ward. There is a meeting with Macmillan and our Director of Nursing in April to discuss the progress of this project and we are looking at another 2 areas to roll out to for 2017 which will focus on our oncology areas.

The Trust that we have been successful in embarking on a Macmillan electronic holistic needs assessment (eHNA) as a pilot site whereby we will be testing tablet devices for patients to undertake a concerns check list. This should assist in empowering patients to highlight their concerns prior to their consultant with a healthcare professional with a care plan generated dependent on their needs. The project has had some unexpected delays but we are now in a position to purchase the electronic equipment. Nationally we have contributed to some major design changes in the Somerset Cancer Register which will assist in Cancer and Palliative Care teams to undertake a robust HNA and record where the patient is being tracked within the Trust.

Macmillan Information Manager and Head of Cancer Nursing undertook a post diagnosis pre-treatment pilot session for new patients and carers last year and are pleased to report the first session was held in January 2017. We are now looking to combine all tumour sites to avoid repetition and provide a place where people with similar experiences can network which has been positively reported in the evaluations.

The Trusts cancer user group underwent a recruitment drive and has welcomed new members they have received informative talks about cancer patient pathways and will be reviewing all patient information for cancer to provide recommendations to improve written information of services to patients.

We are awaiting the 2016 results of the National Cancer Patient survey due for release later this year and continue to monitor the progress on the actions from last year's results these are namely access to a Holistic Needs Assessment which has been discussed earlier in the report and also access to Benefits. We are working with the local Macmillan benefits service to set up in reach support in the Trust from April 2017 so that people affected by cancer can have direct access to specialist benefits support.

The Trust under took an End of Life Care 'In your shoes event' in April 2016 where people were invited to attend if they have either complimented end of life care at the hospital or we have received a complaint.

Referral to Treatment Times (RTT)
Improving performance

Chart 16—the percentage of patients waiting under 18 weeks on Incomplete Pathway

% of patients currently waiting under 18 weeks on Incomplete Pathway
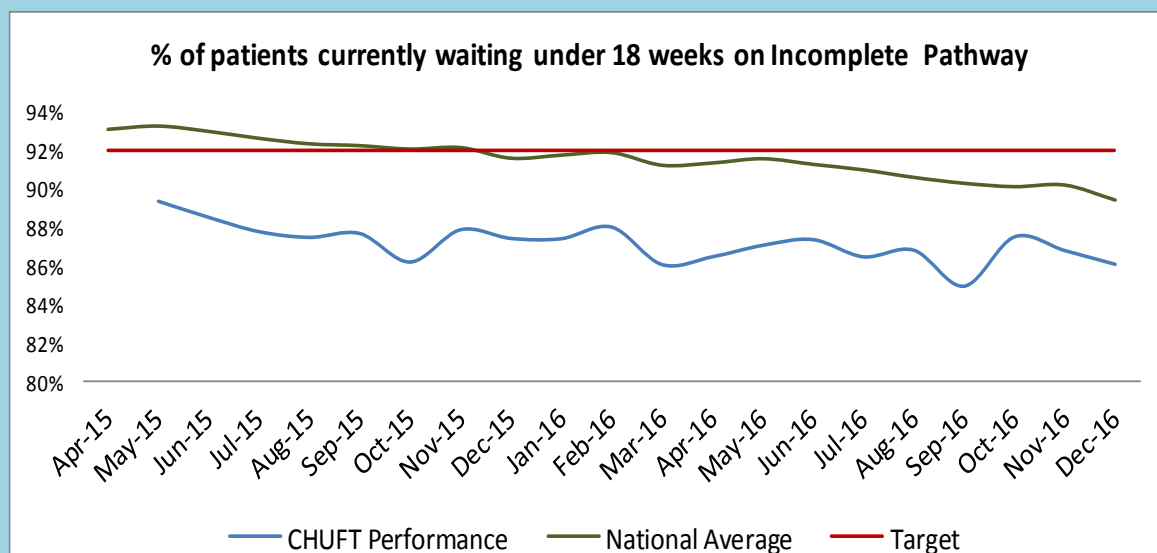
% of patients currently waiting under 18 weeks on Incomplete Pathway	Target	2015/16		2016/17	
		CHUFT Performance	National Average	CHUFT Performance	National Average
April	92%	*	93.09%	86.45%	91.34%
May	92%	89.35%	93.26%	87.05%	91.56%
June	92%	88.51%	92.98%	87.35%	91.27%
July	92%	87.76%	92.62%	94.75%	97.75%
August	92%	87.47%	92.33%	94.73%	97.47%
September	92%	87.67%	92.24%	95.04%	97.05%
October	92%	86.18%	92.06%	93.62%	98.34%
November	92%	87.86%	92.14%	95.36%	96.62%
December	92%	87.41%	91.59%	95.44%	95.96%
January	92%	87.40%	91.75%	86.2%	89.7%
February	92%	88.00%	91.88%	86.3%	89.7%
March	92%	86.05%	91.22%	Not available	Not Available
End of Year position	**92%**	**87.75%**	**92.40%**	**86.59%**	**90.63%**

*CHUFT did not submit RTT data between December 2014 and April 2015

Referral to Treatment Times (RTT)
Improving performance

Colchester Hospital University NHS Foundation Trust is focussed on improving access and reducing waiting times for patients referred for elective treatment, reducing the amount of time patients are waiting to be seen – either for their outpatient appointments or for their procedures.

By targeting support to these areas during October 2016 the Trust started to see marked improvements, most notably an improvement in national referral to treatment waiting times standard with an additional 700 patients seen within 18 weeks of referral. Crucially 10 more specialties met national waiting times standard in October compared with September 2016.

Similarly in November, the Trust reduced the number of unfilled sessions in theatres thereby providing 16 additional theatres session compared with September, largely driven by embedding a clear theatres management process working closely with selected specialities via theatre rota and referral to treatment time (RTT) meetings to book to available capacity.

A set of process observations were undertaken for inpatient and outpatient CT scanner usage to identify process issues and key areas for improvement, which subsequently led to a plan for improved process management. out RTT 'deep dives' were undertaken in four of the lowest performing RTT specialties and work continues with clinical and operational colleagues from these areas to agree and implement performance-improving actions.

In addition, the Trust continues to train staff to ensure everyone understands the access policy, the national RTT rules and the implementation of both. To this end we created an internal 'RTT validation assessment' to provide a clear understanding of our strengths and to direct where our teams need more support. We have also put in an interim patient pathway validation support for key under-performing specialties to cleanse booking lists and thereby maintain their accuracy going forward.

We have refreshed the tools and processes we are using to manage our waiting lists to ensure we are booking in order and according to clinical need. We have our access policy training tools and have started a face to face training programme in outpatients; we have already delivered some preliminary sessions to consultants.

We continue to work with our service management teams to ensure the data they have to book patients for appointments and operations is as up-to-date as possible enabling quicker booking and helping to reduce cancellations and DNAs. We expanded the role of the fitness for anaesthetic (FFA) pre-assessment clinics enabling patients to be pre-assessed on the day of their outpatient clinic or booked immediately into a consultant clinic if required.

We continue to tackle long waits in our some specialties by pulling forward appointments and procedure dates, delivering additional sessions and using capacity at strategic partners to continue to work through our waiting lists in order.

All activity is reported through the Planned Care work stream as part of the Every Patient Every Day programme.

Further work is planned to continue to improve performance in the coming year, which includes:

- Closing the leadership and management gap in some areas through targeted recruitment

- Ensuring the effectiveness of the RTT training with key staff to improve performance

- Short-term resources are to be embedded within existing job roles to ensure sustainability

- Centralised/standardised pre assessment processes to be rolled out across specialties

- Increased focus on known specialities that remain challenged to achieve trajectory improvements and compliance.

Safeguarding
Adult, Children, Maternity and Learning Disability Teams

Colchester Hospital University NHS Foundation Trust (CHUFT) is committed to the protection of all children, young people and adults at risk from abuse and has signed up to the guidelines agreed between the Southend, Essex and Thurrock (SET) local authorities and their respective strategic partners.

Safeguarding individuals is an integral part of patient care. Duties to safeguard patients are required by professional regulators, service regulators and supported by law. It is imperative that all staff involved with the care and wellbeing of children, young people and adults at risk understand what is meant by abuse and what must happen when abuse is suspected or discovered. Abuse does not just happen outside the organisation, but potentially may occur within it. All CHUFT staff have a duty of care towards patients. Omissions in care may lead to significant harm (e.g. the development or worsening of pressure ulcers or an increased incidence of falls).

The Head of Safeguarding leads on the safeguarding of all children, young people and adults at risk within the safeguarding team at CHUFT.

Governance: Safeguarding families

To continue to promote a "safeguarding families" approach to safeguarding within CHUFT supported by the Head of safeguarding, the safeguarding team include the dementia care nurse specialist and learning disabili-

ties hospital liaison nurse. This is achieved by joint working, procedure management, and attendance at the safeguarding management groups (SMG) and committee.

Safeguarding Training

Trajectories for each quarter are set to achieve the targets agreed in the 2016/17 contract standards and maintain PREVENT (counter terrorism) training trajectories to meet the target 80% set by the Home Office (which the Trust has successfully done throughout the year). Currently Child Protection L3 and Looked After Children (LAC) training are below the 95% trajectory set in 2016/17 and this will be a priority in the next year.

Actions to take will include a monthly review of staff training deficits carried out by the Head of Safeguarding and Named Nurse for Children's Safeguarding at all levels and in response to the intercollegiate document requirements for children and the proposed intercollegiate document for adults.

Any concerns will be escalated to the Safeguarding Committee and Quality and Patient Safety (QPS).

Safeguarding Supervision

Providing safeguarding supervision is an integral part of supporting staff who regularly work with children, young people and adults at risk. Safeguarding supervision is currently provided quarterly to staff who regularly work with children and in midwifery services. However for staff groups working regularly with adults this is not so well established.

The target moving forward next year will be to develop and facilitate safeguarding supervision to appropriate staff groups by identifying the most effective way this can be achieved within CHUFT and undertaking regular supervision sessions for staff regularly working with adults at risk. Trajectories will be identified and the feedback from safeguarding supervision sessions will be provided to the SMG's and committee through the governance reporting structure.

Reporting

Quarterly reports and updates are provided at the Safeguarding of Adults at Risk Management Group (SAMG) and Safeguarding Children Management group (SCMG). Each management group is chaired by the named doctor and deputy chair is the Head of Safeguarding and Named Nurse Children Safeguarding.

These groups have multi-disciplinary and relevant divisional and safeguarding agency representation. The groups provide a forum for service leads to work together to address safeguarding issues within the acute setting and to lead the strategic direction of safeguarding within CHUFT.

The SMGs provide a report to the quarterly Safeguarding Committee chaired by the Director of Nursing as Executive Lead and exception reports to the Quality and Patient Safety Committee and Trust Board. An annual safeguarding adult and children report is produced and shared with local safeguarding boards, stakeholders and the public.

Staff Survey
Equality & Diversity

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

National NHS Staff Survey

The Trust aims to ensure that the highest quality of care is consistently delivered to our patients. To enable that we strive to ensure that all our staff have the training and support to deliver exceptional care. Our ambition is that our staff would recommend the Trust as a place to work and to be treated.

The survey was undertaken using a questionnaire sent in September/ October 2016. The Trust used a mixed mode approach (both paper and online).

For 2016, NHS England guidance advised that an increased number of staff members could be included in the 'basic sample'.

1250 staff were included in the initial mailing. A total of 414 responses were receiving giving a return rate of **33.9%**. this was an increase on the **30.7%** who responded in 2015. The average for Picker Trusts was **39.9%**.

Key Findings:

- When looking at the 2016 survey the Trust increased their scores in 2 of the 31 key finding indicators compared to 2015 and did better than average in 4;
- There were no statistically significant changes to the key finding indicators since the 2015 however it needs to be acknowledged that the trust scored in the worst 20% of acute Trusts for 15 of the 31 key finding indicators;

- The findings on two key metrics relating to bullying and harassment, and opportunities for career progression are provided at Chart xx .

The trust's score of 3.70 was in the lowest (worst) 20% when compared with trusts of a similar type.

The full and summary survey reports for Colchester Hospital is available at www.nhsstaffsurveys.com.

Equality and Diversity

There have been a number of developments regarding Equality and Diversity both for patients, service users and the workforce. The Equality and Diversity governance framework for NHS Trusts features the Equality Delivery System 2 (EDS2). Within the EDS2, there are four goals, which the Trust has adopted as Equality Objectives:
- Better Health Outcomes

- Improved Patient Access and Experience.
- A representative and supported workforce
- Inclusive Leadership

During 2015/16, the Trust reviewed the governance arrangements in place to embed the equality agenda, and introduced the role of Diversity Champions.

Working with Stonewall

Colchester Hospital also became one of Stonewall's Diversity Champions, and has started working in partnership with Stonewall on Lesbian, Gay, Bisexual and Transgender developments and issues, which commenced with a training session provided by Stonewall.

Chart 17—2 Key Findings from NHS Staff Survey Results				
Key Finding		2016	Average (median) for acute Trusts 2016	2015
KF26	% experiencing harassment, bullying or abuse from staff in the last 12 months	28%	25%	24%
KF21	% believing that Trust provides equal opportunities for career progression or promotion	78%	87%	79%

Equality & Diversity

Workforce Race Equality Scheme

2015/16 saw the second year of the National Workforce Race Equality Standard, with benchmarking analysis comparing Colchester Hospital favourably to many other Trusts. The standard consists of nine metrics, three of which are workforce data and five related to the national staff survey indicators. There is also an indicator which requires Boards to be representative of the communities they serve.

Accessibility Information Standard

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.
It is of particular relevance to individuals who are blind, d/Deaf, deafblind and / or who have a learning disability, although it will support anyone with information or communication needs relating to a disability, impairment or sensory loss, for example people who have aphasia or a mental health condition which affects their ability to communicate.

The Standard specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing.

There are five basic steps which make up the Accessible Information Standard:

1. **Ask:** identify / find out if an individual has any communication / information needs relating to a disability or sensory loss and if so what they are.

2. **Record:** record those needs in a clear, unambiguous and standardised way in electronic and / or paper based record / administrative systems / documents.

3. **Alert / flag / highlight**: ensure that recorded needs are 'highly visible' whenever the individuals' record is accessed, and prompt for action.

4. **Share**: include information about individuals' information / communication needs as part of existing data sharing processes (and following existing information governance frameworks).

5. **Act**: take steps to ensure that individuals receive information which they can access and understand, and receive communication support if they need it.

Key actions we have taken:

The Trust set up an Accessible Information Standard working group, chaired by the Deputy Director of Nursing with membership including individuals who are able to deliver on all key aspects of the standard requirements.

The following actions have been taken to ensure we support our patients and meet the Standard:

✓   **Ask** – the team have developed a strapline that will be included in all documentation sent from the Trust, as follows;

Can we communicate with you more effectively? Please let us know how by telephoning PALS on 01206 742683 or email: PALS@colchesterhospital.nhs.uk

✓   **Record** – Portal Alert system updates the records electronically and a manual form is also completed that sits within the record until the Trust moves to digitised records management.

✓   **Alert/Flag/Highlight** - the Portal Alert system has been updated to include all specific communication needs as outlined within the standard. Staff will be alerted to this so that they are able to update information when they ask patients.

✓   **Share** – we have liaised with our Learning Disability and Mental Health partners to provide us with information. Communication has been sent from the CCG to GP practices so that they can alert us when they identify patients with communication needs. The Standards are shared on the Trust's intranet and internet to ensure that patients, public and staff are aware of what can be expected.

✓   **Act** – Trust policies and procedures are being updated with the Accessible Information Standard. The Essential Standard relating to Privacy and Dignity includes specific instruction in ensuring that patients' communication needs are identified, recognised and acted upon.

Workforce

Freedom to Speak Up Guardian

Our new Freedom to Speak Up Guardian, Tom Fleetwood, took up his post on 1 December 2016. Tom is working across both Colchester and Ipswich Hospitals for three days each week.

Guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled.

Tom grew up around the Colchester area and was a non-executive director of Colchester Hospitals University NHS Foundation Trust until taking up the Guardian role. He had a long career in the Army, the last three years of which were spent as the Commander of Colchester Garrison.

Tom said: "I am very honoured to be appointed to this role and to be given the opportunity to support all staff, at every level. This will be a challenging job, but with considerable opportunity and I am looking forward to it."

The Freedom to Speak Up Guardian role was developed as a recommendation of the Francis Review, looking at failings in care at Mid-Staffordshire Trust to make sure that hospitals have a dedicated 'go to' person for when staff need to speak up and other avenues are not suitable.

Acting in a genuinely independent capacity, Tom will work alongside both boards of directors and executive teams to continue developing both organisations as open and transparent places to work.

Tom Fleetwood

Freedom to Speak Up Guardian

Guardian of Safe Working Hours (GSWH)

In 2016 the Trust implemented the new junior Doctors Contract. As part of the implementation process it was agreed that there should be an independent person responsible for championing safe working hours and as such the Trust appointed a Guardian of Safe working. The main duties and responsibilities include:-

✓ Champion safe working hours
✓ Oversee safety related exception reports and monitor compliance
✓ Escalate issues for action where not addressed locally
✓ Require work schedule reviews to be undertaken where necessary
✓ Intervene to mitigate safety risks
✓ Intervene where issues are not being resolved satisfactorily

✓ Distribute monies received as a result of fines for safety breaches
✓ Provide assurance on safe working and compliance with Terms and Condition.

In addition to the above it is a requirement that The Board will receive a quarterly report from the guardian, which will include:

✓ Aggregated data on exception reports (including outcomes), broken down by categories such as specialty, department and grade
✓ Details of fines levied
✓ Data on rota gaps
✓ Data on locum usage
✓ Other data deemed to be relevant by the guardian
✓ A qualitative narrative highlighting areas of good practice and / or persistent concern.

The first report was presented to the board sub-committee People and Organisational Development on 25 January 2017.

Workforce
Health & Wellbeing

The patient is at the centre of all we do. In supporting our workforce to uphold this principle, the Trust continues to embed the pledges to our staff within the NHS Constitution, providing a positive working environment, promoting an open culture, engaging staff in decisions, providing staff development and encouraging and supporting staff in raising concerns as soon as possible.

To enable staff to be more closely involved in decisions, a new organisational structure has been introduced, with senior clinicians forming part of the decision making Boards and Committees.

There has been close working with our partner Trust, the Ipswich Hospital NHS Trust, sharing good practice for both, and improving together.

All wards have an Executive Director as a senior "Buddy", and our Directors are often out in the clinical areas, being accessible to staff and patients.

We work in partnership with a number of Trade Unions, developing policies and procedures to provide a framework for supporting and developing our workforce.

Health and Wellbeing

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

All Staff have direct rapid access to physiotherapy to enable them to receive treatment and advice speedily. In addition the Occupa-

tional therapist undertakes home and work assessments providing aids to staff to enable them to manage their chronic health conditions more effectively and reducing sickness.

Staff also have access to an Employee Assistance Programme (EAP) for psychological support, The EAP and also access to citizen's advice database for non-psychological problems, and a managers helpline to support mangers with work issues.

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

The H&W service facilitates mental health first aid providing mangers with the skills to recognise and support staff with mental health issues. In addition emotional resilience sessions are provided for all staff, enabling them to identify their stressors and how they re-act to stress and by employing cognitive behavioural techniques to manage their stress.

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

During the year the a number of wellbeing events are arranged and articles published on wellbeing that follows the national wellbeing agenda see calendar of activities below.

Schwartz rounds

The Trust introduced Schwartz Rounds in September 2015, 558 staff have attended. Schwartz Rounds provide a confidential environment and an opportunity for staff to talk about the emotional and challenges that they experience when caring for patients. The Rounds are held monthly with a panel of three or four who provide a synopsis of an event in how they felt about that event. Once all panellists have told their story the facilitators open the discussion to the floor enabling others to resonate with what they have heard and how they have felt in similar situations. Studies have shown that Schwartz rounds leads to an increase in confidence in dealing with difficult and sensitive issues both clinical and non-clinical.

Schwarts Rounds in 2016/17 have included the following topics:

- ✓ Mental capacity where a patient chooses not to be treated and is supported in their final weeks
- ✓ Resuscitation
- ✓ On the other side- staff being a patient
- ✓ End of life dilemmas
- ✓ a patient says thankyou
- ✓ "working without cure" the chronic pain patient.

Pop up Schwartz Rounds have also been facilitated in areas where staff have found it hard to leave their clinical areas.

Workforce
Professional Practice & Volunteering

Appraisal & Revalidation (medical and nursing staff)

Nursing & Midwifery Revalidation

NMC Nurse Revalidation went live in April 2016, so far 407 Trust staff have successfully been through the process. Revalidation Workshops are run on a monthly basis, as well as regular one to one meetings with the Revalidation Officer.

To ensure that we are aware that people are on track with revalidating the Nursing & Midiwfery Revalidation Officer has requested to be sent copies of the confirmation forms. Ward Sisters, Matrons and Heads of Nursing are advised of staff who are due to revalidate and when, and staff are advised of the process via letter to home address in the first instance at least six months prior to revalidation date (ensuring we capture those on maternity leave). Staff are then advised via trust email address; when the application is open, when they have a month to submit and when they only have one week remaining. Also as the NMC do not advise us we are also asking staff to let us know if they are asked to provide further information for auditing purposes.

Medical Revalidation

Revalidation is the process by which a doctor's license to practice is renewed and is based on local organisational systems of annual medical appraisal and clinical governance. Licenced doctors are required to have a formal link known as a prescribed connection with a single organisation, identified as their Designated Body and headed up by a Responsible Officer, which will provide support with their appraisal and ultimately their revalidation. Following the launch

of Medical Revalidation in 2012, the Trust has been committed to strengthening processes to ensure that all doctors with a prescribed connection are in the system to undertake annual appraisal and revalidation.

The Trust is required to provide assurance to the Board, our regulators and commissioners that we have effective systems in place to ensure we meet with nationally agreed standards for medical appraisal and revalidation.

The Annual Organisational Audit (AOA) is a tool used to achieve a robust, consistent system of revalidation compliant with the Responsible Officer Regulations. The mandatory audit contained within the AOA report provides a process by which every Responsible Officer, on behalf of their designated body, provides a standardised return to the higher level Responsible Officer. The collated audit then forms the basis of a report to Ministers and ultimately the public on the overall performance of revalidation across England.

The Trust currently has 315 doctors with a recognised prescribed connection and in the last three years has successfully revalidated 209 doctors.

Staff sickness

The health of our staff is important, and providing support through what may be difficult times due to ill health is another way in which we demonstrate the At Our Best Values to our staff.

The Trust's rolling 12 month sickness rate is at 3.77% (*12 months to 31 March 2016)*. This compares to 3.82% in March 2016.

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

Volunteers

More than 200 active volunteers work throughout the hospital, who provide their time and commitment to improve patients' experience of their time in hospital. **Every one of our volunteers makes a real difference to people in hospital.**

The CCVS Voluntary service co-ordinator, was appointed to work with the Trust in February 2016 with a site presence of 3 days per week

In the first 12 months of introducing the voluntary services co-ordinator role, significant progress has been made in the developing the service, including:-

✓ A refreshed volunteers database with all previously recorded volunteers contacted and where still interested in supporting the Trust subject to a robust vetting and induction process;

✓ We currently have 215 active volunteers in the hospital, each doing a minimum of two hours a week.;

✓ A monthly induction programme is now established which delivers an average of 15 new volunteers with each session; all of whom are screened, trained and supported in accordance with NHS Governance & Best Practice.

Workforce
Education and training of staff

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

One of the Trust's key aims is for people in training to recommend us as a place to train.

Medical Education

Undergraduate Education

Currently the Trust hosts circa 250 students from Barts and the London. In 2016 following discussion with the University of East Anglia the Trust agreed to host 24 medical students.
The Trust received a site visit relating to undergraduate education on 29.9.16. Highlights from the verbal feedback have shown:

- Good high standard of training
- Students made to feel very welcome
- Educators were very engaging
- Students value the teaching experience
- Wi-Fi has improved
- Positive about accommodation.

Nurse & Midwifery Education

Chart 18: Pre-registration nursing—number of students, 2016/17:

Return to Practice	4
Child	29
General Nursing	112
Midwifery	52

Work based learning

This year saw our first group of 12 staff complete their registered nurse training through the new work-based learning programme, where they worked part time as either a healthcare assistant or associate practitioner whilst they studied for the BSc (Hons) Adult nursing. There are another 15 of our staff currently studying towards this.

Preceptorship

Preceptorship is a "a period of structured transition for the Newly Qualified Practitioner (NQP) during which he or she will be supported by a Preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning" (DOH 2010).

The benefits of undertaking a period of Preceptorship include enhancement of quality care, improved recruitment and retention, developing an understanding of the organisational objectives, supporting lifelong learning, making care the priority and enhancing the image of health care professionals (DoH 2009).

The process supports the newly qualified practitioner (Preceptee) to develop and apply the key skills necessary at foundation level of the knowledge and skills framework under the guidance and supervision of an experienced practitioner (Preceptor).

The trust has recently launched its new Multidisciplinary Preceptorship policy in line with Health Education England Standards that makes Preceptorship a mandatory requirement for all new non-medical registrants. The policy aims to strengthen Preceptorship for all newly registered professionals (non-medical) in the trust to enhance learning and support in the first 12 months post registration. As part of this the trust has committed to protected "Preceptorship "time for all newly qualified registered professionals. Our successful nursing 12 month Preceptorship programme is now available for all non-medical newly registered professionals.

Allied Health Professionals (AHPs)

Our AHPs have been busy this year undertaking a variety of courses to enhance their skills: This year the Trust has funded the following:

- ✓ A Physiotherapist is undertaking a course in cancer care, in order to develop the essential knowledge and skills required to support and care for people with cancer and their family;

- ✓ A Physiotherapist is undertaking a course in contemporary issues in limb loss, this is part of our succession planning within the department but also offers the staff member the opportunity to develop skills and knowledge in the key issues that impact on the delivery of amputation and prosthetic rehabilitation in a range of settings to continue to develop the service provided to patients;

- ✓ A Physiotherapist is completing a course in Respiratory care, this is enabling the practitioner to up-skill in the recognition and assessment of complex patients with respiratory disease as well as

developing awareness of the impact of long-term conditions on a patient's self-management;

✓ An Orthoptist is completing a course in in neuro-opthalmology. As well as developing the practitioners skills in diagnosing and managing neuro-ophthalmological conditions to improve patient care; the Trust is beginning to provide placements for Orthoptic students and is ensuring the educators have the relevant knowledge to provide the support needed;

✓ An Occupational Therapist is undertaking a 5 day key trainer course in manual handling. This course not only provides up to date training in complex manual handling use of equipment and risk assessments etc. but also how to train others. This enables specialist in-house training courses to be developed as well as "on the job training". This improves safety and competence of staff as well as the safety of patients.

Healthcare Assistant training

It is a requirement for all Healthcare Assistants and Maternity Support workers to undertake the care certificate. During 2016, 179 support workers started on the care certificate with 65 successfully completing the qualification to date. A celebration event was held on 10th October 2016 where attendees were presented with a certificate and a care certificate badge by the Deputy Director of Nursing.

To provide on-going assistance with the qualification the trust has also trained 16 "buddies" who provide workplace support and assessment.

The care certificate equips our support workers with the skills and training they need to ensure they consistently provide high quality care. As the care certificate is linked to national occupational standards it provides our support workers with platform to continue with a further qualification such as an apprenticeship. All practical teaching and theory related to the 15 domains of Care are provided Certificate during Healthcare Assistant induction and aims to equip new starters with the fundamental skills to provide quality care for our patients.

A gradual roll out to offer this to existing clinical support workers in the trust has commenced.

Support Staff

The Trust is committed to developing its support workforce. It is known that this group of staff make up 40% of the workforce but generally only receive an investment of 5% of the training budget. As well as the aforementioned care Certificate the Trust has continues to support existing staff progress in their work based learning by offering level 2 and level 3 apprenticeship opportunities. In 2016 37 existing staff signed up to undertake apprenticeships.

Non-registered nursing career pathway

As part of the trust's commitment to "growing our own" staff a non-registered nurse career pathway has been developed that provides the structure through which non-registered nursing staff can progress and develop a career. Commencing with the Trainee

Healthcare Assistant programme staff have the potential for career progression, gain qualifications and potentially obtain nursing registration through our BSc Work based learning (WBL).

Trainee Healthcare Assistant programme

In collaboration with Colchester Institute this 18 month apprenticeship aims to provide Health and Social care college leavers their first career step, providing them with paid clinical employment whilst completing a clinical qualification. On successful completion trainees will be offered a permanent Band 2 HCA post and have the necessary qualifications to move upwards onto the next stage of the Non-registered nursing career ladder (Foundation degree (FdSc) in Health and Social Care). The first cohort commenced in January 2017 with plans to commence a second cohort in July 2017.

New role to assist doctors' workload

The trust has hosted 4 Physicians educational placements that form the second year of their qualification. Physicians Associates are healthcare professionals who are trained in a medical model and when qualified will work as part of the medical team with doctors providing medical care. Currently there are circa 320 physician's associates working across the country in over 20 specialities and demand is outstripping supply.

Workforce
Education and training of staff

Quality Improvement Performance Framework (QIPF)

The QIPF is a process to quality assure the education commissioned by Health Education England (HEE) delivered on behalf of employers providing NHS commissioned care in the East of England. Non-medical education is reviewed annually using this process.

The Trust underwent its annual review in June 2016 and was visited by HEE. Following this 8 out of 8 Key Performance Indicators were scored as green. We are continuing to improve the education environment for all learners as well as improving our Workforce strategy.

Apprenticeships

Number of apprentices	37

2016/17 has seen us further develop the opportunities for integrating apprenticeships across the health and social care sector and enabling all departments within the hospital to welcome apprentices to their teams.

Health Ambassadors

The Talent for Care 'Get in' Agenda is about ensuring NHS staff are actively involved in getting more young people interested in careers within the NHS. Back in February 2016 a selection of Health Ambassador sign up events were launched to form a network of staff who would be happy to promote their careers to the younger generation. The only requirement in becoming a Health Ambassador is that you are passionate about what you do and if possible to try and give time to attend 2 events per year. The array of staff signed up range from Doctors and Nurses to non-clinical roles within HR, Education and Estates management staff. So far we have 49 Health Ambassadors signed up across the organisation.

Enhanced Practice Support Framework (EPSF)

This year in collaboration with our local Higher Education Institutes we launched EPSF which is a coaching method for educating student nurses in practice. This approach to practice learning is based on a framework which is composed of three key roles within each clinical placement: A lead mentor, mentors and coaches. This has created an environment in which practice learning became the responsibility of all registered nurses with involvement from other registered members of the multidisciplinary team. This has provided a more focused learning experience and the opportunity to work with and learn from a wide range of registered practitioners.

Medical Training

There were a number of quality visits to the hospital in 2016 including the site visit (referred to above), a desktop review of education by Health Education England and a visit from the School of Anaesthetics.

For Anaesthetics areas of good practice included:

- ✓ Strong commitment towards training by the senior management team and the core group of anaesthetic trainers;
- ✓ In Anaesthetics all would recommend their current post with all describing the department as an extremely friendly place to work, knew how to escalate concerns, met regularly with their education supervisors, and

had receipt of the relevant training workbook. Trainees described good levels of Consultant support. No trainee had been asked to work beyond their level of competency.

Areas where improvement is required include:

- There is a need to develop a specific in-house novice teaching/tutorial programme - 2 novices started in the department in February 2017 and in addition to the existing novice programme specific simulation sessions will be run in the local teaching schedule;
- There is a need to incorporate lessons learned from the Mortality and Morbidity sessions into the monthly audit meetings. In addition, Trainees should be encouraged to present interesting cases at the audit meeting to share learning - In December 2016 there were three specific trainee delivered audit and governance projects including case presentations and lessons learned from critical incidents in the labour suite.

In the feedback report from the Desktop Review the visiting team commented that they were encouraged and reassured by the discussions and wished to congratulate the Trust on the areas of notable achievement highlighted in the report. These areas included:

Workforce
Education and training of staff

✓ General positive feeling with constructive input from the Trust team in particular from Deputy Director of Nursing and Professional Practice Lead – Education, DME, MD, Education and Development Manager who provided reassurance that actions are being implemented;

✓ Medical Governance arrangements are robust with clear lines of accountability and reports to the Board;

✓ Hospital at Night is to be commended as one of the most effective in the region;

✓ There is a strong trainee/ student voice with active engagement in the Trust's trainee and student for a;

✓ There is an effective electronic patient tracking and task management system;

✓ There is improved consultant presence in the twilight period and positive support from the night matron.

There are areas where improvement is required and these include :

♦ The need for improved feedback in Care of the Elderly – since the visit the College tutor has appointed 3 associate tutors (trainees) who will be tasked with taking on focused feedback and undertaking a programme to improve the overall trainee experience;

♦ Improvement in out of hours supervision – this is being monitored via the Medical Education committee;

♦ Improvement in the training infrastructure to allow the delivery of mandatory Quality improvement projects for core medicine, other medical trainees and learners, as part of their curriculum requirements – a number of Chief residents presented QI projects in February 2017 to the regional group.

Areas for improvement are monitored through the Medical and Non-Medical Education Committees, with key senior individuals identified as responsible for delivery.

Healthcare assistants receiving their Care Certificate qualification from the Deputy Director of Nursing at a celebration in 2016.

Workforce
Corporate Learning and Organisational Development

Corporate Learning and On-going Development

The Trust has continued to improve its compliance with mandatory training. In April 2016 compliance stood at 85.13% and this has increased to 91.34% as at the end of February 2017. Measures to help staff increase their compliance in include weekly e-mails to remind staff if they have a renewal due or if they have expired on any aspect. There has also been the development of a training portal on the Trusts intranet. Well received by staff this allows individuals to view their own compliance records and also assists managed when planning for the release of staff to attend taught training session.

In 2015 the board agreed significant investment for the following financial year in Leadership and Organisational Development for the Trust.

Working with divisional leads and other stakeholders such as the staff involvement group a suite of development opportunities are being launched across the Trust.

The CHUFT Leadership Programme—License to Lead

Licence to Lead is the Trust's new Leadership Development programme. It contains a number of management practice modules to equip Supervisors and Managers with the knowledge, skills and practical application required to be an effective and well-rounded leader. Delivery commenced in December 2016 and to date feedback has been extremely positive.

The programme is delivered at different levels. These are not aimed at certain bandings; the structure is very much based on any manager working at any level can attend any level of training, as long as it relates directly to their current job role, or any personal development plans that are in place to assist with progression opportunities and personal growth.

As a part of the Leadership development Steering Group, it was discussed and agreed that to begin the programme the focus would be on the trust's top training needs and topics included difficult conversation, customer service and team development.

Mary Seacole Local

Developed by the leadership Academy, The Mary Seacole programme is aimed towards clinical and non-clinical colleagues who are moving towards their first recognised leadership or team management role and want to do more to champion compassionate patient care. It's delivered through a combination of face to face and online learning.

Building on the success of the national programme the Essex Workforce Partnership has worked with the Leadership Academy to become an early adopter of "Mary Seacole Local". NHS organisations across Essex have joined forces to deliver the programme in venues across the

county which started January 2017. Working collaboratively across organisations, the programme supports leaders to create a shared understanding of the leadership challenges and opportunities we all face by sharing and learning together.

Staff Development Programme – Licence to Learn

Sitting along the Licence to Lead programme, Licence to learn is a series of development opportunities for all staff who are not in leadership positions.

Licence to Learn contains a number of useful modules to enable staff to increase their knowledge, skills and practical application in a number of areas. Taking feedback from the Staff Involvement Group and also via survey monkey a number of sessions have been developed that will address immediate needs.

Courses commenced in February 2017 include:

- Bitesize WORD
- Bitesize EXCEL
- Bitesize OUTLOOK
- Bitesize ONENOTE
- Minutes and Notetaking
- Customer Service Skills.

Library development

During 2016 the Trust has been working in partnership with the library knowledge and skills partnership at Basildon and

Workforce
Organisational Development—Valuing our staff

Harlow with the aim of improving access to clinical librarians and the facilities at Colchester. We have agreed and are implementing a 24/7 access to the library to meet the challenges of improving access to educational resource that is highlighted in the 2016 GMC Trainee survey.

A major overhaul and improvement of the library facility's opening hours is almost completed and a review of its stock and use of electronic books and journals is improving access for all staff to gain the information they need whether on-site or through remote access.

Valuing our staff

The Trust launched its At Our Best Awards in October 2011 to recognise staff and volunteers' achievements and thank them for what they do with awards being presented to an individual, a volunteer and a team. This is a chance for colleagues, patients and the public to nominate the people they feel have made outstanding contributions at our Trust and to write 50 or so words about why they deserve to win - known as the citation.

Entries judged on the 50 or so words written where a person or team demonstrates the At Our Best behaviours standards and values.

The Spring 2016 the short listing panel of clinical, non-clinical staff, Board members and governors got the entries down to:

✓   11 individuals

✓   13 teams.

Every nominated person gets a letter from the chief executive with the citation included. If the entry is for a team then the chief executive sends a letter with the citation to the team manager.

On 27 July 2016 we held an At Our Best Awards event for everyone shortlisted between May 2015 and May 2016. As usual, anyone - colleagues, patients and the public - could nominate an individual or a team they felt had made an outstanding contribution at our Trust. Public support has been steady with 8 out of 10 entries by the public or from patients.

'This individual took the time and trouble to go through my husband's notes in detail for the whole of last year, as he'd been in and out of hospital. Nothing was too much trouble, he spent time talking to myself and family about the care for my husband and what he needed. The patient and family were always at the forefront of his mind. We were able to ask any questions, no matter how small and he would answer in his caring manner - which made things easier to absorb. He went above the call of duty and wasn't afraid to help. He ensured the care was second-to-none; this is one of the best wards my husband was in, especially in his last few days; even when my husband passed away this member of staff supported us by making tea and ensuring if we needed anything, we only had to ask.'

Statements from key stakeholders

North Essex Clinical Commissioning Group response to Colchester Hospital University NHS Foundation Trust Quality Account report for 2016- 2017

North East Essex Clinical Commissioning Group (CCG) welcomes this Quality Account as a commitment to an open and honest dialogue with patients and the public regarding the quality of care provided by Colchester Hospital University NHS Foundation Trust. The CCG is commenting on this provider's Quality Account for 2016-17.

Though the CCG are commenting on a final draft version of the Quality Account, we are pleased to be able to assure the accuracy of the content in general. We have fed back our comments on the draft report and can confirm that the majority of the proposed changes and recommendations have been made to the final published version.

This has been another challenging year for the Trust, with changes in several executive, senior management and leadership posts whilst under the constant observation of the Care Quality Commission (CQC), National Health Services Improvement (NHSI), CCG and other stakeholders. Added to this has been the requirement to participate in the national Sustainability and Transformation Plan (STP) whilst delivering day to day high quality services for patients.

The priorities for improvement during this year centred on 3 main areas; patient safety, patient experience and clinical effectiveness. Of the 12 priorities the Trust set itself, 5 were delivered and 7 were partially delivered. The Trust demonstrated marked improvement in the management and response to complaints; reductions in missed dose medications; compliance with surgical site safety checklist; improved performance in Friends and Families Test; and reported compliance with venous thromboembolism (VTE) testing. However, the considerable delay in investigating post admission deep vein thrombosis and pulmonary embolism events continues to be challenging for the Trust. The Trust demonstrated good compliance in the management of Clostridium difficile (C.diff) coming in under the anticipated trajectory, however there were 2 Methicillin-resistant Staphylococcus aureus (MRSA) cases reported. The Trust reported improvements in the application of 'My Care Choices' and providing patients with information regarding their condition. The CCG feel that the level of electronic discharge letters is a limited measure in improving patient information and the actions and measures could have been broader.

The CCG supports the identified priorities for 2017/18; reduction in falls, application of NatSSIPs, improved performance in Friends and Family Test performance.

The Trust participated in 81% of the national clinical audits; 100% of national confidential enquiries; and completed an extensive programme of local audits. Through participating in research studies, the Trust continues to demonstrate its commitment to improving the quality of care and treatments, not only to its own client group but to the wider population.

In 2016/17, the Trust signed up to three national and three local Commissioning for Quality and Innovation schemes (CQUINs). These schemes covered a variety of areas including;

Statements from key stakeholders

improving staff health and wellbeing; antimicrobial stewardship; timely treatment of sepsis; identification of patients with a palliative diagnosis; perinatal mental health services; and consultant/urgent connect. These schemes were largely successful and nearly all of the milestones were achieved. It would have been helpful to have some commentary or analysis to describe the improvements implemented. The CQUIN schemes for 2017/18 have not been identified within the document.

The CCG recognises the information pertaining to the long-term partnership agreement between Colchester and Ipswich Hospital NHS Trusts. This partnership was recommended jointly by the CQC Chief Inspector of Hospitals, Professor Sir Mike Richards, and the Chief Executive of NHS Improvement, Jim Mackey as the only way of securing quality services for patients longer term. The CCG welcomes and supports the implementation of the plan for improvement, Every Patient Every Day, which supersedes the previous Quality Improvement Programme.

The CCG notes the Trust's performance against the core quality indicator standards required by the regulatory framework. Of particular concern are; SHMI above the national indicator; insufficient sample size to review PROMS; the percentage of high harm and death incidents being above the national average; and the staff response to Friends and Family Test. We note that each standard has clear and measurable actions to improve performance over the next 12 months.

The Staff Survey was disappointing with little improvement on the previous year. We hope that the 'Every patient every day' work-stream on Workforce Development will help improve staff morale in the coming year.

The conclusion of the NHS North East Essex CCG is that Colchester Hospital University NHS Foundation Trust's Quality Account 2016-17 provides a clear picture of the Trust's performance, improvements and future ambitions for improving quality and safety in your services. The CCG are in agreement with the broad areas of priority you have identified for 2016-17.

The CCG looks forward to continue working with the Trust in 2017/18, to implement and sustain the multiple and wide-ranging improvements and initiatives to improve the quality of its services for our patients and local population

Lisa Llewelyn

Director of Nursing and Clinical Quality

NHS North East Essex Clinical Commissioning Group

Statements from key stakeholders

Response to Colchester Hospital University NHS Foundation Trust (CHUFT) Quality Account 2016-17 from Healthwatch Essex

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

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

As with last year's report, the Quality Account for 2016-17 shows how consistency of quality of care remains an issue for CHUFT, a fact reflected in the Trust's lengthy period of time in special measures and the ongoing scrutiny of the Trust's performance by regulators. The report identifies many areas of good and improving practice, but also shows examples of poor or declining performance, and where the data presents a conflicting or unclear picture of actual performance.

Since 2013, Healthwatch Essex has been closely involved in the workings of the Trust. With this history of involvement, we are pleased to commend the Trust's leadership for its efforts to secure organisational grip, and for its patient-focused improvement plan, 'Every Patient, Every Day'. We know, from our interactions with a variety of clinical and non-clinical staff (at different levels of the organisation), that there is a good degree of determination to tackle the deep-seated challenges at CHUFT.

In terms of progress, we note the targets met in terms of the WHO checklist (for example), and for progress made in terms of missed doses of medication and improved use of My Care Choices. However, it is disappointing that there remains a lack of compliance with targets around Serious Incident timescales, as this has been a recurrent issue for the Trust over a number of years. Higher than expected levels of mortality is also an indicator of progress still yet to be made.

Healthwatch Essex has worked with the Trust on a number of specific projects, including a research study on patient, carer and staff experience of hospital discharge, and an engagement project which has focussed on people's lived experience of neurological conditions. We are pleased to note the Trust's positive response to our findings, as well as note that our work around cancer services (undertaken in 2013-14) is still referenced by the Trust in this report and in other settings. This suggests that the Trust is adopting a more open, evaluative and reflective approach to improving the quality of its care and its efforts to listen to the experience of patients. That said, our work around hospital discharge suggests that the Trust (in common with the other Trusts featured in

Statements from key stakeholders

the study) experiences issues that affect the quality care patients receive, not least around communication and information and continuity of care. Our study also found that resource issues and poor aftercare further compounded problems around discharge. Staff at Colchester, however, were often highly praised in this study, amongst other positive aspects of care detailed in our reports.

Healthwatch Essex also notes the improvements made by CHUFT in its patient experience and PALS functions, and notes the ongoing efforts of the Trust to focus on FFT results as a measure of patient experience. However, we would encourage the Trust to ensure that, wherever possible, high-quality, qualitative evidence of people's lived experience of care is captured in a timely and meaningful way, and used as part of continuous improvement and service change.

Healthwatch Essex's own evidence of service quality at CHUFT gathered through our Information Service and online Feedback Centre is mixed, often reflecting a commonly-observed dichotomy between people who emphatically commend the Trust, and those who emphatically criticise the Trust. People leaving reviews on the Feedback Centre were, in the vast majority, positive, and the Trust received an average of 4.6 out of 5 'stars', based on 25 reviews. Overall the service was rated highly across all areas, with the majority of patients reporting good quality of care, a comfortable environment, useful information provided and that they felt listened to. 9 out of the 25 reviews were about A&E care and all were positive; 24 out of the 25 reviews mentioned caring and respectful treatment by staff; almost half of reviewers mentioned that staff were working under pressure and/or without enough resources, whilst a minority of reviewers felt that the service could have been better in terms of diagnosis and communication.

 Callers to our Information Service, as would perhaps be expected, often reported a negative picture, with people describing poor administrative systems and processes, poor planning and communication around discharge, and occasionally poor and distressing experiences of care. Callers also commented on caring staff.

We also note the priorities for improvement in 2017-18 and recognise these as being back-to-basics measures of quality and care. Healthwatch Essex hopes to continue working with the Trust, not least through our ongoing involvement in the Programme Oversight Group, Ipswich/Colchester Long Term Partnership Clinical Reference Group, STP Programme Board, and other forums and settings.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by working hard to evidence that lived experience, we hope we can continue to support the work of CHUFT.

Dr Tom Nutt
Chief Executive Officer, Healthwatch Essex

April 2017

Statements from key stakeholders
Statement from Trust Governors

Essex County Council

Essex Health Oversight Scrutiny Committee

The Essex HOSC discussed its approach to Quality Accounts/Reports at its last meeting on 20 March 2017. Due to imminent county council elections, the Essex Health Overview and Scrutiny Committee does not intend to comment individually on NHS Quality Accounts this year. This should in no way be taken as a negative response. The Committee has, in the main, been content with the engagement of local healthcare providers in its work over the past year. In the last year your organisation has responded to requests for information and attended meetings to assist the HOSC discuss CQC performance concerns, the progress on the strategic partnership between Colchester and Ipswich Hospitals and the broader development of the Sustainability and Transformation Plan for North East Essex and Suffolk.

The Committee is aware that local Healthwatch also reviews Quality Accounts/Report and is content that they can represent the patient and public voice and comment accordingly.

Colchester Hospital University NHS — NHS Foundation Trust

Statement of Governors—Colchester Hospital University NHS Foundation Trust

The governors of Colchester Hospital University NHS Foundation Trust are pleased to have the opportunity to comment on the draft Quality Account for 2016/17.

We support the Trust's focus on patient safety, experience and quality and take this opportunity to reinforce our view that safety of patients is paramount. We were particularly encouraged by the emphasis made on the patient experience and placing patients, relatives and carers at the heart of everything the Trust does, as we believe this is key to achieving consistent and high quality care.

Both governors and the members continue to be concerned that the Trust's performance remains below the standards to which it aspires. However, we are more assured that with a substantive Executive Team in place, we will begin to see improvements.

The governors role is to hold the Non-Executive Director to account, who in turn will hold the Executive Team to account. We are confident that by continuing to maintain our role as the 'critical friend' by continuing to observe Board Assurance Committees, undertaking regular walkabouts with Non-Executive Director colleagues and attending PLACE visits and inspections, we will be in a much better position to provide assurance to our members.

We support the actions being taken to further improve quality and look forward to working closer with the Board during the coming year and continue to support them in making the Trust the most caring and compassionate provider of healthcare.

Colchester Hospital University NHS — NHS Foundation Trust

Response to stakeholder comments

Colchester Hospital University NHS Foundation Trust thanks its stakeholders for their comments on the 2016/17 Quality Account.

Statement of assurance from the Board of Directors

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality account.

In preparing the Quality Account, directors are required take steps to assure themselves that:

- the content of the Quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external source of information including:

  * Board minutes and papers for the period April 2016 to April 2017

  * Papers relating to quality reported to the board over the period April 2016 to April 2017

  * Feedback from commissioners dated 26/04/2017

  * Feedback from governors dated 24/04/2017

  * Feedback from local Healthwatch organisations dated 28/04/2017

  * Feedback from Overview and Scrutiny Committee dated 12/04/2017

  * The Trust's complaints report published under regulation 18 of the Local Authority Social Service and NHS Complaints Regulations 2009, (pending completion).

  * The national patient survey 01/2017 (pending national publication).

  * The national staff survey (pending national publication)

  * The Head of Internal Audit's annual opinion of the trust's control environment dated May 2017

  * CQC Inspection report dated 15/07/2017

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period.

- 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 ot review to confirm that they are working effectively in practise.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standard and prescribed definitions, is subject to appropriate scrutiny and review

- The Quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

David White, Chair
Date: 30 May 2017

Nick Hulme, Chief Executive
Date: 30 May 2017

Glossary

Bed days The measurement of a day that a patient occupies a hospital bed as part of their treatment.

Care Quality Commission (CQC) The regulatory body for all health and social care organisations in England. The CQC regulates care provided by the NHS, local authorities, private companies, voluntary organisations and aims to make sure better care is provided for everyone in hospitals, care homes and people's own homes.

CCU Critical Care Unit.

Clinical Coding The translation of medical terminology as written in a patient's medical records to describe a problem, diagnosis, treatment of a medical problem, into a coded format.

Clinical Commissioning Group (CCG) CCGs are responsible for commissioning (planning, designing and paying for) all NHS services.

Clinical Delivery Group (CDG) CDGs are sub-groups of one of the Trust's three clinical divisions. Each CDG is accountable to its Divisional Governance Board for all aspects of performance, including patient safety, patient and carer experience, operational standards, financial performance and staff engagement.

Clostridium difficile or C.diff A spore-forming bacterium present as one of the normal bacteria in the gut. *Clostridium difficile* diarrhoea occurs when the normal gut flora is altered, allowing *Clostridium difficile* bacteria to flourish and produce a toxin that causes watery diarrhoea.

Colonisation The presence of bacteria on a body surface (such as the skin, mouth, intestines or airway) without causing disease in the person.

CQUIN The CQUIN (Commissioning for Quality and Innovation) framework enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

Datix A Trust-wide computer system used to record and aid analysis of all incidents, claims, complaints and PALS enquiries.

Dementia A set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning.

Division The hospital is divided into three distinct clinical divisions: Medicine including Emergency Care; Surgery and Cancer; Women and Children and Clinical Support Services. There is an additional division which manages the corporate functions such as Governance, Education, Operations, Human Resources, Finance, Performance, and Information. Each Divisional Board is chaired by a consultant (Divisional Director) together with nursing. and operational leads. The Head of Nursing/Midwifery provides senior nursing and quality of care expertise, with the Head of Operations providing expert oper-

ational advice to the Divisional Boards.

DNACPR Do not attempt cardio-pulmonary resuscitation. A formal decision made when it is not in the best interests of the patient to be resuscitated in certain circumstances.

Dr Foster Provider of comparative information on health and social care issues.

ED Emergency Department, also known as A&E, Accident and Emergency Department or Casualty.

Harm-free care National patient safety initiative targeted at high impact areas such as pressure ulcers, catheter care, VTE and falls.

HDU High Dependency Unit.

Quality & Patient Safety Committee The Trust Board sub-committee responsible for overseeing quality within the Trust.

HealthWatch Champions the views of local people to achieve excellent health and social care services in Suffolk.

HSMR Hospital Standardised Mortality Rate. An indicator of healthcare quality that measures whether a hospital's death rate is higher or lower than expected.

North East Essex Clinical Commissioning Group The main commissioner of services provided by Colchester Hospital University NHS Foundation Trust.

MDT Multi-disciplinary team.

Methicillin Resistant Staphylococcus Aureus (MRSA) MRSA is an antibiotic-resistant form of the common bacterium Staphylococcus Aureus, which grows harmlessly on the skin in the nose of around one in three people in the UK. MRSA bacteraemia is the presence of Methicillin Resistant Staphylococcus Aureus in the blood.

NEWS National Early Warning Score. A system of recording vital signs observations which gives early warning of a deteriorating patient.

MEOWS Modified Early Obstetric Warning Score. A system of recording vital signs observations which gives early warning of a deteriorating obstetric patient.

Morbidity and Mortality (M&M) meetings Morbidity and mortality meetings are held in each Clinical Delivery Group. The goal of such meetings is to derive knowledge and insight from surgical error adverse events. M&M meetings look at: What happened? Why did it occur? How could the issue have been prevented or better managed? What are the key learning points?

NCEPOD National Confidential Enquiry into Patient Outcome and Death.

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

Operation Red to Green A concept recommended nationally by the Emer-

gency and Urgent Care Intensive Team which ensures all the processes required to support flow through the hospital run 'perfectly' so that there are no unnecessary delays that slow down transfers of care. There is input from the whole organisation and joint working between the Trust and its health partners across Essex. All non-essential meetings are cancelled to ensure that all staff can fully commit to the week, without compromising clinical care.

PALS Patient Advice and Liaison Service. For all enquiries to the hospital such as cost of parking, ward visiting times, how to change an appointment etc.

PLACE Patient-Led Assessment of the Care Environment. Annual self-assessment of a range of non-clinical services by local volunteers.

PSG Patient Safety Group.

Q1 or Quarter 1 April - June 2016

Q2 or Quarter 2 July - September 2016

Q3 or Quarter 3 October - December 2016

Q4 or Quarter 4 January - March 2017

RCA Root Cause Analysis. A structured investigation of an incident to ensure effective learning to prevent a similar event from happening.

SHMI Summary Hospital-Level Mortality Indicator. An indicator for mortality. The indicator covers all deaths of patients admitted to hospital and those that die up to 30 days after discharge from hospital.

SI Serious Incident

SLA Service Level Agreement. A contract to provide or purchase named services.

Essex Family Carers A registered charity working with unpaid family carers across Essex, supporting family carers with information, advice and guidance.

SUS Secondary Uses Service. Provides anonymous patient-based information for purposes other than direct clinical care such as healthcare planning, public health, commissioning, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

The King's Fund A charity that seeks to understand how the health system in England can be improved and helps to shape policy, transform services and bring about behaviour change.

VTE Venous Thrombo-embolism. Also known as a blood clot, a VTE is a complication of immobility and surgery.

Independent Practitioner's Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Quality Report

Independent Practitioner's Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Colchester Hospital University NHS Foundation Trust to perform an independent limited assurance engagement in respect of Colchester Hospital University NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2016/17' and additional supporting guidance in the 'Detailed requirements for quality reports for foundation trusts 2016/17' (the 'Criteria').

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (see page 74);
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge (see page 56).

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner
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 2016/17' and supporting guidance issued by NHS Improvement.

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 2016/17 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'; 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 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is

materially inconsistent with:

- Board minutes for the period 1 April 2016 to 30 May 2017
- papers relating to quality reported to the Board over the period 1 April 2016 to 30 May 2017;
- feedback from Commissioners dated 24 April 2017
- feedback from Governors dated 24 April 2017
- feedback from local Healthwatch organisations dated 28 April 2017
- feedback from Overview and Scrutiny Committee dated 12 April 2017
- the national patient survey dated 8 June 2016
- the national staff survey published on 7 March 2017
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26 May 2016
- the Care Quality Commission inspection report dated 15 July 2016; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 10 May 2017.

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.

The firm applies International Standard on Quality Control 1 and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding

Appendix A

Independent Practitioner's Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Quality Report

compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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, to assist the 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 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Colchester Hospital University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures

included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

- making enquiries of management;

- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;

- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance to the categories reported in the Quality Report; and

- reading the documents.

A limited assurance engagement is narrower 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 2016/17' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Colchester Hospital University NHS Foundation Trust.

Our audit work on the financial statements of Colchester Hospital University NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Colchester Hospital University NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Colchester Hospital University NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Colchester Hospital University NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Colchester Hospital University NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Colchester Hospital University NHS Foundation Trust and Colchester Hospital University NHS Foundation Trust's members

Independent Practitioner's Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Quality Report

as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

The indicator reporting the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" did not meet all six dimensions of data quality in the following respects:

- Accuracy - For 6 of the 25 cases we tested we were unable to confirm the start date to source documents within patient files. Our testing also identified 1 case where the clock stop date had passed, but the case had not been marked on the system as completed

- Validity - Our testing identified 2 cases out of the 25 cases we tested where the referral was not a consultant-led service and therefore should not have been included in the indicator.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter(s) 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 2017:

- 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 2016/17 and supporting guidance;

- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external

assurance for quality reports for foundation trusts 2016/17'; and

- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2016/17' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
London

31 May 2017

Definitions for performance indicators subject to external assurance

Percentage of patients risk-assessed for venous thromboembolism (VTE)

Detailed descriptor
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

Data definition
Numerator: Number of adults admitted to hospital as inpatients in the reporting who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool during the reporting period.
Denominator: Total number of adults admitted to hospital in the reporting period.

Details of the indicator
The scope of the indicator includes all adults (those aged 18 at the time of admission) who are admitted to hospital as inpatients including:

- surgical inpatients;
- in-patients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease); trauma inpatients;
- patients admitted to intensive care units;
- cancer inpatients;
- people undergoing long-term rehabilitation in hospital;
- patients admitted to a hospital bed for day-case medical or surgical procedures; and
- private patients attending an NHS hospital.

The following patients are excluded from the indicator:

- people under the age of 18 at the time of admission;
- people attending hospital as outpatients;
- people attending emergency departments who are not admitted to hospital; and
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

Timeframe
Data produced monthly for the 2015-16 financial year.

Detailed guidance
More detail about this indicator can be found on the NHS England website. The data collection standard specification can be found here.
Source: NHS England

Data relating to the percentage of patients risk-assessed for venous thrombo-embolism (VTE) can be found on page 40.

Percentage of patient safety incidents resulting in severe harm or death

Detailed descriptor
Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period.

Data definition
Numerator: Number of reported patient safety incidents resulting in severe harm or death at a trust reported through the National Reporting and Learning Service (NRLS) during the reporting period.
Denominator: Number of reported patient safety incidents at a trust reported through the NRLS during the reporting period.

Details of the indicator
The scope of the indicator includes all patient safety incidents reported through the NRLS. This includes reports made by the trust, staff, patients and the public. From April 2010 it became mandatory for trusts in England to report all serious patient safety incidents to the Care Quality Commission. Trusts do this by reporting incidents on the NRLS.

A case of severe harm is defined in 'Seven steps to patient safety: a full reference guide', published by the National Patient Safety Agency in 2004, as "(a)ny patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care", "Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage."

This indicator does not capture any information about incidents that remain unreported. Incidents with a degree of harm of 'severe' and 'death' are now a mandatory reporting requirement by the CQC, via the NRLS, but the quality statement states that underreporting is still likely to occur.

Timeframe
Six-monthly data produced for April to September and October to March of each financial year.

Detailed guidance
More detail about this indicator and the data can be found on the Patient Safety section of the NHS England website and on the HSCIC website in NHS Outcomes Framework > Domain 5 Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm > Overarching indicators > 5b Severity of harm.
Source: NHS England

Data relating to the percentage of patient safety incidents resulting in severe harm or death can be found on page 41.

How to provide feedback on this Quality Account

If you would like to provide feedback on this account or would like to make suggestions for content for future accounts, please email info@colchesterhospital.nhs.uk or write to:

Trust Offices,
Colchester Hospital University
NHS Foundation Trust,
Turner Road,
Colchester
Essex CO4 5JL

Thank you

We would like to take this opportunity to thank all those involved with Colchester Hospital University NHS Foundation Trust: our fantastic staff and volunteers, all of our patients and visitors, our valuable fundraisers, local media organisations, our local Members of Parliament and health colleagues across the East of England.

Thank you for all that you do to make this a hospital we can all be proud to be part of.

Find out more about the hospital by visiting
our website at www.colchesterhospital.nhs.uk

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This report is available online at http://bit.ly/2d1UAAv