

Annual Report Annual Accounts & Quality Report

1 April 2012 – 31 March 2013



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Colchester Hospital University NHS Foundation Trust

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1 April 2012 – 31 March 2013

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

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Section B – Annual Accounts

Annual Accounts, including Independent Auditor's report to the Board of Governors of the Trust and conclusion on arrangements for securing economy, efficiency and effectiveness in the use of resources.

Section C – Quality Report

Useful contact information

Comments

We welcome comments about this publication.

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We care, do you?

It's easy to show you care about the services we provide. Complete an application form and register to become a member of the Trust, visit our website or phone 0800 051 5143 (free).

Patient Advice and Liaison Service (PALS)

PALS offers confidential, on-the-spot advice and support, helping patients, relatives and other visitors to sort out any concerns they may have about their care.

Freephone: 0800 783 7328 Email: pals@colchesterhospital.nhs.uk

General information and inquiries

Email: info@colchesterhospital.nhs.uk

Full contact details and more information on our website:

www.colchesterhospital.nhs.uk

Copies can be provided in Braille,
large print and foreign language formats

Welcome from the Chair and Chief Executive

We expected that 2012/13 would be a difficult year for the NHS. The breadth of changes described in the Health and Social Care Bill and the size of the efficiency savings produced a range of challenges made more demanding by uncertainties about national economic recovery.

Our Trust responded robustly to those challenges despite their ambiguous nature.



*Dr Sally Irvine
Chair*

*Dr Gordon Coutts
Chief Executive*

Our staff once again made important progress to further improve the quality of treatment and the care we provide.

Overall, the Trust's performance in the 2012 National NHS staff survey, published on 28 February, showed we maintained our scores from previous years. In particular, we were above the national average both for care being our Trust's top priority and for acting on patients' concerns. We also maintained a similar position to the previous year in the national survey of adult inpatients 2012, published on 16 April 2013.

We are also encouraged by the outcomes of the NHS Friends and Family Test which have consistently placed us in the top quarter of hospital trusts in the NHS Midlands and East region. However, both surveys indicate we are average and we have higher ambitions for staff and patient satisfaction. In the course of 2013/14 we will work hard to improve these scores.

In terms of patient safety, improvements announced last year in the way patients who present as emergency cases at the Accident & Emergency Department (A&E) or the Emergency Assessment Unit (EAU) have continued to benefit patient care. The further expansion of seven-day working, which involves more than 600 staff including radiology, therapies, matrons, HR and medical records, has also brought benefits to the consistency of care. We have also seen consistent and encouraging improvements in patient care resulting from intentional rounding (patient rounding) by ward nurses. For example, we have seen a reduction in the number of falls and the number and severity of pressure ulcers. Nevertheless, we are not complacent – improving patient care and safety remains a high priority.

Operationally, the Trust performed strongly. We achieved the four-hour A&E standard apart from February, the national cancer standards from June and the 18-week referral to treatment (RTT) throughout the year. We achieved a reduction in crude mortality and mortality rates while our Hospital Standardised Mortality Ratio (HSMR) was within the expected range. However, our Summary Hospital-level Mortality Indicator (SHMI) was above the expected level which was cited as the reason for the Trust being included, with 13 others, in a review by Professor Sir Bruce Keogh, NHS Medical Director for England. Prof Keogh describes this SHMI performance as a "warning light" – no judgment has been made on the quality of care. We understand that the review, with which we will co-operate fully, will be completed by the end of July.

There are areas where our performance was not as consistent as we would like. For example, we have revised the way we react and respond to serious incidents and are reviewing our complaints process.

The Trust, justifiably, has a good reputation for infection control. Although we exceeded the agreed maximum of 25 cases of hospital-acquired *Clostridium difficile* by four, none of the cases were linked and this places the Trust in the top tier nationally. In March 2013 the Trust had its first case of MRSA bacteraemia since May 2010. We are re-doubling our efforts to further reduce hospital-acquired infections.

The new Sterile Services Unit became fully functional and was able to carry out the Trust's work and, also, temporarily that of Ipswich Hospital while its unit was refurbished. Work on the new radiotherapy centre at Colchester General Hospital, which began in August, is progressing well despite a protracted period of inclement weather.

A new state-of-the-art vascular operating theatre, which is one of only two in Europe, became fully functional in July. This coincided with the start of the centralised major vascular surgery service for patients from north east Essex, east Suffolk and the Colne valley.

These developments have been achieved by investing our own reserves, built up by delivering surpluses year-on-year and thus avoiding the debt burden of Private Finance Initiatives.

Financially, the Trust continues to be in a sound position. We delivered an underlying surplus of £3m and a total surplus of £9.1m.

The Trust is also an active participant in the Eastern Academic Health Science Network. This is made up of four nodes comprising NHS and higher education institutions (Cambridge & Peterborough, Norwich, Stevenage and Colchester). This is an exciting initiative which aims to improve the dissemination of better care and also provide research education and innovation through links with universities, the NHS and industry.

The Trust is affiliated to the University College London Health Partners (UCLP) Academic Health Science Network.

Despite the undoubted challenges that lie ahead – both foreseen and unexpected – our main priorities continue to be on driving up standards and giving patients the best possible services and experiences when they are in our care. We will continue our efforts to improve staff and patient satisfaction, deliver a consistent and predictable performance operationally and ensure we are sound financially.

Our firm belief is that we can achieve this and that Colchester Hospital University NHS Foundation Trust has a very bright future.

Signatures



Dr Sally Irvine
Chair



Dr Gordon Coutts
Chief Executive

Directors' business review

About our Trust – a summary

Monitor, the independent regulator of NHS foundation trusts, authorised Colchester Hospital University NHS Foundation Trust from 1 May 2008. The Trust provides healthcare services for people mainly in north east Essex and is an associate teaching hospital of the University of London.

Our vision To be widely recognised as the Trust that our patients and staff would want to recommend to their friends and relatives (see page 14).

The population we serve Colchester is the largest town in north east Essex. While there are small pockets of social deprivation, it is largely affluent with relatively low unemployment and above average life expectancy. The Tendring peninsula is more rural and has a much higher concentration of elderly and economically less well-off people. Colchester is home to one of the largest UK-based military garrisons. The Trust values its relationship with the garrison and has developed a number of collaborative arrangements to provide services to soldiers and their families and to integrate garrison medical staff into service provision at the Trust. The Trust has developed good relationships with members and officers at Essex County Council, Colchester Borough Council, Tendring District Council, the Essex Health/NHS Overview and Scrutiny Committee and MPs in north east Essex.

Our financial performance The Trust achieved a surplus of £9.1m.

Compared with the previous year, income increased by 5.5%, from £244m to £257.5m. This was higher than planned and resulted from higher than planned levels of activity and one-off funding from NHS North East Essex (the PCT) for major capital expenditure.

	2012/13 £m	2011/12 £m
Operating income	257.5	244.0
Operating costs	(236.0)	(220.8)
EBITDA*	21.5	23.2
Non-operating costs	(12.5)	(12.1)
Impairment of non-current assets	0.1	1.2
Surplus/(Deficit) for the year	9.1	12.3

* EBITDA as defined by Monitor's *Compliance Framework 2012/13* is Earnings Before Interest, Taxation, Depreciation and Amortisation, but also excludes non-current asset impairments

Our services The Trust provides a range of patient services:

	2012/13	2011/12
Outpatient attendances**	418,911	409,491
Accident & Emergency patients*	76,338	73,504
Inpatient and day case admissions*†	90,729	84,336
Babies delivered	4,057	3,962

***Source: figures taken from Trust commissioned activity**

[^] Outpatient attendances include first, follow-up appointments and procedures carried out on an outpatient basis

[†] Inpatient and day case admissions include day cases, electives, non-electives and regular day attenders (RDAs)

Our sites	<p>The Trust owns and manages Colchester General Hospital, which opened in 1984, and Essex County Hospital, which was established in 1820. It has long been the strategy of this Trust and our predecessor organisations to centralise acute services at Colchester General Hospital.</p> <p>Scientific staff are based at the Severalls Hospital site and in the microbiology department near Colchester General Hospital.</p> <p>In addition, the Trust also provides some services, such as outpatient and maternity services, at the community hospitals in Clacton and Harwich – run by Anglian Community Enterprise (ACE) – and Halstead Hospital, run by Central Essex Community Services (CECS), and a limited range of community services.</p>
Our partners	<p>The Trust works with a variety of public, private and voluntary stakeholders. We do this to develop a sustainable environment in which people will continue to enjoy high levels of health and wellbeing but with modern health and social care services available for those who need them.</p> <p>The Trust had formal contracts or service level agreements with third parties that provided some essential services. The main contractor was Serco for payroll services.</p>
Our staff	<p>The Trust is one of the largest employers in north east Essex, employing 4,168 people on 31 March 2013.</p> <p>This has slightly increased from 4,163 on 31 March 2012.</p>
Our Trust's response to The Francis Report	<p>The final report of Robert Francis QC as Chairman of the public inquiry into the serious problems at Mid Staffordshire NHS Foundation Trust was published on 6 February 2013.</p> <p>Our Trust has carried out a comprehensive report of the recommendations from the Francis Report and the subsequent Government response. The Trust's Board of Directors has also set aside time to consider the report in detail and will closely monitor the progress of any action plans.</p> <p>We are committed to engaging staff in the implementation of the recommendations which has been linked to At Our Best (see page 17). A Francis Implementation Working Group has been established to focus on the key themes arising from the report and also on how we communicate and engage with our staff.</p> <p>The Trust's Annual Report for 2013/14 will include a section on how the Trust is taking forward the Francis recommendations, and will provide an annual update in future years on the progress made.</p>
Keogh Review	<p>In January the Health and Social Care Information Centre reported that the Trust was one of five acute hospital trusts in England with a higher than expected SHMI (Summary Hospital-level Mortality Indicator) over the two years beginning 1 July 2010.</p> <p>We achieved a reduction in crude mortality and mortality rates in 2012/13 while our Hospital Standardised Mortality Ratio (HSMR) was within the expected range. However, our Summary Hospital-level Mortality Indicator (SHMI) was above the expected level.</p> <p>In February the Prime Minister requested that Professor Sir Bruce Keogh, NHS Medical Director for England, investigate the 14 hospital trusts that were outliers in terms of either HSMR or SHMI, including this Trust.</p> <p>Prof Keogh describes this SHMI performance as a "warning light" – no judgment has been made on the quality of care. We understand that the review, with which we will co-operate fully, will be completed by the end of July.</p>

Our performance

Innovation in our portfolio of clinical services progressed in 2012/13. Among the many developments, the following are of note:

- Work began on a £25m radiotherapy centre at Colchester General Hospital which in April 2014 will replace the current facility at Essex County Hospital 50 years after it opened
- Colchester General Hospital became a centre for major vascular surgery, such as abdominal aortic aneurysm (AAA) repairs, for the 750,000 population of north east Essex, east Suffolk and the Colne valley. The Trust invested £1.5m in a specialist state-of-the-art operating theatre to support this work
- the establishment of a specialist centre for major vascular surgery enabled the roll-out of the NHS AAA Screening Programme in the same area. Its director is a consultant vascular surgeon at the Trust, which also recruited a team to run the programme
- a purpose-built, state-of-the-art £5m Sterile Services Unit at Colchester General Hospital, the most advanced unit of its kind in the East of England NHS region, became operational
- a total of £814,000 was invested in three new digital mobile screening units for the Chelmsford & Colchester NHS Breast Screening Service, which is run by the Trust. In addition, the breast screening service at Essex County Hospital went fully digital following an investment of £162,000
- operating theatre staff at Colchester General Hospital became among the first in the country to use 3D technology to help with laparoscopic (keyhole) surgery
- Colchester General Hospital became what was believed to be the first hospital in the UK to carry out a new type of minimally-invasive surgery that involves operating through natural orifices – Natural Orifice Translumenal Endoscopic Surgery (NOTES)
- a £170,000 refurbishment of Elmstead Services Day Unit, Colchester General Hospital, included improvements to its reception and waiting area and upgrading and refurbishing two surgical wards and an endoscopy room
- after achieving stringent performance targets, the Chelmsford & Colchester NHS Breast Screening Service joined a national trial to assess the value of extending the age span of the NHS Breast Screening Programme from 50-70 to 47-73.

Care Quality Commission rating and other accreditations

On 1 April 2010 the CQC confirmed the registration of the Trust without conditions.

See also “Service improvements following staff or patient surveys or comments and CQC reports” on page 21.

A&E four-hour standard

A&E is the department where many people come initially for care. The Trust was required to meet the target of 95% of patients spending four hours or less from arrival to admission, transfer or discharge. We achieved 96.10% (96.64% in 2011/12).

During 2012/13 our performance against the challenging national access standards was as shown in the table on the right:

	Standard	Performance 2012/13
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	93%	96.01%
Two-week wait for symptomatic breast patients (cancer not initially suspected)	93%	97.61%
All cancers: 62-day wait for the first treatment from national screening service referral	90%	94.34%
All cancers: 62-day wait for the first treatment from urgent GP referral to treatment	85%	86.71%
All cancers: 31-day wait from diagnosis to first treatment	96%	98.46%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	95%	100%
18-week maximum wait – admitted patients	90%	93.75%
18-week maximum wait – non-admitted patients	95%	98.25%
Percentage of patients on an incomplete pathway with a maximum of 18 weeks waiting time	92%	98.57%
MRSA	0	1
Clostridium difficile	25	29

Source: Performance Framework

Control of infection

The Trust continued to make good progress with controlling and preventing hospital-acquired infections. Rigorous clinical hygiene measures, controls on the prescribing of antibiotics, isolation of infected patients and root cause analysis of cases, supported by learning and implementing changes, had a significant impact. We participated in the Fourth National Prevalence Study on Healthcare Associated Infections which showed a Trust rate of 4.8% against a national average of 6.5%. We will continue our vigilant approach to continue to drive down the incidence of hospital-acquired infections in 2013/14.

Clostridium difficile (C Diff)

Clostridium difficile incidence is assessed as cases detected more than 48 hours after admission which are considered to be attributable to an infection acquired in hospital. The agreed maximum ceiling (based on historic performance) for the Trust was 25 cases. We had 29 cases. Maintaining a low number of cases (there were 28 in each of the two previous years) was testament to the vigilance of staff and compliance with best practice.

MRSA bacteraemia

MRSA incidence is assessed as cases detected more than 48 hours after admission which are considered to be attributable to an infection acquired in hospital. The Trust's target was to have no cases of MRSA bacteraemia but finished the year with one case (the previous case had been in May 2010).

Surgical site infection

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

Hand hygiene monitoring The Trust monitored hand hygiene compliance with best practice in all clinical areas every month. Compliance overall improved and is now consistently audited at 97%-98%.

Data loss and confidentiality breach

As part of NHS information governance rules, details of Serious Incidents involving data loss or a breach of confidentiality have to be reported. Patients and the public can be reassured that the Trust takes security and patient confidentiality very seriously.

The Trust reported 24 incidents relating to breaches of patient confidentiality in 2012/13. Most of these incidents were caused by a single document being given to the wrong patient on discharge from hospital or by being misfiled in their hand-held records.

The Trust self-reported two incidents to the Information Commissioner's Office (ICO) which is responsible for the enforcement of the Data Protection Act 1998.

One of these incidents related to a fax being sent to a bank by mistake. Investigations were carried out by the Trust and the ICO. The ICO decided that no further regulatory action was necessary because the incident was caused by human error. The ICO took into account that the Trust has procedures in place and a training programme for information governance and Data Protection Act issues.

The ICO informed us on 24 April 2013 that no further action will be taken regarding the second self-reported incident.

Future business plans

Our vision and priorities

The Board of Directors continued to support the roll-out of the At Our Best programme to inspire, support and develop all staff to consistently deliver the very best patient experience.

The Trust's vision did not change during the year and is summarised as:

To be widely recognised as the Trust that our patients and staff would want to recommend to their friends and relatives

The priorities that will help deliver the vision are:

- **inspiring our employees** – developing a culture that engages our employees in the business, promotes clear values and behaviours, underpinned by leadership styles of openness and involvement; which recognises and rewards the contribution of individuals
- **doing the core services well** – maintaining and enhancing our reputation as a safe, capable and efficient Trust, delivering high quality standards
- **strengthening our centres of excellence** – supporting existing high-performing services and developing others to serve the local population and beyond
- **shaping the future; ready to respond** – identifying a small number of policy areas of importance to the Trust and to seek to influence these as appropriate; strengthen horizon-scanning capability and have a flexible and dynamic ability to respond to opportunities
- **building a sustainable future** – supporting our long-term future and ability to improve facilities and services by optimising our surplus/contribution from clinical income; and building and growing our non-clinical income.

Principal risks and uncertainties

Managing risks

The Board of Directors monitors the key risks to the Trust through its review of the Risk Register, which maps the high-level risks associated with the achievement of our corporate objectives and embodies those risks in the organisation's Assurance Framework. Its principal aim is to provide a mechanism for the Board to regularly assess the level of risk against the controls in place to mitigate the risks and to also consider the adequacy of the assurance that is in place.

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

Proposed governance risk rating

Monitor gave the Trust a Governance Risk Rating of Amber Red for 2012/13 but await Monitor's confirmation of that rating (see page 47).

Effective risk and performance management

The Trust has robust risk management and clinical governance strategies in place which ensure monitoring of compliance with best practice. The Trust is compliant with the NHS Litigation Authority's Clinical Negligence Scheme for Trusts (NHSLA CNST) Level 2 for Maternity Services and the NHSLA Risk Management Standards Level 2.

Mandatory service risk The Trust's Board of Directors was satisfied that:

- all assets needed for the provision of mandatory goods and services were protected from disposal
- plans were in place to maintain and improve existing performance
- the Trust had adopted organisational objectives and managed and measured performance in line with these objectives
- the Trust was investing in change and capital estate programmes which would improve clinical processes, efficiency and, where required, release additional capacity to ensure we could meet the needs of patients.

A review of the risks associated with mandatory service provision was undertaken and no significant risks were identified.

Risk of any other non-compliance with terms of authorisation

The Board of Directors ensured that the Trust remained compliant with the relevant legislation.

The ongoing review of risks by the Executive Team did not identify any significant risks to compliance with the Trust's terms of authorisation.

Key financial performance indicators

Monitor uses financial risk rating indicators to assess the relative performance of the Trust. These risk ratings are shown in the table opposite along with the original plan for the year and the actual results

2012/13 Performance		Plan	Actual
Financial risk rating (5 = lowest risk)		3	4
<i>Comprising the following key indicators:</i>			
EBITDA margin	<i>EBITDA as a % of total income</i>	6.5%	8.3%
EBITDA % achieved	<i>% of planned EBITDA achieved</i>	100%	136.1%
Net return after financing	<i>Surplus net of financing as a % of assets</i>	1.9%	5.6%
Income & expenditure surplus margin	<i>Retained surplus as a % of total income</i>	1.2%	3.7%
Liquid ratio	<i>Number of days operating expenses that could be covered</i>	39.6	54.1

Contractual or other arrangements

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

Summary of contractual relationships

- NHS North East Essex and associates (healthcare commissioning)
- Mid Essex Hospital Services NHS Trust (plastics)
- North Essex Partnership NHS Foundation Trust (clinical services)
- Havering Primary Care Trust (orthotics, special seating and wheelchairs)
- Anglian Community Enterprise CIC (clinical services)
- East of England Ambulance Service NHS Trust (patient transport service).

Overview of other procurement arrangements

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

- National Blood Service (blood products).
- Serco
- Alliance Medical (MRI scans)
- Blatchford (orthotics service)
- Blatchford (prosthetics service)
- GE Capital (patient monitoring equipment)
- Fresenius (renal service)
- Prime Diagnostics (endoscopy).

Joint ventures and partnership arrangements

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

- a Section 31 partnership under the Health Act 1999 with Essex County Council, Mid Essex Hospital Services NHS Trust, NHS Mid Essex, NHS North East Essex, NHS South East Essex, NHS South West Essex and Thurrock Council for an integrated community equipment service
- partnership arrangements with Ipswich Hospital NHS Trust and Mid Essex Hospital Services NHS Trust for a range of clinical services
- joint venture with Anglia Ruskin University for the development and management of The ICENI Centre for training and research and development in laparoscopic surgical techniques.

Improving the patient experience – At Our Best

Coming to hospital as a patient is not something anyone looks forward to but it is the Trust's ambition to make the patient experience as positive as possible

This is not just about achieving a good clinical outcome (making patients better) but is also about respecting their privacy and dignity, keeping them informed and encouraging them to raise concerns and anxieties.

The Trust is committed to working with patients and clinical staff to provide high levels of patient experience and to learn from reported incidents and patient suggestions to make service quality the best we can achieve.

The Trust has an ongoing audit programme that captures patients' opinions and experiences, and is running a continuous programme called At Our Best which embeds the values and behaviours that are important for staff to ensure we deliver the best possible patient experience.

Our promises

By consistently living up to the expectations we have of each other, we can be 'at our best' for patients and for one another.

Be **welcoming**

- We introduce ourselves: my name, my role, may I
- Be courteous and polite
 - Make eye contact
- Think the best of people
- Treat people as individuals

Caring

Be **kind**

- Compassionate, thoughtful
- Stand in their shoes - how might your patient feel?
- Maintain people's dignity
 - Respect privacy
- Respect pain, be gentle

Be **involving**

- Listen, listen, listen
- Keep people informed
- Explain clearly (no jargon)
 - Answer questions, so people know what to expect
- Involve people in their care

Communication

Be **responsive**

- Be attentive - notice
 - Respond quickly
 - Offer to help
- Keep your word
- Value patients' time

Be **professional**

- Mindful of how things we say and do affect patients
 - Seen to be clean
 - Calm and reassuring so people feel safe
- Set and maintain standards
- Team-work / team-respect

Consistency

Be the **difference**

- Take responsibility
- Choose a positive attitude
 - Ask for feedback
- Can do – look for solutions
- Praise good work, speak up about poor / unsafe care

At Our Best

Launched in March 2011, At Our Best is an ongoing programme of improvement to address concerns that had been expressed by patients and carers about the attitude of some staff. It aims to inspire, develop and support every Trust team by listening to the experiences of patients and carers. As a result of listening, the Trust set three values – Caring, Communication, Consistency – to support the meaning of At Our Best. These values influenced how the Trust set leadership behaviours and recruited staff.

In 2012, 89% of all Trust staff attended a 2½ hour facilitation session. This proved to be a very successful way to enable staff to focus on communication skills and what it is really like to be in a patient's shoes.

Each behaviour had a formal launch and was communicated via posters and Executive Team walkrounds. These enabled the values and behaviours to be embedded throughout the organisation. The development of a set of leadership behaviours underpinned At Our Best to further change the organisational culture.

The Trust held a quarterly At Our Best Awards scheme for individual members of staff, teams and volunteers who had been nominated by colleagues, patients, carers or members of the public for displaying behaviours in line with

the At Our Best behaviours and standards.

As part of the long-term plan, further work has begun to develop “At Our Best Everyone Everywhere” in order to:

- keep improving the patient experience – not just in pockets but for everyone, everywhere
- improve the experience of staff working for the Trust so they feel they are supported to deliver high quality care.

Graffiti boards were distributed throughout the organisation for staff to provide valuable feedback about how the staff experience could be improved.

Patient and Staff Experience Committee

The Patient and Staff Experience Committee, which reports to the Quality & Patient Safety Assurance Committee (see page 59), met monthly and provided assurance that the divisions were monitoring, reporting and acting on patient experience feedback.

Patient safety

Patient safety

Our ultimate aim is to deliver the highest quality health care services to our patients. This is part of the Trust's commitment to be At Our Best for patients and colleagues, and to be widely recognised as the Trust that our patients and staff would want to recommend to their friends and relatives.

The Trust continued to work with the national High Impact Actions and Releasing Time to Care campaigns. We made significant progress for the second consecutive year in reducing harm from both falls and pressure ulcers.

The Patient Safety Strategy 2010-2013 outlines our ambition to promote a safer culture within our hospitals and services in order to deliver significant reductions in both mortality and harm events. This has led to the development of key safety workstreams which each co-ordinates improvement work across the Trust.

As part of the wider strategy, each area is responsible for the setting and delivery of Trust-approved improvement targets. Performance against internal and external quality indicators is monitored by the Patient Safety Committee. Assurance is provided through a quarterly review by the Quality & Patient Safety Assurance Committee.

Patient safety walkrounds

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

Each tool has been developed using national and local best practice and, where possible, the inclusion of objectives and standards set within the organisation's own policies and procedures documents. Each area is then benchmarked against these standards and a RAG (Red, Amber, Green) rating applied.

The assessment involves:

- a review of predetermined key specific indicators relevant to each speciality
- audit of record-keeping standards and identifying areas of poor/positive practice.
- observations of care and identifying areas of poor/positive practice.

A walkround and observations of care and the environment include a review of patient safety, patient experience, governance, clinical effectiveness and risk management.

A report, including detailed findings of the assessment, conclusions and key recommendations, is developed and circulated.

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

As part of a new assurance process, an Executive Team-led follow-up review is held six weeks after the initial visit. Its aim is to ensure that any identified improvement actions are underway where appropriate and that learning has been discussed at local governance meetings.

Mortality

Mortality indicators show whether death rates in hospitals are changing. Standardisation allows comparisons for different mixes of illnesses being treated between hospitals and over time. An estimate of the number of expected deaths is calculated for each hospital based on the characteristics of patients admitted. Then the actual number of deaths is compared with this figure giving a “standardised rate”.

The Trust takes mortality issues very seriously, including the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI).

HSMR and SHMI

The HSMR and SHMI indicators give an indication of whether the mortality ratio of an organisation is higher or lower than expected when compared to the national baseline (England).

There is an important distinction between the two:

- SHMI is about deaths in hospital and deaths up to 30 days after discharge
- HSMR relates only to deaths in hospital.

The Trust’s HSMR for 2011/12 improved to 101.8 (100 is the national average), which was within the expected range. The latest position available for HSMR for 2012/13 (up to the end of January 2013) is 101. This will be rebased at the end of 2013.

The most recent release of SHMI data (24 April 2013) for the 12-month period ending 30 September 2012 gives the Trust a higher than expected rating of 117.2.

In autumn 2012 the Trust commissioned a report from the Dr Foster healthcare information organisation to understand the variance between the HSMR and SHMI performance. The report concluded that the difference was explained partly by inclusion of deaths after discharge and the exclusion of palliative care coding in SHMI but there remained a gap probably explained by the different methods of calculating the two indices.

The Trust has continued to work on the reorganisation of emergency care following a review it initiated by the NHS Emergency Care Intensive Support Team in 2011. The focus has been on providing early, and regular, senior review of patients. Two additional consultant posts were filled in the Emergency Assessment Unit and “board rounds” were developed on acute wards to improve multidisciplinary working.

The Trust is concentrating on:

- internal professional standards related to initial review
- development of a definitive management plan
- providing patients with information on their expected length of stay
- criteria for discharge
- information being given to patients on discharge.

Data from case note reviews in 2012/13 suggests that up to 73% of patients were seen by a consultant within 12 hours of admission.

The Trust's Mortality Review Group was restructured to include representatives from North East Essex Clinical Commissioning Group, community providers, St Helena Hospice and the ambulance service. It developed a joint action plan to improve the care provided to patients, both in the Trust's hospitals and in the community, and to address the findings of case reviews.

The Trust continues to strengthen its governance structure. For example, a coaching programme began for the senior nurse and consultant at ward and departmental level.

Weekly mortality reviews continued, which were attended by the Executive Team.

There were several case note reviews following alerts in diagnostic categories for which the Trust appeared to be an outlier. Those completed include breast cancer, diabetes with complications, aspiration pneumonitis, acute bronchitis, chronic obstructive pulmonary disease and skin and subcutaneous tissue disorders. One common finding related to the need to improve the recording of the primary diagnosis and co-morbidities. The Trust's Medical Director is chairing a documentation group to concentrate on these issues.

Keogh Review Professor Sir Bruce Keogh, NHS Medical Director for England, is investigating 14 hospital trusts that were outliers in terms of either HSMR or SHMI, including this Trust. See page 10 for details.

Falls prevention The Trust has made excellent progress over the past two years in reducing the number of inpatient falls and severity of harm sustained. As a result, the Trust achieved its 2011/12 CQUIN (Commissioning for Quality and Innovation) and its own internal falls reduction target for 2012/13.

The Trust achieved a 12% reduction (167 fewer falls) in the number of inpatient falls for 2011/12 and a 45% reduction (23 fewer falls) in the number of falls resulting in serious harm (moderate, severe, or death) in 2011/12.

Despite the significant progress made in 2011/12, the Falls Operational Group agreed further internal falls reduction targets for 2012/13 to support this key patient safety indicator. A target reduction of 5% in the overall number of inpatient falls for 2012/13 was agreed with a further 5% reduction in falls resulting in serious harm.

Data for 2012/13 confirms the Trust reduced the number of inpatient falls by 11%, significantly higher than the 5% target set in April 2012. This equates to 137 fewer falls for 2012/13 against the 2011/12 baseline. This means that compared to the falls rate recorded for 2010/11, there have been 471 fewer falls over the past 24 months.

Data for 2012/13 confirms that the Trust reduced the number of serious harm falls by a further 7% (internal Trust ceiling of 5%). This equates to two fewer falls resulting in serious harm.

Therefore, when the 24 months of data for 2011/12 and 2012/13 are reviewed, the Trust reduced the total number of serious harm falls by nearly 50% (from 51 to 26), which is an important achievement and one which has had a direct impact on the safety of our patients.

Pressure ulcers Pressure ulcers are an unwanted complication associated with healthcare and estimates suggest that they cost approximately 4% of the total annual NHS expenditure. They are costly in terms of prevention, management and human suffering.

In 2011/12 the Trust achieved a reduction of 84% in grade 3 and 4 hospital-acquired pressure ulcers against a CQUIN target of 35%. The ambition linked to the CQUIN target for 2012/13 was to eliminate all avoidable grade 2, 3 and 4 hospital-acquired pressure ulcers through a zero tolerance approach.

To support the successful delivery of this programme, the Tissue Viability Clinical Nurse Specialist continued to develop a tailored suite of comprehensive training programmes for all staff that highlight the organisation's expectations and attitudes towards pressure ulcer assessment, prevention and management.

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

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

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

Whilst the overarching CQUIN ambition for a zero tolerance to all avoidable grade 2, 3 and 4 pressure ulcers was not met, there was a significant reduction compared to 2011/12.

In 2011/12, 315 hospital-acquired pressure ulcers grades 2 to 4 were recorded on the Trust's Datix Incident Reporting System compared to 136 for 2012/13. This is a reduction of 56.8%. For grade 2 pressure ulcers, there has been a 65% reduction and a 28% reduction in grades 3 and 4. This is an important achievement as patients are increasingly admitted with skin integrity problems as a result of immobility, dehydration, malnutrition and peripheral circulation issues. In 2011/12, 1,062 community pressure ulcers were recorded on admission. This rose by 22% to 1,297 in 2012/13.

*Service improvements
following staff or patient
surveys or comments and
CQC reports*

The Trust has well-developed systems for communicating and monitoring implementation of recommendations following visits, publications and surveys from a range of external healthcare regulatory organisations, including the Care Quality Commission (CQC).

The Trust's current registration status with the CQC is active and the Trust has no conditions on registration. The CQC did not take enforcement action against the Trust in 2012/13. However, the Trust has participated in special reviews or investigations by the CQC relating to the following areas:

May 2012

- people's personal records, including medical records, should be accurate and kept safe and confidential – standard met the part of the regulation which was the subject of this review in relation to the maintenance of HSA1 forms.

January 2012

- respecting and involving people who use services – minor concern
- care and welfare of people who use services – standard met
- meeting nutritional needs – standard met
- management of medicines – standard met
- supporting workers – standard met

- assessing and monitoring the quality of service provision – moderate concern.

The Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- development and implementation of a comprehensive remedial action plan.

The Trust had made the following progress by 31 March 2013 in taking such action:

- a comprehensive action plan was in place from January and a range of improvements have already been successfully implemented in response to any concerns identified.

Improvements in patient information

Our patient information strategy continued to ensure healthcare professionals were able to deliver accurate, up-to-date, easy-to-understand, informative and timely information to patients. Almost 1,000 different leaflets were available, which were compliant with Department of Health guidelines. Regular audits were carried out to ensure standards were maintained. The information was reported to the Patient and Staff Experience Group.

Privacy and dignity

Privacy and dignity

Maintaining patients' privacy and dignity remained a Trust priority. Patients were asked as part of a questionnaire to assess how well the Trust was doing in this essential area. This information was monitored each month, and reported to clinical areas.

Delivering same-sex accommodation

The NHS Constitution confirms a patient's right to dignity and respect, as does the Department of Health, and our Trust is committed to treating all patients with privacy and dignity in a safe, clean and comfortable hospital environment.

The Trust is compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest or reflects their personal choice.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and that same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example, where patients need specialist equipment such as in Intensive Care or when patients actively choose to share, eg Renal Unit).

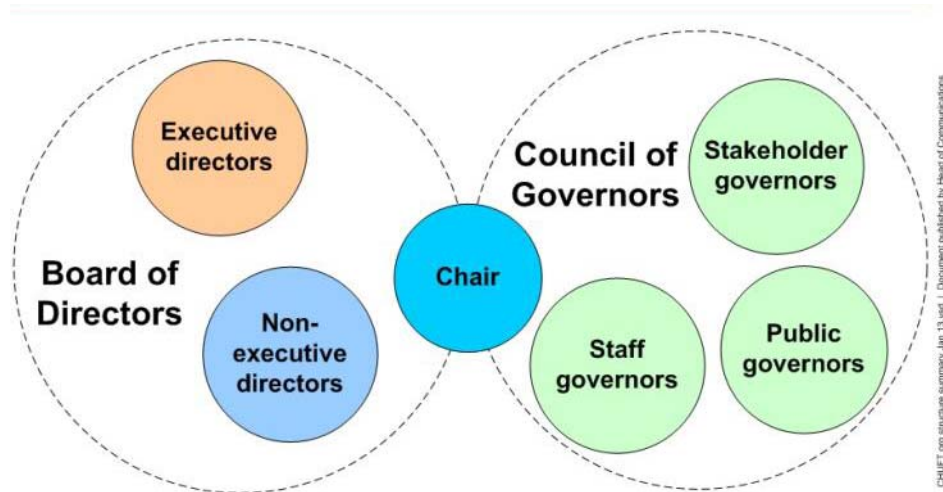
If our care falls short of the required standard, we report it. We also have an audit mechanism to make sure that we do not misclassify any of our reports. We publish the results of that audit as part of our patient experience audits.

There were no breaches during the year and the Trust has declared full compliance with delivering same-sex accommodation. Work by the Trust's estates team has been completed to ensure full compliance. The Trust undertakes continuous monitoring.

Accountability

Our organisational structure

NHS foundation trusts have been created to hand over decision-making from central government to local organisations and communities. This allows our Trust to be more responsive to the needs and wishes of local people. We do this through an elected Council of Governors which works closely with the Trust's Board of Directors to influence decision-making and strategic planning



You can read more about our Council of Governors on page 48 and about our Board of Directors on page 51.

A more detailed diagram is on page 48.

Our membership

Eligibility requirements for joining different membership constituencies

Our Trust has two types of member: public and staff.

Public members are people aged 16 years or over who live in Essex or Suffolk and have registered to become a member.

Staff members are automatically registered when they join the Trust. They include any employee and volunteers (see page 35 for definition of "staff").

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

Public constituency	1 April 2013	31 March 2012
Colchester	3,284	3,228
Halstead & Colne Valley	826	847
Rest of Essex and Suffolk	633	596
Tendring	2,312	2,361
Total	7,055	7,032
Staff constituency		
Allied Health Professionals/Health care scientists	595	497
Medical or dental practitioners	469	420
Not known	4	50
Nurses/midwives	1,195	1,155
Support staff	2,008	2,156
No constituency/Out of catchment	0	0
Total	4,271	4,278

Overall, public membership remained fairly static during 2012/13.

	2013	2012	New members	Leavers
Public	7,055	7,032	390	367
Staff	4,271	4,278	830	837

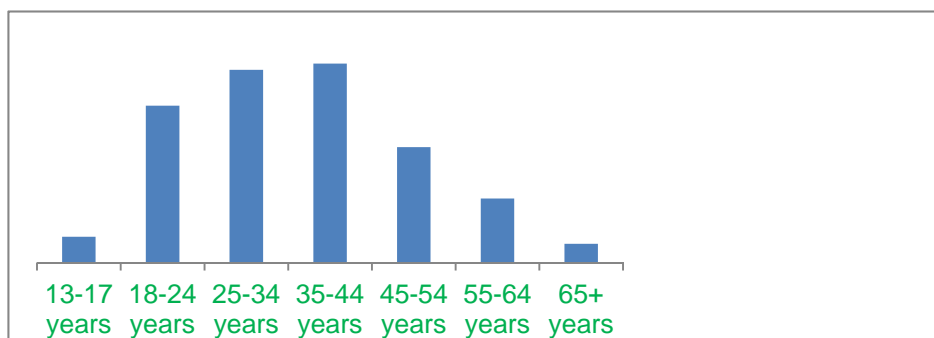
A summary of the membership strategy, an assessment of the membership and a description of any steps taken to ensure a representative membership, including progress towards any recruitment targets for members

There is a fairly uniform distribution of public members across the catchment area of Suffolk and Essex, including areas of deprivation and people from an ethnic minority background. As with many NHS foundation trusts, there is under-representation of people between the ages of 16 and 59.

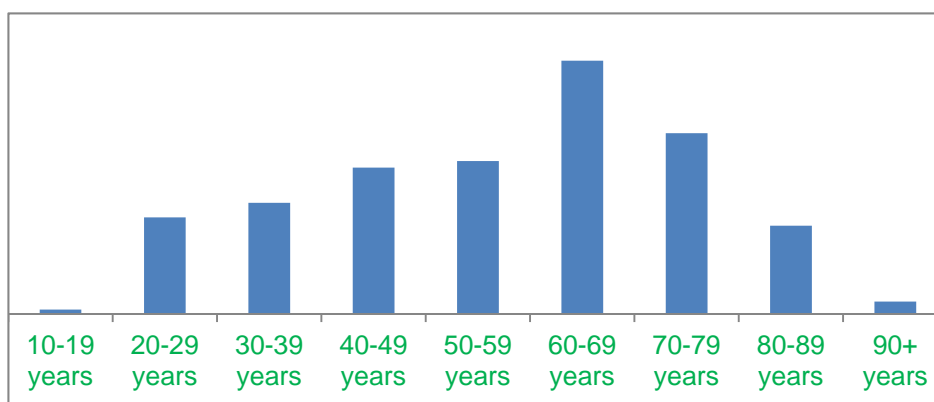
In August the Trust's communications team started formally using social media, such as Facebook and Twitter, to further engage and communicate with users of the Trust's services. The Trust's Twitter page had 388 followers on 31 March and the team had tweeted 438 times (about twice a day) since its launch. By 31 March more than 230 people had "liked" the Colchester General Hospital Facebook page.

Through the use of social media, the Trust is reaching out to a different audience in terms of age:

This chart shows the age profile of people "liking" our Facebook page



This chart shows the age profile of our public members



Contact procedures for members who wish to communicate with governors and/or directors

Members can contact governors via the Membership Office on 01206 742347 during office hours or email ft.membership@colchesterhospital.nhs.uk

We also have a Membership Helpline, 08000 515143, weekdays, 9.30am-5pm.

To contact a director, call 01206 742586 during office hours.

All of this information can be found on our website under "FT members' pages" and "Organisational Structure".

See also page 6 for more contact details.

Monitoring the patient experience

How the Trust monitors the patient experience

The NHS Friends and Family Test was introduced to the Trust in April via a leaflet given to each patient on their discharge. This leaflet includes five pledges to ensure patients had the following information:

1. You are clear about what's happened
2. You have written information about what to do after leaving hospital
3. You are aware of any possible danger signs to look out for
4. You know how to take your medication, and about any possible side effects
5. You know who to contact if you are worried about your condition

Patients were asked to complete the simple question: "How likely is it that you would recommend this service to friends and family?" They were asked to score from 0 to 10, with 0 being not at all likely and 10 extremely likely. There was an opportunity for comments to be added.

The Trust performed well with scores between 76 and 82, placing it in the top quarter regionally for most of the year.

Data was collated each week and a weekly report was sent to all ward areas and divisions. The clinical areas displayed their scores on Patient Experience Boards which include a "You said-We did" comment section which shows that action was taken to address concerns.

Web-based information was gathered via information tablets in order to provide further in-depth information and to ensure the Trust had the best possible insight into how patients perceived services. The questions asked were chosen to reflect aspects of care that were highlighted in other patient surveys, in complaints or derived from the Essence of Care standards. "Live" data enabled staff to evaluate the patient experience and to act on feedback almost immediately. Most clinical areas consistently attained a satisfaction rate in excess of 90%.

Patient and public involvement

As an NHS foundation trust, we are committed to the principle of public, patient and staff involvement. Public and staff members have elected governors to represent their views. Governors are involved in many aspects of Trust monitoring to ensure there are standards in place for their communities. For example, there is a governor on the Patient Environment Action Team (PEAT) – see next page.

Engaging our staff in developing a patient experience approach

The Trust continued to take significant strides to engage staff in developing an approach that focused on improving the patient experience. The Trust provided leadership programmes with specific modules about patient experience. Managers were asked to undertake a work-based project that would contribute to improving patient services and to take part in "Back to the Floor" sessions in order to gain a better understanding of the work of frontline staff and the needs of patients.

All new job descriptions, person specifications, adverts and questions at interview reflected the attitudes, behaviours and standards the Trust expects of employees. We continue to use a DVD that makes the Trust's expectations very explicit for potential employees.

All new staff attended a corporate induction where a half-day was dedicated to patient experience and what all staff must do in terms of behaviours to ensure the Trust is at its best consistently. Staff discussed patient stories shown on a DVD – good and bad – and were joined at these discussions by past and present patients.

The Trust is in the process of updating its human resources policies and procedures to reflect the behaviours expected from its staff. These are now

included in all staff appraisals, and the At Our Best themes are reflected in all internal training.

Patient Environment Action Team

In 2011 the management of Patient Environment Action Team (PEAT) transferred to the NHS Information Centre. In 2012/13 staff from the Trust's facilities management team, together with public governors, held monthly mini-PEAT walkabouts to help monitor cleaning and environmental issues. This drove up standards and enabled the Trust to address concerns as soon as they arose. From April 2013 PEAT was replaced with PLACE – Patient-led Assessments of the Care Environment. These assessments will include local people going into hospitals as part of teams to see how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job.

Compliments, comments and complaints

"Got something to say?"

"We are committed to improving the experience of our patients. You can help by telling us what you think - good or bad."

In 2011 the Trust launched its "Got something to say?" campaign, which highlights to patients how they can raise a concern with the Trust.

It features the Chief Executive Dr Gordon Coutts who asks patients, relatives and/or carers to make sure they tell us if they have a comment, compliment or complaint:

1. If something is not right, ask to see the person in charge. They should be able to sort out the problem straight away.
2. Or ask to speak to the Patient Advice and Liaison Service (PALS) or the Duty Matron.
3. If you are still not satisfied, please write to me.

PALS (office hours): Freephone 0800 783 7328 pals@colchesterhospital.nhs.uk

The Duty Matron can be contacted 24 hours a day, via switchboard: 01206 747474

You can download the poster from our website.

Integrated PALS, Complaints and Litigation Services

The Trust is committed to learning and improving the service offered to patients and visitors who can help by telling us what they think of their experience.

In 2011/12 there was a 24.2% reduction in the number of concerns/complaints received by the Trust compared to 2010/11. This downward trend continued in 2012/13 when there was a further reduction compared to the previous year. There was also a reduction in the number of reopened complaints. The Trust received 20,107 compliments in 2012/13.

Patient Advice and Liaison Service (PALS)

Our Patient Advice and Liaison Service helps patients, carers, relatives and families resolve problems as quickly and easily as possible by putting them in touch with the appropriate member of staff. The Trust aims to resolve all informal concerns and requests at the time they are received or as quickly as possible. If they can be addressed within 24 hours, they are a Level 1 concern. If more in-depth intervention is required, they are considered a Level 2 complaint. A total of 493 requests for information and 56 Level 1 concerns were recorded.

Information on complaints handling

The Trust continued to operate a robust complaints handling system. A total of 809 Level 2 and above complaints were received, 640 of which were written complaints. A total of 732 Level 2 and above complaints were due for first response; of these, 601 (82.1%) were answered in timescales agreed with the complainants.

Local resolution of complaints

A total of 77 (9.51%) complainants were not satisfied by the first response they received from the Trust, which was a 3% improvement on the previous year. The reason for complaints being re-opened was that complainants had concerns that

were either not addressed completely the first time or because further questions were raised. Often, complainants requested a meeting with Trust staff to address their concerns. A number of successful meetings were arranged.

*Referrals to the
Parliamentary Health Service
Ombudsman*

The Trust was informed of 18 referrals made by complainants to the Parliamentary Health Service Ombudsman (PHSO) for further consideration of their complaints.

The Trust was advised of the detailed assessment of six of these complaints. Intervention was required in all six cases. The PHSO identified two cases that required investigation. We received the outcome of two investigations, one of which had started in the previous year. Each case was upheld.

*Service improvements
following complaints*

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

Below are some examples.

- staff in the Neurology Team now ensure an urgent appointment is given so that sensitive results can be shared face-to-face following diagnostic investigations
- work has started to address the issue of delays in answering phone calls on the Emergency Assessment Unit. This includes reviewing the telephone system and the number of extensions
- patients referred to tertiary centres by clinical staff in Women's Services are now directed to the General Office at Colchester General Office to ensure they are aware of how and from whom they can claim their travelling costs, if appropriate
- improvements have been made to the Bereavement Suite at Colchester General Hospital. Staff are also looking into a better way to secure and transport the property of patients who have died
- a daily meeting is held to discuss new referrals to the pain department and any deviation to planned sessions. Additional clinics and Saturday clinics were introduced to reduce waiting times.

Sustainability – energy and resources

<i>Why sustainability reporting is being carried out</i>	<p>The Trust takes its responsibility as a major employer and consumer of energy and resources seriously and is committed to helping reduce the adverse effects of its operations on the wider environment.</p> <p>The Sustainability Reporting Framework, which was available to use on a voluntary basis in 2010/11, became a mandatory part of the annual reporting requirements from 2011/12. You can read the framework later on in this section.</p>
<i>The overall sustainability strategy of the Trust</i>	<p>The Trust drafted a Sustainable Development Plan to provide the necessary tools to address and reduce its carbon footprint while at the same time improving the organisation's overall corporate social responsibility.</p>
<i>The governance processes in place to support the management and reporting of sustainability performance</i>	<p>Tom Fleetwood, non-executive director, leads for the Board of Directors on sustainability issues. The executive director lead is the director of estates and facilities.</p>
<i>Summary of performance</i>	<p>The Trust was the best-performing hospital trust in Essex in the Environment Agency's energy efficiency performance league table, which was published in early 2013. The Trust was in the top 15%, finishing 304th out of 2,097 organisations.</p> <p>The Trust won the Carbon Saver Gold Standard for the second time in succession for reducing carbon emissions over a three-year period and was shortlisted for the East of England Carbon Reduction Award by Business in the Community.</p> <p>In 2012 the Trust signed the National Grid's Short Term Operating Reserve (STOR) with the company KiWi Power, which helps organisations use energy more intelligently. The indicative revenue is twice the amount (£20K) compared with the previous STOR provider.</p> <p>In the winter the Trust for the second time successfully carried out the Triad management programme on its own. The Triad or Transmission Network Use of System (TNUoS) is an element of electricity charges (£55K compared with £45K for 2011) recovered by the National Grid if the Trust uses the grid electricity during three of the peak demands in winter.</p>
<i>Other environmental issues</i>	<p>The Trust attained a silver level in Essex County Council's Travel Plan Accreditation Awards. These awards are made to businesses and large organisations and reflect an organisation's efforts to promote and develop its travel plan, ensuring it delivers measurable progress towards achieving greener travel. This includes a car share scheme for staff, an "Access to Work Group" and a staff hopper bus service.</p> <p>This was the Trust's first attempt at accreditation and to be awarded silver demonstrates its commitment to developing and maintaining an effective travel plan and green transport policy.</p>

Comparative data The table below shows significant discrepancies between the two years, especially on waste to landfill/energy recovery and recycling figures. In 2011/12 general waste was consigned in error by the previous provider, Carillion. Carillion consigned all general waste to the local waste collection supplier where 70% was recycled. This was corrected by the Trust as we cannot consign as general waste and claim as recycled even if this was recycled by the supplier. For 2012/13 the Trust general waste service supplier has confirmed that all Trust domestic/residual waste was baled, wrapped and transported to energy from waste facility.

Water and electricity consumption increased by 1.5% and 4.8% respectively. However, gas consumption increased significantly by 17%, mainly because of a colder winter which went on until March 2013.

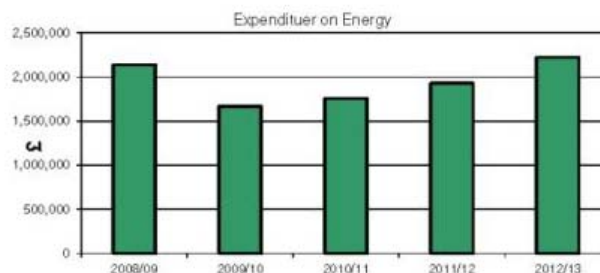
The CRC (Carbon Reduction Commitment) Energy Efficiency Scheme allowance cost at £12/tonne introduced in 2011/12 remained unchanged through to 2012/13. The opening of the new Sterile Services Unit in July 2012 contributed to the increase in CO₂ emissions.

Area	Volume 2012/13	Volume 2011/12	Cost 2012/13	Cost 2011/12
Waste management:				
High temperature disposal waste (tonnes)	493.3	493.5	£238,402	£286,299
Landfill/Energy Recovery disposal waste (tonnes)	590.7	250.1	£93,330	£15,529
Total Waste Recycled	153.3	583.7	£16,106	£36,244
Total	1237.3	1,327.3	£347,838	£338,072
	Consumption 2012/13	Consumption 2011/12	Cost 2012/13	Cost 2011/12
Utilities:				
Water (m ³)	115,965	114,262	£244,000	£229,510
Electricity (kWh)	13,551,000	12,928,888	£1,246,000	£1,186,741
Gas (kWh)	29,300,300	24,912,670	£930,400	£726,953
Oil (kWh)	659,567	268,231	£44,382	£17,359
CO ₂ emissions (tonnes)	12,874	11,427.3	£154,488	£140,916

For more detailed analysis, refer to the Sustainability Reporting Framework, on the following four pages (this is reproduced from the reporting tool, provided by the Department of Health and therefore follows a standard format).

Sustainability Reporting Framework – carbon emissions

15%



The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal.

There is also a financial benefit which comes from reducing our energy bill.

Our energy costs have increased by 15% in 2012/13, the equivalent of 51 hip operations.

£112,000

We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next 10 years we expect to save £112,000 as a result of these measures.

153 tonnes

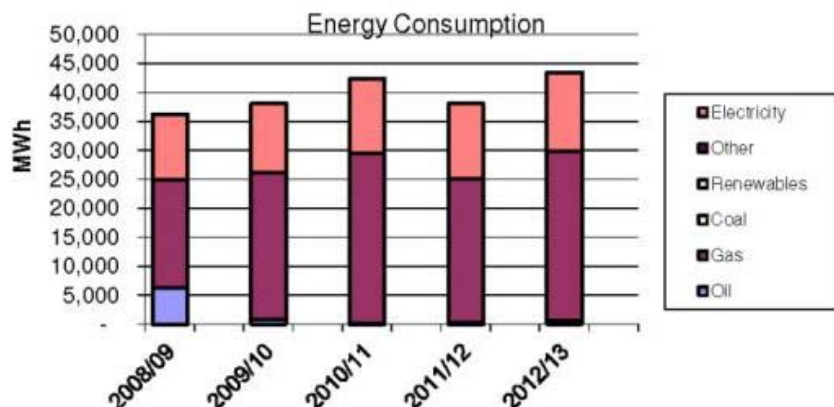


We recover or recycle 153.3 tonnes of waste, which is 12% of the total waste we produce.

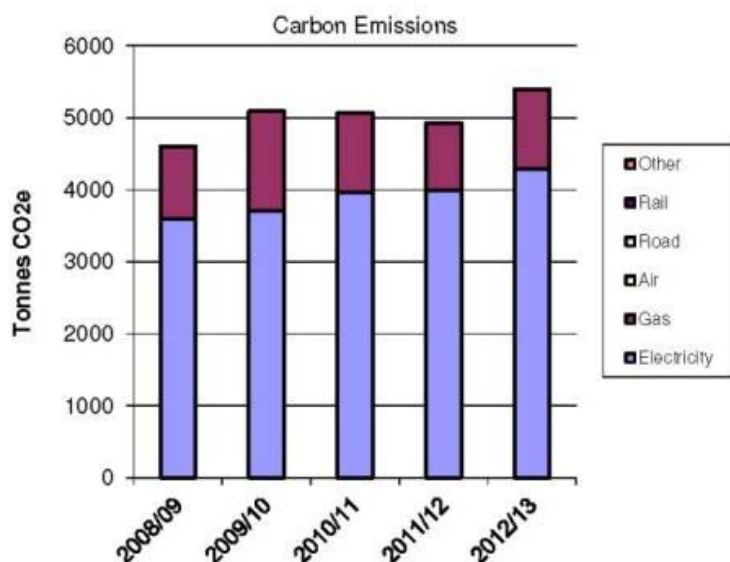
Sustainability Reporting Framework – energy consumption

Our total energy consumption has risen during the year, from 38,110 to 43,511 MWh

Our relative energy consumption has changed during the year, from 0.49 to 0.56 MWh/square metre.



Renewable energy represents 0.0% of our total energy use. We do not generate any energy. We have made arrangements to purchase electricity generated from renewable sources

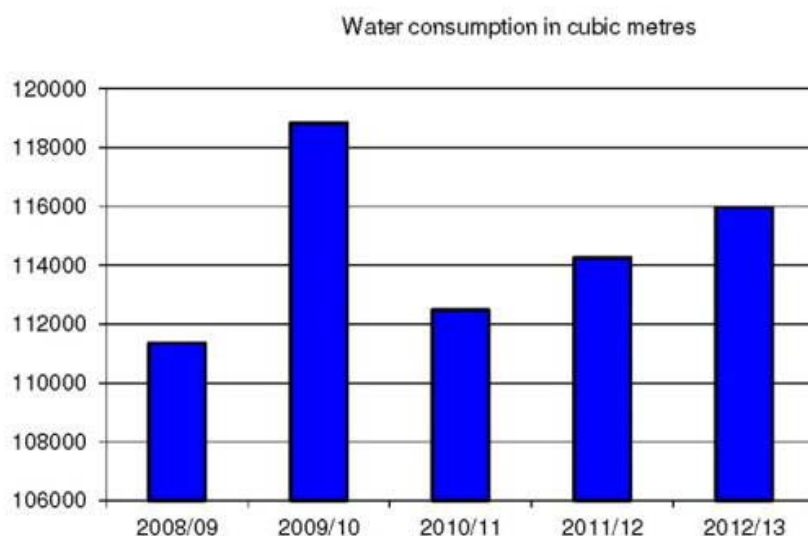


Our measured greenhouse gas emissions have increased by 0,472 tonnes this year.

We do not currently collect data on our annual Scope 3 emissions.

Our water consumption has increased by 1,703 cubic meters in the recent financial year.

In 2012/13 we spent £244,000 on water.



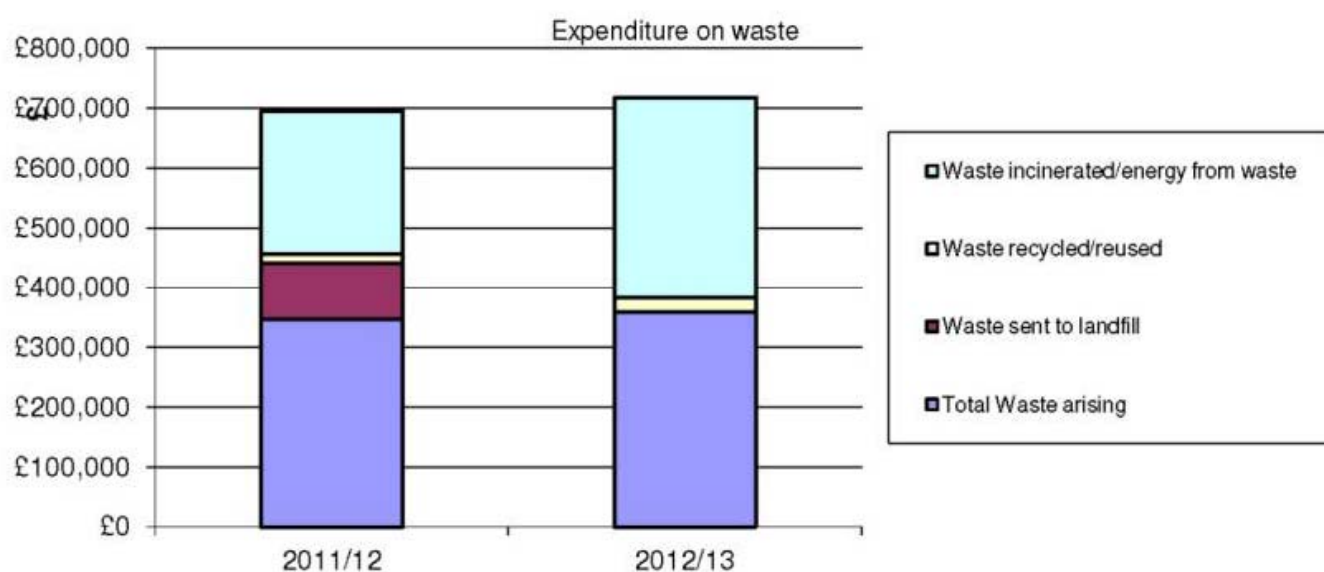
Sustainability Reporting Framework – energy expenditure

During 2012/13 our gross expenditure on the CRC Energy Efficiency Scheme was £154,488

The CRC Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations.

During 2012/13 our total expenditure on business travel was £476,000.

Our expenditure on waste in the last two years was incurred as follows:



Sustainability Reporting Framework – notes

Our organisation has an up to date Sustainable Development Management Plan.

Having an up to date Sustainable Development Management plan is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

We consider neither the potential need to adapt the organisation's activities nor its buildings and estates as a result of climate change

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future.

Sustainability issues are included in our analysis of risks facing our organisation

NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations.

In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This will be set out within our policies on sustainable procurement.

We plan to start work on calculating the carbon emissions associated goods and services we procure.

Tom Fleetwood is the Board Level Lead for Sustainability.

A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Sustainability issues, such as carbon reduction, are not currently included in the job descriptions of all staff.

Our last staff awareness campaign was conducted on the

A sustainable NHS can only be delivered through the efforts of all staff.

Staff awareness campaigns have been shown to deliver cost savings and associated reductions in carbon emissions.

Our organisation does not have a Sustainable Transport Plan.

The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. It is therefore important that we consider what steps are appropriate to reduce or change travel patterns.

Research & Development

Research & Development

Research at the Trust continues to be supported by the National Institute of Health Research (NIHR) via the Essex and Hertfordshire Comprehensive Local Research Network (E&H CLRN). The E&H CLRN distributes funding via the Trust's Research & Development Office (R&D) to provide clinical, research governance and diagnostic staff to engage and contribute to the delivery of portfolio research.

Local Specialty Groups, led by clinicians involved in research, encourage consideration and set-up of studies on the portfolio of research adopted by the NIHR. Cancer, stroke, medicines for children and diabetes research networks continue to promote and support the delivery of new studies.

Also contributing to research activity were collaborations with the University of Essex through its links with the Trust via the Essex Biomedical Sciences Institute annual conference and joint research ventures.

Health Enterprise East supported the Trust in the exploration of potential commercialisation of intellectual property.

The Trust (Physiotherapy) applied successfully to NIHR for a Research for Patient Benefit (RfPB) grant, supported by R&D, the University of Essex and the Research Design Service (RDS). Two further RfPB applications have been submitted in collaboration with R&D, Anglia Ruskin University and RDS.

Median time in calendar days for local checks to be completed & NHS permission issued

All studies processed through the national NIHR Co-ordinated System for gaining NHS Permission (CSP) are required to deliver NHS permission within 30 days. Changes to local processes to avoid delays in issuing NHS permission have been implemented in R&D and researchers educated about submissions of the Site Specific Information (SSI) forms and supporting study documents, including contracts to ensure robust and efficient systems and research delivery are in place to facilitate the speedy set-up and start of studies.

Maximise engagement in NIHR CRN portfolio research

The Trust was involved in 225 studies, of which 147 were open to participant recruitment (58 studies on the NIHR portfolio) with 78 studies closed to recruitment and in participant follow-up status.

The ratio split for interventional/observation studies was 36/64, an increase on the previous year (18/82).

Research within the Trust focused on the following areas: A&E, cardiology, cardiovascular, dermatology, diabetes, gastroenterology, haematology, ITU, microbiology, oncology, ophthalmology, physiotherapy, renal, stroke and urology.

These clinical specialties were supported in their research activity by staff from the following areas: chemotherapy suite, EBME (electro-biomedical engineering department), information governance, nuclear medicine, pathology, pharmacy and radiology.

Engagement within the Trust and with the public to profile research was communicated via the R&D newsletter, Operational Capability Statement, research workshops, Trust intranet and a research article in a local newspaper. Profiling research within the Trust, especially to highlight patient engagement, will continue to be a focus.

Number of commercial studies on the NIHR CRN Portfolio

The Trust participated in nine industry studies adopted onto the NIHR portfolio (three more than the previous year). Income generated from industry studies was re-invested in the Trust to support any additional infrastructure required within the research.

Our staff – facts and figures

About our staff

On 31 March 2013 the Trust directly employed 4,168 staff (3,562 full-time equivalent (FTE), which has slightly increased from 12 months earlier. In October 2011 the Trust brought in-house its facilities management services and transferred 450 Carillion employees onto the payroll. Establishment increased by 99 into 2012-13 and proactive plans are in place to reduce the current Vacancy Gap.

	Headcount	Number of Trust staff	
		Establishment (FTE)	Staff in Post (FTE)
31-Mar-11	3,646	3,309	3,091
31-Mar-12	4,163	3,714	3,548
31-Mar-13	4,168	3,813	3,562

Summary of performance – NHS workforce statistics

NHS foundation trusts are already required to analyse equality and diversity in their membership bases. This has been extended to the Trust's workforce

The data in the table below is sourced from the Trust's membership database and therefore analyses staff members, not just employees. Staff includes any Trust employee* and hospital volunteers.

Age**	Staff members 2012/13	Staff members 2011/12	Public members 2012/13	Public members 2011/12
0 to 16 years	0	0	2	1
17 to 21 years	71	40	159	247
22+ years	4,200	4,201	5,812	5,793
Not specified	0	37	1,082	991
Total	4,271	4,278	7,055	7,032
Ethnicity				
Not specified	333	464	2,379	2,216
White	3,378	3,290	4,424	4,575
Mixed	42	37	41	45
Asian or Asian British	371	358	129	117
Black or Black British	89	79	57	57
Other Ethnic Group	58	50	25	22
Other	0	0	0	0
Total	4,271	4,278	7,055	7,032
Gender				
Male	1,006	1,021	2,493	2,535
Female	3,265	3,257	4,313	4,364
Not specified	0	0	249	133
Transgender	0	0	0	0
Total	4,271	4,278	7,055	7,032

* An individual who is employed by the Trust under a contract of employment may become or continue as a member of the Trust provided: he/she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months, or he/she has been continuously employed by the Trust under a contract of employment for at least 12 months (Trust Constitution).

** Not all active members are included in age analysis where date of birth is not specified

Equality and diversity

The Trust is committed to equality and diversity and has an established Equality & Diversity Steering Group and a Single Equality Scheme which reflects the requirements of the national NHS framework, known as the Equality Delivery System (EDS).

The EDS is intended to help organisations analyse the requirements of the Trust under the Equality Act 2010.

On 6 April 2012, the Trust published its four EDS objectives, which had been approved the previous month by the Board of Directors. These objectives will be reviewed every four years and are shown overleaf:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership at all levels

The Trust is about to begin reassessing the EDS objectives through engagement activities. This will be a joint approach with North East Essex Clinical Commissioning Group. The joint aim is to carry on this engagement throughout the year to develop more knowledge and relationships with the community we serve.

Disabilities

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

Recorded disability	2012/13	2011/12
Public members	540	571

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

Statement of key priority areas for 2012/13

The Trust updated its Single Equality Scheme and its action plan was completed in parallel with the work on the Equality Delivery System:

- the Director of Workforce/Company Secretary reviewed progress with the EDS
- the Single Equality Scheme remained published on the Trust website with the organisation's objectives.

Monitoring arrangements

The Equality & Diversity Steering Group reviewed the Trust's performance against the objectives within the Single Equality Scheme when it met on a quarterly basis. It also received and reviewed the equality impact assessment reports on a quarterly basis.

Sickness absence levels

Sickness absence was 3.91%. This is comparable with neighbouring acute hospital trusts. Every case of sickness is different and, therefore, was judged on its individual merits. The aim of sickness absence monitoring is the reduction of absence levels to an acceptable minimum consistent with genuine illness. The Trust has successfully implemented the Staff Off Sick Project where there was a response on day one from the Health and Wellbeing Department to staff being absent due to ill health.

Staff sickness absence	2012/13	2011/12
Total WTE calendar days lost	50,721	43,123
Total WTE days available	1,300,130	1,216,123
Total staff years lost (days lost/365)	138.96	118.15
Total staff years available	3,562	3,549
Total staff employed in period*	4,808	4,865
Total staff employed in period with absence*	1,732	1,444
Total staff employed in period with no absence*	3,076	3,421
Average working days lost per employee	7.53	6.33

* head count, including starters and leavers
Source: Electronic Staff Record

Safe and healthy workplace

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

Employee assistance

The employee assistance programme continued to offer a range of services to support staff and their family members on both work and private issues. The Health and Wellbeing Department continued to provide a full range of services to manage staff risks. It provided ongoing support to staff experiencing both stress at work and personal stress.

Zero tolerance policy against violence and abuse

The Trust will not hesitate to seek the prosecution of anybody who attacks members of staff while at work. Although the vast majority of assaults are verbal, on rare occasions staff have needed to call the police to resolve a situation. The safety of the Trust's workforce is paramount and a number of procedures are in place to minimise any potential risk to members of staff. The Trust has an accredited security adviser who runs in-house training courses on how to deal with violent and aggressive situations. These courses are mandatory for all frontline staff.

Information on policies and procedures with respect to countering fraud and corruption

The Trust supports the continued establishment and maintenance of a strong anti-fraud culture among all staff, contractors and patients. Fraud is taken seriously and staff are made aware of how to identify and report fraud correctly. The Trust endorses the right and duty of individual members of staff to raise any matters of concern they may have with the delivery of care or services to a patient or client of the Trust, or about financial malpractice, unlawful conduct, dangers to health and safety or the environment. It believes that a culture of openness and dialogue is in the best interests of patient care. However, this must be set in the context of the Trust's duty of confidentiality to patients. Our whistleblowing policy sets out the procedures put in place for staff if they wish to raise their concerns, and the responsibilities managers at all levels have to ensure these are dealt with thoroughly and fairly.

Staff engagement

Staff engagement

The Chief Executive held monthly briefings with senior managers for cascading information to their teams. Attendance at these briefings was reviewed to ensure that the managers with the greatest number of staff attended and disseminated key organisational messages. Snapshot audits were undertaken regularly to ensure that staff were receiving these messages.

A Staff Engagement and Wellbeing Project Board met regularly, chaired by the Director of Workforce/Company Secretary and project managed by the Associate Director, Organisational Development.

Each division had an engagement plan that was informed by the 2011 National NHS staff survey, which was published on 20 March 2012.

In addition, the Trust has a robust staff engagement strategy. Major elements include increasing employee engagement, wellbeing and involvement in decision-making.

Key areas were identified from the 2011 survey and a plan was developed to support improvements in the following:

- making progress on themes that staff said were important to them
- tracking progress against the plan through the Patient and Staff Experience Committee and the Executive Infrastructure Group
- listening to staff
- alleviating work pressure.

The workstreams were informed by a cross-section of staff and a reference group set up as part of the work programme to help shape the plan and to provide feedback on the effects of the actions implemented.

The Partnership Forum (previously the Joint Staff Council), comprising management and staff representatives, has met every six weeks with an agenda including business updates and future strategy as well as a review of key performance indicators.

The opportunity is provided for key topics to be raised by all parties to ensure views are shared to aid decision making and effective engagement. Additionally, a formal mechanism for reviewing and planning change where formal consultation is required was implemented.

This has encouraged discussion and understanding of potential change and how to manage well. Partnership working is further supported with a formal (Medical) Local Negotiating Committee.

There have been a number of joint working parties looking at specific change activities, e.g. changes to appraisal processes and policies.

NHS staff survey

Following publication of the 2012 National NHS staff survey in February, the Board of Directors reviewed and endorsed the Trust's existing engagement strategy as still appropriate.

The 2012 survey overall showed a slight improvement on key indicators compared with the previous year. The Trust remains broadly similar in its results when compared to other acute trusts.

The 2012 showed that we have continued over the past two years to demonstrate improvements in staff recommending the Trust as a place to work or receive treatment and also slight improvements in engagement levels. Staff engagement increased from 3.60 to 3.62 (5 indicates high engagement, and 1 low engagement). Fifty-six per cent of staff would recommend the Trust as a place to work (53% in 2011) and 58% were happy with the care provided for family and friends (55% in 2011). Care of patients as a top priority improved from 60% in 2011 to 64% in 2012.

The Trust made good progress in the areas of appraisals, management feedback, communication from senior leaders and staff feeling valued. We received strong feedback that the Trust takes action on health and wellbeing issues compared to other trusts.

Staff reported an increase in work-related stress and that concern, together with concerns about sufficient resources, will be key priorities to focus on in 2013/14.

We recognise that we have much progress still to make. Our priority outcomes for further improvement in future staff surveys, subject to further discussion, are likely to be:

- improving our overall engagement levels
- more staff will recommend the Trust as a place to work and receive treatment
- staff feel less stressed and believe sufficient resources are available.

The Trust will continue to work with a cross-section of staff to develop plans to make a difference to how staff feel about working for the Trust as we go through 2013/14. We have just started the next phase of the At Our Best programme and we are running In Our Shoes sessions with staff across the Trust, asking them what helps or gets in the way of them providing the very best care for patients. The themes from the 2012 staff survey will be incorporated into the Trust's overall approach within At Our Best. This will continue throughout 2013/14 to provide the Trust with assurance that the interventions we are planning are having a positive impact on staff morale.

Details of the key findings from the latest NHS staff survey are shown overleaf

NHS staff survey | Key findings

A total of 328 Trust staff took part in the 2012 survey, representing a response rate of 39% which is in the lowest 20% of acute trusts in England. The Trust's response rate in 2011 was 57%.

Response rate	2011 survey (published March 2012)		2012 survey (published February 2013)		Trust Improvement/ Deterioration
	Trust	National average	Trust	National average	
	57%	54%	39%	50%	-11%

Top 4 ranking scores	2011 survey (published March 2012)		2012 National NHS staff survey in February 2013		Trust Improvement/ Deterioration
	Trust	National average	Trust	National average	
KF7. Percentage of staff appraised in last 12 months	84%	81%	87%	84%	+3%
KF13. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	-	-	31%	34%	+3%
KF28. Percentage of staff experiencing discrimination at work in last 12 months	-	-	11%	11%	0%
KF20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	30%	34%	29%	29%	0%
KF33. Staff intention to leave jobs	2.49	2.59	-	-	-
KF3. Percentage of staff feeling valued by their work colleagues	78%	76%	-	-	-

The top four questions were different in 2011 compared to 2012.

Bottom 4 ranking scores	2011 survey (published March 2012)		2012 National NHS staff survey in February 2013		Trust Improvement/ Deterioration
	Trust	National average	Trust	National average	
KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	-	-	21%	15%	-6%
KF23. Staff job satisfaction	-	-	3.47	3.58	
KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	69%	74%	72%	78%	-6%
KF17. Percentage of staff experiencing physical violence from staff in last 12 months	-	-	4%	3%	-1%
KF36. Percentage of staff having equality and diversity training in last 12 months	24%	48%	-	-	-
KF29. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	32%	26%	-	-	-
KF23. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	10%	8%	-	-	-

The bottom four questions were different in 2011 compared to 2012.

Statement of key priority areas and performance against targets set

Following publication of the 2011 National NHS staff survey in March 2012, the Board of Directors reviewed and endorsed an action plan which had been developed in partnership with staff representatives. Work has continued with this plan and, as stated above, is in the process of being updated with a cross-section of staff following publication of the 2012 survey. Monitoring was carried out by completing the Staff Survey Action Plan. In addition, the Trust's quarterly staff surveys monitored further areas for development and areas that had improved or deteriorated.

Overleaf, is a table of the key priority areas and performance against targets set:

Staff engagement | Key priority areas

Key priority areas

Performance

Listening to our staff

The importance and quality of appraisal

Gaining regular feedback from staff about how they feel about working at the Trust

Working with staff about how organisational change is undertaken and learning from staff about how that can be improved

Continuing to ensure that divisions are taking forward staff engagement as part of their overall service plans going forward

The Trust's appraisal rate of its staff increased to about 75%. Managers were trained to deliver a good quality appraisal. Close monitoring of appraisal compliance remained in place and areas of historical poor compliance improved. A quarterly reward and recognition scheme – the At Our Best Awards – continued, recognising the contribution of notable individuals, teams and volunteers. The Daily Gazette is the Trust's media partner in this initiative and published details of the winners and their stories. The Trust's first grand At Our Best Awards and Long Service Awards celebration was held on 26 June, funded jointly by Colchester Hospitals Charity (CoHoC) and the Trust. More than 225 people attended the evening at the Weston Homes Community Stadium, Colchester. Good news stories appeared regularly in the Chief Executive's weekly communication, in the Trust's monthly magazine Mainstream and in the local media. "Birthday lunches" with the Chief Executive were held regularly. A children's Christmas party, which involved managers and senior clinicians, was organised for the children of staff. The Trust worked closely with trade unions to ensure that any organisational change was managed well and in consultation with staff. Each Division had an engagement plan focusing on key issues that staff raised and wanted to work on to improve morale.

Improving our visibility, our communication and our leadership

Being clear with leaders about what is expected of them in terms of their performance and behaviours and supporting them with opportunities for leadership development

Ensuring that all new and current staff are trained in the At Our Best values and behaviours

Continuing to recognise the contribution of staff through quarterly and annual awards linked to the At Our Best behaviours

Ensuring that staff demonstrate at appraisal how they are adhering to At Our Best behaviours and embedding these behaviours within all of our HR policies

Continuing to provide two at the top coaching for associate directors and divisional clinical directors and to roll this out to consultant and ward sister pairs

A total of 89% of staff have undertaken training to ensure that they understood the importance and context of the At Our Best behaviours. Every new member of staff receives this training. Our HR policies are being updated to reflect what is expected of staff. Working with managers and staff, we have agreed a set of explicit leadership behaviours that are aligned to the At Our Best values. These were agreed by the Board in the spring of 2012 and form part of our appraisal paperwork. A quarterly cycle of managers undergoing "Back to the Floor" sessions continues with the opportunity for staff to be "Manager for the Day". Leadership development opportunities were delivered for all levels of staff in the organisation, including bespoke coaching and development for senior clinicians. A comprehensive programme of talent mapping began and we are extending this.

Alleviating work pressure

The Executive Team to take stock once a quarter and annually on the change agenda and to consider pressure and phasing

To continue to provide a programme of health and wellbeing activities designed and based on feedback from staff on what they want.

Being aware of areas in the Trust where there is pressure on staff, working with managers to implement more efficient working practices and to reduce work-related stress where it has been highlighted as a particular concern

Specific pieces of work were carried out to support areas that were under particular pressure, such as working with teams to find more efficient and effective ways of working. Alongside this, a comprehensive suite of wellbeing activities were developed to support staff, including sports challenge activities, resilience training and specific interventions to help staff manage their health and wellbeing.

Directors' report

The Trust was authorised as a public benefit corporation under the NHS Act 2006

The Directors' report is presented in the name of the following directors who occupied Board positions in 2012/13 (it also incorporates the operating and financial review):

Name	Position
Sir John Ashworth	Non-Executive Director
Mike Baker	Director of Finance
Sue Barnett	Director of Operations/Deputy Chief Executive
Rob Bowman	Director of Workforce (until 3 March)/Company Secretary (from 1 May until 3 March)
Anna Bradley	Non-Executive Director (until 31 August)
Jude Chin	Non-Executive Director
Dr Gordon Coutts	Chief Executive
Julie Firth	Director of Nursing and Patient Experience
Tom Fleetwood	Non-Executive Director (from 12 October)
Dr Sally Irvine	Chair
Dr Sean MacDonnell	Medical Director
Helen Parr	Non-Executive Director
Sarah Shirtcliff	Acting Director of Human Resources (from 1 February)
Prof Christine Temple	Non-Executive Director
Peter Wilson	Non-Executive Director

An indication of likely future development at the Trust

When developing its plans for the coming year, the Trust took account of the impact of the NHS operating framework for England for 2012/13 and the prevailing economic and financial conditions. The Trust's developments during 2012/13 are in the section "Innovation in our portfolio of clinical services" on page 11.

In its 2013/14 Annual Plan, the Trust will set out a programme to:

- continue to deliver and improve excellent patient care and meet the performance expectations of the NHS
- continue to improve the general environment for care and, in particular, addressing the privacy and dignity needs of patients
- centralise cancer facilities
- progress the construction of the £25m radiotherapy centre at Colchester General Hospital for completion in spring 2014
- complete the first phase of the computerised Clinical Portal system to give clinicians prompter and improved access to patient data in order to support diagnosis and treatment
- upgrade the electrical infrastructure of Colchester General Hospital
- upgrade the provision of pharmacy services.

The Annual Plan was submitted to Monitor in May 2013.

Fixed assets

Although there is no pre-determined frequency at which property, plant and equipment (PPE) assets must be re-valued, accounting standards require that asset values should be kept up-to-date. Therefore, the frequency of revaluation

needs to reflect the volatility of asset values and, in Monitor's view, property assets are likely to require revaluation at least every five years.

The last full valuation of the Trust's land and building assets was undertaken as at 31 March 2012 by the DVS (the commercial arm of the Valuation Office Agency).

*Political or charitable
donations*

The Trust made no political or charitable donations.

*Events after the reporting
period*

There are no events after the reporting period.

*Interest rate or exchange rate
risks*

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

Quality Report

The Quality Report appended to this Annual Report contains full details of the Trust's quality objectives in 2012/13.

Operating and financial review

The Board is working hard to continually improve services and thereby to improve patient safety, outcomes and the quality of our patients' experience

The Trust achieved a surplus of £9.1m. Compared with the previous year, income increased by 5.5%, from £244m to £257.5m. This was higher than planned and resulted from higher than planned levels of activity and one-off funding from NHS North East Essex (the PCT) for major capital expenditure.

The social and economic environment in which the Trust operated continued to be extremely challenging. Patient safety and experience remain the Board's top priorities. The Trust will continue to develop its At Our Best programme, setting practical values and behavioural expectations on staff which, together with patient rounding and improvements in the emergency care pathway, has seen improvements in reduced length of stay, harm due to falls, and top quartile infection control performance. These areas are covered in more detail in the Quality Report (Section C).

Financial target 2012/13	Outcome
Planned surplus of £3.0m	Achieved surplus of £9.1m
Earnings before interest, Tax, Depreciation and Amortisation (EBITDA) £15.8m	Achieved EBITDA of £21.4m
Income and expenditure surplus margin of 1.2%	Achieved margin of 3.7%
EBITDA margin of 6.5%	Achieved margin of 8.3%
Net return after financing of 1.9%	Achieved return of 5.6%
Liquid ratio 39.6 days (measuring liquidity of the Trust)	Achieved ratio of 54.1 days
Overall financial risk rating (FRR) of 3 as determined by Monitor	Achieved FRR of 4
Prudential Borrowing Limit (PBL) £59.4m. The PBL is set by Monitor	The Trust has loans outstanding of £5.5m and finance leases of £2.3m that count against the PBL
Income from the provision of goods and services for the purpose of the Health Service in England The NHS Act 2006 requires that the income from the provision of goods and services for the purpose of the Health Service in England must be greater than its income from the provision of goods and services for any other purpose.	The Trust received most of its income from commissioners for operating activities. This income accounted for 92% of total revenue. Income was also generated from other activities which support the main operating activities of the Trust, such as car parking, catering and pharmacy sales. These activities accounted for only 3% of total revenue. Therefore, the Trust met the requirements of the Act. Income from other operating activities was generated net of the associated costs which were incurred in delivering the activities. Any income surplus generated by these activities was reinvested by the Trust into service improvements or capital developments to improve the hospital environment.

Forward plans

Annual Accounts

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

Financial review and forward plans

In 2012/13 the Trust had a total income of £257m and achieved an underlying surplus of £3m with a total surplus of £9.1m. This included £2m of transformational funding from the PCTs to contribute mainly to our capital programme for digital mammography and the Clinical Portal. We had expected income to fall because of changes to the national tariff structure and a reduction in tariff values. However, activity levels met or exceeded plan and this had a beneficial impact on our income.

During 2012/13 the Trust invested £14.4m in new and replacement capital assets, including the start of the cancer services centralisation plan and the new radiotherapy centre being built at Colchester General Hospital. This centre will meet the expected increase in demand and is due to be completed in spring 2014.

The Trust also opened its purpose-built £5m Sterile Services Unit, which will ensure we are compliant with the necessary standards.

The Trust maintained strong cash reserves, which stood at over £34m at the end of the year. This financial performance means the Trust achieved a Financial Risk Rating of 4 according to the metrics developed by Monitor to measure the financial performance of NHS foundation trusts. This is better than our planned score of 3 (the maximum possible score is 5).

Achieving these financial plans represents a good result for the Trust. Cash balances will reduce as investment in the capital programme progresses in 2013/14, particularly with the radiotherapy centre.

Further changes and reductions in tariff values in 2013/14 mean the Trust will need to deliver at least the same level of activity as in 2012/13 for less money. Consequently, the focus on efficiency savings and new sources of income will increase. Plans are in place to deliver these. The Trust is also working closely with its commissioners to see how we can deliver significant long-term savings to the whole north east Essex health economy.

We are planning to deliver a surplus of £3m in 2013/14, which, under Monitor's risk rating assessment mechanism, will give us a Financial Risk Rating of 3. Similar surpluses are planned for future years. As an NHS foundation trust, we have the ability and autonomy to invest these surpluses in our services, core strategic developments and future facilities.

Financial Risk Rating

Monitor uses a combination of financial information and performance metrics against a selected group of national measures as the primary basis for assessing the risk of trusts breaching their terms of authorisation. Monitor's risk-based framework assigns two risk ratings – financial and governance – to each NHS foundation trust based on its Annual Plan and in-year performance against that plan.

Monitor uses these ratings to guide the intensity of monitoring and to signal to the NHS foundation trust its degree of concern with specific issues identified and the risk of breach of the authorisation. Where issues arise, Monitor may wish to test the basis of Board statements made. Financial risks are rated 1 to 5 where 1 is the highest risk, ie there is a high probability of significant breach of terms of authorisation in the short-term unless remedial action is taken; and 5, being the lowest risk, ie there are no regulatory concerns.

Monitor has been consulting on a new Regulatory Assessment Framework for 2013/14. This is likely to measure financial risk based on a trust's ability to service its financing

costs and cash available for liquidity.

Governance risk ratings are red (high risk), amber-red, amber-green or green (low risk).

The performance rating issued by Monitor for 2012/13 is summarised in the following table along with that from the previous year.

Financial Risk Rating	Annual Plan	Actual Performance			
		Q1	Q2	Q3	Q4
2012/13	3	3	4	4	4*
2011/12	3	4	4	4	5

Governance Risk Rating	Annual Plan	Actual Performance			
		Q1	Q2	Q3	Q4
2012/13					
2011/12					

*Q4 2012/13 – subject to confirmation by Monitor

Governance Risk Rating

The Trust did not achieve the standards in Clostridium difficile and the four-hour A&E target. The Trust saw sporadic cases of different strains of Clostridium difficile in different parts of the organisation. An action plan was put into place to minimise further delays. The Trust has met the A&E four-hour standard every quarter for the last four years. However, we achieved 92% in February because we experienced an impact of the Keogh Review announcement which led to an increase in length of stay and created extra pressure.

Future developments

See section “Directors’ report” on page 43.

Going concern statement

After making inquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Statement regarding audit

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

Better Payment Practice Code

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

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

The Trust aims to pay at least 95% of its invoices in accordance with these obligations.

Cost allocation requirements

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

Code of governance The Board of Directors complied with The NHS Foundation Trust Code of Governance.

Our Council of Governors

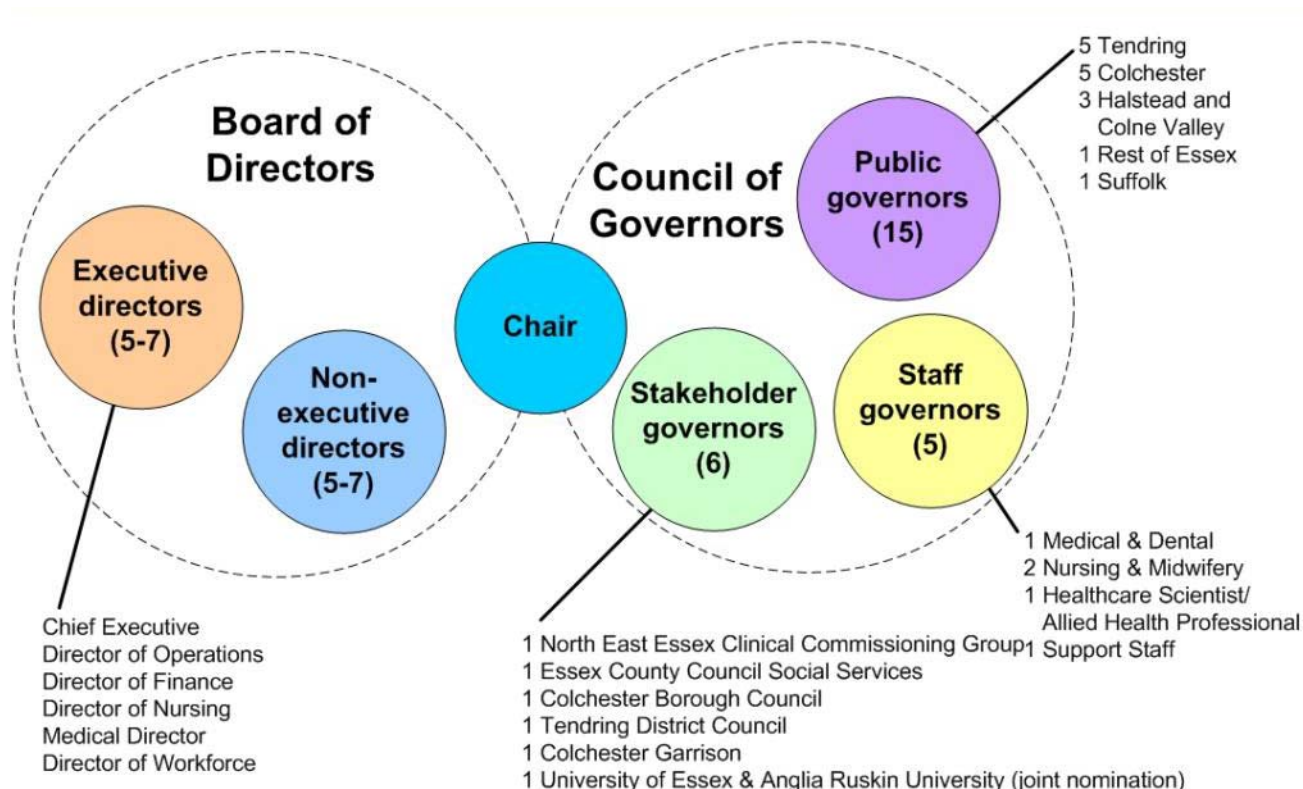
Responsibility The Council of Governors represents the interests of the public and employees through its elected governors and its appointed stakeholder governors.

Independent regulator Monitor confirmed in August that certain sections of the Health & Social Care Act 2012 would come into effect on 1 October. These changes affect the constitutions of all foundation trusts. Monitor required all foundation trusts to make changes to their constitutions to reflect the following changes:

- change of name of the governing body to "Council of Governors"
- changes to the private patient income cap
- technical adjustments to the wording of the Annual Report and business planning process.

At the October meeting of the Members' Council (now known as the Council of Governors), governors approved the changes prior to them being submitted to a meeting of the Board of Directors on 15 November, and then to Monitor.

Composition The Council of Governors comprises 26 members:



Directors and governors working together

The role of the Council of Governors has continued to develop. It has proved to be an effective and highly-valued critical friend of the organisation, working with the Board of Directors to develop plans for the Trust.

The Council of Governors acts as a consultative and advisory forum to the Board of Directors. It provides a steer on how the Trust can carry out its business and helps it to develop long-term strategic plans consistent with the needs of the community it serves. The Council also acts as guardian to ensure that the Trust operates in a way

that fits with its statement of purpose and ensures that the Board of Directors does not breach its terms of authorisation.

A programme of joint non-executive director and governor hospital walkrounds has continued to evolve. Individual non-executive directors and governors accompany one another on tours which give an insight into the operational issues facing the Trust. Feedback is then documented and given to the Trust Chair.

As part of the Trust's membership engagement strategy, 10 health talks, which were open to members of the public, were given at different venues, including GP surgeries. Each talk was hosted by a governor.

Committees and panels

The Council of Governors met with representatives from the Board of Directors to receive an update on the Trust's strategy. Alongside this, two individual governors started meeting regularly with the Chair and Executive Lead for each of the following Board Committees:

- Quality & Patient Safety Assurance Committee
- Audit & Risk Assurance Committee
- Finance & Resourcing Assurance Committee
- Performance Assurance Committee
- Charitable Funds Committee

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

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

Governors continued to be members of the At Our Best Awards judging panels. Four governors took part in monthly Patient Environment Action Team (PEAT) inspections.

About the governors

Elected public governors

Public governors

Public governors: representing and elected by public members of the Trust for a period of three years, effective from 1 May 2011:

Colchester	Tendring	Halstead & Colne Valley
Ray Cole	James Chung	Pauline Aldridge
Vi Haddow	Hazel Law	John Dann
Des McCarron	Andy Patrick	David Johnson
Elaine Smith	Marilyn Jones	
Gillian Wallis	Barry Wheatcroft	
Rest of Essex	Suffolk	
David Linghorn-Baker	Nick Athorne	

Turnout in the constituencies

Elections for Rest of Essex and Suffolk public constituencies took place in March 2012 and July 2012 respectively. Both were uncontested.

The Association of Electoral Administrators acted as returning officer and independent scrutineer for the elections.

Elected staff governors

Staff governors: representing and elected by staff members of the Trust for a period of three years, effective from April 2011:

Medical & dental	Nursing & midwifery	Allied health professionals/ Health care scientists	Support staff
Dr Chandra Sekharan	Donna Booton Kathy Flint	Isaac Ferneyhough	Val Asker

Appointed stakeholder governors

Appointed governors do not have a fixed term.

NHS North East Essex: Renata Drinkwater was appointed in February 2012. She resigned in November 2012.

Colchester Borough Council: Cllr Nigel Offen was appointed in December 2011.

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

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

Colchester Garrison: Major Simon Rothwell was appointed in March 2010.

University of Essex and Anglia Ruskin University: Professor Lesley Dobree was appointed in April 2011 to represent both universities.

Register of interests

All governors are asked to declare any interests on the register of governors' interests at the time of their appointment or election. This register is reviewed and maintained by the Foundation Trust Office, and is available for inspection by members of the public. Anyone who wishes to see the register should contact the Foundation Trust Office at the address on page 6.

Council of Governors meetings

There were five formal meetings of the Council of Governors:

26 April, 12 July, 4 September (Annual Members Meeting), 11 October, 17 January.

There was one informal meeting of the Council of Governors:

4 March.

Governor attendance at Council of Governors meetings

Name	Attended	Name	Attended
David Linghorn-Baker	3/6	Vi Haddow	4/6
Pauline Aldridge	5/6	Cllr Nigel Offen	5/6
Val Asker	5/6	David Johnson	5/6
Nick Athorne	5/5	Marilyn Jones	5/6
Donna Booton	4/6	Hazel Law	3/6
Cllr Anne Brown	2/6	Prof Lesley Dobree	1/6
James Chung	4/6	Des McCarron	4/6
Ray Cole	3/6	Cllr Lynda McWilliams	5/6
John Dann	3/6	Kathy Flint	4/6
Renata Drinkwater*	3/4	Andy Patrick	5/6
Isaac Ferneyhough	4/6	Major Simon Rothwell	3/6
Gillian Wallis	4/6	Dr Chandra Sekharan	3/6
Barry Wheatcroft	5/6	Elaine Smith	5/6

*Renata Drinkwater resigned in November 2012.

Our Board of Directors

Board of Directors' responsibility

The Board of Directors functions as a corporate decision-making body. Non-executive directors and executive directors are full and equal members. The role of the Board is to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions in accordance with the constitution.

The Board continues to review its integrated governance plans to ensure that its systems and processes are effective and efficient. In executing this, it has agreed that the governance of the Trust is best achieved by the delegation of its authority for executive management to the Chief Executive, subject to monitoring and limitations as defined within the policies and procedures of the Trust, including standing financial instructions and the scheme of delegation. The limitations set require that any executive action taken in the course of business does not compromise the integrity and reputation of the Trust and takes account of any potential risk, health and safety, patient experience, finance and working with partner organisations.

Appointment and composition of the Board of Directors

The Board of Directors comprises both full-time executive and part-time non-executive directors, all of whom are appointed because of their experience, business acumen and/or links with the local community.

The Board comprises a Chair, six further non-executive directors and six voting executive directors. The Council of Governors (formerly Members' Council) appointed the Chair and other non-executive directors in accordance with the constitution and in line with paragraphs 19(2) and 19(3) respectively of Schedule 7 of the National Health Service Act 2006. The non-executive directors were appointed by the Council of Governors following national recruitment with the exception of one non-executive director (Helen Parr) who was appointed for the unexpired period of her term of office (or 12 months – whichever was the longer) and for a further term following appraisal, also approved by the Council of Governors. The removal of a non-executive director requires the approval of three-quarters of the Council of Governors.

Details of the appointment of the new non-executive director are described on page 61.

Disclosures of the remuneration paid to the Chair, non-executive directors and executive directors are given in the Remuneration report (page 68).

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

About the non-executive directors

Dr Sally Irvine



Chair

Appointed:
1 August 2010

Term of office:
Expires 31 July 2013

Chair of the Board of Directors and the Remuneration & Terms of Service and Appointments and Performance committees; Chair of the Council of Governors and its Standards Committee.

Sally was a former chair of Newcastle City Health NHS Trust, a community, mental health and regional services Trust, and for 16 years provided consultancy on organisational and human resource development for healthcare organisations, particularly in the primary care sector. She has previously been a member of the General Dental Council, the Law Society Council and the Solicitors Regulation Authority. Her wide experience of the healthcare and regulatory sectors is reflected in her current membership of the Professional Standards Authority (formerly the Council for Healthcare Regulatory Excellence) and the Independent Appointments Selection Board of the Royal Institute of Chartered Surveyors. Now living in Aldeburgh, Sally is a director of Aldeburgh Cinema, a trustee of the Britten-Pears Foundation and has a PhD from the University of East Anglia.

Helen Parr



Non-Executive Director/Deputy Chair

Appointed:
1 December 2006;
reappointed 1 December 2010
(appointed originally to Essex Rivers Healthcare NHS Trust)

Term of office:
Expires 30 November 2013

Chair of the Quality & Patient Safety Assurance Committee; member of the Audit & Risk Assurance and Remuneration & Terms of Service and Nominations committees.

Helen's special interest is patient safety.

Helen has held previous non-executive director roles in other parts of the National Health Service as well as director level roles in education. She is a former Principal and Chief Executive of Colchester Institute and Oaklands College, Hertfordshire. Previously, she had worked in marketing and public relations in the engineering and tobacco industries. Helen is a self-employed management consultant working in education and public relations, and a local magistrate. She lives in West Mersea.

Tom Fleetwood



Non-Executive Director

Appointed:
12 October 2012

Term of Office:
Expires 11 October 2015

Trust non-executive director lead for sustainable development and a member of the Quality & Patient Safety and Performance Assurance committees.

Tom recently retired from the Army. His final appointment was as Commander of Colchester Garrison, his home town. As Garrison Commander he was responsible for the Colchester Garrison PFI scheme and facilities management, training, and the support and welfare of all the soldiers and their dependants in the Garrison area. His previous experience included responsibility as the Chief of Staff for one of the three regional Army Divisions in the UK as well as significant operational deployments working with NATO, the United States and the United Nations. He lives in West Mersea.

Professor Christine Temple



Non-Executive Director

Appointed:
1 August 2010

Term of office:
Expires 31 July 2013

Member of the Audit & Risk Assurance, Performance Assurance and Remuneration & Terms of Service committees.

Christine is professor of neuropsychology at the University of Essex and was the Foundation Chair of its psychology department. She has six years' experience as a pro-vice-chancellor on the university's senior executive group, leading the faculty of science and engineering. She has worked with the NHS throughout her career. Her research has addressed disorders of language and memory, working with diverse clinical populations, from injured war veterans to children with genetic disorders. Christine lives in Wivenhoe.

About the non-executive directors

Sir John Ashworth



Non-Executive Director/Senior Independent Director

Appointed:
1 May 2010

Term of office:
Expires 30 April 2013

Chair of the Charitable Funds Committee; member of the Quality & Patient Safety Assurance and Remuneration & Terms of Service committees.

A retired academic with degrees in chemistry, biochemistry and cell biology, John has been professor of biology at the University of Essex, chief scientific advisor to the Government, vice chancellor of the University of Salford and director of the London School of Economics. He has held a number of non-executive director positions in the private and public sectors, including the NHS. He is president of the Council for Assisting Refugee Academics. He is a member of a number of organisations in Wivenhoe where he lives.

Peter Wilson



Non-Executive Director

Appointed:
1 May 2011

Term of office:
Expires 30 April 2014

Chair of the Finance & Commissioning Assurance Committee; member of the Performance Assurance and Remuneration & Terms of Service committees.

Peter has extensive international experience gained from working in UK and US public companies covering a broad range of engineering and manufacturing. He is a former chief executive of Ransomes, an engineering company, and following its acquisition by Textron became president of the enlarged Ransomes Jacobsen Business. He was managing director of Crane Ltd for more than 10 years and on his retirement in December 2010 formed the PJW Partnership through which he undertakes various consultancy roles for Crane. From 2008 to 2011 he was a non-executive director of EEF Ltd, a company that represents the views and interests of UK manufacturing companies to the Government and European Parliament. Peter is a trustee of the Harwich Mayflower Project and chairman of The Friends of Dedham Church.

Jude Chin



Non-Executive Director

Appointed:
13 September 2011

Term of office:
Expires 12 September 2014

Chair of the Audit & Risk Assurance Committee; member of the Finance & Commissioning Assurance and Remuneration & Terms of Service committees.

Jude is a chartered accountant with extensive commercial and international experience gained from a 30-year career with KPMG. His experience included auditing and advising on mergers, acquisitions and stock exchange listings for public and private companies. He is a governor of the City Academy, Hackney, and the City of London Academy, Southwark. Jude has a degree in biochemistry and is a fellow of the Institute of Chartered Accountants in England and Wales.

Anna Bradley

Non-Executive Director

Appointed:
18 November 2010

Term of office:

Three years. Anna left the Trust on 31 August 2012.

Member of the Performance Assurance, Quality & Patient Safety Assurance, Remuneration & Terms of Service and Charitable Funds committees.

About the executive directors

Dr Gordon Coutts**Chief Executive**

Appointed Board Director:
6 September 2010

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

Accounting Officer for the Trust.

After qualifying at St Thomas' Hospital, London, in 1985, Gordon worked as a hospital doctor for four years. He then spent more than 20 years in the global pharmaceutical industry in the UK, USA, Japan and Belgium. From 2000 to 2004, he was managing director of Eli Lilly for Belgium and Luxembourg and from 2004 to 2009 he was vice president and managing director of Schering Plough in the UK and Ireland. Gordon also holds a qualification from Harvard Business School.

Sue Barnett**Director of Operations/
Deputy Chief Executive**

Appointed Board Director:
1 February 2011

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

Oversees operational performance and services. Deputises for Chief Executive.

Sue is an accountant by profession and has held a number of senior finance and operational management positions in the NHS in Essex, London and the South East, including director of operations at Mid Essex Hospital Services NHS Trust and a similar role at Barking, Havering and Redbridge Hospitals and at Worthing & Southlands NHS Trust. She also has an MBA from Henley Management School.

Mike Baker**Director of Finance**

Appointed Board Director:
3 June 2011

Term of office:
Fixed term

Notice period:
Trust: six months
Employee: three months

Oversees strategy, finance, IT, governance, commercial development and risk management.

Mike was a retired chartered certified accountant until being appointed Director of Finance. He had spent his career in the oil industry, holding roles as finance and IT director in the UK and was latterly head of European internal audit. He has lived in Colchester for 40 years, is a director of a local charity for adults with disabilities and a deacon of a town centre church.

Julie Firth**Director of Nursing and Patient Experience**

Appointed Board Director:
July 2009

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

Professional nursing adviser to the Board of Directors, nursing strategy and nurse management, clinical governance and quality improvement, risk management, integrated governance, complaints and litigation, executive-lead for health and safety, emergency planning, child protection and infection control.

Julie joined the Trust in 2009 from University College London Hospitals NHS Foundation Trust where she was deputy chief nurse. She has held a number of senior nursing positions across London, including at Barts and The London and Guy's and St Thomas' hospitals. Julie is the NHS East of England nurse representative for emergency planning. She has also been involved with a number of national projects including nurse acuity work, ward sister projects (Royal College of Nursing), high impact changes (NHS Institute for Innovation and Improvement) and assistant practitioner development.

About the executive directors

Dr Sean MacDonnell



Medical Director

Appointed Board Director:
31 October 2011

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

Medical workforce appointments, training, appraisal and continuing professional development, clinical governance, audit and effectiveness and Caldicott Guardian.

Since 1996 Sean has been a consultant in anaesthesia at the Trust with a special interest in intensive care medicine. He has been Lead Clinician for Critical Care, Chair of the Medical Staff Committee, Clinical Service Director for Anaesthesia and Technical Services, and Divisional Clinical Director for Surgery.

Sarah Shirtcliff



Acting Director of Human Resources

Appointed Board Director:
1 February 2013. Voting member from 4 March 2013

Term of office:
Interim

Notice period:
Trust: three months
Employee: three months

Sarah joined the Trust as Deputy Director of HR in June 2012. She previously held senior HR leadership roles reporting to the Board within financial services and manufacturing. Sarah has specifically managed significant people change programmes, and has specialised in employee engagement, employee relations and talent management. Sarah is a Fellow of the Chartered Institute of Personnel Management.

Rob Bowman

Director of Workforce/Company Secretary

Appointed Board Director:
December 2008

Term of Office:
Permanent.

Rob left the Trust on 3 March 2013

At the time of their appointment, all directors are asked to declare any interests on the register of directors' interests. They are asked to register any changes to their declarations and to confirm, in writing, on an annual basis that the declarations made are accurate. The register is maintained by the Trust's Company Secretary and is available to anyone who wishes to see it. Inquiries should be made to the Company Secretary at the address on page 6.

Evaluation of the Board of Directors' performance

The Board of Directors' meetings

In line with the quarterly assurance reporting structure, the Board held four meetings in public: 17 May, 16 August, 15 November and 14 February.

It also held six informal meetings: 26 April, 7 June, 12 July, 18 October, 13 December and 14 March, one special meeting to approve the Annual Report and Annual Accounts on 24 May and four joint workshops with the Council of Governors on 26 April, 12 July, 11 October and 17 January. On 4 September the Annual Members' Meeting was held in public.

Meetings attended in 2012/13

Name	Title	Attended
Sir John Ashworth	Non-Executive Director/Senior Independent Director	14/16
Mike Baker	Director of Finance	15/16
Sue Barnett	Director of Operations/Deputy Chief Executive	16/16
Rob Bowman	Director of Workforce (until 3 March)/Company Secretary (from 1 May to 3 March)	15/15
Anna Bradley	Non-Executive Director (until 31 August)	5/7
Jude Chin	Non-Executive Director	15/16
Dr Gordon Coutts	Chief Executive	15/16
Julie Firth	Director of Nursing and Patient Experience	15/16
Tom Fleetwood	Non-Executive Director (from 12 October)	6/6
Dr Sally Irvine	Chair	15/16
Dr Sean MacDonnell	Medical Director	14/16
Helen Parr	Non-Executive Director	14/16
Sarah Shirtcliff	Acting Director of Human Resources (from 1 February)	2/2
Professor Christine Temple	Non-Executive Director	10/16
Peter Wilson	Non-Executive Director	15/16

Evaluation of the Board

Four executive groups meet monthly and are accountable to the Executive Team, providing assurance to the Board assurance committees. The executive committees are:

- Executive Patient Group
- Executive Infrastructure Group
- Executive Operational Group
- Executive Strategy Group

The Board assurance committees meet on a quarterly basis as does the Board of Directors in a private and public meeting style. The intervening months are used for informal Board workshops, public and informal meetings of the Council of Governors and joint workshops of the Board of Directors and Council of Governors.

Board development

Tom Fleetwood took up the post of non-executive director on 12 October to replace Anna Bradley who left the Trust to become Chair of Healthwatch England and a Board member of the Care Quality Commission.

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

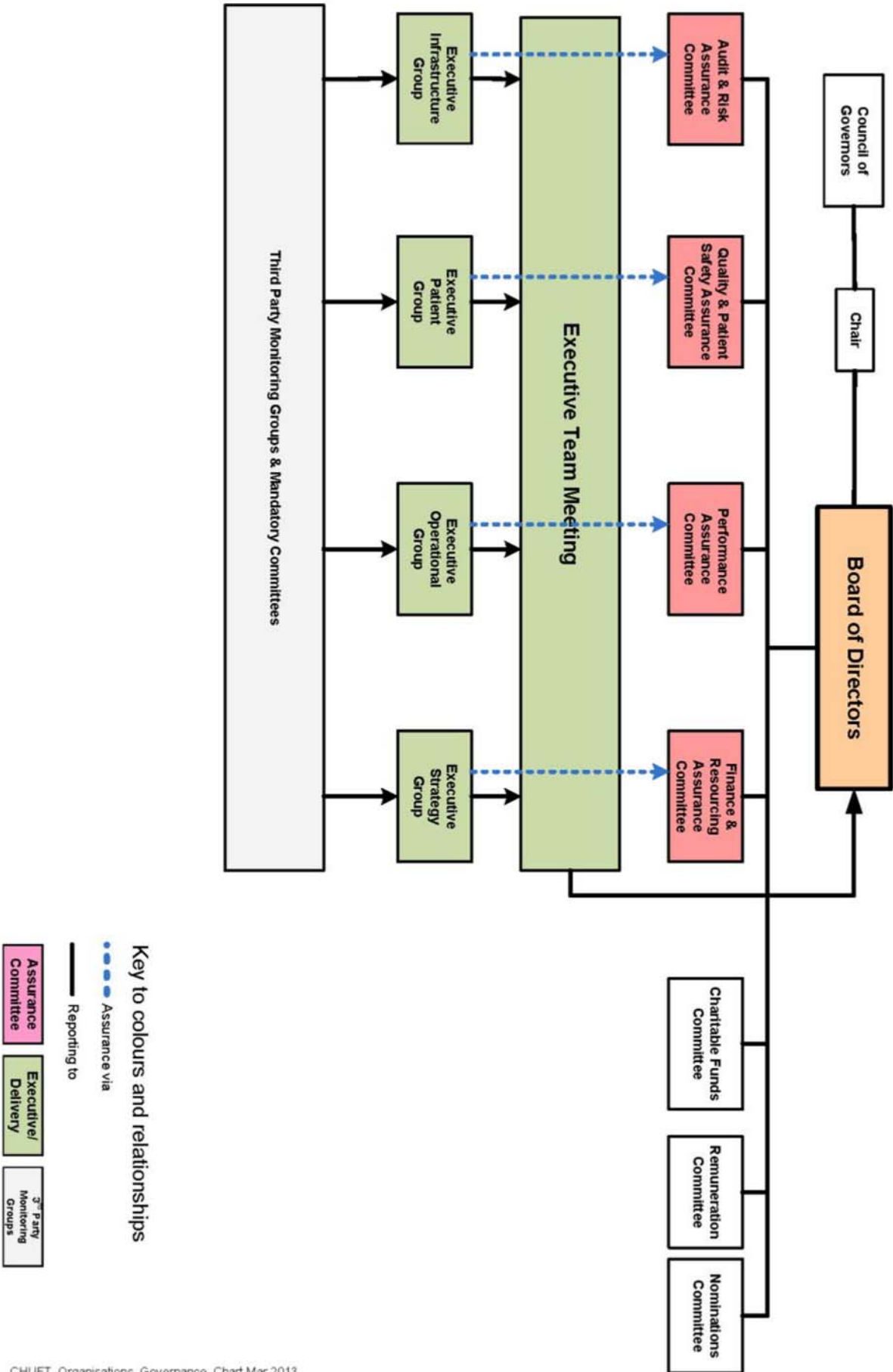
In addition to its routine business meetings, the Board of Directors met informally on a number of occasions as part of its ongoing team development.

Appraisal process for the Chair and non-executive directors The Chair and Director of Workforce/Company Secretary worked with the Council of Governors to maintain the appraisal process for the Chair and non-executive directors.

The Chair is formally appraised by the Senior Independent Director in conjunction with the Council of Governors via its Appointments & Performance Committee.

Appraisal of non-executive directors is carried out by the Chair, advised by the Lead Governor, and reported to the Council of Governors.

Organisation Governance Arrangements



Committees of the Trust Board

The committees of the Trust Board are:

- **Audit & Risk Assurance Committee**
- **Quality & Patient Safety Assurance Committee**
- **Finance & Resourcing Assurance Committee**
- **Performance Assurance Committee**
- **Appointments & Performance Committee (jointly with Council of Governors)**
- **Charitable Funds Committee**
- **Remuneration & Terms of Service Committee.**

Audit & Risk Assurance Committee

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

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

The committee also reviews the work and findings of the external auditors appointed by the Council of Governors and considers the implications and management's responses to its work.

The Audit & Risk Assurance Committee held five meetings: 3 May, 24 May, 2 August, 1 November, 5 February.

Members and meetings attended in brackets

Jude Chin, Committee Chair (5/5), Helen Parr (4/5), Professor Christine Temple (2/5).

Executive directors in attendance: Mike Baker, Dr Gordon Coutts, Julie Firth, Rob Bowman (as Company Secretary).

External auditors

In March 2011 the Council of Governors approved the appointment of Grant Thornton for a period of three years from 1 April 2012.

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

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

As far as the directors are aware, there is no relevant information of which the auditors are unaware.

The directors have taken all of the required steps to make themselves aware of any relevant audit information, and to establish that the auditors know about it.

Quality & Patient Safety Assurance Committee

The committee's remit is to:

- ensure the safety of patients is the highest priority of every member of staff and that no avoidable death or harm happens to patients
- recommend the Trust's patient safety strategy to the Board of Directors

- scrutinise and monitor the implementation of strategic priorities and assure the strategy
- assure the Board of Directors on quality and patient safety.

The Quality & Patient Safety Assurance Committee held four meetings: 30 April, 30 July, 5 November, 28 January.

Members and meetings attended in brackets Helen Parr, Committee Chair (4/4), Anna Bradley (1/2), Sir John Ashworth (4/4), Dr Sally Irvine (2/2), Tom Fleetwood (2/2)

Executive directors in attendance: Dr Gordon Coutts, Julie Firth, Dr Sean MacDonnell, Sue Barnett.

Finance & Resourcing Assurance Committee

The committee's remit is to:

- give detailed scrutiny of financial performance against plans and forecasts, highlighting and seeking assurance on deviation/recovery
- scrutinise contractual principles, plans and performance
- scrutinise the implementation of the capital programme, workforce resourcing and operational capacity
- guide the development of the Trust's financial strategy
- assure the Board of Directors monthly on financial performance.

The Finance & Resourcing Assurance Committee held five meetings: 1 May, 31 July, 12 October, 30 October, 29 January.

Members and meetings attended in brackets Peter Wilson, Committee Chair (5/5), Sir John Ashworth (5/5), Jude Chin (4/5), Dr Sally Irvine (2/2).

Executive directors in attendance: Dr Gordon Coutts, Mike Baker, Sue Barnett, Rob Bowman.

Performance Assurance Committee

The committee's remit is to:

- support the Board in the development and oversight of the performance management framework and systems
- review the efficiency of the organisation in delivering performance, benchmarked against the best nationally.

The Performance Assurance Committee held four meetings: 4 May, 3 August, 2 November, 1 February.

Members and meetings attended in brackets Professor Christine Temple, Committee Chair (2/4), Anna Bradley (2/2), Peter Wilson (4/4), Tom Fleetwood (2/2), Dr Sally Irvine (2/2).

Executive directors in attendance: Dr Gordon Coutts, Sue Barnett.

**Board of Directors &
Council of Governors**

In April 2012 the Board of Directors and Council of Governors reviewed the Nominations Committee arrangements.

**Appointments &
Performance Committee**

A joint committee with membership drawn from the Board of Directors and the Council of Governors was formed and called the Appointments & Performance Committee – it fulfils the role of a nominations committee in respect of Chair and non-executive director appointments.

The committee is responsible for advising the Council of Governors on the appointment, performance and remuneration of the non-executive directors (including the Chair). The committee held three formal meetings: 23 April, 17 August, 21 March.

April attendance (original membership)

Dr Sally Irvine, Committee Chair, Ray Cole, Vi Haddow, Andy Patrick, David Johnson, Hazel Law, Barry Wheatcroft, Pauline Aldridge, Simon Rothwell. Apologies received from Isaac Ferneyhough and Val Asker.

August attendance

Dr Sally Irvine, Committee Chair, Anne Brown, Isaac Ferneyhough, David Johnson, Hazel Law, David Linghorn-Baker, Andy Patrick, Sir John Ashworth and Peter Wilson.

March attendance

Dr Sally Irvine, Committee Chair, Anne Brown, Isaac Ferneyhough, David Johnson, Hazel Law, David Linghorn-Baker, Andy Patrick, Sir John Ashworth and Peter Wilson.

In August the Appointments and Performance Committee convened an appointments panel to interview for the non-executive director post vacated by Anna Bradley.

The Trust's Remuneration & Terms of Service Committee fulfils the role of a nominations committee in respect of the executive directors (including the Chief Executive). See below.

**Charitable Funds
Committee**

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

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

The committee includes representation from operational senior managers from across the Trust. Four formal meetings of the committee were held: 13 June, 27 July, 23 November, 22 March.

Members and meetings attended in brackets

Sir John Ashworth, Committee Chair (4/4), Professor Christine Temple (1/4), Helen Parr (2/4), Anna Bradley (1/1).

Executive directors in attendance: Mike Baker, Rob Bowman (as Company Secretary). The committee chair also invited two nominated governors to attend.

**Remuneration & Terms of
Service Committee**

The Remuneration & Terms of Service Committee reviews the structure, size and composition of the Board of Directors and makes recommendations for changes where and when appropriate. It also considers succession planning arrangements, taking into account the challenges and opportunities facing the Trust and the skills and expertise required on the Board of Directors.

This committee is responsible for advising on the appointment and/or dismissal of the executive directors. It is also responsible for the approval of their remuneration and terms of service and the monitoring of their performance against delivery of organisational objectives. Membership was from the non-executive directors and the Director of Workforce/Company Secretary. The Chief Executive is entitled to attend the committee and to be consulted when the appointment and remuneration of the executive directors is being considered.

He is excluded from meetings about his own position. An appointments panel of the Remuneration & Terms of Service Committee is convened when appointments are to be made. All appointments are by public advertisement. External assessors are part of the recruitment process.

The Remuneration & Terms of Service Committee held five meetings: 23 April, 2 July, 8 October, 21 January, 4 February.

*Members and meetings
attended in brackets*

Dr Sally Irvine, Committee Chair (5/5), Helen Parr (2/5), Sir John Ashworth (5/5), Professor Christine Temple (3/5), Anna Bradley (1/2), Peter Wilson (5/5), Jude Chin (5/5), Tom Fleetwood (2/2).

*Advice or services to the
committee*

The Trust is obliged to publish the name of any person who provided advice or services to the committee that materially assisted the committee in its consideration of any matter. No such advice was provided.

Statement of accounting officer's responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Colchester Hospital University NHS Foundation Trust

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

Under the NHS Act 2006, Monitor has directed Colchester Hospital University NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statement
- prepare the financial statements on a going concern basis.

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

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

Signed



Dr Gordon Coutts
Chief Executive

Annual governance statement

<i>Scope of responsibility</i>	<p>As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.</p>
<i>The purpose of the system of internal control</i>	<p>The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore provide only reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Colchester Hospital University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place at Colchester Hospital University NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the Annual Report and Annual Accounts.</p>
<i>Capacity to handle risk</i>	<p>The Trust is committed to providing high quality patient services in an environment that is safe and secure. I have the overall responsibility for all risk management and ensuring that the organisational structure and resource is in place for this to occur. The importance of senior leadership is recognised and delegated through an Executive Director and operationalised through the corporate and divisional structures. This supports the need for a central steer while ensuring local ownership in managing and controlling all elements of risk to which the Trust may be exposed.</p> <p>Training in risk management is provided to all staff relevant to their grade and situation. Staff have access to additional support and education to ensure that they have the skills and knowledge and are competent to identify, control and manage risk within their work environment. All staff receive training at the mandatory corporate induction. This includes their personal responsibilities as well as the necessary information and training to enable them to work safely.</p> <p>To support staff through the risk assessment process, expert guidance and facilitation is available. Actions taken to reduce risk are regularly monitored and reported through the Datix Risk Management System, trends are analysed at divisional and sub-committee level of the Trust Board with high and extreme risks reported to the Board of Directors on a regular basis. Evaluation of the effectiveness of these actions promotes both individual and organisation learning and the dissemination of good practice.</p>
<i>The risk and control framework</i>	<p>The key elements of the risk strategy are to manage and control identified risks appropriately whether clinical, non-clinical or financial. This is achieved by providing a rigorous organisational framework which enables early identification of risk, co-ordination of risk management activity, provides a safe working environment for staff and for patients, and reduces unnecessary expenditure. It ensures that managers, clinicians and staff are aware of their roles and responsibilities in managing risk and describes the organisational structures and processes in place by which risk is assessed, controlled and monitored.</p> <p>Risks are identified through diverse sources of information such as risk assessments, clinical benchmarking and audit data, clinical and non-clinical incident reporting, complaints, claims, patient and public feedback, stakeholder and partnership feedback and internal/external assessment.</p> <p>Risks are evaluated using a risk assessment tool, which enables the Trust to</p>

assess the impact and likelihood of the risk occurring, using a recognised scoring system. This supports the decision-making process about whether the identified risk is considered acceptable or unacceptable.

The level of control required is informed by the risk assessment score, which assists in prioritising the risk, with a designated person responsible for reviewing, reporting, reassessing and monitoring the effectiveness of the control in place.

Data security risks identified will be risk assessed using the risk assessment tool, entered onto the Trust Risk Register and managed in accordance with the Trust's Risk Management Strategy. In addition ICT carry out a number of internal audits relating to data security. New items/products or changes to current processes/systems are risk assessed by ICT with specialist teams working in partnership such as the Information Governance Team, IT Programme Management, IT Operations, and IT Infrastructure as part of the formal change control process.

Risk management is embedded at all levels of the organisation through the corporate and divisional structures, and reporting feedback mechanisms are in place. Each division has a system in place to identify its risks, assess their impact and evaluate them. Each division and department has a system to ensure that all necessary risk assessments are carried out; that risk registers are maintained and that risk plans are approved; that appropriate control measures are implemented and monitored. The Risk Manager is the custodian of the Risk Register, supported by the Risk Management Department.

The organisational governance arrangements devolve responsibility for achieving Trust objectives, including the management of associated risk, to staff at all levels of the organisation. In particular the Trust's governance arrangements require monitoring, reporting and review of the progress and achievement against the Trust's strategic objectives. This enables the Board to review its strategic vision on an annual basis and provide feedback and communication to all internal and external stakeholders.

The Trust believes that good risk management is an integral part of an efficient and effective organisation and recognises the importance of the involvement of stakeholders. This underpins the process to ensure risks are minimised and patients, visitors, employees, contractors and other members of the public will not be exposed to any unnecessary risks or hazards. User feedback is obtained through complaints, incidents, and interactions with the PALS services, user groups, Local Involvement Networks (LINKs), external and internal surveys and comments. Risks are assessed and managed to ensure that the Trust's systems reflect consideration of all these stakeholder interests whether patients, public or service users.

The Trust is fully compliant with the requirements of registration with the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. We have received assurances from our payroll and pension services supplier (Serco ASP) that control measures were in place throughout 2012/13 to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust Board has considered and implemented policies and procedures to comply with all changes to equality legislation including the Disability Discrimination Act 2005, the Employment Equality (Age) Regulations and the provisions of the Equality Act 2010 outlawing discrimination on the grounds of religion, belief or

sex in the provision of goods, facilities and services and a positive public sector gender equality duty.

The Trust is in the process of putting in place carbon reduction delivery plans to ensure its obligations under the Climate Change Act are complied with. These plans remain in draft format to be put in place during 2013/14.

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

The Audit & Risk Assurance Committee in partnership with the Quality & Patient Safety Assurance Committee functioned throughout 2012/13. Their role is to oversee the risk management and governance arrangements within the Trust by giving careful consideration to financial control arrangements and clinical and corporate governance. This ensures organisation-wide co-ordination and prioritisation of risk management and governance issues, encourages and fosters a greater awareness and ownership of risk management and integrated governance throughout the corporate, business and operational levels of the organisation. Both committees report to the Board of Directors.

Extreme and high-level risks and progress with the action plan are managed by individual executives and monitored by the Audit & Risk Assurance Committee. High-level risks are also considered by the Board of Directors each quarter. The Audit & Risk Assurance Committee also reviews the organisational system and approach to risk management.

The organisational governance committee structure consists of four Board sub-committees which are the Audit & Risk Assurance Committee, Quality & Patient Safety Assurance Committee, Finance & Resource Assurance Committee and Performance Assurance Committee. Each reviews Trust performance in their designated areas and give assurance and reports regularly to the Board on areas of their work.

Capacity: During 2012/13 the Trust engaged in a number of projects to drive forward its economy, efficiency and effectiveness in the use of resources. For example, the new £5m Sterile Services Unit was completed and brought into operation, thus ensuring capacity and achievement of sterilisation standards moving into the future. Work also began on the construction of a new £25m radiotherapy centre, which, when completed in 2014, will enable the service to relocate from Essex County Hospital. The Clinical Portal project will go live in 2013, which will improve the efficiency of clinical support arrangements by significantly reducing the time staff spend looking up patients' test results and documentation, leading to more time being spent with patients.

Board leadership: At the end of 2012/13 the Director of Workforce left the Trust and acting up arrangements are in place. The Trust is recruiting a replacement in 2013/14.

Annual Quality Report

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

The Quality Report 2012/13 has been prepared under the supervision of the Executive Team, in a process led by two executive team members; assurance of the process involved has been by the Audit & Risk Assurance Committee. The Executive Team and the Quality & Patient Safety Assurance Committee have reviewed the process to develop the Quality Report.

The indicators reported for 2012/13 were identified in our Quality Report for 2011/12 and performance on these indicators in 2012/13 has been reviewed at regular intervals throughout the year by the Board and the Quality & Patient Safety Assurance Committee.

Data included in the Quality Report has been validated against the national NHS data definitions.

The quality objectives set for 2013/14 were agreed by the governing body, our Council of Governors, and are consistent with the CQUINs agreed with NHS North East Essex for 2013/14.

Review of effectiveness As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the audit and governance committees. A plan to address weaknesses and ensure continuous improvement of the system is in place.

This year, my review has also been informed by:

- the provision of a Performance Framework to the Trust Board throughout 2012/13; the framework identifies responsible officers and links key deliverables and targets to Trust objectives and tracks their delivery
- comparison of Trust performance to SHA benchmarking, demonstrating the Trust is now performing amongst the best in East of England on access targets, hygiene and infection control measures
- clinical audit reports
- internal audit reports and reviews (eg the financial standard and governance standard audits)
- registration without conditions by the Care Quality Commission
- Care Quality Commission Quality Risk Profile (QRP) analysis
- Level 2 compliance with NHSLA Risk Management standards (Acute) and CNST
- PEAT inspection
- national staff and inpatient surveys and standards held for Investors in People and Improving Working Lives Practice Plus Accreditation
- information governance Toolkit
- Care Quality Commission inspection reports
- the Head of Internal Audit Opinion which provides significant assurance.

Conclusion I am satisfied that Trust has in place an effective system of internal control. The Trust has clear objectives and deliverables which are monitored and reported through its governance arrangements which are outlined in this statement.

As Accounting Officer and based on the information provided above, I am assured that no significant internal control issues have been identified other than in the Head of Internal Audit Opinion which is noted in Section 7. As noted, plans are in place to address issues raised.

Signed



Dr Gordon Coutts
Chief Executive

Remuneration report (unaudited)

Board of Directors' Remuneration and Terms of Service Committee

See section on Committees of the Trust Board (page 59).

Remuneration and performance conditions

The remuneration of the directors and non-executive directors does not include any individual performance-related component. Their remuneration is subject to an annual review which takes into account a benchmarking comparison with other similar organisations, general labour market conditions and the Board's collective achievement of organisational objectives. The Remuneration Committee reviewed benchmarked data provided via an independent review process and determined that no pay awards would be approved with effect from April 2013.

The remuneration of the Chair and non-executive directors is decided by the Council of Governors following advice from its Appointments & Performance Committee. To determine the remuneration, that committee may use one or more of the following independent benchmarking comparative data:

- Croner Director Rewards Survey
- Non-Executive Director Practice and Fees (Monks)
- Independent Remuneration Solutions, Independent Chairman and Non-Executive Director Survey
- NHS Confederation Foundation Trust Network
- Hay Group Report on Private and Public Sector Arrangements for NEDs
- Capita Health Services Partners NHS NEDs Remuneration Survey.

The level of remuneration for non-executive directors is based on an average expected workload of two to four days a month and an average of two to three days a week for the Chair.

To determine executive directors' salary levels, the Remuneration & Terms of Service Committee may use one or more of the following independent benchmarking comparative data:

- Croner Director Rewards Survey
- NHS Confederation Foundation Trust Network
- Capita Health Service Partners NHS Chief Executives and Directors salary survey
- Income Data Services (IDS) NHS Boardroom pay report
- Senior Salaries Review Body (SSRB) to Department of Health for VSMs (Very Senior Managers) Pay Framework
- the Health Report Research Service (HRSS) database of NHS advertised salaries.

Other than the Trust's medical director, amendments to annual salary are decided by the Remuneration & Terms of Service Committee. The annual salary of the executive directors is inclusive of all cash benefits other than business mileage. The medical director's salary is in accordance with the Medical and Dental Consultants Terms and Conditions of Service.

Duration of contracts, notice periods and termination payments

These are summarised in the Board of Directors' profiles section (from page 52). With the exception of the medical director, executive directors are appointed to substantive contracts. During 2012/13, one interim appointment to the Board was made. A new Director of HR was appointed on 1 February for a temporary period pending the substantive appointment following the resignation of the previous postholder.

Contractual compensation provisions for early termination of executive directors' contracts

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

Median salary as a multiple of highest paid director salary

The median salary is £24,554.

The highest salary is £165,000 which is 6.72 more than the median.

Salary and pension entitlement of the Board of Directors

The Chief Executive has determined that "senior managers", being those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust, are the executive and non-executive directors of the NHS foundation trust. Detailed on pages 71-71 are the remuneration, salary and pension entitlements of the Board of Directors. These disclosures have been audited.

Review of tax arrangements of public sector appointees**Review of tax arrangements of public sector appointees**

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

<i>Off-payroll engagements</i>	Off-payroll engagements at a cost of over £58,200 per annum	
	Number In place on 31 January 2012	2
	Of which:	
	Number that have since come onto the Trust's payroll	0
	Of which:	
	Number that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	1
	Number that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
	Number that have come to an end	0
	Total	2
<i>New off-payroll engagements</i>	New off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than six months	
	Number of new engagements	0
	Of which:	
	Number of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
	Of which:	
	Number for whom assurance has been accepted and received	0
	Number for whom assurance has been accepted and not received	0
	Number that have been terminated as a result of assurance not being received	
	Total	0

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

Governor	Amount £
Barry Wheatcroft	243.20
David Johnson	300.80
Gillian Wallis	85.60
Pauline Aldridge	572.40
John Dann	229.20
Nick Athorne	389.00
Kathy Flint	38.40
Renata Drinkwater	112.00
Vi Haddow	69.10
Andy Patrick	94.90
Elaine Smith	28.80

No other governor claimed expenses.

Signed



Dr Gordon Coutts
Chief Executive

Salary and pension entitlements of senior managers (audited)

A) Remuneration

The Financial Reporting Manual requires NHS foundation trusts to prepare a remuneration report in their annual report and accounts which complies with:

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

Name	Title	2012/13			2011/12		
		Salary	Other remuneration	Benefits in kind*	Salary	Other remuneration	Benefits in kind*
		(bands of £5,000)	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(rounded to the nearest £100)
		£000	£000	£	£000	£000	£
Ashworth, J	Non-Executive Director	10 – 15	-	-	10 – 15	-	-
Baker, M	Director of Finance	115 – 120	-	700	100 – 105	-	-
Barnett, S	Director of Operations/Deputy Chief Executive	125 – 130	-	-	125 – 130	-	200
Bowman, R to 3 March	Director of Workforce/Company Secretary	100 – 105	-	-	100 – 105	-	-
Bradley, A to 31 August	Non-Executive Director	0 – 5	-	-	10 – 15	-	-
Chin, J	Non-Executive Director	10 – 15	-	2,300	5 – 10	-	1,000
Coutts, G	Chief Executive	160 – 165	-	600	160 – 165	-	800
Firth, J	Director of Nursing and Patient Experience	110 – 115	-	100	95 – 100	-	-
Fleetwood, T from 12 October	Non-Executive Director	5 – 10	-	-	-	-	-
Irvine, S	Chair	35 – 40	-	3,800	35 – 40	-	3,200
MacDonnell, S ¹	Medical Director	85 – 90	60 – 65	100	60 – 65	75 – 80	-
Parr, H	Non-Executive Director	10 – 15	-	100	10 – 15	-	-
Shirtcliff, S from 1 February	Acting Director of Human Resources	15 – 20	-	-	-	-	-
Temple, C	Non-Executive Director	10 – 15	-	-	10 – 15	-	-
Wilson, P	Non-Executive Director	10 – 15	-	100	10 – 15	-	-

* Benefits in kind relate to expense allowances where these are subject to income tax.

1. S MacDonnell receives a salary for his role as Medical Director. Additional salary for working as a medical consultant is shown under other remuneration.

Pension benefits (audited)

B) Pension Benefits

Name	Real increase in pension at age 60*	Lump sum at age 60 related to real increase in pension*	Total accrued pension at 31 March 2013*	Lump sum at age 60 related to accrued pension at 31 March 2013*	Cash equivalent transfer value at 31 March 2013*	Cash equivalent transfer value at 31 March 2012*	Real increase in cash equivalent transfer value*
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
	£000	£000	£000	£000	£000	£000	£000
Barnett, S	(0 – 2.5)	(2.5 – 5)	45 – 50	145 – 150	933	877	10
Bowman, R	0 – 2.5	2.5 – 5	30 – 35	95 – 100	526	466	33
Coutts, G	2.5 – 5	(0 – 2.5)	5 – 10	0 – 5	109	72	33
Firth, J	0 – 2.5	2.5 – 5	40 – 45	130 – 135	816	727	51
MacDonnell, S	2.5 – 5	7.5 – 10	45 – 50	135 – 140	798	685	78
Shirtcliff, S	0 – 2.5	-	0 – 5	-	13	-	2

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

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive directors.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual had transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in Cash Equivalent Transfer Values

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

Accounting policy for pensions can be found in notes 1.5 and 4.1 of the accounts. Key management compensation can be found in note 4.3 of the accounts.

Section B

Annual Accounts 2012/13

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

We have audited the financial statements of Colchester Hospital University NHS Foundation Trust ('the Trust') for the year ended 31 March 2013 which comprise the statement of comprehensive income, the statement of financial position, the statement of cash flow, the statement of changes in taxpayers' equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

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

- the table of salaries and allowances of senior managers and related narrative notes
- the table of pension benefits of senior managers and related narrative notes
- the table of pay multiples and related narrative notes.

This report is made solely to the Council of Governors and Board of Directors of Colchester Hospital University NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Governors and Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust, the Trust's Governors as a body and the Trust's Board of Directors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of accounting officer and auditor

As explained more fully in the Chief Executive's Statement, the Chief Executive as Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

The Accounting Officer is responsible for the maintenance and integrity of the corporate and financial information on the Trust's website. Legislation in the United Kingdom governing the preparation and dissemination of the financial statements and other information included in annual reports may differ from legislation in other jurisdictions.

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

Scope of the audit of the financial statements

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

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the financial position of Colchester Hospital University NHS Foundation as at 31 March 2013 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006 and the NHS Foundation Trust Annual Reporting Manual 2012-13 issued by Monitor
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

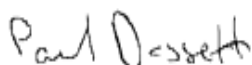
Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit
- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources
- the Trust's Quality Report has not been prepared in line with the requirements set out in the NHS Foundation Trust Annual Reporting Manual or is inconsistent with other sources of evidence.

Certificate

We certify that we have completed the audit of the financial statements of Colchester Hospital University NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Paul Dossett
Senior Statutory Auditor

for and on behalf of Grant Thornton UK LLP

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

24 May 2013

FOREWORD TO THE ACCOUNTS

Colchester Hospital University NHS Foundation Trust

These accounts for the year ended 31 March 2013 have been prepared by the Colchester Hospital University NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

A handwritten signature in blue ink, appearing to read 'Gordon Coutts', with a stylized flourish at the end.

Dr Gordon Coutts, Chief Executive

24th May 2013

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED
31 March 2013**

		2012/13	2011/12
	Note	£000	£000
Operating Income	2	257,808	245,496
Operating Expense	3	(244,138)	(228,927)
Operating Surplus		<u>13,670</u>	<u>16,569</u>
Finance Costs			
Finance income	6	124	105
Finance expense - financial liabilities	6.1	(157)	(136)
Finance expense - unwinding of discount on provisions		(34)	(36)
PDC dividends payable		(4,495)	(4,192)
Net Finance Costs		<u>(4,562)</u>	<u>(4,259)</u>
Surplus from continuing operations		<u>9,108</u>	<u>12,310</u>
SURPLUS FOR THE YEAR		<u>9,108</u>	<u>12,310</u>
Other Comprehensive Income:			
Revaluation gains/(losses) and impairment losses property, plant and equipment		395	6,960
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		<u><u>9,503</u></u>	<u><u>19,270</u></u>

The notes on pages 7 to 41 form part of these accounts.
All income and expenditure is derived from continuing operations.

**STATEMENT OF FINANCIAL POSITION AS AT
31 March 2013**

	Note	31 March 2013 £000	31 March 2012 £000
NON-CURRENT ASSETS			
Intangible assets	7	5,316	4,736
Property, plant and equipment	8	148,412	141,015
Total Non-Current Assets		153,728	145,751
CURRENT ASSETS			
Inventories	10	5,195	5,167
Trade and other receivables	11	7,962	8,698
Cash and cash equivalents	18	34,679	28,629
Total Current Assets		47,836	42,494
CURRENT LIABILITIES			
Trade and other payables	12	(21,794)	(24,609)
Borrowings	15	(340)	(135)
Provisions	17	(1,200)	(324)
Other liabilities	13	(612)	(590)
Total Current Liabilities		(23,946)	(25,658)
Total Assets less Current Liabilities		177,618	162,587
NON-CURRENT LIABILITIES			
Borrowings	15	(7,487)	(1,641)
Provisions	17	(1,160)	(1,152)
Other liabilities	13	(3,908)	(4,234)
Total Non-Current Liabilities		(12,555)	(7,027)
TOTAL ASSETS EMPLOYED		165,063	155,560
TAXPAYERS' EQUITY			
Public Dividend Capital		76,193	76,193
Revaluation Reserve		43,203	43,391
Other Reserves		754	754
Income and Expenditure Reserve		44,913	35,222
TOTAL TAXPAYER'S EQUITY		165,063	155,560

The financial statements on pages 2 to 41 were approved by the Board and signed by:



Dr Gordon Coutts, Chief Executive

24th May 2013

**STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2013**

	2012/13 £000	2011/12 £000 (Restated)
Cash flows from operating activities		
Operating surplus from continuing operations	13,670	16,569
Operating surplus	13,670	16,569
Non-cash income and expense:		
Depreciation and amortisation	7,569	7,890
Impairments	168	223
Reversal of impairments	(295)	(1,441)
(Gain)/loss on disposal of property, plant and equipment	444	81
Non-cash donations credited to income	(78)	0
(Increase)/decrease in trade and other receivables	736	(1,807)
(Increase)/decrease in inventories	(28)	95
Increase/(decrease) in trade and other payables	(2,815)	2,789
Increase/(decrease) in other liabilities	(304)	(2,317)
Increase/(decrease) in provisions	884	(216)
Other movements in operating cash flows	83	(209)
Net cash generated from operations	20,034	21,657
Cash flows from investing activities		
Interest received	121	108
Purchase of intangible assets	(1,320)	(2,724)
Purchase of property, plant and equipment	(13,123)	(7,977)
Sales of property, plant and equipment	6	2
Net cash generated from/(used in) investing activities	(14,316)	(10,591)
Cash flows from financing activities		
Loans received from Foundation Trust Financing Facility	5,500	0
Capital element of finance lease rental payments	(405)	(139)
Interest element of finance lease	(154)	(134)
PDC dividend paid	(4,609)	(4,112)
Net cash generated from/(used in) financing activities	332	(4,385)
Increase/(decrease) in cash and cash equivalents	6,050	6,681
Cash and Cash equivalents at 1 April	28,629	21,948
Cash and Cash equivalents at 31 March	34,679	28,629

**STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT
31 March 2013**

	Total	Public	Revaluation	Other	Income and
	£000	Dividend	Reserve	Reserves	Expenditure
		Capital	£000	£000	Reserve
		£000			£000
Taxpayers' Equity at 1 April 2011	136,292	76,193	36,564	754	22,781
Surplus for the year	12,310	0	0	0	12,310
Revaluation gains and impairment losses property, plant and equipment	6,960	0	6,960	0	0
Transfers to the income and expenditure account in respect of assets disposed of	0	0	(131)	0	131
Other Reserve Movements	(2)	0	(2)	0	0
Taxpayers' Equity at 31 March 2012	155,560	76,193	43,391	754	35,222
Surplus for the year	9,108	0	0	0	9,108
Revaluation gains and impairment losses property, plant and equipment	395	0	395	0	0
Transfers to the income and expenditure account in respect of assets disposed of	0	0	(583)	0	583
Taxpayers' Equity at 31 March 2013	165,063	76,193	43,203	754	44,913

Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust.

Revaluation Reserve

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

Other Reserves

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

Income and Expenditure Reserve

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

NOTES TO THE ACCOUNTS

1. Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. Where the NHS Foundation Trust Annual Reporting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular accounting policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.1 Accounting Convention

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

1.2 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

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

1.3 Consolidation

Subsidiaries

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

The Trust has no subsidiaries. In accordance with the directed accounting policy from Monitor, the Trust will not consolidate the NHS charitable funds for which it is a corporate trustee until 31 March 2014.

1.4 Income

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

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

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Lease income from operating leases is recognised in income on a straight-line basis over the lease term, irrespective of when the payments are due.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhs.uk/pensions

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

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

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

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

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

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

Measurement

Valuation

In accordance with IAS 16, all property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value, with the exception of some blocks at Essex County Hospital, which are held at an impaired value as a result of a Board decision in February 2010 to relocate services to a new radiotherapy centre that is to be built on the site of Colchester General Hospital. All land and buildings are restated to fair value using professional valuations at least every five years, with an interim valuation at 3 years. All plant and equipment is valued using a depreciated historical costs basis as a proxy for fair value.

For land and building assets, professional valuations are carried out by the District Valuer Service of the Valuation Office Agency. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation - Professional Standards, 8th Edition, insofar as these terms are consistent with the agreed requirements of HM Treasury, Monitor and the National Health Service.

A desk top valuation of land and buildings was prepared by the District Valuer Service as at 31 March 2013, with the last full valuation being undertaken as at 31 March 2012.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value. In accordance with Treasury guidance, all revaluations undertaken since 1 May 2008 have been based on "modern equivalent assets".

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

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

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

Revaluation gains and losses

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

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'Other Comprehensive Income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable, i.e.:
 - management are committed to a plan to sell the asset;
 - an active programme has begun to find a buyer and complete the sale;
 - the asset is being actively marketed at a reasonable price;
 - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, Government Grant and Other Grant Funded Assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) Transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The Trust's PFI arrangement for staff accommodation is accounted for as a service concession in accordance with IFRIC 12. The operator receives all of its income from individual users rather than in the form of unitary payments from the Trust. As such there is no service charge but the asset is recognised under non-current assets on the balance sheet with a corresponding deferred income balance.

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

1.8 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where expenditure of at least £5,000 is incurred, and are amortised over the shorter of the term of the licence and their useful economic lives.

Measurement

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

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Inventories

Inventories are valued at current cost. Current cost is considered to be a reasonable approximation to the lower of cost and net realisable value due to the high turnover of stocks.

1.10 Financial Instruments and Financial Liabilities

Financial Assets

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

Financial assets are initially recognised at fair value.

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

Classification and Measurement

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

Loans and Receivables

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

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

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

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

Financial Liabilities

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

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

Other Financial Liabilities

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

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

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

Impairment of Financial Assets

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

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

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

1.11 Leases

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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

Operating Leases

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

Leases of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.12 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.35% (2011/12, 2.8%).

Clinical Negligence Costs

The NHS Litigation Authority (NHS LA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS LA, which, in return, settles all clinical negligence claims. Although the NHS LA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS LA on behalf of the Trust is disclosed at note 17 but is not recognised in the Trust's accounts.

Non-clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

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

1.14 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.15 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation Tax

Foundation Trusts currently have a statutory exemption from Corporation Tax on all of their core healthcare activities. No significant commercial activity on which Corporation Tax would be applicable is undertaken.

1.17 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

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

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

1.18 Cash at Bank, Overdrafts and Cash Equivalents

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

Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.19 Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

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

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

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances/tonnes required to settle the obligation, being initially £12 per allowance/tonne.

1.20 Segmental Analysis

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

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

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

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

There is one major income stream for the Trust's activities: PCT funding for healthcare provision. This comprises 98% of the Trust's total income from activities, and 91% of its total operating income. Only two customers of the Trust make up more than 10% of the Trust's income from activities. These are NHS North East Essex (80%, £191,193k) and NHS Mid Essex (10%, £23,400k).

Revenues from countries outside of England are small (£56k received from Welsh and Scottish Commissioners). The Trust received £51k in relation to overseas visitors.

	2012/13 £000	2011/12 £000
Income	257,513	244,055
Expenditure		
Pay	(159,325)	(145,460)
Non-pay	(77,076)	(75,354)
Total Expenditure	(236,401)	(220,814)
EBITDA*	21,112	23,241
Depreciation, PDC dividend, etc.	(12,131)	(12,149)
Surplus before non-current asset impairments	8,981	11,092
Non-current asset impairments	127	1,218
Surplus after non-current asset impairments	9,108	12,310

* EBITDA as per Monitor's *Compliance Framework 2012/13* is Earnings Before Interest, Taxation, Depreciation, and Amortisation, but also excludes non-current asset impairments.

1.21 Accounting Standards that have been Issued but have not yet been Adopted

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

IFRS 9 Financial Instruments. Financial Assets: Financial Liabilities:

IFRS 10 Consolidated Financial Statements

IFRS 11 Joint Arrangements

IFRS 12 Disclosures of Interests in Other Entities

IFRS 13 Fair Value Measurement

IAS 12 Income Taxes amendment.

IAS 1 Presentation of Financial Statements, on Other Comprehensive Income (OCI)

IAS 27 Separate Financial Statements

IAS 28 Associates and Joint Ventures

IAS 19 (Revised 2011) Employee Benefits

IAS 32 Financial Instruments: Presentation - amendment. Offsetting Financial Assets and Liabilities

IFRS 7 Financial Instruments: Disclosures - amendment. Offsetting Financial Assets and Liabilities

1.22 Accounting Standards Issued that have been Adopted Early

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

2. Operating Income

2.1 Operating Income (by classification)

	2012/13 £000	2011/12 £000
2.1.1 Income from Activities		
Elective income	44,471	41,793
Non-elective income	72,146	71,244
Outpatient income	47,384	45,241
A&E income	8,312	7,630
Other activity income	62,747	58,128
Private patient income	1,085	886
Other non-protected clinical income	1,420	1,269
Total Income from Activities	237,565	226,191

2.1.2 Mandatory Services

Under its Terms of Authorisation, the Trust is required to provide mandatory services. The allocation of operating income between mandatory services and other services is provided in the table below.

	2012/13 £000	2011/12 £000
Mandatory services	173,733	167,177
Non-mandatory services	63,832	59,014
	237,565	226,191

2.1.3 Other Operating Income

	2012/13 £000	2011/12 £000
Research and development	1,229	1,119
Education and training	6,487	6,477
Charitable and other contributions to expenditure	189	333
Receipt of donated assets	78	0
Non-patient care services to other bodies	4,649	3,720
Reversal of impairments of property, plant and equipment	295	1,441
Car parking	900	865
Staff recharges	1,734	1,545
Drug sales	1,428	1,346
Clinical Excellence Awards	136	150
Other	2,699	1,908
Rental revenue from operating leases	93	75
Amortisation of PFI deferred credits	326	326
Total Other Operating Income	20,243	19,305

2.1.4 Total Operating Income

	2012/13 £000	2011/12 £000
Income from activities	237,565	226,191
Other operating income	20,243	19,305
Total Operating Income	257,808	245,496

2.2 Private Patient Income

	2012/13 £000	2011/12 £000
Private patient income	1,085	886
Total patient related income	237,565	226,191

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

2.3 Operating Lease Income

	2012/13 £000	2011/12 £000
Rents recognised as income in the period	93	75
Total	93	75

Future Minimum Lease Payments Due

-not later than 1 year	64	39
-later than 1 year and not later than 5 years	257	50
-later than 5 years	145	56
Total	466	145

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

2.4 Income from Activities (by type)

	2012/13 £000	2011/12 £000
NHS Trusts	461	0
Strategic Health Authorities	272	0
Primary Care Trusts	234,271	224,036
Local Authorities	17	6
Private patients	1,085	886
Overseas patients (non-reciprocal)	51	25
Injury Cost Recovery*	1,280	1,142
Non-NHS: Other	128	96
	237,565	226,191

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

3. Operating Expenses

3.1 Operating Expenses (by type)

	2012/13 £000	2011/12 £000
Purchase of healthcare from non-NHS bodies	3,582	3,360
Executive Directors' costs	910	964
Non-Executive Directors' costs	116	114
Staff costs	158,299	144,382
Drug costs	19,854	18,063
Supplies and services - clinical	25,012	24,242
Supplies and services - general	5,299	6,613
Establishment	2,178	2,337
Research and development	2	7
Transport	598	1,534
Premises	7,376	8,166
Increase in bad debt provision	486	129
Increase in other provisions	61	84
Inventories write down	64	550
Depreciation	7,569	7,890
Fixed asset impairments	168	223
Rentals under operating leases	2,575	2,231
Audit fees in respect of the statutory audit	51	74
Clinical negligence	4,798	4,597
Loss on disposal of other property, plant and equipment	449	81
Legal fees	115	90
Consultancy costs	1,683	765
Training, courses & conferences	747	734
Patient travel	42	40
Car parking & security	29	35
Redundancy	93	43
Insurance	307	263
Other services, e.g. external payroll	542	613
Losses, ex gratia & special payments	474	39
Other	659	664
Total	244,138	228,927

3.2 Arrangements Containing an Operating Lease

	2012/13 £000	2011/12 £000
Minimum lease payments	2,575	2,257
Less sub-lease payments received	0	(26)
Total	2,575	2,231

Future Minimum Lease Payments Due

-not later than 1 year	1,328	877
-later than 1 year and not later than 5 years	1,278	368
Total	2,606	1,245

Total of future minimum sublease lease payments to be received as at 31 March 2013.

0

0

The Trust's operating leases include rentals for the use of NHS premises, lease car contracts and the hire of medical and laboratory equipment. These leases have been reviewed and classified as operating leases in accordance with IAS 17.

3.3 Limitation on Auditor's Liability

The limitation on auditor's liability is £2,000,000 (no limitation on auditor's liability in 2011/12).

4. Staff Costs and Numbers

4.1 Employee Expenses

	2012/13 £000	2011/12 £000
Salaries and wages	123,095	115,156
Social Security costs	9,463	8,844
Employer contributions to NHS Pension Scheme*	13,743	13,147
Termination benefits	93	43
Agency/Contract Staff	12,976	8,199
Total	159,370	145,389

* Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

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

The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform contribution rates to be used from 1 April 2015.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as at 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

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

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

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

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

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

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

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

4.2 Exit Packages Agreed During 2012/13

Exit package cost band (including any special payment element)	2012/13		2011/12	
	Number of compulsory redundancies	Cost of compulsory redundancies	Number of compulsory redundancies	Cost of compulsory redundancies
Less than £10,000	0	0	1	7
£10,001 - £25,000	0	0	0	0
£25,001 - £50,000	0	0	1	36
£50,001 - £100,000	1	93	0	0
£100,001 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,001	0	0	0	0
Total	1	93	2	43

4.3 Key Management Compensation

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

	2012/13 £000	2011/12 £000 (Restated)
Salaries and other short-term employee benefits	844	834
Employer contributions to NHS Pension Scheme	85	78
Total	929	912

4.4 Average Number of Employees (WTE basis)

	2012/13 Total Number	2011/12 Total Number
Medical and dental	419	434
Administration and estates	703	666
Healthcare assistants and other support staff	769	591
Nursing, midwifery and health visiting staff	1,038	1,044
Scientific, therapeutic and technical staff	629	604
Bank and agency Staff	201	131
Other	0	4
Total	3,759	3,474

4.5 Staff Benefits in Kind

	2012/13 £000	2011/12 £000
Subsidised travel permits	36	33
Total	36	33

4.6 Retirements Due to Ill-health

During 2012/13 there were three early retirements from the Trust on the grounds of ill-health (four in 2011/12). The estimated additional pension liabilities of these ill-health retirements is £289,114 (2011/12, £105,149). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

5. Better Payment Practice Code

5.1 Better Payment Practice Code - Measure of Compliance

	2012/13		2011/12	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	68,654	104,107	66,649	81,988
Total non-NHS trade invoices paid within target	59,676	85,861	54,903	66,484
Percentage of non-NHS trade invoices paid within target	87%	82%	82%	81%
Total NHS trade invoices paid in the year	1,873	13,174	1,732	18,706
Total NHS trade invoices paid within target	1,487	9,826	1,373	15,774
Percentage of NHS trade invoices paid within target	79%	75%	79%	84%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

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

	2012/13 £000	2011/12 £000
Amounts included within interest payable (note 6.1) arising from claims made under this legislation	0	2
Total	0	2

6. Finance Income

	2012/13 £000	2011/12 £000
Interest income on short-term bank deposits	124	105
	124	105

6.1 Finance Costs - Interest Expense

	2012/13 £000	2011/12 £000
Finance Leases	154	134
Loans from the Foundation Trust Financing Facility	3	0
Other	0	2
	157	136

7. Intangible Assets

	Software Licences £000	Assets Under Construction £000	Total £000
Gross cost at 1 April 2011	2,531	1,263	3,794
Transfers from assets under construction	1,318	(1,318)	0
Additions purchased	0	2,724	2,724
Disposals	(266)	0	(266)
Gross cost at 31 March 2012	3,583	2,669	6,252
Amortisation at 1 April 2011	1,309	0	1,309
Charged during the year	473	0	473
Disposals	(266)	0	(266)
Amortisation at 31 March 2012	1,516	0	1,516
Net book value			
- Purchased at 31 March 2012	2,064	2,669	4,733
- Donated at 31 March 2012	3	0	3
- Total at 31 March 2012	2,067	2,669	4,736
Gross cost at 1 April 2012	3,583	2,669	6,252
Transfers from assets under construction	723	(723)	0
Additions purchased	0	1,320	1,320
Disposals	(8)	0	(8)
Gross cost at 31 March 2013	4,298	3,266	7,564
Amortisation at 1 April 2012	1,516	0	1,516
Charged during the year	740	0	740
Disposals	(8)	0	(8)
Amortisation at 31 March 2013	2,248	0	2,248
Net book value			
- Purchased at 31 March 2013	2,049	3,266	5,315
- Donated at 31 March 2013	1	0	1
- Total at 31 March 2013	2,050	3,266	5,316

8. Property, Plant and Equipment

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

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2011	28,562	107,209	1,971	31,772	10,943	262	180,719
Additions purchased	0	363	6,526	1,088	0	0	7,977
Additions donated	0	0	0	86	0	0	86
Impairments charged to reserves	0	(20)	0	0	0	0	(20)
Transfers from assets under construction	0	1,888	(3,784)	1,281	582	33	0
Revaluation surpluses	0	3,088	0	0	0	0	3,088
Disposals	0	0	0	(1,537)	(4,813)	0	(6,350)
Cost or Valuation at 31 March 2012	28,562	112,528	4,713	32,690	6,712	295	185,500
Depreciation and impairments at 1 April 2011	147	19,452	27	20,976	7,755	88	48,445
Provided during the year	0	3,301	0	3,029	1,060	27	7,417
Impairments charged to operating costs	0	223	0	0	0	0	223
Reversal of impairments	0	(1,441)	0	0	0	0	(1,441)
Revaluation surpluses	0	(3,892)	0	0	0	0	(3,892)
Disposals	0	0	0	(1,453)	(4,814)	0	(6,267)
Depreciation and Impairments at 31 March 2012	147	17,643	27	22,552	4,001	115	44,485
Net Book Value							
Owned at 31 March 2012	28,415	87,486	4,686	9,648	2,700	179	133,114
Finance Lease at 31 March 2012	0	1,654	0	3	0	0	1,657
On-balance-sheet service concession contracts	0	5,726	0	0	0	0	5,726
Donated at 31 March 2012	0	19	0	487	11	1	518
Total at 31 March 2012	28,415	94,885	4,686	10,138	2,711	180	141,015

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

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2012	28,562	112,528	4,713	32,690	6,712	295	185,500
Additions purchased	0	0	11,970	1,144	9	0	13,123
Additions leased	0	0	0	0	953	0	953
Additions donated	0	0	0	30	48	0	78
Impairments charged to reserves	0	(872)	0	0	0	0	(872)
Transfers from assets under construction	0	6,336	(8,998)	2,399	263	0	0
Revaluation surpluses	0	(7,633)	(39)	0	0	0	(7,672)
Disposals	0	(449)	0	(4,222)	(66)	0	(4,737)
Cost or Valuation at 31 March 2013	28,562	109,910	7,646	32,041	7,919	295	186,373
Depreciation and impairments at 1 April 2012	147	17,643	27	22,552	4,001	115	44,485
Provided during the year	0	3,175	0	2,669	955	30	6,829
Impairments charged to operating costs	0	156	12	0	0	0	168
Reversal of impairments	0	(295)	0	0	0	0	(295)
Revaluation surpluses	0	(8,900)	(39)	0	0	0	(8,939)
Disposals	0	(58)	0	(4,163)	(66)	0	(4,287)
Depreciation and Impairments at 31 March 2013	147	11,721	0	21,058	4,890	145	37,961
Net Book Value							
Owned at 31 March 2013	28,415	90,884	7,646	10,663	2,158	150	139,916
Finance Lease at 31 March 2013	0	1,634	0	0	826	0	2,460
On-balance-sheet service concession contracts	0	5,662	0	0	0	0	5,662
Donated at 31 March 2013	0	9	0	320	45	0	374
Total at 31 March 2013	28,415	98,189	7,646	10,983	3,029	150	148,412

Of the totals at 31 March 2013, no land or buildings were valued at open market value.

In 2010/11 Monitor issued revised guidance regarding the treatment of impairments between asset cost and depreciation. Impairments charged to operating costs are included within accumulated depreciation, with those charged to reserves reducing asset cost. This treatment is derived from IAS16 para. 73d which states that the accounts shall disclose for each class of PPE, 'the gross carrying amount and the accumulated depreciation (aggregated with accumulated impairment losses) at the beginning and end of the period'.

Monitor have interpreted this as expensed impairments (and impairment reversals) being presented with accumulated depreciation.

8.2 Analysis of Property, Plant and Equipment

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net Book Value							
Protected assets at 31 March 2012	28,415	94,885	0	0	0	0	123,300
Unprotected assets at 31 March 2012	0	0	4,686	10,138	2,711	180	17,715
Total at 31 March 2012	28,415	94,885	4,686	10,138	2,711	180	141,015
Net Book Value							
Protected assets at 31 March 2013	28,415	98,189	0	0	0	0	126,604
Unprotected assets at 31 March 2013	0	0	7,646	10,983	3,029	150	21,808
Total at 31 March 2013	28,415	98,189	7,646	10,983	3,029	150	148,412

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

	2012/13 £000	2011/12 £000
Buildings	33	32
Plant & equipment	130	122
Total	163	154

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

	31 March 2013 £000	31 March 2012 £000
Buildings	1,634	1,654
Plant & equipment	0	3
Information technology	826	0
Total	2,460	1,657

9.3 The Net Book Value of Land and Buildings:

	31 March 2013 £000	31 March 2012 £000
Freehold	124,970	121,646
Total	124,970	121,646

9.4 Impairment of Assets

	2012/13 £000	2011/12 £000
Changes in market price	733	(1,198)
Abandonment of assets in course of construction	12	0
Total	745	(1,198)

In 2012/13 a desk top revaluation exercise of the Trust's land and buildings was undertaken by the District Valuer Service, having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 8th Edition. The revaluation was undertaken because of continued volatility in land and building values caused by the unstable economic climate.

In accordance with IAS 16, the valuation of the Trust's land and buildings has been undertaken on a fair value basis, where fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. With the exception of some blocks of Essex County Hospital (see note 1.7), the valuation of each property asset is therefore on the basis of market value, on the assumption that the property is sold as part of the continuing enterprise in occupation (effectively existing use value), as required by the Department of Health for operational assets.

10. Inventories**10.1 Inventories**

	31 March 2013 £000	31 March 2012 £000
Drugs	2,292	2,101
Consumables	2,455	2,660
Energy	62	74
Other	386	332
Total	5,195	5,167

10.2 Inventories Recognised in Expenses

	2012/13 £000	2011/12 £000 (Restated)
Inventories recognised in expenses	36,950	30,040
Write-down of inventories recognised as an expense	64	550
Total	37,014	30,590

11. Receivables**11.1 Trade Receivables and Other Receivables**

	Total	Financial	Non-Financial	Total	Financial	Non-Financial
	31 March 2013	Assets	Assets	31 March 2012	Assets	Assets
	£000	£000	£000	£000	£000	£000
Current Trade and Other Receivables						
NHS receivables	2,022	2,022	0	1,702	1,702	0
Other receivables with related parties	73	73	0	82	82	0
Provision for impaired receivables	(947)	(598)	(349)	(463)	(275)	(188)
Prepayments	1,326	0	1,326	1,228	0	1,228
Accrued income	3,853	1,410	2,443	4,667	2,557	2,110
PDC receivable	27	0	27	0	0	0
Operating lease receivables	5	5	0	4	4	0
Other receivables	1,603	1,385	218	1,478	1,478	0
Sub Total	7,962	4,297	3,665	8,698	5,548	3,150
Non-Current Trade and Other Receivables						
NHS receivables	0	0	0	0	0	0
Sub Total	0	0	0	0	0	0
Total	7,962	4,297	3,665	8,698	5,548	3,150

11.2 Provision for Impairment of Receivables

	Total 31 March 2013 £000	Total 31 March 2012 £000
At 1 April	463	373
Increase in provision	923	258
Amounts utilised	(2)	(39)
Unused amounts reversed	(437)	(129)
At 31 March	947	463

11.3 Analysis of Impaired Receivables

	Total 31 March 2013 £000	Total 31 March 2012 £000
Aging of Impaired Receivables		
Up to 1 month	8	34
In 1 to 2 months	461	19
In 2 to 3 months	3	30
In 3 to 6 months	49	59
Over 6 months	426	121
Total	947	263

	Total 31 March 2013 £000	Total 31 March 2012 £000
Aging of Non-Impaired Receivables Past their Due Date		
Up to 1 month	2,100	2,024
In 1 to 2 months	228	240
In 2 to 3 months	136	101
In 3 to 6 months	191	373
Over 6 months	135	356
Total	2,790	3,094

12. Trade and Other Payables

12.1 Trade and Other Payables comprise the following:

	Total	Financial	Non-Financial	Total	Financial	Non-Financial
	31 March 2013	31 March 2013	31 March 2013	31 March 2012	31 March 2012	31 March 2012
	£000	£000	£000	£000	£000	£000
Current Trade and Other Payables						
Receipts in advance	6	0	6	5	0	5
NHS payables	934	934	0	717	717	0
Amounts due to other related parties	5,250	367	4,883	4,962	198	4,764
Trade payables - capital	3,080	3,080	0	4,975	4,975	0
Other trade payables	5,425	5,425	0	4,286	4,286	0
VAT payable	0	0	0	11	0	11
Accruals	7,099	7,099	0	9,566	9,566	0
PDC payable	0	0	0	87	0	87
Total	21,794	16,905	4,889	24,609	19,742	4,867

13. Other Liabilities

	31 March 2013	31 March 2012
	£000	£000
Current		
Deferred income	612	590
Sub Total	612	590
Non-Current		
Deferred income	3,908	4,234
Sub Total	3,908	4,234
Total	4,520	4,824

14. Finance Lease Obligations

14.1 Future Finance Lease Obligations

The Trust has future finance lease obligations for which the minimum payments at 31 March 2013 are £2,898k over a 23 year period of commitment (£2,394k over 24 years at 31 March 2012). These leases relate to the Trust's MRI Unit and the Icen training facility.

14.2 Finance Lease Obligations

	Minimum Lease Payments		Present Value of Minimum Lease Payments	
	31 March 2013 £000	31 March 2012 £000	31 March 2013 £000	31 March 2012 £000
Gross Lease Liabilities	2,898	2,394	2,325	1,776
<i>of which liabilities are due</i>				
not later than 1 year	437	254	338	135
later than 1 year and not later than 5 years	1,431	1,015	1,171	759
later than 5 years	1,030	1,125	816	882
Finance charges allocated to future periods	(573)	(618)	0	0
Net Lease Liabilities	2,325	1,776	2,325	1,776

14.3 PFI Obligations

The Trust's PFI arrangement for staff accommodation is accounted for as a service concession in accordance with IFRIC 12. The operator receives all of its income from individual users rather than in the form of unitary payments from the Trust. As such there is no service charge but the asset is recognised under non-current assets on the balance sheet with a corresponding deferred income liability (see note 13).

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

15. Borrowings

	31 March 2013 £000	1 April 2012 £000
Current		
Loan from Foundation Trust Financing Facility	2	0
Obligations under finance leases	338	135
Total Current Borrowings	340	135
Non-current		
Loan from Foundation Trust Financing Facility	5,500	0
Obligations under finance leases	1,987	1,641
Total Other Non-Current Liabilities	7,487	1,641

16. Prudential Borrowing Limit

The Trust is required to comply and remain within a prudential borrowing limit (PBL). This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact upon the long-term borrowing limit.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts, at www.monitor-nhsft.gov.uk.

The Trust had a Prudential Borrowing Limit of £76.2m for the period ended 31 March 2013, made up as follows:

	31 March 2013 £000	31 March 2012 £000
Maximum cumulative long term borrowing limit set by Monitor	59,400	40,800
Approved working capital facility	16,800	16,800
Prudential Borrowing Limit	76,200	57,600

Prudential Borrowing Code Ratios	Limit	Actual
Minimum dividend cover	> 1x	4.8
Minimum interest cover	> 3x	137.4
Minimum debt service cover	> 2x	38.4
Minimum debt service to revenue	< 2.5%	0.2

At 31 March 2013 the Trust was performing within all of the approved Prudential Borrowing Limit ratios.

17. Provisions for Liabilities and Charges

	Current 31 March 2013 £000	Current 31 March 2012 £000	Non-Current 31 March 2013 £000	Non-Current 31 March 2012 £000
Pensions relating to former directors	2	2	16	16
Pensions relating to other staff	124	116	1,144	1,136
Other legal claims	122	124	0	0
Redundancy	93	0	0	0
Other	859	82	0	0
Total	1,200	324	1,160	1,152

	Pensions relating to former directors	Pensions relating to former staff	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2011	18	1,297	88	0	289	1,692
Change in the discount rate	0	8	0	0	0	8
Arising during the year	1	39	78	0	47	165
Utilised during the year	(2)	(112)	(30)	0	(165)	(309)
Reversed unused	0	(15)	(12)	0	(89)	(116)
Unwinding of discount	1	35	0	0	0	36
At 31 March 2012	18	1,252	124	0	82	1,476
At 1 April 2012	18	1,252	124	0	82	1,476
Change in the discount rate	0	36	0	0	0	36
Arising during the year	1	65	83	93	792	1,034
Utilised during the year	(1)	(118)	(63)	0	(2)	(184)
Reversed unused	0	(1)	(22)	0	(13)	(36)
Unwinding of discount	0	34	0	0	0	34
At 31 March 2013	18	1,268	122	93	859	2,360

Expected timing of cash flows:						
Within one year	2	124	122	93	859	1,200
Between one and five years	7	438	0	0	0	445
After five years	9	706	0	0	0	715
	18	1,268	122	93	859	2,360

Other provisions relates to the Consultant Contract and new Staff and Associate Specialists contract. The provision was calculated on a person-by-person basis.

Legal claims represent a number of miscellaneous legal claims. The Trust is defending these claims and expects agreement to be reached within the coming year based on the timing of court and other negotiation arrangements.

£52,155,544 is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the Trust.

18. Notes to the Statement of Cash Flows**18.1. Cash and Cash Equivalents**

	At 1 April 2012	Other changes in year	At 31 March 2013
	£000	£000	£000
Cash with the Government Banking Service	28,553	5,847	34,400
Commercial cash at bank and in hand	76	203	279
	<u>28,629</u>	<u>6,050</u>	<u>34,679</u>

19. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2013 were £20,744k (£3,587k, 31 March 2012).

20. Events After the Reporting Period

There are no events after the reporting period.

21. Contingencies

	31 March 2013 £000	31 March 2012 £000
Contingent liabilities	(51)	(61)

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

22. Movement in Public Dividend Capital

	£000
Public Dividend Capital as at 1 April 2011	76,193
Public Dividend Capital as at 31 March 2012	<u>76,193</u>
Public Dividend Capital as at 1 April 2012	76,193
Public Dividend Capital as at 31 March 2013	<u>76,193</u>

23. Related Party Transactions and Balances

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

NHS foundation trusts are deemed to be under the control of the Secretary of State, in common with other NHS trusts. The Department of Health is considered to be the Trust's parent organisation and other NHS bodies are therefore classed as related parties. During the financial period, the Trust had a number of material transactions with NHS bodies, all of which were at arms length. None of the Trust's balances with related parties are held under security or guarantee.

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

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

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

	Revenue		Expenditure		Payables		Receivables	
	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12	2012/13	2011/12
	£000	£000	£000	£000	£000	£000	£000	£000
Colchester Borough Council	25	15	985	1,060	101	1	2	0
Department of Health	415	3	0	626	0	82	0	26
East of England Strategic Health Authority	6,098	6,232	5	2	27	8	0	71
Essex County Council	211	169	637	700	66	60	62	62
HM Revenue & Customs	0	0	9,493	8,844	3,042	3,106	0	0
Ipswich Hospital NHS Trust	1,546	41	617	229	625	9	461	0
Mid Essex Hospitals NHS Trust	944	978	312	405	0	127	45	835
Mid Essex Primary care Trust	23,400	24,787	2	(7)	143	0	714	499
NHS Blood and Transplant	24	13	1,647	1,645	0	44	11	0
NHS Litigation Authority	0	0	4,936	4,722	0	1	3	0
NHS Pension Scheme	0	0	13,743	13,147	1,838	1,669	0	0
NHS Professionals	0	0	2,245	2,030	377	232	0	0
North East Essex Primary Care Trust	191,193	188,691	1,141	1,127	0	1,254	865	2,248
South East Essex Primary Care Trust	13,731	6,047	0	0	0	0	267	4
Suffolk Primary Care Trust	5,101	4,265	0	0	0	157	338	139
West Essex Primary Care Trust	389	724	1	281	1	417	18	47

The Trust holds charitable funds for which transactions between parties is not deemed material.

24. Financial Instruments

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Financial risk management

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is routinely reported and is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. As such, the Trust does not undertake transactions in currencies other than sterling and is therefore not exposed to movements in exchange rates over time. The Trust has no overseas operations.

Credit risk

Due to the fact that the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2013 is in receivables from customers, as disclosed in the receivables note.

Liquidity risk

The NHS Trust's net operating costs are incurred under annual service contracts with local primary care trusts, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

The Trust borrows from Government for capital expenditure subject to affordability. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Alternatively, the Trust can borrow on a commercial basis and would only take such loans on a fixed rate basis. The Trust therefore has low exposure to interest rate fluctuations.

24.1a Financial Assets by Category

Assets as per Statement of Financial Position	Loans and receivables	
	31 March 2013 £000	31 March 2012 £000
Trade and other receivables	4,297	5,548
Cash at bank and in hand	34,679	28,629
Total	38,976	34,177

24.1b Financial Liabilities by Category

Liabilities as per Statement of Financial Position	Other financial liabilities	
	31 March 2013 £000	31 March 2012 £000
Obligations under finance leases	2,325	1,776
Borrowings	5,502	0
Trade and other payables	16,905	19,742
Provisions under contract	952	82
Total	25,684	21,600

25. Fair values

As at 31 March 2013 there are no significant differences between fair value and carrying value of any of the Trust's financial instruments.

The fair value for provisions is not significantly different from book value since in the calculation of book value the expected cash flows have been discounted by the Treasury discount rate of 2.35% in real terms.

26. Losses and Special Payments

Losses and special payments are transactions that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of Parliament. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings on an accruals basis (excluding provisions for future payments), including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums being included as normal revenue expenditure).

There were 150 cases of losses and special payments totalling £617,989 approved during the period.

There were no clinical negligence cases where the net payment exceeded £100,000.

There were no fraud cases where the net payment exceeded £100,000.

There were no personal injury cases where the net payment exceeded £100,000.

There were no compensation under legal obligation cases where the net payment exceeded £100,000.

There were no cases of property obsolescence where the loss exceeded £100,000.

There was 1 fruitless payment where the net payment exceeded £100,000 (£387,682).

Section C

Quality Report 2012/13

Quality Report

2012/2013

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Part 1: Statement on quality from the Chief Executive

Quality Report 2012/13

Introduction by the Chief Executive

The quality of care delivered to our patients, their safety, experience and the outcomes of our services are of paramount importance to the Board of Directors, Council of Governors and all staff.

This is the fifth set of Quality Reports produced by the Trust and I believe they continue to show progress in all of these areas.

Our Quality Report this year states the quality objectives we set for 2012/13 in last year's Report. These covered a cross-section of measures of patient safety, experience and outcomes.

Overall we have made good progress in a number of areas and continue to improve patient safety with consistent reductions in serious harm resulting from falls by 7% and a 41% reduction in hospital acquired pressure ulcers. We continue to see a reduction in our crude mortality and mortality rate, and our HMSR is within the expected range. However, our SHMI is above the expected level. This has been cited as the reason for the Trust being included in the Professor Sir Bruce Keogh review. This is reported as a "smoke alarm" and no judgement on the quality of care has been made. We understand the review will be completed by the end of July and the Trust will cooperate fully. Progress on other indicators has been positive and we continue to see benefits from the changes to the Emergency Care Pathway and to the expansion of 7-day working which involves over 600 staff including but not limited to radiology, therapies, matrons, HR and medical records.

We continue to work with our doctors and nurses and other stakeholders in a number of ways to focus on reducing avoidable deaths in hospital. We are working and building relationships with the newly authorised Clinical Commissioning Groups and we have developed with them a Joint Mortality Action Plan which now has participation from the Ambulance Service, Hospice and Anglian Community Enterprise (ACE).

We remain in the top quartile as one of the trusts with the lowest incidence of *Clostridium difficile*. As a priority we continue to implement effective infection control practices resulting in only one case of MRSA Bacteraemia in the last three years.

Looking forward, our Quality Report sets out our quality objectives for 2013/14. Our Commissioning for Quality and Innovation Payments (CQUINs) for the coming year are aligned to our objectives to further improve patient safety and experience.

Our Quality Report also reflects our clinical audit activity, our participation in research & development activities and the integrity of the data we use to manage and plan patient care and the wider operation of the Trust.

We are constantly aiming to improve patients' experience and we are achieving this through the 'At Our Best' programme which has seen 90% of staff attend a facilitation session to improve communication, consistency and care. We welcome any chance to find out what patients think about their care, food, the environment and how well we keep them and their families updated. This spring we have held a number of 'In Your Shoes' and 'In Our Shoes' sessions to listen to patients, carers and staff to keep improving the quality of care we provide. Our Friends and Family test scores which have reliably been in the upper quartile for the region indicate we are making progress. Of course the quality of the care we provide is delivered by the professionalism and

motivation of our staff. The results from the NHS Inpatient Survey and Staff Surveys demonstrate we have maintained our position nationally, but there is much work to do.

Following external monitoring, comprehensive changes have been made to further strengthen the systems and processes within the Quality Hub, and to embed the learning throughout the organisation.

The Quality & Patient Safety Committee receives and reviews detailed, quality-related information each month about patient safety, patient experience and clinical outcomes and provides assurance to the Board. Every four months the committee meets with the clinical and managerial leaders of each division to give a focus to quality issues.

The Quality Report sets out how we are progressing and where we are focusing our attention to make further improvements.

The complementary themes of patient safety, patient experience and effectiveness of care underpin our quality strategy, the prioritisation of our quality objectives and implementation plans, and the reporting on our quality performance.

I want our Quality Report to develop in a transparent way, recognising not only our success but also areas where we need to work harder or differently to deliver the quality of service and experience our patients deserve. I am delighted that our service users and external stakeholders have been able to comment on and shape our Quality Report, and you can read their comments in this document

To the best of my knowledge, the information contained in this document is accurate. I hope you find it gives a valuable insight into the work of the Trust.



Dr Gordon Coutts

Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Board

Priorities for Improvement

In our Quality Report published in June 2012, we reviewed the progress against our 2011/2012 objectives and set out new and more challenging objectives for 2012/2013, which focused on the annual CQUIN framework. These relate to incentive payments for quality, negotiated and agreed with NHS North East Essex.

These CQUINs were selected after both NHS North East Essex and the Trust considered a longer list of potential quality measures. The initiatives themselves were developed by clinical and management staff from both organisations; some of which were based on national CQUIN exemplar requirements. As part of the final agreement, NHS North East Essex consulted with General Practitioner commissioners in the development of the final measures.

The objectives we set ourselves for 2012/2013 concentrated on specific measures of improvement in:

1. Dementia (Find, Assess, Refer)
2. Venous Thromboembolism (VTE) Risk Assessment
3. Patient Experience (National Survey)
4. Safety Thermometer
5. Pressure Ulcers
6. GP Acquisition
7. Patient Experience
8. End of Life
9. Early Consultant Review
10. Enhanced Recovery programme – Urology
11. Medicines Management

This section of the Quality Report focuses on each of these areas and the specific objectives that we have been seeking to deliver.

Review of 2012/2013 CQUIN Objectives

Objective 1: Dementia (Find, Assess, Refer)

- % of patients admitted aged 75 and over who have been screened following admission to hospital, using the dementia case-finding question

The National Dementia CQUIN for 2012/2013 is aimed at improving awareness and diagnosis of people with dementia using a risk assessment tool within the acute hospital setting.

We have:

- Appointed two Dementia Care Nurses to carry out the assessments and refer directly for specialist reassessment as required.

- Developed an innovative web-based assessment tool, where scoring is automatically calculated and if necessary, following assessment, the tool will email a direct referral to the patient's GP.
- Dementia awareness training has commenced across the Trust and an e-learning package for all clinical staff was launched in March 2013.
- To enhance the assessment of a patient with dementia and support a personalised approach to care, the RCN & Alzheimer's Society 'This Is Me Document' is used within inpatient ward environments.

The Trust Dementia Strategy Group will continue to lead the strategic direction and local implementation of the National Dementia Strategy (2009) to support and promote the sharing of good practice across the Trust in 2013/2014.

Dementia Screening was fully implemented in the Trust in October 2012. Performance against the CQUIN target which has been achieved is outlined in figure 1 below:

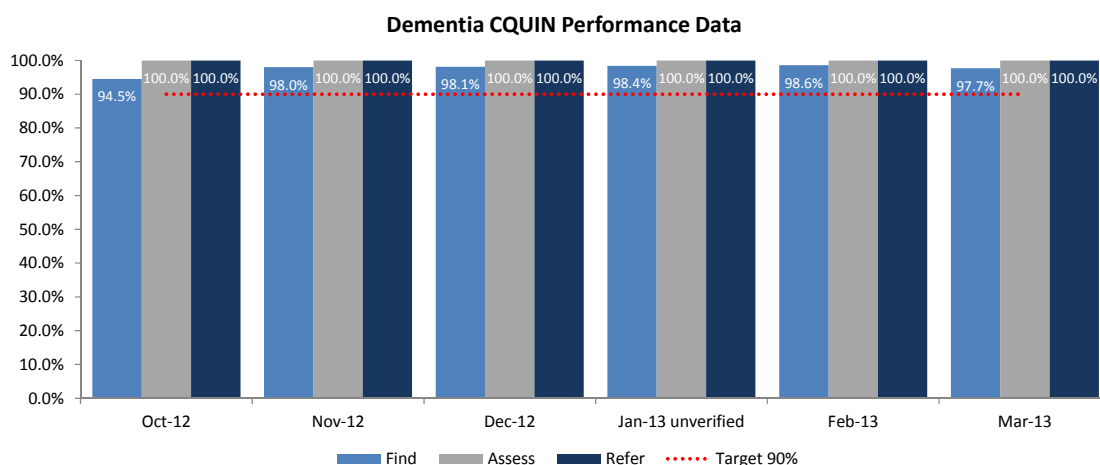


Figure 1: Dementia CQUIN Performance 2012/2013

Objective 2 : VTE Risk Assessment

- 95% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool

The Venous Thromboembolism (VTE) Prevention CQUIN for 2012/2013 is to achieve 95% of all adult inpatients to have a VTE risk assessment within 24 hours of admission; using the clinical criteria of the national tool to include those risk assessed using the cohort approach in line with published guidance.

VTE is a significant cause of mortality, long term disability and chronic ill health. VTE has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS leadership team.

Performance during 2012/2013 has been disappointing and below the target of 95%. This has been the result of various issues including data collation, problems with the on-line reporting tool and staff compliance. A number of actions are already underway to ensure performance improves in 2013/2014; the VTE nurse team continue to work with ward nurses and medical staff to remind them of the importance of this key patient safety issue.

Patients identified as having hospital-related VTE events are regularly investigated using a root cause analysis approach. Feedback following these reviews has not identified that any case was preventable.

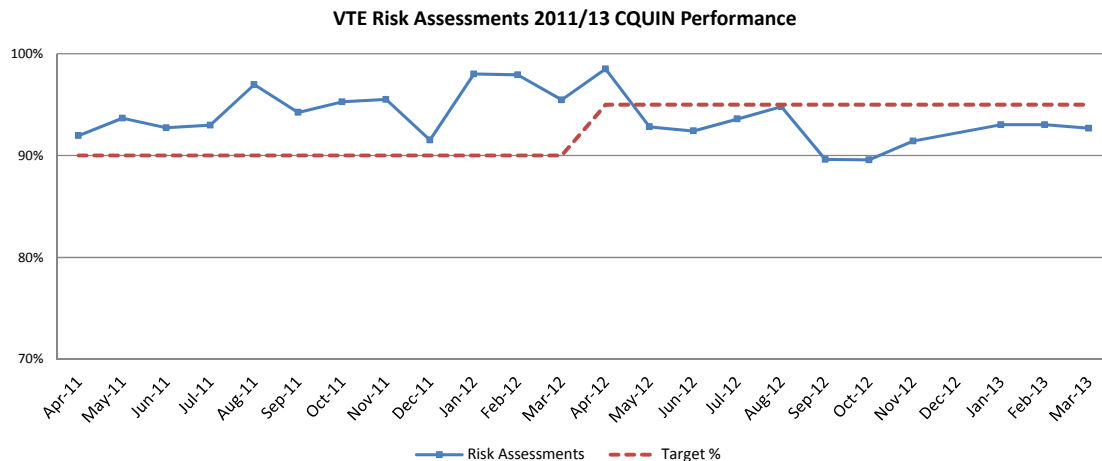


Figure 2: VTE CQUIN Performance 2011/2012 and 2012/2013

Objective 3 : Patient Experience (National Survey)

This indicator is a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme “responsiveness to personal needs of patients”. The 5 individual elements are:

- Involvement in decisions about treatment and care
- Hospital staff being available to talk about worries and concerns
- Privacy when discussing condition or treatment
- Being informed about the side effects of medication
- Being informed who to contact if worried about condition after leaving hospital

The national inpatient survey is a statutory requirement and is undertaken by Picker on behalf of the Trust. The methodology ensures that approximately eight hundred and fifty patients are contacted following discharge and asked to complete the survey by post.

The 2011 survey resulted in significant improvement moving the Trust from the bottom to mid table nationally. The CQUIN framework links a single, composite measure for improving responsiveness to personal needs of patients for each organisation as identified in figure 3 below.

Issue	2008	2009	2010	2011	2012	Performance
Care: wanted to be more involved in decisions	51%	53%	56%	46%	43%	
Care: could not always find staff member to discuss concerns with	61%	67%	72%	59%	66%	
Care: not always enough privacy when discussing condition or treatment	30%	33%	37%	26%	27%	
Discharge: not fully told side-effects of medications		66%	68%	60%	64%	
Discharge: not told who to contact if worried	30%	32%	31%	26%	28%	

Figure 3: National Annual patient Survey results 2011/2012 and 2012/2013

The 2012 National Inpatient Survey uses a total of 54 questions and reflects the questions used within the 2011 survey. The Trust had sustained the huge progress it made in the equivalent survey published in April 2012, when Colchester became the most improved acute hospital trust in the East of England. 79% of patients at Colchester General Hospital and Essex County Hospital, who responded to the CQC's *Survey of adult inpatients 2012*, described their care as either "excellent" or "good". This compares with 78% in the 2011 survey, 72% in 2010, 73% in 2009 and 74% in 2008.

However the five mandated CQUIN questions shown in figure 3 indicate a slight dip in the overall position for these areas.

Objective 4 : Safety Thermometer

This CQUIN incentivised the collection of data on patient harm using the NHS Safety Thermometer.

- Number of months per quarter for which a complete record of Safety Thermometer survey data covering all appropriate patients is submitted to the NHS Information Centre.

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from:

- pressure ulcers,
- falls,
- urinary infection in patients with catheters, and
- treatment for VTE.

The tool was developed for the NHS by the NHS as a point of care survey instrument; the NHS Safety Thermometer provides a 'temperature check' on harm that can be used alongside other indicators to measure local and system progress.

This CQUIN has been achieved and it is anticipated that as a mandatory CQUIN for 2013/2014 a local improvement goal attached to one of the four harms will be developed.

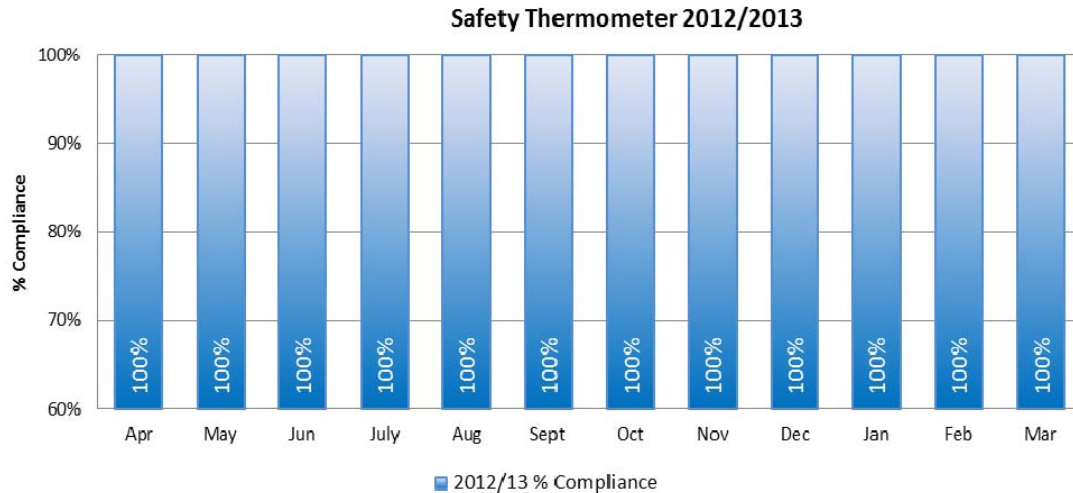


Figure 4: Monthly Safety Thermometer Submission 2012/2013

- The Trust's harm free rate of care for April 2012 to March 2013 is 97.6%. This benchmarks favourably with comparable data across the NHS.
- The national range for harm free care in acute NHS Trusts is between 86.7% - 99.7%.

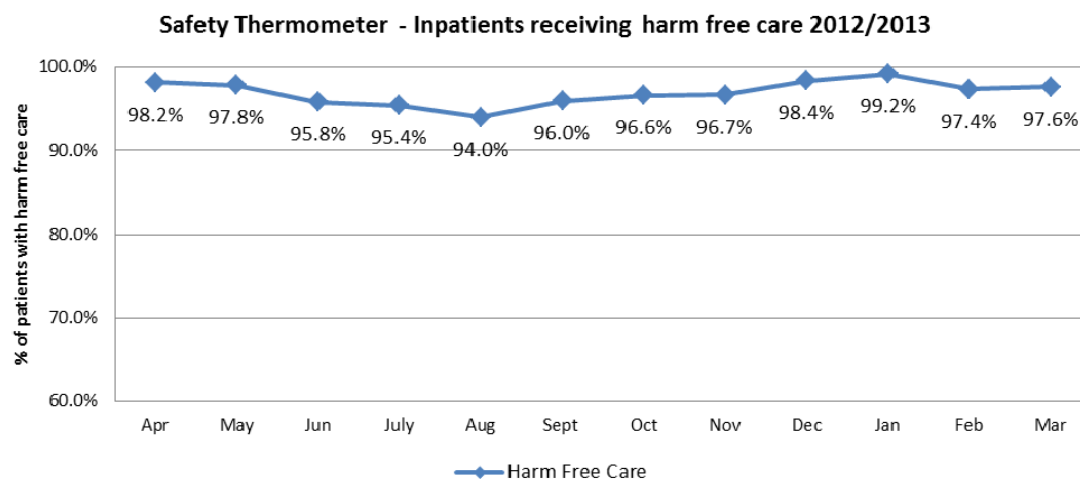


Figure 5: Monthly Safety Thermometer Harm free Care Rate 2012/2013

Objective 5 : Pressure Ulcers

- The elimination of all avoidable grade 2, 3 and 4 hospital pressure ulcers by December 2012.

Pressure ulcers are an unwanted complication associated with healthcare and estimates suggest that they cost approximately 4% of the total annual NHS expenditure. They are costly in terms of prevention, management and human suffering.

In 2011/2012 the Trust achieved a reduction of 84% in grade 3 and 4 hospital acquired pressure ulcers against a CQUIN target of 35%. The ambition linked to the CQUIN target for 2012/2013 was to eliminate all avoidable grade 2, 3 and 4 hospital acquired pressure ulcers through a zero tolerance approach.

Whilst the overarching CQUIN ambition was not met, there has been a significant reduction in these incidents compared to 2011/2012.

- In the financial year 2012/2013 there were 136 hospital acquired pressure ulcers grades 2 to 4 recorded, compared to 315 for 2011/2012. This represents a reduction of 56.8%.
- For grade 2 pressure ulcers, there has been a 65% reduction and a 28% reduction in grades 3 and 4. This is a remarkable achievement when looking at patients who are increasingly admitted with skin integrity problems as a result of immobility, dehydration, malnutrition and peripheral circulation issues.

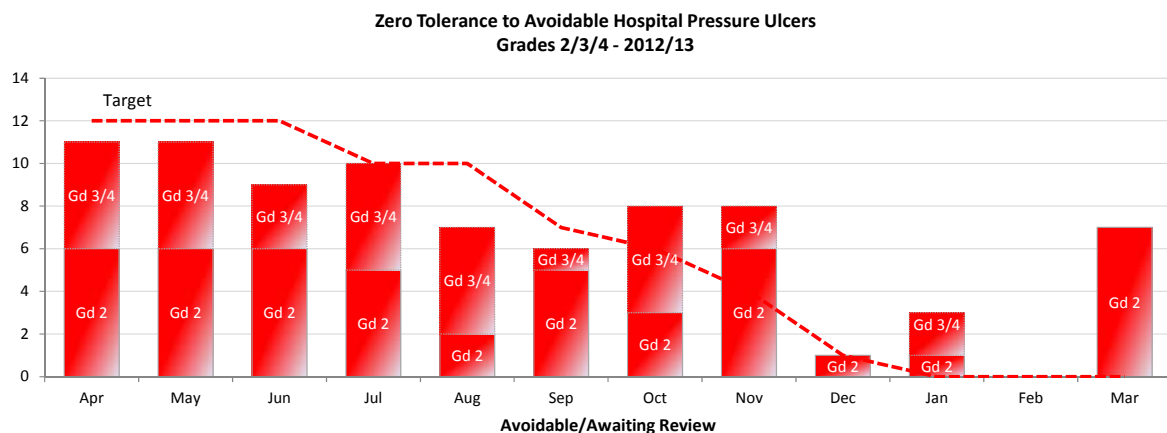


Figure 6: Monthly Avoidable Grade 2, 3 and 4 Pressure Ulcers 2012/2013

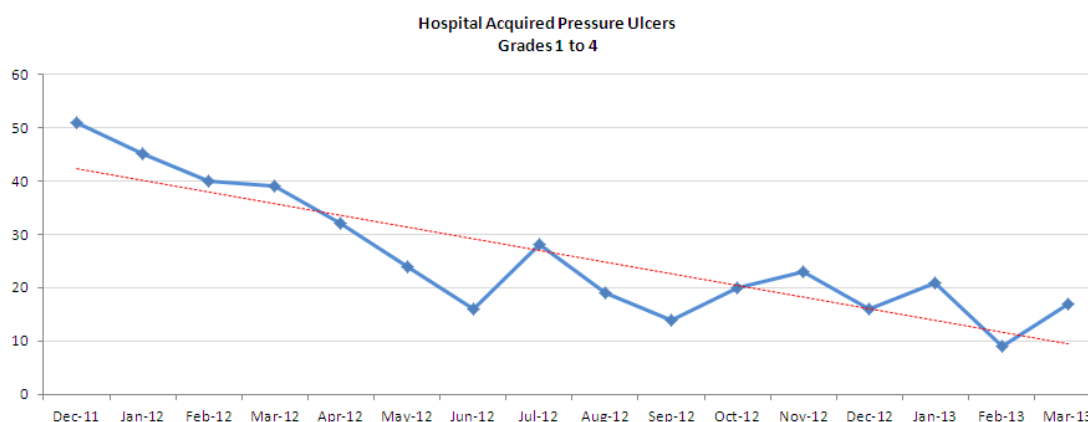


Figure 7: Monthly Hospital Acquired Pressure Ulcers Grades 1- 4

Objective 6 : GP Acquisition

This CQUIN incentivised participation in GP engagement events to demonstrate the benefits of the clinical portal in readiness for year 2 – GP utilisation.

This scheme is related to removing the mismatch of patient data sources and clarifying systems of patient data on every contact with patients, through improved system alignment. This is an essential process as it will enhance patient safety via reduced missed appointments and improve effectiveness of GP communication through safe transfer of patient information communication.

Another component of this scheme has been to improve face to face interaction with patients to confirm patient details and update hospital systems. This is essential to ensure patient confidentiality and Information Governance legislation is not breached. In addition to the regulatory compliance element of the CQUIN, patient safety and communication is paramount.

Following the undertaking of a baseline audit, the Trust subsequently agreed a stretching target for improvement. In terms of achievement:

- In quarter 2, the Trust met the target to train over 90% of eligible front line staff to ensure understanding of their responsibilities to re-affirm patient details including GP
- In quarter 3, following an audit of 150 mismatched patient records to determine numbers solely attributable to internal errors or omission, the Trust subsequently achieved an agreed 30% improvement target
- The Q4 validation of results for this CQUIN is currently being undertaken. However, this CQUIN has been agreed as achieved with the Commissioners.

Objective 7 : Patient Experience

- 10% of inpatient discharges to be asked the Net Promoter Score question “How likely is it that you would recommend this service to friends and family?”

The Friends and Family test was introduced as part of a national programme, with the aim of using a simple metric combined with follow-up questions to drive cultural change. Introduced within the Trust in April 2012, the methodology used is via a leaflet given to each patient on discharge. This information included the following five pledges to ensure patients have the following information:

1. You are clear about what’s happened
2. You have written information about what to do after leaving hospital
3. You are aware of any possible danger signals to look out for
4. You know how to take your medication, and about any possible side-effects
5. You know who to contact if you are worried about your condition

The CQUIN framework for 2012/2013 requires 10% of inpatient discharges to be included for any given week, either at or within 48 hours of discharge.

The Trust has performed well throughout the year with scores between 76 and 82, placing the Trust within the upper quartile regionally for most of the year.

The target was set and agreed using Month 1 data which placed the Trust in the top quartile of national performance. As a Trust therefore the CQUIN target was to maintain top quartile performance during 2012/2013. The only 2 months we did not achieve this were November and December 2012.

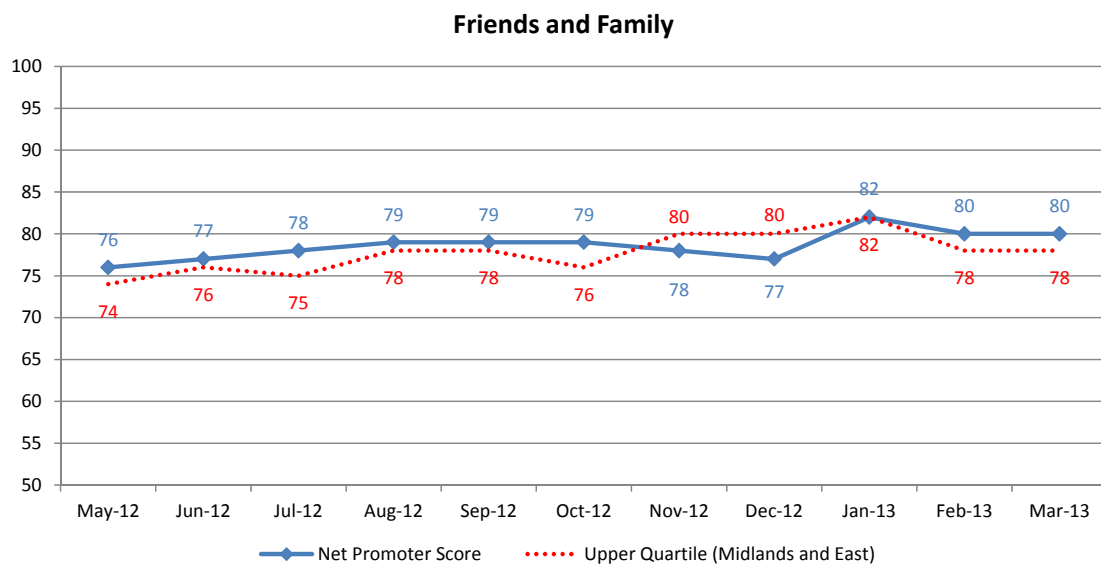


Figure 8: Monthly Net Promoter Scores 2012/2013

Objective 8 : End of Life

- Number of patients audited aged 60 and over, who were admitted as a non-elective admission and died within 3 days of admission.

This CQUIN promoted the development of partnership working between primary/community care providers, the use of an agreed template and multi-professional audit process to drive improvement. This involved the analysis, between April and November 2012, of 90% of deaths of patients over the age of 60 years, who were admitted as an emergency into hospital and who died within 3 days of admission.

The targets for quarter one (development of the template and audit), quarters two and three (collection of audit data) and quarter four (the development of a plan to reduce end of life admissions) were achieved. Learning from these reviews has been developed into a locality action plan to focus on reducing end of life admissions to secondary care.

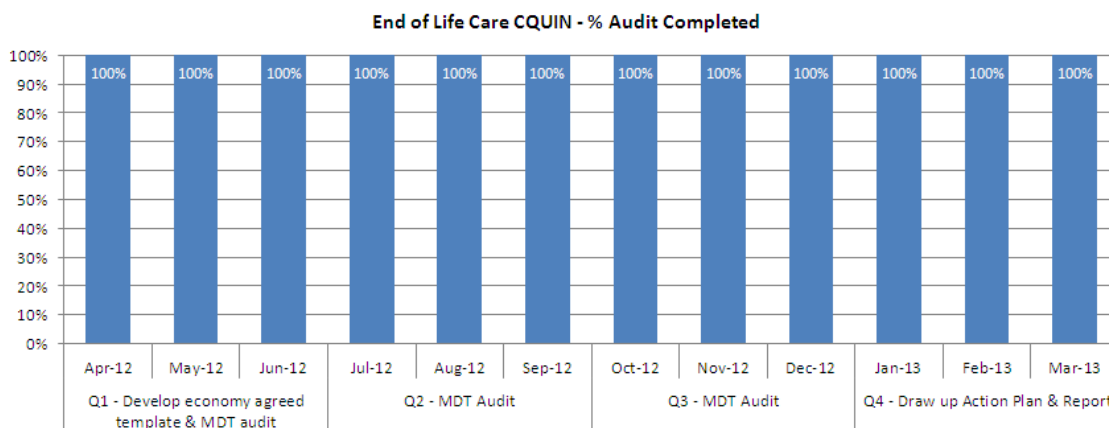


Figure 9: Monthly Audit Compliance for the End of Life CQUIN 2012/2013

As part of wider work across the Trust in relation to end of life care a number of other initiatives have been introduced or are in progress including:

- An integrated approach to a seven days a week service to facilitate discharges for patients at the end of life, ensuring appropriate application of the Liverpool Care Pathway (LCP).
- Refurbishment of the hospital's Bereavement Suite and surrounding corridor area.
- Spirituality and end of life training programmes for Trust staff.

The Liverpool Care Pathway is an integrated care pathway that is used at the bedside to improve sustained quality of care of the dying in the last hours and days of life. It is a means to transfer the best quality for care of the dying from the hospice movement into other clinical areas, so that wherever the person is dying, there can be an equitable model of care. Figure 10 below, reflects the

appropriate and consistent approach to the LCP for patients clearly at an end of life stage in hospital. The graph below shows the number of adult inpatients who have died on the LCP as a percentage of the total number of adult inpatient deaths. Whilst there is no internal target, the aim is for all adult end-of-life inpatients to be assessed and the pathway applied where appropriate.

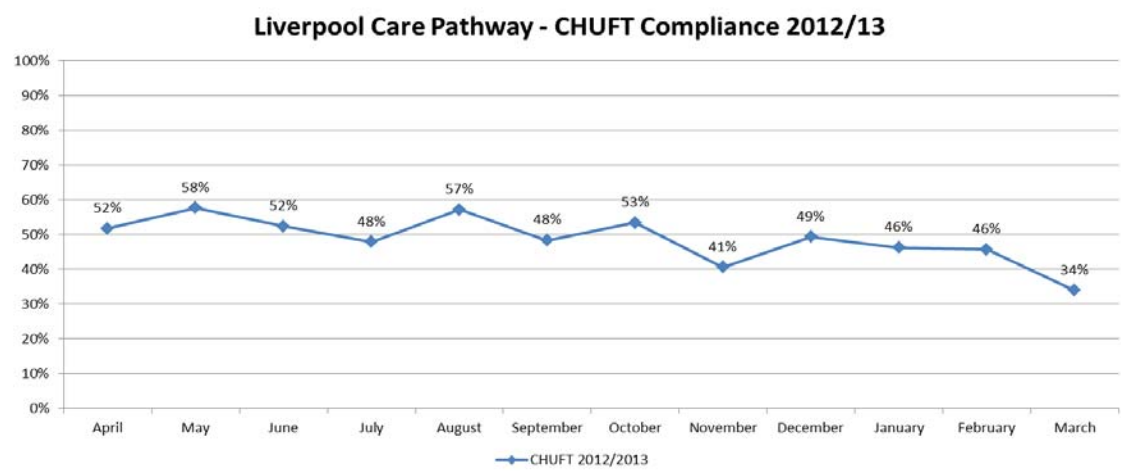


Figure 10: Monthly Percentage of Patient Deaths on the Liverpool Care Pathway 2012/2013

Objective 9 : Early Consultant Review

- Number of non elective patients’ records with documented evidence of consultant review within 6 hours of admission (excluding Maternity and Obstetrics).

This CQUIN proposed that at least 35% of patients should receive a consultant review within 6 hours of admission. Performance against the target was measured through quarterly audits of 150 patient records to identify documented evidence of patients being seen by a consultant and how long this was after admission.

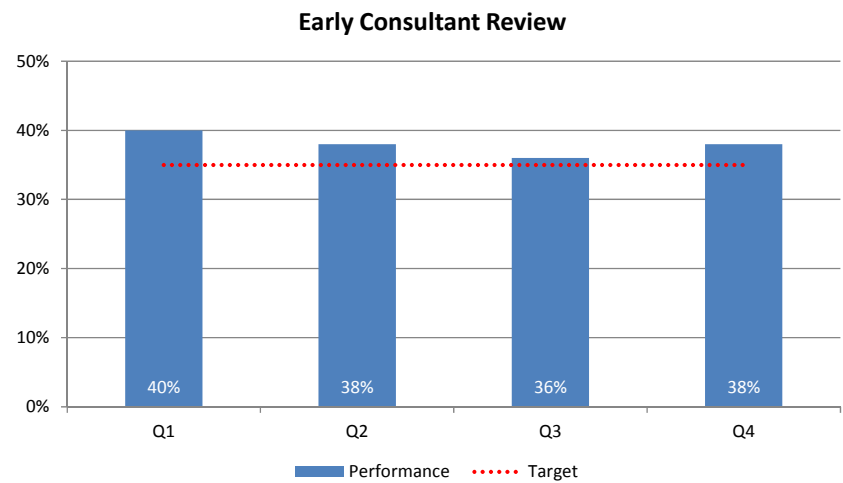


Figure 11: Monthly percentage of patients reviewed within the six hour CQUIN target 2012/2013

The above graph demonstrates that for each of the four quarters, more than the target 35% of patients were assessed and their care documented.

Objective 10 : Enhanced Recovery programme - Urology

- Number of Urology patients admitted electively as a Day Case for Transurethral Resection of Bladder Tumour (TURBT).

This CQUIN scheme related to the introduction of the enhanced recovery programme for patients under-going Transurethral Resection of Bladder Tumour (TURBT). The aim was to improve the quality of pre, intra and post-operative care for urology patients undergoing this elective procedure. This involved the redesign the patient's pathway to increase the percentage of patients admitted through a day case pathway as opposed the current inpatient model.

As a base point, the Trust admitted 21.6% of elective patients as a day case (Dr Foster - January to December 2011) compared to the SHA median of 33.9%. The target, by year-end, was to reach 34.5%, through staged targets.

In terms of achievement:

- In quarter 1, the Trust had to map patient pathway and redesign to improve pre, intra and post-operative care – this was delivered.
- In quarter 2, the Trust had to achieve 25.9% of elective TURBT's to be admitted as day cases – unfortunately this was not delivered, score moved to 16.5%.
- In quarter 3, the Trust had to achieve 30.2% of elective TURBT's to be admitted as day cases – this was delivered, performance back on track at 34.5%.
- In quarter 4, the Trust target, 34.5% of elective TURBT's to be admitted as day cases was achieved, with a compliance of 37.1%

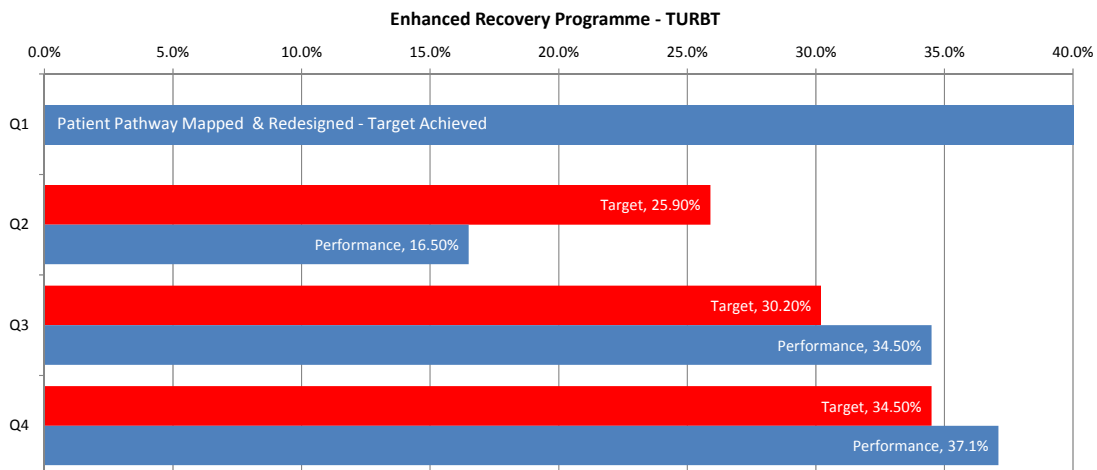


Figure 12: Quarterly percentage of patients admitted via the elective day case model 2012/2013

Objective 11 : Medicines Management

- Reduce the number of missed antibiotic doses and missed Parkinson's disease medication for non-clinical reasons, within previous 48 hours.

Antibiotics Missed Doses CQUIN

- A baseline audit in Quarter one identified a rate of omitted doses of 7%. The data from this audit was used in a variety of ways to influence improvement in performance.
 - It was presented to sisters and matrons and used by the matrons as part of focussed work with ward staff on omitted doses.
 - It prompted development of a poster on omitted doses that was used as part of the training and awareness materials used to encourage good antibiotic prescribing practice at the junior doctors' fare in August and in the subsequent teaching sessions.
 - Antibiotic e-learning for medical staff was also launched in August and subsequently for nursing staff.
- A re-audit in Quarter two showed a reduction in missed doses from 7% to 5%.
- The audit in Quarter three showed a further reduction to 2%. This performance was well in excess of the CQUIN target of 20% reduction from baseline by quarter four.

This CQUIN has been achieved as demonstrated in figure 13 below.

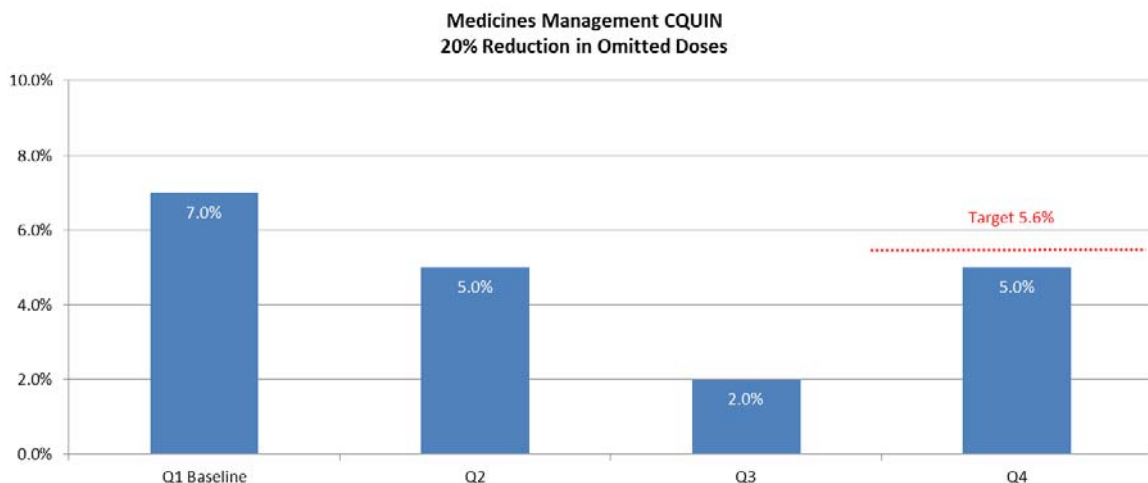


Figure 13: Reduction in omitted doses 2012/2013

Parkinson's Disease Treatment CQUIN

An initial baseline audit in Quarter 2 only identified and collected data on seven appropriate patients. It was therefore decided to do a retrospective audit on one month's data and this approach found that six out of ten patients had one or more missed doses during their hospital stay. In view of this result, the CQUIN steering group agreed not to repeat the audit in Quarter three and instead to take immediate action to improve this baseline figure as follows:

- Publicity about the need to ensure Parkinson's medication was given and distributed to wards.
- An e-learning package, launched in July 2012, was promoted and supported training for ward staff during roll out.
- A poster for each ward detailing where supplies of Parkinson's medication can be found in the hospital was also distributed.

Doses omitted because patients were to be kept nil by mouth due to clinical reasons was a problem in audit areas, so a Trust-wide protocol on which medicines must be given, even when patients are nil by mouth is currently being consulted on. An Integrated Care Pathway for Parkinson's disease patients who are 'nil by mouth' promoting the option of using rotigotine patches is also in the process of development.

The Quarter 4 requirement is to provide a Training plan, developed to target high prevalence wards/departments and monthly performance reports. This CQUIN was achieved.

Other Quality Initiatives

Emergency Care Reorganisation

In September 2011, the Trust invited ECIST (NHS Emergency Care Intensive Support Team) to come into the organisation and undertake a whole system diagnostic assessment of the emergency admission patient pathways. This work resulted in a number of recommendations being made to the Trust. These recommendations comprised a significant programme of change for both the hospital and the local health and social care community.

In response to the recommendations, the Trust formed the Emergency Care Reorganisation Implementation team (ECRIT) with the explicit remit of developing a realistic implementation plan which could be executed within agreed timeframes. Six associated work-streams were identified and each led by a member of the ECRIT. Each has components within it for implementation. A standards group defined the top 8 internal professional standards for implementation. Key elements and achievements of this programme include:

- Agreement of criteria for admission to specialty wards
- Implementation of a daily Consultant-led board/ward round to enhance patient safety and reduce length of stay
- Adoption at the point of admission of clinical and functional estimated date of discharge criteria
- Increase in the number of patients who are routinely discharged in the morning and are given their electronic discharge summary within 24 hours of discharge
- Early establishment of assertive management of patients with cognitive impairment

- Implementation and monitoring of a set of Diagnostic Internal Professional Standards for Acute assessment
- Agreement of a local system between Emergency Department & Imaging that supports improved patient safety and responsiveness to the department
- Establishment of formal processes to access out of hours Pacing
- Establishment of formal processes to access out of hours endoscopy
- Refinement of the Rapid Access and Treatment (RAT) Process
- Agreement of a pathway between North Essex Partnership NHS Foundation Trust (NEPFT) and the Trust's Emergency Department for urgent assessment of mental health patients and ensure there is a link between the Emergency Department, the Emergency Assessment Unit/Short Stay and the Mental Health Liaison Service to support rapid turnaround of patients
- Development of a single set of clerking documentation between the Emergency Department and the Emergency Assessment Unit to avoid unnecessary duplication.

This work has been further supported by an increase in the number of consultants working within the Emergency Department and Emergency Assessment Unit. In addition, rotas have been redesigned to support consultant cover to 24:00 hours in the Emergency Department and 21:00 hours in the Emergency Assessment Unit. These steps, alongside those outlined above, ensure senior decision makers review patients earlier from the point of admission ensuring they are on the most appropriate care pathway.

Clinical Portal

The concept of the Clinical Portal was conceived against a backdrop of isolated clinical systems in the hospital and wider healthcare community. For example, the hospital's Pathology system is not linked to its main Patient Administration System and PACS/RIS. Therefore clinicians are required to enter multiple separate systems to view patient details, images and reports.

Review of the wider healthcare community identifies GPs have access to their own requests from Pathology and Radiology but no access to the wider patient record showing details of hospital requests and results, Emergency Department attendances, outpatient appointments, surgical procedures etc.

In order to address the above highlighted issues and enhance communication between healthcare professionals across the locality, the Trust procured a new information technology system (System C Medway). This new technology is currently being deployed with a proposed go live date at the beginning of November 2013. The infrastructure procured will form the backbone of the clinical portal but benefits that will be immediately delivered will include better sharing of information between hospital departments and the GPs. Key to this will be the delivery of electronic order communications which will be a on a phased rollout from November.

More complex deliverables such as electronic 'paper' records, resource management and the ability to automate and drive activity will be implemented in subsequent phases. Further stakeholder access will also be developed including both health and social care.

In addition to giving full stakeholder access to a single patient record, the portal would ultimately drive administrative and patient care workflows. The ultimate strategy is to achieve the following benefits.

- 24x7 multi-user access to notes
- Alerts

- Pathway driven work flow
- Clinical patient time
- Money saving, reduced duplication
- Improved Income recovery (BPT, contractual penalties, evidence based care)
- Ability to adapt quickly (new datasets/directives, integrate new systems, reduce the 'spider-web' of interfaces)
- Time saving potential

Progress against the set objectives has been slower than anticipated and the Trust is currently looking at how the organisation can better drive the programme and its requirements.

At Our Best

'At Our Best', a long term project, was launched with the aim to address concerns around staff attitude. The objective is to inspire, develop and support every one of our teams by listening to their patients' experiences. Over one hundred patients and carers attended workshops from which their comments and experiences provided valuable information to set organisational standards. This information enabled the Trust to set three values **Caring, Communicate, Consistency** to support the meaning of 'At Our Best'. These values influenced how we set leadership behaviours and recruit staff.

At Our Best is an on-going programme of improvement. The Trust has committed to send all staff on a training session to develop and commit to the agreed behaviours. During 2012, 89% of all Trust staff attended this session. This is proving very successful as it enables staff to focus upon their communication skills and what it is really like to be in a patient's shoes.

Throughout 2012, each behaviour had a formal launch, using communication through posters and Executive walk rounds. These enabled the values and behaviours to embed throughout the organisation. The development of a set of leadership behaviours has underpinned 'At Our Best' to further change the organisational culture.

The Trust has held a quarterly 'At Our Best' awards scheme where staff are nominated by colleagues or patients/carers for exhibiting behaviours in line with 'At Our Best'. These have proved to be very popular, with over 1000 staff nominated to date.

As part of the long-term plan, further work is underway to develop 'At Our Best Everyone Everywhere', with the objective to:

- Keep improving our patient experience – not just in isolated pockets but for everyone, everywhere
- Improve the experience of staff working here in Colchester, so people feel they are supported to deliver high quality care.

Graffiti boards have been distributed and will provide valuable staff feedback as to how the staff experience can be improved. This is showing the Trust commitment to improving both the patient and staff experience and aligning the work to gain the most effective results.

Priorities for Quality Improvement 2013/2014

The Board of Directors' quality priorities overall continue to be built around the three domains of quality:

- Patient Safety
- Clinical effectiveness
- Patient experience

This year we have again evaluated our focus for the coming year. We have assessed our performance against last year's priorities and taken account of national reports and emerging themes. We have consulted with our Quality and Safety Committee, Commissioners and Governors. Through this process we have selected our three top priorities for 2013/14. They are similar in theme to previous years, as we believe there is still more improvement to be made:

- Out of Hours
- At Our Best - Everyone Everywhere
- NICE Quality Standards

There is considerable convergence of the main issues and measures in each of these areas. These have come together in the annual CQUIN objectives – incentive payments negotiated and agreed with NHS North East Essex. The CQUINs represent a good cross-section of quality objectives that can be clearly measured where the Trust is able to influence the outcomes. The CQUINs were selected after both NHS North East Essex and the Trust considered their aims and created a 'long list' of potential quality measures. The CQUINs were developed by clinical and management staff in both organisations; some of the CQUINs draw on national CQUIN exemplar ideas. The list of potential CQUINs was reviewed jointly by both parties and a set of challenging but deliverable CQUINs agreed.

In reaching the decision to use the CQUINs as the basis for our Quality Report reporting in 2013/2014, the Trust consulted with its Governors who approved this approach at the Council of Governors meeting 4th March 2013.

Further priorities for 2013/ 2014 will emerge from the public enquiry and the subsequent Francis report which whilst based on the care delivered by one organisation, its conclusions have far reaching consequences and recommendations for all organisations and every individual providing care.

This is the second report into the failings of Mid Staffordshire NHS Foundation Trust and the system which allowed them to happen. We reviewed all of the recommendations of the first report, published in 2010, to make sure we complied with them and implemented all of the learning from that report. We are now carrying out the same review against the second report.

One of the main themes from the report is the impact of an organization's culture on the attitudes, behaviour and performance of the individuals within it and how they provide and improve care. It is crucial the right culture is embedded within organizations and as such the Board has agreed to hold an away-day with all Board members.

The report makes a number of recommendations around training, compassion, performance management and accountability for everyone working in the NHS. These are fundamental in

delivering compassionate care and in ensuring we have the right staff, with the right skills and the right values.

Our aim is that all our staff always strive to provide excellent care for people at all times. To do this we will continue to develop the education and training of our staff to make sure they have the right knowledge and skills, understand the priorities and the organizational expectations of individuals and demonstrate the right values. We have developed these values with our staff and call them “At our Best”.

These values are being embedded in our recruitment processes, performance appraisal and objective-setting for all staff.

It is vital that our focus is on patient care and outcomes, at all levels of our organisation “from ward to Board”. We will maintain our focus on the experiences of our patients and their carers, so we are constantly improving the care our patients receive. We will do this by ensuring our Board hears the stories of our patients and they are incorporated in training for all our staff and by capturing and monitoring accurate data that reveals what is happening on the frontline of care.

We will continue to communicate and listen to our staff’s views and build on the existing ways that we do this so we always use their feedback and suggestions to help us continually improve quality. We have also established a staff centred Francis Implementation Group to focus on the staff engagement and communications side of the recommendations.

We record feedback from our patients. We already include the “NHS Friends and Family Test” in our surveys, which asks patients how likely they are to recommend our services to their family and friends. We also invite the public to give feedback on our website, where they are also able to “rate” our services.

We are strengthening the recording of patient information, the care patients receive and the outcomes they experience as a result of their care, by rolling out a new electronic system “clinical portal” for managing this information by the end of this year.

We are reviewing our incidents and complaints processes and will strengthen this work to ensure that we learn from them and changes are made.

An in-depth review of the findings of the Francis Report and the themes and recommendations within the report, including benchmarking our Trust, is in progress to identify areas of compliance and where further work is required.

Last year, the Trust invited the Royal College of Obstetricians and Gynaecologists to review the Obstetric Service and advise on any areas for improvement. One recommendation was that there should separation of Elective and Emergency Caesarean sections. This is being piloted on Elmstead whilst the special delivery room in the delivery suite is converted to a second operating theatre.

Electronic Discharge Summary compliance with the key performance indicator has been challenging. There has been a particular focus on improving the quality of discharge communication and a CCG representative has been participating in this work. One of the standards of the Emergency Care Reorganisation is that all patients, where suitable, have their electronic discharge summary explained before discharge.

The Trust has continued to work on understanding the SHMI and the difference between this mortality indicator and the HSMR. This has been through sample reviews of the care of the patients

who died and case note reviews of those patients who were admitted with conditions where there have been alerts.

A report was commissioned from Dr Foster in autumn 2012 to improve understanding of the differences. Also in autumn of 2012, a joint group consisting of local providers and the commissioners was set up to look at the issues highlighted by the SHMI and to work together to improve patient experience and quality of care.

In February 2013, the Trust was identified as one of 14 with a higher than expected death rate in one of the two national indicators for mortality. (Whilst the Trust's HSMR was within the expected range, the SHMI was higher than expected.) Sir Bruce Keogh has been asked to undertake a review into the quality of care in these 14 Trusts. For this Trust, this will be during June and July, with a report expected at the end of July 2013.

CQUINs 2013/2014

The total value of the CQUINs to the Trust in 2013 /2014 is still to be agreed. The detailed content of each CQUIN, required attainment levels for payment and the monitoring period, have been agreed in our 2013/2014 contract with NHS North East Essex.

CQUINs for the specialist commissioning contract are still under review and will not be finalised until the end of May 2013.

The following CQUINs have been agreed:

Name	Description	Measure
Nationally Mandated		
Friends and Family Test	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience. The 2011/12 national inpatient survey showed that only 13 per cent of patients in acute hospital inpatient wards and A&E departments were asked for feedback.	As per national mandated definition
Safety Thermometer	To reduce harm. The power of the NHS Safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally.	As per national mandated definition
Dementia Care	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers.	As per national mandated definition
VTE	To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE).	As per national mandated definition

Name	Description	Measure
NHS NEE CCG Proposed		
Reducing Harm, Cannulation	Reducing harm from peripheral IV access	To be confirmed
Roll out of News	This CQUIN proposes to standardise the approach to recognition of the acutely ill patient through the pilot, adoption and trust-wide implementation of the National Early Warning Score (NEWS) tool.	To be confirmed
Increasing falls risk-assessments on admission	Improving the identification of patients at risk of falling, in an acute hospital setting	To be confirmed
Improved EOL communication, GSF Register	Increasing the use of the GSF through improved discharge communication to GPs	To be confirmed
Foot checks using Ipswich Touch Test	To be finalised	To be confirmed
Nursing Transfer & Discharge Patient Summary (focused to community and residential care)	To be finalised	To be confirmed
SCG Proposed		
Clinical Dashboards	To embed and demonstrate routine use of the specialized services clinical Dashboards	This indicator is aimed at ensuring that Providers continue to embed and routinely use the required clinical dashboards for specialised services
Radiotherapy, IGRT (image-guided radiotherapy)	Improving the proportion of radical intensity modulated radiotherapy (IMRT) (excluding breast and brain) with level 2 imaging – image guided radiotherapy (IGRT)	To ensure accuracy, reducing normal tissue toxicity and minimising side-effects to improve outcomes by using image guided radiotherapy (IGRT). The longer term aim is to achieve at least 50% of all cases using IMRT (excluding breast and brain) to be delivered with level 2 imaging.
NICU 2, timely administration of TPN	Inadequate nutrition in the first weeks of life of premature infants results in growth failure that is often difficult to correct and may lead to permanent detrimental effects	During early postnatal life, the nutritional need of preterm infants is usually met through parenteral nutrition. This indicator aims to improve the proportion of preterm babies

Name	Description	Measure
		who start TPN by day 2 of life. It excludes babies who undergo surgery on day 1 or 2 of life. <i>NB Day of birth being day 1.</i>

Table 1: Agreed CQUINS for 2013/2014

Statements of Assurance from the Board

Services

During 2012/2013, Colchester Hospital University NHS Foundation Trust provided and/or sub-contracted 48 relevant health services.

The Trust has reviewed all the data available to it on the quality of care in all of these NHS services, focusing on assessment of patient safety, clinical effectiveness and patient experience.

The income generated by the NHS services reviewed in 2012/2013 represents 98.9% of the total income generated from the provision of health services by the Trust for 2012/2013.

Clinical Audit

Participation in national clinical audit and confidential enquiries

During 2012/2013, 41 national clinical audits and 2 national confidential enquiries covered NHS services that Colchester Hospital University NHS Foundation Trust provides.

During 2012/2013 Colchester Hospital University NHS Foundation Trust participated in 82% of national clinical audits and 100% of 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 2012/2013 are listed in the table below, The table also includes, where possible and applicable, the number of cases submitted to each audit or enquiry, which is also expressed as a percentage of the number of cases required by the terms of that audit or enquiry.

Table 2: National Clinical Audit & Confidential Enquiries

Title of Audit	Trust eligible to participate ?	Trust participated?	If 'yes', number of cases submitted	% Compliance	Status
Acute					
Adult community acquired pneumonia	Yes	No ¹	NA	NA	Inactive
Adult Critical Care	Yes	Yes	506	100%	Ongoing ²
Emergency use of oxygen	Yes	No ³	NA	NA	Inactive
National Joint Registry	Yes	Yes	1022	100%	Ongoing ⁴
Non-invasive ventilation	Yes	No ⁵	NA	NA	Inactive
Patient Outcome and Death	Yes	Yes	11	73%	Ongoing ⁶
Renal colic	Yes	Yes	50	100%	Complete ⁷
Trauma	Yes	Yes	324	100%	Ongoing ⁸
Blood & Transport					

¹ The Trust did not participate in this audit because of other clinical prioritisations –it was not a mandatory requirement.

² This is an on-going data collection. Data collection and quality issues have meant that no reports have been published for over a year although this should be remedied during 2013.

³ The Trust did not participate in this audit because of other clinical prioritisations –it was not a mandatory requirement.

⁴ Ongoing data collection.

⁵ The Trust did not participate in this audit because of other clinical prioritisations –it was not a mandatory requirement.

⁶ This encompasses an on-going programme of individual studies, several of which may be active at any one time.

⁷ An action plan is in preparation.

⁸ Ongoing data collection.

Title of Audit	Trust eligible to participate ?	Trust participated?	If 'yes', number of cases submitted	% Compliance	Status
Blood Sampling & Labelling (Comparative audit of blood transfusion)	Yes	Yes	36	100%	Complete
Cardiothoracic transplant	No	***	***	***	***
Potential donor audit	Yes	Yes	151	100%	Ongoing ⁹
Use of Anti-D (Comparative audit of blood transfusion)	Yes	Yes	NA	Pending	Starts Apr 2013
Cancer					
Bowel cancer (NBOCAP)	Yes	Yes	146	100%	Ongoing ¹⁰
Head and neck oncology	Yes	Yes	67	100%	Ongoing ¹¹
Lung cancer	Yes	Yes	254	100%	Ongoing
Oesophago-gastric cancer	Yes	Yes	32	100%	Ongoing ¹²
Heart					
Acute Coronary Syndrome or Acute Myocardial Infarction MINAP	Yes	Yes	366	100%	Ongoing
Adult Cardiac surgery	No	***	***	***	***
Cardiac Arrest	Yes	Yes	78	100%	Ongoing
Cardiac Arrhythmia	Yes	Yes	237	100%	Ongoing
Congenital heart disease (Paediatric cardiac surgery)	No	***	***	***	***
Coronary Angioplasty	No	***	***	***	***
Heart failure	Yes	Yes	312	100%	Ongoing
Pulmonary hypertension	No	***	***	***	***

⁹ Ongoing data collection.

¹⁰ An action plan for the most recent report has been written and is summarized below.

¹¹ The 7th report was published last year. An action plan is being prepared and will be ready later in April. The 8th Round of the audit is underway and a report is expected in June 2013.

¹² No reports have been published for this audit so far.

Title of Audit	Trust eligible to participate ?	Trust participated?	If 'yes', number of cases submitted	% Compliance	Status
Vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes	104	94%	Ongoing ¹³
Long-Term Conditions					
Adult Asthma	Yes	No ¹⁴	NA	NA	Inactive
Asthma Deaths	Yes	Yes	3	100%	In Progress
Bronchiectasis	Yes	No ¹⁵	NA	NA	Inactive
Diabetes (Adult)	Yes	No ¹⁶	NA	NA	Inactive
Diabetes (Paediatric)	Yes	Yes	180	100%	Complete ¹⁷
Inflammatory bowel disease	Yes	Yes	NA	In progress	In Progress
Pain Database	Yes	Yes	115	100%	Ongoing
Renal Registry	Yes	Yes	65	100%	Ongoing
Mental Health					
Prescribing Observatory for Mental Health	No	***	***	***	***
Psychological therapies	No	***	***	***	***
Schizophrenia	No	***	***	***	***
Suicide and homicide in mental health	No	***	***	***	***
Older People					
Carotid interventions	Yes	Yes	42	100%	Ongoing ¹⁸
Fractured neck of femur	Yes	Yes	50	100%	Complete ¹⁹
Hip fracture database	Yes	Yes	512	100%	Ongoing ²⁰
National Audit of Dementia	Yes	Yes	40	89%	Complete

¹³ Action Plan in progress.

¹⁴ The Trust did not participate in this audit because of other clinical prioritisations –it was not a mandatory requirement.

¹⁵ The Trust did not participate in this audit because of other clinical prioritisations –it was not a mandatory requirement.

¹⁶ The Trust did not take part in this audit due to concerns about the audit methodology–it was a mandatory requirement.

¹⁷ We are awaiting the report for this audit, which is expected later in 2013.

¹⁸ Action Plan in progress.

¹⁹ Action Plan in progress.

²⁰ Ongoing data collection.

Title of Audit	Trust eligible to participate ?	Trust participated?	If 'yes', number of cases submitted	% Compliance	Status
Parkinson's disease	Yes	No ²¹	NA	NA	Inactive
Stroke National Audit (combined Sentinel and SINAP) Programme	Yes	Yes	269	100%	Ongoing ²²
Other					
Elective surgery (National PROMs Programme)	Yes	Yes	1203	60%	Ongoing ²³
Women's & Children					
Child Health (National Confidential Enquiry)	Yes	NA ²⁴	NA	NA	NA
Epilepsy 12 (Childhood Epilepsy)	Yes	Yes	NA	Pending	In Progress
Fever in children	Yes	Yes	50	100%	Complete ²⁵
Heavy menstrual bleeding	Yes	Yes	NA	NA	Inactive ²⁶
Maternal infant and perinatal	Yes	Yes	28	100%	Ongoing ²⁷
Neonatal intensive and special care	Yes	Yes	4191	100%	Ongoing ²⁸
Paediatric asthma	Yes	Yes	18	100%	Complete - Awaiting Report
Paediatric Intensive Care	No	***	***	***	***
Paediatric pneumonia	Yes	Yes	NA	In Progress	In Progress

The reports of all national audits were reviewed by the Trust during 2012/2013, appropriate learning points were identified, and plans for action prepared.

²¹ The Trust did not participate in this audit because of other clinical prioritisations –it was not a mandatory requirement.

²² The applicability of reports/action plans has been queried.

²³ No 2012 report published yet.

²⁴ This is an epidemiological study of child deaths and the Trust will not be required to submit data directly.

²⁵ Action plan in progress.

²⁶ The Trust finished submitting data before April 1st 2012 and has received no requests since then. A provisional report was published in July 2012 but this concerned compliance with the audit itself and contained no clinical recommendations. It is expected that more work will be done for this audit during the course of 2013.

²⁷ No report as yet. This audit recently changed provider and has had technical problems.

²⁸ Data collection only.

The specific actions planned/taken as a result of participation in a sample of these national reviews are listed below.

National Bowel Cancer Audit (NBOCAP) Report 2012

An action plan addressing the findings of the audit is being compiled by the Consultant lead.

National Diabetes Inpatient Audit (NaDIA)²⁹

The full report will be published in June and an Action Plan produced then.

Renal Colic

An action plan addressing the findings of the audit is being compiled by the Consultant lead.

Feverish Children

An action plan addressing the findings of the audit is being compiled by the Consultant lead.

Fracture Neck of Femur

An action plan addressing the findings of the audit is being compiled by the Consultant lead.

National Pain Audit 2012

An action plan addressing the findings of the audit is being compiled by the Consultant lead.

Audit of Blood Sample Collection and Labelling

The National Comparative Audit of Blood Transfusion has issued some recommendations following this audit. These recommendations have been discussed with the Hospital Transfusion Team and Hospital Transfusion Committee. It is felt the continuation of training and competency assessment for all staff involved in the transfusion process remains important to ensure knowledge and best practice.

It is envisaged the hospital will become compliant with some of the recommendations when Medway Clinical Portal system, which hopefully will include order communications requesting for group and save and cross-matches, becomes available sometime in the future. A full report with any action plans is being completed

Pain in Children (2011)

The following action points are in the process of being addressed:

- Carry out more effective paediatric triage at all times of the day and night.
- Ensure pain scoring is carried out on all paediatric patients and this score is properly recorded in the notes.
- Ensure that every child coming to Emergency Department with pain is offered analgesia as soon as possible and that their pain score is re-evaluated.

Severe Sepsis and Septic Shock (2011)

As a result of the audit, we have taken the following actions:

- Raised awareness amongst nurse team leaders of the importance of documentation of all the actions undertaken for the patients.
- Ensured that the subject is covered at the four-monthly induction for all new trainees joining the Emergency Department.

²⁹ Please note that this is not a Quality Report or National Clinical Audits Patient Outcomes Programme (NCAPOP) audit.

- Ensured that the severe sepsis audit is discussed in detail at one of the weekly educational meetings for the middle grade doctors and that they are aware of the results and how our Trust compares nationally.
- Ensured that all nurses, especially those working in the resuscitation area, are fully aware of the standards set by the clinical effectiveness committee of the college; emphasizing the importance of documenting all the actions in patient's notes.
- Ensured all the Locum doctors working in Emergency Department are fully aware of these standards.

Heart Failure Audit

An action plan addressing the findings of the audit is being compiled by the Consultant lead.

National Cardiac Arrest Audit

No action plan is required for this report as no clinical recommendations were made.

National Lung Cancer Audit

This audit reported in December 2012 (for data collected during 2011) and there were no clinical recommendations.

National Audit of Dementia

The following actions are in process:

- Dementia awareness training has commenced through team away days, junior doctor training and Grand Rounds.
- A dementia E-learning package has been developed and became live at the end of March 2013. Role mapping of all staff requiring this training has been completed.
- 3 places have been booked on a London dementia training programme commencing in October 2013.
- Dementia screening has begun for all eligible patients, in line with national requirements
- An electronic screening and referral tool has been developed to ensure all data is captured for all 3 elements of the CQUIN (achieving >97% compliance).
- A delirium pathway has been developed, which has been submitted to North East Essex Medicines Management Committee for approval.
- A delirium leaflet has been prepared, which is now available Trust wide.
- A transitional care bid has been submitted, to improve the follow-up care of patients and their relatives on discharge from hospital and prevent readmission (and involved the voluntary sector to support this bid).

DAHNO Head & Neck Oncology 7th Round

Action identified includes the need to work with the MDT co-ordinator and consultants to ensure that TNM (Tumour, Nodes Metastasis) staging is recorded in the patient record for the co-coordinator to input.

Epilepsy 2012 Audit

As a result of the audit, we have taken the following action:

- Since October 2010, a dedicated paediatric epilepsy clinic has been running and children with complex epilepsy are seen in it. A 'First Fit' clinic for children presenting with fits, faints and funny turns was started at the beginning of 2011. These clinics are run by Paediatricians with expertise in epilepsies.
- In January 2011, employed a paediatric epilepsy specialist nurse. Children started on anti-epileptic drugs (AEDs) receive input from this nurse.

We are planning:

- By September 2013, we will develop care pathway documentation to include all performance indicators for first clinical assessment.
- By September 2013, care pathway documentation will include ECG for children with convulsive seizures by 1 year.

Local Clinical Audits

The reports of 21 local clinical audits were reviewed by Colchester Hospital University NHS Foundation Trust; the following actions are identified:

Acute Upper GI Bleeders: time to Oesophago-Gastro-Duodenoscopy (OGD) Re-audit 2012

No action points have been identified.

Thrombolysis Audit (SITS Register)

Actions identified include increasing the time from presentation of symptoms when thrombolysis (clot busting) can occur and raising the age limit for the treatment.

Meticillin Resistant *Staphylococcus aureus* (MRSA) Audit Validation of data

Audit findings included:

- 110/258 had documented evidence that screening had been taken and sent.
- 73/258 had no documented evidence of screening.
- 54/258 were Emergency Assessment Unit patients and did not book in or come to A&E at all.
- 10/258 were discharged from A&E and never admitted.
- 9/258 were documented as having refused screening or it would be inappropriate e.g. PV bleed, critical patient.
- 2/258 were failed discharge/return patients.

In conclusion, the MRSA screening score for May was 95.42% (if 73 patients from A&E were not screened out of a total of 1595 admitted from A&E).

Action identified from this audit includes the need for team leaders to re-enforce procedure and policy to capture 100% of admitted patients. Exceptions are to be included in the overall audit.

Outcomes of Acute Coronary Syndrome (ACS) patients with Troponin of 14 or less

Audit findings included:

- There are still a significant proportion of patients with non ACS chest pain referred to the Trust as ACS patients.

Mortality in Acute Bronchitis

Audit findings included:

- The mean age of patients in this group was 85.7 years
- 11 out of 26 patients were from a residential or nursing home

- 11 patients had an incorrectly coded primary diagnosis
- 1 patient – there was inappropriate escalation of treatment
- 12 out of 26 patients were seen within 6 hours of arrival by a consultant

Actions identified include the need to carry out an audit of more recent mortality trends with the same primary diagnosis.

Patient Satisfaction Survey Experience at Parenteral Iron Therapy Clinic

Survey findings included:

- Patients aware of being referred to the Iron Infusion clinic and received a letter confirming their appointment.
- Patients found their parking experience to be either very acceptable or acceptable.
- The clinic was easy to find. Staff were welcoming to patients, on arrival.
- Patients found the environment to be either clean or very clean and also comfortable or very comfortable.
- All patients were notified of delays, received an explanation and were satisfied with the notification and explanation of delay
- Staff explained to patients what would happen during first appointment.
- Patients understood what was explained to them and they were given adequate time to ask questions
- Management plans were explained to patients at the end of their treatment.
- Patients were given further opportunity to ask questions and these were answered to patients' satisfaction
- Patients rated the service as either excellent, very good or good.
- Patients were made aware of the renal nurse specialist contact details for enquiries.
- Patient calls were returned.
- Patients waited between 1-4 weeks from being referred to the clinic to their actual appointment date.
- Patients were given a choice of appointment date.
- Patients were given a choice of location for their appointment.
- Patients were asked how they would like to be addressed.
- Patients experienced a delay between 11-20 minutes.
- Staff checked that patients had received written information.
- Staff gave information to patients who had not previously received the information.

Actions identified include the need to:

- Minimise waiting time to less than 10 minutes by re-configuring appointments
- Check patients have received written information and provide it again if necessary

Audit of Aspiration pneumonia

Audit findings included:

- The total number of patients audited was 188
- 28 patients(15%) developed aspiration pneumonia
- Pneumonia rates show a downward trend
- Total Anterior Circulation Infarct (TACI) Severe strokes tend to cause aspiration pneumonia more frequently than milder and lacunar strokes
- Co-morbidity (the presence of other diseases/disorders) is a strong risk factor
- Acute illnesses increase the likelihood of patients suffering aspiration
- Physically dependent patients (i.e. those on bed rest or needing a full body hoist (FBH)) are at an increased risk of developing aspiration pneumonia
- A significant percentage of patients who developed aspiration pneumonia were nil by mouth

(NBM) or requiring alternative nutrition by other routes than the mouth

Action resulting from this audit will focus on implementing an oral hygiene protocol and very early mobilisation.

The management of acute asthma in A&E

Audit findings included:

- Most patients received Salbutamol nebuliser either in A&E or by the ambulance crew.
- Steroids and paracetamol were given, as appropriate.
- The Discharge Evaluation Form (DEF) served as a good measure for assessing if discharge was satisfactory for some patients.
- Some patients were evaluated due to other problems besides asthma.
- All patients who received magnesium sulphate and aminophylline were admitted.
- The space for recording the prescription of oxygen was not used at all; in only about 30% of patients had oxygen usage been recorded at all.
- Secondary observations were not carried out in most patients.
- Antibiotics were used in about 30% of patients.
- There was no spirometry used in A&E as it was not available.

Actions following this audit include the need to investigate the introduction of a standardised pathway or protocol for acute asthma.

MRSA Protocol Compliance Audit

Audit findings included:

- Isolation ward compliance: 93.9%
- Other wards compliance: 76.5%
- Overall Trust compliance: 76.2% (Previous 2006: 76.6%) Very slight decline in practice

Actions following this audit include the need to launch an updated MRSA Integrated Care Pathway.

Diagnosis of Pulmonary Embolism (PE): Audit of Nice guideline CG144

Audit findings included:

- 646 patient admissions to EAU (Emergency Assessment Unit) were reviewed in the audit
- 51 patients were thought to have PEs (There was 1 pregnant patient and 3 notes were unobtainable)
- The Well's score (used in diagnosing PE) was calculated in only 6 patients (12%)
- The diagnosis of PE was considered 'likely' in 14 patients
 - D-dimer was measured in 86% of patients
 - A Computerised Tomography pulmonary angiogram (CTPA) scan was performed in 71% of patients
 - The average time to do the CTPA scan was 12.5 hours
- The diagnosis of PE was considered 'unlikely' in 37 patients
 - D-dimer was measured in 95% of patients
 - A CTPA scan was performed in 37% patients following +ve D-Dimers

Action resulting from this audit will focus on the Wells score proforma being placed in A&E and EAU for reference by staff. Also, laboratory requests for d-dimer and CTPA scans will require the Wells score to be recorded.

Sepsis Management in Emergency Department

Audit findings included:

- Need for improved SHO education re: sepsis standards.
- Need for improved documentation.
- Need for increased speed of essential treatment.

Action following this audit includes giving presentation at Wednesday teaching for new SHOs

Weekend General Surgery Patient Safety Re-audit

Audit findings included:

- The Patients At Risk (PAR) score was used consistently and correctly
- Escalations were being made appropriately according to the PAR scores in the most part, except for a slight dip in standards on a Friday
- Over the weekend there was a delay in the escalation process concerning both nurse to junior doctor and junior doctor to senior doctor escalations.
- All audited patients saw a doctor every day
- There was considerable improvement on Wednesdays compared to the original audit
- There was poorer documentation of jobs being completed over the weekends

As a result of the audit, we intend to take the following actions:

- Continue the "Sick List" for notifying staff of ill patients
- Continue to register attendance at hand-over
- Move to electronic handover

Ionising Radiation (Medical Exposure) Regulations (IRMER): Compliance Rate of Image Reporting by Non-Radiology Clinicians.

Audit findings included:

- The audit found that 52% (81/156) of radiographs had written documentation within the patient's notes. In the remainder, 40% of the unreported examinations had no obvious indication of the images having ever been observed or evaluated. This equates to 30 examinations (19%) of the original 156 selected.
- Correlation was also made with a formal radiologist report and the clinician's findings; out of the 81 examinations which had a documented clinicians' comment, it was noted that 84% (68/81) were comparable with the radiologist report, and 16% (13/81) had differences of opinion. Of the 75 images which had no documentation by the clinician or referring team, 60% (45/75) were reported as within normal or acceptable limits by the radiologists. 32% (24/75) had minor changes or known conditions. 8%, which equates to six of the 75 images, had differences, which have been classified as major by this audit.

Actions following this audit include feedback to senior team and the Radiology department of the findings and the recruitment of more staff able to report upon x-rays.

Timing of Ventilation Perfusion (V/Q) scanning & Chest X-ray (CXR) in the investigation of acute PE

Audit findings included:

- 59% of patients underwent a chest x-ray within 24 hours of their V/Q or perfusion only scan as per national guidelines. However, 41% of patients did not.
- 6 patients did not have a recent chest x-ray performed at all.

Actions resulting from this audit include:

- Ensuring that all future V/Q or perfusion scans are preceded by a recent chest x-ray
- Ensuring that a repeated chest x-ray is considered where there has been a delay greater than 24-48 hours.

An audit to evaluate the management of patients admitted to the Trust with epistaxis (nose bleeds) between 01/08/12 to 05/11/12

Audit findings included:

- A total of 34 cases were included in the audit
- Of these, 24 patients were admitted and 10 patients with epistaxis were discharged from A&E
- 47% of patients were male and 35% were female
- The mean age was 70 yrs. The average length of hospital stay was 24-72 hrs.
- 59% happened spontaneously with risk factors being hypertension and being on anticoagulants
- The majority of patients were managed with nasal packing and a small number progressed to surgical intervention.
- 38% of inpatients had a flexible endoscopy of the nose and 76% patients were discharged with antibiotics
- The majority of patients did not require clinic follow up

Actions arising from this audit include the need for:

- A leaflet for patients on epistaxis
- The development of an Epistaxis Management Protocol
- The training of Specialist Trainee doctor grades 1 & 2 on the management of epistaxis
- Re audit in 4 months
- The Mersea ward treatment room will be supplied with chlorphenylcaine

Survey results for Brain tumour Patients' support group interest

Survey findings included:

- There was a 60% response rate to the survey, and of the 18 replies received most were in favour of a support group or showed an interest in its development. 14 patients provided their contact details, indicating that they wanted to be kept informed about progress in setting up the group. 12% (2 patients) said no they were not interested in the group.

As a result of the audit, we have taken, or intend to take, the following actions:

- Established a support group with meetings scheduled bi-monthly at Farleigh Hospice and Colchester Hospital. This is running successfully. Membership has now been opened up to anyone with a primary brain or spinal tumour.

Alpha Suite Ultrasound Patient Satisfaction Survey

Survey findings included:

- The department received very positive feedback. Patients were very happy with the care they received in the department and were very complimentary towards the attitude of staff. The only slight criticism noted involved communication. Patients require more information as to why things are happening especially when things are not going to plan; apologies must be accompanied by explanations.

As a result of this survey, the results will be discussed with the clinical team.

Patient experience survey of the Uro-oncology Clinical Nurse Specialist service across the Essex Cancer Network

Survey findings included:

- A high percentage of patients knew their key worker, met the Clinical Nurse Specialist (CNS),

were at ease contacting her and felt the role was of benefit to them; however a third felt their calls were not returned.

- A large percentage of patients did not seem to be aware a holistic assessment was carried out with them even though this is done on every patient referred to the CNS.
- A high percentage of patients obtained all the information they required or wanted.
- A high percentage of patients received information as regards support groups, however only 16% made use of them.
- Nearly two thirds of patients received a written copy of their consultation and most of those did understand it.
- Two out of the three new questions in the survey had a lower positive response.
- CNS not as readily available at subsequent appointments.
- 93% of patients were either very or fairly satisfied with most of those being very satisfied.

As a result of the audit, we have taken, or intend to take, the following actions:

- To endeavour to improve on the amount of phone calls returned to patients although this may prove difficult without extra manpower across some sites
- To improve on the % of patients that are aware of the holistic assessment
- Review and change wording of questions 11 and 15
- To remind Consultants and secretaries re sending copy of the GP letter to patients.
- Promote support groups

Physiotherapy Outpatient & Community Rehabilitation Survey

Survey findings included:

- Patients found staff as professional and friendly and involved patients in their treatment.
- Patients had sufficient time to do therapy and physiotherapy had increased their confidence and helped them achieve their aims and objectives.
- Patients who were seen in their own homes felt, overall, that this was an advantage

As a result of the survey, the trust will:

- Repeat the survey in six months, covering outpatients as well as neuro-rehabilitation, in order to increase the response rate.
- Investigate the use of advocates in the homes of elderly and frail patients, in order to improve response rate

Multi-Disciplinary Falls Clinic Patient Satisfaction Survey

Survey findings included:

- Patients reported staff had positive attitudes, were welcoming and helpful.
- Patients had sufficient time to discuss everything they wanted to, felt they were listened to, and were clear about outcomes.
- Overall, 90% of respondents reported being 'satisfied' or 'very satisfied'.
- 50% of respondents suggested that changing the name of the clinic so it was different from that of the wing would help them to find it more easily.
- The multifactorial cause of falls often means that treatment requires a number of actions to be carried out and these might need to be better explained to patients.

As a result of the survey, the trust will:

- Investigate changing the name of the clinic.
- Monitor patient understanding in clinic and copy letters to patients if necessary.

Thrombo-prophylaxis in Lower Limb Trauma Patient

Audit findings included:

- Unfortunately not many proformas were filled for patients who had lower limb fracture and no documentation of previous medical history in notes which results in potentially missing number of patients requiring thrombo-prophylaxis. Identified number of patients with high risk factor. Treated 1 patient with low molecular weight heparin (LMWH) following proforma and guidelines to prevent deep vein thrombosis (DVT)/Pulmonary Embolism (PE).
- Need to identify high or immediate risk patient for thrombo-prophylaxis to prevent thromboembolic event in patients with lower limb fracture.
- Need to fill the form or documentation of previous medical history in notes. Good record keeping.

As a result of the audit, the trust will:

- Discuss implementing guidelines in the trust

Antibiotic Prophylaxis in pacemaker insertion

Audit findings included:

- The Trust's pacemaker insertion antibiotic prophylaxis guidelines are followed for the majority of patients
- Location of documentation of pre and post prophylaxis is varied (treatment chart, care pathway, electronic discharge summary (EDS), GP letter)

As a result of the audit, the trust will:

- No actions required.

Statement on Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Colchester Hospital University NHS Foundation Trust in 2012/2013 that were recruited during that period to participate in research approved by a research ethics committee was 607 (unratified) as of 31st March 2013.

Research at the Trust continues to be supported by the National Institute of Health Research (NIHR) via the Essex and Hertfordshire Comprehensive Local Research Network (E&H CLRN). The E&H CLRN distribute funding via the Research & Development Office (R&D) to provide clinical, research governance and diagnostic staff to engage and contribute to the delivery of portfolio research.

Local Specialty Groups (LSGs), led by clinicians involved in research, encourage consideration and set-up of studies on the portfolio of research adopted by the NIHR. Cancer, stroke, medicines for children and diabetes research networks continue to promote and support the delivery of new studies.

Collaborations with the University of Essex (UoE) through its links with the trust via the Essex Biomedical Sciences Institute Conference and joint research ventures also contributed to the research activity. Health Enterprise East supported the Trust in the exploration of potential commercialisation of intellectual property.

The Trust Physiotherapy department has been successful in a Research for Patient Benefit (RfPB) grant awarded by the NIHR and supported by R&D, UoE and Research Design Service (RDS). Two further RfPB applications have been submitted, pending award decision in collaboration with R&D, Anglia Ruskin University and RDS.

The Trust is currently involved in 225 studies, of which 147 were open to participant recruitment, (58 studies on the NIHR portfolio) with 78 studies closed to recruitment and in participant follow-up status.

The portfolio studies report that the ratio split for interventional/observation studies is 36/64 which represents an increase in the previous year (18/82). Research within the Trust is focused in the following areas:

- Oncology, Haematology, Ophthalmology, Stroke, Diabetes, Cardiology, Physiotherapy, Cardiovascular, ITU, A&E, Microbiology. Renal, Dermatology, Gastroenterology, Urology and Renal

These clinical specialities are supported in their research activity by Pharmacy, Pathology, Radiology, Nuclear Medicine, EBME, Information Governance and Chemotherapy suite.

Engagement within the Trust and public to profile research has been communicated via the R&D newsletter, Operational Capability Statement, research workshops, trust intranet and a research article in the local newspaper. Profiling research within the trust and especially to highlight patient engagement will continue to be a focus.

In terms of maintaining a continued improvement in service, the Trust had access to network funding c. £850k during 2012-13. This has been utilised to support over 26 whole-time equivalent staff on fixed term contracts to engage and deliver a research agenda within the trust and allow patients access to novel treatments at their local District General Hospital.

The Trust is currently reported as recruiting 426 participants into portfolio studies with the recruitment closing date due in Mid-late April 2013. Recruitment target for the current financial year was set at 800 participants.

Commissioning for Quality and Innovation (CQUIN) Payments

A proportion of Colchester Hospital University NHS Foundation Trust income in 2012/2013 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 2012/13 and for the following 12 month period are available online at: <http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275>

In 2012/2013 the maximum amount of income to the Trust that was conditional upon achieving CQUINs was £5.1m; the Trust achieved £4.3m 84.9% (as of end February 2013). In 2011/2012 the Trust achieved £2.98m (97%).

Care Quality Commission

Colchester Hospital University NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is active. Colchester Hospital University NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Colchester Hospital University NHS Foundation Trust during 2012/2013. The Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/2013:

May 2012

- People's personal records, including medical records, should be accurate and kept safe and confidential – standard met the part of the regulation which was the subject of this review in relation to the maintenance of HSA1 forms.

January 2012

- Respecting and involving people who use services – minor concern
- Care and welfare of people who use services – standard met
- Meeting nutritional needs – standard met
- Management of medicines – standard met
- Supporting workers – standard met
- Assessing and monitoring the quality of service provision – moderate concern

The issues identified by CQC in Outcome 16 “Assessing and monitoring the quality of service provision” related to the timely identification and reporting of serious incident investigations. This factor has also been recognised by the Clinical Commissioning Group who issued a contract query notice in January 2013. The Trust has subsequently undertaken considerable action to improve practice in this area with additional investment in resources, education, training and improved learning processes through the development and implementation of a comprehensive remedial action plan. Our rapid progress and improvement in this area has since been acknowledged by the Clinical Commissioning Group.

As part of a wider response to the CQC inspection we have further assured our Board by undertaking an independent external audit of our internal Risk Management systems and processes. We intend to extend this work in 2013/ 2014 by undertaking a similar transparent review of our internal complaints systems and processes. This learning will also assist the development of improvements arising from the Francis Report.

Data Quality

Colchester Hospital University NHS Foundation Trust considers data quality to be key in informing the delivery of patient care, productivity and performance.

The Trust's Information & Income Assurance Group, which is led by the Director of Finance, continues to feed into the Trust's Executive Finance and Infrastructure Committee. Amongst other core Information & Income priorities, the Information & Income Assurance Group has been key in driving forward the data quality agenda over the last year. All data quality challenges are fed into the Information & Income Assurance Group and are delivered/led by senior officers of the Trust.

NHS Number and general Medicine Practice Code Validity

Colchester Hospital University NHS Foundation Trust submitted records during 2012/2013 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:

- 99.88% for admitted patient care
- 99.99% for outpatient care
- 99.30% for accident and emergency care.

The percentage of records in the published data, which included the patient's valid General Practitioner Registration Code, was:

- 99.94% for admitted patient care
- 99.99% for outpatient care
- 99.59% for accident and emergency care.

The above figures are calculated using the following information:

- admitted patient care – hospital spell discharge date between 01/04/2012 and 31/03/2013
- outpatient care – appointment date between 01/04/2012 and 31/03/2013
- accident and emergency care - arrival date between 01/04/2012 and 31/3/2013

Information Governance Toolkit attainment levels

The Colchester Hospital University NHS Foundation Trust Information Governance Assessment Report score overall for April 2012 to March 2013 was 81% and was graded as Red, 'not satisfactory'.

There are 45 requirements for acute trusts to be assessed against. To receive a 'satisfactory' rating the Trust must achieve Level 2 or above on all 45 of the requirements. If an organisation scored Level 3 against 44 of the requirements but Level 1 on 1, they would be graded as 'not satisfactory'.

The Trust has 5 requirements which only achieved a Level 1 score compared to 6 requirements for the year previously (version 9 2011/2012) which were Level 0 or 1.

The Trust will develop an action plan to improve in areas that have not achieved Level 2 which will be reviewed following the release of the Version 11 Information Governance Toolkit in June/July in readiness for the 2013/2014 submission. Progress against this action plan will be monitored by the Information & Income Assurance Group and any areas of non-compliance or risk will be escalated to the Infrastructure Committee.

Clinical Coding

Colchester Hospital University NHS Foundation Trust was subject to the Payment by Results (PbR) clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding), were:

- 12% of primary diagnoses incorrect
- 9.3% of secondary diagnoses incorrect
- 16.7% of primary procedures incorrect
- 23.2% of secondary procedures incorrect

These results should not be extrapolated further than the actual sample audited. The audit highlights that the Trust's coding against Healthcare Resource Groups (standard groups of clinically similar treatments, which use common levels of health care resource) is 16.7% for 2012/2013 PbR.

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

- Within clinical coding there is an ongoing, 2 hour fortnightly, clinical coding training programme, performed by the in-house Approved Experienced Clinical Coding Trainer, to cover all specialities for the continuation of improvement to the accuracy and consistency of the data provided through clinical coding.
- There is also a 2 hour weekly training program for clinical coders to work towards the National Clinical Coding Qualification (NCCQ) which also improves coding standards and the coder achieving Accredited Clinical Coder (ACC) status.

Together with the audit program performed by the in-house Approved Clinical Coding Auditor, which further highlights individual training needs within the team, all of these practices will help to continue the improvement of clinical coding standards. Further up-dates are given to the whole team, when required, following instructions from Health & Social Care Information Centre (HSCIC) in a timely fashion to maintain the rules and conventions of Clinical Coding.

Quality Report Core Indicators

From 2012/2013 all trusts are required to report against a core set of indicators, for at least the last two reporting periods, using a standardised statement set out in the *NHS (Quality Report) Amendment Regulations 2012*.

As required by point 26 of the *NHS (Quality Report) Amendment Regulations 2012*, where the necessary data is made available by the Health and Social Care information Centre, a comparison should be made of the numbers, percentages, values, scores or rates of each of the NHS foundation trust's indicators with:

- The national average for the same; and
- Those NHS trusts and NHS foundation trusts with the highest and lowest of the same.

Table 3: Quality Report Core Indicators

	2011/2012	2012/2013	National Average	(Highest – Lowest Scores)
Summary Hospital-Level Mortality Indicator (SHMI)	117.59	Oct 11-Sep 12 117.22 ⁽¹⁾	100	121.07 -68.49
Percentage of admitted patients whose treatment included palliative care	2.27%	Oct 11-Sep 12 2.02% ⁽¹⁾	1.07%	3.19%-0.01%
Percentage of patients whose deaths were included in the SHMI and whose treatments included palliative care	30.5%	Oct 11-Sep 12 27.05%	19.21%	43.28%-0.2%
Patient reported outcome score for groin hernia surgery	68%	47.8% ⁽²⁾	46.0%	Not Available
Patient reported outcome score for varicose vein surgery	56%	60.0% ⁽²⁾	39.2%	Not Available
Patient reported outcome score for hip replacement surgery	66%	87.4% ⁽²⁾	87.0%	Not Available
Patient reported outcome score for knee replacement surgery	83%	82.2% ⁽²⁾	78.7%	Not Available
Emergency readmissions to hospital within 28 days of discharge		⁽³⁾		
All	9.2%	9.3%	Not Available	Not Available
0-15yrs	4.03%	3.8%		
16yrs+	10.2%	10.4%		
Responsiveness to inpatients' personal needs	67.3	64.8 ⁽⁴⁾	66.83	75.6-60.1
Staff who would recommend the provider to friends or family needing care	3.48	3.54	3.57	4.08-2.90
Percentage of admitted patients risk assessed for Venous Thromboembolism	94.77%	91.37%	93.74%	99.43%-85.47%
Rate of C. difficile (per 1,000 bed days)	0.13	0.14	0.19	0.32-0.13
Number of patient safety incidents reported to NRLS and percentage resulting in severe harm or death	0.55%	4301 0.67%	0.75% ⁽⁵⁾	3.56%-0.16%

Footnotes

- (1) SHMI and palliative care data: this information has been taken from the most recent refresh covering the period Oct 11 to Sep 12.

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- (2) PROMs data - this information has been taken from the data up to September 2012.
 - (3) Readmission Data - taken from Dr Foster - current position up to October 2012
 - (4) Responsiveness to inpatients' needs - only Midlands and East data available
 - (5) Rate of patient safety incidents - National data refers to medium acute trusts

Part 3: Other Information

This section of the Quality Report gives a four-year overview of performance against:

- Indicators which demonstrate the Trust's performance in aspects of patient safety, patient experience and clinical effectiveness.
- Measures identified in the NHS Operating Framework for England and the national core standards.

In preparing the Quality Report, in 2008/09 (the pilot year) the Board identified a number of quality metrics and performance indicators that it would track and report annually in the Quality Report to identify progressive improvement in performance.

Table 4: Performance of the Trust against selected quality metrics

Indicator	National Benchmark	2009/10	2010/11	2011/12	2012/13
Patient Safety					
Falls per 1,000 bed days	5.6	6.0	6.21	5.76	5.19
Medication errors per 1,000 bed days	NA	0.24	0.34	0.34	3.05
Pressure ulcer incidence	4%	0.52%	0.56%	0.45%	0.25%
MRSA bacteraemia per 10,000 bed days	N/A	0.36	0.04	0	1
C.diff cases per 1,000 bed days	N/A	0.20	0.13	0.13	0.14
Hand hygiene compliance	N/A	97%	97%	96.5%	97.4%
Clinical Effectiveness					
HSMR (Dr Foster 12 month data)	100	97.0	100.0	101.7	100.7 Apr to Jan 13
Caesarean section rate	24%	27.4%	26.4%	22.9%	23.8% ⁽¹⁾
% fractured neck of femur operated within 36 hours	2011/12 National 67%	64.5%	81.7%	87.53%	72.3%
Patient Experience					
Formal written complaints received	N/A	661	661	551	640
Formal complaints reopened	N/A	122	104	104	77
Patient Experience Action Team Score	N/A	Triple Excellent	Triple Excellent	Triple Excellent	Excellent x 2 Good x 1

Footnotes

(1) Data correct as of 19th April, but may change following update

The data sources for the information contained in this table are the Trust's Patient Administration System, laboratory systems, complaints database and ward nursing records.

Table 5: National targets and regulatory requirements

Standard	2012/13 Threshold	2010/11	2011/12	2012/13
Clostridium difficile – year-on-year reduction	25	28	28	29
MRSA – maintaining annual number of bloodstream infections at less than 2003/4 level	1	1	0	1
18-week maximum wait from point of referral to treatment (admitted patients)	90%	92.82%	90.97%	93.75%
18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	95.75%	97.18%	98.25%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge – Trust	95%	97.6%	96.64%	96.10%
Maximum wait – two weeks from urgent GP referral to date first seen cancer	93%	96.6%	94.5%	96.01%
Maximum wait – 31 days from decision to treat to start of treatment for all cancers	96%	98.6%	98.4%	98.46%
Maximum wait – 31 days from decision to treat to subsequent treatment – surgical procedure	94%	95.8%	96.8%	98.19%
Maximum wait – 31 days from decision to treat to subsequent treatment – all drug treatment	98%	99.6%	99.8%	99.77%
Maximum wait – 31 days from decision to treat to subsequent treatment – radiotherapy treatment	94%	94.6%	98.6%	98.11%
Maximum wait – 62 days for all referrals to treatment for all cancers	85%	86.7%	82.2%	86.71%
Maximum wait – 62 days from urgent referral from the national screening service to treatment	90%	90.9%	89.7%	94.34%
Maximum wait – 62 days from urgent referral from a consultant (consultant upgrade) to treatment	85%	91.8%	95.1%	88.78%
Two week wait – symptomatic breast patients (cancer not initially suspected)	93%	95.07%	95.2%	97.61%
Maximum waiting time of 26 weeks for inpatients	99.97%	100%	99.99%	99.83%

Standard	2012/13 Threshold	2010/11	2011/12	2012/13
Maximum waiting time of 13 weeks for outpatients	99.97%	99.99%	99.98%	99.96%
Maximum waiting time of two weeks for rapid access chest pain clinics	100%	100%	100%	100%
Sexual health – 48-hour access to Genito-Urinary Medicine (GUM)	100%	100%	100%	100%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	100%	100%	100%	100%
Minimising delay transfers of care	<3.5%	1.76%	0.24%	0.31%

The data included in this table uses the national data definitions as described in rules for the NHS national data sets, the NHS operating framework and Monitor's compliance framework.

The data sources for the information contained in this table are the Trust's Patient Administration System and laboratory systems.

Annex A: Statements from commissioners, Local Healthwatch organisations and Overview and Scrutiny Committees

Comments from NHS North East Essex

This is the first year that Quality Accounts are being commented on by North East Essex Clinical Commissioning Group (CCG), who have taken over from NHS North East Essex Primary Care Trust (PCT) as the commissioner from 1 April 2013.

The CCG welcomes this Quality Account as a commitment to an open and honest dialogue with the public regarding the quality of care in Colchester Hospital University Foundation NHS Trust. Assurance from the CCG is required to ensure that the information in this Quality Account is accurate, fairly interpreted, and representative of the range of services delivered.

Though the CCG are commenting on a draft version of the Quality Account, we are pleased to be able to assure the accuracy of the content in general.

In your account you celebrate your quality achievements, and as necessary working through any issues that might have arisen in relation to delivering against the priorities for the last year. You give an outline summary of actions taken in the past twelve months and your vision for the year to come. Directors recognise their link to quality care and also the processes involved in delivering and monitoring quality care.

You demonstrate that there have been quality concerns identified during the year, identified through a combination of internal and external reviews, in particular with regard to the Summary Hospital-Level Mortality Indicator (SHMI), serious incidents in maternity services and the Emergency Assessment Unit in particular, and governance around serious incident management. You describe the proactive approach taken in addressing these issues, including inviting external expert review in areas of concern. You have implemented a comprehensive programme of remedial actions to remedy these quality challenges, which the CCG have been working with you to support. You have risen to the challenges resulting from the publication of the Francis Report, which has led to the announcement of a review of CHUFT with regard to high SHMI demonstrating a desire for transparency by encouraging your staff and the local public to contribute to the review.

You describe further quality improvements such as the Clinical Portal development work, and the Emergency Care reorganisation, changes in practice which are expected to deliver improved patient care and experience.

We note your success in delivery of the majority of your quality priorities for 2012-13, via the CQUIN schemes for dementia screening, the NHS Safety Thermometer, GP engagement, end of life care review, enhanced recovery programme and early consultant reviews and missed doses of antibiotics. In general, patient experience measures are positive, with the Friends and Family Test consistently high scoring, although the overall result of the national inpatient survey fell just short of the target. You also describe your areas where the desired improvements have not been achieved, and should be a continued focus for improvement: VTE risk assessment, and the elimination of avoidable hospital acquired pressure ulcers.

You give a comprehensive description of your participation in and learning from clinical audit, in both nationally and locally-driven topics. You give a summary of findings and learning from clinical audits undertaken, and describe a clear commitment in the organisation to clinical research. This desire to learn in order to improve the quality of care and services should also be driven through the incident and complaints processes.

In your report there is information about your performance in respect of the information governance (IG) toolkit. You report that the Trust has fewer requirements (5 of 45) which have not achieved level 2 in this year than in the previous year, but the Trust remains rated as 'not satisfactory' and there have been a number of serious incidents relating to breaches of information governance standards which reflect this area of concern. This remains an area which the CCG feels requires further improvement as a priority in 2013-14.

Your priorities for improvement in 2013–2014 are grouped into three themes:

- Out of Hours
- At Our Best, Everyone, Everywhere
- NICE Quality Standards

These themes map to the domains of quality: Patient Safety, Patient Experience and Clinical Effectiveness, and will be measured through the CQUIN Scheme agreed with the CCG for 2013-14. The CCG support these priorities, however would also stress the significant reduction in targets for infection rates, and note that MRSA emergency admission screening and adherence to protocol will be an internal challenge that requires priority attention.

In conclusion the North East Essex CCG considers Colchester Hospital University Foundation NHS Trust Quality Accounts for 2012 to 2013 as providing an accurate and balanced picture of the reporting period. The CCG looks forward to working in partnership with the Trust to continue to implement the multiple and wide-ranging efforts and initiatives to improve the quality of its services.

Statement from Healthwatch Essex

We recognise that Quality Account reports are a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public about the quality of service they provide. We fully support these reports as a means for providers to review their services in an open and honest manner, acknowledging where services are working well and where there is room for improvement.

We welcome the opportunity to provide a patient and public perspective on the Quality Accounts. As a newly-established organisation (we took on statutory responsibility on 1st April 2013), we are not in a position to comment retrospectively on the findings of the past year. We will, however, cooperate fully in the future production of these reports. We are an organisation which intends to provide comment rooted in evidence – be it 'soft' intelligence or more extensive, quantitative data. Following the Francis Report, we believe there is a significant challenge and opportunity for the whole health and social care system to look at how evidence relating to patient experience can be set on an equal footing with standard NHS data about performance and quality.

We share the aspiration of making the NHS more patient-focussed and placing the patient's experience at the heart of health and social care. An essential part of this is making sure the collective voice of the people of Essex is heard and given due regard, particularly when decisions are being made about quality of care and changes to service delivery and provision.

Our wish is therefore that Healthwatch Essex works with its partners in the health and social care sector to engage patients and service users effectively and to ensure that their views are listened to and acted upon.

We look forward to working together in the production of Quality Accounts in the coming year and making sure that the voice and experience of patients and the public form an integral part of these

documents. At a time when the NHS is facing great change and financial challenge, patient experience and quality of care are more important than ever, and we welcome the opportunity to help shape the NHS of the 21st century.

Comments from Essex NHS/Health Overview & Scrutiny Committee

No comments received

Annex B: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service Quality Report Regulations to prepare Quality Reports for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/2013;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2012 to June 2013
 - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
 - Feedback from Governors at the Council of Governors' Meetings on 4th March 2013 and 10th April 2013
 - Feedback from NHS North East Essex dated 24/05/2013
 - Feedback from Local Health watch organisations dated 20/05/2013
 - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15/08/2012;
 - The [latest] national patient survey 16/04/2013
 - The [latest] national staff survey 28/02/2013
 - The Head of Internal Audit's annual opinion over the trust's control environment dated 24/05/2013
 - CQC quality and risk profiles dated April 2012 to March 2013
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Report regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

24 May 2013

Date



Chair

24 May 2013

Date



Chief Executive

Independent Auditor's Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Colchester Hospital University NHS Foundation Trust to perform an independent assurance engagement in respect of Colchester Hospital University NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- C.difficile; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in Board minutes, board papers relating to quality reports, feedback from commissioners, governors and Healthwatch; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes for the period April 2012 to 22 May 2013;
- papers relating to Quality reported to the Board over the period April 2012 to 22 May 2013;
- feedback from the Commissioners dated May 2013;
- feedback from local Healthwatch organisations dated May 2013
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated August 2012
- the national patient survey dated 2012/13;

- the national staff survey dated 2012/13;
- Care Quality Commission quality and risk profiles dated 2012/13; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 15 May 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Colchester Hospital University NHS Foundation Trust as a body, 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 2013, 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 save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially

different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Colchester Hospital University NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in Board minutes, board papers relating to quality reports, feedback from commissioners, governors and Healthwatch; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

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24 May 2013

