Colchester Hospital University NHS
NHS Foundation Trust

Quality Report 2013/14

Colchester Hospital University NHS
NHS Foundation Trust

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

Quality Report 2013/14

Contents

Quality Report

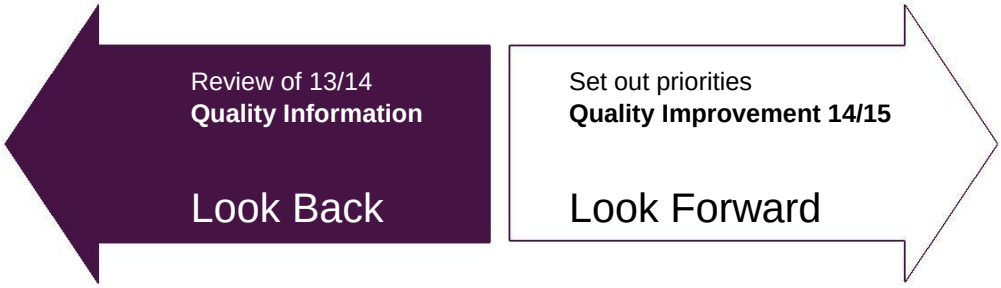
What is a Quality Report?

All NHS hospitals or trusts have to publish their annual financial accounts. Since 2009 as part of the movement across the NHS to be open and transparent about the quality of services provided to the public, all NHS hospitals must publish a Quality Report. The public and patients can also view quality across NHS organisations by viewing the Quality Reports on the NHS Choices website: www.nhs.uk

The dual functions of a Quality Report are to:

1. Summarise performance and improvements against the quality priorities and objectives we set ourselves for 2013/14.

2. Outline the quality priorities and objectives we set ourselves going forward for 2014/15.



Firstly, we have detailed how we performed in 2013/14 against the priorities and objectives we set ourselves under the following categories:

Safe Care
Effective Care
Patient Experience

Where we have not met the priorities and objectives that we set ourselves, we have explained why, and outlined the plans we have put in place to ensure improvements are made in the future.

Secondly, we have outlined our quality priorities and objectives for 2014/15 under the same categories. We have detailed how we decided upon the priorities and objectives we have set ourselves, and how we will achieve and measure our performance. The regulated Statements of Assurance are also included in this part of the report.

The Quality Report is an important document for the Board, which is accountable for the quality of the service provided by the Trust and can be used in the scrutiny and leadership of the Trust. Frontline staff can use the Quality Report or benchmark their care with other Trusts or, if comparable information doesn't exist, with their own performance over time, to help improve their service.

For patients, carers and the public the Quality Report should be a document that is easy to read and understand, and highlights key areas of safety and effective care delivered in a caring and empathetic way. It should also show how a Trust is concentrating on continuously improving its care. As the public get used to reading the Quality Report may also help patients with choice. It is important to remember that some parts of the Quality Report are compulsory and can be difficult to read – they are about important areas such as the time it has taken to get from an appointment with a GP to first receiving treatment – generally they are presented as numbers in a table at the end of this Quality Report. If there are any areas of the Quality Report that are difficult to read or understand or you would like any help with the content, please contact us via our Patient Advice and Liaison Service (PALS) on 0800 783 7328 or online at www.colchesterhospital.nhs.uk.

The Quality Report is divided into four sections:

Part 1 A statement on quality from the Chief Executive
Part 2 Performance against priorities for quality improvement 2012/13
Part 3 Outline of quality priorities 2013/14 and statements of assurance
Part 4 Review of quality performance

Part one

Introduction to Colchester Hospital University NHS Foundation Trust and a statement on quality by the Chief Executive

Of the greatest importance to our Board of Directors, Council of Governors and all staff is the quality of care delivered to our patients, their safety, experience and the outcomes of our services.

The aim of this sixth Quality Report is to give a clear picture of how we are making progress and where we need to make further improvements. The Report has been commented upon and shaped by service users and external stakeholders.

Our Quality Report is based upon the quality objectives for 2013/14 that were set in last year's Report, in which we identified goals for a range of measures of patient safety, experience and outcomes.

In November 2013 the Care Quality Commission (CQC) reported on their investigation into cancer data manipulation. This situation led to the Trust being placed in "Special Measures". 2013/14 has been a very difficult year for the Trust. The Keogh Report and the subsequent CQC inspection into cancer waiting times and pathway issues have significantly impacted on the Trust's assessment of quality. The detail of the Keogh Report and CQC inspection is contained in the Trust's Annual Report for 2013/14.

Priorities emerged as a result of the June 2013 Rapid Response Review under the auspices of Sir Bruce Keogh. This was initiated by the Government because the Trust was one of 14 NHS organisations with higher than expected mortality rates. The NHS England team noted on their return visit in February 2014 that progress has been made on the priorities for improvement, but that the "focus on quality and action must remain a priority". The Board fully endorse this requirement.

The Trust recently has satisfied NHS England inspectors it has fully met one of these action points - that it has enough staff to escort people to radiology. Inspectors were not assured that the Trust had met six action points, although they found improvements had been made in many other areas. We have fully accepted this report and welcomed its highlighting of areas of detail where we need to improve further. We will take action to make these improvements.

Investigation into these matters is still proceeding, and further improvements will be introduced, but major changes have been made in response to this unacceptable situation. In addition, data in this report related to Cancer Services has been checked for its reliability.

Like other Executive Board Members, I joined the Trust as Chief Executive following identification of shortcomings in Cancer Services data and care. Last year's Report noted the importance of the organisation's culture on the care that we provide and individual attitudes, behaviour and performance. We are working hard to identify and rectify any cultural causes of shortcomings, and we are committed to building an open and honest culture in the future. In addition, we are working to ensure in the future the assured integrity of the data that we use plan, manage and report upon the care that we deliver and the operations of the Trust.

An important priority for the Trust is to continue to build a culture of openness and honesty, upon which quality care and accurate reporting depend. We will continue to develop a culture throughout the Trust where bullying and harassment of staff is actively addressed and all staff feel able and confident to raise any concerns.

Patient safety, clinical effectiveness and the patient experience, the three domains of quality, formed the basis of the Board of Directors' quality priorities for 2013/14. The three top priorities selected for 2013/14 were "Out Of Hours", "At Our Best - Everyone Everywhere", and "NICE Quality Standards".

This report identifies some good progress in these areas, as well as areas for further improvement.

In relation to "Out Of Hours", extra consultant staff and cover has been implemented in EAU, A&E and anaesthetics. This has resulted in our emergency patients being seen by a consultant more quickly. Improvements have been made to communication and joint working through the Ipswich and Colchester vascular pathway. Work to improve "Out Of Hours" will continue as a priority.

We have continued our Trust-wide programme of improvement called "At Our Best - Everyone Everywhere". This is not just about making our patients better. It is also about respecting their privacy and dignity, keeping them informed and encouraging them to raise concerns and anxieties. We have developed a Patient and Carer Strategy to link with our Quality Strategy and build upon the Trusts' overall objectives. We have addressed concerns expressed by some patients and carers about the attitude of some staff. In 2013, 89% of all staff attended a facilitated session, aimed at promoting inspiration and providing development and support for caring values and practices.

We have identified that we need to continue to improve the consistency of patient experience throughout the hospital. We need also to improve the experience of our staff, so they feel supported to deliver high quality care for our patients.

Our work to meet the NICE Quality Standards (QSs)" has been significant. Greater Board and senior clinician leadership of QSs was introduced, linked to specialty planning. We have introduced arrangements whereby consultants identify and lead audits for at least part of each relevant QS. The audits are centrally recorded and monitored on the Trust Annual Audit Programme. The audits are also identified as part of Quality Improvement projects that consultants have as part of their appraisal. In this way, we have improved the strength of clinical leadership of our audits and their focus upon national identified priorities.

Implementing the recommendations of the Keogh Review represent a challenge for all staff, and the improvements made so far are a testament to their commitment. One of the consistent features of our feedback from patients and from various inspectors has been regular demonstration of very high commitment and caring values from so many of our staff.

Last year, the Board made CQUINs (Commissioning for Quality and Innovation Payments) the basis of future Quality Reports. I have outlined below some key highlights of developments we have made with CQUINs.

CQUINs focusing upon patient safety have demonstrated some real progress.

We have continued to work as a priority on our mortality rates. The Hospital Standardised Mortality Rate (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) are the indicators used to tell us whether the proportion of our patients dying is higher or lower than expected when compared to the rest of the country. The Trust has had a high SHMI since the measure began, whilst the HSMR has been within expected range since 2010/11. Our mortality rate prompted the Keogh Review of the hospital in June 2013. One of the key recommendations of the Review was related to End of Life care and the Trust has continued to work with representatives from North East Essex Clinical Commissioning Group, community providers, St Helena Hospice and the ambulance service. We have, with a rapid response community team hosted by the St Helena Hospice, developed a joint action plan to improve communication and the care provided to patients who are at the End of Life. We have included information on our mortality performance last year in Part 2 of this report. The SHMI for 2012/13 was

116.8. The latest SHMI data (October 2012 to September 2013) is 111.5. This is reported as band 2, as within expected levels, by the NHS Information Centre.

We have used specialty expertise to increase the recognition of patients with the potential to deteriorate rapidly or who need End of Life care. This has been followed up by improvements in communication with GPs when these patients leave hospital, including requests to add such patients to the “My Care Choices Register”. We will be striving to improve further our recognition of End of Life patients and to take further steps to improve communication and joint working over End of Life care with GPs, hospices and other providers.

Governance around cancer wait times data collection has been systematically improved through Trust and tumour site action plans. We have increased the staffing involved and introduced a new database and new process improvements to track the experience of our patients who are waiting. These will allow us to deliver sustainable 62 day cancer wait performance.

Cancer wait management remains a priority and actions to improve performance are outlined in the Report.

The National Early Warning Score (NEWS) is a new national system for documenting vital signs and escalating the care of deteriorating patients. We rolled out the system and it was fully operational from October 2013. We achieved an average of 95.4% compliance. Our target was to score 100% of patients (excluding paediatrics or maternity) by the end of March 2014.

We have invested in modern new equipment to be used in case of cardiac arrest.

We established a database for recording VTE (venous thromboembolism) root cause analysis outcomes, and provided information to specialties and divisions, to help them improve performance. We will be working to improve the proportion of the VTE risk assessments. Currently, this is greater than 90%, but short of the 2013-14 target of being greater than 95%.

To promote the safety of patients having surgery, we have been strengthening the use of the World Health Organisation (WHO) Surgical Safety Checklist.

The new “Safety Thermometer” is a one day snapshot audit of falls, pressure ulcers and catheter associated urinary tract infections. Monthly, data has been circulated so that wards are aware of the percentage of patients who receive harm-free care during their stay. We are still below the national average of participating NHS Trusts for falls resulting in harm, and hospital acquired pressure ulcers graded 2-4.

Patient safety has also improved in other areas, in particular preventing hospital acquired infection. A performance indicator on Clostridium difficile was to have no more than 18 cases of hospital acquired Clostridium difficile in the financial year and this has been achieved, with only 17 cases. A performance indicator on Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia (MRSA in the blood stream) was to have zero cases. This was achieved. Training, audit and feedback to staff and patients all have contributed to this achievement.

We are increasing the use of electronic systems to alert medical staff to the deteriorating patient. We are increasing the use of Team Simulation training for emergency situations. We plan to improve the management of peripheral vascular lines and reduce cases of unnecessary cannulation. We need to reduce the number of patients having catheters and ensure these are actively reviewed.

Clinical effectiveness was improved in areas concerning several CQUINs.

To improve the identification, care and treatment of patients with dementia, we have appointed two Dementia Care Nurse Specialists and developed dementia awareness training and surveys. Screening

of our patients for dementia has consequently improved, with 100% of all identified patients being screened for signs of dementia. This enables better care with further assessment and specialist referral, if needed.

We have been improving radiotherapy provision, through greater use of image guided radiotherapy, for example for prostate treatment. We have installed new equipment, extending our radiotherapy capacity. We plan to develop these services further.

To improve the care of diabetic foot patients, we have introduced a specialist nurse Ward round to the Emergency Assessment Unit. We have raised awareness of the early identification and prevention of foot ulceration and implemented new screening tools. We need to raise staff awareness further, to increase their use.

Improvements have been made to the nursing transfer and discharge process for in-patients being transferred to community or residential care. Anglia Community Enterprise has adopted the nursing transfer and discharge form developed by Colchester Hospital. Further improvements have been made to the transfer and discharge process to include a dementia score and Care of the Elderly consultant authorisation for transfer. This has streamlined the process of transfer and discharge for our patients. Further work will be done to ensure we can monitor the use of the process, so further improvements can be made.

The key CQUIN regarding the patient experience was the Friends and Family Test and our performance over the last year has consistently been high.

In most areas, about 40% of our patients being discharged from our care completed the Friends and Family test. We extended opportunities for patients to feed back to us by introducing the test into the Accident and Emergency department and Maternity services. We also introduced a text messaging service to allow patients to respond by text, if they wish.

Patient experience has been improving in other areas. In particular, we have not had any breaches of our same-sex accommodation standard and we audit this regularly, checking there has been no misclassification in our reports. This is an important part of maintaining the privacy and dignity or our patients. We have the necessary facilities, resources and culture to ensure that our patients 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.

The hospital has provided leadership programmes for staff with specific modules on the patient experience, related to practical improvements for patients. Any new roles in the hospital are designed to reflect the attitudes, behaviours and standards we expect. Patient stories, good and bad, and sometimes with the patients themselves, are used to develop staff in training sessions.

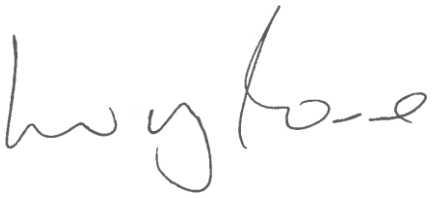
We are committed to maintaining improvements and to listening even more to our patients and carers. This is a key part of our quality strategy.

A new, integrated Quality Strategy has been produced, incorporating overall Trust objectives and requirements reflecting external reviews (E.g. Keogh Review, CQC) and Special Measures priorities. Its themes of ensuring patient safety, a positive patient experience and effectiveness in care are used in prioritising our quality objectives and implementation plans. The Board receives assurance on these matters from the monthly review of quality related information by the Quality and Patient Safety Committee. Implementation of new Specialty Clinical Dashboards has improved rapid transfer of quality related information throughout the organisation. The Board is reviewing processes, systems, communications and cultural factors affecting its own awareness and leadership regarding quality, as well as the framework for openness and quality improvements in the Trust.

The year has seen considerable improvements in the Quality Hub's support for patient safety, clinical effectiveness and patient experience. For example, a process for meeting the requirements of the Duty of Candour has been created and implemented, ensuring that patients who have suffered any significant harm arising from our care are informed quickly and involved in investigation and ensuring learning.

I hope that you find the Report a useful document. The Board and our staff look forward to building upon its achievements and tackling areas for improvement, putting the patient, and values of caring and openness, at the heart of all we do.

I can confirm that, to the best of my knowledge, the information in this document is accurate.



Dr Lucy Moore

Interim Chief Executive

29 May 2014

Part two

Introduction to Colchester Hospital University NHS Foundation Trust

Performance is reported against the specific priorities and targets we set ourselves for Safe care (red) Effective care (green) and Patient experience (blue) for 2013/14 in this section.

Clostridium difficile

Reduce the incidence of Healthcare Associated Infections (HCAIs)

Target

To reduce the number of *Clostridium difficile* Infections (CDI) to no more than 18 during 2013/14.
To maintain a very low incidence of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.

Colchester Hospital University NHS Foundation Trust (CHUFT) serves a population with an increasingly elderly demographic. Infection prevention and control is seen as a key component of the patient safety and quality culture.

What did we do in 2013/14?

- We have maintained a high proportion of single rooms, making it easier to isolate infected patients earlier. Approximately 25% of patient accommodation is single side rooms, many with en-suite facilities.

- The Isolation unit has supported the reduction in the number of HCAIs through the prompt isolation and management of patients identified with MRSA infections/colonisation *& Clostridium difficile* infections.

- Hydrogen peroxide vapour (HPV) is used for the decontamination of patient rooms where the occupant has had an infection that may pose a risk to the next person to use the room. This service is available Trust wide. Priority is given to rooms that have been occupied by patients with symptomatic *Clostridium difficile* infection because HPV is the most effective way to destroy *Clostridium difficile* spores and therefore minimise the risk to other patients.

- Infection prevention and control is included in the mandatory induction programme for new staff. There is mandatory update training every two years, for all existing staff

- Each ward and unit has clinical link nurses for infection prevention and control, who act as clinical champions for Infection Control. The Infection Prevention and Control Team hold quarterly meetings for all 'link' staff. These meetings include an educational session and allow staff to discuss infection prevention and control issues.

- The Infection Prevention and Control Team hosted its 13th annual conference on combating HCAIs in November 2013, including sessions on antimicrobial resistance and stewardship, Sepsis, Tuberculosis and the importance of the environment in infection prevention. 72 delegates from across the Trust attended and feedback on the event was very positive.

- All Trust Infection Prevention and Control policies are reviewed every two years and when new evidence/ guidance changes with new policies added as required.

- On-going mattress audit and evaluation has been undertaken and any faulty mattresses replaced to assist in the prevention of infection.

- Detergent wipes have been standardised across the Trust for cleaning equipment, especially commodes and are available in wall mounted dispensers in each ward/bay area.

The Team at CHUFT have worked hard to achieve the objective of fewer than 18 cases of hospital acquired *Clostridium difficile* infection during 2013/14 with 17 cases reported. One MRSA bacteraemia case was allocated to CHUFT during 2013/14. The case was not, however, attributed to CHUFT and no performance measures are to be taken as confirmed with the commissioner. The Trust is committed to continue reducing the incidence of HCAIs in 2014/15.

What actions are we planning to improve our performance?

We aim to reduce the number of *C. difficile* and infections by antibiotic resistant organisms, including MRSA but particularly multi-resistant gram negative organisms.

We will aim to achieve the following:

1. Ensure that infection prevention is taken into account in all refurbishments, new builds and service developments across the Trust
2. Consolidate and expand the programme of inspections and audits; hand hygiene, Saving Lives, NPSA cleanliness audits, infection control audits; local daily checks and clinical indicators across the Trust
3. Review the arrangements for the deployment and operation of the hydrogen peroxide vapour (HPV) environmental decontamination equipment. Ensure that the equipment is used as effectively as possible and that priority is given to those areas where it will be most beneficial, particularly rooms that have been occupied by symptomatic patients with *Clostridium difficile* infection.
4. Expand the range of modules undertaken for surgical site infection surveillance.
5. Continuing with multidisciplinary team panel reviews for all MRSA, MSSA and *C.difficile* cases with feedback of themes for learning via Infection Control Web page and newsletter.
6. Review teaching for all clinical and facilities staff on the importance of optimal infection prevention and control practices. Teaching will provide staff with the information, knowledge and skills necessary to minimise the risk of infection and will meet the requirements of the Hygiene Code.
7. Host the annual Infection Control Conference in 2014 on combating HCAIs, with the particular emphasis on the growing threat of multi-drug resistant gram negative organisms and intravenous line management.
8. Continue to provide a proactive and responsive infection prevention service to all areas of the Trust, with particular emphasis on increasing awareness of the service in Therapies.
9. Review the costs and benefits of pre-surgical decolonisation for all patients to reduce the risk of postoperative wound infection with a view to introducing universal preoperative decolonisation.
10. Continuing with regular awareness audits and feedback for MRSA screening with the aim to lift compliance from 87%.

How will improvement be measured and monitored?

Compliance and improvements will be monitored on a monthly basis by the Infection Prevention and Control Team. Assurance and feedback will be provided at the Hospital Infection Control Committee, held alternate months. This is a multidisciplinary meeting chaired by the Director of Infection Prevention and Control.

How did we perform in 2013/14?

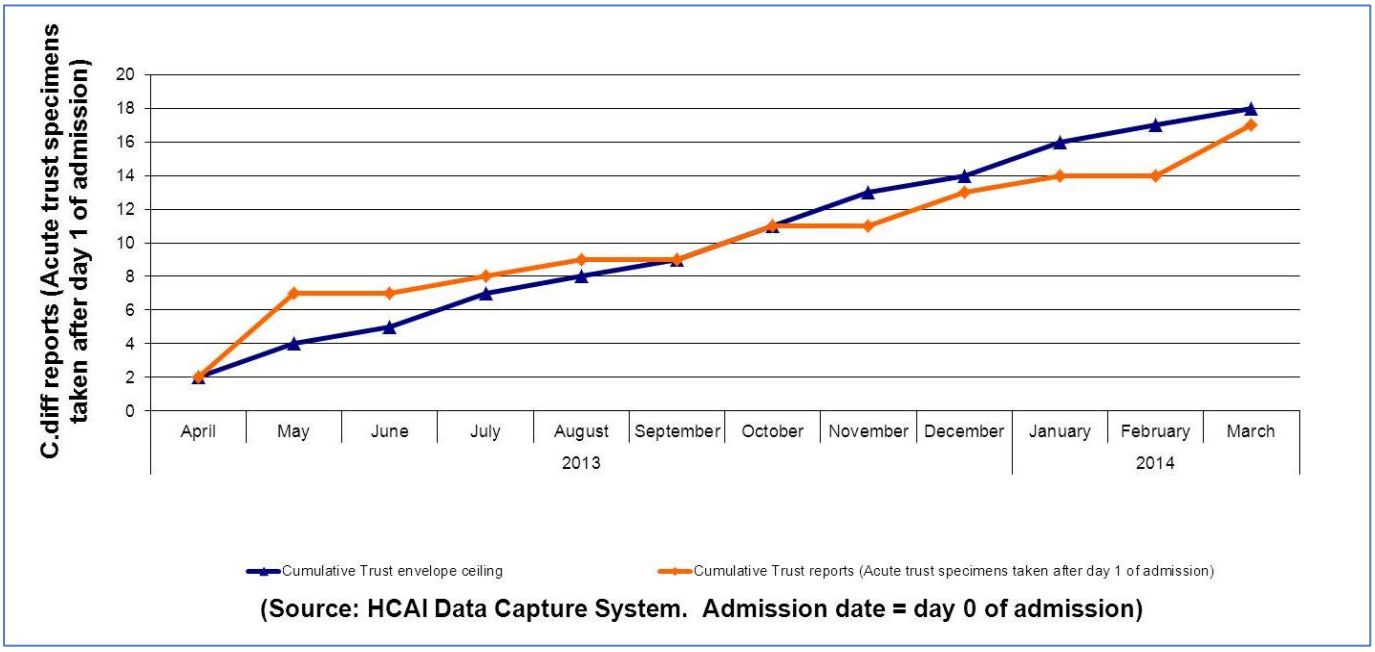
The table below shows the numbers of two important health care associated infections (HCAIs): meticillin resistant *Staphylococcus aureus* bacteraemia (MRSA) and *Clostridium difficile* (CDI) over recent years. These infections are monitored nationally through Public Health England with all hospitals submitting their information to the website monthly.

Infection	Number attributable 2010/11	Number attributable 2011/12	Number attributable 2012/13	Number attributable 2013/14	CHUFT annual objective 2014/15
MRSA bacteraemia	1	0	1	0	0
C. difficile	28	28	29	17	20

The graph below shows the number of *Clostridium difficile* infections from April 2013 to March 2014.

Colchester Hospital University NHS Foundation Trust: Clostridium difficile reports by specimen date month

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust Actual (> day1)	2	5	0	1	1	0	2	0	2	1	0	3
Trust Envelope	2	2	1	2	1	1	2	2	1	2	1	1



(Source: HCAI Data Capture System. Admission date = day 0 of admission)

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Target

To deliver sustainable 62 day performance by improving the governance around cancer waiting times (CWT) data collection, reducing data errors, and improving tracking of patients on a cancer pathway.

What did we do in 2013/14?

- We took on board the recommendations from several external reviews of cancer CHUFT; these included the Keogh review, Care Quality Commission investigation, NHS England review, and the NHS Intensive Support Team review. These reviews explored the organisation's provision of cancer care but also the management of cancer waiting times at CHUFT;

- We developed a programme management approach to ensuring the actions that have arisen from these recommendations are implemented fully; Trust level and tumour level action plans have been developed to support services to undertake these improvements to the care and service we provide;

- We implemented Somerset Cancer Register (SCR – a database which stores all the cancer waiting times data necessary to make sure that a patient is seen, diagnosed and treated as quickly as possible) to replace the previous cancer waiting times database which was not fit for purpose. We are using the SCR for the recording of data related to cancer waiting times and Cancer Outcomes and Services Dataset (COSD);

- We invested in the cancer tracking and MDT (multi-disciplinary team) coordinator team to ensure that there is sufficient resource for this important team who are key in cancer data collection and tracking processes;

- From October 2013, we ensured that any cancer pathway beyond 100 days is reported and investigated as a Serious Incident (SI);

- We developed protocols for the management of suspicious incidental radiological findings, approved by the Trust's Cancer Board in March 2014.

- We implemented Single Point of Referral so that all 2WW referrals, inter-provider transfers, inter-MDT transfers, suspicious incidental radiological findings, and consultant upgrades are received and logged in one central location to allow accurate and timely recording of data onto SCR and the Trust's patient administration system (PAS), and we have documented standard operating procedures(SOPs) to support this;

- We have started work to reduce the number of incidences where patients have waited greater than 100 days for first definitive treatment.

- We have strengthened our consultant oncology team and invested in two further whole time equivalents.

How did we perform in 2013/14?

Our 62 day has deteriorated and has been non-compliant against national CWT standards in Q1, Q2 and Q3 of 2013/14:

Standard	Target	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	2013/14 Q1	2013/14 Q2	2013/14 Q3
62 Day First Treatments	85%	81.9%	88.0%	88.2%	88.6%	90.1%	83.4%	80.1%

Table 1: CHUFT 62 day GP referral to first treatment performance (Q1 2012/13 to Q3 2013/14)

Our 62 day performance has deteriorated and has been non-compliant against national CWT standards in Q1, Q2 and Q3 of 2013/14.

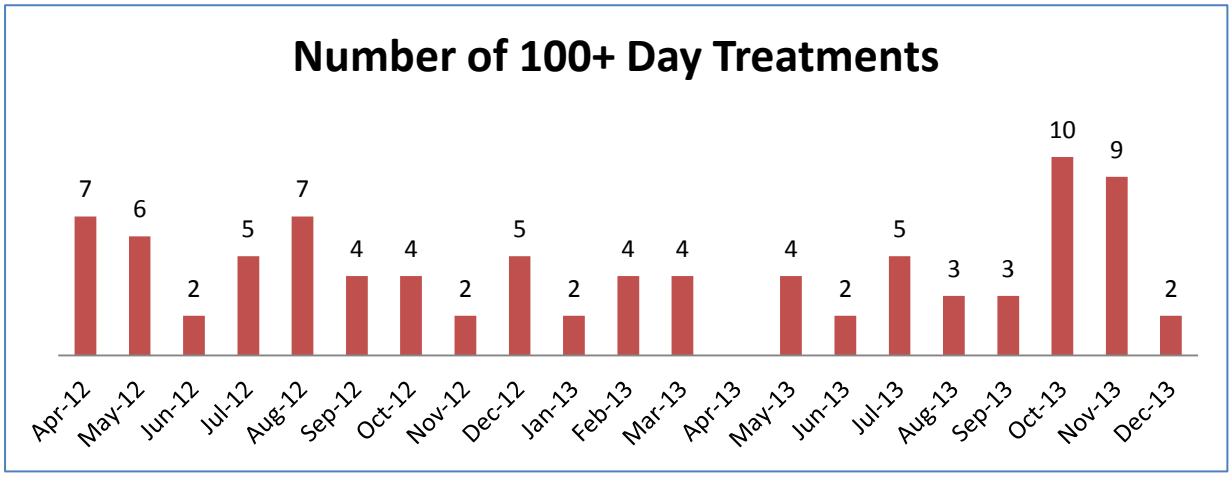


Table 2: Number of 100+ day treatments April 2012 to December 2013

The number of patients whose first definitive treatment was undertaken at greater 100 days is shown in the table above. This will continue to be monitored as the organisation works to reduce this number in 2014/15. In October and November 2013, the organisation started work to understand the reasons for the long waiters. The higher volumes seen in the graph during these months, indicates the period when these long waiters were starting to be treated.

External Audit

Reported performance for 2013/14 against the 'maximum waiting time of 62 days from urgent referral to first treatment for all cancers' indicator has been subject to audit as part of the independent limited assurance engagement conducted by the Trust's external auditors on the Trust's Quality Report. The findings of this work reported that the auditors were unable to verify the accuracy of data being reported for this indicator because of errors identified in their testing of dates recorded in respect of referral and treatment dates for three of twenty-four cases reviewed. This has resulted in a qualification to the Trust's Limited Assurance Report to the Council of Governors. This report is included in full at Annex 3.

What actions are we planning to improve our performance?

- We will continue focus on implementing the recommendations from the external reviews;
- We will implement Phase 2 of the Somerset Cancer Register implementation, which will incorporate live clinical data collection at MDT meetings and will support improving the functionality of the MDTs and accuracy of data collection.

How will improvements be measured and monitored?

- Monitoring will be via the Trust's Cancer Steering Group and Cancer Board Meeting

- Measurement will be via the mandatory CWT and COSD data submissions which are submitted to Open Exeter on a monthly basis;

- There will also be local monitoring of 62 day treatments >100 days.

NHS Safety Thermometer

The NHS Safety Thermometer is a tool which collates point-prevalence audit data measuring harm free care, based on pressure ulcers, falls and treatment for urinary tract infections (UTIs) where the patient has an indwelling urethral catheter.

Two CQUINS were attached to the NHS Safety Thermometer for 2013/14:

- To collect data on pressure ulcers, falls and urinary tract infections in patients with a catheter.
- A reduction in the proportion of inpatients with harm from a fall.

Target

- The target for the first CQUIN was a monthly audit on a prescribed day, of every inpatient as outlined in the guidance.
- That no more than a median of 0.4% of the inpatient population experience a fall with any level of harm as measured using the NHS Safety Thermometer within three days of each monthly survey.

What did we do in 2013/14?

The data was successfully collected and uploaded to the NHS information centre within the defined period. Each month, wards were sent information around the percentage of patients receiving harm free care (new harms) in their area on the Quality Scorecard, which was also discussed at the local ward governance meeting called ‘the 2 at the Top’ involving the ward sister and lead consultant.

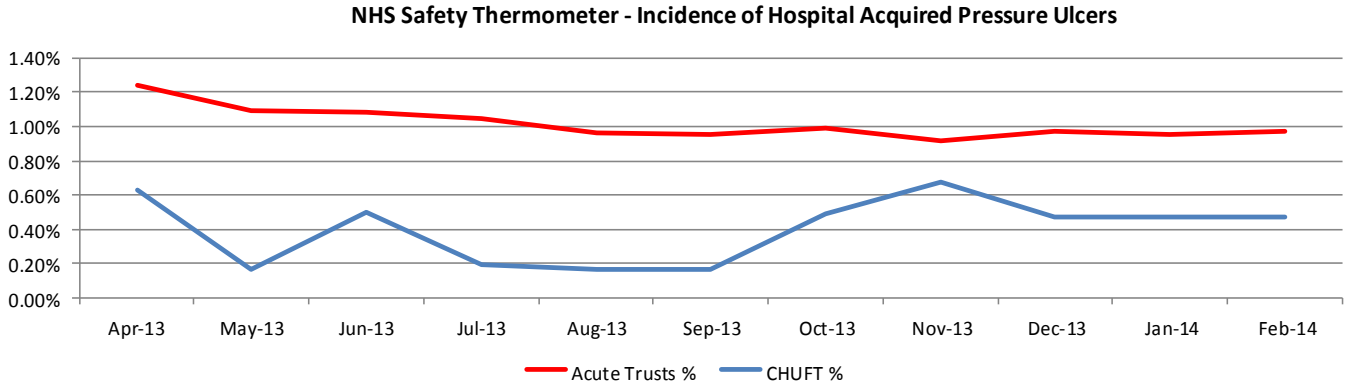
Any falls with harm were cross-checked with the Falls Nurse Specialist and the internal incident-reporting system (Datix), to ensure that the fall had been formally reviewed. This was integrated into the falls prevention work in the Trust, including monitoring the use the Falls Prevention Integrated Care pathway and actions taken as a result if the patient was at risk of falling (assistive technology, low-rise beds, bed rails assessment, lying and standing blood pressure, medication review etc.). The falls were discussed at the Falls Prevention meeting including the findings of the review panel and the route cause analysis for falls resulting in serious harm. The falls data was then reported every month to the Patient Safety Committee and thereafter to the Quality and Patient Safety Committee as part of the CQUIN monitoring process. Local learning was delivered using the learning from experience action plan (LEAP) and themes were included in the Quality Improvement Bulletin, emailed to all staff each month.

In addition, the data around urinary catheters with UTI is displayed in graph form in the Quality Improvement Bulletin, with learning points around catheter care and the importance of regular patient review on a monthly basis. Following analysis of the data where it was indicated that the Trust had a higher than national percentage of catheterised patients, the Infection Control team completed the roll-out of the Catheter Passport initiative, a document given to a patient first catheterised during their stay, that records insertion dates, gives advice to the patient around catheter care, initiates the district nurse referral (if required) and logs the patient on the Infection Control Catheter Passport database. All nursing staff, on induction, are trained in the use of the passport.

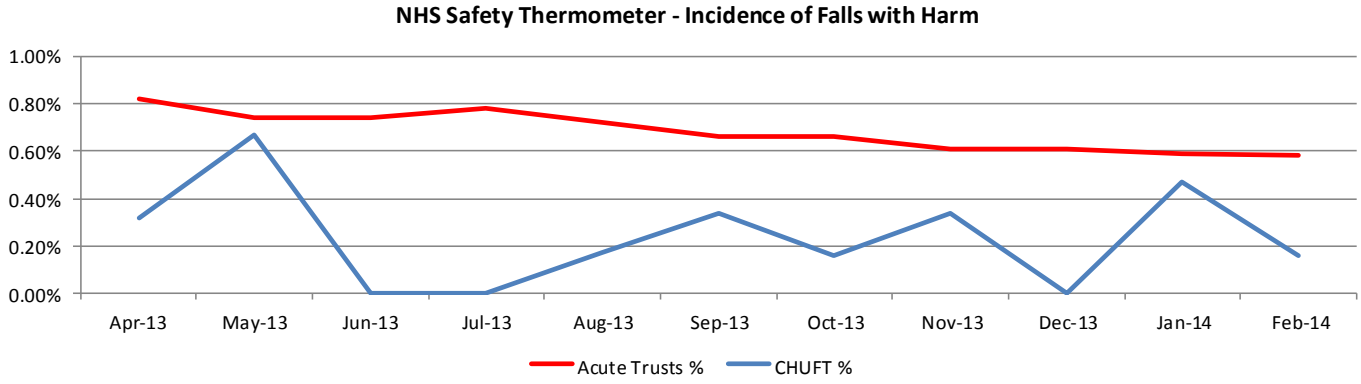
A large number of training sessions have been delivered to Medical and Nursing staff related to urinary tract infection detection and management this past year, supported by the Consultant Microbiologist.

How did we perform in 2013/14?

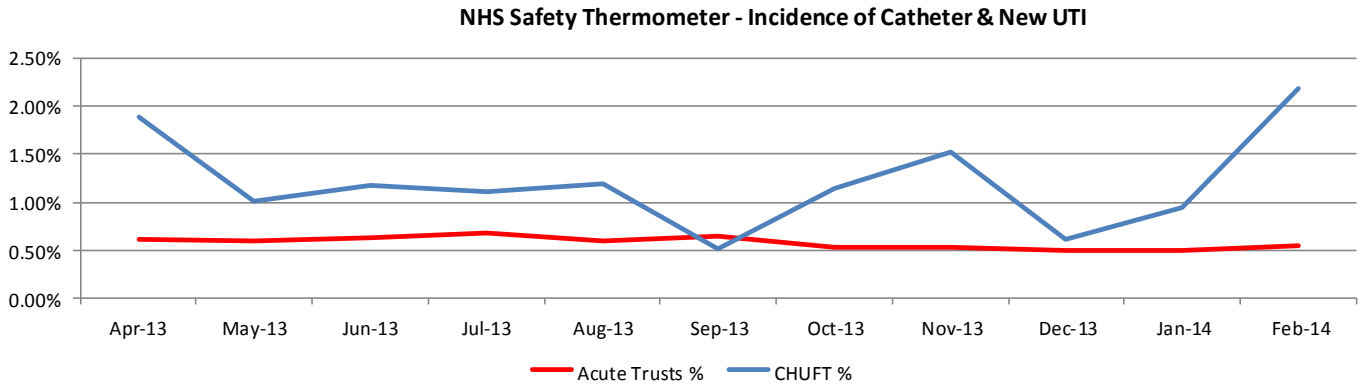
The NHS Safety Thermometer data indicates that for hospital acquired pressure ulcers grades 2 to 4 this Trust consistently performs better than the National average for an acute hospital ward.



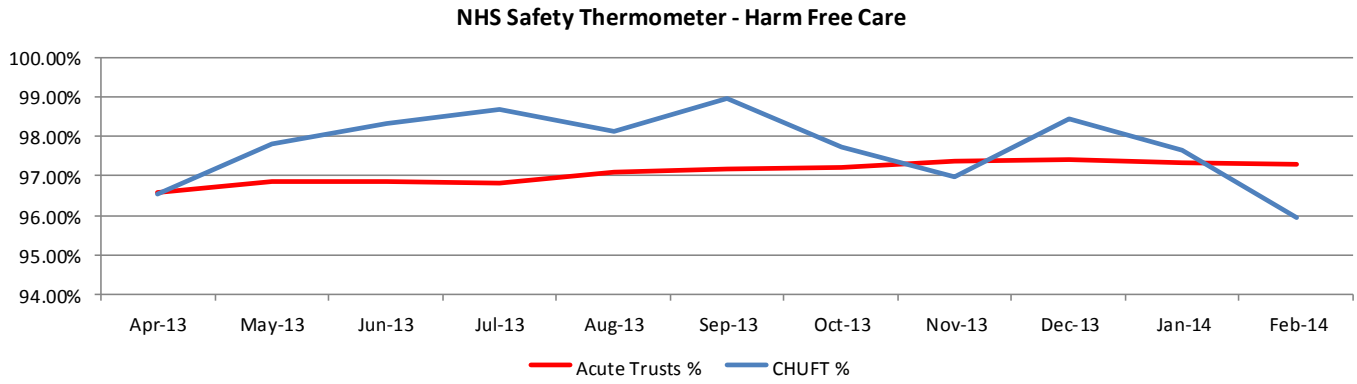
Likewise, the percentage of patients experiencing a fall which results in harm (low, moderate, severe, death) is below that reported for an acute hospital ward. Data to February 2014 indicates a median harm rate of 0.17% against the CQUIN ceiling of 0.4%.



There is a larger percentage than that recorded nationally of catheterised patients in the Trust recorded as first receiving treatment for a urinary tract infection (the definition states that if the treatment for a UTI started whilst the patient was under the care of the organisation, it is classed as a new UTI). However, analysis of samples taken from patients indicates that the infection was present in the community.



Although not mandatory, this Trust also records the incidence of new deep vein thrombosis (DVTs) and pulmonary embolisms (PEs). Even taking this into account (a number of Trusts have opted out of this component), harm free care is generally better than the national picture.



What actions are we planning to improve our performance?

The Falls Nurse Specialist will continue to review every inpatient fall and collate themes. Learning is then delivered locally and Trust-wide.

The Tissue Viability Nurse Specialist is developing the 'Think Heels' project which is described later/earlier in this report. All hospital acquired pressure ulcers graded 2 to 4 are reviewed by a panel to determine if they were avoidable or unavoidable. The Tissue Viability Nurse Specialist meets with staff regularly to offer advice on pressure relieving techniques to maintain the integrity of the skin. Mirrors have been issued to all nursing staff to facilitate heel checks.

Catheter packs are currently being trialled across the Trust containing the equipment needed for catheterisation plus a sticker for the health records containing information around insertion dates. A business case for the appointment of a nurse is being progressed to support the catheter passport/continence programme. This role will support the work of staff on the wards in terms of the following:

- Focus on alternative methods to urinary catheterisation; standardisation of products for catheterisation and the alternatives within the Trust and into the health care economy (improve costs and patient safety).

The post would support the provision of education to staff and patients. This will include the importance of drinking sufficient fluids and maintaining hydration. This will help reduce the risk of infections such as E coli and other infections that can lead to bacteraemia (a blood borne infection).

The post holder would facilitate all catheterised patients being checked at 3 days and before discharge from hospital; ensuring a follow up plan for catheter management. These visits allow for Benign Prostatic Hyperplasia (BHP) to be detected during the hospital admission and for patients to be referred to the Urology teams whilst an in-patient, if required.

A toolkit, developed within the North Essex CCG Infection Control Cluster based on the SIGN work, will be introduced to support staff in decision making and on-going management of urinary tract infections.

Venous Thromboembolism (VTE) prevention

- To ensure that risk assessments are carried out and appropriate VTE prophylaxis is provided for all adult patients
- To ensure that root cause analysis (RCA) is carried out in a timely way and the results reviewed/learning achieved within divisional governance meetings

Target

- To consistently achieve >95% of relevant patients who are risk assessed for VTE
- To ensure that an RCA is undertaken for all patients identified as having possible Hospital Associated VTE, that any learning is reviewed at the relevant divisional governance group and actions shared across the trust and with the commissioners.
- VTE has been highlighted (2005 UK government report - Venous Thromboembolism (VTE) as causing >25,000 preventable deaths per year, ~ half associated with hospital admission) as a significant cause of morbidity and mortality following a hospital stay.
- NICE guidance in 2007 introduced a requirement for mandatory risk assessment and implementation of appropriate prophylaxis in patients who are at risk.
- Undertake RCA of any cases of potentially hospital acquired VTE

What did we do in 2013/14?

- Provided education to all new junior medical staff starting at the trust. Regular education sessions for nursing staff.
- Continued use of the Electronic risk assessment across the trust.
- Provided regular feedback to ward & clinical teams regarding performance and to highlight any missing risk assessment forms for completion.
- Undertook regular “walkabouts” to visit wards and clinical teams, identifying difficulties with completion of the risk assessment forms and encouraging good performance
- Developed a system for completion of RCA in cases of VTE.

How did we perform in 2013/14?

- We achieved >90% performance for risk assessment. However, this fell short of the >95% target set by our commissioners.
- We established a database for recording of VTE RCA outcomes that would enable feedback to divisional governance groups
- We struggled to get engagement with the RCA process from clinicians

What actions are we planning to improve our performance?

- Continue to provide daily (now including the weekend) feedback to ward staff regarding complete and missing risk assessment forms.
- Identify staff who are having difficulty in completing the forms and, working through the Clinical Directors, find a solution to any problems that they may be encountering
- Re-draft the RCA form and, through divisional governance agendas, highlight the importance of ensuring that these are completed, reviewed and learning identified.
- Present Trust wide HNA (Health Needs Assessment) results to all MDTs.
- Improve the response rate for completion of HNA forms.

How will improvement be measured and monitored?

- Monthly feedback to the Clinical Quality Review Group and commissioners
- Feedback from Governance meetings to demonstrate learning and change of practice.

Reducing Harm, Cannulation

To establish a baseline of practice around current issues in IV access

Target

What did we do in 2013/14?

Monthly data collection commenced August 2013 across all inpatient wards/departments. Audit results and CQUIN progress have been escalated to the Patient Safety Committee meeting.

How did we perform in 2013/14?

Baseline data indicates;

6.1 9.4% of patients have an unnecessary peripheral vascular cannula (PVC) in place
6.2 88.2% of patients have a VIP (Visual Infusion Phlebitis scoring tool) score recorded (this would increase to 96.8% if the denominator could be adjusted)
6.3 0% of patients have a VIP score of 2 or greater
6.4 24.9% of patients have had a PVC re-sited 2 or more times (this is an indication of the number of patients who could have benefited from an alternative VAD)

With regards to the milestones;

Quarter 1	Implementation of audit process, monthly audits to determine the baseline position. Key outcomes to be agreed with CCG following baseline audit data available.	Audit process implemented – monthly as part of safety thermometer. Baseline established.
Quarter 2	Training plan implemented targeting learning needs from baseline audit. Training through Matron's and Sisters forums and grand round with evidence of cascade to ward based teams.	E-learning package developed and available to all clinical staff. Classroom version rolled out on nursing team days.
Quarter 3	Monthly Audits of inpatients. 90% of patients audited – target performance to be agreed following baseline audit in Q2	Monthly audits continue Target improvements have not been negotiated as far as I am aware.
Quarter 4	Delivery of improvement objectives to be confirmed following baseline audit in March 2014.	Unachievable without investment – discussed at Patient Safety Committee

What actions are we planning to improve our performance?

- Audit results will be cascaded to the ward governance meetings known as "Two at the Top', divisional directors and the executive team.
- A business case will be developed for an IV Therapy Clinical Nurse Specialist
- Education will be continued.

Roll out of NEWS

To change the track and trigger system used for documenting vital signs and escalating care of the deteriorating patient, to the recommended national documentation (NEWS – National Early Warning Score).

Target

For 100% of patients to be scored using NEWS tool by the end of March 2014. (NEWS excludes paediatrics and Maternity patients).

What did we do in 2013/14?

The roll-out of NEWS was a 2013/2014 CQUIN. In 2012/2013 the Trust was using a the Patient at Risk (PAR) tool and this was monitored on a monthly basis by means of an audit of up to 5 patients.

How did we perform in 2013/14?

The current status of the NEWS roll-out is that it was completed on 16 September 2013 (within the 3 month roll-out time given post Keogh review).

NEWS is excluded from Paediatric and Maternity areas. Paediatrics use PEWS and Midwifery are in the process of developing a plan to roll-out MEWS (Midwifery EWS).

The reporting path for NEWS:

1. Monthly NEWS audits are reported on the Quality Scorecard. Wards discuss variances to compliance at their 2 at the top meetings (minutes provided back to the Quality Hub to enable performance rating (RAG)). Variances also taken to the Specialty Governance meetings.

2. Issues relating to NEWS are discussed at the Patient Safety Committee, and then at the Quality and Patient Safety Committee. NEWS is reported to the Clinical Quality Review Group.

Performance since NEWS has been in place via monthly audits;

Month	Performance
October 2013	95%
November 2013	94%
December 2013	96%
January 2014	99%
February 2014	93%

What actions are we planning to improve our performance?

The Vital Signs, Vital Actions (VIVA) education programme has been running since July 2013 to support the training of escalation of care, and learning from serious incidents related to the deteriorating patient. VIVA is due to run until July 2014.

Falls Prevention

Ensure that all patients admitted to the Trust will be screened for their risk of falls and where indicated, the Falls Prevention Integrated Care Pathway will be followed.

Target

That no more than a median of 0.4% of the inpatient population experiences a fall with any level of harm as measured using the NHS Safety Thermometer within three days of each monthly survey.

What did we do in 2013/14?

The Falls Operational Group chaired by the Assistant Director of Nursing has overseen the following actions:

- Monitoring of the serious incident process incorporating Root Cause Analysis and Panel Reviews for all serious harm falls to ensure learning is captured and actions for improvements implemented
- Themes and trends are monitored and actions agreed
- Reviewed and updated the Falls Prevention Integrated Care Pathway in line with national guidance
- Introduced a post-falls management protocol in line with national guidance incorporating the management of suspected head injuries
- Introduced assistive technology in the prevention of in-patient falls.

More detailed information on falls prevention performance is reported under the Safety Thermometer section of this report.

Mortality - Hospital Standardised Mortality Rate (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI)

This was not a CQUIN, but it was an important priority for the Trust.

Target

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

Previously in 2012 /2013:

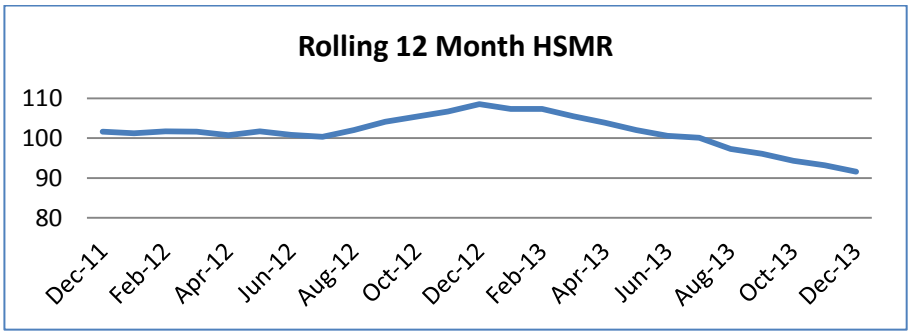
The Trust has had a high SHMI since the inception of the measure whilst the HSMR has been within expected range since 2010/11. This prompted the Keogh Review of the hospital in June 2013.

What did we do in 2013/2014?

One of the key recommendations of the Keogh Review related to end of life care and the Trust has continued to work with representatives from North East Essex Clinical Commissioning Group, community providers, St Helena Hospice and the ambulance service. We have developed a joint action plan to improve communication and the care provided to patients at the end of life, with a rapid response community team hosted by St Helena Hospice. The Trust has a large palliative care team and is one of only 20% of Trusts nationally to provide a 7 day service. According to the Dr Foster data for April to Dec 2013 we are ranked 21st highest for spells with palliative care but 48th highest for deaths with palliative care as we actively support patients at end of life to be cared for in their preferred place in the community.
Another of the key recommendations of the Keogh Review was that the Trust should increase the pace of the planned roll out of the National Early Warning Score for deteriorating patients. This was introduced in all relevant areas of the Trust through the late summer and early autumn of 2013.

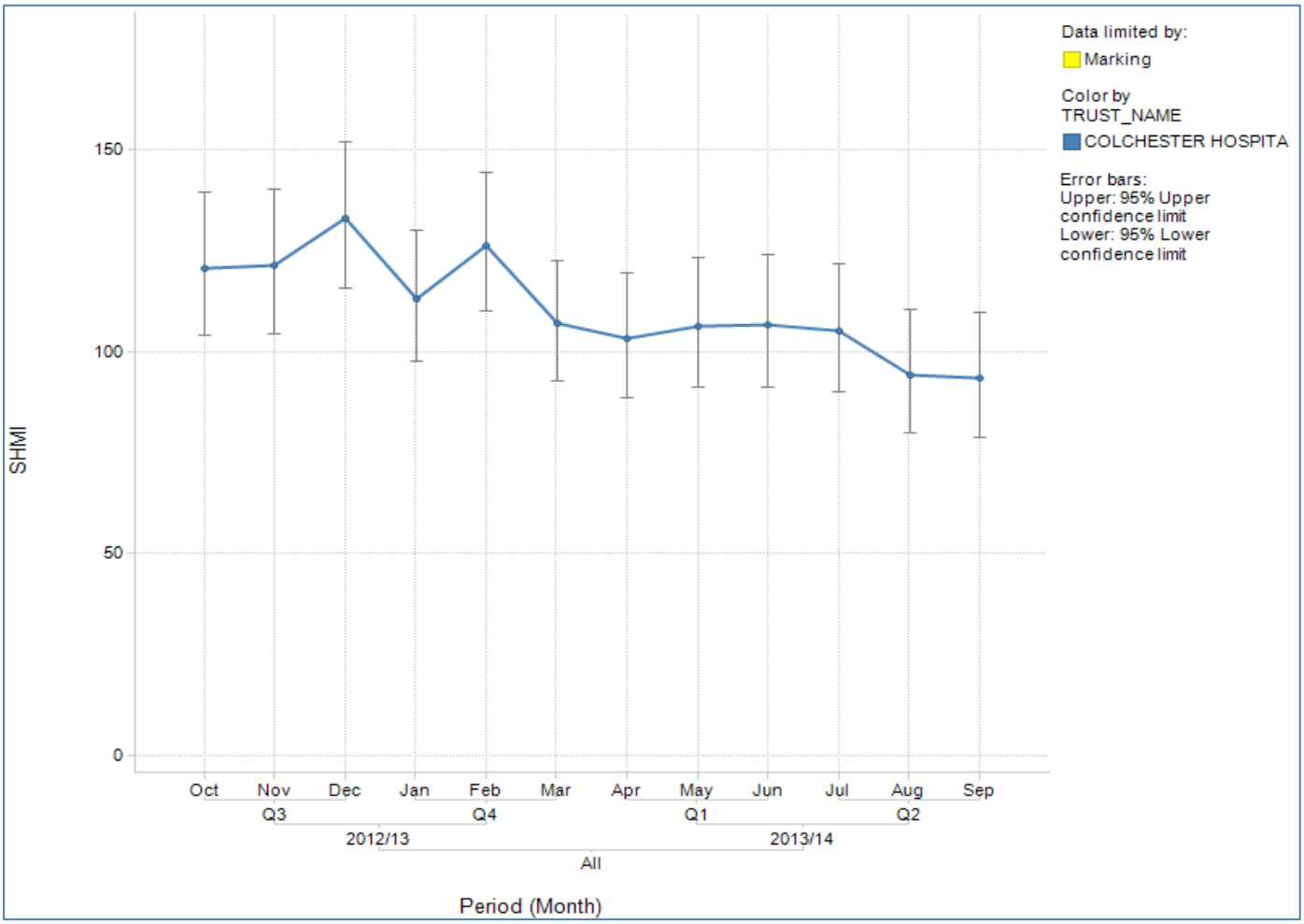
How did we perform in 2013/14?

The HSMR for the Trust for 2012-2013 was 105.5. The latest position as at February 2014 for 2013/14 is 90.8 (this will be rebased at the end of 2014).

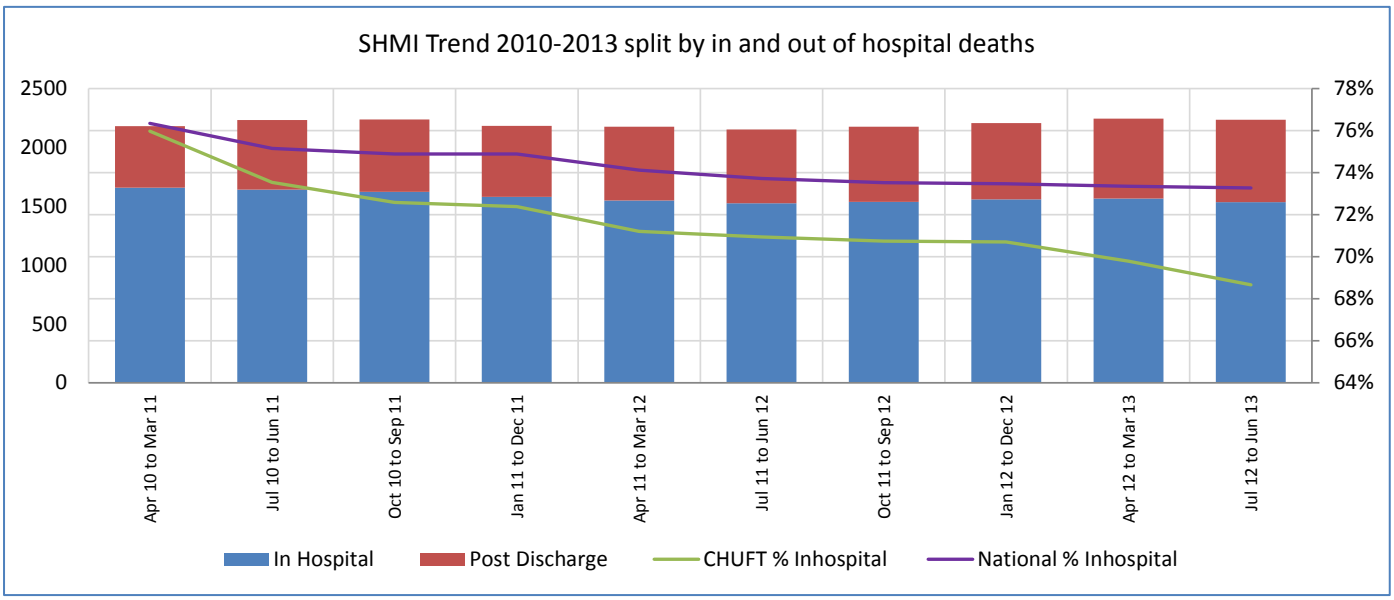


The SHMI for 2012/13 was 116.8. The latest SHMI data (October 2012 to 30 September 2013) is 111.5. This is reported as band 2, as within expected levels, by the NHS Information Centre.

Healthcare Evaluation Data (HED), who provided information for the Keogh Review, publishes monthly SHMI Data and this suggests that the Trust SHMI rating has been within expected range in all months since March 2013.



The Trust has a high proportion of deaths within 30 days of discharge. This is in part a result of early supported discharge of patients to their preferred place of care.



Radiotherapy, IGRT (image-guided radiotherapy)

To improve quality of Radiotherapy Treatments.

Target

Implement IGRT

What did we do in 2013/14?

We introduced the use of Gold Fiducial markers for Prostate Radiotherapy with on-line MV imaging as part of introducing IGRT.

How did we perform in 2013/14?

We started using the technique in March 2014 with our first patient treatment using Gold Fiducial markers.

What actions are we planning to improve our performance?

We have installed four TrueBeam Linacs with kV imaging and CBCT in the new RT Centre at Colchester General Hospital which will open in May 2014. This new equipment will ensure the Trust is able to develop and extend the range of radiation services locally to include new techniques.

How will improvements be measured and monitored?

Via relevant CQUIN:

1. Improving the proportion of radical intensity modulated radiotherapy (IMRT) (excluding breast and brain) with level 2 imaging – image guided radiotherapy (IGRT)

Description: 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 Total Parenteral Nutrition (TPN)

To achieve the timely administration of TPN on the Neonatal Unit.

Target

To administer TPN as per the regional Network guideline 2013 for neonates.

Previously in 2012 /2013

TPN was administered to the neonate on week days only, and not available stock to commence on the weekend.

What did we do in 2013/2014?

Following the attendance of the Regional Implementation meetings in December 2012,
Criteria set by region by Region all babies less than 30 weeks gestation or 1kg in weight, TPN to be commenced within 24hours unless transferred to regional unit.

- We implemented the regional TPN guideline into practice from April 2013 by working closely with the Pharmacist and Dietician.
- We ensured TPN was available 24 hours a day, 7 days a week.
- We provided teaching and in the unit support for staff to promote compliance of the guideline.
- We monitored performance via the neonatal platform (Badgernet).

How did we perform in 2013/14?

The neonatal platform demonstrates 100% compliance with the regional standards.

- To continue teaching for staff to maintain staff awareness of guideline.
- Through monitoring via the Badgernet system (Neonatal platform).

Now participating in Regional TPN Audit data being collected now for in-depth analysis comparison with Regional Network.

Foot checks using Ipswich Touch Test

Early identification of patients at risk of diabetic foot ulcers in patients with diabetes; contributes towards the NHS ambition to eliminate preventable ulcers.

Target

- Patients with Diabetes who are admitted to hospital will have the Ipswich Touch Test within 24 hours of admission and if loss of sensation is detected measures to prevent heel ulceration are put in place.

- Approximately 2.5% of the diabetic population are thought to have foot ulcers at any given time – equivalent to 407 people in NEE based on a diabetic population of 16,305.

- In 2011/12 there were 158 admissions for diabetes related foot ulcers in secondary care. Early identification of loss of sensation could prevent incidents of ulceration.

What did we do in 2013/14?

- We raised awareness of the early identification and prevention of foot ulceration.

- We implemented the Think Glucose and Ipswich Touch Test Screening Tool

- We have introduced the EAU Diabetes Specialist Nurse ward round to capture new patients.

How did we perform in 2013/14?

February 2014 Report: CQUIN 8 – Foot checks using the Ipswich Touch Test

The Diabetes Team have introduced the ITT CQUIN across the Trust with a gradual increase to date in aiming to reach the agreed achievements.

The planning phase (Q1-2) was introduced with reference to the draft CQUIN which was later replaced by the agreed CQUIN on 16th October 2013 (6 month delay).

Despite great efforts by the team, difficulties have been experienced in achieving the combined milestones due to a lack of 7 day working and a reduced workforce during a time when referrals have increased.

Q1-2 2013-14 (Reports November 2013) – Met milestone.

1. Staff training

    a. Ward based nursing and administrative staff were made aware of the changes to the Diabetes Assessment Form (Think Glucose) which now includes the ITT assessment. The awareness has been achieved through communication to Ward Managers, Matrons, Practice Development team and through the Diabetes Newsletter ‘Sweet Talk’.

    b. Diabetes Specialist Nurses have attended team days presented at Induction and held awareness events to demonstrate the process of performing the ITT.

    c. Each ward has a Named Nurse as identified lead for Cascade Training for staff.

    d. A register for the Named Nurse for cascade training is held by the Diabetes Team.

e. Staff awareness/training will be on-going through daily observation by the DSN when visiting the wards and ad hoc audits.

f. Each ward has been issued with the Standard Operating Procedure and a quick reference guide to completing and referring the assessment results.

2. Pilot data collection

   a. The pilot has been completed. Full implementation commenced during November 2013.

   b. October results = 67% referred to MDT within target

3. Setting up reporting procedures

   a. Data set developed.

   b. Reports run monthly.

Q3 2013-4 (Reports February 2014)

The CQUIN has not met all three milestone achievements to date as seen in table below. Factors outside the control of the diabetes team have affected the outcomes which should be considered in future negotiations.

ITT CQUIN	Nov	Dec	Jan	Feb	Mar	Combined Achievement
1. 90% (or above) of all adult inpatients must have been screened using the Ipswich Touch Test within 24hrs of admission		97%	76%	80%		84%
2. 90% of patients with loss of sensation in feet to have this reported in discharge summary	32%	56%	64%	94%		61%
3. 100% of patients with a detected neuropathic or diabetic foot ulcer or other foot care complication to be referred to MDT within 24 hours of the assessment	60%	100%	100%	88%		87%

1. Achievement not met

2. Gradual improvements in completion of the electronic discharge summary have been demonstrated and are expected to continue to be achieved. The Increase in referrals, contacts and administration time was not considered before the agreed CQUIN. Additional casual staff have been required to review patients of who did not have access to EDS causing a delay in completion of point 2 of the CQUIN.

3. 7 day working is required to meet this target. February target not met due to just one patient missing the 24hr referral.

Summary

Although not meeting all milestones, the CQUIN has achieved the aim of raising the awareness of diabetes patients who have reduced sensation to their feet and are high risk of foot ulceration. A total of 146 patients have been referred to the vascular MDT since November 2013 and measures put in place to protect the patient from pressure areas and heal ulcerations.

The initiative has also increased referrals for general diabetes management by an additional 100 contacts per month, each patient receiving support to optimise their diabetes control, improve self-management and promote a safe and effective discharge.

What actions are we planning to improve our performance?

- On-going awareness of the Diabetes Think Glucose and Ipswich Touch Test Assessment.
- Target poor performing areas.
- Robust reporting ITT scores within the electronic discharge summary.

How will improvements be measured and monitored?

- Through monthly audits.
- Awareness through cascading audit results within the Quality Bulletin.

Nursing Transfer & Discharge Patient Summary (focused to community and residential care)

To improve the quality of patient information that is shared between providers.

Target

CHUFT/ACE to work to develop and introduce a shared document that will be used for all transfers and discharges to further care providers by both organisations by end August 2013.

CHUFT/ACE to pilot own processes and recording systems by end September 2013.

What did we do in 2013/14?

A nursing transfer and discharge summary was developed by Colchester Hospital and the Anglia Community Enterprise has adopted the summary. This has enabled a standardised process to be used for all transfers and discharges of in-patients between Colchester, Clacton and Harwich Hospitals and other residential homes.

There has been further refinement of the process to include developments such as the need for dementia scores and Consultant authorisation for the transfer.

The process has been embedded further and is reflected in Colchester Hospital's transfer and discharge policies.

We have identified that we need to design and implement the process and on-going monitoring of nursing transfer and discharge. A retrospective random audit of 30% of cases discharged per month has been undertaken to enable reporting on performance.

What actions are we planning to improve our performance?

A quarterly audit, by month, will be undertaken to enable on-going reporting on performance.

How will improvements be measured and monitored?
Routine reporting will be agreed and developed to the Patient Safety Committee. Findings on performance will be discussed at this committee, and actions to address any issues identified, agreed and monitored.

Clinical Dashboards

To reduce the rate of patient safety incidents that have resulted in severe harm or death.

Target

Reduction in the rate of patient safety incidents per 100 admissions and the proportion that have resulted in severe harm or death.

In 2011/12 the number of deaths from serious incidents per 100 admissions was 0.013; the number of severe harms from incidents was 0.021.

What did we do in 2013/14?

- We strengthened the use of the World Health Organisation (WHO) Surgical Safety Checklist to promote the safety of patients in the pre, peri and post-operative period.
- We invested in new digital assisted defibrillators throughout the Trust to be used in the event of cardiac arrest.
- We strengthened the use of the national venous thromboembolism prevention and treatment algorithms across the Trust.
- We continued to work on preventing medication errors and falls.

What actions are we planning to improve our performance?

- To increase the use of the Team Simulation for Emergency situations to other clinical teams.
- Introduce the use of the new National Early Warning System which will be audited throughout 2013/14.
- Investigate the use of VitalPac systems to ensure clinical teams intervene early when patients deteriorate.

How will improvements be measured and monitored?

- Through the specialist Morbidity and Mortality meetings.
- Clinical Audit.
- National mandatory audits.

How did we perform in 2013/14 with embedding dashboards for specialised services?

Goals and Indicators

Description of goal	Quality Domain(s)	Indicator number	Indicator name	SHA regional indicator	Indicator weighting
To embed and demonstrate routine use of the use of specialised services clinical dashboards	Safety, Clinical Effectiveness Innovation		Quality Dashboards for Specialised Services	National Specialised Services	

Description of indicator	This indicator is aimed at ensuring that Providers continue to embed and routinely use the required clinical dashboards for specialised services
Numerator	n/a
Denominator	n/a
Rationale for inclusion	
Data source	Providers
Frequency of data collection	Quarterly
Organisation responsible for data collection	
Frequency of reporting to commissioner	Quarterly
Baseline period/date	n/a
Baseline value	n/a
Final indicator period/date (on which payment is based)	End of Q4 2013/14
Final indicator value (payment threshold)	Targets are set out as part of quarterly monitoring and payment requirements.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	TBC
Final indicator reporting date	31st March 2014
Are there rules for any agreed in-year milestones that result in payment?	See quarterly monitoring and payment arrangements
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Friends and Family Test

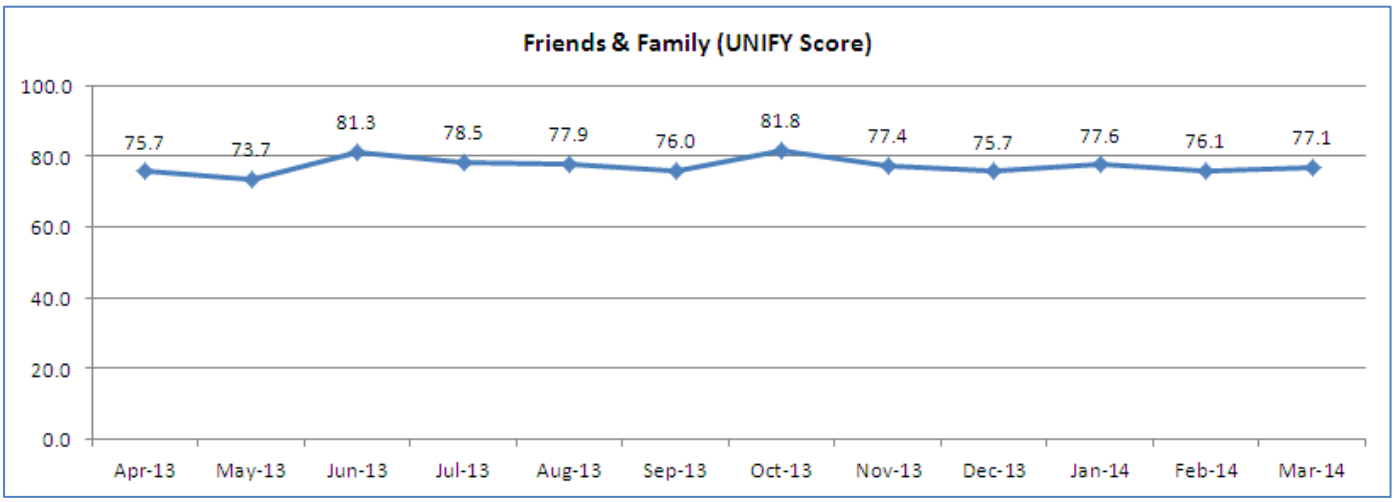
10% of inpatient discharges to be asked the Net Promoter Score question: “How likely is it that you would recommend this service to friends and family?”

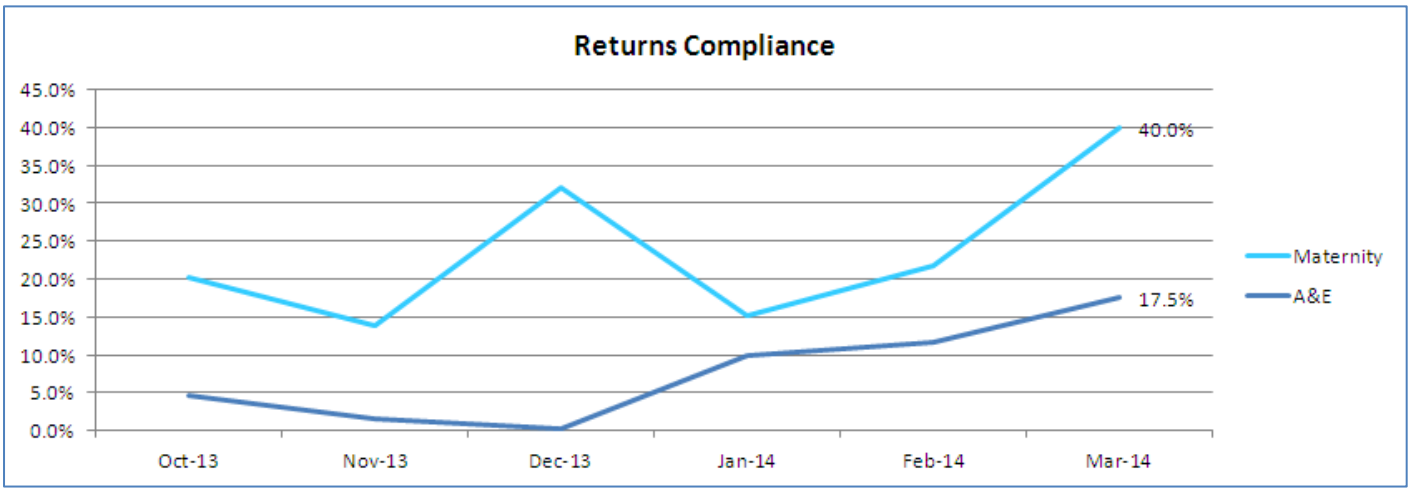
What did we do in 2013/14?

The Friend and Family test was introduced in the Emergency Department and Maternity Services. The graphs below show the return compliance within each area. The introduction of a text messaging service has greatly improved the return compliance which now meets the expected national requirement of 15%.

How did we perform in 2013/14?

The Friend and Family Test has continued successfully over the past year with the Trust showing consistently high scores of > 75. The response rate has remained a consistent level averaging approximately 40% return rate throughout the year.





What actions are we planning to improve our performance?

The feedback and comments from the FFT are displayed on the ward and departments 'You Said / We Did' boards which are updated monthly. Some of the improvement made as result of patient feedback includes:

- Purchase of 'soft close' bins to reduce noise at night.
- Review of food menu and pilot of hot food supper service on surgical wards.
- Improvement of written patient information on discharge for patients following surgery.

Dementia Care

- To increase the proportion of patients screening, assessment and referral of patients identified as potentially having dementia in line with the National Dementia CQUIN.
- Develop a Dementia Awareness training programme for all appropriate staff to complete.
- Supporting carers of people with Dementia.

Target

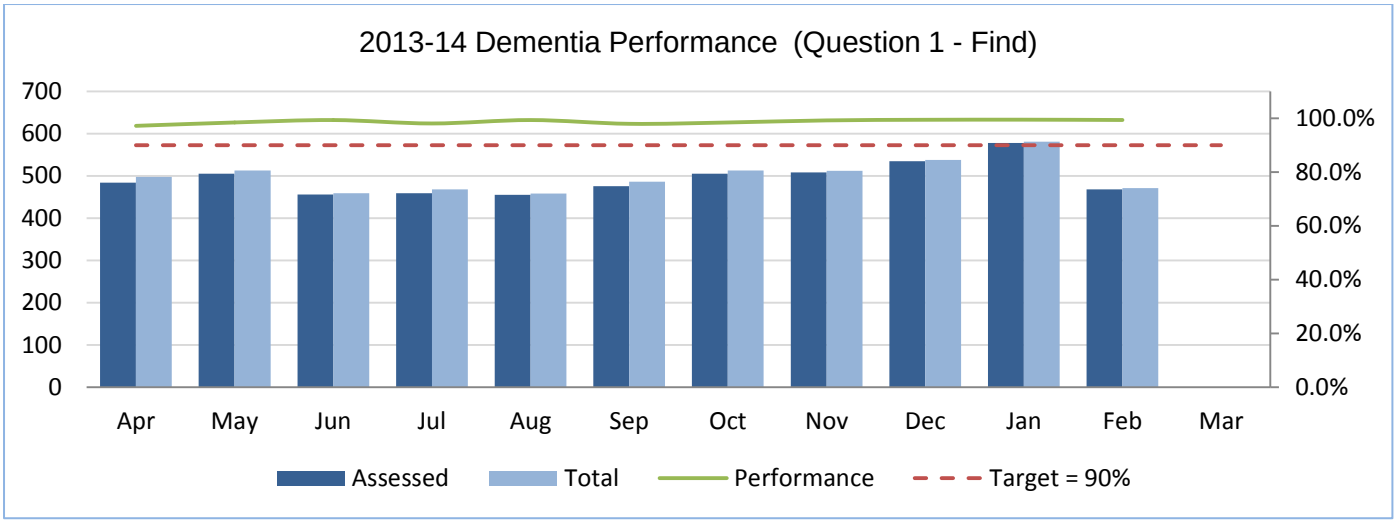
- The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services. To achieve 90% or above against each of the three elements of the indicator.
- Development and implementation of Dementia Awareness Training Programme.
- To establish a monthly audit of carers of people with dementia to test whether they feel supported

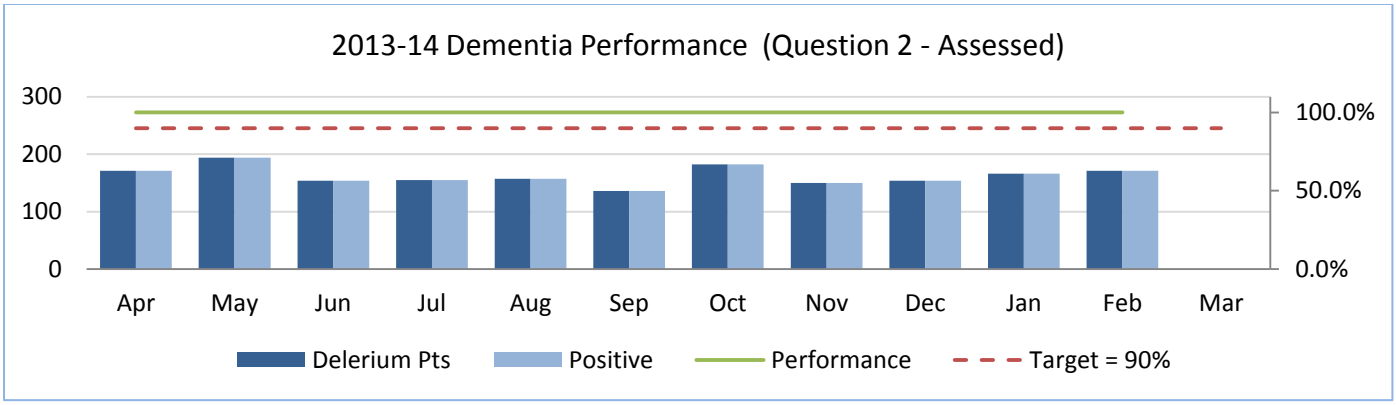
What did we do in 2013/14?

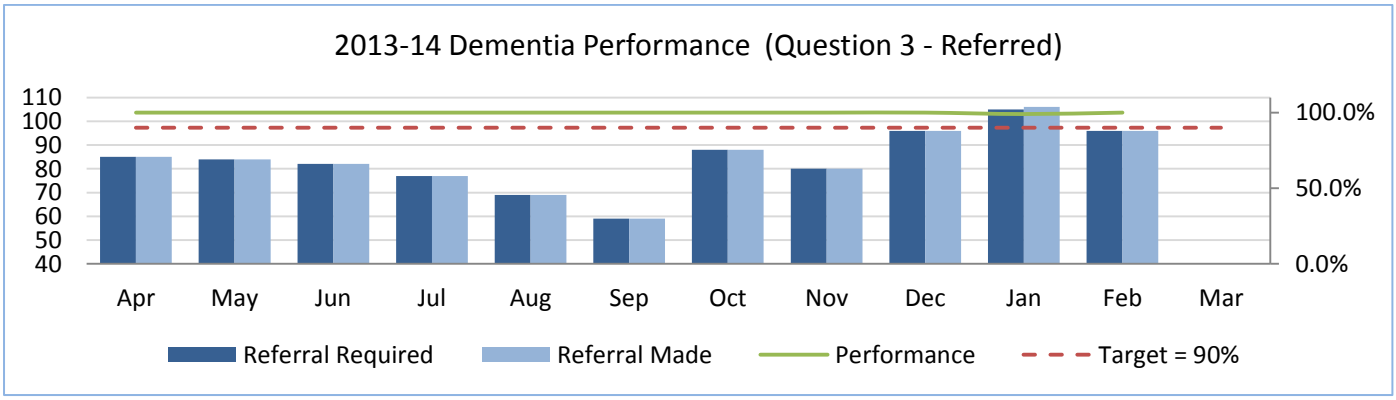
- We funded 2 full time Dementia Care Nurse Specialists to support and improve the care and treatment of patients with a diagnosis of dementia, delirium or signs of cognitive impairment.
- We have established a Dementia Awareness training programme to improve the skills and understanding of clinical staff in the care and treatment of patients with Dementia or clinical signs of Dementia
- All carers of patients who suffer with Dementia receive a questionnaire following discharge from hospital. The aim of the questionnaire is to seek the views and experiences of carers to establish if they feel supported. Findings from these returned questionnaires will help inform necessary changes to the delivery of Dementia care services.
- We have worked with voluntary sectors to establish Dementia Carer ‘drop-in’ session based within the hospital to provide essential information and support.

How did we perform in 2013/14?

- 98.8% of all eligible patients over the age of 75yrs were asked the Dementia case finding questions
- 100% of all identified patients were screened for signs of Dementia
- 99.9% of all patients identified as requiring specialist referral for further diagnostic assessment and advice.







All clinical roles have been aligned to the Dementia Awareness training and training has commenced through e-learning and classroom based sessions. Three members of nursing staff have completed an accredited national Dementia Train the Trainer course. These staff members will provide a more in-depth training programme for staff to improve their skills and knowledge of caring for patients with Dementia.

Questionnaires are sent monthly to carers of patients discharged from the Trust within that month. In Q2 this was done retrospectively and therefore a monthly breakdown is not included. The Trust currently identifies and sends out an average of 10 questionnaires a month and has a 30% response rate.

	Quarter 2 (retrospective)				Quarter 3				Quarter 4 (to date)			
	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total
Number				30	11	10	16	37	10	3		13

Learning themes identified for quarter 2 & quarter 3

- **Theme:** Carer's not always encouraged to share information with staff about their relative during the admission and discharge from hospital.

- **Theme:** Carer's not always being made aware of how to access a Carer's Assessment. Only 27% of respondents were informed by staff how they can access an assessment.

- **Theme:** Carer's not always feeling supported to care for their relative at home.

What actions are we planning to improve our performance?

- Work will continue to sustain the performance relating to the Dementia screening, assessment and referral process as part of this pathway of care

- Dementia Awareness Training trajectories will be agreed and monitored for 2014/15

- Development of in-depth Level 2 Dementia Training programme for key staff

- Themes and trends captured as part of the carers questionnaire will be reviewed and local and Trust wide actions agreed Trust

- The Trust wide implementation of 'This is Me' documents to support person centred care

- Development of a carers information leaflet

- Development of a Trust Patient and Carer Strategy

- Close working between the Trust, social care and voluntary sectors

- Develop the hospital based 'drop-in' sessions for carer support services

How will improvement be measured and monitored?

- To continue with the monthly review of performance outcomes for the screening, assessment and referral of patient with signs of dementia.

- Monthly reporting of training figures against agreed training trajectories.

- Feedback from carers through a carer's forum and user groups following the introduction of The Patient & Carer Strategy and person-centred care initiatives.

Improved End Of Life communication, Gold Standards Framework (GSF) Register

Increasing the use of the GSF through improved discharge communication to GPs.

Target

To support the increase in the number of patients managed on the Gold Standards Framework within North East Essex by identifying more end of life and palliative patients within the acute setting, initiating discussions with them and their families, and ensuring more effective communication via discharge summaries to GPs.

What did we do in 2013/14?

The Health Assessment Team and the Palliative Care Team identified patients that had the potential to rapidly deteriorate or who were confirmed as having end of life status, and whom they'd had appropriate conversations with the patient and family regarding the patient's condition. This was then included in a statement on the Electronic Discharge Summary for the GP, with a request to add the patient to the My Care Choices Register.

How did we perform in 2013/14?

The figures from January 2014 are 74% compliance and February 62% of all patients recognised as rapidly deteriorating and having the statement in their EDS, so therefore with an achievable target of 100% for March the total would only be 79% achievement of the CQUIN with a target of 90% for the final quarter or 2013/2014.

What actions are we planning to improve our performance?

- End of Life Care Facilitator in post to take ownership of the CQUIN and ensure its success.
- To continue this CQUIN into the next financial year as further improvements can be made, and the potential to recognise more End of Life Patients, within the last year of life.
- To facilitate further improvement in communication between the acute and community settings the aim is to educate clinicians in improving the information shared on the EDS. This will include all relevant details pertaining to their condition which will include evidence of DNACPR status, the patients PPC and suggestion of the patient being considered for My Care Choices/end of life care register.
- To educate more ward staff about the My Care Choices register and for staff to access it, whilst that patient is within the acute setting. In this to further support clinicians in recognising more patients at being within the last year of life so that appropriate and timely conversations about advanced care planning can be considered.

How will improvement be measured and monitored?

Through monthly reporting of EDS compliance and monthly reporting of access to My Care Choices register at CHUFT.


Operating Theatres
Operating Theatres
Operating Theatres

Part three

Outline of Quality Improvements Planned for 2014/15 and Statements of Assurance from the Board

This report reflects the Department of Health and Monitor requirements for reporting on quality, as outlined in the 'Detailed Requirements for quality reports 2013/14".

Last autumn, the Trust initiated a process of workshops to engage all staff in developing a Quality Strategy. This is an overarching strategy which is underpinned by a suite of other strategies including the Clinical Strategy. The Quality Strategy gives an overview for the Trust for the next 2-5 years. The key theme of the Quality Strategy is "Your experience is our responsibility". To achieve the Trust's vision of being a place that patients, carers and staff would recommend 100% of the time to their family and friends, the strategy will pave the way for our patients to receive excellent care and have a positive experience delivered by a well-developed and educated workforce. The environment will be safe to ensure no preventable harm and the hospital will strive to put the patient at the heart of everything it does.

Having a Quality Strategy was a requirement of the Keogh Review and the Trust has now identified clear quality objectives which are given equal status with financial sustainability.

There are 5 main quality improvement domains in our Quality Strategy:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Ensuring that people have a positive experience of care
4. Helping people to recover from episodes of ill health or following injury
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

The quality priorities for 2014/15

Key quality priorities for 2014/15 are reflected in the new, integrated Quality Strategy. In determining the priorities, the Trust has aimed to identify areas where current performance needs to improve, focusing most heavily upon preventing loss of life or harm to patients. Priorities also reflect the requirements of external reviews.

Safe Care

1. Ensure strong governance structures that support patient safety and develop an organisational culture that promotes patient safety. Including:
   a. Implement actions from review of committee structures, including empowering leadership of clinicians, in all divisions by 31 March 2015.

2. Work continuously to reduce our incidence of healthcare related infections. Including:
   b. Achieve Trust financial year target for incidence of Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia by 31 March 2015.
   c. Achieve Trust financial year target for incidence of Clostridium difficile by 31 March 2015.

3. Maintain focus on the improvements to standardised hospital mortality indicator. Including:
   a. Design and implement a sustainable model for the safe care of inpatients 24 hours that has been agreed by all key stakeholders, focusing upon recognising and responding to deteriorating patients and reducing preventable cardiac arrests to zero. This is an ongoing objective.
   b. Identify steps to increase the availability of electronic systems to alert medical staff to the deteriorating patient, to all high risk specialities by 31 March 2015.

4. Ensure all our staffing levels are safe and appropriate by completing and implementing regularisation and review of nurse staffing levels and skill mix every six months.

5. Maintain falls screening in EAU above 90% of in patients screened when audited.

6. Maintain 100% compliancy that all Falls with Serious Harm follow the Falls with Serious Harm Protocol.

7. The “Throne Project”, which is a project that aims to reduce the falls in the patient toilet and bathroom areas, has been undertaken including staff education on all 21 identified areas.

8. To have 4 quarters of Falls Prevention Audit on 21 ward areas using the updated Falls Prevention & Bed rails audit completed.

9. To see an increased documentation of daily review and monitoring of patients who have a urinary catheter in place by 31 March 2015.

10. Continue to improve the proportion of patients’ VTE risk assessment by 31 March 2015.

11. To ensure we adhere and are compliant with tissue viability risk assessment and body mapping of patients within 6 hours of admission.

Effective Care

1. Improve the quality and outcome for service users with a fractured neck of femur and fragility fractures.

2. Develop a plan for the introduction of 7/7 day working to avoid wasted days for service users in hospital.

3. Introduce Care Bundles for conditions that affect a large number of patients, where there is evidence of their benefit, aiming at demonstrating a sustained reduction in SMHI in the future. Including:
   a. Demonstrate 90% compliance with these care bundles by September 2014.
   b. Identify other conditions that will benefit by September 2014.

4. Reduce the waiting time that patients wait in the Emergency Department (ED). Including:

   a. By 31 March 2015, ensure that the rapid assessment and treatment (RAT) process is used in ED consistently 24 hours/day, as per current Standard Operating Procedure as part of commitment to continue to meet the DH clinical quality indicator of 50% of total admissions being seen within 1 hour.

   b. Require the individual specialities to arrange patient review in ED such that they are able to meet the agreed internal professional standards by 31 March 2015.

   c. The Trust will continue to work towards achieving timely diagnostics, specialist review and availability of beds to improve the flow of patients in ED.

Patient Experience

1. Improve the way we communicate and ensure that respect, dignity and compassion are at the heart of our relationships with service users. Including:
   a. Improve communication and joint working over End of Life care with GPs, hospices and other providers with particular emphasis on transfer of care.
   b. Improve the experience of care for people with mental illness.

2. Improve the ways in which we communicate with each other, from service to board, from an individual to a whole systems level.

3. Listen to concerns and complaints, ensuring that we respond, act upon and learn from them, promoting an open culture of feedback and improvement and a focus on putting things right at ward level.

Statements of assurance from the Board

Review of services

During 2013/14 Colchester Hospital University Foundation NHS 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 services, focusing on assessment of patient safety, clinical effectiveness and patient experience. We have also recognised the deficiencies identified during the year by the CQC, Keogh and other bodies.

The income generated by the relevant health services reviewed in 2013/14 represents 99.3 % of all the total income generated from the provision of relevant health services by Colchester Hospital University Foundation NHS Trust for 2013/14.

The Trust's draft accounts show:

FTC Code			Income type	Income type	12/13	13/14
140	I-140	5	Non NHS: Private patients	Non NHS: Private patients	1,085	872
145	I-145	6	Non NHS: Overseas patients (non-reciprocal)	Non NHS: Overseas patients (non- reciprocal)	51	84
150	I-150	7	NHS injury scheme (was RTA)	NHS injury scheme (was RTA)	1,280	732
155	I-155	8	Non NHS: Other*	Non NHS: Other	128	143
					237,565	247,287
					98.9%	99.3%

The data reviewed in part three of this Quality Report covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience. In all areas the data has been available to review the service.

A proportion of Colchester Hospital University NHS Foundation Trust's income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between the 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 2013/14 and for the following 12 month period are listed below:

- Friends and family test
- NHS safety thermometer
- Dementia
- Venous Thromboembolism
- National Early Warning Score; reducing harm from deterioration
- Reducing harm through cannulation
- Improved End of Life communication
- Foot checks using the Ipswich Touch Test
- Nursing transfer and Discharge Summary
- Clinical Dashboards
- Neonatal intensive care unit – nutrition in the first weeks of life of premature infants
- Radiotherapy – improving the proportion of radical intensity modulated radiotherapy with level 2 imaging (IGRT)

The monetary total for income in 2013/14 conditional upon achieving quality improvement and innovation goals was planned on 2.5% of Trust. Actual outturn income was circa £5.4m.

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%.

External Audit - CQUINs

The Trust has used CQUINs to continue to make improvements. Following review by external auditors, the need was identified to improve processes to ensure that all CQUINs are systematically and fully monitored and reported upon. One CQUIN was not sufficiently monitored (Nursing Transfer and Discharge Patient Summary – focused to community and residential care). To remedy the situation, a retrospective audit has been underway to enable reporting on performance for 2013/14. Quarterly audits have been added to the Annual Clinical Audit Programme for 2014/15.

National clinical audits and national confidential enquiries are tools that NHS organisations use to assess the quality of services provided, against the best available evidence based guidance and standards.

At Colchester Hospital University Foundation NHS Trust we undertake many clinical audits. We participate in all national audits which are applicable to the organisation. This allows us to benchmark against other hospitals in England. We also have a comprehensive programme of local clinical audits which clinical staff including consultants, junior doctors, nurses and allied health professionals conduct regularly to improve local areas of care.

During 2013/14, 39 national clinical audits and 4 national confidential enquiries covered NHS services provided by the Trust.

During 2013/14 Colchester Hospital participated in 100% national clinical audits and 100% national confidential enquiries in which it was eligible to participate (Table 2).

National confidential enquiries

These are “inspections” that are carried out nationally to investigate areas of care where there may have been problems nationally or where the patients may be particularly vulnerable. All hospitals are asked to take part in them so that all care across England can be monitored.

During 2013/14 Colchester Hospital participated in 4 out of 4, or 100% national confidential enquiries in which it was eligible to participate (Table 2).

The national clinical audits and national confidential enquiries that Colchester Hospital participated in, and for which data collection was completed for the period 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (Table 1 and 2).

Table 1: National clinical audits Colchester General Hospital participated in 2013/14

No.	National Clinical Audit	Participated	% of Participation
1	Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%
2	Emergency use of oxygen (British Thoracic Society)	Yes	100%
3	Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (also known as Medical and Surgical Clinical Outcome Review Programme, or Patient Outcome and Death)	Yes – see below	See below
4	National Audit of Seizure Management (NASH)	Yes	100%
5	National emergency laparotomy audit (NELA) * Contract awarded to The Royal College of Anaesthetists (03.07.12)	Yes	100%
6	National Joint Registry (NJR)	Yes	100%
7	Paracetamol overdose (care provided in Emergency Departments - College of Emergency Medicine)	Yes	0% (In progress)
8	Severe sepsis & septic shock (College of Emergency Medicine)	Yes	0% (In progress)
9	Severe trauma (Trauma Audit & Research Network, TARN)	Yes	100%
10	National Comparative Audit of Blood Transfusion programme	Yes	100%
11	Bowel cancer (NBOCAP) (Subscription funded from April 2012)	Yes	100%
12	Head and neck oncology (DAHNO) (subscription funded from April 2012)	Yes	100%
13	Lung cancer (NLCA) (subscription funded from April 2012)	Yes	100%
14	Oesophago-gastric cancer (NAOGC) (subscription funded from April 2012)	Yes	100%
15	Acute coronary syndrome or Acute myocardial infarction (MINAP) (subscription funded from April 2012)	Yes	100%
16	Adult cardiac surgery audit (ACS)	Not applicable	Not applicable
17	Cardiac arrhythmia (HRM)	Yes	100%
18	Congenital heart disease (Paediatric cardiac surgery) (CHD)	Not applicable	Not applicable
19	Coronary angioplasty (subscription funded from April 2012)	Not applicable	Not applicable
20	Heart failure (HF) (subscription funded from April 2012)	Yes	100%
21	National Cardiac Arrest Audit (NCAA)	Yes	100%
22	National Vascular Registry (elements will include CIA, National Vascular Database, AAA, peripheral vascular surgery/VSGBI Vascular Surgery Database)	Yes	0% (In progress)
23	Paediatric bronchiectasis (British Thoracic Society) (previously part of the Bronchiectasis audit 2010-13)	Not applicable	Did not participate
24	Chronic Obstructive Pulmonary Disease (COPD) * Contract awarded to the Royal College of Physicians (RCP) (17.07.12). Please note: this is NOT the COPD audit run by the British Thoracic Society)	Yes	0% (In progress)
25	Chronic Obstructive Pulmonary Disease (COPD) * Contract awarded to the Royal College of Physicians (RCP) (17.07.12). Please note: this is NOT the COPD audit run by the British Thoracic Society)	Yes	100%
26	Diabetes (Paediatric) (NPDA)	Yes	100%
27	Inflammatory bowel disease (IBD) Includes: Paediatric Inflammatory Bowel Disease Services (previously listed separately on 2010/11 quality reports list)	Yes	100%
28	Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)	Yes	100%

29	Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13)	Yes	100%
30	Elective surgery (National PROMs Programme) – See note below*	Yes	51%
31	Child health programme (CHR-UK) (Also known as the Child Health Clinical Outcome Review Programme)	Not applicable	Not applicable
32	Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
33	Maternal, infant and new born programme (MBRRACE-UK)* (Also known as Maternal, New born and Infant Clinical Outcome Review Programme) *This programme was previously also listed as Perinatal Mortality (in 2010/11, 2011/12 quality accounts)	Yes	100%
34	Moderate or severe asthma in children (care provided in Emergency Departments - College of Emergency Medicine)	Yes	0% (In progress)
35	Neonatal intensive and special care (NNAP) (subscription funded from April 2012)	Yes	100%
36	Paediatric asthma (British Thoracic Society)	Yes	100%
37	Paediatric intensive care (PICANet)	Not applicable	Not applicable
38	National Audit of Intermediate Care	Not applicable	Not applicable
39	Rheumatoid and early inflammatory arthritis (new NCAPOP topic under development)	Yes	0% (In progress)

N.B.: Regarding PROMs programme - the Trust submission figures are reliant on patients completing and returning questionnaires.

Table 2: National Confidential Enquiries in which Colchester was eligible to participate in 2013/14.

No.	National Enquiry into Patient Outcomes and Death Study	Participated?	Cases returned (%)
1	Lower Limb Amputation	Yes	71.4%
2	Tracheostomy Care	Yes	81.3%
3	Subarachnoid Haemorrhage	Yes	60.0%
4	Alcohol-Related Liver	Yes	66.7%

The reports of 14 national clinical audits were reviewed by Colchester Hospital University NHS Foundation Trust (CHUFT) in 2013/14 and CHUFT has taken or intends to take the following actions to improve the quality of healthcare provided:

Table 3: National clinical audit reports published during 2013/14 and actions taken

No.	Report	Actions Taken
1	National Joint Registry (NJR)	Report disseminated
2	Bowel cancer (NBOCAP) (Subscription funded from April 2012)	Report disseminated
3	Lung cancer (NLCA) (subscription funded from April 2012)	Report disseminated
4	Acute coronary syndrome or Acute myocardial infarction (MINAP) (subscription funded from April 2012)	Report disseminated
5	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) *Please note all elements must be reported in quality report	Recommendations reviewed
6	Diabetes (Paediatric) (NPDA)	Report disseminated
7	Falls and Fragility Fractures Audit Programme (FFFAP), includes National Hip Fracture Database (NHFD)	Report disseminated
8	Vascular surgery (VSGBI Vascular Surgery Database)	Report disseminated
9	Oesophago-gastric cancer	Report disseminated
10	National Audit of Dementia	Report disseminated
11	Bowel cancer (NBOCAP)	Report disseminated
12	Head and neck oncology (DAHNO)	Report disseminated
13	Neonatal intensive and special care	Report disseminated
14	Heavy Menstrual Bleeding	Report disseminated

Table 4: National Confidential Enquiries that published reports during 2013/14 and actions taken

No.	National Enquiry into Patient Outcomes and Death Study	Actions Taken
1	Alcohol Related Liver Disease Measuring the Units	Report disseminated
2	Subarachnoid Haemorrhage: Managing the Flow	Report disseminated

The reports of 90 local clinical audits were reviewed by Colchester Hospital University NHS Foundation Trust (CHUFT) in 2013/14 and CHUFT intends to take the following actions to improve the quality of healthcare provided:

Table 5: Completed Local Audits

Medicine Division No.	Audit	Outcome
1	Management of Sepsis	Increase awareness of sepsis management targets; re-audit
2	Paracetamol Overdose in A&E:	Improve proforma in ED
3	Returns to ED within 72 hours	Improve process re escalation to consultant and documentation
4	Re-audit Diagnosis of Pulmonary embolism against nice guideline CG144	Increase awareness with poster in ED and EAU
5	Inpatient falls leading to moderate severe harm:	No actions required
6	Audit of pain relief prescribing in elderly palliative care patients:	Improve rates of prescribing for anti-emetics and paracetamol
7	Re:audit Acute allergic reaction:	Continue e-learning education
8	CQUIN Parkinson's audit:	Design integrated in-patient pathway
9	Review of pre-alert cases for January 2013:	Provide laminated form in pre-alert book; relocate phone into resuscitation; discuss changes
10	Parkinson's nurse service patient satisfaction survey:	Continue effort to ensure timely clinics and responding to phone messages
11	MS Service survey:	Patient information leaflet
12	Cardiac angio suite patient satisfaction survey:	Monitor room temperatures
13	Patients with renal failure / kidney injury on the LCP:	Re-design LCP prescription chart with reminder re action to take
14	Mortality audit in older patients (Aged 65-89) and oldest old (>90 years) during acute medical admission:	Education doctors re importance of postural blood pressures in patients who fall and documenting clinical assessment
15	Endoscopy Cancellation Audit	Improve guidelines and communication; out of hours box for requests
16	Are antipsychotics in dementia patients being prescribed according to NICE guidelines?	Presentation to GPs and psychogeriatricians; re-audit
17	Assessment and administration of analgesia in the ED	Improve assessment at triage and documentation; staff education
18	Pneumothorax in ED	Improve documentation with referencing to the guidelines during care
19	Emergency department pre-alert audit	Re-emphasise use of blue stickers and documenting patient details
20	ACS management - NICE guidelines	Doctors to use risk scoring system; awareness in induction
21	RATing in ED	Improve documentation; education re RAT
22	Head Injury - CT standard	Provide laminated guidelines all departments; education of junior; re-audit
23	Door to needle time in septic patients attending A&E	Improve 1 hour target compliance; education junior doctors; introduce named nurses
24	Epistaxis in ED	Education
25	Ward round checklist in EAU	Improve documentation, checking and process; pilot checklist
26	Pain management in adults and children in the emergency department audit	Improve assessment, recording and prescription for pain relief as per guidelines; educate ED staff
27	Management of abdominal pain in ED	Documentation to include testing of women of reproductive age; improve communication with seniors; need for ultrasound above age 65
28	Re-audit: Endoscopy cancellations	Further meetings to enforce new process
29	Prescription of Eye Drops on the Emergency Assessment Unit	Produce information sheet;re-audit

30	ERCP Audit	Staff training; monitoring patients post ERCP
31	Insulin pump audit	Implement 2011/12 audit; make national presentation
32	IV Therapy	Actions to promote education
33	Medication Stoppages and holdings Care of the Elderly	Practice change re-documenting stoppages
34	Management of Fractured Neck of Femur (NOF) in the Emergency Department	Re-launch fractured NOF pathway in ED; actions re-education all nursing/medical staff
35	Diagnosis in Bronchoscopy Biopsy Rates at Colchester General Hospital	No actions required
36	Sepsis screening on admission: what is our compliance rate?	Actions to promote education; further audit
37	Management of shoulder injuries in A&E	Further research required, actions to promote education
38	Management of Severe Sepsis and Septic Shock in the Emergency Department	Actions to promote education of all new junior doctors; improve doctor-nurse communication.
39	Management of suspected pulmonary embolus in the Emergency department	Devise guidelines; re-audit
40	Audit of NICE CG79 & QS33	Consider systems for rapid access appointments and review
41	AKI re-audit	No actions required
42	Use of alendronate for osteoprotection in the management of elderly patients with fracture transferred to Clacton Hospital. Re-audit	Actions identified prior to transfer of patients.
43	Sepsis screening on admission; what is our compliance rate?	Research into causes of delays needed; staff education
44	Management of severe sepsis and septic shock in the Emergency Department	Education about new standards; improve communication between nurses and doctors
45	Management of Abdominal Aortic Aneurysms (AAA) in ED at CHUFT between 01.11.12 and 01.11.13	Devise guidelines; re-audit
46	Management of suspected pulmonary embolus in the ED	Circulate presentation to consultant teams; poster
47	The Green book	Re-audit in 3 months
48	Audit of NICE CG79 and QS33	Consider rapid access appointment system; increase facilities for patient review
49	Endoscopy patient survey 2013	Information leaflets; change working hours; process changes admission and consent
50	DNACPR Decision Making at CHUFT	Re-audit
51	Assessment of RAT procedure in the ED (Rapid Assessment Team)	Dedicated RAT bay in Majors to streamline RAT procedure
52	Pain and comfort score	Amend audit tool
53	Gout Management Audit	Education
54	Clinical management of patients referred for headache at referral and after first visit	During review of referrals, consider recommendation to GPs re treatments not already used; GP training re NICE guidelines
55	Deaths occurring within 24 hours of arriving into A&E department	Improve awareness of resuscitation proforma; consider audit of NEWS
56	AF management (Atrial fibrillation)	Presentation of learning at Grand Round
57	Re-audit AF management	Promote awareness with fliers
58	Assessment of inter-hospital transfers for neurosurgery and primary coronary angiography from the ED	Further audit into reasons for delay in transfers

Surgery Division		
No.	**Audit**	**Outcome**
1	Orthoptic Patient Satisfaction survey 2013	Remind parents of staff names; more toys to test children; business case to improve capacity
2	Tidal volumes used for ventilation in theatres	Increase anaesthetists' awareness of lowering tidal volumes
3	DNA Audit	Make telephone contact instead of letter to patients
4	Observation and Audit of ICU Readmissions at CGH	Documentation of doctor to doctor handovers and time taken for doctor to review patient on ward
5	Using P-Possum Scoring to identify the high risk surgical patient requiring emergency laparotomy	Increase use of P –possum
6	Reducing unnecessary pre-operative testing in ENT surgery: clinical and financial implications	Actions to promote education
7	An audit to evaluate the management of patients admitted to CHUFT with epistaxis between 04/04/13 – 07/07/13.	Actions to promote awareness of protocol
8	Completion of VTE Risk Assessments in Trauma and Orthopaedics	Raise awareness of staff on Copford ward; re-iterate importance of assessment for every inpatient

Clinical Support Services & Cancer Division		
No.	**Audit**	**Outcome**
1	Lung Cancer Patient Support and Information Giving Survey	Ensure Macmillan information is provided; provide hearing loop system in consultation areas
2	Are Squamous cell and Breast cell carcinomas being adequately excised as per the British Association of Dermatologists (BAD) guidelines?	Increase excision margins in high risk squamous cell carcinomas; re-audit
3	CT Pneumocolon Patient Satisfaction Questionnaire	Increase time explaining to patients; review information sheets
4	Audit of MRI Spine requests in CHUFT patients with suspected Metastatic spinal cord compression	Business plan for co-ordinator; extra sessions

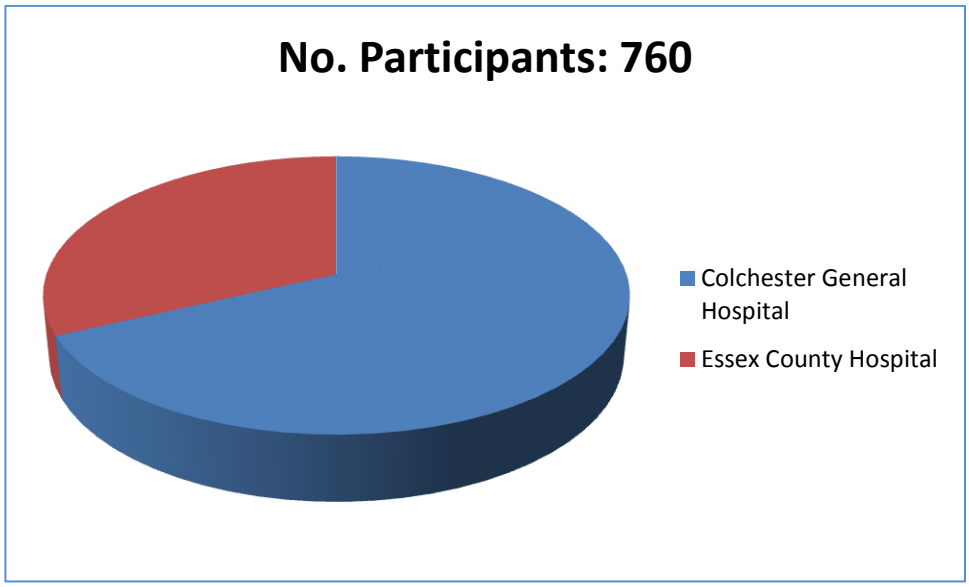
Women, Children and Genito-Urinary Medicine Division		
No.	**Audit**	**Outcome**
1	Antibiotic prescribing for community acquired pneumonia in children	Discussion with microbiology; MDT presentation; re-audit
2	Instrumental Delivery Audit	Presentation MDT; paediatrician to be present for all trials; improve theatres documentation and during labour
3	EPU Audit	EPU information booklet for junior doctors; process improvements with observations stamp and on emergency board
4	Patient satisfaction survey for experience at sexual health clinics	All staff to receive results; increase explanation and listening time with patients
5	Obesity in Children with Autism Spectrum disorder	Devise guideline, record BMIs and discuss with local public health team re lifestyle programmes
6	Prolonged Jaundice in Neonates	Cases to be added routinely to Doctors' job lists to ensure follow up; documentation of discussion with parents in notes
7	Re-Audit: The appropriate use and documentation of ICP in acute gynae and early pregnancy unit	Devise new booklet for junior doctors
8	Audit on Initial Health Assessment s of looked after children 2013	Actions identified
9	Does hysteroscopy lead to cancer cell spread in women with suspected endometrial cancer?	Present findings at conference
10	Audit on Bronchiolitis	Actions identified
11	Quality of referrals for ADOS (Autism diagnosis observation schedule).	Prepare leaflet/guidance, re-audit
12	Audit of NICE guidelines for recognition, referral and diagnosis of children and young people on the autism spectrum.	Need to increase clinic capacity; requirements for examination of patients
13	Audit of NICE guidelines for recognition, referral and diagnosis of children and young people on the autism spectrum	Increase clinic capacity; raise awareness of need for skin examination
14	Safeguarding of adolescents admitted to EAU	Daily safeguarding presence of EAU; increase awareness; process changes with access to information; discharge summary training
15	Stand and deliver	No actions required

16	Review of incomplete medical terminations	No actions required
17	Febrile neutropenia; How are we doing?	No actions required
18	Are routine immunisations being given “on time” in NICU?	No actions required
19	Meningitis protocol	Improve documentation of fluid status/reasons behind fluid decisions
20	Management of headaches in children and young people	Information leaflet; make Triptan available on CARU, explore use of acupuncture and guidelines

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 745. See charts below for details:

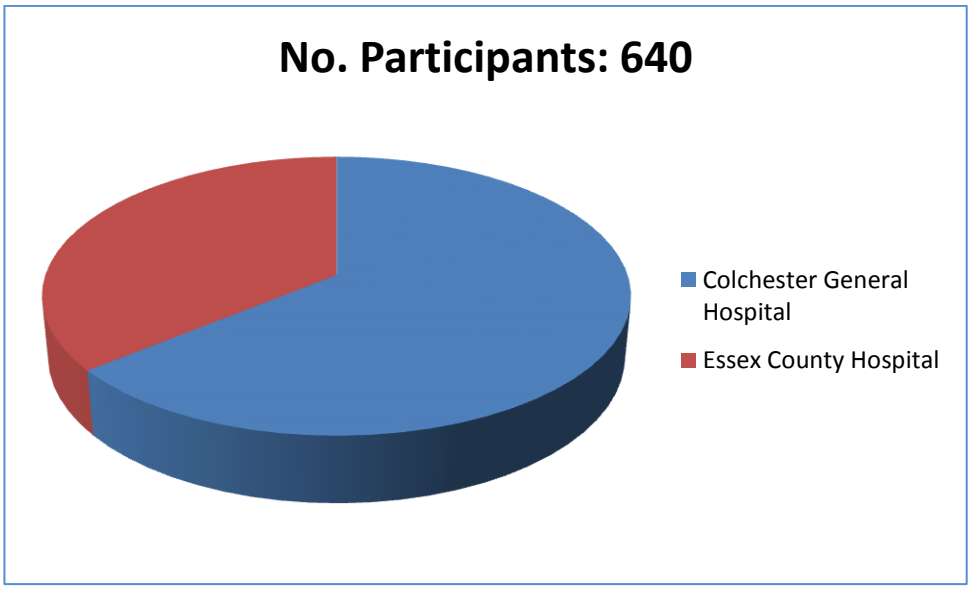
Number of patients recruited into NIHR CRN Portfolio studies

The trust was reported as recruiting 760 participants into portfolio studies for 2013/14 against a target set at 800 participants.

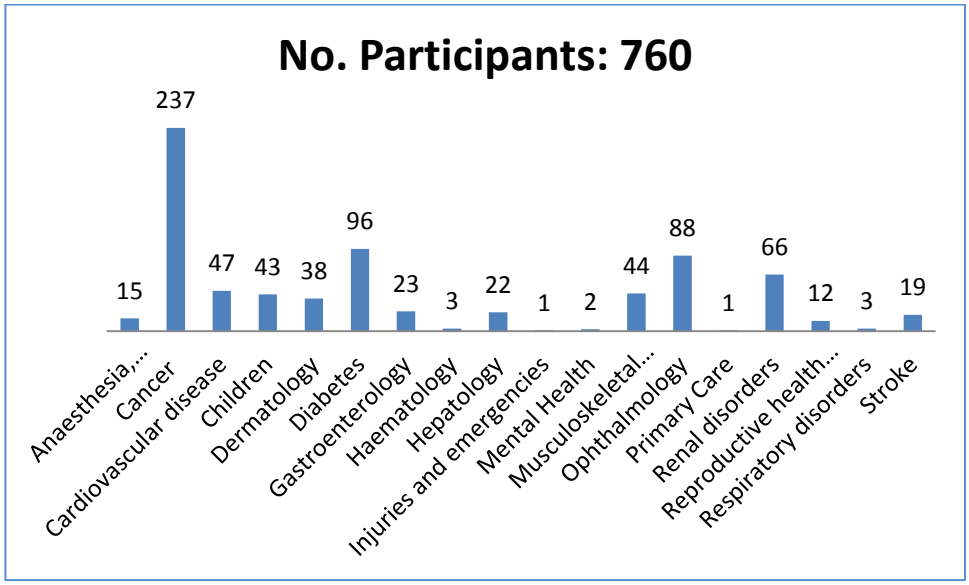


This compares with 640 patients recruited the previous year.

The trust was reported as recruiting 640 participants into portfolio studies for 2012/13 against a target set at 800 participants,

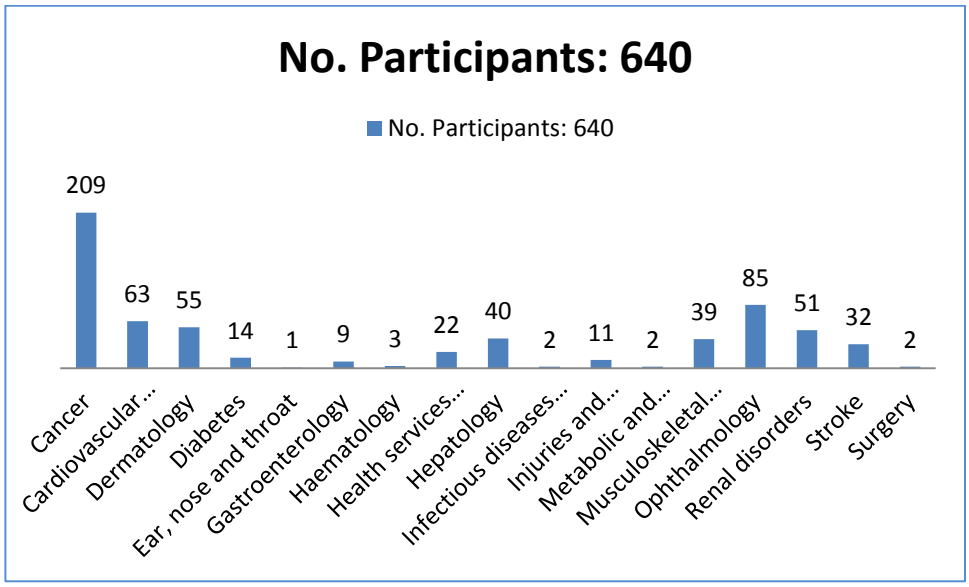


Participant recruitment by Speciality: 2013/14



All patients recruited to Haematology studies which are registered with the NCRN are reported as recruitment to Cancer

Participant recruitment by Speciality: 2012/13



Use of the CQUIN payment framework

The Commissioning Quality and Innovation (CQUIN) payment framework is a method that the NHS introduced in 2009/10 to reward hospitals and other NHS services for implementing quality and innovative patient care initiatives. If hospitals did not achieve their CQUIN targets then, in 2010/11, 1.5% of a hospital's income was removed and, in 2011/12 and onwards, 2.5%. In challenging financial times for the NHS it is important that quality initiatives are linked to a financial lever to ensure that the front line staff and the Board are able to prioritise quality care.

In 2013/14 the CQUINs the Trust undertook to deliver are:

- Friends and family test
- NHS Safety Thermometer
- Dementia
- Venous Thromboembolism (VTE) prevention
- National Early Warning Score: reducing harm form deterioration
- Reducing harm through cannulation
- Improved End Of Life Communication
- Foot checks using the Ipswich Touch Test
- Nursing transfer and Discharge Summary
- Clinical Dashboards
- Neonatal Intensive Care Unit (NICU) - nutrition in the first weeks of life of premature infants
- Radiotherapy - Improving the proportion of radical intensity modulated radiotherapy with level 2 imaging (IGRT)

Statements from the Care Quality Commission (CQC)

Colchester Hospital University NHS Foundation Trust is required to register with the Care Quality Commission. The Trust is not fully compliant with the registration requirements of the Care Quality Commission.

Specifically in the November 2013 report, the CQC found that the Trust was failing to achieve the required standards in relation to:

- Care and welfare of people who use services (Regulation 9) [CQC judgement – Action Needed]
- Assessing and monitoring the quality of service provision (Regulation 10) [CQC Judgement - Enforcement Action Taken]
- Records (Regulation 20) [CQC Judgement – Action Needed]

The Care Quality Commission has taken enforcement action against Colchester Hospital University NHS Foundation Trust during 2013/14

Colchester Hospital University NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14.

Visit dates	Areas
22, 27 & 28 August 2013	Concerns received regarding cancer waiting times specifically in urology and lower gastrointestinal.
3,18,19 & 25 September 2013	As above

Colchester Hospital University NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC.

- Audit outcome of referrals
- Review clinical pathways
- Capacity and Demand study
- Implementation of Somerset cancer database
- Appointment of Project manager team to manage the change process

Colchester Hospital University NHS Foundation Trust has made the following progress by 31 March 2014 in taking such action:

- Somerset implemented with further work required to fully embed into systems and processes
- Recruitment into key vacant clinical post
- Patient pathways reviewed and awaiting ratification
- Review of policy and procedures awaiting ratification
- Audit of 2 week wait pathways

Good quality information is very important in underpinning the effective delivery of the best patient care.

Colchester Hospital University NHS Foundation Trust submitted records during 2013/14 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 99.8% for admitted patient care, 99.95% for outpatient care, and 99.24% for accident and emergency care.

The percentage of records that included the patient's valid General Practitioner Registration Code was 99.92% for admitted patient care, 99.96% for outpatient care and 99.61% for accident and emergency.

These figures are calculated:

- admitted patient care – hospital spell discharge date between 01.04.2013 and 31.03.2014
- outpatient care – appointment date between 01.04.2013 and 31.03.2014
- accident and emergency care – arrival date between 01.04.2013 and 31.03.2014
- percentage with valid NHS number is calculated allowing for 'unrequired' and 'sensitive' records to be blank
- percentage with valid General Medical Practice Code is calculated using the National code for unknown i.e. 'V81999'

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

- The Data Quality Team monitor any missing NHS numbers and any GPs that are free text or unknown and identify the missing numbers

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

- The Data Quality Team monitors any trends with the quality of the data.
- PAS trainers are identified to support specific front line staff who may require training to improve the quality of data.

During 2013/14, Colchester Hospital University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit.

Below is the summary of coders' errors from an internal departmental audit submitted to Information Governance for the 2013/14 financial year. The results should not be extrapolated further than the actual sample audited.

The services reviewed were Gynaecology and Trauma and Orthopaedics:

	Trauma & Orthopaedic 2013/2014		Gynaecology 2012/2013	
	Total of FCE's Audited	% Incorrect	Total of FCE's Audited	% Incorrect
Primary Diagnosis	100	12.0%	100	14%
Secondary Diagnosis	536	9.3%	120	21.7%
Primary Procedures	76	16.7%	89	14.6%
Secondary Procedures	44	23.2%	104	16.3%
Overall	756	11.3%	414	N/A

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

- Internal Trust audits are carried out by an approved experienced clinical coding auditor, using methodology in accordance with the NHS Connecting for Health Audit methodology version 7.
- All specialities are sampled.
- The accuracy and completeness of the clinical coded data is checked against the source document itself e.g. the health record.

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

- On-going individual/departmental audits and training will continue which will include practicing indexing. The aim is to increase the consistency of accurate coding.

Colchester Hospital University NHS Foundation Trust's Information Governance Assessment Report overall score for 2013/14 was 93% and was graded green.

The published score in March 2014 of 87% marks an improvement on the interim submission score in October 2013 of 77%. Furthermore, the Trust scored a minimum of Level 2 on all 45 requirements. Our final position is: satisfactory (Green). The Information Governance Toolkit is available on the Connecting for Health website (www.igt.connectingforhealth.nhs.uk).

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

- Information/evidence is uploaded directly to the IG toolkit.

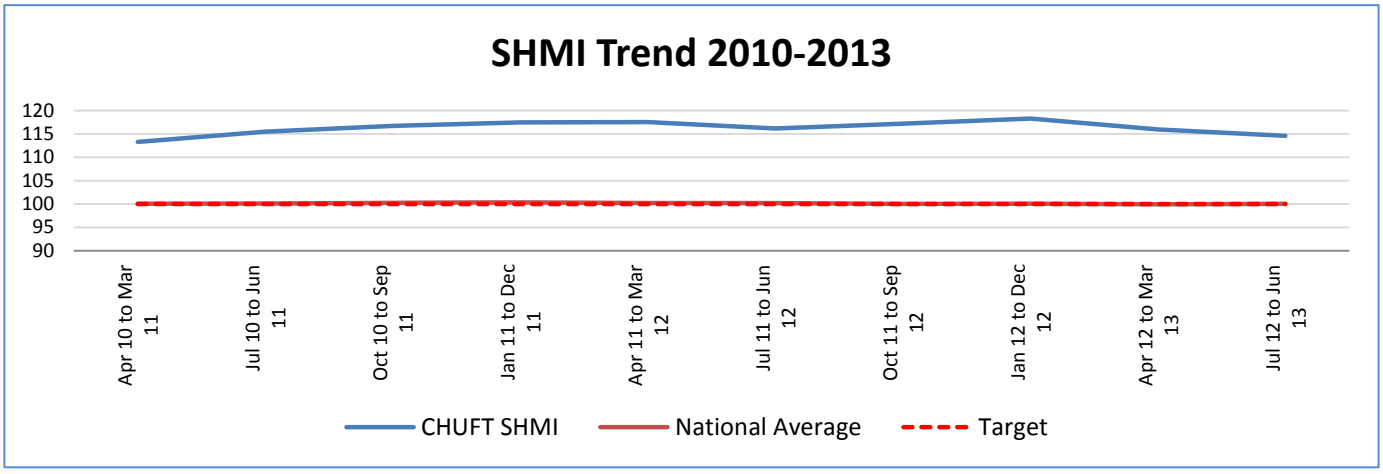
Colchester Hospital University NHS Foundation Trust intends to take/has taken the following actions to improve this published score and so the quality of its services, by:

- An action plan is completed to maintain an evidenced level 2 submission against all 45 requirements
- This is monitored by the Confidential Information Steering Group chaired by the Medical Director in his role as Caldicott Guardian or by the Director of Finance as Senior Information Risk Owner (SIRO).

Part four

Reporting against core indicators (previous year's performance)

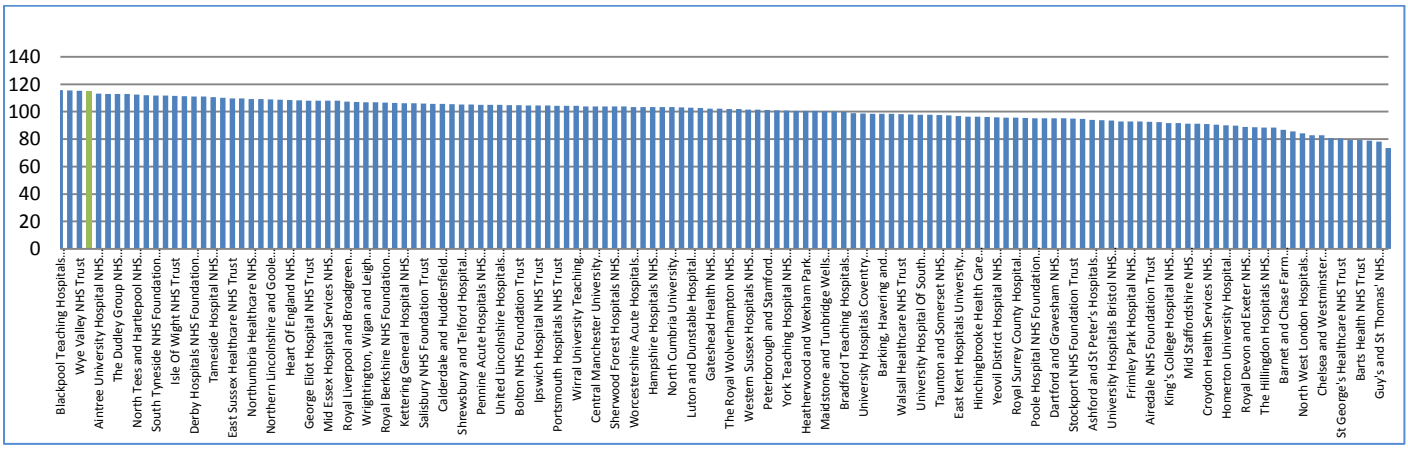
The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period *(Monitor 12a).*



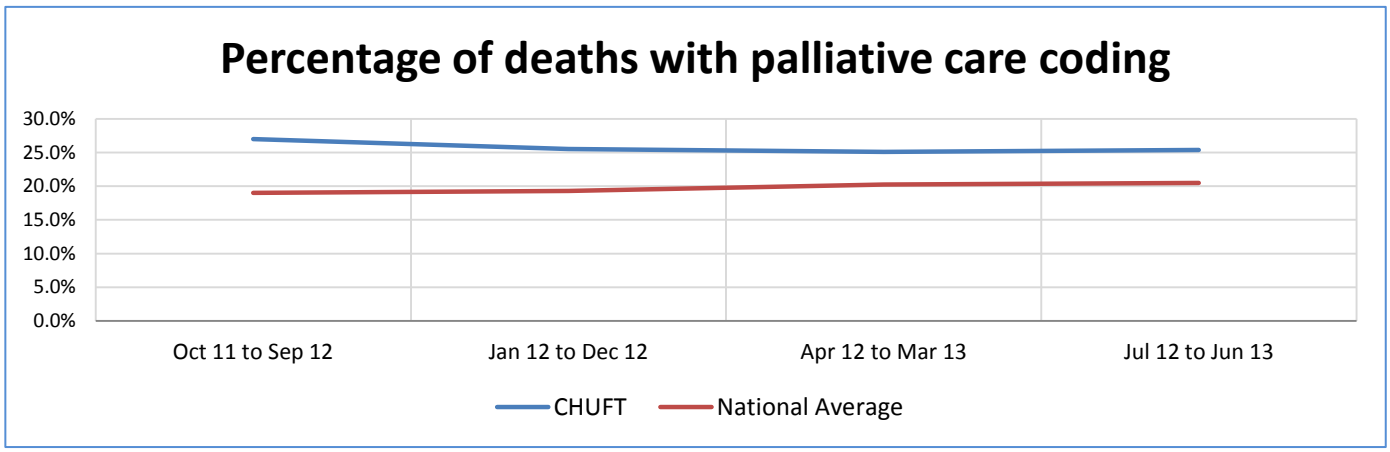
	CHUFT SHMI	National Average	Target
Apr 10 to Mar 11	113.34	100.09	100
Jul 10 to Jun 11	115.50	100.13	100
Oct 10 to Sep 11	116.77	100.27	100
Jan 11 to Dec 11	117.50	100.37	100
Apr 11 to Mar 12	117.59	100.23	100
Jul 11 to Jun 12	116.19	100.22	100
Oct 11 to Sep 12	117.22	100.05	100
Jan 12 to Dec 12	118.32	100.09	100
Apr 12 to Mar 13	115.97	99.97	100
Jul 12 to Jun 13	114.61	100.07	100

Provider	SHMI Spells	SHMI	Obs	Exp	95% CI
The Whittington Hospital NHS Trust	34885	62.59	539	861.16	57.42-68.10
Blackpool Teaching Hospitals NHS Foundation Trust	54727	115.63	2413	2086.8	111.06-120.34

SHMI by provider (all non-specialist acute providers) for all admissions in July 2012 to June 2013

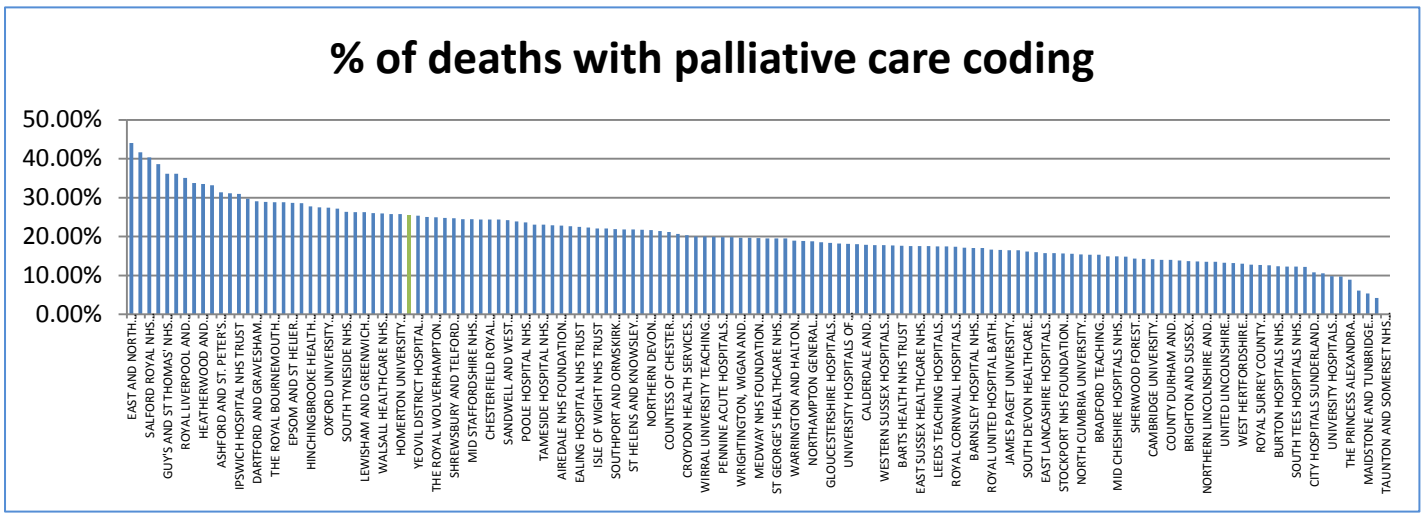


The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period *(Monitor 12b).*



	Colchester Hospital	National Average
Oct 11 to Sep 12	27.0%	19.0%
Jan 12 to Dec 12	25.5%	19.3%
Apr 12 to Mar 13	25.1%	20.3%
Jul 12 to Jun 13	25.4%	20.5%

Provider	Denominator	Treatment Numerator	Diagnosis Numerator
Taunton and Somerset NHS Foundation Trust	1590	0	0
East and North Hertfordshire NHS Trust	2379	165	1048



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

- The data is prepared, published and analysed by Dr Foster, an external national organisation.

Colchester Hospital University NHS Foundation Trust intends to take/has taken the following actions to improve its performance:

- Actions are identified in detail in the Mortality report included earlier in the Patient Safety section of this report

Percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the Trust during 2013/14 *(Monitor 16):*

The metrics reported upon for this indicator are represented in the chart below:

Metric	Standard	Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
% of patients spending at least 90% of their time on a stroke unit	VS / EoE / ASI / KPI / BPT	80%	100.%	95.00%	83.33%	91.97%	86.00%	85.19%	83.33%	84.93%
Proportion of pts admitted directly to an acute stroke unit in 4hrs of arrival	ASI / BPT	90%	88.%	82.05%	81.13%	83.94%	74.00%	86.54%	73.68%	78.57%
% all stroke patients with access to a brain scan within 60 minutes	EoE / ASI	50%	75.61%	64.10%	80.00%	74.07%	70.83%	71.15%	76.19%	72.54%
% patients receiving Thrombolysis within 3 hours of onset	EoE	12%	13.89%	9.68%	6.52%	9.73%	11.11%	13.64%	2.56%	9.38%
% Total thrombolysed patients	EoE	N/A	21.95%	14.71%	16.33%	17.74%	18.00%	12.00%	2.50%	11.43%

Metric	Standard	Target	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD
% of patients spending at least 90% of their time on a stroke unit	VS / EoE / ASI / KPI / BPT	80%	91.89%	76.74%	90.91%	86.67%	83.72%	74.51%	76.09%	77.86%	85.30%
Proportion of pts admitted directly to an acute stroke unit in 4hrs of arrival	ASI / BPT	90%	75.00%	71.79%	82.69%	77.17%	67.57%	69.57%	71.74%	69.77%	77.49%
% all stroke patients with access to a brain scan within 60 minutes	EoE / ASI	50%	88.57%	63.41%	82.69%	78.13%	62.86%	75.56%	66.67%	68.80%	73.40%
% patients receiving Thrombolysis within 3 hours of onset	EoE	12%	6.25%	19.35%	18.60%	15.09%	9.09%	20.00%	7.32%	11.93%	11.40%
% Total thrombolysed patients	EoE	N/A	11.76%	18.92%	17.65%	16.39%	16.67%	26.19%	15.91%	19.67%	16.14%

The quality of stroke care provided at Colchester General Hospital is in the top two hospital trusts in England, Wales and Northern Ireland, according to the Royal College of Physicians (RCP). The RCP Clinical Audit of stroke patients who were admitted to hospital in the three months from July last year shows Colchester was the second best-performing out of the 175 hospital trusts that admit stroke patients directly for acute stroke care.

The RCP website has additional more detailed data on Colchester's performance with stroke.
https://www.strokeaudit.org/

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

- All key steps of the patient's pathway are recorded and timed by the staff involved. This includes the timings from admission to the patient having a CT scan and time from admission to thrombolysis "door-needle".
- The timings and data are entered electronically and also on documentation.
- There is on-going audit and review of the data by stroke specialists.
- There are supernumerary Acute Stroke Nurse Specialists working 24/7
- The Trust participates in the National Stroke Audit
- Stroke metrics have been designed to improve the quality of care stroke. They focus mainly on

the acute assessment, treatment, timing and intensity of rehabilitation. Stroke metrics cover a wide range of important care quality indicators which influence the patient outcomes. Certain metrics are considered to be core ones; such as patients admitted directly to stroke unit within 4 hours and patients spending 90% of hospital stay in a stroke unit will ensure they receive appropriate and high quality specialist care. Further, scanning within 60 minutes is important in ruling out other conditions which can mimic stroke and differentiating the two types of stroke. Early clot busting treatment is an effective treatment for a minority of patients and it has been shown to be effective in reducing disability following stroke. These metrics require excellent collaboration between various departments such as the Stroke Unit, Emergency Department and Radiology.

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

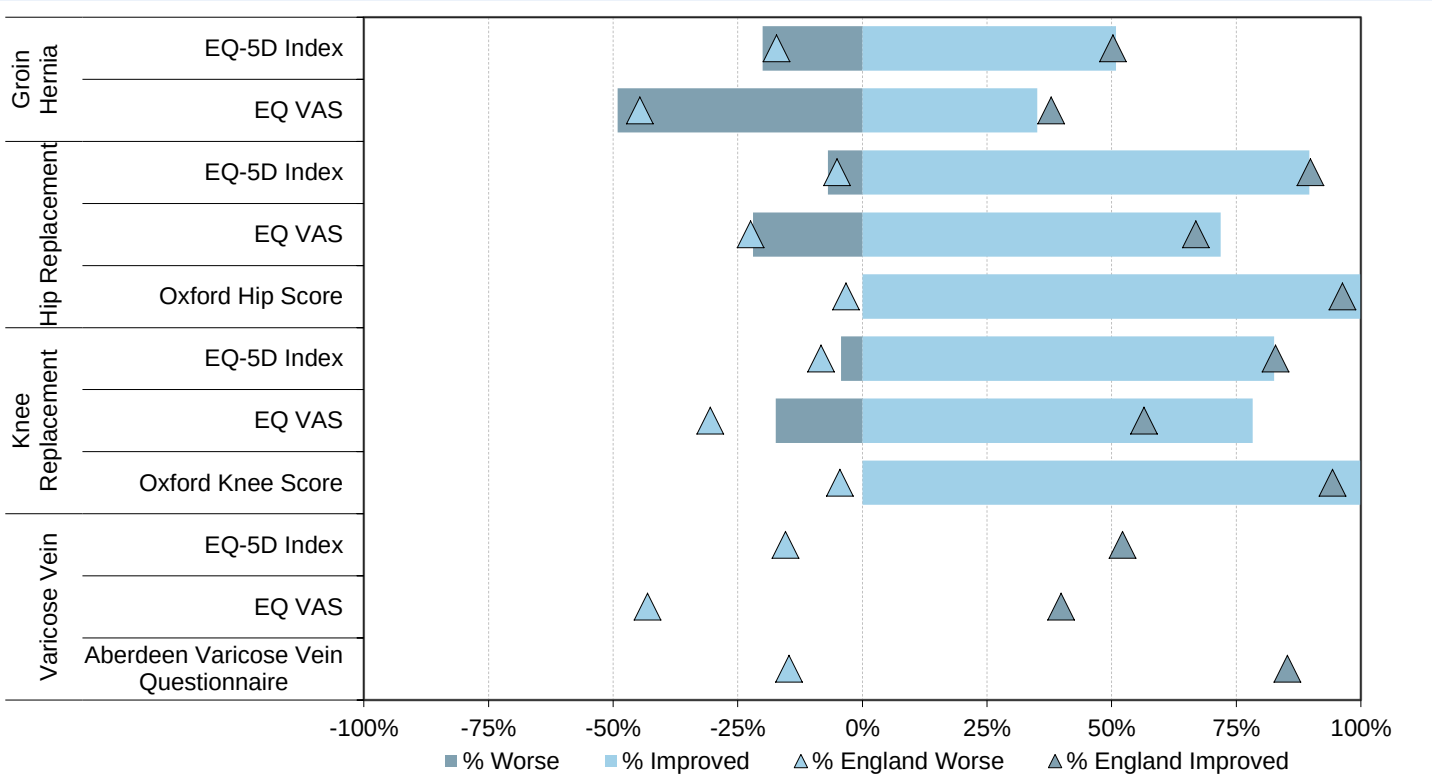
- Continue on-going weekly monitoring and review of stroke performance data by Nurse Stroke Consultant, Stroke Consultants, ward sister, Acute Stroke Nurse, therapists and radiographer and others.
- Education about the stroke pathway is given and personal feedback can be given to individual staff.

The Trust's Patient Reported Outcome Measures (PROMs) scores *(Monitor 18)* during 2013/14 for:

i. **Groin hernia surgery**
ii. **Varicose vein surgery**
iii. **Hip replacement surgery**
iv. **Knee replacement surgery**

April 2013 to September 2013, provisional data (published 13th February 2014)

Percentage of patients that have improved for each procedure and scoring mechanism (unadjusted)



	Percentage improving	EQ-5D Index	EQ VAS	Condition Specific
Procedure	Groin Hernia	50.9%	35.1%	N/A
	Hip Replacement	89.7%	71.9%	100.0%
	Knee Replacement	82.6%	78.3%	100.0%
	Varicose Vein	*	*	*

	Number improving	EQ-5D Index	EQ VAS	Condition Specific
Procedure	Groin Hernia	28	20	N/A
	Hip Replacement	26	23	35
	Knee Replacement	19	18	27
	Varicose Vein	0	*	*

	Percentage getting worse	EQ-5D Index	EQ VAS	Condition Specific
Procedure	Groin Hernia	20.0%	49.1%	N/A
	Hip Replacement	6.9%	21.9%	0.0%
	Knee Replacement	4.3%	17.4%	0.0%
	Varicose Vein	*	*	*

	Number getting worse	EQ-5D Index	EQ VAS	Condition Specific
Procedure	Groin Hernia	11	28	N/A
	Hip Replacement	2	7	0
	Knee Replacement	1	4	0
	Varicose Vein	*	0	0

Key Facts:

EQ-5D Index (a combination of five key criteria concerning general health)

- 50.9% of groin hernia respondents recorded an increase in their EQ-5D Index score following their operation (50.3% in England).
- 89.7% of hip replacement respondents recorded an increase in their EQ-5D Index score following their operation (89.9% in England).
- 82.6% of knee replacement respondents recorded an increase in their EQ-5D Index score following their operation (82.9% in England).
- The number of varicose vein questionnaire pairs returned for Colchester Hospital University NHS Foundation Trust (RDE) is suppressed due to small numbers.

EQ VAS (current state of the patients general health marked on a visual analogue scale)

- 35.1% of groin hernia respondents recorded an increase in their EQ VAS score following their operation (37.9% in England).
- 71.9% of hip replacement respondents recorded an increase in their EQ VAS score following their operation (66.9% in England).
- 78.3% of knee replacement respondents recorded an increase in their EQ VAS score following their operation (56.5% in England).
- The number of varicose vein questionnaire pairs returned for Colchester Hospital University NHS Foundation Trust (RDE) is suppressed due to small numbers.

Condition Specific Measures (a series of questions specific to the patient's condition)

- 100.0% of Oxford Hip Score respondents recorded joint related improvements following their operation (96.3% in England).
- 100.0% of Oxford Knee Score respondents recorded joint related improvements following their operation (94.3% in England).
- The number of varicose vein questionnaire pairs returned for Colchester Hospital University NHS Foundation Trust (RDE) is suppressed due to small numbers.

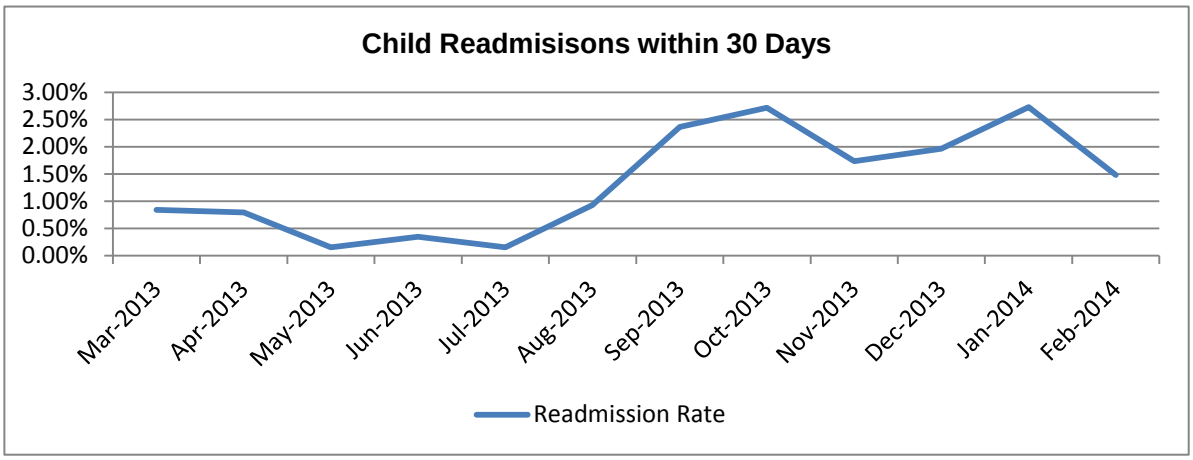
Participation and Coverage

- There were 704 eligible hospital episodes and 542 pre-operative questionnaires returned - a headline participation rate of 77.0% (72.7% in England).
- Of the 285 post-operative questionnaires sent out, 123 have been returned - a response rate of 43.2% (36.7% in England).

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

- Information/evidence is uploaded directly from the Health & Social Care Information website.

Percentage of patients aged 0 -15 readmitted to the Trust within 28 days of being discharged from the Trust during 2013/14 (*Monitor 19):*



	SUS Readmissions	Ordinary Admission Spells	Readmission Rate
Mar-2013	6	717	0.84%
Apr- 2013	5	630	0.79%
May- 2013	1	657	0.15%
Jun-2013	2	582	0.34%
Jul-2013	1	668	0.15%
Aug- 2013	6	647	0.93%
Sep- 2013	18	761	2.37%
Oct- 2013	23	847	2.72%
Nov- 2013	17	981	1.73%
Dec- 2013	21	1069	1.96%
Jan- 2014	25	916	2.73%
Feb- 2014	13	879	1.48%

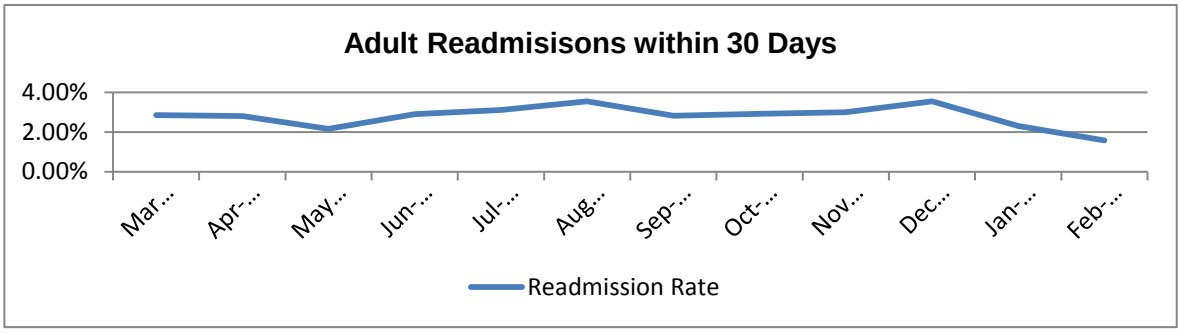
Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons:

- This is data prepared by a national body external to the Trust.
- The Data Quality Team has extracted this data.

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

- The Children's Assessment Unit provides parents with a 24-48 hour window to access advice by telephone
- Parents are provided with patient information leaflets so they are fully informed before their child is discharged.
- A follow up post discharge phone call is made by Children Nurse Specialists to all parents of children who have had surgery. Advice is given concerning pain relief, wound care and any concerns. The Nurse Specialist liaises with the GP, as needed.
- There is direct telephone access for parents with specialists in the field of oncology, asthma and allergy, cystic fibrosis, neurology, epilepsy etc
- A helpline is provided for parents of diabetic children run by the Children's Diabetes Nurse specialist
- The Children's Community Nursing team support children with long term conditions at home and undertake home visits, preventing unnecessary admissions
- Regular monitoring and review of readmission data

SUS PbR 30 Day Readmissions to Any Hospital Within 30 Days of Discharge - Number of Spells with a SUS Readmission / Number of Discharged Ordinary Admission Spells

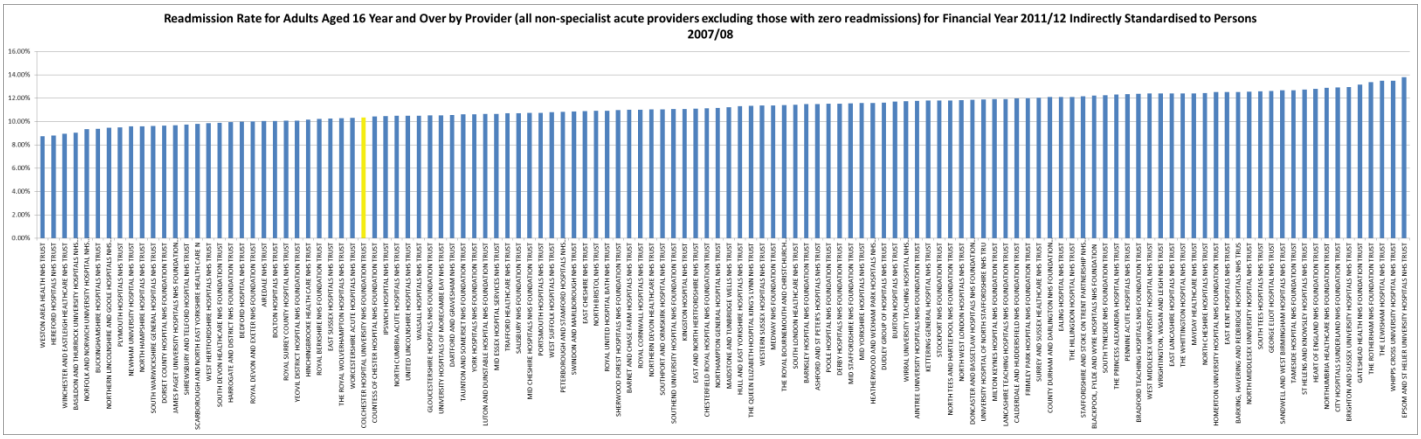


	SUS Readmissions	Ordinary Admission Spells	Readmission Rate
Mar-2013	109	3824	2.85%
Apr- 2013	100	3561	2.81%
May- 2013	80	3687	2.17%
Jun-2013	100	3446	2.90%
Jul-2013	115	3685	3.12%
Aug- 2013	135	3800	3.55%
Sep- 2013	99	3514	2.82%
Oct- 2013	111	3810	2.91%
Nov- 2013	111	3697	3.00%
Dec- 2013	132	3725	3.54%
Jan- 2014	88	3807	2.31%
Feb- 2014	56	3525	1.59%

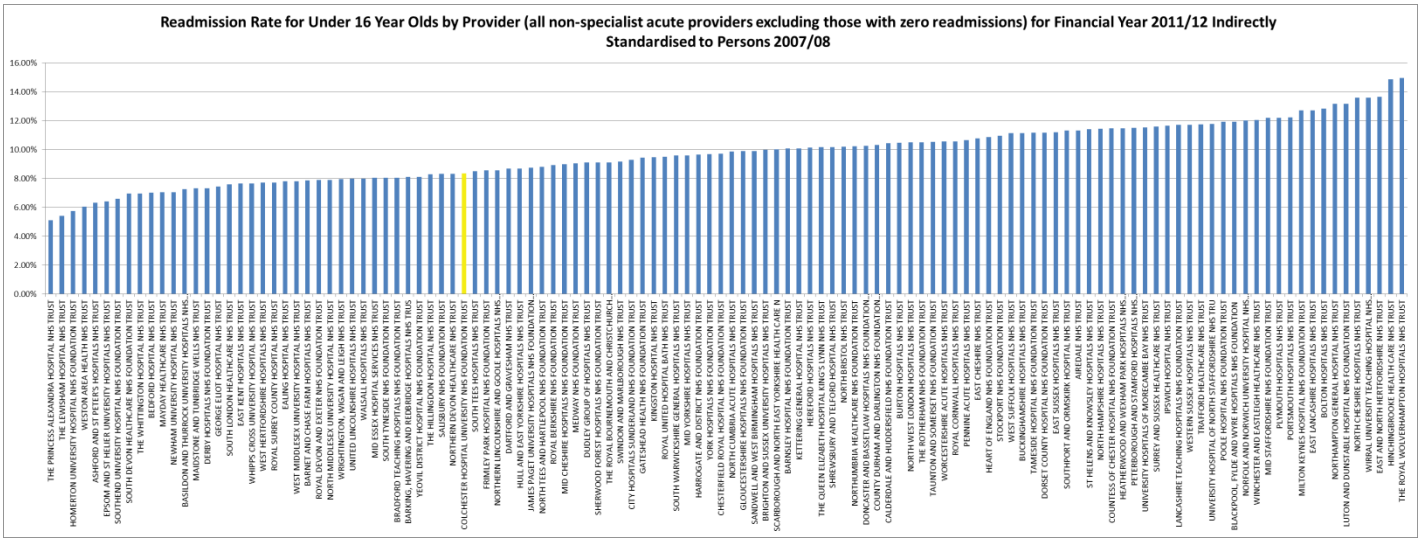
HSCIC Emergency Readmissions to Any Hospital Within 28 Days of Discharge - Number of CIP Spells With a Readmission / Number of CIP Spells (*Monitor 19):*

P00904 - 16+

The most recent data 2011/12 is provided; standardised to 2007/08.



P00913 - < 16 years



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

- This is data prepared by a national body external to the Trust.
- The Data Quality Team have extracted this data.

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

- Regular monitoring and review of readmission data by wards to reduce re-admissions
- Clinicians review any patients who were re-admitted to see if there was a different cause for readmission or if they had been discharged too early

The Trust's responsiveness to the personal needs of its patients during the reporting period *(Monitor 20).*

The Trust has several methods of obtaining feedback from our patients on their experience in our hospital. Some examples of this include an i-pad Meridian tracker which is available for patients to complete.

Feedback from patients is reported and monitored on a monthly basis in the Trust. All wards have access to the Meridian database to get up to date feedback on their performance. The Trust has adopted a continuous improvement process with feedback on what patients tell us being given to wards and departments so that improvements can be made. Discussion about improvements occurs at ward meetings routinely and progress is monitored.

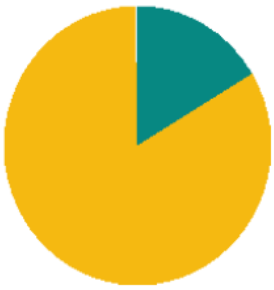
"You Said - We Did" boards are displayed in every ward area to inform patients and carers that we have listened and acted to improve our care in response to their feedback.

The National Inpatient Survey one of the main feedback tools which is used by the Trust to identify what is going well and what needs to improve in meeting patients' personal needs. The survey was undertaken in August 2013 and a 50% response rate was achieved. In 2012/13 the response rate was 56%.

Some key facts about the 405 inpatients who responded:

- 30% were on a waiting list planned in advance
- 63% came in as an emergency or urgent case
- 55% had an operation or procedure during the stay
- 43% were male; 55% were female and 2% did not say

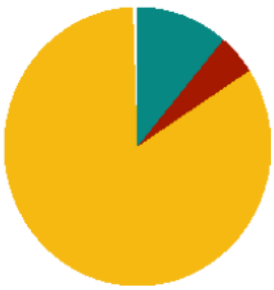
Key overall findings from the in-patient survey and the Trust's progress over the last two years are shown below.



Have we improved since the 2012 survey?

A total of 61 questions were used in both the 2012 and 2013 surveys.
Compared to the 2012 survey, your Trust is:

- Significantly BETTER on 10 questions
- Significantly WORSE on 0 questions
- The scores show no significant difference on 51 questions



How do we compare to other trusts?

The survey showed that your Trust is:

- Significantly BETTER than average on 7 questions
- Significantly WORSE than average on 3 questions
- The scores were average on 52 questions

Areas of positive feedback

- The survey highlighted the many positive aspects of the patient experience:
- Overall: 78% rated care 7 + out of 10
- Overall: treated with respect and dignity 80%
- Doctors: always had confidence and trust 75%
- Hospital: room or ward was very/fairly clean 97%
- Hospital: toilets and bathrooms were very/fairly clean 93%
- Care: always enough privacy when being examined or treated 92%

Main areas of concern

Problem scores 50%+ (Lower scores are better)	Trust	Average
Discharge: delayed by 1 hour or more	85%	85%
Planned admission: not offered a choice of hospitals	71%	63%
Discharge: not fully told side-effects of medications	64%	58%
Overall: not asked to give views on quality of care	63%	68%
Care: could not always find staff member to discuss concerns with	58%	58%
Discharge: not fully told of danger signals to look for	57%	54%
Overall: Did not receive any information explaining how to complain	53%	58%
Discharge: family not given enough information to help	50%	48%

Your results were significantly worse than the 'Picker average' for the following questions: (Lower scores are better)	Trust	Average
Planned admission: not offered a choice of hospitals	71%	63%
Hospital: food was fair or poor	48%	42%
Care: not enough (or too much) information given on condition or treatment	24%	20%

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

- The data is prepared by an external company, the Picker institute

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

- Continue the process of continuous improvement and learning with wards actively using feedback to improve
- Continue with routine monitoring of performance at ward, service area, divisional and Trust levels
- Continue the Trust's broad strategy of staff engagement and other quality initiatives.

Percentage of staff employed by, or under contract to the Trust during 2013/14 who would recommend the Trust as a provider of care to their family or friends *(Monitor 21*)

In the staff survey 2013-14, the percentage of staff who said they would recommend the Trust as a provider of care to their family or friends, is described in the chart below. Q12a, Q12c and Q12d of the Staff Survey feed into Key Finding 24 “Staff recommendation of the trust as a place to work or receive treatment”. The relevant percentage scores are 65% for Q12a, 66% for Q12b, 57% for Q12c and 58% for Q12d.

		Your Trust in 2013	Average (median) for acute trusts	Your Trust in 2012
Q12a	“Care of patients/ service users is my organisation’s top priority”	65%	68	64
Q12b	“My organisation acts on concerns raised by patients/ service users”	66%	71	68
Q12c	“I would recommend my organisation as a place to work”	57%	59	53
Q12d	“If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation”	58%	64	58
KF24	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.53	3.68	3.53

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

- The staff survey is done by an external organisation, Picker Institute Europe.
- A dataset of 850 staff is sent by the Trust to Picker Institute Europe.
- Picker Institute Europe distributes the survey, manages the returns and carries out an analysis of the results.

Colchester Hospital University NHS Foundation Trust intends to take/has taken the following actions to improve this:

- A major programme of work has been planned and undertaken during the year to increase staff engagement. Discussion and listening sessions, reflecting issues identified in the Keogh review, were carried out with staff in divisions which resulted in divisional action plans to improve staff engagement.
- A new Human Resources Director has been appointed to continue this work and develop further the Trust’s staff engagement strategy.

Friends and Family Test – patients

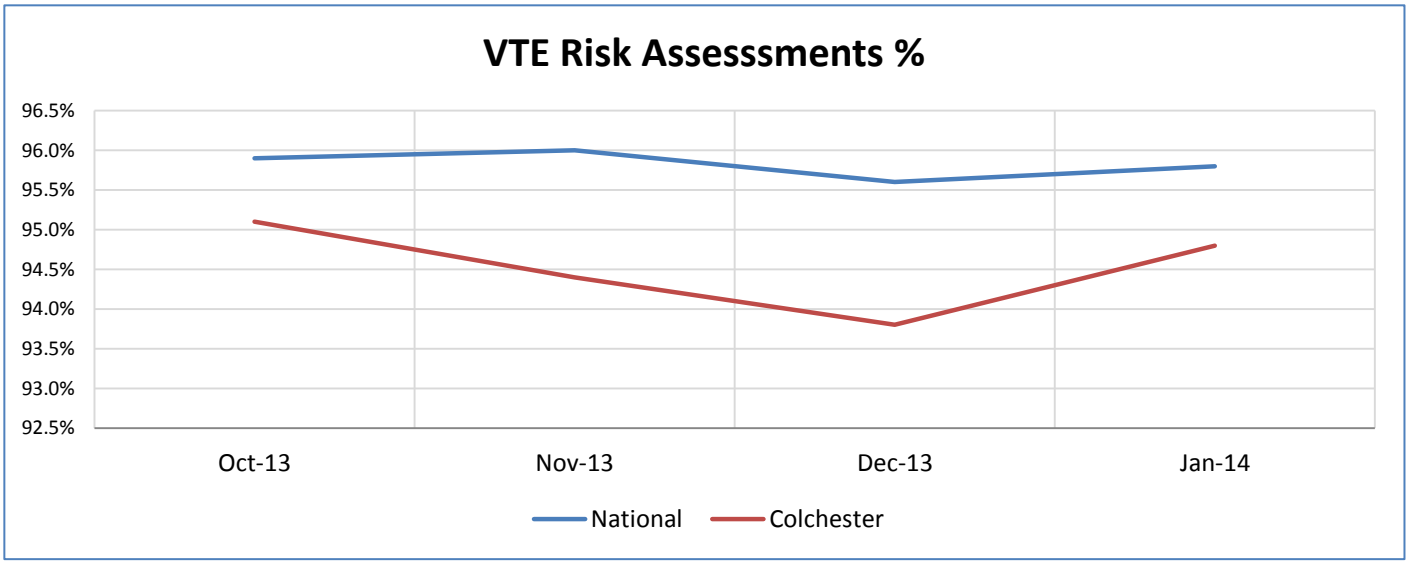
The chart below shows the patient scores of the Friends and Family test by area, compared to other Trusts with the highest and lowest scores:

Number	Description	Month	CHUFT Score	England Score	Lowest Score	Highest Score
26	A&E scores	Nov-13	67	56		
26	A&E scores	Dec-13	67	56		
26	A&E scores	Jan-14	44	57		
26	A&E scores	Feb-14	49	55	Medway NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust
26	Inpatient scores	Nov-13	76	73		
26	Inpatient scores	Dec-13	74	72		
26	Inpatient scores	Jan-14	76	73		
26	Inpatient scores	Feb-14	74	73	Medway NHS Foundation Trust	Benenden Hospital
26	Combined FFT (IP & A&E) score	Nov-13	76	65		
26	Combined FFT (IP & A&E) score	Dec-13	74	64		
26	Combined FFT (IP & A&E) score	Jan-14	67	65		
26	Combined FFT (IP & A&E) score	Feb-14	67	64	Medway NHS Foundation Trust	Benenden Hospital
26	Friends and Family Test - Maternity - Question 1 - Antenatal Care	Nov-13	100	65		
26	Friends and Family Test - Maternity - Question 1 - Antenatal Care	Dec-13	80	63		
26	Friends and Family Test - Maternity - Question 1 - Antenatal Care	Jan-14	100	67		
26	Friends and Family Test - Maternity - Question 1 - Antenatal Care	Feb-14	50	67	Mid Cheshire Hospitals NHS Foundation Trust	Countess of Chester Hospital NHS Foundation Trust
26	Friends and Family Test - Maternity - Question 2 - Birth	Nov-13	76	77		
26	Friends and Family Test - Maternity - Question 2 - Birth	Dec-13	89	75		
26	Friends and Family Test - Maternity - Question 2 - Birth	Jan-14	91	78		
26	Friends and Family Test - Maternity - Question 2 - Birth	Feb-14	90	75	Chelsea and Westminster Hospital NHS Foundation Trust	South Tyneside NHS Foundation Trust
26	Friends and Family Test - Maternity - Question 3 - Postnatal Ward	Nov-13	81	66		
26	Friends and Family Test - Maternity - Question 3 - Postnatal Ward	Dec-13	76	66		
26	Friends and Family Test - Maternity - Question 3 - Postnatal Ward	Jan-14	72	65		

26	Friends and Family Test - Maternity - Question 3 - Postnatal Ward	Feb-14	78	64	North Middlesex University Hospital NHS Trust	Northern Devon Healthcare NHS Trust
26	Friends and Family Test - Maternity - Question 4 - Postnatal Community Provision	Nov-13	NA	72		
26	Friends and Family Test - Maternity - Question 4 - Postnatal Community Provision	Dec-13	NA	74		
26	Friends and Family Test - Maternity - Question 4 - Postnatal Community Provision	Jan-14	NA	75		
26	Friends and Family Test - Maternity - Question 4 - Postnatal Community Provision	Feb-14	NA	75		

Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during 2013/14 *(Monitor 23)*

Number	Description	Month	CHUFT Score	England Score	Lowest Score	Highest Score
23	VTE Risk Assessments	Oct-13	95.1%	95.9%	North Cumbria University Hospitals NHS Trust	Bridgewater Community Healthcare NHS Trust/ Queen Victoria Hospital NHS Foundation Trust/ Royal National Hospital for Rheumatic diseases NHS Foundation Trust/ South Essex Partnership University NHS Foundation Trust
23	VTE Risk Assessments	Nov-13	94.4%	96.0%	North Cumbria University Hospitals NHS Trust	Bridgewater Community Healthcare NHS Trust / Cambridgeshire Community Services NHS Trust/ Queen Victoria Hospital NHS Foundation Trust / Royal National Hospital for Rheumatic diseases NHS Foundation Trust / South Essex Partnership University NHS Foundation Trust
23	VTE Risk Assessments	Dec-13	93.8%	95.6%	Southend University Hospital NHS Foundation Trust	Bridgewater Community Healthcare NHS Trust / Cambridgeshire Community Services NHS Trust / Queen Victoria Hospital NHS Foundation Trust / Royal National Hospital for Rheumatic diseases NHS Foundation Trust/ South Essex Partnership University NHS Foundation Trust
23	VTE Risk Assessments	Jan-14	94.8%	95.8%	North Cumbria University Hospitals NHS Trust	Salisbury NHS Foundation Trust/ The Clatterbridge Cancer Centre NHS Foundation Trust/ Derbyshire Community Health Services NHS Trust/ Blackpool Teaching Hospitals NHS Foundation Trust/ Cambridgeshire Community Services NHS Trust / Queen Victoria Hospital NHS Foundation Trust / Royal National Hospital for Rheumatic diseases NHS Foundation Trust / South Essex Partnership University NHS Foundation Trust / The Robert Jones and Agnes Orthopaedic Hospital NHS Foundation Trust



VTE Risk Assessments %	Oct 2013	Nov 13	Dec 13	Jan 13
Colchester	95.1%	94.4%	93.8%	94.8%
National	95.9%	96.0%	95.6%	95.8%

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

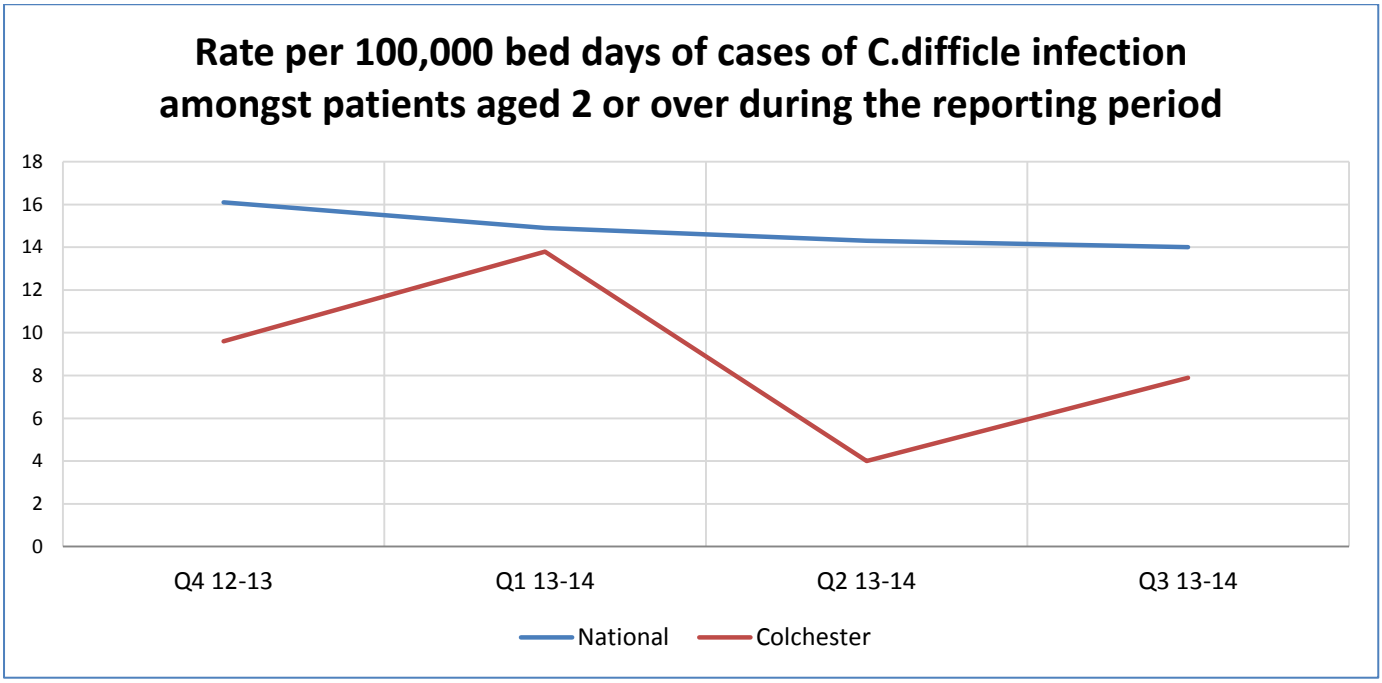
- A monthly VTE audit is carried out by the Clinical Audit department in all areas of the Trust.
- The audit checks that drug prescription charts are signed by the pharmacist or doctor. The audit checks the patient has had a VTE risk assessment completed and that anti-embolism measures have been prescribed.

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

- The priority is to maintain a high awareness with feedback to ward staff on complete and missing risk assessment forms.
- Please see the VTE report under Part 2, Patient Safety of this report for further actions to improve performance.

Rate per 100,000 bed days of cases of *C. difficile* infection reported within the trust amongst patients aged 2 or over during 2013/14: *(Monitor 24)*

Number	Description	Quarter	CHUFT Score	England Score	Best Performance Score	Worst Performance Score
24	Rate per 100,000 bed days of cases of C. difficile infection amongst patients aged 2 or over during the reporting period	Q4 12-13	9.6	16.1	South Tyneside NHS Foundation Trust	North Bristol NHS Trust
24		Q1 13-14	13.8	14.9	Homerton University Hospital NHS Foundation Trust/ Chelsea and Westminster Hospital NHS Foundation Trust/ Bedford Hospital NHS Trust	Aintree University Hospital NHS Foundation Trust
24		Q2 13-14	4.0	14.3	Homerton University Hospital NHS Foundation Trust/ Northern Devon Healthcare NHS Trust/ Wye Valley NHS Trust	Aintree University Hospital NHS Foundation Trust
24		Q3 13-14	7.9	14.0	Hinchingbrooke Healthcare NHS Trust	Milton Keynes Hospital NHS Foundation Trust



C. diff rate per 100,000	Quarter 4 12-13	Quarter 1 13-14	Quarter 2 13-14	Quarter 3 13-14
Colchester	9.6	13.8	4	7.9
National	16.1	14.9	14.3	14

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

- There is a high awareness amongst staff to take specimens where infection is a possible diagnosis
- It is mandatory to report all Clostridium difficile positive cases to Public Health England via a database known as MESS.
- Pathology Services and the Infection Control department routinely monitor pathology results and report any positive cases.

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

- An on-going programme of undertaking root cause analysis and Panel Reviews of all Clostridium difficile cases in patients diagnosed with infection within 72 hours of admission to hospital.
- The Panel Reviews include all appropriate staff such as ward sister, matron, clinician, Consultant Microbiologist, Infection Control Nurse and Pharmacy staff so effective learning and improvements can occur.

Number, and where available, rate of patient safety incidents reported within the Trust during 2013/14, and the number and percentage of such patient safety incidents that resulted in severe harm or death (*Monitor 25*)

Count of Incidents by Division and Incident Date 2013/14

	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Total
Clinical Support Services & Cancer	76	67	74	79	70	80	76	79	72	102	134	118	1027
Corporate	21	43	40	63	52	44	82	73	56	39	31	25	569
Medicine	321	309	355	405	341	319	320	316	377	340	357	369	4129
Other Healthcare Service Provider	13	12	21	31	11	23	14	14	16	20	15	12	202
Surgery	121	119	171	146	147	161	177	174	205	176	136	155	1888
Women's & Children	123	96	164	170	145	95	96	102	90	115	96	135	1427
Total	675	646	825	894	766	722	765	758	816	792	769	814	9242

There were 9242 patient safety incidents reported during 2013/14. The rate of severe and death incidents is approximately 1% of these.

There were 94 severe harm or death incidents during 2013/14.

Count of Severe/Death Incidents by Division and Incident Date 2013/14

	Apr 2013	May 2013	Jun 2013	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Total
Clinical Support Services & Cancer	1	0	0	0	0	0	2	1	0	0	0	0	4
Corporate	0	0	0	0	0	0	22	0	0	0	0	0	22
Medicine	2	0	1	3	3	2	3	2	3	3	6	8	36
Surgery	1	1	2	0	0	3	6	2	0	1	5	6	27
Women's & Children	0	0	0	0	0	0	1	0	1	2	1	0	5
Total	4	1	3	3	3	5	34	5	4	6	12	14	94

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

- All members of CHUFT staff attend a mandatory induction into the Trust. A section of the induction training covers the importance of reporting incidents and providing information to members of staff how to contact the support network when completing a Datix incident report form.
- Immediately after induction training all members of staff receive Datix training on how to use the online reporting system and submit an incident. This training is completed by Datix Trainers

- Once a patient related incident has been submitted it is checked by a member of the clinical governance team support by the risk management team. On all Datix Dif 2 forms there is a specific section where the team can comment and record any changes to the report. The team checks the clarity of the report and in particular:
    - Correct investigator
    - The correct level of harm
    - What and if required level of support to the reporter or investigator of the incident.
    - If in the opinion of the team this incident may meet the Serious incident criteria – the incident is reported to the Trust's SI panel. This consists of senior risk, governance, clinical and executive team members.

Colchester Hospital University NHS Foundation Trust intends to take/has taken the following actions to improve this performance, and so the quality of its services.

- The Trust's focus on measures to prevent patients from deteriorating (e.g. NEWS), emphasising the importance of the sepsis pathway (e.g. VIVA training), reduction of falls (falls integrated pathway and platform of preventive measures) and focus on improving timely diagnosis and treatment.
- At least monthly review of incidents and performance in all wards with the 2 at the Top meetings involving consultant leads and ward sisters.
- The emphasis on effective governance and learning in divisions.
- Once Serious Incident investigation reports have been completed and approved for quality in the Trust, they are reviewed by divisions and service areas to ensure actions to prevent recurrence have been implemented.

Performance against the relevant indicators and performance thresholds set out in Appendix A of Monitor's Risk Assessment Framework (where they have not been reported upon elsewhere in this report)

The Trust's performance is detailed below:

NHS 18 week targets

Target/ Priority	National target 2012/13	% Achieved 2011/12	% Achieved 2012/13	% Achieved 2013/14	National target 2013/14
Patients requiring admission who waited <18 weeks from referral to treatment (not national targets since 2010)	90%	90.97%	93.75%	90.69%	90%
Patients not requiring admission who waited <18 weeks from referral to treatment (not national targets since 2010)	95%	97.18%	98.25%	97.61%	95%
A&E 4 Hour Standard	95%	96.64%	96.07%	94.75%	95%

National targets

Cancer waiting times targets 2013-14

	National Target	Q1	Q2	Q3	Q4	Performance 2013/14 (Apr-Mar)
All urgent GP referrals seen within 14 days	93%	95.8%	98.4%	95.9%	94.5%	96.2%
All referrals for breast symptoms seen within 14 days	93%	96.1%	93.7%	91.9%	88.3%	92.6%
Treatment within 31 days of decision to treat for first treatment	96%	98.5%	96.0%	95.6%	92.2%	95.6%
Subsequent surgical treatment started within 31 days of decision to treat	94%	97.3%	95.1%	92.2%	85.4%	93.3%
Subsequent drug treatment started within 31 days of decision to treat	98%	100.0%	100.0%	100.0%	98.5%	99.7%
Subsequent radiotherapy treatment started within 31 days of decision to treat	94%	98.4%	96.5%	98.4%	97.9%	97.8%
Treatment started within 62 days of urgent GP referrals	85%	90.1%	83.4%	80.1%	78.5%	82.7%
Treatment started within 62 days of recall date for urgent screening centre referrals	90%	90.5%	97.9%*	89.6%	95.3%	93.4%

Access targets

2013/14	Target	Q1 Performance	Q2 Performance	Q3 Performance	Q4 Performance	Performance 2013/14
Operations cancelled by the Trust at the last minute	0.8%	0.74%	0.76%	0.67%	0.66%	0.66%

Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway:

92% of patients on an In-complete pathway should be waiting less than 18 weeks from receipt of referral This target includes all patients who are yet to receive their first definitive treatment. This will include all patients who are still waiting for an outpatient appointment, diagnostic test or elective admission added together.
This target does not allow any adjustments to be taken into account.

The expectation is that we will not have more than 8% of the waiting list to exceed 18 weeks without the possibility of incurring a penalty.

The longest wait for 2013/14 is 203 weeks. The longest wait for April 2014 (the last submitted position) is 51 weeks.

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

- This is data prepared by a national body external to the Trust.
- The Data Quality Team has extracted this data.

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

- Regular monitoring and review of 18 week and cancer data by Trust teams to identify problems and improve performance.
- A Referral To Treatment (RTT) programme manager is in place to support the Trust in achieving the appropriate admitted and non-admitted performance for quarter 2.
- Operational teams are engaged in improving their RTT performance and improving their service to ensure long term sustainability.

Annex 1

Statements from key stakeholders

Statement from the Council of Governors on the Quality Report 2013/14

Two Governors represent the Council of Governors as observers on the Patient Quality and Safety Assurance Committee which is authorised by the Trust Board to investigate any activity within its terms of reference. The Committee meets monthly and the role of the Governors is to assure themselves that the appointed Non-executive Directors (one of whom is the Chair) are robustly performing their duties of ensuring the safety of patients is the highest priority and scrutinising and monitoring the implementation of strategic priorities in relation to quality, patient safety and patient experience. The Governors report on these meetings to the Council of Governors. To date the reports to the Council have confirmed that the key responsibilities of the Patient Quality and Safety Assurance Committee are being performed well in the receipt of reports and action plans from Divisions on a rolling basis with Executive Directors and Senior members of divisions in attendance to support those reports and plans and where necessary to be challenged on content. Governors have also witnessed clinical presentations based around key priorities together with active monitoring and reviewing of, for example, the systems and processes in place within the Trust in relation to Infection Control and the reviewing of progress against identified risks to reducing hospital acquired infections.

The committee has shown responsibility for reviewing all finance related risks allocated to it as outlined in the Assurance Framework and Corporate Risk Register.

Statement from North East Essex Clinical Commissioning Group (NECCG) on the Quality Report 2013/14

North East Essex Clinical Commissioning Group response to Colchester Hospital University Foundation NHS Trust Quality Report 2013-14

North East Essex Clinical Commissioning Group (CCG) welcomes this Quality Report as a commitment to an open and honest dialogue with the public regarding the quality of care provided by Colchester Hospital University Foundation Trust. Assurance from the CCG is required to ensure that the information in this Quality Report is accurate, fairly interpreted, and representative of the range of services delivered.

Though the CCG are aware that they are commenting on a draft version of this Quality Report, there are some concerns as to the accuracy of the content in general. We have fed back our comments on accuracy in the draft report and anticipate that these changes will be made to the final published version. The CCG is however unable to assure all data reported, as some data will have been provided or updated prior to publication.

The CCG recognises that it has been a challenging year for the Trust following the Keogh report; the concerns raised by the Care Quality Commission about the delivery of cancer services; and the concerns raised by the CCG In January 2014 regarding maternity services at Colchester Hospital. We had anticipated a more detailed report on each of the above issues as these significantly impacted upon the Trust's assessment of quality and the Trust response to improving the safety and quality of each of these services.

Mindful that this report is a public facing document, the report in general is fairly well presented and could benefit from using less technical acronyms and a better description of the services provided in order that the reader is able to better interpret the statistical information provided.

Part 1 of the report meets with the NHS Quality Accounts regulations and provides a statement summarising the provider's view of the quality of the services provided during the reporting period. Quality statements are contained throughout the document. Part 2 also meets with the regulations; however Part 3 has some omissions and errors, which have been fed back to the Trust.

The report demonstrates that there have been quality concerns raised during the year, identified through a combination of internal and external reviews. We are pleased to see 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 has been working with you to support. The CCG recognises that 2014/15 will continue to be a significantly challenging time as the Trust needs to continue to embed and provide assurance that quality and safety improvements are being delivered.

For 2013/14, the Trust identified three key priorities which can be mapped to the domains of quality, patient safety; patient experience and clinical effectiveness. These were

- 'Out of Hours';
- 'At Our Best - Everyone, Everywhere'; and
- 'NICE Quality Standards'.

The report identifies good progress in these areas as well as areas for further improvement in 2014/15. We note the additional staff you have recruited in your emergency departments to improve the experience of patients. The Trust states that it will continue to develop its 'At Our Best - Everyone, Everywhere' programme, which is aimed at helping staff to understand the values and behaviours which underpin best patient experience. In this last year, the focus on improving culture and staff attitudes has been a key theme arising from external reviews. The CCG notes this is an area which requires further improvement to ensure the privacy and dignity of patients are maintained; patients and their carers are well informed; and patients are encouraged to raise concerns. The need to improve the experience of staff is also welcomed, as supported staff will deliver safe and quality care to patients.

The CCG fully recognises the challenges the trust has faced in 2013/14 and will continue to review the implementation of regulatory recommendations and seek assurances on the continued improvement on the delivery of safe and quality services. The CCG opinion is that the Quality Report provided sufficient assurance with regard to the safety and quality of services, with the exception of:

1. Insufficient detail on the
    - Keogh Review
    - Cancer Review
    - Maternity quality and safety review
2. Overly technical presentation which detracts readability for the public

The CCG looks forward to continuing its work with Colchester Hospital University Foundation Trust in the coming year, and encourages Colchester Hospital to continue to implement the multiple and wide-ranging efforts and initiatives to improve the quality of its services.

29 May 2014
Lisa Llewelyn
Director of Nursing and Clinical Quality
NHS North East Essex Clinical Commissioning Group

Statement from Health Overview and Scrutiny Committee on the Quality Report 2013/14

The HOSC has continued to engage with the Trust to seek assurances on continued patient safety and on the robustness of the action plans to address regulatory issues. Trust representatives appeared before the HOSC in March 2013 in response to concerns about it being an outlier on mortality indicators and most recently in February 2014 to discuss issues arising from concerns highlighted by the Care Quality Commission on cancer care pathways and the resulting report by the Incident Management Team. The most recent session was also attended by representatives from the local clinical commissioning group and the NHS England Area Team. The Trust is due to re-appear before the HOSC on 4 June 2014 to give a further update on these regulatory concerns and the issues still requiring attention.

In addition to the above, the HOSC recently has also engaged with representatives from the Trust and the local clinical commissioning group on temporary changes to maternity services being provided from the community hospitals in the north east of the County, with further consultation expected in the near future on any permanent changes and the future structure of the service. Finally, the HOSC has also requested to be briefed and consulted in July 2014 on the planned relocation of services from the County Hospital site.

The HOSC will continue to review the implementation of regulatory recommendations and seek assurances on the continued delivery and quality of services, patient safety, confidence in the services being provided, and patient accessibility. In addition, the HOSC is always interested in the leadership at an organisation, the culture it fosters and initiatives to maintain and improve staff morale during challenging times.

21.May 2014
Graham Hughes
Scrutiny Officer
Corporate Law and Assurance
Essex County Council

Statement from Healthwatch Essex on the Quality Report 2013/14

Healthwatch Essex is an independent organisation with a vision to be a voice for the people of Essex, helping to shape and improve local health and social care services. We recognise that Quality Account

reports are an important way for local NHS services to report on what services are working well, as well as where there may be scope for improvements.

We welcome the opportunity to provide a critical, but constructive, perspective on the Quality Accounts for CHUFT, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by CHUFT.

In this Quality Account, CHUFT recognises that it has been a difficult year following the Keogh Report and concerns raised by the Care Quality Commission. The Trust has provided an outline summary of actions taken in the past twelve months and its vision for the year to come.

The Trust demonstrates that there have been quality concerns identified during the year, through a combination of internal and external reviews, in particular with regard to the Summary Hospital-Level Mortality Indicator (SHMI), cancer waiting times and pathways, and a high percentage of UTI's in catheterised patients. The Account subsequently describes the proactive approach taken in addressing these issues.

We are pleased the Trust is working actively to improve its provision of cancer services, and the management of waiting times. The Trust has described further quality improvements such as the implementation of the Somerset Cancer register to monitor cancer waiting times; increased staff to escort people to radiology; a single point or referral, and a rapid response community team to improve communication and End of Life Care.

In addition to this work lead by the Trust, Healthwatch Essex looks forward to sharing the results of our recent study of cancer services in Colchester, and working collectively to ensure that this evidence ensures patient experience is used to drive continued service change and improvement. Preliminary findings from the study, at the time of response (May 2014), demonstrate that although the majority of people are satisfied with their care and treatment, there are concerning reports of patients whose lived experience of services have fallen below the standards that would be expected. Additionally, there are indications that people feel they were not properly listened to by the Trust. As such, Healthwatch Essex is pleased to see that CHUFT has made listening to patients' concerns and complaints a quality priority of 2014/2015. Healthwatch Essex believes that listening to the voice and lived experience of patients, service users, their carers, and the wider population, is a vital component of providing good quality care.

The Trust has made improvements towards the top priorities for 2013/14, 'Out of hours', 'At Our Best – Everyone Everywhere', and 'NICE Quality Standards'. The Trust states it has continued work on the 'At Our Best – Everyone Everywhere' improvement programme, which aims to help staff understand the values and behaviours for the best patient experience. This focus on culture and staff attitudes is important, as it foregrounds vital aspects of care around respecting patients' dignity, keeping them informed, and encouraging them to raise concerns. Additionally, patient stories, both positive and negative are being used by the Trust in training sessions to help develop staff. We look forward to seeing the Trust development mechanisms for evaluating and monitoring the impact this has had on patient care.

The Trust has introduced the Friends and Family Test to the Emergency Department and Maternity Services, and now provides a text messaging service making it easier for people to respond. We are pleased that the Trust is being pro-active in gathering the views and experiences of its patients. Despite this, there is work to be done; with the Friends and Family Test have varying returns compliance in departments, with an average of 40%. On the Inpatient Survey, CHUFT scored average compared to other Trusts. Healthwatch Essex welcomes the introduction of the 'You Said / We Did' boards on wards, showing patients that their feedback has led to improvements and are being listened to.

We support the work being done around dementia care, especially the carers' questionnaire which will inform change in the Dementia care services.

Healthwatch Essex supports the commitment of CHUFT to maintaining improvements and listening to their patients, and over the last year, Healthwatch Essex and the Trust have demonstrated the value of working closely together. 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.

15 May 2014
Dr Tom Nutt
Chief Executive Officer
Healthwatch Essex

Annex 2

Statement of Director's responsibilities in respect of the Quality Report

The Directors are required under the National Health Service Quality Accounts Regulations to prepare Quality accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support data quality for the preparation of the Quality Report.

In preparing this Quality Report directors have taken steps to satisfy themselves that the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual* 2013/14.

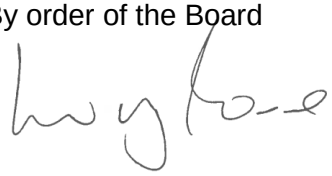
- The quality of the Quality Report is consistent with internal and external sources of information including:

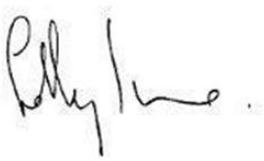
- Board minutes and papers for the period April 2013 to May 2014
- Feedback from North East Essex CCG 29 May 2014
- Papers relating to quality reported to the Board over the period April 2013 to May 2014
- The Keogh Review July 2013
- Care Quality Commission report published March 2014
- Feedback from HOSC dated May 2014
- Feedback from Governors through the Council of Governors dated May 2014
- Feedback from local Healthwatch organisations dated 15 May 2014
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Regulations 2009, dated 1 April 2012-31 March 2013
- The 2013 national in-patient survey results dated February 2014
- The 2013 national staff survey dated January 2014
- The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2014
- CQC quality and risk profiles throughout April 2013 to March 2014

- The Quality Report presents a balanced picture of Colchester Hospital University NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions is subject to appropriate scrutiny and review;
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/ annual reporting manual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board





29 May 2014	29 May 2014
Dr Lucy Moore	Dr Sally Irvine
Interim Chief Executive	Chair

Independent Auditor's Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Colchester Hospital University NHS Foundation Trust to perform an independent limited assurance engagement in respect of Colchester Hospital University NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of those national priority indicators mandated by Monitor:

- C.difficile
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and Auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in Monitor's *2013/14 Detailed Guidance for External Assurance on Quality Reports*; 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 2013 to 29 May 2014;
- Papers relating to quality reported to the Board over the period April 2013 to 29 May 2014;
- The Keogh Review- July 2013
- Feedback from the North East Essex CCG dated 29/05/2014;
- Feedback from HOSC dated May 2014
- Feedback from local Healthwatch organisations dated 15 May 2014;
- Feedback from Governors through the Council of Governors dated May 2014
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 April 2013 – 31 March 2013
- The latest national in-patient survey dated February 2014
- The 2013 national staff survey dated January 2014
- Care Quality Commission Intelligent Monitoring Report dated 13/03/2014;and

- The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2014.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Colchester Hospital University NHS Foundation Trust as a body, 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 Trust's Annual Report for the year ended 31 March 2014, 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 indicators back to supporting documentation
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report
- 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

With the exception of the matter noted below, 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 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*; and
- the Quality Report is not consistent in all material respects with the sources specified above.

Testing of an indicator mandated by Monitor, 'maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers' resulted in us identifying errors in dates recorded in respect of referral and treatment dates. On this basis, we were unable to verify the accuracy of data being reported for this indicator in the Trust's Quality Report. We, therefore, qualify our audit report in respect of being able to provide assurance that:

- the indicators in the Quality Report subject to limited assurance have been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

Grant Thornton UK LLP

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29 May 2014