Colchester Hospital University
NHS Foundation Trust

Quality Report 2017/18

Contents

Who was involved in the development of our Quality Account?

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

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

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

Our front cover shows

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

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

Part 1 - Statement on quality

Chief Executive's commentary

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

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

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

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

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

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

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

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

The flow of patients through our Emergency Department, Assessment Units, Wards and back home again is the most important issue we face. At its heart are the stories of people just like Ivy who need our care but aren't able to access it quickly enough.

Project Ivy was launched in August 2017 with the goal that no patient would spend a moment longer in hospital than was needed, to progress their care. It is being led by a small team of staff-clinical and non-clinical who are committed to making multiple rapid improvements on an incremental basis.

Areas of focus have included:

- ✓ Effective board rounds
- ✓ Creating an excellent discharge lounge
- ✓ Gaining some insight why some patients are in hospital for more than seven days
- ✓ Bringing energy to the Red to Green process
- ✓ Introducing non-clinical staff volunteers to help with peaks in demand

The CQC completed a full inspection of the hospital in July 2017, published in November 2017 and I am pleased with the progress recognised in the inspection; but aware of the significant work yet to be undertaken. The CQC found that significant improvement had been made across all services at the Trust. The team in place now worked together with more structured disciplines being embedded around executive and performance behaviours and responsibilities. With the Every Patient, Every Day programme (EPED), the responsibility, accountability and ownership of service improvement had been given back to the local leaders.

The boards of both Colchester Hospital and Ipswich Hospital are continuing to work together to merge the organisations to improve care for patients and create a more sustainable future.

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

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

Nick Hulme
Chief Executive

Part 2 - Priorities for improvement and statements of assurance

2017/18 quality improvement priorities

Progress against the priorities we set as a Trust

Patient safety priority 1 (a):

To reduce the numbers of inpatient falls

Why was this a priority?

Ensuring that our patients receive 'Harm Free' care during their admission is a key priority for any healthcare provider. The impact on patients following a fall in hospital can be wide ranging and complex.

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

Lead Director

Director of Nursing

What was our target?

A reduction of inpatient falls per 1000 bed days to below 5.

What did we do to improve our performance?

- ✓ A Trust-wide improvement plan for Falls has been developed
- ✓ An aggregated action plan was implemented for falls incidents resulting in harm
- ✓ The Falls Prevention inpatient service has been developed within Corporate Nursing and Quality Divisions, with leadership provided by the Deputy Director of Nursing on behalf of the Director of Nursing

How did we measure and monitor our performance?

- ✓ Incident reporting of all inpatient falls were monitored through Patient Safety & Quality Team and reported upon via Ward Safety Dashboard to Matrons Group, chaired by Director of Nursing.
- ✓ All falls resulting in serious harm were investigated at the earliest opportunity and case were reviewed through the weekly Harm Free Forum chaired by Deputy Director of Nursing. This identified immediate learning and informed quality improvement plans.
- ✓ Monthly review of falls activity and trends has formed part of the Patient Safety and Experience Report.
- ✓ Inpatient falls incidents have been triangulated with PALS complaints and Safeguarding information to identify any emerging themes and trends to any specific areas of the Trust. This has identified 'early warning' signals which enabled quality improvement actions to be undertaken.

Did we achieve our intended target?

- ✓ Overall, the Trust has demonstrated a reduction of inpatient falls by 14%
- ✓ There has been a reduction in the number of falls resulting in serious harm by 6%.

How and where was progress reported?

Regular reports and updates were provided to:

- ✓ Matrons Meeting
- ✓ Patient Safety and Experience Group
- ✓ Quality & Patient Safety Committee.

Our key achievements

- ✓ Achieving a reduction in the overall number of inpatient falls and consistency in <5 falls per 1,000 bed days
- ✓ A reduction in the number of falls resulting in serious harm
- ✓ Development of a weekly Harm Free Forum Group to discuss inpatients falls incidents resulting in serious harm in order to identify areas for learning and to target support.

2017/18 quality improvement priorities
Progress against the priorities we set as a Trust

Patient safety priority 1 (b):

A reduction in hospital acquired pressure ulcers

Why was this a priority?

To reduce the burden on patients living with them

To reduce resources spent by the Trust on treating them.

To ensure that clinical care supports best practise in pressure ulcer prevention.

To reduce incidence of patient harm .

Lead Director

Director of Nursing

What was our target?

A reduction by 30% of hospital acquired pressure ulcers (total numbers) compared to 2016/17.

What did we do to improve our performance?

- ✓ Delivered 1:1 training on pressure ulcer prevention across the Trust
- ✓ Engaged with NHSI Pressure Ulcer Collaborative 2017/2018
- ✓ Increase staffing within the Tissue Viability (TV) team allowing for increased face to face support across the Trust
- ✓ Reviewed current pressure ulcer prevention practises and implemented improvements in line with best practise
- ✓ Delivered education on pressure ulcers to enhance skills and knowledge for Trust staff
- ✓ Provided monthly training to all new staff on pressure ulcers via clinical induction
- ✓ Implemented pressure redistribution surfaces within A&E to protect at risk patients.
- ✓ Audited use of pressure redistribution surfaces to ensure correct selection
- ✓ Harm Free panel setup revised focusing on lessons learnt and shared learning.

How did we measure and monitor our performance?

- ✓ Monitored via Datix system
- ✓ Against national Patient Safety Thermometer data
- ✓ Completion of Root Cause Analysis into PU incidences.

Did we achieve our intended target?

Yes—reduction of total pressure ulcer numbers by 30%.

How and where was progress reported?

Matrons meetings

Harm Free Panel

Monthly patient safety report

Quarterly reports to Patient Safety & Experience Group and Quality & Patient Safety Committee.

Our key achievements

- ✓ Reduction of 30% of total PU figures (all grades) compared to 2016/2017
- ✓ Involvement in the NHSI PU Collaborative 2017/2018
- ✓ An increase in staffing within the Tissue Viability Service enhancing Ward support and patient education
- ✓ Raising awareness of appropriate use of dynamic support surfaces to aid PU prevention/management
- ✓ Introduction of pressure reducing mattresses in A & E to ensure ‘at risk’ patients receive preventative care
- ✓ 1:1 individual training with Ward staff on PU prevention
- ✓ Patients that require Tissue Viability support are identified on inpatient whiteboards
- ✓ Implementation of a recognised tool to aid staff in differentiating between different types of skin damage
- ✓ Improved resources to support Heel elevation as a tool to aid PU prevention
- ✓ User friendly Wound Care Formulary to guide staff on appropriate choice of dressings.

Part 2 - Priorities for improvement and statements of assurance

2017/18 quality improvement priorities

Progress against the priorities we set as a Trust

Clinical Effectiveness priority:

To ensure the Trust has completed its requirements in relation to NatSSIPS

Why was this a priority?

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

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

Lead Director

Medical Director

What was our target?

Ensure the Trust has completed its requirements in relation to NatSIPPS in 80% of settings.

What did we do to improve our performance?

The Trust identified a lead clinician with administrative support to coordinate and assure the Board the required work is being undertaken, to provide regular updates on progress and to support the clinical teams in identifying the required procedures and undertake the requirements.

The Trust has compiled a centralised database of procedures across all clinical settings where NatSSIPs are applicable. The database will continue to be monitored centrally as further procedures continue to be identified and logged or where there are changes to the guidance;

Intervention teams have been identified within the clinical specialties and the clinical lead and administrator meet to support them to complete their LocSSIPs for the relevant procedures.

How did we measure and monitor our performance?

The performance was monitored on a monthly basis at the Clinical Delivery Group and Divisional Governance and Quality meetings.

Progress has been measured against the identified number of LocSSIPs required as well as identifying and completing more Trust wide Policy and Procedure based on the NatSSIPs requirements.

Did we achieve our intended target?

There have been 123 interventions requiring a LocSSIPs identified as at 31st March 2018. 7 of these are in progress and 99 are now complete, which shows a 88.61% completion target against the 80% identified.

How and where was progress reported?

The performance was monitored on a monthly basis at the Clinical Delivery Group and Divisional Governance and Quality meetings. Monthly updates have been provided to the Clinical Effectiveness Group and to the Quality and Patient Safety Committee which reports to the Trust Board. Updates have also been presented monthly to the Trust's Quality & Risk Executive Meeting to provide assurance that risks to the workplan have been identified and are being mitigated or to request support where needed.

Our key achievements

A Safer Surgery Policy has been developed and was launched in August 2017. The policy ensures staff use the safest practice in minimising risks to patients during the perioperative patient episode. The policy focuses on key patient safety processes including Patient consent and identification, surgical site marking, Pregnancy check before surgery, surgical safety checklist, Stop before you block (regional Anaesthesia) and focuses on the World Health Organisation core standards for safer surgery.

The Policy for the checking of pregnancy before surgery, x-ray/ diagnostics and chemotherapy was approved in August 2017. This was a key document which the Trust did not have in place at the time despite a historic NPSA Rapid Response Alert. The policy is one of the necessary safety mechanisms to support NatSSIPs.

2017/18 quality improvement priorities
Progress against the priorities we set as a Trust

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

Why was this a priority?

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

Lead Director
Director of Nursing

What was our target?

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

What did we do to improve our performance?
- ✓ FFT compliance was tracked as part of the senior nursing accountability programme.
- ✓ FFT metrics were utilised within the Trust's Accountability Framework
- ✓ The process to move to an electronic FFT collection process was commenced with the closing of the tender happening in April 2018.

How did we measure and monitor our performance?
- ✓ FFT weekly, monthly tracking through Patient Safety and Experience Group and assured through Quality and Patient Safety Committee
- ✓ Programme oversight for new FFT system implementation to be tracked through the Projects Management office.

Did we achieve our intended target?

The Trust achieved its target for recommender being at or above 95% for Inpatients with a score of 97.9% (national average 95.7%) ; the score for ED was 87.7% - this was, however, higher than the national average.

How and where was progress reported?

Regular reports and updates to:
- ✓ Divisional Governance meetings
- ✓ Patient Safety and Experience Group
- ✓ Quality and Patient Safety Committee
- ✓ Weekly Matrons Meetings
- ✓ Divisional Integrated Performance Meetings
- ✓ Trust Board through Integrated Performance Report Accountability Framework.

Our key achievements

✓ Improved response rates for ED, becoming one of the better performing trusts nationally for response rates and recommender rate above the national average.

✓ Listening to patient feedback and making improvements

Our priorities for improvement in 2018/19

Qualitative information from a number of sources including patient surveys, staff surveys, complaints, compliments and the views of users and user groups at a community engagement event has helped inform the Trust's priorities for 2018/19.

Patient safety priority:

To improve compliance with the Sepsis 6 care bundle

Why is this a priority?

The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. It was developed in 2006 by a group of physicians and nurses working on an educational programme to raise awareness and improve the treatment of patients with sepsis.

The management of sepsis from presentation in ED after admission to hospital usually involves three treatments and three tests, known as the 'Sepsis Six'. These should be initiated by the medical/ nursing team within an hour of red flag marker identification unless a non-sepsis rationale is documented by a clinician for diagnosis.

Lead Director

Medical Director and Director of Nursing

2017/18 performance

- Identification of sepsis in the Emergency Department Was 58% and acute inpatient settings was 40%.
- Timely treatment of sepsis within 60 minutes is 52% and inpatient areas 24.92%

What is our target?

- Timely identification of sepsis in the Emergency Department and acute inpatient settings as per the National Guidelines of the 'Sepsis 6' defined above
- Timely treatment of sepsis within 60 minutes
- Compliance with Sepsis 6 in ED >90% at end of 12 months

What will we do to improve our performance?

- ✓ Implement clinical sepsis tool to guide screening and treatment
- ✓ Implement mandatory training (e-learning programme) for all clinical staff
- ✓ Enable the prescribing of intravenous fluids by nursing staff to manage the early treatment of sepsis
- ✓ Increase awareness of the signs and symptoms of sepsis for healthcare professionals and the public through education
- ✓ Bespoke training sessions for ward-based staff.

How will we measure and monitor our performance?

- ✓ Audit timely identification and treatment of sepsis
- ✓ Monitor compliance with staff training for doctors and nurses
- ✓ Compliance with Commissioning for Quality and Innovation (CQUIN) national goals for identification and treatment of suspected sepsis

How and where will progress be reported?

Regular reports and updates to: Patient Safety & Experience Group, Quality and Patient Safety Committee and Deteriorating Patient Group

Clinical effectiveness priority:

To improve access to psychiatric liaison services for hospital inpatients

Why is this a priority?

This is a national priority to ensure patients receive prompt access to ensure parity of both mental health and physical health care.

There is evidence that 25-33% of people admitted to acute hospitals also have a mental health condition, with mental health disorders accounting for 5% of all Emergency Department (ED) admissions.

By providing effective mental health support to patients, and expertise to staff where required, we can minimise the time a patient needs to stay in an acute hospital environment.

This will support the hospital to meet NICE guidance criteria for managing mental health and psychological conditions and those co-morbid with long-term conditions and ensure patients are treated appropriately.

Lead Director

Director of Operations

2017/18 performance

The Trust reported a reduction of 44.75%, meeting the expectation of a 20% reduction in the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.

Our priorities for improvement in 2018/19

What is our target?

- Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions.
- Reduce total number of attendances to A&E by 10% for all people with primary mental health needs.

What will we do to improve our performance?

✓ Work with our partners, both education providers and staff to provide education and training for all staff to increase confidence

✓ Monitor the ED breaches for patients requiring mental health support.

✓ Monitor the length of stay for patients who have a mental health co-morbidity.

How will we measure and monitor our performance?

✓ Monitor the ED breaches for patients requiring mental health support.

✓ Monitor the length of stay for patients who have a mental health co-morbidity

✓ Reporting on Outcomes Framework to the Operational Board.

How and where will progress be reported?

Regular reports and updates to:

✓ A&E Operational Board

✓ Executive Management Committee

✓ Quality & Contract Performance Meeting with the Commissioners

Patient experience priority:

To continue to improve our care to those at the end of their life and support patients who have limited treatment options.

Why is this a priority?

There is only one chance to get end of life care right. In the final stages of illness, care priorities shift with the focus often changing to palliative care for the relief of pain, symptoms, and emotional distress. Compassionate high quality care enables us to make a loved one's final weeks or days as comfortable as possible by offering the person at end of life, and those identified as important to them, choice around decisions concerning treatment and care wanted, and an individual plan of care tailored to the needs, wishes and preferences of the dying person; agreed, coordinated and delivered with compassion.

Lead Director
Director of Nursing & Medical Director

2016/17 performance

✓ >75% of admitted emergency patients who are on My Care Choices Register being accessed during their hospital stay, achieved 76%

✓ <17 Complaints related to end of life care. Performance was 21

✓ 50% Use of the Individual Care Record End of Life documentation, 58% achieved

✓ 90% of Patients who are rapidly deteriorating (last weeks of life) and discharged to their Preferred Place of Death ("PPD"), 87% achieved

✓ <=24hrsTime taken to discharge rapidly deteriorating patients (last weeks of life) to their preferred place of discharge from time of referral to complex discharge team, achieved 192hrs (average)

What is our target?

- To deliver high quality, compassionate and dignified end of life care for all patients.
- Patients will receive the right care in the right place
- To increase the number of patients dying in the place of their choice.

What will we do to improve our performance?

- Recognise timely identification of patients in the last year of life by increasing use of SPICT
- Discuss with patients and their families their wishes and document on My Care Choices Register (MCCR).
- Access patient's MCCR on every emergency admission
- Work with system partners to improve end of life care at home provision..
- · Use national and locally recognised tools, ie the regional DNACPR form, the yellow folder , treatment options form and the Individual Care Record for the last days of life, SPICT

Our priorities for improvement in 2018/19

and MCCR

- Promote co-ordinated care for discharge planning, enabling patients to die in their preferred surroundings, be that at home, hospital or hospice.
- Facilitate palliative and end of life care training and education for staff using innovative and creative approaches to learning.
- Continued access to specialist palliative care assessments, seven days a week.
- Improve bereavement support for families of patients who have died by promoting and/or referring to NEE Bereavement services

How will we measure and monitor our performance?

- Monitored themes from complaints relating to end of life care and share these complaints with clinical staff.
- Monitored results from DNACPR and national end of life audits to highlight themes for improvement.
- Audited use of individualised care Individual Care Record for the Last Days of Life plans to ensure best possible practice.
- Expanded post bereavement follow up service with families

How and where will progress be reported?

Regular reports and updates to:

✓ Patient Safety & Experience

✓ Quality & Patient Safety Committee

Our priorities for improvement in 2018/19

Karen Magill, Sepsis and Deteriorating Patient Nurse Specialist and the Children's Emergency Department Team following the short listing for the improvements made to the Care of a Child with Sepsis in the Emergency Department, for the National Patient Safety Awards.

Provided and sub-contracted services

Provided and sub-contracted services

During 2017/18 Colchester Hospital University NHS Foundation Trust provided and/ or sub-contracted 68 relevant health services.

Colchester Hospital University NHS Foundation Trust has reviewed all the data available to them on the quality of care in 68 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18, represents 100% of the total income generated from the provision of relevant health services by Colchester Hospital University NHS Foundation Trust for 2017/18.

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

.

Colchester Hospital now offers a new service , 'brachytherapy with needles' for advanced cervical cancer. Pictured below the Brachytherapy Team with the equipment

Participation in clinical audit

During 2017/18, 36 national clinical audits and 5 national confidential enquiries covered relevant health services that Colchester Hospital University NHS Foundation Trust provides.

During 2017/18 Colchester Hospital University NHS Foundation Trust participated in 81% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

Table 1.—National Audits

National Audits 2017/18
Heart
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Cardiac Rhythm Management (CRM)
National Cardiac Arrest Audit (NCAA)
National Heart Failure Audit
National Vascular Registry
Acute
Case Mix Programme (CMP)
Falls and Fragility Fractures Audit programme (FFFAP)
Major Trauma Audit
National Emergency Laparotomy Audit (NELA)
National Joint Registry (NJR)
Fractured Neck of Femur (care in emergency departments)
Procedural Sedation in Adults (care in emergency departments)
BAUS Urology Audits
Women's & Children
Diabetes (Paediatric) (NPDA)
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)
Child Health Clinical Outcome Review Programme
Maternal, Newborn and Infant Clinical Outcome Review Programme
National Maternity and Perinatal Audit (NMPA)
Pain in Children (care in emergency departments)
Older People
National Audit of Dementia
Sentinel Stroke National Audit programme (SSNAP)
Long Term Conditions
Endocrine and Thyroid National Audit
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
National Diabetes Audit - Adults
UK Parkinson's Audit
Cancer
Bowel Cancer (NBOCAP)
National Lung Cancer Audit (NLCA)
National Prostate Cancer Audit
Oesophago-gastric Cancer (NAOGC)
National Audit of Breast Cancer in Older People (NABCOP)
Haematology
National Comparative Audit of Blood Transfusion programme
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
Other
Elective Surgery (National PROMs Programme)
Learning Disability Mortality Review Programme (LeDeR)
National Ophthalmology Audit
Medical and Surgical Clinical Outcome Review Programme
National Confidentional Enquiries 2017/18
Chronic Neurodisability
Young People's Mental Health
Cancer in Children, Teens and Young Adults
Acute Heart Failure
Perioperative Diabetes

Participation in clinical audit

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust participated in during 2017/18 are as follows:

The national clinical audits and national confidential enquiries that Colchester Hospital University NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Audits 2017/18	Cases Sub-mitted	Cases Ex-pected	%
Heart			
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	294	294	100 %
Cardiac Rhythm Management (CRM)	279	279	100 %
National Cardiac Arrest Audit (NCAA)	59	59	100 %
National Heart Failure Audit	631	631	100 %
National Vascular Registry	201	201	100 %
Acute			
Case Mix Programme (CMP)			NA
Falls and Fragility Fractures Audit programme (FFFAP)	30	30	100 %
Major Trauma Audit	364	364	100 %
National Emergency Laparotomy Audit (NELA)	176	176	100 %
National Joint Registry (NJR)	908	908	100 %
Fractured Neck of Femur (care in emergency departments)	41	41	100 %
Procedural Sedation in Adults (care in emergency departments)	51	51	100 %
BAUS Urology Audits			NA
Women's & Children			
Diabetes (Paediatric) (NPDA)	211	211	100 %
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)			NA
Child Health Clinical Outcome Review Programme			NA
Maternal, Newborn and Infant Clinical Outcome Review Programme	44	44	100 %
National Maternity and Perinatal Audit (NMPA)	NA	NA	100 %
Pain in Children (care in emergency departments)	51	51	100 %
Older People			
National Audit of Dementia	56	50	100 %
Sentinel Stroke National Audit programme (SSNAP)	653	653	100 %
Long Term Conditions			
Endocrine and Thyroid National Audit			NA
National Chronic Obstructive Pulmonary Disease (COPD) Audit pro-gramme	616	616	100 %
National Diabetes Audit - Adults	47	47	100 %
UK Parkinson's Audit			NA

Participation in clinical audit

Cancer			
Bowel Cancer (NBOCAP)	339	339	100%
National Lung Cancer Audit (NLCA)			NA
National Prostate Cancer Audit			NA
Oesophago-gastric Cancer (NAOGC)	52	52	100%
National Audit of Breast Cancer in Older People (NABCOP)			
Haematology			
National Comparative Audit of Blood Transfusion programme	135	135	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	NA	NA	NA
Other			
Elective Surgery (National PROMs Programme)	98	98	100%
Learning Disability Mortality Review Programme (LeDeR)	20	0	0%
National Ophthalmology Audit	***	***	***
Medical and Surgical Clinical Outcome Review Programme			NA

***Studies still open

National Confidentional Enquiries 2017/18	Cases Submitted	Cases Expected	%
Chronic Neurodisability	2	2	100%
Young People's Mental Health	1	4	25%
Cancer in Children, Teens and Young Adults	N/A (Ongoing)	N/A (Ongoing)	N/A (Ongoing)
Acute Heart Failure	1	3	33%
Perioperative Diabetes	N/A (Ongoing)	N/A (Ongoing)	N/A (Ongoing)

Participation in clinical audit

The reports of 5 national clinical audits were reviewed by the provider in 2017/18 and Colchester Hospital University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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

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

National Cardiac Arrest Audit

Cumulative reports are received quarterly and are reviewed at the Resuscitation Group. Results demonstrate that our rate of cardiac arrests per 1000 admissions is 1.1 the same as the national average rate of 1.1. The ratio of observed to predicted survivors to hospital discharge remains stable at 1.06.

National Emergency Laparotomy Audit

Trust: 5 areas good. 5 areas amber. 1 area red – assessment by elderly medicine specialist in patients aged 70 years and over. Local audits being carried out to assess the quality of the data being submitted.

National Joint Registry

We constantly review our performance on the NJR both as individual surgeons and as a trust. In the past this has identified issues with prostheses and techniques which have been addressed and our implant revision rate improved. We now have a weekly lower limb arthroplasty MDT where registry data is analysed and discussed and problems identified and actions discussed to improve performance. These meetings are attended by surgeons performing lower limb arthroplasty and are minuted.
The current report has flagged consent rate for the registry, quality of trainee operations and individual revision rates for surgeons. We are instituting changes to our practise and documentation to improve them.

National Bowel Cancer Report 2016

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

MINAP

In general, we are better or similar to national standards (eg patients seeing a Cardiologist, being admitted to a cardiology ward, having angiography if appropriate and receiving the full package of secondary prevention therapies). We are worse for our length of stay for NSTEMI and our ability to provide angiography/PCI within 72 hours of admission (the NICE QS). Both these areas are due to the inability of the tertiary centre to accept patients for angiography/ PCI in an appropriate timescale. Further improvements will come from moving to a 7/7 Consultant service (which will be achieved with 2 additional Consultant appointments, currently out to advert). A 7/7 Clinical Nurse Specialist service will also improve our NICE QS in NSTEMI and heart failure.

Participation in clinical audit

The reports of the 85 local clinical audits were reviewed by the provider in 2017/18 and Colchester Hospital University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Trust wide large scale NEWS & Sepsis audit

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

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)

Monthly audit of DNACPR form completion takes place in line with the Documentation Audit Proposal (September 2017). Every ward is audited on a 3 monthly rolling basis. Feedback is provided immediately following the audit with the report being disseminated via relevant heads of nursing.

Compliance has remained static around the 85% mark with reports being discussed at the Resuscitation Committee.

This is in addition to the work surrounding DNACPR decision making by the End of Life Steering Group and the EOL work stream as part of the Every Patient, Every Day improvement programme

Last Days of Life Audit

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

Classic Safety Thermometer Audit

The Safety Thermometer (Classic) is an audit undertaken for all inpatients once a month looking at pressure ulcers, falls with harm, catheters with a Urinary Tract Infection (UTI) and new Deep Vein Thrombosis (DVT) & Pulmonary Embolism (PE). For the period 1/4/2017 to 28/2/2018, 98.5% of inpatients did not experience a new-harm event - the national average for acute organisations was 97.9%.

0.1% patients had had a fall resulting in harm in the 3 days prior to the audit
0.3% patients had developed a new pressure ulcer
0.4% patients had started treatment for a new DVT or PE
0.8% patients had a urethral catheter and had started treatment for a new UTI
(Some patients had more than 1 new harm event.)

Participation in clinical audit

Table 2—Local Audits

Division 1 - Surgery	
Audit	Description of Actions
Think ABCD on emergency admission	Introduce new proforma and re-audit
General Surgery VTE audit on compression stockings	No Actions
Notes & Record Keeping in General Surgery	No Actions
Antibiotic prescribing and compliance with local guidelines	No Actions
Are ventilation strategies on the critical care unit complying with evidence based guidance on tidal volume targets?	Education Sessions
Appropriate Imaging in Acute Pancreatitis	Education of junior staff about the importance of avoiding early CECT and performing an early USS examination in acute pancreatitis
Evaluation of Surgical Drains in General Surgery	Provide information on appropriate handling and positioning of surgical drains to nursing colleagues on the ward Design, produce and introduce patient information leaflet on care of surgical drains
Evaluation of Pre-Operative Surgical Site Marking	No Actions
General surgery antibiotic Re-audit	Update guideline in collaboration with microbiology department Include guideline in induction for junior/locum doctors Encourage frequent guideline/App review
Can inpatient access to angioplasty be improved?	No Actions
Major Lower Limb Amputations: an audit of patient selection, management and postoperative care	Implement local pathway
Thromboprophylaxis and Anticoagulation on the Vascular Ward	To add an extra section in handover sheet that records the anticoagulation of each patient. To implement teaching on renal failure and anticoagulation.
Radiograph reporting in fracture clinic: are we meeting IRMER standards?	No Actions
Operation notes audit for Orthopaedic Trauma	Consider whether consultants would like to make computer templates for operations Doctors reminded of post-op instructions, incision, blood loss documentation Nurses reminded re: elective/emergency documentation
Thromboprophylaxis in Neck of Femur Fractures	No Actions
The Essex Monopost Efficiency and Safety Study (EMESS)	No Actions
Pilot of Optometrist Led Cataract clinic	Clinic to increase capacity Referral pathway for other pathology to be refined

Participation in clinical audit

Are ENT clinics follow-up appointments being allocated appropriately?	Clinicians check outcomes on clinic forms Clinicians to consider discharging patients from clinic if for procedure only +/- stipulate this on clinic coding form Administrative staff to check all patients with final discharge letters are not listed as awaiting appointment from ENT
Pre-operative fasting in elective surgical patients	No Actions
Central Venous Catheters (CVC) and CVC related bloodstream infections in critical care	Encourage the use of gained blood cultures if CVC infection suspected Encourage IN team to chase results of CVC tips Promote clear documentation in the notes Encourage nursing staff to send CVC tips to microbiology Continue recording and collecting data after adjusting date collection proforma
Humidification of breathing circuits in critical care	Draft guidance for nursing staff regarding humidification of circuits in critical care
Anaesthetic Chart Review	Feedback to Anaesthetists with poor performance
Re-Audit of Acute Kidney Injury in Lower Limb Arthroplasties	Preoperative airway assessment for patients undergoing general anaesthetic
Preoperative airway assessment for patients undergoing general anaesthetic	No Actions
ITU magnificent 7 – nutrition	No Actions
Noise Level in Adult Critical Care Unit and Achieving a Better Sleeping Pattern for Patients	Reduce the volume of discussions around patients; use the handover room especially in the evening; have discussions away from the patient when possible Adjust alarm parameters to patient physiological state Non-work related conversations should happen away from patients; keep mobiles on silent mode; small number of visits/patient Introduce earplugs to reduce the amount of noise perceived by the patient
Central Venous Catheter Project – revisiting practice following recent intervention	Continue careful CVC monitoring and meticulous care Encourage higher standards for documentation in clinical notes re: CVC insertion and CXR Acknowledge teams' efforts in sending the CVC tips to microbiology – to be continued

Participation in clinical audit

Division 1 - Cancer Services and Haematology (including Breast and Radiology)	
Audit	Description of Actions
Open Access Follow Up (OAFU) service for breast Cancer Patients - a patient evaluation	1. Recruitment of OAFU co-ordinator, 2. Recruitment of Breast Care Nurse Secretary, 3. Ensure all topics are covered in nurse led consultation (as per holistic needs assessment), 4. Assess patient's understanding of treatment and risk, 5. Ward staff to plan appropriate dressing removal, suitable to patients needs
Chelmsford & Colchester Breast Screening Service Assessment - Client Satisfaction Survey	1. Remove landline line from assessment letter and information so screening nurse is more available to contact, 2. Try to speak with client's pre assessment to ensure they have read info pre assessment, 3. Feedback to Linda Kearton assessment letter invites not be sent to arrive on Fridays and put on letter that there is no one to contact over the weekends, 4. Review assessment leaflet
Audit of Level 2 High Intensity chemotherapy for Hodgkin's/High grade Non –Hodgkin's Lymphomas	1. To continue to monitor patients receiving salvage closely, 2. To continue selecting appropriate patients to receive these regimens.
Enteral feed audit - Head & Neck Oncology	Now developed a Head and Neck flow chart for the placement of enteral feeding tubes in patients admitted to West Bergholt ward. The flow chart ensures optimisation of analgesia, optimal times of the day for tube placement, confirmation from the oncology consultant that they are happy for a nurse, or if they ned a medic to place the NG tube
Patients attending the Head & Neck Cancer Clinics - a patient evaluation	1. Add financial support information into the patient information pack, 2. Bring back all CHUFT patients from MEHT (this was completed in June 2017), 3. Work with the Network to streamline the MDT clinic process.
Re-audit of Documentation Procedure compliance for 'administration of Intrathecal Chemotherapy'	1. ITC folders and registers need to be checked for completeness as new guidelines and registers are produced. Now a standing item on the Chemo Quality Group Agenda, 2. 2. Clerical staff should make every effort to ensure notes are available prior to the procedure being carried out, and failing that details of the visit should be documented separately and filed at a later date, 3. 3. Annual training sessions to highlight and enforce the need for all doctors and nurses involved in the administration of ITC need to formally document all the 12 steps on the ITC proforma, every time including patient participation, most recent FBC and that proforma's are being faxed back to pharmacy

Participation in clinical audit

Lung Cancer Support and Information Giving for newly diagnosed patients - Patient Satisfaction Survey	1. Business case for additional Band 5/6 Lung Cancer Nurse, 2. Ensure to question patient's understanding and follow up phone call, 3. Review the printed patient information
Patient Satisfaction Survey for Lymphoma Patients (support and information giving)	1. To make sure booklets are available in the day unit, clinic rooms and CNS office. Haematology support nurse will be available when CNS is not to offer written information, 2. The CNS to make sure they make clear to the patient that a holistic assessment has been carried out.
Patients Undergoing Chemotherapy treatment in the Mary Barron Suite - a patient evaluation	1. Formalise roles & responsibilities of the Co-coordinator role, 2. 2. Feedback back Audit during monthly Meeting
An audit comparing the survival benefit between Pertuzumzb-Herceptin and T-DM1 in HER2 positive metastatic breast cancer patients at Colchester Hospital Oncology Department	1. Convey the findings to chemotherapy funding association for efficacy and toxicity monitoring, 2. Plan to re-audit in 3 years' time to have more convincing data with the ongoing regimen, 3. Implication of the result after 3 years data analysis
CT Pneumocolon Service - a patient evaluation	1. To review the leaflets again to ensure they are kept up to date with any change in our current practise, 2. To keep up in-house training to ensure maintenance of good patient care
Radiology Service - annual Trust wide service evaluation	1. Restructure Appointment Letters, 2. Improve Signage, 3. Create platform of information about pathways (simplistic), 4. Recondition Waiting areas
Quality Improvement Project Aiming to Improve Teaching and Support for Junior Doctors on West Bergholt Ward (Re-audit following changes made in December 2016)	1. Haematology/oncology teaching to be re-introduced, 2. 1 hour communication skills training session introduced to the West Bergholt junior doctors induction programme should continue, 3. Breakout sessions once a month to openly discuss difficult cases
External user evaluation for the Renal Surveillance Clinic	1. Additional clinic set up in Clacton, 2.
Patient Satisfaction Survey - Information & Support Radiographer (ISR)	1. Continue to audit Radiotherapy leaflets (the service is audited in this survey), 2. Continue to give out ISR's business cards, 3. Provide information that is relevant to patients tailored for their needs, 4. Continue to address patients' needs using the Concerns Assessment
Patient satisfaction survey for the Uro-oncology Clinical Nurse Specialist service across the Essex Cancer Network	1. With regards to negative feedback received about the department regarding surgical secretaries and admissions, these comments have been brought to the attention of our management, the team are working together to make improvements.
External user evaluation for the Urology Advanced Nurse Practitioner Led – Active Surveillance Programme	1. Review patient literature regarding active surveillance, 2. Review current literature/consider new literature regarding the need for reimaging/re-biopsy during active surveillance

Participation in clinical audit

Division 2 - Medicine	
Audit	Description of Actions
Use of the Rapid Access Chest Pain Clinic to facilitate A+E discharges	All RACPC forms to be printed and attached to criteria – Administrative staff and clinicians. Time Scale- From 14/6/17 New clear RACPC posters to be printed and displayed in department- Auditor– Time Scale- 14/6/17 This report to be circulated to the department - Dr Koshonko- Time Scale- 14/6/17 Plans for Re-Audit- Actions implemented 14/06/17. Dr. Selwyn-Gotha to re-audit 30 days of data from this date to complete audit cycle.
Trauma team activation in the ED - An assessment of documentation and radiological response time	Meet with management to discuss Qlikview + poor data storage A&E education- A&E consultants- Deadline: Next teaching day Audit into radiological response time- Deadline: ASAP
Re-audit of Use of Rapid Access Chest Pain Clinic to facilitate A&E discharges	No Actions
Management of Head injury in A&E	No Actions
Thrombo prophylaxis in lower limb fracture	No Actions
Process of diagnosing SAH in patients presenting with headache	No Actions
Variation of MUSt scores between COTE and general medical wards	Add to the bottom of ASKIN chart as a prompt to calculate MUST Laminated print out of how to calculate MUST score at the start of nursing notes/at each nurses station Writing the weight on admission and the weight on last booklet on each next nursing booklet Documenting rationale when MUST score changes
Are referrals for NIV (non-invasive ventilation) in patients with MND (Motor neurone disease) compliant with NICE guidelines	Audit project results to be discussed at Neurology Governance meeting Dr Roebuck to meet Dr P. Hawkins & Dr F. Kapsimalis to explore ways of improving the service
Hypoglycaemia Audit	Ongoing education to trust staff Continuous review of blood glucose levels <3mmols
Completion of stool charts on COTE	All patients to have stool charts in bedside notes All patients to have bowel motions completed daily in nursing notes
Inpatient Catheter Audit	Presentation Informative Sessions: Grand Round Informative Sessions: Infection Control Possible Interventions Catheter Tags Posters

Participation in clinical audit

A retrospective audit into IBD care and IBD pathways	To be discussed at IBD meeting
Audit to investigate the uptake os spict screening and TREC forms	Email ward team to inform them of audit findings Present audit to ward and emphasise benefits of SPICT and TREC completion Compile SPICT and TREC pack with guidance on using both and place this on ward to aid and encourage uptake Present in clinical audit half day

Participation in clinical audit

Division 3 - Women & Children	
Audit	Description of Actions
Talley Mattress Audit	Reduce number of dynamic mattresses used within the Trust by increasing staff awareness of Policy/ Guidance on the use of pressure reducing/relieving mattresses and their role in PU prevention. Re-audit Talley mattress usage in 3 months' time. To renegotiate the dynamic mattress contract.
Impact of Pathology Services on Colposcopy Treatment	R/V process of receiving reports from pathology lab. To provide data gathered to share with pathology partnership to ensure optimal work force planning.
Assessing communication regarding shoulder dystocia within DGH following Montgomery report	To check to see if NIPE's have been done by a paediatrician. To add a compulsory field for anterior shoulder on Medway.
Neonatal sepsis	The development of a lumbar puncture guideline specific to neonates. Re-audit results.
Thyrotoxicosis in pregnancy – controlling the storm	No Actions
Management of coeliac disease in children	Dedicated multidisciplinary Coeliac clinic has now been established (from April 2017) 6 clinics a year. New local guidelines.
IRMER Regulations: Compliance Rate of Image Reporting by Non-Radiology Clinicians	Re-audit.
Claustrophobia and MRI-an audit to ascertain the number of failed MRI scans due claustrophobia	No Actions
Abnormal Chest X-Ray Urgent Referral Pathway Vs Straight to Test Lung Pathway	No Actions
Audit to Optimize CT KUB Imaging in Investigation of Renal Colic	No Actions
An audit into the quality of ADOS referrals	Design new referral from. Information about module selection and significant information shared with team. Clerical team informed of new referral process.

Participation in clinical research

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

The number of patients receiving relevant health services provided or sub-contracted by Colchester Hospital University NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 695

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

Colchester Hospital University NHS Foundation Trust was involved in conducting 53 clinical research studies during 2017/18, examples of which include:

The Maven Study – Trust spooned nationally adopted. This is a randomised controlled clinical trial comparing the effectiveness of bandaging compared to the Juxta Cures™ device in the MAnagement of people with VEnous ulceratioN: Feasibility Study;

PrEP Impact Trial: A pragmatic health technology assessment of PREP and implementation. This trial aims to determine what proportion of people who attend sexual health clinics in England will be eligible for PrEP according to the eligibility criteria set out for PrEP use and how long they are eligible for. Through the trial it will be able to measure how many attendees at sexual health clinics meet eligibility criteria for PrEP, how many of these take up the offer of PrEP and how long they remain on PrEP for;

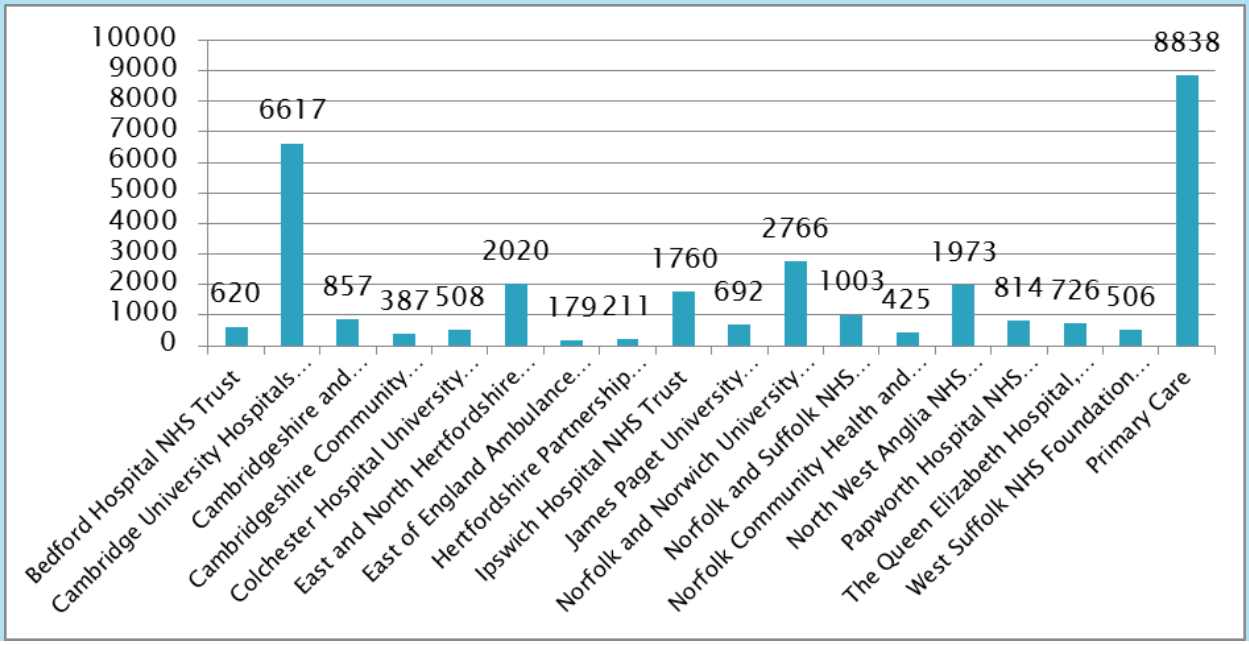
Molecular Profiling for Lymphoma Study (MaPLe Study) - To aid the identification of patients with lymphoma that may be suitable for specific targeted therapies.
To test whether molecular characterisation of lymphoma can be carried out as a standardised, routine practice during the treatment of patients in the NHS;

RAPPER Study (Radiogenomics: Assessment of Polymorphisms Predicting the Effects of Radiotherapy) The purpose of the study is to understand why some patients who receive radiotherapy are more likely to experience side effects than others.

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

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

Chart 1 -Recruitment 17/18 – CRN Eastern Comparison:



Participation in clinical research

of the Eastern AHSN, which is hosted by Addenbrookes.

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

The research staff consist of 15 nurses, 1 AHP, clinical support staff, administrative staff and a pharmacy position. The research staff recruit and support patients in NIHR clinical trials and ensure that the research is being conducted within the recommended frameworks and conducted to International Conference Harmonisation – Good Clinical Practice (ICH-GCP) standards. The research service also includes governance reviews, assurance and risk assessment, specialist advice, clinical feasibility, patient recruitment, patient follow-up, research specific training, performance and financial management.

CHUFT has an established research infrastructure that supports the clinical divisions to participate in research. However, research integration varies amongst clinical specialities. Research active specialities are led by research engaged clinicians (Principle Investigators) who incorporate research into their routine clinical practice to offer more choice and opportunities to their patients. R&I continues to promote research for patient benefit with an aspiration for all patients to have an opportunity to have treatment within a clinical trial.

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

The current merger with Ipswich Hospital will increase the range of availability of areas of research in clinical services within a single organisation. This gives the potential to be the 3rd largest recruiting Trust in the eastern network. Commitment, leadership and drive will be required for harmonisation of workforce, policies and procedures to work towards delivering top quality research and innovative technologies within the required value for money.

Maximise engagement in research

The Trust sponsors two NIHR projects within Vascular and Cancer; a non-portfolio Haematology project, and also supports students with MSc and PhD projects. R&I aims to further develop Trust sponsored research and collaborations with other pharma and academia onto the national portfolio.

We are now into Year 2 of the Trust sponsored study called MAVEN (Management of People with Venous Ulceration: Feasibility Study). This interventional study compares the effectiveness of bandaging compared to the Juxta-CuresTM device in the management of people with venous ulceration. A funding award of £125,000 was secured from the healthcare company. This includes the budget for a research nurse, consumables and supply of the juxta-cures device. To date, a total of 20 patients have been recruited into this trial, with a target of 50. Depending on the study results, the Trust hopes to run a multicentre trial and would need to apply for an NIHR Research for Patient Benefit grant.

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

Research activities are further supported by the Mary Barron chemotherapy suite, the Electro-Biomedical Engineering Department (EBME), Cardio-Respiratory Department, Nuclear Medicine Department, Radiotherapy Centre, pathology, pharmacy and radiology departments. Activities within the Trust and engagement with the public to advertise research takes place by specialty meetings, through internal communications and also articles in the local press. The Head of R&I is a committee member of the CRNE Communications Steering Group, the Patient and Public Involvement Steering Group, attends regional Research managers' meetings and regional network events. The Clinical Research Nurse Manager is a regional Good Clinical Practice (GCP) facilitator and delivers GCP training in the Trust; is lead for the regional informed consent in research course working group; a member of the steering group of the Advance Research in Practice (ARIP); chair of the research team leaders group and a member of the regional workforce development steering group.

The Trust is currently involved in 173 studies on the NIHR portfolio which are recorded on the Local Portfolio Management System

Participation in clinical research

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

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

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

Other opportunities for innovation include programs such as the Dragons' Den style innovation scheme. A previous winner: "Falls Prevention Education & Support Group for Inpatients and their Relatives" was developed by staff with R&I guidance and has now been developed as an in-house training tool for patients and carers on hospital wards. Staff are also encouraged to submit application for innovation funding programmes such as the Medtech Accelerator programme. This has been set up to facilitate the early stage development of medical technology and software innovations from within the NHS.

Research governance

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

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

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

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

The R&I department has recorded the following:

20 number of studies receiving confirmation of capacity and capability

160 number of studies require amendment confirmations

16 reported SAEs to study teams, 75% compliance for reporting to R&I with 24 Hours.

The key policies for R&I at this Trust are in place as follows: R&I policy, Intellectual Property Policy, Procedure for Reporting Adverse Events and Reactions during a Research Study.

Teams are responsible for producing local Standard Operating Procedures to support with service delivery and training of new staff.

Performance metrics

The NIHR CRN High Level Objectives (HLOs) for research, applicable to this Trust for 2017/18 are:

- HLO1: Number of participants recruited into NIHR CRN Portfolio studies
- HLO2a: Commercial sites recruiting to time and target (RTT)
- HLO2b: Non-commercial studies achieving RTT
- HLO4: Reduce the time taken for eligible studies to achieve set up
- HLO5: Reduce the time taken to recruit first participant
- Value for Money: Activity based funding model using a study complexity weighted

Participation in clinical research

score to determine budget setting.

The NIHR continues to publish outcomes against contract NIHR benchmarks. The Trust holds one of these contracts – NIHR: Performance in Initiating and Delivering (PID) Clinical Research. These outcomes include an initial benchmark of 70 days or less from the time a provider of NHS services receives a valid research application to the time when that provider recruits the first patient for that study (performance in initiating clinical research). It also includes the NHS provider's performance in recruiting to time and target for commercial contract clinical trials (performance in delivery of clinical research). These reports are available on the R&I page of the Trust website.

Life sciences industry

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

Research income generated approximately £200,000 to contribute to Trust overheads, research infrastructure and re-investment into research activities.

Pharmacy drug-saving costs as a result of pharmaceuticals supplying trial drugs free of charge provide savings to the Trust.

Patient involvement

Based upon the national submissions, there were 550 participants recruited into NIHR portfolio studies compared to 930 participants the previous year. This is a decrease of 40% from the previous year and as documented above reflects the reduction in funding from the CRN this year with resultant staff reductions. The current merger brings new opportunities to offset the changes in the funding going forward and openings for the future.

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

The Trust Research Team

Participation in clinical research

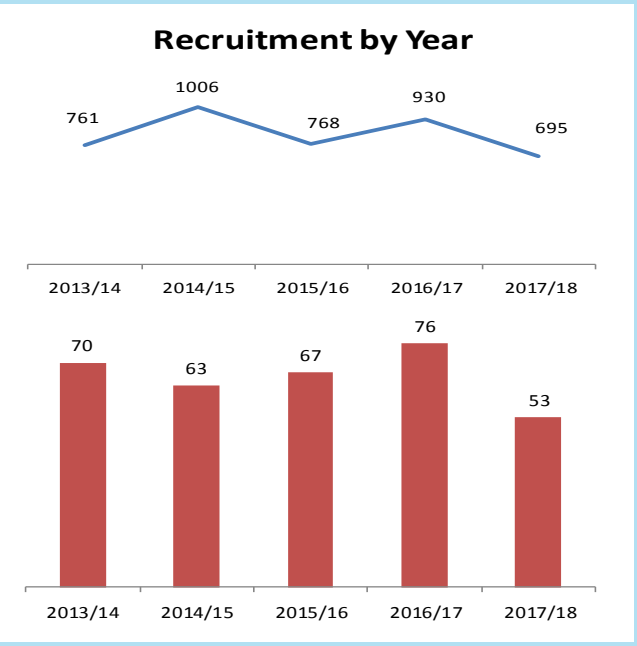
Chart 2—Five-year Performance *Data Source:CRN Eastern, Performance, Recruitment and VFM tables.*

Recruitment

2013/14	2017/18
761	695

Recruiting Studies

2013/14	2017/18
70	53



Monitoring quality

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

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

The CQUIN payment framework enables our commissioners to reward excellence and innovation, by linking a proportion of the Trust's income to the achievement of locally-agreed quality improvement goals. A proportion of Colchester Hospital University NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Colchester Hospital University NHS Foundation Trust and commissioners which they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/.

The monetary income total for 2017/18, based on plan and conditional upon achieving quality improvement and innovation goals, was c. £5.6m. The CQUIN schemes following the schema of the national CQUIN formats, available at the web link above, and were supplemented with locally defined schemes. The listing of schemes being:

- ✓ Improving Staff Health and Wellbeing
- ✓ Reducing the impact of serious infections (Antimicrobial and Sepsis)
- ✓ Improving Services for people with mental health needs who present to A&E
- ✓ Offering Advice and Guidance
- ✓ NHS e-Referrals
- ✓ Supporting proactive and safe discharge (8a)
- ✓ Full provider engagement and commitment to the STP process
- ✓ Risk reserve as part of a more collaborative and system-wide approach
- ✓ Dose Banding
- ✓ Optimising Palliative Chemotherapy Decision Making
- ✓ Hospital Medicines Optimisation
- ✓ Armed forces policy
- ✓ Improving AAA Screening uptake in GP Practices with poor uptake
- ✓ Increased Access to breast screening
- ✓ Dental dashboard.

The table on the following page details the outcomes.

These CQUINs all being two year based, aligning with the national contract timeframes, with the exception of the scheme for NHS e-Referrals which is to be replaced by a scheme for Preventing ill health by risky behaviours (alcohol and tobacco).

Table 1 overleaf demonstrates the actual performance for the CQUIN indicators for 2017/18 for Colchester Hospital University NHS Foundation Trust.

Monitoring quality

***Table 3** – Actual performance for the CQUIN indicators for 2017/18*

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

CCG	Scheme	Sub-scheme		Q1	Q2	Q3	Q4
	Improving Staff health and wellbeing		Improvement of Health and well Being of NHS Staff				Data not available
			Healthy food for NHS staff, visitors and patients				
			Improving the uptake of flu vaccinations for front line staff within Providers				
	Reducing the impact of serious infections (Antimicrobial and Sepsis)		Timely identification of Patients with Sepsis in EDs and Acute Inpatient Settings				
			Timely treatment of Sepsis in EDs and Acute Inpatient Settings				
			Antibiotic Review				
			Reduction in antibiotic consumption per 1,000 admissions				
	Improving Services for people with MH needs who present at A&E		Improving Services for people with MH needs who present at A&E				
	Offering Advice and Guidance		Offering Advice and Guidance				
	NHS e-Referrals		NHS e-Referrals				
	Supporting proactive and safe discharge		Supporting proactive and safe discharge				
	Provider engagement & commitment to STP		Provider engagement & commitment to STP				
	Risk reserve (collaborative and system-wide approach)		Risk reserve (collaborative and system-wide approach)				

Specialist Commissioning Scheme						
Scheme	Sub-scheme		Q1	Q2	Q3	Q4
Dose Banding		Dose Banding				No data available
Optimising Palliative Chemotherapy Decision Making		Optimising Palliative Chemotherapy Decision Making				
Hospital Medicines Optimisation		Hospital Medicines Optimisation				
Improving AAA Screening in GP Practices with poor uptake		Improving AAA Screening in GP Practices with poor uptake				
Increase Access to Breast screening		Increase Access to Breast screening				
Armed forces policy		Armed forces policy				
Dental Quality dashboard		Dental Quality dashboard				

Key

Green Standard achieved

Red Standard not achieved

Amber Standard partially achieved

Grey Development, implementation or not deliverable for this Quarter

How healthcare is regulated

Table 4 *- Care Quality Commission (CQC) ratings published 2nd November 2017*

	Safe	Effective	Caring	Respon-sive	Well-led		Overall
Urgent and Emer-gency Services	Requires Improve-ment	Good	Good	Good	Requires Improve-ment		Requires Improve-ment
Medical Care	Requires Improve-ment	Good	Good	Good	Good		Good
Surgery	Good	Good	Good	Requires Improve-ment	Good		Good
Critical Care	Good	Good	Good	Good	Requires Improve-ment		Good
Maternity and Gy-naecology	Good	Good	Good	Good	Good		Good
Services for Chil-dren and Young People	Requires Improve-ment	Good	Good	Good	Good		Good
End of Life Care	Good	Good	Good	Good	Good		Good
Outpatients and Diagnostic Imaging	Requires Improve-ment	N/A	Good	Requires Improve-ment	Requires Improve-ment		Requires Improve-ment
Overall	Requires Improve-ment	Good	Good	Requires Improve-ment	Requires Improve-ment		Requires Improve-ment

How healthcare is regulated

Colchester Hospital University NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is full registration. Colchester Hospital University NHS Foundation Trust has the following conditions on registration: None.

The Care Quality Commission has not taken enforcement action against Colchester Hospital University NHS Foundation Trust

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

CQC monitoring and inspection process

Inspections by the Care Quality Commission

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

On 30 December 2015, the Trust was served with a Section 29A letter relating to the findings of the September inspection requesting significant improvements by 18 February 2016.
A CQC follow-up visit in April 2016, focusing on A&E, Surgery, Medical Care and End of Life Care, concluded that the Trust had not made sufficient progress in a number of key areas. The CQC continued to have significant concerns about the completion of the Five Steps to Safer Surgery checklist, a continuing lack of awareness over when to place a patient on the individual care plan for the last days of their life and leadership in A&E. Two Section 31 letters were issued, in relation to A&E and the safer surgery checklist. These were removed after the CQC report was published in November 2017.

The CQC carried out a comprehensive inspection of the Trust in July 2017 and published its findings in November 2017

The inspection assigned an overall rating of "Requires Improvement" for the Trust. During this inspection the CQC found that significant improvement had been made across all services at the Trust. The Chief Executive and Managing Director had created stability in the senior executive team that had not been previously in place. The executive team understood the challenges to good quality care and the wider challenges faced by the NHS, and could see the importance of exploring solutions such as the long-term partnership with Ipswich Hospital.

The team in place now worked together with more structured disciplines being embedded around executive and performance behaviours and responsibilities. Within the every patient, every day programme (EPED), the responsibility, accountability and ownership of service improvement had been given back to the local leaders. They saw many examples of local leaders and senior staff being highly motivated, engaged in seeking solutions to drive improvements locally.
Their key findings were as follows:
They saw several areas of outstanding practice including:

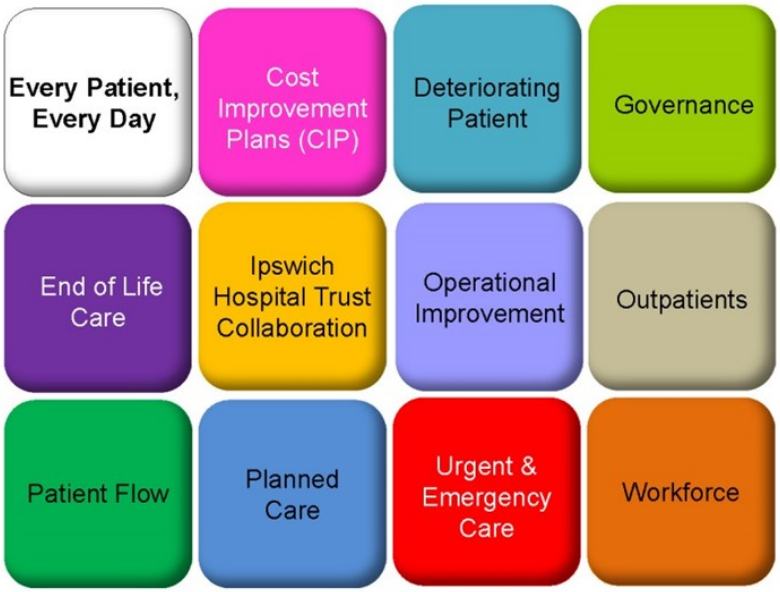
- ✓ The service's dedicated children's transition team was the only one in the region and other trusts sought advice from them. The transition team worked with other teams to meet the more complex individual needs of patients at the age of transitioning to other services. For example, they ran a joint clinic with the epilepsy specialist nurse three to four times a year.
- ✓ The neonatal unit (NNU) was piloting a 'discharge passport' to empower parent involvement in ensuring a timely discharge for babies.

However, there were also areas of poor practice where the trust needs to make improvements and these were categorised in the form of must dos and should dos. These actions are currently being managed by the Director of Nursing.

How we addressed the issues raised by the CQC:

- ✓ The Trust's Every Patient, Every Day programme continues with the aim of establishing and maintaining consistent standards of care across the Trust and achieving the outcomes associated with such standards. This will ensure safe staffing levels, further improvements in governance and leadership, and the continuing implementation of measures to ensure all staff are aware .

Every Patient Every Day



"Every Patient, Every Day" is the name of the transformation programme that the Trust established to provide safe, compassionate care to patients each and every day.

It was launched in September 2016 as a programme of clinical, operational and financial improvement to improve the quality of care, increase efficiency and deliver financial sustainability. The Chief Executive notes: *'It has started to address our many challenges – for example, I'm pleased with the progress we've made on end of life care and there has been significant improvements with the booking processes including moving towards 'paper free' in March.*

'The programme has centred on three key modules of work:

- ✓ quality and governance
- ✓ operational turnaround and Cost Improvement Plan (CIP) delivery
- ✓ cross-cutting improvements

CIP Workstream

The Trust has a target of delivering £16.7m of cost reductions (known as CIP) in 2017/18. The CIP EPED Workstream is tasked with ensuring this is on track. This is achieved through regular meetings with each Division, chaired by the DoF (SRO) for the project and actions taken as appropriate. So far, £13.7m has been delivered.

Urgent Care Workstream

2017 saw the launch of the ED streaming service with the aim of utilising primary care services to ease pressure on A&E and reduce patient waiting times. The newly built GP room co-located in ED was set up specifically for the service.

Frailty Workstream

The Frailty Assessment Unit (FAU) opened October 2017 providing a Monday to Friday service with 5 bays for patients with expected same day discharge. Rapid identification of newly arrived frailty patients across ED and EAU is in place now and early comprehensive geriatric assessment involving a multi-discipline team now follows.

Outpatients Workstream

The main focus of this Workstream has been to improve patient experience by improving the Outpatient environments and ensuring the patient is seen in the right place at the right time.

Measures Introduced:

- ✓ Self-service check-in kiosks in Outpatient areas to increase patient check-in choice, reduce queues at the reception desk and help clinicians manage their clinics more effectively
- ✓ Increased utilisation of Outpatient clinic slots to ensure the optimum number of patients are seen in each session – reducing waiting times for patients
- ✓ Improved signage in Outpatient areas to optimise the flow of patients on their journey through Outpatients
- ✓ Improved appointment reminder service to reduce number of clinic DNAs
- ✓ Re-launch of the electronic booking service to provide patients with greater choice of where and when they are seen

The aim for 18/19 is to increase patient electronic access to appointment systems and clinic information and further reduction of paper processes.

Advice & Guidance Workstream

The aim of the Advice & Guidance development was to set up and operate a system allowing GPs to access consultant advice prior to referring patients in to secondary care,

Every Patient Every Day

for non-urgent GP referrals. The intended benefits being assisting clinical decision making and patient pathways, enhanced clinical communication, and looking to assist reducing GP referral demand on the Trust. This by enabling (at the point of GP / patient consultation) a call to a Consultant for an expert clinical opinion for advice and considering if a patient referral would be needed, and if so, urgently or routine.

During 17/18 the service has been established in c.11 live specialities, covering c.40% of speciality referral areas (target being 35%), with further flexibility remaining for additional specialities to be introduced in 18/19. Certain specialities that have triage service inclusion within the established patient pathways (such as Ophthalmology and Orthopaedic specialities) are agreed to not be implementing A&G in the near future.

Additionally to the above, the Trust has established stretch targets of 65% of calls answered (achieved 80% of the weeks) and 80% of calls answered having feedback recorded. Currently in 17/18 the Trust is slightly below these measures at c. 54% and 66% respectively.

The aim in 18/19 is to achieve coverage of more than 75% of appropriate speciality referral areas and to continue to enhance the call answer and feedback recording rates.

Planned Care Workstream

The Planned Care Workstream has been focussing on maximising the utilisation of theatre slots and lists to ensure that patients are treated within the appropriate timeframes.

Measures Introduced:

- ✓ Check and challenge processes in place to ensure that theatre lists start on time
- ✓ Profiling of lists to ensure lists run in the most efficient way possible
- ✓ Increase of number of cases per list to accommodate a greater throughput of patients
- ✓ Robust root cause analysis procedures in place to review preventable on-the-day cancellations and DNAs - to identify recurring themes and measures to be put in place to prevent further occurrences.

The aim for 18/19 is to review the pre-admission processes to increase efficiency and capacity and continued improvement in theatre utilisation and scheduling.

Deteriorating Patient Workstream

The Deteriorating Patient Workstream predominantly focuses on improving Sepsis compliance Trust-wide and escalation processes of the deteriorating patient.

Achievements in 17/18:

- ✓ Improved Sepsis Compliance within ED as explained in detail within the section Key Priorities for 2018/19.
- ✓ Completed a Trust-wide NEWS escalation Audit to identify areas for focussed work
- ✓ Rolled out Treatment Escalation Form (TEP) Trust wide following trialling and feedback from Clinical Teams
- ✓ Established cohort of Sepsis Champions Trust wide

Aims for 18/19:

- ✓ Further improve Sepsis Compliance in ED towards target of 90%
- ✓ Improve Sepsis compliance on the Wards
- ✓ Implement monthly Sepsis and Escalation auditing on all Wards
- ✓ Monitor usage and quality of completion of Treatment Escalation Plans
- ✓ Work with Ambulance Service on redesigning sepsis pathway.

Every Patient Every Day

End of Life Care

End of Life Workstream

The End of Life Workstream has now exited the EPED programme due to reaching target and delivering on milestones of the project.

Achievements in 17/18:

- ✓ Achieved green in all domains for End of Life Care in CQC report improving from 5 red 'inadequate'
- ✓ Increased usage of Individual Care Record Last Days of Life (ICRLDL) to over 60% increase use of Wathcpoint last days of life data base, allowing staff to see where the dying patients are across the hospital;
- ✓ Reduced number of complaints pertaining to End of Life Care with continued work to improve EOL complaints
- ✓ Increased usage of My Care Choices Register (MCCR)
- ✓ Developed business case for x2 Rapid Discharge Nurse Assessors and recruited to posts, to unlock delays of discharge for our rapidly deteriorating patients
- ✓ End of Life Care Champions established on Wards with quarterly training. Also non-clinical champions recruited
- ✓ Education Strategy and teaching programme in place including communication skills for Band 6/7 and CMT doctors and above; 1 hour intensive role play for junior doctors; education on recognising dying and sensitive communication to all band 2-6 offered every month for half day; all newly qualified nurses receive 1 day of EOL training in their preceptor training package.
- ✓ New End of Life Care Strategy 2018-2020 developed
- ✓ Recruited EOL volunteers to support dying patients and their families in the wards with a plan to increase numbers and to offer a more robust service
- ✓ Complete fund raising for the Time Garden with a proposed opening date of May 14th 2018 to coincide with Dying Matters Week 2018
- ✓ Yearly Memorial Services set up for family/friends of patients who died at CHUFT
- ✓ 230 staff trained in 3 hour workshop on Communication skills with joint working with St Helena Hospice
- ✓ Improved communication with complaints team so that the EOL team see all complaints immediately and these complaint are shared across the clinical teams as part of the 2 at the top process
- ✓ 'CHUFT Blanketeers' set up by Sister Sarah Sands and supported by the End of Life Steering Group so that dying patients are offered a blanket if dying to reduce clinical feel for the family and then given as a gift after death if the family would like it. This is now being discussed at other hospitals who are interested in the idea
- ✓ Improvements in the bereavement suite with soft furnishings and pictures; tea/coffee; quarterly bereavement survey given out from there and results fed back through the EOL steering group. Continues work planned regarding the property bags and jewellery boxes. 3 bereavement walkthroughs have been completed; from A&E; paediatrics and neonates and then from the wards with associated work from these that is still ongoing.

Every Patient Every Day

Project Ivy

Project Ivy

One patient's story driving change. Ivy spent nine hours lying on her kitchen floor in pain, cold and frightened while the ambulance service tried to get to her.

They took the best part of a day because they were tied up at Colchester Hospital waiting to drop other patients off at our Emergency Department (ED).

The flow of patients through our ED, assessment units, wards and back home again is the most important issue we face. At its heart are the stories of people just like Ivy who need our care but aren't able to access it quickly enough. We launched Project Ivy in August 2017 with the goal that no patient will spend a moment longer in hospital than is needed, to progress their care.

It is being led by a small team of staff – clinical and non-clinical – who are committed to making multiple rapid improvements on an incremental basis.

Areas of focus have included:

- ✓ Effective board rounds
- ✓ Creating an discharge lounge
- ✓ Creating and auditing clinical standards of care we expect for our patients
- ✓ Developed a standard operating procedure for patients with regard to admission, transfer and discharge.
- ✓ Gaining new insights into why some patients are in hospital for more than seven days
- ✓ Bringing energy to the Red to Green process
- ✓ Introducing staff volunteers to help with peaks in demand
- ✓ Reviewing processes in ED and EAU
- ✓ More of our patients are getting 'home for lunch' as part of our focus on the discharge process
- ✓ Peldon ward is now supported by a senior physiotherapist on nurse-led ward rounds
- ✓ Physios and OTs are now able to refer directly to Swan and reablement solutions, rather than having to go through the discharge hub
- ✓ Computers on wheels have been ordered for Emergency Assessment Unit (EAU) following observations of delays in EAU processes, so that medication and Electronic Discharge Summaries (EDS) are being ordered more promptly.

Next Steps include:

- ✓ Auditing polypharmacy in order to reduce the burden of taking many tablets for patients which in turn will support prompter turnaround in pharmacy
- ✓ Allocating wards mobile telephones in order that the nurse in charge can be contacted promptly with regard to patient admissions
- ✓ Rolling out the "Community Navigators" a joint project with Essex County Council, North Essex CCG and the Rural Community Council of Essex which has been developed following the length of stay work undertaken. We are actively working together to improve the way in which people leave hospital, return home and live well in the community.

Every Patient Every Day

Quality Improvement Faculty

Quality in the NHS has been defined by NHS England and was used as the basis of the NHS England Outcomes Framework. It is as follows:

- ✓ Safety-doing no harm to patients
- ✓ Experience of Care-this should be characterised by compassion, dignity and respect.

Effectiveness of Care-including preventing people from dying prematurely, enhancing quality of life and helping people to recover following episodes of ill health.

The Institute of Medicine defines the six dimensions of quality as follows:

- ✓ Safety-avoiding harm to patients from care
- ✓ Timeliness-avoiding non-instrumental delays for patients and clinicians
- ✓ Effectiveness-aligning care with the best of clinical science
- ✓ Efficiency-reducing waste in all its forms
- ✓ Equity-closing racial, ethnic and other gaps in health status and care
- ✓ Patient-centeredness-customising care to the needs, resources, values and background of each individual patient and carer.

There have been intrinsic and extrinsic drivers for Quality Improvement (QI) within healthcare. Nationally poor safety and poor patient experience has been seen in some trusts e.g. Morecombe bay. At CHUFT quality issues have been raised by the CQC and other regulators, in addition to horizon programmes such as GIRFT which will have significant positive impact on supporting QI by providing peer and benchmarking data.

QI is a systematic approach to improving health services based on iterative change, continuous testing, measurement and empowerment of frontline teams to bring about these changes. The main ethos is that the patient should be at the centre of any QI programme, they bring their unique knowledge and experience and are expert on the experience of being a patient and often an expert in their illness.

QI is an integral part of all clinical encounters it requires:

- ✓ Individual and team improvement capabilities
- ✓ Improvement methodology : effective, easy for staff to learn and engage
- ✓ Supporting structure: education, training, project management and governance
- ✓ Links with external improvement communities and/or national benchmarking.

The difference between QI and audit is that audit is performed against a set of standards whereas the QI model takes a problem or an issue and enables staff to make small test changes, before rollout occurs, this then leads to a clear process and improves sustainability. QI methodology looks at processes and uses a set of tools and techniques that supports implementation of improvements.

Within the Trust there is currently no QI Faculty function. QI training or support for individuals or teams to help development and monitoring of QI projects is limited. The current route for reporting is through clinical audit and Divisional Governance. Currently, in some cases audit outcomes are not recorded, reported or disseminated to the wider trust. There is a lack of cross specialty working and trust wide learning. The QIF will provide links between different clinical teams, patient groups involved in QI and also drive forward trust wide learning from QI.

The QI faculty reports to and is governed by the Every Patient Every Day Improvement Board which has an improvement focus. The benefit to the Trust is that QI will become embedded as a part of everyone's daily routine and that the culture of QI seen as 'normal'. This will undoubtedly lead to proactive improvement and innovation in care from staff of all disciplines and levels.

The proposal is to establish a QI faculty in order to place a support structure for QI development within the new organisation from ward to board and in all staff groups. Training, coaching, spreading learning, co-ordination and monitoring will be the key roles of the QIF. This will help to develop a QI ethos and expertise across the trust initially within Colchester and once the team is established they will work to develop the team at Ipswich and in the new trust.

Statements relating to the quality of relevant health services provided

NHS number and General Medical Practice Code validity

Colchester Hospital University NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 99.2% for admitted patient care;
- 99.6% for outpatient care; and
- 97.7% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care; and
- 100% for accident and emergency care.

Source: NHS and Social Care Information Centre data quality dashboards January 2018

.

Information Governance Toolkit attainment levels

Colchester Hospital University NHS Foundation Trust (including community services) Information Governance Assessment Report overall score for 2017/18 was 90% and was graded satisfactory (Green).

Clinical coding

Colchester Hospital University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period..

Data Quality

Colchester Hospital University NHS Foundation Trust will be taking the follow-

Data Quality Indicator	Data Quality or Data Flow	When	Update
IG Toolkit – Data Quality Output Standards	Data Quality	2018/19	Plan to retain current level of attainment – Trust currently achieved scores of 9.8 for Outpatients and 9.4 for Inpatients.
Improved reporting, from a centrally accessible dashboard. Change being taken forward as part of merger plans with Ipswich Hospital	Data Quality and Data Flow	Between May 2018 and December 2018	Plan to have dashboards fully operational by the end of 2018. Dashboards will give oversight of the new organisations data quality, and individual site level detail – as quality will need to be maintained on two separate PAS systems as part of this change.
Merger of Colchester and Ipswich Hospitals – looking to maintain current levels of data quality. Given the complexity of working with two separate PAS system, this will be challenging.	Data Quality	On-going	Core metrics will be monitored on the Accountability Framework.

Learning from Deaths

During 2017/18, 1369* of Colchester Hospital University NHS Foundation Trust patients died**. This comprised the following number of deaths which occurred in each quarter of that reporting period:

421 in the first quarter;
396 in the second quarter;
552 in the third quarter;
(365 in January & February*)
* full quarter four data not available at time of reporting
** all hospital deaths included, both in-patient and A&E

Case Record Reviews and Investigations

By 05/03/17, 828* case record reviews and 18 investigations have been carried out in relation to 1369 of deaths included in item 27.1

In 11 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

327 in the first quarter;
247 in the second quarter;
254 in the third quarter;
* quarter four data not available at time of reporting

19 representing 1.39% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
4 representing 0.95% for the first quarter
7 representing 1.77% for the second quarter
8 representing 1.45% for the third quarter
* quarter four data not available at time of reporting

These numbers have been estimated using the judgement score methodology as requested by the Learning From Deaths Dashboard, or, where that judgment score is not available, by meeting Serious Incident or Internal Incident criteria.

Lessons Learned from Case Record Reviews and Investigations

Deteriorating Patients:

- The need for timely observations and accurate NEWS Scores
- The need for early recognition of deteriorating patients
- The need to correctly follow escalation procedures

End of Life and Palliative Care:

- The need for earlier recognition of patients who may be in the last days / weeks of life
- Earlier consideration for the individual care record of the last days of life pathway (ICR LDL), a document that supports best practice with a person-centred approach, focusing on food, drink, symptom control and psychological, social and spiritual support
- The need to communicate between hospital and community about deterioration and patient choice

Sepsis:

- The need for early diagnosis and treatment for red flag sepsis
- The importance of a thorough ED clinical assessment that considers all possible diagnoses including sepsis
- The reminder that the protocol states that all patients with a NEWS of 5 or more, 3 in 1 parameter, or a suspicion of infection need to be screened for sepsis

Hyperglycaemia:

- Importance of recognising and treating hyperglycaemia

Actions taken following Care Record Review and Investigation

Deteriorating Patients:

- ✓ Targets set for greater than 95% of Early Warning Scores to be completed fully and calculated correctly, with patients escalated according to trust guidelines when appropriate.
- ✓ NEWS Scoring to be monitored twice monthly during an independent point prevalence audit and at least monthly by the senior ward nursing staff.
- ✓ Additional observation training for HCAs, AHPs and registered nurses
- ✓ Relevant staff to attend RED training (Recognition and Escalation of the Deteriorating patient)
- ✓ Commence development of electronic vital signs

Learning from Deaths

monitoring (Sentinel)

- ✓ The roll out across the Trust of the new Treatment and Escalation Plan (TEP), which prompts staff to consider the patient's prognosis regularly with consideration for the completion of a DNACPR form. Medical staff can also document the level of escalation appropriate for that patient, the frequency of observations required, and revise parameters within allowed ranges
- ✓ All agency staff to be trained on NEWS and escalation procedure before being employed by the trust.
- ✓ Changes to board rounds so that sick patients are identified and reviewed immediately after the board round.

End of Life and Palliative Care:

- ✓ Targets set for >90% of patients to achieve preferred place of death and for >50% of patients who die to have a completed ICR LDL
- ✓ Earlier consideration for rapid discharge for patients to die in their preferred place of care, with the aim of reducing the time taken to get people home
- ✓ Increased audits into the completion of the ICR LDL
- ✓ Increased awareness across the Trust of the role of and support offered 24/7 by the Palliative Care Team
- ✓ Increasing Advance Care Planning and communicating this to our Primary Care colleagues. Also increased use of the locality End of Life Register (My Care Choices Register) to view and record patient wishes
- ✓ Launch of Project Ivy – with the goal that no patient will spend a moment longer in hospital than is needed.

Sepsis:

- ✓ The introduction of new sepsis screening paperwork
- ✓ The introduction of Sepsis Nurse Champions who conduct peer reviews and deliver training where required
- ✓ A weekly randomised audit of all patients through the Emergency Department for compliance with sepsis screening and use of the Sepsis 6 pathway
- ✓ Implementation of Code Sepsis calls in the Emergency Department to ensure the prompt treatment of patients with possible sepsis.
- ✓ Work with the Ambulance Service to pre-alert any patients with Red Flag Sepsis
- ✓ The development of a PGD allowing the outreach team to prescribe and deliver first dose antibiotics for patients with a red flag sepsis marker
- ✓ Local initiatives within ED, EAU, SAU and ED paediatrics to assist with increasing compliance with sepsis management are now underway, with monthly regular auditing in each area and reporting back to the Every Patient Every Day Deteriorating Patient Workstream and the Sepsis and Deteriorating Patient Group

Hyperglycaemia:

The senior diabetologist is:

- ✓ Revising the blood glucose charts so that the ranges reflect lab results
- ✓ Revising the chart to provide better signposting to staff as to what actions are required, who should be contacted, when, and what to do if there is no improvement after delivering treatment
- ✓ In light of the increasing number of patients with diabetes, looking at including the blood glucose chart with the drug chart to increase visibility
- ✓ Reviewing the number of patients with very high blood glucose to see if the diabetes nurse specialists should be undertaking ward visits for patients with very high blood glucose values.

Learning from Deaths

The Impact of the Actions taken following Case Record Review and investigation

Deteriorating Patients:

- ✓ An increase in the number of escalation to doctors and the use of Watchpoint – an in hospital developed web based tool for patients requiring review, additional support or are end of life, bringing them to the attention of the site team and doctors.
- ✓ A reduction in the number of avoidable in hospital cardiac arrests due to a failure to escalate – from 20 for the rolling 12 months in March 2016, to 3 in the rolling 12 months in January 2018.

End of Life:

- ✓ Better end of life care provided to patients and their family
- ✓ Better use of the Independent Care Record Last Days of Life and the prescribing of anticipatory medication (use of the ICR LDL in hospital deaths up from 45% April 2017, to 63% in January 2018)
- ✓ Increased uptake on the My Care Choices Register (EPaCCs- Electronic Palliative Care Coordination System or end of life register), which records patients' wishes in the last 12 month of life, giving healthcare professionals information about the type of care the patient would like to receive, cultural or religious wishes and preferred place of care in the last days / weeks of life (number of patients on the My Care Choices Register admitted to hospital up from 0.9% in January 2017 to 2.0% in January 2018)

Sepsis:

- ✓ Improvement in the identification of patients who potentially have sepsis to ensure they receive the Sepsis 6 pathway within 1 hour of presentation
- ✓ Areas for improvement highlighted and targeted regarding the recognition and treatment of sepsis
- ✓ Increased general awareness of sepsis across the Trust
- ✓ National ranking for HSMR Septicaemia has increased from 123rd to 70th out of 136 Trusts.

Hyperglycaemia:

- ✓ Impact to be seen once the actions have been carried out.

Previous Reporting Period

0 case record reviews and 0 investigations completed after 1st April 2017 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the the judgement score methodology as requested by the Learning From Deaths Dashboard, or, where that judgment score is not available, by meeting Serious Incident or Internal Incident criteria

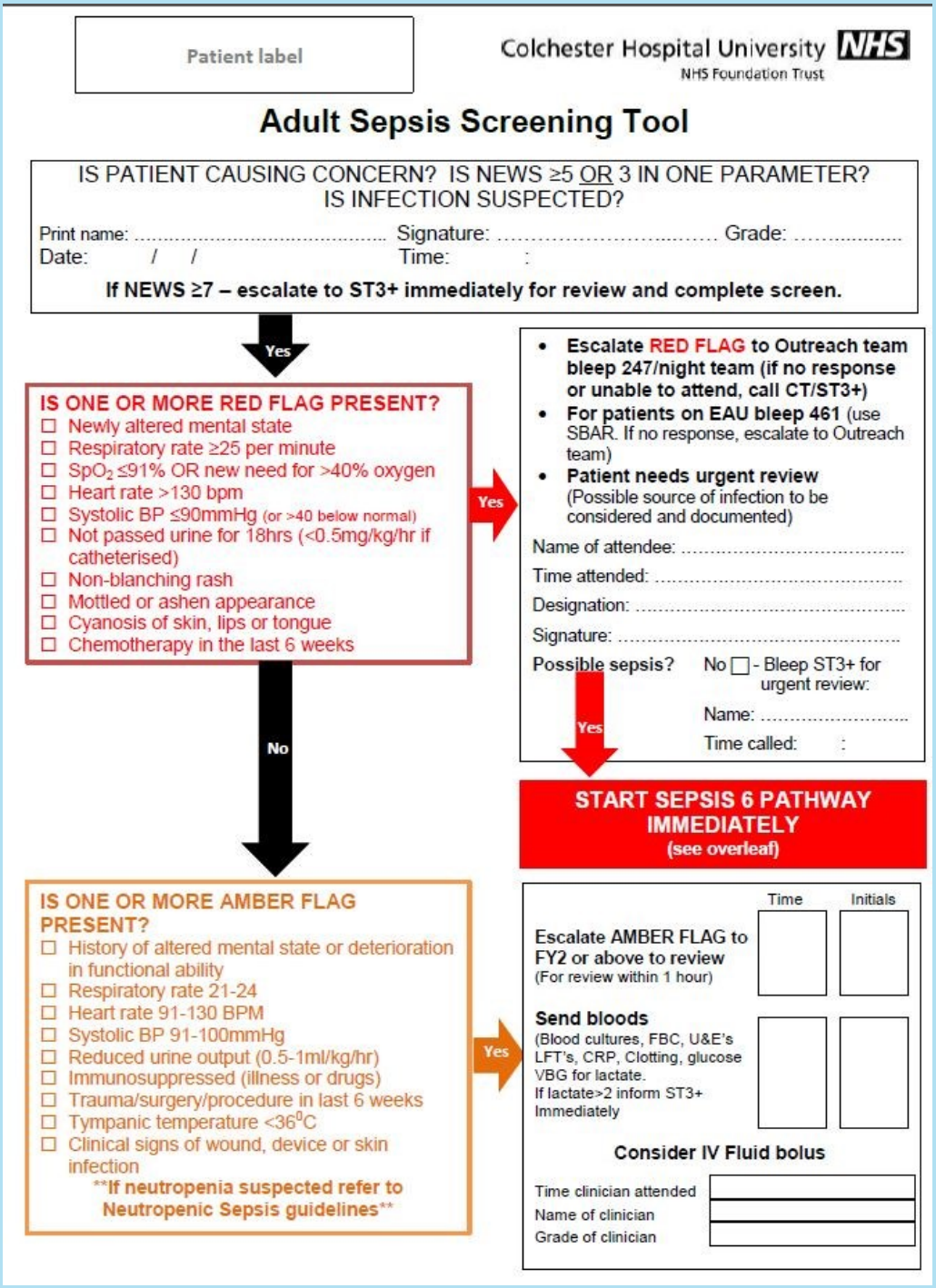
0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient. "

Although reviews were undertaken, there was no statutory requirement to submit this information.

From April 2017, Trusts were required to collect and publish on a quarterly basis specified information on deaths. Information prior to this time is not available to report.

Learning from Deaths

The Adult Sepsis Screening Tool that was rolled out throughout the Trust during January 2018



Patient label

Colchester Hospital University NHS
NHS Foundation Trust

Adult Sepsis Screening Tool

IS PATIENT CAUSING CONCERN? IS NEWS ≥5 OR 3 IN ONE PARAMETER?
IS INFECTION SUSPECTED?

Print name: ..... Signature: ..... Grade: .....
Date: / / Time: :

If NEWS ≥7 – escalate to ST3+ immediately for review and complete screen.

Yes

IS ONE OR MORE RED FLAG PRESENT?
- ☐ Newly altered mental state
- ☐ Respiratory rate ≥25 per minute
- ☐ SpO_2 ≤91% OR new need for >40% oxygen
- ☐ Heart rate >130 bpm
- ☐ Systolic BP ≤90mmHg (or >40 below normal)
- ☐ Not passed urine for 18hrs (<0.5mg/kg/hr if catheterised)
- ☐ Non-blanching rash
- ☐ Mottled or ashen appearance
- ☐ Cyanosis of skin, lips or tongue
- ☐ Chemotherapy in the last 6 weeks

Yes

- **Escalate RED FLAG to Outreach team bleep 247/night team (if no response or unable to attend, call CT/ST3+)**
- **For patients on EAU bleep 461** (use SBAR. If no response, escalate to Outreach team)
- **Patient needs urgent review** (Possible source of infection to be considered and documented)

Name of attendee: .....
Time attended: .....
Designation: .....
Signature: .....

Possible sepsis? No ☐ - Bleep ST3+ for urgent review:

Yes

Name: .....
Time called: :

START SEPSIS 6 PATHWAY IMMEDIATELY
(see overleaf)

No

IS ONE OR MORE AMBER FLAG PRESENT?
- ☐ History of altered mental state or deterioration in functional ability
- ☐ Respiratory rate 21-24
- ☐ Heart rate 91-130 BPM
- ☐ Systolic BP 91-100mmHg
- ☐ Reduced urine output (0.5-1ml/kg/hr)
- ☐ Immunosuppressed (illness or drugs)
- ☐ Trauma/surgery/procedure in last 6 weeks
- ☐ Tympanic temperature <36^{0}C
- ☐ Clinical signs of wound, device or skin infection

****If neutropenia suspected refer to Neutropenic Sepsis guidelines****

Yes

	Time	Initials
Escalate AMBER FLAG to FY2 or above to review (For review within 1 hour)		
Send bloods (Blood cultures, FBC, U&E's LFT's, CRP, Clotting, glucose VBG for lactate. If lactate>2 inform ST3+ Immediately		

Consider IV Fluid bolus

Time clinician attended	
Name of clinician	
Grade of clinician	

Core Quality Indicators

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

Indicator: Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality, however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period.

The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score	Banding
The value and banding of the SHMI for the Trust for the reporting period	Jan 16 - Dec 16	1.090	1.0			2
	Apr 16 - Mar 17	1.088	1.0			2
	Jul 16 - Jun 17	1.081	1.0			2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)	Jan 16 - Dec 16	25.2%	30.1%	55.9%	7.3%	
	Apr 16 - Mar 17	25.8%	30.7%	56.88%	11.1%	
	Jul 16 - Jun 17	27.1%	31.1%	58.59%	11.2%	

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

- Trust is banded as a '2' which is 'as expected' mortality. This correlates with the information gained from local morbidity & mortality meetings.

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

- Using mortality indicators in conjunction with patient/family/carer feedback, incident reporting and summaries from mortality reviews to identify both good practice and any potential areas of concern.
- Dealing with individual issues according to severity in line with Trust governance processes and aggregating incidents to form part of the Trust's Quality Improvement Project.
- Appointing specialist staff to lead projects, auditing, teaching and monitoring processes and outcomes so that we know the changes made have benefited patient care and experience, with reporting from ward to Trust Board. An example of this would be the screening and treatment of patients admitted with sepsis. In 16 months, the Trust's ranking for mortality ratio for septicaemia has improved from 123rd out of 136 acute trusts to 70th. There has also been continued focus on the recognition and escalation of the deteriorating patient through staff training, process audits and mortality reviews.

Core Quality Indicators

Indicator: Patient Reported Outcome Measures (PROMs) scores

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

The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
The Trust's patient reported outcome measures scores for groin hernia surgery during the reporting period	2015/16	0.057	0.084	0.154	0.027
	2016/17		**0.087**	**0.135**	**0.019**
	2017/18*		**0.089**	**0.140**	**0.055**
The Trust's patient reported outcome measures scores for varicose vein surgery during the reporting period	2015/16		0.094	0.154	0.009
	2016/17		**0.092**	**0.155**	**0.010**
	2017/18*		**0.096**	**0.134**	**0.068**
The Trust's patient reported outcome measures scores for hip replacement surgery during the reporting period	2015/16	0.430	0.438	0.510	0.320
	2016/17	0.449	**0.437**	**0.533**	**0.329**
	2017/18**				
The Trust's patient reported outcome measures scores for knee replacement surgery during the reporting period	2015/16	0.292	0.320	0.398	0.198
	2016/17	0.336	**0.324**	**0.404**	**0.242**
	2017/18**				

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

- A disparity in process for patient questionnaires between day case and inpatient has led to totally inadequate sampling for day case procedures which covers varicose vein and groin hernia surgery. This arose due to changes in personnel and has now been rectified with a clear process for questionnaire handout and patient information regarding questionnaire return. This is beginning to show in significant improvement in sampling for the day case procedures which is not apparent in this period of the dataset.
- Inpatient procedures for hip and knee replacement have shown a gradual improvement during this period and again improvement in patient information has led to this benefit.

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

- Improved patient information has led to better sample size which is anticipated will be seen in the next years data set.

Core Quality Indicators

Indicator: Readmission rates

The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
% of patients aged 0-15 years readmitted within 28 days	2010/11	8.79			
	2011/12	8.35		14.94	5.1
% of patients aged 16 years or over readmitted within 28 days	2010/11	9.89			
	2011/12	10.35	11.45	13.8	8.73

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

Recent national data sets are not available for readmission rates as provided by NHS Digital (HSCIC).
Local data sets have provided the following data for readmission rates:

- These figures are generated using live data as at 23/04/2018
- Showing data for Elective to Non Elective readmissions
- Age as at parent (elective) admission

Reporting period	0-15 years	16+ years
2015/16	9.8%	4.5%
2016/17	10.2%	4.0%
2017/18*	11.2%	4.0%

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

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

Indicator: Responsiveness to the personal needs of patients during the reporting period

The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
The Trust's responsiveness to the personal needs of its patients during the reporting period	2014/15	63.9	68.9	86.1	59.1
	2015/16	64.9	69.6	86.2	58.9
	2016/17*	66.9	68.1	85.2	60.0

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

* Recent national data sets are not available as provided by NHS Digital (HSCIC).

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

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

Core Quality Indicators

Indicator: Staff recommendation (Friends and Family Test) Taken from Question 21d of the NHS staff survey					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
The % of staff employed by or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends.“	2016/17 Q1	82.4%	81.7%	92.3%	23.1%
	2016/17 Q2	63.9%	81.9%	100.0%	43.8%
	2016/17 Q3	-	-	-	-
	2016/17 Q4	65.7%	81.5%	81.7%	60.0%
	2017/18 Q1	82.4%	83.4%	98.6%	54.9%
	2017/18 Q2	73.4%	81.5%	100.0%	41.1%
	2017/18 Q3	-	-	-	-
	2017/18 Q4	-	-	-	-

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

- National Average is BASED ON ACUTE TRUSTS
- Highest and Lowest is as at Reporting Quarter

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

✓ By working with the Essex Leadership group the Trust has been delivering and giving access to the Mary Secole

✓ Programme which has a specific module on line of sight to the patient

✓ Developing and delivering further modules within the Licence to Lead Programme such as coaching conversations

✓ Developing joint programmes with Ipswich Hospital for new consultants, clinical leads and operation leads to equip them with the skills to be compassionate, inclusive and effective leaders

Indicator: Patient recommendation (Friends and Family Test)					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from A&E (types 1 and 2)	2015/16 (Inpatients)	97.1%	95.4%	100.0%	83.3%
	2016/17 (Inpatients)*	97.8%	95.4%	100.0%	82.2%
* 2016/17 Highest & Lowest Score is based on March 2017 ** 2017/18 YTD (April 2017 - February 2018) with Highest & Lowest Score being based on February 2018 (Latest Report)	2017/18 (Inpatients) **	97.9%	95.7%	100.0%	45.9%
	2015/16 (A&E)	82.1%	87.7%	98.9%	49.3%
	2016/17 (A&E)*	88.1%	86.2%	100.0%	45.9%
	2017/18 (A&E) **	87.7%	86.6%	100.0%	67.3%

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

Results are monitored by the Information Department, Divisions, Patient Safety & Experience Group andTrust Board using the Integrated Performance Report; and any outlying scores trigger a review.

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

reviewing results within the relevant CDG and Divisional meetings and at Patient Safety & Experience Group meetings, and any actions required to improve responses are taken;

✓ teams working with wards and clinics to review feedback to make improvements ;

✓ emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary team meetings.

Core Quality Indicators

Indicator: Risk assessment for venous thromboembolism (VTE)					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
% of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	2015/16	94.70%	95.64%	100%	61.47%
	2016/17	96.10%	95.53%	100%	63.02%
	2017/18*	95.56%	95.20%	100%	51.38%

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

- The indicator as reported nationally is the national data set and confirms local data analysed and reported internally

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

✓ Education and training for doctors and nurses by the VTE nurse team;

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

✓ Support from the VTE nurse team in capturing any outstanding VTE RAs in EAU/MDU/SAU and wards;

✓ A weekly and monthly VTE RA report is provided to the divisions which identifies their performance looking at elective and non-elective admissions, they then deal with any performance issues in their area;

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

Indicator: Clostridium difficile infection rate					
The data made available to the Trust by the HSCIC with regard to:	Reporting period	CHUFT score	National average	Highest score	Lowest score
the rate for 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	Apr 14-Mar 15	15.5	15.0	62.6	0.0
	Apr 15-Mar 16	12.4	14.9	67.2	0.0
	Apr 16-Mar 17	18.0	13.2	82.7	0.0

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

- The indicator as reported nationally is the national data set and confirms local data analysed and reported internally

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

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

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

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

✓ Continue to investigate and invest in new cleaning technologies to support best practice and efficiency including the use of HPV fogging, micro-fibre implemented in June 2017. Trials of UV technology to support enhanced, timely deep cleaning is being investigated.

Core Quality Indicators

Indicator: Patient safety incident rate									
The data made available to the Trust by the HSCIC with regard to:	Reporting period	Colchester Score		National average		Highest score		Lowest score	
		Number	Rate	Number	Rate	Number	Rate	Number	Rate
the number and rate of patient safety incidents reported within the Trust during the reporting period (please note that the reporting period changed to 'per 1,000 bed days' in April 2014)	October 14 - March 15	3,326	31.97	621,776	36.24	3,225	82.21	443	3.57
	April 15 - September 15	3,798	39.55	632,050	38.11	3,948	74.67	4,078	18.07
	October 15- March 16	3,969	40.94	655,193	38.58	3,426	75.91	1,499	14.77
	April 16 - September 16	3,789	39.79	673,865	39.89	3,620	71.81	2,305	21.15
	October 16 - March 17	3,667	36.77	696,643	40.52	3,300	68.97	3,219	23.13
	April 17 - March 18	Data not available at time of publishing.							
		Number	%	Number	%	Number	%	Number	%
the number and percentage of such patient safety incidents that resulted in severe harm or death during the reporting period	October 14 - March 15	10	0.10	3,089	0.18				
	April 15 - September 15	16	0.17	2,717	0.16				
	October 15 - March 16	32	0.33	2,642	0.16				
	April 16 - September 16	16	0.4%	2,516	0.4%	98	1.4%	1	0.02%
	October 16 - March 17	16	0.4%	2,623	0.4%	92	1.1%	1	0.03%
	April 17 - March 18	Data not available at time of publishing.							

Core Quality Indicators

Indicator: Patient safety incident rate
Colchester Hospital University NHS Foundation Trust considers that this data is as described for the following reasons: • All incidents are reviewed by the Patient Safety & Quality Team to assess and validate the level of harm reported and ensure those reported as no and low harm are accurately graded. There is also clinical judgement in the classification of an incident as moderate and above harm as it requires moderation and judgement against subjective criteria and processes. All incidents are investigated to ensure that lessons are learned to safeguard future patient care. All patient safety incidents (irrespective of level of harm) are uploaded to the NRLS within one month of reporting; and those initially considered to have caused severe harm or above are reported within 72 hours; • The last data set reported from the NRLS shows the Trust to be slightly below average reporters of incidents, this is the first dip in trend since 2013. Trusts which are high reporters of incidents are very good indicators of a strong reporting culture. We have robust processes in place to capture incidents. However there are risks at every trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. We have provided training to staff and there are various policies in place relating to incident reporting but this does not provide full assurance that all incidents are reported. The Trust is promoting incident reporting through patient safety initiatives and awareness weeks and it is anticipated the trend will once again improve. • The percentage of high harm and death incidents taken from the NRLS report (as mandated by the Quality Account Guidance) for April 2016 – September 2017 is 0.4% for the Trust, which is equivalent to the national average for medium acute Trusts and an improvement from the previous dataset. The Trust has implemented a robust process for the investigation of all potential serious incidents despite the initial grading chosen by the reporter. All incidents are reviewed by the Patient Safety & Quality Team and where there is a suspicion of harm or a near miss, further information or a 24 hour review is requested. The 24 hour report is presented at SI Panel, held twice weekly and chaired by either the Medical Director or Director of Nursing; and a decision made as to level of harm caused and whether or not the incident fits SI criteria. Within the open reporting culture of the Trust, staff are encouraged to identify and escalate any Serious Incidents (SIs) and as with any other incident the Trust reviews SIs for trends and themes to look for opportunities for improvement.
Colchester Hospital University NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by: ✓ Continue to build our culture for reporting patient safety incidents at all levels of harm. An E-learning training package has been implemented to encourage reporting of incidents and near misses as well as give guidance for risk assessment and escalation of incidents. The Trusts Procedure for the Management of Incidents and Serious Incidents gives staff clear guidance on how to report and escalate and also details the SI process; ✓ Key performance indicators for the management of incidents and SI's have been developed and are included within our Accountability Framework.

Part 3 - Other information

Patient safety

Infection prevention and control

Healthcare Associated Infections (HCAIs)

Achieve Trust Target of zero for MRSA cases in 2017/18

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

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

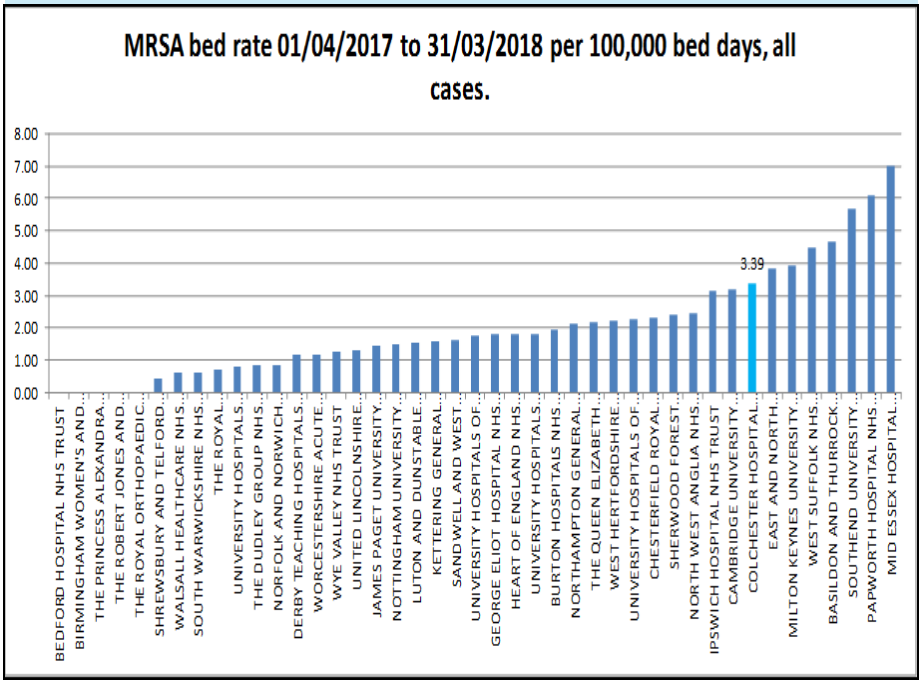
All Acute Trusts have participated in PHE mandatory enhanced surveillance of MRSA bacteraemia since October 2005:

- ✓ The root cause of the MRSA bacteraemia cases in 2017/18; one patient was previously known to be MRSA positive and was not screened in a timely way on admission, this did not allow the patient to undergo decolonisation treatment in a timely way.
- ✓ Continued education and support in promoting appropriate MRSA screening continues with an active process of highlighting to Wards/ Departments patients whom are previously positive.

Table 5— *Number of cases of MRSA bacteraemia apportioned to Colchester Hospital*

Year	Number of cases of MRSA bacteraemia cases apportioned to Colchester Hospital	Target
2014/15	0	0
2015/16	2	0
2016/17	2 (1 of which was a contaminant)	0
2017/18 to date	2	0

Chart 3 –
The performance of Colchester Hospital in rates of MRSA bacteraemia, compared with the other hospitals in the East of England region for 2017/18



Patient safety
Infection prevention and control

Clostridium difficile

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

The Trust has made great strides in reducing the number of people affected by CDI, however, the rate of improvement has slowed over recent years and it is recognised that some infections are a consequence of factors outside of the control of the NHS organisation that detected the infection. (NHS England 2016/17). NHS improvement carried over the objectives for 2016/17 into 2017/18, with CHUFT objective trajectory was set at no more than 18 cases in which there had been breaches in policy. Each case identified in the Trust is subject to post infection review. If all care and treatment is managed within nationally and locally recognised policy the Clinical Commissioning Group (CCG) scrutiny panel may agree that it is deemed as 'Non trajectory'. (2015/16 onwards).

18c *difficile* cases identified of which 17 cases for Colchester have been agreed as non- trajectory 2017/18 and therefore not attributed to the Trust.

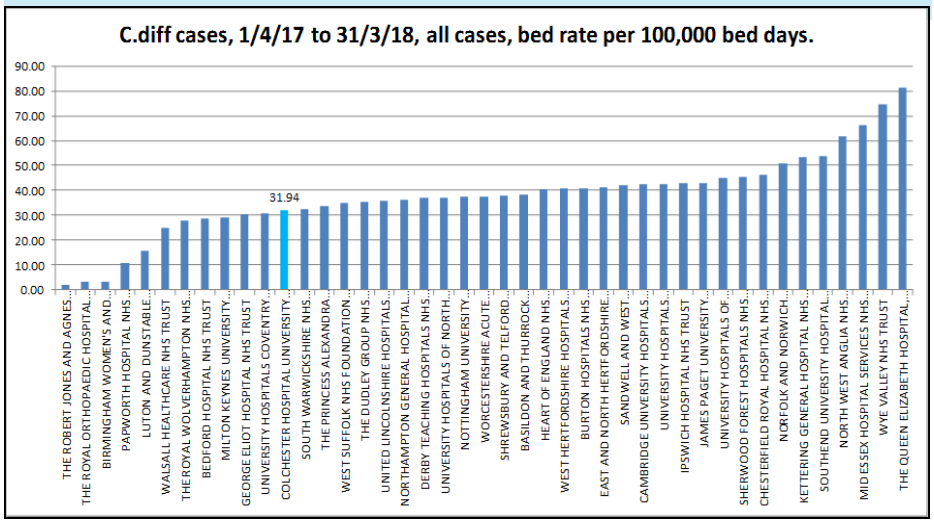
- ✓ Patients identified as carriers are monitored closely and managed in much the same way as patients with CDI.
- ✓ Work continues through scrutiny panel reviews with Clinical Commissioning Group to identify areas which may impact on further reduction of cases. Including looking at antimicrobial prescribing in the local health care economy.
- ✓ Patients whom are identified with CDI are given a credit card size information card to show to other healthcare professionals who may be involved in their care in the future to highlight the need for prudence in antibiotic prescribing for those individuals
- ✓ Antimicrobial auditing and awareness training continues to be a priority
- ✓ There have been challenges nationally with the availability of certain groups of antibiotics which then pushes clinical teams to the groups of antibiotics which can drive the risk of c difficile acquisition up

The incidence of cases of *Clostridium difficile* is higher in Medicine and Care of the Elderly Wards, 7 of the 8 Wards have had a significant investment in refurbishments in the past 4 years with a plan for the final COTE Ward to be refurbished in 2017/18.

***Table 6** — Number of C.Diff cases apportioned to Colchester*

Year	Number of cases of *Clostridium difficile apportioned to Colchester Hospital*	Target No more than
2014/15	32 cases	20 cases
2015/16	10 trajectory cases – 14 non - trajectory	18 trajectory cases
2016/17	9 trajectory cases - 26 non-trajectory	18 trajectory cases
2017/18 to date	1 trajectory case – 17 non - trajectory	18 trajectory cases

***Chart 4 –** The performance of Colchester Hospital in rates of Clostridium difficile, compared with the other hospitals in the East of England region for 2017/18*



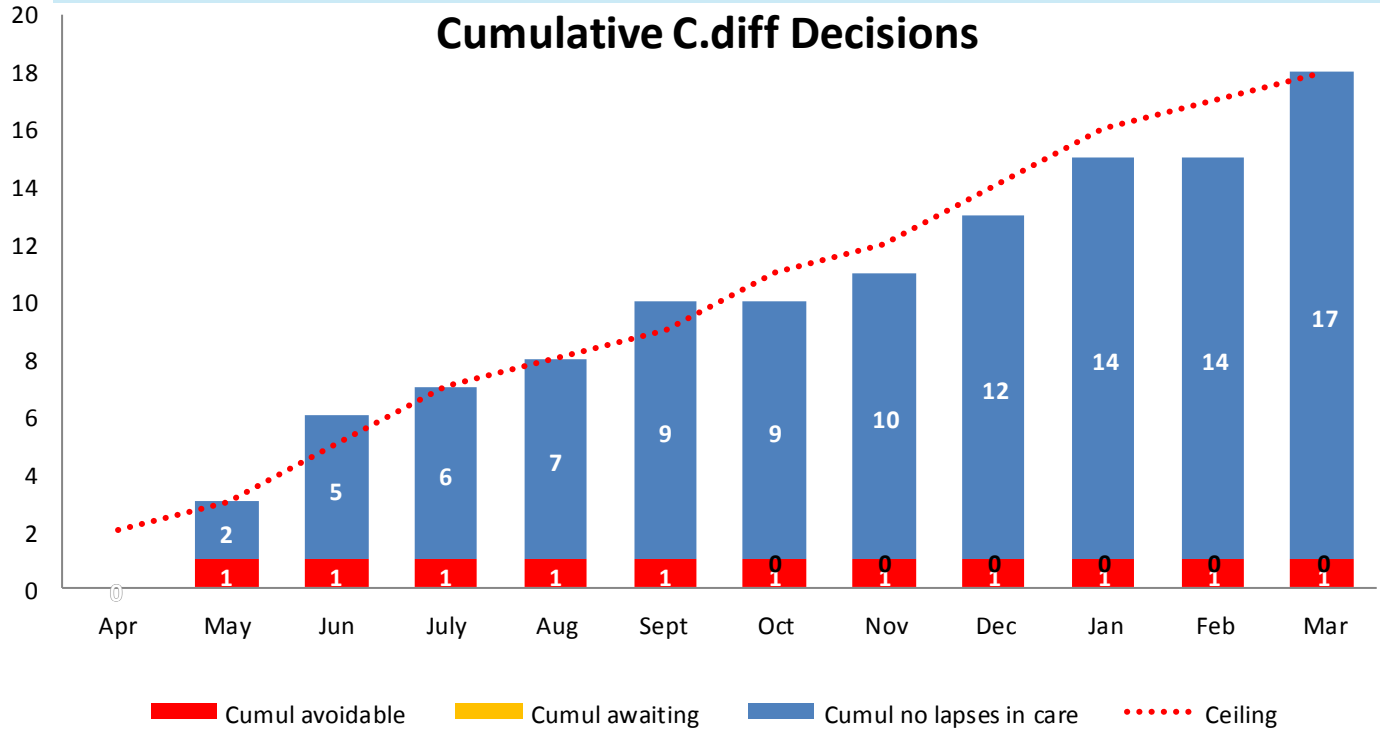
Patient safety
Infection prevention and control

Achieve Trust Target of 18 cases of Clostridium difficile in 2017/18.

The Trust has seen a decrease in cases identified as Trust apportioned 18 in total compared to total of 35 cases in the last financial year this equates to a 48.57% reduction in cases.

The Infection Control Conference held at Colchester Hospital during 2017

***Chart 5 -** Clostridium difficile cases 2017/18 to date, with areas of responsibility (Hospital, Community, yet to be decided)*



Patient safety
Prevention of inpatient falls

What is a fall?

A fall is defined as ".. *an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level..*"

Inpatient falls are commonly reported patient safety incidents and result in loss of confidence, slower recovery even when physical harm is minimal. The estimated overall cost to hospital Trusts due to inpatient falls is £630 million per year.

Who is most at risk?

The National Institute for Clinical Excellence (NICE) identifies that people aged 65 or over present the highest risk of falling. People aged 50—64 who are admitted to hospital and are judged by a clinician to be at a higher risk of falling because of an underlying condition may also present as a higher falls risk. Acute illness, particularly in frail older people or those recovering from serious injury or surgery can increase the risk of sustaining a fall whilst in hospital. Patients can be vulnerable to delirium, dehydration and become deconditioned, all of which can affect balance and mobility especially in unfamiliar surroundings. A high proportion of falls occur during the first few days of admission.

Assessing risk

On admission, patients are assessed for their risk of falls and if appropriate are commenced on the Falls Prevention Integrated Care Pathway. Completion of a series of preventative actions will help to ensure the optimum care plan is in place and reduce the risk of falls. The Trust has a Falls Prevention Practitioner who supports members of the multi-professional team in a wide variety of aspects in the safe management of patients identified at risk of falling.

Our key achievements:

- ✓ Achieving a reduction in the overall number of inpatient falls and consistency in <5 falls per 1,000 bed days
- ✓ A reduction in the number of falls resulting in serious harm
- ✓ Widespread implementation of 'Bay Watch' cohort nursing for those patients deemed at highest risk of falls and which has aided the reduction in falls incidents
- ✓ Implementation of a revised and improved Falls Prevention Integrated Care Pathway
- ✓ Introduction of a short educational film produced by a multi-disciplinary team to help educate inpatients and their family members or carers about all aspects of falls and falls prevention;
- ✓ Implementation of a new and improved falls prevention educational booklet for patients
- ✓ Development of a weekly Harm Free Forum Group to discuss inpatients falls incidents resulting in serious harm in order to identify areas for learning and to target support;
- ✓ Purchase of new low-rise bed frames and roll-out mats for those patients at highest risk
- ✓ Purchase of an age simulator kit and training mannequin for use as part of ward based scenario training.

Patient safety

Prevention of inpatient falls

Aims and goals for 2018/19

- ✓ Continue to reduce the number of inpatient falls including falls resulting in serious harm
- ✓ Continue to promote 'Harm Free' care as part of 'Every Patient, Every Day' and get the basics right for all patients
- ✓ Implement rolling programme of ward based theory and practical falls prevention training across Divisions
- ✓ Replacement and upgrade of falls prevention assistive technology.

Key challenges

- ✓ The Trust continues to experience operational pressures which can impact on the release of staff to attend training at ward level.

National Patient Safety Agency (NPSA) Definitions of Harm

No harm
No injury at the time of the assessment post fall

Low Harm

An injury which requires minor first aid. It does not prolong the patient's length of stay or require out-patient treatment following discharge

Moderate Harm

The patient will have an increased length of stay and /or require out-patient treatment as a result of their injury or the patient may require interventions that are considered more than minor first aid, such as surgery or a blood transfusion, but will make a full recovery

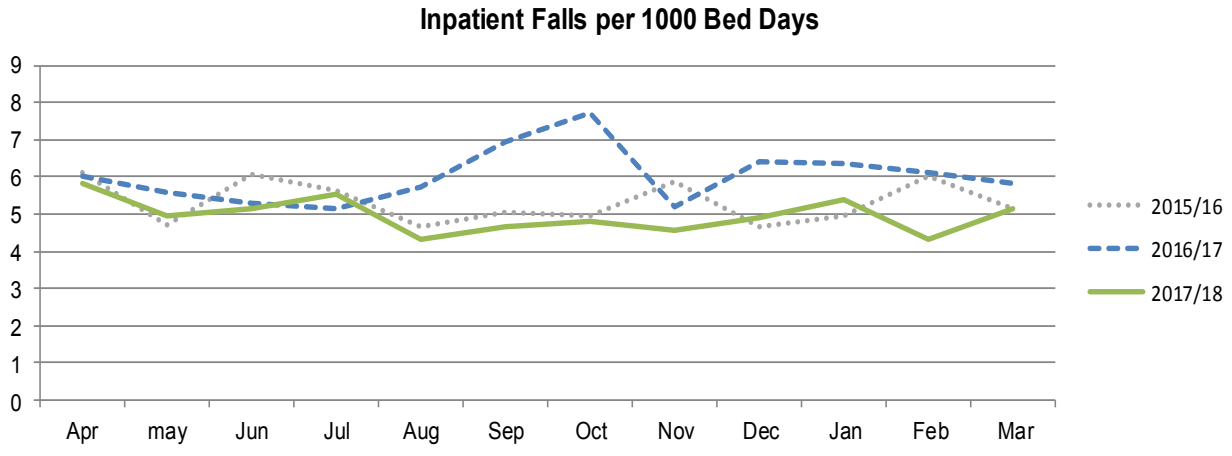
Severe Harm

This category of harm leaves the patient with a permanent injury or disability

Death

This is reported as a Serious Incident and follows the same process as a Moderate & Severe harm fall. This incident will be reported to the Coroner.

Chart 6 *– Our performance over the last three years: inpatient falls per 1,000 bed days*



Patient safety

Prevention of pressure ulcers which develop in hospital

Pressure ulcers remain an unwanted complication associated with healthcare and it is widely acknowledged that they are largely preventable.

They are costly in terms of human suffering, treatment/management and rising litigation costs due them being seen as an indicator of clinical negligence. Despite many national prevention campaigns in recent years, pressure ulcer inci-dence rates continue to rise and this is reflected in Patient Safety Thermometer data.

In 2017/2018 the total number of CHUFT hospital acquired pressure ulcers graded at Stage 2-4 was 115 an increase of 4% on the previous year. It should be noted that there has been a 6% increase in Grade 3 & 4 pressure ulcers noted on admission (652 in 2017/2018 and 615 in 2016/17) which is indicative of increasing frailty of patients amongst other contributing fac-tors such as reduced funding in the social care sector and an increased burden on community resources.

The Trust continues to promote the use of the Midlands & East (2009) ASKIN care bundle as an effective 5 step model of pressure ulcer prevention. This ensures that patients who are at risk of developing pressure damage are identified early and actions can be taken to ensure appropriate care interventions are implemented to prevent pressure ulcer occurrence.

A = Assessment

S = Surface

K = Keep Moving

I = Incontinence/Moisture

N = Nutrition

Our key achievements

- ✓ Reduction of 30% of total PU figures (all grades) compared to 2016/2017
- ✓ Involvement in the NHSI PU Collaborative 2017/2018
- ✓ An increase in staffing within the Tissue Viability Service enhancing Ward support and patient education
- ✓ Raising awareness of appropriate use of dynamic support surfaces to aid PU prevention/management
- ✓ Introduction of pressure reducing mattresses in A & E to ensure 'at risk' patients receive preventative care
- ✓ 1:1 individual training with Ward staff on PU prevention
- ✓ Improved resources to support Heel elevation as a tool to aid PU prevention
- ✓ User friendly Wound Care Formulary to guide staff on appropriate choice of dressings.

NHS Improvements (NHSi) Pressure Ulcer Collaborative 2017/18

- ✓ Launched October 2017
- ✓ 25 Healthcare Trusts were enrolled nationwide.

Aims:

- ✓ A reduction in the number and severity of patient harm incidents
- ✓ Improve incident reporting
- ✓ Improve Quality Improvement skills
- ✓ Encourage a multidisciplinery focus on Pressure Ulcer care.

What we did as a Trust:

- ✓ Created and implemented an individual Trust action plan.

Patient safety

Prevention of pressure ulcers which develop in hospital

Aims and goals for 2018/19

- ✓ Review A.S.K.I.N assessment tool and identify where im-provements could be made to enable improved completion
- ✓ Continue to support the im-provements that have been identified as part of the NHSI PU Collaborative and escalate to all Wards across the Trust
- ✓ Improve engagement from Ward Link Nurses to drive for-ward changes and embed evi-dence based care
- ✓ Raise awareness of PU pre -vention via campaign days.

How will we measure and monitor our performance?

- ✓ Against national PST data
- ✓ Reduction of errors in reporting on Datix system
- ✓ Timely completion of Root Cause Analysis (RCA) investigations allowing for prompt review at Harm Free panel.
- ✓ Monitor trends/themes from RCA's to to identify learning that supports best practice.

How and where will progress be reported?

- ✓ Matrons meetings
- ✓ Harm Free Panel
- ✓ Monthly patient safety report
- ✓ 6/52 PSEG meetings
- ✓ Quarterly reports.

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

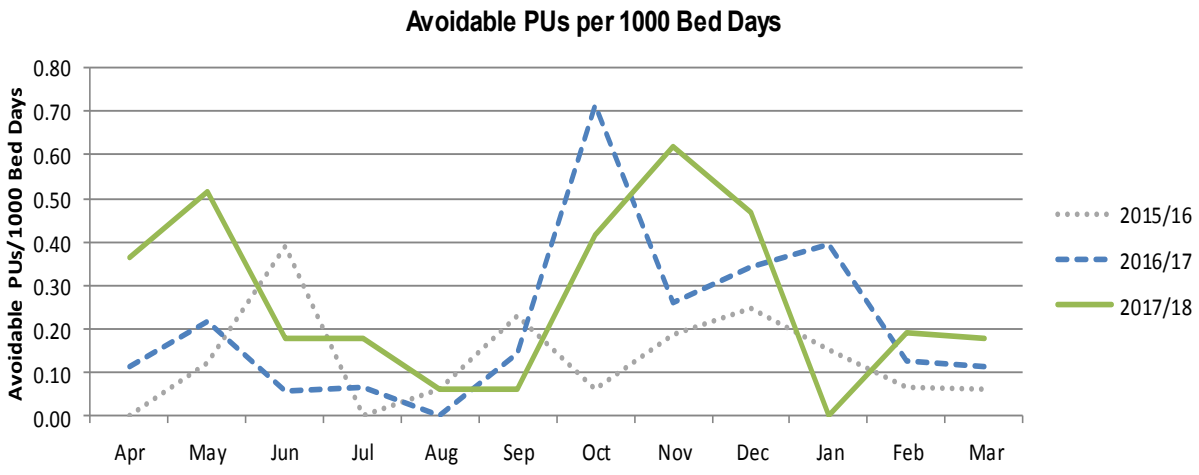
Grade 1
Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with

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

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

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

Chart 7 – *Our performance over the last three years: Avoidable pressure ulcers per 1,000 bed days*



Patient safety
Learning from incidents, SIRIs and Never Events

Learning from incidents

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

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

The higher level incidents are categorised as Serious Incidents Requiring Investigation (SIRIs) and are reported to the North East Essex Clinical Commissioning Group. These incidents are investigated, a comprehensive report written and actions implemented and the learning shared.
The percentage of patient safety incidents resulting in severe harm or death is subject to external assurance. The detailed definition for this performance indicator is presented on page xx

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

- ✓ The introduction and embedding of 'Baywatch' to ensure the safe care for patient's who are at risk of falling
- ✓ A review of the medical examination proforma in the ED to enable Doctors to use a body map to document the clinical examination of patients who have attended following a fall at home.
- ✓ Review of the Extravasation Policy to include specific timescales for patients to re-attend for examination of extravasation as this is a common complication of chemo administration.
- ✓ Changes to the observation charts to aid staff to escalate the deteriorating patient quickly and to the correct

Duty of Candour

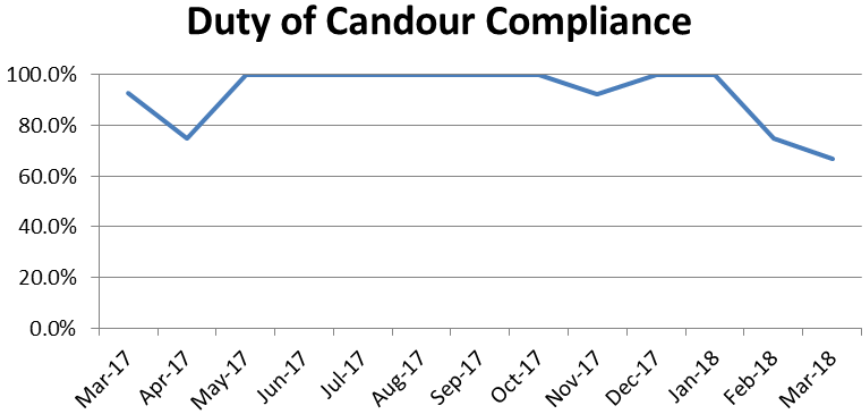
Open and honest communication with patients is essential to collaborative working and directly impacts the experience and outcomes for the patient as well as for staff in the delivery of safe care. Healthcare professionals must be open and honest with patients when something that goes wrong with their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

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

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

- ✓ Face to face and E-Learning training for Incidents, SI's and Duty of Candour;
- ✓ Foot Cause Analysis Training for SI's;
- ✓ Introduction of the Trust's License to Lead Programme and the module 'Managing Governance'
- ✓ Review of process of sharing SI's and lessons learned within the area affected and wider as a Trust.

***Chart 8** — Duty of Candour compliance during 2017/18*



Patient safety
Learning from incidents, SIRIs and Never Events

***Table 6** – Adverse events and SIRIs reported*

For the year 2017/18, there have been the following adverse events (categorised as low harm to severe harm) reported on the Datix risk management computer system.

Type of adverse event	No. of adverse events
Access, Appointment, Admission, Transfer, Discharge	745
Abusive, violent, disruptive or self-harming behaviour	199
Accident that may result in personal injury	1369
Anaesthesia	49
Clinical assessment (investigations, images and lab tests)	1120
Consent, Confidentiality or Communication	904
Diagnosis, failed or delayed	195
Financial loss	0
Patient Information (records, documents, test results, scans)	596
Infrastructure or resources (staffing, facilities, environment)	606
Labour or Delivery	347
Medical device/equipment	206
Medication	857
Implementation of care or ongoing monitoring/review	825
Other - please specify in description	824
Security	58
Treatment, procedure	720
Totals:	**9620**

Of these, 84 were reported as Serious Incidents Requiring Investigation (SIRIs):

Type of adverse event	No. of SIRIs
Abuse/alleged abuse of child patient by third party	2
Apparent/actual/suspected self-inflicted harm meeting SI Criteria-Mental Health SI	1
Information Governance breach	1
Diagnostic incident including delay meeting SI criteria	19
Infection control incident meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria (mother/baby)	2
Maternity/Obstetric incident meeting SI Criteria: Baby Only	4
Maternity/Obstetric incident meeting SI Criteria: Mother Only	1
Medication incident meeting SI criteria	6
Pressure ulcers meeting SI criteria	1
Slip/trip/fall meeting SI criteria	8
Suboptimal care of the deteriorating patient meeting SI criteria	10
Surgical/Invasive procedure incident meeting SI criteria	10
Treatment delay meeting SI criteria	17
Totals:	**84**

Never Events

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

The nationally agreed list of Never Events for 2017/18 are:

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

There are exclusions to each Never Event.

Patient safety
Learning from incidents, SIRIs and Never Events

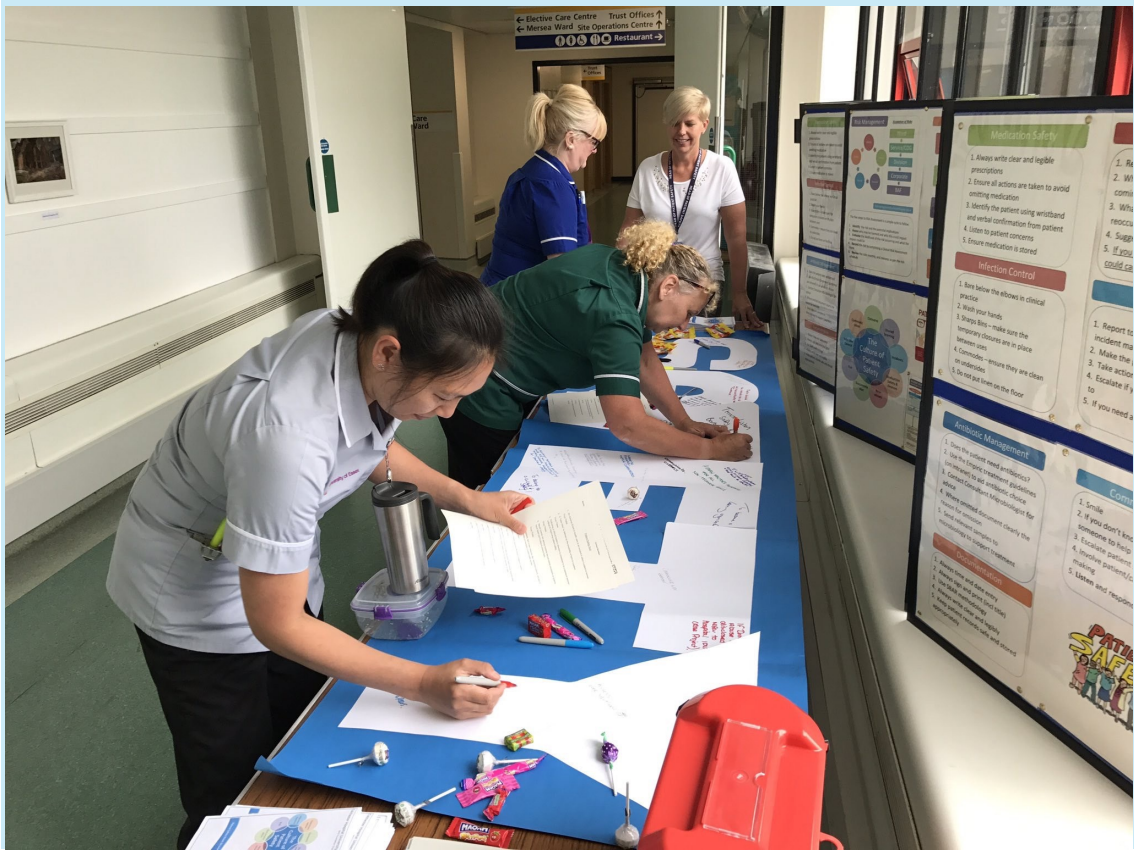
Never Events at Colchester Hospital University NHS Foundation Trust

2015/16	2016/17	2017/18
4	3	3

Whilst no patients had long-lasting or permanent damage, regrettably, three Never Events occurred in 2017/18:

- Wrong site surgery
- Misplaced naso- or oro-gastric tubes
- Wrong site local anaesthetic block

Staff writing Patient Safety pledges during Patient Safety Week, June 2017, at Colchester Hospital



Medication safety

Prevention of harm from medication

Medication Safety

The trust remains committed to the safe use of medicines. During 17/18 the Trust Medication Safety Group continued to effectively engage with representatives from all divisions and relevant clinical groups/staffing groups and the medication safety agenda was reinvigorated with a newly appointed Medication Safety Officer (MSO). Medicines Management Link Nurses also continued to meet bimonthly with the MSO to ensure medication safety work was highlighted at ward level and good practice shared.

A priority for the medication safety agenda 17/18 was to decrease the potential risk of patient harm as a result of an omitted prescribed critical medicine.

Why was this chosen as a priority:

Risks associated with the omission of medication administration are significant and have been known to cause significant harm or death in other organisations. Omitted critical medicine rates are an important metric to assess medication safety within an organisation.

How did we measure success:

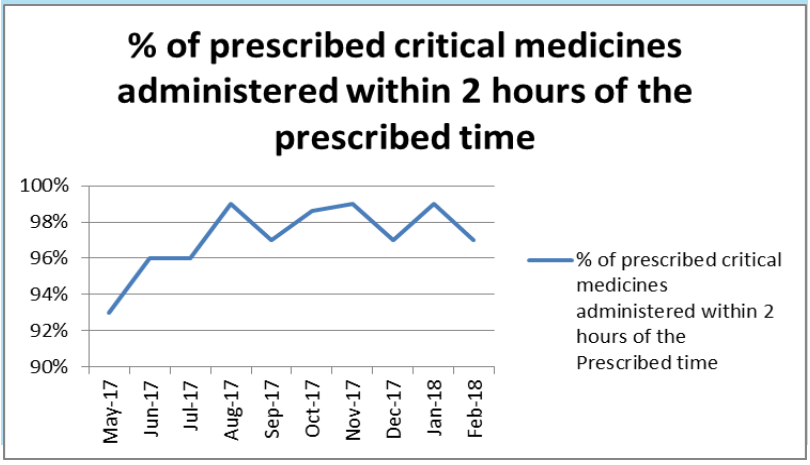
A focus was put on the timely administration of prescribed critical medicines. A critical medicine is one which is known to have a high risk of harm if delayed or omitted. The pharmacy department conducted a monthly snap shot audit of 10 patients per in-patient ward area to establish the percentage of prescribed critical medicines that were administered within 2 hours of the prescribed time (unless omitted for a clinically appropriate reason).

What was our target:

The trust aims to have 100% of prescribed critical medicines administered in a timely fashion.

What actions were taken to promote timely administration of medicines: The Medication Safety Group oversaw all actions related to this priority and the action plan was discussed monthly. The risk associated with omitted doses and the audit work was presented at the Sister and Matrons in June to engage with nursing staff and the response has been very positive. Communication between Sisters and Matrons and pharmacy staff has been strong and nursing staff regularly use the audit results to feedback to their frontline staff. Good documentation of administration has been targeted as an area for improvement. The trust 'Critical Medicines' list was updated in August 17 and posters were put up in all clinical areas to ensure all staff were aware of the high risk medicines. To prevent omissions as a result of a drug being unavailable a full review of the Trust Emergency Drug Cupboard has been undertaken and a flowchart for nursing staff on 'how to obtain medicines' was printed and placed in each clinical area.

Chart 9 *- Percentage of prescribed Critical Medicines administered within 2 hours of the prescribed time during 2017/18*



What was our performance:

A baseline audit in May 17 showed that 93% of prescribed critical medicines were administered within 2 hours of the prescribed time (unless there was a clinically appropriate reason). Following a focus on promoting the timely administration of medicines this increased to 99% in August 17. The trust remains within 97-99% adherence.

Other Key achievements in the Medicines Safety Agenda include:

- ✓ Regular 'Safe Storage of Medicines' audits including assessing medicines storage within the pharmacy department and theatres.
- ✓ Introduction of 'Grab Bags' for the safe administration of medicines during resuscitation events.
- ✓ Review of the Medicines Management Governance structure.

Clinical effectiveness
Stroke care

Specialist stroke care - the impact on recovery

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

The National Stroke Specific National Audit Program (SSNAP) audit aims to improve the quality of stroke services and patient care by reviewing care against set standards. Since the last report, Colchester Stroke Unit has maintained the top banding of "A" for Nov- Jan 16 -17 and April- July 17-18 in SSNAP national audit (within top 10% nationally).

CHUFT provides excellent stroke services across the whole pathway (hyperacute, acute and rehabilitation). It adopts evidence based practices and it is reflected in excellent clinical outcomes – lowest rates of new institutionalisation in East of England and lowest mortality in East of England (both below the national average). CHUFT's stroke specific Standardised mortality ratio was 0.82 for the year 2016-17 with the national average being 1. (source: SSNAP national database)

There is an active stroke research programme and CHUFT has recruited more than 40 patients for the year 2016-17. It is the top recruiter amongst the DGHs in the region.

MDT team is involved in an active clinical governance programme which regularly monitors the quality and performance: twice monthly performance meeting, monthly team at the top meeting and monthly mortality review meeting.

For two years running the Stroke Unit team are proud to report that no patients have developed a hospital acquired pressure ulcer of grade 2 and above since April 2016. This is a highly commendable achievement considering the high level of disability and dependency and level of care required for patients post stroke.

Physiotherapy and Occupational therapy have maintained the top banding of "A" for Nov- Jan 16 -17 and April- July 17-18 in SSNAP national audit and SLT have maintained "C" banding.

Close links have been established with the Emergency Department (ED) to facilitate sustaining and further improving direct admission within 4 hours and regular teaching sessions are being held for nurses and doctors in ED.

The Stroke unit has been involved in the Trust's piloting and improving End of Life (EOL) care for patients following a devastating stroke such as in-putting into the My Care Choices Register (MCCR) and Treatment Escalation Plan (TEP). The TEP form has enabled clear individualised parameters of care to be set for patients whilst they are in hospital. The MCCR helps improve EOL care by ensuring the patient has their choices respected, recorded and shared between hospital and community with the aim of improving the last days of life.

Some of the innovations listed below have been led by the Stroke Team members over the past year; they have included environmental and patient experience improvements.

The Stroke Unit is not immune to the national shortage of qualified nurses

Staff showing 'Poster Presentation' related to Cognition stimulation room

Clinical effectiveness
Stroke care

and has looked progressively and creatively at recruiting stroke specialist nursing staffing and focusing on growing our own team. Five of the unqualified staff on the stroke unit have developed their skills and knowledge on the nursing foundation degree course. This makes them uniquely qualified in nursing skills, stroke care and rehabilitation and enabled them to qualify and to be promoted to the assistant practitioners (AP) role within the stroke unit, enabling them to assist the qualified registered nurses provide nursing care. In addition to this two of the AP staff is continuing their training on a work based learning course and aim to become fully qualified registered nurses in the very near future.

The development of the Cognition stimulation room commenced in September 2017. Two of our senior Occupational Therapists produced a poster presentation about their innovative practice and presented at the RCOT Specialist Section Neurological Practice Conference. They developed an un-utilised space into the 'Cognitive Stimulation Room' and with funding from the non-medical tariff they invested in training and purchased resources to transform the room into a specific and meaningful environment to focus on cognition and cognitive rehabilitation.

***Chart 10** – Our performance over the last three years: % of people admitted to a Stroke Unit within 4 hours*

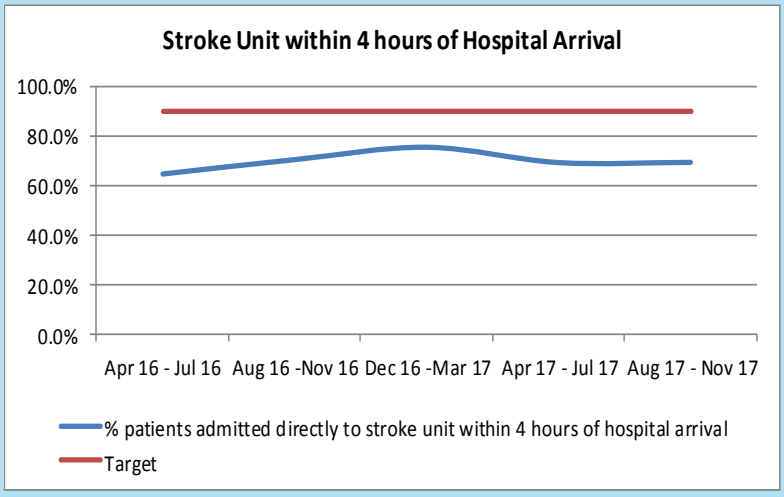
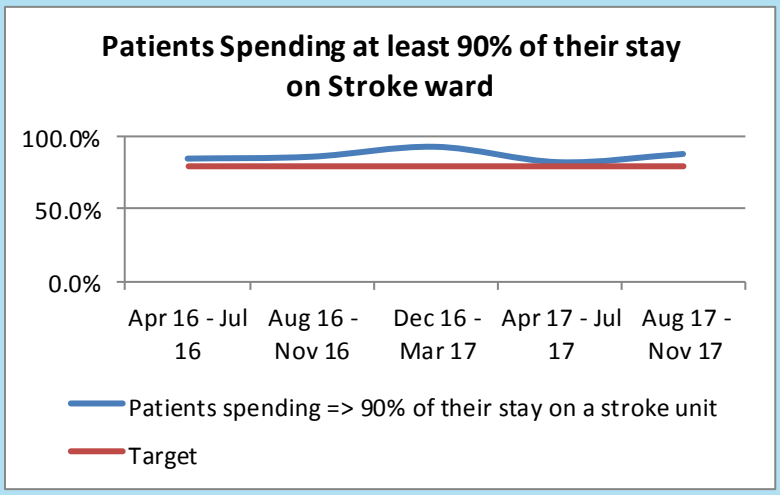


***Chart 11** – Our performance over the last three years: % of people treated on a Stroke Unit for >90% of the time*



Clinical effectiveness
Emergency care

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

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

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

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

- ✓ Standardise and embed ED processes so that these are adhered to 24 hours per day
- ✓ Embed the use of the Escalation and Whole Hospital Response policy and Action Cards
- ✓ Trial the use of the ED Trigger Tool in conjunction with the Escalation and Whole Hospital Response policy and Action Cards
- ✓ Monitor breaches, identify breach reasons and hold people/areas to account for these.

Table 7 *– Our performance over the last three years: 4 hours to discharge from Emergency Department*

		2016/17		2017/18	
	Target	CHUFT Performance	National Average	CHUFT Performance	National Average
April	95.00%	73.7%	85.0%	78.9%	85.7%
May	95.00%	85.3%	85.4%	79.9%	84.6%
June	95.00%	86.2%	85.8%	82.3%	86.1%
July	95.00%	87.9%	85.4%	69.2%	85.5%
August	95.00%	81.6%	86.4%	82.3%	85.4%
September	95.00%	94.4%	86.0%	80.2%	84.6%
October	95.00%	85.7%	83.7%	78.8%	84.9%
November	95.00%	87.2%	82.7%	88.2%	83.0%
December	95.00%	70.6%	79.3%	81.4%	77.4%
January	95.00%	76.4%	77.6%	88.5%	77.1%
February	95.00%	87.8%	81.2%	87.5%	76.9%
March	95.00%	91.4%	85.1%	93.0%	76.4%
YTD	**95.00%**	**84.13%**	**83.68%**	82.6%	82.3%

Table 8 *– Our performance over the last three years:*

Financial Year	CHUFT Number of Attendances	CHUFT 4 hr Performance	National 4 hr Performance
2015/16	68083	80.3%	87.4%
2016/17	85977	84.1%	83.7%
2017/18 *	91132	82.6%	82.3%

Clinical effectiveness
Emergency care

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

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

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

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

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

The Trust continues to run these intensive Red to Green weeks in order to embed the processes into our systems. Red to Green aims to break the cycle of repeated escalation measures and end the continuing disruption to normal clinical business, which disadvantages patients.

Clinical effectiveness

Hospital Standardized Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

What is HSMR?

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a group of 56 common diagnosis, which make up approximately 83% of in-hospital deaths. It is a subset and represents about 35% of admitted patient activity.

What is SHMI?

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

How do they work?

Mortality indicators show whether the number of deaths linked to a particular hospital or diagnosis group is more or less than expected, and whether that difference is statistically significant.

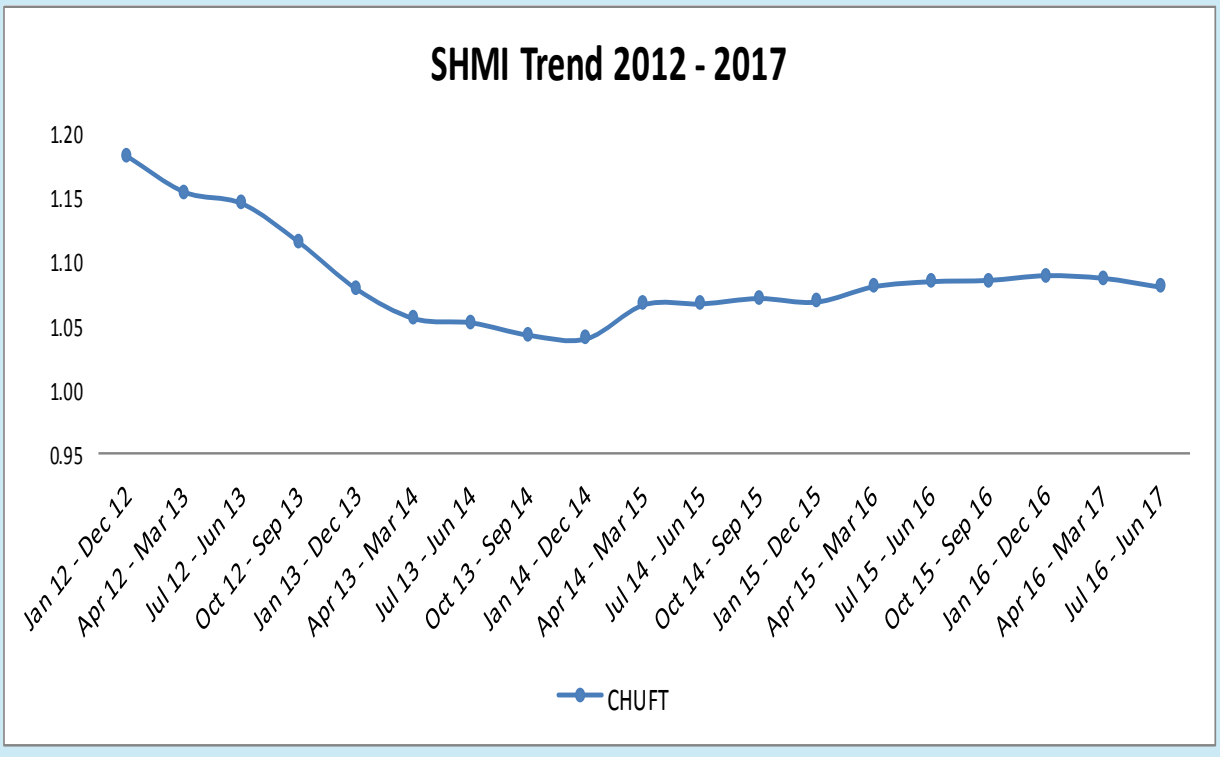
Why are mortality ratios/indicators important?

They are useful in combination with other metrics, providing an indication of where a problem might exist.

They are a method of comparing mortality levels in different years, or for different sub-populations in the same year, while taking account of differences in case mix (e.g. patient age, deprivation, gender etc.).

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

Chart 12 *- Mortality: SHMI trend January 2012 – July 2017*



Clinical effectiveness

Hospital Standardized Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

The national benchmark for HSMR is set at 100 - trusts with a relative risk below 100 are (statistically) performing better than other acute trusts in terms of lower risk of mortality. For the period March to October 2017, the published monthly relative risk for the Trust was below 100, ranging from 85 to 95.

Mortality indicators are reviewed at the Mortality Review Group and are used, in combination with information from patient feedback, peer mortality reviews, incident-reporting and Divisional Morbidity and Mortality reports to identify potential issues which may require further investigation and action. In addition, where good care is identified, this is shared trust-wide.

From April 2017, the National Quality Board published guidance setting out the minimum standards for mortality reviews for NHS trusts. This Trust was already reviewing more than half of all deaths prior to these changes; however, the reviews are now being selected systematically according to recommendations and also where staff or families of patients have raised concerns.

The Chief Executive writes to the families/carers of every patient who has died in hospital. The response has been overwhelmingly positive, but any issues raised undergo thorough investigation by the team who looked after the patient. An additional review is completed by other medical staff not directly involved in their care to ensure a high level of objectivity and to ensure themes for improvement are captured

Following correlation of information from reviews and other sources, a number of key areas of focus have been identified including treatment of respiratory conditions such as pneumonia and COPD, sepsis screening and treatment and end of life care.

The HSMR relative risk for sepsis has improved the Trust's position from 123rd out of 136 trusts to 70th in 16 months.

Table 9 - *Results summary for January 2017 - December 2017*

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

Metric	Result
HSMR	103.6 12 mth to Oct within the 'as expected' range
HSMR position vs. East of England peers	The Trust is 1 of 8 within the peer group of 16 that sit within the 'as expected' range.
HSMR diagnosis groups attracting higher than expected deaths	There are 5 outlying groups attracting significantly higher than expected deaths: Complication of device, implant or graft Relative risk 200 - 14 deaths, 7 expected COPD and bronchiectasis Relative risk 141 - 66 deaths, 47 expected Other lower respiratory disease Relative risk 194 - 14 deaths, 7 expected Senility and organic mental disorders Relative risk 162 - 23 deaths, 14 expected Pneumonia Relative risk 112 - 302 deaths, 269 expected
HSMR Weekday/Weekend Analysis	There is no significant difference between the weekday HSMR and weekend HSMR for emergency admissions. Both are statistically 'as expected'
Patient Safety Indicators (mortality metrics)	There are 0 mortality outliers
SHMI (April 2016 to March 2017)	Published SHMI = 108.06 'as expected' (band 2) 4 outlying SHMI groups What dates do you need for this Kerry? We have the 12 months to June 17 at the mo which is this figure. For March the figure was 108.76

Waiting times for Diagnostic Procedures
Clinical Effectiveness

The percentage of patients waiting over 6 weeks for a diagnostic test at month end has fluctuated throughout the year, however on average remains below the National Average but slightly above the Target. Services have been reviewed to provide assurance the resources available are being used to full potential. Each service reports independently to the Divisions and Trust Board and targets are monitored via the Accountability Framework.

***Chart 13** - Percentage of patients waiting over 6 weeks for a diagnostic test at month end*

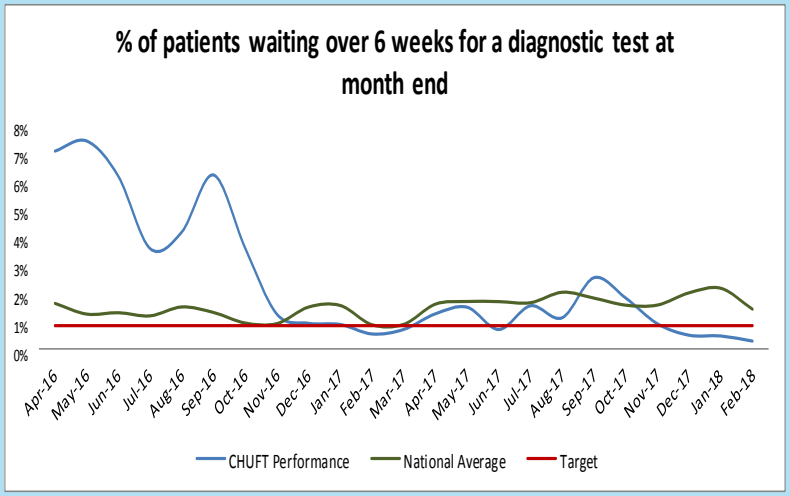


***Table 10** - Percentage of patients currently waiting under 18 weeks on an incomplete pathway*

		2016/17		2017/18	
% of patients currently waiting under 18 weeks on Incomplete Pathway	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
April	<1%	7.24%	1.81%	1.43%	1.78%
May	<1%	7.61%	1.42%	1.67%	1.87%
June	<1%	6.34%	1.47%	0.87%	1.87%
July	<1%	3.77%	1.36%	1.72%	1.83%
August	<1%	4.35%	1.68%	1.29%	2.20%
September	<1%	6.39%	1.48%	2.72%	1.99%
October	<1%	3.78%	1.10%	2.00%	1.74%
November	<1%	1.42%	1.08%	1.08%	1.74%
December	<1%	1.09%	1.67%	0.67%	2.18%
January	<1%	1.05%	1.73%	0.64%	2.35%
February	<1%	0.71%	1.04%	0.46%	1.60%
March	<1%	0.87%	1.06%		
End of Year position	**<1%**	**3.90%**	**1.40%**	**1.31%**	**1.92%**

Clinical Standards for Seven Day Hospital Services

Clinical Effectiveness

The 7-day services (7DS)programme is designed to ensure that patients admitted as an emergency receive prompt, high quality, consistent care, whatever day they enter hospital.

Of the ten clinical standards, four are deemed of priority:

- Std 2 - time to first consultant review (no longer than 14 hours)
- Std 5 - access to diagnostic tests (within 24 hours, 12 hours or 1 hour depending on need)
- Std 6 - access to consultant-directed interventions
- Std 8 - ongoing review by a consultant (twice daily or daily depending on need)

How did we measure and monitor our performance?

Two reviews were undertaken: a full review in March and a partial review in September 2017, as part of the national programme.

There is a national requirement that all Trusts meet the four priority standards for 7DS by March 2020. With this in mind, a number of key performance indicators (KPIs) have been set (please see the table below).

Will we achieve our intended target and what have we done to improve our performance?

Standard 2 time to first consultant review

✓Although some way below the current KPI, the Trust's performance for March 2017 was above the national average. Job plans and protocols are under review to make sure that there is capacity within the system.

Standard 5 access to diagnostic tests

✓ The Trust achieved 6/6 for weekday services and 5/6 for weekend. (The service requiring improvement, echocardiography, is only provided by 56% of trusts at weekends.) The Trust is investigating the possibility of shared services following the merger with Ipswich Hospital NHS Trust and potential recruitment opportunities.

Standard 6 consultant-directed interventions

✓The trust provided 9 out of 9 consultant-directed interventions on-site or by formal arrangement.

Standard 8 ongoing review by a consultant

✓The trust achieved 100% in twice-daily reviews of high dependency (very unwell) patients .

✓For those patients requiring daily review, compliance was 84% overall (91% weekday compared to national average compliance of 90% and 63% weekend compared to a national average of 68%).

Daily Consultant review is particularly challenging in some specialties, particularly at the weekend; however, the Trust has a number of mechanisms in place to make sure that unwell patients are identified and seen by the right grade of doctor including Watchpoint, an in-house software system which flags patients requiring review. This standard will be a focus of the clinical strategy going forward. Progress will be reported to Clinical Effectiveness Group, Quality & Patient Safety and Trust Board as appropriate.

Table 11— Key performance Indicators relating to 7-day services

Key Performance Indicators – (Level 1)

KPI Ref	KPI Metric Description	Measurement Metric	Current KPI (as at dd/mm/yy)	KPI Target	Target KPI score		
					Green	Amber	Red
7DS-01	Time to first consultant review	- Percentage of patients seen by consultant within 14 hours of admission for weekends and weekdays	Weekday 76% Weekend 73%	90%	90%	75-89%	<75%
7DS-02	Access to diagnostic tests	- Number of six key diagnostics available at weekends and weekdays	Weekday 6/6 Weekend 5/6	6/6	6/6	4-5	<4
7DS-03	Access to consultant directed interventions	- Number of nine key consultant led interventions available at weekends and weekdays	Weekday 9/9 Weekend 9/9	9/9	9/9	7-8	<7
7DS-04	Ongoing review by consultant	- Percentage of patients who have twice daily review for high dependency patients and daily review for all other patients unless this would not affect the patient's care pathway	Weekday HDU 100% Weekend HDU 100% Weekday ward 91% Weekend ward 63%	90%	90%	75-89%	<75%

Patient experience
Improving the patient and carer experience

Key achievements
We aimed to ensure that we delivered first class care by continuing to demonstrate kindness, compassion, professionalism and skill, together with an ambition to do even better for our patients, relatives and carers.
Last year saw some innovative schemes to support our patients experience, this included as follows:

Enhancing the environment for our most vulnerable patients

- ✓ The Maternity ward (Lexden) was reopened following the completion of a seven-week refurbishment programme. The ward now feels less clinical and more spacious, and has a different ambience. League of Friends also provided comfortable chairs for the ward for partners staying overnight.
- ✓ Funding secured to help towards the Time Garden for terminally ill patients
- ✓ Grills fitted onto the French doors that open onto the balcony on West Bergholt ward (oncology ward) - this means that in the hot weather the doors can be opened to allow fresh air flow into the ward.
- ✓ Maternity garden developed by Tesco and Wyvale.
- ✓ Installation of a Changing Places toilet - the Changing Places toilet gives people with multiple physical and learning disabilities, such as spinal injuries, muscular dystrophy and multiple sclerosis, the extra space and equipment they need to ensure their safety and comfort. Available in the Gainsborough Wing and close to the new Outpatients Department (OPD), it includes a hoist, adult-sized changing table and shower, along with space for both the individual and their carer. It will be available 24 hours a day.

The Changing Places toilet

- ✓ A drab dining room has been transformed into a popular and well-used facility for stroke patients and their relatives, thanks to an initiative by Colchester hospital staff. What was previously simply the “Dining Room” on the Stroke Unit at Colchester General Hospital has been redesigned and upgraded into a “Day and Dining Room” where patients can relax with their visitors and work on their rehabilitation, as well as enjoy meals.

The Newly refurbished Maternity Ward

Patient experience
Improving the patient and carer experience

Reducing loneliness, isolation and anxiety or boredom for patients and carers:

- ✓ Activity boxes were distributed to virtually all wards and departments at Colchester General Hospital to give patients an opportunity to alleviate boredom. Each box contains a variety of activities, including colouring books, word search books, board games, pens, pencils, arts and crafts materials, playing cards and dominoes. They also include sensory bands – also called “twiddle muffs” which can provide visual and tactile stimulation, comfort and distraction.
- ✓ Pets as therapy (pat) dog visits are a huge hit and distract patients from feeling anxious.

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

- ✓ Members of staff joined patients who are currently undergoing medical trials, for a research showcase on the main corridor in January 2018. The hospital currently carries out research in the following areas: Neonates, renal, paediatrics, anaesthetics, surgery, haematology, oncology, vascular, stroke, ophthalmology, gastroenterology and maternity. The Trust is keen to raise awareness amongst staff, patients and visitors that trials and research are a big part of the work at Colchester Hospital.

Activity boxes

- ✓ The "one-stop shop" information service at Colchester General Hospital celebrated its first anniversary. Birthday cake was handed out and balloons blown up when the weekly drop-in service for palliative and end of life care patients, their families and other carers reached the milestone. The sessions take place 2pm-3pm every Tuesday in the dayroom on West Bergholt Ward, which is located on the first floor of the main hospital building. In September the service was extended from palliative and end of life care patients currently in Colchester General Hospital and their families and other carers to include outpatients who are visiting the hospital and who may need support.
- ✓ A New film to educate patients and carers about the risks of falling has been produced; so far, the feedback has been positive with patients reporting that the film has given them a greater understanding of what they can do to minimize the risk of falls and has made them feel more confident they will be able to manage when they return home.
- ✓ Education day with Essex schools by children’s nurses
- ✓ Hypo Awareness Week activities took place
- ✓ Baby loss awareness week activities took place and remembrance service held.

Patient experience
Improving the patient and carer experience

Highlighting the importance of Carers in our community

- ✓ The Trust continued to work very closely with Essex Action for Family Carers. Family members can drop into the PALS Office during the week to seek support and guidance on what may be happening to their loved one. The team also visits wards daily speaking to carers to offer guidance and support. **Over 300 family carers have been supported during the year.**
- ✓ The dementia nurse specialists have signed up for John's Campaign to support family carers of patients with dementia to be able to stay and be more involved
- ✓ Carers Week, Carers' Rights Day and Young Carers' Awareness Days were all marked with an exhibition, stand and information workers providing advice and signposting to services.

Improving services for patients with learning disabilities:

- ✓ Learning Disability Good practice guide launched in July.
- ✓ Learning Disabilities Liaison worked with Essex County Council and Colchester Institute to provide films of having an MRI, blood test and attending A&E. These videos are available on you tube and also available in video brochures that can be loaned out to people to help reduce anxieties.

Supporting new mums:

- ✓ Seven mums have just started in a new voluntary role at Colchester General Hospital to support and encourage new mothers to breastfeed their babies. The "Colchester Volunteer Breastfeeding Supporters" currently help women on the hospital's maternity ward (Lexden Ward) but the plan is for them to also go onto the neonatal unit, delivery suite and midwife-led unit (the Juno Suite) as their numbers increase, as well as visiting mothers in their own homes. The seven volunteers who are currently supporting women range in age from a mother in her early 20s to a woman with grown-up children.

Making children and young people feel less scared or anxious:

- ✓ Colchester Children's Charity donated a saturation monitor to young patient, Renee Lewis-Driver (16), who is about to move to adult services for her continued care.
- ✓ The Starlight Children's Foundation sparkled some Christmas magic on our hospital when they performed their very special version of Cinderella for patients on the children's ward
- ✓ Ipswich Town & Colchester FC players took a break from their festive schedule to deliver some Christmas cheer to patients on our children's ward

The exhibition stand marking Carer's Week, Carer's Rights Day and Young Carer's Awareness Days

Patient experience
Improving the patient and carer experience

End of Life Care Focus:

Family care packs given to the patient's next of kin who stay as their relative is dying funded by Colchester Hospital League of Friends.

EOL volunteers available for hand holding, sitting with patients who are dying to allow family to go and get some food or to pop home. This is a new service and currently being trialled across a couple of ward areas with further 12 volunteers having some training next week. Plan for a 7 day service one day!

Memorial service set up last year for deceased adults where we held two small services last year and one bigger one this year when 48 next of kin attended. Plan to continue this for 2018

Bereavement walk-throughs – now completed four across paediatrics and adult services and have user and governor involvement. Bereavement suite improvements from this, funded by donations. Improvements to processes and policies made.

Quarterly bereavement survey given out from bereavement suite to help guide future service developments

Some ideas from wards include Acute Cardiac unit using **blankets** for dying patients which are then given to family if wanted or to cover patient when they go to the mortuary to reduce the clinical feel of dying in hospital. Critical care have **jewellery boxes** that they use for deceased patients.

Increase EOL champions across the hospital including clinical and non-clinical staff and the purchase of purple enamel pin badges to highlight who these staff are. Quarterly training days to share good practice and educate these staff.

Reviewing property bags for deceased patients to incorporate the purple butterfly as our EOL symbol

Ipswich Town & Colchester FC players deliver some Christmas cheer to patients on our children's ward

Blanketeers:

A Colchester ward sister has set up a group of volunteers to make blankets for patients who are nearing the end of their lives and also to reduce loneliness.

Sarah Sands from the Acute Cardiac Unit at Colchester General Hospital has been encouraged by the positive response from patients and their loved ones after blankets were donated by a knitting group in Norfolk led by her partner's mother.

She also believes that the group of volunteers, which will be called the "CHUFT Blanketeers", will bring together people who are often socially isolated, and give them a chance to get out of their home and meet other people. Ms Sands said: "When a patient is nearing the end of their life, we try to make their room less clinical by removing as much of the medical equipment as possible and make it more homely.

Each of their blankets has a handwritten tag giving the name of the person who knitted it and stating: "to bring you warmth and comfort at a difficult time". The other side of the tag is printed with the words "Knitted With Love" and has a motif comprising a ball of wool and two knitting needles.

Patient experience
Caring for people with dementia

Dementia Care

Each year the number of people living with dementia is growing and this number is expected to double during the next 30 years. Currently it is estimated that there are 850,000 people living with dementia in the UK, with numbers set to rise to over 1 million by 2025. 1 in 6 people over the age of 80 and over 40,000 people under the age of 65 have dementia in the UK. It is widely recognised that for patients who have a dementia diagnosis or a cognitive impairment who are admitted to hospital it can be very frightening and distressing experience and can reduce the person's level of independence. Last year CHUFT launched its 3 year Dementia Strategy to focus on improving the experience of patients, their families and carers when admitted. The Dementia strategy promotes a patient centered approach to care and includes improvements to the hospital environments, the use of distraction therapies, focused training for staff in supporting patients and increasing the support for families / carers.

It has been a key priority for the organisation over the past two years to create dementia friendly wards to reduce the anxiety of patients with dementia as part of the PLACE programme in the ward refurbishment plans at CHUFT. It is well known that reducing distress in patients can reduce length of stay, falls and other potential complications associated with admission to hospital. The Admiral Nurses have continued to be instrumental in advising the estates and facilities department regarding the creation of dementia friendly environments using evidence based practice. The Admiral Nurses are members of the Trusts refurbishment work stream and ensure that key areas of creating environments such as flooring, lighting, signage and quiet spaces are now incorporated into the ward and department plans as standard.

Governance and reporting:

Quarterly reports and updates are provided at the Dementia Management Group (DMG) Group which is chaired by the clinical lead and the deputy chair is the Head of Safeguarding. The DMG provides a forum for service leads to work together to address Dementia issues within the acute hospital setting and to ensure delivery of the 3 year Dementia strategy launched last year. The DMG provide a report to the quarterly Safeguarding Committee chaired by the Director of Nursing as Executive Lead and exception reports to the Quality and Patient Safety Committee and Trust Board. An annual Dementia activity report is produced and shared, stakeholders and the public.

The Dementia Care nurse specialists have undertaken further training to become Admiral nurses in partnership with Dementia UK (who are the charity that support them), and it is envisaged that the Admiral Nursing service will be an asset to our patients and families of people with dementia.

The Admiral Nurses regularly attend the dementia action alliance, the dementia partnership with EPT, the CHUFT end of life work-stream, the Essex Dementia Forum and the PLACE meetings to ensure that Dementia is considered throughout the organisation.

Training: supporting staff in the organisation

Ensuring a skilled and confident workforce to improve the experience of patient with dementia is a key priority. Along with mandatory training for all staff regarding Dementia, the Admiral Nurses run a two day advanced workshop. The workshop helps staff develop a person-centred approach to dementia care in an acute hospital setting. The programme is a multi-disciplinary approach to care in hospital including sessions which focus on communication, pain management, mobility and nutrition. Staff learn about the special needs of people with dementia and how to meet these needs by developing care practices, making the best possible use of time and resources available. Staff are encouraged to share their ideas, skills and experience and to give and receive feedback. The Admiral Nurses have increased the frequency of this workshop to monthly and will continue to provide training for staff to ensure they have coping strategies and the understanding to work confidently with patients with dementia.

In addition to this a volunteer Dementia day training programme has also been developed and feedback from the volunteers has been extremely positive. The volunteers have stated that the skills they have learnt during the training day has enabled them to feel more confident when communicating with patients in ward and community area.

In addition to the significant improvements to the hospital environment and appointment of the Admiral Nurses at CHUFT, work continues in supporting the individual with Dementia through distraction therapies such as the use of sensory bands to reduce distress and anxiety. Another Key priority for the team moving forward is to provide more support carers. The team have developed strong links with other Admiral Nurses at neighbouring acute hospitals and this will help in developing our Admiral Service further. A referral form has been developed for all staff to refer patients / families for advice and support. The Admiral Nurses and Dementia team can help with minimising distress that people with dementia may feel whilst they are in hospital; liaise with families, helping them cope with what is happening to their loved one, and ensuring they are equipped to continue with their caring role once their relative leaves hospital. This will hopefully reduce future crisis and unnecessary admissions.

Patient experience
Measuring and reporting the patient experience

Care Quality Commission National Patient Surveys

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

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

- Above (Better): the Trust is better for that particular question than most other trusts that took part in the survey.
- Average (About the same): the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Below (Worse): the trust did not perform as well for that particular question as most other trusts that took part in the survey.

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

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

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

National Maternity Survey

The results from the CQC survey of maternity experiences of acute trusts 2017 was published on 30 January 2018. This survey looked at the experiences of 18,426 women who gave birth in February 2017.
During the summer of 2017, a questionnaire was sent to all women who gave birth in February 2017. Responses were received from 96 patients at CHUFT.

Colchester received an overall 'better rating (better compared to most other trusts that took part in the survey) for Labour and Birth.

We were the only Trust in the East of England that received a 'better rating' in any category.

Colchester did not receive a 'worse than' score in any area.

Colchester scored better than other trusts for mums being able to move around and choose the most comfortable position during labour, and for partners being involved as much as they wanted, for which the hospital recorded a maximum score of 10 out of 10.

Of the 36 questions that received an average response the percentage for the question concerning the amount of time taken for discharge had decreased from the previous survey.

This had already been identified as a concern from in-house patient feedback and the department has been working on improving the discharge process for our women.

Early discharges are a priority for midwives on Lexden and in times of increased workload the ward sister and/or the maternity bleep holder will complete discharges for women on the ward.

Currently each woman receives discharge information prior to discharge; this is undertaken by the maternity support staff. In order to both speed up the process and for the women to be able to revisit the information we will be changing to electronic information.

***Table 12** – Based on patients' responses to the National Maternity Survey, this is how Colchester Hospital compares with other Trusts*

Labour and birth	9.4/ 10	WORSE · ABOUT THE SAME · **BETTER**
Staff during labour and birth	9.1/ 10	WORSE · **ABOUT THE SAME** · BETTER
Care in hospital after birth	7.9/ 10	WORSE · **ABOUT THE SAME** · BETTER

Patient experience
Measuring and reporting the patient experience

National Inpatient Survey

The results from the Care Quality Commission Survey of inpatient experiences of acute trusts 2017 was published on (not yet published).
The final response rate for the Trust was xx% (national response rate xx%).

The sample size was xxx. People were eligible for the survey if they were aged 16 years or older and spent at least one night in hospital and were not admitted to maternity or psychiatric units. The survey took place for one month during the summer of 2017

The National Inpatient Survey 2017 results for Colchester Hospital show the hospital as being 'about the same' as all other hospitals overall, (add top and bottom answers)

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Table 13 *– Based on patients' responses to the National Inpatient Survey, this is how Colchester Hospital compares with other Trusts* Not yet published

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

Patient experience
Measuring and reporting the patient experience

National Accident and Emergency Survey

The results of the national Accident and Emergency Survey were published on 17th October 2017.

The final response rate for the Trust was 30% (national response rate 28%).

The survey sought the views of more than 45,000 people aged 16 years and older who attended emergency and urgent care departments at 137 acute and specialist NHS trusts during September 2016. At CHUFT the questionnaire was sent to 1,250people who had used emergency department services at the hospital, with responses received from 362 people.

The sample size was 362. People were eligible for the survey if they attended the Accident and Emergency Department during September 2016.

The National Accident and Emergency Survey 2017 results for Colchester Hospital show the hospital as being 'about the same'/ better/worse as all other hospitals overall,

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Table 14 *– Based on patients' responses to the National Accident and Emergency Survey, this is how Colchester Hospital compares with other Trusts*

Arrival at Accident and Emergency	8.3/ 10	WORSE ABOUT THE SAME BETTER
Waiting times	6.1/ 10	WORSE ABOUT THE SAME BETTER
Doctors and Nurses	8.4/ 10	WORSE ABOUT THE SAME BETTER
Care and Treatment	8.1/ 10	WORSE ABOUT THE SAME BETTER
Tests	8.7 / 10	WORSE ABOUT THE SAME BETTER
Hospital Environment and Facilities	8.8 / 10	WORSE ABOUT THE SAME BETTER
Leaving Accident and Emergency	6.5/ 10	WORSE ABOUT THE SAME BETTER
Respect and Dignity	9.1/ 10	WORSE ABOUT THE SAME BETTER
Overall experience	8.3/ 10	WORSE ABOUT THE SAME BETTER

Patient experience
Measuring and reporting the patient experience

National Children and Young Peoples Survey

The results of the national Children and Young Peoples Survey was published on 28th November 2017.

The final response rate for the Trust was 24.9% (national response rate 26%).

The sample size was 1,250 with 306 responding. People were eligible for the survey if they were October, November and December 2016.

The survey looked at the experiences of 34,708 children and young people under the age of 16 who received inpatient or day case care during October, November and December 2016. Between February and June 2017, a questionnaire was sent to a maximum of 1,250 recent patients at each trust. Responses were received from 306 patients at Colchester Hospital University NHS Foundation Trust

The National Children and Young Peoples Survey 2017 results for Colchester Hospital show the hospital as being 'about the same'/better/worse as all other hospitals overall, for each section of the survey (there is no overall rating)
Top scoring question – 9.9 / 10 – for children spending most or all of their stay on a ward designed for children or adolescents, and not on an adult ward
Bottom scoring question – 2.1 / 10 – for parents and carers being given a choice of admission date

The full report can be found at www.cqc.org.uk/provider/RGQ/surveys

Table 15 *– Based on patients' responses to the National Children and Young Peoples Survey, this is how Colchester Hospital compares with other Trusts*

Going to hospital		**No overall score available**
Choice of admission date	2.1/10	About the same
Change of admission date	9.1/10	About the same
The hospital ward		**No overall score available**
Things to do	6.9/10	About the same
Food	6.0/10	About the same
Sleep	6.1/10	About the same
Privacy	9.1/10	About the same
Play	4.9/10	About the same
Suitability of ward	8.710	About the same
Play for younger children	7.8/10	About the same
Enough things for younger children	8.2/10	About the same
Food for young children	5.4/10	About the same
Privacy for younger children	9.2/10	About the same
Type of ward stayed on	9.9/10	About the same
Appropriate equipment or adaptions	9.2/10	About the same
Cleanliness	9.1/10	About the same
Hospital staff		**No overall score available**
Speaking with staff	9.3/10	About the same
Understanding what staff say	8.1/10	About the same
Able to ask questions	9.3/10	About the same
Questions being answered	9.6/10	About the same
Involvement	6.3/10	About the same
Support when worried	8.5/10	About the same
Talking to a doctor or nurse alone	Not applicable	
Staff introducing themselves	8.9/10	About the same
Communicating with young children	7.8/10	About the same
Conflicting information	8.1/10	About the same
Parents and carers feeling listened to	8.7/10	About the same
Explanations parents and carers could understand	9.2/10	About the same
Keeping parents and carers informed	8.2/10	About the same
Parents and carers able to ask questions	8.8/10	About the same
Planning care	9.3/10	About the same
Parent and carer involvement	8.2/10	About the same
Information	8.6/10	About the same
Children's medical history	7.6/10	About the same
Individual or special needs	8.2/10	About the same
Help when needed	8.0/10	About the same
Staff working together	8.7/10	About the same
Confidence and trust	9.0/10	About the same
Facilities for parents and carers		**No overall score available**
Access to hot drinks	8.1/10	About the same
Food preparation	4.9/10	About the same
Facilities for staying overnight	7.9/10	About the same
Pain management		**No overall score available**
Pain management	8.5/10	About the same
Parent and carer's views on pain management	7.9/10	About the same

Continued

Patient experience
Measuring and reporting the patient experience

Continued

Operations and procedures	**No overall score available**	
Information before an operation or procedure	9.5/10	About the same
Information after an operation or procedure	8.9/10	About the same
Information for parents and carers before an operation or procedure	9.1/10	About the same
Answers to questions before an operation or procedure	9.1/10	About the same
Distracting a child during an operation or procedure	7.6/10	About the same
Information for parents and carers after an operation or procedure	8.3/10	About the same
Medicines	**No overall score available**	
Information about medicines	9.6/10	About the same
Leaving hospital	**No overall score available**	
What to do in case of further concerns	7.9/10	About the same
Information about next steps	8.2/10	About the same
Advice on self care	8.7/10	About the same
What to do if concerned about their child	8.2/10	About the same
Parents & carers being given information/next steps	8.1/10	About the same
Advice on caring for child	8.6/10	About the same
Information to take home	8.4/10	About the same
Overall experience	**No overall score available**	
Friendliness	9.1/10	About the same
Being well looked after	9.1/10	About the same
Parents and carers feeling staff were friendly	9.3/10	About the same
Parents view of child being well looked after	9.4/10	About the same
Dignity and respect	9.2/10	About the same
Parent and carer being well looked after	7.9/10	About the same
Parents view of child's overall experience	8.6/10	About the same

Friends and Families Test (FFT)

The Trust achieved its target for recommender being at or above 95% for Inpatients with a score of 97.9% (national average 95.7%); the return rate was consistently higher (over 30%) than the national average (24.5%)

The score for ED was 87.7% - this was higher than the national average (86.6%) with a return rate that exceeded the national average of 12% month on month at above 20% up to 28% in February 2018.

The scores for outpatients remained above 95% at 97% throughout the year. There is no national comparator for return rate.

Maternity return rates were variable throughout the year but scores for 'birth' touchpoint were above 95%; with post-natal ward scores being on average above 95%.

Table 16– *Friends and Family Test Data April 2017 to March 2018*

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Inpatient FFT return %	39	37	44	43	43	39	36	41	33	36	35	39
Inpatient recommenders %	97	96	96	98	96	97	98	96	96	98	97	97
ED FFT return %	19	19	19	19	23	23	24	26	25	26	25	28
ED recommenders %	81	80	82	85	87	84	87	89	89	90	89	85
Outpatient FFT return %	1	1	1	1	2	1	1	1	1	1	1	1
Outpatient recommenders%	96	98	97	97	96	98	97	96	97	99	97	98
Maternity FFT return %												
Antenatal return %	0	0	0	0	0	12	26	38	9	0	6	2
Antenatal recommenders %	-	-	100	-	-	90	85	88	81	-	95	100
Birth return %	15	11	10	13	14	20	11	22	14	7	19	17
Trust-wide Birth recommenders %	95	100	100	100	100	95	100	100	100	100	100	100
Postnatal ward %	33	28	24	16	22	25	48	35	41	42	49	31
Trust-wide Postnatal ward recommenders %	94	98	98	100	98	95	96	99	100	92	100	98
Postnatal community %	0	1	1	1	0	13	1	0	0	0	0	12.8
Trust-wide Postnatal community recommenders %	-	100	100	100	-	74	100	-	100	-	-	100

Patient experience
Measuring and reporting the patient experience

New Initiative - Patient Experience Collaborative

What is the Collaborative?

12 trusts across the UK coming together to work with Northumbria Healthcare and Patient Experience Network (PEN) for 12 months to trial use of the Northumbria model for gathering patient experience feedback and applying quality improvement ideas, methodology.

The focus of the collaborative is to identify, develop, share and embed ideas and processes for improving patient experience, sustaining that improvement and providing a measurement framework to evidence improvement.

What is the Northumbria Model?

Realtime surveying of at least 50% of patients on a ward utilising a set survey covering key aspects of care and experience which are considered to have the strongest relationship to patients' overall satisfaction (Picker Institute 2009).
The following are recognised as the 'core domains' – the priority areas – for assessing patient experience of acute hospital inpatient care:

- Consistency and coordination of care
- Treatment with respect and dignity
- Involvement in decisions
- Doctors
- Nurses
- Cleanliness
- Pain control

Surveys, covering these domains, are undertaken and reported on as close to realtime as possible enabling immediate action to improve. This is then monitored over time to map and show the improvements.

How are Colchester Hospital NHS Foundation Trust & Ipswich Hospital NHS Trust involved?

Working as one overall team from both hospitals, 6 core team members have been identified to take the project forward on both sites, which will involve up to 8 patient wards/departments across the sites.

The 6 core team members will attend 5 learning events during the year and there will be a real time measurement uploaded twice a month giving robust evidence on impact and change.

The core team will have additional membership to create a 'steering group' to guide and support the programme, including the wider multidisciplinary team

In addition several data collectors have been identified to undertake the surveys, upload and share the data with the wards/steering group.

Next steps

- ✓ 08/09 November - Visit from Northumbria team to train the data collectors and core team in the methodology.
- ✓ First, base-line data collection – during November and December.
- ✓ Monitoring of results and action plans until end of

'Magic' the donated Giraffe to the Children's ward pictured with Nursing staff

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

The Trust has continued to involve patients and carers in a number of ways:

- ✓ Patient stories to public board
- ✓ Patient stories at corporate Induction
- ✓ Establishment of a patient advisory group to support the discussions around partnership working with Ipswich Hospital; development of a rolling action log to manage concerns and queries; establishment of a joint patient advisory group with Ipswich Hospital NHS Trust
- ✓ Supported user groups such as the Cancer Services User Group to develop further
- ✓ Collaborated with Ipswich Hospital User Group (IHUG) via key governors as the partnership discussions continued to review and build on existing good practice
- ✓ Attendance at Tendring Show
- ✓ Liaison with Healthwatch Essex and the Essex Health Forum

A patient 'You said, We did' poster

You said	We did
Patient explained by the time the food trolley reaches her bay on Nayland Ward there is no food left.	PALS visited ward and discussed the patients concern with Matron. Matron said she would raise this with the house keeper on the ward as rotation of bays should be made. The Matron has informed the patient of the action taken.
You said you could not hear the A&E receptionists and they could not hear you through the glass barrier in A&E Reception	We removed the glass barrier in the recent refurb' to make it easier for patients and staff to have confidential conversations in the A&E Reception
Several PALS contacts cover delays or problems in getting/making appointments	PALS proactively sort out the blockages and ensure the appointments are arranged appropriately
In the annual patient survey in Endoscopy one point of feedback was that on discharge only 80% of patients felt they were informed as to any necessary follow up appointments following their test.	We added a line to the ICP to ensure any follow up procedures or instructions are communicated to the patient and documented and signed
In the annual patient survey in Endoscopy one point of feedback was that a quarter of patients experienced a delay on the day of their procedure	This was recognised as a challenge funnelling three procedure rooms of patients through two admission rooms. A third admission room has been designed and fitted out – almost ready to go live with minimal snagging work left to do.
It gets hot and stuffy on the ward	Grills fitted onto the French doors that open onto the balcony on West Bergholt ward - this means that in the hot weather the doors can be opened to allow fresh air flow into the ward

Table 17 *— Number of plaudits received by Colchester Hospital during*

Month	Plaudits received
April 2017	1607
May 2017	1255
June 2017	1022
July 2017	1294
August 2017	1096
September 2017	995
October 2017	689
November 2017	687
December 2017	1351
January 2018	976
February 2018	1028
March 2018	1300
Total Plaudits for 2017-18	**13300**

Patient experience
Learning from complaints

What are complaints?

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

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

Complaints Service

Complaints are always taken seriously as they highlight the times we let down our patients and their families. Each complaint is treated as an opportunity to learn and improve the service we provide. The Trust listens and responds to all concerns and complaints which are treated confidentially and kept separately from the complainant's medical records. Making a complaint does not harm or prejudice the care provided to the complainant.

How complaints are managed within the hospital

We aim to respond to complaints within 28 working days from receiving the complaint. This year

90% of complaints received were responded to within 28 working days or a revised timeframe agreed with the complainant, against a Trust target of 100%.

Every effort is made to contact each complainant within 24 hours of the complaint being logged by the complaints team. These calls, known as 24 hour courtesy calls, are made by a senior manager and are seen as an opportunity to:

- Take time to understand the exact nature of the complaint as this will help to ensure a thorough and meaningful response;
- Gain insight to understand the key issues that need to be resolved;
- Help build relationships with the complainant, help them to feel part of the process and demonstrate that we take their concerns seriously; and
- Explain the 28 working day timeframe for our response and establish the method in which the complainant would like to receive our feedback, for example a letter, telephone call or a face to face meeting.

This year 90% of courtesy calls were made within the 24 hour standard.

All complaints are assigned to a complaints coordinator who liaises with the complainant and ensures that the service area/responsible for investigating and responding to the complaint does so within the agreed time limits.

Once a complaint investigation has been completed, it is checked

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

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

Patient experience
Learning from complaints

by the complaints coordinator to ensure all questions have been answered before being passed to the Chief Executive, Managing Director or another Executive Director to review and sign the letter of response.

Reopened complaints

During the year 2017/18 59 (8.8%) of the complaints received were reopened. One of the main reasons for reopening a complaint has been identified as poor or inaccurate investigation. In these cases, complaints are returned to the investigating team for further explanation and clarification.

Analysis of reopened complaints is being undertaken to ensure that we fully understand why first responses are not meeting the satisfaction of complainants and to enable the complaints team to offer Division appropriate support.

Complaints to the Parliamentary and Health Service Ombudsman (PHSO)

During 2017/18, 9 complaints were investigated by the PHSO as the complainant was unhappy with the response received from the Trust.

During this reporting period 9 cases are still being investigated. 2 cases were not upheld, 1 case was partially upheld and no cases were fully upheld

Learning from complaints

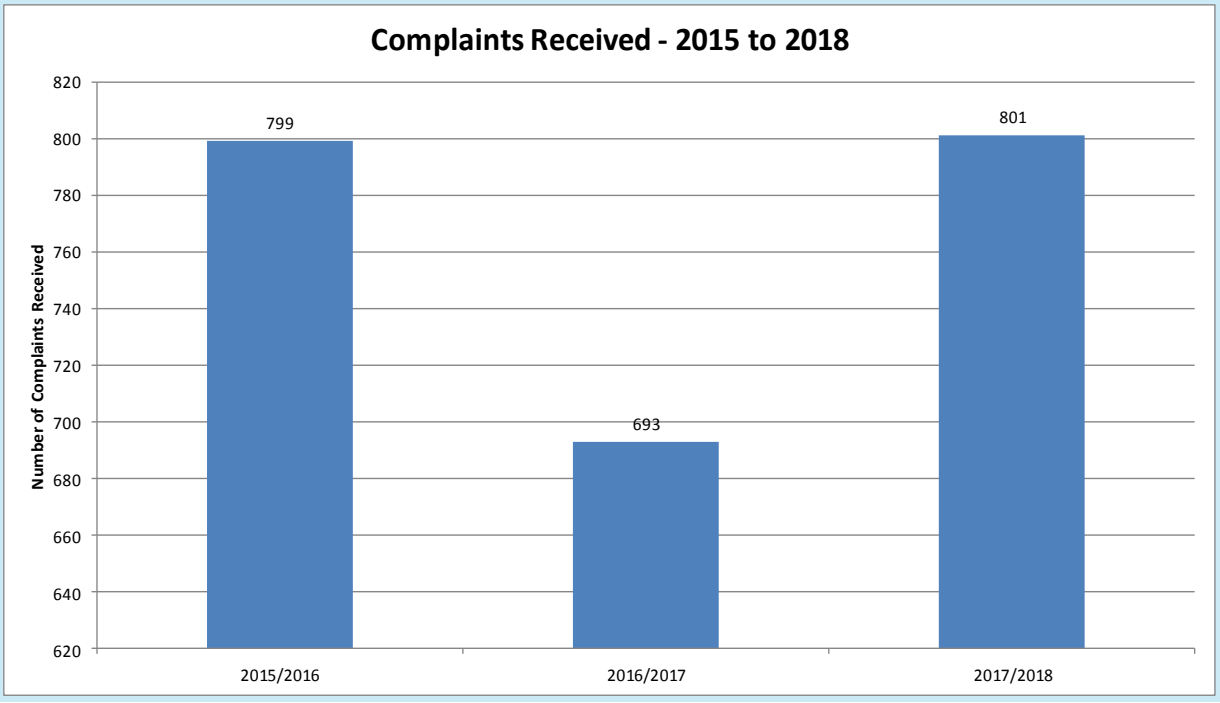
While information drawn from surveys and other forms of patient feedback is important, every complaint received indicates that for that patient or their family, they did not receive the high quality of care they rightly expect.

Complaints are an important method by which the Trust assesses the quality of service it provides. We take all complaints seriously and have taken action in response to them in various ways to improve the quality of the care we provide, as examples on the next page show.

It is acknowledged that there needs to be further Trust wide improvement in identifying, reporting and sharing lessons learned and actions taken from complaints.

Through the new Divisional Accountability and Performance framework we expect to see clear

***Chart 14** – Our performance over the last three years:*



Patient experience
Learning from complaints

evidence of learning from complaints in future.

Patient Advice and Liaison Service (PALS)

The PALS team handles queries and concerns in a practical way, resolving and addressing issues at source to prevent matters escalating. This is seen as a positive step towards taking more responsibility for issues as they arise.

PALS offer patients, carers and visitors:

- Advice and signposting– helping to navigate the hospital and its services;
- Compliments and comments– PALS can pass on compliments and ideas to improve services; and
- PALS can address non-complex issues informally, often preventing the need to raise a formal complaint.

PALS contacts are graded as either PALS 1 or PALS 2:

PALS 1 are contacts that require straightforward information or signposting, for example, ward visiting times, how a patient can obtain a copy of their medical records, GP services or Ambulance Trust services.

PALS 2 are contacts relating to a matter that needs to be resolved or addressed, for example , ward related issues for inpatients and their families, waiting list enquiries and appointment enquiries.

Table 18—Colchester Hospital Top three subjects of complaints for the last 3 years

Top three subjects of complaints		
2015/16	**2016/17**	**2017/18**
Attitude of staff	Attitude of Staff	Attitude of Staff
Elements of treatment	Elements of treatment	Elements of treatment
Clinical Communication and Co-ordination	Discharge	Discharge

Examples of PALS stories

✓ Patient's wife was unclear in relation to elements of the patient's care and did not know what treatment he should receive or what the discharge arrangements were. The patient suffers with Parkinson's and was admitted here after suffering a fall at the care home.

PALS arranged for the issues to be discussed with the patient's wife to enable her to understand what treatment plan was being put in place.

✓ Patient was concerned that he was told he needed a 2 week follow -up appointment after a minor operation in Oral Surgery but it was booked for 2 months.

PALS contacted the service area and arranged for the patient's appointment to be brought forward.

✓ Patient explained by the time the food trolley reaches her bay on Nayland Ward there is no food left.

PALS visited ward and discussed the patient's concern with Matron. Matron raised this with the house keeper on the ward to ensure rotation of bays was happening consistently.

✓ Patient was admitted on 29th December following clinic appointment for a scan. Scan did not occur until 2nd January. Patient was waiting to know when their chemotherapy would start.

PALS spoke to the Ward Sister who advised the patient that they would be seen by the doctor that morning and then would start chemotherapy the next

Patient experience
Learning from complaints

day.

✓ Patient contacted PALS suggesting we install screen filters for self-service kiosks in outpatients.

Estates confirmed that we are aware of this issue and are looking into filter screens being fitted. PALS relayed this information to the patient and advised that she could report to the reception desk to be checked in for future appointments.

***Chart 15** - PALS Queries April 2017 until March 2018*

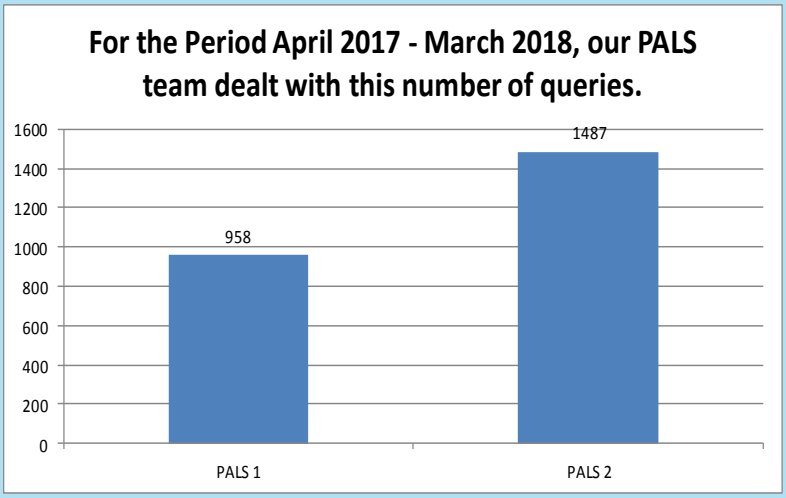
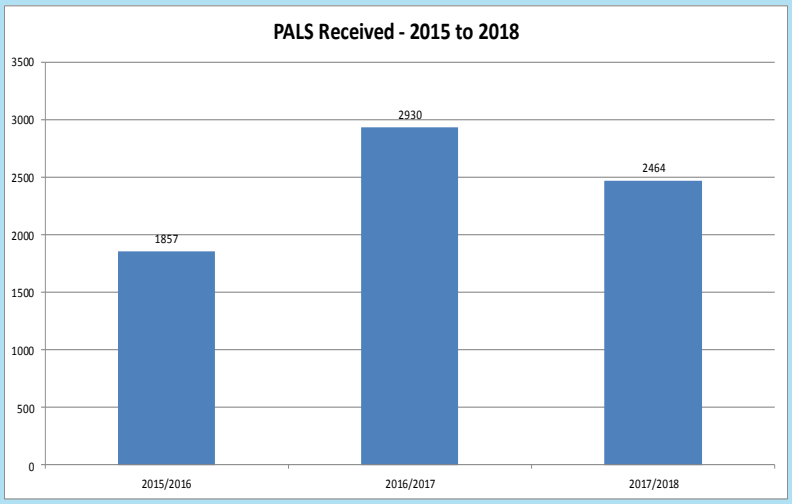


***Chart 16** - PALS Queries received for the last 3 years*



Patient experience

Patient-Led Assessment of the Care Environment (PLACE)

Patient-Led Assessment of the Care Environment or PLACE is a self-assessment of a range of non-clinical services by patient assessors in conjunction with Trust staff. The patient assessors are volunteers from the local community who use the healthcare services provided by the Trust and the Trust is represented by the Estates & Facilities departments as they are responsible for the majority of the non-clinical services such as cleaning and maintenance. The assessments are carried out in both the NHS and independent healthcare sector in England.

PLACE is a self-assessment of non-clinical services and replaced the Patient Environment Action Team (PEAT) assessments which ran from 2000- 2012 inclusive. PLACE assessments were introduced in April 2013 to and the scope of assessments is intended to focus on non-clinical areas which matter to patients, their families and carers. The aspects of the assessment include:

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

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

The programme encourages the involvement of patients, the public and other stakeholders with an interest in Healthcare. Consequently the Patient Assessors who assisted with the 2017 annual PLACE inspection consisted of people from all walks of life with an interest in Colchester hospital and the Healthcare it provides.

The role of the patient assessor

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

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

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

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

Scope of the assessment

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

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

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

Scoring

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

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

guidance.

To achieve a pass, all aspects of all items must meet the definition/ guidance as set out in the assessment criteria. When the definition criteria are not met, the score will either be a fail or a qualified pass. A qualified pass is awarded when the criteria are generally met, but there may be a minor exception, i.e. the walls on a ward are mostly in a good state of repair, but one wall may not be up to the required standard. This is detailed and a qualified pass is awarded/scored.

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

Food audits

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

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

The assessments

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

At Colchester, the assessments took place over a two week period, with two assessments taking place in the morning, taking in food audits at lunchtime, and two assessments in the afternoon/ early evening to take in supper service. This was to ensure that as many assessors who were available had an opportunity to take part in the assessment process and also to ensure that assessors did not have to spend overly long days at the hospital.

PLACE recognises that hospital buildings vary in age and design; which may impact on their ability to meet the criteria. However, it is important that the assessment is based on standard criteria and no allowances are made for such factors. The scores awarded reflect what was seen on the day. The assessments take place annually, and results are reported publicly by the Health and Social Care Information Centre (HSCIC) to drive improvement. Due to changes in the criteria to be scored it is not easy to draw comparisons between the scores achieved between 2013 and 2015 and those achieved in 2016 and 2017.

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

Areas assessed in 2017

The following areas were assessed in 2017:

Wards:
Tiptree, Layer Marney. Langham, Lexden, Wivenhoe, Nayland, Brightingsea, Mersea, Aldham, Stanway, Great Tey, Darcy, Peldon , Acute Cardiac Unit

Outpatient Clinics:
Physiotherapy, Hydrotherapy, X-Ray, Ante-natal, Mary Barron, Haematology, Elmstead Day Unit, Central Delivery Suite, Surgical Assessment Unit

Food audits were conducted on:
Layer Marney , Wivenhoe, Aldham, Stanway

General areas (these must be assessed every year)
Emergency Department
Communal areas inside the hospital building
External grounds

Results of the PLACE assessments

The assessments identify that the following action is required in order to improve the environment:

- Continue to refurbish bathrooms on wards identified in the relevant programme
- Provide day rooms/social spaces

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

on wards when wards are refurbished
- Extend the 'dementia friendly' ward programme
- Make finger foods available for specific groups of patients
- Continue to improve signage and wayfinding around the site

The results of the PLACE assessments were submitted and published in August 2017. The scores achieved by Colchester hospital are detailed in Table 1 (see below). Table 2 details how Colchester performed against other local Hospital Trusts.

Next Steps

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

The PLACE Action Plan is updated and is then reviewed/discussed at the quarterly PLACE Steering Group meetings. The Group is attended by the Patient and Staff assessors who take part in the audit process.

The Trust will conduct six PLACE lite assessments throughout the year to audit the environment and monitor the impact of actions taken and improvements made.

***Table 19** - PLACE Overall Scores with the 2017 national average and the overall score achieved by CHUFT in (2016 & 2017)*

PLACE CRITERIA	National Average	Colchester General 2016	Colchester General 2017
Cleanliness	98.38%	99.43%	99.29%
Food and Hydration	89.68%	88.82%	91.88%
Privacy, Dignity and Wellbeing	83.68%	89.16%	85.41%
Condition, Appearance & Maintenance	94.02%	93.80%	95.62%
Dementia	76.71%	68.53%	76.39%
Disability	82.56%	71.58%	86.25%

***Table 20 -** PLACE Overall Organisational Scores against local Hospital Trusts*

Organisational Name	Cleanliness	Food and Hydration	Privacy, Dignity and Wellbeing	Condition, Appearance & Maintenance	Dementia	Disability
Colchester Hospital University NHS Foundation Trust	99.29%	91.88 %	85.41 %	95.62%	76.39 %	86.25%
Southend University Hospital NHS Foundation Trust	98.41%	91.01 %	75.18 %	90.28%	70.23 %	81.18%
Mid Essex Hospital	99.29%	89.00 %	84.68 %	94.59%	77.99 %	84.69%
Basildon & Thurrock University Hospitals NHS Foundation Trust	99.77%	92.00 %	86.43 %	98.82%	91.20 %	92.04%
Ipswich Hospital NHS Trust	96.50%	82.52 %	76.86 %	86.77%	63.70 %	72.87%
West Suffolk Hospitals NHS Foundation Trust	99.73%	93.99 %	83.96 %	96.14.%	78.39 %	84.07%
Cambridge University Hospitals NHS Foundation Trust	96.17%	82.81 %	80.48 %	91.66%	70.57 %	79.55%

Cancer Care Delivery
Referral to Treatment Times (RTT)
And Improving performance

Ensuring that patients with either a suspected cancer are diagnosed quickly and receive effective treatment is a key priority for all staff at Colchester Hospital

Cancer performance continues to improve across all standards. Although the focus from NHS Improvement (NHSI) and NHS England (NHSE) has been on the 62 day first standard, it has been acknowledged that by reviewing pathways and processes across every tumour site, overall performance across all standards has increased.

With perhaps the exception of the introduction of Straight to Test (MRI) for patients under the age of 75 referred in on a 2 week wait prostate pathway, there have not been any real changes to any of the cancer pathways. What has made the difference is the consistent approach to managing the cancer Patient Tracking List (PTL) and the focus not only to reduce the backlog (patients waiting longer than 62 days) but on a more robust escalation process which has enabled us to identify any potential issues or blocks to a patients cancer pathway. Communication and face to face engagement with all departments, in particular radiology, building on relationships and increasing the understanding of cancer waiting time rules amongst the admin staff, has enabled us to raise the profile of cancer within the trust. This in itself has almost, in a subliminal way, increased performance.

Cancer PTL meetings, chaired by the Director of Operations and supported by the Lead Cancer Manager, are attended by the General Manager for each tumour site. These meetings are mandatory and take place every Thursday afternoon. The trust has a set recovery trajectory, agreed by NHSI/NHSE and the CCG and weekly performance (actual and forecast) is recorded against this trajectory at each meeting. These reports are then submitted to all stakeholders with accompanying narrative which describes the discussions that have taken place at the meeting. The reports and some accompanying narrative (as well as ad hoc performance calls) provide an element of assurance to all concerned that recovery is on track and sustainable.

In addition to Cancer PTL Performance meeting, the Lead Cancer Manager (LCM) runs Cancer Red to Green every Tuesday afternoon. This is an opportunity for service managers to go through all patients on their PTL and identify where patients will be treated within the standard and more importantly, where there are any blocks in the patient's pathway of care. Following these meetings any unresolved issues are escalated by the LCM to senior managers within respective departments (this could be a tertiary issue, or internal radiology or histology) and where possible the issues are resolved before the Thursday performance meeting where a further update is given. Any issues still unresolved at this point are escalated to the Director of Operations.

62 day first standard has not been achieved at Colchester since December 2013. Although there have been a succession of recovery plans in place since then, it is only the trajectory agreed and set in September 2017 forecasting recovery in February 2018 that has been the most robust. The plan was based on each tumour site submitting their own recovery plan and being held to account to deliver against it. Previously the RAP's (Remedial Action Plans) had been 'trust' level documents that were never fully signed up to by either the service teams or the clinicians. The 'new' recovery plan is 'owned' by each Tumour Site Service Group and delivery in each tumour site has been facilitated and supported by Lead Cancer Manager and MDT Coordinator team. Colchester has also received external support from a NHS Elect 'coach' and a 6 month programme of collaborative events also hosted by NHS Elect.

104 day breaches: A weekly 104 day report is also sent to NHSI. The overall number of patients waiting over 104 days is at its lowest in over 3 years, with currently 8 patients waiting, all of which are either due to patient choice or require repeat diagnostic tests. For these patients, as there is still a suspicion of cancer, in line with Cancer Waiting Time rules they must remain on the PTL. The number of 104 day waits has reduced from over 40 patients 12 months ago.

The Root Cause Analysis (RCA) process has also changed and become more robust in recent months. All patients waiting longer than 62 days are now reported as incidents on Datix by the Cancer team.

Cancer Care Delivery
Referral to Treatment Times (RTT)
And Improving performance

The Divisional Governance Leads then request that a RCA is completed for each patient by the appropriate of the service managers. Where the delay has been caused by a failure of an internal process (clinical or administrative) a full RCA is required which included a clinical harm review. This will be recorded on DATIX and consideration as to whether or not clinical harm has occurred an SI should be raised. Where the breach is due to a delay in removing patient from a pathway (tracking) meaning that the patient hasn't actually breached or patient choice to wait or defer, the DATIX is closed.

The incident RCA's are reported as part of the Divisional AF (Accountability Framework) process

Colchester has a Cancer Board that meet's bi-monthly which is chaired by the Trusts Lead Cancer Clinician, Mr Subash Vasudevan. There is a requirement for each tumour site lead clinician to attend along with the Divisional Lead and the Head of Operations. Each Division is required to produce a performance report which they are asked to present at the meeting.

The Board is also attended by the CCG, a representative from the trust's Cancer User Group (CUG), the Lead Cancer Nurse and the Lead Cancer Manager.

Chart 17 *—Percentage of patients currently waiting under 18 weeks on incomplete pathway*

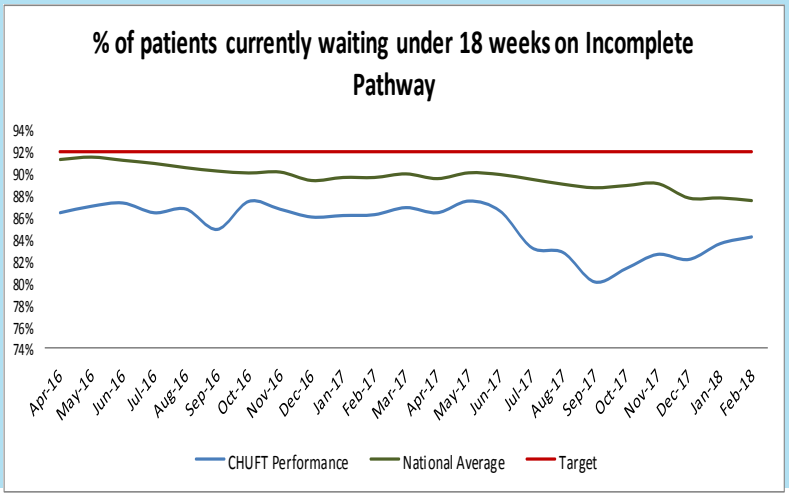
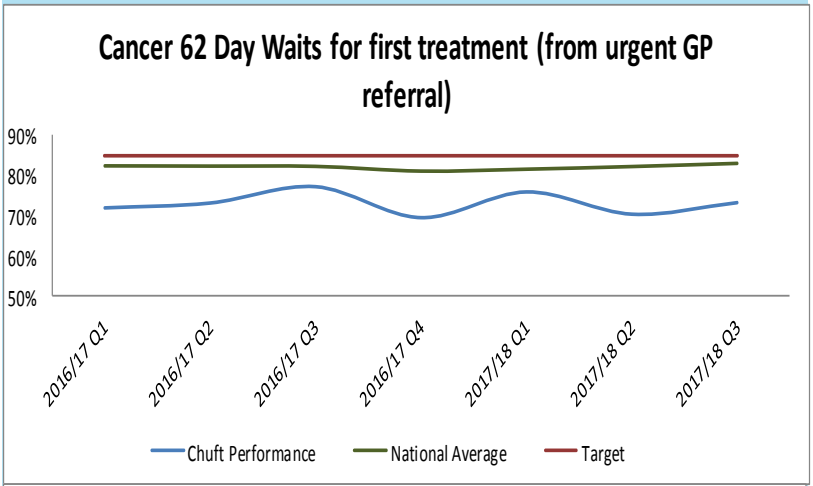


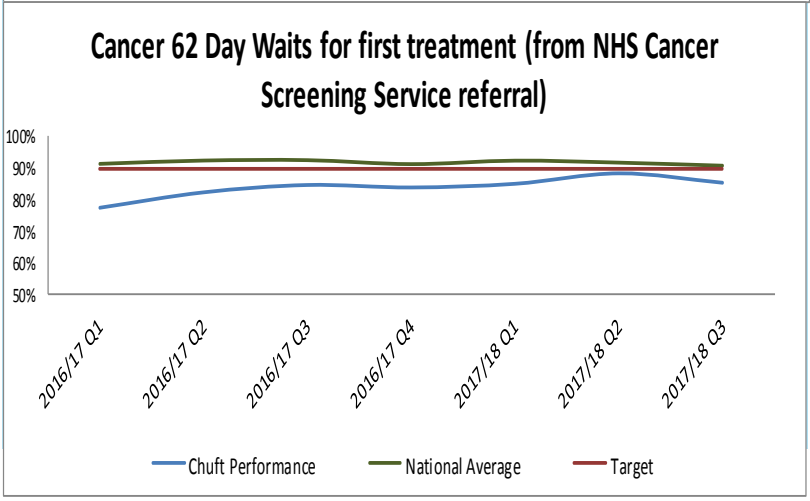
Table 21*—Percentage of patients currently waiting under 18 weeks on incomplete pathway*

		2016/17		2017/18	
% of patients currently waiting under 18 weeks on Incomplete Pathway	**Target**	**CHUFT Performance**	**National Average**	**CHUFT Performance**	**National Average**
April	92%	86.45%	91.34%	86.46%	89.59%
May	92%	87.05%	91.56%	87.53%	90.12%
June	92%	87.35%	91.27%	86.59%	89.96%
July	92%	86.45%	90.98%	83.26%	89.52%
August	92%	86.80%	90.59%	82.81%	89.07%
September	92%	84.93%	90.28%	80.11%	88.75%
October	92%	87.49%	90.11%	81.33%	88.95%
November	92%	86.78%	90.19%	82.64%	89.13%
December	92%	86.06%	89.41%	82.17%	87.80%
January	92%	86.20%	89.69%	83.63%	87.81%
February	92%	86.28%	89.69%	84.24%	87.57%
March	92%	86.93%	90.02%	-	-
End of Year position	**92%**	**86.56%**	**90.42%**	**83.79%**	**88.94%**

Cancer Care Delivery
Patient Experience

***Charts 18**—Cancer 62 Day Waits*





Patient Experience

The Trust Cancer User Group (CUG) underwent a recruitment drive and has welcomed new members and they have received informative talks about cancer patient pathways. They have designed and produced a patient information leaflet, poster and business card to be displayed and given out to patients who are visiting their GP and are being referred with a suspected cancer to the hospital. This will be officially launched at the GP afternoon event in April 2018. They have also been involved in the Cancer Unit plan to ensure that the cancer patient experience is listened to the design is for purpose. Finally the CUG have been seeking real time feedback from patients visiting the Outpatient department as well as the radiotherapy and chemotherapy units.

The Strategic Transformation Partnership (STP) Cancer Board has been meeting to discuss as a locality what our strategy should be to be able to deliver the NHS Five Year Forward View. The Colchester Hospital Cancer Strategy for 2017 – 2012 highlights key areas of work required including consistently complying with 2 week, 31 day and 62 day targets, continuing to plan the new cancer centre with an opening date of 2019 and including a wellness centre accessible to all cancer patients.

The Trust was successful in embarking on a Macmillan electronic holistic needs assessment (eHNA) as a pilot site with the use of a tablet device for patients to use. There have been some teething problems but there is ongoing work and further CNS are keen to trial. Macmillan have also been instrumental in developing the new roles of Survivorship Lead and Survivorship Support worker, along with a Programme Manager all as 2 year fixed term funded posts. These posts will enable further work on stratified follow up for some patients, and continued work on patient pathways as well as the planning and implementation of the Wellness Centre.

Continued work by the Macmillan Information Manager and Lead Cancer Nurse on the pre-treatment sessions for new patients and carers. These are currently being evaluated and are ready to recommence in April 2018 but with the aim of inviting all tumour sites to avoid repetition and provide a place where people with similar experiences can network.

The National Cancer Patient Experience Survey results were released late 2017 and even though Colchester was above average on 'Overall, how would you rate your care?', there were still some specific areas to work on and improve such as ensuring patients were aware they could bring a family/friend with them to their appointments, improving patients awareness of who their CNS is and the access to them, improve the trust and confidence in the nurses and Doctors by a more robust education plan.

Finally with Colchester Hospital joining with Ipswich hospital, the Lead Cancer Nurse has commenced work to look at the CNS service at CHUFT and in turn will arrange meetings with the IHT CNS team to ensure that patient pathways

Safeguarding

Adult, Children, Maternity and Learning Disability Teams

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

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

Governance: Safeguarding families
The safeguarding team supported by the head of Safeguarding and which includes the newly appointed Admiral Nurses for Dementia care continue to promote a "safeguarding families" approach to safeguarding within CHUFT. This approach was commended in the most recent NHSI and CQC visits to CHUFT. A Safeguarding families approach is achieved by joint working, procedure management, and attendance at the safeguarding management groups (SMG) and committee. It is envisaged that the safeguarding families approach will continue as CHUFT merges with Ipswich NHS Trust later this year.

The safeguarding team regularly attend the serious incident review panel, the harm free panel and patient experience committee to ensure that safeguarding is considered throughout the organisation.

Reporting: providing assurance
Quarterly reports and updates are provided at the Safeguarding of Adults at Risk Management Group (SAMG) and Safeguarding Children Management group (SCMG). Each management group is chaired by the named doctor and deputy chair is the Head of Safeguarding and Named Nurse Children Safeguarding. These groups have multi-disciplinary and relevant divisional and safeguarding agency representation. Within the SCMG the named midwife for safeguarding has commenced quarterly reporting and updates. Within SAMG Dementia and LD are represented and provide updates. The groups provide a forum for service leads to work together to address safeguarding issues within the acute setting and to lead the strategic direction of safeguarding within CHUFT.

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

Training: supporting staff in the organisation
There has been a significant increase in safeguarding training across all levels over the past twelve months with continued focus on L3 and LAC child protection training. Trajectories for each quarter are set to achieve the targets agreed in the 2017/18 contract standards. The PREVENT (counter terrorism) target has been increased to 90% set by the Home Office (which the Trust has successfully met throughout the year).

The Trust has seen an increase in disclosures of domestic abuse in the community from patients who access services at CHUFT and a training package has been developed in partnership with Essex Domestic abuse Partnership Programme (EDAAP) to support staff in identifying domestic abuse, providing guidance for staff in how to respond to disclosures including seeking the support of Independent Domestic Violence Advisors for patients. And identifying risk to any children or young people that might also be affected.

Key priorities will include continued monthly monitoring of training to maintain training levels, any concerns will be escalated to the Safeguarding Committee and Quality and Patient Safety (QPS). The safeguarding team will promote the use of the domestic abuse training package across the organisation.

Learning Disabilities: supporting patients and staff in the organisation
The Learning Disabilities Liaison Nurse (LDLN) receives referrals from a number of sources for patients with a learning disability and/or autism and their carers / family as appropriate accessing the Acute Hospital. This is through both the emergency or elective pathways and includes a pre-alert system into A&E. There has been a significant increase in referrals

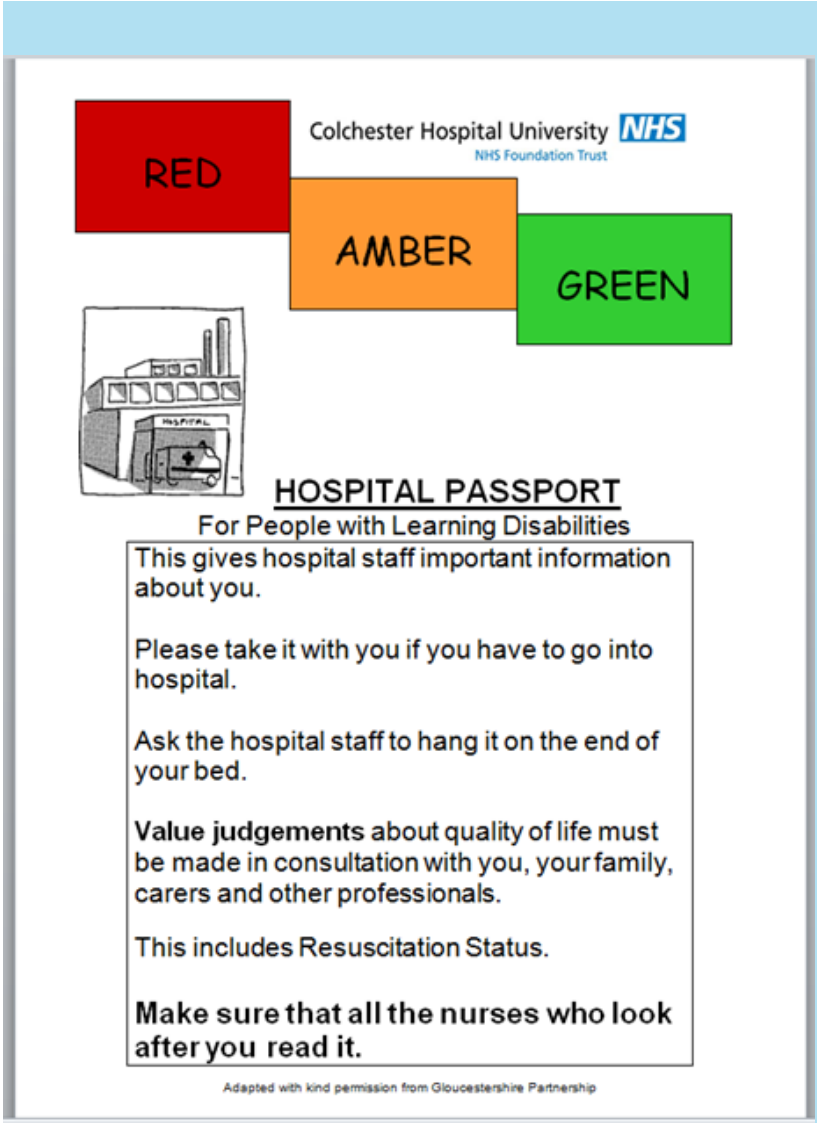
Safeguarding

over the last 12months. Referrals are from hospital staff, community learning disabilities team from HPFT (Hertfordshire Partnership Foundation Trust) and ACE (Anglian Community Enterprise), community care providers, social workers, GP's, family / carers and individuals with a learning disability. A number of referrals have been received from the transitions nurses at the hospital.

In addition to this the LDLN has made referrals to the community learning disabilities nurses, community AHP's, Independent Mental Capacity Advocate's and music therapy by the learning disabilities hospital liaison nurse to support patients on discharge. The LDLN provides valuable support for family / carers whilst the person accesses the hospital setting. Verbal feedback from carers has been very positive.

Learning disability training is provided for all staff and is mandatory to job role within the organisation and includes how to refer to the LDLN and to promote the use of the hospital communication book and hospital passport which are key for ensuring good quality care for people with learning disabilities or autism. The passports are discussed at each interaction with the LDLN. An electronic way of keeping these hospital passports is also being considered.

The importance of hospital passports has been a key theme discussed with care providers to try to increase their use. In addition to this a nurse practitioner from A&E and the LDLN visited one of the local care homes where we had a high number of visitors to the emergency department. This joint working approach has proved successful in reducing hospital attendances and this work will continue with other care providers.



CHUFT recognises that for patients with a learning disability and/or autism hospital can be a very new and often frightening place. To help reduce some anxiety often expressed by patients the LDLN launched the "activity box" in November 2017. The activity boxes contain games, puzzles, colouring pages, activity books, craft supplies to provide distraction and copies of the communication book to assist staff. Ten wards have been provided with the boxes and feedback has been very positive. We have had a number of donations and so will be able to provide more boxes over the coming months.

Staff Survey

Equality and Diversity

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

National NHS Staff Survey

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

The Trust takes part in the quarterly staff friends and family test as well and the annual NHS staff survey.

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

There is a key indicator which is the percentage of staff employed by, or under contract to, the Trust during 2016/17 who would recommend the Trust as a provider of care to their family or friends (staff survey question 21 d).

The scores presented below are unweighted question level scores for questions 21a – 21d and the unweighted score for Key Finding 1. The percentages for questions 21a – 21d are created by combining the responses for those who agree and strongly agree compared to the total number of staff who answered the question.

Questions 21a, 21c and 21d (shown below) feed into key finding 1 – staff recommendation of the organisation as a place to work or receive treatment.

Table 22—Data Source 2017 National Staff Survey

		2016	Average (median) for acute Trusts 2017	2017
Q21 a	"Care of patients / service users is my organisation's top priority"	75%	76%	74%
Q21 b	"My organisation acts on concerns raised by patients / service users"	69%	73%	73%
Q21 c	"I would recommend my organisation as a place to work"	50%	61%	50%
Q21 d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	59%	71%	62%
KF1	**Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)**	**3.56**	**3.75**	**3.63**

Table 23—shows the past 3 years results and the national comparison from the annual NHS staff survey.

Year	CHUFT % Recommended	Acute Trusts average
2015	62%	69%
2016	59%	70%
2017	62%	71%

Staff Survey
Equality and Diversity

Quarterly staff friends and family survey

Results from the annual and quarterly surveys are shown below. The indicator methodology used is as indicated on HSCIC – percentages are added for options “agree” and “strongly agree”.

National Staff Survey key findings and staff engagement

Overall indicator of staff engagement for Colchester Hospital University NHS Foundation Trust

The overall indicator for staff engagement comprises three key findings in the NHS Staff Survey:
• staff members perceived ability to contribute to improvements at work (KF7)
• their willingness to recommend the Trust as a place to work or receive treatment (KF1)
• staff motivation at work (KF4).

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

Chart 19— Data source 2017 National Staff Survey

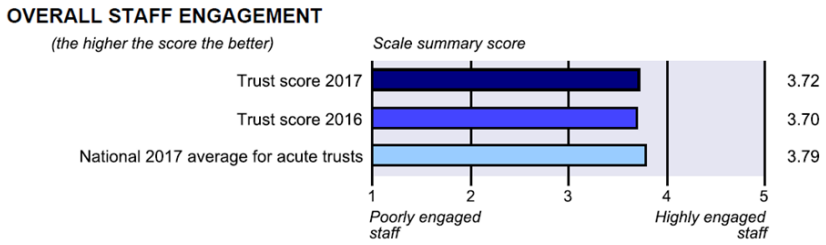


Table 24-Data source www.england.nhs.uk/data

Quarter	CHUFT % Recommended - WORK	England % Recommended - WORK	CHUFT % Recommended - CARE	England % Recommended - CARE
2014/15 Q2	88%	61%	88%	77%
2014/15 Q3	Results from National Staff Survey			
2014/15 Q4	43%	62%	58%	77%
2015/16 Q 1	49%	63%	68%	79%
2015/16 Q 2	47%	62%	66%	79%
2015/16 Q3	Results from National Staff Survey			
2015/16 Q4	60%	62%	70%	79%
2016/17 Q1	56%	64%	74%	80%
2016/17 Q2	48%	64%	64%	80%
2016/17 Q3	Results from National Staff Survey			
2016/17 Q4	43%	64%	66%	79%
2017/18 Q1	53%	64%	82%	81%
2017/18 Q2	61%	63%	73%	80%
2017/18 Q3	Results from National Staff Survey			

Staff Survey
Equality and Diversity

Equality and Diversity

The Equality Delivery System2, (EDS2), is the national framework, which supports NHS Trusts to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse.

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

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

The Trust's Diversity Champions continue to work on the equality and diversity agenda and have been involved in progressing the Workforce Race Equality Action Plan and the LGBT agenda.

Stonewall Diversity Champion

As one of Stonewall's Diversity Champions, Colchester Hospital has continued to work with Stonewall to provide support and guidance on Lesbian, Gay, Bisexual and Transgender matters. An on-line survey asking staff if they wished to have an LGBT Network, received overwhelming support, and Stonewall colleagues are working with the Trust to launch the Network early in 2018/19.

Workforce Race Equality Standard

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

Gender Pay Gap Reporting

2017/18 was the first year for gender pay gap reporting to take place within the NHS for the year ending 31 March 2017. The gender pay gap is different to equal pay. Equal pay relates to the differences between individuals or groups performing the same or similar work. It is unlawful to pay people unequally because of their gender.

Gender pay gap has a focus on the differences between the average earnings for all men and all women within the work-

Table 25—Sample of Staff Survey results

			Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	28%	27%	28%
		BME	30%	28%	30%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	28%	25%	27%
		BME	31%	27%	26%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	81%	87%	78%
		BME	67%	75%	73%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	6%	7%	8%
		BME	12%	15%	13%

Staff Survey
Equality and Diversity

force, regardless of their level or role within the organisation.

There are six gender pay gap indicators, which all NHS Trusts report upon:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment

Proportion of males and females when divided into four groups ordered from lowest to highest pay

Armed Forces

The Trust is a positive champion of the Armed Forces, and signed the Armed Forces Covenant in 2016. In 2017, the Trust received the revalidation of the Silver Award, highlighting continued commitment to Defence personnel since 2014. In September 2017, the Trust was represented at 254 Medical Regiment's training camp in Croatia, and In November, the Trust welcomed our first Step Into Health work placement. There is continued involvement in the Injured, Wounded and Sick Programme, supporting soldiers who are being discharged on medical grounds.

The outcomes for 31 March 2017 gender pay gap indicators are shown:

Tables 26—Gender pay gap indicators

Average & Median Hourly Rates

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	20.9958	14.7967
Female	15.2345	13.7296
Difference	5.7613	1.0672
Pay Gap %	27.4404	7.2123

Average & Median Hourly Rates

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	20.9958	14.7967
Female	15.2345	13.7296
Difference	5.7613	1.0672
Pay Gap %	27.4404	7.2123

Gender	Employees Paid Bonus	Total Relevant Employees	%
Female	15.00	3376.00	0.44
Male	59.00	1050.00	5.62

Number of employees | Q1 = Low, Q4 = High

Quartile	Female	Male	Female %	Male %
Lower Quartile 1	807.00	209.00	79.43	20.57
Lower Middle Quartile 2	784.00	232.00	77.17	22.83
Upper Middle Quartile 3	862.00	154.00	84.84	15.16
Upper Quartile 4	639.00	378.00	62.83	37.17

Workforce
Health and Well-being

The patient is at the centre of all we do.

In supporting our workforce e to uphold this principle, the Trust continues to embed the pledges to our staff within the NHS Constitution, providing a positive working environment, promoting an open culture, engaging staff in decisions, providing staff development and encouraging and sup-porting staff in raising concerns as soon as possible.
To enable staff to be more closely involved in decisions, a new organisational structure has been introduced, with senior clinicians forming part of the decision making Boards and Committees.
There has been close working with our partner Trust, the Ipswich Hospital NHS Trust, sharing good practice for both, and improving together.
All wards have an Executive Dire-tor as a senior “Buddy”, and our Directors are often out in the clinical areas, being accessible to staff and patients.
We work in partnership with a number of Trade Unions, developing policies and procedures to provide a framework for supporting and developing our workforce.

Health and Wellbeing

The Trust provides a Health and Wellbeing (H&W) service which all staff have access to.

The H&W is staffed by a multidisciplinary team to include specialist practitioners in occupational health, a registered mental health nurse, and occupational therapist, clinical nurses, technicians and a part time consultant.

All Staff have direct rapid access to physiotherapy to enable them to receive treatment and advice speedily.

In addition the Occupational thera-pist undertakes home and work assessments providing aids to staff to enable them to manage their chronic health conditions more effectively and reducing sickness.

Staff also have access to an Em-ployee Assistance Programme (EAP) for psychological support, The EAP and also access to citi-zen's advice database for non-psychological problems, and a managers helpline to support mangers with work issues.

The Trust has signed achieved the Staying Healthy at work award. This has a focus on supporting staff with mental health issues and to this end the Trust has also signed up to being a “mindful em-ployer”.

The H&W service facilitates men-tal health first aid providing man-agers with the skills to recognise and support staff with mental health issues.

In addition anxiety management workshops are being developed to support staff and provide them with the tools to manage there anxiety.

Emotional resilience sessions are provided for all staff, enabling them to identify their stressors and how they re-act to stress and by employing cognitive behavioural techniques to manage their stress.

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

During the year the a number of wellbeing events are arranged and articles published on wellbeing that follows the national wellbeing agenda see calendar of activities below.

- ✓ Dry January
- ✓ Stop smoking
- ✓ World mental health week
- ✓ Men’s health
- ✓ H&W day

Schwartz rounds

The Trust continues to facilitate Schwartz Rounds in September 2017/18 saw 356 staff attending.

The Schwartz Rounds provide a confidential environment and an opportunity for staff to talk about the emotional and challenges that they experience when caring for patients.

The Rounds are held monthly with a panel of three or four who pro-vide a synopsis of an event in how they felt about that event. Once all panellists have told their story the facilitators open the discussion to the floor enabling others to reso-nate with what they have heard and how they have felt in similar situations.

Studies have shown that Schwartz rounds leads to an increase in confidence in dealing with difficult and sensitive issues both clinical and non-clinical, a change in prac-tice and that attendance at them also reduces stress.

Schwartz Rounds in 2016/17 have included the following topics:

- ✓ Palliative Care
- ✓ Making a difference
- ✓ Life as an SAS doctor
- ✓ Complaints
- ✓ Discharge Planning
- ✓ Supporting families through challenging times

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

Workforce

Professional Practice and Volunteering

Appraisal & Revalidation (medical and nursing staff)

Nursing & Midwifery Revalidation

NMC Nurse Revalidation went live in April 2016, so far 760 Trust staff have successfully been through the process. Revalidation Workshops are run on a monthly basis, as well as regular one to one meetings with the Revalidation Officer.

To ensure that we are aware that people are on track with revalidating the Nursing & Midiwfery Revalidation Officer has requested to be sent copies of the confirmation forms. Ward Sisters, Matrons and Heads of Nursing are advised of staff who are due to revalidate and when, and staff are advised of the process via letter to home address in the first instance at least six months prior to revalidation date (ensuring we capture those on maternity leave). Staff are then advised via trust email address; when the application is open, when they have a month to submit and when they only have one week remaining. Also as the NMC do not advise us we are also asking staff to let us know if they are asked to provide further information for auditing purposes.

Medical Revalidation

Revalidation is the process by which a doctor's license to practice is renewed and is based on local organisational systems of annual medical appraisal and clinical governance. Licenced doctors are required to have a formal link known as a prescribed connection with a single organisation, identified as their Designated Body and headed up by a Responsible Officer, which will provide support with their appraisal and ultimately their revalidation. Following the launch of Medical Revalidation in 2012, the Trust has been committed to strengthening processes to ensure that all doctors with a prescribed connection are in the system to undertake annual appraisal and revalidation.

The Trust is required to provide assurance to the Board, our regulators and commissioners that we have effective systems in place to ensure we meet with nationally agreed standards for medical appraisal and revalidation.

The Annual Organisational Audit (AOA) is a tool used to achieve a robust, consistent system of revalidation compliant with the Responsible Officer Regulations. The mandatory audit contained within the AOA report provides a process by which every Responsible Officer, on behalf of their designated body, provides a standardised return to the higher level Responsible Officer. The collated audit then forms the basis of a report to Ministers and ultimately the public on the overall performance of revalidation across England.

The Trust currently has 318 doctors with a recognised prescribed connection and in the last five years has successfully revalidated 267 doctors.

Volunteers

Our volunteers services are coordinated in partnership with Community 360 (formally known as Colchester Community Volunteers Services or CCVS) and have gone from strength to strength over the past 12 months.

Highlights from our volunteers are summarised below:-

- ✓ Over 350 active volunteers (150 more than in 2016/17) providing more than 4000 hours a month of voluntary services.
- ✓ 30 new volunteers roles identified, mostly providing direct benefit to our patients.
- ✓ We now have 7 visiting therapy dogs which are very popular on our childrens, adults and older people wards.
- ✓ All our volunteers attend induction training and are carefully vetted and subject to DBS checks before contact with patients can take place.
- ✓ Volunteers from NCS decorated our childrens ward garden area and a team of 40 volunteers from the local branch of Tesco transformed one of our courtyard gardens in the maternity unit.
- ✓ One of our volunteers celebrated her 50th year of volunteering
- ✓ We have 11 volunteers in our emergency department to provide extra support to our patients, 3 volunteers helping our pharmacy team, 6 "meet and greet-ers" , 10 who help with medical records scanning and other admin support, 6 dementia companions, 20 specially trained end of life care volunteers, breast feeding support volunteers and many more providing fantastic support to our patients, their families and our staff.
- ✓ We held a summer tea party for all our volunteers which was attended by the Chief Executive and Managing Director to thank them for their contribution to the Hospital and our patients followed by a winter coffee morning.

We have entered into a further one year partnership agreement with Community 360 and look forward to the relationship delivering further benefits to our patients during 2018 and beyond.

Workforce

Education and training of staff

The Trust is committed to providing a multifaceted learning environment for all staff and trainees to ensure it has a high quality workforce which is committed, engaged, trained and supported to deliver safe, effective, dignified and respectful care.

One of the Trust's key aims is for people in training to recommend us as a place to train.

Medical Education

Undergraduate Education

The Trust currently hosts circa 250 students from Barts and the London School of Medicine and Dentistry and 24 from the University of East Anglia . During 2017/18 Anglia Ruskin University were confirmed as a new medical school and the Trust will host medical students from September 2018.

There was no site visit by Barts and the London in 2017/18; however one planned is for 20th April 2018.

Pre-registration nursing

Number of students, 2017/18:

Return to Practice	7
Child	39
Adult Nursing	263
Midwifery	48
Operating Department Practitioner	9
Physiotherapy	63
Speech and Language Therapy	2
Occupational Therapy	19
Dietetics	5
Paramedic	81

In response to the changing landscape of pre-registration training we have now increased our partnership working with universities. We now support students from:
University of Hertfordshire
University of Essex
Anglia Ruskin University
University of East Anglia
University of Suffolk
For various programmes of learning
Practice Education Facilitators

Investment has been made in employing more Practice Education Facilitators to provide support and training to both our mentors and pre-registration students. Further developments have included:

- 4 distinct student learning opportunities available regularly to promote active learning and application of theory to practice utilising skills of experts within the Trust and community
- Clinical skills for student nurses programme – field & year specific
- Case studies for students – multi-professional
- Student forums – informal learning and networking
- Student Forum Extra's – invited speakers
- Increased mentor support resulting in student needs being identified earlier and more specifically, preventing student failure or resulting in students failing and being supported to address learning needs prior to further progression
- Specific programmes to support students from branches such as Mental Health or Radiology.
- Increased multidisciplinary involvement.

Education programmes have been developed to engage all disciplines of pre-registration students, to improve both the educational experience and understanding of differing roles.

We have seen a continued improvement in our evaluations by learners on placement with us, and respond quickly to address any areas where improvements could be made.

The Health Education East of England Student Survey which invites all pre-registration learners to participate , has reflected the findings of our individual student evaluations. Whilst the audit indicated some areas where we could improve the learning environment , overall it was very positive.

All student evaluations are reviewed to see how we can continue to improve .

Collaborative Assessment Learning Model (CALM)

In January we introduced a new model of supporting learners in practice; CALM. This does not replace the existing model, but compliments and develops it. This approach however, moves away from a traditional mentoring role to a more collaborative team approach to supporting learning in practice. Students will be coached daily by registered practitioners and will be allocated patient to lead care for, dependant on their experience and prior learning. Students are encouraged to participate in peer learning and development of new clinical skills.

Extra learning resources have been provided to support the learning in the clinical area.

Although still in its infancy we are already seeing fantastic results and positive feedback from learners, mentors and patients. Some of the feedback includes:

"*I personally like the CALM project, first day I was a bit nervous as was caring for 2 patients, involved in board round and handover. But by end of the shift I*

Workforce

Education and training of staff

was confident enough to perform all care. I felt very positive." Student nurse – year 2

"It (CALM) has made me question my knowledge more and pushed me to ask more questions. I am being more independent in my learning and have used the IPad to aid this." Student nurse – year 2

Non-registered nursing career pathway

As part of the trust's commitment to "growing our own" staff a non-registered nurse career pathway has been developed that provides the structure through which non-registered nursing staff can progress and develop a career. Commencing with the Trainee

Healthcare Assistant programme staff have the potential for career progression, to gain qualifications and potentially obtain nursing registration through our BSc Work based learning (WBL) and apprenticeship scheme.

Apprentice Assistant Practitioner

As part of our "grow your own" the Trust is also investing in developing new roles for our healthcare assistants by supporting them through an apprenticeship to become an Assistant practitioner. This allows us to have more skilled practitioners to care for our patients and be more responsive to the changing needs, ensuring we have the right staff in the right place at the right time

Work based learning

This year saw our second group of staff (5)complete their registered nurse training through the work-based learning programme, where they worked part time as either a healthcare assistant or associate practitioner whilst they studied for the BSc (Hons) Adult nursing. There are another 9 of our staff currently studying towards this.

Whilst this programme is coming to an end. We are commencing staff on the new apprenticeship nurse programme, which similarly allows staff to work and learn whilst they undertake a BSc (Hons) nursing.

Preceptorship

The trust recognises the importance of a period of Preceptorship which the Department of Health (DoH 2010) as "a period of structured transition for the Newly Qualified Practitioner (NQP) during which he or she will be supported by a Preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning".
The benefits of undertaking a period of Preceptorship include enhancement of quality care, improved recruitment and retention, developed understanding of the organisational objectives, supporting lifelong learning, making care the priority and enhancing the image of health care professionals (DoH 2009).
The trust delivers a multidisciplinary programme of monthly Preceptorship days over 12 months which enables new registrants to learn and support each other to improve their confidence and practice. A mixture of formal training education and skills training is incorporated into a programme that encourages peer support and sharing of good practice.

OSCE preparation for overseas nurses

As part of our overseas recruitment programme the trust has a very successful objective structured clinical examination (OSCE) preparation programme to prepare overseas nurses for part 2 of the NMC (Nursing & Midwifery Council) application process. This 3 hour practical examination assesses nursing knowledge and clinical practice. Newly recruited overseas nurses attend a 4 week programme to support them in preparing for this examination. The trust has a 94% overall pass rate in comparison to 55% nationally (NMC January 2018) and a number of other NHS trusts have been learning from our success.

Allied Health Professionals (AHPs)

Our AHPs have been busy this year undertaking a variety of courses to enhance their skills: This year some of the training funded includes:

- ✓ A Physiotherapist is undertaking courses in advanced practice, in order to develop the essential knowledge and skills required to provide the specialist care required to intensive care and patients with severe respiratory problems.
- ✓ An Occupational therapist is undertaking training to become an Advanced Care Practitioner, to provide greater specialist skills within the Emergency Department
- ✓ Dieticians are undertaking training in Paediatric dietetics, in response to challenges in recruitment of paediatric dieticians, so ensuring service provision
- ✓ A radiotherapist is undertaking a course in Cancer Care, in order to develop the essential knowledge and skills required to support and care for people with cancer and their family.

One of our Occupational Therapists is currently managing a project to role out a programme of training for coaching conversations across the organisation. The coaching conversations programme will have the ability to give large volumes of staff a basic understanding of coaching and essential conversational skills to enable them to use these, where appropriate, in their conversations on a daily basis. The programme was designed to be relevant for all staff groups, within health and Social Care; clinical and non-clinical.

Workforce

Education and training of staff

Nursing and Midwifery

Across nursing and midwifery the Trust has supported additional training and education for staff within clinical practice, to ensure that we have suitably trained staff to be able to safely care for the more diverse and complex health issues which patients are admitted with. Training has been particularly focused around:

- Specialist training i.e cardiac / respiratory care, non-medical prescribing, to enable more holistic treatment by practitioners and reduce delay to patient care
- Cancer care—Specialist education to support the delivery of care to patients with cancer to improved services and patient experience
- Mental health—to improve awareness of mental health conditions and support recovery with a patient centred focus
- Midwifery and Children training to support the development of these services to improve care and experience to patients.

- Emergency and urgent care— providing increased skills in identifying and caring for the acutely ill patients
- Leadership and Coaching – developing the leadership and communication skills of staff across the Trust to help move forward with innovation and initiative, supporting staff to drive change and continually improve the services we offer.

Healthcare Assistant training

All HCAs and Maternity Care Assistants now undertake the Care Certificate. This is seen as an indicator of quality by the Care Quality Commission. This has succeeded the Colchester Hospital Healthcare Assistant competency framework.

Support staff

Our hospital has signed up to a national pledge which helps widen access to working in the NHS and then provides support to develop through apprenticeships and employment opportunities.

Quality Improvement Performance Framework (QIPF)

In 2016 Health Education England (HEE) launched their new Quality Strategy, which outlined a new quality framework moving from a joint assessment and validation process previously known as Quality Improvement Performance Framework (QIPF) to organisational self-assessment. This framework is used to assess the quality of the organisation as a learning environment for students and trainees, to ensure we train a workforce with the right skills, values and behaviours to ensure high quality care for patients. The inaugural self-assessment was submitted to HEE as required and will be a dynamic document which will evolve over time to reflect changes within the learning environment. Whilst challenges were identified relating to vacancies and workload to adequately support and educate learners in practice, actions to improve this are in place.

Apprenticeships

Number of apprentices, 2017/18:

Number of apprentices	55

2017/18 has seen us further develop the opportunities for integrating apprenticeships across the health and social care sector and enabling all departments within the hospital to welcome apprentices to their teams.

Workforce

Corporate Learning, Organisational Development

Corporate Learning and Organisational Development and effectiveness

The renewed organisational effectiveness plan has been used to continue and implement a number of interventions. The Licence to Lead programme has continued and expanded to contain new modules such as sickness absence and coaching conversation. Licence to learn was launched which gives staff the chance to develop in areas such as customer service skills. Further development programmes include a clinical leadership development programme and the delivery of the Mary Secole Leadership programme on a local basis.

Staff Involvement

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

Leadership

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

Library development

Access to the library is now 24/7 ensuring that staff are able to use its facilities at a time that is convenient. The recent refurbishment includes new stock, more workstations and an area to hold meetings.

Mandatory Training

The Trust has continued to improve its compliance with mandatory training. In March 2017 compliance stood at 97.189% and this has decreased to 93.30% as at 20th February 2018. Measures to help staff increase their compliance in include the continuation of weekly e-mails to remind staff if they have a renewal due or if they have expired on any aspect. E-mails to managers have also been introduced reminding them they have staff who are on complaint. The training portal continues to be well received by staff allowing individuals to view their own compliance records and also assisting managers when planning for the release of staff to attend taught training session.

Organisational Development - Valuing our staff

During 2017/18 the Trust has continued to recognise staff and volunteers achievements through the Tryst commendation scheme. Commendations are a chance for colleagues, patients and the public to nominate the people they feel have made outstanding contributions at our Trust and to write 50 or so words about why they deserve to win - known as the citation.
Entries judged on the 50 or so words written where a person or team demonstrates the Trust behaviours standards and values.
Every nominated person gets a letter from the chief executive with the citation included. If the entry is for a team then the chief executive sends a letter with the citation to the team manager.
Winners and runners up are invited to attend the monthly core brief when they are presented with a certificate by a member of the executive team.

Workforce

Organisational Development, Valuing Our Staff

Winners of the Trust Commendation Scheme are pictured

Sarah Sands, Ward sister Acute Cardiac Unit
Winner in the Individual category

"Sarah has organised for volunteers to crochet/knit beautiful patchwork blankets for patients. These are being used for patients on the ward receiving end of life care. These blankets help create a more homely/ comforting less hospitalized environment. The ward staff also spray the blankets with patients perfume/sprays etc so when then patient dies they are given to the families as a special keepsake. This initiative is simple yet really enhances end of life care for our patients at CHUFT, and will also be of great comfort to the families who live on."

Workforce

Organisational Development, Valuing Our Staff

Stroke Unit

Winner in the Team category

"My mother was in the stroke ward at Colchester General hospital for six days recently. On arrival she was very ill with a serious stroke and the care and empathy she received was outstanding, particularly with the very specialist skills shown by your staff. On discharge back to her care home she was largely well again, thanks to your considerable efforts. We observed the ward staff working so very hard but always having time for each patient and of course some of the patients are very confused with stroke effects. Well done Colchester Hospital and generally we found everything connected with the establishment very satisfactory, and staff most helpful. I genuinely think you should be very proud of what you are achieving, and mother was also so very grateful to you all."

Statements from key stakeholders

North East Essex Clinical Commissioning Group response to Colchester Hospital University NHS Foundation Trust Quality Report 2017-2018

North East Essex Clinical Commissioning Group (CCG) welcomes this Quality Report as a commitment to an open and honest dialogue with patients and the public regarding the quality of care provided by Colchester Hospital University Foundation NHS Trust (CHUFT). The CCG is commenting on this provider's Quality Report for 2017-18.

Though the CCG is commenting on the final draft version of the Quality Report, we are pleased to be able to assure the accuracy of the content in general. We have relayed our comments on the previous draft report and can confirm the majority of the proposed changes and recommendations were taken under consideration.

In line with the NHSI Detailed Requirements for Quality Reports 2017/18 (January 2018), CHUFT have met the mandatory requirements within their report as well as reporting on the indicators identified in section 3 of the guidance.

Part 1 of the report provides a satisfactory statement summarising the key achievements throughout 2016-17 as a measure of the quality of the health services provided by the organisation.

Part 2 demonstrates the excellent achievements against the priorities for improvement for 2017-18 with regard to the reduction in falls; hospital acquired pressure ulcers; and the progress made in meeting the requirements in relation to NatSSIPs.

The priorities for improvement for 2018-19 are welcomed as a continuation of the economy wide programmes of work to improve the physical health of patients with mental health problems; to continue the improvements in care and support to those patients at the end of their life and their carers; and to continue the excellent work undertaken in the management of Sepsis.

The CCG notes the information on the CQC full inspection in July 2017 and recognises the improved progress reported following the complete organisation inspection, particularly the end of life care provision.

The CCG notes that some of the reporting data is either missing or a previous year's data, for example quarter 4 Commissioning for Quality and Innovation Schemes (CQUIN) performance, some workforce data and the rate of patient safety incidents.

In 2017-18, The Trust signed-up to 8 national CQUINs and the report identifies the Trust performance against these. The CCG recognises the incremental improvement against the Sepsis CQUIN and supports the continued work being undertaken as a 2018-19 priority. The majority of the CQUIN work was achieved and the CCG acknowledges a continued improved position throughout the year.

The CCG notes the Trust performance against the core quality indicator standards required by the regulatory framework. There are clear improvement plans in place in the continued work in improving the SHMI position. It is however disappointing that the reporting issues in relation to PROMs have not been resolved. We acknowledge the difficulties in accessing national readmission figures and note the work that is being undertaken locally to ensure re-admissions are being reviewed and appropriate actions taken. There is limited data on Staff FFT, similar to last year, and the planned work on the EPED workforce work stream has not provided the improvements anticipated or has not identified the appropriate data capture systems to reflect the work undertaken.

The conclusion of NHS North East Essex CCG is that Colchester Hospital University NHS Foundation Trust's Quality Report 2017-18 provides an accurate overview of the Trust's performance for the year; clearly identifies improvements and future ambitions for improving quality and safety in the services it provides; and agrees with the priorities identified for 2018-19.

The CCG looks forward to continuing the collaborative working with the Trust and to providing support as the organisation merges with Ipswich Hospital, to ensure services remain safe and of a high quality to our patients and local population.

Lisa Llewelyn
Director of Nursing & Clinical Quality
NHS North East Essex Clinical Commissioning Group.

Response to Colchester Hospital University NHS Foundation Trust (CHUFT) Account 2017/18 from Healthwatch Essex

Healthwatch Essex is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it. We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by CHUFT. We offer the following comments on the CHUFT Quality Account.

Statements from key stakeholders

HWE is encouraged by the way the boards of both Colchester Hospital and Ipswich Hospital are continuing to work together to merge the organisations to improve care for patients and create a more sustainable future.

HWE is impressed that CHUFT is actively using patient stories to drive change – for example, through Project Ivy, and involving patients in various groups and panels.

The number of innovative schemes implemented by CHUFT to improve the patient and carer experience, is a great achievement.

It is impressive that, based on patients response to national maternity survey, CHUFT was the only trust in the East of England that received a 'better rating' in any category.

HWE is reassured that the Trust acknowledges the need for improvement in identifying, reporting and sharing lessons learned and actions taken from complaints.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by working hard to evidence that lived experience we hope we can continue to support the encouraging work of CHUFT.

Dr David Sollis
Chief Executive Officer, Healthwatch Essex

22/5/18

Statement from the Council of Governors on the Quality Report 2017/18

The governors of Colchester Hospital University NHS Foundation Trust are pleased to have the opportunity to comment on the draft Quality Account for 2017/18 and to provide input onto the quality improvement priorities on both 2017/18 and 2018/19.

We continue to support the Trust's focus on patient safety, experience and quality and take this opportunity to reinforce our view that safety of patients is paramount. We believe that putting the patients, relatives and carers first is the key to achieving consistent and high quality care and we look forward to progress being made on the 'Time Matters' philosophy bringing improvements to patient care in 2018 and beyond.

Governors have been actively involved with Ipswich Hospital and Colchester Hospital becoming one organisation and there was representation at a number of public engagement events in February and March 2018, where feedback has been heard around the quality of care at Colchester Hospital, in the main the feedback has been very positive. Governors were pleased to note that at these engagement events, over 40 new public members were recruited which signified an interest within the local community in their local hospitals.

Colchester Hospital University NHS
NHS Foundation Trust

Response to stakeholder comments

Colchester Hospital University NHS Foundation Trust thanks its stakeholders for their comments on the 2017/18 Quality Account.

Statement of assurance from the Board of Directors

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year.

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

• the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance

• the content of the Quality Report is not inconsistent with internal and external sources of information including:

o board minutes and papers for the period April 2017 to [the date of this statement]

o papers relating to quality reported to the board over the period April 2017 to [the date of this statement]

o feedback from commissioners dated 24/05/2018

o feedback from governors dated 09/05/2018

o feedback from local Healthwatch organisations dated 22/05/2018

o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24/05/2018

o the [latest] national patient survey 06/2017

o the [latest] national staff survey 06/03/2018

o the Head of Internal Audit's annual opinion of the trust's control environment dated 29/05/2018

o CQC inspection report dated 02/11/2017

• the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

• the performance information reported in the Quality Report is reliable and accurate

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

• [this point is only required where the foundation trust is not reporting performance against an indicator that otherwise would have been subject to assurance] as the trust is currently not reporting performance against the indiactor [xxx] due to [xxx], the directors have a plan in place to remedy this and return to full reporting by [xxx]

• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

• the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report. 27 | > Annex 2: Statement of directors' responsibilities for the quality report .

By order of the board

.....Date.....
.....Chairman

.....Date.....
.....Chief Executive

Glossary

Bed days The measurement of a day that a patient occupies a hospital bed as part of their treatment.
Care Quality Commission (CQC) The regulatory body for all health and social care organisations in England. The CQC regulates care provided by the NHS, local authorities, private companies, voluntary organisations and aims to make sure better care is provided for everyone in hospitals, care homes and people's own homes.
CCU Critical Care Unit.
Clinical Coding The translation of medical terminology as written in a patient's medical records to describe a problem, diagnosis, treatment of a medical problem, into a coded format.
Clinical Commissioning Group (CCG) CCGs are responsible for commissioning (planning, designing and paying for) all NHS services.
Clinical Delivery Group (CDG) CDGs are sub-groups of one of the Trust's three clinical divisions. Each CDG is accountable to its Divisional Governance Board for all aspects of performance, including patient safety, patient and carer experience, operational standards, financial performance and staff engagement.
Clostridium difficile* or *C.diff A spore-forming bacterium present as one of the normal bacteria in the gut. *Clostridium difficile* diarrhoea occurs when the normal gut flora is altered, allowing *Clostridium difficile* bacteria to flourish and produce a toxin that causes watery diarrhoea.
Colonisation The presence of bacteria on a body surface (such as the skin, mouth, intestines or airway) without causing disease in the person.
CQUIN The CQUIN (Commissioning for Quality and Innovation) framework enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.
Datix A Trust-wide computer system used to record and aid analysis of all incidents, claims, complaints and PALS enquiries.
Dementia A set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning.
Division The hospital is divided into three distinct clinical divisions: Medicine including Emergency Care; Surgery and Cancer; Women and Children and Clinical Support Services. There is an additional division which manages the corporate functions such as Governance, Education, Operations, Human Resources, Finance, Performance, and Information. Each Divisional Board is chaired by a consultant (Divisional Director) together with nursing. and operational leads. The Head of Nursing/Midwifery provides senior nursing and quality of care expertise, with the Head of Operations providing expert operational advice to the Divisional Boards.
DNACPR Do not attempt cardio-pulmonary resuscitation. A formal decision made when it is not in the best interests of the patient to be resuscitated in certain circumstances.
Dr Foster Provider of comparative information on health and social care issues.
ED Emergency Department, also known as A&E, Accident and Emergency Department or Casualty.
Harm-free care National patient safety initiative targeted at high impact areas such as pressure ulcers, catheter care, VTE and falls.
HDU High Dependency Unit.
Quality & Patient Safety Committee The Trust Board sub-committee responsible for overseeing quality within the Trust.
HealthWatch Champions the views of local people to achieve excellent health and social care services in Suffolk.
HSMR Hospital Standardised Mortality Rate. An indicator of healthcare quality that measures whether a hospital's death rate is higher or lower than expected.
North East Essex Clinical Commissioning Group The main commissioner of services provided by Colchester Hospital University NHS Foundation Trust.
MDT Multi-disciplinary team.
Methicillin Resistant Staphylococcus Aureus (MRSA) MRSA is an antibiotic-resistant form of the common bacterium Staphylococcus Aureus, which grows harmlessly on the skin in the nose of around one in three people in the UK. MRSA bacteraemia is the presence of Meticillin Resistant Staphylococcus Aureus in the blood.
NEWS National Early Warning Score. A system of recording vital signs observations which gives early warning of a deteriorating patient.
MEOWS Modified Early Obstetric Warning Score. A system of recording vital signs observations which gives early warning of a deteriorating obstetric patient.
Morbidity and Mortality (M&M) meetings Morbidity and mortality meetings are held in each Clinical Delivery Group. The goal of such meetings is to derive knowledge and insight from surgical error adverse events. M&M meetings look at: What happened? Why did it occur? How could the issue have been prevented or better managed? What are the key learning points?
NCEPOD National Confidential Enquiry into Patient Outcome and Death.
Never Events Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
Operation Red to Green A concept recommended nationally by the Emergency and Urgent Care Intensive Team which ensures all the processes required to support flow through the hospital run 'perfectly' so that there are no unnecessary delays that slow down transfers of care. There is input from the whole organisation and joint working between the Trust and its health partners across Essex. All non-essential meetings are cancelled to ensure that all staff can fully commit to the week, without compromising clinical care.
PALS Patient Advice and Liaison Service. For all enquiries to the hospital such as cost of parking, ward visiting times, how to change an appointment etc.
PLACE Patient-Led Assessment of the Care Environment. Annual self-assessment of a range of non-clinical services by local volunteers.
PSG Patient Safety Group.
Q1 or Quarter 1 April - June 2016
Q2 or Quarter 2 July - September 2016
Q3 or Quarter 3 October - December 2016
Q4 or Quarter 4 January - March 2017
RCA Root Cause Analysis. A structured investigation of an incident to ensure effective learning to prevent a similar event from happening.
SHMI Summary Hospital-Level Mortality Indicator. An indicator for mortality. The indicator covers all deaths of patients admitted to hospital and those that die up to 30 days after discharge from hospital.
SI Serious Incident
SLA Service Level Agreement. A contract to provide or purchase named services.
Essex Family Carers A registered charity working with unpaid family carers across Essex, supporting family carers with information, advice and guidance.
SUS Secondary Uses Service. Provides anonymous patient-based information for purposes other than direct clinical care such as healthcare planning, public health, commissioning, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
The King's Fund A charity that seeks to understand how the health system in England can be improved and helps to shape policy, transform services and bring about behaviour change.
VTE Venous Thrombo-embolism. Also known as a blood clot, a VTE is a complication of immobility and surgery.

Appendix A

Independent Auditors' Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Annual Quality Account

INDEPENDENT CHARTERED ACCOUNTANT'S LIMITED ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS OF COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Colchester Hospital University NHS Foundation Trust to perform an independent assurance engagement in respect of Colchester Hospital University NHS Foundation Trust's Quality Report for the year ended 31 March 2018 ("the Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge;
- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;

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

Directors' responsibilities

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

Our responsibilities

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Requirements for External Assurance for Quality Reports 2017/18 issued by NHS Improvement in February 2018 ("the Guidance"); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- ✓ Board minutes for the period April 2017 to May 2018;
- ✓ papers relating to quality reported to the Board over the period April 2017 to May 2018;
- ✓ feedback from commissioners, dated 24/05/2018;
- ✓ feedback from governors, dated 09/05/2018;
- ✓ feedback from local Healthwatch organisations, dated 22/05/2018;
- ✓ the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/03/2018;

Appendix A

Independent Auditors' Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Annu-

- ✓ the latest national patient survey, dated 2017;
- ✓ the latest national staff survey, dated 2017;
- ✓ Care Quality Commission inspection report, dated 02/11/2017; and
- ✓ the Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2018.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Colchester Hospital University NHS Foundation Trust as a body, in reporting Colchester Hospital University NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Colchester Hospital University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) Assurance Engagements other than Audits or Reviews of Historical Financial Information, issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- ✓ evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- ✓ making enquiries of management;
- ✓ testing key management controls;
- ✓ limited testing, on a selective basis, of the data used to calculate the indicator against supporting documentation;
- ✓ comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- ✓ reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary.

Appendix A

Independent Auditors' Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Annual Quality Account

Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Colchester Hospital University NHS Foundation Trust.

Basis for qualified conclusion

Our testing completed over the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator has identified errors in relation to the accuracy and validity of the data recorded that lead us to conclude that the indicator has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- ✓ the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- ✓ the Quality Report is not consistent in all material respects with the sources specified in Detailed Requirements for External Assurance for Quality Reports 2017/18 issued by NHS Improvement in February 2018; and
- ✓ the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

BDO LLP

Chartered Accountants

Ipswich, UK

29 May 2018

Appendix A

Independent Auditors' Limited Assurance Report to the Council of Governors of Colchester Hospital University NHS Foundation Trust on the Annual Quality Account

Definitions for performance indicators subject to external assurance

Percentage of patients risk-assessed for venous thromboembolism (VTE)

Detailed descriptor
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

Data definition
Numerator: Number of adults admitted to hospital as inpatients in the reporting who have been risk assessed for VTE according to the criteria in the national VTE risk assessment tool during the reporting period.
Denominator: Total number of adults admitted to hospital in the reporting period.

Details of the indicator
The scope of the indicator includes all adults (those aged 18 at the time of admission) who are admitted to hospital as inpatients including:

- surgical inpatients;
- in-patients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease); trauma inpatients;
- patients admitted to intensive care units;
- cancer inpatients;
- people undergoing long-term rehabilitation in hospital;
- patients admitted to a hospital bed for day-case medical or surgical procedures; and
- private patients attending an NHS hospital.

The following patients are excluded from the indicator:

- people under the age of 18 at the time of admission;
- people attending hospital as outpatients;
- people attending emergency departments who are not admitted to hospital; and
- people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.

Timeframe
Data produced monthly for the 2015-16 financial year.

Detailed guidance
More detail about this indicator can be found on the NHS England website. The data collection standard specification can be found here.
Source: NHS England

Data relating to the percentage of patients risk-assessed for venous thrombo-embolism (VTE) can be found on page 40.

Percentage of patient safety incidents resulting in severe harm or death

Detailed descriptor
Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period.

Data definition
Numerator: Number of reported patient safety incidents resulting in severe harm or death at a trust reported through the National Reporting and Learning Service (NRLS) during the reporting period.
Denominator: Number of reported patient safety incidents at a trust reported through the NRLS during the reporting period.

Details of the indicator
The scope of the indicator includes all patient safety incidents reported through the NRLS. This includes reports made by the trust, staff, patients and the public. From April 2010 it became mandatory for trusts in England to report all serious patient safety incidents to the Care Quality Commission. Trusts do this by reporting incidents on the NRLS.

A case of severe harm is defined in 'Seven steps to patient safety: a full reference guide', published by the National Patient Safety Agency in 2004, as "(a)ny patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care", "Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage."

This indicator does not capture any information about incidents that remain unreported. Incidents with a degree of harm of 'severe' and 'death' are now a mandatory reporting requirement by the CQC, via the NRLS, but the quality statement states that underreporting is still likely to occur.

Timeframe
Six-monthly data produced for April to September and October to March of each financial year.

Detailed guidance
More detail about this indicator and the data can be found on the Patient Safety section of the NHS England website and on the HSCIC website in NHS Outcomes Framework > Domain 5 Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm > Overarching indicators > 5b Severity of harm.
Source: NHS England

Data relating to the percentage of patient safety incidents resulting in severe harm or death can be found on page 41.

How to provide feedback on this Quality Account

If you would like to provide feedback on this account or would like to make suggestions for content for future accounts, please email info@colchesterhospital.nhs.uk or write to:

Trust Offices,
Colchester Hospital University NHS Foundation Trust,
Turner Road,
Colchester
Essex CO4 5JL

Thank you

We would like to take this opportunity to thank all those involved with Colchester Hospital University NHS Foundation Trust: our fantastic staff and volunteers, all of our patients and visitors, our valuable fundraisers, local media organisations, our local Members of Parliament and health colleagues across the East of England.

Thank you for all that you do to make this a hospital we can all be proud to be part of.

Find out more about the hospital by visiting
our website at www.colchesterhospital.nhs.uk

Colchester Hospital University NHS Foundation Trust
Turner Road, Colchester, Essex CO4 5JL
Tel: 01473 712233

This report is available online in this format and as an easy-read document at
www.colchesterhospital.nhs.uk/qualityaccount