Colchester Hospital University NHS
NHS Foundation Trust

Annual Report
Annual Accounts
&
Quality Report

1 April 2011 – 31 March 2012

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

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Contents

Useful contact information

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Patient Advice and Liaison Service (PALS)
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Welcome from the Chair and Chief Executive

The year 2011/12 was one of change – both for our Trust and the NHS as a whole.

We anticipated that 2011/12 would be a challenging year for the NHS. The breadth of changes described in the Health and Social Care Bill and the magnitude of the efficiency savings produced a confluence of challenges which were compounded by uncertainties about the economic recovery.

Colchester Hospital University NHS Foundation Trust responded robustly to those challenges and made significant progress in many areas.

Encouragingly, we saw an improvement in employee satisfaction at our Trust in the *2011 National NHS staff survey*, which was published on 20 March 2012. We also saw a marked improvement in patient satisfaction from the Care Quality Commission's (CQC) inpatient survey. An important new Trust initiative that links staff and patient satisfaction is "At Our Best", which describes a set of behaviours that our patients have told us are important. We are committed to making further progress to improve patient and staff experience.

A highlight of the year was the recognition given to a team of physiotherapists and nurses who were the overall winners of the 2011 Capgemini and Health Service Journal Liberating Ideas Awards for a project that reduced the length of stay of patients who had undergone emergency hip replacement surgery to almost half the national average. This is an example of a practice we are encouraging – staff on the frontline finding ways to do more with less.

Operationally, the Trust performed strongly with a reduction in mortality resulting from a major initiative to reorganise the emergency care pathway. For most of the year we saw a progressive reduction in crude mortality, mortality rates and the Hospital Standardised Mortality Ratio (HSMR). Consultant cover is now provided in A&E until midnight, seven days a week, and in the Emergency Assessment Unit (EAU) until 10pm, also seven days a week. These changes, combined with others on the wards, had an important impact on patient care. For example, we saw a halving in the number of cardiac arrests and in the number of falls that resulted in harm to inpatients.

There were areas where our performance was not as consistent as we would have liked. For example, whilst we have met the main A&E targets every quarter for the past 2½ years, our performance on cancer waiting targets needs to be more predictable.

The Trust has a good reputation for infection control. This year we again achieved the MRSA target (we had no cases) but exceeded the agreed maximum ceiling of 25 cases of hospital-acquired Clostridium difficile by three. In the middle of the year an increase in C. difficile cases was seen across the whole health economy but it has now returned to previous levels.

Looking ahead, the £5m Hospital Sterilisation and Decontamination Unit (HSDU) currently under construction at Colchester General Hospital will become operational in July. Work is expected to start the next month on a new purpose-built radiotherapy centre at Colchester General Hospital which will treat patients from mid Essex as well as north east Essex.

In June the first operations will take place at a new centre for major vascular surgery at Colchester General Hospital, which will serve patients from north east Essex, east Suffolk and the Colne Valley. This has involved creating a state-of-the-art operating theatre with a £1.5m investment with special imaging equipment (C-arm image intensifier). Having agreed to establish this centre also meant that the local roll-out of the NHS Abdominal Aortic Aneurysm (AAA) Screening Programme could begin at the very end of the year.

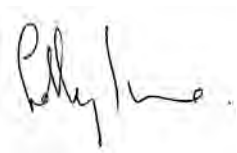
The unannounced two-day inspection made by the CQC in November recognised the significant progress made across the Trust. So much of what we achieved is down to the talent, quality, commitment and professionalism of our staff. But there are others too, including governors, public members, volunteers, the Colchester League of Hospital and Community Friends and key partners, such as NHS North East Essex and local authorities. Our thanks to them all.

Financially, the Trust remains in a sound position. We delivered an underlying surplus of £6m which, after one-off transactions, resulted in a total surplus of £12.3m. As an NHS foundation trust, we will invest this surplus in patient services.

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

Our firm belief is that if we get this right, Colchester Hospital University NHS Foundation Trust has a very bright future.

Signatures



Dr Sally Irvine
Chair

Dr Gordon Coutts
Chief Executive

Directors' business review

About our Trust – a summary

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

Our vision

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

The population we serve

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

Our financial performance

The Trust achieved a surplus of £12.3m.

Compared to last year, income increased by 8.4%. This was higher than planned and was caused by high levels of activity and one-off funding for major developments, such as electronic prescribing, a theatre C-arm and a new Clinical Portal.

	2011/12 £m	2010/11 £m (Restated)
Operating income	244.0	225.1
Operating costs	(220.8)	(212.3)
EBITDA*	23.2	12.8
Depreciation, dividend and other financing costs	(12.1)	(10.8)
Impairment of non-current assets	1.2	(4.9)
Surplus/(Deficit) for the year	12.3	(2.9)

* EBITA as per Monitor's *Compliance Framework 2011/12* is Earnings Before Interest, Taxation, Depreciation and Amortisation, but also excludes non-current asset impairments

Our services

The Trust provides a range of patient services:

	2011/12	2010/11
Outpatient attendances*[^]	409,491	399,291
Accident & Emergency patients*[†]	73,504	73,390
Inpatient and day case admissions*[†]	84,336	80,223
Babies delivered	3,962	4,021

***Source: figures taken from Colchester Hospital University NHS Foundation Trust commissioned activity**

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

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

Our sites

The Trust owns and manages Colchester General Hospital, which opened in 1984, and Essex County Hospital, which was established in 1820. It has long been the strategy of this Trust and our predecessor organisations to centralise acute services at Colchester General Hospital.

Scientific staff are based at the Severalls Hospital site and in the microbiology department near Colchester General Hospital.

In addition, the Trust also provides some services, such as outpatient and maternity services, at the community hospitals in Clacton and Harwich – run by Anglian Community Enterprise (ACE) – and Halstead Hospital, run by Central Essex Community Services (CECS).

Our partners

The Trust works with a variety of public, private and voluntary stakeholders. We do this to develop a sustainable environment in which people will continue to enjoy high levels of health and wellbeing but with modern health and social care services available for those who need them.

The Trust had formal contracts or service level agreements with third parties which provided some essential services. The two main contractors were Anglia Support Partnership for payroll and financial services and Carillion plc for facilities management services.

In June, the Trust's Board of Directors decided to bring in-house the facilities management services that had been provided by Carillion.

Beginning on 1 October, when the Trust's contract with Carillion expired, FM services were managed in-house and provided by the Trust's own staff.

Our staff

The Trust is one of the largest employers in north east Essex, employing 4,163 people on 31 March 2012.

This was up from 3,646 people 12 months earlier, due to the Trust bringing facilities management services in-house – an increase of 14%.

During the year, we employed an additional 60 whole-time equivalent staff.

Our performance

Innovation in our portfolio of clinical services progressed in 2011/12. Among the many developments, the following are of note:

- a year-long expansion of the Trust's Palliative Care Team was completed, leaving it with two consultants, six specialist nurses and an end of life care facilitator
- the Emergency Assessment Unit at Colchester General Hospital increased from 20 beds to 45 beds by merging with the adjoining Short Stay Unit
- potentially life-saving defibrillators (implantable cardioverter defibrillators (ICDs)) were implanted in patients for the first time at Colchester General Hospital to shock abnormal fast heart rhythms back to normal
- work began on a £1.5m project to create a specialist vascular operating theatre at Colchester General Hospital, which is due to open in June
- following a successful pilot on Fordham Ward at Colchester General Hospital, an intensive rehabilitation programme called CORP (Colchester Orthopaedic Rehabilitation Protocol) was made permanent and was extended to all orthopaedic patients
- a new cancer clinic was established at Colchester General Hospital for patients with neuroendocrine tumours (NETs), meaning that patients living in north east Essex no longer had to travel to London, apart from for the most specialised treatments
- the Trust became only the second in the UK to offer hypnobirthing classes, which help couples to have an easy, comfortable and drug-free birth by using easily-learned self-hypnosis, relaxation and breathing techniques
- a CT coronary angiography service was introduced at Colchester General Hospital, meaning that patients from north east Essex who needed to have the procedure, which is used to diagnose coronary heart disease, no longer had to travel to The Essex Cardiothoracic Centre at Basildon
- Colchester General Hospital became only the fourth hospital in the UK to pilot a patient journal on behalf of Leukaemia CARE, a national charity. The Patient Journal includes information in a user-friendly way and addresses some of the most common queries
- a new type of radiotherapy was introduced for patients with head and neck cancer or cancer of the pharynx. Intensity-Modulated Radiation Therapy (IMRT) increases survival rates and also improves patients' quality of life by reducing the side effects associated with standard radiotherapy
- the Trust became one of only a handful in the UK to use a new type of ultrasound machine – the Ultrasound Cardiac Output Monitor (USCOM) – at ward level to assess patients who have become unwell
- preliminary work began in advance of construction of a multi-million pound radiotherapy centre at Colchester General Hospital
- construction work began in August on a £5m Hospital Sterilisation and Decontamination Unit (HSDU) at Colchester General Hospital, which is scheduled to become operational in July.

Care Quality Commission rating and other accreditations

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

A&E four-hour standard

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

During 2011/12 our performance against the challenging national access standards was as shown in the table on the right:

	Standard	Performance
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	93%	94.5%
Two-week wait for symptomatic breast patients (cancer not initially suspected)	93%	95.2%
Maximum waiting time of 26 weeks for inpatients	99.97%	99.99%
Maximum waiting time of 13 weeks for outpatients	99.97%	99.98%
18-week maximum wait – admitted patients	90%	90.97%
18-week maximum wait – non-admitted patients	95%	97.18%
Maximum waiting time of two weeks for rapid access chest pain clinics	100%	100%
MRSA	1	0
Clostridium difficile	25	28
Sexual health – 48-hour access to Genito-Urinary Medicine (GUM) clinics	95%	100%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	95%	100%
Minimising delayed transfers of care	≤3.5%	0.24%

Source: Performance Framework

Control of infection

The Trust continued to make good progress with controlling and preventing hospital-acquired infections. Rigorous clinical hygiene measures, controls on the prescribing of antibiotics, isolation of infected patients and root cause analysis of cases, supported by learning and implementing changes, had a significant impact.

Clostridium difficile

Clostridium difficile incidence is assessed as cases detected more than 48 hours after admission which are considered to be attributable to an infection acquired in hospital. The agreed maximum ceiling (based on historic performance) for the Trust was 25 cases. We had 28 cases. We will continue our vigilant approach to drive down the incidence of hospital-acquired infections in 2012/13.

MRSA bacteraemia

MRSA incidence is assessed as cases detected more than 48 hours after admission which are considered to be attributable to an infection acquired in hospital. The Trust's target was to have no more than one case of MRSA bacteraemia, but has not had any cases since May 2010.

Surgical site infection

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

Hand hygiene monitoring

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

Data loss and confidentiality breach

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

It was discovered in August that a file containing the forename, surname, date of birth and NHS Number of 122 patients had been sent via unencrypted email from the Trust to the Health Protection Agency (HPA) in June. Despite a warning from the HPA, a further file was sent in July with an additional 121 patients' details.

After a detailed investigation and following a disciplinary hearing held in September, a member of staff was dismissed from the Trust with immediate effect. The unanimous decision of the disciplinary panel sends out a clear statement about how seriously the Trust takes security and patient confidentiality. The incident was reported to the Information Commissioner's Office (ICO), who were satisfied the Trust had managed the incident appropriately and gave us the following recommendation: "We would suggest that as well as induction training, the Trust consider providing mandatory annual refresher training for their employees." The Trust has since introduced a mandatory information governance e-learning programme which has been approved by Connecting for Health and will include an annual update.

In March the Trust was informed by a health care contractor that the contractor had inadvertently collected items of personal patient information from diagnostic scanners provided to the Trust. The Trust was one of a number of NHS organisations where this had happened and, therefore, the incident investigation and management was undertaken by the Department of Health. The ICO was notified and the joint view of the Department of Health and ICO was that the risk of harm to patients was negligible. The data is held in a complex format and is not readily accessible and the contractor has given assurance, independently verified, that the data remains secure, has not been subject to loss, hacking, misuse or theft and will be destroyed on the completion of the investigation.

Future business plans

Our vision and priorities

The Board of Directors gave considerable thought to the Trust's vision and the key behaviours required to deliver that vision for our patients and staff.

In March 2011, to aid promoting its vision, the Trust started a programme called At Our Best to inspire, support and develop all staff to consistently deliver the very best patient experience.

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

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

The priorities that will help deliver the vision are:

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

Principal risks and uncertainties

Managing risks

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

The Board is routinely informed of all Serious Incidents and the lessons learned from them. This reinforces the Trust's approach to developing a safety and risk management culture across the organisation. Staff are encouraged to report any incidents that occur so we learn from them and improve practice.

All incidents identified as moderate, major or extreme undergo detailed investigation to establish their root cause and are written into a formal report with an action plan, which is reviewed by the Audit & Risk Assurance Committee.

Governance risk rating

Monitor gave the Trust a governance risk rating of amber-green for 2011/12. The major contributing factors to this rating included an outbreak of C. difficile, which breached our agreed maximum ceiling for the year (also an issue experienced by other acute trusts). Other factors included compliance actions requested by the CQC to do with dignity and nutrition and mandatory training, all of which were resolved by year-end.

Effective risk and performance management

The Trust has robust risk management and clinical governance strategies in place, which ensure monitoring of compliance with best practice.

The Trust is compliant with the NHS Litigation Authority's Clinical Negligence Scheme for Trusts (NHSLA CNST) Level 2 for Maternity Services and the NHSLA Risk Management Standards Level 2.

Mandatory service risk

The Trust's Board of Directors was satisfied that:

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

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

Risk of any other non-compliance with terms of authorisation

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

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

Key financial performance indicators

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

2011/12 Performance		Plan	Actual
Financial risk rating (5 = lowest risk) *Comprising the following key indicators:*		3	5
EBITDA margin	*EBITDA as a % of total income*	6.6%	9.5%
EBITDA % achieved	*% of planned EBITDA achieved*	100%	157.8%
Return on assets	*Public dividend % of assets employed*	4.5%	10.0%
Income & expenditure surplus margin	*Retained surplus as a % of total income*	1.1%	4.6%
Liquid ratio	*Number of days operating expenses that could be covered*	34	46

Contractual or other arrangements

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

Summary of contractual relationships

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

Overview of other procurement arrangements

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

- Carillion (facilities management (FM) services). This contract expired during the year and the services brought in-house
- National Blood Service (blood products).
- InHealth (catheterisation laboratory and service). This contract expired during the year and the services brought in-house
- Cambridgeshire and Peterborough NHS Foundation Trust, operating as Anglia Support Partnership (payroll and financial services)
- Alliance Medical (MRI scans)
- Blatchford (orthotics service)
- Blatchford (prosthetics service)
- GE Capital (patient monitoring equipment)
- Fresenius (renal service)
- Prime Diagnostics (endoscopy).

Joint ventures and partnership arrangements

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

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

Improving the patient experience

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

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

The Trust does not always get it right but we are committed to working with patients and clinical staff to do our best and to learn from reported incidents and patient suggestions to make service quality the best we can achieve.

The Trust has an ongoing audit programme that captures patients' opinions and experiences. We are developing a patient experience strategy that will ensure the experience of patients and carers influences care pathways and is part of the framework to improve standards. The Trust ran a programme called "At Our Best", which embedded the values and behaviours that are important for staff to ensure we delivered the best possible patient experience.

At Our Best

In March 2011, to aid promoting its vision, the Trust started At Our Best to inspire, support and develop all staff to consistently deliver the very best patient experience.

One of the programme's key components – which continues into 2012/13 – is to encourage better communication with patients.

To achieve this, more than 100 patients and carers were invited to share their experiences with over 100 staff of all disciplines at five In Your Shoes sessions held in April, May and June.

As a response to these sessions, in July we launched a We Care campaign, comprising:

- **Welcoming**: We will always introduce ourselves with our name, and what we are here to do
- **Clean hands**: We want you to feel safe so we will let you know we have cleaned our hands
- **Compassionate**: We know being in hospital can be an anxious time, so please ask us if you need anything
- **Show respect**: We will always remember your personal dignity, as we would want for our own families
- **Keeping you informed:** Especially when you are leaving the hospital after treatment

October saw the launch of our Trust's behaviour standards and values. Over 500 members of staff were involved in creating the standards. The three themes – caring, communication, consistency – have key actions underlying them.

The Trust also launched its At Our Best Awards in October to recognise staff and volunteers' achievements and to thank them for what they do. Awards are presented to an individual and a team on a quarterly basis, and the first annual ceremony will be held in June.

The programme continued throughout the year and continues into 2012/13.

Patient safety

The Trust continued to work with the national Patient Safety First Campaign and to deliver the *Safety Express* initiative. We made significant progress in improving the care of the deteriorating patient, implementing the World Health Organization's Safer Surgery Checklist and reducing the harm caused by interventions used in critical care, such as ventilator-acquired pneumonia (VAP) and central line infections, as covered in the Trust's patient safety strategy. We are developing that strategy and outlining our goals beyond that.

The *Patient Safety Strategy 2010-2013* outlines our ambition to promote a safer culture within our hospitals and services in order to deliver significant

reductions in both mortality and harm events. This has led to the development of key safety workstreams which each co-ordinates improvement work in their associated portfolios across the Trust.

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

The significant progress the Trust made in its patient safety strategy is evidenced by the 97% attainment of the organisation's Commissioning for Quality and Innovation (CQUIN) targets.

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

Therefore, to help deliver this vision, Julie Firth, Director of Nursing and Patient Experience, has developed a "Quality Hub", bringing together staff from existing areas including risk management, governance, complaints and litigation, patient safety and experience, clinical audit, infection control and safeguarding. The Quality Hub will work towards improving the triangulation of data in order to identify emerging risks and to support improvement work across the Trust.

Patient safety walkrounds

In response to our objective to ensure that improved patient safety and experience are at the heart of Trust business, the Board approved the introduction of a Clinical Area Assessment Programme (CAAP) in March 2011.

This is a peer review of clinical areas using a set of predetermined tools. The key objectives are to encourage service areas to share examples of best practice and to identify common themes and trends.

A report is developed, which includes detailed findings from the assessment, conclusions and key recommendations. An action plan is then created and monitored by each division within their governance groups. These plans are monitored by the Executive Patient Committee. From April 2012, the CAAP assessment visits will be unannounced.

Mortality

The Trust has always taken issues in relation to mortality, Hospital Standardised Mortality Ratio (HSMR) and the new Summary Hospital- level Mortality Indicator (SHMI) very seriously. Consequently, early in 2011/12 we initiated a number of additional actions in order to further improve patient safety and experience.

In summary, these included:

- revising the structure and membership of the Trust's Mortality Review Group
- expanding the number of clinical pathway workstreams
- developing a local economy *Reducing Mortality – Clinical Focused Plan*
- adopting a ceiling of care of treatment for each patient
- establishing an HSMR Administration Group to concentrate on data quality
- investing in the Trust's Clinical Coding Department
- developing "Consultant Scorecards" and "Divisional Dashboards" to improve information flows
- weekly, executive-led mortality reviews
- departmental mortality and morbidity meetings
- implementing a new governance structure (see diagram, page 48).

In order to assure ourselves that we were undertaking all the appropriate actions to improve our mortality outcomes, we invited the NHS Emergency Care Intensive Support Team (ECIST) to visit the Trust to carry out an independent review. As a result of their assessment we implemented a number of further improvements. These included increasing consultant working cover to midnight in A&E, to 10pm in the Emergency Assessment Unit (EAU) and to 9pm in Surgery – all seven days a week. These changes ensure the timeliness of early senior review and enable patients to move onto the most appropriate management pathway as early in admission as possible. In addition, we have begun work on adopting a new set of internal professional standards to ensure our systems and processes are patient-centred from arrival to discharge.

The impact of this work has seen our HSMR fall from 107.3 in 2010/11 to 92.5 for April-February 2011/12. We are now also working with the local health economy in order to understand our new SHMI data more clearly.

Falls prevention

Across the NHS, hospital falls are a common occurrence, especially among elderly inpatients. They often result in a loss of confidence and mobility, leading to a reduction in normal social and physical activity. Hospital falls also have a dramatic impact on the cost of health care, extend lengths of stay and increase discharge to long-term care settings.

Significant improvement work was co-ordinated by the Trust's multidisciplinary Falls Prevention Steering Group. As a result of improvements and initiatives, there was a:

- 12% reduction in the number of falls compared with 2010/11
- 45% reduction in falls resulting in serious harm (moderate, severe or death) compared with the previous year.

The Trust has invested in a substantive falls prevention nurse post and assistive technology products that will further reduce the risk of falling in high-risk patient groups. This approach will lead to more improvements in 2012/13 and beyond.

Pressure ulcers

It is estimated that about 1 in 20 people admitted to hospital with an acute illness will develop a pressure ulcer. In response, the Trust's Pressure Ulcer Prevention Group worked to improve the identification and management of patients at risk of developing ulcers.

As a result, there was an 84% reduction in the most serious pressure ulcers (grades 3 and 4). The Trust invested in a substantive nurse specialist post to ensure this performance is, as a minimum, maintained.

In early 2011, the Trust introduced "patient rounding". This process involves health care staff using predetermined questions to ask patients on a regular (two-hourly) basis about their care needs and checking the patient environment to ensure that it is clean and uncluttered, and that everything is within easy reach of the patient. Patient rounding has contributed to the significant improvements in our falls and pressure ulcers performance.

Patient Experience Committee

A review of the Trust's governance structure (see diagram, page 48) resulted in the formation of a Patient and Staff Experience Committee, which reports to the Executive Patient Committee. This monthly meeting provides assurance that the divisions are monitoring, reporting and acting on patient experience feedback.

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

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

"In Your Shoes" sessions were held in the early part of the year, at which staff listened to what more than 100 patients and carers had to say about their experience. This helped shape the values and behaviours that underpinned staff training during 2011/12. All staff are undergoing development sessions to

ensure we are at our best consistently. The Trust produced a bedside booklet for inpatients and staff photo boards to keep patients and visitors informed.

The *Outpatient Department Survey 2011*, published by the CQC in February 2012, was very positive. A comprehensive action plan was developed to address concerns.

In April 2011, the CQC visited Colchester General Hospital with a particular focus on dignity and nutrition for older people. Its review identified "moderate concerns" with these two essential standards. The Trust developed and implemented an action plan. During a follow-up visit in November, the CQC confirmed the Trust had made significant improvements and was now fully compliant with both standards.

The CQC looked at a total of eight essential standards during its two-day visit in November and found that the Trust was compliant with seven of them. It found a "minor concern" to do with a shortfall in the number of staff being up-to-date with mandatory safeguarding training. This has since been addressed.

Privacy and dignity

Maintaining patients' privacy and dignity is a Trust priority. As part of daily questionnaires, patients are asked to assess the Trust on how well it is doing in this essential area. This information is monitored each month.

Delivering same-sex accommodation

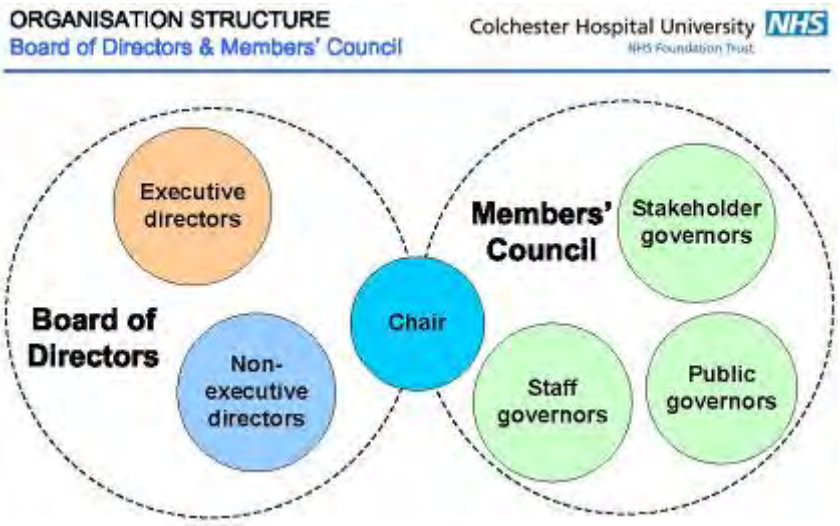
The Trust has declared full compliance with delivering same-sex accommodation. Estates work has been completed to ensure full compliance. The Trust undertakes continuous monitoring.

Improvements in patient information

Our patient information strategy continues to ensure health care professionals are able to deliver accurate, up-to-date, easy-to-understand, informative and timely information to patients. Almost 1,000 different leaflets are available, which are compliant with Department of Health guidelines.

Accountability

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



See more detailed diagram on page 38

Eligibility requirements for joining different membership constituencies

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

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

Staff members are automatically registered when they join the Trust. They include any employee but also employees of Carillion and volunteers.

Overall, public membership remained fairly static during 2011/12.

The public constituencies are shown below:

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

Public constituency	2011/12	2010/11
Colchester	3,228	3,199
Halstead & Colne Valley	847	875
Rest of Essex and Suffolk	596	532
Tendring	2,361	2,367
Total	**7,032**	**6,973**
Staff constituency		
Allied Health Professionals/Healthcare scientists	497	435
Medical or dental practitioners	420	352
Not known	50	51
Nurses/midwives	1,155	1,145
Support staff	2,156	1,703
No constituency/Out of catchment	0	3
Total	**4,278**	**3,689**

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

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

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

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

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

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

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

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

Monitoring the patient experience

To ensure the Trust has the best possible insight into how patients perceived services, web-based information is gathered via information tablets. The questions asked were chosen to reflect aspects of care that were highlighted in other patient surveys, in complaints or derived from the Essence of Care standards. The new trackers continue to provide "live" data to enable staff to evaluate the patient experience and to act on feedback almost immediately. Most clinical areas consistently attained a satisfaction rate in excess of 90%.

Patient and public involvement

As an NHS foundation trust, we are committed to the principle of public, patient and staff involvement. Public and staff members have elected governors to represent their views. Governors are involved in many aspects of Trust monitoring to ensure there are standards in place for their communities. For example, there is a governor on the Patient Environment Action Team (PEAT). The governors are involved in the benchmarking process for Essence of Care standards which cover a wide range of issues, including privacy and dignity.

Engaging our staff in developing a patient experience approach

The Trust continued to take significant strides to engage staff in developing a patient experience approach. We continued to provide leadership programmes with specific modules that were focused on the patient experience. Participants were asked to undertake "Back to the Floor" sessions and a work-based project that would contribute to improving the services we provide patients.

All new job descriptions, person specifications, adverts and questions at interview reflected the behaviours we expect of new employees. A DVD that makes the Trust's expectations very explicit was produced for potential employees. All new staff attended a corporate induction where a half-day was dedicated to patient experience and what we must do in terms of our behaviours to ensure we are at our best consistently. Staff discussed patient stories – good and bad – presented on DVD and were joined at these discussions by past and present patients.

We are in the process of updating our human resources policies and procedures to reflect the behaviours we expect from staff. The At Our Best themes are reflected in all of our internal training.

Patient Environment Action Team

The Patient Environment Action Team (PEAT) process is managed by the National Patient Safety Agency. Throughout the year staff from our facilities management team, together with one of our public governors, held monthly mini-PEAT walkabouts to assist in monitoring cleaning and environmental issues. This drove up standards and enabled the Trust to address concerns as they arose.

Integrated PALS, Complaints and Litigation Services

The Trust is committed to learning and improving the service offered to our patients and visitors. Patients and visitors can help by telling us what they think of their experience. If something is not right, they should ask to see the person in charge of the ward, department or clinic, who may be able to sort out the problem straight away. The Trust also has a Site Matron available 24 hours a day, seven days a week, and an Integrated PALS, Complaints and Litigation Services team working during office hours.

Overall, there was a 24.2% reduction in the number of concerns/complaints received by the Trust compared to the previous year and a 16.6% reduction in written complaints.

PALS

Our Patient Advice and Liaison Service helps patients, carers, relatives and families resolve problems as quickly and easily as possible by putting them in touch with the appropriate member of staff. The Trust aims to resolve all informal concerns and requests at the time they are received or as quickly as possible. If they can be addressed within 24 hours, they are a Level 1 concern. If more in-depth intervention is required, they are considered a Level 2 complaint. A total of 631 requests for information and 64 Level 1 concerns were recorded.

Information on complaints handling

The Trust continued to operate a robust complaints handling system. A total of 828 Level 2 and above complaints were received and 551 written complaints. A total of 827 Level 2 and above complaints were due for first response; of these, 757 (91.54%) were answered in the timescales agreed with the complainants. The improvement during the second half of 2010/11 was sustained during 2011/12.

Local resolution of complaints

A total of 104 (12.56%) complainants were not satisfied by the first response they received from the Trust, and additional work was required. The reason for complaints being re-opened was that complainants had concerns that were either not addressed completely the first time or further questions were raised. Often, complainants requested a meeting with Trust staff to address their concerns. A number of successful meetings were arranged.

Referrals to the Parliamentary Health Service Ombudsman

The Trust was informed of 19 referrals made by complainants to the Parliamentary Health Service Ombudsman (PHSO) for further consideration of their complaints.

The Trust was advised of the detailed assessment of seven complaints; of these, intervention was required in five cases. The PHSO identified two cases that required investigation. We received the outcome of one investigation; the case was upheld. Following completion of work on the recommendations, the PHSO closed the case. The other case is still under investigation.

Service improvements following complaints

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

Examples of these included:

- changes were made to the focus chart to reflect the emotional and mental needs of confused patients
- revision of the use of FemoStop, a compression device, following an angiogram
- changes were made to the way student nurses are trained in dietetic procedures
- changes were made to the production of theatre lists for patients accompanied by carers.

Sustainability

Why sustainability reporting is being carried out

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

The Sustainability Reporting Framework, which was available to use on a voluntary basis in 2010/11, is a mandatory part of the annual reporting requirements for 2011/12 onwards. You can read the framework in Appendix 1 on page 61

The overall sustainability strategy of the Trust

The Trust took advice from the NHS Sustainable Development Unit on developing its sustainability development plan, which will be finalised in 2012/13. The Trust has registered and carried out the first Good Corporate Citizenship Assessment Model – a tool designed to help organisations and their staff contribute to sustainable development – and will use this as a baseline to develop its sustainability development plan.

The governance processes in place to support the management and reporting of sustainability performance

Anna Bradley, non-executive director, leads for the Board of Directors on sustainability issues. The director lead on sustainability is the director of estates and facilities.

Summary of performance

The Trust finished joint first out of more than 2,000 UK businesses and organisations in the first energy efficiency performance Carbon Reduction Commitment (CRC) league table, published by the Environment Agency in November. Contributory factors to this success included:

- the installation of Automatic Meter Reading (AMR) so the Trust could monitor how much electricity and gas it was using
- becoming only the second NHS trust to be awarded the Carbon Saver Gold Standard for reducing carbon emissions over a three-year period
- the installation of LED lighting which can cut emissions by up to 90% on conventional lighting.

The Trust successfully completed the National Grid's Short Term Operating Reserve (STOR) trial one year programme with the company EnerNOC, which helps organisations to use energy more intelligently. STOR is a service for the provision of additional active power from generation and/or demand reduction. The Trust's income from this programme was £10,159.30p.

In the winter the Trust for the first time successfully carried out the Triad management programme on its own. The Triad or Transmission Network Use of System (TNUoS) is an element of electricity charges (£45,000 a year) recovered by the National Grid if we use the grid electricity during three of the peak demands in winter. The energy supplier issues us with 20 to 30 Triad warnings of up to two hours from November to February. We hit all three warnings and therefore recovered all the Triad charges for the year. With both STOR and TNUoS, our standby electricity generators were used when the National Grid was under pressure. The Trust aligned its mandatory testing of back-up generators with the needs of the grid. We therefore turned this annual expense into an efficient use of network resources and a source of new income for the Trust. The Trust signed up to the first NHS Day of Action on Sustainability on Wednesday 28 March.

Other environmental issues

The Travel Plan and Waste Management Strategy will be reviewed in the light of the new HSDU building. The Travel Plan will need to incorporate more sustainable modes of travel, such as car sharing, public transport and cycling. For waste management, more local recycling of waste will be considered along with the current compaction of general waste. To reduce carbon emissions from electricity use, the Trust will move from standard fluorescent lamps to low-energy fittings.

Comparative data

The table below shows that the generation of total waste by the Trust fell by 20% compared with last year. The recycling rate fell from 51% to 44% mainly due to additional clinical waste.

Water and electricity consumption increased marginally by 1.6% and 0.7% respectively. However, gas consumption fell by 17%, mainly because of effective building management by the estates and facilities team in controlling the Trust's heating system during the mild winter and also the sustainability awareness campaign. These measures contributed an overall carbon reduction of 6% compared with last year. For more detailed analysis, refer to the Sustainability Reporting Framework, Appendix 1, on page 61.

Area	Volume 2011/12	Volume 2010/11	Cost 2011/12	Cost 2010/11
Waste management: High temperature disposal waste (tonnes)	493.5	440.5	£286,299	£197,465
Landfill disposal waste (tonnes)	250.1	345.6	£15,529	£20,655
Total Waste Recycled	583.7	806.3	£36,244	£48,188
Total	1,327.3	1,592.4	**£338,072**	**£266,308**
	Consumption 2011/12	**Consumption 2010/11**	**Cost 2011/12**	**Cost 2010/11**
Utilities: Water (m^3)	114,262	112,479	£229,510	£210,672
Electricity (kWh)	12,928,888	12,844,698	£1,186,741	£1,013,541
Gas (kWh)	24,912,670	29,268,700	£726,953	£721,728
Oil (kWh)	268,231	208,196	£17,359	£11,170
CO2 emissions (tonnes)	11,427.3	12,167.1		

Research & Development

Research & Development

The majority of research activity was centred on recruitment into non-commercial, multi-centre studies in cancer. However, there was an increase in non-oncology research, particularly in the fields of intensive care, ophthalmology, stroke, dermatology and renal medicine. Some pharmaceutical company sponsored clinical trials were also conducted at the Trust. Research was supported by the National Institute of Health Research (NIHR) via the Essex and Hertfordshire Comprehensive Local Research Network (E&H CLRN). The E&H CLRN contributed funding for staff, based in the Trust's Research & Development Office, to deliver a comprehensive research management and governance service to our researchers, which also included the support of a clinical site co-ordinator and a team of research nurses to provide pre- and post-study delivery. Local Specialty Groups (LSGs), led by clinicians involved in research, encouraged consideration and set-up of studies on the portfolio of research adopted by the NIHR. Cancer, stroke, medicines for children and diabetes research networks continued to promote and support the delivery of new studies. Increased research activity in a number of clinical areas contributed to a sustained level of E&H CLRN and commercial income. Collaborations with the University of Essex (investigating biomarkers in breast and colorectal cancer) also contributed to the research activity and gave the opportunity for the development of medical careers. Health Enterprise East supported the Trust in the exploration of potential commercialisation of intellectual property. The Trust was involved in 181 studies, of which 109 were open to participant recruitment, with 72 studies closed to recruitment and in participant follow-up status. A total of 958 participants were recruited into studies recorded on the NIHR database.

Our staff

About our staff

On 31 March 2012 the Trust directly employed 4,163 staff (3,549 full-time equivalent (FTE)), an increase of more than 500 staff on 12 months earlier. In October the Trust brought in-house its facilities management services and transferred 450 Carillion employees onto the payroll. In addition, there was a large recruitment drive over the year, resulting in an overall increase of 60 FTE staff (excluding facilities management staff).

	Number of Trust staff (actual numbers, not full-time equivalents)
31 March 2010	**3,655**
31 March 2011	**3,646**
31 March 2012	**4,163**

Summary of performance – NHS workforce statistics

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

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

Age**	Staff members 2011/12	Staff members 2010/11	Public members 2011/12	Public members 2010/11
0 to 16 years	0	0	1	2
17 to 21 years	40	43	247	294
22+ years	4,201	3,606	5,793	5,638
Not specified	37	37	991	1,041
Total	**4,278**	**3,686**	**7,032**	**6,975**
Ethnicity				
Not specified	464	584	2,216	2,156
White	3,290	2,775	4,575	4,576
Mixed	37	21	45	46
Asian or Asian British	358	259	117	114
Black or Black British	79	31	57	60
Other Ethnic Group	50	16	22	23
Other	0	0	0	0
Total	**4,278**	**3,686**	**7,032**	**6,975**
Gender				
Male	1,021	721	2,535	2,563
Female	3,257	2,965	4,364	4,254
Not specified	0	0	133	158
Transgender	0	0	**0**	**0**
Total	**4,278**	**3,686**	**7,032**	**6,975**

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

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

Equality and diversity

The Trust is committed to equality and diversity and has an established Equality & Diversity Steering Group and a Single Equality Scheme which reflects the requirements of the national NHS framework, known as the Equality Delivery System (EDS). The EDS is intended to help organisations analyse the requirements of the Trust under the Equality Act 2010.

The Essex EDS Implementation Group meets monthly to:

- provide a co-ordinated approach to EDS implementation across Essex
- ensure support for all organisations in the implementation of the EDS
- work collectively on engaging local interests and uses the results of

engagement work to evidence that actions reflect the needs of local communities

- provide routine feedback and assurance on EDS implementation progress to the regional core governance group and to member organisations.

The core membership comprises representatives from acute and mental health trusts, the ambulance service, LINk/HealthWatch and the PCT clusters.

Engagement activities were held in September and January to begin a community conversation on health inequalities with local interests to identify areas of improvement.

The Trust finalised its four EDS objectives which were approved by the Trust Board in March in time for them to be published for the required date of 6 April 2012. These objectives will be reviewed every four years.

Disabilities

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

Recorded disability	Public members 2011/12	Public members 2010/11
Colchester	251	267
Halstead & Colne Valley	90	95
Rest of Essex and Suffolk	5	4
Tendring	225	241

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

Statement of key priority areas for 2012/13

We have updated our Single Equality Scheme and our action plan has been completed in parallel with the work on the Equality Delivery System as follows:

- the Director of Workforce/Company Secretary reviews progress with the Equality Delivery System
- the Single Equality Scheme remains published on our website together with our objectives.

Monitoring arrangements

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

Staff engagement

The Chief Executive holds monthly briefings with senior managers for cascading information to their teams. Attendance at these briefings has been reviewed to ensure that managers with the greatest number of staff attend and disseminate key organisational messages. Snapshot audits are undertaken regularly to ensure that staff are receiving these messages.

A Staff Engagement and Wellbeing Project Board met regularly, chaired by the Director of Workforce/Company Secretary and project managed by the Associate Director, Organisational Development. Each division has an engagement plan that was informed by the *2010 National NHS staff survey*.

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

Key areas were identified from the 2010 survey and a plan was developed to support improvements in the following:

- valuing staff
- making our values and behaviours real
- developing an engaging leadership style
- real staff engagement
- providing resources to staff
- communication
- taking stress seriously.

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

The Partnership Forum (previously the Joint Staff Council), comprising management and staff representatives, met every six weeks so that the views of employees could be taken into account when decisions were taken that were likely to affect them.

The Trust sustained arrangements for partnership working with staff representatives with a formal Partnership Forum and a (Medical) Local Negotiating Committee. Development activity was undertaken to further enhance the working partnership arrangements. This has resulted in our approach to partnership working with staff being reflected in joint working with staff representatives on, for example, human resources strategy, education and development.

Staff survey

Following publication of the *2010 National NHS staff survey* in March 2011, the Board of Directors reviewed and endorsed an action plan the next month which had been developed in partnership with staff representatives. Work has continued with this plan and is in the process of being updated with a cross-section of staff within the organisation following publication of the 2011 survey on 20 March 2012. This showed that more staff recommended the Trust as a place to work or receive treatment than in the 2010 survey and that the level of staff engagement had risen, but was still fractionally below the national average. More staff felt satisfied with the quality of work and patient care they were able to deliver (69% compared with 66%); more agreed their role made a difference to patients (90% compared with 87%); and more felt better valued by their work colleagues (78% compared with 74%).

The Trust scored “average” or above for 16 of the 38 indicators and “below average” for the remaining 22 when compared with all acute trusts. In the 2010 survey, the Trust scored “average” or above for only three of the 38 indicators and “below average” for the other 35.

The 2011 survey shows we have made significant progress since the outcome of the 2010 survey, both compared with our own results and against the national average. However, there is still a very long way to go and it is essential we sustain the progress that has been made to maintain the momentum.

Our priority outcomes for further improvement in future staff surveys will be:

- more staff feel able to contribute towards improvements at work
- more staff will recommend the Trust as a place to work and receive treatment
- staff report they feel more motivated at work.

We will continue to work with a cross-section of staff to develop plans to make

a difference to how staff feel about working for the Trust as we go through 2012/13. We have already started a round of soliciting regular feedback on how staff feel about the above issues. This will continue throughout 2012/13 to provide the Trust with assurance that the interventions we are planning are having a positive impact on staff morale.

Statement of key priority areas

Following publication of the 2010 *National NHS staff survey* in March 2011, the Board of Directors reviewed and endorsed an action plan which had been developed in partnership with staff representatives. Work has continued with this plan and, as stated above, is in the process of being updated with a cross-section of staff following publication of the 2011 survey.

Valuing staff: Establishing ways to recognise and thank staff for a job well done and celebrating achievements, both at a local and a Trust-wide level. Ensuring that all staff have good quality appraisals.

Making our values and behaviours real: It was evident from the In Your Shoes sessions that there was a need to agree an explicit set of behaviours that would define the way we behaved with patients and each other.

Developing an engaging leadership style: From ward to Board there was a need to review how managers led staff, to increase the visibility of senior managers and to find ways to bring managers and non-managers together in ways that resulted in different relationships.

Real staff engagement: There was a need to consider all the information we had, including the reasons why staff left the Trust, to ensure that our engagement plans were responsive to organisational requirements. We needed to consider different staff groups, eg administrative and clerical staff, that can often be overlooked in terms of the essential role they play in the success of the Trust.

Providing resources to staff: We needed to listen and act on feedback from staff about the equipment they required to provide the best patient care and to do our best to reduce vacancies, particularly in nursing, therefore ensuring we used fewer temporary staff.

Communication: There was a need to find innovative ways to engage with staff and ensure that key messages were shared at all levels.

Taking stress seriously: We needed to support staff by finding ways to reduce levels of stress.

Performance against priority areas (against targets set)

Valuing staff: Our appraisal rate increased to about 73%. Managers were trained to deliver a good quality appraisal. Close monitoring of appraisal compliance remained in place and areas of historical poor compliance improved. A quarterly reward and recognition scheme – the At Our Best Awards – was implemented, recognising the contribution of notable individuals, teams and volunteers. The *Daily Gazette* is the Trust's media partner in this initiative and publishes details of the winners and their stories. We are planning an annual celebration in June 2012 for our winners and also staff who have achieved long service with the Trust and its predecessor organisations. Good news stories appear regularly in the Chief Executive's weekly communication, in *Mainstream* and the local media. "Birthday lunches" with the Chief Executive are held on a monthly basis. A children's Christmas party, which involved managers, senior clinicians and the Chief Executive, was held for the children of staff.

Making our values and behaviours real: A set of At Our Best values and behaviours was agreed and signed off by the Board in July. A comprehensive training plan to ensure that staff understood the importance and context of these behaviours started in September. This began with the Board and is being disseminated throughout the Trust. Every member of new and existing staff will receive this training. Our human resources policies are being updated to reflect what is expected of staff. We are working with managers and staff to agree a set of explicit leadership behaviours that are aligned to the At Our Best values. These will be agreed by the Board in the spring of 2012.

Developing an engaging leadership style: A quarterly cycle of managers undergoing "Back to the Floor" sessions was implemented as was the opportunity for staff to be "Manager for the Day". Leadership development opportunities were delivered for all levels of staff in the organisation, including bespoke coaching and development for senior clinicians. A comprehensive programme of talent mapping began. We are about to pilot a "Mentoring for Success" programme where managers and clinicians will be paired up to share ideas and experience.

Providing resources to staff: A total of £100,000 was spent on wheelchairs, drip stands and other essential safety items after staff were consulted about what resources were needed. The Trust embarked on a recruitment campaign to reduce vacancies, particularly in nursing. We reviewed our mandatory training and how this was delivered to ensure that staff were away from the workplace for as little time as possible while remaining safe and competent to deliver an excellent service.

Real staff engagement: Business planning events were held which included a cross-section of staff, led by the Executive Team. An administrative and clerical benefits day took place in October where staff learnt about new technology that would support their work, heard about training and development opportunities and had an opportunity to highlight where additional support was needed. A small working party was developed from this, which included a staff governor. Each division has an engagement plan, with progress monitored regularly through the governance structure. Rather than wait for the annual NHS staff survey results, we launched the first of our in-year staff surveys in February. The results will influence our Trust-wide engagement plan and workforce strategy. We reviewed the questions we ask staff when they leave the organisation. We retained the Investors in People standard which included obtaining feedback from staff from all areas of the Trust. We will use this information to refresh the staff engagement plan.

Communication: Better communication came high on the list of improvements that staff identified in surveys. Most said they wanted to know more about what was happening across the Trust, in their department, ward or team. It was therefore decided to review the Chief Executive's monthly briefing process to assess whether the right people were attending the meetings. Attendance sheets from seven meetings (March - September) were analysed and the data cross-referenced with a list of Band 8 managers who appraise at least one person. It was subsequently decided to not have separate quarterly meetings. Instead, we invited executive directors, divisional clinical directors, associate/deputy directors (or equivalent) and any Band 8 manager or higher who appraised more than 10 staff to attend monthly.

Every March, June, September and December we send a printed magazine called Mainstream to all public members. Originally a staff newsletter, Mainstream replaced FT Members' Update for public members but remains a staff magazine too. We still publish Mainstream monthly for distribution within the hospitals. Also, every edition is available on our website for reading, downloading and printing.

We created a quarterly display at Colchester General Hospital of the many emails received praising staff, the Trust and our services. Each email was also forwarded to the chief executive and relevant directors, managers and matrons, and was included in the compilation of plaudits we received. Copies were sent, where possible, to any named staff in the email.

Taking stress seriously: Areas reporting high levels of stress were targeted and supported. A service was developed to provide immediate help and advice to staff on their first day of sickness. This resulted in staff receiving fast-tracked referrals to services such as physiotherapy, and the earlier identification of stress and mental health issues.

Monitoring arrangements

Monitoring is carried out by completing the Staff Survey Action Plan. In addition, the Trust's quarterly staff surveys monitor further areas for development and areas that have improved or deteriorated.

Sickness absence levels

Sickness absence was 3.46% (3.55% including facilities management (FM) staff) against 3.68% last year. This was the lowest sickness rate when compared with neighbouring acute hospital trusts. Every case of sickness is different and, therefore, was judged on its individual merits. The aim of sickness absence monitoring is the reduction of absence levels to an acceptable minimum consistent with genuine illness. The Trust successfully implemented the Staff Off Sick Project where there was a response on day one from the Health and Wellbeing Department to staff being absent due to ill health.

Staff sickness absence	2011/12	2010/11
Total WTE calendar days lost	43,123	41,582
Total WTE days available	1,216,123	1,135,850
Total staff years lost (days lost/365)	118.15	113.92
Total staff years available	3,549	3,111.92
Total staff employed in period*	4,865	4,215
Total staff employed in period with absence*	1,444	2,464
Total staff employed in period with no absence*	3,421	1,751
Average working days lost per employee	6.33	8.15

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

Safe and healthy workplace

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

Employee assistance

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

Zero tolerance policy against violence and abuse

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

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

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

Directors' report

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

The Directors' report is presented in the name of the following directors who occupied Board positions in 2011/12 (it also incorporates the operating and financial review):

Name	Position
Andrew Armour	Interim Director of Finance (until 30 June)
Sir John Ashworth	Non-Executive Director
Mike Baker	Non-Executive Director (until 2 June) Director of Finance (from 3 June)
Sue Barnett	Director of Operations/Deputy Chief Executive
Rob Bowman	Director of Workforce Company Secretary (from 1 May)
Anna Bradley	Non-Executive Director
Nick Chatten	Director of Corporate Development/Company Secretary (until 30 April)
Jude Chin	Non-Executive Director (from 12 September)
Dr Gordon Coutts	Chief Executive
Nick Elliott	Chief Information Officer (until 19 April)
Julie Firth	Director of Nursing and Patient Experience
Dr Sally Irvine	Chair
Dr Sean MacDonnell	Medical Director (from 31 October)
Mr Andrew May	Medical Director (until 31 October)
Helen Parr	Non-Executive Director
Prof Christine Temple	Non-Executive Director
Peter Wilson	Non-Executive Director (from 1 May)

An indication of likely future development at the Trust

The Trust, in developing its 2012/13 Annual Plan, built on its original integrated business plan and the plans implemented in 2009/10 and 2010/11. We have modified these to take into account the impact of the NHS operating framework for England for 2012/13 and the prevailing economic and financial conditions.

In 2011/12 the Trust:

- strengthened its clinical leadership by appointing four Divisional Clinical Directors to support divisional service management and the Trust Executive
- began building a new Hospital Sterilisation and Decontamination Unit (HSDU) at a cost of £5m
- was awarded the contract to develop major vascular surgery for the people of north east Essex, east Suffolk and the Colne Valley
- started the detailed planning of a new radiotherapy centre at Colchester General Hospital which will provide state-of-the-art treatment to the residents of north east, mid Essex and beyond
- approved and contracted for the installation of a Clinical Portal to give clinicians prompter and improved access to patient data in order to support diagnosis and treatment.

In the 2012/13 Annual Plan, the Trust will set out a programme to:

- seek Board approval and planning approval to develop the radiotherapy centre
- implement the Clinical Portal.

The Plan will be submitted to Monitor in May 2012.

Fixed assets

Although there is no pre-determined frequency at which property, plant and equipment (PPE) assets must be re-valued, accounting standards require that asset values should be kept up-to-date. Therefore, the frequency of revaluation needs to reflect the volatility of asset values and, in Monitor's view, property assets are likely to require revaluation at least every five years.

The last full valuation of the Trust's land and building assets was undertaken as at 1 May 2008, when the Trust received its authorisation as an NHS foundation trust. Since that time there has been significant volatility in asset values due to the prevailing economic climate. The Trust Board has made a decision to decommission some of the Essex County Hospital site as part of a significant investment in a new radiotherapy facility, and there has been large-scale investment in new facilities, such as a new two-storey ward block and Hospital Sterilisation and Decontamination Unit (HSDU).

As a consequence of all of the above changes, a further full valuation of both Trust sites was undertaken by the DVS (the commercial arm of the Valuation Office Agency) as at 31 March 2012.

Political or charitable donations

The Trust made no political or charitable donations.

Events after the reporting period

There are no events after the reporting period.

Interest rate or exchange rate risks

The Trust does not have any significant exposure to interest rate or exchange rate risks and therefore does not hold any complicated financial instruments to hedge against such risks. Details of the Trust's financial instruments are shown in note 24 of the accounts.

Quality Report

The Quality Report appended to this Annual Report contain full details of the Trust's quality objectives in 2011/12.

Operating and financial review

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

The Trust delivered a financial surplus of £12.3m, which was £10.1m above plan, after accounting for exceptional items of £4m. The underlying over-performance was attributable to higher levels of activity above plan without a compensating increase in costs.

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

The Trust was selected to be the centralised site for major vascular surgery for the people of north east Essex, east Suffolk and the Colne Valley. A state-of-the-art vascular operating theatre is being established with the first operation expected to take place there in June 2012.

Financial target 2011/12	Outcome
Planned surplus of £2.2m	Achieved surplus of £12.3m
Earnings before interest, Tax, Depreciation and Amortisation (EBITDA) £14.7m	Achieved EBITDA of £22.2m
Income and expenditure surplus margin of 1.1%	Achieved margin of 4.6%
EBITDA margin of 6.6%	Achieved margin of 9.2%
Return on assets employed of 4.5%	Achieved return of 9.4%
Liquid ratio 33.9 days (measuring liquidity of the Trust)	Achieved ratio of 46 days
Overall financial risk rating (FRR) of 3 as determined by Monitor	Achieved FRR of 5
Prudential Borrowing Limit (PBL) £40.8m. **The PBL is set by Monitor**	The Trust does not have any loans outstanding but does have finance leases of £1.78m that count against the PBL.
Private patient income cap **Under our terms of authorisation as an NHS foundation trust our private patient income must not exceed 1.1% of total clinical income**	Private patient income was well within the cap at 0.39%

Financial review and forward plans

Annual Accounts

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

Financial review and forward plans

The Trust achieved a surplus of £12.3m. Our total income was £245m, which included £3.3m of transformational funding from the PCTs to mainly contribute to our capital programme for vascular surgery and the Clinical Portal. We had expected income to fall because of changes to the national tariff structure and a reduction in tariff values. However, activity levels met or exceeded plan and this had a beneficial impact on our income.

The Trust invested £10.7m in new and replacement capital assets, including the start of a £5m purpose-built Hospital Sterilisation and Decontamination Unit (HSDU) at Colchester General Hospital to meet the necessary standards, due to open in July 2012. This investment is being met internally.

The Trust maintained strong cash reserves, which stood at over £28m at the end of the year. This financial performance means the Trust achieved a financial risk rating of 5 according to the metrics developed by Monitor to measure the financial performance of NHS foundation trusts, compared with a plan of 3 (the maximum possible score is 5).

Achieving these financial plans represents a good result for the Trust. However, the economic environment going forward will make it more difficult to build up significant cash reserves. Cash balances will reduce as investment in the capital programme progresses, particularly as we plan to start building a multi-million pound radiotherapy centre in 2012/13.

Further changes and reductions in tariff values in 2012/13 mean the Trust will need to deliver at least the same level of activity as in 2011/12 for less money. Consequently, the focus on efficiency savings and new sources of income will increase. Detailed plans are in place to deliver these. The Trust is also working closely with our commissioners to see how we can deliver significant long-term savings to the whole north east Essex health economy.

For 2012/13, we are planning to deliver a surplus of £3m which, under Monitor's risk rating assessment mechanism, will give us a rating of 3. Further surpluses are planned for future years at a similar level. As an NHS foundation trust, we have the ability and autonomy to invest these surpluses in our services, our core strategic developments and our future facilities.

Financial risk rating

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

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

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

The performance rating issued by Monitor for 2011/12 is summarised in the following table along with that from the previous year.

	Annual Plan 2011/12	Actual Performance			
		Q1 2011/12	Q2 2011/12	Q3 2011/12‡	Q4 2011/12*
Financial risk rating	3	4	4	4	5
Governance risk rating	No risks declared				

	Annual Plan 2010/11	Actual Performance			
		Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial Risk Rating	3	3	2	3	3
Governance risk rating	No risks declared				

Governance risk rating

The Trust did not achieve the standards in Clostridium difficile and the cancer maximum 62 day wait for first treatment. The Trust saw sporadic cases of different strains of Clostridium difficile in different parts of the organisation. An action plan was put in place to minimise further cases. The Trust failed to achieve the cancer standard in the last quarter of the year. Cancer target breaches are usually the result of complex symptoms requiring considerable research. The number of breaches in the last quarter was at normal levels but the number of total cases seen was considerably lower than normal, resulting in the percentage of breaches exceeding the target.

Future developments

The Trust is committed to the principle of developing the Colchester General Hospital site. This includes:

- opening a purpose-built Hospital Sterilisation and Decontamination Unit (HSDU) to meet the necessary standards
- centralising cancer facilities
- introducing a Clinical Portal system to improve clinicians' on -line access to patient data, tests and results
- relocating over the next three to five years from Essex County Hospital as far as practicable and, as appropriate, disposing of parts of that site as alternative provision is made for services
- improving the general environment for care and, in particular, addressing the privacy and dignity needs of patients.

Going concern statement

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

Statement regarding audit

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

Better Payment Practice Code

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

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

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

Cost allocation requirements

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

Code of governance

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

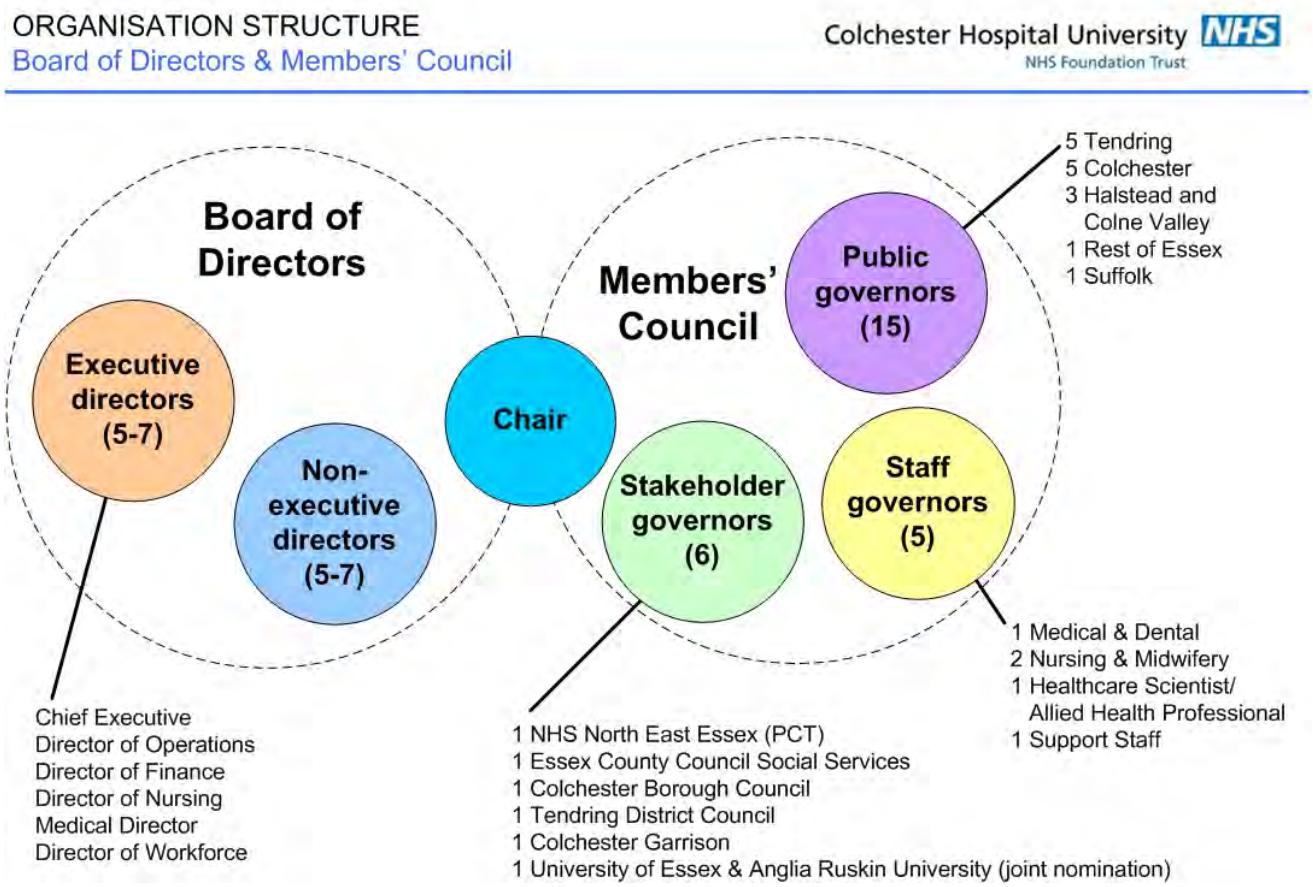
Our Members' Council

Members' Council responsibility

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

Composition of the Members' Council

The Members' Council comprises 26 members:



Directors and governors working together

The Members' Council's role has continued to develop and it has proved to be an effective and highly-valued critical friend of the organisation, working with the Board of Directors in developing plans for the Trust and in expanding its membership numbers and involvement with the organisation. The Members' Council as a consultative and advisory forum to the Board of Directors provides a steer on how the Trust can carry out its business and helps it in the development of long-term strategic plans consistent with the needs of the community it serves. The Members' Council also acts as guardian to ensure that the Trust operates in a way that fits with its statement of purpose and ensures that the Board of Directors does not breach its terms of authorisation. A programme of joint non-executive director and governor hospital walkrounds continued to evolve. Individual non-executive directors and governors accompany one another on tours which give an insight into the operational issues facing the Trust. Feedback is then documented and given to the Trust Chair. Governors completed the appointment of one non-executive director (Jude Chin) who joined the Trust in September 2011. As part of the Trust's membership engagement strategy, 12 health talks on topical subjects relating to the organisation's clinical services were given at different venues in north east Essex, including GP surgeries. Between 20 and 120 people attended each talk, which was hosted by a governor.

Committees and panels

The Members' Council met with representatives from the Board of Directors in January to receive an update on the Trust's strategy. Interaction between governors and representatives of the Board took place regularly at the following working groups of the Members' Council:

- Patient Care Panel
- Membership Engagement Panel
- Front of Hospital Working Group
- Visual Arts in Hospital Working Group
- Annual Members Meeting Working Group.

Governor representation on the following committees also began:

- Quality & Patient Safety Assurance Committee
- Patient & Staff Experience Committee
- Women & Children's Committee
- Governors were invited to take part in the At Our Best Awards judging panels.

Elected governors

Public governors

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

Colchester	Tendring	Halstead & Colne Valley
Ray Cole	James Chung	Pauline Aldridge
Vi Haddow	Hazel Law	John Dann
Des McCarron	Andy Patrick	David Johnson
Elaine Smith	Marilyn Jones	
Gillian Wallis	Barry Wheatcroft	
Rest of Essex	**Suffolk**	
Jack Bell*	Mark Aitken	

* resigned with effect from 7 November

Elections for all the public and staff governor posts, including for the new Rest of Essex and Suffolk public constituencies, were completed in April 2011**.**

Staff governors

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

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

Turnout in the constituencies

All governors were elected by members of the Trust from their own constituencies.

Constituency	Turnout April 2011
Colchester	24.5%
Tendring	26.3%
Halstead & Colne Valley	32.2%
Rest of Essex	Unopposed
Suffolk	18.3%
Medical & dental	27.8%
Nursing & midwifery	Unopposed
Allied health professionals/Healthcare scientists	Unopposed
Support staff	24.9%

The Association of Electoral Administrators acted as returning officer and independent scrutineer for the elections in 2011.

Appointed stakeholder governors

NHS North East Essex: Diane Leacock was appointed for three years in September 2010. She resigned in November 2011 and was replaced by Renata Drinkwater in February 2012.

Colchester Borough Council: Cllr Martin Hunt was appointed in July 2008 for three years. He resigned in May 2011 and was replaced in July 2011 by Cllr Tina Dopson. She resigned in December 2011 and was replaced immediately by Cllr Nigel Offen.

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

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

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

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

Register of interests

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

Members' Council meetings

There were five formal Members' Council meetings:

17 May, 11 August, 13 September (Annual Members Meeting), 10 November, 19 January.

Governor attendance at Members' Council meetings

Name	Attended	Name	Attended
Mark Aitken	5/5	Vi Haddow	3/5
Pauline Aldridge	5/5	Cllr Martin Hunt	0/0
Val Asker	5/5	David Johnson	4/5
Jack Bell	2/3	Marilyn Jones	3/5
Donna Booton	4/5	Hazel Law	5/5
Cllr Anne Brown	3/5	Diane Leacock	0/5
James Chung	5/5	Des McCarron	5/5
Ray Cole	4/5	Cllr Lynda McWilliams	3/5
John Dann	3/5	Cllr Nigel Offen	1/1
Professor Lesley Dobree	1/5	Andy Patrick	3/5
Cllr Tina Dopson	0/3	Major Simon Rothwell	2/5
Renata Drinkwater	0/0	Dr Chandra Sekharan	4/5
Isaac Ferneyhough	5/5	Elaine Smith	3/5
Kathy Flint	3/5	Gillian Wallis	3/5
		Barry Wheatcroft	5/5

Our Board of Directors

Board of Directors' responsibility

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

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

Appointment and composition of the Board of Directors

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

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

Details of the appointment of the new non-executive director (Chair of the Audit & Risk Assurance Committee) are described elsewhere (page 47).

Disclosures of the remuneration paid to the Chair, non-executive directors and executive directors are given in the Remuneration report (page 57).

About the non-executive directors

Dr Sally Irvine

Chair

Appointed:
1 August 2010

Term of office:
Expires 31 July 2013

Chair of the Board of Directors and Remuneration & Terms of Service Committee; Chair of the Members' Council and its Nominations and Appointments & Performance committees.

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

Mike Baker

Non-Executive Director

Appointed:
1 May 2010 (appointed Board Director on 3 June 2011, see page 44)

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

Anna Bradley

Non-Executive Director

Appointed:
18 November 2010

Term of office:
Expires 17 November 2013

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

Anna is the Chair of a number of national regulatory bodies including the General Optical Council, and a trustee of Addaction – a drug and alcohol service delivery charity. She has had an executive career in regulation, public policy and representing the consumer and citizen interest, having worked as consumer director at the Financial Services Authority and as chief executive of the National Consumer Council, among other roles. She lives in Colchester, where her children have grown up.

Helen Parr

Non-Executive Director/Deputy Chair

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

Term of office:
Expires 30 November 2013

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

Helen's special interest in the Trust is patient safety.

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

About the non-executive directors

Professor Christine Temple

Non-Executive Director

Appointed:
1 August 2010

Term of office:
31 July 2013

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

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

Sir John Ashworth

Non-Executive Director/Senior Independent Director

Appointed:
1 May 2010

Term of office:
30 April 2013

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

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

Peter Wilson

Non-Executive Director

Appointed:
1 May 2011

Term of office:
30 April 2014

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

Peter has extensive international experience gained from working in UK and US public companies covering a broad range of engineering and manufacturing. He was managing director of Crane Ltd for more than 10 years and since retiring in December 2010 has undertaken various consultancy and executive roles for Crane. Since 2008 he has been a non-executive director at EEF Ltd, a company that represents the views and interests of UK manufacturing companies to the Government and European Parliament. He is a former chief executive of Ransomes, an engineering company with factories in the UK, including Ipswich, and overseas.

Jude Chin

Non-Executive Director

Appointed:
13 September 2011

Term of office:
12 September 2014

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

Jude is a chartered accountant with extensive commercial and international experience gained from a 30-year career with KPMG. Following his retirement, he has developed extensive experience in the education sector. He is a board member and trustee of The Schools Network and governor of the City Academy, Hackney, and the City of London Academy, Southwark. Jude has a degree in biochemistry and is a fellow of the Institute of Chartered Accountants in England and Wales.

Bill Craig

Non-Executive Director/Deputy Chairman

Term of office:
1 May 2007 to 30 April 2011 (appointed originally to Essex Rivers Healthcare NHS Trust)

Deputy Chair of the Board of Directors; Chair of the Performance Assurance Committee; member of the Audit & Risk Assurance and Remuneration & Terms of Service committees.

About the executive directors

Dr Gordon Coutts

Chief Executive

Appointed Board Director:
6 September 2010

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

Accounting Officer for the Trust.

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

Sue Barnett

Director of Operations/ Deputy Chief Executive

Appointed Board Director:
1 February 2011

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

Oversees operational performance and services. Deputises for Chief Executive.

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

Mike Baker

Director of Finance

Appointed Board Director:
3 June 2011

Term of office:
Fixed term

Notice period:
Trust: six months
Employee: three months

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

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

Julie Firth

Director of Nursing and Patient Experience

Appointed Board Director:
July 2009

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

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

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

About the executive directors

Dr Sean MacDonnell

Medical Director

Appointed Board Director:
31 October 2011

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

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

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

Rob Bowman

Director of Workforce/Company Secretary

Appointed Board Director:
December 2008

Term of office:
Permanent

Notice period:
Trust: six months
Employee: three months

Oversees all aspects of the Trust's workforce including leadership and management development, education, training and development, welfare and wellbeing, pay and reward, employee engagement, employee relations and workforce planning. Also fulfils the Company Secretary role and is responsible for Trust communications.

Rob was chair of the East of England Human Resources Directors' Network from 2009 to 2011. He has a particular interest in staff engagement and is very committed to how this can be improved and developed at the Trust. He has over 20 years' experience of human resources practice, gained across all sectors of the NHS and social care. Before joining the Trust in 2006, he was associate director of workforce at a major teaching hospital in Manchester.

Nick Elliott

Chief Information Officer ++

Appointed Board Director: August 2009

Term of office: Interim (18 months). Nick left the Trust on 19 April.

Andrew Armour

Director of Finance

Appointed Board Director: October 2009

Term of office: Interim. Andrew left the Trust on 30 June.

Mr Andrew May

Medical Director

Appointed Board Director: November 2008

Term of office: Three years. Andrew retired from the Trust on 31 October.

Nick Chatten

Director of Corporate Development/Company Secretary ++

Appointed Board Director: 1 April 2009

Term of office: Permanent. On 1 May Nick took up the new post of Director of Special Projects and Estates, which is not a Board post.

++ non-voting director (ex officio)

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

Evaluation of the Board of Directors' performance

The Board of Directors' meetings

The Board held 13 meetings: 14 April, 12 May, 2 June (special meeting – Annual Accounts), 9 June, 14 July, 11 August, 8 September, 13 October, 10 November, 7 December, 19 January (joint workshop with Members' Council), 16 February, 15 March.

Meetings attended in 2011/12

Name	Title	Attended
Andrew Armour	Interim Director of Finance (until 30 June)	2/2
Sir John Ashworth	Non-Executive Director/Senior Independent Director	13/13
Mike Baker	Non-Executive Director (until 2 June)	3/3
Mike Baker	Director of Finance (from 3 June)	10/10
Sue Barnett	Director of Operations/Deputy Chief Executive	12/13
Rob Bowman	Director of Workforce/Company Secretary (Company Secretary from 1 May)	12/13
Anna Bradley	Non-Executive Director	11/13
Nick Chatten	Director of Corporate Development/ Company Secretary (until 1 May)	1/1
Jude Chin	Non-Executive Director (from 13 September)	5/6
Dr Gordon Coutts	Chief Executive	12/13
Bill Craig	Non-Executive Director/Deputy Chairman (until 30 April)	1/1
Nick Elliott	Chief Information Officer (until 19 April)	1/1
Julie Firth	Director of Nursing and Patient Experience	10/13
Dr Sally Irvine	Chair	12/13
Dr Sean MacDonnell	Medical Director (from 31 October)	3/5
Mr Andrew May	Medical Director (until 31 October)	6/8
Helen Parr	Non-Executive Director/Deputy Chair	11/13
Professor Christine Temple	Non-Executive Director	10/13
Peter Wilson	Non-Executive Director (from 1 May)	9/12

Evaluation of the Board

In June the Board approved a new quarterly reporting structure which was implemented in December. Four executive committees were formed which meet monthly and which are accountable to the Executive Team, providing assurance to the Board assurance committees. The executive committees are:

- Executive Patient Committee
- Executive Infrastructure Committee
- Executive Operational Committee
- Executive Strategy Committee.

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

Board development

Peter Wilson took up the post of non-executive director on 1 May to replace Bill Craig whose second term of office expired the previous day. This appointment resulted from an earlier recruitment round in November 2010.

The process to appoint a new non-executive director & Chair of the Audit & Risk Assurance Committee to replace Mike Baker, who became Director of Finance on 3 June, was concluded with the appointment of Jude Chin who started on 13 September.

Ongoing development

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

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

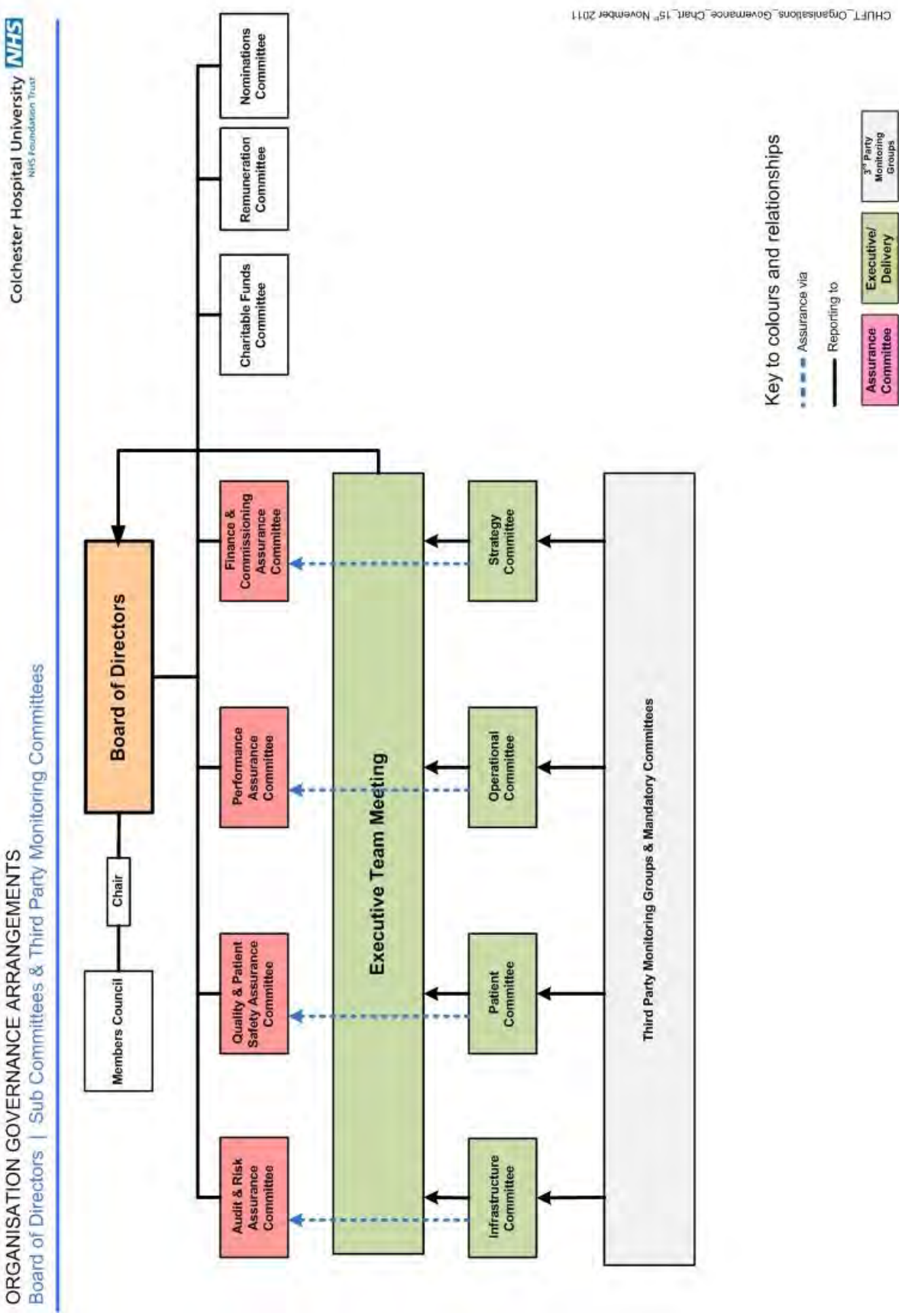
Appraisal process for the Chair and non-executive directors

The Chair and Director of Workforce/Company Secretary have worked with the Members' Council to develop an appropriate appraisal process for the Chair and non-executive directors.

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

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

Organisation Governance Arrangements



Committees of the Trust Board

The committees of the Trust Board are:

- **Audit & Risk Assurance Committee**
- **Quality & Patient Safety Assurance Committee**
- **Finance & Commissioning Assurance Committee**
- **Performance Assurance Committee**
- **Nominations Committee (jointly with Members' Council)**
- **Charitable Funds Committee**
- **Remuneration & Terms of Service Committee.**

Audit & Risk Assurance Committee

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

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

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

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

Members and meetings attended in brackets

Mike Baker, outgoing Committee Chair (2/2), Jude Chin, incoming Committee Chair (2/2), Helen Parr (1/1), Professor Christine Temple (5/5), Anna Bradley (1/1).

External auditors

In August 2010 the Government announced that the Audit Commission would be disbanded. Therefore, the Members' Council followed a competitive procurement process to review and appoint external auditors for the Trust. As a result of this process, in March 2011 the Members' Council approved the appointment of Grant Thornton for a period of three years from 1 April 2012.

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

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

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

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

Quality & Patient Safety Assurance Committee

The committee's remit is to:

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

	o scrutinise and monitor the implementation of strategic priorities and assure the strategy o assure the Board of Directors on quality and patient safety. The Quality & Patient Safety Assurance Committee held eight meetings: 5 May, 2 June, 27 June, 1 August, 1 September, 3 October, 31 October, 30 January.
Members and meetings attended in brackets	Helen Parr, Committee Chair (6/8), Anna Bradley (7/8), Sir John Ashworth (7/8), Julie Firth (6/8), Sue Barnett (6/8), Andrew May (4/6), Dr Gordon Coutts (7/8), Dr Sean MacDonnell (2/2).
Finance & Commissioning Assurance Committee	The committee's remit is to: o give detailed scrutiny of financial performance against plans and forecasts, highlighting and seeking assurance on deviation/recovery o scrutinise contractual principles, plans and performance o scrutinise the implementation of the capital programme, workforce resourcing and operational capacity o guide the development of the Trust's financial strategy o assure the Board of Directors monthly on financial performance. The Finance & Commissioning Assurance Committee held seven meetings: 3 May, 31 May, 28 June, 2 August, 30 August, 4 October, 31 January.
Members and meetings attended in brackets	Helen Parr (1/3), Mike Baker (non-executive director) (2/2), Sir John Ashworth, outgoing Committee Chair (7/7), Peter Wilson, incoming Committee Chair (7/7), Sue Barnett (4/7), Rob Bowman (0/1), Dr Gordon Coutts (4/7), Mike Baker (Director of Finance) (3/5).
Performance Assurance Committee	The committee's remit is to: o support the Board in the development and oversight of the performance management framework and systems o review the efficiency of the organisation in delivering performance, benchmarked against the best nationally. The Performance Assurance Committee held seven meetings: 10 May, 27 May, 29 July, 26 August, 30 September, 4 November, 3 February.
Members and meetings attended in brackets	Professor Christine Temple, Committee Chair (7/7), Anna Bradley (4/7), Peter Wilson (5/5), Sue Barnett (6/7), Dr Gordon Coutts (4/7).

Nominations Committee *A joint committee with membership drawn from the Board of Directors and the Members' Council*	The Nominations Committee reviews the structure, size and composition of the Board of Directors and makes recommendations for changes where and when appropriate. It also considers succession planning arrangements, taking into account the challenges and opportunities facing the Trust and the skills and expertise required on the Board of Directors. The Nominations Committee uses the outcome of this evaluation to prepare a description of the role and capabilities required for the particular appointment of both executive and non-executive directors, including the Chair. The committee then devolves this information to the Board of Directors' Remuneration & Terms of Service Committee for the appointment of executive directors and to the Members' Council's Appointments & Performance Committee for the appointment of non-executive directors, including the Chair. It held two meetings: 20 June, 4 August.
Members and meetings attended in brackets	Dr Sally Irvine, Committee Chair (2/2), Helen Parr (1/2), Marilyn Jones (2/2), Donna Booton (2/2), Dr Gordon Coutts (1/2).
Charitable Funds Committee *The Board of Directors is the corporate trustee of the charities that are together registered with the Charity Commission under number 1051504*	The Charitable Funds Committee has delegated responsibility from the Board of Directors to adhere to the principles and responsibilities of trusteeship as defined by the Charity Commission and the Trustee Act 2000, Section 11. In the main, the committee reviews the policies and procedures for fundraising, acceptance and expenditure, including the internal control arrangements operating within the Trust for charitable funds. The committee includes representation from operational senior managers from across the Trust. Three formal meetings of the committee were held: 16 September, 9 December, 23 March.
Members and meetings attended in brackets	Sir John Ashworth, Committee Chair (3/3), Mike Baker (3/3), Professor Christine Temple (2/3), Dr Gordon Coutts (1/3), Julie Firth (1/3), Helen Parr (2/3), Anna Bradley (2/3).
Remuneration & Terms of Service Committee	This committee is responsible for advising on the appointment and/or dismissal of the executive directors. It is also responsible for the approval of their remuneration and terms of service and the monitoring of their performance against delivery of organisational objectives. Membership is from the non-executive directors of the Board of Directors and the Director of Workforce/Company Secretary. The Chief Executive is entitled to attend the committee and to be consulted when the appointment and remuneration of the executive directors is being considered. He is excluded from meetings about his own position. An appointments panel of the Remuneration & Terms of Service Committee is convened when appointments are to be made. All appointments are by public advertisement. External assessors are part of the recruitment process. The appointments panel met once, on 6 September, to appoint a replacement to a vacancy arising in year for the post of Medical Director. The Remuneration & Terms of Service Committee held three meetings: 4 July, 3 October, 16 January.
Members and meetings attended in brackets	Dr Sally Irvine, Committee Chair (3/3), Helen Parr (2/3), Sir John Ashworth (3/3), Professor Christine Temple (3/3), Anna Bradley (3/3), Peter Wilson (3/3), Jude Chin (1/2) Dr Gordon Coutts (3/3), Rob Bowman (3/3).
Advice or services to the committee	The Trust is obliged to publish the name of any person who provided advice or services to the committee that materially assisted the committee in its consideration of any matter. No such advice was provided.

Statement of accounting officer's responsibilities

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

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

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

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

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

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

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

Signed

Dr Gordon Coutts
Chief Executive

24 May 2012

Annual governance statement

Scope of responsibility	As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.
The purpose of the system of internal control	The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore provide only reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Colchester Hospital University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place at Colchester Hospital University NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the Annual Report and Accounts.
Capacity to handle risk	The Trust is committed to providing high quality patient services in an environment that is safe and secure. I have the overall responsibility for all risk management and ensuring that the organisational structure and resource is in place for this to occur. The importance of senior leadership is recognised and delegated through an Executive Director and operationalised through the corporate and divisional structures. This supports the need for a central steer while ensuring local ownership in managing and controlling all elements of risk to which the Trust may be exposed. Training in risk management is provided to all staff relevant to their grade and situation. Staff have access to additional support and education to ensure that they have the skills and knowledge and are competent to identify, control and manage risk within their work environment. All staff receive training at the mandatory corporate induction. This includes their personal responsibilities as well as the necessary information and training to enable them to work safely. To support staff through the risk assessment process, expert guidance and facilitation is available. Actions taken to reduce risk are monitored regularly and reported through the Datix Risk Management System. Trends are analysed at divisional and sub-committee level of the Trust Board with high and extreme risks reported to the Board of Directors on a quarterly basis. Evaluation of the effectiveness of these actions promotes both individual and organisation learning and the dissemination of good practice.
The risk and control framework	The key elements of the risk strategy are to manage and control identified risks appropriately, whether clinical, non-clinical or financial. This is achieved by providing a rigorous organisational framework which enables early identification of risk, co-ordination of risk management activity, provides a safe working environment for staff and for patients, and reduces unnecessary expenditure. It ensures that managers, clinicians and staff are aware of their roles and responsibilities in managing risk and describes the organisational structures and processes in place by which risk is assessed, controlled and monitored. Risks are identified through diverse sources of information such as formal risk assessments, audit data, clinical and non-clinical incident reporting, complaints, claims, patient and user feedback, information for partnership arrangements and identification of shared and individual risks as a result of internal and external requirements. Risks are evaluated using a risk assessment tool, which enables the Trust to assess the impact and likelihood of the risk occurring, using a

recognised scoring system. This supports the decision-making process about whether the identified risk is considered acceptable or unacceptable.

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

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

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

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

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

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

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. We have received assurances from our payroll and pension services supplier (Anglia Support Partnership) that control measures were in place throughout 2011/12 to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

The Trust is in the process of putting in place carbon reduction delivery plans to ensure its obligations under the Climate Change Act are complied with. These plans are in draft format and will be put in place in 2012/13.

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

The Audit and Risk Assurance Committee in partnership with the Quality and Patient Safety Assurance Committee functioned throughput 2011/12. Their role is to oversee the risk management and governance arrangements within the Trust by giving careful consideration to financial control arrangements and clinical and corporate governance. This ensures organisation-wide co-ordination and prioritisation of risk management and governance issues, encourages and fosters a greater awareness and ownership of risk management and integrated governance throughout the corporate, business and operational levels of the organisation. Both committees report to the Board of Directors.

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

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

Capacity: During 2011/12 a number of projects were undertaken to drive forward the Trust's economy, efficiency and effectiveness in the use of resources. These included starting the construction of a new £5m Hospital Decontamination and Sterilisation Unit (to be completed in 2012/13) to ensure capacity and achievement of sterilisation standards moving into the future. Outsourced FM services were brought in-house with the purpose of improving cost-effectiveness of these support services and their alignment with frontline services. The Trust was also successful in its bid to become a centre for major vascular surgery.

Board leadership: During 2011/12 the post of Director of Finance was filled on a permanent basis. Two non-executive directors were also successfully recruited in the year.

Annual Quality Report

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

The Quality Report 2011/12 has been prepared under the supervision of the Executive Team, in a process led by two executive team members; assurance of the process involved has been by the Audit & Risk Assurance Committee. The Quality Report follows the Department of Health recommended format. The Executive Team and the Quality & Patient Safety Assurance Committee have reviewed the process to develop the Quality Report. The indicators reported for 2011/12 were identified in our Quality Accounts for 2010/11 and performance on these indicators in 2011/12 was reviewed at regular intervals throughout the year by the Board and the Quality & Patient Safety Assurance Committee.

Data included in the Quality Report has been validated against the national NHS data definitions. The quality objectives set for 2012/13 were agreed by the governing body, our Members' Council, and are consistent with the CQUINs agreed with NHS North East Essex for 2012/13.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the

development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by external auditors in their external audit reports and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the audit and governance committees. A plan to address weaknesses and ensure continuous improvement of the system is in place.

This year, my review has also been informed by:

- the provision of a Performance Framework to the Trust Board throughout 2011/12. The framework identifies responsible officers and links key deliverables and targets to Trust objectives and tracks their delivery
- comparison of Trust performance to SHA benchmarking, demonstrating the Trust is now performing amongst the best in the East of England on access targets, hygiene and infection control measures
- clinical audit reports
- internal audit reports and reviews (eg the financial standard and governance standard audits)
- registration without conditions by the Care Quality Commission
- Care Quality Commission Quality Risk Profile (QRP) analysis
- Level 2 compliance with NHSLA risk management standards (acute) and CNST
- PEAT inspection
- national staff and inpatient surveys and standards held for Investors in People and Improving Working Lives Practice Plus Accreditation
- Information Governance Toolkit showing improved performance
- Healthcare Commission's Hygiene Code Inspection Report
- the Head of Internal Audit Opinion Statement which provides significant assurance.

Conclusion

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

As Accounting Officer and based on the information provided above I am assured that no significant internal control issues have been identified.

As noted, plans are in place to address this issue.

Signed

Dr Gordon Coutts
Chief Executive
24 May 2012

Remuneration report (unaudited)

Members' Council Appointments & Performance Committee

The Members' Council and the Board of Directors have a joint Nominations Committee. Its responsibilities and activities are described under the section Our Board of Directors (which starts on page 41).

The Members' Council's Appointments & Performance Committee is responsible for advising the Members' Council on the appointment and performance assessment of the non-executive directors (including the Chair). The committee held two formal meetings: 27 June, 4 August (jointly with the Nominations Committee).

Members and meetings attended in brackets

Dr Sally Irvine, Committee Chair (2/2), Ray Cole (2/2), Isaac Ferneyhough (1/2), Vi Haddow (2/2), Andy Patrick (2/2), David Johnson (2/2), Val Asker (2/2), Hazel Law (2/2), Barry Wheatcroft (1/2), Pauline Aldridge (2/2), Simon Rothwell (1/2).

The committee considered a review of its terms of reference. It also convened an appointments panel to interview for the post of Non-Executive Director/Chair of the Audit & Risk Assurance Committee.

Board of Directors' Remuneration and Terms of Service Committee

See section on Committees of the Trust Board (page 49).

Remuneration and performance conditions

There is not an individual performance-related element to the remuneration of the directors and non-executive directors. Their remuneration is subject to an annual review which takes into account a benchmarking comparison with other similar organisations, general labour market conditions and the Board's collective achievement of organisational objectives.

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

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

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

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

- Croner Director Rewards Survey
- NHS Confederation Foundation Trust Network
- Capita Health Service Partners NHS Chief Executives and Directors salary survey
- Income Data Services (IDS) NHS Boardroom pay report
- Senior Salaries Review Body (SSRB) to Department of Health for

VSMs (Very Senior Managers) Pay Framework

- the Health Report Research Service (HRSS) database of NHS advertised salaries.

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

Duration of contracts, notice periods and termination payments

These are summarised in the Board of Directors' profiles section (from page 42). With the exception of the medical director, executive directors are appointed to substantive contracts.

Contractual compensation provisions for early termination of executive directors' contracts

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

Median salary as a multiple of highest paid director salary

The median salary is £24,554

The highest salary is £165,000 which is 6.71 more than the median.

Salary and pension entitlement of the Board of Directors

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

Signed

Dr Gordon Coutts
Chief Executive

24 May 2012

Salary and pension entitlements of senior managers (audited)

A) Remuneration

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

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

Name	Title	2011/12			2010/11		
		Salary	Other remuneration	Benefits in kind*	Salary	Other remuneration	Benefits in kind* (restated)
		(bands of £5,000)	(bands of £5,000)	(rounded to nearest £100)	(bands of £5,000)	(bands of £5,000)	(rounded to nearest £100)
		£000	£000	£00	£000	£000	£00
Andrew Armour[1]	Director of Finance	35 - 40	0	0	140 - 145	0	0
Sue Barnett	Director of Operations/Deputy Chief Executive	125 - 130	0	2	240 - 245	0	0
Dr Sally Irvine	Chair	35 - 40	0	32	25 - 30	0	30
Rob Bowman[2]	Director of Workforce/Company Secretary	100 - 105	0	0	95 - 100	0	1
Dr Sean MacDonnell[3]	Medical Director	135 - 140	0	0			
Bill Craig[4]	Non-Executive Director	0 - 5	0	3	10 - 15	0	10
Jude Chin[5]	Non-Executive Director	5 - 10	0	10			
Julie Firth	Director of Nursing and Patient Experience	95 - 100	0	0	95 - 100	0	3
Dr Gordon Coutts	Chief Executive	160 - 165	0	8	95 - 100	0	5
Andrew May[6]	Medical Director	30 - 35	0	2	50 - 55	0	1
Peter Wilson[7]	Non-Executive Director	10 - 15	0	0			
Sir John Ashworth	Non-Executive Director	10 - 15	0	0	10 - 15	0	0
Mike Baker[8]	Director of Finance	100 - 105	0	0	10 - 15	0	3
Professor Christine Temple	Non-Executive Director	10 - 15	0	0	5 - 10	0	0
Anna Bradley	Non-Executive Director	10 - 15	0	0	0 - 5	0	0
Helen Parr	Non-Executive Director	10 - 15	0	0	10 - 15	0	0

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

1. Andrew Armour left the Trust as Interim Director of Finance on 30 June. The amount disclosed represents payments in 2011/12 (including VAT) to Andrew Armour Limited for his services.
2. Rob Bowman took on additional duties at Company Secretary on 1 May.
3. Dr Sean MacDonnell took up the role of Medical Director on 31 October. His time is split between the medical director role (5 PA's) and his clinical role (7 PA's).
4. Left 30 April.
5. Started 13 September.
6. Left 31 October.
7. Started 1 May.
8. Mike Baker left the role as a Non-Executive Director on 2 June and took up the role as Director of Finance on 3 June.

Pension benefits (audited)

B) Pension Benefits

Name	Title	Real increase in pension at age 60* (bands of £2,500)	Lump sum at age 60 related to real increase in pension* (bands of £2,500)	Total accrued pension at 31 March 2012* (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012* (bands of £5,000)	Cash equivalent transfer value at 31 March 2012*	Cash equivalent transfer value at 31 March 2011*	Real increase in cash equivalent transfer value*
		£000	£000	£000	£000	£000	£000	£000
Sue Barnett	Director of Operations/ Deputy Chief Executive	(5 – 7.5)	(20 - 22.5)	45 - 50	140 - 145	877	900	(51)
Rob Bowman	Director of Workforce/Company Secretary	(0 - 2.5)	(0 - 2.5)	25 - 30	85 - 90	466	397	57
Dr Gordon Coutts	Chief Executive	0 - 2.5	(0 - 2.5)	0 - 5	0 - 5	72	44	26
Julie Firth	Director of Nursing and Patient Experience	0 - 2.5	0 - 2.5	35 - 40	115 - 120	727	638	70
Dr Sean MacDonnell	Medical Director	2.5 - 5	7.5 - 10	40 - 45	120 - 125	685	547	121

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

Non-executive directors do not receive pensionable remuneration and therefore there are no entries in respect of pensions for such directors.

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

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement). In the budget on 23 March 2011, HM Treasury confirmed its intention to review the basis for the calculation of CETVs payable from public service schemes, including the NHS Pension Scheme. The review was undertaken and revised guidance was issued on 26 October 2011. For the calculation of CETVs as at 31 March 2012, NHS Pensions have followed the revised guidance and have used the updated Government Actuary Department (GAD) factors in their calculations. The revised GAD factors are different to those used as at 31 March 2011, so direct comparison between financial periods is not possible. The new factors will have differing impacts of the CETVs of the individuals concerned depending on their age and normal retirement age.

Accounting policy for pensions can be found in note 4.1 of the accounts.

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

Appendix 1 Sustainability Reporting Data

What is your Trust identification code? RDE

What is your Trust name? Colchester Hospital University NHS Foundation Trust

What was your total expenditure on energy in each of the last three financial years?

	2007/08	2008/09	2009/10	2010/11	2011/12	% Reduction	£ Reduction	Hip Operations
Energy Cost £	1,234,116	2,136,999	£1,668,156	1,757,760	1,931,053	-10	173,293	31
				10%			173293	

What is the NPV of the savings expected as as a result of your plans to change your organisation to make it more sustainable. What length of time does this assessment cover?

		Nurses
NPV		0
Time period		

What weight of the waste you generate is recycled, and what does this represent as a proportion of total waste?

	2011/12	Proportion	Percentage
Total Waste	1327.3		
Recycled waste	583.6	0.44	44

What was your total consumption of energy in each of the last three years (MWh), what was your floor area (in order to calculate energy intensity), what proportion of your energy comes form renewable sources and how much of your energy is generated on site?

	2007/08		2008/09		2009/10		2010/11		2011/12		
Oil	13358.9		6,365		803.5		208.2		268.23		
Gas	10899.1		18661.8		25422.7		29268.7		24912.67		
Coal											
Renewables											**0**
Other											
Electricity	11004.9		11271.3		11854.3		12844.7		12928.9		Risen/Fallen
TOTAL		**35262.9**		**36298.3**		**38080.5**		**42321.6**		**38109.8**	fallen

	2010/11	2011/12
Floor Area (m2)	71,630	77,230
	0.59	0.49

Proportion of Energy Generated on site: 0 — We do not generate any energy.

Is the tariff which you pay for electricity a "green" or "renewable" tariff?

Yes

Appendix 1 Sustainability Reporting Data

What was your Operating Expenditure (per the financial statements) in the last 2 financial years?

2010/11	2011/12
224,300,000	228,788,000

Energy as a proportion of costs

2010/11	2011/12
0.74	0.77

212.3

What were your gross scope 1-3 carbon emissions over the last 3 years, and how were they constituted?

		2007/08	2008/09	2009/10	2010/11	2011/12	INCLUSION
Emissions as a result of Electricity Consumption	Electricity	5766.6	5906.2	6211.6	6730.6	6774.7	44.1
Emissions as a result of Gas Consumption	Gas	2910	4982	6787.9	5356.2	4559	-797.2
Emissions as a result of Business Travel - Air	Air						0
Emissions as a result of Business Travel - Road	Road				21.6	23.7	2.1
Emissions as a result of Business Travel - Rail	Rail				3	3.3	0.3
Emissions as a result of Other activities	Other						0

All CO2e tonnes

Change in Emissions -750.7 reduced 750.7

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

If you gather data on your Other (Scope 3) emissions, please enter details as to what this assessment includes in the form of the sentence

"Our Other emissions value includes healthcare purchased from non NHS organisations, emissions arising from water and waste use, purchased pharaceuticals and medical instruments, staff, patient and visitor travel."

Appendix 1 Sustainability Reporting Data

What was your water consumption in m3 in the last 4 financial years?

	2007/08	2008/09	2009/10	2010/11	2011/12	Gross reduction		
Water consumption	112,700	111361	118839	112479	114262	1783	increased	1783

What was your total expenditure on water in the last financial year? £229,510

What was your gross expenditure on the CRC Energy Efficiency Scheme in 2011/12? £136,004 Complete

What was your expenditure on official business travel in 2011/12? £475,250 Complete

What was your expenditure on waste disposal in the following categories:

	2010/11	2011/12
Total Waste arising	£266,308	£338,071
Waste sent to landfill	£20,655	£15,529
Waste recycled/reused	£48,188	£36,243
Waste incinerated/energy from waste	£197,465	£286,299

If you have consumed finite resources, and in in doing so incurred material expenditure, then please complete the following boxes

Expenditure	
Nature of resource	

			Yes/No	
Has your Board approved a Sustainable Development Management Plan in the last 12 months?			No	1
Has your board approved plans which address the potential need to adapt the organisation's activities (models of care) as a result of climate change?			No	2
Has your board approved plans which address the potential need to adapt the organisation's buildings or estates as a result of climate change?			No	3
Does your board consider sustainability issues as part of its risk management process?			Yes	4
Have you developed policies on sustainable procurement?			No	5
Have you begun to calculate carbon emissions related to procurement of goods and services?			No	
Is there a Board Level lead for Sustainability on your Board?			Yes	6
			Anna Bradley	
Are sustainability issues, such as carbon reduction, included in the job descriptions of all staff?			No	7
When was your last staff energy awareness campaign?	28th	March	2012	8
			Yes	
			Yes	9
Do you have a Sustainable Transport Plan?			Yes	

If you have used estimation, please indicate what quarters this estimation applies to:

Q1	
Q2	
Q3	
Q4	

Section B

Annual Accounts 2011/12

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS OF COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST

I have audited the financial statements of Colchester Hospital University NHS Foundation Trust for the year ended 31 March 2012 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is described as having been audited.

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

Respective responsibilities of the Accounting Officer and auditor

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

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Colchester Hospital University NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and

- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and

- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I report to you if, in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

Certificate

I certify that I have completed the audit of the accounts of Colchester Hospital University NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Rob Murray
Officer of the Audit Commission

25th May 2012

Audit Commission, 3rd Floor, Eastbrook, Shaftesbury Road, Cambridge, CB2 8BF

FOREWORD TO THE ACCOUNTS

Colchester Hospital University NHS Foundation Trust

These accounts for the year ended 31 March 2012 have been prepared by the Colchester Hospital University NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Dr. Gordon Coutts, Chief Executive  24th May 2012

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2012

	Note		2011/12 £000		2010/11 £000 (Restated)
Operating Income	2		245,496		225,123
Operating Expense	3		(228,927)		(224,307)
Operating Surplus			**16,569**		**816**
Finance Costs					
Finance income	6	105		102	
Finance expense - financial liabilities	6.1	(136)		(126)	
Finance expense - unwinding of discount on provisions		(36)		(30)	
PDC Dividends payable		(4,192)		(3,620)	
Net Finance Costs			**(4,259)**		**(3,674)**
Surplus/(Deficit) from continuing operations			**12,310**		**(2,858)**
SURPLUS/(DEFICIT) FOR THE YEAR			**12,310**		**(2,858)**
Other Comprehensive Income:					
Revaluation gains/(losses) and impairment losses property, plant and equipment			6,960		(546)
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR			**19,270**		**(3,404)**

The notes on pages 7 to 40 form part of these accounts.
All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2012

	Note	31 March 2012 £000	31 March 2011 £000 (Restated)	1 April 2010 £000 (Restated)
NON-CURRENT ASSETS				
Intangible assets	7	4,736	2,485	2,106
Property, plant and equipment	8	141,015	132,274	124,732
Trade and other receivables	11	0	0	166
Total Non-Current Assets		**145,751**	**134,759**	**127,004**
CURRENT ASSETS				
Inventories	10	5,167	5,262	5,635
Trade and other receivables	11	8,698	6,891	7,303
Cash and cash equivalents	18	28,629	21,948	44,563
Total Current Assets		**42,494**	**34,101**	**57,501**
CURRENT LIABILITIES				
Trade and other payables	12	(24,609)	(21,820)	(22,267)
Borrowings	15	(135)	(139)	(14,513)
Provisions	17	(324)	(492)	(471)
Other liabilities	13	(590)	(2,438)	(475)
Total Current Liabilities		**(25,658)**	**(24,889)**	**(37,726)**
Total Assets less Current Liabilities		**162,587**	**143,971**	**146,779**
NON-CURRENT LIABILITIES				
Borrowings	15	(1,641)	(1,776)	(823)
Provisions	17	(1,152)	(1,200)	(1,375)
Other liabilities	13	(4,234)	(4,703)	(4,885)
Total Non-Current Liabilities		**(7,027)**	**(7,679)**	**(7,083)**
TOTAL ASSETS EMPLOYED		**155,560**	**136,292**	**139,696**
TAXPAYERS' EQUITY				
Public Dividend Capital		76,193	76,193	76,193
Revaluation Reserve		43,391	36,564	37,141
Other Reserves		754	754	754
Income and Expenditure Reserve		35,222	22,781	25,608
TOTAL TAXPAYER'S EQUITY		**155,560**	**136,292**	**139,696**

The financial statements on pages 2 to 40 were approved by the Board and signed by:

Dr. Gordon Coutts, Chief Executive  24th May 2012

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2012

	2011/12	2010/11
	£000	£000
		(Restated)
Cash flows from operating activities		
Operating surplus from continuing operations	16,569	816
Operating surplus	**16,569**	**816**
Non-cash income and expense:		
Depreciation and amortisation	7,890	7,167
Impairments	223	4,858
Reversal of Impairments	(1,441)	0
(Increase)/Decrease in Trade and Other Receivables	(1,807)	578
(Increase)/Decrease in Inventories	95	373
Increase/(Decrease) in Trade and Other Payables	2,789	(447)
Increase/(Decrease) in Other Liabilities	(2,317)	1,781
Decrease in Provisions	(216)	(154)
Other movements in operating cash flows	(128)	(27)
NET CASH GENERATED FROM OPERATIONS	**21,657**	**14,945**
Cash flows from investing activities		
Interest received	108	102
Purchase of intangible assets	(2,724)	(824)
Purchase of Property, Plant and Equipment	(7,977)	(18,648)
Sales of Property, Plant and Equipment	2	5
Net cash generated from/(used in) investing activities	**(10,591)**	**(19,365)**
Cash flows from financing activities		
Loans repaid	0	(14,400)
Capital element of finance lease rental payments	(139)	(114)
Interest element of finance lease	(134)	(119)
PDC Dividend paid	(4,112)	(3,562)
Net cash generated from/(used in) financing activities	**(4,385)**	**(18,195)**
Increase/(decrease) in cash and cash equivalents	**6,681**	**(22,615)**
Cash and Cash equivalents at 1 April	**21,948**	**44,563**
Cash and Cash equivalents at 31 March	**28,629**	**21,948**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 March 2012

	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Other Reserves	Income and Expenditure Reserve
	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	**139,696**	**76,193**	**36,938**	**853**	**754**	**24,958**
Prior period adjustment	0	0	203	(853)	0	650
Taxpayers' Equity at 1 April 2010 (Restated)	**139,696**	**76,193**	**37,141**	**0**	**754**	**25,608**
Deficit for the year	**(2,858)**	0	0		0	(2,858)
Revaluation gains and impairment losses property, plant and equipment	**(546)**	0	(546)		0	0
Transfers to the income and expenditure account in respect of assets disposed of	**0**	0	(31)		0	31
Taxpayers' Equity at 31 March 2011 (Restated)	**136,292**	**76,193**	**36,564**		**754**	**22,781**
Surplus for the year	**12,310**	0	0		0	12,310
Revaluation gains and impairment losses property, plant and equipment	**6,960**	0	6,960		0	0
Transfers to the income and expenditure account in respect of assets disposed of	**0**	0	(131)		0	131
Other Reserve Movements	**(2)**	0	(2)		0	0
Taxpayers' Equity at 31 March 2012	**155,560**	**76,193**	**43,391**		**754**	**35,222**

Public Dividend Capital

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

Revaluation Reserve

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

Other Reserves

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

Income and Expenditure Reserve

The income and expenditure reserve is the cumulative surplus made by the Trust since it's inception. It is held in perpetuity and cannot be released to the statement of comprehensive income and expenditure.

Donated Asset Reserve

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010/11 results have been restated.

	Revaluation Reserve £000	Donated Assets Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2010	**36,938**	**853**	**24,958**
Adjustment for change in donated asset accounting policy:	203	(853)	650
Taxpayers' Equity at 1 April 2010 (Restated)	**37,141**	**0**	**25,608**

	£000
Deficit for 2010/11 under previous donated asset policy	(2,670)
Adjustments for donated asset policy changes:	
Transfer from donated asset reserve in respect of depreciation on donated assets	(203)
Impairments previously recognised against donated asset reserve	(7)
Income in respect of donated assets previously recognised in donated asset reserve	22
Deficit for 2010/11 under revised donated asset policy	**(2,858)**

	£000
Surplus for 2011/12 under revised donated asset policy	12,310
Adjustments for donated asset policy changes:	
Income that would have been recorded as a transfer from donated asset reserve in respect of depreciation on donated assets	212
Loss on disposal of donated asset that would previously have been offset by a transfer from the donated asset reserve	18
Income recognised in other operating income that would previously have been recognised in donated asset reserve	(86)
Surplus for 2011/12 under previous donated asset policy	**12,454**

NOTES TO THE ACCOUNTS

1. Accounting Policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. Where the NHS Foundation Trust Annual Reporting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular accounting policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.1 Accounting Convention

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

1.2 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

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

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

1.3 Consolidation

Subsidiaries

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

The Trust has no subsidiaries. In accordance with the directed accounting policy from Monitor, the Trust will not consolidate the NHS charitable funds for which it is a corporate trustee until 31 March 2013.

1.4 Income

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

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

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

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

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

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

1.5 Expenditure on Employee Benefits

Short-term Employee Benefits

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

Pension Costs

NHS Pension Scheme

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

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

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

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

1.6 Expenditure on Other Goods and Services

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

1.7 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

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

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

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

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

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

Measurement

Valuation

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

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

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

A full revaluation of land and buildings was undertaken as at 31 March 2012.

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

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

Subsequent expenditure

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

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

Depreciation

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

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

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

Medical Equipment and Engineering Plant and Equipment	5 to 15 years
Furniture & Fittings	10 years
Mainframe Information Technology Installations	8 years
Soft Furnishings	7 years
Office and Information Technology Equipment	5 years
Software	5 years
Set-up Costs in New Buildings	10 years

Revaluation gains and losses

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

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

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

Impairments

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

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

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

De-recognition

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

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

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

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

Donated, Government Grant and Other Grant Funded Assets

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

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

Private Finance Initiative (PFI) Transactions

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

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

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

1.8 Intangible Assets

Recognition

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

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Measurement

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

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

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

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

Amortisation

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

1.9 Inventories

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

1.10 Financial Instruments and Financial Liabilities

Financial Assets

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

Financial assets are initially recognised at fair value.

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

Classification and Measurement

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

Loans and Receivables

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

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

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

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

Financial Liabilities

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

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

Other Financial Liabilities

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

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

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

Impairment of Financial Assets

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

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

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

1.11 Leases

Finance Leases

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

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

Operating Leases

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

Leases of Land and Buildings

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

1.12 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% (2010/11, 2.9%).

Clinical Negligence Costs

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

Non-clinical Risk Pooling

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

1.13 Contingencies

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

1.14 Public Dividend Capital

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

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

1.15 Value Added Tax

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

1.16 Corporation Tax

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

1.17 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

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

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

1.18 Cash at Bank, Overdrafts and Cash Equivalents

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

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

1.19 Segmental Analysis

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

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

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

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

There is one major income stream for the Trust's activities: local PCT funding for healthcare provision. This comprises 98% of the Trust's total income from activities, and 90% of its total operating income. Only two customers of the Trust make up more than 10% of the Trust's income from activities. These are NHS North East Essex (82%, £184,807k) and NHS Mid Essex (11%, £24,705k).

Revenues from countries outside of England are small (£35k received from Welsh Commissioners). The Trust received £24.5k in relation to overseas visitors.

		2011/12 £000		2010/11 £000 (Restated)
Income		**244,055**		**225,123**
Expenditure				
Pay	**(145,460)**		**(137,816)**	
Non-pay	**(75,354)**		**(74,459)**	
Total Expenditure		**(220,814)**		**(212,275)**
EBITDA*		**23,241**		**12,848**
Depreciation, PDC dividend, etc.		**(12,149)**		**(10,841)**
Surplus before non-current asset impairments		**11,092**		**2,007**
Non-current asset impairments		1,218		(4,865)
Surplus/(Deficit) after non-current asset impairments		**12,310**		**(2,858)**

* EBITDA as per Monitor's *Compliance Framework 2011/12* is Earnings Before Interest, Taxation, Depreciation, and Amortisation, but also excludes non-current asset impairments.

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

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

IFRS 7 Financial Instruments: Disclosures - amendment. Transfers of financial assets.

IFRS 9 Financial Instruments. Financial assets. Financial Liabilities.

IFRS 10 Consolidated Financial Statements

IFRS 11 Joint Arrangements

IFRS 12 Disclosures of Interests in Other Entities

IFRS 13 Fair Value Measurement

IAS 12 Income Taxes amendment.

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

IAS 27 Separate Financial Statements

IAS 28 Associates and Joint Ventures

1.21 Accounting Standards Issued that have been Adopted Early

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

2. Operating Income

2.1 Operating Income (by classification)

	2011/12 £000	2010/11 £000
2.1.1 Income from Activities		
Elective Income	**41,793**	**42,490**
Non Elective Income	**71,244**	**67,824**
Outpatient Income	**45,241**	**41,529**
A&E Income	**7,630**	**6,870**
Other Activity Income	**58,128**	**47,258**
Private Patient Income	**886**	**919**
Other Non-protected Clinical Income	**1,269**	**1,436**
Total Income from Activities	**226,191**	**208,326**

2.1.2 Mandatory Services

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

	2011/12 £000	2010/11 £000
Mandatory services	**167,177**	**160,149**
Non-mandatory services	**59,014**	**48,177**
	226,191	**208,326**

2.1.3 Other Operating Income

	2011/12 £000	2010/11 £000 (Restated)
Research and development	**1,119**	**999**
Education and training	**6,477**	**6,689**
Charitable and other contributions to expenditure	**333**	**199**
Non-patient care services to other bodies	**3,720**	**3,644**
Reversal of impairments of property, plant and equipment	**1,441**	**0**
Car parking	**865**	**801**
Staff recharges	**1,545**	**1,495**
Drug sales	**1,346**	**1,816**
Clinical Excellence Awards	**150**	**277**
Other	**1,908**	**621**
Rental revenue from operating leases	**75**	**74**
Amortisation of PFI deferred credits	**326**	**182**
Total Other Operating Income	**19,305**	**16,797**

2.1.4 Total Operating Income

	2011/12 £000	2010/11 £000 (Restated)
Income from Activities	**226,191**	**208,326**
Other Operating Income	**19,305**	**16,797**
TOTAL OPERATING INCOME	**245,496**	**225,123**

2.2 Private Patient Income

	2011/12 £000	2010/11 £000
Private patient income	**886**	**919**
Total patient related income	**226,191**	**208,326**
Proportion (as percentage)	**0.39%**	**0.44%**

Section 44 of the National Health Service Act 2006 states that the proportion of total income of the Trust in any financial year derived from private patient income (the "Private Patient Cap") should not exceed that same percentage whilst the Trust was an NHS Trust in 2002/03, i.e.1.1%. The Trust's Private Patient Cap is set out in the Trust's Terms of Authorisation. The Trust has met this requirement.

2.3 Operating Lease Income

	2011/12 £000	2010/11 £000
Rents recognised as income in the period	**75**	**74**
Total	**75**	**74**

Future Minimum Lease Payments Due

-not later than 1 year	**39**	**72**
-later than 1 year and not later than 5 years	**50**	**75**
-later than 5 years	**56**	**69**
Total	**145**	**216**

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

2.4 Income from Activities (by type)

	2011/12 £000	2010/11 £000
Primary Care Trusts	**224,036**	**205,971**
Local Authorities	**6**	**402**
Private patients	**886**	**919**
Overseas patients (non-reciprocal)	**25**	**34**
Injury Cost Recovery*	**1,142**	**766**
Ministry of Defence	**0**	**77**
Non NHS: Other	**96**	**157**
	226,191	**208,326**

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

3. Operating Expenses

3.1 Operating Expenses (by type)

	2011/12 £000	2010/11 £000 (Restated)
Purchase of healthcare from non-NHS bodies	3,360	4,346
Executive Directors' costs	964	788
Non-Executive Directors' costs	114	113
Staff costs	144,382	136,915
Drug costs	18,063	17,239
Supplies and services - clinical	25,004	22,404
Supplies and services - general	6,613	8,585
Establishment	2,401	2,202
Research and development	7	2
Transport	1,807	2,510
Premises	9,298	9,709
Increase in bad debt provision	129	13
Increase in other provisions	84	0
Inventories write down	550	0
Depreciation	7,890	7,167
Fixed asset impairments	223	4,865
Audit fees in respect of the statutory audit	74	73
Clinical negligence	4,597	3,878
Loss on disposal of other property, plant and equipment	81	74
Legal fees	90	49
Consultancy costs	765	844
Training, courses & conferences	734	734
Patient travel	40	28
Car parking & security	35	70
Redundancy	43	0
Insurance	263	92
Other services, e.g. external payroll	613	1,152
Losses, ex gratia & Special Payments	39	16
Other	664	439
Total	**228,927**	**224,307**

3.2 Arrangements Containing an Operating Lease

	2011/12 £000	2010/11 £000
Minimum Lease Payments	2,257	2,049
Less Sublease Payments Received	(26)	(67)
Total	**2,231**	**1,982**

Future Minimum Lease Payments Due

-not later than 1 year	877	926
-later than 1 year and not later than 5 years	368	449
Total	**1,245**	**1,375**
Total of future minimum sublease lease payments to be received as at 31 March 2012.	0	0

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

3.3 Limitation on Auditor's Liability

There is no limitation on auditor's liability in 2011/12.

4. Staff Costs and Numbers

4.1 Employee Expenses

	2011/12 £000	2010/11 £000
Salaries and wages	**115,156**	**107,870**
Social Security costs	**8,844**	**8,193**
Employer contributions to NHS Pension Scheme*	**13,147**	**12,564**
Termination benefits	**43**	**0**
Agency/Contract Staff	**8,199**	**9,076**
Total	**145,389**	**137,703**

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

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

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

b) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions

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

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

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

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

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

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

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

4.2 Exit Packages Agreed During 2011/12

	2011/12		2010/11	
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of compulsory redundancies**	**Cost of compulsory redundancies**
Less than £10,000	1	7	2	0
£10,001 - £25,000	0	0	0	0
£25,001 - £50,000	1	36	0	0
£50,001 - £100,000	0	0	0	0
£100,001 £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,001	0	0	0	0
Total	**2**	**43**	**2**	**0**

4.3 Key Management Compensation

The key management of the Trust are the executive and non-executive directors. The compensation paid or payable to key management for employee services is shown below:

	2011/12 £000	2010/11 £000
Salaries and other short-term employee benefits	897	845
Employer contributions to NHS Pension Scheme	52	54
Total	949	899

4.4 Average Number of Employees (WTE basis)

	2011/12 Total Number	2010/11 Total Number
Medical and dental	434	415
Administration and estates	666	648
Healthcare assistants and other support staff	591	414
Nursing, midwifery and health visiting staff	1,044	1,036
Scientific, therapeutic and technical staff	604	607
Bank and agency Staff	131	161
Other	4	6
Total	3,474	3,287

4.5 Staff Benefits in Kind

	2011/12 £000	2010/11 £000
Subsidised travel permits	33	41
Total	33	41

4.6 Retirements Due to Ill-health

During 2011/12 there were four early retirements from the Trust on the grounds of ill-health (two in 2010/11). The estimated additional pension liabilities of these ill-health retirements is £105,149 (2010/11, £88,265). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

5. Better Payment Practice Code

5.1 Better Payment Practice Code - Measure of Compliance

	2011/12		2010/11	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	**66,649**	**81,988**	**58,512**	**97,145**
Total non-NHS trade invoices paid within target	**54,903**	**66,484**	**48,553**	**79,081**
Percentage of non-NHS trade invoices paid within target	**82%**	**81%**	**83%**	**81%**
Total NHS trade invoices paid in the year	**1,732**	**18,706**	**1,874**	**18,683**
Total NHS trade invoices paid within target	**1,373**	**15,774**	**1,526**	**16,763**
Percentage of NHS trade invoices paid within target	**79%**	**84%**	**81%**	**90%**

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

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

	2011/12 £000	2010/11 £000
Amounts included within interest payable (note 6.1) arising from claims made under this legislation	**2**	**0**
Total	**2**	**0**

6. Finance Income

	2011/12 £000	2010/11 £000
Interest income on short-term bank deposits	**105**	**102**
	105	**102**

6.1 Finance Costs - Interest Expense

	2011/12 £000	2010/11 £000
Finance Leases	**134**	**119**
Other	**2**	**7**
	136	**126**

7. Intangible Fixed Assets

	Software Licences £000	Assets Under Construction £000	Total £000
Gross cost at 1 April 2010	1,821	1,149	2,970
Transfers from assets under construction	710	(710)	0
Additions purchased	0	824	824
Gross cost at 31 March 2011	**2,531**	**1,263**	**3,794**
Amortisation at 1 April 2010	864	0	864
Charged during the year	334	0	334
Impairments	111	0	111
Amortisation at 31 March 2011	**1,309**	**0**	**1,309**
Net book value			
- Purchased at 31 March 2011	1,214	1,263	2,477
- Donated at 31 March 2011	8	0	8
- Total at 31 March 2011	**1,222**	**1,263**	**2,485**
Gross cost at 1 April 2011	2,531	1,263	3,794
Transfers from assets under construction	1,318	(1,318)	0
Additions purchased	0	2,724	2,724
Disposals	(266)	0	(266)
Gross cost at 31 March 2012	**3,583**	**2,669**	**6,252**
Amortisation at 1 April 2011	1,309	0	1,309
Charged during the year	473	0	473
Disposals	(266)	0	(266)
Amortisation at 31 March 2012	**1,516**	**0**	**1,516**
Net book value			
- Purchased at 31 March 2012	2,064	2,669	4,733
- Donated at 31 March 2012	3	0	3
- Total at 31 March 2012	**2,067**	**2,669**	**4,736**

8. Property, Plant and Equipment

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

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	28,555	87,325	5,987	30,411	9,720	148	162,146
Additions purchased	0	1,084	17,431	1,217	0	0	19,732
Additions donated	0	7	0	15	0	0	22
Impairments charged to reserves	0	(553)	0	0	0	0	(553)
Impairments charged to operating costs	7	0	0	0	0	0	7
Transfers from assets under construction	0	19,346	(21,447)	632	1,355	114	0
Disposals	0	0	0	(503)	(132)	0	(635)
Cost or Valuation at 31 March 2011	**28,562**	**107,209**	**1,971**	**31,772**	**10,943**	**262**	**180,719**
Depreciation and impairments at 1 April 2010	140	11,684	0	18,618	6,903	69	37,414
Provided during the year	0	3,048	0	2,799	967	19	6,833
Impairments charged to operating costs	7	4,720	27	0	0	0	4,754
Revaluation surpluses	0	0	0	0	0	0	0
Disposals	0	0	0	(441)	(115)	0	(556)
Depreciation and Impairments at 31 March 2011	**147**	**19,452**	**27**	**20,976**	**7,755**	**88**	**48,445**
Net Book Value							
Owned at 31 March 2011	28,415	80,717	1,944	10,075	3,166	173	124,490
Finance Lease at 31 March 2011	0	1,604	0	125	0	0	1,729
On-balance-sheet service concession contracts	0	5,398	0	0	0	0	5,398
Donated at 31 March 2011	0	38	0	596	22	1	657
Total at 31 March 2011	**28,415**	**87,757**	**1,944**	**10,796**	**3,188**	**174**	**132,274**

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

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

Of the totals at 31 March 2012, no land or buildings were valued at open market value.

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

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

8.2 Analysis of Property, Plant and Equipment

	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant and machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net Book Value							
Protected Assets at 31 March 2011	28,415	87,757	0	0	0	0	116,172
Unprotected Assets at 31 March 2011	0	0	1,944	10,796	3,188	174	16,102
Total at 31 March 2011	**28,415**	**87,757**	**1,944**	**10,796**	**3,188**	**174**	**132,274**
Net Book Value							
Protected Assets at 31 March 2012	28,415	94,885	0	0	0	0	123,300
Unprotected Assets at 31 March 2012	0	0	4,686	10,138	2,711	180	17,715
Total at 31 March 2012	**28,415**	**94,885**	**4,686**	**10,138**	**2,711**	**180**	**141,015**

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

	2011/12 £000	2010/11 £000 (Restated)
Buildings	32	16
Plant & Machinery	122	120
Total	154	136

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

	31 March 2012 £000	31 March 2011 £000 (Restated)
Buildings	1,654	1,603
Plant & Machinery	3	125
Total	1,657	1,728

9.3 The Net Book Value of Land and Buildings:

	31 March 2012 £000	31 March 2011 £000
Freehold	121,646	116,172
Total	121,646	116,172

9.4 Impairment of Assets

	2011/12 £000	2010/11 £000
Changes in market price*	(1,198)	5,273
Abandonment of assets in course of construction	0	138
Total	**(1,198)**	**5,411**

In 2011/12 a full revaluation of the Trust's land and buildings was undertaken by the District Valuer Service, having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 8th Edition. The revaluation was undertaken because of continued volatility in land and building values caused by the unstable economic climate.

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

* In 2010/11 the Trust completed the construction of a new ward block. Following professional valuation by the District Valuer, an impairment of £4,095k was recognised upon bringing the asset into use.

10. Inventories

10.1 Inventories

	31 March 2012 £000	31 March 2011 £000	1 April 2010 £000
Drugs	2,101	2,006	1,890
Consumables	2,660	2,988	3,526
Energy	74	61	39
Other	332	207	180
Total	5,167	5,262	5,635

10.2 Inventories Recognised in Expenses

	2011/12 £000	2010/11 £000
Inventories recognised in expenses	31,675	28,101
Write-down of inventories recognised as an expense	550	80
Total	32,225	28,181

11. Receivables

11.1 Trade Receivables and Other Receivables

	Total 31 March 2012 £000	Financial Assets 31 March 2012 £000	Non Financial Assets 31 March 2012 £000	Total 31 March 2011 £000 (Restated)	Financial Assets 31 March 2011 £000 (Restated)	Non Financial Assets 31 March 2011 £000 (Restated)	Total 1 April 2010 £000 (Restated)	Financial Assets 1 April 2010 £000 (Restated)	Non Financial Assets 1 April 2010 £000 (Restated)
Current Trade and Other Receivables									
NHS Receivables	**1,702**	1,702	0	**1,637**	1,637	0	**2,391**	2,391	0
Other Receivables with Related Parties	**82**	82	0	**811**	304	507	**730**	0	730
Provision for Impaired Receivables	**(463)**	(275)	(188)	**(373)**	(139)	(234)	**(375)**	(375)	0
Prepayments	**1,228**	0	1,228	**967**	0	967	**744**	0	744
Accrued Income	**4,667**	2,557	2,110	**2,621**	784	1,837	**1,782**	125	1,657
PDC Receivable	**0**	0	0	**0**	0	0	**51**	0	51
Operating Lease Receivables	**4**	4	0	**0**	0	0	**0**	0	0
Other Receivables	**1,478**	1,478	0	**1,228**	1,228	0	**1,980**	1,934	46
Sub Total	**8,698**	**5,548**	**3,150**	**6,891**	**3,814**	**3,077**	**7,303**	**4,075**	**3,228**
Non Current Trade and Other Receivables									
NHS Receivables	**0**	0	0	**0**	0	0	**166**	166	0
Sub Total	**0**	**0**	**0**	**0**	**0**	**0**	**166**	**166**	**0**
Total	**8,698**	**5,548**	**3,150**	**6,891**	**3,814**	**3,077**	**7,469**	**4,241**	**3,228**

11.2 Provision for Impairment of Receivables

	Total 31 March 2012 £000	Total 31 March 2011 £000	Total 1 April 2010 £000
At 1 April	**373**	**375**	**328**
Increase in provision	**258**	**88**	**66**
Amounts utilised	**(39)**	**(15)**	**0**
Unused amounts reversed	**(129)**	**(75)**	**(19)**
At 31 March	**463**	**373**	**375**

11.3 Analysis of Impaired Receivables

	Total 31 March 2012 £000	Total 31 March 2011 £000	Total 1 April 2010 £000
Aging of Impaired Receivables			
Up to 1 month	34	22	0
In 1 to 2 months	19	0	0
In 2 to 3 months	30	3	0
In 3 to 6 months	59	8	8
Over 6 months	121	97	129
Total	**263**	**130**	**137**
Aging of Non-impaired Receivables Past their Due Date			
Up to 1 month	2,024	2,830	2,090
In 1 to 2 months	240	246	246
In 2 to 3 months	101	342	455
In 3 to 6 months	373	309	283
Over 6 months	356	(29)	952
Total	**3,094**	**3,698**	**4,026**

12. Trade and Other Payables

12.1 Trade and Other Payables comprise the following:

	Total 31 March 2012 £000	Financial Liabilities 31 March 2012 £000	Non Financial Liabilities 31 March 2012 £000	Total 31 March 2011 £000 (Restated)	Financial Liabilities 31 March 2011 £000 (Restated)	Non Financial Liabilities 31 March 2011 £000 (Restated)	Total 1 April 2010 £000 (Restated)	Financial Liabilities 1 April 2010 £000 (Restated)	Non Financial Liabilities 1 April 2010 £000 (Restated)
Current Trade and Other Payables									
Receipts in advance	**5**	0	5	**5**	0	5	**6**	0	6
NHS payables	**717**	717	0	**3,628**	3,628	0	**2,804**	2,804	0
Amounts due to other related parties	**4,962**	198	4,764	**4,779**	355	4,424	**3,826**	107	3,719
Trade payables - capital	**4,975**	4,975	0	**915**	915	0	**4,535**	4,535	0
Other trade payables	**4,286**	4,286	0	**7,581**	7,581	0	**5,138**	5,138	0
VAT Payable	**11**	0	11	**0**	0	0	**0**	0	0
Accruals	**9,566**	9,566	0	**4,905**	4,905	0	**5,958**	5,958	0
PDC payable	**87**	0	87	**7**	0	7	**0**	0	0
Total	**24,609**	**19,742**	**4,867**	**21,820**	**17,384**	**4,436**	**22,267**	**18,542**	**3,725**

13. Other Liabilities

	31 March 2012 £000	31 March 2011 £000	1 April 2010 £000
Current			
Deferred Income	590	2,438	475
Sub Total	**590**	**2,438**	**475**
Non Current			
Deferred Income	4,234	4,703	4,885
Sub Total	**4,234**	**4,703**	**4,885**
Total	**4,824**	**7,141**	**5,360**

14. Finance lease obligations

14.1 Future Finance Lease Obligations

The Trust has future finance lease obligations for which the minimum payments at 31 March 2012 are £2,394 over a 24 year period of commitment (£2,667k over 25 years at 31 March 2011). These leases relate to the Trust's MRI Unit and the Iceni training facility.

14.2 Finance Lease Obligations

	Minimum Lease Payments		Present Value of Minimum Lease Payments	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Gross Lease Liabilities	**2,394**	**2,667**	**1,776**	**1,915**
of which liabilities are due				
not later than 1 year	254	273	135	139
later than 1 year and not later than 5 years	1,015	1,015	759	666
later than 5 years	1,125	1,379	882	1,110
Finance charges allocated to future periods	(618)	(752)	0	0
Net Lease Liabilities	**1,776**	**1,915**	**1,776**	**1,915**

14.3 PFI Obligations

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

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

15. Borrowings

	31 March 2012 £000	31 March 2011 £000	1 April 2010 £000
Current			
Drawdown in committed facility	0	0	14,400
Obligations under finance leases	135	139	113
Total Current Borrowings	**135**	**139**	**14,513**
Non-current			
Obligations under finance leases	1,641	1,776	823
Total Other Non Current Liabilities	**1,641**	**1,776**	**823**

16. Prudential Borrowing Limit

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

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

- the amount of any working capital facility approved by Monitor.

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

The Trust had a Prudential Borrowing Limit of £57.6m in the period ended 31 March 2012, made up as follows:

	31 March 2012 £000	31 March 2011 £000
Maximum cumulative long term borrowing limit set by Monitor	40,800	39,900
Approved working capital facility	16,800	16,750
Prudential Borrowing Limit	**57,600**	**56,650**

Prudential Borrowing Code Ratios	**Limit**	**Actual**
Minimum dividend cover	> 1x	**5.9**
Minimum interest cover	> 3x	**184.8**
Minimum debt service cover	> 2x	**90.7**
Minimum debt service to revenue	< 2.5%	**0.1**

17. Provisions for Liabilities and Charges

	Current 31 March 2012 £000	Current 31 March 2011 £000	Current 1 April 2010 £000	Non-Current 31 March 2012 £000	Non-Current 31 March 2011 £000	Non-Current 1 April 2010 £000
Pensions relating to former directors	2	1	2	16	17	18
Pensions relating to other staff	116	114	115	1,136	1,183	1,357
Other legal claims	124	88	76	0	0	0
Other	82	289	278	0	0	0
Total	**324**	**492**	**471**	**1,152**	**1,200**	**1,375**

		Pensions relating to former directors	Pensions relating to former staff	Legal claims	Other	Total
		£000	£000	£000	£000	£000
At 1 April 2010		20	1,472	76	278	**1,846**
Change in the discount rate		(1)	(65)	0	0	**(66)**
Arising during the year		0	0	83	226	**309**
Utilised during the year		(2)	(113)	(59)	(92)	**(266)**
Reversed unused		0	(26)	(12)	(123)	**(161)**
Unwinding of discount		1	29	0	0	**30**
At 31 March 2011		**18**	**1,297**	**88**	**289**	**1,692**
At 1 April 2011	2010	18	1,297	88	289	**1,692**
Change in the discount rate		0	8	0	0	**8**
Arising during the year		1	39	78	47	**165**
Utilised during the year		(2)	(112)	(30)	(165)	**(309)**
Reversed unused		0	(15)	(12)	(89)	**(116)**
Unwinding of discount		1	35	0	0	**36**
At 31 March 2012	2011	**18**	**1,252**	**124**	**82**	**1,476**
Expected timing of cash flows:						
Within one year		2	116	124	82	**324**
Between one and five years		6	421	0	0	**427**
After five years		10	715	0	0	**725**
		18	**1,252**	**124**	**82**	**1,476**

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

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

£55,537,917 is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the Trust.

18. Notes to the Statement of Cash Flows

18.1. Cash and Cash Equivalents

	At 1 April 2011	Other changes in year	**At 31 March 2012**
	£000	£000	**£000**
Cash with the Government Banking Service	21,780	6,773	**28,553**
Commercial cash at bank and in hand	168	(92)	**76**
	21,948	**6,681**	**28,629**

19. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2012 were £3,587k (£717k 31 March 2011).

20. Events After the Reporting Period

There are no events after the reporting period.

21. Contingencies

	31 March 2012 £000	**31 March 2011 £000**
Contingent liabilities	**(61)**	**(49)**

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

22. Movement in Public Dividend Capital

	£000
Public Dividend Capital as at 1 April 2010	76,193
Public Dividend Capital as at 31 March 2011	**76,193**
Public Dividend Capital as at 1 April 2011	76,193
Public Dividend Capital as at 31 March 2012	**76,193**

23. Related Party Transactions and Balances

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

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

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

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

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

	Income		Expenditure		Payables		Receivables	
	2011/12	2010/11	2011/12	2010/11	2011/12	2010/11	2011/12	2010/11
	£000	£000	£000	£000	£000	£000	£000	£000
Colchester Borough Council	15	12	1,060	735	1	11	0	1
Department of Health	3	(3)	626	9	82	10	26	8
East of England Strategic Health Authority	6,232	6,467	2	9	8	67	71	28
Essex County Council	169	536	700	709	60	195	62	303
HM Revenue & Customs	0	0	8,844	8,193	3,106	2,830	0	507
Mid Essex Hospitals NHS Trust	978	1,040	405	315	127	99	835	340
Mid Essex Primary care Trust	24,787	23,356	(7)	10	0	17	499	880
NHS Blood and Transplant	13	25	1,645	1,535	44	4	0	0
NHS Litigation Authority	0	0	4,722	3,901	1	0	0	5
NHS Pension Scheme	0	0	13,147	12,565	1,669	1,595	0	0
NHS Professionals	0	0	2,030	2,519	232	385	0	0
North East Essex Primary Care Trust	188,691	173,439	1,127	1,415	1,254	4,113	2,248	0
South East Essex Primary Care Trust	6,047	5,473	0	0	0	83	4	0
Suffolk Primary Care Trust	4,265	3,814	0	0	157	0	139	0
West Essex Primary Care Trust	724	611	281	678	417	335	47	0

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

24. Financial Instruments

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

Financial risk management

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

Currency risk

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

Credit risk

Due to the fact that the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2012 is in receivables from customers, as disclosed in the receivables note.

Liquidity risk

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

Interest-rate risk

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

24.1a Financial Assets by Category

	Loans and receivables	
Assets as per Statement of Financial Position	**31 March 2012 £000**	**31 March 2011 £000**
Trade and other receivables	5,548	3,814
Cash at bank and in hand	28,629	21,948
Total	**34,177**	**25,762**

24.1b. Financial Liabilities by Category

	Other financial liabilities	
Liabilities as per Statement of Financial Position	**31 March 2012 £000**	**31 March 2011 £000**
Obligations under finance leases	1,776	1,915
Trade and other payables	19,742	17,384
Provisions under contract	82	289
Total	**21,600**	**19,588**

25. Fair values

As at 31 March 2012 there are no significant differences between fair value and carrying value of any of the Trust's financial instruments.

The fair value for provisions is not significantly different from book value since in the calculation of book value the expected cash flows have been discounted by the Treasury discount rate of 2.8% in real terms.

26. Losses and Special Payments

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

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

There were 216 cases of losses and special payments totalling £681,480 approved during the period.

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

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

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

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

There were 2 cases of property obsolescence where the loss exceeded £100,000 (£229,643 and £263,864 respectively).

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

Section C

Quality Report 2011/12

Colchester Hospital University NHS
NHS Foundation Trust

Quality Report
2011 / 2012

Contents

Part 1: Statement on quality from the Chief Executive

The quality of care delivered to our patients, their safety, experience and the outcomes of our services are of paramount importance to the Board of Directors, Members' Council and all staff.

This is the fourth set of Quality Reports produced by the Trust and I believe they continue to show progress in all of these areas.

Our Quality Report this year reflect on the quality objectives we set for 2011/12 in last year's report, which covered a cross-section of measures of patient safety, experience and outcomes.

Overall, we have made good progress and have built on the improvements of last year. Our hospitals have experienced reductions in the number of cardiac arrests, harm caused by falls and the incidence of pressure ulcers. We have maintained a strong focus on infection control and on providing a clean environment, which has been reflected in our MRSA infection rates. However, the number of cases of hospital-acquired Clostridium difficile exceeded the agreed ceiling by three cases. We will continue our work to reduce this and other hospital-acquired infections.

The measures we initiated last year to improve our Hospital Standardised Mortality Ratio (HSMR) have reduced our HSMR to below 100 (the national average). Improvements to emergency care, combined with changes on the wards, have been instrumental in this reduction. Consultants in our Emergency Department (A&E) now work until midnight, seven days a week and their counterparts in our Emergency Assessment Unit, to which patients are referred by General Practitioners, work until 22:00 hours every day.

We continue to work with our doctors and nurses to focus on reducing avoidable deaths in our hospitals. I have taken, and will continue to take, a personal lead on this and will carry on working with clinical staff to ensure sustained progress.

Looking forward, our Quality Report set objectives for 2012/13. Once again, we have directly aligned the objectives to the CQUIN (Commissioning for Quality and Innovation) goals we have agreed with NHS North East Essex, the local cluster of Primary Care Trusts.

Our Quality Report also reflect on our clinical audit activity, our participation in research and development activities and the integrity of the data we use to manage and plan patient care and the wider operation of the Trust.

The Board of Directors recognises its role in leading on quality, and is concentrating a great deal of its attention on the quality of services and the patient experience. The Board continues to strengthen the infrastructure needed to support the quality agenda. In March 2012, a "Quality Hub" was established, which is a multidisciplinary co-located team of staff who are dedicated to improve the quality of care across a wide range of areas, including clinical audit, patient experience and safety, infection control and risk management. The Clinical Area Assessment Programme (CAAP), which we established last year, brings together clinicians and healthcare professionals with patient experience and safety expertise and executive and non-executive directors of the Board to undertake in-depth assessment of clinical areas and to agree:

- what's good and going well in the area – that can be properly recognised by the Board and that can be developed and transferred to other areas
- what needs attention – and will be monitored and supported as necessary by divisional managers and the executive team.

Since March 2012, these visits are unannounced.

The Quality & Patient Safety Assurance Committee, on behalf of the Board, receives and reviews detailed, quality-related information each quarter about patient safety, patient experience and clinical outcomes.

This Quality Report sets out how we are progressing and where we are focusing our attention to make further improvements.

The complementary themes of patient safety, patient experience and effectiveness of care underpin our quality strategy.

Of course the quality of the care we provide is delivered by the professionalism, dedication and motivation of our staff. The National Staff Satisfaction Survey results for 2011 show that we have made progress.

We have seen a substantial improvement in the national inpatient survey published by the Care Quality Commission (CQC). The survey results show a 13% improvement over last year, which places the Trust in the middle of the East of England performance league table. There is much more to do, but these improvements are encouraging.

I want our Quality Report to develop in a transparent way, recognising not only our success but also areas where we need to work harder or differently to deliver the quality of service and experience our patients deserve.

To the best of my knowledge, the information contained in this document is accurate. I hope you find it gives a valuable insight into the work of the Trust.

Dr Gordon Coutts
Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Board

Priorities for Improvement

In our Quality Report published in June 2011, we reviewed the progress against our 2010 / 2011 objectives and set out new and more challenging objectives for 2011 / 2012, which focused on continuing to improve patient safety and our patients' experience of care. In this section, we assess how we performed against the 2011 / 2012 objectives.

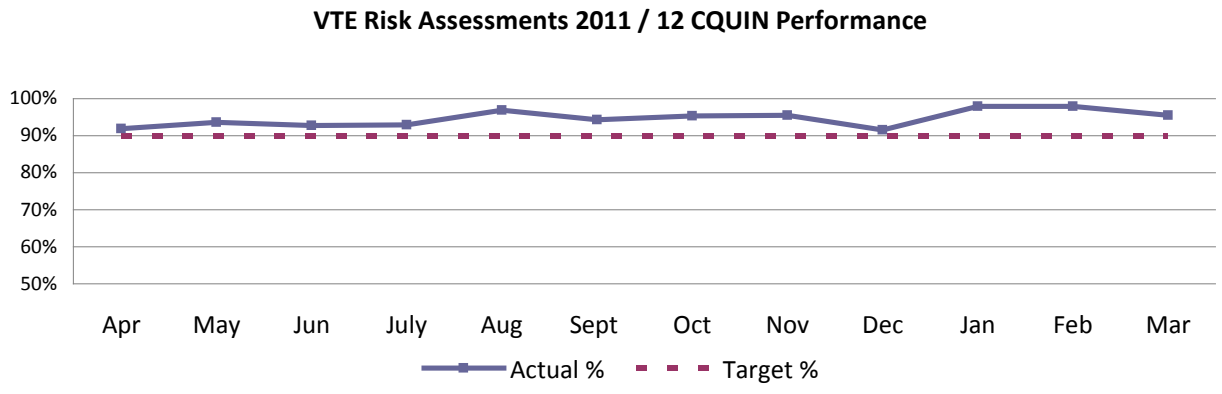
The objectives we set ourselves for 2011/12 concentrated on specific measures of improvement in:

1. VTE
2. Patient Experience
3. Delivering Safety Express Programme
4. Diabetic care – *Think Glucose*
5. Maternity – normal births
6. Intentional rounding
7. Developing an integrated stroke care pathway
8. Reduce admissions relating to alcohol

This section of the Quality Report, focuses on each of these areas and the specific objectives that we have been seeking to deliver. It also includes some details of other quality initiatives the Trust took in 2011/12.

Reviewing our 2011 / 2012 Objectives

Target attainment and commentary on delivery
Objective 1: VTE ❑ we will reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE) ❑ we will measure the percentage of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the agreed national tool



The Trust is on trajectory to achieve its CQUIN target, that 90% of all adult inpatients will have a venous thromboembolism (VTE) risk assessment on admission to hospital using the national tool by the end of Quarter 4 2011/12. Performance for February 2012 was 97.91%.

Completion of these assessments ensures that patients can then be commenced on the appropriate prophylactic treatment. In addition, the VTE project team undertake a root cause analysis investigation in relation to any incidents where despite prophylaxis; patients still develop a deep vein thrombosis or pulmonary embolus. This process assists in wider learning across the organisation and has subsequently led to improvements in the care of patients with anti-embolic stockings.

Target attainment and commentary on delivery

Objective 2: Patient Experience

- we will improve responsiveness to personal needs of patients
- we will involve patients in decisions about treatment and care
- we will ensure that hospital staff are available to talk about worries or concerns
- we will ensure privacy when discussing condition and treatment
- we will inform patient about the side effects of medication
- we will ensure that patients know who to contact if worried about condition after leaving hospital

The above elements of patient experience; are determined by the outcome of the national in patient survey. The Care Quality Commission report, published 24th April 2012 identified a significant improvement in the outcome of the aggregated total for the above questions over the past year: 67.3% in 2011 compared to 59.6% in 2010.

However, much work has progressed concerning the patient experience, through the Trusts 'At Our Best' project.

In April 2011, 'At Our Best', was launched, a long-term project with the aim to address concerns around staff attitude. The objective being, to inspire, develop and support every one of our teams, by listening to their patients' experiences. To do this, the Trust launched a programme called 'In Your Shoes'.

Over one hundred patients and carers attended four sessions, to tell us what it looks like when we are *at our best.* What standards should we set, and what support staff need to maintain this every day. This information enabled the Trust to set three core values, namely - **Caring, Communication and Consistency**.

'At Our Best', is an on-going programme of improvement and the Trust has committed to send all staff on a two and a half hour training session to develop and commit to the agreed values. This is proving very successful, as it enables staff to focus upon their communication skills and what it is really like to be 'in a patients shoes'.

Other actions taken, to ensure our patients were involved as much as they wanted in their care and treatment, include Matrons and Ward Sisters undertaking daily ward rounds to introduce themselves. Ward staff ensure they are visible with the introduction of photo boards at the entrance of clinical areas. All in-patients are given a bedside booklet to inform them of the ward routine, including who to contact if they have a query whilst in hospital or when they go home. Information leaflets are distributed with take home medication, together with a helpline number for patients to phone if they are unsure of what to take or any possible side effects.

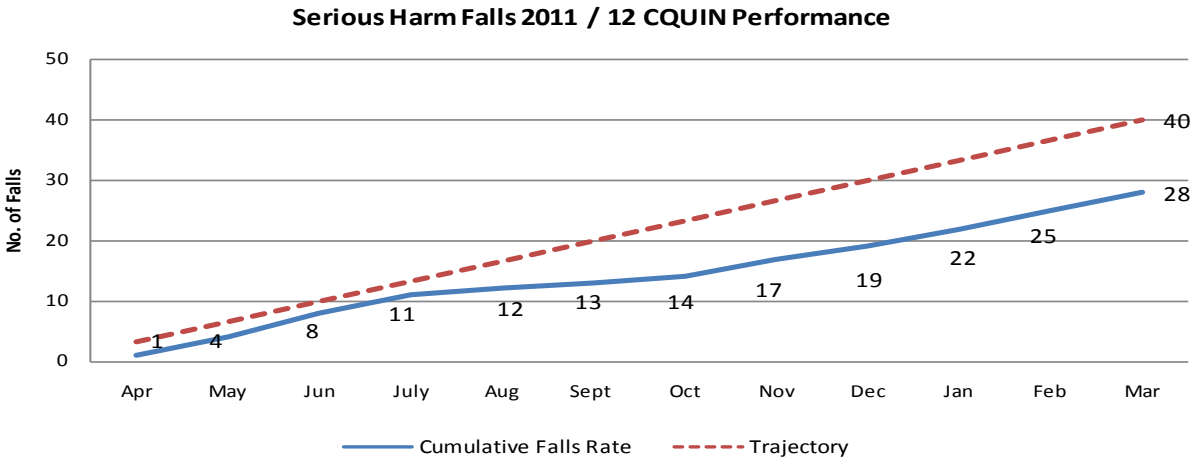
Further initiatives

The Trust implemented a web based live patient feedback method, which replace the existing Patient Experience Trackers, known as Meridian Trackers. These enable richer feedback, as more in-depth questions are asked and patients can add comments if they wish, enabling areas to respond quickly to patients concerns. Results are reported monthly to the Executive Patient Committee and quarterly to the Trust Board.

Target attainment and commentary on delivery

Objective 3: Delivering Safety Express Programme

- we will reduce the number of inpatient falls resulting in serious harm against 2010 / 2011 baseline
- we will reduce the number of hospital acquired grade 3 and 4 pressure ulcers in Quarter 4 against Quarter 1 2011 / 2012 baseline

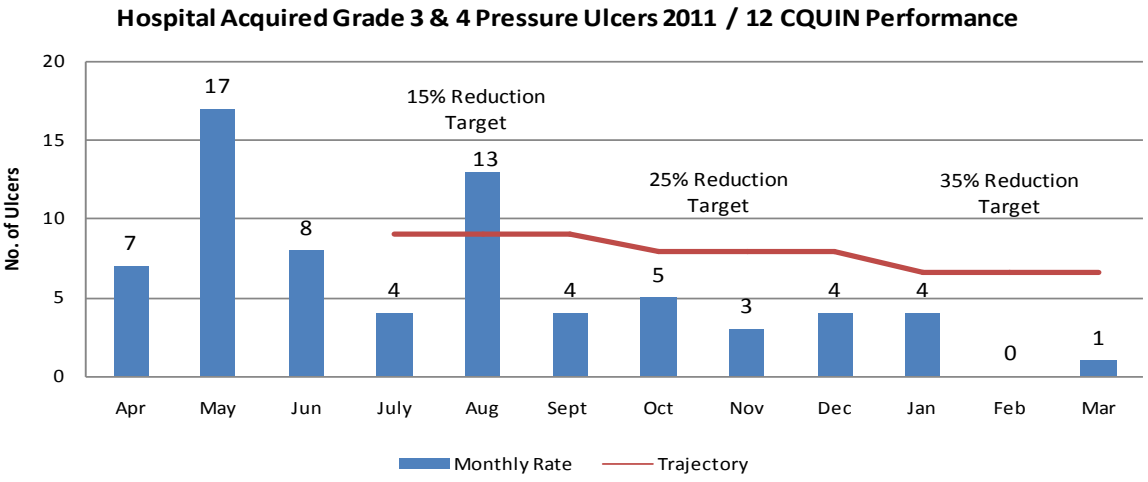


The falls CQUIN relates to a 20% reduction in serious harm falls based on the 2010/11 baseline. The run chart above plots the monthly cumulative performance against a cumulative 20% reduction target based on last year's data. There were 28 serious harm falls in 2011/12 against a CQUIN trajectory of 40. This improvement reflects an actual reduction in harmful falls of 45% compared to 2010/11.

In addition, we have seen an overall reduction of 167 falls across the Trust in 2011/12; this represents a reduction of 12% in total falls rates compared to 2010/11.

During the last twelve months, work has concentrated on improving the screening of all appropriate patients on admission. With the development of a new Falls Care Pathway, these actions ensure that all the relevant multidisciplinary interventions to reduce a patient's risk are implemented. In some cases, assistive technology can be introduced to further reduce the likelihood of a patient falling. In response to the early success of many of our local initiatives, the Trust has reflected their ongoing commitment in this area by investing in a new, permanent, falls prevention nurse post. This will help ensure that the advances made this year continue through 2012/13.

Progress for pressure ulcer CQUIN



The target for this CQUIN was to reduce the number of grade 3 and 4 hospital acquired pressure ulcers by 35% in Quarter 4 compared to the baseline of 35 agreed through reported performance in Quarter 1. Therefore, in order to achieve this target we required a performance of fewer than 20 pressure ulcers. Actual performance for Quarter 4 identified only five recorded grade 3 and 4 hospital acquired pressure ulcers. This represents an 83% reduction compared to Quarter 1.

Improvement work over the last 12 months has focused on staff education and training programmes to improve the early identification of patients who may be at risk of developing pressure ulcer damage. In addition, a revised Pressure Ulcer Prevention & Management Pathway was successfully piloted, which ensures that staff implement all appropriate interventions to reduce the risk for those patients. A newly

funded Tissue Viability Nurse Specialist has led this work across the organisation. This investment will now allow the opportunity to continue this work and seek to reduce the number of grade 2 pressure ulcers in 2012/13.

Target attainment and commentary on delivery

Objective 4: Diabetic care – *Think Glucose*

- percentage of diabetic patients with a *Think Glucose* patient assessment tool completed on admission
- we will measure our performance by monthly audit of a sample of 40 eligible patients with diabetes admitted to the Trust

The number of people with diabetes is steadily increasing; 'Think Glucose' is an NHS Institute initiative aimed at supporting NHS Trusts to deliver a clinical pathway that improves the management of these patients. The Think Glucose assessment tool ensures that at-risk patients receive both the appropriate treatment and referral to specialist services early following admission to hospital. The CQUIN target was to ensure that over 95% of patients were assessed using this tool within 48 hours of admission.

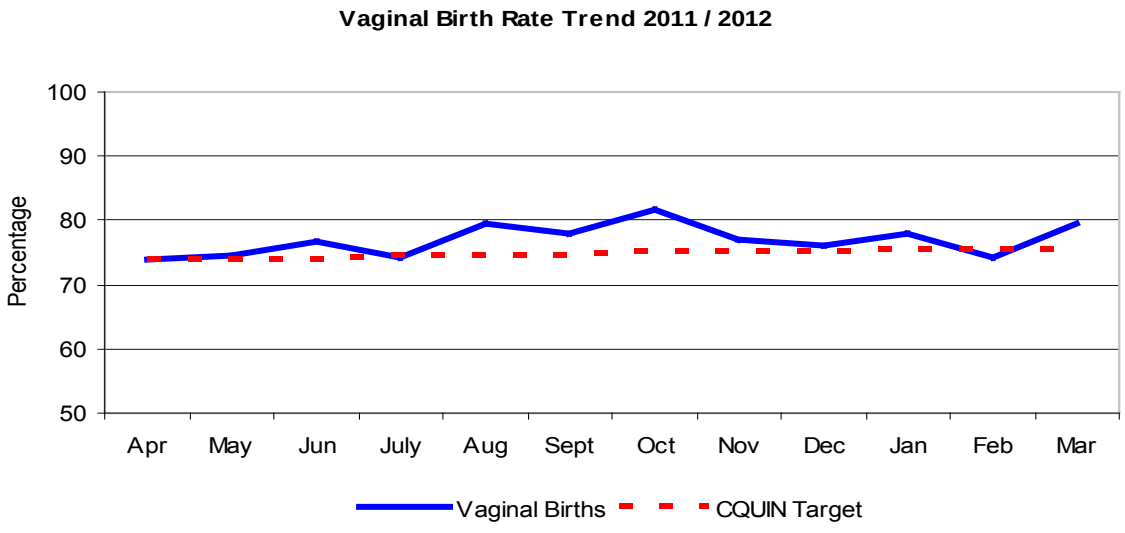
As part of the first milestone for this CQUIN by the end of Quarter 2, we were able to demonstrate that all ward staff had undertaken the appropriate Think Glucose training programme. By the end of Quarter 3, we evidenced that over 90% of appropriate in-patients had received a Think Glucose assessment within 48 hours of admission. By the end of Quarter 4 performance had increased to 96.7%.

In addition, Think Glucose has led to an increased awareness of insulin prescribing and administration issues. These factors will help towards reducing potential errors and improving the overall management and experience for patients with diabetes.

Target attainment and commentary on delivery

Objective 5: Maternity – normal births

- we will increase the percentage of vaginal births by 2% at a rate of 0.55% per quarter.



This CQUIN, aimed at increasing the normal birth rate by 2% over the course of 2011/12 with a staggered 0.5% reduction required each quarter. In order to reduce the number of potential inappropriate Caesarean sections, a team of midwives and obstetricians assessed current local practices against the National Caesarean toolkit, which suggests best practice to support women in achieving normal birth. Initial areas for improvement were identified and the introduction of a daily inter-professional review of the previous 24-hours emergency Caesarean sections and a weekly inter-professional meeting to review highlighted cases has assisted in the continued identification of areas of good practice and areas to improve.

The normal birth implementation inter-professional team still meets monthly to plan, drive forward changes and evaluate them. This strategy has been highly successful and a multitude of changes supporting this initiative have been implemented.

Target attainment and commentary on delivery

Objective 6: Intentional Rounding

- ❑ we will contribute to improvements in patient safety, clinical effectiveness and patient experience by implementing intentional rounding on medical wards
- ❑ 80% or more of patients on 75% or more of eligible wards receiving 2-hourly intentional rounding, as evidenced through monthly audit.

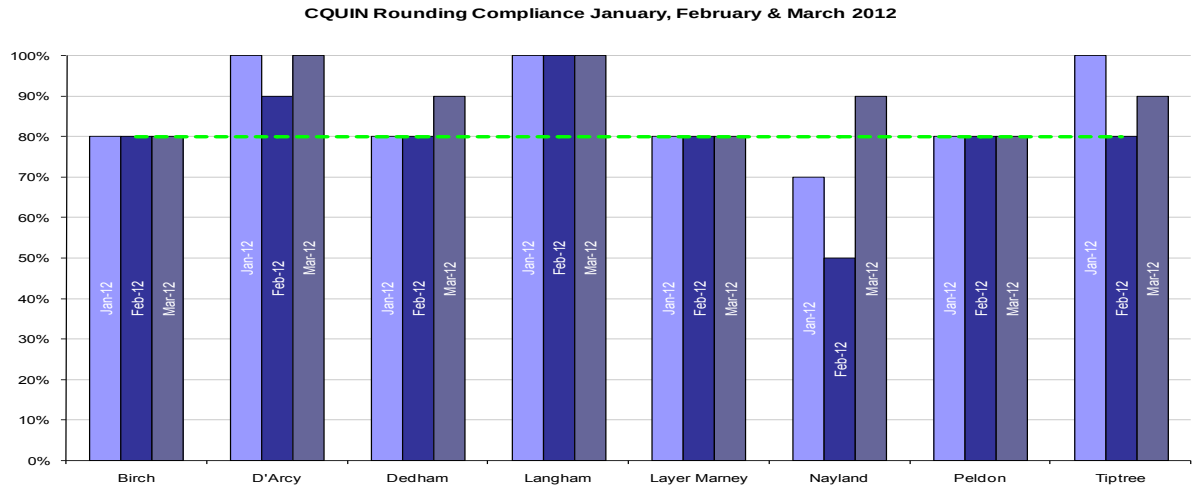
Intentional rounding; refers to two hourly nursing rounds involving staff speaking and assisting every patient to ensure that all their basic care needs are met.

The rounding activities include:

- Pain assessment / management
- Toileting assistance
- Positioning / pressure area care
- Provision of fluids and mouth care
- Environment is tidy and call bell is in reach
- The bed height and position of bed rails is appropriate for the patient

After each round, the staff member asks if the patient needs anything else and reminds him or her that someone will be back in two hours. This initiative has had a significant positive impact on patients, visitors and staff alike with increased reassurance resulting from greater staff visibility. Likewise, staff favour this intervention, as it provides more time to spend with direct patient contact

As part of the CQUIN target, we have evidenced that 80% or more of patients on 75% or more of eligible wards did receive 2-hourly intentional rounding, as evidenced through monthly audit.



Target attainment and commentary on delivery

Objective 7: Developing an integrated stroke care pathway

- develop a Stroke Joint Care Plan
- development of a flow chart of the patient pathway across the local economy
- implementation of the Stroke Joint Care Plan, for all patients admitted on to the Stroke Unit and transferred in month

As part of the first milestone for this CQUIN by the end of Quarter 2, a Stroke Joint Care Plan was developed, including a flow chart of the patient pathway across the local health economy.

By the end of Quarter 3, we evidenced that over 60% of patients admitted to the Stoke Unit that were transferred to another provider had a Stroke Joint Care Plan in place. By the end of Quarter 4 our performance had increased to over 90% and achieved in full the CQUIN objectives.

Target attainment and commentary on delivery

Objective 8: Reduce admissions relating to alcohol

- we will reduce the number of hospital admissions relating to harmful levels of alcohol consumption

Following discussions, the Alcohol CQUIN scheme was withdrawn during 2011 / 2012. In replacement of this, as a QIPP initiative, the Commissioner, Trust and Community provider have committed to work together to enhance the profile of the Alcohol Nurse specialist (commissioned by the Commissioner and provided by the Community provider in the Acute Trust) with an aim of increasing referrals.

Other Quality Initiatives

Clinical Area Assessment Programme

In 2011 / 2012, the Trust embarked on delivering a number of other quality initiatives designed to improve patient safety and patients' experience of care. One major example is the introduction of the Clinical Area Assessment Programme.

The Department of Health in its recent White Paper, *Equity and excellence: Liberating the NHS*, has reiterated the demand for placing increased safety and experience at the heart of its proposals, emphasising that the NHS should refuse to tolerate unsafe and substandard care. To meet this challenging agenda as an organisation we will require to continuously and systematically review and improve all aspects of our activities that directly affect quality. This will necessitate a new approach and one that builds upon the traditional NHS reactive process of responding to issues after an adverse incident has occurred.

At the February 2011 Clinical Executive Board it was agreed that the introduction of a Clinical Area Assessment Programme (CAAP) will become the foundation block of a new framework that moves to assess and respond to quality issues in a systematic and proactive manner; before adverse incidents occur.

The Clinical Area Assessment Programme commenced in April 2011 and involves a two-year programme that includes the assessment of three clinical areas / departments within each Clinical Division per financial year.

The programme is essentially a peer review of clinical areas using a set of predetermined tools, with underlying objectives to encourage areas to share good practice and identify common themes and trends within the organisation.

Each tool has been developed using national and local best practice and where possible, the inclusion of objectives and standards set within the organisations' own Polices and Procedure documents. Each area is then benchmarked against these standards and a RAG rating applied.

The benefits of the assessment, involves the following:

- √ A review of predetermined key specific indicators relevant to each speciality.
- √ Audit of record keeping standards and identifying areas of poor / positive practice
- √ Reviewing the care and identifying areas of poor / positive practice for the following:
  - ❑ Intravenous therapy
  - ❑ Blood transfusion
  - ❑ Peripheral cannula
  - ❑ Urinary catheters
  - ❑ Pressure area care
  - ❑ Nil by mouth 48 hour standard
  - ❑ Oxygen therapy
  - ❑ Diabetic sliding scale therapy
  - ❑ Anticoagulation charts
  - ❑ Patient identification wristbands

- √ Walkabout and observations of the environment, that includes:
  - ❑ Identifying good practice relating to handover of care
  - ❑ Communication and planning of clinical care
  - ❑ Use of SBAR tool within the clinical area
  - ❑ Patient at Risk scoring
  - ❑ Infection control and wound care
  - ❑ Patient safety
  - ❑ Review of governance arrangements within the clinical area and speciality
  - ❑ Review of compliance with mandatory training and equipment competency

- √ Patient Experience interviews of 10 randomly selected patients for each area

A report is developed and circulated predominantly within one week of the visit and includes detailed findings of the assessment, conclusions and key recommendations.

Each Service / Division then ensures through their own governance groups, any action and / or learning highlighted from the recommendations. It is essential in order to provide assurance that an action plan is created and developments of that action plan reported to the Executive Patient Committee.

Throughout 2011/12, twelve Clinical Area Assessment Programme visits have been undertaken and where relevant, improvements have been made with the support of divisional managers and the executive team. Whilst at the same time, areas of innovation have been recognised and developed throughout the Trust.

The Trust wishes to build of the success of the Clinical Area Assessment Programme and for the forthcoming year, a programme has been created for a further twelve assessments that will be unannounced visits.

Complaints

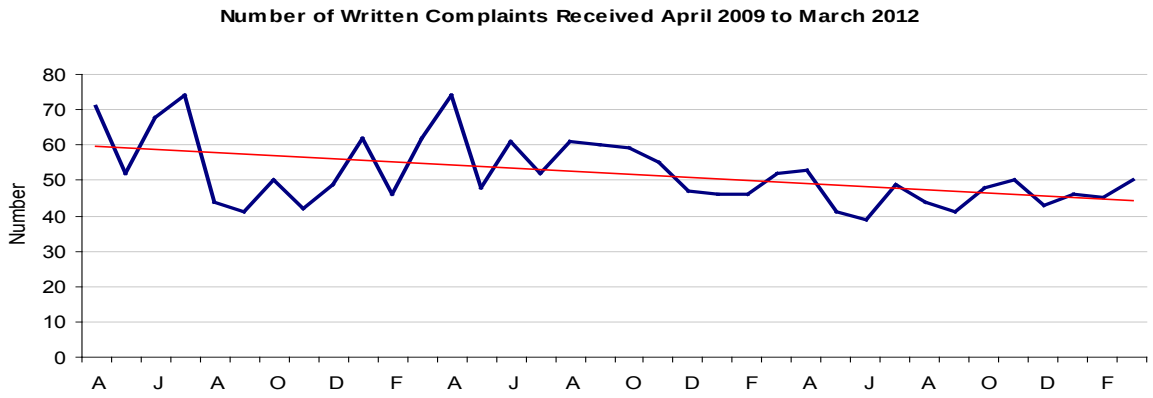
The Trust received 551 written complaints in 2011/12, which is a 16.6% reduction when compared to complaints received the previous year. Complaints received cover a wide range of issues and identify areas within our services where improvements can be made.

In order to ensure that there is learning from complaints and that changes occur as a result, key issues from individual complaints are identified in Learning from Experience Action Plans. These plans are implemented and reviewed through local service/divisional governance groups to ensure the issues have been addressed.

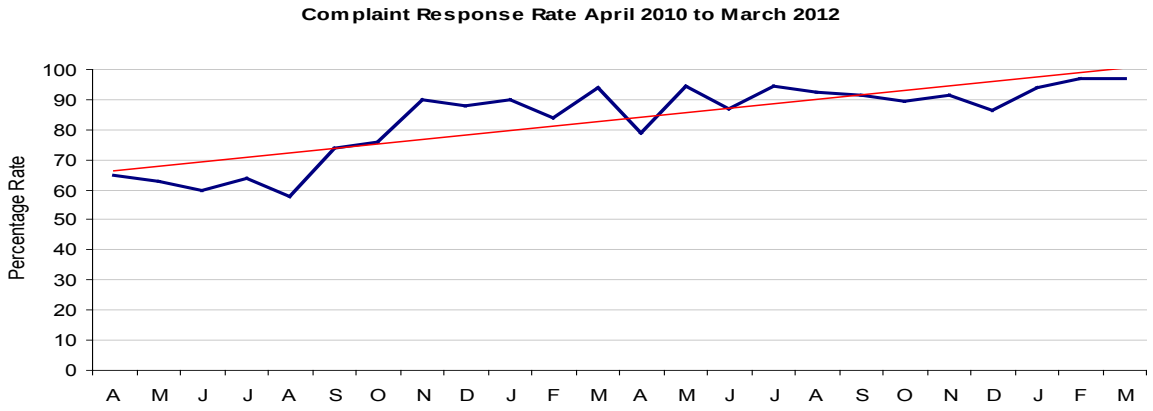
Throughout the year, the Trust has worked hard to improve the percentage performance of responding to complaints within the timescale agreed with the complainant.

The following graphs demonstrate the reduction in complaints received and the improved response rate, when compared to 2010/11.

Graph 1: Written Complaints



Graph 2: Percentage Response Rate



Priorities for improvement 2012 / 2013

The Board of Directors' quality priorities overall continue to be built around the three domains of quality:

- Patient safety
- Clinical effectiveness
- Patient experience

Within the Trust, a number of convergent areas of work have identified improvement objectives, which are reflected in the priorities we have set for 2012 / 2013 in the Quality Report. These include:

- Emergency Care Reorganisation
- Clinical Portal
- At Our Best

There is considerable convergence of the main issues and measures in each of these areas. These have come together in the annual CQUIN objectives – incentive payments negotiated and agreed with NHS North East Essex. The CQUINs represent a good cross-section of quality objectives that can be clearly measured where the Trust is able to influence the outcomes. The CQUINs were selected after both NHS North East Essex and the Trust considered their aims and created a 'long list' of potential quality measures. The CQUINs were developed by clinical and management staff in both organisations; some of the CQUINs draw on national CQUIN exemplar ideas. The long list of potential CQUINs was reviewed jointly by both parties and a set of challenging but deliverable CQUINs agreed. NHS North East Essex has consulted with General Practitioner commissioners in the development of the measures.

In reaching the decision to use the CQUINs as the basis for our Quality Report reporting in 2012 / 2013, the Trust consulted with its governors who approved this approach at the Members' Council meeting on 1st March 2012.

CQUINs 2012 / 2013

The total value of the CQUINs to the Trust in 2012/13 will be £5.2m. The detailed content of each CQUIN, required attainment levels for payment and the monitoring period, have been agreed in our 2012 / 2012 contract with NHS North East Essex.

CQUIN's for the specialist commissioning contract are still under review and will not be finalised until the end of April 2012.

The following CQUINs have been agreed:

Name	Description	Measure
National Mandated		
Dementia, Find, Assess, Refer	% of all patients admitted aged 75 and over who have been screened following admission to hospital, using the dementia case finding question: *'Has the person been more forgetful in the last 12 months to the extent that it has significantly affected their life?'*	Number of patients aged 75 and over admitted with a diagnosis of delirium, dementia, **or** reported as having been screened for dementia following admission to hospital, using the dementia case finding question within 72 hours of admission.
VTE Risk Assessment	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (includes day cases, maternity and transfers; both elective and non-elective admissions).

Name	Description	Measure
Patient Experience (National Survey)	The indicator is a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme "responsiveness to personal needs of patients". The elements are: 1) Involvement in decisions about treatment/care 2) Hospital staff being available to talk about worries/concerns 3) Privacy when discussing condition/treatment 4) Being informed about side effects of medication 5) Being informed who to contact if worried about condition after leaving hospital.	Index-based score reflecting positive responses to the 5 questions within the composite indicator
Safety Thermometer	This CQUIN incentivises the collection of data on patient harm using the NHS Safety Thermometer harm measurement instrument (developed as part of the QIPP Safe Care national work stream) to survey all relevant patients in all relevant NHS providers in England on a monthly basis	This CQUIN will require monthly surveying all appropriate patients (as defined in the NHS Safety Thermometer guidance) to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE). Number of months per quarter for which a complete record of Safety Thermometer survey data covering all appropriate patients in all appropriate settings for all relevant measures is submitted.
Local Priorities		
Pressure Ulcer	This CQUIN incentivises a reduction of grade 2, 3 and 4 avoidable pressure ulcers in quarter 1, 2 and 3 of 2012/13, building to the elimination of grade 2, 3 and 4 avoidable pressure ulcers by December 2012. This CQUIN supports the NHS Midlands and East SHA ambition for the elimination of grade 2, 3 and 4 pressure ulcers by December 2012	This CQUIN will require monthly measurement of all grade 2, 3 and 4 pressure ulcers, which will by December 2012 indicate the elimination of all avoidable grade 2, 3 and 4 pressure ulcers. This performance will be required to be sustained through quarter 4 2012/13.
GP Acquisition	Participation in GP engagement events to demonstrate benefits of clinical portal in readiness for year two GP utilisation – participation includes attendance at GP “shut down” events, Practice manager meetings etc.	Project plan of engagement with GP.
Patient Experience	To establish the question and baseline Net Promoter Score For 10% of inpatient discharges for any given week (excludes discharge destination code 4 – Died). At or within 48 hours of discharge “How likely is it that you would recommend	Total number of Promoters minus the total number of Detractors Total number of patients surveyed

<table>
<tr><th>Name</th><th>Description</th><th>Measure</th></tr>
<tr><td></td><td>this service to friends and family?” Please rate on a scale of 0 to 10

The ten point scale should be mapped to the following scoring system:

<table><tr><th>Score</th><th>Point Scale</th></tr><tr><td>Promoters</td><td>10 or 9</td></tr><tr><td>Passive</td><td>8 or 7</td></tr><tr><td>Detractors</td><td>0 -6</td></tr></table>
The percentage of Detractors should be then subtracted from the percentage of promoters to obtain a Net Promoter Score.</td><td></td></tr>
<tr><td>End of Life</td><td>Reducing admissions to secondary care for end of life care</td><td>Number of patients aged 60 and over audited who were admitted as a non elective admission’s and died within 3 days of admission.</td></tr>
<tr><td>Early Consultant Review</td><td>NCEPOD (2005) and Royal College best practice guidance recommends all patients admitted non electively should be seen by a Consultant within 24 hours of admission. To further drive the Trust’s safety strategy the Trust would like to increase the percentage of patients seen within 6 hours.</td><td>Number of non elective patient records with documented evidence of consultant review within 6 hours of admission (excluding Maternity/Obstetrics)</td></tr>
<tr><td>Enhanced Recovery Programme – Urology</td><td>To improve the quality of pre, intra and post-operative care for Urology patients undergoing elective Transurethral Resection of Bladder Tumour through implementation of the enhanced recovery model of care. This CQUIN incentivises the Trust to redesign the patient’s pathway to increase the percentage of patients admitted through a day case pathway as opposed the current inpatient model.</td><td>Number of Urology patients admitted electively as a Day Case for TURBT</td></tr>
<tr><td>Medicines Management</td><td>This CQUIN incentivises the collection of data on patient harm related to missed Antibiotic doses to enable delivery of a reduction in the number of missed doses.</td><td>Number of missed antibiotic dose for non clinical reasons within previous 48 hours</td></tr>
</table>

The Board of Directors will monitor and report on CQUIN attainment monthly as part of the overall performance report. The Trust will report on CQUIN performance at regular intervals throughout the year to NHS North East Essex as part of its ongoing contractual relationship with the PCT.

Statements of assurance from the Board

Services

During 2011 / 2012, Colchester Hospital University NHS Foundation Trust provided 48 NHS services.

The Trust has reviewed all the data available to it on the quality of care in all of these NHS services, focusing on assessment of patient safety, clinical effectiveness and patient experience.

The income generated by the NHS services reviewed in 201/12 represents 92.1% of the total income generated from the provision of NHS services by the Trust for 2011/12.

The Trust reviewed data on clinical quality and performance in specialty areas throughout the year. The schedule at Annex A outlines a summary of the activity in each specialty.

Clinical Audit

Participation in national clinical audit and confidential enquiries

During 2011 / 2012, 41 national clinical audits and 3 national confidential enquiries covered NHS services that the Trust provides.

In the same period, the Trust participated in 93% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2011 / 2012 are listed in the table below. The table also includes, where possible and applicable, the number of cases submitted to each audit or enquiry, which is also expressed as a percentage of the number of cases required by the terms of that audit or enquiry.

Table 2: National Clinical Audit & Confidential Enquiries

Title of audit	Trust eligible to participate?	Trust participated?	If Y, number of cases submitted	Percentage compliance
Perinatal and Neonatal				
Perinatal Mortality (CEMACH) [MBRACE]	Yes	Yes	15	100%
Neonatal Intensive and Special Care	Yes	Yes	4582 bed days	100%
Children				
Paediatric Pneumonia	Yes	Yes	30	100%
Paediatric Asthma	Yes	Yes	19	100%
Pain Management in the ED	Yes	Yes	50	100%
Childhood Epilepsy	Yes	Yes	3	100%
Paediatric intensive care	No	-	-	-
Paediatric Cardiac Surgery (Congenital Heart Disease Audit)	No	-	-	-
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	179	100%
Acute Care				
Emergency Use of Oxygen	Yes	No	-	-
Adult Community Acquired Pneumonia	Yes	Yes	30	100%
Non Invasive Ventilation (NIV) – Adults	No	Yes	In progress[1]	In progress

[1] The collection period for this audit expires on 31/05/12 and the number of cases required cannot be known at time of writing.

Title of audit	Trust eligible to participate?	Trust participated?	If Y, number of cases submitted	Percentage compliance
Pleural Procedures	Yes	Yes	23	100%
Cardiac Arrest	Yes	Yes	82	100%
Severe Sepsis & Septic Shock	Yes	Yes	30	100%
Adult Critical Care	Yes	Yes	468	100%
Potential Donor Audit	Yes	Yes	154	100%
Seizure Management	Yes	No	-	-
Long Term Conditions				
Diabetes (National Adult Diabetes Audit)	Yes	Yes	6761	99%[2]
Heavy Menstrual Bleeding (RCOG National Audit of HMB)	Yes	Yes	20	100%
Chronic Pain	Yes	Yes	134	100%
Ulcerative Colitis & Crohn's Disease	Yes	Yes	40	100%
Parkinson's Disease	Yes	Yes	40	100%
Chronic Obstructive Pulmonary Disease	No	-	-	-
Adult Asthma	No	-	-	-
Bronchiectasis	Yes	No	-	-
Elective Procedures				
Hip, knee and ankle replacements	Yes	Yes	964	100%
Elective Surgery	Yes	Yes	1567	86%[3]
(Intra)Cardiothoracic transplantation	No	-	-	-
Liver Transplantation	No	-	-	-
Coronary Angioplasty	No	-	-	-
Peripheral Vascular Surgery	Yes	Yes	106	99%[4]
Carotid interventions	Yes	Yes	34	83%[5]
CABG and Valvular Surgery	No	-	-	-
Cardiovascular Disease				
Acute Myocardial Infarction & other ACS	Yes	Yes	25	100%
Heart Failure	Yes	Yes	370	100%
Acute Stroke	Yes	Yes	20	100%
Cardiac arrhythmia	Yes	Yes	236	71%[6]
Renal Disease				
Renal Replacement Therapy	No	-	-	-
Renal Transplantation	No	-	-	-

[2] The 1% deficit represents a negligible number of cases, of approximately 7000, which did not meet data completeness requirements. We are fully compliant with the terms of the audit.
[3] The Elective Surgery audit is a patient survey; 86% represents the response rate.
[4] This is a rolling audit with irregular freezes. This figure is the percentage of our own backlog submitted.
[5] The deadline for the current round of submissions is expected in December 2012. This figure is the percentage of our own backlog submitted.
[6] This audit is a registry of pacemaker implants. There is no submission target as such and the percentage figure given represents the number of cases so far submitted against the number of implants we have performed.

Title of audit	Trust eligible to participate?	Trust participated?	If Y, number of cases submitted	Percentage compliance
Cancer				
Lung Cancer	Yes	Yes	170	100%
Bowel Cancer (NBOCAP)	Yes	Yes	179	100%
Head & Neck Cancer (Data for Head and Neck Oncology)	Yes	Yes	44	100%
Oesophago-Gastric cancer	Yes	Yes	59	64%[7]
Trauma				
Hip Fracture	Yes	Yes	896	100%
Severe Trauma (TARN)	Yes	Yes	79	100%
Psychological Conditions				
Prescribing in Mental Health Services	No	-	-	-
National Audit of Schizophrenia	No	-	-	-
Blood Transfusion				
Bedside transfusion	Yes	Yes	70	100%
Medical Use of Red Cells	Yes	Yes	65	100%
Health Promotion				
Risk Factors	Yes	No	-	-
End of Life				
Care of the Dying in Hospitals (NCDAH)	Yes	Yes	80	100%
National Confidential Enquiries				
NCEPOD	Yes	Yes	5	55%[8]

The reports of all national audits were reviewed by the Trust during 2011/12, appropriate learning points were identified, and plans for action prepared.

The specific actions planned / taken as a result of participation in a sample of these national reviews are listed below.

Cardiac Rhythm Management Audit (Report published September 2011)
The audit found that the current implant rates for Implanted Cardioverter Defibrillators (ICD) for cardiac arrest and Cardiac Resynchronisation Therapy (CRT) in NE Essex, including CHUFT, fell short of accepted targets.

The Trust had identified these issues prior to publication of the audit and had already begun to increase ICD and CRT implantation rates.

- An ICD implantation service has been established.
- CRT implants are performed at the Essex Cardiothoracic Centre.
- Outpatient clinics have dedicated slots for evaluating patients for pacing and complex device therapy.

[7] This audit is still in progress. The deadline for submissions is October 1st 2012.
[8] This compliance rate is based on the number of consultant questionnaires returned to NCEPOD. As the total figure required is fewer than 15, a small number of omissions show as a high percentage deficit.

National Care of the Dying Audit – Round 3, (Report published December 2011).
As a result of the audit, we are taking the following action:

- Ensure leaflets are available at the time of bereavement.
- Develop a LCP programme of education for appropriate staff.
- Develop guidelines specifically for patients at the end of life.
- Although prescribing has improved greatly, we will continue to monitor the errors in prescribing.
- Ensure the documentation of conversations with patients and families and share information with Primary Care.
- Ensure 4-hourly checks are documented within the clinical records.
- Ensure the completion of the LCP.

National Diabetes Audit (Report published December 2011)
As a result of the audit, we have taken the following action:

- We have reorganised our clinics to accommodate patients with Type 1 Diabetes into more MDT style sessions, seeing them more often to improve glycaemic control (HbA1c).
- In collaboration with ACE, we support an Outreach Project to target hard to reach patients, who usually have poor control.
- Run specialist clinics in the community/closer to home, to reduce DNA rates and numbers of patients lost to the system.
- We run regular telephone support clinics and are planning a 24/7 helpline and inpatient support from April 2013.
- We have increased the number of spaces available for Structured Education for type 1 diabetes, including rolling out a programme of DAFNE (Diabetes Adjustment for Normal Eating) which is the gold standard structured education course in the UK, to gradually replace our current BERTIE programme.

National Comparative Audit of Blood Transfusion (Report published October 2011)
As a result of the audit, we are taking the following action:

- Ensure our identification policy specifically covers blood transfusion.
- The blood administration policy will state “no wristband, no transfusion” and it will be the responsibility of the person administering the blood to ensure a wristband is applied if it is found to be missing.
- Incidents where patients are transfused without wearing a wristband will be investigated.
- 24/7 access to PAS for wristband printing will be enabled.
- If any other form of ID is used it will be physically attached to the patient, rather than the cot, incubator, bed, chair, etc.
- A risk-assessed alternative will be put in place if the patient cannot, or refuses to, wear a wristband.
- Patients will be encouraged to take an active role in the bedside check by stating their full name and date of birth, helping to ensure the correct identification.
- All staff will be made aware of the need for transfusion training, updates and competency assessments. Results will be posted to Transfusion/Infusion News and circulated to staff.
- Reminders for observations will be placed on the transfusion/infusion chart.
- Post transfusion observations will be carried out prior to the discharge for day patients and contact information provided.

National Lung Cancer Audit (Report published December 2011)
The National Lung Cancer Audit performance on casemix-adjusted outcomes identified the Trust as an outlier, performing above the level of comparator trusts for active treatment and small cell lung cancer receiving chemotherapy. The measure of small cell lung cancer receiving surgery and median survival were not statistically different from comparator trusts.

As a result of the audit, we are taking the following action:

- The specialist nurse service will be reviewed and extra nursing support will be allocated, alongside lung cancer clinics.
- Tracking data will be captured at MDT and submitted to the audit.
- All surgical resections will be submitted to the audit and, where data allows, treatment

policies for early stage lung cancer in patients with good performance. Status will be reviewed. A thoracic surgeon will attend MDT meetings.
- Review treatment policies for lung cancer patients.
- Review treatment policies for small cell lung cancer patients.
- Review treatment policies for non-small cell lung cancer patients with advanced stage.

Vital Signs in Majors (Report Published 2011)
This audit found that nursing staff in the Emergency Department (ED) need more training for better understanding College of Emergency Medicine standards for recording vital signs, that triage nurses need more training and better understanding of the importance of recording triage time, and that there should be more awareness of the importance of documenting all communications by ED staff.

As a result of the audit, we have taken the following action:
- We have reviewed the Nursing staff / triage nurse training.
- We have reviewed and strengthened the Emergency Department staff rota.

National Dementia Audit (December 2011)
This audit recommended strengthening governance, standardizing dementia and cognitative impairment assessment, creating an environment sensitive to dementia sufferers, providing specialist mental health assessment, improving patient and relative information, and establishing dementia awareness training.

As a result of the audit, we are taking the following action:
- Establish a Trust Dementia Strategy Group with representation from all relevant disciplines.
- Develop a care pathway for patients with dementia to standardise care and management.
- Develop a Trust procedure for managing patients with dementia, including MCA, DOLs issues.
- Development of a protocol governing the use of interventions for patients displaying violent, challenging, or aggressive behaviour.
- Establish an auditing process to monitor the length of stay of patients with dementia.
- Establish an auditing process to monitor readmission numbers of people with dementia.
- Establish a reporting mechanism to record the numbers of delayed transfers of care of people with dementia.
- Incorporate the Multiple Falls Alert into the Patient Administration System.
- Ensure that the Falls Operational Group submits monthly report of the number of falls suffered by patients with confusion.
- The Safeguarding of Vulnerable Adults Committee will submit a quarterly report of the number of safeguard alerts raised about patients with dementia.
- There will be an annual Trust wide review of complaints relating to patients suffering with confusion or dementia.
- The trust will investigate the possibility of establishing a cognitive impairment alert on PAS.
- The Abbreviated Mini Mental assessment will be included in all adult medical / surgical clerking for patients over the age of 65 years.
- The trust wide Dementia pathway will include standard cognition assessment, delirium screening, and a depression tool.
- A trust wide Delirium pathway will be agreed and implemented.
- Standardised behaviour charts to assess and monitor behaviour will be implemented
- The trust will agree measures to assess and reduce the use of antipsychotic medications.
- The trust will agree procedures around the administration of covert medications.
- The trust will develop and implement pain assessment methods for patients with cognitive impairment.
- Improvements will be made to the signage, toilet seats, time/date, and pictures within care of the elderly wards.
- The trust will investigate making changes to flooring to reduce the number of patient falls.
- The trust will establish therapeutic aspects of care to compliment medical and nursing care such as reminiscence, cognitive stimulation and Pet Therapy.

- The trust will establish a process to identify patients who will benefit from the Tiptree Box.
- There will be a scoping exercise to establish the benefits of specialist dementia beds or a designated area of care within specialist medicine.
- Increase the number of volunteers to enhance care.
- Promote flexible visiting routines
- The trust will explore the possibility of Liaison Mental Health Nurses monitoring transferred patients from King's Wood / Clacton in-patient wards.
- The trust will agree a transfer protocol for patients returning to inpatient mental health beds at King's Wood & Clacton mental health wards
- The trust will establish quarterly consultant NEPFT & NEPFT meetings to promote partnership working.
- The trust will investigate including a section/prompt on the EDS for mental health diagnosis & management.
- Develop a transfer procedure to restrict the inter-ward transfer of patients with confusion/dementia and only indicated for reasons pertaining to the individual's care and treatment.
- Introduce 'This is Me' to complete a comprehensive assessment of individuals needs.
- Information about delirium and dementia for patient relative's information will be developed.
- A review of patient / relative information on each care of the elderly ward will incorporate local support agencies and carers support.
- The trust will develop a generic Carers' Strategy.
- Explore the possibility of establishing a patient carer forum for people with cognitive impairment.
- The trust will review current dementia training for all HCPs.
- NC for Older People to complete Dementia Training and establish in-house Train the Trainer dementia training
- Establish dementia awareness training – accessing mandatory training, ward team day training and as 'stand-alone' sessions.
- Establish Delirium training.
- Explore the possibility of involving people with dementia and carers and use of their experiences in training.
- Reciprocal access to specialist dementia training to be established with NEPFT.

Vascular Access Audit (August 2011)

As a result of the audit, we have taken the following action:

- Developed a 'root cause analysis' for chronic patients on HD using tunnelled lines.
- Significantly improved the percentage of patients with both a fistula and starting dialysis with a fistula by putting in place a Renal Nurse Specialist with specific responsibility for access.

National Bowel Cancer Audit (Published Autumn 2011)

The Trust's laparoscopic resection rate for colorectal cancer remains extremely high at 86%, when compared to the national average of 30%.

As a result of the audit, we have taken the following action:

- We have recently employed extra personnel to ensure full submission of data to NBOCAP, which should lead to further improvements in data in future reports.
- We have started a prospective weekly MDT audit of complications following surgery for colorectal cancer (initially concentrating on elective outcomes with the plan to extend to include emergency cases, though much of the data is already also captured for emergency cases).
- All postoperative deaths are reviewed both in surgical audit, in the weekly MDT audit figures and in the Chief Executive Mortality Meeting.
- The MDT team are involved in the LOREC process attending the LOREC training at Basingstoke on 15 March 2011.

Local Clinical Audits
The reports of several local clinical audits were reviewed by the Trust in 2011/12. We intend to take the following actions to improve the quality of health care provided:

Time to First Antibiotic Dose in EAU re-audit (February 2011)
The original audit, undertaken November 2009 found that 53% of patients were treated within 4 hours, 26.5% in 4-8 hours, and 20.5% in over 8 hours, with an average TFAD of 4 hours 56 minutes. The key learning points were that X-rays needed to be ordered more quickly, more efficient assessment systems were needed in EAU, and antibiotics should initially be prescribed in STAT doses. The re-audit found a decline in standards (average time had risen to 5.3 hours).

As a result of the audit, we have taken the following action:

- Increased awareness of the need for TFAD of less than 4 hours
- Improved senior input and addressed staffing issues at key times during the day to prevent delays.

Pulmonary Embolism Audit 2011
This audit found that patients were not having clinical risk & probability of PE formally assessed or documented. From its conclusions, it was evident that a trust care pathway should be established for PE patients.

As a result of these findings, we are taking the following action:

- Devise a trust pathway for investigating patients with PE, including a validated method of assessing clinical risk & probability.
- Devise a trust pathway for ambulatory care of patients with suspected or proven PE.

Diabetes Stickers, Reducing a Never Event.
This audit made the following recommendations:

- When prescribing insulin, use the word ‘unit’ and not abbreviations U or IU.
- Staff should look for diabetic stickers on medicine charts of diabetics scheduled for elective surgery.
- Staff should refer to diabetic management guidelines.

As a result of this audit, we have taken the following action:

- Staff have been made aware of these recommendations.

Evaluating whether increased rehabilitation for fractured neck of femur patients can reduce the length of stay.
The audit found that the length of stay for these patients was an average of 11 days, a saving of 5 days from the previous average of 17. Neither Physiotherapy nor Occupational Therapy delayed discharges, but social services delayed discharge when they were involved with patients by an average of 5 days. 78% of patients who went through the rehabilitation unit were discharged directly home, compared to 42% previously. This new way of working across the disciplines can improve patient outcomes and efficiency.

As a result of this audit, we have taken the following action:

- The scheme has been rolled out and is currently being audited over a 6-month period.

Central Venous Access Device (CVAD) (Completed December 2011)
This audit found, among other things, a general need for more training for nursing staff on team days and a need for more training and information for theatre staff on CVC packs and bionecters. It also recommended developing a CVAD Integrated Care Pathway.

As a result of the audit, we are taking the following action:

- Provide CVAD training for nursing staff.
- Ensure senior ward nurses complete competencies.
- Provide training to theatre staff.
- Develop a CVAD ICP.

Dip & Stick re-audit (Completed November 2011)
This re-audit found that documentation of urinalysis continues to be inadequate, despite the introduction of the urinalysis sticker. Therefore, a need for greater awareness of the issue has been identified.

As a result of this re-audit, we have taken the following action:

- Improve awareness of the urinalysis stickers in case notes.
- Presented re-audit findings at clinical audit half-day.

Secondary Prevention of Acute Myocardial Infarctions (Completed November 2011)
This audit found that more aggressive uptitration of prognostic medications is needed, requiring instructions to that effect in TTOs to GPs. It also recommended that cardiac rehabilitation clinics and heart failure nurse clinics be used to review and uptitrate medications.

As a result of these findings, we will consider:

- Asking general medical teams to uptitrate prognostic medications in hospital
- Putting clearer instructions to GPs in TTOs to uptitrate medications
- Use cardiac rehabilitation clinics and heart failure clinics to review medications

Management of Epistaxis in A&E (Completed December 2011)
This audit recommended that all patients with nasal packing should be admitted under ENT. It further recommended that patients who are successfully managed with conservative measures should receive advice about preventing recurrence and also a trial of Naseptin cream.

As a result of this audit, we have taken the following action:

- All patients with nasal packing are admitted under ENT.
- All patients discharged will receive written advice about preventing recurrence.

Hip Fractures Mortality Audit
This audit found that head injury, should be sought and documented especially in high-risk patients and all patients with fractured neck-of-femur should have an AMTS assessment. A comprehensive multi-disciplinary approach is required, that there should be an early post operation review, and an early take-over by COTE staff.

The audit identified the need for a comprehensive multidisciplinary approach and that there should be earlier take-over by Care of the Elderly as almost all mortalities are from co-morbidities and medical deterioration.

As a result of the audit, we have taken the following actions:

- Instituted associated injuries and AMTS assessment
- Provide for take-over by COTE and comprehensive MDT approach.

Audit of Paroxysmal SVT management in the Emergency Department (January 2012)
This audit found that, although SVTs are generally treated appropriately, ALS guidelines are not followed. It also found that stable SVTs are not all being treated with Vagal manoeuvres prior to adenosine and that referrals are happening too early through the ALS algorithm.

As a result of the audit, we are taking the following action:

- Develop a simple, one page handout, including example ECG and algorithm, to be given to SHOs and Staff Grades.
- Increase awareness amongst clinical staff of the importance of accurate documentation.
- Provide tachyarrhythmia training for new SHOs in introductory lectures.
- Increase availability of ALS course places for FY2s.

Audit of The Investigation of Macrocytosis in COTE Inpatients (Completed June 2011)
This audit found that a standardised form would help with the investigation of patients with suspected macrocytosis.

As a result of the audit, we have taken the following action:

- Posters were placed on COTE wards showing the flowchart for investigation.

Management of cardiac arrest in A&E (Competed November 2011)
This audit found that the trauma team is handling as many cases of cardiac arrest as it was before a policy of in-house handling was established. The audit recommended a recommitment to the policy, with the in-house team handling all patients presenting with cardiac arrest that are not trauma calls.

As a result of the audit, we are taking the following action:

- Alter the policy so that, by November 2012, the in-house team will handle all patients presenting with cardiac arrest.

To review consistency in management of patients admitted to Accident and Emergency Department following a head injury
What the audit found (*inter alia*):

- Patients admitted with head trauma were 60% male and 40% female.
- Admissions were spread equally across day and night.
- Mechanism of injury varied considerably with fall, RTA, and assaults the commonest mechanism of injury.
- Pre-hospital GCS was missing in 50% of patients.
- No significant improvement at GCS at Golden Hour in comparison to NCEPOD report, for nearly 44% of patients GCS was not recorded.
- Blood glucose was missing in 75% of patients.

As a result of the audit, we have taken the following action:

- All patients coming to the Emergency Department are seen within 60 minutes by a clinical decision maker.
- Patients coming in an ambulance are seen by a triage nurse within 15 minutes.
- All patients with a history of head injury have an initial assessment that includes GCS and blood glucose recording.
- Ambulance PRFs are now completed electronically and handed to the nurse at triage and are later filed into case notes.
- An audit on ‘CT scans and head injury’ has been undertaken.

To evaluate the local standards of care at CHUFT for patients admitted to EAU following acute kidney injuries and to compare the findings with the NCEPOD 2009
This audit found, among other things, that the urine dipstick is a key element in identifying acute kidney injury and that reagent analysis should be performed on all emergency admissions with results documented.

As a result of the audit, the following actions were suggested:

- Initial clerking of all emergency patients should include risk assessment for AKI.
- Implementation of guideline for management of AKI in emergency setting at CHUFT
- 24 hours service provision for ultrasound to exclude post renal causes of AKI

CURB scoring in the Emergency Department and appropriate antibiotic prescribing (Completed April 2011)
This audit found poor documentation of CURB scoring and its elements, a possible need for an antibiotic policy for chest infections, and that most patients receive Augmentin instead of Amoxicillin.

As a result of the audit, we have taken the following action:

- Improved CURB education for A&E staff

Management of Pancreatitis Against BSG Guidelines (Completed July 2011)
What the Audit Found:

- CHUFT is meeting targets for diagnosis and assessment of pancreatitis aetiology, but not meeting targets for assessment of severity and early laparoscopic cholecystectomy in patients with gallstone pancreatitis.
- CHUFT mortality figures in this area were consistent with national average.

As a result of this audit, we have taken the following action:

- CHUFT is in the progress of establishing a Pancreatitis care pathway.

Pilot Cataract Pathway Audit (Completed February 2012)
What the audit found:

- 43% of the patients initially booked into a cataract clinic are not listed for surgery.
- The majority of patients needing additional appointments is due to not having had their A-Scan or pre-operative eye measurements done on the same day as their original appointment,
- Of all the patients listed for surgery, 44% were listed bilaterally, with another 15% listed for the single eye but having already had the other eye done previously.
- With the right set-up and support, an optometrist-led cataract clinic could run parallel with the other cataract clinics but considerably more work would need to be done to determine the financial and clinical implications before further decisions could be made.

The learning points from the audit include finding out where improvements can be made in the current pathway, including why some patients require additional appointments, and highlighting changes that can be made to the current system while further research is conducted into the possibility of creating an optometrist-led cataract clinic.

As a result of the audit, numerous recommendations were made, including the following:

- Better documentation as to why doing bilateral/patient with 6/9 or better VA
- Further investigation into why so many patients who have appointments are not listed for surgery.
- Financial implications to be calculated in regards to an optometrist-led cataract clinic.
- Contact to be made with Suffolk PCT to discuss how their optometrist-led cataract clinics and referral system works.

Pain in Adults Re-audit (Completed January 2012)
What the audit found:

- 73% of patients had their pain score documented at triage, compared to 47% in Sept/Dec 2010.
- 34% of patients received analgesia within 20 minutes of arriving within the Emergency Department.
- 73% of patients received analgesia within 60 minutes of arriving within the Emergency Department.
- Only 23% of patients were documented as having their pain reassessed after analgesia but timing of reassessment was not always clear.

What we have learned:

- There has been an improvement in documentation of pain scores.
- There is better documentation of times (including triage, prescription and administration).
- Analgesia needs to be given earlier in vast majority of patients in order to comply with College of Emergency Medicine guidelines.

An Audit of Paroxysmal Supraventricular Tachycardia Management in A&E (Completed December 2011).

What the audit found:

- SVTs identified appropriately
- 27% treated exactly as per ALS guidelines
- Unstable tachycardias not receiving synchronised shock, some straight to amiodarone.
- Vagal manoeuvres not being documented in all stable SVTs.
- Adenosine doses being given correctly
- 55% of SVT presentations result in admission

What we have learned:

- For the most part, SVTs are being treated appropriately, just not according to ALS guidelines
- Unstable tachyarrhythmia's need to be shocked
- Stable SVTs are not all being treated with Vagal manoeuvres prior to adenosine.
- Referrals are happening too early through the ALS algorithm.

As a result of the audit, we have taken the following action:

- Introduced a simple, one-page handout, including example ECG and algorithm to be given to SHOs and Staff Grades.
- Reminded all doctors of the importance of accurate documentation
- Provided tachyarrhythmia teaching to new SHOs in introductory lectures
- Increased availability of ALS course places for FY2s

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was recorded at 985 on the National Institute of Health Research (NIHR) database of portfolio studies and 53 participants recruited onto non-portfolio studies.

The Trust has a long-standing and evidenced commitment to clinical research as a driver for high quality patient care and experience. Research at the Trust is supported by the NIHR via the Essex and Hertfordshire Comprehensive Local Research Network (E&HCLRN) which provides a comprehensive research management and governance service to researchers at the Trust, facilitated through the R&D office using the Trust and E&HCLRN database systems and research governance documents.

In 2011/12 the Trust was involved in conducting 134 studies to which we actively recruited and 78 studies which are closed to new patients but which are seeing follow-up patients. Research studies are taking place in cancer, cardiology, care of the elderly, critical care, dermatology, diabetes, ENT, epidemiology, gastroenterology, infectious diseases, microbiology, neurology, obstetrics and gynaecology, ophthalmology, renal, respiratory, rheumatology, stroke, urology, general surgery & A&E.

Over 80 clinical staff participated in research approved by a research ethics committee at the Trust during 2011/12. These staff participated in research covering most medical specialties, with 45% attributed to cancer related studies.

Research activity in these clinical areas has contributed to on-going E&H CLRN funding in 2012/13 in addition to R&D income generated from commercially sponsored studies.

Commissioning for Quality and Innovation (CQUIN) payments
A proportion of the Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services through the CQUIN payment framework. Further details of the agreed goals for 2011/12 and for the following 12-month period are available on line at: http://www.monitornhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275

In 2011/12 the maximum amount of income to the Trust that was conditional upon achieving CQUINs was £3.08m; the Trust achieved £2.98m (97%). In 2010/11 the Trust achieved £1.74m (62%)

Care Quality Commission
Colchester Hospital University NHS Foundation Trust is required to register with the Care Quality Commission. Our current registration status is fully registered at all locations without compliance conditions.

The Care Quality Commission has not taken enforcement action against Colchester Hospital University NHS Foundation Trust during 2011/12.

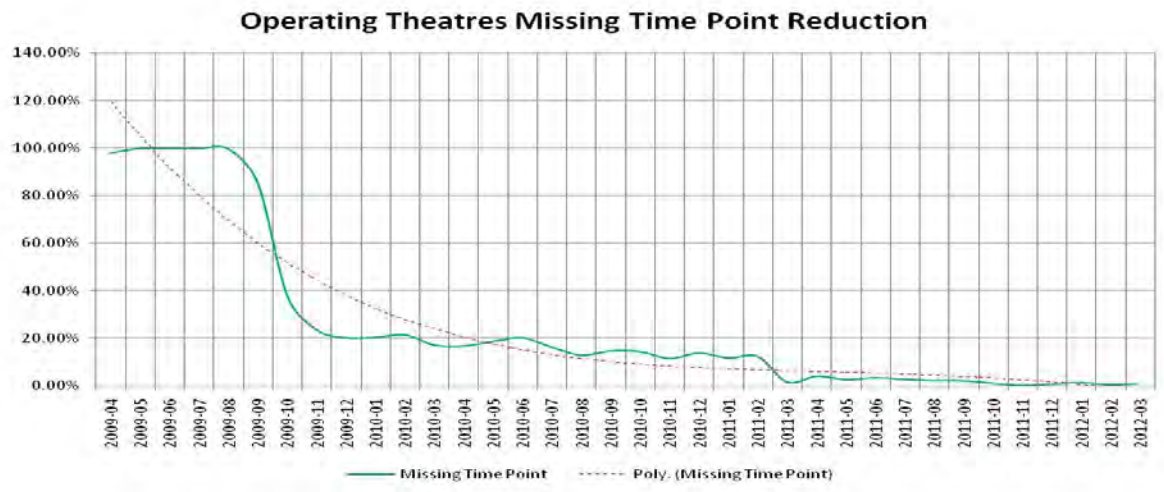
Colchester Hospital University NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Data quality
Colchester Hospital University NHS Foundation Trust considers data quality to be key in informing the delivery of patient care, productivity and performance. During 2011/12, the organisation made further improvements to its overall data quality and has focused on improving data quality within a number of business critical areas.

Areas of focus in 2011/12 were:

- Working closely with the clinical and operational teams to improve the quality of maternity data; specifically around the recording of Caesarean Sections. The data quality element of the Normalising Birth CQUIN has significantly contributed to the delivery of this CQUIN month on month and has also driven the data reported nationally via the Secondary Uses Service (SUS).

- The recording and validation of patient operations and Timing Points within the Trust's Theatre clinical information system has been an area of core focus for the data quality team over the last year. The delivery of daily operations/management reports on missing timing points against patient's records and other daily efforts by the team has seen significant improvements in this area (see the attached).



- In recognition of the need for all patient records to have a valid NHS number, the data quality drive over the past year has seen measurable improvements in the recording of NHS numbers for Inpatients (IP), Outpatients (OP) and within the Accident and Emergency department (see attached). This will remain an area of focus for the trust over 2012/13 inline with the NHS 2012/13 Operating Framework - National focus for all patient records to have an NHS number.

In 2011/12, the Trust implemented its first Income and Information (I&I) group, which is led by the Director of Finance and feeds into the Trust's executive Finance and Infrastructure committee. Amongst other core Income and Information priorities, the I&I group has been key in driving forward the data quality agenda over the last year; which has seen fundamental improvements in a number of areas across the organisation. All data quality challenges are fed into the I&I group and are delivered/led by senior officers of the trust.

NHS Number and General Medical Practice Code Validity

Colchester Hospital University NHS Foundation Trust submitted records during 2011/12 to the NHS Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data (month 11: published May 2012).

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

- 99.7% for admitted patient care
- 99.9% for outpatient care
- 98.4% for accident and emergency care.

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

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 100% for accident and emergency care.

The Trust continues to perform strongly in this area.

Information Governance Toolkit attainment levels

The Colchester Hospital University NHS Foundation Trust Information Governance Assessment Report score overall for April 2011 to March 2012 was 76% and was graded as red (not satisfactory), for the Version 9 Submission of the IG toolkit as we had 6 requirements that scored below Level 2 out of the 45 requirements.

In order for Trusts to obtain an overall score of satisfactory, the organisation must achieve level 2 or above for all 45 requirements within the Information Governance Toolkit. The Trust has fewer requirements, which have not achieved level 2 in Version 9 than the previous Version 8 submission. It should be noted that requirements previously marked as level 0 in Version 8 have improved to level 1 for Version 9 and although not yet compliant at level 2 or above have involved significant pieces of work to make improvements such as changes in reporting structure, working practices and a cultural shift in behaviour.

Progress against Information Governance is monitored by the Information and Income Assurance Steering Group with any areas of risk escalated to the Audit & Risk Assurance Committee.

Clinical Coding Error Rate

Colchester Hospital University NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission (March 2012). The error rates reported in the latest published audit for that period for diagnoses and treatment clinical coding were:

- 11.0% of primary diagnoses incorrect
- 9.7% of secondary diagnoses incorrect
- 12.2% of primary procedures incorrect
- 15.7% of secondary procedures incorrect

These results should not be extrapolated further than the actual sample audited. The audit highlights that the Trust's coding against Healthcare Resource Groups (standard groups of clinically similar treatments, which use common levels of health care resource) is 12.5%.

To further improve the quality and depth of coding, the Trust have implemented an enhanced training and internal self-audit plan for the coding team.

Training and Development Project
The Trust will establish a robust internal and external training programme for the Clinical Coding Officers to ensure that they are trained to national standards and acquire the knowledge and skills required to produce high quality coded data across all specialities. This involves the implementation of a routine internal training programme, which will be delivered by a newly appointed qualified Coding Trainer with external training provided by the Regional Coding Training unit at Connecting for Health. It is anticipated that the training programme will commence in March 2012 and ongoing gaps in knowledge identified by regular internal audits for context-based training.

Auditing of Clinical Information
The Trust will increase the frequency of internal self-validation audits and widen their scope by identifying specific streams (which may include streams identified by external audits) and reviewing symptom codes used in the primary diagnosis/procedure field, sequencing errors, episodes coded to a chest pain/angina and auditing the activity pertinent to these streams. Any errors will result in corrective action to amend or rectify these codes within the quarterly deadline. Audits will be held internally every three months from March 2012. The Senior Coders will conduct peer reviews monthly and validation quarterly.

Part 3: Other information

This section of the Quality Report gives a three-year overview of performance against:

- indicators which demonstrate the Trust's performance in aspects of patient safety, patient experience and clinical effectiveness
- measures identified in the NHS operating framework for England and the national core standards.

In preparing the Quality Report in 2008/9 (the pilot year for Quality Reports) the Board identified a number of quality metrics and performance indicators that it would track and report annually in the Quality Report to identify progressive improvement in performance. The indicators have been updated to reflect new national standards in line with revisions to the NHS operating framework and Monitor's compliance framework.

Performance of the Trust against selected quality metrics

	National Benchmark	2008/9	2009/10	2010/11	2011/12
Patient Safety					
Falls per 1,000 bed days	5.4(1)	6.05	6.0	6.21	5.76
Medication errors per 1,000 bed days	NA(2)	0.17	0.24	0.34	0.34
Pressure ulcer incidence	0.5-4%(3)	0.89%	0.52%	0.56%	0.45%
MRSA bacteraemia per 10,000 bed days	N/A	0.72	0.36	0.04	0
C.diff cases per 1,000 bed days	N/A	0.37	0.20	0.13	0.13
Hand hygiene compliance	N/A	95%	97%	97%	96.5%
Clinical Effectiveness					
HSMR (Dr Foster 12 month data)*	100	112.2	97.0	100.0	91.5(4)
Caesarean section rate	24%	24.7%	27.4%	26.4%	22.9%
% fractured neck of femur operated within 36 hours	Na	76.9%	64.5%	81.7%	87.53%
Patient Experience					
Formal written complaints received	N/A	672	661	661	551
Formal complaints reopened	N/A	100	122	104	104
Patient Experience Action Team Score	N/A	Triple Excellent	Triple Excellent	Triple Excellent	Excellent x 2 Good x 1(5)

(1) National Patient Safety Agency Benchmark
(2) National Patient Safety Agency Benchmark refers to 100 admissions only, 100 bed days not available.
(3) Research based benchmark
(4) From April 2011 to February 2012
(5) PEAT scores are independently validated assessments of the Trust. They measure the quality of the environment, food and hydration and privacy and dignity (Triple Excellent for Essex County Hospital, Excellent x 2 and Good x 1 for Colchester General Hospital)

The data sources for the information contained in this table are the Trust's Patient Administration System, laboratory systems, complaints database and ward nursing records.

National targets and regulatory requirements

Standard	2011/12 Threshold	2009/10	2010/11	2011/12
Clostridium difficile – year-on-year reduction	25	44	28	28
MRSA – maintaining annual number of bloodstream infections at less than 2003/4 level	1	9	1	0
18-week maximum wait from point of referral to treatment (admitted patients)	90%	90.5%	92.82%	90.97%
18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	97.2%	95.75%	97.18%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge – Trust	95%	98.2%	97.6%	96.64%
Maximum wait – two weeks from urgent GP referral to date first seen cancer	93%	97.9%	96.6%	94.5%
Maximum wait – 31 days from decision to treat to start of treatment for all cancers	96%	95.2%	98.6%	98.4%
Maximum wait – 31 days from decision to treat to subsequent treatment – surgical procedure	94%	86.7%(1)	95.8%	96.8%
Maximum wait – 31 days from decision to treat to subsequent treatment – all drug treatment	98%	99.7%(1)	99.6%	99.8%
Maximum wait – 31 days from decision to treat to subsequent treatment – radiotherapy treatment	94%	N/A	94.6%(2)	98.6%
Maximum wait – 62 days for all referrals to treatment for all cancers	85%	83.2%	86.7%	82.2%
Maximum wait – 62 days from urgent referral from the national screening service to treatment	90%	92.2%	90.9%	89.7%
Maximum wait – 62 days from urgent referral from a consultant (consultant upgrade) to treatment	85%	100%	91.8%	95.1%
Two week wait – symptomatic breast patients (cancer not initially suspected)	93%	94.6%	95.07%	95.2%
Maximum waiting time of 26 weeks for inpatients	99.97%	100%	100%	99.99%
Maximum waiting time of 13 weeks for outpatients	99.97%	99.98%	99.99%	99.98%
Maximum waiting time of two weeks for rapid access chest pain clinics	100%	100%	100%	100%
Sexual health – 48-hour access to Genito-Urinary Medicine (GUM)	95%	98.56%	100%	100%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	95%	100%	100%	100%
Minimising delay transfers of care	<3.5%	1.06%	1.76%	0.24%

(1) Quarter 4 2009/10 only
(2) Quarter 4 2010/11 only

The data included in this table uses the national data definitions as described in rules for the NHS national data sets, the NHS operating framework and Monitor's compliance framework.

The data sources for the information contained in this table are the Trust's Patient Administration System and laboratory systems.

Department of Health Indicators for 2012 / 2013 Quality Report

The following are the Department of Health Indicators that the Trust has chosen to include within the Quality Report for 2011 / 2012.

	2011/12
Emergency readmissions to hospital within 28 days of discharge	6.25%(1)
Responsiveness to inpatients' personal needs	67.3%(2)
Staff who would recommend the provider to friends or family needing care	3.48(3)
Percentage of admitted patients risk assessed for Venous Thromboembolism	94.77%
Rate of C. difficile	0.013%
Rate of patient safety incidents and percentage resulting in moderate, severe harm or death	0.34%

(1) Source – Dr Foster, as at November 2011 (month 8)

(2) Care Quality Commission report, published 24th April 2012. Significant improvement on last year (59.6%) due to the 'At Our Best' programme

(3) Staff Survey, published 20th March 2012. Improvement when compared to last year (3.34), the Trust has worked hard to increase staff engagement.

Annex: Statement from primary care trust, Local Involvement Networks and Overview and Scrutiny Committees

Comments from NHS North East Essex

North East Essex PCT response to Colchester Hospital University Foundation NHS Trust Quality Report for 2011 to 2012

This is the final year that Quality Accounts are being commented on by North East Essex PCT (NHS North East Essex Primary Care Trust [PCT]). The PCT welcomes this Quality Account as a commitment to an open and honest dialogue with the public regarding the quality of care in Colchester Hospital University Foundation NHS Trust. Assurance from the PCT is required to ensure that the information in this Quality Account is accurate, fairly interpreted, and representative of the range of services delivered.

Though the PCT are commenting on a draft version of this Quality Account, it is pleased to be able to assure the accuracy of the content in general. The PCT is however unable to assure all data reported, as some data will have been updated prior to publication.

You describe processes to monitor your own progress through the year, these appear robust. In your account you also celebrate your quality achievements, and as necessary working through any issues that might have arisen in relation to delivering against the priorities for the last year. You give an outline summary of actions taken in the past twelve months and your vision for the year to come. Directors recognise their link to quality care and also the processes involved in delivering and monitoring quality care. You describe changes in practice which have improved patient care and experience, for instance the extension of cover in the Accident and Emergency Department, your progress in the national staff satisfaction survey results and national adult inpatient survey published by the Care Quality Commission.

We note also the improvements in the Hospital Standardised Mortality Ratio (HSMR), a product of significant and wide-ranging work in the Trust during the year. Sustained attention in this area is required, however, in relation to the new mortality measure, the Summary Hospital-Level Mortality Indicator (SHMI), where the Trust has a significantly higher mortality rate in comparison with its peers. An immediate review of your Focussed Clinical Plan is required to address issues related to quality of coding; specific clinical areas of concern; and the interface between secondary and primary care in relation to end of life care.

Your priorities for improvement in 2011 – 2012 have been supported by the North Essex PCT Cluster through the agreement of CQUIN schemes which provide financial incentives to improve quality. We note your success in delivery of the CQUINs, namely reducing the number of falls with serious outcomes for inpatient, the reduction of incidence of pressure ulcers, the commitment to *Think Glucose*; the use of national guidelines to match best practice in the management of births; and the use of intentional rounding that has had a significant positive impact on patients, visitors and staff alike with increased reassurance resulting from greater staff visibility.

We further note your successes in other areas to improve the quality of care for instance:

- A review of predetermined key specific indicators relevant to each speciality
- Reviewing the care and identifying areas of poor / positive practice
- Walkabout and observations of the environment

You give a comprehensive description of your participation in and learning from clinical audit. You give a summary of findings and learning from all clinical audits undertaken.

In your report there is information about your performance in respect of data quality and the improvements you have made in the last twelve months, in particular the improvement in all areas of the recording of the person's NHS number and GP information. In respect of the information governance (IG) tool kit, you report that the Trust has fewer requirements which have not achieved level 2 in Version 9 than the previous Version 8 submission. This remains an area which the PCT feels requires further improvement.

Your priorities for improvement in 2012–2013 are grouped into the dimensions of quality care: Patient Safety, Clinical Effectiveness, and Patient Experience.

We note that within the Trust, a number of convergent areas of work have identified improvement objectives, which are reflected in the priorities we have set for 2012-2013 in the Quality Accounts.

These include:

- Emergency Care Reorganisation
- Clinical Portal
- At Our Best

There are many shared issues in these areas and we note that they come together in the annual CQUIN objectives.

In conclusion the North Essex PCT Cluster considers Colchester Hospital University Foundation NHS Trust Quality Accounts for 2011 to 2012 as providing an accurate and balanced picture of the reporting period. The PCT encourages the Trust to continue to implement the multiple and wide-ranging efforts and initiatives to improve the quality of its services.

Denise Hagel
Interim Director of Nursing
NHS North Essex
24th May 2012

Comments from Essex NHS/Health Overview & Scrutiny Committee (HOSC)

Thank you for giving the Essex HOSC the opportunity to comment on the Quality Report.

The Hospital Trust has liaised closely with the HOSC over recent months. Members of staff met with HOSC officers in January 2012 to discuss a number of issues of mutual interest and how developments could best be reported to, and considered by, the HOSC. Proposals for maternity services in North East Essex have been discussed with the HOSC and will be looked at again once the consultation period is over and the comments received have been considered by the Trust. The HOSC shares the Trust's disappointment that the public feedback during the consultation process has been limited. The proposals for Cancer Services are to be discussed in detail in May 2012 and a tour of the Hospital by HOSC members will take place later that month. This is a valuable opportunity for HOSC Members to see the latest technology and medical practices in operation, as well as a chance to speak to hospital managers, front line staff and patients. One of the HOSC Members now serves on the Hospital's Management Board in an individual capacity.

The HOSC remained aware of the ongoing implications of issues around the Trust's previous management, which culminated in the Chairman being dismissed. The HOSC had a meeting with the newly appointed Chairman and the Chief Executive and welcomed the proposals they put in place to build up staff morale and support after a difficult time for the Trust.

There has been one issue of concern over the past year, with the Trust receiving adverse comments in a CQC inspection looking at standards of care in dignity and nutrition for older people. The HOSC has pursued this issue and how the Trust has responded to it and is satisfied that the concerns of the CQC have been addressed. This will be one of the issues to be discussed in the Member visit in May.

Graham Redgwell
(Secretary to Essex HOSC)
30th April 2012

Comments from Essex & Southend Local Involvement Network (LINk)

The Essex & Southend LINK raised some questions regarding the detail within the report which the Trust is responding to separately. The nature of the comments raised questions of interpretation and detail rather than an overall assessment of the LINK's view of the Quality Report.

The Trust is pursuing the issues identified by the LINK with them directly and will respond to the questions raised, a meeting is in the process of being arranged for the near future. However, in agreement with LINK officers, we are not including those questions in this section.

Annex: Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Reports for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2011-12*;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2011 to May 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to May 2012
  - Feedback from the commissioners dated 24th May 2012
  - Feedback from the LINks dated 10th May 2012
  - Feedback from Essex NHS / Health Overview Scrutiny Committee dated 30th April 2012
  - Feedback from governors at their meetings on 1st March and 26th April 2012
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2011 (in respect of 2010/11 complaints); throughout 2011/12 the Executive Patient Committee and Board's Quality & Patient Safety Committee received and reviewed each month a report on complaints.
  - The national inpatient survey 2011, CQC report published April 2012.
  - The national outpatient survey 2011, published November 2011.
  - The national staff survey, published 20th March 2012
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 18th May 2012.
  - Care Quality Commission quality and risk profiles dated April 2011 to March 2012

- the Quality Report presents a balanced picture of the Colchester Hospital University NHS Foundation Trust's performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate;

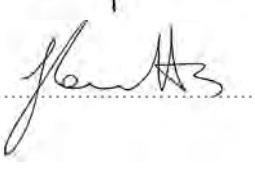
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

24 May 2012.....Date..... .....Chair



24 May 2012.....Date..... .....Chief Executive

Independent Assurance Report to the Board of Governors[9] of Colchester Hospital University NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Board 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 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

Clostridium Difficile cases (page 31)

Maximum wait- 62 days for all referrals to treatment for all cancers (page 31)

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

Respective responsibilities of the Directors and auditors

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

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in the list below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports..

I read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for my report if I became aware of any material omissions.

I read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2011 to May 2012
- Papers relating to quality reported to the Board over the period April 2011 to May 2012
- Feedback from the commissioners dated 24 May 2012
- Feedback from the LINks dated 10 May 2012
- Feedback from Essex NHS / Health Overview Scrutiny Committee dated 30th April 2012
- Feedback from governors at their meetings on 1st March and 26th April 2012
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2011 (in respect of 2010/11 complaints); and monthly complaints reports reviewed by Executive Patient Committee and Board's Quality & Patient Safety Committee from April 2011 to March 2012
- The national inpatient survey 2011, published April 2012).
- The national outpatient survey 2011, published November 2011.
- The national staff survey, published 20th March 2012
- The Head of Internal Audit's annual opinion over the trust's control environment dated 18th May 2012.
- Care Quality Commission quality and risk profiles dated April 2011 to March 2012

[9] The Members' Council

I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). My responsibilities do not extend to any other information.

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

This report, including the conclusion, has been prepared solely for the Board of Governors of Colchester Hospital University NHS Foundation Trust as a body, to assist the Board of Governors in reporting Colchester Hospital University NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Board of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Board of Governors as a body and Colchester Hospital University NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

I 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'). My limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents as listed above.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Colchester Hospital University NHS Foundation Trust.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

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

- the Quality Report is not consistent in all material respects with the sources specified in the list; 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 the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

Rob Murray Date:

Officer of the Audit Commission
Audit Commission, 3rd Floor, Eastbrook, Shaftesbury Road, Cambridge, CB2 8BF

Annex A

Mandatory Services: Evidence on quality of care

Mandatory Services	NPSA Global Trigger Tool assessment	External accreditation	National audits/ Confidential enquiries	Registered completed local clinical audit reports 2011/12	Department & Ward Quality scorecards	Patient Experience Tracker/Meridian Tracker and Net Promoter	Hand Hygiene and Saving Lives	Incident reports	Complaints monitoring	Other evidence
All Trust services										
	Yes	CQC essential standards 1 & 5 dignity & nutrition CQC unannounced visit standards 1,4,5,7,8,14,16,17 Essex Safeguarding Children Board audit	4 national surveys	1	Yes	Yes	Yes	Yes	Yes	Trust wide post-discharge telephone survey. Trust wide Consultants scorecard Trust wide palliative care audit
Surgical Services										
General surgery	Yes		Review of action plan Mid Staffs Enquiry Cardiac Arrest Potential Donor Audit Elective Surgery	1	Yes	Yes	Yes	Yes	Yes	
Breast surgery	Yes	Essex Cancer Network Cancer Peer Review – Breast MDT		4	Yes	Yes	Yes	Yes	Yes	External Quality Assurance East of England Quality Assurance Reference Centre
Colorectal surgery	Yes	Essex Cancer Network Cancer Peer Review - Colorectal MDT - Colorectal Loc group	National Bowel Cancer Audit	1	Yes	Yes	Yes	Yes	Yes	

Mandatory Services	NPSA Global Trigger Tool assessment	External accreditation	National audits/ Confidential enquiries	Registered completed local clinical audit reports 2011/12	Department & Ward Quality scorecards	Patient Experience Tracker/Meridian Tracker and Net Promoter	Hand Hygiene and Saving Lives	Incident reports	Complaints monitoring	Other evidence
Upper gastro-intestinal (GI) surgery	Yes	Essex Cancer Network Cancer Peer Review – Local Upper GI MDT	Oesophago-Gastric Cancer Audit	4			Yes	Yes	Yes	
Vascular surgery	Yes	SHA Vascular Team	Peripheral Vascular Surgery Carotid Interventions	1	Yes	Yes	Yes	Yes	Yes	National Clinical Assessment Team review External review (Professor Michael Gough)
Urology	Yes	Essex Cancer Network Cancer Peer Review - Local Urology MDT	British Association of Urological Surgeons (BAUS) Renal Services Audit (Vascular access; Patient transport) Continence Care Audit	0	Yes	Yes	Yes	Yes	Yes	
Trauma & Orthopaedics	Yes		National Joint Registry Audit Hip Fracture Database Audit Hip, Knee and Ankle Replacements Trauma & Orthopaedic Research Network (TARN)	2	Yes	Yes	Yes	Yes	Yes	

Mandatory Services	NPSA Global Trigger Tool assessment	External accreditation	National audits/ Confidential enquiries	Registered completed local clinical audit reports 2011/12	Department & Ward Quality scorecards	Patient Experience Tracker/Meridian Tracker and Net Promoter	Hand Hygiene and Saving Lives	Incident reports	Complaints monitoring	Other evidence
Ear, Nose & Throat (ENT)	Yes	Essex Cancer Network	Head & Neck Cancer Data for Head and Neck Oncology (DAHNO)	1	Yes	Yes	Yes	Yes	Yes	
Audiology							Yes	Yes	Yes	
Anaesthetics				4			Yes	Yes	Yes	
Critical care	Yes	Intensive Care National Audit Research Centre (ICNARC)	Intensive Care National Audit & Research Centre Severe Sepsis and Septic Shock	1	Yes	Yes	Yes	Yes	Yes	
Pain management	Yes		Pain Management in the ED	1	Yes	Yes	Yes	Yes	Yes	
Ophthalmology	Yes			1	Yes		Yes	Yes	Yes	
Orthoptics				1			Yes	Yes	Yes	
Oral surgery				0			Yes	Yes	Yes	
Orthodontics				0			Yes	Yes	Yes	
Medical Specialties										
Accident & Emergency	Yes	EoE School of Medicine Emergency Care Intensive Support Team (ECIST) Public Health Service Ombudsman (PHSO)	Emergency Use of Oxygen National Audit of Fractured Neck of Femur National Audit of Asthma National Audit of Pain in Children College of Emergency Medicine (CEM): paediatric fever CEM: vital signs In	17		Yes	Yes	Yes	Yes	

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			majors CEM: renal colic Trauma & Orthopaedic Research Network (TARN) Pain Management in the ED Actions to be completed for NCEPOD Emergency Admission National Confidential Enquiries Actions to be completed for NCEPOD Severely Injured Patient, National Confidential Enquiries							
General medicine	Yes		Review of action plan Mid Staffs Enquiry Actions to be completed for Death in Acute Hospitals, National Confidential Enquiries	14	Yes	Yes	Yes	Yes	Yes	
Gastroenterology	Yes	Gastro-intestinal peer review Essex Cancer Network Public Health Service Ombudsman (PHSO)	National Bowel Cancer Audit Project Inflammatory Bowel Disease (IBD) Ulcerative Colitis & Crohn's Disease (National IBD Audit)	1	Yes	Yes	Yes	Yes	Yes	
Cardiology	Yes		Myocardial Ischaemia National Audit	4	Yes	Yes	Yes	Yes	Yes	

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			Programme (MINAP) Heart Rhythm Management Audit Heart failure Audit Acute Myocardial Infarction and other ACS Acute Stroke Stroke Care – National Sentinel Stroke Audit Cardiac Arrhythmia							
Endocrinology	Yes			1	Yes	Yes	Yes	Yes	Yes	
Clinical genetics							Yes	Yes	Yes	
Dermatology	Yes	Essex Cancer Network Cancer Peer Reviews: -Local skin MDT		0			Yes	Yes	Yes	
Thoracic medicine	Yes	Essex Cancer Network Cancer Peer Review – Lung MDT	Adult Community Acquired Pneumonia BTS: pleural procedures BTS: adult asthma Lung Cancer	0	Yes	Yes	Yes	Yes	Yes	
Nephrology	Yes		Renal (vascular access, patient transport)	0	Yes	Yes	Yes	Yes	Yes	

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Neurology	Yes		Stroke Parkinson's UK: National Parkinson's Audit Stroke Improvement National Audit Programme: acute stoke	0	Yes	Yes	Yes	Yes	Yes	
Neurophysiology							Yes	Yes	Yes	
Rheumatology	Yes			0	Yes	Yes	Yes	Yes	Yes	
Geriatric medicine	Yes	Royal College of Physicians stroke accreditation	Falls and Bone Health Audit Dementia Audit	4	Yes	Yes	Yes	Yes	Yes	
Diabetic medicine	Yes		National Adult Diabetes Audit Diabetes (RCPH National Paediatric Diabetes Audit)	1			Yes	Yes	Yes	
Women's & Children's Services										
Obstetrics	Yes	Royal College of Obstetrics and Gynaecology CQC Maternity Services Survey	Perinatal Mortality Centre for Maternal and Child Enquiries (CMACE, MBRACE) Review of action plan Mid Staffs Enquiry	6	Yes	Yes	Yes	Yes	Yes	
Gynaecology	Yes	Colposcopy Quality Assurance Essex Cancer Network Cancer Peer Review – Local Gynae MDT	Heavy Menstrual Bleeding Review of action plan Mid Staffs Enquiry	1	Yes	Yes	Yes	Yes	Yes	

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Midwifery			Perinatal Mortality CMACE Review of action plan Mid Staffs Enquiry	11	Yes	Yes	Yes	Yes	Yes	
Paediatrics/SCBU	Yes	Paediatric Oncology Shared Unit (POSCU) MDT and Level 1 Essex Cancer Network CQC review of support for families with disabled children	Neonatal Intensive and Special Care National Neonatal Audit Programme BTS: emergency use of oxygen BTS: paediatric pneumonia BTS: paediatric asthma Neonatal Intensive and Special Care Childhood Epilepsy (Royal College of Paediatrics and Child Health (RCPCH) National Childhood Epilepsy 12 Audit) Diabetes (RCPCH National Paediatric Diabetes Audit) Pain Management in the ED Review of action plan Mid Staffs Enquiry	6	Yes	Yes	Yes	Yes	Yes	
Genito-Urinary Medicine (GUM)				2			Yes	Yes	Yes	

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Cancer and Clinical Support Services										
Clinical haematology	Yes	Essex Cancer Network		9				Yes	Yes	
Medical oncology	Yes	Cancer Peer Review POSCU Essex Cancer Network Cancer Peer Review - General Acute Oncology MDT - Intrathecal chemotherapy ITC MDT	National Care of Dying in Hospital (NCADH)l	12	Yes	Yes	Yes	Yes	Yes	
Clinical oncology		Cancer Peer Reviews -POSCU MDT and Level 1 -Acute Oncology In-patients MDT -Sarcoma Loc Group -Brain CNS Loc Group Essex Cancer Network	Review of action plan Mid Staffs Enquiry Oesophago-Gastric cancer Head & Neck Cancer DAHNO Bowel Cancer (NBOCAP) Lung Cancer	2	Yes	Yes	Yes	Yes	Yes	
Radiology		Essex Cancer Network Cancer Peer Reviews: -Radiotherapy Brachiotherapy -Radiotherapy IMRT		4			Yes	Yes	Yes	

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		- Radiotherapy external beam Radiotherapy generic								
Blood transfusion		NPSA self-assessment tool Clinical Pathology Accreditation (CPA)	National Comparative Audit of Blood Transfusion: platelets Potential Donor Audit (NHS Blood and Transplant) Bedside Transfusion Medical Use of Red Cells				Yes	Yes	Yes	
Chemical pathology		CPA		5			Yes	Yes	Yes	
Haematology		CPA Essex Cancer Network		12			Yes	Yes	Yes	
Histopathology		CPA		2			Yes	Yes	Yes	
Medical microbiology		CPA EoE Quality Assurance Visit Cytology HSE microbiology		5			Yes	Yes	Yes	
Podiatry							Yes	Yes	Yes	
Physiotherapy				4			Yes	Yes	Yes	
Occupational therapy		Cancer Peer Review - LOC Comp Therapy		0			Yes	Yes	Yes	
Dietetics				2			Yes	Yes	Yes	
Pharmacy		UK Medicines Information		10						

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		Cancer Peer Reviews: -Oncology pharmacy services - Chemotherapy Services MDT								