Colchester Hospital University NHS
NHS Foundation Trust

Annual Report
Annual Accounts
&
Quality Accounts

1 April 2009 – 31 March 2010

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

Colchester Hospital University NHS Foundation Trust

Annual Report, Annual Accounts & Quality Accounts
1 April 2009 – 31 March 2010

Useful contact information

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We care, do you?
It's easy to show you care about the services we provide. Complete an application form and register to become a member of the Trust, or visit our website or phone 0800 783 7328 (free).

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

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www.colchesterhospital.nhs.uk

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

Section C – Quality Accounts

Welcome from the Chair and Chief Executive

It is gratifying to report that the Trust finished the year in a much stronger position than it started, culminating with an announcement by the Care Quality Commission on 1 April 2010 to license the Trust without conditions.

Much of 2009/10 was overshadowed by the Trust's poor performance during the final quarter of the previous year (January to March 2009) which led ultimately to intervention by Monitor in November.

The Trust analysed the reasons for this unacceptable level of performance and concluded that the main cause was a lack of capacity in terms of beds and staff. Even before 2009/10 began, we were putting plans in place to improve performance, and in November Monitor acknowledged that some progress had been made from the start of the year but called for this to be accelerated.

We have successfully executed our plans to expand capacity so that by the end of 2009/10 we had approximately 50 more beds and 300 more staff than we did at the beginning of the year. In the autumn we opened an 11-bed isolation unit and extended our stroke unit by 12 beds at a total cost of £2.8m. These major developments highlight one of the main benefits of NHS foundation trust status, which is to allow surpluses to be invested to improve services and facilities.

Our four-hour A&E performance improved consistently from the beginning of 2009/10 and was the best out of the 17 acute trusts in the East of England for the whole year, despite an exceptionally cold winter. We achieved the 18-week standard for admitted patients from August, which was a month ahead of our schedule, and made significant progress on reducing the Trust's mortality rate, a key component of our patient safety agenda. We continued to perform well in terms of infection control, worked hard to address privacy and dignity issues, such as by implementing a package of measures designed to all but eliminate mixed-sex accommodation, and started to improve the quality of our data.

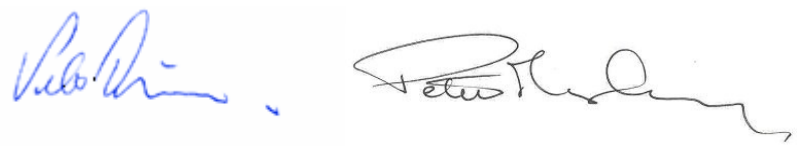
However, this progress was not achieved simply as the result of additional investment and changes to systems and processes. None of this would have been possible without the professionalism, commitment and sheer hard work of our 3,700 staff, support from key partners such as NHS North East Essex and local authorities, and our volunteers. Our thanks go to all of them.

Looking ahead to 2010/11, all NHS organisations will start to feel the squeeze on public sector spending and can expect more of the same in future years. However, the Trust starts from a position of strength because we have no historic debt and have consistently achieved financial surpluses in the recent past.

We have already started to talk to partner organisations about how we can work together more effectively. Our contingency plans do not rest on major cuts to services or increases in waiting times, but on greater efficiency. We are also working hard with staff and the Members' Council to ensure there is no deterioration in patient services, even if funding is restricted.

The Trust is now placing patient safety, improved outcomes and the quality of patient experience even more firmly at the heart of all that we do. If the whole of the care system locally works well together, we will be able to continue to build on the progress we made during the course of 2009/10.

Signatures



Sir Peter Dixon
Chairman

Peter Murphy
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 to people mainly in north east Essex and is an associate teaching hospital of the University of London.

Our vision

Our vision is to become the recognised leading provider of health services in Essex and Suffolk by demonstrating excellence in five key domains:

- patient satisfaction
- financial performance
- employee satisfaction
- clinical performance
- health partners' satisfaction.

Our strategy

The Trust will maintain and develop its market position in north east Essex by placing the patient at the centre of everything we do, based on principles of safety, sustainability and accountability, with a commitment to continuous improvement.

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 is an active member of the Colchester Public Service Partnership and has engaged with a number of other projects concerned with the future development of the local economy and environment.

The Trust has developed good relationships with members and officers at Essex County Council, Colchester Borough Council, Tendring District Council, the Essex Health Overview and Scrutiny Committee and MPs in north east Essex.

Our financial performance

We achieved a financial surplus for the year of £2.3m compared with a surplus of £12.9m for the 11 month period ended 31st March 2009.

	2009/10 £000	2008/09 (11 Months) £000
Operating income	224,324	189,493
Operating costs	206,379	166,727
EBITDA* Surplus	**17,945**	**22,766**
Depreciation, dividend and other costs	10,558	9,108
Fixed asset impairments	5,054	732
Retained earnings	**2,333**	**12,926**

* Earnings Before Interest, Taxation, Depreciation and Amortisation

Our services

The Trust provides a range of patient services:

	2009/10	2008/09
Outpatient attendances*	381,414*	317,005
Accident & Emergency patients	72,354	70,811
Inpatient and day case admissions	77,274	75,437
Babies delivered	3,947	3,880

* This activity includes some specialties which were not included in the 2008/09 figure: clinical neuro-physiology, physiotherapy, occupational therapy and dietetics. If these (45,764) were excluded from the 2009/10 figure, the increase would be just under 6%.

Our sites

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

Scientific staff are also 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 NHS North East Essex – and Halstead Hospital, run by NHS Mid Essex.

Our staff

The Trust is one of the largest employers in north east Essex, employing 3,655 people on 31 March 2010.

Our partners

As a member of Colchester 2020, the Local Strategic Partnership, the Trust works with other public, private and voluntary stakeholders. These include Colchester Borough Council, Colchester Garrison and the University of Essex. 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 has formal contracts or service level agreements with third parties who provide some essential services. The three main contractors are Carillion for facilities management services, Anglia Support Partnerships for payroll and financial systems, and Essex Shared Services Agency (ESSA) for IT support.

Our performance

Innovation in our portfolio of clinical services progressed in 2009/10. Among the many developments, the following are of note:

The Trust:

- created a contingency ward for use at times of excessive demand or to enable the refurbishment and deep cleaning of other wards
- introduced a 24/7 thrombolysis service for stroke patients and weekend clinics for people who have suffered a mini stroke
- opened new drop-in family planning clinics in Clacton and Mistley
- created a third laparoscopic operating theatre for emergency patients following an investment of £277,000
- purchased a heart scanner specifically for use by babies and children following a successful £60,000 appeal
- extended the successful outpatients Appointment Confirmation Service to patients with day case hospital appointments
- in partnership with Anglia Ruskin University, work began on a £2m project to build a world-class training and research and development centre for laparoscopic surgery at Colchester General Hospital (the ICENI Centre)
- established a Level 2 neonatal service, meaning that fewer very sick newborn babies have to be transferred to other hospitals
- developed ophthalmology services to include facilities for the treatment of more diseases affecting the retina, including vitreoretinal surgery and an age-related macular degeneration service
- commissioned more delivery rooms as a Colchester midwife-led delivery unit. The Trust appointed additional midwives to support this facility.

Care Quality Commission rating and other accreditations

In October 2009 the Trust received a Care Quality Commission (CQC) rating of "excellent" for use of resources and "fair" for quality of services for 2008/09.

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

Monitor intervention

In the period from December 2008 to March 2009 performance in the Trust against a number of national standards was poor. This included significant problems in achieving the four-hour A&E 98% standard and the 18-week referral to treatment standard for admitted patients.

These failings exposed weaknesses in the operating systems of the Trust and inadequacies in preparedness and capacity planning, underpinned by poor information systems and analytical capability.

As a consequence of these issues, Monitor became involved with the Trust in reviewing performance and governance arrangements.

While the Trust demonstrated good progress in addressing the specific issues with the four-hour A&E and 18-week standards, during the early part of 2009/10 a number of other concerns were identified by the regulator, including concerns regarding the pace of improvement and the engagement and leadership of the Board of Directors with the urgency of action.

This culminated in Monitor formally intervening in the Trust in November 2009, exercising its powers under section 52 of the 2006 Health Act.

As a consequence of the regulatory intervention, Monitor removed Richard Bourne as chairman of the Trust and replaced him with Sir Peter Dixon as interim chair from 30 November 2009.

Our performance

A&E four-hour standard

A&E is the department where many people come initially for care, and from where many are admitted to hospital. The Trust needs to meet the target of 98% of patients spending four hours or less from arrival to admission, transfer or discharge. Performance was much better than in the previous year. Overall, the Trust achieved 98.18%, with performance during the last three quarters (July – March) higher than the annual average.

18-week referral to treatment standard

The Trust made steady progress in achieving the 18-week referral to treatment national standards. It achieved 90.52% for admitted patients and 97.23% for non-admitted patients for the year, against targets of 90% and 95%.

Our capacity plans for 2009/10 included additional bed capacity to help the Trust cope better with the type of extreme pressures it experienced the previous year, which contributed to this improvement in performance.

During 2009/10 our performance against the challenging national access targets was as shown in the table on the right:

2009/10	Target	Actual March 2010
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	93%	97.92%
Two-week wait for symptomatic breast patients (cancer not initially suspected)	93%	94.56%
Maximum waiting time of 26 weeks for inpatients	99.97%	100%
Maximum waiting time of 13 weeks for outpatients	99.97%	99.98%
18-week maximum wait – admitted patients	90%	91.16%
18-week maximum wait – non-admitted patients	95%	96.44%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	98.18%
Maximum waiting time of two weeks for rapid access chest pain clinics	98%	100%
MRSA year-on-year reduction (year-end target) (annual figure)	13	9
Clostridium difficile year-on-year reduction	84	44
Sexual health – 48-hour access to Genito-Urinary Medicine (GUM) clinics by 2008	95%	98.56%
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days	95%	100%
People suffering a heart attack to receive thrombolysis within 60 minutes of call	68%	88.02%
Maximum waiting time of three months for revascularisation	99%	Not applicable
Minimising delayed transfers of care by 2008	<=3.5%	1.06%

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 (including investment in relocation of the isolation unit for MRSA and Clostridium difficile patients) and a root cause analysis of cases, supported by learning and implementing changes, had a significant impact.

Clostridium difficile	C. difficile incidence is assessed on two measures: o 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 84 cases. We had 44 cases o cases detected in the community, on or within 48 hours of hospital admission – which are considered to be community contracted. The agreed maximum ceiling for the year was 48 cases. We had 48 cases. The quantum of improvement in reducing incidence of C. difficile was substantial and was testament to the vigilance of staff and compliance with best practice. We will continue our vigilant approach to continue to drive down the incidence of hospital-acquired infections in 2010/11.
MRSA bacteraemia	The Trust's target was to have no more than 13 cases of MRSA bacteraemia. The total number was nine, five of which were either on admission or within 48 hours of admission. Compared with other trusts, our starting position on MRSA was quite low and to contain incidence to less than one case a month was a significant achievement.
Surgical site infection	Orthopaedic surgical site infection data reporting has been mandatory since 2005 and the Trust has consistently achieved rates well under the national benchmark.
Hand hygiene monitoring	The Trust monitored hand hygiene compliance with best practice in all clinical areas every month. Compliance overall has improved from 60% in January 2007 to 82% in January 2008, 95% in January 2009 and 98% February 2010.
Data loss and confidentiality breach	As part of NHS information governance rules, details of Serious Untoward Incidents involving data loss or a confidentiality breach have to be reported. There was one instance of inadvertent sharing of confidential patient data to a third party organisation reported as a Serious Untoward Incident.

Future business plans

Our Trust aims to become the health care provider of choice for the population of north east Essex

To achieve this the Trust must demonstrate excellence in five key domains:

- patient satisfaction
- financial performance
- employee satisfaction
- clinical performance
- health partners' satisfaction.

Principal risks and uncertainties

Managing risks through the Assurance Framework

The Board of Directors monitors the key risks to the Trust through the Assurance Framework. The framework maps the high-level risks associated with the achievement of the corporate objectives. Its principal aim is to provide a mechanism for the Board of Directors 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.

There are good levels of incident reporting in keeping with the Trust's approach to developing the safety and risk management culture across the organisation, whereby staff are encouraged to report any incidents that occur so that the Trust learns from them and improves practice.

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

Proposed governance risk rating

Because of their intervention, Monitor risk rated the Trust as red. This status will remain until such time as Monitor's board is satisfied that the Trust can revert to normal rating and regulatory management.

Were it not for the overriding rating by Monitor, the Trust's Board of Directors would have proposed a governance risk rating of green or amber. This assessment was made on the basis of the following factors:

- legality of constitution
- representative membership
- appropriate board roles and structures
- service performance (targets and national core standards)
- clinical quality.

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 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 proposed a risk rating of green. This assessment was made on the basis of the following factors:

- 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 manages and measures performance in line with these objectives
- the Trust was investing in a transformational change programme which will improve clinical processes, efficiency and, where required, release additional capacity, to ensure it can 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 relevant legislation.

Executive directors undertook formal risk assessments against each of the conditions in the terms of authorisation.

No significant risks were identified.

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 below along with the original plan for the year and the actual results

Financial risk ratio (5 = lowest risk)		2009/10 Plan 5	2009/10 Actual 4
Comprising the following key indicators:			
EBITDA margin	*EBITDA as a % of total income*	**9.10%**	**8.00%**
EBITDA % achieved	*% of planned EBITDA achieved*	**100%**	**89%**
ROA	*Public dividend % of assets employed*	**7.70%**	**8.40%**
I&E surplus margin	*Retained surplus as a % of total income*	**4.00%**	**1.00%**
Liquid ratio	*Number of days operating expenses that could be covered*	**61**	**52**

Key balance sheet metrics	2009/10 Plan	2009/10 Actual
Stock days	**42**	**56**
NHS trade debtor days	**6**	**2**
Non NHS trade debtor days	**31**	**13**
Trade creditor days	**18**	**38**

Contractual or other arrangements

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

Summary of contractual relationships

- NHS North East Essex (health care commissioning)
- Mid Essex Hospital Services NHS Trust (plastics)
- North Essex Partnership NHS Foundation Trust (clinical support/ overheads)
- Havering PCT (orthotics, special seating and wheelchairs)
- East of England Ambulance Service NHS Trust (patient transport service)

Overview of other procurement arrangements

The Trust had a number of other procurement arrangements summarised below:

- Carillion (facilities management (FM) services)
- National Blood Service (blood products)
- InHealth (catheter laboratory)
- Essex Shared Services Agency – West Essex PCT (IT services)
- Cambridge and Peterborough NHS Foundation Trust (payroll and financial services)
- Essex County Council (equipment service)
- Alliance Medical (MRI)
- 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 arrangement under the Health Act 1999 with Essex County Council Social Services Department for the procurement, delivery and fitting, collection, refurbishment and recycling of specialist equipment and adaptations to assist in tasks of daily living
- partnership arrangements with Ipswich Hospital NHS Trust and Mid Essex Hospital Services NHS Trust for a range of clinical services
- partnership agreement 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 patients to raise any concerns and anxieties.

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

The Trust has an ongoing audit programme that captures patients' opinions and experiences. It is 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.

An appointment was made to the new post of Deputy Director of Nursing for Patient Safety & Patient Experience.

Patient safety

The Trust signed up to the national Patient Safety First Campaign at the end of 2008 following attendance by senior clinicians, nurses and other allied health professional staff at the Leading Improvement in Patient Safety (LIPS) programme led by the NHS Institute for Innovation and Improvement. From March 2010 a second team attended LIPS to ensure greater understanding of the underlying science improvement techniques taught as part of this national campaign within the Trust.

You can read more about this in our Quality Report in Section C.

Patient safety walkrounds

In August 2009 the Trust began a programme of executive-led patient safety walkrounds based on a new national format. This provides an opportunity for executive and non-executive directors and governors to join the patient safety team on scheduled visits to each clinical area. Discussion focuses on patient safety issues and incident reporting themes, providing an opportunity for areas to present the work they have implemented.

Mortality

Towards the end of 2008 the Trust Board had identified a deterioration in the organisation's Hospital Standardised Mortality Ration (HSMR) as reported by Dr Foster Intelligence, a public-private partnership that aims to improve the quality and efficiency of health and social care.

Supported by the Dr Foster team, the Trust undertook an extensive case note review programme. One of the themes from this audit work showed that documentation and clinical coding of admission data needed to be improved. A significant investment was made in resources, training and education to improve the underlying processes to deliver that improvement.

The Trust also identified areas where care pathways needed improving. For example, it worked with NHS North East Essex to take forward improvements in end of life pathways.

The impact of these improvements is reflected in our up-to-date HSMR data, standing at 84.8 for the period April to December 2009, compared with the figure of 112.1 for 2008/09.

Falls prevention

By 31 March 2012, the Trust aims to reduce the number of falls by 10%, which represents a reduction of 200 falls.

It made substantial further investment, purchasing a range of equipment for high-risk patients. These products prevent falls in the first place and reduce the severity of injury as a consequence of unavoidable falls.

Pressure ulcers

The incidence of patients who acquire or develop pressure ulcers during admission was significantly below the national benchmark. A new system has been developed to ensure a full investigation is completed on any patient that develops significant tissue damage as an inpatient to ensure any potential

failings can be identified and corrected.

Patient Experience Committee

A newly-formed multidisciplinary Patient Experience Committee, with patient involvement, will monitor and drive through improvements. This is chaired by the Director of Nursing & Patient Experience and meets monthly, providing a forum to direct change and advance standards.

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

The Healthcare Commission (predecessor to the CQC) published a children's hospital services follow-up review in December 2008 as an action plan for the Trust with 19 indicators against which the Trust was assessed.

The report identified deficiencies in training for staff coming into contact with children as part of their role in some parts of the Trust, such as A&E, outpatients and day surgery. It highlighted the need for a higher proportion of these staff to receive additional training in areas such as resuscitation and pain management for children, and a need to ensure comprehensive coverage in safeguarding training. The Trust has responded to this with a concerted programme of training and assessment to ensure that, at all times, children are in the care of staff able to identify risks and manage their care safely.

In line with national policy, the Trust invested to preserve patient dignity and privacy on all wards. This included improvements to toilet and bathrooms, and the screening of bays.

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 CQC.

National outpatient survey

The Trust was one of 163 acute NHS trusts involved in the *Outpatient Survey 2009*. The CQC received responses from 420 outpatients seen by Trust staff in the spring of 2009. It shows that the Trust has made significant progress since the last outpatient survey in 2004. It reported that 94.8% of outpatients rated their care as good, very good or excellent. In many areas the Trust performed as well as, or better than, other trusts. Areas for improvement include patients not receiving sufficient information and not all staff introducing themselves.

Parkinson's disease service patient survey

More than 95% of patients in north east Essex rated the communication skills of a specialist nurse service as "excellent", "very good" or "good". The finding was just part of the favourable feedback that the Parkinson's Disease Nurse Service provided by the Trust received in a patient satisfaction survey. A total of 100 patients using the service were sent a questionnaire to their home address, with 63 responding.

Hygiene code inspection

An independent report published in July 2009 gave the Trust full marks for its work to prevent and control infections like MRSA and Clostridium difficile.

The CQC "found no areas for concern" following an unannounced visit by a team of assessors on 19 June.

Its report concluded: "On inspection, we found no evidence that the Trust has breached the regulations to protect patients, workers and others from the risk of acquiring a healthcare-associated infection. Of the 16 measures we inspected, we found no areas for concern."

Privacy and dignity

The Trust's privacy and dignity programme continued to focus on practical improvements to the patient experience. The Trust's arrangements include a quarterly privacy and dignity audit programme as part of the Essence of Care initiative to improve patient care.

Delivering same-sex accommodation

The Trust has completed a statement of compliance recognising that it is virtually same-sex compliant. Much work was undertaken to improve the patient experience regarding same-sex accommodation, including:

- installing sliding doors on wards in the main hospital block at Colchester General Hospital to improve privacy and dignity

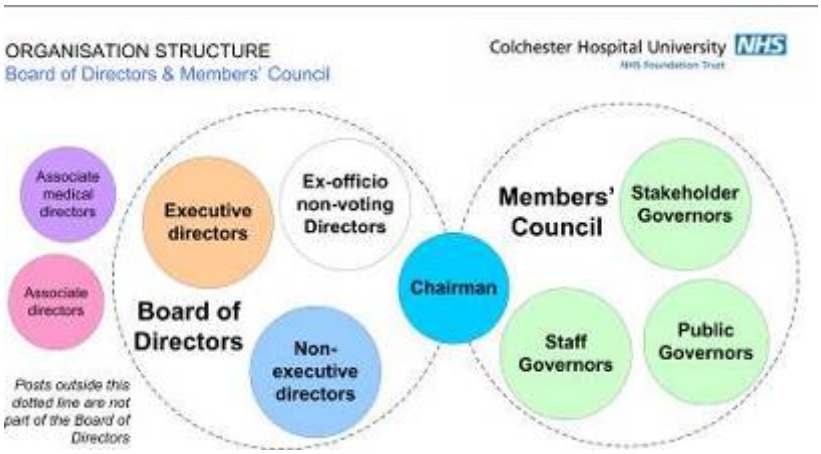
- refurbishing bathrooms and toilets to enable patients to have same-sex facilities
- new male/female signage in all areas
- introducing single-sex wards in specialist medicine
- service redesign in relevant areas to accommodate male/female lists, eg angiography
- developing information leaflets for patients so they know what to expect and are aware of the Trust's commitment to delivering this.

Improvements in patient information

Our patient information strategy continues to ensure health care professionals are able to deliver to patients accurate, up-to-date, easy-to-understand, informative and timely information. Just under 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



Eligibility requirements for joining different membership constituencies

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

Public members are people aged 16 years and over who live in Essex or Suffolk and have registered to become a member (in February 2010, the Trust expanded the area from which it can recruit public members from north east Essex to the whole of Essex and Suffolk).

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

Overall, public membership grew 45% during 2009/10.

The public constituencies are shown below:

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

Public constituency	2009/10	2008/09
Total	**6,352**	**4,377**
o Colchester	3,195	2,274
o Halstead & Colne Valley	876	693
o Rest of Essex and Suffolk	8	0
o Tendring	2,273	1,410
Staff constituency	**2009/10**	**2008/09**
Total	**3,750**	**3,508**
o Allied health professionals/ Healthcare scientists	442	410
o Medical or dental practitioners	349	386
o Not known	18	24
o Nurses/midwives	1,205	1,097
o Support staff	1,736	1,591
o No constituency/Out of catchment	0	0

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

The Trust launched its membership drive in May 2007 and achieved its objective of a public membership of 6,000 by September 2009. There is a fairly uniform distribution across the original catchment area of north east Essex, including areas of deprivation and people from an ethnic minority background.

As with many NHS foundation trusts, there is under-representation of people aged 16 to 59 years.

The Trust's Membership Office ran successful mail-shot and telephone campaigns based on a "We care, do you?" theme.

The Trust aims to recruit 1,000 public members from the Rest of Essex and Suffolk catchment area where there will be two governors representing this new public constituency.

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

Members can contact governors via the Membership Office on 01206 742586 during office hours, email ft.membership@colchesterhospital.nhs.uk

We also have a Membership Helpline 8734610 weekdays, 9.30am to 5pm

To contact a director, people should call 01206 742347 during office hours.

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

Patient trackers monitoring the patient experience

To ensure the Trust has the best possible insight into how patients perceive its services, patient experience tracker devices are used. The questions they ask are chosen to reflect aspects of care that were highlighted in other patient surveys, in complaints and derived from the Essence of Care standards.

The Trust received 43,428 individual patient results from the patient experience tracker devices. Patient satisfaction on our wards in key areas were as follows: hand hygiene 92%, ward/department cleanliness 83.5%, privacy and dignity 93.4% and nutrition 91%.

The tracker continues to provide "live" data to enable staff to evaluate the patient experience and to act on feedback almost immediately.

Most clinical areas consistently attain above 90% satisfaction.

Patient and public involvement

The Trust participated in the consultation regarding the establishment of Local Involvement Networks (LINkS) in Essex. Governors are taking a keen interest in how the organisation complies with the Standards for Better Health. They are involved in many aspects of Trust monitoring to ensure there are standards in place for their communities. For example, there is a governor on the Patient Environment Action Team (PEAT) – see page 18. The governors are involved in the benchmarking process for Essence of Care standards which cover a wide range of patient care standards from privacy and dignity to basic hygiene and tissue viability.

Engaging our staff in developing a patient experience approach

We continued to make significant strides to engage our staff in developing a patient experience approach. There was considerable work in improving communication and developing a customer service and client-based approach to care which will form the fundamentals of our patient experience strategy. To that end, we have undertaken a partnership with the Institute of Customer Service to deliver an accredited customer service training programme aligned to Trust objectives. This accreditation will provide the organisation with a quality standard and deliver a recognised qualification for customer care.

Your Views Count

The Trust has patient representatives on nursing communication, wound management and patient experience groups. Your Views Count suggestion boxes are available around the Trust for feedback on the hospital experience. Sometimes patients do not wish to express their views until they leave. Feedback is encouraged via the PALS office or the Trust website.

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 our external partners Carillion and one of our public governors, held monthly mini-PEAT walkabouts to assist in maintaining cleaning and environmental issues. This has driven standards up and enabled the Trust to address issues as they arose.

Integrated PALS, Complaints and Litigation Services

The Trust is committed to looking at ways of improving its service. People can help by telling the Trust what they think – good or bad. If something is not right, people 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 on call 24 hours a day. In addition, the Trust has an Integrated PALS, Complaints and Litigation Services (IPCLS) team operating during office hours.

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 324 requests for information and 204 Level 1 concerns were recorded.

Information on complaints handling

The Trust continued to operate a robust complaints handling system throughout the year. A total of 1,076 Level 2 and above complaints were received. Of these, 657 (61%) complaints were answered in the timescales agreed with the complainants. A total of 373 (35%) breached the Trust's agreed timescale and 50 (5%) complaints remain open. It is difficult to accurately compare complaint numbers for the reporting period with the previous year. The Local Authority Social Services and NHS Complaints (England) Regulations 2009 changed the way complaints were managed and recorded. The Trust, in line with comparative organisations, has recorded an increase in the number of complaints raised. The Department of Health had expected this development. In recognition of the higher number of complaints and the additional work needed to implement new regulations, an increased staffing level for IPCLS was agreed by the Board.

Local resolution of complaints

A total of 122 (11%) 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 is that complainants have 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

Eighteen referrals were made to the Parliamentary Health Service Ombudsman for further assessment of the complaint. Of these cases, five were transferred from the Healthcare Commission when it ceased to exist from 31 March 2009. Its work is now carried out by the Care Quality Commission.

Service improvements following complaints

The Trust ensured that complaints were reviewed by local clinical governance meetings and that action plans were implemented and reviewed so that learning and changes were made. These included:

- improved staffing and space for A&E and EAU (Emergency Assessment Unit) and the introduction of a new model of care with closer co-operation between the two areas
- developing a comprehensive training programme to improve the way dying patients are cared for
- setting up a working group to look at the prevention of pressure ulcers for orthopaedic patients
- giving basic life support training to all phlebotomy staff as a result of a patient having a heart attack at a phlebotomy clinic
- appointing two new ophthalmology consultants to improve access.

Sustainability and climate change

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 to reduce the adverse effects of its operations on the wider environment.

The overall sustainability strategy of the Trust (or plans in place to develop a sustainability strategy)

The Trust is taking advice and support from the NHS Sustainable Development Unit in developing its draft sustainability development plan, which will be finalised in 2010/11.

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

The Trust has established a Carbon Reduction Steering Group, chaired by an executive director, which oversees the development of plans and acts as a forum for engagement with departmental staff and managers.

Summary performance

Commentary on performance together with prior year comparatives if available

The Trust has worked in partnership with other local public sector organisations, including Colchester 2020, particularly on addressing green transport initiatives.

The Trust's sustainable transport and travel plan helps staff and patients to minimise their impact on the environment through the use of alternative modes of transport.

The Trust has taken significant steps to reduce its energy usage and began to see the benefits, in both financial and emissions terms, of replacing old oil-fired boilers with new modern and more efficient dual-fuel boilers, using a Department of Health grant. The Trust is also, through a phased programme, replacing older light fittings with energy efficient ones.

Comparative data

The table below shows that the generation of both clinical and domestic waste increased over the year in line with rising activity and expansion of the Trust's estate. The rise in energy consumption as a result of the expanding estate is less than would be expected at just under 5%, mainly due to the improved efficiency of the new dual-fuel boilers. Energy costs are significantly lower than last year as a result of the lower prices in the utilities markets.

Area	Volume 2008/09	Volume 2009/10	Cost 2008/09	Cost 2009/10
Waste management: High temp disposal waste (tonnes)	415.49	437.97	£190,182	£188,049
Landfill disposal waste (tonnes)	940.9	1,202.33	£54,971	£63,149
Total Cost			**£245,153**	**£251,198**
	Consumption 2008/09	**Consumption 2009/10**	**Cost 2008/09**	**Cost 2009/10**
Utilities: Water (m^3)	111,361	117,218	£85,184	£95,977
Electricity (Kwh)	11,423,773	12,006,396	£1,272,574	£1,032,289
Gas (Kwh)	18,661,830	25,422,737	£594,617	£610,357
Oil (Kwh)	6,365,151	798,106	£287,495	£37,557
Energy Totals	36,450,754	38,227,239	**£2,239,870**	**£1,776,180**

Future priorities

- appoint an energy & sustainability manager to lead on technical initiatives designed to reduce energy use, emissions and waste, generating both environmental and financial benefits to the Trust
- complete the Good Corporate Citizen Guide assessment as part of the baseline assessment of the Trust's current status
- review and update the sustainable transport and travel plan to ensure the Trust is addressing all practical solutions to minimise unnecessary emissions
- sign up to the Carbon Trust's NHS Carbon Management Programme, learning from others and sharing good practice
- conduct a waste audit to ensure the correct disposal of waste and to maximise opportunities for recycling in all parts of the Trust.

Other environmental issues

The Trust has taken a number of actions to reduce its impact on the environment, including:

- increasing access for staff to recycle paper and cardboard
- continuing the subsidy of bus travel for staff
- continuing the staff Hoppa Bus between Essex County Hospital and Colchester General Hospital.

The Trust completed the conversion of the main steam boilers at Colchester General Hospital from heavy fuel oil to natural gas. This project cost £1.6m with revenue savings of some £200,000, annual energy savings of almost 9,200GJ and carbon dioxide savings of over 1,500 tonnes.

The Trust needs to register for the carbon reduction commitment scheme in 2010/11, although there will be no financial implications until 2011/12. In subsequent years, the financial penalty for not making energy improvements will be quite severe.

Meanwhile, the Trust has bought 500 LED light tubes which use less than 30% of the energy of traditional fluorescent lights. The Trust will draw up a plan to have these tubes fitted in corridors at both hospitals.

Research & Development

The Trust continues to recruit patients primarily to non-commercial, multi-centre studies in the field of cancer. There are a few commercially sponsored studies in cancer, respiratory medicine, cardiology, rheumatology and diabetes. Collaborations with the University of Essex (investigating biomarkers in breast and colorectal cancer) also contribute to the research activity and give the opportunity for the development of medical careers. Health Enterprise East supports the Trust in the exploration of potential commercialisation of intellectual property. Research is supported by the National Institute of Health Research (NIHR) via the Essex and Hertfordshire Comprehensive Local Research Network (E&H CLRN) and other research networks, such as in cancer and diabetes. The Trust is currently involved in 164 studies. In 2009/10, a total of 1,138 participants were recruited into studies recorded on the NIHR database, making the Trust the second highest recruiter among the 18 trusts in E&H CLRN.

Our staff

About our staff

At the end of March 2010 the Trust directly employed 3,655 staff. This is an increase on the previous year and reflects the significant investment made in staffing levels during 2009/10:

	Number of staff (actual numbers, not whole-time equivalents)
31 March 2009	**3,375**
31 March 2010	**3,655**

Equality and diversity

The Trust is committed to equality and to the right of every member of staff to be treated with dignity and respect in the workplace.

It has published equality schemes in line with its public duty, including a bullying and harassment policy and race, disability and gender equality schemes.

Summary of performance – NHS workforce statistics

The data in the table below is from the Trust's membership database and therefore analyses staff members, not all employees.

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

Staff* members are automatically registered when they join the Trust. Staff includes any Trust employee, employees of Carillion who work at the hospitals and also volunteers at the hospitals.

Age**	Staff members 2008/09	Staff members 2009/10	Public members 2008/09	Public members 2009/10
Total	**3,502**	**3,744**	**3,880**	**5,497**
0 to 16 years	0	0	28	7
17 to 21 years	69	73	269	314
22 years +	3,433	3,671	3,583	5,176
Ethnicity				
Total	**3,511**	**3,749**	**4,386**	**6,358**
Not specified	249	241	546	1,699
White	2,875	3,088	3,636	4,434
Mixed	31	22	38	42
Asian or Asian British	248	297	90	93
Black or Black British	54	50	48	59
Other Ethnic Group	54	51	28	31
Other	0	0	0	0
Gender				
Total	**3,511**	**3,750**	**4,386**	**6,358**
Male	704	724	1,760	2,391
Female	2,807	3,026	2,577	3,814
Not specified	0	0	49	153
Transgender data unavailable	-	-	-	-

* 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's Constitution: February 2010).

** Please note:

- 5 active member(s) are excluded from the above table (member type not specified)
- 871 active member(s) are excluded from age analysis (date of birth not specified)

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	Staff members 2008/09	Staff members 2009/10	Public members 2008/09	Public members 2009/10
Colchester	-	-	242	280
Halstead & Colne Valley	-	-	94	104
Rest of Essex and Suffolk	-	-	0	0
Tendring	-	-	222	250
Staff**	2	2	-	-

** In 2010/11 the Trust is due to perform a staff details validation exercise. This will involve sending members of staff details the Trust holds about them (including disabled status) and asking them to confirm that the information is up to date. The Trust will use the Disability Discrimination Act definition of disabled: "someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities".

Future priorities and targets

A single equality scheme is being developed. This work is being overseen by the Equality & Diversity Steering Group which is also developing links with the Trust's stakeholders on equality and diversity issues.

Statement of key priority areas for 2010/2011

- complete the development of the single equality scheme
- win Trust Board approval for the single equality scheme, which will be followed by consultation and implementation
- effective use of the equality impact assessment process on policies, services and functions
- all staff to have received update training on equality and diversity, including a workshop for the Trust Board.

Performance against priority areas (against targets set)

Good progress was made on equality and diversity with the development of a draft single equality scheme and equality impact assessment tool.

Monitoring arrangements

A quarterly workforce report, which covers equality and diversity, was provided for the Trust Board. The Equality & Diversity Steering Group will review the Trust's performance against the objectives within the single equality scheme when it meets on a quarterly basis. It will also receive and review the equality impact assessment reports on a quarterly basis. Workforce statistics will also be reviewed.

Future priorities and how they will be measured

The key priority areas of work will be overseen by the Equality & Diversity Steering Group.

Staff engagement

The Chief Executive holds monthly briefings with senior managers for cascading information to their teams. In addition the Trust has a robust staff engagement strategy. A key element of this is to increase employee engagement and involvement in decision-making. On a monthly basis the Joint Staff Council (JSC) – made up of management and staff representatives – meets so that the views of employees can be taken into account when decisions are taken that are likely to affect them. The Trust sustained arrangements for partnership working with staff representatives with a formal JSC and a (Medical) Local Negotiating Committee. Our approach to partnership working with staff is also reflected in joint working with staff representatives on human resources strategy, education and development, equality and diversity and policy development. The Trust has also sustained its

approach to staff engagement through effective use of the staff survey, a cultural audit and continuation of our focus group approach to meeting with staff. In addition, the Trust also has an intranet to which all employees have access and are able to contribute to the forums.

Staff survey

The *National NHS staff survey 2009* was published by the Care Quality Commission on 17 March. In summary, the survey for the Trust showed a significant deterioration on the 2008 survey when the improvements made in 2007 had been sustained.The 2009 staff survey identified a number of areas where the Trust was among the best 20% performing acute trusts nationally. However, it also identified a number of areas of concern and where the Trust's position had slipped significantly. Overall the number of areas of concern exceeded the number of areas with positive findings.

Details of the key findings from the NHS staff survey 2009

	2008	2008	2009	2009	Trust improvement/ deterioration
Response rate	Trust	National average	Trust	National average	
	59%	52%	54%	51%	Decrease in 5% points
Top four ranking scores 2009	**Trust**	**National average**	**Trust**	**National average**	
Question KF25	1%	2%	1%	2%	No change
Question KF2	91%	89%	93%	90%	Increase of 2% points
Question KF12	81%	80%	82%	78%	Increase of 1% points
Question KF18	15%	17%	15%	17%	No change
Bottom four ranking scores 2009	**Trust**	**National average**	**Trust**	**National average**	
Question KF22	92%	95%	87%	95%	Decrease of 5% points
Question KF32*	44%	45%	35%	47%	Decrease of 9% points
Question KF17	69%	76%	63%	78%	Decrease of 6% points
Question KF16	3.59	3.57	3.48	3.60	Decrease in 0.11% points

Key

KF25: Percentage of staff experiencing physical violence from staff in last 12 months
KF2: Percentage of staff agreeing that their role makes a difference to patients
KF12: Percentage of staff receiving job-relevant training, learning or development in last 12 months
KF18: Percentage of staff suffering work-related injury in last 12 months
KF22: Percentage of staff reporting errors, near misses or incidents witnessed in the last month
KF32: Percentage of staff agreeing that they understand their role and where it fits in
KF17: Percentage of staff receiving health and safety training in last 12 months
KF16: Support from immediate managers

*Please note that question KF32 in 2009 was KF30 in 2008. The comparison figures in this report reflect this.

Action plans to address areas of concerns

We were among the worst 20% of acute trusts nationally in 14 categories, including support from immediate managers, levels of job satisfaction, communications, and work pressure. There was only one area of improvement on the previous year – satisfaction with quality of work and standard of patient care given. The Trust was in the best 20% of acute trusts for perceptions of the staff roles making a difference to patients, extent of job relevant training, incidence of work-related injury and extent of physical violence. Also, the level of workplace stress reported by the 451 randomly chosen staff who responded to the survey was relatively low (which is hard to reconcile with our poor work pressure performance).

Future priorities and targets

The Board of Directors reviewed and endorsed an action plan in April 2010 which was developed in partnership with staff representatives. It has seven themes:

Statement of key priority areas

Communications – this needs to be improved at every level, from the Board to front line managers. A comprehensive approach is needed, using corporate tools and technology but also emphasising face-to-face contact, dialogue, engagement and empowerment. Raising the visibility of the Board will be important.

Leadership style – our leadership style must evolve to emphasise and reinforce the communications approach. This is about moving away from the traditional command and control culture, and senior leaders, middle and immediate line managers engaging and interacting more effectively with staff.

Appraisal – to achieve the aim of 100% of staff having an annual appraisal, which fits in with commitment to communicate and engage more effectively.

Key training – address concerns in the 2009 staff survey by increasing the effectiveness of training in health and safety, equality and diversity, conflict resolution and aggression management, incident reporting and hand hygiene.

Staff engagement and wellbeing framework – relaunch the Staff Engagement Group and, by working closely with staff representatives, develop a health and wellbeing strategy – then publicise and launch it.

Regular staff surveys – continue quarterly online staff surveys to allow the Trust to move away from reliance on an annual survey. One of the aims of these surveys, will be to review the progress made against the action plan.

Workforce strategy – ensure that that the action plan developed as a result of the 2009 staff survey is incorporated into this strategy, updated annually.

Performance against priority areas (against targets set)

- staff engagement events held
- clinical engagement events undertaken
- Trust online surveys developed in March 2010 and now being run on a quarterly basis to monitor progress against particular areas.

Monitoring arrangements

Monitoring will be carried out by completing the Staff Survey Action Plan. Outcomes of the Trust's quarterly staff surveys will monitor further areas for development and areas that are and have improved.

Sickness absence levels

Sickness absence was 3.7% (3.73% last year) – marginally above the Trust's target of 3.5% A revised attendance and absence policy and procedure was approved by the Trust. It is recognised there may be no easy short-term solutions to improving attendance. Every case will be different and, therefore, must be judged on its individual merits. The importance of following a fair procedure cannot be overemphasised. The aim of sickness absence monitoring and control systems within the policy is the reduction of absence levels to an acceptable minimum consistent with genuine illness.

Staff Sickness Absence	2009/10
Total calendar days lost	40,145.09
Total days available	1,084,564.52
Total staff years lost (days lost/365)	109.99
Total staff years available	2,971.41
Total staff employed in period*	4301
Total staff employed in period with absence*	2451
Total staff employed in period with no absence*	1850
Average working days lost per employee	9.65

* headcount, including starters and leavers

Source: Electronic Staff Record

Safe and healthy workplace

In recognition of the full range of services provided and functions performed, the Occupational Health Department changed its name to the Health and Wellbeing Department.

The Trust has well-developed health and safety arrangements as part of its overall risk management strategy. It achieved full compliance at Level 2 for its health and safety arrangements when assessed by the National Health Service Litigation Authority (NHSLA) in January 2008. A further assessment is scheduled for April 2010.

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 provides 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 prosecute 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. Safety of the Trust 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 front line staff.

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

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 which have been 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 2009/10. It also incorporates the operating and financial review:

NAME	POSITION
Sir Peter Dixon	Interim Chairman (from 30 November 2009)
Richard Bourne	Chairman (removed from office 26 November 2009)
Jim Addison	Non-Executive Director/Senior Independent Director (resigned 27 November 2009)
Penny Cavenagh	Non-Executive Director
Bill Craig	Non-Executive Director/Deputy Chairman
Helen Parr	Non-Executive Director
Ian Pettitt	Non-Executive Director
Peter Murphy	Chief Executive
Andrew Armour	Acting Director of Finance (from 9 October 2009)
Sue Barnett	Interim Director of Operations
Rob Bowman	Director of Workforce
Nick Chatten	Director of Corporate Development & Company Secretary
Nick Elliott	Chief Information Officer (from 18 August 2009)
Julie Firth	Director of Nursing & Patient Experience (from 1 June 2009)
Denise Hagel	Director of Nursing & Patient Experience (to 31 May 2009)
Andrew May	Medical Director
Stephanie Watson	Director of Finance (to 6 October 2009)

An indication of likely future development at the Trust

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

It will set out an ambitious programme of infrastructure development, including the following:

- completion of a £20m development in October 2010 to improve the environment of care for children and planned care inpatients
- redevelopment of space released to extend the Emergency Assessment Unit (EAU)
- beginning work on the relocation of cancer services from Essex County Hospital to Colchester General Hospital, which will include providing a new radiotherapy department
- investment in medical equipment and information technology systems to help clinical staff deliver state-of-the-art care.

The plan also includes measures to consolidate the Trust's performance and to strengthen clinical leadership, board governance, performance management systems and patient satisfaction.

It will be published in May 2010.

The Trust is using the freedoms that NHS foundation trust status gives to develop a joint venture with Anglia Ruskin University for a state-of-the-art specialist training and research centre for laparoscopic surgery (the ICENI Centre). Building work is underway and the new department will open in the autumn of 2010.

The Trust will also explore other ventures with NHS and non-NHS providers to develop business opportunities that complement and support its core business. Progress was made on a project to provide a new decontamination unit to serve the Trust, Ipswich Hospital and local PCTs. It will be provided in partnership with G4S and the 10-month building programme is scheduled to begin in 2010/11.

Fixed assets

As the Trust received its authorisation as a foundation trust from 1 May 2008, a full revaluation of land and buildings was undertaken in 2008/09 with a valuation date of 1 May 2008. As a consequence of the prevailing economic climate and the Trust's decision to decommission part of Essex County Hospital, a further revaluation of both hospital sites was undertaken as at 31 March 2010.

Political or charitable donations

The Trust made no political or charitable donations.

Post balance sheet events

Details of any post balance sheet events are provided in note 20 to the accounts.

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 25 to the accounts.

Details of the Trust's quality objectives and performance against those objectives

The Trust's Board Assurance Framework was reviewed in 2009/10 to ensure that it provided an adequate evidence base to support the effective and focused management of the principal risks to meeting the organisation's strategic objectives.

Linking in with the performance management framework, which demonstrates progress against organisational objectives, the Assurance Framework also shows the escalation processes to the Board of Directors and its committees when risk and quality performance issues arise which require corrective action.

The executive director with delegated responsibility for managing and monitoring each risk is clearly identified within the Assurance Framework. It identifies the key controls in place to manage each of the principal risks and explains how the Board of Directors is assured that those controls are in place and operating effectively.

The Board of Directors receives regular reports that detail risk and performance issues in relation to the quality objectives and, where required, the action being taken to address any identified weaknesses. These include monthly "Service Performance Scorecard Rating" operational performance reports against quality and Trust objectives, monthly infection control reports, and disclosure statements relating to the Standards for Better Health.

Operating and financial review

In October 2009 the Care Quality Commission awarded the Trust an annual health check rating of "fair" for quality of services and "excellent" for use of resources in 2008/09. This "fair/excellent" performance assessment was disappointing compared to the "excellent/good" for 2007/08. The Board is working hard to improve its quality of services performance whilst looking to maintain its use of resources rating, although this will be challenging given the economic environment facing the NHS

On the basis of performance in 2009/10 the Trust anticipates a rating of "good/excellent" on similar criteria. This recognises the improvement in performance in the four-hour A&E access times target and achievement of the 18-week referral to treatment standard for admitted patients. The Trust's level of performance on use of resources has been maintained and a rating of excellent is anticipated.

The Trust delivered a surplus of £2.3m against a planned surplus of £8.9m. This £6.6m reduction was mainly due to the revaluation of the Trust's land and buildings. Significant reductions in land and building valuations have occurred since the Trust was last revalued in 2008. The majority of this reduction in value has been written against the revaluation reserve (where these assets had been previously written up). However, £5m has been taken as an expense to the Comprehensive Statement of Income. Part of the write-down relates to Essex County Hospital. The Trust took the decision towards the end of 2009/10 to move all acute services and radiotherapy from Essex County Hospital to Colchester General Hospital. This will release up to three-quarters of the Essex County Hospital site which the Trust can then vacate. This changes the useful life of the site and further contributed to the reduction in asset valuations.

In December 2009 the Department of Health released the NHS operating framework for England for 2010/11. It was clear that the economic environment would deteriorate going forward. The Trust therefore took the decision to bring forward certain items of patient safety related expenditure in to 2009/10 to reduce the need for that expenditure in 2010/11 when finances are likely to be under greater pressure. This expenditure also contributed to the reduction in surplus compared to plan.

The Trust's performance on control of infection was very strong in 2009/10. We achieved fewer MRSA bacteraemia and Clostridium difficile cases than allowed for in our contracts with NHS North East Essex. The reduction in C. diff incidence is considerable, with only 44 cases against a ceiling of 84. There were 70 cases last year (2008/09).

Performance on national standards in relation to the four-hour A&E and 18-week referral to treatment targets was satisfying given the performance in 2008/09 when winter pressures from November onward significantly affected the delivery of both standards. In 2009/10 the Board took a number of measures to build capacity and capability to manage any recurrence of similar pressures. This included investment in additional beds and clinical staff, and stronger clinical and executive management oversight of the emergency system. This made a significant difference at peak periods of demand, particularly during adverse weather. In 2009/10 we achieved both the four-hour A&E and 18-week referral to treatment standards throughout the winter and continue to do so.

In November 2009 Monitor used its regulatory powers to remove Richard Bourne as Chair of the Trust and appointed Sir Peter Dixon as Interim Chair. The decision to intervene was taken by Monitor's Board as it considered the Trust was in significant breach of its terms of authorisation. In particular Monitor considered that the Trust had failed to comply with health care standards; failed to exercise its functions effectively, efficiently and economically; and had serious and wide-ranging concerns as to overall governance and leadership at the Trust. The Trust has been working with Monitor since the intervention to address its concerns and significant progress has been made, which has been acknowledged by the regulator.

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 was made on 7 April 2010 and required 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 continued to perform strongly during 2009/10, achieving a retained surplus for the year of £2.3m (£7.4m pre-asset valuations) compared to £12.9 for the 11 month period ended 31st March 2009. Total income grew by 8.5% during the year to £224m. The Trust invested over £16m in new and replacement capital assets, including £4m on a two-storey ward block (the total cost of which will be £20m) which is due for completion in late 2010. This investment was financed internally. The Trust had very strong cash reserves, which stood at £44m at the end of March 2010. This strong financial performance gives the Trust a score of 4 against the financial risk rating metrics developed by Monitor to measure the financial performance of NHS foundation trusts (the maximum possible score is 5), which represents a good result for the organisation. The economic environment going forward will make it harder for the Trust to build up significant cash reserves and as the capital programme progresses we expect cash balances to reduce significantly.

Due to the changes in tariff in 2010/11 we are expecting our income to fall in real terms and we expect further reductions in 2011/12 and beyond. This will mean that the Trust needs to deliver at least the same level of activity as 2009/10 for less money. The focus on efficiency savings will be increased and 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 2010/11 we are planning to deliver a surplus of £2.3m which, under Monitor's risk rating assessment mechanism, will give us a rating of 3 (the maximum possible score is 5). Further surpluses are planned for future years at a similar level. As a foundation trust we have the ability and autonomy to invest these surpluses in our services, our core strategic developments and our future facilities.

We have further developed our service line reporting capability and implemented Service Line Management (SLM) on 1 April 2010. This has involved the creation of four divisions: Surgery, Medicine, Women's and Children's, and Cancer and Support Services. SLM allows specialist clinical areas to be managed as distinct operational units. It enables us to understand our performance and organise our services in a way which benefit patients and deliver efficiencies for the Trust. It also provides a structure within which clinicians can take the lead on service development, resulting in better patient care.

Future developments

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

- developing purposed-designed facilities for the assessment and admission of acutely ill patients
- centralising cancer care facilities
- 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 can be made for services
- moving pathology services from the Severalls Hospital site by 2012
- improving the general environment for care and, in particular, addressing the privacy and dignity needs of patients.

Going concern statement

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 of the steps that 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 exits 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

In developing its constitution as an NHS foundation trust, the Board reviewed the code of governance and incorporated into its constitutional documents the main and supporting principles detailed within the code

As part of this review it determined that all of the non-executive directors are independent in character and judgement and that there were no relationships or circumstances which were likely to affect, or could appear to affect, the directors' judgement. The Board of Directors complies with the NHS Foundation Trust Code of Governance with the exception of two areas, C.2.1 and E.1.1. The Remuneration and Terms of Service Committee considered these two areas and agreed:

- C.2.1 – Issue of five-year contracts to its executive directors should not be introduced for the following reasons

  - executive directors hold substantive open-ended contracts of employment with the exception of the medical director. To change to fixed term contracts would be detrimental to recruitment of highly skilled staff

  - executive directors are subject to regular review of performance, and existing procedures allow for appointments to be terminated if performance is not satisfactory

  - the structure of the Board of Directors is reviewed regularly under existing procedures and, upon any vacancy which may arise, the scope for refreshing the Board is taken.

- E.1.1 – Performance-related elements of the remuneration of executive directors should not be introduced for the following reasons:

  - the level of remuneration was considered to be adequate and in line with industry standards

  - concern that the introduction of performance-related pay at this time would not further promote the Trust's ability to achieve standards and targets, nor was it consistent with the strategy to develop a team-based approach to executive directors' performance management.

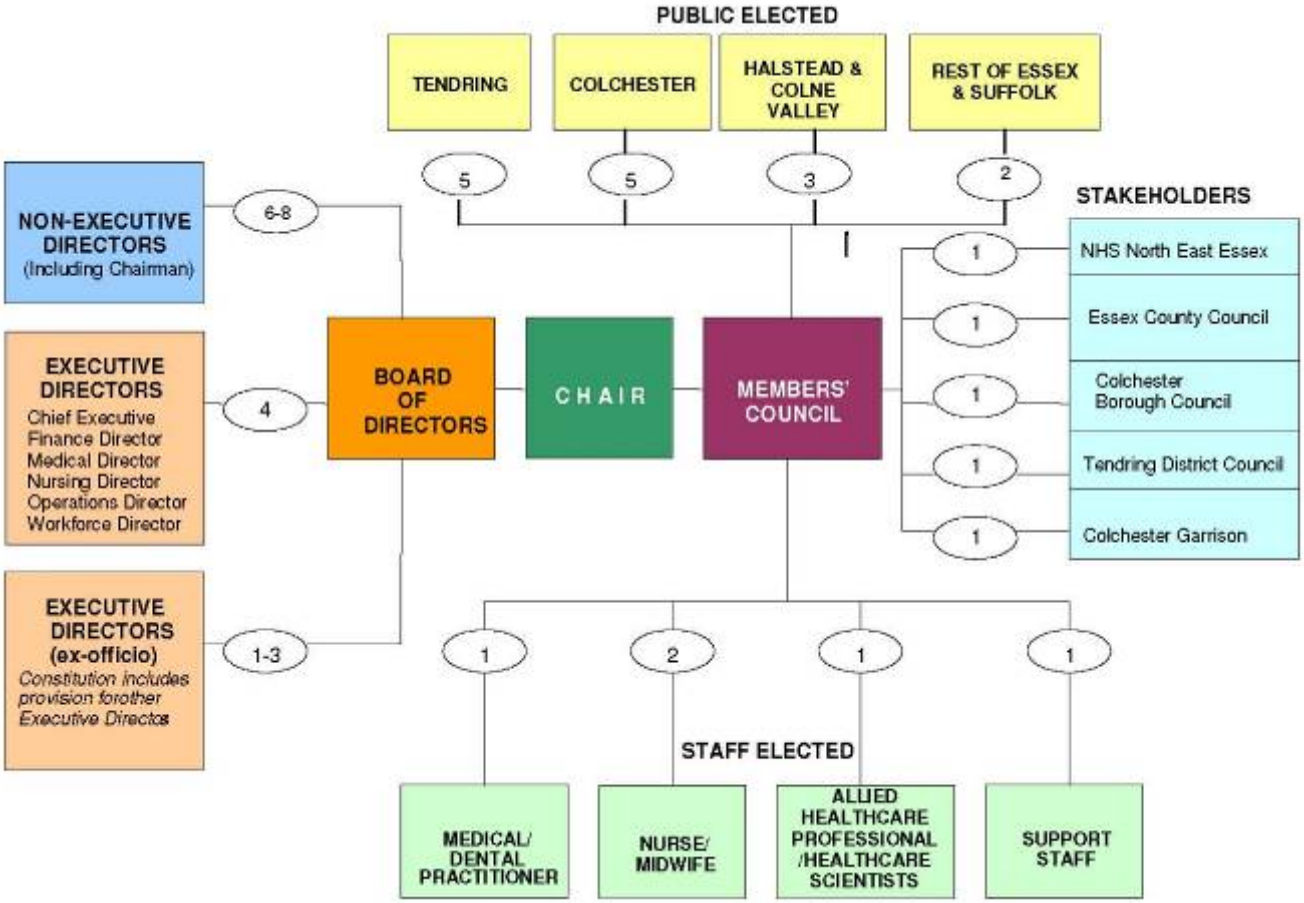
Our Members' Council

Members' Council responsibility

The Members' Council represents the interests of the public and employees through its elected governors and its appointed stakeholder governors (from certain local partner organisations).

Composition of the Members' Council

The Members' Council is composed of 25 members, following the decision to add two new public governors to represent the Rest of Essex and Suffolk:



Directors and governors working together

The Members' Council's role continues to develop but 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 assists 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.

Committees and panels

The Members' Council met with representatives from the Board of Directors in December 2009 to receive an update on the Trust's clinical strategy.

Formal interaction between governors and the Board of Directors takes place at the following joint Board and Members' Council committees:

- Nominations Committee
- Appointments and Performance Committee.

Less formal interaction between governors and representatives of the Board of Directors takes place at the following three working groups of the Members' Council:

- Strategy and Planning Panel
- Healthcare Standards Panel
- Membership Engagement Panel.

Governor representation on the following also began:

- Quality & Patient Safety Committee
- Patient Safety Committee
- Resilience Planning Group.

In January 2010, Board meetings were opened to the public, although governors had already been able to attend in an observational capacity.

A programme of non-executive director and governor hospital walkrounds was implemented which involved individual non-executive directors and governors accompanying one another on site tours of Trust premises.

In March 2010, a panel made up of governors, non-executive directors and an executive director shortlisted, interviewed and appointed the Trust's external auditors.

January 2010 saw the implementation of the recruitment process to appoint four non-executive directors. In March 2010 the shortlisting and informal and formal interview process was undertaken by a mixture of governors, executive directors and current non-executive directors.

As part of the Trust's membership engagement strategy, monthly health talks are held across north east Essex, hosted by a director or governor. Between 20 and 120 people attended each talk.

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 2008:

Colchester	Tendring	Halstead & Colne Valley
Claire Askham *(resigned March 2010. By-elections to be announced)*	Frank Baker	James Buckley-Saxon (*resigned December 2009)* Pauline Aldridge (*elected March 2010)*
Ray Cole	Hazel Law	John Dann
Violet Haddow	Mark Lowdell *(resigned July 2009)* Marilyn Jones (*elected March 2010)*	Tina Sivyer
Samantha Laycock	Andrew Patrick	
Des McCarron	Jean Smith	

Elections for two new public governors to represent the Rest of Essex and Suffolk have not yet been held. Eventually, there will be two public governors representing this new constituency. This is consistent with the Trust's long-term vision as it increases opportunities for patient representation in mid Essex and south Suffolk, and expands the catchment area for recruiting non-executive directors. Monitor approved the change to the Trust's constitution, which had already been supported by the Members' Council and Board of Directors.

Staff governors

Staff governors: representing and elected by staff members of the Trust for a period of three years, effective from 1 May 2008:

Medical & dental	Nursing & midwifery	Allied healthcare professionals/ Healthcare scientists	Support staff
John Eddy	Donna Booton Carrie Tyler	Isaac Ferneyhough	Val Asker

Turnout in the constituencies

All governors were elected by members of the Trust from their own constituencies with the exception of Val Asker, who was elected unopposed. The first elections, which were "first past the post", closed on 10 April 2008. Two by-elections were held in March 2010 following the resignation of two public governors.

Constituency	Turnout April 2008	By-election turnout
Colchester	48.6%	
Tendring	54.7%	
Halstead & Colne Valley	47.8%	
Medical & dental	32.4%	
Nursing & midwifery	31.9%	
Allied healthcare professionals/ Healthcare scientists	30.1%	
Support staff	Unopposed	
Tendring by-election (closed 4 March 2010)		30.9%
Halstead & Colne Valley by-election (closed 19 March 2010)		33.7%

The Association of Electoral Administrators acted as returning officer and independent scrutineer for the first elections in 2008 and the two by-elections in 2010.

Appointed stakeholder governors

NHS North East Essex: Matt Bushell was appointed for three years in May 2008. He stepped down in September 2008 and was replaced by Richard Kearton in April 2009 for a period of three years.

Colchester Borough Council: Gareth Mitchell was appointed for three years in May 2008. He stepped down in June 2008 and was replaced by Cllr Martin Hunt in July 2008 for a period of three years.

Tendring District Council: Cllr Les Double was appointed for three years in May 2008. He stepped down in March 2010 and has not yet been replaced.

Essex County Council: Cllr David Finch was appointed in May 2008 for a period of three years. He stepped down from in December 2009 was replaced by Cllr Anne Brown in January 2009 for a period of three years.

Colchester Garrison: Colonel Nick Strowbridge was appointed for a period of three years in May 2008. He stepped down in February 2010 and was replaced by Major Simon Rothwell in March 2010 for a period of three 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 Trust company secretary, and is available for inspection by members of the public. Anyone who wishes to see the register should contact the Trust company secretary at the address on page 2.

Members' Council meetings

There were eight formal Members' Council meetings:

2 April, 15 July, 10 September (Annual Public Meeting for the year 2008/09), 9 October, 22 October, 2 December, 25 January, 4 March.

Governor attendance at Members' Council meetings

Name	Attended	Name	Attended
Andy Patrick	5/8	Hazel Law	6/8
Carrie Tyler	8/8	Isaac Ferneyhough	8/8
Claire Askham	3/8	James Buckley-Saxon***	6/6
Cllr Anne Brown	4/4	Jean Smith	7/8
Cllr David Finch*	2/6	John Dann	4/8
Cllr Les Double	5/8	John Eddy	7/8
Cllr Martin Hunt	6/8	Major Simon Rothwell	1/1
Colonel Nick Strowbridge	5/8	Marilyn Jones	0/0
Des McCarron	4/8	Ray Cole	6/8
Donna Booton	7/8	Richard Kearton	5/8
Mark Lowdell**	1/1	Tina Sivyer	7/8
Samantha Laycock	6/8	Val Asker	8/8
Frank Baker	7/8	Violet Haddow	4/8

* On two occasions Cllr David Finch sent a deputy
** Mark Lowdell resigned in July 2009
*** James Buckley-Saxon resigned in December 2009

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, their business acumen and their links with the local community.

The Board of Directors comprises a chairman, six further non-executive directors and six voting executive directors. There are two further non-voting executive directors. The Board also has a clinical adviser, a retired senior NHS consultant, who is able to give advice to the non-executive directors where necessary.

The Members' Council appointed the chairman 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 Act stipulates that the chairman and non-executive directors of the NHS foundation trust should be the chairman and non-executive directors of the applicant NHS Trust if they wish to be appointed. The chairman and non-executive directors were appointed for the unexpired period of their terms of office (or 12 months – whichever was the longer) by the Members' Council at its inaugural meeting in May 2008.

On 26 November Monitor removed Richard Bourne from the office of chairman of the Trust. Monitor appointed Sir Peter Dixon as interim chair for a period to be reviewed by the regulator.

The removal of a non-executive director requires the approval of three-quarters of the Members' Council.

Disclosures of the remuneration paid to the chairman, non-executive directors and executive directors are given in the remuneration report (page 56).

About the non-executive directors

NAME & POSITION	APPOINTMENT & TERM OF OFFICE	AREAS OF EXPERTISE, INTEREST or RESPONSIBILITY
Richard Bourne*	**Chairman** **Appointed:** 1 December 2005 **Term of office:** Terminated 26 November 2009 *Chairman of the Board of Directors, Members' Council, Nominations, Remuneration and Terms of Service Committees.* *Member of the Members' Council's Appointment and Performance Committee.*	Richard has served on the policy board of NHS Employers and has been a member of the NHS Social Partnership Forum. He works as a management consultant and as a director of a family business.
 **Sir Peter Dixon****	**Interim Chair** **Appointed:** 30 November 2009 **Term of office:** To be reviewed by Monitor *Chairman of the Board of Directors, Members' Council, Nominations, Remuneration and Terms of Service Committees.* *Member of the Members' Council's Appointment and Performance Committee*.	Sir Peter was appointed chairman of University College London Hospitals NHS Foundation Trust (UCLH) in 2001 and was re-appointed for a final two-year term in June 2008. He was Chairman of the Housing Corporation, the government's affordable housing agency, until 2008. His previous working life included running a variety of businesses as well as working in banking and finance. He was awarded a knighthood for services to the housing sector in the New Year Honours List 2009.
 **Bill Craig***	**Non-Executive Director and Deputy Chairman** **Appointed:** 1 May 2007 **Term of office:** Expires 30 April 2011 *Deputy Chairman of the Board of Directors, and Member of the Audit and Remuneration and Terms of Service Committees. He is also Chairman of the Finance Panel. Bill's specialist interests in the Trust include finance, delivery of sustainable financial performance, coupled with improving patient experience and satisfaction and developing effective governance structures.*	Bill has been a non-executive director in the NHS since 1995, with experience in both the mental health and acute sectors. He also has over eight years' non-executive director experience in the Department of Transport including: Group Board Membership, Agency Board Membership and Membership of the Department of Transport Group Audit Committee. His commercial career, mainly with the Ford Motor Company, focused on finance, sales and marketing, general management at Board level, including programme and project management responsibility.
Jim Addison*	**Non-Executive Director and Senior Independent Director** **Appointed:** Second term of office: 1 March 2008 **Term of office:** Resigned 27 November 2009 *Education, training, patient experience, clinical governance, local health care developments and workforce development. Member of the Audit and Remuneration and Terms of Service Committees.*	Jim has been a senior manager at Colchester Institute since 1989, a magistrate since 1990 and a non-executive director of the Trust since March 2004. Before joining Colchester Institute, he worked at The Philip Morant School, Colchester, for seven years. He started his career in education in 1974 as a mathematics teacher at another Colchester comprehensive, Sir Charles Lucas School, before leaving in 1977 to teach at The British Schools, Montevideo, Uruguay, for four years.

About the non-executive directors

NAME & POSITION	APPOINTMENT & TERM OF OFFICE	AREAS OF EXPERTISE, INTEREST or RESPONSIBILITY
 **Penny Cavenagh***	**Non-Executive Director** **Appointed:** 1 January 2005 **Term of office:** Expires 30 April 2010 *Chair of Charitable Funds Committee, Chair of Clinical Excellence Awards, member of Nominations and Remuneration and Terms of Service Committees. Interests in particular lie in medical management and organisational development.*	Penny is a chartered psychologist, a qualified speech and language therapist and a Fellow of the Higher Education Academy. Current position: Director of Research and Enterprise at University Campus Ipswich. Her research interests are in medical education. She is currently working on a research project with the University of East Anglia's medical school on F1 doctors' fitness to practice.
 **Helen Parr***	**Non-Executive Director** **Appointed:** 1 December 2006 **Term of office:** Expires 30 November 2010 *Member of the Audit, Remuneration and Terms of Service and Nominations Committees and the Finance Panel. Helen's specialist interests in the Trust are in reputation management, workforce development and patient safety.*	Helen has held previous non-executive director roles in other parts of the Health Service as well as director level roles in education. She is a former Principal and Chief Executive of Colchester Institute and Oaklands College in Hertfordshire. Previously, she had worked in marketing and public relations in the engineering industry and then the tobacco industry. She is currently a self-employed management consultant working in education and public relations, and a local magistrate.
 **Ian Pettitt***	**Non-Executive Director** **Appointed:** 1 January 2005 **Term of office:** Expires 30 April 2010 *Chair of Audit Committee and a member of the Charitable Funds and Remuneration and Terms of Service Committees. His particular areas of interest include finance, estates and the patient experience. He has specialist skills in leadership, finance and business and organisational change.*	Educated at Colchester Royal Grammar School, Ian is former chairman and chief executive of the Hutton Group. He has long experience in construction, property development and investment with more than 30 years' experience of operating at board level in public and private companies. He is the honorary treasurer of the Old Colcestrian Society and chairman of Littlegarth School.

* appointed originally to Essex Rivers Healthcare NHS Trust

** At its Board meeting on 26 November 2009, Monitor reconsidered the Trust's position and concluded that it was in breach of its terms of authorisation. Consequently, Monitor's Board decided to use its powers of intervention to remove Richard Bourne as Chair with immediate effect. On 30 November, Sir Peter Dixon became our interim Chair. He maintained his UCLH role.

About the executive directors

NAME & POSITION	APPOINTMENT & TERM OF OFFICE	AREAS OF EXPERTISE, INTEREST or RESPONSIBILITY
 **Peter Murphy**	**Chief Executive** **Appointed as Board Director:** July 2004 **Term of office:** Permanent **Notice period:** Trust: six months Employee: three months *Accounting officer for the Trust, carrying full responsibility for its performance, forward planning and leadership of the executive directors and clinical leads.*	Provides highest level of leadership and direction and develops and maintains a shared vision of the strategic aims, values and culture of the Trust across the organisation. Accountable officer responsible for the overall performance of the Trust. Accountable officer responsible for ensuring the Trust meets all of its statutory and service obligations and works in partnership.
 **Sue Barnett**	**Director of Operations** **Appointed as Board Director:** April 2009 **Term of office:** Interim *Overseeing operational performance and services.*	An accountant by profession, Sue has held senior finance and operational management positions in the NHS in Essex, London and the South East.
Stephanie Watson	**Director of Finance & Performance** **Appointed as Board Director:** March 2004 Stephanie left the Trust on 8 October 2009.	Stephanie was a Director of Finance at James Paget Healthcare NHS Trust, and before that a former accountant in the private sector (mostly retail). She is treasurer and trustee of St Mary's the Virgin Church, Withersfield, and a trustee of the Withersfield Village Hall Committee.
 **Andrew Armour**	**Director of Finance** **Appointed as Board Director:** October 2009 **Term of office:** Interim **Notice period:** Trust: one month Employee: three months *Finance, capital investment and commissioning.*	Andrew joined the Trust from Grant Thornton chartered accountants where he latterly worked with trusts going through the foundation trust process, on mergers between trusts and helping trusts with efficiency plans. Before this, he worked in insolvency, corporate restructuring and corporate finance.

About the executive directors

NAME & POSITION	APPOINTMENT & TERM OF OFFICE	AREAS OF EXPERTISE, INTEREST or RESPONSIBILITY
Denise Hagel	**Director of Nursing & Patient Experience** **Appointed as Board Director:** August 1998 Denise retired on 8 July 2009.	Denise joined the Trust in 1998 as Director of Nursing & Quality Improvement and became Deputy Chief Executive in 2002. She has over 30 years' experience in acute, primary and community nursing, and has had senior nurse management roles in both providing and commissioning health care. Denise had significant professional involvement at a national level, being a past Chairman of The Community Practitioners' and Health Visitors' Association and the first nurse adviser to sit on the Medicines Commission.
 **Julie Firth**	**Director of Nursing & Patient Experience** **Appointed as Board Director:** July 2009 **Term of office:** Permanent **Notice period:** Trust: six months Employee: three months *Professional nursing adviser to Board, nursing strategy and nurse management, clinical governance and quality improvement, risk management, integrated governance, complaints and litigation, executive-lead for health and safety, pandemic flu, emergency planning, child protection and infection control.*	Julie was Deputy Chief Nurse at University College London Hospitals NHS Foundation Trust (UCLH) before joining the Trust. She has held a number of senior nursing positions across London, including at Barts and The London and Guys and St Thomas'. Julie has been involved with a number of national level projects including the Association of UK University Hospitals nurse acuity scoring steering group, ward sister project (Royal College of Nursing) and assistant practitioner development with London higher education institutes. She was also interim director of nursing at the Luton and Dunstable Hospital NHS Foundation Trust.
 **Andrew May**	**Medical Director** **Appointed as Board Director:** November 2008 **Term of office:** Three years **Notice period:** Trust: three months Employee: three months *Medical workforce appointments, training, appraisal and continuing professional development, clinical governance, audit and effectiveness and Caldicott Guardian.*	Andrew was a full-time consultant surgeon at Colchester from 1982, with a particular interest in vascular work and endocrine surgery before he retired in August 2008. His continued interest in local health care led him to apply successfully for the post of Medical Director.

About the executive directors

NAME & POSITION	APPOINTMENT & TERM OF OFFICE	AREAS OF EXPERTISE, INTEREST or RESPONSIBILITY
 **Rob Bowman**	**Director of Workforce** **Appointed as Board Director:** December 2008 **Term of office:** Permanent **Notice period:** Trust: six months Employee: three months *Overseeing 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.*	Rob is also chair of the East of England Human Resources Directors Network, making sure the Trust is well connected to developments in the regional area. He has a particular interest in staff engagement and is very committed to how this can be improved and developed in the Trust. He has over 20 years' experience of human resources practice, gained across all sectors of the NHS. Before joining the Trust he was associate director of workforce at a major teaching hospital in Manchester.
 **Nick Elliott**	**Chief Information Officer + +** **Appointed as Board Director:** August 2009 **Term of office:** Interim (18 months) **Notice period:** Trust: three months Employee: three months *Overseeing transformation programme, information reporting and assurance, information technology, data quality, performance reporting, senior responsible officer for information governance.*	Nick has experience in the public and private sectors in both information technology and operational management roles. Having led substantial change programmes as chief information officer, then chief operating officer, in the Midlands, he joined the Trust following an interim role as director of operations at Ipswich Hospital.
 **Nick Chatten**	**Director of Corporate Development & Company Secretary + +** **Appointed as Board Director:** April 2009 (substantive from September 2009) **Term of office:** Permanent **Notice period:** Trust: three months Employee; three months *Overseeing corporate governance; planning and business development; estates and facilities management.*	Nick has worked in and with the NHS all his working life. His career has included spells as an executive director with trusts in London and the Home Counties. Prior to joining the Trust he worked as a management consultant with a number of NHS organisations supporting operational management, turnaround, strategic development and process design.

++ 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 company secretary and is available to anyone who wishes to see it. Inquiries should be made to the Trust Secretary at the address on page 2.

Evaluation of the Board of Directors' performance

The Board of Directors' meetings

The Board held 14 meetings: 30 April, 28 May, 4 June, 25 June, 21 July, 30 July, 27 August, 24 September, 29 October, 26 November, 31 December, 28 January, 25 February and 25 March.

From January 2010 all Board meetings were held in public.

Meetings attended in 2009/10

NAME	TITLE	ATTENDED
Sir Peter Dixon	Interim Chairman (from 30 November 2009)	4/4
Richard Bourne	Chairman (to 26 November 2009)	10/10
Jim Addison	Non-Executive Director (to 27 November 2009)	9/10
Penny Cavenagh	Non-Executive Director	11/14
Bill Craig	Non-Executive Director/Deputy Chairman	13/14
Helen Parr	Non-Executive Director	10/14
Ian Pettitt	Non-Executive Director	13/14
Peter Murphy	Chief Executive	14/14
Andrew Armour	Acting Director of Finance (from 9 October 2009)	6/6
Sue Barnett	Interim Director of Operations	12/14
Rob Bowman	Director of Workforce	12/14
Nick Chatten	Director of Corporate Development & Company Secretary	13/14
Nick Elliott	Chief Information Officer (from 18 August 2009)	6/8
Julie Firth	Director of Nursing & Patient Experience (from 1 June 2009)	8/12
Denise Hagel	Director of Nursing & Patient Experience (to 31 May 2009)	4/4
Andrew May	Medical Director	13/14
Stephanie Watson	Director of Finance (to 6 October 2009)	7/8

Evaluation of the Board

As part of the response to Monitor's concerns, in summer 2009 the Trust commissioned from PricewaterhouseCoopers LLP an independent review of aspects of its operations, including the clarity of lines of governance reporting to the Board. This review highlighted concern that the Board committee arrangements were not sufficiently robust to give assurance on all aspects of the Trust's operations and that, in particular, there was confusion and duplication around some aspects of assurance. In December 2009 the Board began a review of all lines of assurance and in March 2010 approved a revised committee structure led by non-executive directors focusing on the key assurance lines – audit & risk, quality & patient safety and finance & commissioning. The Board has also committed to establishing early in 2010/11 a committee to review any major investment decisions, and another to oversee and assure the Trust's transformation and organisational development work.

The new committee structure became fully operational on 1 April 2010 and will be reviewed during 2010/11 to ensure it is performing as required to strengthen board assurance.

Board development

In February and March 2010 the Trust began processes to appoint to four non-executive director posts. Appointments were made by the Members' Council in early April 2010. Early in 2010/11 the Members' Council will recruit to the position of chairman. The current chief executive has given notice of his resignation with effect from 31 August 2010. A process to appoint to this critical role will also begin early in 2010/11.

With a new chairman, chief executive and four new non-executive directors, together with planned substantive appointments to two executive director posts, there will be a need to review the board's development needs in 2010/11.

Ongoing development

The Chairman holds 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 meets informally every two/three months as part of its ongoing team development.

Appraisal process for the non-executive directors

After authorisation as an NHS foundation trust, the Chairman and Director of Workforce worked with the Members' Council's to develop an appropriate appraisal process for the non-executive directors.

Appraisal of non-executive directors is carried out by the Chairman, advised by the Members' Council Appointments and Performance Committee.

Committees of the Trust Board

There are four committees of the Trust Board:

- Audit Committee
- Nominations Committee
- Charitable Funds Committee
- Remuneration and Terms of Service Committee

Audit Committee

Comprises four non-executive directors

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 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 their work.

The Audit Committee held four meetings: 14 May, 4 June, 22 October and 20 February.

Throughout 2009/10 the Audit Committee maintained a Finance & Performance sub-committee which met monthly, with direct access and monthly reporting and assurance to the Board.

Members and meetings attended in brackets

Ian Pettitt, Committee Chairman (2/4); James Addison (1/3); Bill Craig (3/4); Helen Parr (4/4); Sir Peter Dixon (1/1).

External auditors

The responsibility of the Trust's external auditors, PricewaterhouseCoopers LLP, 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 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 are aware of it.

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. In the light of this evaluation, the Nominations Committee prepares a description of the role and capabilities required for the particular appointment of both executive and non-executive directors, including the Chairman. The committee then devolves this information to the Board of Directors' Remuneration and Terms of Service Committee for the appointment of executive directors and to the Members' Council's Appointments and Performance Committee for the appointment of non-executive directors, including the Chairman. The Chairman, as an independent non-executive director, chairs the committee. It held seven meetings: 3 July, 30 July, 19 August, 5 October, 23 November, 5 January and 19 March.
Members and meetings attended in brackets	Richard Bourne, Committee Chairman (3/5); Helen Parr (5/7); Penny Cavenagh (2/7*); John Eddy (6/7); Jean Smith (6/7); Peter Murphy (7/7). * Penny Cavenagh declined to attend one meeting due to a conflict of interest
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 comprises two non-executive directors and two executive directors and has representation from operational senior management personnel from across the Trust. Two formal meetings of the committee were held: 6 November and 5 March.
Members and meetings attended in brackets	Penny Cavenagh, Committee Chairman, (2/2); Ian Pettitt (1/2); Peter Murphy (0/2); Andrew Armour (2/2).
Remuneration and Terms of Service Committee	Details of this formal committee of the Trust Board can be found elsewhere in this annual report.

Head of Internal Audit opinion

This is the Head of Internal Audit Opinion On the effectiveness of the system of internal control at Colchester Hospital University NHS Foundation Trust for the year ended 31 March 2010.

Roles and responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Statement on Internal Control (SIC) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the SIC requirements.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its SIC.

The Head of Internal Audit opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board in the completion of its SIC, and may also be taken into account by the are Quality Commission in relation to the Standards for Better Health.

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion;
3. Commentary.

My overall opinion is that

- Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

   Additional areas of work that may support the opinion will be determined locally but are not required for DH purposes e.g.
3. An assessment of the process by which the organisation has arrived at its declaration in respect of the Standards for Better Health;
4. Any reliance that is being placed upon third party assurances.

The commentary below provides the context for my opinion and together with the opinion should be read in its entirety.

The design and operation of the Assurance Framework and associated processes

The Assurance Framework is a tool to assist the Board in monitoring the risks associated with the achievement of the Trust's Corporate Objectives. It is monitored by the Governance Risk Management Committee, Clinical Executive Board and the Trust Board and the 2009/10 document is presented to the Board on a regular basis. The Assurance Framework is updated to take account of changes that have occurred since it was last presented to the Board and highlights key revisions.

Based on the work undertaken, we were satisfied that an Assurance Framework has been established, which is subject to regular review.

PricewaterhouseCoopers LLP (PwC) undertook a Rapid Review Assessment with the support of Monitor during the year in respect of five aspects of the Trust's capacity and capability. The Rapid Review Assessment made a number of recommendations in respect of mortality and patient safety, capacity and clinical risk, clinical staffing, patient experience, and governance arrangements in respect of care standards.

As a result, the Trust produced a high level action plan, as well as a number of more detailed action plans and associated documents and we understand that these are being performance managed by the Trust in a number of ways, including the use of key performance indicators, such as the indicator in respect of Board Governance and how the Trust is strengthening the accountability and anticipation of risk through a more integrated governance structure of Board sub-committees. Although these issues were highlighted, the actions taken to date and those planned have provided assurance around the improvements being made by the Trust.

The Department of Heath – 18 Weeks Intensive Support Team (IST) undertook a review in March 2009 and raised a number of recommendations regarding the construction of the Referral to Treatment Database V1. This work was followed up by the IST in October 2009 and they have confirmed that their discussions, together with their report, has provided the necessary reassurance that each point has been addressed appropriately and that the Trust is fully aware of the impact that changes to the processing and reporting of its data will have.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the period

Our annual report describes how our audit plan was constructed from an audit needs assessment. It further shows, at a high level, a summary of those resulting opinions and assurances including any major control weaknesses. The judgements relating to respective materiality, risk and control issues are also explained together with an explanation as to the impact of this work aspect upon the overall opinion.

An audit assurance level of 'full assurance' has been assigned to the following audits; this has been considered in the basis for the overall opinion:

- Financial Reporting and Budgetary Control
- Treasury Management

An audit assurance level of 'substantial assurance' has been assigned to the following audits; this has been considered in the basis for the overall opinion:

- Building Maintenance
- Debtors
- ESR Payroll
- Financial Ledger
- Fixed Assets
- Governance Structure
- Health and Safety
- Mandatory Training
- Pharmacy
- Risk Management
- Serious Untoward Incidents
- Assurance Framework and the Essential Standards of Quality and Safety (Draft Report)
- Bank and Agency (Draft Report)
- Creditors (Draft Report)
- Pathology, PAS, Radiology and Pharmacy Applications (Draft Report)
- Patient Monies and Valuables (Draft Report)

Some weaknesses were identified in the design and application of the controls, providing an assurance level of 'no assurance' to the following audits; this has been considered in the basis for the overall opinion:

- 18 Weeks Referral to Treat – Data Quality*

We also undertook a regularity audit of Sickness and Absence Reporting. Three recommendations were made as a result of this audit, including a priority 1 recommendation regarding the need for the Trust to have more effective arrangements in place with regard to the communication of data requirements in respect of sickness reporting.

The following audits have still to be concluded:

- Performance Management
- Commissioning and Payment by Results

It is the Board's responsibility to satisfy itself it has sufficient assurance about the operation of controls in place to manage other principal risks.

Signed Mike Clarkson

DELOITTE & TOUCHE PSIA LIMITED

21 May 2010

**Trust Footnote:* *Following the 18 Weeks Referral to Treatment Data Quality audit the Trust implemented a number of actions to deal with the points raised in the audit. The Department of Health 18 Weeks Intensive Support Team (IST) also undertook an assessment of data quality and the outcomes of this review are referred to in the final paragraph of the "design and operation of the Assurance Framework and associated processes" section above.*

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 National Health Service Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Colchester University Hospitals 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 Colchester University Hospitals NHS foundation 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 Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- 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 NHS foundation trust and to enable him/her 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 NHS foundation 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

Peter Murphy

Chief Executive

3 June 2010

Statement of directors' responsibilities in respect of Internal Control

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 only provide 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
- 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 in Colchester Hospital University NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

As an employer with staff entitled to membership of the NHS Pension Scheme, measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

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 board leadership while ensuring local ownership in managing and controlling all elements of risk to which the Trust may be exposed.

Each division has a system in place to identify its risks, assess their impact and evaluate them. Training in risk management is provided to all staff relevant to their grade and situation. To support them through the risk assessment process, expert guidance and facilitation is available. Actions taken to reduce risk are regularly monitored, reported and through the Datix Risk Management System, trends are analysed at divisional and sub-committee level of the Board with high and extreme risks reported to the Board of Directors on a monthly 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 an 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 scoring system. This supports the decision-making process about whether the identified risk is considered acceptable and can be managed or unacceptable, requiring intervention.

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.

Risk management is incorporated at all levels of the organisation through the corporate and divisional structures, and the reporting feedback mechanisms in place. 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 Management Department maintains and supports the risk register.

Staff are appropriately trained and 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.

The Assurance Framework is based on structured and ongoing assessment of the key risks to the Trust achieving its strategic objectives which have been matched to the Standards for Better Health: Safety; Clinical and Cost Effectiveness, Governance, Patient Focus, Accessible and Responsive Care, Care Environment and Amenities, Public Health and NHS key targets.

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

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

The Trust 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 in the Equality Bill 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.

As an employer with staff entitled to membership of the NHS Pension scheme, control the Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. Measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's

contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

A Governance Risk Management Committee continued to function throughout 2009/10. Its 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. The committee reports to the Clinical Executive Board.

The Assurance Framework, high-level risks and progress with the action plan are monitored by the Governance Risk Management Committee and Clinical Executive Board. It is also considered by the Board of Directors at periodic intervals. The Audit Committee reviews the organisational system and approach to risk management.

In January 2010 the Trust completed its application for registering with the Care Quality Commission. Registration has been granted to the Trust without conditions.

In March 2010 the Board agreed a number of changes to its governance committee arrangements designed to enhance the Board's assurance function. These arrangements will be implemented from 1 April 2010.

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

In the period from December 2008 to March 2009 performance in the Trust against a number of national standards was poor; this included significant problems in achieving the A&E 98% standard and the 18-week referral to treatment standard for admitted patients.

These failings exposed weaknesses both in the wider local health system and within the operating systems of the Trust. This included inadequacies in preparedness and capacity planning, underpinned by poor information systems, analytical capability and an inability of the local NHS and social care organisations to respond promptly under extreme pressures of demand.

In May 2009 the PCT issued the Trust with a performance notice highlighting concerns with the emergency access standard, the 18-week standard and issues with mortality and the Hospital Standardised Mortality ratio. As a consequence of this the independent regulator of foundation trusts, Monitor, became involved with the Trust in reviewing performance and governance arrangements.

The Trust responded to the intervention by Monitor with a detailed action plans to address the issues, focussing on addressing capacity problems and committing in the 2009/10 Annual Plan to significant increases in beds and staffing to be in place in advance of the onset of winter 2009/10. The Trust also used external support to assess systems and processes. The Department of Health Intensive Support team reviewed and advised on all aspects of 18-week systems, and PricewaterhouseCoopers LLP (PwC) undertook a rapid review of wider governance issues in relation to areas of Monitor's concerns.

Whilst the Trust demonstrated good progress in addressing the specific issues with the A&E and 18-week standards, a number of other concerns were identified by Monitor, including concerns regarding the pace of improvement and the engagement and leadership of the Board with the urgency of action.

Despite recognising the progress made in year, following a series of reviews Monitor formally intervened in the Trust in November 2009, exercising their powers under section 52 of the 2006 Health Act.

The detail from the Monitor intervention notice is reproduced overleaf:

Monitor intervention notice

On the basis of information made available to the Independent Regulator of NHS Foundation Trusts ("Monitor") by Colchester Hospital University NHS Foundation Trust ("the Foundation Trust") and having taken into account representations made to Monitor by the Foundation Trust, Monitor is satisfied that:

a. the Foundation Trust has contravened, and is failing to comply with its terms of Authorisation, in particular:

   (i) Condition 2, which requires the Foundation Trust to exercise its functions "effectively, efficiently and economically";

   (ii) Condition 5(1), which requires the Foundation Trust to ensure the existence of appropriate arrangements to provide representative and comprehensive governance and to maintain the organisational capacity necessary to deliver the mandatory goods and services set out in Schedule 2 to its terms of Authorisation;

   (iii) Condition 6(1), which requires the Foundation Trust to put and keep in place and comply with arrangements for the purpose of monitoring and improving the quality of health care provided by and for the Foundation Trust; and

   (iv) Condition 6(2) which requires the Foundation Trust to comply with statements of standards in relation to the provision of health care published by the Secretary of State under section 46 of the Health and Social Care (Community Health and Standards) Act 2003, as set out in the Department of Health publication Health and Social Care Standards and Planning Framework (July 2004) as may be amended from time to time; and

b. the contravention and failure are significant under section 52(1) of the Act.

As a consequence of the regulatory intervention Monitor removed Richard Bourne as Chairman of the Trust and replaced him with Sir Peter Dixon as interim Chairman from 1 December 2009.

The Monitor finding under condition 2 that the Trust was not exercising its functions "effectively, efficiently and economically" is based on the following aspects of their assessment of the Trust:

Effective	Effectiveness of 18 weeks admitted patient target planning (breach for 3 consecutive quarters Feb 2009 – Jul 2009) and red rating at Q2 2009/10. Future risk of breaching target as declared to Monitor in annual board statement
	Effectiveness of planning to meet 31 and 62 day cancer targets (planned breach Q2 and Q3)
	Effectiveness of A&E winter 2008/09 plan Breach of target Q4 2008/09 Future risk of breaching target as declared to Monitor in annual board statement
	Effectiveness of Children's services improvements (original review 2006, poor follow up review 2009) SMRs unchanged 2007/08 to 2008/09 CQC AHC 2008/09 – fair
	Effectiveness of board at transitioning permanent changes in executive team
	Effectiveness of relationship with PCT (large volumes of contract queries and notices)

Efficient	No concerns as strong financial performance FRR 5
Economic	PCT funding of unplanned additional activity to reduce the backlog of patients already breaching the 18 weeks admitted patient target
	PCT fines for breach of 18 weeks admitted patient target
	Trust repayment of £275k to PCT for activity queried in relation to emergency admissions in Q1 and Q2 2009/10

Following Monitor's intervention the Trust continued to implement its previously published plans many of which were designed to bring sustainable resolution to the performance issues once additional capacity was in place for the fourth quarter of the year. This table highlights how this has been demonstrated:

Standard	Q1	Q2	Q3	Q4	Operating Standard
A&E 4-hour access	97.5%	98.6%	98.3%	98.3%	98%
18 weeks admitted	89.8%	90.9%	91.1%	90.6%	90%
18 weeks non-admitted	97.7%	98.4%	96.8%	96.2%	95%
Cancer – maximum wait of 2 weeks from urgent GP referral to date first seen	97.7%	98.4%	98.3%	97.1%	93%
Cancer – maximum wait of 31 days from decision to treat to start of treatment for all cancers	92.9%	94.1%	96.1%	97.4%	96%
Cancer – maximum wait of 31 days from decision to treat to subsequent treatment – surgery	83.1%	85.7%	90.8%	88.3%	94%
Cancer – maximum wait of 31 days from decision to treat to subsequent treatment – drugs	100%	98.7%	100%	100%	98%
Cancer – maximum wait of 62 days for all referrals to treatment for all cancers	79.3%	76.9%	87.2%	89.4%	85%
Cancer – maximum wait of 62 days from urgent referral from the national screening service to treatment	89.8%	97.8%	90.6	90.5	90%
Cancer – maximum wait of 62 days from urgent referral from a consultant (consultant upgrade) to treatment	100%	100%	100%	100%	86%
Cancer – two week wait for symptomatic breast patients (cancer not initially suspected)	N/A	N/A	N/A	94.6%	93%

Capacity: The Trust successfully commissioned 30 additional general beds in November 2009, with a further 20 contingency beds for the winter period. The additional capacity has supported the achievement of the above targets over winter 2009/10

Hospital Standardised Mortality Ratio (HSMR): The Trust delivered a cumulative HSMR for the period April to November 2009 of 83.7 compared with a national rate of 87.2.

Children's Services: The Health Care Commission report in February 2009 identified shortcomings in the training of non-children's specialist staff in aspects of care for children. These shortcomings have been remedied with programmes of training and changes in staffing arrangements.

Reliance on temporary staff at Board level: During 2009/10 two key roles at the board (Director of Finance and Director of Operations) have been filled by interim appointments. The appointees have been two very experienced and capable individuals who have both agreed to commit to the Trust for an extended period to give continuity through the period of stabilisation and recovery.

Relationship with NHS North East Essex: Considerable effort has been made since the appointment of the interim Chair and some changes in the leadership of the PCT to improve the relationship with the Trust's main commissioner.

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 Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit and governance committees. A plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is informed by a number of internal and external assurances. This year, these have included:

- The regulatory intervention by Monitor and the action taken by the Trust to address the issues
- Comparison of Trust performance to SHA benchmarking, demonstrating the Trust is now performing amongst the best in East of England on emergency access targets
- The review of Elective access arrangements undertaken by the DH Intensive Support team
- The Rapid review prepared for the Trust by PwC (July 2009) and the follow-up report on progress with the recommendations (March 2010)
- The East of England Deanery report on medical training
- The Head of Internal Audit Opinion Statement which indicates that for 2009/10 the Trust achieved significant assurance for the Assurance Framework
- Clinical audit reports
- Internal audit reports & reviews (e.g. the financial standard and governance standard audits, the Assurance Framework)
- Self assessment against the Care Quality Commission core standards (formerly Standards for Better Health) where full assurance was maintained for the year.
- Registration without conditions by the Care Quality Commission
- Level 2 compliance with NHSLA CNST and risk management standards.
- PEAT inspection
- National staff and inpatient surveys and standards held for Investors in People and Improving working Lives Practice Plus Accreditation
- Information Governance Toolkit
- Healthcare Commission's Hygiene Code Inspection Report
- Human Tissue Authority accreditation for our tissue bank.

The Trust has, and will continue to develop, a robust process for maintaining and reviewing the effectiveness of its systems of internal control as described in section 4.

As part of NHS Information Governance standards, details of Serious Untoward Incidents involving data loss or confidentiality breach have to be reported. There was one instance of inadvertent sharing of confidential patient data to a third party organisation in 2009/10.

The Trust takes its responsibility as a major local employer and consumer of energy and resources seriously and is committed to helping to reduce the adverse effects of its operations on the wider environment. The Trust has taken significant steps to reduce its energy usage and in 2009/10 began to fully see the benefits in both financial and emissions terms of replacing old oil fired boilers with new modern and more efficient dual-fuel boilers, using a

Department of Health grant. The Trust is also, through a phased programme, replacing older light fittings with energy efficient ones

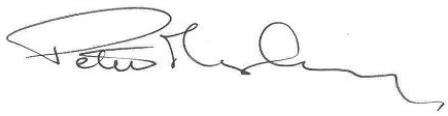
NHS Pension Scheme contributions

As an employer with staff entitled to membership of the NHS pension scheme, we have received assurances from our payroll & pension services supplier (Anglia Support Partnerships) that control measures were in place throughout 2009/10 to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Conclusion

As accounting officer and based on the information provided above I am assured that no significant internal control issues have been identified other than the issues giving rise to the Monitor Intervention detailed above. I am satisfied that the actions taken since this intervention have significantly reduced the risk of any breach of the Trust's terms of authorisation.

Signed



Peter Murphy Chief Executive

(on behalf of the Board)

3 June 2010

Remuneration report (unaudited)

Members' Council Appointments and Performance Committee

The Members' Council and the Board of Directors have a joint Nominations Committee. Its responsibilities and activities are described under the Board of Directors' section (which starts on p28). The Members' Council's Appointments and Performance Committee is responsible for advising the Members' Council on the appointment and performance assessment of the non-executive directors (including the Chairman). The committee held six formal meetings: 6 May, 3 July, 19 August, 19 October, 20 November and 22 February.

Members and meetings attended in brackets

Frank Baker, Committee Chairman (6/6); Richard Bourne (0/5); Ray Cole (3/6); Isaac Ferneyhough (4/6); Violet Haddow (4/6); Cllr Martin Hunt (5/6); Andrew Patrick (5/6); Tina Sivyer (4/6); Carrie Tyler (3/6), Cllr Les Double (0/2), Colonel Nick Strowbridge (1/1), Sir Peter Dixon (1/1).

The committee considered the remuneration of the non-executive directors and reviewed the appraisal process for the Chair and non- executive directors. It also convened an appointments panel to interview for the post of Trust Chair and later during the year the same for the four vacant non-executive director posts.

Board of Directors' Remuneration and 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. The Chief Executive is entitled to attend the committee and be consulted upon when the appointment and remuneration of the executive directors is being considered. He is excluded from meetings on his own position. An appointments panel of the Remuneration and 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 on one occasion in 2009/10 to appoint a replacement to a vacancy arising in year for the Director of Finance. This appointment was not completed. The Remuneration and Terms of Service Committee held two meetings: 30 April and 30 July.

Members and meetings attended in brackets

Richard Bourne, Committee Chairman (2/2); James Addison (2/2); Penny Cavenagh (1/2); William Craig (2/2); Helen Parr (1/2); Ian Pettitt (2/2); Peter Murphy (2/2).

Advice or services to the committee

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

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 Chairman and non-executive directors is decided by the Members' Council following advice from its Appointments and 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 three days per month and two to three days per week for the Chairman. To determine executive directors' salary levels, the Remuneration and 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
- IDS NHS Boardroom pay report
- SSRB (Senior Salaries Review Body) to Department of Health for VSMs (Very Senior Managers) Pay Framework
- HRSS database of NHS advertised salaries.

Other than the Trust's medical director, amendments to annual salary are decided by the Remuneration and Terms of Service Committee. The annual salary of the executive directors is inclusive. 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 of this report. With the exception of the Medical Director, executive directors are appointed to permanent 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 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 or "in the interests of the efficiency of the service" 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.

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

Peter Murphy

Chief Executive

3 June 2010

Salary and pension entitlements of senior managers (audited)

The Secretary of State has determined that NHS Foundation Trusts should disclose certain information in relation to those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body.

This means those who influence the decisions of the entity as a whole rather than the decisions of the individual divisions or departments.

The Chief Executive has determined that these senior positions of the Trust in 2009/10 were the executive and non executive directors of the Board.

Name	Title	2009/10			2008/09 (11 months)		
		Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
		(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
James Addison [1]	Non-executive Director	5 – 10	-	-	10 – 15	-	-
Andrew Armour [2]	Director of Finance	70 – 75	-	-	-	-	-
Sue Barnett [3]	Director of Operational Performance	260 – 265	-	-	-	-	-
Richard Bourne [4]	Chairman	20 – 25	-	-	30 – 35	-	-
Rob Bowman	Director of Workforce	95 – 100	-	-	35 – 40	-	-
Penelope Cavenagh	Non-executive Director	10 – 15	-	-	10 – 15	-	-
William Craig	Non-executive Director	10 – 15	-	-	10 – 15	-	-
Sir Peter Dixon [5]	Chairman	10 – 15	-	-	-	-	-
Julie Firth [6]	Director of Nursing and Patient Experience	80 – 85	-	-	-	-	-
Denise Hagel [7]	Director of Nursing/Deputy Chief Executive	35 – 40	-	-	100 – 105	-	-
Andrew May	Medical Director	50 – 55	-	-	20 – 25		
Peter Murphy	Chief Executive	160 – 165	-	-	145 – 150	-	-
Helen Parr	Non-executive Director	10 – 15	-	-	10 – 15	-	-
Ian Pettitt	Non-executive Director	10 – 15	-	-	10 – 15	-	-
Stephanie Watson [8]	Director of Finance & Performance	70 – 75	-	-	105 – 110	-	-

1. Left 27 November 2009.
2. Andrew Armour was engaged as Interim Director of Finance from 6 October 2009. The amount disclosed represents payments to Andrew Armour Limited for his services.
3. Sue Barnett was engaged as Interim Director of Operational Performance from 1 April 2009. The amount disclosed represents payments (including VAT) to Xtra Consulting Limited for her services.
4. Left 26 November 2009.
5. Started 30 November 2009.
6. Started 1 June 2009.
7. Left 31 May 2009.
8. Left 6 October 2009

Pension benefits

The NHS Pensions Scheme covers past and present employees. The scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period. For more details see "Pension Costs" in the "Notes to Accounts" of the full annual accounts. The table below show the pension entitlements of senior managers; these disclosures have been audited

Name	Title	Real increase in pension at age 60* (bands of £2,500) £000	Lump sum at age 60 related to real increase in pension* (bands of £2,500) £000	Total accrued pension at 31 March 2010* (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010* (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2010* £000	Cash equivalent transfer value at 31 March 2009* £000	Real increase in cash equivalent transfer value* £000
Rob Bowman	Director of Workforce	2.5 – 5	7.5 – 10	25 – 30	80 – 85	435	354	63
Denise Hagel	Director of Nursing/ Deputy Chief Executive	(0 – 2.5)	(0 – 2.5)	35 – 40	115 – 120	Nil	925	(162)
Julie Firth	Director of Nursing & Patient Experience	2.5 – 5	12.5 – 15	30 – 35	100 – 105	645	494	106
Peter Murphy	Chief Executive	(0 – 2.5)	(2.5 – 5)	65 – 70	195 – 200	1,436	1,291	81
Stephanie Watson	Director of Finance & Performance	0 – 2.5	0 – 2.5	30 – 35	90 – 95	565	498	22

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

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 capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and 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, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Section B

Annual Accounts 2009/10

Independent Auditors' Report to the Members' Council of Colchester Hospital University NHS Foundation Trust

We have audited the financial statements of Colchester Hospital University NHS Foundation Trust for the year ended 31 March 2010 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors
As explained more fully in the Statement of Accounting Officer's Responsibilities, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the financial statements in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for 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 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

The maintenance and integrity of the Colchester Hospital University NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

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 NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements.

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2010 and of its income and expenditure and cash flows for the year then ended; and

- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

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

In our opinion

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and

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

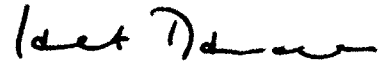
Matters on which we are required to report by exception

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

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from locations not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit; or
- the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit; or
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

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



Janet Dawson (Senior Statutory Auditor)

For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
80 Strand, London
WC2R 0AF

7 June 2010

FOREWORD TO THE ACCOUNTS

Colchester Hospital University NHS Foundation Trust

These accounts for the year ended 31 March 2010 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.

Signed:.....(Chief Executive) Date: 3rd June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2010

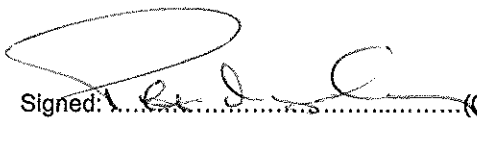
	Note		2009/10 £000		2008/09 (11 Months) £000
Operating Income	2		225,020		190,381
Operating Expense	3		(218,641)		(173,723)
Operating Surplus			**6,379**		**16,658**
Finance Costs					
Finance income	6	148		706	
Finance expense - financial liabilities	6.1	(133)		(5)	
Finance expense - unwinding of discount on provisions		(32)		(32)	
PDC Dividends payable		(4,029)		(4,401)	
Net Finance Costs			**(4,046)**		**(3,732)**
Surplus from continuing operations			**2,333**		**12,926**
SURPLUS FOR THE YEAR			**2,333**		**12,926**
Other Comprehensive Income:					
Revaluation gains/(losses) and impairment losses property, plant and equipment			(28,019)		5,609
Increase in the donated asset reserve due to receipt of donated assets			54		84
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets			(263)		(1,179)
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD			**(25,895)**		**17,440**
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR			**(25,895)**		**17,440**

The notes on pages 7 to 39 form part of these accounts.
All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT
31 March 2010

	Note	31 March 2010 £000	31 March 2009 £000	1 May 2008 £000
NON-CURRENT ASSETS				
Intangible assets	7	2,106	1,315	1,200
Property, plant and equipment	8	124,732	149,635	150,967
Trade and other receivables	11	166	193	218
Total Non-Current Assets		**127,004**	**151,143**	**152,385**
CURRENT ASSETS				
Inventories	10	5,635	4,150	3,075
Trade and other receivables	11	7,303	5,626	8,902
Cash and cash equivalents	18	44,563	28,144	8,015
Total Current Assets		**57,501**	**37,920**	**19,992**
CURRENT LIABILITIES				
Trade and other payables	12	(22,267)	(15,510)	(12,787)
Borrowings	15	(14,513)	(236)	(229)
Provisions	17	(471)	(1,018)	(2,267)
Other liabilities	13	(475)	(640)	(671)
Total Current Liabilities		(37,726)	(17,404)	(15,954)
Total Assets less Current Liabilities		**146,779**	**171,659**	**156,423**
NON-CURRENT LIABILITIES				
Borrowings	15	(823)	(769)	(861)
Provisions	17	(1,375)	(1,391)	(1,412)
Other liabilities	13	(4,885)	(5,068)	(5,235)
Total Non-Current Liabilities		(7,083)	(7,228)	(7,508)
TOTAL ASSETS EMPLOYED		**139,696**	**164,431**	**148,915**
TAXPAYERS' EQUITY				
Public Dividend Capital		76,193	75,033	74,055
Revaluation Reserve		36,938	64,675	60,474
Donated Asset Reserve		853	1,475	2,423
Other Reserves		754	754	754
Income and Expenditure Reserve		24,958	22,494	11,209
TOTAL TAXPAYER'S EQUITY		**139,696**	**164,431**	**148,915**

The financial statements on pages 2 to 39 were approved by the Board and signed by:



Signed: .....(Chief Executive) Date: 3rd June 2010

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2010

	2009/10	2008/09 (11 Months)
	£000	£000
Cash flows from operating activities		
Operating surplus from continuing operations	6,379	16,658
Operating surplus	**6,379**	**16,658**
Non-cash income and expense:		
Depreciation and amortisation	7,208	6,264
Impairments	5,055	732
Transfer from the donated asset reserve	(263)	(1,179)
(Increase)/Decrease in Trade and Other Receivables	(1,650)	3,301
Increase in Inventories	(1,485)	(1,075)
Increase/(Decrease) in Trade and Other Payables	2,997	2,277
Increase/(Decrease) in Other Liabilities	(348)	198
Decrease in Provisions	(563)	(1,270)
Other movements in operating cash flows	96	859
NET CASH GENERATED FROM OPERATIONS	**17,426**	**26,765**
Cash flows from investing activities		
Interest received	149	669
Purchase of intangible assets	(1,065)	(322)
Purchase of Property, Plant and Equipment	(11,667)	(5,349)
Sales of Property, Plant and Equipment	100	2,194
Net cash generated from/(used in) investing activities	**(12,483)**	**(2,808)**
Cash flows from financing activities		
Public dividend capital received	1,160	978
Public dividend capital repaid	0	0
Loans received	14,400	0
Loans repaid	0	0
Capital element of finance lease rental payments	0	0
Interest paid	0	(5)
Interest element of finance lease	(4)	0
Interest element of Private Finance Initiative obligations	0	0
PDC Dividend paid	(4,080)	(4,801)
Cash flows from (used in) other financing activities	0	0
Net cash generated from/(used in) financing activities	**11,476**	**(3,828)**
Increase/(decrease) in cash and cash equivalents	**16,419**	**20,129**
Cash and Cash equivalents at 1 April	**28,144**	**8,015**
Cash and Cash equivalents at 31 March	**44,563**	**28,144**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AS AT 31 March 2010

	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 May 2008	**148,915**	**74,055**	**60,474**	**2,423**	**754**	**11,209**
Surplus for the year	**12,926**	0	0	0	0	12,926
Revaluation gains and impairment losses property, plant and equipment	**5,609**	0	5,462	147	0	0
Increase in the donated asset reserve due to receipt of donated assets	**84**	0	0	84	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	**(1,179)**	0	0	(1,179)	0	0
Transfers to the income and expenditure account in respect of assets disposed of	**0**	0	0	0	0	0
Public Dividend Capital received	**978**	978	0	0	0	0
Other transfers between reserves	**0**	0	2,022	0	0	(2,022)
Movements on other reserves	**(2,902)**	0	(3,283)	0	0	381
Taxpayers' Equity at 31 March 2009	**164,431**	**75,033**	**64,675**	**1,475**	**754**	**22,494**
Surplus for the year	**2,333**	0	0	0	0	2,333
Revaluation gains and impairment losses property, plant and equipment	**(28,019)**	0	(27,606)	(413)	0	0
Increase in the donated asset reserve due to receipt of donated assets	**54**	0	0	54	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	**(263)**	0	0	(263)	0	0
Transfers to the income and expenditure account in respect of assets disposed of	**0**	0	(131)	0	0	131
Public Dividend Capital received	**1,160**	1,160	0	0	0	0
Taxpayers' Equity at 31 March 2010	**139,696**	**76,193**	**36,938**	**853**	**754**	**24,958**

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.

Donated Assets Reserve

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

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.

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 2009/10 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.

2009/10 is the first year in which the Trust has reported under IFRS. Prior year comparator data has been re-stated to reflect the requirements of IFRS.

The transition to IFRS had no material effect on the Trust's financial statements. The reconciliation of how the transition to IFRS has affected the reported financial position is recorded in note 27 to the accounts.

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 does not consolidate the NHS charitable funds for which it is a corporate trustee.

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.

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 have 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. 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 buildings professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. As the Trust received its authorisation as a Foundation Trust effective from 1 May 2008, a full revaluation of land and buildings was undertaken in 2008/09 with a valuation date of 1 May 2008. As a consequence of the prevailing economic climate and the Trust's decision to decommission part of its Essex County site, a further revaluation of both Trust sites was undertaken as at 31 March 2010.

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 line with Treasury guidance, the revaluations 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

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset’s carrying value. 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.

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.

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

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation and impairment

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'.

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 Assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

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. Items under £5,000 are also capitalised where they form part of a network asset that has a total cost of at least £5,000 in aggregate.

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. 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'.

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

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost 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.

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.

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

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

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.

Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

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

The legislation introducing corporation tax to foundation trusts has been deferred and 2011/12 will be the first year that government will have chance to introduce corporation tax to foundation trusts.

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 activities: local PCT funding for healthcare provision by the Trust. This makes up 98% of the Trust's Income. Only one customer to the Trust makes up more than 10% of the total income for the Trust. This is NHS North East Essex (76%, £171,951k).

Revenues from countries outside of England are marginal (£1,368 from Welsh PCTs). £8,025k was received by the Trust for 2009/10 in relation to overseas visitors.

		2009/10		2008/09 (11 Months)
		£000		£000
Income		224,324		189,493
Expenditure				
Pay	(131,718)		(105,792)	
Non-pay	(74,661)		(60,935)	
Total Expenditure		(206,379)		(166,727)
EBITDA		17,945		22,766
Depreciation, PDC dividend, etc.		(10,558)		(9,108)
Surplus before non-current asset impairments		7,387		13,658
Non-current asset impairments		(5,054)		(732)
Surplus after non-current asset impairments		2,333		12,926

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

The following standards and interpretations have been adopted by the European Union but are not required to be followed until 201/11. None of the are expected to impact upon the Trust financial statements.

IAS 27 (Revised) Consolidated and separate financial statements

Amendment to IAS 32 Financial instruments: Presentation on classification or rights issues

Amendment to IAS 39 Eligible hedged items

IFRS 3 (Revised) Business combinations

IFRIC 17 Distributions of Non-cash Assets to Owners

IFRIC 18 Transfer of assets from customers

1.21 Accounting Standards Issued that have been Adopted Early

The amendment to IFRS 8 Operating segments that was included in the April 2009 Improvements to IFRS has been adopted early. As a result, total assets are not reported by operating segment.

2. Operating Income

2.1 Operating Income (by classification)

	2009/10 £000	2008/09 (11 Months) £000
Income from Activities		
Elective Income	**41,998**	**37,264**
Non Elective Income	**68,864**	**59,744**
Outpatient Income	**41,868**	**33,436**
A&E Income	**6,332**	**5,511**
Other Activity Income	**46,889**	**37,477**
Private Patient Income	**1,088**	**940**
Other Non-protected Clinical Income	**1,256**	**1,466**
Total Income from Activities	**208,295**	**175,838**
Other Operating Income		
Research and development	**566**	**710**
Education and training	**6,946**	**5,919**
Charitable and other contributions to expenditure	**70**	**101**
Transfer from donated asset reserve in respect of depreciation on donated assets	**263**	**1,178**
Non-patient care services to other bodies	**3,622**	**2,579**
Car parking	**805**	**742**
Staff recharges	**1,079**	**796**
Drug sales	**1,731**	**1,722**
Clinical Excellence Awards	**277**	**195**
Creche services	**51**	**45**
Other	**413**	**389**
Profit on disposal of land and buildings	**720**	**0**
Amortisation of PFI deferred credits	**182**	**167**
Total Other Operating Income	**16,725**	**14,543**
TOTAL OPERATING INCOME	**225,020**	**190,381**

2.2 Private Patient Income

	2009/10 £000	2008/09 (11 Months) £000
Private patient income	**1,088**	**940**
Total patient related income	**208,295**	**175,838**
Proportion (as percentage)	**0.52%**	**0.53%**

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 should not exceed that same percentage whilst the Trust was an NHS Trust in 2002/03, i.e.1.1%. The Trust has met this requirement.

2.3 Operating Lease Income

	2009/10	2008/09 (11 Months)
	£000	£000
Rents recognised as income in the period	56	52
Total	56	52

Future Minimum Lease Payments Due

-not later than 1 year	38	65
-later than 1 year and not later than 5 years	27	66
Total	65	131

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)

	2009/10	2008/09 (11 Months)
	£000	£000
Primary Care Trusts	205,151	162,137
Local Authorities	115	252
Department of Health	51	11,295
NHS Other	749	0
Private patients	1,088	940
Overseas patients (non-reciprocal)	8	2
Injury Cost Recovery*	739	794
Ministry of Defence	189	223
Non NHS: Other	205	195
	208,295	175,838

*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)

	2009/10 £000	2008/09 (11 Months) £000
Purchase of healthcare from non-NHS bodies	4,775	4,102
Executive Directors' costs	1,282	776
Non-Executive Directors' costs	95	87
Staff costs	130,341	104,929
Drug costs	15,676	10,855
Supplies and services - clinical	21,730	18,906
Supplies and services - general	7,663	6,307
Establishment	2,716	2,223
Transport	2,412	1,940
Premises	9,535	8,958
Increase in bad debt provision	47	62
Depreciation	7,208	6,264
Fixed asset impairments	5,054	732
Audit fees in respect of the statutory audit	150	113
Audit fees in respect of regulatory reporting	0	27
Clinical negligence	3,405	1,756
Loss on disposal of land and buildings	0	882
Loss on disposal of other property, plant and equipment	24	5
Legal fees	149	106
Consultancy costs	1,874	723
Training, courses & conferences	935	496
Patient travel	20	17
Car parking & security	71	87
Insurance	139	118
Other services, e.g. external payroll	2,883	2,921
Losses, ex gratia & Special Payments	10	20
Other	447	311
Total	**218,641**	**173,723**

3.2 Arrangements Containing an Operating Lease

	2009/10 £000	2008/09 (11 Months) £000
Minimum Lease Payments	2,072	1,203
Less Sublease Payments Received	(90)	0
Total	**1,982**	**1,203**

Future Minimum Lease Payments Due

-not later than 1 year	1,060	97
-later than 1 year and not later than 5 years	1,011	964
Total	**2,071**	**1,061**
Total of future minimum sublease lease payments to be received as at 31 March 2010.	(81)	0

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

3.3 Limitation on Auditor's Liability

The limitation on auditor's liability is £1,000k for 2009/10 (£1,000k for 2008/09).

4. Staff Costs and Numbers

4.1 Employee Expenses

	2009/10	2008/09 (11 Months)
	£000	£000
Salaries and wages*	**101,274**	**83,675**
Social Security costs	**7,506**	**6,896**
Employer contributions to NHS Pension Scheme**	**11,805**	**10,904**
Other pension costs	**75**	**63**
Agency/Contract Staff	**10,963**	**4,167**
Total	**131,623**	**105,705**

* Included in Salaries and wages is £361,396 capitalised employer costs for the early retirement of the Chief Executive. It was agreed by the Trust's Remuneration Committee that the Chief Executive would retire in August 2010. Under the terms of his contract this resulted in an enhanced payment to his pension. No compensation or payment in lieu of notice was made.

** 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.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

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 by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can be obtained from the Stationery Office.

c) Scheme provisions

In 2008-09 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:

Annual Pensions

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".

Pensions Indexation

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.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

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

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

4.2 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:

	2009/10	2008/09 (11 Months)
	£000	£000
Salaries and other short-term employee benefits	811	745
Employer contributions to NHS Pension Scheme	402	77
Total	1,213	822

4.3 Average Number of Employees (WTE basis)

	2009/10	2008/09 (11 Months)
	Total Number	Total Number
Medical and dental	423	397
Administration and estates	612	555
Healthcare assistants and other support staff	384	349
Nursing, midwifery and health visiting staff	1,000	954
Scientific, therapeutic and technical staff	585	571
Bank and agency Staff	191	112
Total	3,195	2,938

4.4 Staff Benefits in Kind

	2009/10	2008/09 (11 Months)
	£000	£000
Subsidised travel permits	33	30
Total	33	30

4.5 Retirements Due to Ill-health

During 2009/10 there was one early retirement from the Trust on the grounds of ill-health. The estimated additional pension liabilities of this ill-health retirement is £3,774. The cost of this ill-health retirement 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

	2009/10		2008/09	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	**70,988**	**89,555**	**55,285**	**64,874**
Total non-NHS trade invoices paid within target	**59,055**	**73,345**	**47,573**	**55,254**
Percentage of non-NHS trade invoices paid within target	**83%**	**82%**	**86%**	**85%**
Total NHS trade invoices paid in the year	**2,129**	**20,628**	**1,957**	**17,286**
Total NHS trade invoices paid within target	**1,779**	**18,368**	**1,649**	**15,694**
Percentage of NHS trade invoices paid within target	**84%**	**89%**	**84%**	**91%**

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

	2009/10	2008/09 (11 Months)
	£000	£000
Amounts included within interest payable (note 6.1) arising from claims made under this legislation	**1**	**1**
Total	**1**	**1**

6. Finance Income

	2009/10	2008/09 (11 Months)
	£000	£000
Interest income on short-term bank deposits	148	647
Other	0	59
	148	**706**

6.1 Finance Costs - Interest Expense

	2009/10	2008/09 (11 Months)
	£000	£000
Finance Leases	132	4
Late payment of commercial debt	1	1
	133	**5**

7. Intangible Fixed Assets

	Software Licences £000	Assets Under Construction £000	Total £000
Gross cost at 1 May 2008	1,262	308	1,570
Transfers from assets under construction	178	(178)	0
Additions purchased	6	316	322
Gross cost at 31 March 2009	**1,446**	**446**	**1,892**
Amortisation at 1 May 2008	370	0	370
Charged during the year	220	0	220
Amortisation at 31 March 2009	**590**	**0**	**590**
Net book value			
- Purchased at 31 March 2009	852	446	1,298
- Donated at 31 March 2009	17	0	17
- Total at 31 March 2009	**869**	**446**	**1,315**
Gross cost at 1 April 2009	1,459	446	1,905
Transfers from assets under construction	362	(362)	0
Additions purchased	0	1,065	1,065
Gross cost at 31 March 2010	**1,821**	**1,149**	**2,970**
Amortisation at 1 April 2009	590	0	590
Charged during the year	274	0	274
Amortisation at 31 March 2010	**864**	**0**	**864**
Net book value			
- Purchased at 31 March 2010	945	1,149	2,094
- Donated at 31 March 2010	12	0	12
- Total at 31 March 2010	**957**	**1,149**	**2,106**

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 May 2008	45,988	91,234	1,317	28,111	8,631	126	175,407
Additions purchased	0	0	4,903	901	50	0	5,854
Additions donated	0	0	16	27	28	0	71
Impairments	(304)	(1,341)	0	0	0	0	(1,645)
Transfers from assets under construction	0	3,515	(4,146)	499	132	0	0
Revaluation surpluses	(3,924)	3,864	0	11	0	0	(49)
Disposals	(1,325)	(1,808)	0	(636)	0	0	(3,769)
Cost or Valuation at 31 March 2009	**40,435**	**95,464**	**2,090**	**28,913**	**8,841**	**126**	**175,869**
Depreciation at 1 April 2008	0	4,294	0	14,904	5,197	45	24,440
Provided during the year	0	2,770	0	2,235	790	11	5,806
Impairments recognised in operating expenses	0	732	0	0	0	0	732
Revaluation surpluses	0	(4,169)	0	112	0	0	(4,057)
Disposals	0	(58)	0	(629)	0	0	(687)
Depreciation at 31 March 2009	**0**	**3,569**	**0**	**16,622**	**5,987**	**56**	**26,234**
Net Book Value							
Owned at 31 March 2009	40,435	84,219	2,090	10,958	2,791	67	140,560
Finance Lease at 31 March 2009	0	7,184	0	434	0	0	7,618
Donated at 31 March 2009	0	492	0	899	63	3	1,457
Total at 31 March 2009	**40,435**	**91,895**	**2,090**	**12,291**	**2,854**	**70**	**149,635**

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 2009	40,435	95,464	2,090	28,913	8,841	126	175,869
Additions purchased	0	0	13,843	1,584	0	0	15,427
Additions donated	0	0	0	54	0	0	54
Impairments	(11,865)	(21,743)	0	0	0	0	(33,608)
Transfers from assets under construction	0	8,114	(9,700)	685	879	22	0
Revaluation surpluses	(140)	(5,370)	(246)	0	0	0	(5,756)
Disposals	(15)	(92)	0	(825)	0	0	(932)
Cost or Valuation at 31 March 2010	**28,415**	**76,373**	**5,987**	**30,411**	**9,720**	**148**	**151,054**
Depreciation at 1 April 2009	0	3,569	0	16,622	5,987	56	26,234
Provided during the year	0	3,209	0	2,796	916	13	6,934
Revaluation surpluses	0	(6,038)	0	0	0	0	(6,038)
Disposals	0	(8)	0	(800)	0	0	(808)
Depreciation at 31 March 2010	**0**	**732**	**0**	**18,618**	**6,903**	**69**	**26,322**
Net Book Value							
Owned at 31 March 2010	28,415	69,536	5,987	10,775	2,774	77	117,564
Finance Lease at 31 March 2010	0	6,048	0	279	0	0	6,327
Donated at 31 March 2010	0	57	0	739	43	2	841
Total at 31 March 2010	**28,415**	**75,641**	**5,987**	**11,793**	**2,817**	**79**	**124,732**

Of the totals at 31 March 2010, no land or buildings were valued at open market value.

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 2010	28,415	75,641	0	0	0	0	104,056
Unprotected Assets at 31 March 2010	0	0	5,987	11,793	2,817	79	20,676
Total at 31 March 2010	**28,415**	**75,641**	**5,987**	**11,793**	**2,817**	**79**	**124,732**

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

	2009/10	2008/09 (11 Months)
	£000	£000
Buildings	150	967
Plant & Machinery	155	72
Total	305	1,039

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

	31 March 2010	31 March 2009
	£000	£000
Buildings	6,048	7,185
Plant & Machinery	279	420
Total	6,327	7,605

9.3 The Net Book Value of Land and Buildings:

	31 March 2010	31 March 2009
	£000	£000
Freehold	104,056	132,330
Total	104,056	132,330

9.4 Impairment of Assets

	2009/10	2008/09 (11 Months)
	£000	£000
Changes in market price	31,228	1,171
Other *	1,852	304
Abandonment of assets in course of construction	246	0
Total	33,326	1,475

In 2009/10 a desk top revaluation exercise of the Trust's land and buildings was undertaken by the District Valuer, 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 6th 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. 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.

* The figure for 2009/10 results from a decision by the Trust (Trust Board meeting February 2010) to relocate some clinical services from Essex County Hospital within three years. This decision will result in parts of the site becoming dormant and an impairment has been recorded in the 2009/10 financial statements to reflect this decision. These assets have been valued on the basis of Market Value of non-operational properties. The District Valuation Office defines this as the estimated amount for which the asset should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction after proper marketing wherein the parties had each acted knowledgeably, prudently and without compulsion. However, in recognition of the fact that the assets will become idle, they have been impaired to the extent that their fair value represents the remaining depreciation to be charged against them over their remaining anticipated useful life of three years.

10. Inventories

10.1 Inventories

	31 March 2010 £000	31 March 2009 £000	1 May 2008 £000
Materials	**5,635**	**4,150**	**3,075**
Total	**5,635**	**4,150**	**3,075**

10.2 Inventories Recognised in Expenses

	31 March 2010 £000	31 March 2009 £000
Write-down of inventories recognised as an expense	**68**	**79**
Total	**68**	**79**

11. Receivables

11.1 Trade Receivables and Other Receivables

	Total 31 March 2010 £000	Financial Assets 31 March 2010 £000	Non Financial Assets 31 March 2010 £000	Total 31 March 2009 £000	Financial Assets 31 March 2009 £000	Non Financial Assets 31 March 2009 £000	Total 1 May 2008 £000	Financial Assets 1 May 2008 £000	Non Financial Assets 1 May 2008 £000
Current Trade and Other Receivables									
NHS Receivables	**3,121**	3,121	0	**2,222**	2,222	0	**1,934**	1,934	0
Provision for Impaired Receivables	**(375)**	(375)	0	**(328)**	(328)	0	**(265)**	(265)	0
Prepayments	**744**	0	744	**555**	0	555	**3,469**	0	3,469
PFI Prepayments - Capital Contributions	**0**	0	0	**(161)**	0	(161)	**0**	0	0
Accrued Income	**1,782**	125	1,657	**1,948**	243	1,705	**1,915**	298	1,617
PDC Receivable	**51**	0	51	**0**	0	0	**0**	0	0
Other Receivables	**1,980**	1,980	0	**1,390**	1,390	0	**1,849**	1,849	0
Sub Total	**7,303**	**4,851**	**2,452**	**5,626**	**3,527**	**2,099**	**8,902**	**3,816**	**5,086**
Non Current Trade and Other Receivables									
NHS Receivables	**166**	166	0	**193**	193	0	**218**	218	0
Sub Total	**166**	**166**	**0**	**193**	**193**	**0**	**218**	**218**	**0**
Total	**7,469**	**5,017**	**2,452**	**5,819**	**3,720**	**2,099**	**9,120**	**4,034**	**5,086**

11.2 Provision for Impairment of Receivables

	Total 31 March 2010 £000	Total 31 March 2009 £000
At 1 April	**328**	**266**
Increase in provision	**66**	**75**
Unused amounts reversed	**(19)**	**(13)**
At 31 March	**375**	**328**

11.3 Analysis of Impaired Receivables

	Total 31 March 2010 £000	Total 31 March 2009 £000
Aging of Impaired Receivables		
Up to 3 months	0	6
In 3 to 6 months	8	7
Over 6 months	129	75
Total	**137**	**88**
Aging of Non-impaired Receivables Past their Due Date		
Up to 3 months	553	655
In 3 to 6 months	132	73
Over 6 months	190	76
Total	**875**	**804**

12. Trade and Other Payables

12.1 Trade and Other Payables comprise the following:

	Total 31 March 2010 £000	Financial Liabilities 31 March 2010 £000	Non Financial Liabilities 31 March 2010 £000	Total 31 March 2009 £000	Financial Liabilities 31 March 2009 £000	Non Financial Liabilities 31 March 2009 £000	Total 1 May 2008 £000	Financial Liabilities 1 May 2008 £000	Non Financial Liabilities 1 May 2008 £000
Current Trade and Other Payables									
Receipts in advance	**6**	0	6	**0**	0	0	**0**	0	0
NHS payables	**3,832**	3,832	0	**2,778**	2,778	0	**2,686**	2,686	0
Trade payables - capital	**4,535**	4,535	0	**775**	775	0	**329**	329	0
Other trade payables	**7,208**	7,208	0	**6,560**	6,560	0	**2,979**	2,979	0
Other payables	**728**	728	0	**1,445**	1,445	0	**1,853**	1,853	0
Accruals	**5,958**	5,958	0	**3,952**	3,952	0	**4,940**	4,940	0
Total	**22,267**	**22,261**	**6**	**15,510**	**15,510**	**0**	**12,787**	**12,787**	**0**

13. Other Liabilities

	31 March 2010 £000	31 March 2009 £000	1 May 2008 £000
Current			
Deferred Income	475	640	671
Sub Total	**475**	**640**	**671**
Non Current			
Deferred Income	4,885	5,068	5,235
Sub Total	**4,885**	**5,068**	**5,235**
Total	**5,360**	**5,708**	**5,906**

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 2010 are £1,399k over a 7 year period of commitment (£1,596k over 8 years at 31 March 2009). These leases relate to the Trust's MRI Unit, a haematology analyser and an item of nuclear medicine equipment.

14.2 Finance Lease Obligations

	Minimum Lease Payments			Present Value of Minimum Lease Payments		
	31 March 2010 £000	31 March 2009 £000	1 May 2008 £000	31 March 2010 £000	31 March 2009 £000	1 May 2008 £000
Gross Lease Liabilities	**1,399**	**1,596**	**1,809**	**936**	**1,005**	**1,090**
of which liabilities are due						
not later than 1 year	232	231	231	113	100	90
later than 1 year and not later than 5 years	779	783	822	463	402	383
later than 5 years	388	582	756	360	503	617
Finance charges allocated to future periods	(463)	(591)	(719)	0	0	0
Net Lease Liabilities	**936**	**1,005**	**1,090**	**936**	**1,005**	**1,090**

14.3 PFI Obligations (on SoFP)

	31 March 2010 £000	31 March 2009 £000	1 May 2008 £000
Gross Lease Liabilities	**5,067**	**5,250**	**5,417**
of which liabilities are due			
not later than 1 year	182	182	182
later than 1 year and not later than 5 years	729	729	729
later than 5 years	4,156	4,339	4,506
Net Lease Liabilities	**5,067**	**5,250**	**5,417**
not later than 1 year	182	182	182
later than 1 year and not later than 5 years	729	729	729
later than 5 years	4,156	4,339	4,506

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 2010 £000	31 March 2009 £000	1 May 2008 £000
Current			
Drawdown in committed facility	14,400	0	0
Obligations under finance leases	113	236	229
Total Current Borrowings	**14,513**	**236**	**229**
Non-current			
Obligations under finance leases	823	769	861
Total Other Non Current Liabilities	**823**	**769**	**861**

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 five 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 £60.6m in the period ended 31 March 2010, made up as follows:

	31 March 2010 £000	31 March 2009 £000
Maximum cumulative long term borrowing limit set by Monitor	46,200	43,500
Approved working capital facility	14,400	14,400
Prudential Borrowing Limit	**60,600**	**57,900**

The Trust borrowed against its working capital facility in March 2010. In 2009/10 the Department of Health clarified the rules around calculation of public dividend capital. This change incentivised the Trust to maximise the cash it held in our main Paymaster General account at the year end. The Trust responded to this incentive in a number or ways, included deferring some large payments to creditors, with their agreement, and drawing down its working capital facility. The effect of this on the Statement of Financial Position is increased cash at bank together with increased liabilities for trade payables and borrowings.

Prudential Borrowing Code Ratios	**Limit**	**Actual**
Minimum dividend cover	> 1x	**4.5**
Minimum interest cover	> 3x	**135.7**
Minimum debt service cover	> 2x	**121.1**
Minimum debt service to revenue	< 3%	**0.1**

17. Provisions for Liabilities and Charges

	Current 31 March 2010 £000	Current 31 March 2009 £000	Current 1 May 2008 £000	Non-Current 31 March 2010 £000	Non-Current 31 March 2009 £000	Non-Current 1 May 2008 £000
Pensions relating to former directors	2	2	2	18	19	19
Pensions relating to other staff	115	110	108	1,357	1,372	1,392
Other legal claims	76	102	258	0	0	0
Other	278	804	1,900	0	0	0
Total	**471**	**1,018**	**2,267**	**1,375**	**1,391**	**1,412**

	Pensions relating to former directors	Pensions relating to former staff	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 May 2008	21	1,500	258	1,900	**3,679**
Arising during the year	2	62	36	667	**767**
Utilised during the year	(2)	(101)	(18)	(1,233)	**(1,354)**
Reversed unused	0	(11)	(174)	(530)	**(715)**
Unwinding of discount	0	32	0	0	**32**
At 31 March 2009	**21**	**1,482**	**102**	**804**	**2,409**
At 1 April 2009	21	1,482	102	804	**2,409**
Arising during the year	1	73	56	132	**262**
Utilised during the year	(2)	(115)	(40)	(488)	**(645)**
Reversed unused	0	0	(42)	(170)	**(212)**
Unwinding of discount	0	32	0	0	**32**
At 31 March 2010	**20**	**1,472**	**76**	**278**	**1,846**
Expected timing of cash flows:					
Within one year	2	115	76	278	**471**
Between one and five years	6	438	0	0	**444**
After five years	12	919	0	0	**931**
	20	**1,472**	**76**	**278**	**1,846**

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.

£37,742,254 is included in the provisions of the NHS Litigation Authority at 31 March 2010 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 2009	Other changes in year	**At 31 March 2010**
	£000	£000	**£000**
Cash with the Government Banking Service	27,273	17,005	**44,278**
Commercial cash at bank and in hand	871	(586)	**285**
	28,144	**16,419**	**44,563**

19. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2010 were £14,555k (£586k 31 March 2009). The most significant commitment is due to the construction of a new two-storey ward block (£12,994k).

20. Events After the Reporting Period

There are no events after the reporting period.

21. Contingencies

	31 March 2010 £000	**31 March 2009 £000**
Contingent liabilities	**(37)**	**(29)**
Contingent assets	**0**	**8**

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

22. Movement in Public Dividend Capital

	£000
Public Dividend Capital as at 1 May 2008	74,055
New Public Dividend Capital received	978
Public Dividend Capital as at 31 March 2009	**75,033**
Public Dividend Capital as at 1 April 2009	75,033
New Public Dividend Capital received	1,160
Public Dividend Capital as at 31 March 2010	**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. 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.

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 4.2.

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

	Income		Expenditure		Creditors		Debtors	
	2009/10	2008/09	2009/10	2008/09	2009/10	2008/09	2009/10	2008/09
	£000	£000	£000	£000	£000	£000	£000	£000
East of England Ambulance Service NHS Trust	52	246	1,175	2,269	52	358	0	123
East of England Strategic Health Authority	6,607	5,719	7	5	81	0	196	495
HM Revenue & Customs	0	0	7,506	6,356	1,482	1,359	730	247
Mid Essex Hospitals NHS Trust	660	707	492	408	129	4	30	234
Mid Essex Primary care Trust	22,177	18,844	74	1	175	0	484	729
National Blood Authority	16	12	2,073	1,693	9	16	0	0
NHS Business Services Authority	0	0	4,888	3,874	349	274	0	0
NHS Litigation Authority	0	0	3,536	1,857	0	0	0	16
NHS Pension Scheme (Employers)	0	0	11,805	10,032	1,027	972	0	0
NHS Professionals	1	0	2,180	2,130	280	454	0	0
North East Essex Primary Care Trust	171,951	136,798	1,673	1,116	841	803	212	135
North Essex Partnership NHS Foundation Trust	918	918	2	17	20	0	599	141
South East Essex Primary Care Trust	7,137	3,469	0	0	504	0	513	64
Suffolk Primary Care Trust	3,807	2,699	(2)	0	0	38	420	0
West Essex Primary Care Trust	531	587	177	0	6	141	58	12

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 2010 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.

The fair value for provisions under contract is not significantly different from book value since in the calculation of book value the expected cash flows have already been discounted by the Treasury discount rate of 2.2% in real terms.

24.1a Financial Assets by Category

	Loans and receivables		
	31 March 2010	**31 March 2009**	**1 May 2008**
Assets as per Statement of Financial Position	**£000**	**£000**	**£000**
Trade and other receivables	5,017	3,720	4,034
Cash at bank and in hand	44,563	28,144	8,015
Total	**49,580**	**31,864**	**12,049**

24.1b. Financial Liabilities by Category

	Other financial liabilities		
	31 March 2010	**31 March 2009**	**1 May 2008**
Liabilities as per Statement of Financial Position	**£000**	**£000**	**£000**
Borrowings	14,400	0	0
Obligations under finance leases	936	1,005	1,090
Trade and other payables	22,261	15,510	10,916
Provisions under contract	1,770	2,307	3,421
Total at 31 March 2010	**39,367**	**18,822**	**15,427**

25. Fair values

As at 31 March 2010 there are no significant differences between fair value and carrying value of any of the Trust's financial instruments.

The fair value for provisions under contract is not significantly different from book value since in the calculation of book value the expected cash flows have already been discounted by the Treasury discount rate of 2.2% 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 143 cases of losses and special payments totalling £119,578 approved during the period.

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

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

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

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

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

27. Transition to IFRS

	Retained Earnings £000	Donated Asset Reserve £000	Revaluation Reserve £000	Other Reserve £000
Taxpayers' equity at 31 March 2009 under UK GAAP:				
Adjustments for IFRS changes:	24,200	1,475	64,192	754
Private finance initiative	(1,696)	0	471	0
Leases	(10)	0	12	0
Taxpayers' equity at 1 April 2009 under IFRS:	22,494	1,475	64,675	754

	£000
Surplus for 2008/09 under UK GAAP	13,001
Adjustments for IFRS changes:	
Private finance initiative	(37)
Leases	(38)
Surplus for 2008/09 under IFRS	12,926

Under IFRS the Trust has recognised additional finance lease obligations under IAS 17 for two pieces of equipment previously recorded as operating leases. Additionally, the Trust's Private Finance Initiative staff accommodation block has been reclassified as an on balance sheet service concession under IFRIC 12, with the creation of a deferred income liability to reflect the fact that the scheme has no unitary payments associated with it.

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £20,129k. This net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cash flows under IFRS.

Section C

Quality Accounts 2009/10

Quality Accounts 2009/10

At Colchester Hospital University NHS Foundation Trust we are ambitious to provide services that consistently deliver the best clinical outcomes for our patients, which are safe, accessible and responsive to patients' needs.

The Board of Directors is committed to developing quality reporting and quality accounts that are transparent, which recognise current performance and that help to focus on areas where the Trust is performing both well and less well, acknowledging and recognising areas of excellence, and identifying where there is more to do.

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 took action in 2008/09 to strengthen the infrastructure needed to support the quality agenda, specifically in joining the national Patient Safety First programme and the designation and appointment to clinical and support roles to support this work. In 2009/10 the Board built on this safety commitment and has demonstrated significant improvement in this area, being recognised as one of the top performing trusts in addressing patient safety by the national Patient Safety First team.

In late 2009/10 the Board revised its governance committee arrangements; it has now established a Quality & Patient Safety Committee to give assurance to the Board on all aspects of the quality of patient services. The Committee, which is chaired by one of our non-executive directors, is supported by two executive led groups – one focussing on Patient Safety, under the leadership of the Medical Director, and the other on the Patient Experience, led by the Nursing Director.

The Members' Council, our governing body, has also refocused its efforts to concentrate on the 'patient perspective' and has formed a patient care panel to support it in this work.

The Board agrees an Assurance Framework outlining its key deliverables for each year. It is on the basis of this that the Board will monitor progress and direct interventions where it identifies problems. The quality priorities outlined herein will form an integral part of the Board Assurance Framework.

The Quality & Patient Safety Committee on behalf of the Board receives and reviews detailed quality related information each month about patient safety, patient experience and clinical outcomes. In 2010/11 the Board will continue to receive regular reports and will review its future needs for information and analysis to give assurance in this crucial area of its work.

These Quality Accounts set out how we are progressing and where we are focusing our attention to make further progress.

The complementary themes of patient safety, patient experience and effectiveness of care underpin our quality strategy, the prioritisation of our quality objectives and implementation plans, and the reporting on our quality performance.

I want our Quality Accounts 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.

In this report, for the second time, we set out our assessment of our quality performance in 2009/10, our plans for 2010/11 and how we will report on these to our commissioners, stakeholders, members and the wider public.

The report has four sections

- Looking back at our performance on our quality objectives in 2009/10
- Looking forward to how we address our quality priorities in 2010/11
- Statements of assurance from the board in a number of mandated areas
- A summary of a number of quality indicators monitored by the board and its committees reviewing performance over the last three years

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.

Peter Murphy
Chief Executive

Looking Back

In spring 2009, as a Foundation Trust, we produced our first quality accounts setting out our quality priorities for 2009/10. The deliverable quality priorities identified by the Board in the Assurance Framework were:

Strategic Objective 1: Excellent Patient Satisfaction

2009/10 Deliverables

1. **Reduce the number of hospital acquired infections**
2. **Reduce the Hospital Standardised Mortality Rate**
3. **Deliver *Making Experiences Count* (the new NHS and social care complaints system)**
4. **Improve performance against the *Inpatient survey 2008***
5. **Reduce the number of instances of patient harm**

Strategic Objective 4: Excellent Clinical Performance
In addition, the Trust identified further indicators, based on national targets, which represent a high quality access to services for patients.

2009/10 Deliverables

1. **Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge**
2. **18 weeks Referral To Treatment (RTT) – admitted and non-admitted**
3. **16 weeks RTT – admitted**
4. **Maximum waiting time for elective inpatients/day case patients**
5. **Cancer standards**

This section of the Quality Accounts reports on the actions taken and the level of attainment of these objectives over the last twelve months.

Strategic Objective 1: Excellent Patient Satisfaction.

Target Attainment and commentary delivery

1. Reduce the number of hospital acquired infections

The Trust had agreed MRSA and C.Difficile thresholds for 2009/10 set in conjunction with NHS Northeast Essex, these were:

	2008/9 Actual	2089/10 Threshold	2009/10 Actual
MRSA	14	13	9
C Diff	71	84	44

The Trust's performance on reducing the incidence of these two high profile infections was particularly strong with a significant reduction on the 2008/9 levels of incidence of both, and substantially under the 2009/10 theshold for both.

The national measure for MRSA will change in 2010/11 to reflect MRSA identified 48 hours after admission. This better reflects the hospital acquisition of MRSA. The 2010/11 threshold for post 48-hour cases will be 6 in total; it should be noted that of the 9 cases recorded in 2009/10 only 4 were post 48-hours.

2. Reduce the Hospital Standardised Mortality Rate (HSMR)

In 2009/10 the Trust committed to a progressively improve in the HSMR to:

- achieve HSMR below 100 by February 2010
- achieve HSMR below 92 by March 2011 (Board internal target)
- achieve HSMR below 85 by September 2011 (Board internal target).

The HSMR has shown excellent progress in 2009/10. The latest position, based on data covering the 10 months from April 2009 to January 2010 inclusive shows a HSMR of 87.

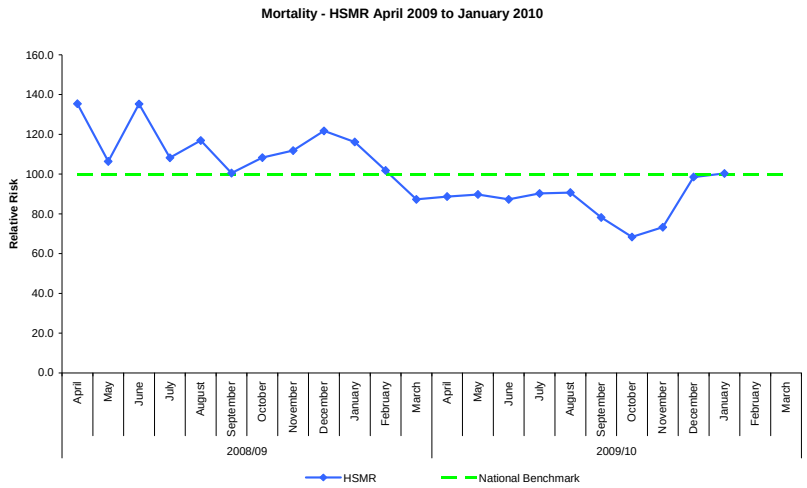
The Monthly HSMR rate for the last 18 months is shown in the chart.

HSMR was identified by Monitor and NHS NEE as an area of concern in early 2009 when data relating to the period April to November 2008 showed HSMR in excess of 117. The Trust implemented a comprehensive plan focussing on:

- Clinical data capture and the correct coding of deaths;

Reviewing a 10% sample of all deaths through the Mortality Review Group;

Investigating any specialties of clinical diagnoses giving rise to higher than expected rates of death and acting upon the findings



Target Attainment and commentary delivery

3. Deliver *Making Experiences Count* (the new NHS and social care complaints system)

In 2009/10 the Trust set the target to:

- reduce the number of formal complaints by 5% against the number received in 2008/9
- reduce the number of re-opened cases by 5% against the number re-opened in 2008/9.

During 2009/10, there were 1,076 Level 2 and above complaints received. Of these, 657 (61%) complaints were answered in the timescales agreed with the complainant. A total of 373 (35%) breached the Trust's agreed timescale and 50 complaints remain open. The Department of Health no longer has a target relating to the response times for complaints.

The new complaint regulations put the complaints requirements for resolution first, therefore the management of the complaint is no longer target driven. In recognition of the increased numbers of complaints and additional work created to implement the improved system an increased staffing level for Integrated PALS, Complaints & Litigation Service (IPCLS) was agreed by the Board.

It is difficult to accurately compare complaint numbers for the reporting period compared to the previous year. The Local Authority Social Services and NHS Complaints (England) Regulations 2009 (amended later in the year) changed the way complaints were managed and recorded. The Trust, in line with comparative organisations, has recorded an increase in the number of complaints raised. The Department of Health had expected this development.

122 (11%) 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 is that complainants have concerns that were either not addressed completely the first time or further questions were raised. Often, complainants request a meeting with Trust staff to address their concerns a number of successful meetings have been arranged.

4. Improve performance against the *Inpatient survey 2008*

The results of the National Inpatient Survey published in May 2009 showed no improvement on the 2008 performance.

As a result, in June 2009, the newly appointed Director of Nursing & Patient Experience put in place a number of initiatives designed to result in a better patient experience, to be reflected in improved survey results in future years.

The data collection for the 2010 survey took place in July 2009 and the Board was made aware that the impact of the initiatives taken may not be sufficiently embedded to result in an improved survey publication in May 2010.

Target Attainment and commentary delivery

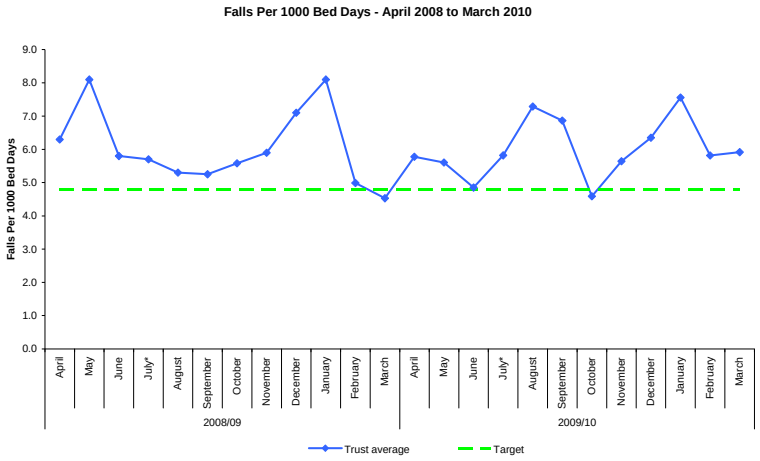
5. Reduce the number of instances of patient harm

As part of the Leading Improvement in Patient Safety (LIPS) programme the Trust has developed a stronger understanding of the harm, or potential harm, done to patients in acute hospitals. As a result the Trust is committed to developing the capabilities and technology for measuring patient harm events and developing responses to prevent recurrence and to reduce risk to future patients.

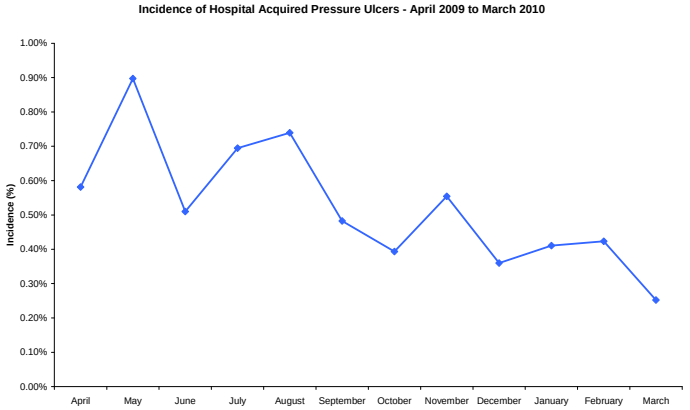
In 2009/10 the Trust set the target to reduce the number of harms to below the national average of 10% of all admitted patients, as defined by the Global Trigger Tool (GTT).

Specifically the Trust has focussed on a group of three indicators that form part of the National Patient safety programme (see graphs). These graphs show the progress made on each of these month by month in 2009/10 on our three priorities for 2009/10.

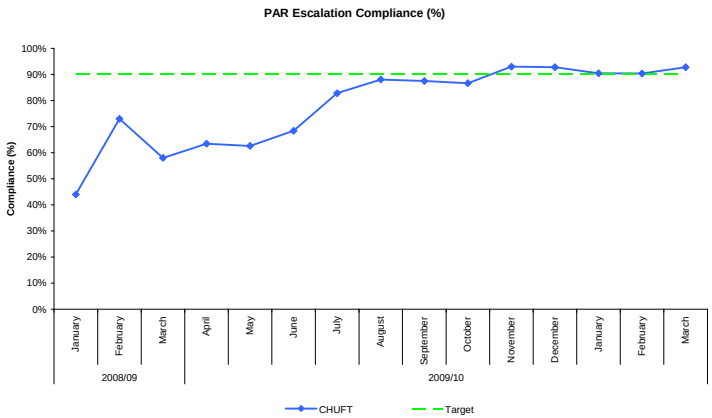
Falls



Pressure Ulcer Incidence



Patient At Risk scoring



Target Attainment and commentary delivery

The rate of incidence of falls has been variable and is still above the target threshold. Action within the Trust in the provision of low-rise beds and other equipment, training and awareness raising has been implemented. In 2010/11 our new Care of The Elderly Nurse Consultant will be leading further work in this area. Falls will be one of our quality priorities for 2010//11..

Progress on Pressure Ulcer incidence and the effectiveness of prevention through best practice is good with the overall incidence having fallen significantly.

Similarly the chart shows that the appropriate use of Patient At Risk scoring has been embedded in clinical practice with an acceptably high rate of compliance

Strategic Objective 4: Excellent Clinical Performance

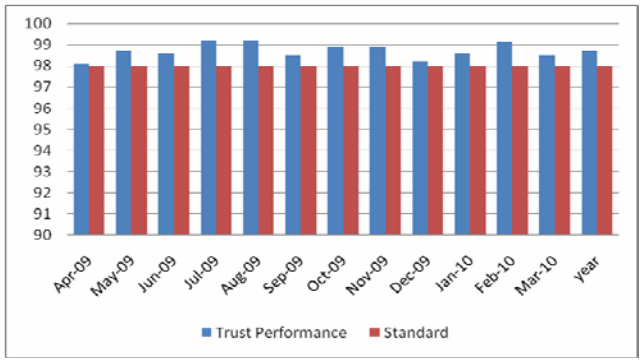
Target and delivery

1. Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge

The overall target is for the Trust to see, treat and admit or discharge over 98% of patients attending A&E within 4 hours of arrival. Performance has two measures reflecting the performance of the health economy overall, including the Minor Injuries and walk-in services provided by the PCT.

Health Economy 2008/9

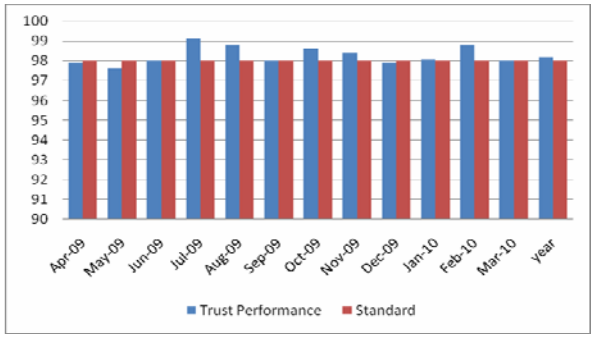
Apr	98.1%	Aug	99.2%	Dec	98.2%
May	98.7%	Sep	98.5%	Jan	98.6%
Jun	98.6%	Oct	98.9%	Feb	99.1%
Jul	99.2%	Nov	98.9%	Mar	98.5%



For the health economy, monthly performance throughout 2009/10 has exceeded this standard, and the health economy year-end position was 98.7%, this was the best in East of England SHA. For the Trust A&E service only three months performance was slightly under the standard, but for the year overall the year-end position was 98.2%.

Trust only 2008/9

Apr	97.9%	Aug	98.8%	Dec	97.9%
May	97.6%	Sep	98.0%	Jan	98.1%
Jun	98.0%	Oct	98.6%	Feb	98.8%
Jul	99.1%	Nov	98.4%	Mar	98.0%



Target and delivery

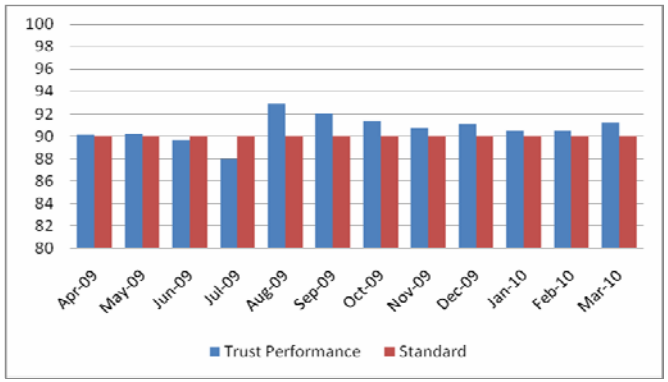
2. 18 weeks Referral To Treatment (RTT) – admitted and non-admitted

The overall targets are for the Trust to:

- Admit and treat over 90% of patients requiring admission within 18 weeks of being referred
- See in clinics and initiate treatment for over 95% of patients who do not need to be admitted within 18 weeks of being referred.

Admitted performance 2008/9

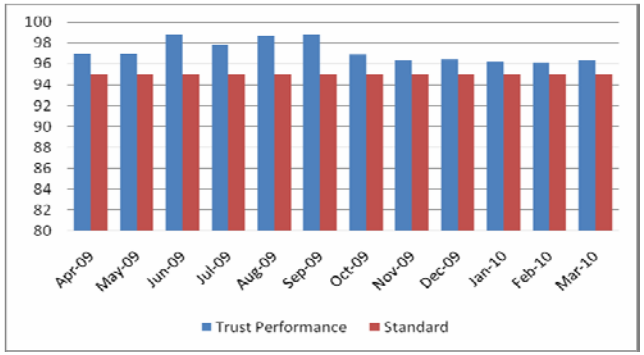
Apr	90.1%	Aug	92.9%	Dec	91.1%
May	90.2%	Sep	92.0%	Jan	90.5%
Jun	89.7%	Oct	91.4%	Feb	90.5%
Jul	88.0%	Nov	90.7%	Mar	91.2%



Trust Performance on this target was under standard in two months (June and July) as a result of an exercise to clear a backlog of breaching patients accumulated in quarter 4 of 2008/9. otherwise performance throughout the year exceeded the national standard.

Non-admitted performance 2008/9

Apr	97.0%	Aug	98.7%	Dec	96.5%
May	97.0%	Sep	98.8%	Jan	96.2%
Jun	98.8%	Oct	96.9%	Feb	96.1%
Jul	97.8%	Nov	96.4%	Mar	96.4%



Non-admitted performance was consistently above the national standard.

3. 16 weeks RTT – admitted

In agreeing the 2009/10 contract with the PCT both parties agreed that they should work together to improve on the national 18-weeks standard and work towards achieving a 16-week standard for North East Essex.

Moving to a 16-week target was agreed with the PCT as a local priority, in the event this was unaffordable for the PCT commissioners.

This objective has therefore not been delivered.

Target and delivery

4. Maximum waiting time for elective inpatients/day case patients

Maximum wait is 26 weeks; the national standard is that the Trust should have no breaches.

In 2009/10 there was one case where a patient was not admitted within the standard, giving an overall compliance rate of 99.987%.

5. Cancer standards

In 2009/10 new national access standards for cancer diagnosis and treatment were introduced. The eight standards and the Trusts performance over the whole year and in each of the last three months are shown below.

Cancer Standard	Standard	Jan 10	Feb 10	Mar 10	Full Year
Maximum Wait - 2 weeks from Urgent GP Referral to Date First Seen	93%	96.4%	98.1%	97.0%	97.9%
Maximum Wait - 31 Days from Decision to Treat to Start of Treatment for all cancers	96%	96.9%	97.6%	97.7%	94.2%
Maximum Wait - 31 Days from Decision to Treat to Subsequent Treatment – Surgical procedure	94%	82.6%	95.7%	87.1%	88.3%**
Maximum Wait - 31 Days from Decision to Treat to Subsequent Treatment – chemotherapy	98%	100%	100%	100%	100%**
Maximum Wait - 62 Days for All Referrals to Treatment for All Cancers	85%	88.7%	87.2%	91.9%	82.6%
Maximum Wait - 62 days from urgent referral from the national screening service to treatment	90%	91.1%	85.3%	93.6%	92.2%
Maximum Wait - 62 days from Urgent Referral from a Consultant (Consultant Upgrade) to Treatment	86%	None	None	100%	100%
Two Week wait - Symptomatic Breast Patients (cancer not initially suspected)	93%	85.6%	99.1%	98.4%	94.6%

** Q4 only

Early in the year the Trust performance against a number of these standards was below the required level. However, the Trust has made steady progress in the third and fourth quarters of 2009/10 in delivering the new national cancer access standards, as shown by the January February and March data.

Robust plans and resources are in place to achieve on all of these standards in 2010/11.

Looking Forward

Priorities for Improvement 2010/11
The Board's quality priorities overall continue to be built around the three domains of quality identified in *High Quality Care for All*:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

Our overall priority is to provide care to patients that is safe and that reduces avoidable harm to patients.

a. Infection control

- We will maintain the reduction in the number of Hospital Acquired Infections
- We will implement MRSA screening on admission for all emergency patients
- We will reduce the incidence of CVC bloodstream infections.

b. Avoidable Mortality

- We will maintain the Hospital Standard Mortality Rate (HSMR) performance below 100
- We will meet the overall and condition specific CQUIN targets for HSMR.

c. Reducing Patient Harm
Our improvement priorities in 2010/11 are drawn from evidence based on best practice building on the National Patient Safety Agency (NPSA) LIPS programme, they are to reduce the number of instances of patient harm:

- **Reducing harm from deterioration**
  We have set ourselves a target to reduce the number of ward cardiac arrest calls by 30 per cent in 2010/11 compared to 2009/10
- **Reducing harm from high risk medicines**
  We aim to reduce the harm to patients associated with the use of warfarin: we aim to halve the number of inpatients with an INR >6 compared to 2009/10; and ensure that no inpatient admitted for >48 hours to have an INR >8
- **Reducing incidence of Venous thromboembolism (VTE)**
  We also aim to reduce the risk of venous thromboembolism by risk screening all inpatients ensuring there are given the appropriate prophylactic treatment. We will improve the coverage of VTE screening to achieve the CQUIN target of 90% of all adult admitted patients to be risk-assessed for VTE by Quarter 4 2010/11.
- **Reducing harm from peri-operative care**
  We will ensure 100 per cent compliance with the World Health Organisation surgical checklist, all patients will have a completed consent form before arrival to theatre and all relevant patients will be surgical site marked before undergoing surgery
- **Reducing harm in critical care**
  In intensive care, we are working to ensure that no more than 5% of patients ventilated for more than 48 hours acquire a ventilator associated pneumonia
- **Falls**
  We will pursue our objective to reduce the actual number of inpatient falls by 10% in 2010/11 and a further 10% by 2011/12
- **Pressure Ulcers**
  We will pursue our policy of no avoidable grade 3 and grade 4 hospital acquired pressure ulcers.

We want all our patients (and their families and carers) to have a positive experience of the care we deliver. The measure of our success would be that, if the need arises, our patients would recommend the hospitals to their friends and family. We want the Trust to become our local public's provider of choice, not simply of necessity.

Our patient care priorities are designed to address issues that are reported to be of concern to patients, some of which are theme that can be drawn from the results of the National Patient Surveys and others from issues arising in complaints. The priorities are:

d. Same Sex Accommodation and improving privacy and dignity

- We will maintain the Delivering Single Sex Accommodation (DSSA) standards for the segregation of male and female patients in clinical areas
- We will report on all breaches and undertaking root cause analysis. All breaches are reported monthly to Board. The Director of Nursing will continue same sex monitoring walkabouts with PCT Executive lead
- We will monitor patient experience regarding privacy and dignity; we will assess success by achieving above 90% satisfaction on the Patient Experience Tracker and from the results of the Essence of Care annual privacy and dignity audits.

e. Improving the environment and maintaining high standards of cleanliness

- We will maintain a clean and welcoming environment; we will assess this by performance in maintaining high Patient Environment Action Team (PEAT) scores across the Trust and in the review of patients complaints and comments
- We will undertake monthly environmental inspections in line with National Patient Safety Agency infection control standards which are reported via the Patient Experience Scorecard to Executive Board. We will also undertake monthly Executive Nurse walk-about with Matrons

f. Improving communication with patients

- We will improve communication at all levels with patients and service users
- We will measure success in addressing communication issues using measures of improvement derived from the questions asked in the National Patient Survey and our quarterly patient survey and Patient Experience Tracker results.

g. Patient Surveys.

- We will maintain scores above agreed CQUIN targets (between 90-95%) for patient experience tracker
- We will develop action plans, within Divisions, to demonstrate in-patient survey improvements
- We will undertake quarterly in patient surveys to monitor improvements in line with in-patient survey.

Managing and assuring quality improvement

The Board has established a non-executive Quality and Patient Safety Committee, to review and give assurance to the board on all aspects of this pivotal area of our work. The committee will agree the specific objectives, performance targets and monitoring arrangements for all of these areas of work, reporting to the full board every month on the progress and key challenges throughout the year.

Within our operational management the Patient Safety Committee (chaired by the Medical Director) and the Patient Experience Committee (chaired by the Director of Nursing & Patient Experience) will lead on delivering the improvements, ensuring that resources are allocated and actions taken as agreed to drive improvement.

The Members' Council, through its Patient Care Panel, will monitor the agenda from a patient perspective, undertaking visits and working through their membership engagement responsibilities to ensure that the actions taken respond to real patients views of services.

Statements of Assurance from the Board

Services
During 2009/10, Colchester Hospital University NHS Foundation Trust (CHUFT) provided 48 NHS services.

The Trust has reviewed all the data available to it on the quality of care in 42 of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents over 95% percent of the total income generated from the provision of NHS services by Colchester Hospital University NHS Foundation Trust for 2009/10.

The Trust reviews 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. In preparing the Trust's response to this mandatory requirement in its Quality Accounts the Board has considered its approach to the phrase "has reviewed all the data available". For the purposes of the declaration the Trust has identified the forty-two service areas where the coverage and triangulation of data sources is sufficiently robust to allow the Trust to affirm assurance.

In 2010/11 the Trust will establish processes to review a wider range of clinical quality indicators in all service areas. Assurance on this will be sought through the Quality & Patient Safety Committee.

Clinical Audit
Participation in National Clinical Audit and Confidential Enquiries
During 2009/10, 23 national clinical audits and 6 national confidential enquiries were conducted which covered NHS services that CHUFT provides.

During 2009/10 the Trust participated in 83% (19 of the 23) national clinical audits of those it was eligible to participate in. The Trust participated in 100% of the national confidential enquiries which it was eligible to participate in.

It is noteworthy that CHUFT's clinical audit has passed the NHSLA Level 2 Pilot standard.

The national clinical audits and national confidential enquiries that CHUFT was eligible to participate in during 2009/10 together with levels of participation were as follows:

	Trust eligible to participate	Trust participated Y/N	If 'Y' number of cases submitted	% compliance with required number
National Clinical Audits				
National Head & Neck Cancer comparative audit (DAHNO)	Yes	Yes	15	100%
National Lung Cancer Audit (NLCA)	Yes	Yes	245/176	139%
National Bowel Cancer Audit Programme (NBOCAP)	Yes	Yes	286	100%
Oesophago-gastric Cancer Audit	Yes	Yes	172	100%
Heart Failure Audit	Yes	No[1]	-	-
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	20/20	100%
National Diabetes Audit (NDA)	Yes	No[2]	-	-
National Kidney Care Audit	Yes	Yes	N/A (patient survey)	100%
National Audit of Dementia Care	Yes	Yes	(In progress)	(In progress)
National Audit of Continence Care for Older People (NACCOP)	Yes	Yes	21/40	52.5%

[1] This is managed by the PCT chronic heart team.
[2] This was deemed unsuitable by a consultant. We did participate in an NHS diabetes inpatient audit.

	Trust eligible to participate	Trust participated Y/N	If 'Y' number of cases submitted	% compliance with required number
National Mastectomy and Breast Reconstruction Audit	Yes	Yes	54	100%
National Hip Fracture Database (NHFD)[3]	Yes	Yes	?	?
National Sentinel Stroke Audit	Yes	No (commencing 10/11)	-	-
National Vascular Database (VSSCBI VSD)	Yes	Yes	76/130	58%
National Joint Registry (NJR)[4]	Yes	Yes	?	?
College of Emergency Medicine:				
Pain in Children	Yes	Yes	50/50	100%
Asthma	Yes	Yes	50/50	100%
Fractured Neck of Femur	Yes	Yes	50/50	100%
Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme	Yes	Yes	N/A	100%
National Comparative Audit of Blood Transfusion	Yes	Yes	27/40	67.5%
OHCEU National Audits:				
Patient Reported Outcome Measures	Yes	Yes	891/1089	82%
Royal College of Radiologists Audits				
TARN Severe Trauma	Yes	No	-	-
Trauma Audit & Research Network				
Peri-natal Mortality	Yes	Yes	43	100%
National Confidential Enquiries				
Peri-operative Care	Yes	Yes	114/tbc	data collection in progress
Parenteral Nutrition	Yes	Yes	4/12	33%
Elective & Emergency Surgery in the Elderly	Yes	Yes	13/30	43%
Peri-natal Mortality	Yes	Yes	43	100%
Obesity in Pregnancy	Yes	Yes	60	100%
Head Injury in Children	Yes	Yes	100+	100%

The national clinical audits and confidential enquiries that CHUFT participated in and for which data collection was completed during 2009/10 are shown in the table alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry. In several cases, no target number is stipulated and, instead, cases are submitted on the basis of specified criteria.

The reports of several of these national clinical audits were reviewed by the Trust in 2009/10. As a result the Trust is taking the following actions to improve the quality of healthcare provided as a result of learning from the audits. Examples include:

National Lung Cancer Audit (NLCA)

Actions identified and implemented as a result of the audit included the following:

- Improved arrangements for liaison with radiology department to identify all imaging suspicious of lung cancer or mesothelioma
- Review clinical diagnoses and diagnostics protocols if HCR is below optimum.
- Review the specialist nurse service, ensuring all nursing posts are staffed and that clear referral pathways exist
- Ensure that thoracic surgeon attends multidisciplinary team meetings
- Ensure that all treatments are submitted to the audit
- Review treatment policies for lung cancer and small cell lung cancer patients

National Bowel Cancer Audit Programme (NBOCAP)

[3] Data not available.
[4] Data not available.

Actions identified and implemented as a result of the audit included the following:

- Case note review of each post operative death for lessons learned.
- Improving liaison with radiology department to identify all imaging suspicious of bowel cancer.
- Review the specialist nurse service and ensure that a clear referral process exists.

National Sentinel Stroke Audit

Examples of action taken as a result of the audit include:

- Nurses within stroke unit trained to undertake swallow assessment.
- Competency package completed and in use.
- Improved documentation of assessments undertaken.
- Additional SALT staffing within Stroke business case to bring level up to national standard.
- Increased knowledge of stroke as an emergency and requirement to scan within 24 hours by all medical staff.
- Acute stroke nurse in place to meet stroke patients in A&E and commence assessments

Local Clinical Audits

In 2009/10 the Trust's Clinical Audit Committee had the opportunity to review all available local audit reports. The following section includes details of just some of the audits undertaken by our clinical teams and the action that has been taken as a result of these to improve the quality of healthcare provided:

Essex Cancer Network Audit: Oral Chemotherapy Standards.

As a result of this audit we are taking the following action:

- Introducing new CIP and treatment evaluation record that can be used for haematology as well as oncology patients
- Changing pre-printed profomas to state the criteria for stopping or modifying treatment.
- Oral chemotherapy dispensing policy to be updated to include directions for labelling medication given continuously
- Reminding all nursing and medical staff that all appropriate written information MUST be given to patients

Essex Cancer Network: Patient Satisfaction Survey of Patients undergoing Chemotherapy Treatment.

As a result of this audit we are taking the following action:

- Improve capacity of pre assessment clinics to improve level and detail of information given.
- Review patient waiting times and identify bottlenecks. Doctors clinics to start on time. Inform patients of delays.
- Review out of hours policy and identify blocks that cause concern and difficulty for patients. Re-enforce to patients.
- Haematology to proactively hand out audit proforma to patients

External user evaluation for the Oncology Specialist Pharmacist (NMP) Clinic service.

Actions/recommendations

- To continue the clinic and possibly extend to other areas/cycles of chemotherapy.
- To look at a more private area/dedicated area/room on MBS for the NMP to see patients.

VTE 'Nurse-led-Doctors-complete' pilot

Based on the audit results, it was clearly determined that cooperative practice between both clinicians and nurses achieved a near 100% compliance rate with trust protocol and NICE guidance relating to VTE prophylaxis. This is a practice planned to be rolled out to the rest of the trust over the course of 2010, as a result the following actions have been taken:

- Senior nursing staff are trained assist in process of risk assessing
- Protocols implemented to ensure risk assessments take place

Temporal Artery Biopsy referrals

A project team was asked to look into the validity of referrals from GPs to vascular surgeons for Temporal Artery Biopsy. Measuring against national criteria, the project team found referrals to be meeting recommendations. Improvements to the process were made by designing and introducing a standard pro forma for all future referrals of this type.

Repair of perforated peptic ulcer: Laparoscopic vs Open

The benefits of laparoscopic repair for perforated peptic ulcer versus open repair was audited and produced recommendations for an increase in diagnostic laparoscopy and improved training facilities such as a laparoscopic simulator

Acute Pancreatitis
Continued auditing of managing acute pancreatitis produced an online protocol and additional online aids such as a scoring chart and instructions for management. Benefits of the audit include

- Improved training of junior doctors and supervisory attention by seniors
- Acute pancreatitis protocol available on intranet with scoring chart and management instructions
- Consider Expanding hours of availability of ultrasound services
- Use of CT in all severe cases
- ITU referral for all severe cases
- Outpatient follow-up to ensure assessment of aetiology and possible further prevention

Post EVAR surveillance
The post-operative surveillance for EVAR patients was audited in terms of cost to patient health and cost to organisational time. As a result it was recommended that if both a 30-day duplex scan and 3-month CTA showed normal then this would obviate the need for a 6-month scan, thus reducing the patient's exposure to contrast and freeing up imaging resources.

Research
The number of patients receiving NHS services provided by Colchester Hospital University NHS Foundation Trust that were recruited during 2009/10 to participate in research approved by a Research Ethics Committee was 1895.

Colchester Hospital University NHS Foundation Trust has a long-standing and evidenced commitment to clinical research as a driver for high quality patient care and experience.

Commissioning for Quality and Innovation (CQUIN) payments
A proportion of Colchester Hospital University NHS Foundation Trust's income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and NCL Agency through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2009/10 and for 2010/11 are available from:

Sarit Avny, Associate Director, Commissioning
Email: sarit.avny@colchesterhospital.nhs.uk
Tel: 01206 745259
Address: Colchester Hospital University NHS Foundation Trust, Trust Headquarters, Turner Road, Colchester, CO4 5JL

The amount of income in 2010/11 conditional upon achieving quality improvement and innovation goals is £2.8m.

Care Quality Commission
Colchester Hospital University NHS Foundation Trust is required to register with the Care Quality Commission and its 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 2009/10.

The Trust is not subject to periodic review by the Care Quality Commission.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Data Quality

NHS Number and General Medical Practice Code Validity

Colchester Hospital University NHS Foundation Trust submitted records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  98.6% for admitted patient care
  99.3% for outpatient care
  93.3% for accident and emergency care

- Which included the patient's valid General Medical Practice Code was:
  100% for admitted patient care
  100% for outpatient care
  99.5% for accident and emergency care

Information Governance Toolkit Attainment Levels

Colchester Hospital University NHS Foundation Trust's score for 2009/10 for Information Quality and Records Management assessed using the Information Governance Toolkit was 77%.

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 and the error rates reported in the latest published audit for that period for diagnoses and treatment coding were:

Primary Diagnosis incorrect	17.7%
Secondary diagnosis incorrect	13.3%
Primary procedures incorrect	28.1%
Secondary procedures incorrect	13.0%

These results should not be extrapolated further than the actual sample audited.

Quality: three year overview of performance

This section of the Quality Report gives details of performance against a:

- indicators which demonstrate the Trust's performance in aspects of patient safety, patient experience and clinical effectiveness
- measures identified in the Department of Health Operating Framework and the national core standards.

Performance of the Trust against selected quality metrics

	2009/10	2008/09	2007/08	National benchmark
Patient safety				
Falls per 1,000 bed days	6.0	6.05	No data	4.8*
Medication errors per 100 bed days	0.24	0.17	No data	1-2*
Pressure ulcer care incidence	0.52%	0.89%	No data	0.5 – 4%**
MRSA bacteraemia per 10,000 bed days	0.36	0.72	0.72	
C. diff cases per 1,000 bed days	0.20	0.37	1.44	
Hand hygiene compliance	97%	95%	92%	
Number of Serious Untoward Incidents	8	8	12	
Clinical effectiveness				
HSMR	88.1***	107.5	112.6	100
Caesarean section rate	27.4%	24.7%	26.1%	24.6%
% Fractured neck of femur operated within 48hrs	64.5%	76.9%	No data	
Patient experience				
Formal complaints received	1076****	672	547	
Formal complaints reopened	122	100	79	

* National Patient Safety Agency benchmark
** Research based benchmark
*** Dr Foster Intelligence – data for 10 months April to January 2009/10 only
**** Data definition changes in 2009/10 make year on year comparisons unreliable

National targets and regulatory requirements

	2009/10	2008/09	2007/08	2009/10 Standard/ Threshold
Clostridium difficile – year-on-year reduction	44	71	161	84
MRSA – maintaining the annual number of bloodstream infections at less than the 2003/04 level	9	14	14	13
18-week maximum wait from point of referral to treatment (admitted patients)	90.5%	86.1%*	87.7%**	90%
18-week maximum wait from point of referral to treatment (non-admitted patients)	97.2%	97.4%*	93.0%**	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge - Health Economy	98.7%	97.8%	98.9%	98%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge - Trust	98.2%			98%
People suffering a heart attack receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	88.2%	87.3%	73.9%	68%
Maximum Wait - 2 weeks from Urgent GP Referral to Date First Seen Cancer	97.9%			93%
Maximum Wait - 31 Days from Decision to Treat to Start of Treatment for all cancers	95.2%	90.7%*		96%
Maximum Wait - 31 Days from Decision to Treat to Subsequent Treatment – Surgical procedure	86.7%****			94%
Maximum Wait - 31 Days from Decision to Treat to Subsequent Treatment – chemotherapy treatment	99.7%****			98%
Maximum Wait - 62 Days for All Referrals to Treatment for All Cancers	83.2%	83.4%*		85%
Maximum Wait - 62 days from urgent referral from the national screening service to treatment	92.2%			90%
Maximum Wait - 62 days from Urgent Referral from a Consultant (Consultant Upgrade) to Treatment	100%			86%
Two Week wait - Symptomatic Breast Patients (cancer not initially suspected)	94.6%			93%
Maximum waiting time of 31 days from diagnosis to treatment for all cancers (old definition)		100%	99.2%	
Maximum waiting time of 62 days from urgent referral to treatment for all cancers (old definition)		97.3%	99.3%	
Maximum time of two weeks from urgent GP referral to first outpatient attendance for all urgent suspect cancer referrals (old definition)		99.3%	98.7%	

* based on January-March 2008/09 only
** March 2008 (one month) data
*** based on all A&E attendances in north east Essex health economy
**** Q4 2009/10 only

Mandatory Services: Evidence on Quality of Care

Mandatory Services	Dr Foster Mortality and safety measures	NPSA GTT assessment	External accreditation	National Audits /Confidential Enquiries	Local Clinical Audit reports in 2009/10 (number)	Departmental & Ward Quality scorecards	Patient Experience Tracker	Hand Hygiene & Saving Lives	Other evidence
General Surgery	Yes	Yes		PROMS	20	Yes	Yes	Yes	NCAT emergency process review
Urology	Yes	Yes	Cancer Network		4	Yes	Yes	Yes	
Trauma & Orthopaedics	Yes	Yes		NHFD, NJR, # NoF audit, PROMS	5	Yes	Yes	Yes	NCAT emergency process review
Ear, Nose & Throat	Yes	Yes	Cancer Network	DAHNO	2	Yes	Yes	Yes	
Ophthalmology	Yes	Yes			11	Yes	Yes	Yes	
Oral Surgery								Yes	
Orthodontics								Yes	
Accident & Emergency		Yes			23		Yes	Yes	NCAT emergency process review
Anaesthetics					12			Yes	
Critical Care Medicine	Yes	Yes		ICNARC	6	Yes	Yes	Yes	
General Medicine	Yes	Yes				Yes	Yes	Yes	NCAT emergency process review
Gastroenterology	Yes	Yes	Cancer Network		3	Yes	Yes	Yes	
Endocrinology	Yes	Yes			1	Yes	Yes	Yes	
Clinical Haematology	Yes	Yes	Cancer Network		3	Yes	Yes	Yes	
Audiological Medicine								Yes	
Clinical Genetics								Yes	
Cardiology	Yes	Yes		MINAP	7	Yes	Yes	Yes	
Dermatology	Yes	Yes	Cancer Network		1			Yes	
Thoracic Medicine	Yes	Yes	Cancer Network	NLCA, Asthma Audit	6	Yes	Yes	Yes	
GU Medicine								Yes	
Nephrology	Yes	Yes		National Kidney Care Audit		Yes	Yes	Yes	
Medical Oncology	Yes	Yes	Cancer		15	Yes	Yes	Yes	

Mandatory Services	Dr Foster Mortality and safety measures	NPSA GTT assessment	External accreditation	National Audits /Confidential Enquiries	Local Clinical Audit reports in 2009/10 (number)	Departmental & Ward Quality scorecards	Patient Experience Tracker	Hand Hygiene & Saving Lives	Other evidence
			Network						
Neurology	Yes	Yes				Yes	Yes	Yes	
Neuro-physiology					1			Yes	
Rheumatology	Yes	Yes			2	Yes	Yes	Yes	
Paediatrics/SCBU	Yes	Yes	Neonatal Level 2 accreditation Cancer Network	Pain in Children Audit, Head Injury in Children Conf Enquiry	8	Yes	Yes	Yes	NCAT emergency process review
Geriatric Medicine	Yes	Yes	RCP Stroke Accreditation	NACCOP, Nat Audit of Dementia Care, Sentinel Stroke Audit, Elect & Emergency Surgery in the Elderly Conf Enquiry	5	Yes	Yes	Yes	NCAT emergency process review
Obstetrics	Yes	Yes	CNST Level 2	Perinatal Audit, Perinatal Conf Enquiry, Obesity in Pregnancy Conf Enquiry	64	Yes	Yes	Yes	
Gynaecology	Yes	Yes	Cancer Network			Yes	Yes	Yes	
Midwifery			CNST Level 2			Yes	Yes	Yes	
Clinical Oncology			Cancer Network		In Med Onc			Yes	
Radiology			Cancer Network					Yes	Rad Protect Board Review, IR(NER) Regulation
Blood Transfusion		NPSA self assessment tool	CPA accreditation Cancer Network	Nat Blood Transfusion Audit				Yes	
Chemical Pathology								Yes	
Haematology								Yes	
Histopathology								Yes	
Medical Microbiology								Yes	
Breast Surgery	Yes	Yes	Cancer	Nat Mastectomy &		Yes	Yes	Yes	EQA, EoEQARC,

Mandatory Services	Dr Foster Mortality and safety measures	NPSA GTT assessment	External accreditation	National Audits /Confidential Enquiries	Local Clinical Audit reports in 2009/10 (number)	Departmental & Ward Quality scorecards	Patient Experience Tracker	Hand Hygiene & Saving Lives	Other evidence
			Network	Reconstruction Audit					
Colorectal Surgery	Yes	Yes	Cancer Network	NBOCAP		Yes	Yes	Yes	
Vascular Surgery	Yes	Yes			1	Yes	Yes	Yes	
Pain Management	Yes	Yes				Yes	Yes	Yes	
Podiatry								Yes	
Orthoptics					Inc in Ophthal			Yes	
Upper Gastro Surgery	Yes	Yes	Cancer Network	Oesophogastric Audit				Yes	
Diabetic Medicine	Yes	Yes						Yes	
Physiotherapy					2			Yes	
Occupational Therapy								Yes	
Dietetics				Parenteral Nutrition Conf Enquiry	2			Yes	