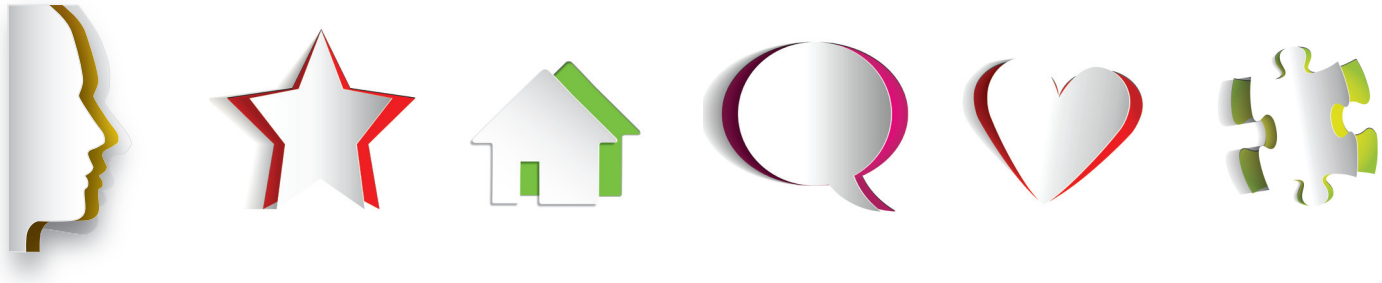
North Essex Partnership University NHS Foundation Trust

Annual Report & Accounts

1 April 2013 – 31 March 2014



all together, better

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Strive for Excellence

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North Essex Partnership University NHS Foundation Trust

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

Our values:

Humanity, Strive for Excellence, Our cause, our passion, Commercial Head, Community Heart, Creative Collaboration, Keep it simple

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The accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7, paragraph 25(4) of the National Health Service Act 2006

FOI Ref: 011402
FOI Ref: 011403 (Summary)

From the Chairman and Chief Executive
Outstanding Care, Transforming Lives

This is our second year as a University Foundation Trust, and what a year it's been! From back to back inspections by the Care Quality Commission (CQC) to award winning performances by our staff and the opening of Edward House, our new state-of-the-art low secure unit in Chelmsford.

We had a series of unannounced CQC inspections and for the majority of them we were found to have met all of the essential standards. There were some areas where we did not meet all of the requirements at the time of the inspections, but we have since addressed those areas and are now fully compliant. One of the CQC reports says that we are the only Trust in the entire country to provide a dedicated NHS 'place of safety' for young people. The St Aubyn Centre in Colchester is that place of safety and what a remarkable place it is. The young people who are treated there also think so. The centre also came under the spotlight when it was featured on BBC Look East. The footage highlighted the importance of treating young people in specialist units that are appropriate for them. The young people who were interviewed for the broadcast spoke of how well they were treated there.

As a Trust, we are expanding. Not only do we provide specialist mental health services, we also run three GP practices in Thurrock – Acorns, Dilip Sabnis and St Clements. We also took on the service for marginalised and vulnerable people (homeless, travellers, migrants and other hard to reach groups) in Suffolk.

It's been a challenging year with us having to do much more with much less money. The sums do not really add up. Everyone is feeling the pinch we know, but high quality patient care deserves funding and investment. We value our relationship with our commissioners and we want to continue working fairly and positively with them. The Government speaks about giving mental health a parity of esteem with physical health and we want this to be a reality.

We are reorganising the way our services are delivered, through the Journeys Programme, which is all about improving patient care, access to our services and making the patient journey from referral, right through to care planning, treatment and discharge much more streamlined. Providing the right treatment at the right time and in the right place is vital to the Journeys Programme.

Compassion is at the core of what we do and our new brand and values reflects that; Humanity, Strive for Excellence, Our cause, our passion, Commercial head, community heart, Creative collaboration and keep it simple. We are a forward

thinking organisation, constantly working to improve patient care and working conditions for our staff.

As a University Foundation Trust, we value and promote research. We continue to work closely with Universities and other experts in mental healthcare to conduct research that will benefit the people of Essex and beyond.

We have achieved a lot this year and all of this would not have been possible without the dedication and hard work of our staff, most of whom go the extra mile every day to make the experience of our patients the best that it can be – for this we thank you.

Thank you to our governors, stakeholders, members and partners for your help in our efforts to stop mental health discrimination and stigma.

Chris Paveley	**Andrew Geldard**
Chair	Chief Executive

Who we are

- We provide specialist mental health and substance misuse services across Essex
- Marginalised and Vulnerable Adults (MVA)
- GP Practices

We are a large organisation (covering most of Essex, from the Central Line in west Essex, up from Epping Forest into Harlow through to Uttlesford and Stansted airport and across Essex from Chelmsford and Braintree to Colchester, Clacton and Harwich and south to Maldon and South Woodham Ferrers).

We provide

- Consultant Psychiatrist clinics (including in some GP surgeries)
- Psychology
- Hospital care for all ages – including a Mother and Baby Unit and intensive care units, day care and partial hospitalisation and Rehabilitation services
- Crisis Resolution and Home Treatment
- Assertive Outreach
- Early Intervention in Psychosis
- Community Mental Health Teams
- Memory Assessment Services
- Child and Adolescent Services
- Specialist Eating Disorders Services
- Community Drug and Alcohol Services
- Prison and Criminal Justice teams

At the time of writing we had provided:

- 131,683 Occupied bed days
- 38,744 Outpatient Attendances
- 34,582 Day Care Attendances
- 79,290 Face to face Community Contacts
- 19,073 Drug & Alcohol Attendances
- 42,599 Telephone Contacts to Patient regarding their care

We support the ***Green Light for Mental Health*** which means that people with a learning disability can be treated alongside anyone else who uses our services.

We support patient choice and want the best experience for patients; we want patients and carers and their families to have clinically effective treatments; and we want people to be safe with us. We campaign in the community against discrimination and for a greater awareness of mental health.

We have regular feedback from patients. How we do something is as important as what we do; and we want to continue to improve. We want to be the natural choice in North Essex – for people to choose us when they need help and to work here when they want a fulfilling and rewarding job.

Our vision is to provide care that is outstanding in its quality, transforming the lives of individuals and families every day. Our communities will have total confidence in our services, our staff feel a strong sense of belonging and satisfaction, and our partners be proud to work purposefully with us.

Our commitments

To individuals and families (including carers):

- we will work together, building on strengths, to improve mental health and wellbeing,

To our staff:

- we will value everyone individually, promote wellbeing, support involvement and encourage personal development and leadership
- we will support teams in their delivery of best value, innovation and excellence

To our commissioners and key partners:

- we will listen, work with you, create ideas, demonstrate our effectiveness and flexibility, and earn recognition as provider of choice

Our values underpin everything we do:

Humanity, Strive for Excellence, Our cause, our passion, Commercial Head, Community Heart, Creative Collaboration, Keep it simple

Trust-wide Highlights

This area of the Annual Report focusses on highlights over the past year. A lot has happened that the Trust, its staff, patients, stakeholders and partners can be proud of. Most of what is reported, here in Trust-wide highlights, was featured in the local media. There was some negative media coverage concerning shortage of beds, a case involving a mother who needed to have a caesarean to keep her and her baby safe. We also had compliments and complaints.

Award Winning Veterans First

Veterans First, won the national *Care of Veterans* Award at the Military and Civilian Health Partnership Awards in Cardiff in May 2013. Diane Palmer, the Area Team Manager of the service won the Care Innovator Award in the Great East of England Care Awards. Diane was also the runner up for the Outstanding Contribution to Social Care Award category.

Top marks for older adults services

The King's Wood Centre in Colchester, and the Landermere Centre in Clacton; providers of mental health services for people over 65, were independently recognised as providing high quality services around patient need. Both centres were awarded Practice Development Status.

World Mental Health Day

Our annual celebration on World Mental Health day was a great success again on 10 October 2013. The Extra Mile walk in the park attracted more than 300 people! Local businesses, students from Sandon School and Chelmsford College, members of the public, and patients and staff came to support the event. We were sponsored by Virgin Active, Baxter Harris Solicitors and Morrison's Supermarket.

Recovery College opens in Chelmsford

In October, we opened the first ever Recovery College in Mid Essex for people who had experienced mental health difficulties, their families, carers and staff who work alongside them.

The courses help people to recognise, develop and make the most of their talents and resources to become experts in their own care and do the things they want to do.

Derwent Centre gets a makeover

A major refurbishment of the Derwent Centre in Harlow got underway in September with a Turf Cutting ceremony. The Derwent Centre is set to be transformed into a state-of-the-art facility for treating people with mental illness.

Students wows audience in Harlow
Over 300 people watched the grand finale of SoapSense – the drama competition for schools about mental illness at the Trust's Annual Public Meeting on 18 September 2013. The winning performance was from Chelmer Valley School, Chelmsford and runner up was Alderman Blaxill, Colchester.

Severalls Farewell Tour
Staff and patients from the Trust said their final farewells to Severalls Hospital in Colchester on 7 November 2013. There were over 100 people who went on the tour - most wrote farewell messages on a commemorative wall.

Patient survey
We received one of the highest scores in the country following the Care Quality Commission's report about the patient survey for community mental health services. The CQC gave the Trust an overall score of 7 out of 10. (The highest in the country scored 7.4.) The Trust's highest score was for its staff – 8.4 out of 10 (with our respect and dignity score at 92%!)

University Day
We became a University Foundation Trust in May 2013. To celebrate this, the Trust held its first University Day on 10 June with a public lecture by Dr Malte Flechtner, Medical Director. Dr Flechtner spoke about "From Madness and Lunacy to Psychiatric Illness - A Historical Perspective on Psychiatry and Mental Health".

Edward House Opens
In August 2013 the Trust opened a new purpose-built facility in Chelmsford for treating people with complex mental illness, requiring conditions of stability, safety and security. The building has 20 beds with en suite facilities. Edward House is named after Edward Jackson, a young man who sadly took his own life in 2007 whilst in care. His parents and brother officially opened the building.

Civil Servants
A senior policy maker, Lindsay Wilkinson, CBE, from the Department of Health spoke at the Trust's Annual Public Meeting in September. Lindsay spoke about giving mental health "parity of esteem" with physical health. A group of civil servants, also from the Department of Health, spent a week with our frontline staff. Some went onto the wards and others shadowed community mental health teams. Feedback

from the civil servants was that they enjoyed and valued the experience here at North Essex Partnership.

War and mental health
Consultant Clinical Psychologist, Steve Davies did a public talk about war and its impact on mental health on 11 November (Remembrance Day). The event was held at the Essex Records Office. Members of the public attended the event.

Dementia Campaign
We became a Dementia friendly organisation. Several staff from the Trust became Dementia friends and champions. In January, the Trust produced a sixty second advert to raise awareness of Dementia. The advert was shown for a week at the Meadows Shopping Centre in Chelmsford.

Patient Care Highlights by Area

Children & Young People's Services
Child and Adolescent Mental health Services (CAMHS)
Early Intervention in Psychosis (EIP)
Children's Learning Disability Service (CLDS)

Toni Scales
Area Director

CAMHS fast facts:

1,300 people were referred to us. We run a Single Point of access – the CAMHS Gateway. This means that referrals are more appropriate and accurate so referrals are down 50% but we are busier than ever. Generic CAMHS beds have increased from 13 to 15 this year with the addition of a further 10 Psychiatric Intensive Care Unit (PICU) beds (all located within our new Tier 4 service at The St Aubyn Centre). During the first 6 months of operation we have admitted over 70 young people to this facility.

235 A & E Assessments undertaken annually by the CAMHS crisis team who have recently re-located to The St Aubyn Centre (minimum caseload of 85 young people).

97 Referrals received by the CAMHS Eating Disorders Team who have recently re-located to Maplehurst on the Severalls site (caseload of 76 young people).

Early Intervention in Psychosis (EIP) fast facts:
200 new referrals received
34 cases receiving a service for more than 3 years
49 cases were young people aged under 18 years
Current caseload 285

Children's Learning Disability Service (CLDS) fast facts:
96 referrals received
Current caseload 64

This year has seen the successful completion of the CAMHS Gateway Pilot in partnership with Tier 2 CAMHS in ECC. The current Gateway model will continue into 2013/14 as a CQUIN scheme. The Gateway ensures that all referrals to Tiers 2 and 3 are screened jointly and either signposted to other providers or assessed by the most appropriate CAMHS service.

In June 2012 our adolescent unit was re-located from Turner Road in Colchester to a new purpose-built facility on the Severalls site. This new unit, the St Aubyn Centre, provides 15 generic beds and 10 new Psychiatric Intensive Care Unit (PICU) beds (all en-suite) with improved facilities for education, therapy and recreation.

All admissions to The St Aubyn Centre are managed through an assessment which includes the referrer, inpatient staff, the Crisis Team and any other professionals involved. This ensures that families are not subjected to multiple assessments and that all treatment options are considered. The St Aubyn Centre admits young people aged up to 17 years (18th birthday) unless adult services are deemed to be more appropriate. New intensive care pathways have been developed to reduce the length of stay for young people in hospital and to improve their clinical outcomes.

A very positive achievement in 2011 was the development of a Pilot CAMHS Specialist Eating Disorders Team. The treatment provided is an evidence-based model called Multi-Family Therapy and is already showing improved outcomes for young people affected by Anorexia Nervosa. Rising demand and the continued success of this service has secured recurrent income from our commissioners to provide this service from 2013/14.

The Tier 3 CAMHS Teams in Mid-Essex re-located to the Chelmsford and Essex (C&E) Centre in Chelmsford in April 2013 (satellite clinics will operate in Maldon and Halstead).

Early Intervention in Psychosis has been raising their profile with a Public Awareness Campaign in schools, colleges and town centres in West Essex. This resulted in the

MP for Harlow, Robert Halfon making a visit to the service to gain a greater understanding of their work.

We have re-modelled our service delivery and now offer an extended period of treatment (5 years from 3 years) with an increased awareness of “watch and wait” cases that are now reported to commissioners.

As part of a Young Person’s Directorate we have developed the opportunity for staff to gain experience/take up secondments in other services within our management sphere.

Children’s Learning Disability Service has extended their remit across all three CCG cluster areas and is an integral part of the Accommodation Review in Mid Essex.

All clinical teams have participated in the Journeys Programme mapping exercise and we have made significant progress with our Care Pathways.

North East Area
Toni Scales
Area Director

53 Adult Acute in-patient beds
45 Older Adult in-patient beds
11 Rehab beds
21 continuing care beds (in process of being found alternative placements due to changes in commissioning)
7 Multidisciplinary Community Mental Health Teams
Dedicated, all age Dementia Service
Specialist Older Adult Duty and Home Treatment service
Specialist Adult Duty and Home Treatment service
Therapeutic day services on Adult in –patient wards
Older Adult Recovery Service
Oxford Road Project

The North East Essex area provides mental health services to a local population of approximately 355,000 people across the Colchester, Halstead and Tendring localities with services that aim to deliver a holistic approach to recovery and social inclusion.

Our staff are our largest and most valued resource. We intend to build on the work we had already begun by ensuring that staff feel listened to, empowered, involved

in service planning, are appropriately trained and have development opportunities and future career development plans.

Our commitment to a collaborative approach with service users and carers is well established with North East area having led the development of the recently adopted Service User and Carer Engagement and Involvement Strategy.

Engagement with a wide range of partners will also continue to be a priority and we will ensure that our already successful approach with our Governors continues as will our engagement with GPs, Commissioners, the whole health economy as well as a broad range of third sector and other agencies.

We have continued to build on the planning and development work of previous years and some of the highlights of the last 12 months are outlined below:-

- Dedicated Dementia service now more established – age inclusive service located at the Emerald Centre at Kingswood Centre, in Colchester. Services offered are a help line to service users and carers, home treatment and admission avoidance, memory monitoring clinics, which have become part of the specialised service aimed at improving quality and effectiveness and close working with other agencies to provide holistic care.
- The Dementia service attained PDU status.
- The development of an Older Adult home treatment service offering specialised interventions as alternative to admission and early discharge support over seven days.
- Development of an Older Adult Recovery service – aimed at psycho-education and social inclusion.
- Functional model embedded in Colchester/Halstead adult services – involving community and in-patient services and affected staff and services relocated into CMHT.
- Veterans Service established providing Trust-wide service. Achieving national awards.
- Introduction of Therapeutic Day programme for Adult in-patient wards across Colchester and Clacton.
- Centralisation of Adult Duty and Home Treatment service to Colchester with sub base in Tendring.
- Changes in the provision of care in Severalls House/Rivendell and Activity Centre.
- Relocation of Cedar/Maple to new Edward House unit in Chelmsford – secure services.

- Refurbishment of estates for alternative use. i.e. Herrick House as part of Colchester CMHT, The Bungalow for Psychology services and Abberton Centre.
- Older Adult Redesign of services.

In the year ahead we plan to:-

Implement the Journeys Programme for the NE and CAMHS area ensuring we maintain our close working relationships with the whole health economy to ensure service developments link with evolving local needs and services. The completion of the site optimisation of our local estate to ensure that our buildings better meet the needs of our services, staff and service users will be integral to the planning and delivery of new services within the local Journeys Programme.

David Olive
Area Director
West and Substance Misuse

West fast facts

32 Acute Adult Beds
30 Older Adult Acute Beds
16 Older Adult High Dependency Beds
4 Rehab beds supported by intensive community rehabilitation support
6 Multi-Disciplinary Community Mental Health Teams plus Crisis Resolution Home Treatment Team and Community Drug and Alcohol Team
Specialist Psychology and Therapy services
422 Staff (West and Substance Misuse)

The west area, including Epping, Harlow and Uttlesford, has a slightly higher proportion of older people and fewer 15-34 year olds than average in other parts of England.

As in previous years, there has been a continuous emphasis on engaging with a wide range of stakeholders to get their views about our services and how these should develop.

We provide mental health services to a wide range of individuals and families across a large and diverse geographical area. This could not be achieved without a skilled and enthusiastic workforce, committed to delivering high quality services at a time of huge change and constant uncertainties.

Our aim is to be the 'provider of choice' within west Essex. Some of our key achievements during the last year are:

- Enabling works for phases 2 - 5 of the Derwent Centre Project were completed and the substantive works began in November 2013.
- Specialist Psychology and Psychotherapy services were brought under local management.
- Teams have continued to work closely with colleagues from Employability who have developed an innovative computer skills programme based at Rectory Lane.
- The West locality was selected as the pilot site for the Single Point of Access project as part of the *Journeys Programme*. This service began in September 2013 and was named the Mental Health Access and Assessment Service.
- We are actively involved in the *Journeys Programme* supporting plans to redesign services for both adults and older adults in line with HoNOS clusters.
- Staff have supported and engaged with the REMEDY programme which was implemented in November 2013.
- Dispensing by the Trust In-house Pharmacy has reduced medication costs and has had positive feedback from service users and carers.
- The Young Onset Dementia pathway has been rolled out across west Essex.
- A new Dementia Care Pathway began a pilot phase in November 2013, providing quicker diagnoses and care closer to home.
- Partners in the development of a new Frailty Pathway due to start in shadow form in April 2014.
- Redesign of gardens at St Margaret's Hospital to provide therapeutic space for older adults with both functional and organic disorders.
- A west Essex Estate Optimisation Plan is in progress, rationalising our service delivery hubs and bringing together essential services to ensure sustainability.
- New model of care for Chelmer and Stort Wards continues to be piloted during the phased development of the Derwent Centre refurbishment project.
- Active research programme involving a range of clinicians which includes some international trials.
- Active engagement has continued with quarterly meetings for Governors and a number of member engagement events.
- All teams and units have actively participated in ensuring we maintain compliance with the CQC essential standards of quality and safety.
- The west Essex Patient Experience Board has enabled us to develop local action plans to respond to outcomes of national surveys and to support implementation of the Trust Service user and Carer Involvement Strategy.
- Good compliance with performance targets including CQUIN measures.

Jo Paul
Area Director
Mother and Baby Unit, Mid Essex and Secure Services

Mid Essex Fast Facts

475 staff of which 411 are in clinical roles and 64 in non-clinical roles
A dedicated 5-bedded In-Patient Mother and Baby Service
47 Adult Beds
13 PICU Beds
20 Low Secure Beds
6 Multi-Disciplinary Community Mental Health Teams
CJMHT Trustwide
Prison In Reach
Family Group Conferencing
Health Outreach Service

Edward House, the Trust's Low Secure Unit (LSU) at the Broomfield Hospital site, Chelmsford officially opened in August 2013. This is a purpose built facility which has:

- 20 en suite bedrooms
- Courtyard gardens
- Activities for daily living
- ADL training kitchen and facilities
- Therapy/meeting rooms
- Art Therapy room / facilities
- Women's only facilities
- Gymnasium
- Extra Care and seclusion facilities
- Staff rest room
- Co-location alongside other mental health in-patient facilities offers resilience to service delivery
- An experience multi-disciplinary staff team with appropriate skills and competencies to deliver a high class service
- All care delivered under CPA framework linked to My Shared Care Pathway outcomes
- Access to independent Advocacy and IMHA arrangements
- Membership of the Quality Network for Forensic Mental Health Services
- Successful pilot project implemented providing mental health practitioners to police custody areas. This initiative is being rolled out Trustwide for 2013/14

- Partnering with Essex Probation to embed Psychologists within the service to support safe management and work with high risk offenders
- Continuing to provide Psychiatric Interim Care Unit (PICU) beds to Suffolk PCT and neighbouring NHS Trusts
- Christopher Unit PICU maintains it Accreditation as a centre of excellence with the Royal College of Psychiatry
- Cedar Unit (LSU) has delivered 6 regional CQUIN's improving the experience of the service user and enhancing the efficiency and effectiveness of the service.

Older Adult Services in Mid Essex continue to offer a high standard of care across the locality. To ensure we optimise the services, Maldon & Braintree Older Adult Community Mental Health Teams have become one and has relocated to New Ivy Chimneys as part of the Mid Essex Estates Optimisation Programme.

There are several initiatives that continue to be worked on and are detailed further in the local area annual plan. We continue to ensure that our services are service user led and are fit for purpose, as well as building on national priorities ensuring that our core values and patient experience are embedded within our services. The Memory Assessment and Support Service (MASS) continues to grow in demand and is supported by the commissioners.

Crisis Resolution and Home Treatment and Assertive Outreach Teams have now been successfully relocated as an integrated service into accommodation at the Linden Centre as part of the Mid Essex Estates Optimisation programme, to support the implementation of improved care pathways with the acute admission wards.

TRUSTLine, an out-of-hours telephone support line, continues to offer support and advice to service users, family and friends through a partnership between NEPFT and Mid Essex Mind.

Psychological Services
David Olive
Area Director for Psychological and Psychotherapy Services (APP)

In October 2013 a decision to devolve the Directorate was implemented. This was part of a senior level reorganisation in the Trust reducing expenditure on senior management posts and rationalising portfolios as part of wider efficiency savings required in NHS provision. The adult and older adult services were devolved to the three main Area Directorates (Mid, North-East and West) with the specialist Trust-wide adult Eating Disorder Service managed by the West Area Director.

Psychology and Psychotherapy services in the Trust will continue to provide assessment, formulation, and treatment interventions to individuals, families and groups and provide training, supervision and consultancy to other staff and organisations. We have clinicians skilled in each of the main schools of therapy (CBT, Psychodynamic and Systemic) and strive to provide high quality, evidenced-based interventions.

We continue to provide placements to 15 to 20 trainee psychologists and/or honorary/trainee psychotherapists on part time placements with our teams. As well as the University of Essex we provide placements to trainee psychologists from the University of Hertfordshire and for various accredited psychotherapy training institutions in London.

In the last year, some of our achievements were:

- Diagnosing and advising people with Aspergers/ASD (the ASD -3D service was nominated for a national award)

    - Treating people with very severe eating disorders both in the community and in the new Intensive Day Service for Eating Disorders (EDICT).

    - Consolidation of the new service to provide Psychological Support for Stroke patients in Mid Essex.

    - Extending the Commissioning for Quality Innovation (CQUIN) programme for the enhancement of Personality Disorder awareness and working with complexity across Trust services.
    - Successfully implementing our support service for the Probation Service in Essex, working with serious offenders with a personality disorder.
    - Delivering Interpersonal Therapy training for Improving Access to Psychological Therapies (IAPT) services as the preferred provider in the Eastern region.
- Delivering CBT training to a range of MDT colleagues, junior doctors and GPs.
    - Establishing an “outcomes” based culture and the introduction of CORE-NET (a system for scoring and reporting outcome data) - to further improve progress monitoring and reporting.
    - Full engagement with both the REMEDY and *Journeys Programme*.

Community Care
Vince McCabe,
Director of Commercial and Service Integration

Marginalised and Vulnerable Adults Outreach Service (MVAOS)
This service is in its second year of provision within NEP. The aims of the service are to:

- Improve the health and wellbeing of the Marginalised and Vulnerable Adults across the deprived areas of Suffolk
- Support and assist Marginalised and Vulnerable Adults to integrate into mainstream services where there are particular challenges or barriers to access
- Improve access to primary healthcare through increased GP registration and facilitating access to mental health, substance misuse and social care services and networks.

The service provides an integrated NHS Suffolk wide primary care support service through:

- A main static base located in Ipswich
- "Spokes" model service in the 20 per cent most deprived areas in Suffolk and other locations identified (and via a mobile unit)
- Provision of specialist support to all GP practices

This support covers Marginalised and Vulnerable Adults across six communities:

- Homeless
- Refugee and asylum seekers
- Gypsy and travellers
- Migrant workers
- Other Black and Ethnic Minority people
- Ex-offenders

The current active caseload of the team is over 200 however there is a potential client base in excess of 2000, and therefore a very flexible set of services is required to prioritise areas of most need. From October 2013 management responsibility for these services passed to the Mid Area Directorate.

Essex-wide Reablement Service
This service is in its second year of provision in a partnership between Essex Cares Ltd, NEP and Age UK. NEP is providing the nursing component of the service.

The objective of reablement is to support people to establish or re-establish their ability to live in the community in a sustainable way including:

- Preventing inappropriate hospital admission/readmission
- Allowing timely discharge from hospital
- Reducing the risk of accident
- Reducing ill health and disability
- Reducing the need for on-going care input

An Independent Living Strategy (covering house and home/daily living /self-care / connecting with others) is built with each individual for them to use at the end of their (average 6 weeks) reablement.

The service is run within 5 teams across Essex, with an expected volume of activity of at least 5,100 reablement packages per annum. The role of the NEP nurses is being developed to further support the Essex Cares Rapid Response Services.

Personal Medical Service (PMS)

The provision of PMS services to over 9000 patients in Thurrock was won in open tender and began on 1 March 2013. These services cover core GP as well as other enhanced services across 3 specific practice populations. A restructuring of clinical and support services is in progress whilst improvements in the delivery of service KPIs have been made.

Quality Report and Quality Account 2013/14
Part 1 Statement on Quality from the Chief Executive

We have now been writing a Quality Report/Account for 6 years and have seen big changes during that time within our own Trust, the local health economy, commissioning and competition for services, and nationally the outcome of the Mid Staffordshire Inquiry and the subsequent recommendations from the Francis Report. Our service users have a right to high quality services and we believe that quality should never be compromised. To reflect our partnership status and our approach North Essex Partnership (NEP) has simplified its statement of purpose to 'all together, better'.

Each year we hold six of our board meetings in public, at various locations throughout NEP. These meetings begin and end with questions from the public, who get a real sense of everything we do to help people recover from serious mental illness.

NEP became a university foundation trust in May 2013. This recognised the importance of academic excellence, research and development, clinical effectiveness and better outcomes for patients. Our Medical Director delivered the first public lecture at our University Day in June. He spoke about "From Madness and Lunacy to Psychiatric Illness – A Historical Perspective on Psychiatry and Mental Health". This coincided with the 100th anniversary of Severalls Hospital. We can now appoint Fellows of the Trust and our first appointment was to Dave Monk, BBC Radio Essex presenter, who talks about mental health and mental illness like no other journalist in the area and does so out of a commitment to fairness and because it's a good thing to do!

What a long way mental health services have come in 100 years. There is still stigma and discrimination and in the lead up to World Mental Health Day NEP launched a 'Face up to mental illness' campaign in May. We know that 1 in 4 people will be affected by some form of mental illness in their lifetime. NEP has embraced the "6 C's" – care, compassion, competence, communication, courage and commitment, in its drive to provide high quality care. Where better to promote anti-stigma than with young people in schools. A total of 15 Essex schools submitted plays to our annual drama competition SoapSense and 5 were shortlisted for the final held as part of our Annual Public Meeting in September. The students worked really hard to portray various types of mental illness in realistic and compelling ways. The winner was Chelmer Valley School from Chelmsford.

Staff on the front line know about quality and recognise special people with whom they work. We launched our 'Proud Awards' aligned with Berwick Report published by the Department of Health about improving patient safety and a call to "rely on

pride". The five winners were Judith Skargon, Judith Woolley, Kelly Webb, Pauline Keeling and Dr Bhags Sharma. Our annual celebration of achievements goes from strength to strength with excellent staff, teams and projects being acknowledged and rewarded.

One of the ways in which the quality of our services is measured is through the Care Quality Commission Essential Standards of Quality and Safety compliance inspections. Throughout this year we received our largest number of visits to date to all of our in-patient facilities. These were planned, but unannounced, visits by the CQC. Our previous year's non-compliance at The Linden Centre was lifted in June following a comprehensive inspection, very good news for NEP and the staff delivering high quality care. We had 15 inspections in all with 9 of those fully compliant. The 6 non-compliant areas raised minor issues with a common theme around consent, which we have addressed. More information is contained within this report.

The quality of our Veterans First community mental health team was rewarded with the national Care of Veterans Award in May at the Military and Civilian Health Partnerships Awards in Cardiff, a proud moment for NEP. Independent recognition of high quality services around patient need makes us very proud. Bournemouth University awarded Practice Development Unit status to The King's Wood Centre in Colchester and the Landermere Centre in Clacton in October for their pioneering work, the dedication of staff to putting patients genuinely at the centre of everything they do.

NEP opened the first Recovery College in Mid Essex in October. This offers recovery focussed educational courses for people with mental health difficulties, their families, carers and staff who work alongside people who experience mental ill health. It is proving a great success as yet another high quality approach to helping people recognise, develop and make the most of their talents and resources to become experts in their own care.

Providing high quality care in high quality environments is important to us and we started a major refurbishment of The Derwent Centre in Harlow in September. The work is transforming the Derwent Centre into a state-of-the-art facility for treating people with mental illness. This will take two years to complete and keeping it operational whilst building work goes on is a challenge we are facing head on.

During 2013 we opened our low secure recovery service in the purpose built Edward House with 20 beds for men requiring conditions of stability, safety and security. A high quality building empowering high quality care from a comprehensive range of onsite mental health services in Chelmsford.

We opened a newly refurbished Cherry Trees Therapy Centre at St Peter's Hospital, Maldon. This investment brings the building into the 21st century with modern design and facilities, and extra space to provide community mental health, recovery/reablement and occupational therapy.

Our journeys programme, mentioned in last year's Quality Account, has been coming to fruition. We want to further improve the quality of care and improve the experience of people who use our services. Journeys will release more clinical time by doing things differently and make financial savings by cutting out unnecessary bureaucracy and reducing duplication of effort. We have been testing news ways of working throughout the year and are now entering a consultation phase.

This Quality Report/Account tells the story of our journey through 2013/14. I declare that this Quality Report/Account is a fair and accurate reflection of quality in NEP and as always your comments are welcomed.

Andrew Geldard,
Chief Executive

Statement of purpose 2013/14

'Outstanding care, transforming lives'

Who we are and how we work

Our **vision** is to provide care that is outstanding in its quality, transforming the lives of individuals and families every day. Our communities will have total confidence in our services, our staff feel a strong sense of belonging and satisfaction, and our partners be proud to work purposefully with us.

Our **values** underpin everything we do:

- Promoting dignity, respect and compassion
- Demonstrating openness, honesty and integrity
- Building on individual strengths
- Tackling stigma, promoting inclusion and valuing diversity
- Listening, learning and continuously improving to deliver quality and value

Our **commitments:**

To individuals and families:

- to work together, building on strengths, to improve mental health and wellbeing

To our staff:

- We will value everyone individually, promote wellbeing, support involvement and encourage personal development and leadership
- We will support teams in their delivery of best value, innovation and excellence

To our Commissioners and key partners:

- We will listen, work with you, create ideas, demonstrate our effectiveness and flexibility, and earn recognition as provider of choice

Our **strategic objectives** are:

- To provide high quality care that is effective, safe and as positive an experience as possible
- To be a model employer
- To achieve good governance, inclusive involvement and excellent partnerships
- To provide value for money (economy, efficiency and effectiveness)

- To expand the business

With a workforce of over 2,000 staff we currently provide mental health and substance misuse services to a population of one million people in north Essex, serving around 23,600 people each year. We also provide some services to people living in Suffolk, and South Essex – this includes specialist inpatient care. Our services are delivered in community, outpatient and inpatient settings.

Our vision and values drive our approach and focus, building on individual strengths whilst delivering outstanding care and support that is empowering and promotes inclusion. We recognise that we can only achieve our vision through the strength of our partnerships with others in health and social care, whether in primary or secondary care settings and whether in statutory, private or third sector services, and through ensuring an engaged and informed workforce.

NEP has started a process of rebranding and our statement of purpose has changed to 'all together, better' and our values are 'humanity; keep it simple; our cause, our passion; creative collaboration; commercial head, community heart; strive for excellence.' This work will continue with our commitments, strategic objectives and key priorities. In the meantime our 2013/14 strategic objectives and key priorities are set out in the following table.

Strategic Objectives	Key Priorities
1. To provide high quality care that is effective, safe and as positive an experience as possible	**Effective**
	1. Improving access to, and accessibility of, services
	Safe
	2. Improving patient safety and general wellbeing, ensuring all care and other environments are appropriate, safe and therapeutic
	Positive experience
	3. Continuing to improve the experience of service users, families and carers, ensuring embedded systems for receiving and acting on feedback
2. To be a model employer	4. Creating positive experiences for staff within an efficient and effective workforce

Strategic Objectives	Key Priorities
3. To achieve good governance, inclusive involvement and excellent partnerships	5. Engaging widely with local communities and key stakeholders, developing productive partnerships with partner organisations and helping promote positive mental health
4. To provide value for money (economy, efficiency, effectiveness)	6. Ensuring an ongoing programme to ensure services are clinically and cost effective, use of estate is maximised and carbon footprint is reduced
	7. Realising development of, and benefits from, the Trust's information systems
5. To expand the business	8. Exploiting opportunities for growth and broader business development

Terms of Licence with Monitor (Foundation Trust Regulator)

As a Foundation Trust we work within our conditions of the provider licence laid down by the 2012 Health and Social Care Act. Our schedule of goods and services can be found together with further information about our terms of authorisation through the following updated link:

http://www.monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register-licence-holders/north-essex-partnership-univer

Registered Regulated Activities with the Care Quality Commission

Our regulated activities are:

- Treatment of disease, disorder or injury
- Assessment of medical treatment for persons detained under the 1983 (Mental Health) Act

Services and Locations

Our Directory of Services can be found as part of our Statement of Purpose on our Trust website www.nepft.nhs.uk. This outlines details of our locations and the services provided.

PART 2 PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Review of Priorities for improvement 2013/14

In our 2012/13 Quality Account/Report we set ourselves a number of priorities for improvement for 2013/14. We have done this each year we have published a Quality Account/Report and several of the main headings have remained consistent for that period of time, with new priorities added each year. We involve our Council of Governors in this process and this follows on from the annual planning events that take place each autumn; this includes our staff governors. We also take account of national patient and staff surveys when setting these priorities. This section looks back at what we said we would measure and what we actually achieved during the year.

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
1. Social inclusion and recovery model Continue to develop a framework of approaches, interventions and structured activities that are both socially inclusive	Linden Centre improvement plan – produce and implement revised Linden Centre improvement plan aligned to the domains of the Care Quality Commission Essential Standards of Quality and Safety.	A Mid Essex and Secure Services Improvement Plan was received and approved at RGE on 9th October 2013 detailing actions relating to the following improvements: • Maximise clinical time available to care in all services (March 2014). New ways of working has enabled staff to focus on 1 Doctor 1 review for patients and therefore frees up time. Also in-patient Consultant secretaries now type up reviews and attend the review freeing clinical time to focus on staff/patient interactions and time • Achieve clear care pathways for all service users minimising handoffs and barriers between internal services (March 2014) New way of working has improved this greatly and regular professional meetings occur • Improve staff engagement and communications across and throughout the Directorate (December 2013) Mid	Director of Operations and Nursing

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
and recovery-orientated for all acute in-patient wards.		Essex communication event in October 2013 over 200 staff attended to contribute to the future design of services in mid. Acute inpatient areas have had team building days which will continue to feature as part of standard operations. Finchingfield and Galleywood Ward have undertaken team building day and Rainbow is booked for April 2014. • Ensure Mother and Baby Unit complies with the Royal College guidance (March 2014) M&B benchmarking completed and unit currently under review. Rainbow is registered and the earliest date that the Royal College can come to award accreditation to the unit is April 2014, visit awaited. • Improve Broomfield MH site communication and maximise site resources (September 2013) Communication with Broomfield site requires constant attention due to the nature of its use. Links are good at both clinical and managerial levels with regular liaison meetings taking place. Joint NEP/MEH conference workshop for DH Connecting for Health Programme planned in February to demonstrate the contribution mental health can play in an acute environment. Regular meetings between service managers/clinicians continue at all levels. • Enhance the acute ward environment (November 2013) Work on staff offices and visitors room completed in 2013.	

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
		Programme of work undertaken to improve clinic and pharmacy facilities currently underway. Staff room on Galleywood now complete. Clinical/pharmacy room now complete.	
1. Social inclusion and recovery model Continue to develop a framework of approaches interventions and structured activities that are both socially inclusive and recovery-orientated for all acute in-patient wards.	Develop recovery hub offering a range of services to patients and carers; and recovery college in the Trust offering study/training facilities providing a range of courses & resources for service users, carers and staff	Mid Essex Recovery Hub and College is up and running offering recovery focussed educational courses and resources for people with mental health difficulties, their families, carers and staff who work alongside people who experience mental ill health. In addition it offers an educational and coaching model of services to help people to recognise, develop and make the most of their talents and resources to become experts in their own care and do the things they want to do in life.	Director of Operations and Nursing
	Embed and monitor the structured activity levels of 18 hours minimum per patient	The original target for increasing and sustaining therapeutic activity on all adult acute inpatient wards is indicated below: • Review process for data collection and introduce a new tool • Review the content of all current ward based programmes and the interface with other Recovery services in the locality • Review and redesign the skill mix of teams delivering inpatient activity. To consider introducing new roles • Each Consultant OT to, as a priority,	Director of Operations and Nursing

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
		with the AD for OT & AHPs ensure that new ward based programmes, which meet the CQUIN targets are implemented and sustained • Extend review of opportunities for therapeutic engagement to older adults inpatient wards and to recovery units • Design ward based programmes which interface with recovery and promote a whole system change which keeps supporting people through their own individual journey • Staff will be facilitated to work across the inpatient and community environments fostering the education and recovery college concept • Increase partnership working with multi professionals, other agencies, volunteers and peer support workers in the delivery of a comprehensive portfolio of therapeutic engagement As at the end of December, activity data was continuing to be submitted, but the sustainability of the former target is being impacted upon by factors which include staff vacancies, the absence of dedicated therapy staff through long term sickness, maternity leave and local service redesign and cost improvement programme savings with posts being under threat. The data for January – March 2014 has yet to be received. It has become apparent that the accurate recording of data electronically is also	

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
		being hampered by REMEDY and OT staff not recording consistently. Staff from each of the areas are being brought together to explore and make recommendations as to how to rectify this. It is becoming increasingly evident that there are insufficient resources dedicated to the therapeutic day to sustain the original levels of activity intended, and the skill mix of staff and original expectations need to be addressed. Activity is taking place on a planned and ad hoc basis by staff other than Occupational Therapists and this is not being captured and reported upon. This needs to be identified and added to the data collection tool. This priority improvement is being carried forward to 2014/15 and the next steps can be found in the next table.	
2. The promotion of mental health (1) Community engage-ment (2) Physical healthcare	Hold 20 members meetings across the new constituencies demonstrating effective engagement with members and governors	14 meetings have been held in Colchester, Uttlesford, Harlow, Braintree, Chelmsford, Tendring and Epping Forest. These meetings will continue.	Associate Director of Communications
	Develop staff representative meetings following elections for	There have been two blogs posted from staff Governors – Lloyd Armstrong and Russell White; a poster about staff governors has been circulated with material in Connections too. Staff	Associate Director of Communications

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
	staff governors to demonstrate effective engagement	Governors continue to meet the Chief Executive and Chair. Reports from Clever Together (staff comments) are circulated to them for information.	
	Develop the "Patient and Family Echo" with clever**together** – designed to hear staff views on such things as compassionate care to improve patient experience – run 5 in 2013/14	We have run four Clever Together conversations (which are all anonymous except for geographical location). The third (Journeys) helped clarify issues about some paperwork being included in clinical time (like risk management) and the latest is a conversation about our proposed new values. There are around 100 people commenting on each one. It has been a very useful tool. The contract for CT has come to an end and we are discussing next steps.	Associate Director of Communications
	Run successful drama competition demonstrating effective engagement with Essex schools	Around 20 plays were entered into our drama competition and the finals were held at the APM on 18 September – judged by Robert Halfon MP, Cllr Mike Fish, Mayor of Thurrock and Dave Monk from BBC Essex. The overall winner was Chelmer Vally (whose production featured in the local press and Robert Halfon has put down a Parliamentary Question about self-harming based on it). We are proposing to run this again but as part of our youth conference and the winner invited to perform at our APM.	Associate Director of Communications
	Celebrate World Mental Health Day	Over 300 people attended our World Mental Health Day event in Chelmsford; good turnout from Chelmsford College	Associate Director of Communicatio

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
	with activities aligned to older adult services	and Sandon School. There were a number of speakers including the Alzheimer's Society and an older service user (with Personality Disorder). The Chief Executive also spoke as did the CEO of Mid Essex CCG. The Trust signed up to the Dementia Action Alliance at the APM and we are training 20 Governors and staff to be Dementia Champions (to raise awareness in the community).	ns
	Continue to implement the service user and carer involvement strategy	We have recruited over 30 service users/carers to participate in the PLACE inspections in early 2014 (training starts in December); service users have been on the interview panels for many senior positions, as well as providing focus groups for candidates to talk to; service user stories at the APM were very well received and there are stories provided at the monthly staff induction. The latest blog about stigma is from a service user who is also a staff member; three service users have also been taken on as Peer Support Workers in the Recovery Hub and College. The Plain English Group is running well (chair Cathy Trevaldwyn) and 17 people volunteered for an older adults event (on 21 Jan) based on a Recovery College. This work continues.	Associate Director of Communicatio ns
	Embed physical healthcare checks into the community (and outpatients) to ensure they	We have been working to encourage staff to ensure that evidence that physical health is being monitored is recorded, and our safety barometer now includes this information for community teams. Whilst it is appropriate to monitor our findings, we are not able (it seems) to fully reflect the amount of checks taking place for	Director of Operations and Nursing & Nurse Consultant Physical Health

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
	are being offered to 'appropriate' patients – those who have severe and enduring mental health and probably on anti-psychotic medication prescribed by the Trust	community clients. We need to establish clear recording systems to ensure that our records reflect the work we are doing, even if, as in many cases, it may simply be that we signpost the patient to the GP, with corresponding evidence. We are still expecting the recording to continue post implementation of Remedy. This work will be carried forward.	
	Monitor the recording of physical healthcare checks through the community quality barometer	Physical healthcare checks have been incorporated into the community barometer and continue to be monitored by RGE. A revised mental and physical health promotion strategy is underway and this looks at how we embed Public Health England Policy (8 themes) into practice.	Ditto above
3. Improving medicines manage-ment Continue to implement the pharmacy 5-year business	Develop the Quality Prescribing Group with clear terms of reference and a focus on NICE guidance and POMH UK audit results	The Prescribing Quality Group has been set up and running for about a year. It has been found to be a very important sub-group to the MMG focusing on prescribing. At the last MMG (Jan 2014) it was agreed that the terms of reference should be reviewed: a) The TOR is explicit with regards to the POMH UK audits. It should also mention the development, implementation and follow-up of the action plans	Medical Director & Associate Director of Pharmacy

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
plan (incorporated into the Pharmacy Business Plan)		b) It should also facilitate development of local prescribing audits and facilitate learning from these audits c) Ward pharmacy interventions has not been discussed to date. It is easier to capture the data on Datix and get a report for the group to consider and action. The group should consider high severity incidents This will be followed through in 2014/15.	
	Achieve a more consistent pattern of pharmacy interventions across all Trust areas and use the information in an enhanced way e.g. analysis and learning	Analysis and learning from pharmacy interventions is now a function of the Prescribing Quality Group. The dissemination of the learnings will be reviewed as part of the PQG work plan. Analysis and learning from pharmacy interventions is now a function of the Prescribing Quality Group. The dissemination of the learnings will be reviewed as part of the PQG work plan.	Medical Director & Associate Director of Pharmacy
	MaPPS roll out	MaPPs is now implemented on individual patients where appropriate.	Ditto above
	Achieve access to System One and ensure phases 2 and 3 of the Remedy project enhance the medicines management template on the patient information	A summary care access policy has been written. A pilot is taking place with pharmacy staff to test summary care access via the SmartCard. This provides a 12 month drug history on the prescribing of a particular GP for their patient and is one aspect of drug reconciliation. Patient concordance will remain an issue as some continue to obtain medication from more than one source. Phases 2 and 3 of the Remedy	Medical Director & Associate Director of Pharmacy

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
	system. Change to: "Achieve access via SmartCard, which increases the ability to reconcile medications. It is anticipated that due to the delay in implementation of Remedy any enhancements to the medicines management template are likely to take place during 2014/15 in phases 2 and 3. For 2013/14 pharmacy staff will draft a summary care access policy and pilot summary care access."	programme. We have identified this as a risk in the Pharmacy business plan. A sub-group of Remedy is now looking at different EPMA options.	
4. Customer and stakehold	Identify new key customers with influences and	Relationships developing between Executive Team and key influencers in all three CCGs, South Essex and Suffolk. Engagement with GP consortium North	Director of Commercial & Service Integration

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
er relationship management Continue to ensure the Trust is marketing itself in a positive manner and is in a position to bid/win new business	communicate with them	Essex and Suffolk as well as Essex County Council. Regular meetings are held regarding their wants and our interests. Examples include proposals for locked rehabilitation being developed, SPOR Mid Essex, and continuing healthcare	
	Undertake a full customer analysis around the whole regional system	Customer analysis is completed and used to inform bidding and partnership decisions and will be refreshed in May 2014 and will be kept updated using strategies of CCG's	Ditto above
	Manage intelligence and activity	Analysis has been carried out and will be refreshed and included in Board papers. Trialled CRM solutions and will develop another CRM solution.	Ditto above
	Refresh our branding and story/vision to be communicated to customers through a unique selling point e.g. to be the best learning organisation (encompassing Darzi's 3 definitions of quality)	First stage of rebranding/story/vision completed with implementation in progress with workshops ensuring a consistent organisational voice.	Director of Strategy Director of Commercial & Service Integration
	Communicate well internally to establish ownership	Internal briefings are underway. Finalising annual plan which is focussed internally on supporting areas to be put forward service developments to commissioners.	Director for Director of Commercial & Service Integration

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
		The difference on the ground will mean more effort on consolidation of our services and building on these rather than bidding for services further afield. We look for opportunities where we have the right expertise.	
5. Improving engage-ment and support of staff (1) Continue to meet CQC Essential Standards of Quality and Safety Outcomes 12, 13 and 14 all relating to staff. (2) Continue to act on staff survey results. (3) Continue to engage with staff at all	Strengthening resilience programme rolled out	Resilience training will now form part of the Trust internal Leadership programme commencing in October. Occupational Health are running team and 1:1 resilience sessions for staff. As part of the new leadership modules open to senior staff group, a session on resilience is now included. It is intended to run these programmes through 2014.	Director of Workforce and Development
	Level 4 apprenticeships in business administration and HR management	Apprenticeships are underway and approximately 30 staff have taken up places on the two programmes. There have been some changes to government funding going forward and the trust is in discussion with the deanery representative regarding running further programmes	Director of Workforce and Development
	Administration conference 15th November 2013	The conference was a significant success with a full house on the day. Following the programme several staff members requested coaching and other development which is being put in place on an individual basis. The external speakers from the Leadership Academy of the DH were very impressed with the Trust's commitment to administrative staff.	Director of Workforce and Development
	Local improvements around issues	Comprehensive action plan received from Workforce and Development. The Staff Health and Wellbeing Steering Group	Director of Workforce and Development

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
levels of the organisation	arising from the 2012 staff survey	monitor the action plan and HR managers provide updated reports from their local areas. Following the 2013 survey data, a new action plan is being developed to take forward in 2014/15.	
	Evidence of greater recognition by the Trust of the "little things that make a difference"	"Proud" awards and celebration – 13th August recognising valued colleagues. Andrews Update regularly mentioning staff by name who have been identified as "making a difference"	Director of Workforce and Development
	Clinical Conferences in October 2013 and March 2014	Another very successful clinical conference took place in October using a different format and with some very engaging speakers	Director of Strategy
	Trust wide discussion forums for Essex County Council seconded staff	Discussion forums were held in September along with TUPE consultation meetings. ECC staff transferred to the Trust under TUPE on 1st October 2013	Director of Strategy
	Improvements in training management and mandatory training delivery and uptake through centralisation of administration and recording and progress against key action plan	Centralisation of mandatory training administration is now complete. Despite a few initial problems processes are now in place for all mandatory subjects. There has been a significant increase in applications since centralisation, partly due to staff being aware of the need to be 100% compliant by March 2014. We hold bi-monthly meetings with subject leads, have arranged for them to have access to non-compliance reports from Information Team to target non-compliant teams and we have regular dialogue if it is considered that more training dates are required.	Director of Workforce and Development

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
		Workforce development supports e-learning in teams and when required by visiting sites and there is on-going telephone support.	
6. Improving the patient experience (1) Continue to implement the service user and carer involvement strategy (2) Improve service user survey results	Establish how on-going central involvement co-ordination will take place for 2013/14	Julia Hiley, Associate at Enable East continues to be funded by NEPFT to provide a Central Coordination Project Management function for service user and carer involvement. This post is funded until the end of March 2014 on the basis of 3 days per month. Kevin Whiteley, previously held an Administrative post for this project and was the main point of contact for service users, carers and staff in relation to the Involvement Register. Kevin has moved to a substantive post with the Veterans team. His role is now absorbed by Julia Hiley. Risks: There is a need to identify a long-term plan for managing 'business as usual' for Involvement within the Trust, post March 2014.	Medical Director
	Establish how the central database will be managed for 2013/14	The database is securely saved on the Trust server. Julia Hiley will continue to manage the database until end March 2014. Risks: There is a need to identify a long-term plan for holding and managing the Involvement database within the Trust post March 2014	Medical Director
	Reinforce key reporting mechanisms through local co-ordinators	Involvement co-ordinators are having local meetings with staff to reinforce the strategy and direct staff to iconnect where tools can be found. In Mid Essex they are setting up a Service User and Carer Board who will work alongside the locality group to input into and agree the options being put forward to management teams. In	Medical Director

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
		North East Essex they have recruited a service user to their locality group and offered the opportunity to service users to attend two meetings. In West Essex they will be recruiting service users and carers to participate in an evaluation of their pilot which went live on 1st September. A new carers group has been set up in west. West ran a stall at the APM around service user involvement. West have an Associate Practitioner role which includes involvement and team meetings have this as a standing agenda item.	
	Ensure on-going communication with staff to embed the strategy into day-to-day working	Ditto above. Additionally circulated involvement opportunity with University of Essex for School of Health and Human Sciences event; Service users have been involved in interviews for staff. Patient led assessments of the care environment have continued well throughout the last part of the programme in June. Involvement at staff inductions continues to produce good results. A new carers group set up and running well at The Lakes for the veterans' service. Quarterly involvement co-ordinator meetings have been set up, first meeting December.	Medical Director
	Achieve on-going printing and distribution of publicity and training	Service user/carer specification to be sent to members on the database and those known to the Trust asking for 2-3 people to work with J Hiley to design a new recruitment leaflet. This is likely to include 'making it real' information outlining the breadth of involvement across the Trust and how it has made a difference to both service users/carers and the Trust itself. A communications plan has been discussed	Medical Director

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
		particularly around external publicity to service users and carers, partners and their service users.	
	Focus locally on the areas of day-to-day living highlighted in the patient survey, in particular support with accommodation and help with benefits in line with the strategic direction provided by the Patient Experience Board – what we are able to offer, how we are able to signpost and the advice that we can give	The Patient Experience Board has been reformed with Area Director in the chair. Updated action plans as per internal audit recommendation have been received and signed off.	Medical Director
	Take account of weaker areas of the patient survey as part of the Journeys/Big Issues programme	CQC patient survey report has now been received and will be acted upon. There are similar themes to last year	Medical Director
	Analyse and	Will be developing a KPI through the	Medical

What we said we would do in 2013/14	How we said we would measure	What we achieved in 2013/14	Responsibility
	learn from the qualitative data gleaned from the local in-patient and community patient questionnaires	patient experience board. Qualitative data received for patient discharge questionnaires is discussed in Risk and Governance Executive on a monthly basis and this will continue.	Director
	Embed the family and friends test in a reliable manner to address variability in type of wards and numbers of discharges	The Friends and Family Test guidelines for implementation in Mental health and Community Services is expected during first half of 2014 (for mandatory implementation December 2014). The F&F test remains an agenda item on the Patient Experience Board to determine the introduction and ongoing use of the F&F test.	Medical Director
	Develop a business plan for the use of technology to achieve real-time patient feedback	RGE consider that this may not be the best way forward on a value-for-money basis; however, additional costing has been received from Optimum for consideration. To be EMT discussion on this. The INotify system (from the CSU) only collects feedback and does not analyse it	Medical Director

Priorities for improvement 2014/15

As described in the introduction to the previous section our priorities for improvement for the coming year have been set with the help of our Council of Governors. We will monitor our progress on a quarterly basis and report in through our Risk and Governance Executive, Trust Board and Council of Governors. In the second column we state whether the priority is related to patient safety, patient experience or clinical effectiveness, or any combination of the three.

Priority for improvement	PS PE CE	How we will measure	Responsibility
1 Social inclusion and anti-stigma – continue to develop a framework of approaches to social inclusion and further promote anti-stigma	**PE** **PS** **CE**	1. Refresh the anti-stigma campaign during 2014/15 2. Target schools and employers to promote mental health and build on the work already done by the communications team • Hold a conference in the autumn with a national speaker 3. Improve engagement with local press in order to promote mental health and anti-stigma • Build positive working relationships with local media • Collaborate on good news stories • Use positive and honest approach to press statements 4. Governors' social inclusion group (SIG) to take forward objectives they have set for the year	Associate Director of Communications Council of Governors SIG
2. Improving medicines management – focus on medicines security, reporting and benchmarking of medicines management activity	**PE** **PS** **CE**	1. Review medicines security in relation to recent guidance from NHS Protect, considering implementation of: • Medicine security self-assessment tool • Medicine security pharmacy checklist	Associate Director of Pharmacy

Priority for improvement	PS PE CE	How we will measure	Responsibility
		• Medicine security ward/department checklist • Medicines security action plan template 2. Develop more meaningful reporting • Produce breakdown of expenditure on wards and clinics and relating this to activity. This way we will be able to compare like with like so for example how an adult acute ward in East compares with an acute adult ward in Mid 3. Focus on quality and benchmarking • Purchase software tool called Define which will allow benchmarking with other Trusts	
3. Improving engagement and support of staff – continue to build on work already done with staff and focus on staff survey information	**PE PS CE**	1. Staff Governors to form a conduit for feedback direct from grassroots through to the Council of Governors and the Executive Team 2. Implement action plan from 2014 staff survey including the staff friends and family test 3. Take forward actions from the administration	Staff Governors Director of Workforce and Development

Priority for improvement	PS PE CE	How we will measure	Responsibility
		review in conjunction with the implementation of the Journeys programme 4. Continue with the leadership and resilience training programme 5. Hold a clinical conference in October 2014	
4.(a) Improving the patient experience – through structured activity for in-patients and a focus on real patient experiences at an operational level	**PE**	**Structured patient activity levels** Embed and monitor the structured activity levels of 18 hours minimum per patient. The following steps are carried forward from 2013/14: • To bring together a new cohort of practitioners, (OTs) to map practice and levels of engagement as at April 2014 (First meeting 7th April 2014) • Promote the ownership for the delivery of therapeutic activity in in-patient wards and engagement across all professions including ward managers, clinical managers and other key practitioners • Consultant OTs to	Director of Operations and Nursing Medical Director

Priority for improvement	PS PE CE	How we will measure	Responsibility
		take the lead for their own designated areas in the collection of data, evaluation, development of sustained levels of therapeutic activity, and engagement on adult acute in-patient wards. • Analyse data received for quarter 4 (2013/14)	Director of Operations and Nursing Medical Director Associate Director of Social Care
		Patient Experience Continue to develop the patient experience board with a particular focus on real patient experience and outcomes of patient surveys • Area Director as chair of the patient experience board with operational support from each of the 3 areas/localities • Named operational patient experience lead in each area • Align the work of the patient experience board with the journeys programme to contribute to a smooth transition • Develop formal feedback form for	Director of Operations and Nursing Associate Director of Social Care

Priority for improvement	PS PE CE	How we will measure	Responsibility
4.(b) Improving the carer experience – implementation of the service user and carer involvement strategy and the carer's strategy		use by governors to feedback from public meetings/events • Risk and Governance Executive to receive the feedback from governors alongside the verbatims from discharge questionnaires **Service user and carer involvement strategy** Continue to implement the service user and carer involvement strategy • Implementation of the strategy to be brought in-house with a handover from Enable East • Develop involvement boards in each area **Carers Strategy 2014-17 – implement action plan** • Updated information leaflet published • Updated resources on website • Maintain and improve reported performance against targets • Increased number of carers on the involvement database • Improved carer	

Priority for improvement	PS PE CE	How we will measure	Responsibility
		satisfaction via surveys and feedback • Updating on the development of new groups via annual review • Annual review will provide an update on staff trained • Production of e-learning module • Carers information at corporate induction • Production and delivery of the course via recovery college and production of web based course • Annual review will provide an update on support accessed	
5. Trust response to Francis Report – implement an action plan developed from the gap analysis		1. Consultation on gap analysis 2. Develop, consult on and implement agreed actions 3. Actions from Chief Executive Board paper 4. Embedding the revised Being Open and Duty of Candour policy 5. Report on staffing levels	Risk and Governance Executive

Review of services

During 2013/14 North Essex Partnership University NHS Foundation Trust provided 28 NHS services across its three geographical areas. The entire breakdown of our services by geographical area can be found in our directory of services at the link in part 1, statement of purpose.

The Trust has reviewed all the data available to it on the quality of care in all 28 services covered by our three main block contracts that are subject to monthly quality assurance and contract monitoring processes. The income generated by the NHS services reviewed in 2013/14 represents 75% (£82m) of the total income of £110m generated from the provision of NHS services by the Trust for 2013/14.

All data from the reviews is analysed and action plans in place and monitored throughout implementation and signed off as appropriate by RGE or EMT. We take account of both national and local patient and carer survey information when reviewing our services. In addition we take full account of staff survey results.

The Board and RGE carried out detailed reviews on a number of services and these are detailed below or summarised in the Chief Executive's introduction to this Quality Account.

Project Hope (Health, Opportunity and Purpose for Everyone) ended in July 2013 with the following agreed outcomes with commissioners:

- West undertook the agreed transformation transferring in-patient care in Cam Ward to beds in supported housing and the development of a community outreach recovery team
- Severalls House/Rivendell to cease its Continuing Care function with all patients re-provided for within community settings
- An 8 bedded intensive rehabilitation unit to be created from the re-provision of Severalls House and Activities Centre
- The original intention and agreement of investment to create a new Recovery Hub and Recovery College was not realised in the NE. Investment was agreed with Mid CCG and funding transferred to the Athol House pilot currently in place in Chelmsford
- Care Farm pilot took place, ending July 2013, awaiting outcome of evaluation

In the absence of project HOPE in the North East, the intention to develop and embed evidenced based recovery focussed practice continues. A stakeholder engagement event occurred in June 2013 to propose a redesign of recovery services

in the North East area. A case for change paper was presented to the NE CCG in December 2013. Following this presentation to a different set of commissioners, support was given to continue with the re-provision of Severalls House/Rivendell and the development of a Recovery Hub/Recovery College for the NE area. The CCG were keen for the Trust to explore the proposed 8 bedded in patient facility for a different purpose – rather than an open intensive rehab unit, a locked low secure rehab unit to accommodate the repatriation of people currently in out of area high cost specialist placements.

As part of the Trust's Journeys programme, the philosophy of recovery is planned to remain at the core of the multidisciplinary care pathways and future redesign of services.

The Linden Centre review final update on the action plan can be found in progress against 2013/14 priority improvements.

The Journeys programme moved forward considerably during 2013/14 with wide stakeholder participation especially from staff at all levels in the organisation. A detailed action plan has now been produced moving into 2014/15. Data sets are in place with demographic demand tools to improve quality. Three model options have been developed with a preferred option. Key decisions will now be taken by the Executive Management Team in relation to stakeholder and staff consultation (in April/May respectively) and responding to the consultation and recommended model. Stakeholder consultation is key to the process. Capacity modelling will require a validation process. Considerable work has been done around the human resource transition up to the point of wider consultation. Terms of reference are being developed for a Journeys Operational Capability Group that will link representatives from Clinical Boards and corporate support functions.

Administration review – this is closely aligned to the Journeys programme and has been completed for all the operational areas in each locality. The review will be continued through all corporate functions up to and including band 7 posts.

Clinical boards – as a result of the operational management restructuring a review of the clinical boards has taken place with new terms of reference and membership/structure. Clinical Board development days were held bringing all three areas together for a consistent approach. Area Directors are now supported by Deputy Area Directors and a Chief Nurse. The 5 Directorates have been reduced to 3 – West, Mid and North East (the latter includes child and adolescent services).

Kitwood Ward – a review of Kitwood Ward has taken place resulting in key actions being taken to address issues with the cultural health of the ward. An action plan has been developed and being implemented and embedded throughout 2014/15.

West transformation – got underway during the past year with a major 5-year capital investment programme taking place to develop and make improvements to the Derwent Centre in Harlow.

Eating disorders service – was reviewed during the year and the adult and children eating disorder services were brought together under the North East directorate to provide a jointly managed, inclusive and seamless trust wide service.

Older adult services – were reviewed during the year and a new 'functional model' introduced within North East with a view to rolling this out trust wide. In North East this has resulted in improvements around length of stay on older adult wards.

Dementia services – a new re-assessment pathway has been introduced in West area.

CAMHS teams – the Maldon, Braintree and Chelmsford CAMHS teams have been brought together in the Chelmsford and Essex Centre with satellite operations in each area.

Prison healthcare – NEP won the contract for prison healthcare services and this became operational during the latter part of 2013/14.

Each quarter the Trust, through R&GE, takes a critical view of a Quality and Risk Profile (QRP) prepared by the Care Quality Commission encompassing information about all of our services. We have maintained a consistently good standard throughout the year.
We have developed our own Quality and Risk Profile with combined rolling compliance report submitted to R&GE on a monthly basis. The aim of this is to triangulate information within the organisation that provides a more real-time snapshot of how the Trust is performing and how we are managing our learning. With this document we are also able to horizon plan for changes in the CQC compliance report and be dealing with issues on a proactive rather than reactive manner. We have also set up a Quality and Risk Learning Circle to bring our learning together and assist the triangulation of information both within the Quality, Risk and Patient Safety Department and other corporate functions in the Trust. There has been a focus within this process of detailed analyses on safeguarding training and huge improvements have been seen in the compliance against this mandatory

training and we are now targeting the training to the outstanding staff. A safeguarding barometer has also been introduced.

The R&GE receives regular reports on a range of governance issues, including the assurance framework, risk register, complaints, serious incidents, claims, infection control, quality and audit. In addition it receives dashboards relating to patient safety and early warnings around patient safety measures at ward and community level. We involve clinicians and encourage challenge and peer review on a number of counts, in particular the measures relating to patient safety and mandatory/statutory training and supervision. This group is assured on compliance with the Essential Standards of Quality and Safety across the Trust. We use the same judgement framework of the CQC to self-assess against the standards and we have prepared for planned reviews. Certain auditable standards are also reviewed as part of the Internal Audit Plan and reported to the Audit Committee.

Participation in clinical audits

The programme of national and corporate audit is managed through the Quality Improvement Group with local clinical audit activity managed through local audit groups. This is overseen by the Quality and Audit Team and reviewed/monitored through the Quality Improvement Group and clinical boards. Exception reporting on limited assurance audits is made to the Risk and Governance Executive on a quarterly basis.

During 2013/14 there were 8 national clinical audits (including POMH) and 1 national confidential enquiry covering NHS services that the Trust provides. During 2013/14 the Trust participated in 87.5% of the total clinical audits (including POMH) and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The following table outlines the national audits and national confidential enquiry for which North Essex Partnership NHS Foundation Trust was eligible for during 2013/14, those that it participated in, whether the data collection was completed during the period, and the number of cases submitted to the audit, if applicable.

Eligible national audits for Trust 100%	Trust participated in 87.5%	Data collection completed 2013/14	No. of cases submitted to audit as % no. of registered cases required by the terms of the audit
National audit of schizophrenia	Yes	Yes	Unable to confirm

Eligible national audits for Trust 100%	Trust participated in 87.5%	Data collection completed 2013/14	No. of cases submitted to audit as % no. of registered cases required by the terms of the audit
			numbers due to data cleansing stage, local report released June 2014 national report December 2014.
National audit of memory clinics	Yes	Yes	100%
National audit of psychological therapies for anxiety and depression	No	No	No
Prescribing Observatory in Mental Health (POMH)			
Topic 4b prescribing anti-dementia drugs	Yes	Yes	86 patients, 6 teams
Topic 7d monitoring of patients prescribed lithium	Yes	Yes	64 patients, 15 teams
Topic 10c use of antipsychotic medication in CAMHS	Yes	Yes	41 patients (before data cleansing), 4 teams (before data cleansing)
Topic 13a prescribing for ADHA	Yes	Yes	114 patients, 8 teams
Topic 14a prescribing for substance misuse: alcohol detoxification	Yes	No	Commenced March 2014
Eligible National Confidential Enquiries for Trust			
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (and its various constituent studies into sudden unexplained deaths and victims of homicide)	Yes	Yes	

Learning/actions from national and local clinical audits

The reports of 5 national audits (including National Audit of Dementia from 2012/13 and 29 Trust/local clinical audits were reviewed by NEP in 2013/14 through its Quality Improvement Group (QIG), direct to Risk and Governance Executive, Quality Prescribing Group or through one of the local audit groups, reporting to the clinical boards and to the Risk and Governance Executive. A total of 13 reports and action plans were received, reviewed and given a level of assurance at the QIG. Each audit report has an action plan and implementation is monitored by the audit group and/or the most appropriate group working to the RGE. Some of the learning and actions from these audits are iterated in the table below.

Title/Subject	Learning/actions
Audit CPA Care Plans for Service Users Subject to Treatment Sections of the MHA and therefore Entitled to S117 Aftercare	This audit undertaken by the Consultant Social worker who looked to see whether those service users treated under the MHA and subject to S117 aftercare were receiving this. Findings suggested clinicians in most instances understand the criteria for those entitled to s117 provision, but did not recognise the need to state the nature of the s117 need and service/care required to address these needs. This audit highlighted the need for training to continue to be delivered across the Trust to staff especially as the audit highlighted a lack of clarity around the exact purpose of s117, how s117 needs should be discussed, recorded and reviewed. Further training has been put into place and will continue to take place will show a greater understanding of how to identify record and review s117 needs. As a result a re-audit is recommended to be undertaken in 6 months' time built into the 2014/15 Trust plan.
Quality of Inpatient Specialist Care Plans	This audit was commissioned as part of the Linden centre improvement plan and completed prior to full implementation and completion of the plan. The audit proved to be a useful tool in identifying areas for improvement and areas of good practice though assessing the quality of care plans is problematic and is in the auditors view subjective and may vary with different auditors. It was noted there was variation in quality amongst different practitioners, it would be sensible to identify those that need support in developing care planning skills further and utilising those staff who are producing good quality care plans to assist other staff in their development. The following audit objectives were met; • Checking the quality of care planning • Inform change in practice/staff development/learning needs • Support the Trust barometer monitoring process

Title/Subject	Learning/actions
	• Identify good practice • Identify poor practice The following objectives should be met pending the implementation of the action plan and a further audit cycle • Ensure CQC evidence is robust • Aid improvement in quality of care plans A re audit is recommended to evaluate improvements made since the initial audit.
National Audit of Memory Clinics	Participation of this audit consisted of a survey completed by the memory clinics across the Trust and covered the various components. ***Waiting times*** The average waiting time for assessment is within the Memory Services National Accreditation Programme recommended standard of 6 weeks, which should be commended. ***Timely diagnosis*** Memory clinics should consider their relationships with GPs and other referrers to ensure that they refer patients on at the earliest opportunity, at the same time as ensuring high quality, appropriate referrals. Awareness-raising work can be done in the community, and teams can consider making contact with hard-to-reach groups. ***Research*** Clinics that do not currently recruit people with dementia to research studies could consider linking up with organisations such as the Dementias and Neurodegenerative Diseases Research Network (DeNDRoN) which helps memory clinics to connect with research studies, and in 2014 will launch a register for people who are interested in taking part in future research. ***Patient numbers*** Patient numbers have increased, at an estimate, almost four times since the 2010/11 audit, with memory clinics currently seeing an average of 1206.2 patients compared to 317 in 2010/11. There are several factors which could have contributed to this rise, but regardless of the reasons the rise in patient numbers should be taken seriously and plans should be made to deal with potential future increases.
Suicide Prevention – Ward Manager's	"With suicide prevention continuing to be a key national priority for public health and mental health services as people with mental health problems particularly a high-risk group it is vital mental health services continue to strengthen clinical practice if suicides are

Title/Subject	Learning/actions
Checklist	to be prevented." (NPSA 2009 p3). A documentation audit using the NPSA- Preventing Suicide Ward Manager Check list was used by the ward managers at the Derwent Centre. The toolkit recommends two levels of assessment; Annual General Audit tool & Ward Manager's Checklist. The audit pertained only to the Ward Manager Checklist and looked at the assessment of care for each individual at-risk patient against the eight standards. Findings indicated there is a need for improvement particularly in relation to observation & engagement. A number of key recommendations include a review of the current Trust policy (management of the suicidal service user's policy) with a view of embedding the checklist as standard practice along with a rollout of the checklist across all adult acute units within NEPFT. A re audit in the use and performance of the checklist to be scheduled in at 6 months post role out and incorporated within the Trust's audit plan for 2015/16. Overall learning from the audit had to be the provision of real-time data to ward managers on their performance against the standards enabling managers to pick up issues directly with their teams through shift handovers and through staff management supervision.
Data Quality Audits	During 2013/14 the CQC data quality audit methodology has developed; the audit focuses on the CQC outcomes that are inspected by the CQC e.g. older adult wards had a nutritional focus during the audit, mimicking the activity carried out by the CQC inspectors. The top 5 themes found during the audit process were 1) training records not 100% compliant with the trust standard 2) care plans lack detail 3) risk plans lack detail 4) outstanding Datix incidents 5) health and safety folders and audits out of date. The CQC data quality audit process is audited by the Trust's internal auditors and for the second year running the process has been given adequate assurance that shows the process is consistently robust.
Hand Hygiene Audits	These audits are carried out on a monthly or quarterly basis depending on the risk assessment by the infection control link nurse with the results monitored though the quality barometer and Infection control meetings which demonstrated consistently 100% compliance with the audit criteria. This audit criteria measures both hand hygiene technique as well as compliance with the dress code policy such as bare below the elbow with no jewellery worn. However, it was recognised data could not be 100% accurate, therefore the decision was taken to introduce peer review auditing from July/Aug 2013 with the infection control link nurses auditing

Title/Subject	Learning/actions
	each other's wards across the Trust enabling a "fresh pair of eyes" to review staff compliance. In addition service user auditing has been introduced across community and inpatient areas in response to the NE Infection Control Cluster group meetings to provide objectivity to the data and to be more reflective of practice.
Anti-Microbial Audits	Anti-microbial prescribing is monitored within the organisation as part of the Health Act Code. This is undertaken on a quarterly basis by pharmacy staff auditing the inpatient prescription and medicines administration cards (PMAC). With the introduction of training provided to doctors by the consultant microbiologist every six months on appropriate antimicrobial prescribing there has been higher level of compliance achieved overtime.
Enhanced Cleaning Audits	Monitoring of these audits within the organisation has taken place 6 monthly. With the reporting of high results and improved compliance together with better cleaning and monthly C4C audits that monitored through the quality barometer, these enhanced cleaning audits are now been undertaken across facilities on an annual basis. A physical check has also been introduced for those units reporting below the Trust threshold for improving engagement with the areas by the infection control team.
Safeguarding Audit Activity	The ESCB/ESAB is now a combined audit for the Trust. This year the Trust has achieved 97% compliance against section 11 Essex Safeguarding Adult /children's board giving the Trust a green RAG rating. It has been recognised the current data tool is easy for Trust's to complete; as a result the Safeguarding Academy have been commissioned to re-design the reporting tool with the Trust due to complete again September 2014. The team have developed a safeguarding barometer that is reported monthly into RGE providing details of levels of safeguarding activities across the Trust. This enables the team to target those areas with low activity for training and safeguarding reviews.

Research and Development (R&D)

The number of patients receiving NHS services provided or sub-contracted by North Essex Partnership University NHS Foundation Trust in 2013/2014 that were recruited during that period to participate in research approved by a research ethics committee was 547.

Participation in clinical research demonstrates North Essex Partnership University NHS Foundation Trust's commitment to improving the quality of care we offer and

to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Over the last year, 37 publications were authored by Trust staff. A list is available on the Trust public website http://www.nepft.nhs.uk/your-trust/research-and-development/documents/. The Trust approved 21 new research projects and currently 53 are open within the organisation. The majority of these projects are around Mental Health (66%) and Dementias and Neurodegenerative Diseases topics (28%). Research themes include Mild Cognitive Impairment, Alzheimer's disease, anxiety, post-traumatic stress disorder, substance misuse, public health research, bipolar affective disorder, eating disorders, health services research, psychosis, schizophrenia, and suicide and self-harm.

Performance on recruitment into NIHR portfolio studies has been above the 'value for money' target of 468, set by the Essex and Hertfordshire Comprehensive Local Research Network. In addition, the organisation has consistently been among the top performers in the region in terms of recruitment to time and target, demonstrating our commitment to support studies of national significance in order to improve patient outcomes and experience across the NHS.

The R&D Legacy Awards continued for the third year, with Chris Paveley as Chair. An award for £20,000 was presented at the Celebration of Achievements Awards to Annie Pavitt, Lean Lee and Dr Zuzana Walker for their study "Sexual Relationships in Young Onset Dementia". This funding opportunity will be repeated in 2014/15.

The New Year saw a radical shakeup in terms of research partnerships, with the merging of 105 research networks nationally into 15. From 2014/15, North Essex Partnership University NHS Foundation Trust is part of the Clinical Research Network Eastern (CRN Eastern) as well as the Eastern Academic Health Science Network (EAHSN).

Use of CQUIN (Commissioning for Quality and Innovation) Payment Framework

A proportion of Trust income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The following table outlines the income received from CQUIN for 2013/14 and the proposed income for 2014/15 and the headline goals attached to them.

Contract	2013/14	2014/15		
	£	£		Goals
Adult and Older Adult Main block	1,744,588	*Value to be agreed	1	Friends and Family Test
			2	Improving Physical healthcare to reduce premature mortality in people with Severe Mental Illness (SMI)
			3	Consent to share information
			4	Compassion – Year 2
			5	Suicide Prevention
			6	Frailty Pathway
			7	Management of urgent and acute pathways (improving inpatient flows)
Children & Young People (Tier 3)	174,624	176,571	1	HoNOSCA
			2	Training and Education to Universal Services
Specialist Commissioning	166,084	227,766	1	Quality Dashboards for Specialised Services
			2	Improving Physical healthcare to reduce premature mortality in people with Severe Mental Illness (SMI)
			3	Friends and Family Test
			4	Collaborative Risk Assessments for Secure Services
			5	Delivering interventions to improve mother/infant interaction and care
			6	Assuring the appropriateness of unplanned admissions for Tier 4 CAMHS
Total	**2,085,296**	*To be confirmed		

Note: contract negotiations are currently under mediation

Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission and its current registration status is compliant without conditions. This section details the compliance inspections received by us in 2013/14. There is more detail online at http://www.cqc.org.uk/node/276654. The CQC has not taken enforcement action against the Trust in 2013/14. The following table reflects our compliance with the planned/responsive inspections received at our 15 in-patient locations.

Unit	Date of Visit	1. Involvement and information	2. Personalised care, treatment and support	3. Safeguarding and safety	4. Suitability of Staffing	5. Quality and Management
439 Ipswich Road	8th January 2014	✗	✗	✓	✗	✗
Peter Bruff Unit	17th December 2013	✓	✓	✓	✓	✓
Severalls House	28th January 2014	✓	✓	✓	✓	✓
Landermere (Tower)	2nd December 2013	✗	✓	✓	✓	✓
King's Wood Centre	13th January 2014	✗	✗	✓	✓	✓
The Lakes	9th October 2013	✓	✓	✓	✓	✓
Brian Roycroft Unit	30th September 2013	✓	✓	✓	✓	✓
Chelmer & Stort	4th February 2014	✗	✗	✓	✓	✓
Kitwood & Roding	20th November 2013	✗	✓	✓	✓	✓
Edward House	10th February 2014	✗	✓	✓	✓	✓
Shannon House	20th January 2014	✓	✓	✓	✓	✓
Christopher Unit	26th November 2013	✓	✓	✓	✓	✓
The Crystal Centre	11th December 2013	✓	✓	✓	✓	✓
The Linden Centre	13th June 2013	✓	✓	✓	✓	✓
St Aubyn Centre	26th February 2014	✓	✓	✓	✓	✓

Key:

✓	All standards were being met	✗	At least one standard in this area required improvement(s).	⊗	At least one standard in this area was not being met and the CQC have taken enforcement action

The following are verbatim extracts from the full CQC reports published on the CQC website. Any non-compliant locations have robust action plans in place, monitored by RGE.

The Linden Centre – compliant – (June 2013)

We used a number of different methods to help us understand the experiences of people who used the service. This was because the people at the service had differing needs which meant that they did not all feel able to tell us their experiences. We spoke to some people at the service and were able to observe staff supporting people.

We saw that people were supported and encouraged to exercise choice in their day to day lives. Independence was also promoted and staff worked with people to achieve this. People received the care, support and treatment they needed and this was provided in an individual way.

During the course of our inspection we saw that people were supported to express their views and choices by whatever means they were able to and staff clearly understood each person's behaviours and their individual ways of communicating their needs.

Staff looked after people's healthcare needs in a proactive way. The staff team were well trained and supported to carry out their roles.

None of the people we spoke with expressed any concerns about their safety. One person said: "I feel safe here but I would rather be at home."

The provider had effective systems in place to monitor the quality and safety of service that people received.

Peter Bruff Ward – compliant (September 2013)

People spoken with told us that they were mostly happy in the service and that they were involved in their own care. For example one person told us: "I have been here more than once. It depends which member of staff you get but some are very good especially the OT's." This showed us that people experienced care, treatment and support that met their needs and protected their rights.

We saw that people were actively encouraged to participate in their individual treatment programme and that they accessed specialist therapies and other support from staff. This demonstrated to us that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

We saw evidence of close and collaborative working with other mental health care services and other health professionals. None of the people we spoke with expressed any concerns about their safety. One person said: "The ward is really good. It is my first time and I am not well, I feel safe here." This showed us that the provider ensured that people who used the service were protected from the risk of abuse.

Staff reported that there were good opportunities for training and career development. This demonstrated to us that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

Kitwood and Roding Wards – non-compliant outcome 2 (November 2013)

People we spoke with told us that they were mostly happy in the service. Because of significant cognitive impairment it was more difficult to interview people on Kitwood ward. We saw that people experienced care, treatment and support that met their needs and protected their rights.

Before people received any care or treatment we found that they had not always been asked for their consent. Where people did not have the capacity to consent, the provider had not in all cases acted in accordance with legal requirements.

We were told that people were actively encouraged to participate in their individual treatment programme and that they accessed specialist therapies and other support from staff. This demonstrated to us that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We also saw evidence of close and collaborative working with other healthcare professionals.

None of the people we spoke with expressed any concerns about their safety. One person said: "They are quite good here to be honest, they know me as I have been here before. If I need anything the staff are usually helpful. I don't feel like anything will happen to me as it is quite relaxed most of the time." This showed us that the provider ensured that people who used the service were protected from the risk of abuse.

Staff reported that there were good opportunities for training. This demonstrated to us that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

Christopher Unit – compliant (November 2013)

We spoke with five people who used the service. They told us they were satisfied with the service they received. One person told us: "Staff are on hand all the time and always quick to respond to my needs." Another person told us: "They are just really caring." and another person referred to staff as 'compassionate'.

We found that people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We found that all people had a named staff member each shift with whom they identified and who helped them with their treatment and recovery. This information was clearly displayed in the main ward area.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse, and prevent abuse from happening. All the staff we spoke to had a clear understanding of how to safeguard vulnerable people.

Staff had received regular training, supervision sessions and an annual appraisal. This showed us that suitable arrangements were in place to train staff to care and support people on The Christopher Unit.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Landermere Centre (Tower Ward) non-compliant outcome 2 (November 2013)

People we spoke with told us that they were satisfied with the care they received. Because of significant cognitive impairment it was more difficult to interview people on Tower Ward. We saw that people experienced care, treatment and support that met their needs and protected their rights.

Before people received any care or treatment we found that they had not always been asked for their consent. Where people did not have the capacity to consent, the provider had not in all cases acted in accordance with legal requirements.

We were told that people were actively encouraged to participate in their individual treatment programme and that they accessed specialist therapies and other support from staff. This demonstrated to us that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

None of the people we spoke with expressed any concerns about their safety. This showed us that the provider ensured that people who used the service were protected from the risk of abuse.

Staff reported that there were good opportunities for training. This demonstrated to us that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

Brian Roycroft Unit – compliant (December 2013)

Because of significant cognitive impairment it was difficult to interview people on Brian Roycroft Ward. We saw that people experienced care, treatment and support that met their needs and protected their rights.

We were told that people, where able, were actively encouraged to participate in their individual treatment programme and that they accessed specialists and other support from staff. This demonstrated to us that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We also saw evidence of close and collaborative working with other healthcare professionals.

None of the people we spoke with expressed any concerns about their safety. We saw staff dealt with challenging situations calmly and effectively. This showed us that the provider ensured that people who used the service were protected from the risk of abuse.

Staff reported that there were good opportunities for training. This demonstrated to us that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

The Crystal Centre – compliant (December 2013)

We spoke with ten people who used the service. They told us they were satisfied with the service they received. One person told us: "There are activities if I want to do them, I enjoy painting." Another person told us: "All the staff are very helpful and the food is good there is always a choice."

We found that people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We found that all people had a named staff member or keyworker with whom they identified and who helped them with their treatment and recovery.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse, and prevent abuse from happening. All the staff we spoke to had a good understanding of how to safeguard vulnerable people.

Staff had received training and appraisals however we noted that formal supervision sessions needed to be held more regularly and training updates were to be planned to ensure all staff were fully supported in their role.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

439 Ipswich Road – non-compliance with outcomes 2,4,14 and 21 (January 2014)

People we spoke with told us that they were generally happy with the service. People told us they were well cared for and liked the unit and staff were helpful and kind.

Before people received any care or treatment we found that they had not always been asked for their consent. Where people did not have the capacity to consent, the provider had not in all cases acted in accordance with legal requirements.

We were told that people were actively encouraged to participate in their individual treatment programme and that they accessed specialist therapies and other support from staff. We saw people's needs were assessed, however care and treatment was not planned and delivered in line with their individual care plan.

None of the people we spoke with expressed any concerns about their safety.

Staff were not consistently trained and supported sufficiently by way of appraisals and supervisions. This demonstrated to us that people were not fully cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

People were not protected from the risks of unsafe or inappropriate care and treatment. People's personal records including medical records and staff records were not all accurate and fit for purpose.

The King's Wood centre – non-compliance with outcomes 2 and 4 (January 2014)

People we spoke with told us that they were mostly happy in the service. Because of significant cognitive impairment it was more difficult to interview people on Bernard Ward. We saw that people experienced care, treatment and support that met their needs and protected their rights.

Before people received any care or treatment we found that they had not always been asked for their consent. Where people did not have the capacity to consent, the provider had not in all cases acted in accordance with legal requirements.

We were told that people were actively encouraged to participate in their individual treatment programme and that they accessed specialist therapies and other support from staff. We saw people's needs were assessed, however care and treatment was not always planned and delivered in line with people's individual care plans.

None of the people we spoke with expressed any concerns about their safety.

Staff were generally trained and supported sufficiently by way of appraisals and supervisions. Staff reported that there were good opportunities for training. This demonstrated to us that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

Chelmer and Stort Wards – non-compliance with outcomes 2 and 4 (February 2014)

People we spoke with told us that they were generally happy with the service. We saw that overall people experienced care, treatment and support that met their needs and protected their rights.

Before people received any care or treatment we found that they had not always been asked for their consent. Where people did not have the capacity to consent, the provider had not in all cases acted in accordance with legal requirements.

We were told that people were actively encouraged to participate in their individual treatment programme and that they accessed specialist therapies and other support from staff. We saw people's needs were assessed, however care and treatment was not always planned and delivered in line with people's individual care plans.

None of the people we spoke with expressed any concerns about their safety. We saw staff dealt with challenging situations calmly and effectively. The provider ensured that people who used the service were protected from the risk of abuse.

Staff were trained and supported sufficiently by way of appraisals and supervisions. Staff reported that there were good opportunities for training. This demonstrated to us that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

Edward House – non-compliance with outcome 2 (February 2014)

People we spoke with told us that they were happy with the service. We saw that people experienced care, treatment and support that met their needs and protected their rights.

Before people received any care or treatment we found that they had not always been asked for their consent. Where people did not have the capacity to consent, the provider had not in all cases acted in accordance with legal requirements.

We were told that people were actively encouraged to participate in their individual treatment programme and that they accessed specialist therapies and other support from staff. We saw people's needs were assessed, and that care and treatment was planned and delivered in line with people's individual care plans.

None of the people we spoke with expressed any concerns about their safety. We saw staff dealt with challenging situations calmly and effectively. The provider ensured that people who used the service were protected from the risk of abuse.

Staff were trained and supported by way of appraisals and supervisions. Staff reported that there were good opportunities for training.

The provider had effective systems in place to monitor the quality and safety of service that people received.

You can see our judgements on the front page of this report.

St Aubyn Centre – compliant (February 2014)

Our inspection on 25 January 2013 was in response to concerns raised about the Centre.

The St Aubyn Centre provided care and treatment to young people on an informal (voluntary) basis as well as those detained under the Mental Health Act 1983.

The Centre was found to be warm, bright, spacious and welcoming. Young people were involved in their care and treatment and most had agreed to their care pathway. They were given choices and supported to make decisions.

Care plans, risk assessments, daily notes, observations, safeguarding and restraint records were comprehensive and clear which provided all staff and the young people with an understanding of their treatment and care pathway.

Staff had the necessary skills and training to provide care and treatment to the young people. They were provided with appropriate clinical supervision and support in order to carry out their duties effectively.

The young people told us they felt supported by the staff. They listened and gave them advice when they needed it. One young person said, "I am really supported here and it's the best place I have been." Another young person said, "Eventually I was listened to and my views were acknowledged."

There were effective systems in place to assess and monitor the quality of the service.

You can see our judgements on the front page of this report.

The Christopher Unit – compliant (November 2013)

We spoke with five people who used the service. They told us they were satisfied with the service they received. One person told us: "Staff are on hand all the time and always quick to respond to my needs." Another person told us: "They are just really caring." and another person referred to staff as 'compassionate'.

We found that people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We found that all people had a named staff member each shift with whom they identified and who helped them with their treatment and recovery. This information was clearly displayed in the main ward area.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse, and prevent abuse from happening. All the staff we spoke to had a clear understanding of how to safeguard vulnerable people.

Staff had received regular training, supervision sessions and an annual appraisal. This showed us that suitable arrangements were in place to train staff to care and support people on The Christopher Unit.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

You can see our judgements on the front page of this report.

Shannon House – compliant (January 2014)

We saw that people experienced care, treatment and support that met their needs and protected their rights.

We saw that people, where able, were actively encouraged to participate in their individual treatment programme and that they accessed specialists and other support from staff. Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We also saw evidence of close and collaborative working with other healthcare professionals.

None of the people we spoke with expressed any concerns about their safety. We saw staff dealt with challenging situations calmly and effectively. The provider ensured that people who used the service were protected from the risk of abuse.

Staff reported that there were good opportunities for training and we saw that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

You can see our judgements on the front page of this report.

Severalls House – compliant (January 2014)

Because of some cognitive impairment it was difficult to interview some people on Severalls House Complex. We saw that people experienced care, treatment and support that met their needs and protected their rights.

We were told that people, where able, were actively encouraged to participate in their individual treatment programme and that they accessed specialists and other support from staff. This demonstrated to us that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We also saw evidence of close and collaborative working with other healthcare professionals.

None of the people we spoke with expressed any concerns about their safety. We saw staff dealt with challenging situations calmly and effectively. This showed us that the provider ensured that people who used the service were protected from the risk of abuse.

Staff reported that there were good opportunities for training. This demonstrated to us that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider had effective systems in place to monitor the quality and safety of service that people received.

You can see our judgements on the front page of this report.

Data Quality

Statement on relevance of Data Quality and actions to improve Data Quality; we have taken or will be taking the following actions to improve data quality:

- The Director of Resources is Executive Director with strategic responsibility for data quality
- A Data Quality Policy has been approved and implemented; communicated widely via e-mail, induction and IT training workshops, and staff news briefings
- There is a framework of monthly performance monitoring and challenge by the Executive Management Team, which sets aside one morning each month to review in-depth the performance of the Trust, including data quality. This is reinforced with bi-monthly meetings in each of the 3 clinical areas, with the Director of Operations and Nursing, the Director of Resources and the Trust's Information Manager drilling down into team level data. This same data is aggregated and reported to the Board of Directors monthly.
- Data quality reports sent out monthly to each of the 3 areas with details of all data quality issues for all data framework performance reports.
- The Risk and Governance Executive monitors and manages significant data within the quality and safety arena.

- The Performance Improvement Manager routinely searches for data anomalies and inconsistent patterns to investigate and rectify. Reports are checked and validated before issue
- Actions identified in the external audit on data quality of the Quality Account/Report have been completed.

NHS Number Validity and General Medical Practice Code

The Trust submitted a total of 1,911 inpatient records (includes finished and unfinished consultant episodes) and 23,726 records up to 31st October 2013 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The % records in the published data which included the patient's valid NHS no. and General Medical Practice Code was (correct as at 31/10/13):

- Admitted patient care 99.27% valid NHS No. – 98.53% valid General Medical Practice Code
- Outpatient care 99.97% valid NHS No. – 99.99% valid General Medical Practice GP Code

Note: due to the implementation of the new clinical information system this information is not currently available for the period November to March 2014

Information Governance Toolkit Attainment Levels

Information governance is the way organisations handle personal information relating to patients and staff, and corporate information relating to finance and accounts. It provides a way for staff to deal consistently with many rules and regulations, e.g. Data Protection Act 1998 and Confidentiality NHS Code of Practice. The Toolkit is a performance tool produced by the Department of Health that sets all rules and regulations into one framework allowing self-assessment of compliance with the law and central guidance.
The Trust Information Governance Assessment Report score overall score on version 11 at level 2 or above for 2013/14 is 78% (satisfactory) with a breakdown as follows:

Information governance management	Score: 93% Grade: satisfactory
Confidentiality and data protection assurance	Score: 87% Grade: satisfactory
Information security assurance	Score: 66% Grade: satisfactory
Clinical information assurance	Score: 86% Grade: satisfactory
Secondary use assurance	Score: 75% Grade: satisfactory

Corporate information assurance Score: 77% Grade: satisfactory

Overall assessment Version 11 Score: 78% Grade: satisfactory

Clinical Coding Error Rate

As a mental health organisation, NEP does not use clinical coding.

PART 3: OTHER INFORMATION AND REVIEW OF QUALITY PERFORMANCE INDICATORS

Introduction

Part 3 of our Quality Report reviews our quality performance indicators. This is divided up into three sections:

- Patient safety measures (identified by the Risk and Governance Executive on behalf of the Trust Board). The rationale for these measures is the importance of patient safety; people need to feel safe while using our services and if they do not then this has the potential to impact on serious incidents and complaints.

- Clinical effectiveness measures – these measures include the key national priorities identified by the Department of Health Operating Framework; in addition there are a number of locally agreed performance measures agreed by the Executive Management Team and the Trust Board. The rationale for these measures is not only the need to comply with national targets but to monitor our performance against a whole range of measures that impact on the quality of care we offer to our service users.

- Patient experience measures – Executive Directors, on behalf of the Trust Board, agreed elements of the national patient survey results together with complaints and compliments. The rationale for including these measures is that complaints are a gauge to how well we are doing and identifies potential areas for improvement. Each complaint (or expression of concern) is taken seriously and acted on in each case but they also alert us to potential areas for improvement. We also record compliments a service receives, as there is potentially learning there too and they are a general indicator about good customer care.

We regularly involve stakeholders in planning workshops, which help to identify areas of concern that it may be appropriate to measure and monitor on a regular basis. Our Council of Governors represent a wide range of stakeholders from

constituencies across the geographical area, service users and service user groups, carers and members of staff .

The Trust has a reference cost index (RCI) for Mental Health Clusters of 102 (falling from 109 in the previous year), and continues to drive efficiencies where they can be safely delivered.

According to recent NHS benchmarking data, based upon returns from 57 providers in 2013/14, the Trust performs well on a range of mental health productivity measures, with well below average available acute adult beds per 100,000 head of population.

- Below average admissions for acute adult patients per 100,000 population
- Below-average acute adult readmission rates (2.7% versus national average of 8.72%)
- Above average occupancy rates
- Below lower quartile average length of stay
- Below lower quartile delayed discharge rates.

The comparative spending on mental health by one of the local clinical commissioning groups is below both the national and local area average (source NHSE Programme Budgeting, for 12/13 published February 2014).

Performance of Trust against selected metrics (measures)

We have chosen to measure our performance against the following metrics in each of the domains of quality – patient safety, clinical effectiveness and patient experience:

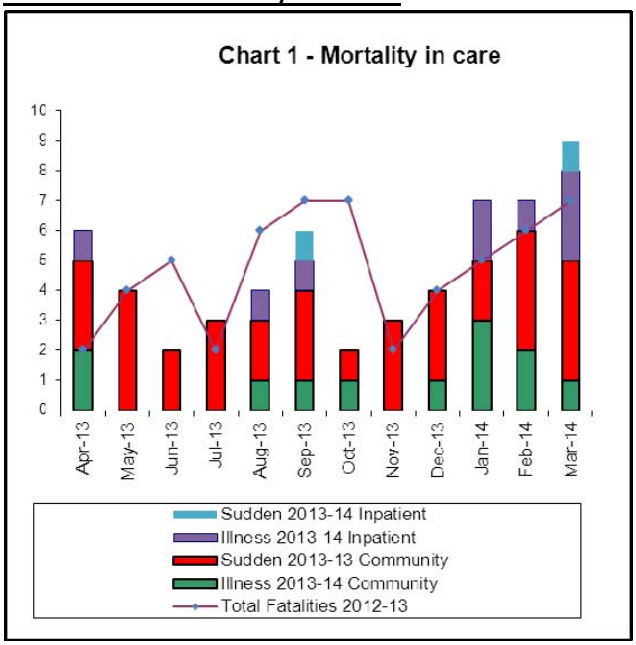
Quality Report – Patient Safety measures

The charts that follow are an extract from our monthly Quality Report patient safety dashboard as at the end of March 2014. We have been able to benchmark the figures over several years. We have developed clear targets for the reports within the dashboard. We also use National Patient Safety Agency national reports for benchmarking.

The Patient Safety Dashboard is part of the patient safety element of our Quality Report, which encompasses all three quality headings of patient safety, patient experience and clinical effectiveness. All of the indicators are used by the Trust to support its drive for quality and achieve outstanding care, transforming lives. The

data sources are our local incident reports and the indicators are in line with National Learning and Reporting Service (NLRS) requirements.

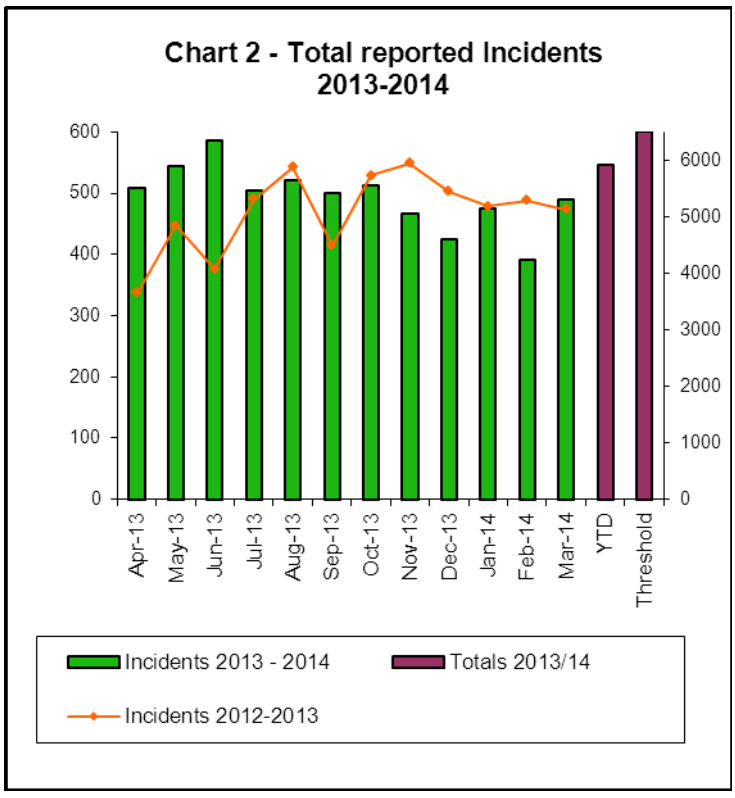
Chart 1 – Mortality in care



This indicator measures mortality in care due to physical illness and self-harm or accident. For this indicator, we record and analyse deaths in our direct care, including those in the community. All deaths where no physical illness is evident are fully investigated. We are not subject to the Standard Hospital Mortality Indicator used by acute hospitals.

The total number of deaths in 2013/14 is the same as the previous year at 57. We have separated in-patient deaths from those in the community. These are in turn broken down by sudden and those due to physical illness. Almost 60% of the total deaths were sudden and in the community.

Chart 2 – Total number of incidents



An incident in the Trust is any adverse event that has the potential to cause harm to an individual. There is proactive reporting of incidents in the Trust. It is imperative that incidents are reported if we are to continue to learn from events. A high level of reporting is actively encouraged nationally.

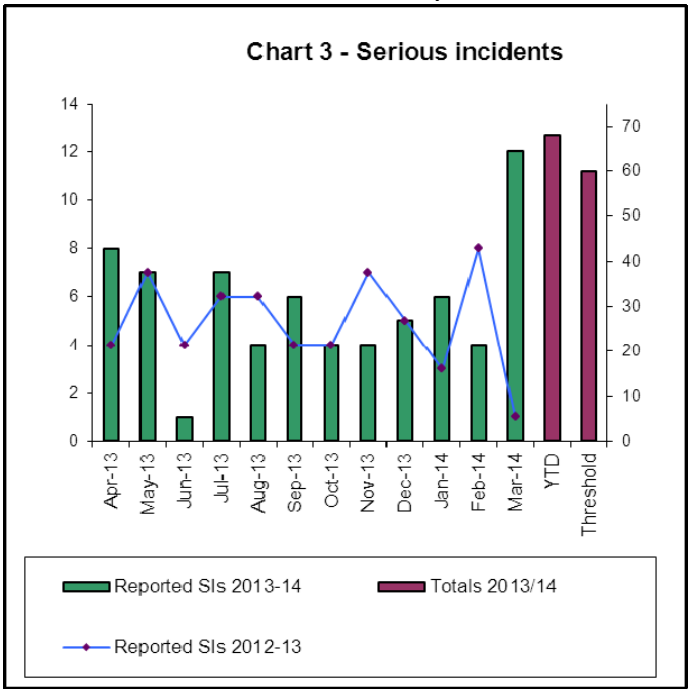
The total number of incidents for the year is 5922 and this represents an increase on the previous year of 5.2%.

Monitor requires the Trust to report on two indicators relating to patient safety incidents:

Indicator 1: Patient safety incidents (PSI) reported to the NRLS (A PSI is defined as any unintended or unexpected incident that could or did lead to harm for one or more persons receiving NHS funded healthcare). The number of patient safety incidents reported to the NRLS in 2013/14 is 2343.

Indicator 2: Patient safety incidents reported to the NRLS where degree of harm is recorded as severe harm or death as a percentage of all patient safety incidents reported (severe – the patient has been permanently harmed as a result of the PSI, and death – the PSI has resulted in the death of the patient). A total of 0.085% of the total number of PSI's reported to the NRLS resulted in severe harm or death in 2013/14.

Chart 3 – Total number of reported serious incidents (SIs)



The full definition of a serious incident requiring investigation (SI) can be found at the following link: http://www.screening.nhs.uk/si-toolkit-incidents#fileid12137

There were 68 reported (through Strategic Executive Information System STEIS) serious incidents during 2013/14 and this is an 11% increase on the previous year. It should be noted that there were 9 deaths in the community related to drug/alcohol misuse. The Trust continues to implement its suicide prevention strategy including measures covering inpatient and community care.

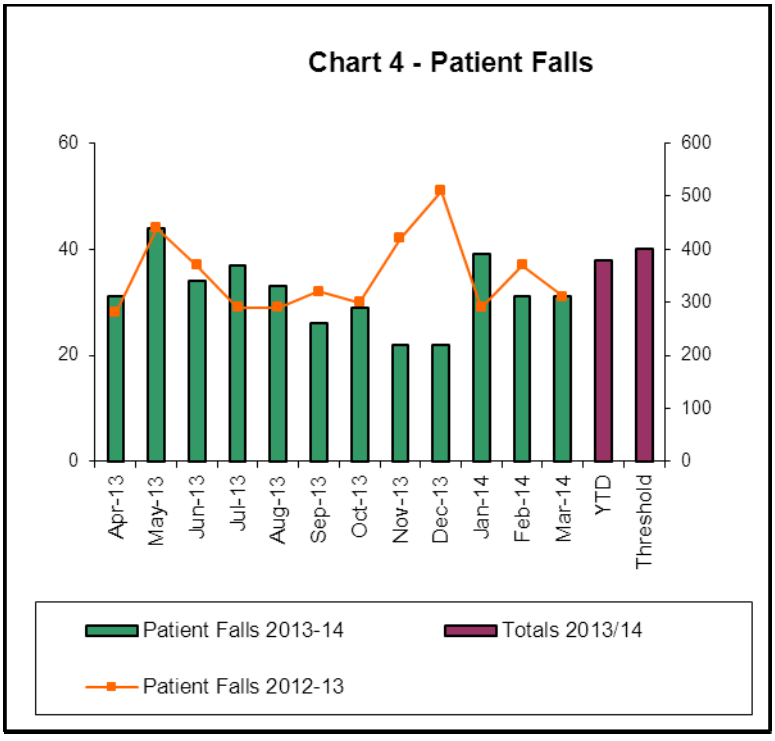


Chart 4 – Falls (patient)

Our falls prevention strategy has resulted in the year on year reductions below as well as a reduced number of fractures resulting from falls.

2013/14 379 (9.5% reduction)

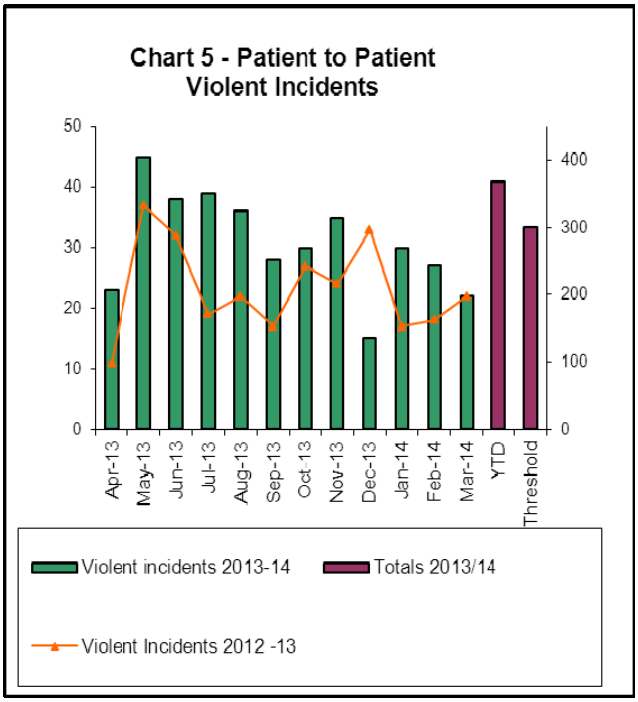
2012/13 419 (19% reduction)

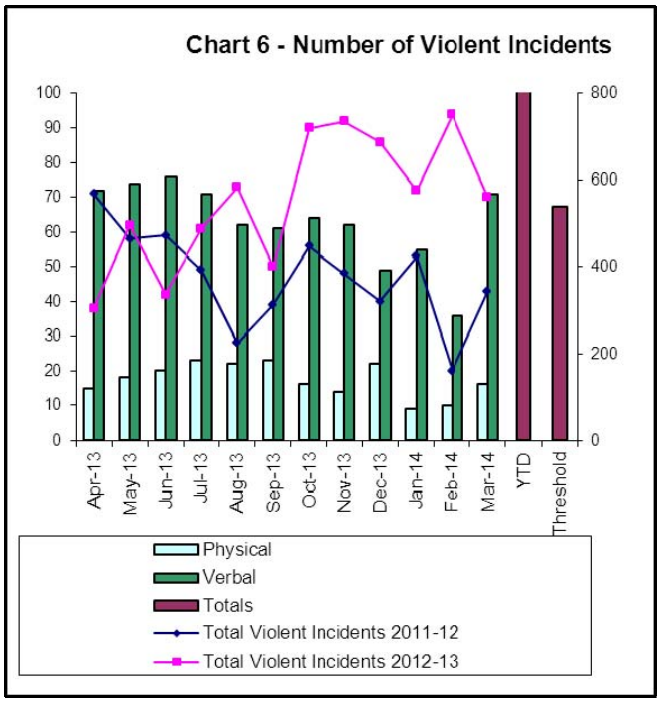
2011/12 515 (21% reduction)

2010/11 674 (23% reduction)

2009/10 876 (16% reduction)

<u>Chart 5 – patient to patient violent incidents and Chart 6 – total number of violent incidents</u>

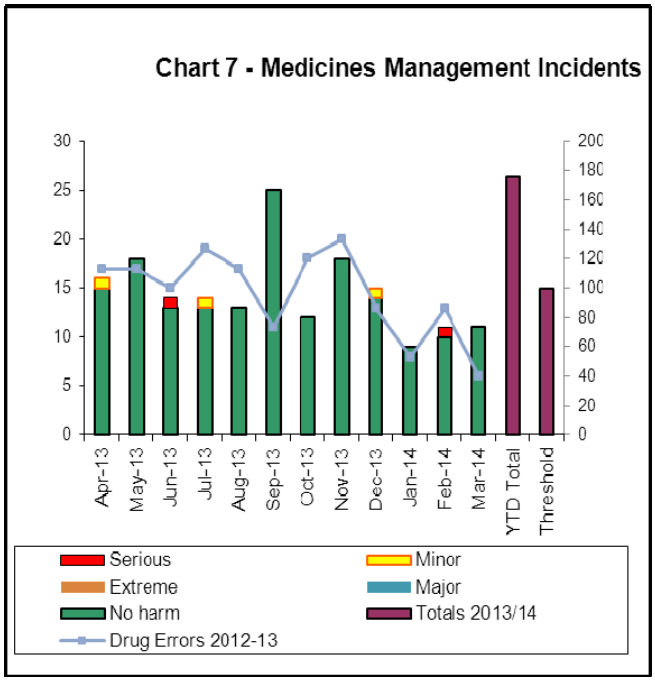


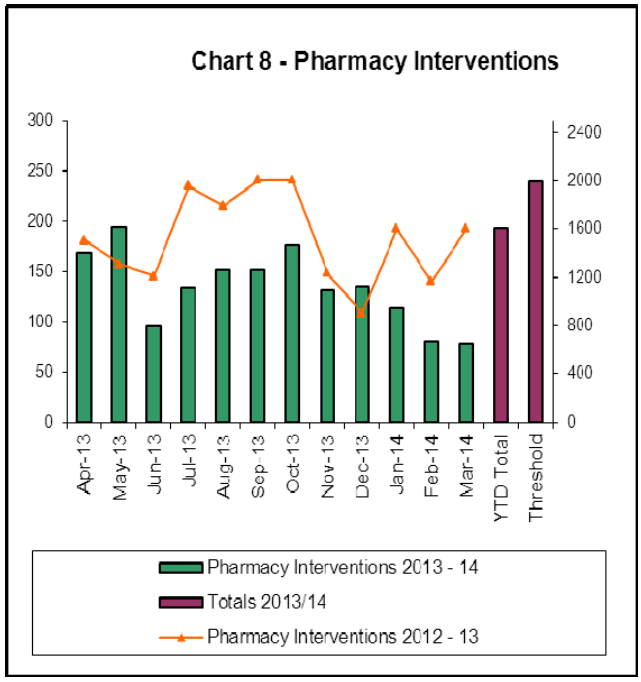


Patient to patient violence incorporates aggression, harassment, actual assault and inappropriate behaviour towards another patient and is tracked in chart 5 whilst violence towards property is closely tracked in chart 6. It must be stressed that in chart 6 there is a high level of verbal aggression towards staff reported rather than physical damage to property.

Patient to patient violent incidents has increased by 131 incidents on last year; this represents an increase of 31% and can mainly be attributed to the older adult wards. Violent incidents have increased by 15.78% on last year's total; the majority of these can be attributed to verbal aggression.

Chart 7 and 8 – drug errors and pharmacy interventions



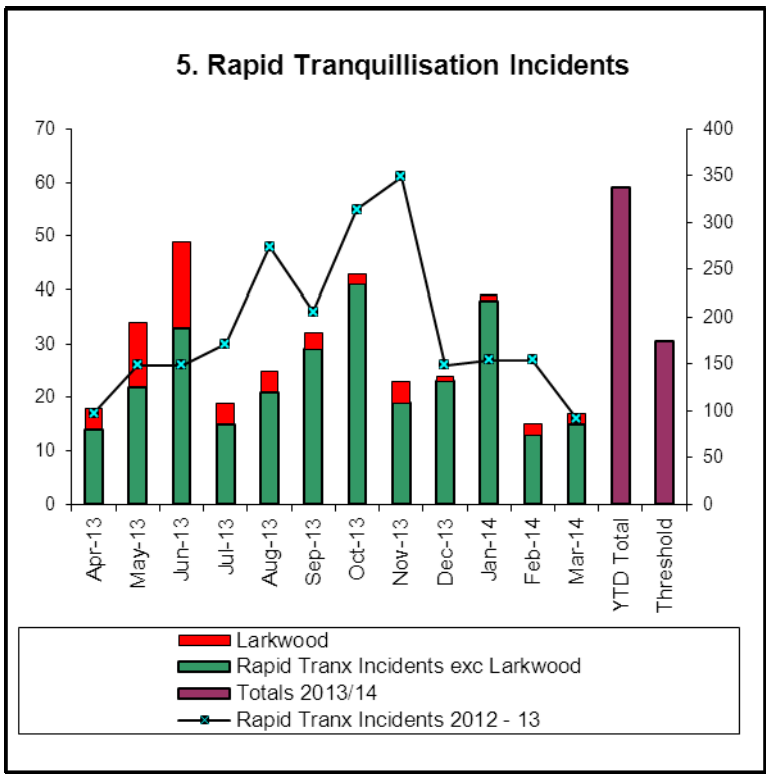


Medicines management incidents are patient safety incidents involving medicines in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred. This is a broad definition and the majority of medication errors do not result in harm.
(http://www.npc.nhs.uk/improving_safety/improving_safety/resources/Medication_Error/Reducing_5mg.pdf)

Medicines management incident reporting is actively encouraged in order to promote safety. Numerically there has been very little change with an increase of 2 on last year. This includes the addition of 'near miss' reporting. There were 2 incidents in the year that resulted in serious harm.

Pharmacy interventions are monitored to ensure that correct prescribing practices are being followed and a high level in this area should be viewed as proactive medicines management. Pharmacy interventions have increased as expected with the recruitment of qualified pharmacy staff. All interventions are risk assessed and only a small number are high risk.

Chart 9 – rapid tranquillisation incidents



Rapid tranquillisation incidents are where medication in line with the protocol has been administered to control behaviour usually precipitated by violence/impulsivity. This chart looks at the number of rapid tranquillisations that have taken place.

The addition of Larkwood ward (St Aubyn Centre) as mentioned previously has resulted in an increase in rapid tranquillisation incidents.

Every incident is audited and in the case of Larkwood Ward the CQC compliance inspection covered this aspect of care, with a positive outcome.

Clinical Effectiveness and other outcome measures

National targets, key priorities, regulatory requirements and primary indicators

The following indicators are collected from the data sources below and referenced in brackets in the table. This includes key national priorities from the DH operating framework that are relevant to mental health service.

We produce a newsletter for staff called 'Perform' aimed at providing a performance and finance update for staff.

In the following key to data sources, the bracketed information refers to any nationally defined standards:

(1) CareBase and Remedy – patient database (nationally defined by Department of Health/ Care Quality Commission/ Monitor)
(2) Electronic staff records (nationally defined as above)
(3) Poppie database (in line with Drug Action Team requirements)
(4) Electronic staff records (locally defined indicators)

Performance of Trust against selected metrics (as at 31/03/14)					
(data source – see legend above)	**2013/ 14**	**2012/ 13**	**2011/ 12**	**2010/1 1**	**Comment**
Early intervention in psychosis (new cases) (1)	115.5 %	298	315	312	Significant decrease – this is being monitored
Carer assessments (completed and declined) (1)*	1103	1612	2402	1724	Significant decrease – staff have been reminded of importance of recording carers assessments
Crisis Resolution Home Treatment (gatekeeping) (1)	96.6%	100%	100%	100%	No difference
Staff turnover (12month average) (2)	8.60%	7.60%	8.00%	8.30%	To end February ‘14
Sickness absence (in months) (2)	4.2%	4.40%	5.20%	4.50%	To end Feb ‘14
Clients 18+ receiving a review (1)*	75.40 %	97.70 %	96.70 %	96%	Significant decrease
Care Programme Approach 7 day follow up (1)*	94.47 %	98.80 %	99.20 %	98.90%	Decrease due to under performance in Qtr. 03
Delayed transfers of care (in total % occupied bed days delayed) (1)*	2.7%	2.40%	0.8% Monit or	0.7% Monito r	Increase – clarity required around definition (Remedy coding)
18 week referral to treatment (Consultant led services) (1)	91.40 %	99.70 %	99.90 %	99.90%	No significant difference
MHMDS data completeness (1)	98.83 %	99.80 %	99.50 %	99.52%	Decrease – being closely monitored

Monitor data completeness (1)*	99.80 %	97.60 %	95.10 %	89.20%	Significant decrease – improve accuracy of recording of employment and accommodation status
Inpatient discharges with a diagnosis recorded (1)	N/A	94.50 %	90.40 %	91.20%	
Problematic drug users in effective treatment (3) (to end Feb 2014)	89.20 %	89.70 %	89.20 %	91.40%	No significant difference
5 week wait for 1st appointment (Consultant led services) (1)	N/A	75.00 %	94.30 %	82.40%	
18 week referral to treatment (non-Consultant led services) (1)	N/A	96.80 %	95.10 %	97.60%	
Under 18 admissions to an adult ward (1)	9	4	7	5	Clinically appropriate admissions
Under 16 admissions (1)	0	0	0	0	No change
Inpatient re-admissions within 28 days of previous discharge* (1)	2.42%	2.53%	10.70 %	9.20%	No significant difference
Long term Sickness absence (4)	2.76%	4.40%	3.80%	2.90%	To end Jan ‘14
Turnover excluding retirement (4)	5.70%	5.10%	6.00%	6.20%	To end Feb ‘14
Leavers (4)	176.75	163.64	131.41	172.85	To end Feb ‘14
Leavers excluding retirement (4)	133.03	138.26	92.52	130.98	To end Feb ‘14
% of staff who would recommend the trust as a provider of care to family or friends (Q12d of staff survey ‘13)	59%	60%	N/A	N/A	

All indicators as at 31st March 2014 except where indicated
**data quality issue (Remedy training issue around fields)*

Patient experience measures

We have measured ourselves on the following patient experience measures. The data source for formal complaints and compliments is our local Respond and Datix databases and the data source for PALS low level complaints is from an Excel spread sheet with extracted information from Customisable Analysis Management Software (CAMS) database on 2nd April 2013 (extracted to ensure no duplicated issues from single enquiries). The complaints data is nationally defined whilst the compliments is locally defined. The patient survey indicators are taken from the national community survey and are nationally defined questions. How we compared with other Trusts in this survey can be found on the Care Quality Commission website at http://www.cqc.org.uk/survey/mentalhealth/RRD

	2013/14	2012/13	2011/12	2010/11
Complaints (including PALS)	**441**	**531**	**593**	**666**
Compliments	**447**	**399**	**352**	**273**
Patient Survey Were the purposes of the medications explained to you?*	**80%**	**79%**	**84%**	**88%**
Patient Survey Do you understand what is in your care plan?*	**75%**	**75%**	**75%**	**77%**
Patient Survey Overall, how would you rate the care you have received from Mental Health Services in the last 12 months?*	**72%**	**73%**	**71%**	**73%**
Patient experience of contact with a health or social care worker during the reporting period*	**84%**			

* Community Mental Health Service Users Survey results

The patient survey results put the Trust's performance at around the same level as other Trusts participating in the survey. More specifically the Trust performed better than most other Trusts in patients 'understanding their care plan', 'given their care plan' and 'out of hours contact' and we performed worse than most other Trusts on 'support with accommodation' and 'help with benefits'. These latter items associated with daily living are not within our expertise but we have put objectives

in place in order to provide the right amount of guidance and signposting as we possibly can.

We welcome feedback in the form of comments, compliments and complaints. We are a very large organisation with thousands of episodes of care delivered. We want to provide the best but there will be occasions where people are not satisfied or are unhappy so we want to hear about it. We have many ways people can pass these on to team managers, reception staff, direct to the Chief Executive, or through the patient advice and liaison service. People do not generally like to complain but other people can benefit from complaints where shortcomings in the service are highlighted.

ANNEXE 1 STATEMENTS FROM CLINICAL COMMISSIONING GROUPS, HEALTH OVERVIEW AND SCRUTINY COMMITTEE AND HEALTHWATCH

North Essex Partnership NHS Foundation Trust has requested third party commentaries from local Clinical Commissioning Groups, local Healthwatch and the Health Overview and Scrutiny Committee.

Statement from Healthwatch Essex for NEPFT Quality Account 2013-2014

Healthwatch Essex is an independent organisation with a vision to be a voice for the people of Essex, helping to shape and improve local health and social care services. We recognise that Quality Account reports are an important way for local NHS services to report on what services are working well, as well as where there may be scope for improvements.

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

Healthwatch Essex has begun to work with NEPFT through the Healthwatch study into '*The impact of dementia: an exploration of the lived experiences of women and men in mid-Essex who care at home for people who suffer from dementia'.* This highlighted some excellent practice, but also inconsistencies and a patchwork of service provision across health and social care. The follow-up to this report remains ongoing, but NEPFT has responded in a positive and encouraging way, and we look forward to continuing to work with the Trust in this vein.

On mental health more generally, the engagement work undertaken by Healthwatch Essex in 2013-14 has focused mainly on areas of Essex outside of NEPFT's service areas. However, a number of themes emerge to which all service providers, across NHS and social care, should be vigilant – these include individual access to mental health services through primary care, support for carers, and access to crisis teams. Healthwatch Essex has also raised – via the Health and Wellbeing Board – concerns about a lack of coordinated working across health and social care in relation to services for people with autism.

NEPFT's own Account presents some quality concerns around patient safety measures, in particular with regard to an increased number of Serious Incidents, but the Trust indicates it continues to implement the suicide prevention strategy to help reduce this. There is also increased patient to patient violence, and an increased level of verbal aggression towards staff.

Healthwatch Essex supports the Trust's efforts towards meaningful patient and carer engagement. In particular, we recognise the work around the Mid Essex

Recovery Hub and College; involving service user and carer participation in the PLACE inspections; service users on the interview panels for senior positions; and inviting service users to share their stories at the APM.

NEPFT is performing well on patient experience measures. The Trust received the least amount of complaints this year in comparison to the past three years, and the most compliments over the same time period. In the Care Quality Commission national community mental health survey, NEPFT scored around the same as other Trusts participating.

Healthwatch Essex supports NEPFT's priorities for 2014/15 to improve patient experience through structured activity for in-patients and focusing on real patient experiences, as well as carers experience through the implementation of the service user and carer involvement strategy. We look forward to working together in the production of Quality Accounts in the coming year and making sure that the voice and experience of patients and the public form an integral part of these.

NHS
North East Essex
Clinical Commissioning Group

North Essex Clinical Commissioning Groups' response to

North Essex University Foundation Trust's Quality Account for 2013/14

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

North East Essex Clinical Commissioning Group has commented on this Quality Account by virtue of its role as Lead Commissioner for the Clinical Commissioning Groups of North Essex (i.e. including Mid Essex CCG and West Essex CCG). Although commenting on a draft version of this Quality Account, we are pleased to be able to assure the accuracy of the content in general. The CCG is, however, unable to assure all data reported, as some data will have been provided or updated prior to publication.

It is clear from your statement of purpose that you continue to be actively seeking to provide care that is outstanding in its quality, imbuing confidence in both service users and their families in the quality of the services provided. We note the many positive improvements that have occurred during the year and also wish to highlight those areas where further progress is required.

Your review of priorities for improvement and assurance statements provides many examples of how you have delivered your intended developments for 2013-14.

These included:

- Collaborative working with the local acute trust in the mid area of the Trust leading to a joint presentation at a national conference on connecting for health.
- The opening of a recovery hub.
- The use of structured therapeutic activity for patients. These activities have been adversely impacted by a variety of human resource issues and this programme will continue as one of the developments in 2014/15.
- Commendable work on promoting mental health through engaging both your own staff and local schools.
- Improving engagement and support of staff through the development of apprenticeship programmes for administrative staff.

You identified that physical healthcare checks have been incorporated into the community barometer. Unfortunately, the commissioners are unable to comment on the quality of the implementation of the community barometer in 2013/14 as the information formally requested has not yet been made available to the commissioners.

You report that accurate recording of data electronically is being hampered by REMEDY- the newly introduced electronic patient system which has superseded CAREBASE. This has had an adverse impact on the Trust's ability to accurately report on the quality and safety of the services being delivered since its introduction in November 2013. The CCG is actively seeking alternative evidence of assurance and is expecting to see an improvement in the accurate recording and reporting of performance as a matter of urgent priority.

You have identified 5 key priorities for the coming year which relate to patient safety, patient experience and clinical effectiveness. These will include:

- Building on the work already started to promote metal health by promoting anti-stigma.
- Continuing to progress the structured therapeutic activities programme for patients as part of improving patient experience.
- Implementing the action plan developed in response to the Francis report.

In your review of services you describe how the Journey's programme has moved forward considerably during the last year, with considerable stakeholder and staff participation. The commissioners consider it is absolutely imperative that this development is supportive of the Clinical Commissioning Groups' mental health strategy.

The Trust's memory services achieved compliance with the Memory Services National Accreditation Programme recommended standard of 6 weeks. The four fold increase in numbers of patients seen in this service since 2010/11 is noted and reflects an increasing requirement to manage this demand.

The Trust has responded positively to the audit findings relating to the use of the Suicide Prevention Ward Manager's checklist. A key aspect of this audit is the provision of real time data, which enables ward teams to discuss and address issues of safety and quality as they arise in a proactive and constructive way.

It is noted that the Trust achieved a green Risk Assessment Grading on completion of the combined Essex Safeguarding Adult/Children's Boards audit tool.

This Commissioning for Quality and Innovation (CQUIN) payment scheme was in operation in 2013-14 and it is disappointing that no information has been provided on the schemes introduced to enhance the quality and safety of services to service users. It is encouraging that the schemes to be implemented in 2014/15 will aid collaborative working across health care systems.

The Care Quality Commission (CQC) carried out inspections at 15 locations across the organisation, with 9 of the areas visited assessed as being fully compliant with the standards. The commissioners note that in the 6 areas where improvements were required, action plans have been implemented to improve the quality and safety of services.

The Trust has provided information concerning the numbers of incidents, serious incidents, mortality in care, patient falls, violent incidents, patient to patient violent incidents as well as drug errors, pharmacy interventions and rapid tranquillisation incidents. The increased level of incident reporting during 2013/14 is to be commended as this is an indicator of the Trust's safety culture; the eagerness to learn from such events and to implement improvements for services users and staff.

The Trust's Falls Strategy has resulted in a year on year reduction in the number of falls. Patient to patient violent incidents have increased and mainly occur in older adult wards. At the same time it is noted that the number of violent incidents, mainly attributed to verbal aggression towards staff, has also increased.

The Trust is to be complemented on its performance in helping patients understand their care plan. It is pleasing to note that where the Trust has performed worse - 'support with accommodation and help with benefits', plans are already in place to help improve this aspect of patient experience.

This was an informative report which clearly identifies that North Essex University Foundation Trust is committed to providing high quality services that meet the needs of people with mental health conditions.

The three CCGs face different challenges in their own centres of population and it would have been useful to identify any significant variances between the areas covered by north east, mid and west Essex clinical commissioning groups.

In conclusion, the lead commissioner for North Essex CCGs is assured that overall the Trust's Quality Account for 2013/14 provides a clear picture of improvements and future ambitions for enhancing quality and safety in your services. The CCG looks forward to continuing its work with North Essex University Foundation Trust in the coming year.

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

ANNEXE 2 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

In preparing the Quality Report the Directors are satisfied that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2013 to March 2014
    - Papers relating to quality reported to the Board over the period April 2013 to March 2014
    - Feedback from the commissioners dated
    - Feedback from governors in minutes over the period April 2013 to March 2014
    - Feedback from Healthwatch (Essex) dated 15 May 2014
    - The Trust's annual complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 as at 31st March 2014.
    - Care Quality Commission Community Mental Health Survey 2013
    - 2013 NHS Staff Survey
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 20 May 2014
    - CQC quality and risk profiles 2013/14
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

21st May 2014	Chris Paveley	Chairman
21st May 2014	Andrew Geldard	Chief Executive
21st May 2014	Lisa Anastasiou	Director of Workforce and Development
21st May 2014	Charles Beaumont	Non-Executive Director
21st May 2014	Mike Chapman	Director of Strategy
21st May 2014	Ray Cox	Deputy Chairman & Non-Executive Director
21st May 2014	Jan Crame	Non-Executive Director
21st May 2014	Dr Malte Flechtner	Medical Director
21st May 2014	John Gilbert	Non-Executive Director and Senior Independent Director
21st May 2014	Brian Johnson	Non-Executive Director
21st May 2014	Paul Keedwell	Director of Operations and Nursing
21st May 2014	Vince McCabe	Director of Commercial and Service Integration
21st May 2014	Rick Tazzini	Director of Resources

HOW TO PROVIDE FEEDBACK ON THE QUALITY REPORT

We would welcome feedback on our Quality Report and you may telephone, write, email, or contact us through our website or our facebook page, all details below:

Freephone 0800 169 1625

Andrew Geldard
Chief Executive
North Essex Partnership NHS FT
Freepost
RLXX-ZXRZ-ESZG
Trust Headquarters, Stapleford House

Stapleford Close, Chelmsford
CM2 0QX
Email enquiries@nepft.nhs.uk
Website http://www.nepft.nhs.uk/

Facebook: facebook.com/NorthEssexPartnership

Strategic Report

Our Strategic Objectives

Our annual plan sets out how we will achieve our five key strategic objectives;

Objective 1:
Providing high quality care that is effective, safe and as positive an experience as possible

Objective 2:
Being a model employer

Objective 3:
Achieving good governance, inclusive involvement and excellent partnerships

Objective 4:
Providing value for money

Objective 5:
Expanding our business

We've met these objectives for the past year – for more detail, please see the Quality Report.

The Fair Review of the Foundation Trust Business

The trust was authorised as a Foundation Trust (FT) in October 2007. So for 2013/14, its fifth year as a FT, the Trust has continued to maintain performance, fulfilling contractual requirements and responding positively to regulator requirements across the range of services it provides.

The Trust is licensed to provide NHS services (licence number 120073) and carries out the full range of Commissioner Requested Services for secondary mental health care, substance misuse and some primary care services.

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The Trust continues to drive service quality improvements, reduce risk and be alert to new risks. At the same time the Trust must find ways of saving money and working more efficiently if it is to continue to safely provide the same range of commissioned services.

The Trust experienced increased demand and patient acuity in 2013/14. Referral rates from GPs continue to rise, bed occupancy has increases and the Trust and CCGs made considerable use of the inpatient risk share. The Trust's 360 beds produce 40% of income, yet account for less than 10% of all patient numbers. More than 90% of our 20,000 patients seen each year are cared for at home or in outpatient clinics

The Trust's business activity in 2013/14 was similar to that of the previous year but for the inclusion of new primary care GP services in south Essex. In all other regards it was "business as usual".

Description of the Foundation Trust Business Model

The Trust has successfully reached the final year of a 5-year strategy that set the following strategic objectives and key priorities:

Strategic objectives	Key priorities
1. To provide high quality care that is effective, safe and as positive an experience as possible	**Effective**
	1. Improving access to, and accessibility of, services
	Safe
	2. Improving patient safety and general wellbeing, ensuring all care and other environments are appropriate, safe and therapeutic
	Positive Experience
	3. Continuing to improve the experience of service users, families and carers, ensuring

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	embedded systems for receiving and acting on feedback
2. To be a model employer	4. Creating positive experiences for staff within an efficient and effective workforce
3. To achieve good Governance, inclusive Involvement and excellent partnerships	5. Engaging widely with local communities and key stakeholders, developing productive partnerships with partner organisations and helping promote positive mental health
4. To provide value for money (economy, efficiency, and effectiveness)	6. Ensuring an ongoing programme to ensure services are clinically and cost effective, use of estate is maximised and carbon footprint is reduced
	7. Realising development of, and benefits from, the Trust's information systems
5. To expand the business	8. Exploiting opportunities for growth and broader business development

These strategic objectives and key priorities have been and remain the basis for the Trust's service development plans and the framework within which we are responding to the changing commissioning environment and the system financial imperatives. This Operational Plan for 2014 – 16 delineates how we plan to respond to this rapidly-changing environment so that we can continue to deliver high-quality health, wellbeing and social care across Essex and Suffolk to meet the evolving needs of our catchment populations.

Strategy Development

During 2013/14, we have been working with staff, patients, governors and members to update our corporate values to reflect how we feel about ourselves and how we want to be seen. This project, called "Our NEP", is refreshing our values, refreshing our objectives and re-presenting our voice.

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Our values reflect truths about us, particularly the care and compassion we share with our patients combined with our desire to see of the business thrive and develop.

We are developing our 5-year strategy for 2014 – 2019 on the groundwork of these restated values, building on our existing strategic objectives and key priorities to ensure a sustainable direction.

Access and outcome quality indicators

The Trust has met the FT regulator's access and outcome indicators within the Risk Assessment Framework, with the exception of the Care Programme Approach in quarters 3 and 4. The Trust recorded deterioration in performance in the "7-day follow-up" and "12month review" components in quarter 3 to 68.1% and 78.1% respectively. Performance improved to 98.1% and 84.1% in quarter 4. The implementation of the clinical information system in November created recording difficulties as staff grappled with new way in which CPA review activity was recorded. Improvements and further training have been put in place. Trust management is directing attention to the recording of this important CPA access measure, to ensure that by the end of quarter 1 in 2014/15, the threshold is being met.

Financial headlines

The Trust broadly met its financial targets for EBITDA, I&E operating surplus (before technical adjustments), cash and continuity of services risk rating. There was some slippage on the capital programme due to contractual delays with the Derwent Centre and two planned asset disposals will now complete in 2014/15.

Financial Headlines For The Year Ended 31 March 2014

Turnover	£112,749,000
Cost Improvement Programme	£2,635,000
Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA)	£5,735,000
EBITDA Margin (as a percentage of turnover)	5.1%

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Net Surplus Before Technical Accounting Adjustments	£849,000
Net Surplus Margin (as a percentage of turnover)	0.8%
Technical Accounting Adjustments	£13,595,000
Net Deficit	(£12,746,000)
Cash Balance	£9,243,000
Continuity of Service Risk Rating	3
Capital Spend	£8,174,000
Asset Disposals – Proceeds	£2,363,000
Asset Disposals – Profit on Disposal	£771,000
Principal Repayment on Debt	£2,215,000

After some mid-year difficulties with its outsourced provider, the Trust generally maintains good payment performance (approx 90% paid within 30 days and 40% within 10 days). The Trust has been successful in reducing trade debts outstanding over 30 days to £64,000 /4% (prior to provision for impairments).

Service Transformation

The Trust focussed considerable attention and resource during the year on two major strategic programmes; the JOURNEYS care pathway redesign programme and REMEDY, the replacement for the trust's long-serving patient record and clinical information system. REMEDY went live on 25 November, and implementation of "release 1" is on course to be completed with a full, 17-year history transfer, by 31 May, with the switch-off of the read-only previous clinical system in June. The new systems will facilitate enhanced safety, security and efficiency improvements including mobile working and interfaces with other systems.

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Severalls

At the time of writing the Trust is negotiation, together with the Homes & Community Agency to sell the former Severalls Hospital site in Colchester to a national house builder. The disposal of this iconic 119 acre site on the north side of the town is complex and involves significant contributions by the two landowners and the developer to provide new schools, roads, cycle and bus lanes and community infrastructure. The receipt from the land sale will be paid over a 3 year period following completion and initial receipt, which is expected to take place in 2014/15. The receipt will be used to repay on-going loan commitments, support the capital programme and cash/liquidity requirements as the Trust enters and uncertain financial climate.

Future trends and developments

The main trends and factors likely to affect the Trust's future development include;

- Move away from block contracts to a new payment system including cost and volume for mental health services based upon care clusters.
- Acuity and demand pressures for both community and inpatient services;
- Market testing and service changes;
    - CAMHS tier 3
    - Substance Misuse services
    - Service redesign and integration with physical care
- Continuation of the provider tariff efficiency regime;
- National pay and conditions including pension contribution increases;
- Increasing regulation and inspection into community services;
- 2015/16 Better Care Fund impacts on CCGs;
- Local health economy finances;

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Environmental
The Trust has been reducing its carbon footprint through a number of measures including estate optimisation, new buildings and energy efficiency measures with power (voltage optimisation) insulation, heating and lighting improvements.

As at 31 March, the Trust has disposed of 13 owned or rented buildings, and releasing reducing the estate by more than 3,500 sq/m. There are plans to sell a further 8 properties over the next two years and release another 1,700 sq/m.

Commercial
The CCG's development of local IAPT services will see a reduction in the overall volume of patients with mild to moderate, non-psychotic symptoms (care clusters 1-4) being referred into the Trust for treatment. Within a cost and volume contract, the Trust will need to match resources to changes in income.

The Trust continues to work with existing commissioners to develop and enhance the service offering to complement existing services. We are working closely with commissioners and other providers to see how integrated models of care and contract can help to improve services and save money. The Trust is also engaged beyond the county both alone and as a consortia member in bidding for new services.

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Breakdown of male and female directors and senior managers

	Gender		
Employment Group	**Female**	**Male**	**Trust Total *** **
Chair	-	1	1
CEO	-	1	1
Non Exec Director	1	4	5
Director	1	5	6
Associate Director	7	6	13
Deputy Director	2	1	3
Senior Manager *	134	54	188
Medical	59	82	141
Other **	1,574	529	2,103
Hospital Manager	20	15	35
Trust Total	***1,798***	***698***	***2,496***

Staff Sickness Absence

Staff Sickness Absence	**2013/14**
Average FTE staff:	1837
FTE days available:	562119
FT days lost to sickness absence:	21693
Average sick days per FTE:	11.8

Staff Survey

The Trust employs 2,496 staff across Essex. We take staff engagement very seriously and believes that a happy workforce directly links to better patient care.

Staff are encouraged to give regular feedback through a variety of

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channels and the Chief Executive holds regular informal meetings with staff to hear their comments about what is working well in the Trust and how things could be improved.

The annual Staff Survey provides a more formal opportunity for staff to give their views of what it is like to work in the organisation. Feedback data from the survey provides a measure of staff opinions around a number of important performance areas.

The response rate to our 2013/14 staff survey conducted by The Picker Institute on behalf of the Department of Health was 42% and is below average when compared nationally.

The results show that our staff believe we are doing well in some important areas:

- The number of staff having an annual appraisal has increased by 9%
- Overall results indicate that there has been an increase in the number of staff accessing learning and development opportunities
- Staff feel that there is better communication with senior managers
- Staff feel satisfied with the quality of care they are able to give to patients

There are areas that we still have to improve on and the survey showed that these are:

- Despite launching a Respect campaign there has been an increase in the number of staff experiencing bullying and harassment. This is of concern and attempts will be made to further address this.
- People putting themselves under pressure to come to work when they may be unwell.
- Staff still report working long hours
- Staff feel that there are not equal opportunities for career progression or promotion in the organisation

The overall response rate to the survey is shown in the table below:

	2012/13		2013/14		Trust Improvement/ Deterioration
Response rate	Trust	National Average	Trust	National Average	
	53%	**53%**	**42%**	**46%**	

Key findings where the Trust is better than average

	2012/13		2013/14		Trust Improvement/ Deterioration
Top 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
KF7. Percentage of staff appraised in last 12 months	**84%**	**87%**	**94%**	**87%**	**+ 10%**
KF21. Percentage of staff reporting good communication between senior management and staff	**35%**	**30%**	**36%**	**31%**	**+ 1%**
KF12. Percentage of staff saying hand washing materials are always available	**57%**	**55%**	**60%**	**54%**	**+ 3%**
KF2. Percentage of staff agreeing that their role makes a difference to patients	**91%**	**90%**	**91%**	**90%**	**No change**

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Key findings of bottom ranking scores

	2012/13		2013/14		Trust Improvement/ Deterioration
Bottom 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**40%**	**30%**	**42%**	**30%**	**+ 2%**
KF5. Percentage of staff working extra hours	**73%**	**70%**	**78%**	**71%**	**+ 5%**
KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**23%**	**21%**	**27%**	**20%**	**+ 4%**
KF20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	**18%**	**22%**	**26%**	**22**	**+ 8%**

Future priorities and targets

The staff survey indicates some areas that we have to focus on to improve our staff experience at work. The wellbeing of our staff is important to us in helping us deliver outstanding care for our patients.

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Our 2014/15 priorities around the staff survey are:

Promoting a work-life balance to address the long hours working culture in the organisation.

Reinforcing our zero tolerance policy to harassment, bullying, violence and discrimination.

Supporting staff so that they feel able to take time off at times of sickness until they are recovered

Monitoring arrangements
The Staff Survey Action Plan is monitored by the Staff Health and Wellbeing Strategy Group and the Equality and Diversity Group.

Future priorities
Our priorities for 2014/15 are:

- A continued focus on increasing appraisal rates and the quality of the appraisal experience.
- Supporting staff who indicate that they are feeling under pressure at work with a targeted project around stress prevention
- Reinforcing, through the Respect agenda, our zero tolerance approach to harassment, bullying, violence and discrimination; supporting staff to report their experiences.
- To continue with The Succession Planning Agenda and provide development opportunities for staff including shadowing, career coaching and secondments.

Going Concern
There is no presumption of going concern status for NHS foundation trusts. The Directors have considered whether or not it is appropriate for the trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows. After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. The Board of Directors confirms that there are no material uncertainties that may cast significant doubt about Trust's ability to continue as a going concern for at least 12 months beyond the date of the 2013/14 statement of accounts. For this reason, they

continue to adopt the going concern basis in preparing the accounts

The accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

Equality and Diversity

NEPFT Demographic breakdown of Service Users on CPA as at 31 December 13

Summary			Service Users on CPA as at 31/12/13
Ethnicity			
White	A	British	14,983
	B	Irish	106
	C	Any other White background	278
Mixed	D	White and Black Caribbean	42
	E	White and Black African	25
	F	White and Asian	20
	G	Any other mixed background	75
Asian or Asian British	H	Indian	42
	J	Pakistani	32
	K	Bangladeshi	12
	L	Any other Asian background	69
Black or Black British	M	Caribbean	27
	N	African	41
	P	Any other Black background	18
Other Ethnic Groups	R	Chinese	21
	S	Any other ethnic group	37
	Z	Not stated	36
		Not Recorded	13

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Summary		
Age Group		
Under 18	1,647	10.4%
18 yrs to 24 yrs	971	6.1%
25 yrs to 49 yrs	4,467	28.1%
50 yrs to 64 yrs	2,395	15.1%
65yrs or Over	6,397	40.3%
Not Recorded	0	0.0%
Gender		
Male	6,867	43.3%
Female	8,995	56.7%
Other		
Not Recorded	15	0.1%
Employment		
Unemployed	3,141	19.8%
Employed	1,715	10.8%
Other	11,012	69.4%
Not Recorded	9	0.1%
Accommodation		
Settled	14,879	93.7%
Not Settled	531	3.3%
Not Recorded	467	2.9%

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Sustainability Report

The Trust continues to make good progress in line with the Trust Board's approved Carbon Management Plan (CMP) of December 2009 where a three year carbon reduction plan was agreed and an objective to aim for an overall 30% reduction in carbon emissions for the Trust, a number of low carbon initiatives were set out to achieve the target by use of various technologies, applications and policies.

The Trust is already using less energy and generating less carbon emissions since the baseline year of 2007.

The purpose of implementing a carbon management programme is to achieve the latest targets set within the NHS Sustainability Strategy and statutory legislation linked to the Climate Change Act 2008. Using 2007/08 as the baseline year the Trust is on target to reduce carbon emissions in its use of buildings by 30% before March 2015 and had already achieved the 10% overall reduction by the end of 2010.

Carbon emissions come from the three sources which are procurement, travel and buildings, procurement accounting for 60%, travel 18%, and buildings 22% of the NHS total respectively. The baseline study found that the 30% reduction in carbon emissions can be best achieved through an approach entirely consistent with the Trust's vision and values. Carbon management will most effectively optimise emissions in buildings, transport, and procurement if it is centred on service users, promotes staff participation and includes genuine consultation with stakeholders.

Capital Development

Edward House

The Trust's new Low Secure Unit was opened in 2013 and has been primarily designed with natural ventilation throughout the building consisting of opening windows to all rooms whilst still maintaining the security requirements of a low secure unit. In addition local heat recovery units are installed throughout the building to reduce heat loss and minimise energy consumption. This coupled with high efficiency gas

fired boilers and controls help reduce our carbon emissions. The unit is controlled via a Building Management System (Trend) that not only controls temperatures within the building but also allows the optimisation and compensation of the boilers in line with external temperatures. In addition due to the electrical services infrastructure, this building is also part of the voltage optimisation system installed for the Linden Centre which also helps in reducing energy costs.

The following items have been designed within the building to achieve a high level of sustainability:

- Heat Recovery Exchanger on Air Plant to L2 Building Regulations approved Document ADL2
- Condensing Boilers to L2 Building Regulations
- Meter Strategy linked to a Building Management System (BMS)
- All lighting to have high frequency control gear with T5 high efficiency lamps and low energy lamps to down lights
- Emergency exit signs will have LED lamps
- External column lighting and wall lights will have LED lamps with auto set black illumination during out of hours
- PIR room sensors controlling room lighting
- Dimming lighting controls in certain rooms

<u>Mid Essex Estates Optimisation Project (MEEOP)</u>

This project has seen a number of teams relocated across the Mid Essex area to optimise space utilisation within the buildings, reduce the Trusts estate footprint, reduce running costs (including energy etc.) and improve clinical service delivery. The Trust has reduced the footprint of the Mid Essex estate by 1,580 M², which means that the Trust no longer has to heat or light these buildings. In addition, and directly as part of the MEEOP works, we installed cavity insulation into the walls and insulation into the ceilings to current regulations at Maldon Clinic, improved the insulation of the roof space at New Ivy Chimneys and also introduced additional insulation above the suspended ceilings at Cherry Trees to improve the thermal efficiency of the buildings. All new construction as part of this project is to current building regulations in terms of energy efficiency. All the lighting schemes were designed in house on this project as a whole, and the systems installed have used the latest energy efficient luminaries where possible.

West Essex Estates Optimisation Project (WEEOP)

A similar exercise to the MEEOP above has been carried out in the West Essex area which will see a reduction of the overall footprint of the Estate in the West Essex area by 572 M^2.

New Construction Projects

Phases 2 to 5 of the refurbishment of the Derwent Centre, located within the main Princes Alexandra Hospital in Harlow were commenced in late 2013 through Vinci Construction with this element of the refurbishment lasting two years. This building is a 1960's concrete constructed, flat roof building with single glazed 'Crittall' steel windows and heated via a high pressure steam main from the hospitals boiler house.

The refurbishment will take around 5 years overall (to phase 10) to complete as it's being carried out in a 'live' working environment with Health and Safety at the 'top of the agenda', however a number of energy initiatives have been encompassed within the design of the building, which are as follows:

- New gas main to be installed to the Derwent centre and new gas fired Condensing Boilers to L2 Building Regulations to be installed, and existing steam main heating system disconnected to the building
- Double glazed windows installed throughout to replace old single glazed steel 'Crittall' windows and external cladding of all external concrete panelling therefore enclosing the building in an highly 'insulated' cladding system
- Installation of an insulated 'pitched' roof system which will be overlaid across the existing un-insulated flat roof
- Meter Strategy linked to a Building Management System (BMS)
- All lighting to have high frequency control gear with T5 high efficiency lamps and low energy lamps to down lights
- PIR room sensors controlling room lighting & dimming lighting controls in certain rooms
- Heat Recovery Exchanger on Air Plant to L2 Building Regulations approved Document ADL2

Energy Supplier

Our current energy supplier of electricity, British Gas has started to install smart meters into some of our properties across the Trust. This will ensure that we receive accurate monthly bills unlike the current estimated ones and that we only pay for energy we have used. In addition we will also be able to monitor sudden rises in usage and thus investigate what has caused this to happen and take any necessary action promptly to reduce our usage.

Energy Usage 2014/15

The energy use for 2014/15 is indicated below, albeit the last three months usage for this year have been extrapolated for the purpose of this report, final figures will be available from May 2014 and these will be corrected for the benefit of the Trusts ERIC returns to the Department of Health.

Electric

2013 Kwh	2014 Kwh	% Difference	CO2 (Tonnes)
3571372	4142418	+15%	2051.34
2013 Cost	**2014Cost**		
£328,327	£429,820.32		

Gas

2013 Kwh	2014 Kwh	% Difference	CO2 (Tonnes)
7827786	8254720	+5.45%	1515.57
2013 Cost	**2014 Cost**		
£236,838	£272,701.06		

Water & Sewerage

2013 M3	2014 M3	% Difference
26454	28211	+6.64%
2012 Cost	**2014 Cost**	
£74,771	£84,209.85	

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Energy Usage 2008/9 to 2014/15

The Trusts investment in recent years renewing plant and using sustainable building techniques along with renewable energy and the use of power optimisers in the larger units is now assisting in reducing energy consumption. However, it should be noted that the Trust has opened new buildings over the last few years, namely the St Aubyn's Centre (which is three times larger than the old CAMHS service in Longview and is now showing the full year effect of energy use), Edward House (twice as large as the old LSU building it replaces and over half year full effect), Atholl House, Suffolk MVA and three GP surgeries in Thurrock (all additional to the estate), all of which have increased energy use. In addition, the Trust has seen increased patient activity across its operational activities and has invested in three large ICT training suites amongst other capital developments all of which have also increased the Trusts use of energy, particularly electricity.

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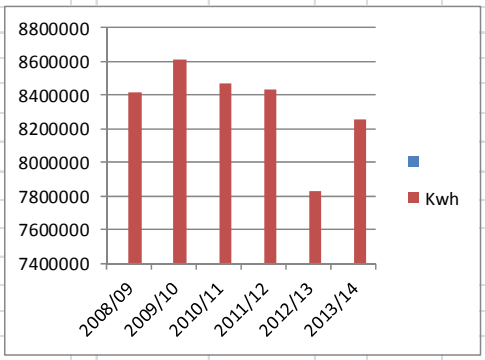
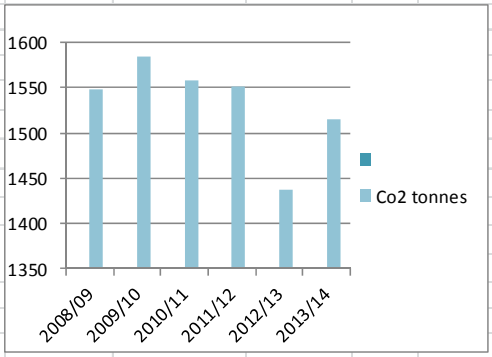
ENERGY CONSUMPTION COMPARISONS 2008-2014

GAS

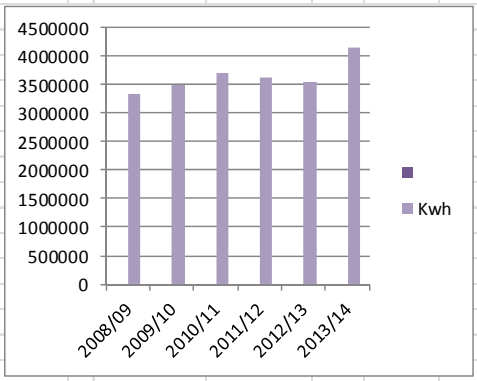
Year	Kwh	Co^2 tonnes
2008/09	8411110	1547.64
2009/10	8612242	1584.65
2010/11	8469771	1558.44
2011/12	8433023	1551.68
2012/13	7827786	1437.18
2013/14	8254720	1515.57

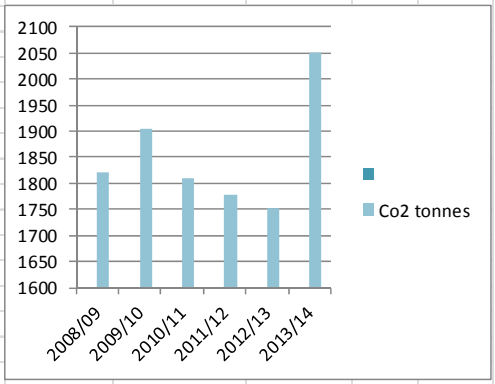




ELECTRIC

Year	Kwh	Co^2 tonnes
2008/09	3345000	1819.68
2009/10	3497944	1902.88
2010/11	3698346	1810.71
2011/12	3629294	1776.91
2012/13	3535814	1750.95
2013/14	4142418	2051.34





Procurement

The Trust's procurement team is continually reviewing both how it delivers it services to its clients and how the Trust procures from the external market. This year it has been working with the East of England Procurement hub to gain a full baseline for all of its external procurements to ensure that the 2014/15 procurement plan will include a plan on reviewing the higher Carbon Footprint areas. We have also worked with our stationery providers to look at environmentally friendly alternatives to products we purchase and we now have 17.7% of our total stationery spend going through this route. There has also been a

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review of our internal procurement processes which has led to a reduction in the numbers of requisitions being received through the procurement department in a manual manner. In the last 12 months we have gone from 100% paper based requisitions to the number of requisitions being received electronically accounting for 25% of all orders.

We have increased our number of plumbed in water coolers to 54 (from 35 last year). Those additional 19 coolers would provide (based on the average saving of 154kg of CO2) a total saving of 2,926kg of CO2 emissions saved. The procurement team is looking to increase the use of electronic requisitioning and the ultimate aim is to get everyone using this route, therefore saving paper, printer ink and resource time.

The Head of Procurement also has responsibility for the car leasing team and they have increased the uptake of cars within the organisation from 164 last year to 211 this year. Therefore we have increased our non-grey fleet users by 12% thus ensuring a greater duty of care to our employees. The Car Leasing team will shortly be relaunching its schemes to encourage more employees away from grey fleet and into vehicles that will provide the organisation with greater confidence of their suitability and security for work purposes. This launch will include a number of presntations and drop in areas that will allow those not currently on the scheme to investigate the suitability for their purposes. This will happen at a number of venues across the region so that everyone should have access to at least one session. There will also be a relaunch of the information on the intranet for employees to peruse.

Information Communications Technology

The Trust embarked upon the largest ICT project it has ever undertaken through the replacement of the main clinical information system (Carebase) with a new system (PARIS) to which the Trust has renamed REMEDY.

The program has been far reaching and whilst the system was only launched in November 2013 it encompasses many workstreams including one of mobile working technologies which have been trialled across many staff over the last six months. It is hoped that upon full implemention of this project (when the Remedy product version 2 is implemented and stable) that further rationalisation and optimsation of the Trusts estates can be realised through the use of the mobile

platform. In addition, the Remedy product is 'Cloud Based' and therefore the Trust has not had to invest in IT Servers, or buildings to place them in, therefore saving energy costs. Another workstream is also looking into printer rationalisation using Multi Functional Devices, linking to Remedy and medical records digitisation.

Conclusion

The Trust continues to progress its Carbon Reduction plans across the procurement, travel and buildings activities that it manages. As can be seen the Trust has grown its estate portfolio in recent years and this has had a detrimental effect on energy usage across the estate, in respect of volume and cost. But it should be noted that whilst the Trust continues to invest into its buildings, both in fabric and services, these are predominately creating more energy efficient buildings and therefore the Trust should start to see the benefit of this work over the following years.

Further work will continue through the period 2014/15 in accordance with the following objectives:

- Continue to implement energy efficient designs into all capital schemes
- Re-write the Trust Board approved Carbon Management Plan into a Sustainability Development Management Plan
- Further rationalisation of the estate through the benefit of the Remedy program and the implementation of mobile working technologies to all staff.
- Implementation of electric vehicles, possibly pool vehicles, for staff to use when travelling to/from major Trust buildings for meetings or site visits etc.

Governance

Regulatory Ratings

Foundation Trusts receive a risk rating each quarter from Monitor, the regulator.
Foundation Trusts were rated for 2 areas:

1) Finance
Rated from 1 (highest risk) to 5 (lowest risk)

2) Governance
(Achieving key measurable targets)

The key targets include;

a) Care programme Approach – patients receiving follow-up contact within 7 days of discharge from hospital
b) Care programme Approach – patients having a formal review within 12 months
c) Minimising delayed transfers of care
d) Admissions to inpatient services having access to crisis resolution and home treatment teams
e) Maintaining commitment to serve new psychosis cases by early intervention teams

At the time of publication the position for the Trust is as follows:

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Evaluation of the Board

The Board of Directors has chosen to undertake an externally facilitated evaluation this year, a 'Board Health Review', conducted by the Foresight Partnership, which included the following core elements:

- Desk review of Board documentation
- Board observation
- On-line assessments of whole Board effectiveness by both Board members and internal and external stakeholders
- In-depth interviews with all Board members
- External stakeholder interviews.

The outcome of this work will be taken forward via a Board Development Plan. This project was undertaken by the Foresight Partnership which has no other relationship with the Trust.

The Board had constructive feedback on the findings, which reported strengths and areas for further development. The Board will be producing a Board Development Plan for 2014/15, based on development areas arising from it.

Patient Advice & Liaison Service (PALS)

PALS offers support, advice and information to service users, carers, family and friends, and members of the public about Trust services.

A total of **626** enquiries were received during the period April 2013 - March 2014.

North East: 93 – Mid: 106 – West: 68 – CYPS: 17 – Community Services: 8 – Corporate: 5 - Psychology: 4 – Business Infrastructure: 1 – Medical Directorate: 1 – Substance Misuse: 1 – Non Specific: 322.

322 were calls for various information requests, e.g. access to other PALS, clearer understanding of mental health services, to discuss in confidence a concern, how to make a complaint etc.

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In total 304 Key issues were received by the Trust Directorates. PALS LOW complaints are included in the Making Experience Count Complaints report to the Board.

PALS, Low Complaints April 2013 – March 2014

PALS Categories	**Total**
Information	322
Care & Treatment	117
Communication	69
Appointment	33
Attitude	19
Change of mental health worker	14
Facilities	13
Access to Services	11
Compensation/Reimbursement	9
Medication	7
Funding commissioning	4
Health & Safety	3
Respect & Dignity	3
Confidentiality	2
	626

Safeguarding

We are committed to safeguarding all of our service users across the range of services provided by the organisation.

North Essex Partnership (NEP) continues to promote and develop the Safeguarding agenda within its Corporate Plan, Strategic Plans and in clinical practice. The Trust continues to play an active role in the Essex Safeguarding Adults Board, the Essex Safeguarding Children Board and many of their sub-committees.

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A number of initiatives have been developed over the past year including improved performance monitoring (with 482 Safeguarding Adults investigations led by CPA coordinators from NEP during this financial year and 129 referrals of children to Social Care). Key performance measures have been agreed and are reported through the NEP Safeguarding Group to the Trust Risk and Governance Executive Board, including the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS).

NEP was commissioned to provide Best Interest assessors as part of the DoLS service for Essex County Council in their capacity as a Supervisory Body during 2013 - 2014. This included provision of training and consultation to staff on the MCA and DoLS and a DoLS assessment process. The Trust submitted 246 DoLS applications during the financial year - a reflection on the work completed during this year across the trust to provide assurance that no service user is unlawfully detained.

All clinical staff working within NEP are required to complete a level3 trainings in both Safeguarding Adults and Safeguarding Children. They are supported in their work by access to consultation and supervision, comprehensive policies and procedures underpinned by the SET Safeguarding Procedures (both children and adult).

Directors' Report

The NHS Foundation Trust Code of Governance was published by Monitor on 29 September 2006, and updated on 10 March 2010. The purpose of the Code is to assist NHS Foundation Trusts in improving their governance practices. It is issued as best practice advice, but imposes some disclosure requirements. This Annual Report includes all the disclosures required by the Code.

The Board of Directors of the Trust support and agree with the principles set out in the NHS Foundation Trust Code of Governance, and to the best of their knowledge, information, and belief the Trust has complied with the Code throughout the year to the 31 March 2014 save in the following respects: -

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There is no formal process in place for the resolution of any dispute between the Board of Directors and the Council of Governors. The Chairman of the Board and the Chief Executive meet with the Lead Governor and the Deputy Lead Governor every month to discuss matters which are within the role and responsibilities of the governors, and to resolve any issues which there may be between them.

Chairman and Non Executive Appointments

Current	**Expiry**
John Gilbert	31 May 2014
Ray Cox	30 September 2014
Brian Johnson	11 March 2015
Chris Paveley	31 December 2015
Charles Beaumont	30 September 2016
Jane Crame	30 September 2016

The Chairman and each of the Non-Executive Directors is an independent director. Ray Cox was appointed Deputy Chairman by the Council of Governors in March 2010. The appointments of the Chairman and each of the Non-Executive Directors may be terminated in accordance with the Trust's Constitution. The balance of the membership of the Board is regularly considered by the Nominations Committee whose report appears below.

Executive Directors

The table below is a list of Executive Directors, their position, contract status, start date and notice periods. The contract start date is when the individual first joined the Trust. In other sections of this report, there are incidences where the individual may have been promoted to another role and this is shown as the appointment date.

Name	**Position**	**Contract Date**	**Contract Status**	**Notice Period**
Lisa Anastasiou	Director of Workforce & Development	29/03/2010	Permanent	3 Months
Mike Chapman	Director of Strategy	06/02/2010	Permanent	3 Months

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Dr. Malte Flechtner	Medical Director	01/02/2005	Permanent	3 Months
Andrew Geldard	Chief Executive	30/07/2009	Permanent	6 months
Paul Keedwell	Director of Operations & Nursing	12/03/2010	Permanent	3 Months
Rick Tazzini	Director of Resources	23/11/2009	Permanent	3 Months
Vince McCabe	Director of Commercial and Service Integration	04/06/2011	Permanent	3 Months

All Executive Directors are employed on permanent contracts with a notice period of three months except for the Chief Executive, where the notice period is six months. There are no provisions for early termination within the contracts nor do they contain other details sufficient to ascertain the Trust's liability in the event of early termination. The register of Directors interests can be inspected on appointment with the Trust Secretary.

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Profile of Board Members

Chris Paveley, Chairman

Appointed January 2013

Responsibilities:

- Independent Director
- Chairman of Board of Directors and Council of Governors
- Nominations Committee
- Remuneration Committee
- Liaison with Governors
- Estates, financial controls, budget & environmental development
- Assurance Framework

Experience, Expertise and Other Interests

Chris brings over 40 years of private and public sector experience to the Trust. Chris was previously the Chair of North Essex PCT. He did his formative business education in Japan. Chris returned to the UK in the mid 1980s' and set up his own business and has been on the boards of multiple organisations.

Andrew Geldard, Chief Executive

Appointed July 2009

Responsibilities:

- Trust Accounting Officer
- Leading strategic development, corporate and clinical governance
- Internal Control Systems
- Assurance Framework Implementation

Experience, Expertise and Other Interests:

- 2002-2008 Director of Resources, North Essex Mental Health Partnership NHS Trust (from October 2007, North Essex Partnership NHS Foundation Trust)
- 2000-2002 Director of Finance and Performance, Southend Primary Care Trust
- 1996-2000 Deputy Director of Finance, Surrey and Sussex Healthcare NHS Trust
- 1992-1996 Deputy Finance Manager, Brighton Healthcare NHS Trust
- 1986-1992 South East Thames Regional Health Authority
- BSc Hons (Geography and American Studies), MA (Geography)
- Member of Chartered Institute of Public Finance and Accountancy Officer

Dr Malte Flechtner, Medical Director
Appointed October 2007

Responsibilities:

- Medical leadership
- Caldicott Guardian
- Research and Development
- Pharmacy
- Medical Education
- Risk Management
- Clinical Governance
- Complaints & Serious Incidents

Experience, Expertise and Other Interests:

- 2002 Elected as member of the Royal College of Psychiatrists
- 2002 Associate Medical Director for the mid Essex area, North Essex Mental Health Partnership NHS Trust
- 2001 Consultant Psychiatrist, North Essex Mental Health Partnership NHS Trust
- 1993-2001 Deputy Head of the Department for Social Psychiatry, Free University of Berlin
- MD, MRCPsych (Psychiatry and Neurology)
- Specialist training in Psychodynamic Psychotherapy

Paul Keedwell,
Director of Operations and Nursing
Appointed October 2007

Responsibilities:

- Operational Services - Adults of Working Age, Older Peoples' Services, Child and Adolescent Mental Health Services, Specialist Services, Psychology, Occupational Therapy,
- Operation of the Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards and Nursing Leadership

Experience, Expertise and Other Interests

- 2003-2005 Area Director for central area, North Essex Mental Health Partnership NHS Trust
- 2001-2003 Service Manager, North Essex Mental Health Partnership NHS Trust
- Experience in psychiatric intensive care, rehabilitation, aggression management, criminal justice and prison in-reach, day services and community care
- RMN
- BSc (Hons) Health Studies

Mike Chapman, Director of Strategy
Appointed October 2013

Responsibilities:

- Strategy
- Communications
- Commissioner Relationships
- Annual Planning
- Social Care

Experience, Expertise and Other Interests:

- 2009 - 2013 Director of Commercial and Service Development
- 2006 - 2009 Area Director for Tendring Operational Services and Trust-wide substance misuse
- 2003 - 2006 Essex Strategic Health Authority, Policy Lead for Mental Health, Substance Misuse, Children's Learning Disabilities and Prison Healthcare.
- Experience as a local authority and PCT Commissioner, Social Services Mental Health lead and practised as a social worker in mental health, Older Adult and Children's Services
- Masters Degree in Business Administration
- Approved Social Work, CQSW

Rick Tazzini, Director of Resources
Appointed November 2009

Responsibilities:

- Finance
- Estates & Facilities
- IT and Clinical Systems
- Contracting and Performance
- Procurement

Experience, Expertise and Other Interests:

- 2004 –2009 Director of Finance & Admin, Essex Police
- 2002 –2004 Assistant Director of Finance, Essex SHA
- 1998 –2002 Head of Finance, Essex Police
- 1994 –1998 Deputy Director of Finance, BHB Community Healthcare NHS Trust
- Prior to this, various posts with Essex County Council and Colchester Borough Council
- Chartered Institute of Public Finance & Accountancy Officer
- Masters in Business Administration
- UK Police Strategic Command Course
- Institute of Directors – Certificate in Company Direction

Lisa Anastasiou, Director of Workforce & Development (Non-voting Board member)

Appointed March 2010

Responsibilities:

- Human Resources
- Workforce Development
- Staff engagement
- Occupational Health
- Equality & Diversity

Experience, Expertise and Other Interests:

- 2005 - 2010 Head of Employment, Newham University Hospital NHS Trust
- 2001 - 2005 Human Resources Manager, Barking, Havering and Redbridge Hospitals NHS Trust
- Improvement Facilitator, NHS Modernisation Agency
- 1999 - 2001 Human Resources Adviser, Newham Community Health Services NHS Trust
- 1996 -1999 Human Resources Officer, Redbridge Healthcare NHS Trust
- Diploma in Personnel Management
- Member of the Chartered Institute of Personnel Development

Vince McCabe, Director of Commercial and Service Integration (Non-voting Board member)

Appointed October 2013

Responsibilities:

- Delivery of Community Health Services
- Leadership of Suffolk Community Healthcare Interim Management Agreement
- Identify and bid for new opportunities for Community Service Provision

Experience, Expertise and Other Interests:

- PCT Chief Executive in Hertfordshire,
- Managing Director of West Essex Community Health Services Certificate and Diploma in Health Service Management,
- Accounting Technician, MBA (Cranfield/OU)

Independent Non Executive Directors

Ray Cox

Reappointed December 2009 –
30 September 2014

Responsibilities:

- Independent Director
- Deputy Chairman
- Chairman of the Audit Committee
- Takes an overview for Older Adults' services
- Nominations Committee
- Liaison with Governors
- Assurance Framework Implementation

Experience, Expertise and Other Interests:

- 1998-2001 Chairman of the Audit Committee, North East Essex Mental Health Partnership NHS Trust
- 1986-1997 Director of Finance, Tendring District Council
- Prior to this, Deputy Borough Treasurer, Colchester Borough Council
- Chartered Member, Chartered Institute of Public Finance and Accountancy

John Gilbert

Appointed June 2008
Reappointed March 2011 –
31 May 2014

Responsibilities:

- Senior Independent Director
- Audit Committee
- Nominations Committee
- Chairs Risk and Governance Executive
- Liaison with Governors
- Overview of clinical services
- Special interests in investment bids and partnerships
- Assurance Framework implementation

Experience, Expertise and Other Interests:

- Career includes director level posts with Essex County Council and various management and senior executive posts with Barclays Bank plc
- Scope - Trustee and Treasurer
- Fellow of Royal Society for Encouragement of Arts, Manufactures and Commerce (FRSA)
- Fellow of Chartered Institute of Bankers
- Charities/Voluntary – Chair of Governors at Great Totham Primary School)
- Chair of Little Braxted Parish Council

Brian Johnson
Appointed March 2012 –
12 March 2015

Responsibilities:

- Independent Director
- Remuneration Committee
- Nomination Committee
- Liaison with Governors
- Marketing Commercial Communications
- Overview of Clinical Services (West Area)
- Assurance Framework Implementation

Experience, Expertise and Other Interests:

- 2012 – present, Chief Executive – Metropolitan (Metropolitan Housing Trust Limited, and Clapham Park Homes)
- 2008 – 2012, Chief Executive Moat Homes Limited
- Chief Executive City West Homes
- Executive Director of Remploy
- Business Engineering Manager, Tate and Lyle
- Manufacturing Improvement Project Manager, ICI
- Process Research / Development Manager, ICI
- Venture Manager, ICI
- Commissioning Manager, ICI

Charles Beaumont
Appointed June 2013

Responsibilities:

- Independent Director
- Audit Committee
- Nominations Committee
- Remuneration Committee
- Charitable Funds Forum
- Liaison with Governors
- Assurance Framework Implementation

Experience, Expertise and Other Interests:

- Chartered Accountant
- Director of Tax Ford Britain to 2010
- Working party advisor to UK government on tax reform Associate Non Executive Director NHS North East London
- Non Executive Director Barking and Dagenham NHS Trust

Jane Crame
Appointed June 2013

Responsibilities:

- Independent Director
- Nominations Committee
- Remuneration Committee
- Charitable Funds Forum
- Equality & Diversity
- Liaison with Governors
- Assurance Framework Implementation

Experience, Expertise and Other Interests:

- Chartered Accountant
- Teacher of Mathematics (PGCE)
- Bursar of large co-educational 3-18 Independent School
- Finance Director (Advertising Industry)

Dermot McCarthy, Trust Secretary

Responsibilities:

- Support to Board of Directors
- Support to Council of Governors
- Governance
- Liaison with Monitor
- Legal Services
- Commercial Insurance

Experience, Expertise and Other Interests:

- Chartered Secretary (ICSA)
- Master of Arts (International Governance)
- Masters degree in Business Administration
- BA (Hons) Modern English Studies

Attendance at Board meetings

		Note	24/04/2013	22/05/2013	26/06/2013	31/07/2013	25/09/2013	27/11/2013	29/01/2014	26/03/2014	No of Meetings Attended	Out of
Chris	Paveley		1	1	1	1	1	1	1	1	8	8
Charles	Abel Smith	to 30/09/13	1	0	1	1	1	N/A	N/A	N/A	4	5
Charles	Beaumont	from 01/10/13	N/A	N/A	N/A	N/A	N/A	1	1	1	3	3
Ray	Cox		1	1	1	1	1	1	1	1	8	8
Jane	Crame	from 01/10/13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0
John	Gilbert		1	1	1	1	1	1	1	1	8	8
Brian	Johnson		1	0	1	1	1	1	1	1	7	8
Sarah	Phillips	to 30/09/13	1	1	1	1	1	N/A	N/A	N/A	5	5
Andrew	Geldard		1	1	1	1	1	1	1	1	8	8
Dr Malte	Flechtner		1	1	1	1	1	0	1	1	7	8
Paul	Keedwell		1	1	1	1	0	1	1	1	7	8
Geoff	Scott	to 30/09/13	1	1	1	1	1	N/A	N/A	N/A	5	5
Rick	Tazzini		1	1	1	1	1	1	1	1	8	8
Lisa	Anastasiou		1	1	1	1	1	1	1	1	8	8
Mike	Chapman		1	1	1	0	1	1	1	1	7	8
Vince	McCabe		1	1	1	1	1	1	1	1	8	8

Attendance at Meetings of the Council of Governors

Attendance at Meetings of the Council of Governors			Note	11/06/2013	AGM (18/09/12)	08/10/2012	10/12/2012	11/03/2013	No of Meetings Attended	Out of
Chairman	Chris	Paveley		1	1	1	1	1	5	5
Non Executive Directors	Charles	Abel Smith	to 30/09/13	0	1	N/A	N/A	N/A	1	2
	Charles	Beaumont	from 01/10/13	N/A	N/A	1	1	1	3	3
	Ray	Cox		1	1	1	1	1	5	5
	Jane	Crame	from 01/10/13	N/A	N/A	1	N/A	N/A	1	1
	John	Gilbert		1	1	1	1	1	5	5
	Brian	Johnson		1	0	1	0	1	3	5
	Sarah	Phillips	to 30/09/13	1	1	N/A	N/A	N/A	2	2
Chief Executive	Andrew	Geldard		1	1	1	1	1	5	5
Executive Directors	Dr Malte	Flechtner		1	1	1	1	1	5	5
	Paul	Keedwell		1	1	1	1	0	4	5

	Geoff	Scott	to 30/09/13	1	1	N/A	N/A	N/A	2	2
	Rick	Tazzini		1	1	1	1	0	4	5
Other Directors	Lisa	Anastasiou		1	1	1	1	1	5	5
	Mike	Chapman		1	1	1	0	1	4	5
	Vince	McCabe		1	1	1	0	0	3	5

The Council of Governors

The Council of Governors works with the Board of Directors, which is responsible for the day-to-day running of the Foundation Trust, to ensure that the Foundation Trust delivers high quality care and plays a role in helping to set the overall direction of the organisation. Councils of governors are expected to focus on ensuring that NHS Foundation Trusts listen and respond to the needs and preferences of stakeholders, especially local communities.

Governors' statutory roles include:

- holding the Non-Executive Directors individually and collectively to account for the performance of the board of directors;
- representing the interests of the Foundation Trust members and of the public;
- appointing, removing and deciding the terms of office of the chair and other non-executive directors;
- approving the appointment of the chief executive;
- receiving the annual report and accounts, and auditor's report, at a general meeting;
- appointing and removing the auditor;
- approving increases to non-NHS income of more than 5% of total income;
- approving acquisitions, mergers, separations and dissolutions;
- approving changes to the Trust's constitution; and
- expressing a view on the Board's plans for the NHS Foundation Trust, in advance of the plan's submission to Monitor.

The Board of Directors is responsible for the day-to-day running of the Trust and is made up of both executive, for example the Chief Executive, and Non-Executive Directors.

The council of governors does not have an operational role. Governors are responsible primarily for holding the Non-Executive Directors individually and collectively to account for the performance of the Board

of Directors and for representing the interests of the Foundation Trust members and of the public.

The minutes of meetings of the Council are considered at the following Board meeting in public. The Council is consulted on the development of forward plans for the Trust and approves the Trust's membership strategy.

The Council has four regular meetings in public every year which are publicised via the Trust's website.

There are 47 governors in total. 29 of these are from our 10 public constituencies: Braintree, Colchester, Chelmsford, Epping Forest, Harlow, Maldon, Tendring and Uttlesford (all in north Essex), plus south Essex and Suffolk. There are 9 elected Staff Governors and 9 appointed Governors representing partner organisations.

Trust Governors have opportunities to meet their constituents and the public at events organised by the Trust throughout the year. Any Trust member age 16 or over can apply to become a Governor when a vacancy becomes available.

Members are encouraged to communicate with Governors through the Trust membership office by telephone – 01245 546400, by email: foundationtrust@nepft.nhs.uk or in writing to the Trust Secretary at the address below.

Trust Secretary, North Essex Partnership NHS Foundation Trust
Stapleford House, 103 Stapleford Close, Chelmsford, Essex, CM2 0QX

Council of Governors Attendance Record

First Name	Last Name	Meeting 11/06/13	APM 18/09/13	Meeting 08/10/13	Meeting 10/12/13	Meeting 11/03/14	No of Meetings Attended	Out of
Ron	Abbott	1	1	1	1	1	5	5
Lloyd	Armstrong	1	1	1	0	0	3	5
David	Bamber	0	1	1	1	1	4	5
Angela	Barnes	1	0	0	N/A	N/A	1	3
Cllr Graham	Butland	0	1	1	0	1	3	5
Peter	Cheng	0	1	1	1	1	4	5
Benita	Christie	1	1	0	0	1	3	5
Janet	Crane	1	0	1	1	0	3	5
Mark	Dale	1	1	0	1	0	3	5
Pippa	Ecclestone	1	1	1	1	1	5	5
Linda	Embleton	0	0	0	0	0	0	5
David	Fairweather	1	0	0	0	1	2	5
Hamid	Farahi	0	0	1	1	0	2	5
Pavel	Fridrich	1	1	1	0	0	3	5
Jane-Marie	Hardy	0	0	1	0	0	1	5
Michael	Hartless	0	N/A	N/A	N/A	N/A	0	1
Sheila	Jackman	1	1	1	1	1	5	5
Chuda	Karki	1	1	1	0	1	4	5
Pauline	Keeling	1	1	1	0	0	3	5
Keith	Lever	1	1	1	1	1	5	5
Jayne	Lingard	0	0	0	0	1	1	5
Mary	Martin	1	0	1	1	1	4	5
Mark	McGrath	1	0	1	0	0	2	5
James	McQuiggan	1	1	1	1	0	4	5
Nick	Ntiako Brown	1	1	0	0	0	2	5
Andy	Payne	0	0	0	N/A	N/A	0	3
Linda	Pearson	1	1	1	1	0	4	5
David	Pickles [1]	1	1	1	1	1	5	5
Mary	Power	1	1	1	0	1	4	5
Hazel	Ruane	1	0	1	1	1	4	5
Paul	Sergent	N/A	0	0	1	1	2	4
Nazir	Shivji	1	1	1	1	1	5	5
Andrew	Smith	1	1	1	1	1	5	5
Brian	Spinks [2]	1	1	1	1	1	5	5
Lucy	Taylor	1	1	1	1	1	5	5
Cathy	Trevaldwyn	1	1	1	1	1	5	5
Professor Graham	Underwood	N/A	N/A	1	0	1	2	3
Clive	White	1	1	1	1	1	5	5
Russell	White	0	1	1	1	1	4	5
Marie	Whitfield	1	0	0	N/A	N/A	1	3
David	Williams	0	0	1	0	1	2	4

[1] Lead Governor (to 11 March 2014)

[2] Deputy Lead Governor

Audit Committee Annual Report 2013/14

1. Introduction

This annual report which is in respect of the work of the Committee in 2013/14, follows guidance contained in the NHS Audit Committee Handbook, and is divided into six sections reflecting the key duties of the Committee.

The Audit Committee is established by the Board with approved terms of reference that are set out in the appendix.

2013/14 has been a year of change for the Audit Committee. The membership of the Committee has changed with Charles Beaumont joining and Charles Abel Smith leaving, and also during the year the Trust appointed Baker Tilly wef from 1 April 2014 (replacing Deloittes) as its Internal Auditor.

I am pleased to say that 2013/14 has been a successful and interesting year and through its activities the Committee has I believe made an effective contribution to the quality of the Trust's internal governance system by scrutinising and challenging, and also by encouraging and supporting the Executive. It is pleasing to note that in the opinion of its external regulators (Monitor and CQC), the Trust continues to achieve high performance in both the quality and safety of its services and in the financial management of its affairs.

The Committee is independent of the Executive and therefore to be effective it must establish a working relationship with the Executive that is based on mutual respect and understanding. One of the major strengths of the Committee is the way in which the executive directors and staff support the work and activities the Committee carries out.

The Committee consists of three non executive directors and it has met on five occasions during the year. The membership of the Committee and the number of meetings attended by each member is set out below.

Name	Role	Meetings attended	Out of
Ray Cox	Chairman	5	5
Charles Abel Smith (to 04th October 2013)	Non Executive Director	2	3
John Gilbert	Non Executive Director	5	5
Charles Beaumont wef October 2013	Non Executive Director	2	2

During 2014/15 there will be two further changes to the membership of the Audit Committee due to the departure of John Gilbert (31 May 2014) and myself (30 September 2014) as Non Executive Directors. We have both been long term members and it has been a privilege and pleasure for us both to serve on the Committee.

2. Governance, risk management and internal control.

- The Committee reviewed and scrutinised various disclosure statements, including the Head of Internal Audit's opinion on internal control, the external auditor's opinion on the financial statements and Quality Accounts, and other appropriate assurances, including going concern. The Committee considered and reviewed the Chief Executive's Annual Governance Statement (AGS) and concluded that it is consistent with these disclosure statements and therefore the Committee recommended Board approval of the AGS.
- The Committee has reviewed the Board Assurance Framework, and consider it to be fit for purpose. The Committee also

reviewed the risk management strategy and the extent it is embedded in the organisation. Using evidence and assurance from the Risk and Governance Executive and the Internal Auditor (Deloittes), the Committee is satisfied that adequate systems for risk management are in place and will continue to improve.

- The Committee reviewed the Standing Orders of the Trust and is satisfied that appropriate controls and regulation for the conduct of business are in place.
- The Committee always includes a standing item on its meeting agenda to consider issues of a legal or regulatory nature.
- The Committee undertook a planned review of the Reservation of Powers to the Board of Directors and Scheme of Delegation and the Standing Financial Instructions and made recommendations to the Board regarding amendments.
- The chairman makes a verbal report to the Board of Directors that follows each meeting of the committee. Once approved minutes are brought to the subsequent meeting of the Board of Directors.

3. Internal Audit

Internal audit services were provided by Deloitte & Touche Public Sector Internal Audit Ltd until the 31 March 2014. On 31st January 2014, the Deloitte Group completed the sale of Deloitte & Touche Public Sector Internal Audit Limited to Mazars. The new company is known as Mazars Public Sector Internal Audit Ltd a wholly owned subsidiary of Mazars LLP.

Throughout the year the Committee has worked effectively with them to assess, scrutinise and strengthen internal control processes and levels of assurance. A summary of this work is set out below.

3.1 The Internal Audit Plan

The work of the Internal Auditor is based on an agreed a strategic audit plan which is prioritised through an audit needs and risk assessment process aimed at identifying potential areas of highest risk. Each audit subject is reviewed and is assigned an assurance level by the Internal

Auditor. Recommendations where appropriate are agreed with management, and these are assigned a priority rating as follows:

- Priority One Recommendations – Major issue for the attention of senior management and the Audit Committee.
- Priority Two Recommendations – Important issue to be addressed by management in their areas of responsibility.
- Priority Three Recommendations – Minor issue resolved on site for local management.

For each audit subject report, the Internal Auditor determines an assurance level based on his opinion using the following criteria:

- Good Assurance – There is a sound system of control designed to achieve the system objectives and the controls are being consistently applied.
- Adequate Assurance – While there is a basically sound system, there are weaknesses which put some of the system objectives at risk, and/or there is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.
- Limited Assurance – Weaknesses in the system of controls are such as to put some of the system objectives at risk, and/or the level of non-compliance puts the system objectives at risk.
- Nil Assurance – Control is generally weak, leaving the system open to significant error or abuse, and/or significant non-compliance with basic controls leaves the system open to error or abuse.

Details of the internal audit report outcomes for the 2013/14 audit plan are summarised below:

Audit Subject	**Assurance Level**
Asset Management	Adequate
Financial Ledger	Adequate
Order and Receipt of Goods	Adequate
Payroll	Adequate
Financial Systems and Key Controls (5 opinions of adequate)	Adequate
Assurance Framework and Risk Management	Adequate
Quality Accounts	Adequate
Essential Standards of Quality & Safety	Adequate
Governance	Good
Patient Experience	Limited
Incident Reporting	Adequate
Payment by Results and Reference Costing	Adequate
Doctors and Additional Payments	Limited
Corporate Records Management	Limited
Pharmacy	Limited
Medical Records	Limited
IM&T Systems	N/A

In conjunction with these reports the Committee has:

- Reviewed and considered the internal audit plan and recommended approval to the Board. The Committee is satisfied the internal audit plan and work is based on an effective strategy and risk assessment, and therefore the audit subjects are effectively focused reflecting the Trust's priorities. The internal audit plan is based on a total of 158 days work per year and covers a three year strategic audit plan period.

- Considered and scrutinised all reports from internal audit and monitored the implementation of recommendations made. The Committee is assured that management action is appropriately monitored and managed and that material interim risks during the implementation phase are managed by the executive directors.

- Noted a general and consistently satisfactory performance in the implementation of recommendations by the Executive. At the same time the Committee has been very strict in the attention it pays to internal audit recommendations and in particular to priority one recommendations. It should be noted that due to focusing the internal audit plan on areas of risk, it is appropriate that weaknesses are exposed and recommendations are made, in order to improve controls, safety and quality of work.

3.2 Management of Internal Audit

- The Committee received from the Internal Auditor regular performance indicators and is satisfied that the work of internal audit is efficiently and effectively carried out.
- The Committee is satisfied that based on advice from internal and external audit and management, the base number of days of internal audit work at 158 per year is adequate.
- The Committee received and reviewed the Internal Auditor's Annual Opinion on Internal Control which provided a significant level of assurance.

3.3 Internal Audit and Counter Fraud Services retendering

In 2013, the Trust established a small working group, comprising two non-executive directors, the Director of Resources, Trust Secretary and the Associate Director of Finance to retender the Trust's internal audit and counter fraud service. The result of the retendering exercise was that the Board awarded the contract to Baker Tilly with effect from the 1 April 2014, for a three year period with an option (exercisable by the Trust) to extend for a further year. During the latter part of the year 2013/14 Mazars and Baker Tilly have worked together to ensure a smooth change over, and the Committee is confident there will be a continuation of excellent internal audit and counter fraud services provided.

4. External Audit

Throughout the year the Committee has worked effectively with Grant Thornton. The work, advice and support provided by Grant Thornton is most satisfactory and highly valued. The Committee is confident they will continue to provide an excellent audit service into the future and a report to this effect has been presented to the Council of Governors. The External Auditor has direct access to the Chairman of the Trust, Chief Executive, and Director of Resources. The Audit Committee acts as their formal lines of communication. The Committee has:

- Received regular updates and reports from the External Auditor.
- Received the draft audit letter, and has been assured that appropriate action has been taken by management.
- Considered and reviewed the plans for auditing the 2013/14 accounts, and discussed topical auditing and accounting standards and solutions that have arisen.
- Reviewed in conjunction with the Director of Resources the draft accounts and annual report, the reports and comments of the External Auditor (unqualified audit opinion) and assisted in resolving all matters arising from the annual audit.

5. Counter Fraud

The activities of the local counter fraud specialist (LCFS) were provided by Deloitte & Touche Public Sector Internal Audit Ltd in 2013/14. They have reported regularly to the Committee, on progress in completing the agreed annual plan for counter fraud work and the Trust's performance in managing and minimising the risk of fraud.
The Committee is satisfied there continues to be satisfactory progress in the arrangements for avoiding, minimising and managing the risk of fraud, and also in the arrangements for identifying and taking action on actual cases of fraud.
The counter fraud plan is based on 50.5 days planned work per year plus additional reactive days as required for investigations. For 2013/14, 48 days of planned work were delivered, plus a further 38 days for such investigations.

6. Clinical Audit

The Risk and Governance Executive has the responsibility of agreeing and supervising the programme of clinical audit. As a key component of the assurance agenda the Audit Committee satisfies itself that clinical audit processes and outcomes meet recommended standards. The Committee receive an annual update summarising the methodology, programme and performance and outcomes of clinical audit, and this is considered in detail. In addition at the annual joint meeting of the Audit Committee and the Risk and Governance Executive, the plans and priorities in clinical audit are discussed. Through these means the Committee is assured standards are met.

A brief summary of the year's work for 2013/14 in shown below:

- No of clinical audits planned in year – 27
- No carried forward to 2014/15 - 3
- No of limited level of assurance - 1
- No of adequate level of assurance - 15
- No of good level of assurance - 8

7. Management

The Committee receives continuous commitment and assistance from management. In particular the Director of Resources and his Secretary, the Trust Secretary, and other members of staff who attend meetings of the Committee, have all played a vital role in supporting the work of the Committee.

An important part of the Committee's role is to challenge and test the processes that underpin the Trust's Assurance Framework, and this is made more effective by the cooperation and participation of staff.

The Committee plays an important role in reviewing and scrutinising the annual financial statements prepared by the Director of Resources before submission to the Board for adoption. The production of the accounts and the timing of the approval process are extremely challenging, requiring the highest levels of professionalism and

commitment by the staff involved. Special meetings of the Committee are arranged as required to meet deadlines, and it is necessary for members of the Committee to have a ready understanding of the accounting standards and other technical issues involved so that an assured recommendation is submitted to the board. This process has again worked very well in 2013/14, and the ready advice and support of the Associate Director of Finance and his staff to members of the Audit Committee is highly valued and fully appreciated.

The Committee is satisfied the Whistle-blowing Policy operates effectively and that staff are confident regarding its use. Arrangements are in place to enable the Committee to receive periodic reports so that its continued effectiveness can be assessed.

The Committee receives regular reports to review treasury management including compliance with the Trust's policy. In addition it approves and scrutinises compliance with accounting policies, and the Asset Management Policy. The Committee has monitored the implementation of REMEDY (clinical IT system) and progress towards the disposal of Severalls land. The Committee also commissioned a review by Deloittes of the Governance compliance of the ongoing Derwent Centre capital project.

The Committee maintains an overview of the Charitable Funds Accounts.

8. Effectiveness of the Committee

Each year the Committee undertakes a self assessment of its effectiveness and uses the check lists contained in the NHS Audit Committee Handbook and the Audit Commission publication 'Taking it on Trust'. This ensures the Committee maintains its compliance with good practice.

Members of the Committee attend relevant seminars and other training opportunities, and the Chairman attends various regional and national Audit Chair meetings to establish links and discuss issues and exchange ideas and practice.

The Director of Resources provides copies of relevant publications and discussion documents and constantly draws the attention of the Committee to future changes in auditing and governance practice.

9. Conclusion

The Committee is of the opinion that this Annual Report is consistent with the draft Annual Governance Statement, the Head of Internal Audit Opinion, and the declarations and opinion of the External Auditor. The Committee considers there are no material matters that have not been disclosed appropriately.

On a personal note, this is my final Audit Committee Annual Report and therefore I would like to express my sincere thanks to all those who have helped and contributed to the Committee over the years, and wish the Committee every success for the future.

Ray Cox, Chairman Audit Committee

AUDIT COMMITTEE OF THE BOARD OF DIRECTORS

TERMS OF REFERENCE

1. CONSTITUTION

The Board of Directors of the Trust ('the Board') has resolved to establish a committee of the Board to be known as the Audit Committee ('the Committee') which shall have the following terms of reference but no executive powers save as specifically delegated to it by these terms of reference.

2. DUTIES OF THE COMMITTEE

2.1 Governance, risk management and internal control

The Committee shall ensure that the Trust establishes and maintains effective systems of integrated governance**,** risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that support the achievement of the organisation's objectives, and shall bring to the attention of the Chief Executive any concern which it may have regarding those systems.

In particular, the Committee will satisfy itself as to the adequacy and effectiveness of the Trust's:

- internal financial controls
- risk and control related disclosure statements and declarations of compliance (in particular the Statement on Internal Control), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness

of the management of principal risks and the appropriateness of the above disclosure statements

- underlying assurance processes supporting the preparation and issue of the Trust's Quality Accounts
- policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Local Counter Fraud Service
- arrangements by which staff of the Trust may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, the objective being to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action

In carrying out this work the Committee will:

- ensure that an effective Assurance Framework has been established to guide its work and that of the audit and assurance functions that report to it.
- utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions
- seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, internal financial control, risk management and other internal controls, together with indicators of their effectiveness.

2.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets the requirements of the *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the Committee, the Chief Executive and the Board. This will be achieved by:

- considering the effectiveness of the internal audit service, and the cost of the audit, including any question of resignation or dismissal;
- considering and approving the internal audit strategy, operational plan and more detailed program of work, ensuring that this is consistent with the audit needs of the organization as identified in the Assurance Framework
- considering the major findings of internal audit work and management's responses
- ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- undertaking a market-testing exercise for the appointment of an Internal Auditor at least once every five years
- the holding of a private meeting with the Head of Internal Audit at least once a year.

2.3 External Audit

The Committee shall:

- discuss and agree with the External Auditor, before the audit commences, the nature and scope of the audit as

set out in the proposed Annual Plan, and ensure coordination, as appropriate, with other external auditors in the local health economy;

- discuss with the External Auditors their local evaluation of audit risks and assessment of the Trust and the associated impact on the audit fee

- review all External Audit reports, the Annual Governance report and the Auditor's report on the Financial Statements before submission to the Board and any work outside the annual audit plan, together with the appropriateness of management responses

- assess the External Auditor's work and fees on an annual basis to ensure that the work is of sufficiently high standard and that the fees are reasonable

- make recommendations to the Council of Governors, in relation to the appointment, re-appointment or removal of the External Auditor, and approve the remuneration and terms of engagement of the External Auditor

- review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements

- in considering the engagement of the External Auditor to supply non-audit services, take into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm in accordance with the Monitor's *Audit Code for NHS Foundation Trusts* which requires the prior approval of the Council of Governors

- hold a private meeting with the External Auditor at least once a year

2.4 Local Counter Fraud Specialist

The Committee shall ensure that there is an effective local counter fraud function established by management that meets the requirements set out in the 'General Conditions' section of the NHS Standard Contract 2013/14.

The Committee shall:

- consider the appointment of the Local Counter Fraud Specialists (LCFS), the LCFS' scope and any question of resignation and dismissal

- consider and approve the counter fraud strategy and the annual workplan, ensuring that this is consistent with the needs of the organisation

- monitor the performance of the LCFS in the provision of both reactive and proactive fraud work in line with the requirements set out in the 'General Conditions' section of the NHS Standard Contract regarding fraud and corruption

- review LCFS reports, consider the major findings of fraud investigations, and management's response, and ensure co-ordination between the LCFS, internal and external auditors.

2.5 Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to:

- any reviews by Department of Health arms' length bodies regulators inspectors or professional bodies with responsibility for performance

- the work of other groups teams or committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work, particularly in the fields of clinical governance (including clinical audit) and risk management.

- the Committee shall be responsible for the monitoring compliance with the Trust's Treasury Management Policy and the performance of the Trust's treasury management activities. The Committee will approve the Treasury Management Policy and any subsequent changes to the Treasury Management Policy.

2.6 Financial Reporting

The Committee shall satisfy itself as to the integrity of the financial statements of the Trust and any formal announcement relating to the Trust's financial performance including any significant financial reporting judgments contained in them.

The Committee shall also ensure that the systems for financial reporting to the Board, including those of budgetary control, are sound and effective and provide appropriate and accurate information to the Board.

The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas, and significant adjustments resulting from the audit.
- the Letter of Representation.

2.7 Quality Account

The Committee needs to satisfy itself that:

- the data used is reported accurately in terms of reliability and interpretation
- the content of the Quality Account is a fair representation of the services provided by the Trust including issues of concern to the Trust's stakeholders and encompasses planned improvements.

3. MEMBERSHIP

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust. Its membership shall consist of not less than three independent non-executive directors and one of the members shall have recent and relevant financial experience. A quorum shall be two members. The Board will appoint one of the members Chair of the Committee. The Chairman of the Trust shall not be a member of the Committee.

4. ATTENDANCE

The following persons shall attend meetings of the Committee:

- The Director of Resources or his or her deputy, and
- appropriate Internal Audit, the Local Counter Fraud Specialist (LCFS) and External Audit representatives
- any executive director or officer of the Trust asked by the Committee to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director or officer
- the Chief Executive when requested, to discuss the internal audit plan, the process for assurance that supports the Statement of Internal Control and the annual Financial Statements when presented
- the Trust Secretary to provide appropriate support to the Committee.

5. FREQUENCY OF MEETINGS

Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request the Chair of the Committee to call a meeting if they consider that one is necessary. The Chair of the Committee or any two members of the Committee may also call a meeting at any time. Committee members shall also meet once a year with no other person present**.**

6. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee of the Trust or from any provider of goods or services to the Trust and all employees of the Trust are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. REPORTING

The minutes of Committee meetings shall be formally recorded by the Trust Secretary and submitted to the Board. The Chair of the Committee shall draw the Board's attention to issues that the Committee feel require disclosure to the full Board, or executive action.

The Committee will report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embedding of risk management in the organisation, the integration of governance arrangements and the appropriateness of all declarations of compliance.

The Committee will, when appropriate issues arise, make a report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

The Committee shall also report to the Council of Governors in relation to the performance of the External Auditor including detail of the quality

and value of their work, the timeliness of reporting and their fees, to enable the Council to consider whether or not to reappoint them.

The Terms of Reference of the Committee, including its role and the authority delegated to it by the Board and by the Council of Governors, shall be publicly available and a separate section of the annual report shall describe the work of the Committee in discharging these responsibilities.

8. ANNUAL REVIEW AND SELF ASSESSMENT

These Terms of Reference shall be reviewed annually by the Committee and the Board. The Audit Committee will also conduct an annual self-assessment of its own performance and effectiveness.[1]

[1] These Terms of Reference are based on the recommendations contained in the NHS Audit Committee Handbook published by the Healthcare Financial Management Association (HFMA) for the Department of Health, and the NHS Foundation Trust Code of Governance published by the Independent Regulator.

Nominations Committee Report 2013/14

1. Membership - updated

Name	Role	Meetings Attended	Out of
Chris Paveley	Chairman	1	1
Charles Beaumont	Non Executive Director	1	1
Ray Cox	Non Executive Director	0	1
Jane Crame[1]	Non Executive Director	0	1
John Gilbert	Non Executive Director	1	1
Brian Johnson	Non Executive Director	1	1
Andrew Geldard[2]	Chief Executive	0	1

1 On leave of absence

2 Represented by Rick Tazzini, Director of Resources

2. Committee Duties and Business

The Nominations Committee consists of the above named Non-Executive Directors. The duties of the Nominations Committee centre on keeping the size, structure, and composition of the Board of Directors under regular review and making recommendations to the Chairman of the Trust regarding the Executive Directors, and to the Council of Governors regarding the Non Executive Directors, for any change which the Committee may consider to be desirable. During the year 1 April 2013 to 31 March 2014 the Nominations Committee of the Board of Directors met on one occasion as described below. In the course of the processes which lead to the appointment of two new Non Executive Directors in June 2013 (taking up post on 1 October 2013) and a further two Non Executive Directors in March 2014 (taking up post from 01 June 2014) members of the committee also liaised with members of the Remuneration and Appointments Committee of the Council of Governors to consider the composition of the interview panel, the shortlisting of applicants and the selection of the successful candidates.

3. Meeting

The focus of the meeting held on 11 October 2013 was to review the successful process for the appointment of two Non Executive Directors and to consider feedback from the Remuneration and Appointments Committee of the Council of Governors (RAC) in planning the next round of Non Executive recruitment and selection. This included detailed aspects of the job description and the structure of the selection process including a draft timetable.

On the 14 November 2013 the RAC met to agree the process for the appointments of two Non Executive Directors to fill the vacancies arising from the impending departure of John Gilbert and Ray Cox in 2014. At this meeting the RAC considered the recommendations from the Nominations Committee of the Board of Directors with regard to the role description and person specification.

After due consideration the RAC took the decision not to appoint professional executive search advisers. Lisa Anastasiou, Director of Workforce and Development acted as adviser to the RAC throughout the recruitment and selection process.

The appointment process commenced in November 2013 with the positions advertised in the local press, Trust and Institute of Directors websites and NHS Jobs. A total of 39 applications were received with longlisting and shortlisting processes undertaken by members of the RAC, supported by Lisa Anastasiou and Brian Johnson, Non Executive Director (long list stage). Nine longlisted candidates attended a preliminary interview with Rob Peters, former Non Executive Director of South Essex PCT, who performed the role of independent adviser to the Trust. Longlisted candidates also met informally with the Chairman.

The shortlist comprised of 5 candidates who attended for interview on 30 January 2014. The interview panel was supported by Janet Wood who holds the position of Non Executive Director and Vice Chair at South Essex Partnership NHS Foundation Trust. Governors were in the majority as panel members.

The interview panel was unanimous in its decision that two of the five candidates were appointable; Amanda Sherlock and Peter Little.

On the same day as the interviews, shortlisted candidates were invited to meet and lead discussions with Governors, Executive Directors and

Senior Managers. The Chair of the stakeholder group, Ray Cox, provided feedback on the group's view of the candidates against set criteria to the RAC. Having received the feedback the RAC was also unanimous in its view that both candidates should be recommended to the Council of Governors for appointment.

The RAC and the Nominations Committee led a thorough and robust recruitment and selection process and has identified two individuals with the right skills and experience to successfully fulfil the role of Non Executive Director.

Amanda Sherlock and Peter Little were each appointed by the Council of Governors at their meeting held on 11 March 2014 for a period of 3 years commencing on 01 June 2014 on the same terms and conditions as the other Non Executive Directors who do not chair the Audit Committee.

Remuneration Committee & Remuneration Report

The Remuneration Committee met on 24th April 2013 to review Directors remuneration for the period 2013/14.

The work of the Committee receives professional support from the Director of Workforce and Development or her deputy. The Committees' terms of reference are reviewed annually.

The role of the Remuneration Committee is to ensure remuneration levels are appropriate. The Committee considers benchmarking information from different sources including the annual Foundation Trust Network executive director salary survey and the remuneration of Directors in neighbouring NHS organisations. The Committee also considers the national picture in terms of any pay restraints in the public sector and their impact on pay increases or freezes that affect the whole workforce.

At its meeting on 24 April 2013, the Committee considered and agreed a proposal to award the Executive Directors a 1% cost of living increase in keeping with the pay award to all NHS staff for the same period. The Committee also considered benchmarking information as described above.

The median remuneration of the Trust's staff and the midpoint of the Chief Executives remuneration, as the highest paid Director is represented as a ratio of 1:8.

The Remuneration Committee has convened a meeting on 24 April 2013 to review remuneration for 2013/14.

Andrew Geldard
Chief Executive

The membership of the Remuneration Committee during the year has been as follows:

Table 1:

Name	Role	Meetings attended
Sarah Phillips	Non Executive Director Committee, Chairman	1
Chris Paveley	Trust Chairman	1
Charles Abel Smith	Non Executive Director;	1
Ray Cox	Non Executive Director;	1
John Gilbert	Non Executive Director	1
Brian Johnson	Non Executive Director	1

Details of senior employees' remuneration, including pension entitlements and expenses can be seen in the annual accounts, see table below:

Table 2:

Year Ended 31 March 2014

Name and Title	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (to the nearest £100)	Annual real increase in pension at age 60 (bands of £2,500)	Pension value at 31 March 2014 (bands of £5,000)	Annual real increase in related lump sum at age 60 (bands of £2,500)	Lump sum value at 31 March 2014 (bands of £5,000)	Cash equivalent transfer value at 31 March 2013 £'000	Annual real increase in cash equivalent transfer value £'000	Cash equivalent transfer values at 31 March 2014 £'000	Total
C Paveley, Chairman	40,001-45,000	-	-	-	-	-	-	-	-	-	40,001-45,000
R Cox, Non-Executive Director and Deputy Chairman	10,001-15,000	-	-	-	-	-	-	-	-	-	10,001-15,000
C Abel Smith, Non-Executive Director[1]	5,001-10,000	-	100	-	-	-	-	-	-	-	5,001-10,000
J Gilbert, Non-Executive Director	10,001-15,000	-	300	-	-	-	-	-	-	-	10,001-15,000
S Phillips, Non-Executive Director[2]	5,001-10,000	-	0	-	-	-	-	-	-	-	5,001-10,000
B Johnson, Non-Executive Director	10,001-15,000	-	-	-	-	-	-	-	-	-	10,001-15,000
C Beaumont, Non-Executive Director [3]	5,001-10,000	-	-	-	-	-	-	-	-	-	5,001-10,000

Name and Title	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (to the nearest £100)	Annual real increase in pension at age 60 (bands of £2,500)	Pension value at 31 March 2014 (bands of £5,000)	Annual real increase in related lump sum at age 60 (bands of £2,500)	Lump sum value at 31 March 2014 (bands of £5,000)	Cash equivalent transfer value at 31 March 2013 £'000	Annual real increase in cash equivalent transfer value £'000	Cash equivalent transfer values at 31 March 2014 £'000	Total
J Crame, Non-Executive Director[4]	0-5,000	-	-	-	-	-	-	-	-	-	0-5,000
A Geldard, Chief Executive	150,001-155,000	-	700	2,501-5,000	55,001-60,000	7,501-10,000	165,001-170,000	979	80	1,080	160,001-165,000
M Flechtner, Medical Director [5]	190,001-195,000	-	300	2,501-5,000	30,001-35,000	7,501-10,000	95,001-100,000	573	69	654	201,000-205,000
P Keedwell, Director of Operations and Nursing	110,001-115,000	-	6,100	0-2,500	40,001-45,000	2,501-5,000	125,001-130,000	711	37	764	125,001-130,000
G Scott, Director of Strategy [6]	50,001-55,000	-	1,600	-	-	-	-	-	-	-	50,001-55,000
R Tazzini, Director of Resources	115,001-120,000	-	3,800	0-2,500	60,001-65,000	-	-	613	22	648	125,001-130,000
L Anastasiou, Director of Workforce and Development	95,001-100,000	-	200	0-2,500	15,001-20,000	2,501-5,000	45,001-50,000	214	23	241	105,001-110,000
M Chapman, Director of Strategy (as of October 2013)	95,001-100,000	-	700	0-2,500	30,001-35,000	2,501-5,000	95,001-100,000	570	32	615	105,001-110,000
V McCabe, Director of Commercial and Service Integration (as of October 2013)	95,001-100,000	-	11,500	(2,500)-0	35,001-40,000	(7,499)-(5,000)	110,001-115,000	683	(16)	682	110,001-115,000

Year Ended 31 March 2013

Name and Title	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (to the nearest £100)	Annual real increase in pension at age 60 (bands of £2,500)	Pension value at 31 March 2013 (bands of £5,000)	Annual real increase in related lump sum at age 60 (bands of £2,500)	Lump sum value at 31 March 2013 (bands of £5,000)	Cash equivalent transfer value at 31 March 2012 £'000	Annual real increase in cash equivalent transfer value £'000	Cash equivalent transfer values at 31 March 2013 £'000	Total
M St Aubyn, Chairman [7]	25,001-30,000	-	0	-	-	-	-	-	-	-	25,001-30,000
C Paveley, Chairman [8]	10,001-15,000	-	200	-	-	-	-	-	-	-	10,001-15,000
R Cox, Non-Executive Director and Deputy Chairman [9]	15,001-20,000	-	200	-	-	-	-	-	-	-	15,001-20,000
C Abel Smith, Non-Executive Director	10,001-15,000	-	0	-	-	-	-	-	-	-	10,001-15,000
J Gilbert, Non-Executive Director	10,001-15,000	-	400	-	-	-	-	-	-	-	10,001-15,000
S Phillips, Non-Executive Director	10,001-15,000	-	0	-	-	-	-	-	-	-	10,001-15,000
B Johnson, Non-Executive Director [10]	10,001-15,000	-	500	-	-	-	-	-	-	-	10,001-15,000
A Geldard, Chief Executive	145,001-150,000	-	800	0-2,500	50,001-55,000	0-2,500	155,001-160,000	904	28	979	155,001-160,000
M Flechtner, Medical Director [5]	190,001-195,000	-	-	0-2,500	25,001-30,000	5,001-7,500	85,001-90,000	500	47	573	200,001-205,000
P Keedwell, Director of Operations and Nursing	105,001-110,000	-	3,200	2,501-5,000	40,001-45,000	10,001-12,500	120,001-125,000	595	85	711	115,001-120,000
G Scott, Director of Strategy [6]	95,001-100,000	-	1,210								95,001-100,000

Name and Title	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (to the nearest £100)	Annual real increase in pension at age 60 (bands of £2,500)	Pension value at 31 March 2013 (bands of £5,000)	Annual real increase in related lump sum at age 60 (bands of £2,500)	Lump sum value at 31 March 2013 (bands of £5,000)	Cash equivalent transfer value at 31 March 2012 £'000	Annual real increase in cash equivalent transfer value £'000	Cash equivalent transfer values at 31 March 2013 £'000	Total
R Tazzini, Director of Resources	110,001-115,000	-	3,900	(5,000)-(2,501)	55,001-60,000	-	-	597	(15)	613	115,001-120,000
L Anastasiou, Director of Workforce and Development	95,001-100,000	-	-	0-2,500	10,001-15,000	0-2,500	40,001-45,000	189	14	214	105,001-110,000
M Chapman, Director of Commercial and Service Development	95,001-100,000	-	800	(2,500)-0	30,001-35,000	(2,500)-0	90,001-95,000	531	11	570	100,001-105,000
V McCabe, Director of Community Services	95,001-100,000	-	4,600	(2,500)-0	35,001-40,000	(7,500)-(5,001)	110,001-115,000	663	(15)	683	100,001-105,000

All benefits in kind relate to usage of cars for business purposes, either in the form of a 'regular user' allowance, or a taxable element paid per mile.

1 M St Aubyn resigned as Chairman on 30 November 2012

2 C Paveley was appointed as Chairman on 1 January 2013

3 R Cox acted as Chairman from 1 December 2012 to 31 December 2012

4 B Johnson was appointed as a Non-Executive Director on1 April 2012

5 G Scott is a member of the Local Government Pension Scheme. This Scheme is fully funded with all liabilities resting with the pension fund and not the employer

6 M Flechtner receives a salary for his role as Medical Director and a salary as a Consultant. The information in this table reflects his total salary for both positions

7 M Simpson resigned on 15 August 2011

8 V McCabe was appointed on 6 June 2011

9 R Cox acted as Chairman from 1 December 2012 to 31 December 2012
10 B Johnson was appointed as a Non-Executive Director on 1 April 2012

P Keedwell held Non-Executive Directorships in other organisations during the current year, and P Keedwell and M Chapman both held Non-Executive Directorships in other organisations during the preceding year. No remuneration was received for these positions.

North Essex Partnership University NHS Foundation Trust does not operate any Profit-Related Pay scheme.

No payments for compensation for loss of office have been made to any former Director or Senior Manager during the year.

All expenses are paid in line with entitlements set out in both national terms and conditions and local policy, see table below:

Table 3: Executive Directors

Name	Position	Contract Date	Contract Status	Notice Period
Lisa Anastasiou	Director of Workforce & Development	29/03/2010	Permanent	3 Months
Mike Chapman	Director of Strategy	06/02/2010	Permanent	3 Months
Dr. Malte Flechtner	Medical Director	01/02/2005	Permanent	3 Months
Andrew Geldard	Chief Executive	30/07/2009	Permanent	6 months
Paul Keedwell	Director of Operations & Nursing	12/03/2010	Permanent	3 Months
Rick Tazzini	Director of Resources	23/11/2009	Permanent	3 Months
Vince McCabe	Director of Commercial and Service Integration	04/06/2011	Permanent	3 Months

Table 4: Directors Expenses

Name	Expenses (to the nearest £100)
Chris Paveley	Nil
Charles Beaumont	Nil
Ray Cox	Nil
Jane Crame	Nil
Sarah Phillips	Nil
John Gilbert	300
Charles Abel Smith	100
Brian Johnson	100
Andrew Geldard	700
Rick Tazzini	Nil
Dr Malte Flechtner	300
Paul Keedwell	100
Lisa Anastasiou	Nil
Mike Chapman	700
Vince McCabe	Nil

The table below illustrates expenses paid to Governors during the period 2013/14

Table 5: Governors Expenses

First Name	Surname	Honour	Disclosure required
Ron	Abbott		£200
Lloyd	Armstrong		N/A
David	Bamber		£1,300
Angela	Barnes		£500
Graham	Butland		£-
Peter	Cheng	MBE	£700
Benita	Christie		£-
Janet	Crane		N/A
Mark	Dale		£100
Pippa	Ecclestone		£1,300
Linda	Embleton		N/A
David	Fairweather		£500
Hamid	Farahi		£-
Pavel	Fridrich		N/A
Jane-Marie	Hardy		N/A
Sheila	Jackman	MBE	£400
Chuda	Karki		N/A
Pauline	Keeling		N/A
Keith	Lever		£800
Jayne	Lingard		N/A
Mary	Martin		£300
Mark	McGrath		£400
James	McQuiggan		N/A
Nick	Ntiako Brown		N/A
Andy	Payne		N/A
Linda	Pearson		N/A
David	Pickles		N/A
Mary	Power		£-

First Name	Surname	Honour	Disclosure required
Hazel	Ruane		N/A
Paul	Sergent		N/A
Nazir	Shivji		N/A
Andrew	Smith		N/A
Brian	Spinks		£2,000
Lucy	Taylor		£900
Cathy	Trevaldwyn		N/A
Graham	Underwood		£100
Clive	White		£1,200
Russell	White		N/A
Marie	Whitfield		N/A
David	Williams		£-

Membership Report

Membership is free and open to anyone aged over 14 who lives in Essex or Suffolk.

The current membership (as at 13 March 2014) is 5,910. See table below:

Churn Report 01/04/2013 to 13/03/2014

	Public	Staff	Total
Start date total (01/04/2013)	6,360	12	6,372
Added	155	0	155
Deleted	616	1	617
End date total (13/03/2014)	5,899	11	5,910

Diversity Report as at 13/03/2014

	Public	Staff	Total	*Eligible pop.*
Age				
0 to 16 years	11	0	11	*86,266*
17 to 21 years	161	2	163	*125,234*
22 years +	4,402	8	4,410	*2,160,356*
Not Specified (DOB not given)	1,325	1	1,326	*NA*
Total	5,899	11	5,910	*2,371,856*
Ethnicity				
Not specified	114	1	115	*NA*
White	5,248	10	5,258	*2,231,711*
Mixed	36	0	36	*37,447*
Asian or Asian British	94	0	94	*56,190*
Black or Black British	88	0	88	*38,001*
Other Ethnic Group	319	0	319	*8,507*
Total	5,899	11	5,910	*2,371,856*
Social Grade				
ABC1	4,186	8	4,194	*939,987*
C2	1,273	2	1,275	*281,441*
D	39	0	39	*271,355*
E	294	0	294	*272,887*
Not assigned	107	1	108	*NA*
Total	5,899	11	5,910	*1,765,670*

Gender				
Male	2,603	5	2,608	*1,178,950*
Female	3,256	6	3,262	*1,192,906*
Not specified	40	0	40	*0*
Total	5,899	11	5,910	*2,371,856*
NS-SEC				
Not assigned			0	
1. Higher managerial & professional occupations			0	
2. Lower managerial & professional occupations			0	
3. Intermediate occupations			0	
4. Small employers & own account workers			0	
5. Lower supervisory and technical occupations			0	
6. Semi-routine occupations			0	
7. Routine occupations			0	
8. Never worked and long term unemployed			0	
Not classified			0	
Total	0	0	0	*0*

Elections during 2013/14

A round of elections to the Council of Governors commenced in January 2013 with the results of contested elections to be notified by the end of March 2014, and governors to commence their duties from 01 April 2014.

The process related to 8 public governor seats (out of 29):

- Braintree - 3 seats (out of 4)
- Colchester - 2 seats (out of 3)
- Suffolk - 2 seats (out of 2)
- Tendring - 1 seat (out of 4).

The nominations process has resulted in the following position:

Constituency	Number of Seats to Fill	Number of Nominations	Note
Braintree	3	3	Uncontested - 3 nominees
Colchester	2	4	Election held in March 2014 – 2 governors elected
Suffolk	2	2	Uncontested - 2 nominees
Tendring	1	1	Uncontested – 1 nominee

If you wish to contact the Governors or Directors you can write to the Trust Secretary, North Essex Partnership NHS Foundation Trust, 103 Stapleford Close, Chelmsford, CM2 0QX.

or email foundationtrust@nepft.nhs.uk or call 0800 169 1635

For any issues about individual care please contact PALS

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore 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 North Essex Partnership University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in North Essex Partnership University NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has established a risk management framework in order to manage risks effectively within all areas of the Trust's operations. The responsibility for overseeing the management of organisational hazards is defined within the Risk Management Strategy, approved by the Board of Directors on 27 November 2013. The Board of Directors retains strategic responsibility for the risk management agenda with operational responsibility delegated to the Risk and Governance Executive. The risk register, which defines actions and sources of assurance, has been established and approved by the Board of Directors. Within this trust-wide approach, arrangements have been embedded to manage appropriate risks at a local level. The risk register is regularly reviewed,

revised and submitted for approval to the Board of Directors. The Board of Directors has adopted an Assurance Framework.
All staff within the Trust contribute to the risk management process including the identification of risks and hazards and participate in risk assessment training programmes. All clinicians are involved in clinical risk assessment and attend training. Non clinical risk assessment training is mandatory for all managers. Specialist risk assessment training is provided to staff who have been delegated a risk assessor role. All teams have identified staff who undertake risk assessments and these are monitored by the Health and Safety Group and the Risk and Governance Executive (R&GE). Clinical Boards hold a local risk register, which identifies mitigating actions; this is reviewed and submitted to the Risk and Governance Executive twice a year. Local risk management structures ensure that capacity exists to undertake assessments, identify hazards and to create and maintain the local risk registers.

The Risk & Governance Executive regularly reviews the Assurance Framework and this is submitted to the Board of Directors for approval (most recently in January 2014).

The risk and control framework
The Risk Management Strategy sets out the Trust's approach to risk, including the ways in which risk is identified, evaluated and controlled. The Board of Directors oversees the risk management agenda within the Trust receiving periodic updates from the Risk and Governance Executive (R&GE). The R&GE, has adopted an integrated approach to risk management which takes into account a broad spectrum of risk categories covering strategic risks, operational risks, financial risks, and their associated control and mitigation strategies both from the perspective of impacts on quality of care and the continuing viability of the organisation.

The Trust has in place policies and procedures for the identification of hazards and the subsequent assessment and prioritisation of risks. Risk assessments are supported by risk treatment plans in order to create a planned approach to reducing or minimising risk.

Departments and services undertake hazard identification and risk assessments of operational hazards identified through working groups or by undertaking safety inspections of the workplace or task.

Risk Registers are subject to annual and systematic review. The Risk Register is reviewed by the executive directors and submitted to the Risk and Governance Executive (R&GE) for approval prior to submission to the Board on a quarterly basis. This assists in embedding the risk management culture and activity throughout the Trust. The Risk Register details the sources of independent assurance and is subject to continuous review as a live, dynamic management tool. The Trust actively uses the sources of independent assurance contained within this framework to underpin this Annual Governance Statement.

The Risk and Governance Executive is responsible for the monitoring of the framework. The Trust updates our Council of Governors on our management of risk, as the forum representing the views of members and the public in the constituencies we serve, as well as those of our staff and partner organisations.

The effectiveness of the governance structures was reviewed in 2013/14 by a focussed internal audit of governance which considered areas including; governance structure, board committees, board appointments and roles and responsibilities. This resulted in a finding of 'good assurance' (highest level). This was complemented by a comprehensive externally facilitated Board Evaluation in the context of 'The Health NHS Board'. This project included; a desk review of Board and Committee documentation, observation at Board meeting, on-line assessment, stakeholder survey, in-depth interviews. The skills and experience required of the Non Executive Directors are kept under review by the Nominations Committee of the Board of Directors and the Remuneration and Appointments Committee of the Council of Governors. This joint work has resulted in the appointment of two new Non Executive Directors by the Council of Governors in June 2013 and a further two in March 2014.

Up to date and timely information regarding quality of care is brought to the Board via a Performance Report and Ward Quality Barometer which are considered at each meeting in public. An update form the Chief Executive, including quality of care indicators, is brought to each meeting of the Council of Governors. These include metrics required by the regulator and a suite of indicators identified by the Trust.

Information Security is fundamental to the operation of all NHS bodies including the Trust, due to the sensitive and confidential patient data it captures.

The Trust has established an Information Governance & Security Steering Group to co-ordinate the review of the Trust's information governance management and monitor our information governance data security. This steering group reports directly to the R&GE.

The Information Governance & Security arrangements take into account statutory arrangements and good practice. All staff are required to pass the relevant Information Governance training module supplied by the NHS Information Centre.

The Trust has reviewed its compliance with the Clinical Negligence Scheme for Trusts (CNST) and NHS Litigation Authority Risk Management Standards**.** The Trust has achieved Level 1 of the NHSLA Risk Management Standards for Mental Health Trusts (Level 0, low to level 3, High).

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Executive Team has responsibility for overseeing the day-to-day operations of the Trust and for ensuring that resources are being used economically, efficiently and effectively. To inform them in these matters the Team receives regular monthly finance and performance reports, which highlight any areas of concern.

Additionally, the Board of Directors receives monthly finance and performance reports and approves the quarterly compliance reports, which are required by the independent regulator, Monitor. For Quarters 1 and 2 the Trust retained a Monitor financial risk rating of 4 (scale 5 lowest risk to 1 highest risk) and a traffic light governance (performance) rating of green (highest rating). For Quarter 3 the Trust recorded a continuity of service (new finance) risk rating of 3 (scale 4 lowest risk to 1 highest risk) and retained a governance (performance) rating of green. Similar performance is expected to be confirmed for Quarter 4.

Internal Audit conducts a review of the Trust's systems of internal control as part of an annually agreed audit plan. This review encompasses the committee structure, the flow of information pertaining to risk and associated assurances throughout the organisation. The focus of the work is to ensure that appropriate systems are in place and can be evidenced by a range of documents available within the organisation. Audits performed by internal audit have reviewed the governance arrangements within the Trust over a range of core functions and activities to ensure that there is an appropriate and robust approach to the use of resources.

Annual Quality Account and Report

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

Production of the Trust's Quality Report/Account is governed and led by the Risk & Governance Executive (R&GE), which reports into the Board of Directors. The Trust employs a comprehensive range of systems,

reporting processes, training, data validity checks, as well as internal audit and external audit. The Trust has a Quality and Compliance Manager who manages the process for the Quality Account/Report and reports to the R&GE. This approach provides the Board with the assurance that the Quality Account/Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data.

The Trust's Quality Account/Report follows the Department of Health Toolkit and the Monitor Compliance Framework incorporating all mandatory statements including quality information with additional narrative where required. Governors have identified priorities for improvement and monitor progress during the year. Members of the R&GE provide input to the Quality Account/Report. A project plan is in place and updated on a regular basis to ensure that the correct staff are asked to submit information and that this can be validated through the data sources. The Trust's internal audit programme includes an annual internal audit of the Quality Account/Report and in addition to input from the external auditors.

The Medical Director's responsibilities include production of the Quality Account/Report and the drafts are reviewed by the Risk and Governance Executive. The host commissioners are also involved in the process and are kept appraised of progress on the priority improvements as well as the draft Quality Account/Report. Performance data is benchmarked with previous years and data source information is included. The Quality Account/Report includes a number of soft measures that take account of staff survey information and Governor planning events. This is balanced with the hard measured data incorporating Trust-chosen metrics (Board, R&GE and Executive Management Team) as well as national targets and key performance indicators. Information is also included about performance against our Commissioning for Quality and Innovation (CQUIN) targets. Full information is included regarding any planned or responsive review visits by the Care Quality Commission together with their findings.

The Trust Board approves the Quality Account/Report priority improvements to be included for the following year and approves the final version as part of the Annual Report. The Trust publishes the same document as its Quality Report and Quality Account.

The metrics included in the Quality Account/Report are monitored throughout the year by the Executive Management Team performance meetings and R&GE meetings. R&GE annual report is presented to the Board by the Medical Director. R&GE is chaired by a Non Executive Director who also serves on the Audit Committee. A joint R&GE and Audit Committee meeting is held once a year. Presentation of quality data is in the form of performance reports, patient safety dashboard, ward quality barometer, serious incident and complaints reports among others. The R&GE manages a number of groups that make a key contribution to the Trust's assurance reporting process.

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, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the Risk & Governance Executive and a plan to address weaknesses and ensure continuous improvement of the system is in place.

During the year internal audit issued 21 reports. Five of these received a limited assurance opinion; Medical records, Patient Experience, Pharmacy, Corporate records, and Doctors additional payments. A "limited assurance" opinion is defined as "weaknesses in the system of controls are such as to put the system's objectives at risk". Detailed action plans have been implemented to address these weaknesses and further work has been commissioned to validate the implementation of the relevant corrective actions. For one of the reports on ITIL Change and Service Desk Management, no opinion was given due to the nature of the work undertaken. The report included two recommendations, which provide guidance as to how the organisation can bring the Trust in

line with ITIL Guidance on Change and Service Desk Management. No reports received “nil assurance”.

I am able to place reliance upon the detailed programme of work undertaken by the Internal Auditors resulting in their opinion of ‘significant assurance’.

All reports with less than adequate assurance are taken to the Executive Management Team for review. Plans have also been put in place to address other, less significant, weaknesses and ensure continual improvement in systems of internal control.

The Assurance Framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed, and evidence from Deloitte LLP (part of Mazars from February 2014) as Internal Auditors and Local Counter Fraud Service provider, Grant Thornton as External Auditors, the NHS Litigation Authority and the Care Quality Commission also inform my view of the Trust. This evidence is supplemented by views from our stakeholders through Staff and Service User Opinion Surveys and through views from our Council of Governors.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit Opinion for the year ended 31 March 2014 is as follows:

“Significant assurance can be given that there is a generally sound system of internal control, designed to meet the Trust’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 Head of Internal Audit also states, *“Overall we have seen a deterioration in the number of reports receiving Good/Adequate assurance. However, our audit plan was changed by mutual consent within the year, in order to focus on areas of concern that had been identified by management. These changes led to a greater number of audits with Limited/Nil Assurance being identified, but we believe that*

this approach demonstrates the effective working relationship that has been established between Internal Audit and the Trust, and management's willingness to identify areas of concern and take action to improve the overall control environment.

During the year progress has been made in reviewing and following up outstanding audit recommendations and a number of recommendations from previous years have now been confirmed as completed. This focus on the implementation of recommendations needs to continue to ensure the Audit Committee is receiving adequate assurance that control weaknesses are being addressed. Independent verification of successful implementation was undertaken as part of our ongoing recommendation follow up work."

The following information summarises some of the key activities that allow the Board to review the effectiveness of the system of control:

i) The Board of Directors

The Board of Directors receives performance, safety, quality and financial reports at each of its meetings and receives reports from its Sub Committees to which it has delegated powers and responsibilities. The Board has reviewed the Assurance Framework and receives regular information from the Audit Committee and the Risk and Governance Executive. In 2013/14, the Board reviewed a number of significant policies and strategies during the period including the CPA & Non CPA Policy, the Risk Management Strategy and the Disciplinary Policy & Procedure. Executive Directors are responsible for risk management within their area of control and also have corporate responsibility as Board members.

ii) Area and Assistant Directors

The second tier of management has responsibility for risk management and the effective management and deployment of their staff and other resources to maximise the efficiency of their Directorates and services.

iii) The Audit Committee

The Audit Committee provides independent scrutiny within the Trust's framework of governance. A Non-Executive Director chairs

the Audit Committee, which comprises three independent Non-Executive Directors and which is attended by representatives of the internal and external auditors. The Annual Internal Audit Plan is a key means by which the Board of Directors is assured that key internal financial controls and other matters relating to risk are regularly reviewed. It has reviewed internal and external audit reports, and reviewed progress on the implementation of recommendations. The Audit Committee regularly reports progress to the Board of Directors as well as making an annual report. The Committee also assesses its effectiveness.

iv) The Risk and Governance Executive

A Non-Executive Director, who is also a member of the Audit Committee, chairs the Risk and Governance Executive. Operational management of the risk management agenda sits with the Risk and Governance Executive, which has responsibility for implementing the Risk Management Strategy. The group is also responsible for developing the Trust's Quality Strategy.

v) Internal Audit

Deloitte were appointed 1 August 2004 to provide Internal Audit services, and re-appointed for a further three years in March 2009. A further, final one-year extension was agreed for internal audit and local counter fraud services until 31 March 2014. Deloitte became part of Mazars from February 2014. Following a procurement exercise during 2013 the contract for both Internal Audit and Local Counter Fraud Services was awarded to Baker Tilly with effect from 1 April 2014.

vi) Monitor

As reported above, the Trust has maintained very good performance throughout the year against the financial and governance framework set by Monitor.

vii) Care Quality Commission (CQC)

The Trust received 15 planned/responsive compliance inspections during 2013/14 covering all in-patient areas. Of these 9 locations were found to be fully compliant with the Essential Standards of Quality and Safety. 3 locations were found non-compliant (minor concerns) with

outcome 2 (consent). 2 locations were found non-compliant (minor concerns) with outcome 2 and 4 (care and welfare). 1 location was found to be non-compliant (minor/moderate concerns) with outcomes 2, 4, 7 (safeguarding) and 14 (supporting workers). The CQC have received full responses and robust action plans for each of the 6 locations. A plan is in place to monitor implementation of the action plans and to validate by internal data quality audit before sending back to the CQC.

The Trust considers itself to be compliant with the requirements of registration with the Care Quality Commission (CQC).

Conclusion
Based upon the available guidance and requirements of the regulator, Monitor, the CQC, the Trust's internal and external auditor's views, the Board of Directors has not identified any significant internal control issues.

Signed

Andrew Geldard
Chief Executive Date: 28 May 2014