Essex Partnership University
NHS Foundation Trust

Annual Report and Accounts 2018/19

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paragraph 25 (4) (a) of the National Health Service Act 2006.

Contents

PERFORMANCE REPORT

Foreword by the Chair and Chief Executive

Welcome to our Annual Report and Accounts for Essex Partnership University NHS Foundation Trust (EPUT) 2018 – 2019

Our second year and what a year it has been. We embraced and enjoyed marking the 70th birthday of the NHS and celebrated our GOOD rating from the CQC (Care Quality Commission). As a newly established NHS Foundation Trust, we are pleased that throughout our second year we continued to achieve our strategic objectives, embedded our vision and values, honoured our staff and maintained our programme of service improvement. This tradition continues underpinning our ambition of being an 'outstanding' organisation by 2022.

Between 30 April and 16 May 2018, the CQC inspectors visited the Trust's core services. Inspectors rated the care provided by staff to be GOOD and were impressed by the extent to which the new values of the merged Trust have been embraced by everyone and displayed by all the staff they met. This was particularly important following the merger in April 2017.

However, the inspection identified a few services where improvements need to be made. We are addressing each one of these; and at the time of writing this report, we can confirm that excellent progress continues in all areas.

> *Overall, Essex Partnership University NHS Foundation Trust provides good care to the population that it serves. The Trust can be proud of many of the services that it manages.* ***CQC July 2018***

Patients are Our Top Priority

Excellent patient care is acknowledged and appreciated not only by our patients, but also the Trust as an organisation. We understand that this standard of patient care would not be possible without our staff. We held our second annual Quality Awards event at the end of March 2019. We celebrated many staff from across the Trust for their significant contribution to excellent patient care. Our annual Quality Awards build on two important initiatives where we recognise the impact our staff have on the quality of services we provide to our patients, services users and carers:

- The staff recognition scheme for the Trust, EPUT Excellence Awards, was established in 2017. These awards are nominated by patients, carers and colleagues. We hold events across the Trust throughout the year where we invite staff and present them with awards for excellent patient care, performance, innovation, contribution to the wellbeing of colleagues and long service.
- The EPUT Quality Academy and Champions ensure that we create an environment where staff are equipped with the best tools and a support network to drive forward real improvements in care. This year our network numbers have increased to over 300 Quality Champions working together on over 250 initiatives with colleagues, patients, service users and carers on a continuous improvement journey.

In the CQC's report they highlighted that staff demonstrated the Trust's values in their day-to-day work, showed kindness, respect and a caring attitude towards patients, service users, carers, visitors and each other. They also remarked that the Trust had worked at pace to harmonise policies and procedures to support staff following the merger.

The benefits this has brought to local patient care has been made possible through the hard work by very many of our staff, service users, patients, carers and the support of our NHS and local authority partners. We are extremely grateful to everyone involved.

The NHS 70th birthday afforded us the opportunity to commemorate the achievements of one of the nation's most loved institutions. The Trust hosted a number of local events throughout the year to recognise and thank our amazing staff.

Supporting our Staff

Staff wellbeing and safety continue to be priorities for the Trust. Work continues on implementing our Staff Survey Action Plan. We were pleased to see that the Staff Survey this year had an increased response rate. We will again be meeting with staff from across the Trust to further explore concerns and issues raised from the Staff Survey.

Our intranet, 'Input', goes from strength to strength. It is a popular channel that meets the needs of staff with quality initiatives and networks encouraging staff involvement. The 'I'm worried about' feature for staff to raise concerns anonymously is a visible pathway for addressing issues. Staff are also able to feedback on any matters anonymously via the Staff Friends and Family test.

We support the wellbeing and safety of our staff as much as possible with a Trust wide staff counselling service, a dedicated staff engagement team and the national 'Freedom to Speak Up' initiative in place. Our Principal Guardian and local guardians located across Trust are available for all staff to contact directly to help them raise any concerns.

These initiatives all help our staff to feel supported and encourage them to speak out about any issues, concerns or challenges so that prompt and appropriate action may be taken.

Valuing the diversity of our workforce, we are delighted that our dynamic and passionate BAME (Black, Asian and Minority Ethnic) Network has continued with their excellent work into our second year. In addition to being recognised within the Trust, this year members of the network received national recognition for their initiatives and training. In addition to BAME, our intranet hosts a wealth of information and opportunities for all staff to get involved through the recent establishment of a number of networks including Carers, Faith, Disability and LGBTQ.

> *Staff were enabled to take actions to improve services and to make a difference. Leaders promoted an environment where staff felt able to suggest improvements and ways to better care for patients.* ***CQC July 2018***

Looking Forward

EPUT is currently developing its Five Year Strategy in line with its vision 'Working to improve lives' and values 'Compassionate – Empowering – Open'. The strategy will set out the Trust's priorities following the ambitions of the NHS Long Term Plan and Sustainability Transformation Partnership (STP) Plans due in summer 2019. Our strategic plans include partnership working with NHS, statutory, third sector and voluntary organisations. Over the past year this has led to a number of significant local developments and improvements for patients and service users. The Trust's geographical locations cover a number of Sustainability Transformation Partnerships (STPs). We are actively working with CCGs (Clinical Commissioning Groups) and each of the STP organisations on their plans for local service developments.

We are pleased to report that during 2018/19 progress has been positive in developing the Trust's new mental health services transformation model. We are now into the third year of this wide-ranging co-produced five-year programme. With service users and carers on board providing their experience and feedback, our new model will update and improve Essex-wide inpatient and community mental health services. As well as mental health services, we have been moving forward with partners in developing new models of care for people who use our community physical health services. There is more information about all of these projects and schemes detailed throughout the annual report.

Ensuring Continuity of Quality

During this past year, EPUT's Council of Governors and Board of Directors have led the Trust well, ensuring compliance with corporate and clinical governance regulation.

Our NHS Foundation Trust has remained compliant consistently with the quality targets set by our external regulator, NHS Improvement, and we are not forecasting any risk to continuing to achieve these targets.

We said farewell to two of our Non Executive Directors, Mary Ann Munford and Nikki Statham, and thank them for their significant to contribution to our Board of Directors. We welcomed two new Non Executive Directors, Drs Alison Rose-Quirie and Rufus Helm.

You will find more details of our quality targets and performance in the Quality Report on page **102** in this document.

Listening To and Acting on Feedback

In 2018/19 we continued to recognise the importance of listening to, involving and engaging with the people who come into contact with our services. We promote the 'Friends and Family' test across the organisation – in both mental health and community health services. We have harmonised our compliments, comments and complaints systems. Focus has been given over the past year to increasing knowledge among staff of how to resolve complaints satisfactorily at a local level and ensure organisational learning is taken from local resolution as well as formal complaints processes.

Compliments are also important to us, and we share these proudly with colleagues through our internal communication systems as well as display them on the Trust's website. In 2018 – 2019 we received more than 4,200 compliments. We also received 285 complaints – a reduction from 312 received in 2017/18. During the coming year, we will continue to work on improving our response times as we are very mindful that it is important for people to receive timely responses to their concerns.

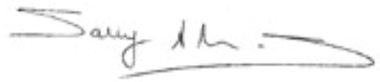
As mentioned earlier, we have been working with service users and carers on developing a new mental health services transformational model. Their input and lived experience is invaluable when designing and developing new services. We have also continued to support a number of smaller, service-focused forums where local issues are discussed. Feedback from these forums goes directly to our front line services and all actions are overseen by the Trust's Patient and Carer Experience Steering Group.

Vote of Thanks

We hope you enjoy reading about our services, our staff, our achievements and our future plans. Our foreword only touches on the Trust's huge amount of news and information published about our second year. The comprehensive Annual Report and Accounts that follows goes into greater detail on all aspects of our past year. Everybody working at the Trust makes a significant contribution to the health and wellbeing of the people we serve. We hope you will agree that we have made tremendous progress in our second year. We want to take this opportunity to say a huge thank you to our staff, our governors and members, partners, patients, carers, volunteers and fellow board members for playing such key roles in the Trust's success.

Thank you.

Professor Sheila Salmon
Chair
Essex Partnership University NHS FT
23 May 2019



Sally Morris
Chief Executive
Essex Partnership University NHS FT
23 May 2019

Professor Sheila Salmon (L) and Sally Morris (R)

Rainbow staff were all outstanding going the extra mile to ensure that patients felt welcome, supported and valued. It was fabulous to be supported by such an amazing team and even more fabulous to be with my precious baby while unwell. The time where I was separated from her was intolerable and my recovery is owed to the staff at Rainbow and being reunited with her.

PERFORMANCE OVERVIEW

Purpose of Overview

In this section we introduce our organisation, Essex Partnership University NHS Foundation Trust (EPUT). We tell you about our services, where we provide them, the population we serve and how many staff care for our patients and service users. We also highlight our vision and values, our performance and achievements for the past year.

Introduction

EPUT was formed on 1 April 2017 following the merger of South Essex Partnership NHS Foundation Trust (SEPT) and North Essex Partnership NHS Foundation Trust (NEP). During 2018/19 EPUT provided community health, mental health and learning disability services for a population of approximately 2.5 million people throughout Bedfordshire, Essex, and Luton, employing circa 5000 staff across 200 sites.

Our Strategic Objectives for 2018/19 were:

- Strategic Objective 1: Continuously improve patient safety, experience and outcomes and reduce variations.
- Strategic Objective 2: Attract, develop, enable and retain high performing and diverse individuals and teams.
- Strategic Objective 3: Achieve top 25% performance for national operational, financial and productivity measures.
- Strategic Objective 4: Co-design and co-produce service improvement plans with system partners, including commissioners and service users.

These are outlined in more detail in the Performance Analysis section on page **13**.

At the beginning of 2019, we undertook a review of our strategic objectives and these were updated for the year 2019/20 and are now as follows for the coming year:

- Strategic Objective 1: To continuously improve service user experience and outcomes through the delivery of high quality, safe, and innovative services.
- Strategic Objective 2: To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts.
- Strategic Objective 3: To be a valued system leader focused on integrated solutions that are shaped by the communities we serve.

OUR VISION, VALUES & STRATEGIC OBJECTIVES

Our Vision

Working to improve lives

Our Values

Compassionate

Empowering

Open

Our Strategic Objectives

1. Continuously improve patient safety, experience and outcomes and reduce variations
2. Attract, develop, enable and retain high performing and diverse individuals and teams
3. Achieve top 25% performance for national operational, financial and productivity measures
4. Co-design and co-produce service improvement plans with system partners, including commissioners and service users

Our services include:

- **Mental Health Services:** Treatment and support is provided to young people, adults and older people experiencing mental illness – including treatment in hospitals, care homes, secure and specialised settings. This incorporates:
  - adult and older people services;
  - specialist services including forensic services, Child and Adolescent Mental Health Services (CAMHS) and substance misuse services including an integrated drug treatment service in HMP Chelmsford.
- **Community Health Services:** Our community health services provide support and treatment to both adults and children. We deliver this care in community hospitals, health centres, and in our patients' homes.
- **Learning Disabilities Services:** We provide crisis support and inpatient services, and our community learning disability teams work in partnership with local councils to provide assessment and support for adults with learning disabilities.
- **Social Care:** We provide personalised social care support to people with a range of needs, including people with learning disabilities or mental illness, supporting people to live independently.

Involving local people

EPUT is a foundation trust. NHS foundation trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital, mental health and ambulance services and were created to devolve decision making from central government to local organisations and communities. They provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay.

> *I would like to thank you and your staff for the care and attention I received when having an operation on my right foot. I would like to thank the nurse who checked me in and out on that day and the young man in recovery and two lovely ladies that assisted you in the theatre. Also the nurse who was in the recovery lounge, not forgetting the gent who sat by my head while the operation was being done.*

What makes NHS Foundation Trusts different from NHS Trusts?

NHS foundation trusts are not directed by Government so have greater freedom to decide, with their governors and members, their own strategy and the way services are run. They can also retain their surpluses and borrow to invest in new and improved services for patients and service users; and are accountable to:

- their local communities through their members and governors;
- their commissioners through contracts;
- Parliament (each foundation trust must lay its annual report and accounts before Parliament);
- The CQC (Care Quality Commission);
- Monitor (NHS Improvement) through the NHS provider licence.

NHS foundation trusts can be more responsive to the needs and wishes of their local communities – anyone who lives in the area, works for a foundation trust, or has been a patient or service user there, can become a member of the Trust and these members elect the Council of Governors. Want to have your say? Find out more about becoming a member. You can be involved as little or as much as you like – find out more about being a governor or member by visiting our website: www.eput.nhs.uk

How we got to where we are today

The merger of the former North Essex Partnership University NHS Foundation Trust (NEP) and the former South Essex Partnership University NHS Foundation Trust (SEPT) to create Essex Partnership University NHS Foundation Trust (EPUT) was completed on 1 April 2017. It was the first successful merger of two NHS Foundation Trusts. It was delivered on time and within budget, attaining a green governance rating from NHS Improvement – the highest available.

EPUT is currently developing its Five Year Strategy in line with its vision 'Working to improve lives' and values 'Compassionate – Empowering – Open'. The strategy will set out the Trust's priorities following the ambitions of the NHS Long Term Plan and STP Plans due in summer 2019.

Innovation During the Past Year

Throughout this annual report we will provide examples of things we are proud of. Some examples of innovative service developments are outlined in the Quality Report which forms part of this Annual Report.

Staff celebrate GOOD CQC Rating

External and internal consultation on Trust Strategic Plan

A requirement of the merger of NEP and SEPT was that a full business case was submitted to NHS Improvement for approval. This document is the Trust's Five Year Strategic Plan.

Each year the Trust develops an operational plan to support delivery of the Strategic Plan. These operational plans are developed in consultation with our partners and key stakeholders. The same process has been followed this year to develop the Trust's Operational Plan for the coming year 2019/20. This has been produced with input from the Board, the Trust's Leadership Team, health economy partners and the Council of Governors (CoG). In addition, a number of economy wide discussions have been held with partners at Board and Executive level on the delivery of the NHS Long Term Plan and system wide Sustainability Transformation Partnerships (STPs).

Planning Day

A Stakeholder Planning Day took place on 31 January 2019 to support the shaping of the plan for 2019/20. Those in attendance included commissioners, representatives from statutory and voluntary partners, staff, governors and service users and carers. In addition to the Planning Day, staff have been asked for their views.

Principle risks and uncertainties

We define risk as uncertain future events that could influence the achievement of the Trust's aims and objectives. The Trust has a comprehensive Risk Management and Assurance Framework in place which enables informed management decisions in the identification, assessment, treatment and monitoring of risk. The Risk Management and Assurance Framework was subject to full review in July 2018.

At the start of the year the organisation identified 11 corporate objectives for 2018/19 and assessed the potential risks that may have prevented their achievement. The Trust's Directors considered each risk in terms of its potential impact taking into account financial, safety and reputational risk and the likelihood of occurrence during the financial year.

The high and extreme potential risks to achieving the corporate objectives if they were not achieved provided the basis for the Board Assurance Framework and governance systems. 29 potential significant risks were escalated to the Board Assurance Framework during the period 2018/19. These risks included:

- the robustness of fire safety systems and processes;
- vacancy rates in excess of benchmark;
- the potential impact arising from an investigation by the Health and Safety Executive into failings in the former NEP;
- adult mental health in-patient capacity;
- achievement of in-patient shift fill rates;
- implications of EU exit;
- oversight and leadership in non-core services post CQC inspection;
- learning from incidents;
- reducing restrictive interventions;
- providing high quality services from safe premises;
- performance against contractual targets;
- reducing agency spend;
- ability to meet Cost Improvement Programmes;
- adequate preparation for cyber attacks.

A Board of Directors Task and Finish Group reviewed the potential risks that remained open as at March 2019 and identified 14 risks for carry forward into 2019/20 and three new risks.

Going Concern Statement

The Directors have considered whether it is appropriate, taking into account best estimates of future activity and cashflow and the ongoing service provision by the Trust, for the accounts to be prepared on the basis of the Trust being a 'going concern'. The Trust's Directors have considered and declared:

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

Performance Analysis

Strategic Priorities

We identified four strategic objectives that would drive our activities in 2017/18 and 2018/19 as part of our two year Operational Plan post-merger. The Board of Directors agreed following a review in 2017 that they remained pertinent to our plans for 2018/19 and these were confirmed in our Operational Plan agreed with our regulator in April 2018.

Three of our strategic objectives for 2018/19 confirmed our commitment to providing the best quality services; with the best possible leadership and workforce and sustaining EPUT and the health care delivery systems in which we operate. The fourth strategic objective confirmed our commitment to work with system partners, commissioners and service users to co-produce and co-design service improvement plans. In 2018/19 each strategic objective was underpinned by corporate objectives to support achievement.

■ Strategic Objective 1: Continuously improve patient safety, experience and outcomes and reduce variations.

Corporate Objectives:

- Provide services that are compliant with our regulators
- Deliver the Trust's quality priorities
- Have an estate that is fit for purpose
- Complete planned ligature works
- Improve patient experience

■ Strategic Objective 2: Attract, develop, enable and retain high performing and diverse individuals and teams.

Corporate Objectives:

- Engage with our workforce to embed an open and learning culture
- Have a highly trained workforce

■ Strategic Objective 3: Achieve top 25% performance for national operational, financial and productivity measures.

Corporate Objectives:

- Achieve contract targets
- Deliver the Trust's financial plan for 2018/19

■ Strategic Objective 4: Co-design and co-produce service improvement plans with system partners, including commissioners and service users.

Corporate Objectives:

- Participate as a partner in the STPs
- Transform services

Malcolm McCann, Sheila Salmon and Cllr Barbara Rice officially open Gloucester Ward at Thurrock Community Hospital

Sheila Salmon and Sally Morris cutting the ribbon at the official opening of Cumberlege Intermediate Care Centre

Staff celebrate opening of Kelvedon Ward at Basildon Mental Health Unit

Natalie Hammond pictured with Mayor Peter Chillingworth and Mayoress Ann Chillingworth at the Sensory Garden opening at Kings Wood

Our Performance

Because we deliver a wide range of services commissioned by different Clinical Commissioning Groups (CCGs) and specialist commissioners, we have a great number and wide variety of mandated, contractual and locally identified key performance indicators (KPIs) that are used to monitor the performance and quality of services delivered.

In this section we have provided a summary of 2018/19 performance against the key operational metrics, quality of care metrics and organisational health metrics that NHS Improvement set out in its Single Oversight Framework (SOF).

In our Quality Report for 2018/19 we have provided further details on our performance against a range of mandated and locally agreed quality related performance metrics. Full details of performance against all KPIs across the whole of Essex and Bedfordshire were presented to the Finance and Performance Committee each month during 2018/19 and any areas of significant under-achievement were advised to the Board of Directors as 'hotspots' each month.

Table 1: Summary of 2018/19 performance against key operational metrics, quality of care metrics and organisational health metrics that NHS Improvement set out in its Single Oversight Framework (SOF)

Key Operational Metric	SOF Target	Year End Position
Patients with a First Episode Psychosis (FEP) begin treatment with a NICE recommended package of care within two weeks of Referral	53%	ACHIEVED 68%
Ensure that cardio metabolic assessment and treatment for people with psychosis is delivered routinely in: a) Inpatients b) EIP c) Community on CPA	a)90% b)90% c)75%	ACHIEVED a) 100% b) 92% c) 98%
IAPT % Moving to Recovery	50%	ACHIEVED 50.3% at end of Feb 2019 awaiting year end national publication
IAPT Waiting Time to begin treatment within 6 weeks	75%	ACHIEVED 99.6%
IAPT Waiting Time to begin treatment within 18 weeks	95%	ACHIEVED 99.9%
Out of Area Placements	<1105 bed days per quarter to ensure ongoing reduction.	ACHIEVED 358 Bed days for Q4
Data Quality Maturity Index (DQMI) – MHSDS dataset score	95%	ACHIEVED 98.8% At Q2 awaiting Q3 &Q4 national publication

Nurses make their pledges for the Trust's Nursing Framework

Quality of Care Metric	SOF Target	Year End Position
Written Complaints Rate per 100 WTE	No target set	7.08
Staff FFT recommend the Trust as place to receive treatment	No target set	75% (National average 71%)
Never Events	No target set	2
Patient Safety Alerts not completed by deadline	No target set	0
Friends and Family Test % Patients Extremely Likely / Likely to recommend the Trust as a Place to Receive Care	No target set	97.7% CHS 83.6% MH (National average CHS 97% MH 88%)
CQC MH Patient Survey	No target set	EPUT achieved about the same or better in all domains for the 2018 Patient Survey
Under Reporting of Incidents	No target set	44.8 National MH Benchmark <44.33 February figure provided, awaiting March final figure
% of Clients in settled accommodation	No target set	70.1% (LA Target 70%)
% of Clients in employment	No target set	38.4% (LA Target 7%)
% of discharges followed up in 7 days	95%	ACHIEVED 96.5%
Admissions of under 16s to adult in-patient beds	No target set	0

Organisational Health Metric	SOF Target	Year End Position
Staff Turnover	No target set	11.6% (Local target based on national benchmarking <12%)
Sickness Absence	No target set	5.3%
Proportion of Temp Staff	No target set	4.9%

Important events since year end affecting the foundation trust

CQC Inspection

The CQC carried out an un-announced focused inspection of adult in-patient mental health services in April 2019. Inspectors visited in-patient services at The Derwent Centre, Harlow; The Linden Centre, Chelmsford; and the Mental Health Unit, Basildon. At the time of writing this report, the CQC had not shared findings from this inspection. The inspection will not be rated but the final report of findings will be published on the CQC website.

Overseas Operations

The Trust did not undertake any overseas operations during the year 2018/19.

Modern Day Slavery

The Trust is committed to ensuring there is no modern slavery or human trafficking in any part of our business and in so far as possible to requiring our suppliers to hold similar ethos. We adhere to the NHS Employment Checks standards which include the right to work and suitable references. Human trafficking and modern slavery guidance is embedded into Trust safeguarding policies.

Sustainability and Environmental Stewardship

Leadership and Engagement

The Trust's vision is to be a sustainable organisation. As such, we have continued to deliver our Sustainable Development Strategy using SDU metrics to demonstrate compliance with the Climate Change Act and will be using the Sustainable Development Assessment tool in 2019 to support this. The commitment is to focus on carbon reduction and transport and travel policies, procurement processes, energy efficient properties, waste management and recycling, community engagement and workforce issues including diversity and inclusion.

One of the ways we embed sustainability is through the use of a Sustainable Development Management Plan, which is currently being updated to take account of significant recent organisational change.

EPUT's Board level lead for sustainability is Mark Madden, Chief Finance Officer. The principle person responsible for implementing Sustainable Development is Paul Bailey, Sustainable Development Manager.

As part of the NHS, public health and social care system, we recognise our duty to contribute towards the target set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline). This is equivalent to 28% reduction from 2013 baseline by 2020. Following the merger, a new baseline has been established to manage this reduction target for EPUT over the coming months.

> *Amazing staff and care throughout the years. The Derwent Centre staff have always treated me with a superb level of care and respect throughout the many years I have known them. Everyone I have ever known there - nurses, doctors, orderlies and psychiatrists, including fellow patients, have been kind, compassionate, and understanding. It is a great hospital, with exceptional people who really care for what they do.*

Cllr Maggie Hulcoop, Chair, Harlow Council, joins Mark Madden and Sheila Salmon to cut the ribbon at the official opening of the Derwent Centre

Quality Awards 2019

Our People

Staff engagement in sustainability agenda

The Trust is committed to ensuring staff, patients, visitors and suppliers and contractors are able to effectively engage with and support our carbon reduction plan.

An environmental awareness training module and test is available in our online training site, and an environmental awareness section has been included in new staff inductions.

Tender questionnaires, including that for the recently renewed waste contract have an environmental section for tenderers to demonstrate their environmental commitment and credentials.

Employment practices

As one of the largest employers in Essex, EPUT takes great pride and care in its staff. We ensure that their health and wellbeing is a valued priority and performs annual Staff Surveys to measure opinions, attitudes and trends, ensuring that findings are valued, considered and acted upon.

Supporting the workforce

EPUT embraces the health and wellbeing of its staff inside and outside of the workplace. We provide various supporting policies and resources as well as a recently introduced phone app to support an ongoing stress management and mental resilience programme for staff.

We also celebrate success with an annual staff Quality Award Event recognising quality, innovation as well as staff and patient safety in a challenging health environment.

Quality Awards 2019

Resources, Purchasing and Waste

Many high value changes have been made by EPUT and predecessor organisations over the past 10 years that are producing reductions and mitigating rising energy costs as well as emissions. This year we carried out boiler upgrades in the order of £100,000 and have been granted £470,000 from NHS Improvement for LED lighting upgrades at high use sites within the Trust. Further capital funding will be made available in the Trust's five year plan to achieve further efficiencies and opportunities for reducing carbon emissions.

Energy – direct consumption

Carbon emissions associated with our buildings account for approximately 20% of our carbon footprint. In the baseline year of 2017/18 the reported emissions were 5,399 tonnes of CO2 and during 2018/19 there were 4,501 tonnes CO2. There is an encouraging downward trend on our main consumptions. It is worth noting that some estimated projections have been used for the 2018/19 figures below as most recent consumptions and final billing for the year are not available at the time of preparing this report.

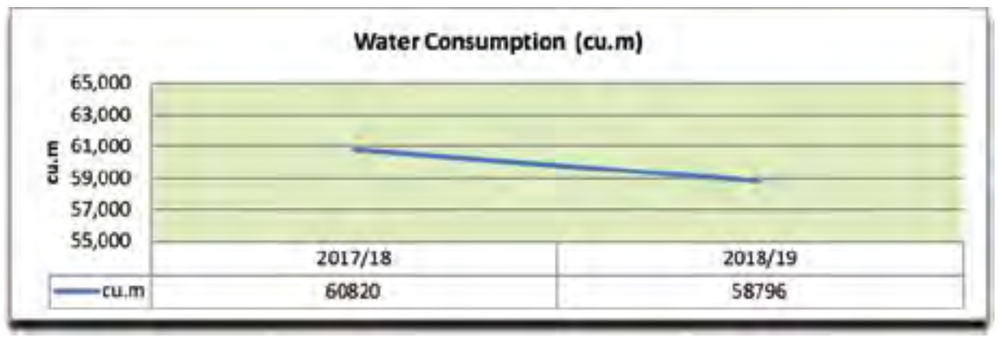
Table 2: Energy – direct consumption

Collection	2017/18 EPUT	2018/19 EPUT
Occupied floor area (m²)	151,100	146,180
Electricity consumed (kWh)	10,287,236	7,319,779
Gas consumed (kWh)	17,998,670	16,651,433
Renewable Energy - Electricity (kWh)	5,642,162	4,121,485
Site energy consumed per occupied floor area (kWh/m²)	187	164

Water – direct consumption

Since last year there has been a small reduction (0.33%) in consumption. This is due in part to a slight reduction of the estate and monitoring and repair of any reported leaks and installation of water saving devices where possible.

Figure 1: Water – direct consumption



Waste

Efforts to reduce waste and increase recycling are ongoing, and measures are in place to improve this further by the introduction of identified waste bins and training to encourage staff to separate waste at source. The recent merger and deregulation of the industry has given us the opportunity to review the process and, following an in depth tendering process, waste management has been made more efficient with the appointment of a new contractor.

Supply chain impact

The carbon impact from the supply chain is considered in purchasing choices and supplier engagement. We are investigating how to engage with and monitor and report on CO2 from our supply chain using Sustainability Development Unit methodology and carbon factors.

For each new request to tender, we include weighted questions on the tenderer's sustainable behaviour, working practices and aspirations.

The capital projects team manages a budget dedicated to environmental improvements which are considered for incorporation in every building related project.

Social value

We are also looking to explore how we can embed social accounting within the Trust to enable us to demonstrate and measure the impact we make socially on the community we serve.

Travel

We promote and support active travel to reduce unnecessary journeys during the work commute. We publicise the bike purchase scheme annually to encourage a healthier and greener way to commute to our sites.

The Trust logs significant mileage associated with its leased and grey travel fleet. We are exploring ways to reduce our travel footprint by way of installing Plug in Electric Vehicle (PHEV) points to encourage the take up of personal Hybrid/Electric cars for staff enabling the conversion of the fleet to more sustainable vehicles.

Service delivery reductions are being driven through the encouragement of agile working where appropriate with the issue of internet enabled laptops, mobile phones, teleconferencing and 'Touchdown' hot desking facilities.

Future Proof

Adaption to climate change

Climate change increasingly poses a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that it is considered when planning how we will best serve patients. We continue to consider the potential need to adapt the organisation's activities and buildings as a result of the potential risks posed by climate change and when required, report this through the Sustainable Development Unit to satisfy the requirements of national reporting criteria.

Sustainable care models

The Trust will seek to develop ways to ensure that sustainability and the achievement of sustainable models of care support the reduction of carbon emissions associated service delivery methods.

Biodiversity and green space

While some of the estate is dispersed and rural or semi-rural, much of it is located in urban areas. It has always been the policy to provide safe green spaces that are maintained within the confines of our premises for their therapeutic value to patients and the health and wellbeing of staff and visitors. The Trust will continue with this policy and will endeavour to introduce more biodiversity into these spaces.

Financial Review

Overview

This part of the Performance Report provides a commentary on the financial position of the Trust.

The Trust's annual report and accounts cover the period of 1 April 2018 to 31 March 2019, and have been prepared in accordance with directions issued by NHS Improvement under the National Health Service Act 2006. They are also prepared to comply with International Financial Reporting Standards (IFRS) and are designed to give a true and fair view of the Trust's financial activities.

Financial Performance

The Trust submitted an operational plan for the 2018/19 financial year which included a planned deficit of £2.7 million, a recurrent efficiency requirement of £11.6 million and the receipt of £3.2 million of non-recurrent core Provider Sustainability Funding (PSF). When this non-recurrent PSF funding is excluded, the Trust's underlying plan for the year was a £5.9 million deficit.

As in previous financial years, the Board was required to confirm its agreement to the delivery of a control total for the year. NHS Improvement (NHSI) set this for the year at a deficit of £2.7 million which includes the receipt of PSF core funding.

During the year, the Trust had the opportunity to receive additional PSF incentive funding in return for an improvement in the Trust's performance against the control total. Following a review of the financial forecast for the year, a £2.7 million improvement was agreed with NHSI, which in turn generated additional PSF incentive funding.

As at the end of the financial year, the Trust reported an overall surplus of £5.6 million. However, this includes three accounting adjustments relating to the receipt of non-recurrent PSF core and incentive funding, the impairment of land and buildings and the non-cash element of the Local Government Pension Scheme, which when excluded, reduce the Trust's position to an underlying deficit of £3 million.

The tables below provide a summary of the Trust's performance on its Statement of Comprehensive Income and the Statement of Financial Position.

Table 3: Summary of Statement of Comprehensive Income

	2018/19 £m	2017/18 £m
Total Income	318.7	352.3
Operating Expenses	(305.3)	(348.4)
Finance Costs / Other Gains and Losses	(7.8)	(7.3)
Gain on Transfer by Absorption	0.0	203.2
Reported Surplus / (Deficit) for the year	5.6	199.8
Exclude: PSF Core Funding	(3.3)	(2.3)
Exclude: PSF Incentive Funding	(5.5)	(5.5)
Exclude: Impairment of Land and Buildings	0.1	3.9
Exclude: Transfer by Absorption	0.0	(203.2)
Exclude: Local Government Pension Scheme (non-cash element)	0.1	0.2
Underlying Surplus / (Deficit) excluding PSF Core and Incentive Funding	(3.0)	(7.1)

Table 4: Summary of Statement of Financial Position

Summary of Statement of Financial Position	2018/19 £m	2017/18* £m
Non Current Assets	219.9	219.6
Current Assets (excluding cash)	21.8	28.7
Cash and Cash Equivalents	63.3	60.0
Current Liabilities	(43.6)	(52.0)
Non-Current Liabilities	(53.1)	(56.3)
Total Assets Employed	208.3	200.0
Total Taxpayers Equity	208.3	200.0

*See note 1.29 of annual accounts

Income from Health Care Activities

The Trust's income received for the purposes of the health service in England totalled £289.4 million in 2018/19, which is greater than the income received from the provision of goods and services for any other purposes of £29.3 million. This is in line with the requirement of section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Income from Non Health Care Activities

The Trust provided an Information and Communications Technology service to other NHS organisations during the 2018/19 financial year, as well a car leasing service to a number of local NHS organisations and housing associations.

Operating Expenditure

The total operating expenditure of the Trust for 2018/19 was £305.3 million. The largest area of spend relates to staff costs of £222.8 million.

Efficiency and Income Generation Initiatives

Against the total efficiency requirement for the year of £11.6 million, the Trust successfully achieved the full target through a mix of both recurrent and non-recurrent measures. On a recurrent basis, the Trust identified recurrent savings of £8.8 million, with the residual £2.8 million being factored into the 2019/20 plan.

Wherever possible, the Trust aims to minimise the impact of generating savings on front line services and maximise savings from corporate and back office functions. During 2018/19, the Trust successfully delivered savings in this area of £5.7 million.

Finance Costs

The Trust is required to pay the Treasury dividends in respect of the Public Dividend Capital held by the Trust and which was historically given by Treasury for capital financing. Dividends are paid to Treasury twice a year during September and March, and are payable at a rate determined by Treasury (currently 3.5%) on the average relevant net assets of the Trust. Average relevant net assets are based on the opening and closing balances of the Statement of Financial Position, and therefore a debtor or creditor arrangement may exist at year end between the Treasury and the Trust.

In addition, the Trust is required to pay finance costs in respect of PFI obligations for the Trust's three PFI-funded locations at Rawreth Court in Rawreth, Clifton Lodge at Westcliff and Brockfield House in Wickford. The Trust also holds loans with the Department of Health which incurred interest costs of £0.2 million.

Local Government Pension Scheme (LGPS)

The Trust is required to obtain an actuarial valuation on the Local Government Pension Scheme (LGPS) on an annual basis, which relates to social workers employed by the Trust under Section 75 agreements. This is based on figures provided by the actuary at Essex Pension Fund, with the figures subsequently verified by the Trust's External Auditors.

The operational cost, finance income and finance costs of the scheme for 2018/19 have been reflected in the Trust's Statement of Comprehensive Income and reduced the Trust's surplus by £0.1 million. In addition, the Trust is required to account for an actuarial gain of £0.6 million resulting from a reduction in the value of scheme assets has been reflected as a reduction in reserves within the Statement of Comprehensive Income.

Revaluation of Investment Property

In accordance with accounting guidelines, the Trust has opted to undertake an annual revaluation of its investment properties and in addition this year, has adopted an income based valuation for one of our leased properties previously valued on the basis of depreciated replacement cost. This has resulted in a net decrease in the overall value of the Trusts investment properties of £0.3 million in 2018/19. This decrease is reported as part of the Statement of Comprehensive Income.

Impaired Value of Land and Property

The Trust has undertaken an assessment of the value of its land and building assets as at the end of 2018/19, and confirmed that these have not materially increased since the full revaluation of the estate undertaken for the 2017/18 financial year. The Trust has therefore not incurred any impairments on its main land and buildings during 2018/19.

Transfers by Absorption

As of 1 April 2018, the provision of community services across Bedfordshire transferred from the Trust to the East London NHS Foundation Trust and Cambridgeshire Community Services NHS Trust. In line with NHS guidance, the Trust has accounted for this transaction as a 'transfer by absorption' during 2018/19 and invoiced the receiving organisations for their respective share of the net assets and liabilities totaling £0.3 million.

Capital Expenditure

Within non-current assets on the face of the Statement of Financial Position, the Trust held intangible assets, plus property, plant and equipment totaling £201.7 million as at the end of March 2019.

During the year, the Trust invested £6.1 million on items of capital expenditure, of which £0.3 million was funded from Department of Health Public Dividend Capital. The total capital spend for the year included the following:

- £0.7 million on the Derwent Centre in Harlow;
- £0.8 million on the Ashingdon Ward Refurbishment at Thurrock Hospital;
- £1.3 million of CQC related improvements;
- £1.7 million on IT related projects including cyber-security;
- £0.7 million on backlog maintenance of Trust properties;
- £0.1 million on medical equipment;
- £0.2 million on carbon reduction project; and
- £0.6 million on improvements to Trust facilities.

Investment Property

The Trust holds a number of investment properties within the classification of non-current assets totaling £18.1 million. These properties are leased out to various organisations including other NHS organisations, housing associations and private individuals.

During the year, one new property was reclassified as an investment property. This relates to number 72/74 London Road, Wickford in Essex.

Assets Held for Sale

As at the end of the 2018/19 financial year, the Trust held one asset in preparation for disposal. This relates to number 4 The Glades based in Bedfordshire. This was revalued during the year, and an impairment of £0.1 million was charged to the Statement of Comprehensive Income.

The Trust disposed of one asset during the year which had previously been held as available for sale in respect of number 32 Thoroughgood Road, Essex.

Working Capital and Liquidity

The Trust has robust cash management and forecasting arrangements in place, which are further supported by a Finance and Performance Committee. This Committee was chaired by a Non-Executive Director, and included a further two Non-Executive Directors, the Chief Executive, the Executive Chief Finance Officer, the Executive Director for Corporate Governance, the Executive Director for Mental Health and the Executive Medical Director.

The Trust invests surplus cash on a day-to-day basis in line with the Operating Cash Management Procedure, and generated interest from cash management activities of £0.4 million in 2018/19. The interest earned is used to offset the associated costs of banking and cash transit services. The Trust ended the financial year with a strong working capital position of positive £41.5 million.

Policy and Payment of Creditors

The Non NHS Trade Creditor Payment Policy of the NHS is to comply with both the CBI Prompt Payment Code and government accounting rules. The government accounting rules state: ***"The timing of payment should normally be stated in the contract. Where there is no contractual provision, departments should pay within 30 days of receipt of goods and services or on the presentation of a valid invoice, whichever is the later"***.

As a result of this policy, the Trust ensures that:

- a clear consistent policy of paying bills in accordance with contracts exists and that finance and purchasing divisions are aware of this policy;
- payment terms are agreed at the outset of a contract and are adhered to;
- payment terms are not altered without prior agreement of the supplier;
- suppliers are given clear guidance on payment terms;
- a system exists for dealing quickly with disputes and complaints;
- bills are paid within 30 days unless covered by other agreed payment terms.

The Trust's performance on its creditor payments for the 2018/19 financial year is detailed below:

Table 5: Performance on creditor payments 2018/19

	NHS		Non-NHS	
	Number of Invoices	Value £000	Number of Invoices	Value £000
Invoices paid within 30 days	1,305	17,507	65,799	129,000
Invoices paid in excess of 30 days	853	6,453	12,991	19,076
Total invoices that were or should have been paid in 30 days	2,158	23,960	78,790	148,076
	60.2%	73.1%	83.5%	87.1%

The Trust's performance on the payment of non-NHS invoices of 83.5% for 2018/19 (based on number of invoices) is an increase on the previous financial year of 76%. However, as a result of the settlement and processing of historic invoices relating to 2016/17 with NHS Property Services and Community Health Partnerships, our performance on the payment of NHS invoices has reduced from 79% last financial year to 60.2% for 2018/19.

During the year, the Trust incurred actual interest charges on the late payment of invoices of £91 compared to £474 in 2017/18. This compares to a potential interest charge on those invoices not paid within the 30 day period of £352,000, using an interest rate of 8.25% in accordance with the Late Payment of Commercial Debts (Interest) Act 1998.

Taxpayers Equity

As at the end of 2018/19, the Trust holds Public Dividend Capital of £127.6 million, plus reserves relating to income and expenditure surpluses generated over the year, and from asset revaluations arising from the impact of the valuations of the Trusts estate. The total of these represents the level of taxpayers' equity in the Trust.

Accounting Policies

The Trust has detailed accounting policies which comply with the NHS Foundation Trust Annual Reporting Manual. These have been thoroughly reviewed by the Trust and agreed with External Auditors. Details of the policies are shown on pages **6 – 25** of the 2018/19 annual accounts.

Cost Allocation and Charging Requirements

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury.

NHS Pensions and Directors Remuneration

The accounting policy in relation to employee pension and retirement benefits and the remuneration report is set out on pages **45 – 59**.

Charitable Funds

For the 2018/19 financial year, the Trust has operated with one registered charity in the name of Essex Partnership University NHS Foundation Trust Charities (number 1053793). This was following the granting of the legacy North Essex Partnership NHS Foundation Charitable Fund (1053509) to the legacy South Essex Partnership NHS Foundation Trust Charitable Fund (1053793) in March 2019, and its subsequent renaming from April 2019. All restrictions in place on the two legacy funds have continued in the name of the Essex Partnership Charity.

The Trust's charitable funds have resulted from fund raising activities, donations and legacies received over many years. It consists of a number of restricted funds which are used to purchase equipment and other services in accordance with the purpose for which the funds were raised or donated, and as well as unrestricted (general purpose) funds which are more widely available for the benefit of patients and staff.

The Board of Directors act as Corporate Trustee for the Charity and is further supported by the Charitable Funds Committee. The Committee is chaired by a Non-Executive Director and includes two further Non-Executive Directors, the Executive Chief Finance Officer and the Executive Director of Corporate Governance. The Audit Committee considered and approved the non-consolidation of the charity accounts into the Trust's main accounts on the grounds of materiality at their meeting in March 2019.

A copy of the charity's Annual Report and Accounts for 2018/19 will be available from January 2020 upon request to the Executive Chief Finance Officer.

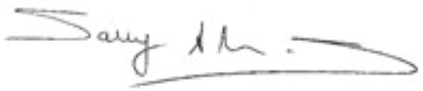
Political Donations

The Trust did not make any political donations from its exchequer or charitable funds during 2018/19.

Financial Risk Management

The Trust's financial performance is assessed by NHS Improvement, based on the Single Oversight Framework. This measure includes five themes, of which one is the Trust's performance on finance and use of resources rating.

The Trust has a robust risk management process into which any identified financial risks are included and monitored on a regular basis.



Sally Morris
Chief Executive
Essex Partnership University NHS FT
23 May 2019

> *I wanted to write to say how good your DSN was on the training sessions I have undertaken. She was very patient with us all in the group not matter how many questions we asked. Her knowledge was outstanding and the way she built a relationship with us all was amazing. I think she is a wonderful nurse in so many ways and wanted to let you know a patient experience*

ACCOUNTABILITY REPORT

Directors' Report

Introduction

Our Board of Directors provides overall leadership and vision to the Trust. It is ultimately and collectively responsible for the Trust's strategic direction, its day to day operations and all aspects of performance, including clinical and service quality, financial and governance. The powers, duties, roles and responsibilities of the Board are set out in the Board's Standing Orders and Scheme of Reservation and Delegation.

The main role of the Board is to:

- provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed;
- set the Trust's strategic objectives taking into consideration the views of the Council of Governors, ensuring that financial resources and staff are in place for the Trust to meet its objectives and review management performance;
- ensure the quality and safety of healthcare services, education and training delivered by the Trust and to apply the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission, and other relevant NHS bodies;
- ensure compliance by the Trust with its provider licence, its constitution, mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations;
- regularly review the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.

The Board believes that its membership is balanced, complete and appropriate and that no individual group or individuals dominate the Board meetings. The Board has also agreed a clear division of responsibilities between the Chair and Chief Executive which ensures a balance of power and authority.

The Board has a wide range of skills and the majority of members have a medical, nursing or other health professional background. Non-Executive Directors have wide-ranging expertise and experience with backgrounds in finance, audit, business and organisational development, primary care, commercial and marketing. The Board has demonstrated a clear balance in its membership through extensive debate and development.

Our Board of Directors

The descriptions on the following pages of each Director's expertise and experience demonstrates the balance and relevance of the skills and knowledge that each of the Directors bring to the Trust.

Executive Directors

Sally Morris, Chief Executive

As Chief Executive of SEPT Sally saw through the successful merger between SEPT and NEP – the first FT to FT merger – and was appointed as the Chief Executive of the EPUT Board of Directors in August 2017 having previously been appointed as the Chief Executive of the Interim Board.

Sally first joined SEPT in 2005 as the Executive Director with operational leadership responsibility for all mental health and learning disability services across South Essex and subsequently Bedfordshire and Luton. During this time, Sally was pivotal in establishing a dedicated contracting function and led subsequent contract acquisitions. She was appointed Chief Executive of SEPT in September 2013, having previously been Deputy Chief Executive with the portfolio for Specialist Services and Contracts; a role which was operationally accountable for forensic, child and adolescent mental health services (CAMHS) and psychological and therapy services across Bedfordshire, Luton and Essex.

Previous roles included being the Director of Finance and Specialist Commissioning for Southend Primary Care Trust, as well as being involved with mental health and learning disability services for a number of years, ranging from consultancy work when in the private sector to director of mental health commissioning at South Essex Health Authority and lead for mental health at the Essex Strategic Health Authority. With a history of successful partnership working with local authorities, the voluntary sector and other NHS Trusts, Sally has a proven track record of managing major change in complex environments and where key stakeholders have polarised views.

A chartered accountant by profession and a keen sailor in her leisure time, Sally also represented Wales in lacrosse.

Andy Brogan, Executive Director Mental Health & Deputy Chief Executive

Andy has a wealth of experience within the NHS initially in direct care. Over the past 20 years he has held a variety of Nursing Director and Governance posts as well as spending time at Care Services Improvement Partnership (CSIP) and the Department of Health. His Executive Director experience has been a mixture of clinical leadership, operational and strategic management and policy development.

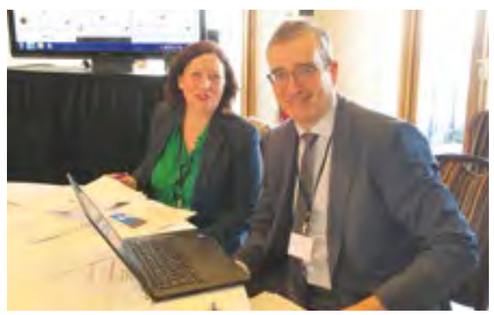
Andy first joined SEPT in September 2009 as the Interim Executive Nurse and then to the substantive post of Executive Director Clinical Governance and Executive Nurse in February 2014; and later included the role of Deputy Chief Executive to his responsibilities. He was a key member of the Project Board that managed the successful merger between SEPT and NEP and he provided support to NEP in the role of Director of Operations from January 2017. Andy was appointed as the Executive Director Mental Health and Deputy Chief Executive on the EPUT Board of Directors in August 2017 having previously been appointed to the same role on the Interim Board.

In previous posts Andy led the clinical workstream in the merger of two mental health trusts in Cheshire and Wirral. He supported the transfer of a mental health directorate from an acute trust to a mental health trust. At SEPT he supported the Trust in the acquisition of the Bedfordshire and Luton Trust, the transition of Transforming Community Services and the disaggregation of services in Bedfordshire and Luton.

Andy has been heavily involved in national leadership work being a founding member of the Mental Health Nurse Directors Group and participated in national working groups including NICE Expert Reference, as a member of the National Intensive Care Group, and he is currently an Associate National Clinical Director for Mental Health for NHS Improvement. His experience at national level has enabled him to gain valuable insights into development of national policy and how this is translated into operational practice.

Andy's portfolio includes:

- Carers
- Learning Disabilities
- Locality Clinical Administration
- Mental Health Services
- Social Work
- Psychology and Therapy Services
- Specialist Operational Services
- Training and Development
- Workforce Planning



Professor Natalie Hammond, Executive Nurse

Natalie was appointed as Executive Nurse on EPUT's Board of Directors in August 2017 having previously been appointed to the same role on the Interim Board. She has responsibility for the professional leadership of the nursing, allied health professionals and psychology workforce ensuring care is delivered with compassion and safely meeting the high quality standards provided to our patients and service users. Natalie has specific responsibility for safety, service user experience and outcomes, and executive responsibility for safeguarding and infection control.

Natalie has a wealth of experience and has been involved with research in mortality, addictions, service design, reducing restrictive practice and police liaison. She was involved in the development of National Guidance for Reducing Restrictive Practice at the Department of Health; and Independent Police Commission Mental Health Deaths in Custody.

Natalie was previously a Consultant Nurse for the Promotion of Safe and Therapeutic Services specifically at reducing harm to patients in South London and Maudsley Trust, Deputy Director of Nursing and Quality in North London and the Executive Nurse at NEP.

Natalie's portfolio includes:

- Clinical Audit
- Clinical Governance
- Clinical Risk
- Infection Control
- Mental Health Act (MHA) Office
- Nurse Leadership
- Quality including the Quality Academy
- Safeguarding

Dr Milind Karale, Executive Medical Director FRCPsych, MSc (Forensic Psychiatry), DNB, DPM, MBBS

Milind is a Consultant Psychiatrist at West Essex Community Mental Health Team and rTMS Services, Caldicott Guardian and Executive Medical Director for the Trust. Milind was appointed as the Executive Medical Director for the EPUT Board of Directors in August 2017 having previously been appointed to the same role on the Interim Board.

Milind trained in Cambridge and Eastern Deanery to attain membership of the Royal College of Psychiatrists and later completed a Masters in Forensic Psychiatry (merit) at the Institute of Psychiatry, Maudsley. His areas of interest include patient safety, clinical governance, liaison psychiatry and mood disorders. He chairs the Trust's Physical Health, Learning Oversight and Mortality Review Sub-Committees.

He has been involved in medical management for last ten years, working as Clinical Director for Clinical Governance, Deputy Medical Director and recently Medical Director from 2012. He has a keen interest in teaching and has written several chapters in books for MRCPsych examination. He is on the Board of Examiners for The Royal College of Psychiatrists and was previously the Chair of the Anglia Ruskin University Health and Wellbeing Academy. Milind was awarded a fellowship by The Royal College of Psychiatrists in 2017 in acknowledgement of his dedication and commitment to improving the lives of patients.

Milind's portfolio includes:

- Caldicott Guardian
- Medical Staff
- Pharmacy
- Research

Nigel Leonard, Executive Director Corporate Governance & Strategy

Nigel is the Executive Director Corporate Governance and Strategy at EPUT and the Trust's LSMS (Local Security Management) lead.

Nigel joined SEPT as the Executive Director Corporate Governance in February 2014. He was the Merger Project Director for the first successful merger of two FTs – SEPT and NEP – in April 2017. He was appointed as the Executive Director Corporate Governance and Strategy on EPUT's Board of Directors in August 2017 having previously been appointed to the same role on the Interim Board.

Nigel has worked in the NHS for over 20 years in a variety of planning, governance and project management roles in acute, community and mental health organisations. He has worked as a Programme Director delivering changes in mental health services in Essex and Berkshire and, more recently, was the Director of Planning and Corporate Affairs at West London Mental Health NHS Trust.

Nigel is a qualified Company Secretary and has an MSc in Project Management. He is also a member of the Association for Project Management.

Nigel's portfolio includes:

- Business Development
- Complaints
- Compliance
- Communications
- Contracting
- Corporate Governance
- Emergency Planning
- Legal
- Human Resources
- Non-Clinical Risk Management
- Occupational Health
- Organisational Development
- Patient Engagement
- Payroll/Medical Staffing
- Planning
- Programme Management Office
- Public Health
- Security Management (LSMS)
- Trust Secretary
- Workforce Information.

Mark Madden, Executive Chief Finance & Resources Officer

Mark was appointed as the Executive Chief Finance and Resources Officer for EPUT in August 2017. He first joined SEPT in April 2014 in the same role and was appointed as the Executive Chief Finance and Resources Officer for the Interim Board. He was a key member of the Project Board that managed the successful merger first FT to FT merger between SEPT and NEP. Mark is also the Trust's Senior Information Risk Owner (SIRO). A qualified accountant, Mark has worked in a variety of NHS and non NHS financial roles.

Mark is married and has two children and is a passionate sportsman. He formerly played rugby for Norwich and his hobbies include running, cycling and keeping up with his children.

Mark's portfolio includes:

- Estates and Facilities
- Finance
- Information Management and Technology
- Information
- Information Governance
- Performance
- Purchasing
- Records Management
- SIRO

Malcolm McCann, Executive Director Community Services & Partnerships

Malcolm studied Nursing at the University of Manchester and has worked for more than 25 years in the NHS. During this time, he has gained a wealth of experience, at senior management level, managing a wide range of different services across various sectors including in-patient and community services for adults, older people and children and working at Board level since the late 1990s.

As Chief Executive of Castle Point and Rochford Primary Care Trust (PCT) from 2001 to 2006, he led the organisation from its inception through its development into a highly successful PCT. He has since worked as the Chief Operating Officer in both South West and South East Essex, joining SEPT as Director of Acute and Community Services in June 2010. In this role and in partnership with director colleagues, Malcolm led the successful bid for the three community services that were acquired by SEPT in August 2011 and was member of the bid team with SERCO who were identified (April 2012) as the preferred bidder in Suffolk.

Malcolm was appointed as the Executive Director Community and Partnerships on EPUT's Board of Directors in August 2017 having previously been appointed to the same role on the Interim Board. His partnership portfolio involves working collegiately with commissioning organisations, acute hospitals and local authorities, together with a range of third sector and other stakeholders, and particularly with the STPs.

Malcolm's portfolio includes:

- Children's Services
- Community Services
- Equality and Diversity
- Faith Communities
- Partnership Working
- Recovery College

Non-Executive Directors

Professor Sheila Salmon, Chair

Professor Sheila Salmon was appointed as the Chair of EPUT with effect from 1 November 2017. She previously chaired Mid Essex Hospitals NHS Trust from 2010-2017 and was also the Founding Chair of the Joint Working Board (2016/17) forged through the collaboration of Mid Essex Hospitals with Basildon and Thurrock University Hospital FT and Southend University Hospital University FT within the Mid and South Essex Strategic Transformation Partnership (STP).

Sheila was previously Chair of the North East Essex Primary Care Trust from 2006 to 2010 and prior to that, chaired the Essex Ambulance Service, before being appointed to the Board of the East of England Ambulance Regional Service. Coming with a strong clinical background, she has built significant and diverse senior leadership experience in health and social care and in the University sector. She was the Executive Dean of Health at Anglia Ruskin University, where she led the establishment of a Regional Faculty of Health and Social Care, and has represented the Nursing and Midwifery Council on numerous quality and standards visits to British universities and their partner NHS Trusts.

Sheila has served as a quality partner with the Postgraduate Medical Education and Training Board (PMETB) and the General Medical Council (GMC). She holds a government appointment as an Equality and Diversity Ambassador and has worked internationally as a developmental consultant and strategic advisor. She is an experienced executive coach and leadership mentor and actively supports the East of England Coaching Network operated through Health Education England.

Sheila is the Emeritus Professor of Health Services Development at Anglia Ruskin University, currently advising on the establishment of the new Medical School, and has considerable previous experience both as an appointed Foundation Trust Governor and as a Non-Executive Director.

As well as chairing the Board of Directors and Council of Governors meetings, Sheila also currently chairs the Board of Directors and Council of Governors Remuneration and Nominations Committee meetings and is currently a member of the Strategy and Planning Committee. She is currently the Non-Executive Board champion / lead for organisational development, culture and education and training. Sheila is also the current Chair of the Mid and South Essex STP Chairs Advisory Group.

Alison Davis, Non-Executive Director and Senior Independent Director

Alison started her career as a State Registered Nurse, working in both acute and community settings. She later qualified as a solicitor, focusing on family and mental health law. She has been an NHS Chair for 11 years across mental health, learning disability and community services, and a Non-Executive Director for 18 years. She has broad experience in governance, patient safety and quality, with a strong focus on service user, staff and stakeholder engagement.

Alison has a track record leading major organisational change having successfully taken Bedfordshire and Luton Partnership Trust (BLPT) through the first competitive tendering process in the NHS in 2009/2010. Alison chaired Luton Community Services through their transfer out of NHS Luton in April 2011. Alison joined SEPT as a Non-Executive Director in January 2012.

Alison is a company director of Looking After Mum and Dad, a web-based community interest company, providing information, support and a forum for people caring for elderly relatives. She is also a Trustee of ImpactMH, a mental health social enterprise run by and for people who have experienced or are experiencing mental ill health.

Alison was appointed as a Non-Executive Director on the Interim Board of Directors of EPUT and subsequently as Non-Executive Director on the substantive Board of Directors. She was appointed as the Senior Independent Director in December 2017. Alison is currently a member of the Audit Committee as well as the Board of Directors Remuneration and Nominations Committee. She is currently the Non-Executive Director Board champion / lead for Freedom to Speak Up, whistle blowing, Mental Health Act, vulnerable adults and for children.

Dr Rufus Helm, Non-Executive Director (from 24 July 2018)

Rufus Helm originally trained as a doctor, specialising in Obstetrics and Gynaecology before making the transition to management consultancy. Starting his consultancy career with Arthur Andersen Consulting, he helped establish Andersen's Consultancy offering in healthcare before moving on to commercial roles with Serco and Circle Health. Here he concentrated on the design and implementation of new service models focusing on improving the management of long term conditions and, in particular, the interface between acute and community settings.

Rufus joined the British Medical Journal (BMJ) as their Head of Business Development in 2012 where he focused on how digital resources can drive clinical improvements in areas such as clinical decision support, shared decision making and the delivery of evidence based medicine. More recently, he helped Health Navigator implement its innovative tele-coaching model as their Chief Operating Officer / Chief Medical Officer and now provides freelance consultancy to healthcare organisations country-wide.

Rufus was appointed as a Non-Executive Director onto the substantive Board of Directors for EPUT from July 2018. Rufus is currently a member of the Board of Directors Remuneration and Nominations Committee, Quality Committee and Strategy and Planning Committee. He is currently the Non-Executive Director Board champion / lead for innovations and dementia.

Manny Lewis, Non-Executive Director

Manny began his career at the Inner London Education Authority, following completion of an LLB Honours degree at University College London. He then gained a Masters degree in Manpower Planning and shortly afterwards became a corporate member of the Institute of Personnel and Development (CIPD) specialising in Human Resources in the public sector.

In 1988 he became Head of Education Personnel at Waltham Forest Council followed by promotions to senior jobs as Assistant Director for Education in Birmingham (1990), Head of Personnel and Democratic Services at Thurrock Council (1997) and Executive Director, Corporate Services at the Greater London Authority (2001) where he helped develop the structures and operations for the new London Government. He was then appointed as Chief Executive of the London Development Agency in 2004 where he successfully led the land assembly for the London Olympics.

In 2008 he was awarded an Honorary Doctorate of Business Administration for services to regeneration and development in London.

Manny became Managing Director of Watford Borough Council in 2009 which remains his current executive position. As a Non-Executive Director, he held the role of Deputy Chair of Mid-Essex Hospital Trust for two terms and chaired its Finance and Performance Committee. With a strong commitment towards disability rights, he is a trustee at Golden Lane Housing, a charity providing housing for people with a learning disability and also the Chair of Habinteg, a regulated housing association providing accessible homes for people with a physical disability.

Manny was appointed as a Non-Executive Director at EPUT in February 2018. Manny is currently the Chair of the Finance and Performance Committee and a member of the Board of Directors Remuneration and Nominations and the Strategy and Planning Committees. He is currently the Non-Executive Director Board champion / lead for equality and diversity, older people / age equality and learning disability.

Mary-Ann Munford, Non-Executive Director (until 31 May 2018)

Mary-Ann brought wide experience from her varied, 40 year career in health services. Originally trained as a general nurse and mental health nurse she specialised in psychosocial and family centred nursing where she became interested in individual and organisational development. After studying for a degree in Psychology and Anthropology and encouraged by the Griffiths Report, she trained as a General Manager and held a variety of director roles in both the NHS and the independent sector.

After completing an MBA she took on the role of Primary Care Group (PCG) and PCT Chief Executive and led considerable change developing these new commissioning organisations in Essex. Since then she has been involved in setting up a social enterprise, promoting nutrition and mental health, marketing patient safety, quality and efficiency tools with the NHS Institute for Innovation and Improvement and working as a volunteer with older people.

Mary-Ann was appointed as a Non-Executive Director at SEPT in January 2015 and was appointed as a Non-Executive Director on the Interim Board of Directors, then subsequently to the EPUT substantive Board of Directors.

Mary-Ann was the chair of the Mental Health and Safeguarding and Remuneration Committees as well as being a member of the Audit, Charitable Funds, Investment and Planning, Nominations and Quality Committees. She was the Board champion/lead for safeguarding, training and development, and joint lead for organisational development.

Dr Alison Rose-Quirie, Non-Executive Director (from 24 July 2018)

Dr Alison Rose-Quirie began her career as a Prison Governor, first operational female into Wandsworth Prison and youngest Governor of a male prison on transfer to the independent sector. Alison was also the Managing Director of GSL (now G4S) prisons and immigration and advised on international development projects.

She changed career path to Secure Mental Health as Managing Director for the Priory Group and later Care UK where she led the development of innovative rehabilitation service and a unique philosophy of care, always putting the service user at the very heart of the business. She was, twice, elected to Chair the Independent Mental Health Alliance and championed the cause of the sector and service users. Alison is involved in Parliamentary Groups, Ministerial Advisory Groups and co-authored 'The Pursuit of Happiness, a new ambition for our Mental Health services in 2014'.

Until taking the decision to step out of operational management, Alison was the CEO of the multi award winning Swanton Care and Community. Alison is on the Board of Care England and was a founder trustee of Learning Disability England. She is a Chair of an architectural practice and her son's event management business, and a visiting Chair for the Care Quality Commission (CQC). Alison holds a Law Degree, a Masters of Business Administration and a PhD.

Alison was appointed as a Non-Executive Director onto the substantive Board of Directors for EPUT from July 2018. Alison is currently the Chair of the Strategy and Planning Committee and a member of the Board of Directors Remuneration and Nominations Committee. She is currently the Non-Executive Director Board champion / lead for energy and sustainability and procurement.

Amanda Sherlock, Non-Executive Director

Amanda started her career as an Occupational Therapist before moving into a variety of NHS general management and director roles working across acute, mental health and community services. She spent time at the Department of Health leading the strategy and performance portfolio for Eastern Region and steering through the transition programme of PCG to PCT status.

Moving into care regulation to set up the first national regulator for care, Amanda spent several years in regulation culminating in holding the role of Director of Operations for the CQC. Now working for a large commercial organisation she is responsible for quality, risk and governance for health and social care services.

Amanda was formerly appointed as a Non-Executive Director at NEP and was appointed as a Non-Executive Director on the Interim Board of Directors, then subsequently to the EPUT substantive Board of Directors.

Amanda is currently the chair of the Quality Committee as well as being a member of the Audit Committee, Board of Directors Remuneration and Nominations Committee and Charitable Funds Committees. She is the Non-Executive Director Board champion/lead for quality, patient safety and end of life care.

Nicci Statham, Non-Executive Director (until 30 April 2018)

Nicci brought a wide range of experience from private, non-profit and public sectors. She originally started out her career as an accountant working in finance for over 15 years. Following this she spent a number of years in programme management, working in both medium sized and corporate businesses.

Nicci started running her own business in 2004, firstly a small business consultancy and then a social enterprise delivering local corporate social responsibility projects. Nicci then simultaneously re-trained as an executive coach and leadership trainer – delivering training in equality & diversity, self-esteem, purpose/visioning, communication and many leadership topics. She now specialises in behaviour change predominantly in the accounting, legal and not for profit sectors.

Nicci is passionate about personal development, building powerful relationships and empowering others to transform their results through changing their attitude and behaviour.

Nicci joined the EPUT Board of Directors as a Non-Executive Director in October 2017 and was a member of the Charitable Funds, Finance and Performance, Mental Health and Safeguarding and Nominations Committees. She was the Board lead for equality and diversity, and joint lead for organisational development, and was the older people's and age equality champion.

Nigel Turner, Non-Executive Director

Nigel is a senior financial executive (to Chief Finance Officer / Finance Director level) with over 30 years of general, financial, strategic and cross-national management experience in both the new economy and traditional business environments. He has practical hands-on experience of start-ups, business creation and development, and fund raising.

Since 2001, Nigel has been providing management consultancy support to the NHS, including four foundation trust applications. He has worked with the full spectrum of NHS organisations, including acute and mental health trusts, and clinical commissioning groups. Projects include, financial planning and modelling, financial turnaround, Sustainability and Transformation Plans, funding applications, IFRS implementation, cash flow forecasting, options appraisal, financial control and budgeting, plus advising NHS boards on strategy and business development.

Prior to working with the NHS, Nigel was Chief Finance Officer of e-exchange plc, a B2B platform for the computer industry, where he raised more than US$14 million in post-seed finance and a US$50 million private placement for a pre-NASDAQ IPO funding. He joined e-exchange after spending five years with Sun Chemical Corporation, the world's largest supplier to the graphical arts industry, as a European financial controller. From 1991 to 1993 Nigel worked for the German chemical and consumer goods group, Henkel KGaA, as their UK financial controller, and prior to that he was a manager at Coopers & Lybrand (PwC).

Nigel is a fellow (FCA) of the Institute of Chartered Accountants in England & Wales and holds an Executive MBA from the London Business School and the Financial Times' Non-Executive Director Diploma.

Nigel was appointed as a Non-Executive Director of EPUT in October 2017. He is currently the chair of the Charitable Funds Committee and a member of the Audit, Board of Directors Remuneration and Nominations and Finance and Performance Committees. He is currently the Non-Executive Director Board champion / lead for security and risk management (LSMS) and counter fraud.

Janet Wood, Non-Executive Director and Vice-Chair

Janet has a degree in Business Studies and Accountancy from Edinburgh University and is a member of the Institute of Chartered Accountants of Scotland, having trained with Deloittes. She joined the NHS in 1992, working for Redbridge Healthcare and then South Essex Health Authority, initially as chief accountant. Janet took a career break in 1999 to spend time with her family. At this point she was Finance Manager at Southend and Billericay, Brentwood and Wickford Primary Care Groups (the forerunners to PCTs). During her career break she undertook consultancy work for HFMA (Healthcare Financial Managers Association) covering a wide area of NHS finance issues and in particular assurance and governance. She was appointed a Non-Executive Director for SEPT in November 2005.

Janet had a very successful career as an NHS accountant and, therefore, is fully conversant with all NHS finance issues. She was involved in getting the Essex PCTs up and running and putting in place finance and early governance structures. Through her work with HFMA she helped run successful training events and has contributed to several publications explaining NHS finance and governance issues.

Janet was the former Vice-Chair and a Non-Executive Director of SEPT. When EPUT was established, Janet was appointed as Vice-Chair of the Interim Board and undertook the role of Acting Chair until 31 October 2018. She was appointed as the Vice-Chair of the substantive Board with effect from 1 October 2018.

Janet is currently the chair of the Audit Committee, and is also an ex-officio member of the Finance and Performance and Quality Committees. She is also currently the Non-Executive Director Board champion / lead for emergency planning and cyber security.

Board Directors Contact Details

Board Directors can be contacted by telephone via the Trust's main switchboard on 0300 123 0808 or by email.

Direct email addresses for Directors can be obtained from the Trust Secretary at: epunft.membership@nhs.net

Board Directors Register of Interests

All members of the Board of Directors have a responsibility to declare relevant interests as defined in the Trust's constitution. These declarations are made known to the Trust Secretary and entered onto a register which is available to the public.

Details can be requested from the Trust Secretary at:

The Lodge, Lodge Approach, Wickford SS11 7XX

or email: epunft.membership@nhs.net

In addition, the Register of Interests for Board members is published on the Trust website.

Responsibilities of Directors for Preparing the Annual Accounts and Report

The Directors are required under the NHS Act 2006, and as directed by NHS Improvement, to prepare accounts for each financial year. NHS Improvement, with the approval of HM Treasury, directs that these accounts shall show, and give a true and fair view of the NHS FT's gains and losses, cash flow and financial state at the end of the financial year.

NHS Improvement further directs that the accounts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury. In preparing these accounts, the Directors are required to:

- apply on a consistent basis, for all items considered material in relation to the accounts, accounting policies contained in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement;
- make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant accounting standards, and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the Trust. This is to ensure proper financial procedures are followed, and that accounting records are maintained in a form suited to the requirements of effective management, as well as in the form prescribed for published accounts.

The Directors are responsible for safeguarding all the assets of the Trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors are required to confirm that:

- as far as they are aware, there is no relevant information of which the Trust's auditor is unaware; and
- they have taken all steps they ought to have taken as a Director in order to make themselves aware of any such information and to establish that the auditor is aware of that information.

The Directors confirm, to the best of their knowledge and belief, they have complied with the above requirement in preparing the accounts.

The Directors consider that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

NHS Improvement's Well Led Framework

Overview

NHS Improvement's Well Led Framework identifies the characteristics required of good provider organisations that ensure quality services are provided – these are:

- leadership capacity and capability;
- clear vision and credible strategy;
- culture of high quality care;
- clear responsibilities, roles and systems of accountability;
- clear and effective processes for managing risks;
- robust and appropriate information effectively processed and challenged;
- people using services, the public, staff and partners engaged and involved;
- robust systems and processes for learning, continuous improvement and innovation.

In 2017/18, our first year as a newly merged organisation, we invested heavily in taking action to create the corporate and quality governance infrastructure required to consistently deliver high quality services. Following a comprehensive self-assessment, the Board of Directors was able to self-certify compliance with NHS Improvement's Corporate Governance Statement in May 2018 and actions to continue to strengthen the governance arrangements in place were identified and taken forward in a Governance Development Plan, monitored by the Finance and Performance Committee. The CQC Comprehensive Inspection in April / May 2018 rated the Trust as 'good' in respect of the 'Well Led' domain. A self-assessment against the detailed criteria that supports the characteristics of a 'well led' organisation was carried out during Quarter 4 2018/19 which confirmed arrangements in place meet the criteria expected of 'good' rated organisations. A range of actions have been identified to enable the Trust to meet criteria associated with 'outstanding' rated organisations in the future.

In accordance with NHSI guidance, which states that organisations should ideally commission an externally facilitated review against the well-led framework every three years, we decided to undertake an externally facilitated developmental well-led review at the end of 2018/19. Deloitte LLP were appointed, following a competitive selection process, to undertake the review. Deloitte LLP had not undertaken any audit or governance-related work at the Trust or predecessor organisations within the past three years, and there were deemed to be no conflicts of interest. At the time of preparing this annual report the findings of their review are awaited. We anticipate that an action plan to address their findings will be in place by July 2019 and we will report on the findings and progress against any actions agreed in our annual report for 2019/20.

The Annual Governance Statement (pages **iv – xi** of the annual accounts) particularly provides details of the systems of internal control that have been established and the Quality Report identifies many examples of how these have created the infrastructure within which quality services are delivered.

There are no material inconsistencies between our Annual Governance Statement and this annual report.

Open Arts celebrates their 10th Anniversary

Open Arts joins the Trust in celebrating Spiritual Care Week

Stakeholder Relations

As a partnership Trust we remain firmly committed to working with all of our partners (our staff, our service users and their carers, our governors, members, clinical commissioning groups, local authorities and the voluntary sector) to deliver services that our local communities need. We are also working with all of our partners to develop shared proposals to improve health and care designed around the needs of whole areas, not just individual organisations.

EPUT is actively contributing to sustainability transformation partnership plans in three local economies.

NHS Improvement's Single Oversight Framework

Overview

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes as below:

- quality of care;
- finance and use of resources;
- operational performance;
- strategic change;
- leadership and improvement capability (well led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving most support and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

EPUT has been placed in Segment 2. Regular performance review meetings have taken place in year between the Trust and NHS Improvement. NHS Improvement has not taken any enforcement action in respect of the Trust.

The segmentation information is the Trust's position as at Quarter 4. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and Use of Resources

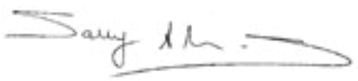
The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score.

> *The work that Open Arts does is absolutely invaluable and an absolutely crucial resource in the assistance of mental health recovery. And what's more - Open Arts never give up on any service user, because they have that very rare gift of seeking out the potential and possibilities that each client possesses who passes through the door.*

Table 6 Finance and use of resources scoring

Area	Metric	2018/19			
		Q1	Q2	Q3	Q4
Financial sustainability	Capital Service Capacity	2	3	3	2
	Liquidity	1	1	1	1
Financial efficiency	I & E margin	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1
	Agency spend	2	2	2	2
Overall scoring		**1**	**2**	**2**	**2**

Area	Metric	2017/18			
		Q1	Q2	Q3	Q4
Financial sustainability	Capital Service Capacity	3	4	4	3
	Liquidity	1	1	1	1
Financial efficiency	I & E margin	3	4	4	2
Financial controls	Distance from financial plan	1	2	1	1
	Agency spend	1	2	2	2
Overall scoring		**2**	**3**	**3**	**2**



Sally Morris
Chief Executive
Essex Partnership University NHS FT
23 May 2019

Thank you so much for your caring and kindness whilst looking after mum. Love and thanks to you all at Mountnessing Court. Nurses, cleaners, doctors, physios, OT staff, food staff. In fact, everyone in the hospital who makes it run smoothly. The family cannot thank you enough for all your care and help. Thank you, Thank you, Thank you.

REMUNERATION REPORT

Introduction

This section covers the remuneration of the most senior managers of the Trust – those people who have the authority and responsibility for controlling the major activities of the Trust. In effect this means the Board of Directors, including both Executive Directors (including the Chief Executive) and Non-Executive Directors (including the Chair).

Information is also provided about the Remuneration Committees, the policy on remuneration and detailed information about the remuneration of the Executive and Non-Executive Directors of the Trust.

Annual Statement on Remuneration

Executive Directors (including the Chief Executive)

The Board of Directors Remuneration and Nominations Committee has delegated responsibility to review and set the remuneration, allowances and other terms and conditions of the Executive Directors who are the Trust's most senior managers. The Trust's Executive Directors have the authority and responsibility for directing and controlling major activities of the Trust.

The remuneration policy for the Trust's Executive Directors is to ensure remuneration is consistent with market rates for equivalent roles in foundation trusts of comparable size and complexity. It also takes into account the performance of the Trust, comparability with employees holding national pay and conditions of employment, pay awards for senior roles elsewhere in the NHS and pay/price changes in the broader economy, any changes to individual roles and responsibilities, as well as overall affordability. Decisions regarding individual remuneration are made with due regard to the size and complexity of the senior managers' portfolios of responsibility. In setting the remuneration levels, the Committee balances the need to attract, retain and motivate directors of the quality required.

The Executive Director salary is a 'spot' salary within an agreed remuneration framework. The current remuneration policy is not to award any performance related bonus or other performance payment to Executive Directors. The Trust does not make termination payments to Executive Directors which are in excess of contractual obligations, and there have been no such payments during the past year.

The Committee refers to the NHS Providers' annual salary benchmarking survey analysis together with publicly available information about trends within the NHS and broader economy.

Non-Executive Directors (including the Chair)

The Council of Governors Remuneration Committee has delegated responsibility to recommend to the Council of Governors the remuneration levels for all Non-Executive Directors including allowances and the other terms and conditions of office in accordance with all relevant legislation and regulations.

In reviewing the remuneration of Non-Executive Directors, the Committee balances the need to attract and retain directors with the appropriate knowledge, skills and experience required on the Board to meet current and future business needs without paying more than is necessary and at a level which is affordable to the Trust.

The remuneration policy for the Trust's Non-Executive Directors is to ensure remuneration is consistent with market rates for equivalent roles in foundation trusts of comparable size and complexity, taking account of the NHS Providers' annual salary benchmarking survey analysis. It also takes into account the pay and employment conditions of staff in the Trust, the performance of the Trust, and the time commitment and responsibilities of Non-Executive Directors and Chair, as well as succession planning requirements.

The Chair and Non-Executive Directors are entitled to receive remuneration only in relation to the period for which they hold office; there is no entitlement to compensation for loss of office.

Decisions made during 2018/19

During the year, the Board of Directors Remuneration Committee agreed:

- a flat rate annual pay uplift of £2,075 per annum for Executive Directors for 2018/19 in line with the recommendation from NHS Improvement for staff on Very Senior Manager contracts - this uplift was awarded to all Executive Directors with the exception of the Medical Director who is employed on a Consultant Contract and thus received their annual uplift through the Medical and Dental annual pay increase;
- an additional uplift for the Executive Nurse role to £135,000 to bring it in line with other Executive Directors of the Trust and benchmarking analysis;
- the implementation of a Retention Bonus Scheme to be available for all staff (detailed further in table below) to address Government pension rule changes and the circulation of information to staff. This included an agreement to ensure that new joiners to the Trust are made aware of the Scheme if their basic Lifetime Allowances are reached;
- a salary rate for the Director of Estates and Facilities post to be advertised.

During the year, following recommendation by the Council of Governors Remuneration Committee, the Council of Governors agreed:

- the performance review process for the Chair and Non-Executive Directors for performance year 2018/19.

Professor Sheila Salmon
Trust Chair and Chair of the Board of Directors
Remuneration and Nominations Committee and Council of Governors Remuneration Committee
Essex Partnership University NHS FT
23 May 2019

Spencer Orchard, Diane Palmer and David Powell at Veterans Conference where it was announced that the service had been awarded the Centre of Excellence

Senior Managers Remuneration Policy

Future Policy

Remuneration Package Components	The Executive Directors' (including the Chief Executive) remuneration package consists of salary and the entitlement to NHS pension benefits or a Retention Bonus Scheme should they have reached their Life Time Allowance and opted to withdraw from the NHS Pension Scheme. Non-Executive Directors (including the Chair) are remunerated for an agreed number of days work per month. There is no entitlement to the NHS pension scheme.
Remuneration Package	The Executive Director salary is a 'spot' salary within an agreed remuneration framework. The salary levels are set to attract and retain appropriately skilled executives. The Trust believes that by setting an appropriate salary then no additional components are necessary to drive forward the Trust's strategic objectives. The Trust has two Executive Directors who are paid more than £150,000. These salaries were set to match the current market rates at the time of their appointment to the Trust and yearly objectives are set and monitored internally to ensure the continuation of these salaries. We believe they are a fair and competitive salary rate to support succession planning.
Remuneration Package Framework	**Executive Directors (including the Chief Executive)** The current remuneration policy is not to award any performance related bonus or other performance payment to Executive Directors. Executive Director contracts stipulate that if monies are owed to the Trust the post-holder will agree to repay them by salary deduction or by any other method acceptable to the Trust. The Trust may withhold payment in circumstances of unauthorised absence. This policy applies to all Executive Directors. For the 2018/19 financial year, there are no instances of monies owed to or by the Trust in respect of Executive Directors. A new component has been added to the remuneration package. Where an individual has reached their Lifetime Allowance based on his/her NHS Pension entitlement and after seeking financial advice, s/he ceases to be an active member of the NHS Pension Scheme s/he may be eligible to join the Trust's Retention Bonus Scheme. The Trust will make a retention payment equal to 7.5% of an individual's annual basic salary (no allowances, on call supplements or other additional payments will be taken into account). This retention payment will be taxable and paid [in two instalments of 3.75%] six months in arrears of the 30 September and 31 March in each financial year ("a Qualifying Date") in the next payroll run after a Qualifying Date. Also as part of the Scheme the Trust will award an additional five days paid annual leave earned in arrears for each six months of continued employment (ten days maximum per financial year). This annual leave cannot, under any circumstances, be converted in to a cash payment; it must be taken and/or before the individual's employment ends.

Remuneration Package Framework	It should be noted that this scheme is available for all staff who may have reached their Life Time Allowance, not just Executive Directors. The key difference between the Trust's policy on Executive Directors' remuneration and its general policy on employees' remuneration are: • Salary: the Trust appoints Executive Directors on a range of spot salaries within an agreed remuneration framework, i.e. salaries with no incremental progression; • Notice period: Executive Directors are expected to give six months' notice of termination of employment. This is in recognition of the need to have sufficient time to recruit a replacement or alternatively to appoint to a different post; • Pay review: the Board of Directors Remuneration Committee determines whether or not to award cost of living pay awards to Executive Directors. **Executive Directors (including the Chief Executive)** The remuneration policy for the Trust's Non-Executive Directors is to ensure remuneration is consistent with market rates for equivalent roles in foundation trusts of comparable size and complexity, taking account of the NHS Providers' annual salary benchmarking analysis. It also takes into account the pay and employment conditions of staff in the Trust, the performance of the Trust, and the time commitment, responsibilities of Non-Executive Directors and Chair, as well as the skills, knowledge and experience required on the Board to meet business needs and succession planning.

Service Contract Obligations

The Trust is obliged to give Executive Directors six months' notice of termination of employment, which matches the notice expected of Executive Directors from the Trust. The Trust does not make termination payments beyond its contractual obligations which are set out in the contract of service and related terms and conditions. Executive Directors' terms and conditions, with the exception of salary, shadow the national Agenda for Change arrangements, inclusive of sick pay and redundancy arrangements and do not contain any obligations above the national level.

Policy on Payment for Loss of Office

Executive Directors' service contracts contain a requirement for the Trust to provide six months' notice of termination to directors. In turn, it requires Executive Directors to provide six months' notice to the Trust if they resign from its service. The Trust retains the right to make payment in lieu of the notice period be it in part or for the whole period where it considers it is in the Trust's interest to do so. Any decision on this would be taken by the Board of Directors Remuneration Committee.

Executive Directors are covered by the same policy in terms of conduct and capability as other Trust staff and if found to have engaged in gross misconduct or committed any act or omission which breaches the trust and confidence of the Trust they can be summarily dismissed, i.e. their contract would be terminated without notice and/or compensation.

In cases of termination due to organisational change, Executive Directors are covered by the national Agenda for Change arrangements for redundancy for NHS staff. This states that one month's pay will be provided for each complete year of reckonable service in the NHS without a break of 12 months or more. Limits are set on this payment which is currently £160,000. However, we are aware that this potentially may change nationally in terms of the maximum limit, how the payment is calculated and restrictions to continue working in the public sector. The Trust will follow agreed national guidelines should changes be made.

Statement of Consideration of Employment Conditions Elsewhere in the Trust

The Trust's Board of Directors Remuneration Committee carries out an annual review of pay and terms and conditions for Executive Directors. This includes their having regard to salary and the remuneration package as a whole. Salary levels are set taking into account the need to recruit and retain able directors and balancing that against a proper regard for use of public funds. In setting salary levels the Remuneration Committee satisfies itself that the salary is competitive with other NHS providers of a similar constitution.

The Remuneration Committee will also review the pay progression framework in light of the current and emerging economic environment. There is no performance based progression in place in the Trust although performance is managed by a robust appraisal and supervision framework. Trust Executive Directors are subject to the same capability arrangements as other Trust staff and 9 Box Talent Management tool was implemented for our Executive Directors to further support this. 360° appraisal feedback has also been implemented for the Board of Directors.

Annual Report on Remuneration

The Trust has two Remuneration Committees; the Board of Directors Remuneration and Nominations Committee and the Council of Governors Remuneration Committee.

Board of Directors Remuneration Committee

Membership of the Committee wholly comprises Non-Executive Directors who are viewed as independent having no financial interest in matters to be decided and the Committee is chaired by the Trust's Chair. The Chief Executive will attend meetings of the Committee if invited to do so by the chair of the Committee but may not receive any papers in relation to or be present when her remuneration or conditions of service are considered. The Deputy Director of HR is invited to attend the meeting in an advisory capacity as required. The Trust Secretary is the Committee Secretary. The Committee may commission independent professional advice if considered necessary. No consultants were commissioned during 2018/19.

The Board of Directors Remuneration Committee has the responsibility for setting the remuneration of the Executive Directors. Details are included in the section on Senior Managers Remuneration Policy.

The Committee meets when necessary but at least annually.

A review of the governance structure underpinning the Board of Directors was undertaken in 2018. One of the recommendations of this review was to amalgamate the Remuneration and Nominations Committees of the Board of Directors into one Committee. This recommendation was approved by the Board of Directors in September 2018 and the Committees were combined to form a Remuneration and Nominations Committee with immediate effect. This is reflected in the attendance information below.

Members of the Committee and the number of meetings attended by each member during the year are set out on the following page in table 7.

Table 7: Board of Directors Remuneration Committee Membership and Meeting Attendance (up to 26 September 2018)

Name	Role	Meetings Attended (actual/possible)
Prof Sheila Salmon	Chair of the Committee	2/2
Alison Davis	Non-Executive Director	0/2
Amanda Sherlock	Non-Executive Director	2/2
Janet Wood	Non-Executive Director	2/2

Table 8: Board of Directors Remuneration and Nominations Committee Membership and Meeting Attendance (from 26 September 2018)

Name	Role	Meetings Attended (actual/possible)
Prof Sheila Salmon	Chair of the Committee	2/2
Alison Davis	Non-Executive Director	2/2
Dr Rufus Helm	Non-Executive Director	1/2
Manny Lewis	Non-Executive Director	2/2
Dr Alison Rose-Quirie	Non-Executive Director	2/2
Amanda Sherlock	Non-Executive Director	1/2
Nigel Turner	Non-Executive Director	2/2
Janet Wood	Non-Executive Director	2/2

In addition to the considerations by the Committee listed under the Annual Statement of Remuneration on page 37, the Committee also:

- considered the CEO and Executive Directors' end of year reviews for 2017/18 and agreed that a robust appraisal process was in place and that appropriate assurance had been provided of their effectiveness;
- endorsed the Chief Executive's and Executive Directors' objectives and proxy measures for 2018/19;
- reviewed the mid-year progress against the Chief Executive's and Executive Directors' objectives for 2018/19 and agreed that appropriate assurance had been provided of their effectiveness.

Council of Governors Remuneration Committee

The Council of Governors has delegated responsibility to its Remuneration Committee for assessing and making recommendations to the Council in relation to the remuneration, allowances and other terms and conditions of office for the Chair and all Non-Executive Directors.

In addition, the Committee leads on the process to receive assurance on the performance evaluation of the Chair, working with the Senior Independent Director, and Non-Executive Directors, working with the Chair.

The Committee may, as appropriate, retain external consultants or commission independent professional advice. In such instances the Committee will be responsible for establishing the selection criteria, appointing and setting the terms of reference for remuneration consultants or advisers to the Committee. No consultants were commissioned during2018/19. The Deputy Director of HR is invited to attend the meeting in an advisory capacity as required. The Trust Secretary is the Committee Secretary.

Members of the Committee and the number of meetings attended by each member during the year are set out below in table 9:

Table 9: Council of Governors Remuneration Committee Membership and Meeting Attendance

Name	Role	Meetings Attended (actual/possible)
John Jones	Public Governor (chair of Committee)	7/7
David Bowater	Appointed Governor	5/7
Peter Cheng	Public Governor	7/7
James Clarke (until 02/07/18)	Public Governor	1/1
Paula Grayson	Public Governor	7/7
Tracy Reed	Staff Governor	5/7
Graham Underwood	Appointed Governor	0/7
Clive White	Public Governor	6/7
Judith Woolley (from 13/08/18)	Public Governor	2/4

During the year the Council of Governors Remuneration Committee:

- received assurance that the end of year appraisal process for Non-Executive Directors for 2017/18 had been satisfactorily completed in line with the performance review process agreed by the Council of Governors;
- received assurance on the satisfactory performance of the Chairs / Non-Executive Directors for 2017/18 following appraisal (including progress against personal and development objectives);
- received assurance that appropriate objectives for 2018/19 for the Chair and Non-Executive Directors were in place;
- received assurance of the mid-year review of progress against the Chair's and Non-Executive Directors' objectives for 2018/19;
- reviewed and noted the Non-Executive Director time schedule 2017/18;
- reviewed the Senior Independent Director report to 31 March 2018;
- considered the NHS Providers Remuneration Benchmarking Survey 2017 for Chairs and Non-Executive Directors;
- considered a draft Remuneration Policy and Procedure for Chairs and Non-Executive Directors.

Table 10: Service Contracts: Executive Directors

Name	Role	Contract Start Date at Predecessor Trusts	Interim Board Contract Start Date	Substantive Board Contract Start Date
Sally Morris	Chief Executive	14 Jul 2006	1 Apr 2017	17 Aug 2017
Andy Brogan	Executive Director Mental Health & Deputy Chief Executive	1 Sept 2009	1 Apr 2017	25 Aug 2017
Prof Natalie Hammond	Executive Nurse		1 Apr 2017	25 Aug 2017
Nigel Leonard	Executive Director Corporate Governance & Strategy	1 Feb 2014	1 Apr 2017	25 Aug 2017
Dr Milind Karale	Executive Medical Director	30 Jul 2012	1 Apr 2017	25 Aug 2017
Mark Madden	Executive Chief Finance & Resources Officer	9 Apr 2014	1 Apr 2017	25 Aug 2017
Malcolm McCann	Executive Director Community Services & Partnerships	15 Apr 2013	1 Apr 2017	25 Aug 2017

Table 11: Service Contracts: Non-Executive Directors

Name	Role	Period of Office	Contract Start date at Predecessor Trusts	Start Date	End Date
Prof Sheila Salmon	Chair	3 years	N/A	1 November 2017	31 October 2020
Alison Davis	NED/SID	3 years	5 January 2012	1 October 2017	30 September 2020
Dr Rufus Helm (from 24/07/18)	NED	3 years	N/A	24 July 2018	23 July 2021
Manny Lewis	NED	3 years	N/A	28 February 2018	27 February 2021
Mary-Ann Munford (until 31/05/18)	NED	3 years	5 January 2015	1 October 2017	30 September 2020
Dr Alison Rose-Quirie (from 24/07/18)	NED	3 years	N/A	24 July 2018	23 July 2021
Amanda Sherlock	NED	3 years	1 June 2014	1 October 2017	30 September 2020
Nicci Statham (until 30/04/18)	NED	3 years	N/A	1 October 2017	30 September 2020
Nigel Turner	NED	3 years	N/A	1 October 2017	30 September 2020
Janet Wood	Vice-Chair and Chair of Audit Committee	3 years	1 November 2005	1 October 2017	30 September 2020

Table 12: Non-Executive Directors Remuneration

Name	Role	Remuneration (£)	Working Days	Additional Fees (£)
Professor Sheila Salmon	Chair	40-45	11 per month	Nil
Alison Davis	NED/SID	15-20	5 per month	Nil
Dr Rufus Helm (from 24/07/18)	NED	15-20	5 per month	Nil
Manny Lewis	NED	15-20	5 per month	Nil
Mary-Ann Munford (until 31/05/18)	NED	15-20	5 per month	Nil
Dr Alison Rose-Quirie (from 24/07/18)	NED	15-20	5 per month	Nil
Amanda Sherlock	NED	15-20	5 per month	Nil
Nicci Statham (until 30/04/18)	NED	15-20	5 per month	Nil
Nigel Turner	NED	15-20	5 per month	Nil
Janet Wood	Vice-Chair and Chair of Audit Committee	20-25	6 per month	Nil

Executive and Non-Executive Director Expenses

Total Executive and Non-Executive Directors expenses incurred by the Trust during 2018/19 totalled £24,200 and were claimed by 15 of the Directors in post during the year (2017/18: £24,400 claimed by 19 Directors).

Table 13: Senior Managers Pay (subject to audit)

2018/19									
		Salary £000	Other Remuneration £000	Expense Payments (Taxable) £000	Annual Performance Related Bonuses £000	Long Term Performance Related Bonuses £000	All Pension Related Benefits £000	Exit Package £000	Total £000
Sally Morris	Chief Executive	185 – 190	0	0	0	0	2.5 – 5.0	0	185 – 190
Andy Brogan	Executive Director of Mental Health/ Deputy Chief Executive	145 – 150	0	0	0	0	0	0	145 – 150
Mark Madden	Executive Chief Finance & Resources Officer	155 – 160	0	0	0	0	0	0	155 - 160
Malcolm McCann	Executive Director of Community Services & Partnerships	135 – 140	0	0	0	0	0	0	135 – 140
Dr Milind Karale	Executive Medical Director	200 – 205	0	0	0	0	30.0 – 32.5	0	230 -235
Nigel Leonard	Executive Director of Corporate Governance & Strategy	135 – 140	0	0	0	0	2.5 – 5.0	0	140 -145
Professor Natalie Hammond	Executive Nurse	135 – 140	0	0	0	0	100.0 – 102.5	0	225 -230
Professor Sheila Salmon	Chair	40 – 45	0	0	0	0	0	0	40-45
Janet Wood	Non-Executive Director / Vice Chair	20 – 25	0	0	0	0	0	0	20 -25
Alison Davis	Non-Executive Director	15 – 20	0	0	0	0	0	0	15 – 20
Mary-Ann Munford	Non-Executive Director (until 31/05/2018)	0 – 5	0	0	0	0	0	0	0 – 5
Amanda Sherlock	Non-Executive Director	15 – 20	0	0	0	0	0	0	15 -20
Nigel Turner	Non-Executive Director (from 01/10/2017)	5 – 10	0	0	0	0	0	0	15 – 20
Rufus Helm	Non-Executive Director (from 24/07/18)	10 – 15	0	0	0	0	0	0	10 – 15
Alison Rose-Quirie	Non-Executive Director (from 24/07/18)	10 – 15	0	0	0	0	0	0	10 -15
Nicci Statham	Non-Executive Director (until 30/04/18)	0 – 5	0	0	0	0	0	0	0 - 5
Manny Lewis	Non-Executive Director	15 – 20	0	0	0	0	0	0	15 - 20

* With effect from May 2017, Andy Brogan has been seconded for one day per week to the role of Associate National Clinical Director – Mental Health, with NHS Improvement. The above salary information represents the gross cost to the Trust.

2017/18									
		Salary £000	Other Remuneration £000	Expense Payments (Taxable) £000	Annual Performance Related Bonuses £000	Long Term Performance Related Bonuses £000	All Pension Related Benefits £000	Exit Package £000	Total £000
Sally Morris	Chief Executive	185 – 190	0	0	0	0	45.0 – 47.5	0	230 – 235
Andy Brogan	Executive Director of Mental Health/ Deputy Chief Executive	145 – 150	0	0	0	0	n/a	0	145 – 150
Mark Madden	Executive Chief Finance & Resources Officer	155 – 160	0	0	0	0	25.0 – 27.5	0	180 – 185
Malcolm McCann	Executive Director of Community Services & Partnerships	135 – 140	0	0	0	0	27.5 – 30	0	165 – 170
Dr Milind Karale	Executive Medical Director	190 – 195	0	0	0	0	27.5 – 30	0	215 – 220
Nigel Leonard	Executive Director of Corporate Governance & Strategy	135 – 140	0	0	0	0	20 – 22.5	0	150 – 155
Professor Natalie Hammond	Executive Nurse	120 – 125	0	0	0	0	152.5 – 155	0	275 – 280
Professor Sheila Salmon	Chair (from 01/11/2017)	15 – 20	0	0	0	0	0	0	15 – 20
Janet Wood	Non-Executive Director/Vice Chair/ Acting Chair until 31/10/2017	30 – 35	0	0	0	0	0	0	30 –35
Alison Davis	Non-Executive Director	15 – 20	0	0	0	0	0	0	15 – 20
Mary-Ann Munford	Non-Executive Director	15 – 20	0	0	0	0	0	0	15 – 20
Amanda Sherlock	Non-Executive Director	10 – 15	0	0	0	0	0	0	10 – 15
Nigel Turner	Non-Executive Director (from 01/10/2017)	5 – 10	0	0	0	0	0	0	5 – 10
Nicci Statham	Non-Executive Director (from 01/10/2017)	5 – 10	0	0	0	0	0	0	5 – 10
Manny Lewis	Non-Executive Director (from 28/02/2018)	0 – 5	0	0	0	0	0	0	0 – 5
Steve Currell	Non-Executive Director (until 30/09/2017)	5 – 10	0	0	0	0	0	0	5 – 10
Steve Cotter	Non-Executive Director (until 30/09/2017)	5 – 10	0	0	0	0	0	0	5 – 10
Jan Hutchinson	Non-Executive Director (until 30/09/2017)	5 – 10	0	0	0	0	0	0	5 – 10

The value of pension benefits accrued during the year (column entitled 'all pension related benefits' in the Single Figure Table above), is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Table 14: Total Pension Entitlement (subject to audit)

2018/19						
		Real Increase/ (Decrease) in Pension & related lump sum at age 60 £000	Total Accrued pension and related lump sum at age 60 at 31 March 2019 £000	Cash Equivalent Value at 31 March 2018 £000	Real Increase in cash equivalent Transfer Value £000	Cash Equivalent Value at 31 March 2019 £000
Sally Morris	Chief Executive	2.5 – 5.0	195 – 200	961	119	1,108
Andy Brogan	Executive Director of Mental Health/ Deputy Chief Executive	n/a	n/a	n/a	n/a	n/a
Mark Madden	Executive Chief Finance & Resources Officer	0 – 2.5	215 – 220	1,008	121	1,241
Malcolm McCann	Executive Director of Community Services & Partnerships	n/a	n/a	n/a	n/a	n/a
Dr Milind Karale	Executive Medical Director	2.5 – 5.0	95 – 100	465	90	570
Nigel Leonard	Executive Director of Corporate Governance & Strategy	2.5 – 5.0	185 – 190	909	112	1,049
Prof Natalie Hammond	Executive Nurse	12.5 – 15.0	160 – 165	660	171	850

2017/18						
		Real Increase/ (Decrease) in Pension & related lump sum at age 60 £000	Total Accrued pension and related lump sum at age 60 at 31 March 2018 £000	Cash Equivalent Value at 31 March 2017 £000	Real Increase in cash equivalent Transfer Value £000	Cash Equivalent Value at 31 March 2018 £000
Sally Morris	Chief Executive	12.5 – 15.0	185 - 190	857	95	961
Andy Brogan	Executive Director of Mental Health/ Deputy Chief Executive	n/a	n/a	n/a	n/a	n/a
Mark Madden	Executive Chief Finance & Resources Officer	7.5 – 10.0	205 -210	1,008	71	1,088
Malcolm McCann	Executive Director of Community Services & Partnerships	0 – 2.5	180 - 185	847	43	929
Dr Milind Karale	Executive Medical Director	0 – 2.5	90 - 95	410	49	463
Nigel Leonard	Executive Director of Corporate Governance & Strategy	5.0 – 7.5	175 - 180	819	83	909
Prof Natalie Hammond	Executive Nurse	22.5 - 25	145 - 150	503	152	660

Fair pay multiple (subject to audit)

The Trust is required to disclose the relationship between the remuneration of the highest paid Director and the median remuneration of the Trust's workforce.

The banded remuneration of the highest paid Director in the Trust in the financial year 2018/19 was £195,000 to £200,000 (2017/18: £190,000 to £195,000). This was 7.53 times (2017/18: 7.53 times) the median remuneration of the workforce, which was £26,220 (2017/18: £25,551).

In 2018/19, there were no employees (2017/18: nil) who received remuneration in excess of the highest paid Director.

Total remuneration includes salary, non-consolidated performance related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Loss of Office Payments (subject to audit)

The Trust did not make any payments to Senior Managers in respect of loss of office during 2018/19.

Payments to Past Senior Managers (subject to audit)

The Trust has not made any payments to past Senior Managers during the financial year.

Sally Morris
Chief Executive
Essex Partnership University NHS FT
23 May 2019

Thank you for all your help throughout my admission, before and after PICU you were always there to speak to and helped me so many times to look at things from a different perspective and helped me during my flashbacks. You helped keep me safe and helped me to use and remember the coping skills.

STAFF REPORT

Our Staff

Staff Costs (subject to audit)

During 2018/19, the Trust incurred total staffing costs of £222.7 million which can be analysed as follows between permanent staff and other staff:

Table 15: Staff costs 2018/19

	Permanent Staff £000s	Other Staff £000s	Total Staff £000s
Salaries and Wages	168,335	2,386	170,721
Social Security Costs	15,902	0	15,902
Apprenticeship Levy	753	0	753
Pension Cost (employer contributions to NHS Pension Scheme	20,171	0	20,171
Pension Cost (other)	252	0	252
Other Post Employment Benefits	(144)	0	(144)
Termination Benefits	44	0	44
Temporary Staff – agency / contract staff	0	15,149	15,149
Total Staff Costs	**205,313**	**17,535**	**222,848**

Average Staff Numbers (subject to audit)

During 2018/19, the Trust employed an average of 5,340 staff as follows:

Table 16: Average staff numbers 2018/199

	Permanent Staff (WTE)	Other Staff (WTE)	Total Staff (WTE)
Medical & Dental	204	62	266
Administration & Estates	1,057	2	1,059
Healthcare Assistants & Other Support Staff	1,672	8	1,680
Nursing, Midwifery & Health Visiting Staff	1,535	0	1,535
Nursing, Midwifery & Health Visiting Learners	4	0	4
Scientific, Therapeutic & Technical Staff	522	0	522
Social Care Staff	53	0	53
Other	0	221	221
Total Average Staff Numbers	**5,046**	**292**	**5,340**
Of which: Number of employees (WTE) engaged on capital projects	1	0	1

Gender Analysis

Our workforce profile is similar to many foundation trusts, in that half of our staff are over the age of 45 and our workforce is predominantly female. This is detailed further in table 17 below:

Table 17: Workforce Profile

Staff Group	TOTAL	Gender		Age			
		Female	Male	<25	26-45	46-65	>65
Board of Directors	15	7	8	0	0	14	1
Senior Managers	30	24	6	0	6	24	0
Doctors and Dentists	220	96	124	0	115	98	7
Nursing	1,511	1,226	285	50	674	773	14
Other healthcare staff	1,830	1,498	332	112	893	788	37
Support staff	1,429	1,160	269	67	462	838	62
All Employees	5,035	4,011	1,024	229	2,150	2,535	121
All Employees %		79.7%	20.3%	4.5%	42.8%	50.3%	2.4%

Sickness Absence (taken from December 2018 NHS Digital report)

The average sickness absence rate for EPUT during 2018/2019 (based on NHS Digital December 2018 report) was 10.4 days sickness per full time member of staff.

Table 18: Sickness Absence

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
4,550	47,439	10.4	1,660,728	76,956

In accordance with the Treasury guidance, all public bodies must report sickness absence data on a consistent basis per calendar year, in order to permit aggregation across the NHS. The Trust is required to use the published statistics which are produced using data from the Electronic Staff Record (ESR) Data Warehouse. The latest publication, covering up to December 2018, can be found on the website of NHS Digital.

The number of Full Time Equivalent (FTE) Days Available of 1,660,728 has been taken directly from ESR and has then been converted to Average FTE's for the period January 2018 to December 2018 which gives 4,550.

The number of FTE days lost due to sickness of 76,956 has been taken directly from ESR, and has been converted to Adjusted FTE days due to sickness of 47,439 by taking account of the number of working days in the period January 2018 to December 2018 as per the cabinet office definition.

The average sick days per FTE of 10.4 days has then been calculated by dividing the adjusted FTE days as per the cabinet office measure, by the average FTE for the year.

The Trust is committed to placing high priority on tackling absence and looking at ways of supporting staff whilst they are off. Where possible, returning them to work on restricted duties or in other suitable alternative roles temporarily or permanently for those staff that are no longer able to fulfil their substantive role. We continue to work in partnership with staff side and union representatives to identify the best outcomes for our workforce and ensure that the appropriate support is in place for their return to work or to continue to manage their absence.

With stress and musculoskeletal conditions being some of our top reasons for absence we have invested in fast track physiotherapy for staff either in or out of work. We have also recently launched an on line support tool for staff with musculoskeletal conditions including exercises, tips and preventative advice. In addition, we provide free 24 hour access to counselling and support for staff. This also includes an on line tool with a range of advice on lifestyle matters including financial, bereavement and health. We provide a range of support for staff suffering with work related stress including a suite of learning on resilience and managing stress and bespoke sessions in teams where necessary. We also have a new Mental Health and Disability Staff Equality Network which has representation from the wellbeing and HR teams as a further voice for staff who need help and support.

We have recently developed and implemented a Stress and Mental Ill Health Toolkit for managers and staff to access online.

The Trust manages and monitors sickness absence using the Bradford Factor trigger point methodology. We introduced an informal management procedure to its process as a tool for managers and staff to ensure all the relevant support and interventions in place at the earliest opportunity to avoid further absences ensuring that patient care and service levels are as unaffected as possible. The Trust continues to regularly review its managing sickness and absence procedures to streamline the processes and ensure managers are supported in roles when tackling absence.

Managers with responsibility for managing staff are required to undergo specific sickness absence training as part of their management development programme. There is also a good range of information accessible to managers on the staff intranet to support them as well as each service having a dedicated HR team and access to an Occupational Health provider to support with the management of health conditions and sickness absence.

Trade Union (Facility Time Publication Requirements) Regulations 2017

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires NHS employers to publish certain information on trade union officials and facility time on their website as follows:

- the number of employees who were relevant union officials during the relevant period, and the number of full time equivalent employees;
- the percentage of time spent on facility time for each relevant union official;
- the percentage of pay bill spent on facility time;
- the number of hours spent by relevant union officials on paid trade union activities as a percentage of total paid facility time hours.

For these purposes, 'facility time' is defined as time that is taken off to carry out trade union duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

The Trust reported their first data in June 2018 as required of them set by the regulations described above.

Schedule 2 -The Trade Union (Facility) Time Publication Requirements) Regulations 2017. The detail of trade union activity for 1 April 2018 - 30 June 2018 is as below. The next report is due June 2019 and will be made available on the Trust's website.

Table 19: Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
23*	4989

Table 20: Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent:

a) 0%

b) 1% – 50%

c) 51% – 99% or

d) 100%

of their working hours on facility time?

Percentage of time	Number of employees
0%	12*
1% – 50%	10*
51% – 99%	0*
100%	1*

Table 21: Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
The total cost of facility time	£6357.77*
The total pay bill	£ 50,027,000
The percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.0127%

Table 22: Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	100%*

**Disclaimer; Please note the information is correct from the returns received from trade union officials. Nil returns have been received and therefore may be subject to change. This information will be updated upon receipt of additional information.*

This return was completed prior to the implementation of the new Agenda for Change Pay Award and so figures are based on salaries as they were recorded as at the 30 June 2018.

Disability

At present approximately 3% of our workforce consider themselves as disabled or living with long term conditions. We use a range of measures to ensure that disabled people are supported and treated fairly both when seeking employment with us – and during their employment with us including:

- robust recruitment processes that guarantee applicants with disabilities an interview if they meet the minimum criteria;
- secure job offers before any health information is requested;
- a dedicated staff disability network, open to all staff
- support from an overall equality champions network that includes other staff with disabilities or long term health conditions;
- inclusion in all staff engagement initiatives and specific competitions and tasks for those with disabilities;
- advice and support from the Staff Engagement/Equalities team where required;
- consultation of our disabled workforce on our Equality and Diversity Training to ensure that it supports and truly reflects those in the workforce with disabilities;
- access to fast track physiotherapy for staff including those with long term physical conditions.

The Health, Safety & Security Committee co-ordinates the implementation and management of health, safety & security as well as non-clinical risk management across the organisation. The Trust has a range of policies and procedures in place to support staff in maintaining compliance with health and safety requirements.

EPUT is an official holder of the government's Disability Confident Badge (Level 2) meaning we signed up to a range of commitments to support people with disabilities to find and stay in work.

In April 2019, the Workforce Race Disability Standard comes into force which will enable us to compare ourselves against a range of metrics and identify where improvements can be made for our disabled workforce.

Staff Concerns

The Trust has in place policies, procedures, systems and processes to ensure that all staff are able to raise concerns quickly and have these resolved in a timely manner. The Trust's Grievance Policy and Procedure contains robust mechanisms for dealing with grievances and complaints relating to dignity at work (bullying, harassment and discrimination). During the year a range of engagement sessions/workshops have been held across all areas of the Trust focusing on bullying and harassment and raising concerns. The Trust has also developed and introduced Dealing with Bullying and Harassment Guide for staff and managers to access and forms part of our engagement with staff. Staff are also required to undergo e-learning training which covers how to raise concerns and managers are able to attend specific training as part of the management development programme.

There are a good range of mechanisms for staff to share concerns anonymously through the Staff Friends and Family Test and the 'I'm Worried About' tool on the staff intranet. We will be changing the look of our 'I'm Worried About' function during 2019 to a 'Listening to You' landing page which will include the ability for staff to report compliments as well as concerns.

The Trust also has in place the Raising Concerns, Whistleblowing Policy and Procedure for staff and workers. This is designed to provide a process for staff to be able to speak up freely and raise any concerns they may have. The Trust has an internal Freedom to Speak Up Guardian service which is an independent and impartial source of advice to staff enabling access to anyone in the Trust, including the Chief Executive, or, if necessary, refer staff to outside the Trust to the National Guardian Office.

The professional Duty of Candour makes a clear requirement to be open with patients and families when mistakes occur. The Freedom to Speak Up review encourages an environment where staff feel it is safe to raise concerns with confidence, that they will be listened to and the concerns will be acted upon across the NHS.

Our performance in the area of staff having confidence to raise concerns at work is extremely positive, with the majority of all grievance complaints being concluded within a timely timeframe.

Freedom to Speak Up:

EPUT's Freedom to Speak Up Guardian was voted into post by Trust employees following an election process in the autumn of 2017.

Significant work has been undertaken in the past year to promote awareness of the Freedom to Speak Up (F2SU) agenda and embed a 'Speak Up' culture within the Trust that is both responsive to feedback and focused on learning and continual improvement. An assessment of the Trust's performance against NHS Improvement's F2SU self-review tool was presented to the Board in November 2018 detailing where best practice had already been met and proposed actions for areas requiring improvement.

In addition to the Principal Guardian there are now 21 fully trained Local F2SU Guardians employed in various roles and at a number of different sites across the Trust. This growing network of Speak Up experts gives staff real choice in whom they can approach to raise their concerns if they do not feel able to address them directly through their chain of line management. This demonstrates great progress in making the process as easy, as accessible and as comfortable as possible for staff who want to speak up.

Seven concerns were raised in Q1 of 2018/19; four in Q2; nine in Q3 and nine in Q4. The concerns were evenly spread across the Trust's geographical area and came from staff employed in a number of different roles.

The Trust has an established Learning Oversight Sub-Committee. All learning and improvements identified by the sub-committee are circulated throughout the Trust. The Principal Guardian receives the papers for every sub-committee meeting and attends in person twice a year. Patient stories are received at the Patient and Carer Experience Sub-Committee and Quality Committee, the Executive Team is responsible for ensuring lessons and improvements identified here are shared throughout the organisation.

In National 'Speak Up' month in October 2018, the Principal Guardian wrote weekly blogs covering various aspects of the agenda and visited all the Trust's sites to meet staff and raise awareness of EPUT's Guardian service. She was supported in this by a number of Local Guardians who joined her at her drop-in sessions. A competition was run throughout the month for staff to come up with the Trust's vision for its own Guardian Service. A number of suggestions were put before the Board in November for consideration and the winning entry was:

'Freedom to Speak Up: Supporting compassion, openness and empowerment'

The Board felt that this entry was the most relevant due to its close alignment with the values under which the Trust operates.

Much emphasis has been placed on internal messaging that the Guardian service is a facility that anyone in the Trust can access. It is a service open to everyone, from Board to Base, and the contribution from the Board in helping to deliver this message has been significant. During 'Speak Up' month the Chair, Chief Executive, and the Executive and Non-Executive Directors with responsibility for the agenda recorded video messages for staff. The Chief Executive also continues to run regular messages to raise awareness of the agenda and its importance to the Trust. The Principal Guardian attends student nurse inductions, junior doctor meetings and training sessions, and BAME meetings and she is engaging with the LGBTQ+ staff community to ensure awareness and build the confidence necessary for people in all these groups to report any concerns they might have.

Work to increase the Local Guardian network is ongoing and a Communications Strategy is in place with the aim of ensuring that all staff are fully aware of the agenda and its purpose. Increasing the use of social media platforms is being considered as it is recognised that in many roles staff do not have regular access to a desktop computer and the opportunity to easily read articles on the intranet.

Staff Consultations

During the past year the Trust has undertaken a variety of consultations with staff which also included restructure of teams/services, change in shift patterns, relocation of staff, changes in the delivery of services and the closure of services. As we did last year, the restructures were to support the continued reductions in our corporate functions to implement the Trust's transformation post-merger and savings initiatives.

We are currently consulting on our operational administrative support functions across all clinical areas of the Trust and we will ensure that staff are fully engaged and consulted with and minimise potential redundancies wherever possible.

The Trust has also managed TUPE transfers out to new providers and in to EPUT. Some of these have been the transfer of HMP Prison service in Chelmsford to CRG, IAPT Basildon and Brentwood to Beta Health Group, Southend Sexual Health Services to Provide and Southend Borough Council and 0-5 services have transferred to Southend Borough Council.

All consultations and TUPE transfers were communicated with and involved staff side input. We also ensured staff affected had access to a good range of support during the process including access to guidance and support, counselling and HR advice should they need it.

Health and Safety

The Trust's Corporate Statement and Policy on Health and Safety (RM01) sets out the organisational structure for managing Health and Safety and how the Board of Directors fulfils its statutory obligations as required by the:

- Health & Safety at Work etc., Act 1974;
- Management of Health & Safety at Work Regulations 1992;
- Workplace (Health, Safety, and Welfare) Regulations 1992.

The Health, Safety and Security Committee co-ordinates the implementation and management of health, safety & security as well as non-clinical risk management across the organisation.

The Trust has a range of policies and procedures in place to support staff in maintaining compliance with health and safety requirements:

- Corporate Statement and Policy on Health and Safety
- Fire Safety Policy
- Control of Substances Hazardous to Health (COSHH)
- Display Screen Equipment Policy
- First Aid Policy
- General Work Place Risk Assessment Policy
- Adverse Incident (inc Serious Incident) Reporting Policy
- Lone Worker Safety Policy
- Health and Safety of Young Persons Policy
- Ligature Risk Assessment and Management Policy
- Manual Handling Policy

Carrying out safety checks on fire extinguishers

EPUT recognises the need for the effective management of health, safety and security. Day-to-day management of health, safety and security is undertaken by the Risk Management Department in cooperation with unit and locality managers and all staff according to their level of responsibility.

Ligature Risk Assessment Inspections have been completed in all in-patient areas of the organisation. Risks identified have been removed, replaced with a reduced ligature solution or action has been taken to ensure that staff are aware of risks and take them into account when planning care for vulnerable patients.

Community Mental Health Teams are required to complete a general work place risk assessment which identifies ligature hotspots within their building and actions to mitigate the risks.

Health and safety inspections were carried out across the organisation in line with legislation and guidance. These have been shared with staff and corrective action identified to minimise risk.

Workforce Equality and Inclusion

Our current workforce equality objective is:

"For all staff including those who fall into legal protected characteristics and other vulnerable groups will feel safe, included and have fair access to all areas of employment including recruitment, career progression, training and development. They will be supported dependent on their specific equality needs and there will be clear user-friendly monitoring information which shows progress and any areas that may require attention."

EPUT is committed to making improvements each year to the experience of our workforce through a range of equality work streams and our main achievements during this period were:

- launching a variety of staff networks to give staff a voice;
  - BAME Network
  - LGBTQ+ Network
  - Disability and Mental Health Network
  - Carers Network
  - Faith and Spirituality Network
- introducing the WDES (Workforce Disability Equality Standard);
- seeing progress in some of the Workforce Race Equality Standard Metrics;
- widening membership of the Equality Steering Group to include our equality champions;
- celebration of awareness events;
  - Equality and Inclusion Week
  - LGBT Awareness Month
  - Black History Month
  - Carers Week
- commitment to national initiatives and charter marks which support our workforce equality objectives (e.g. Mindful Employer, Time to Talk, Stonewall, Learning Disabilities in Recruitment, Working Forward, WRES);
- strengthening and updating of the equality online training tool – required annually for all staff.

Sharon Akinkunmi, Vice-chair of Trust's BAME Network, graduated from the WRES Programme and is now Trust WRES Expert

BAME Conference - BAME Network Chair, Edith Akinkede, and Professor Michael Wright

Equality and inclusion initiatives going forward are:

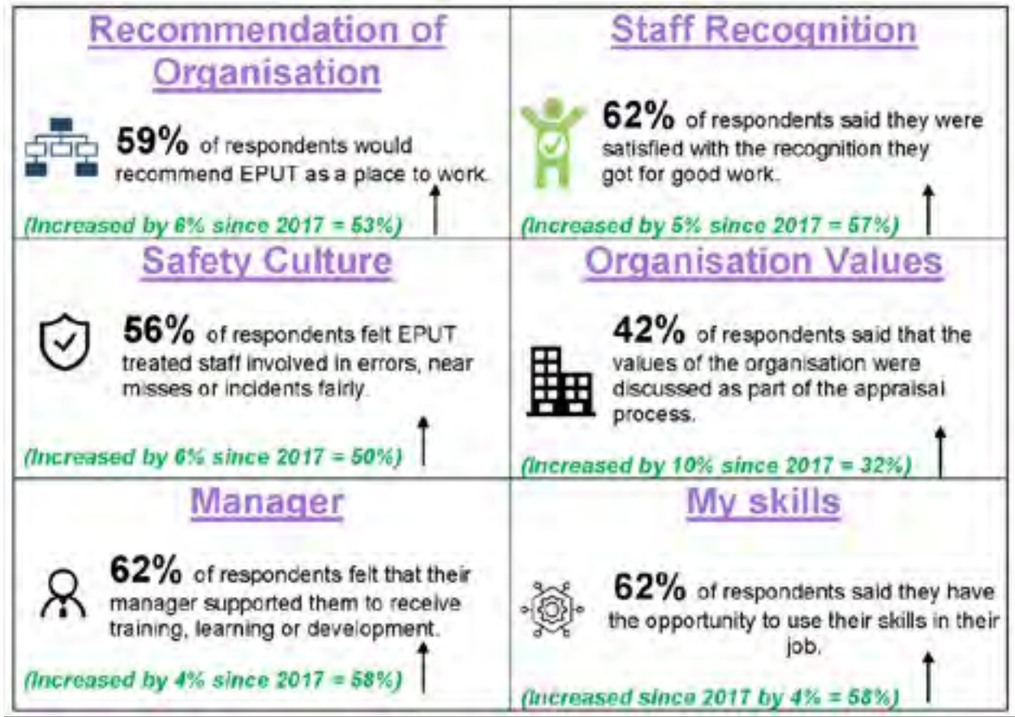
- an equality conference and equality champions event;
- improvements in the % of staff who declare themselves as disabled or with a long term condition;
- strengthening the equality staff networks and promotion;
- celebrating National Equality and Diversity Week;
- Increasing the proportion of staff that are happy to record their equality information.

Staff Health and Wellbeing

EPUT has a well-established health and wellbeing service. The health and wellbeing of our patients is directly related to the health and wellbeing of our staff and so it remains a top priority for the organisation to ensure our staff are as healthy as possible.

This year some of our key wellbeing achievements were:

- improvements in staff survey key findings around wellbeing;
- the update and re-launch of a flexible working handbook for staff to support work life balance;
- the introduction of a guide to bullying and harassment for staff;
- continued 'new year new you' health campaign with tangible results for staff covering both physical and mental wellbeing;
- the continued investment in dedicated absence advisers to support staff;
- the provision of fast-track physiotherapy for staff with musculoskeletal conditions in and out of work;
- continued a range of health fayres for staff;
- continued onsite fitness classes, e.g. zumba and yoga;
- published a guide to support staff suffering from mental ill health;
- health promotion days based around national health days, e.g. Stoptober, Dry January, etc; and
- dedicated support for staff involved in incidents of physical violence.



Staff Survey Results

Mobolaji Lewis wins Nigerian Healthcare Professional Award

We continue to provide full occupational health and employee assistance programmes for staff.

Priorities 2019/2020 – Building on this work we will prioritise some key areas including:

- the continuation of a strong plan to tackle discrimination, bullying and harassment;
- supporting areas of low staff morale through team development and wellbeing days;
- Mindfulness courses for staff supported by access to a range of on-line mindfulness tool;
- wide health promotion of support available to staff; and
- undertaking a review of our managing absence and wellbeing of staff policy and procedure to support staff with long term conditions and mental health illness.

All of this will be monitored through an agreed action plan which is reported and updated each quarter.

The Trust's Occupational Health Provider is Optima Health. The Trust also has a confidential employee assistance provider provided by HELP. Health checks as well as fast track physiotherapy is available under the new provider and stringent key performance indicators have been set to manage service delivery and are monitored monthly with the contract providers.

Policies on Counter Fraud/Corruption

The Trust has detailed procedures on counter fraud, and all finance policies and procedures are reviewed by our Local Counter Fraud Specialists to ensure fraud is minimised. Any lessons learned from fraud or staff investigations are factored into the regular reviews of procedures.

Expenditure on Consultancy

During 2018/19, the Trust spent £2.5 million on consultancy expenditure in respect of the provision of objective advice and assistance to the Trust in delivering its purpose and objectives.

This includes expert advice around the implementation of IT projects and project management support for estates and service related projects.

Off Payroll Arrangements

In line with HM Treasury guidance, the Trust has put controls in place around the use of off-payroll arrangements. These engagements are only entered into on the basis of the provider's relevant skills, experience and knowledge and are supported by individual contracts. All contracts are signed by both parties and include such terms as services to be provided, amount payable per day and responsibility for tax and national insurance contributions.

Table 23: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months

Number of existing engagements as of 31 March 2019 of which…	**12**
Number that have existed for less than one year at time of reporting	2
Number that have existed for between one and two years at time of reporting	5
Number that have existed for between two and three years at time of reporting	3
Number that have existed for between three and four years at time of reporting	1
Number that have existed for four or more years at time of reporting.	1

Table 24: New off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019 of which…	**4**
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	2
Number engaged directly (via Personal Service Companies (PSC) contracted to the Trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 25: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed board members and/or senior officials with significant financial responsibility during the financial year. This figure should include both off-payroll and on-payroll engagements.	7

Staff Exit Packages (subject to audit)

During the year the Trust has incurred total termination costs of £1,695,000 in respect of 53 individuals. These terminations arose from the requirement to deliver its efficiency target for the year.

Table 26: Staff exit packages 2018/19

2018/19						
	Compulsory Redundancies		Other Departures Agreed		Total Termination Costs	
	Number	£000's	Number	£000's	Number	£000's
< £10,000	8	51	1	6	9	57
£10,001 - £25,000	13	192	0	0	13	192
£25,001 - £50,000	22	723	0	0	22	723
£50,001 - £100,000	7	513	1	64	8	577
£100,001 - £150,000	1	146	0	0	1	146
£150,001 - £200,000	0	0	0	0	0	0
Total	**51**	**1,625**	**2**	**70**	**53**	**1,695**

The above table includes two instances where a special severance payment was made that required HM Treasury approval. This was at a cost of £70,000.

Table 27: Staff exit packages 2017/18

2017/18						
	Compulsory Redundancies		Other Departures Agreed		Total Termination Costs	
	Number	£000's	Number	£000's	Number	£000's
< £10,000	15	102	5	29	20	131
£10,001 - £25,000	43	685	3	37	46	722
£25,001 - £50,000	27	959	0	0	27	959
£50,001 - £100,000	24	1,709	0	0	24	1,709
£100,001 - £150,000	8	965	0	0	8	965
£150,001 - £200,000	3	480	0	0	3	480
Total	**120**	**4,900**	**8**	**66**	**128**	**4,966**

Staff Exit Packages: Non Compulsory Departure Payments

This note discloses the number of non-compulsory departures which attracted an exit package and the value of payments by individual types.

Table 28: Non compulsory departure payments 2018/19

Non Compulsory Departure Payments	2018/19	
	Number	£000's
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	2	70
Total	**2**	**70**

Table 29: Non compulsory departure payments 2017/18

Non Compulsory Departure Payments	2017/18	
	Number	£000's
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	5	36
Exit payments following employment tribunals or court orders	2	20
Non-contractual payments requiring HMT approval	1	10
Total	**8**	**66**

Staff Survey

Staff Engagement

Staff Engagement is a priority for EPUT. We have a dedicated Staff Engagement / Organisational Development Team and Communications Team to support our workforce in this area. There is wide research to show that an engaged and supported workforce provide a higher quality service to our patients and their families. Our ethos is based on ensuring our staff are cared for and engaged so that they are able to deliver high quality care.

We listen to feedback from our staff through the staff survey – and the constantly live Staff Friends and Family Test. In addition to this, we have held listening events, team away days and have introduced a cultural engagement network made up of a broad range of staff. They tell us what it's like to work at EPUT, what we do well and what we need to do to make things better.

We use a wide range of communication methods to engage with our staff. From Big Conversation Listening events, weekly CEO staff briefs, virtual networks and formal staff networks, right through to formal consultation processes and we work closely with our staff side and union representatives.

We have a wide range of staff equality networks which act as a voice and source of support for staff – either for themselves – or for learning more about equality groups for their colleagues or patients. These currently include BAME, Disability and Mental Health, LGBTQ+, Carers, Faith and Spirituality and these have direct access to support and Senior Management.

We have excellent working relationships within the organisation, but are also proud of our close working network with other local trusts across our STP landscape as well as strong links to NHS Employers.

Performance

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among trust staff was 43% (2017: 42%). Scores for each indicator together with that of the survey benchmarking group (Combined Mental Health/ Learning Disability and Community Trusts) are presented on page **81**.

> *I have visited a number of care and nursing homes a few years ago not one matched the standards of Rawreth Court. Many thanks to all concerned.*

NHS 70th Birthday celebrations at St Margaret's Hospital

Manny Lewis and Prof Dame Elizabeth Nneka Anionwu pictured at the Windrush 70th Anniversary event

Staff joining in with the celebrations to mark the Windrush 70th Anniversary

Trust Park Run to mark NHS 70th Birthday

Trust Matrons celebrate NHS 70th Birthday

Staff at Tilbury marking the Windrush 70th Anniversary

When comparing our performance to other Trusts in our grouping:

Table 30: Performance of EPUT in comparison to other Trusts in grouping

	2018	%
Better than Average	2	20
Average	4	40
Worse than Average	4	40
Total	**10**	**100%**

We improved our staff engagement score – a score made up of questions around motivation, ability to contribute towards improvements at work and recommendation of the organisation as a place to work/ receive treatment.

EPUT was created on 1 April 2017 and this is our second set of results. Whilst we perform below average in some areas, we have made excellent progress since last year. Each year we invite our workforce to support with the development of our staff engagement plans and we provide quarterly progress updates throughout the year.

Table 31: Performance of EPUT in staff survey

	2018/19		2017/18		2016/17*	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	8.9	9.2	9.1	9.2		
Health and wellbeing	6.1	6.1	6.1	6.1		
Immediate managers	7.2	7.2	7.2	7.1		
Morale	6.2	6.2	n/a	n/a		
Quality of appraisals	5.8	5.5	5.4	5.4		
Quality of care	7.5	7.4	7.4	7.4		
Safe environment – bullying and harassment	7.9	8.2	8.1	8.3		
Safe environment – violence	9.4	9.5	9.4	9.5		
Safety culture	6.7	6.8	6.6	6.7		
Staff engagement	7.0	7.0	6.9	7.0		

**There are no results for this reporting period for EPUT as EPUT did not exist at this time. SEPT and NEPT merged to become EPUT from 1st April 2017.*

Future Priorities and Targets

As well as a wider plan of continuous improvement of staff engagement, see below the other areas that we will continue to focus on in 2019.

- Equality and Inclusion – we are currently investing in additional resources to support this agenda and will work closely with our newly developed networks to ensure staff understand their role and how to access. We are also developing more modern ways of communicating with equality groups such as live blogs, lived experience films and virtual networks. We will be focusing on widening and strengthening the role of equality champion.
- Bullying and Violence – we will build on our Year 1 plan to address this by training and creating a pool of mediators across the Trust supported by Anti-Bullying Ambassadors. We will also continue to focus on reducing bullying and violence from patients and the public.
- Continuing to analyse a range of staff information including discipline, grievance and incident reporting to look for patterns and trends.
- Drilling down into specific areas such as staff groups and areas of work to identify hotspots for attention.
- 'Big Conversation' staff survey events for staff to engage and participate in plans for 2019/20.

NHS FOUNDATION TRUST: CODE OF GOVERNANCE

Introduction

Code of Governance

The Trust has applied the principles of Monitor's NHS Foundation Trust Code of Governance revised July 2014 (Code) on a 'comply or explain' basis. The Code is based on the principles of the UK Corporate Governance Code issued in 2012. The purpose of the Code is to assist Foundation Trusts to deliver effective and quality corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients.

The Code is best practice advice but imposes specific disclosure requirements. The annual report includes all the disclosures required by the Code.

Statement of compliance

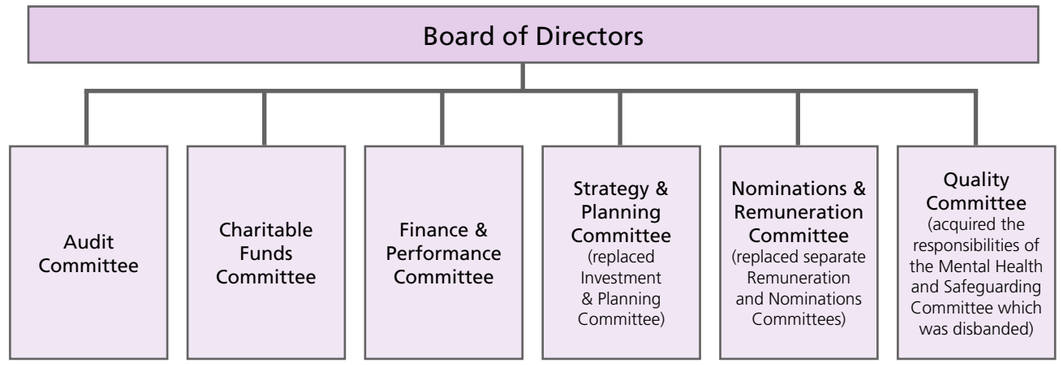
EPUT's Board of Directors and Council of Governors are committed to continuing to operate according to the highest standards of corporate governance. The Trust Secretary, Executive Operational Sub-Committee consisting of Executive Directors and the Governor members of the Council of Governors Governance Committee undertook an annual review of the Trust's compliance with the Code. This review was also considered by the Finance and Performance Committee comprising both Executive and Non-Executive Directors. In the opinion of these committees, there is strong evidence that the Trust is compliant with all the provisions in the Code for the period 1 April 2018 to 31 March 2019. Some actions were identified to further strengthen compliance which will be taken forward over the coming year.

Board of Directors

Our Board of Directors operates according to the highest corporate governance standards. It is a unitary Board providing overall leadership and vision to the Trust and is ultimately and collectively responsible for all aspects of performance, including clinical and service quality, financial performance and governance as well as the management of significant risks. The Board leads the Trust by formulating strategy; ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; and shaping a positive culture for the Board and the organisation.
The Board is also responsible for establishing the values and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life (The Nolan Principles) including selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

The Board exercises all the powers of the Trust on its behalf and delegates specific functions to committees of Directors. In addition, certain decisions are made by the Council of Governors, and some Board decisions require the approval of the Council. The powers and decisions are set out clearly in the Scheme of Reservation and Delegation and the Detailed Scheme of Delegation available at: www.eput.nhs.uk All Directors have joint responsibility for decisions.

Figure 2: Committee structure underpinning Board of Directors as at 31 March 2019



The Executive Directors manage the day-to-day running of the Trust while the Chair and Non-Executive Directors provide operational and Board-level experience gained from other public and private sector bodies; among their skills are accountancy, audit, clinical, law, business development, consultancy, quality, risk and governance. The Board includes members with a diverse range of skills, experience and backgrounds which incorporate the skills required of the Board.

The Board has a Vice-Chair and has a Senior Independent Director. All Non-Executive Directors are considered by the Board to be independent taking into account, character, judgement and length of tenure. None of the Executive Directors hold Non-Executive appointments.

During the course of the year the Board met 12 times. Ten meetings were held in public with two meetings being held in private due to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business discussed. The attendance record of meetings for the Board of Directors for the year ended 31 March 2019 is as follows in table 32.

Table 32: Board of Directors Attendance at Meetings 2018/19

Name	Role	Meetings Attended (actual/ possible)
Prof Sheila Salmon	Chair	10/12
Andy Brogan	Executive Director Mental Health & Deputy CEO	11/12
Alison Davis	Non-Executive Director	10/12
Prof Natalie Hammond	Executive Nurse	11/12
Dr Rufus Helm (from 24/07/18)	Non-Executive Director	7/8
Dr Milind Karale	Executive Medical Director	9/12
Nigel Leonard	Executive Director Corporate Governance & Strategy	12/12
Manny Lewis	Non-Executive Director	11/12
Mark Madden	Executive Chief Finance Officer	10/12
Malcolm McCann	Executive Director Community Services & Partnerships	10/12
Sally Morris	Chief Executive	11/12
Mary-Ann Munford (until 31/05/18)	Non-Executive Director	3/3
Dr Alison Rose-Quirie (from 24/07/18)	Non-Executive Director	8/8
Amanda Sherlock	Non-Executive Director	11/12
Nicci Statham (until 30/04/18)	Non-Executive Director	1/1
Nigel Turner	Non-Executive Director	10/12
Janet Wood	Vice-Chair (and Acting Chair 1 Apr 2017 – 30 Sept 2017)	11/12

Board of Directors Appointments

The Trust has a formal, rigorous and transparent procedure for the appointment of both Executive and Non-Executive Directors. Appointments are made on merit, based on objective criteria.

Executive Directors are permanent appointments, while Non-Executive Directors are appointed to a three year term of office and where possible appointments are staggered. The reappointment of a Non-Executive Director after their first term of office will be subject to a satisfactory performance appraisal. Any term beyond six years will be subject to a rigorous review and satisfactory annual performance appraisal, and takes account of the need for progressive refreshing of the Board. However, the Council of Governors will also consider the skills and experience required on the Board taking account of the Trust's current and future business needs, as well as continuity during any period of change.

Both the Chair and Non-Executive Directors are appointed by the Council who may also terminate their appointment as set out in the Trust's constitution.

The following Directors were appointed to the Board of Directors during 2018/19:

- Dr Rufus Helm (from 24/07/18)
- Dr Alison Rose-Quirie (from 24/07/18)

All appointments were managed internally by Trust teams and advertised externally through various channels including the Trust's website, NHS Jobs, NHS Improvement's website, the Centre for Public Appointments and LinkedIn. No external consultants were involved or commissioned to undertake the recruitment.

Chair's Significant Commitments

Professor Sheila Salmon has no other significant commitments other than to the Trust. However, she has declared her involvement with Anglia Ruskin University where she is the Emeritus Professor of Health Services Development which is a non-remunerated role.

Independence of the Non-Executive Directors

Following consideration of the Code of Governance and completion by all Non-Executive Directors of a test of independence statement, the Board takes the view that all Non-Executive Directors are independent. All Non-Executive Directors declare their interest and, in the unlikelihood that such interests conflict with those of the Trust, then the individual would be excluded from any discussion and decision relating to that specific matter.

Balance, Completeness and Appropriateness of the Membership of the Board of Directors

The current Board of Directors comprises eight Non-Executive Directors (including the Trust Chair) and seven Executive Directors (including the Chief Executive). The structure is compliant with the provisions of the Code of Governance and the Trust's constitution.

Taking into account the wide experience of the whole Board as well as the balance and completeness of membership, the composition of the Board is considered to be appropriate for the requirements of the business and future direction of the Trust. Arrangements are in place to enable appropriate review of the Board's balance, completeness and appropriateness to the requirements of the Trust.

Board of Directors Performance Evaluation

The Trust has put in place processes for an annual performance evaluation of the Board, its Directors and its committees in relation to their performance. At the time of writing this report, the various end of year evaluations for 2018/19 were being undertaken; however, a mid-year review had been undertaken of the individual performances of the Board Directors in place at the time.

All members of the Board receive a full and tailored induction on joining the Trust and undertake a personal induction programme during the first 12 months of appointment. All Directors will undergo an annual performance review against agreed objectives, skills and competences and agree personal development plans for the forthcoming year. In addition, the Chair will annually review and agree the Chief Executive's and Executive Directors' training and development needs as they relate to their role on the Board.

A 360° appraisal is in place for the Chair, Chief Executive, Executive Directors and Non-Executive Directors. The 360° element will be undertaken every two years. A 360° appraisal was recently completed for all Non-Executive Directors appertaining to the performance year 2018/19. A 360°appraisal of the Chair's performance was completed for the performance year 2017/18 and will thus be completed again for performance year 2019/20. In addition, an external stakeholder review of the collective performance of the Board was conducted during 2018/19, which enabled the Trust to implement actions to further strengthen its performance from an external stakeholder perspective.

The performance evaluation of the Executive Directors is carried out by the Chief Executive whose performance is appraised by the Chair. The outcomes are reported to the Board of Directors Remuneration Committee.

The Chair conducts the annual performance evaluation and appraisal of each Non-Executive Director. The Senior Independent Director conducts the annual performance evaluation and appraisal of the Chair, having met with all other Non-Executive Directors and received feedback from Governors. Detailed consideration of the results of the performance evaluation of the Chair and Non-Executive Directors for 2017/18 was undertaken by the Council of Governors Remuneration Committee in line with the process agreed by the Council and a report from the Committee made to the Council of Governors in 2018/19. The same performance evaluation and appraisal process is currently being conducted for performance during 2018/19 and a report from the Council of Governors Remuneration Committee is to be presented to a meeting of the Council in May 2019.

As detailed above, a mid-year review of key aspects of the Trust's governance arrangements was undertaken with the aim of ensuring the effectiveness of decision-making at Board and committee level. No major concerns or issues were raised but some changes to the committee structure were implemented to streamline the existing committee structure and give greater focus on strategic development and the transformation agenda.

The Board undertakes annual self-assessments reflecting NHS Improvement's and CQC's well-led framework to evaluate its own effectiveness and, in line with NHS Improvement's requirements that an external evaluation is carried out every three years, commissioned an externally facilitated developmental well-led review to be completed at the end of 2018/19 . This contributes to providing an insight into how the Trust gauges its own leadership and governance performance. It will also help to identify the Board's development needs and to shape its development programme.

Board performance is also evaluated further through focused discussions at Board Development Days and on-going in-year review of the Board Assurance Framework which enables continuous and comprehensive review of the performance of the Trust against agreed plans and objectives.

All Directors meet the criteria for being a fit and proper person as prescribed by the Trust's Provider Licence and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nominations Committees

The Trust has two Nominations Committees: the Board of Directors Remuneration and Nominations Committee and the Council of Governors Nominations Committee.

Board of Directors Nominations Committee

The Board of Directors Remuneration and Nominations Committee is constituted as a standing committee of the Board. It has the statutory responsibility for identifying and appointing suitable candidates to fill Executive Director posts on the Board, ensuring compliance with any mandatory guidance and relevant statutory requirements.

This Committee is also responsible for succession planning and reviewing Board structure, size and composition, taking into account future challenges, risks and opportunities facing the Trust and the balance of skills, knowledge and experience required on the Board to meet them.

The Committee is chaired by the Trust's Chair with membership comprising all Non-Executive Directors and the Chief Executive, except in the case of the nomination of the Chief Executive's post. At the invitation of the Committee, representation from HR will be invited to attend a meeting in an advisory capacity in relation to a specific agenda item. The Trust Secretary is the Committee Secretary.

The Committee's terms of reference are reviewed annually in line with good practice. The Committee meets at least annually or as and when required to undertake its roles and responsibilities.

A review of the governance structure underpinning the Board of Directors was undertaken in 2018. One of the recommendations of this review was to amalgamate the Remuneration and Nominations Committees of the Board of Directors into one Committee. This recommendation was approved by the Board of Directors in September 2018 and the Committees were amalgamated to form a Remuneration and Nominations Committee with immediate effect. This is reflected in the attendance information below.

The Committee met four times during the year with the main considerations being temporary arrangements to cover planned sickness absence of one of the Executive Directors and succession planning for Senior and Executive Director roles.

Members of the Nominations Committee and the number of meetings attended by each member during the year are set out on the following page in table 33.

Table 33: Membership and attendance at Board of Directors Nominations Committee meetings (until 26/09/18)

Name	Role	Meetings Attended (actual/ possible)
Prof Sheila Salmon	Chair	2/2
Alison Davis	Non-Executive Director	1/2
Dr Rufus Helm (from 24/07/18)	Non-Executive Director	0/1
Manny Lewis	Non-Executive Director	0/2
Sally Morris	Chief Executive	2/2
Dr Alison Rose-Quirie (from 24/07/18)	Non-Executive Director	0/1
Amanda Sherlock	Non-Executive Director	2/2
Nigel Turner	Non-Executive Director	1/2
Janet Wood	Vice-Chair (and Acting Chair 1 Apr 2017 – 30 Sept 2017)	2/2

Attendance at the combined Board of Directors Remuneration and Nominations Committee is detailed at Table 8 above.

Council of Governors Nominations Committee

The Council of Governors Nominations Committee is responsible for establishing a clear and transparent process for the identification and nomination of suitable candidates that fit the criteria set out by the Board of Directors Nominations Committee for the appointment of the Trust Chair and Non-Executive Directors for approval by the Council.

The Committee is chaired by the Trust's Chair with membership comprising elected and appointed Governors. If the Chair is being appointed or not available, the Vice-Chair or one of the other Non-Executive Directors who is not standing for appointment will be the Chair. When the Trust Chair is being appointed, the Committee comprises only of Governors who will elect a Chair of the Committee from amongst its members. The Trust Secretary is the Committee Secretary.

During the year, the Committee led and delivered the process for the appointment of two Non-Executive Directors for the Board of Directors. It also considered the role, term of office and appointment process for a Vice Chair.

Members of the Committee and the number of meetings attended by each member during the year are set out on the following page in table 34.

Table 34: Membership and attendance at Council of Governors Nominations Committee meetings

Name	Role	Meetings Attended (actual/ possible)
Prof Sheila Salmon	Chair	9/9
Brian Arney	Public Governor	8/9
Roy Birch	Public Governor	7/9
David Bowater	Appointed Governor	8/9
Pippa Ecclestone	Public Governor	7/9
Paula Grayson	Public Governor	7/9
John Jones	Public Governor	9/9
Clive White	Public Governor	8/9
Judith Woolley	Public Governor	4/9

Audit Committee

The Audit Committee comprises solely of independent Non-Executive Directors who have a broad set of financial, legal and commercial expertise to fulfil the Committee's duties. Members of the Committee and the number of meetings attended by each member during the year are set out below:

Table 35: Membership and attendance at Audit Committee meetings

Name	Role	Meetings Attended (actual/ possible)
Janet Wood	Chair of Committee	6/7
Mary-Ann Munford (until 31/05/18)	Non-Executive Director	2/2
Amanda Sherlock	Non-Executive Director	6/7
Nigel Turner	Non-Executive Director	7/7
Alison Davis	Non-Executive Director	3/3

At the request of the Committee Chair, each meeting is attended by the Executive Chief Finance Officer, Head of Financial Accounts, an External Audit representative, an Internal Audit representative, and the Local Counter Fraud Specialist. In addition, the Chief Executive presents the Annual Governance Statement on an annual basis.

Internal Audit

The Trust has an internal audit function which forms an important part of the organisation's internal control environment. This was provided by BDO LLP during 2018/19. The functions of the internal audit service are to provide an 'independent, objective assurance and consulting activity designed to add value to an organisation's activities'. This means that the role embraces two key areas:

1. The provision of an independent and objective opinion to the Accounting Officer, the governing body and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives;

2. The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

Local Counter Fraud Specialist

BDO LLP provide the Trust with a dedicated counter fraud service, and agrees a detailed counter fraud work plan with the Trust, based on guidance received from the NHS Counter Fraud Authority. The Trust also has a counter fraud policy and response plan which has been approved by the Board of Directors. Anyone suspecting fraudulent activities within the Trust's services should report their suspicions to the Executive Chief Finance Officer or telephone the confidential hotline on **0800 028 4060**.

External Audit

In August 2017 the Council of Governors approved the appointment of Ernst and Young as the Trust's external auditors for a 12 month period, with the option to extend for a further 48 months following an annual review of their service and recommendation from the Audit Committee.

At their meeting in September 2018, the Council of Governors subsequently approved the reappointment of Ernst and Young for a further 12 month period to cover the 2018/19 year end accounts.

The value of the external audit contract for 2018/19 was £50,000 (excluding VAT). There was no non-audit work undertaken during 2018/19.

Work of the Audit Committee

During the year the Committee considered a number of significant issues including the fire safety audits and progress made by the Trust in addressing these risks.

In addition, further significant issues relating to the 2018/19 annual accounts which were discussed by the Committee were as follows:

- the accounting treatment for the legacy Severalls Hospital development, the associated agreements for which the Trust continues to remain liable and the subsequent reclassification of these from accruals to provisions, and the requirement due to its materiality, to show this as a prior period adjustment;
- the impact that the receipt of Provider Sustainability Funding from the Department of Health had on the Trusts reported surplus and which totalled £8,778,000;
- the negligible impact the implementation of IFRS 9 (Financial Instruments) and IFRS 15 (Revenue Contracts with Customers) had on the Trusts accounts for the year;
- the Audit Committee considered the issue of going concern and the Trust's future financial plans that are in place, and recommended that the Board sign off the appropriate statements.

Council of Governors

An integral part of the Trust is the Council of Governors which brings the views and interests of the public, service users and patients, carers, our staff and other stakeholders into the heart of our governance. This group of committed individuals has an essential involvement with the Trust and contributes to its work and future developments in order to help improve the quality of services and care for all our service users and patients.

The Council comprises 40 members; 27 of which are elected to represent public constituencies, six who are elected as staff representatives and seven appointed partnership organisations.

> *To the most caring bunch of people I've ever met. You are all stars in my eyes. I couldn't wish for better support. Thank you for putting up with me and being there when I've needed you. This really is a special place. Thank you all in the Eating Disorders Team.*

Role of the Council

The over-riding role of the Council is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and to represent the interests of the members of the Trust and of the public. This includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust, to ensure that the interests of the Trust's members and public are represented.

The roles and responsibilities of the Council are set out in our constitution. The Council's statutory responsibilities include:

- to amend/approve amendments to the Trust's constitution;
- to appoint/remove the Chair and other Non-Executive Directors;
- to approve the appointment of the Chief Executive;
- to determine the remuneration, allowances and other terms and conditions of office of the Chair and Non-Executive Directors;
- to appoint/remove the Trust's external auditor;
- to provide views to the Board of Directors in the preparation of the Trust's annual plan;
- to receive the Trust's annual report and accounts and any report of the auditor;
- to take decisions on significant transactions and on non-NHS income.

The Council of Governors is required to meet a minimum of four times a year.

The Health and Social Care Act 2012 requires the Board of Directors to empower Governors by:

- holding open Board meetings;
- before holding a Board meeting the Board must send a copy of the agendas to the Council;
- sending copies of the approved minutes to the Council as soon as practicable after holding a Board meeting;
- ensuring that Governors are equipped with the skills and knowledge they need to undertake their role.

Composition of the Council of Governors

The Council is led by the Chair of the Trust. The composition of the Council of Governors is in accordance with the Trust's constitution as below:

Table 36: Composition of Council of Governors

Constituency		Number of Governors
Public	Essex Mid & South	11
	Milton Keynes, Bedfordshire & Luton	6
	North East Essex & Suffolk	5
	West Essex & Herts	5
Staff	Clinical	3
	Non-clinical	3
Appointed	Bedford Borough Council and Central Bedfordshire Council*	1
	Essex County Council	1
	Southend Borough Council	1
	Thurrock Council	1
	Anglia Ruskin and Essex Universities*	1
	CVS Essex	1
	Service Users & Carers Forum	1

** Joint appointment*

Council of Governors Elections

There has been no requirement to undertake elections to appoint Governors during 2018/19.

Board's Relationship with the Council

The Trust Chair is responsible for the leadership of both the Council of Governors and the Board of Directors. The Chair has overall responsibility for ensuring that the views of the Council and Trust members are communicated to the Board as a whole and considered as part of decision-making processes and that the two bodies work effectively together.

The Chair works closely with the nominated Lead and Deputy Lead Governors and meets with them prior to Council meetings to set the agenda and review key issues.

The Executive and Non-Executive Directors attend each meeting of the Council presenting agenda items and take part in open discussions that form part of each meeting. Standing agenda items also include reports from the Chief Executive and Executive Directors on Trust performance, finance and quality matters, a report from the Chair, and national and local systems updates. Non-Executive chairs of each Board standing committee also present on a rotational basis a summary report of the committees' deliberations.

The Senior Independent Director actively pursues an effective relationship between the Council and the Board. Governors can contact the Senior Independent Director if they have concerns regarding any issues which have not been addressed by the Chair, Chief Executive or Executive Chief Finance Officer. The Council in liaison with the Senior Independent Director is developing a Policy for Engagement with the Board of Directors (where there is Disagreement or Concerns with Performance) which outlines how the Council and Board engage as well as the procedure to be followed when there are disagreements and/or when the Council has concerns about the performance of the Board.

Board of Directors meetings are held in public and Governors can and do attend, having the opportunity to ask questions of the Board on matters relating to agenda items. In addition, the Trust has established working groups of Board and Council representatives to take forward specific work including, for example, the review of the Trust's Constitution.

Both the Board of Directors and the Council of Governors are committed to continuing to promote enhanced joint working so that they can deliver their respective statutory roles and responsibilities in the most effective way possible.

The Board values the relationship it has with the Council and recognises that its work promotes the strategic aims and assists in shaping the culture of the Trust. Both the Board and the Council are committed to continuing to promote enhanced joint working so that they can deliver their respective statutory roles and responsibilities in the most effective way possible.

Keeping Informed of Governors' and Members' Views

During the year the Board was kept informed of the views of Governors and members in a number of ways. The Board recognises the importance of ensuring the relations with stakeholders are embedded and in particular there is dialogue with members, patients and the local community. The Trust encourages quality engagement with stakeholders and regularly consults and involves Governors, members, patients and the local community through various routes. It also supports Governors in ensuring they represent the interests of the Trust's members and the public, through seeking their views and keeping them informed.

The Trust has a Membership Framework which outlines the vision for membership over the period 2018-2021. It includes the priorities to build an effective, responsive and representative membership body that will assist in ensuring the Trust is fit for its future in the changing NHS environment. The Framework recognises that there will be a wide variation in the level of participation of our members and, therefore, provides a range of pathways from which choices can be made. Every effort is, and will continue to be, made to be inclusive in the approach to involvement with the aim of the membership community reflecting the social and cultural mix of the Trust's constituencies. Further information in terms of our approach to membership over 2018/19 is included in the section below.

Some of the key features of the wide-range of engagement mechanisms with Governors and members include:

- attendance and agenda item presentations by Executive Directors and Non-Executive Directors at all Council meetings held quarterly (Governors are provided with the opportunity of asking questions and providing feedback);
- Council meetings held in public;
- Non-Executive Directors and Governors informal meetings held quarterly;
- Chief Executive briefing sessions with Governors held quarterly;
- Lead and Deputy Lead Governors meetings with Chair and with Senior Independent Director and Trust Secretary held regularly;
- attendance by Governors at Board of Director meetings;
- joint Quality Visits by Governors and Board Directors to Trust sites;
- joint Director/Governor Task and Finish Groups established as required;
- public member meetings: five 'Your Voice' meetings were held during 2018/19 across Trust constituencies enabling members and the public to meet with the Chair, Chief Executive, Directors, Senior Managers and Governors);
- our website www.eput.nhs.uk.

The Trust fosters an 'open door' policy where issues, queries and feedback can be raised with the Chair, the Chief Executive and any Board member as appropriate either on a face to face basis or via email.

Feedback and views are captured and shared with the Board as described above and are also reported, for example, through:

- statement from the Council in Trust's Quality Report;
- Annual Members Meeting;
- Our Voice (members' magazine).

Table 37: Council of Governors Meeting Attendance 2018-2019

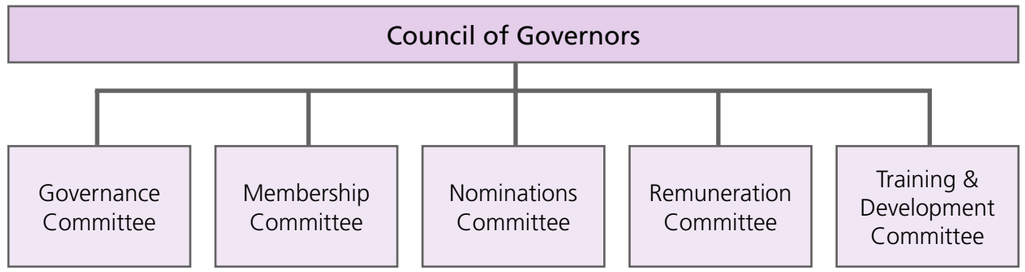
Name	Term		Attendance at Council of Governor Meetings (actual/ possible)
Public: Milton Keynes, Bedfordshire & Luton			
Paula Grayson	1st term: 2 years	Jun 2017 – Jun 2019	7/7
John Jones	1st term: 2 years	Jun 2017 – Jun 2019	7/7
Hasan Kayani	1st term: 2 years	Jun 2017 – Jun 2019	1/7
Clive Travis	1st term: 3 years	Jun 2017 – Jun 2019	4/7
Alex Zihute	1st term: 3 years	Jul 2017 – Jun 2020	6/7
Pubic: Essex Mid & South			
Roy Birch	1st term: 3 years	Jun 2017 – Jun 2020	6/7
Toby Blunsten	1st term: 3 years	Jun 2017 – Jun 2020	2/7
Keith Bobbin	1st term: 3 years	Jun 2017 – Jun 2020	6/7
Karen Brown	1st term: 2 years	Jun 2017 – Jun 2020	1/7
Bob Calver	1st term: 2 years	Aug 2017 – Jun 2019	5/7
James Clarke	1st term: 3 years	Jun 2017 – Jun 2020	4/7
Shurleea Harding	1st term: 3 years	Jun 2017 – Jun 2020	1/7
Andrew Hensman	1st term: 2 years	Jun 2017 – Jun 2020	1/7
Poppy Miller (until May 2018)	1st term: 3 years	Jun 2017 – Jun 2020	1/2
Sam Rakusen	1st term: 2 years	Feb 2018 – Jun 2019	5/7
Judith Woolley	1st term: 2 years	Jun 2017 – Jun 2020	4/7
Public: North East Essex & Suffolk			
Ted Beckwith (until December 2018)	1st term: 3 years	Jun 2017 – Jun 2020	3/6
Peter Cheng	1st term: 2 years	Jun 2017 – Jun 2019	6/7
Mikey Henderson (until May 2018)	1st term: 2 years	Jun 2017 – Jun 2019	0/2
James Mcguiggan (until September 2018)	1st term: 3 years	Jun 2017 – Jun 2020	1/4
Clive White	1st term: 3 years	Jun 2017 – Jun 2020	7/7
Public: West Essex & Herts			
Brian Arney	1st term: 3 years	Jun 2017 – Jun 2020	6/7
David Bamber	1st term: 3 years	Jun 2017 – Jun 2020	7/7
Nadiene Birch	1st term: 2 years	Jun 2017 – Jun 2019	2/7
Pippa Ecclestone	1st term: 3 years	Jun 2017 – Jun 2020	6/7
Michael Waller	1st term: 2 years	Jun 2017 – Jun 2019	7/7
Staff: Clinical			
Ben Victor-Okoh (until October 2018)	1st term: 3 years	Sept 2017 – Jun 2020	0/4
Gail Gibbs	1st term: 2 years	Jun 2017 – Jun 2019	3/7
Tracy Reed	1st term: 3 years	Jun 2017 – Jun 2019	3/7
Staff Non-Clinical			
Pam Madison	1st term: 3 years	Jun 2017 – Jun 2020	5/7
Gill Toby	1st term: 3 years	Jun 2017 – Jun 2020	5/7

Bedford Borough Council and Central Bedfordshire Council			
David Bowater	1st term: 3 years	Jun 2017 – Jun 2020	3/7
Essex County Council			
Andy Wood	1st term: 3 years	Jun 2017 – Jun 2020	5/7
Southend Borough Council			
James Moyies (until May 2018)	1st term: 3 years	Aug 2017 – Jun 2020	0/1
Faye Evans (from May 2018)	1st term: 3 years	May 2018 – May 2021	2/5
Thurrock Council			
Tony Fish (until May 2018)	1st term: 3 years	Jun 2017 – Jun 2020	0/2
Sue Shinnick (from May 2018)	1st term: 3 years	May 2018 – May 2021	2/5
Anglia Ruskin and Essex Universities			
Graham Underwood	1st term: 3 years	Jun 2017 – May 2020	2/7
CVS			
Clive Emmett	1st term: 3 years	Sept 2017 – May 2020	2/7

Council of Governors Committees

The Council's committee governance framework is designed to ensure it robustly supports and enables the Council to fulfil its duties, roles and responsibilities effectively. The Committees do not have any delegated authority. All responsibilities are undertaken in support of the Council as it is the Council of Governors that holds the responsibility for decisions relating to all issues covered by the Committees.

Figure 3: Committee structure underpinning Council of Governors



Governor Training and Development

The Governor Training and Development Committee is a standing committee of the Council that provides support in ensuring that there are effective and robust training and development arrangements in place to develop Governors' skills, knowledge and capabilities. This enables them to be confident, effective, engaged and informed members of the Council, thereby ensuring that the Council as a body remains fit for purpose and is developed to ensure continued delivery of its responsibilities effectively.

During the year the Trust has hosted or provided Governors with access to a range of training and development opportunities with the purpose of enhancing their knowledge and understanding of the organisation.

All Governors have undertaken a comprehensive induction programme which is regularly reviewed and updated, taking account of best practice from the centre. This is part of the Trust's Governor Learning and Development Pathway modular framework that covers the life-cycle of a Governor.

During 2018/19 there have been various opportunities for providing support to Governors with their training and development including:

- two away days to develop Governor skills and the effectiveness of the Council of Governors as a collective – focussing on the role and core functions, working effectively together, understanding effective challenge and creating an atmosphere of collaboration;
- briefings to develop Governor knowledge and understanding on subjects including CQC inspection preparations, Cost Improvement Plans, STPs, Personality Disorders and Recruitment and Retention Plans.

The Trust has also kept Governors well informed of training and development workshops and conferences hosted by other organisations, including NHS Providers, and encouraged all to utilise these development opportunities. Our Governors are encouraged to share their experiences of events attended through a written event feedback form which is circulated to the wider Council.

The Lead Governor is also the Deputy Chair and a member of the NHS Providers Governor Advisory Panel and provides quarterly updates to the Council. He has also established a Regional Lead Governors network and provides written updates to the Council.

Governors are also kept regularly informed through direct emails and the internal Governor e-newsletter. Knowledge is kept up to date through the sharing of best practice and centrally published information. In addition, the Chief Executive provides a briefing in private prior to each Council meeting.

In addition, the Council has established a buddy framework to support new Governors. They introduced a skills and interests check list that identifies the skills and knowledge gaps for Governors so that appropriate training and development modules and/or briefings can be developed. This also identifies the wealth of skills and interest areas that could be usefully utilised by the Council and therefore be shared with fellow Governors.

Council of Governors Register of Interests

All members of the Board of Directors and Council of Governors have a responsibility to declare relevant interests as defined in the Trust's constitution. These declarations are made known to the Trust Secretary and entered into two registers which are available to the public.

Details can be requested from the Trust Secretary at:
The Lodge, Lodge Approach, Wickford SS11 7XX
or email: epunft.membership@nhs.net

Governor Expenses

Governors do not receive remuneration but are able to claim travel and other expenses in line with Trust policy. During the year Governor expenses incurred totalled £14,600 and were claimed by 20 Governors out of a total of 37 in office (2017/18: £8,100 by 20 Governors).

Governors Contact Details

Governors can be contacted through the Trust Secretary Office by any of the following methods:
Email: epunft.membership@nhs.net
Freephone: 0800 023 2059

Post:
Freepost RTRG–UCEC-CYXU
Trust Secretary Office
The Lodge
Lodge Approach
Wickford SS11 7XX

Council meetings are open to the public and details are published on the website together with the papers and minutes of the meetings.

Membership

What is membership?

"Just keep your work going as good as you are and the team won't go wrong. START is a very good team.

Foundation Trust membership aims to give local people, service users, patients and staff a greater influence in how the Trust's services are provided and developed. The benefits to the Trust in developing an effective membership and providing active engagement are:

- wider engagement with and improved access to the views of the population and community we serve
- improved and more representative feedback from the local population as a whole
- a better understanding of service user/patients' views in identifying particular service needs/ gaps in service and valuable feedback on how well services are meeting the requirements of the local population, improving the quality of care
- continuing to build good and trusting relationships
- to inform / consult with the local population on the work of the Trust including service developments

Membership is important in helping to make the Trust more accountable to the people we serve, to raise awareness of mental health, community health and learning disability issues, and assists the Trust to work in partnership with our local communities.

The membership structure for the Trust is made up of two categories of membership:

Public Members - Anyone aged 12 and over living in England can become a member. Public membership is sub-divided into four constituencies which reflect the Sustainability and Transformation Partnership boundaries within which the Trust delivers services (one of which, Bedford, Luton, Milton Keynes, also includes the 'rest of England').

Staff Members - All staff who are on permanent or fixed term contracts that run for 12 months or longer automatically become members, unless they opt out. Staff who are seconded from our partnership organisations and working in the Trust on permanent or fixed term contracts that run for 12 months or longer are also automatically eligible to become members. Staff are members of one of two sub-groups which are linked to their different fields of work – clinical or non-clinical.

Membership Size and Breakdown

Our aim is to establish and maintain a broad and engaged membership that is evenly spread geographically across the areas we serve and reflects the ages and diversity of our local population.

Upon establishment of EPUT, the membership comprised members from the predecessor Trusts (NEP and SEPT) unless they took the opportunity offered to them to opt out of the new Trust's membership prior to the merger. This level of membership was retained for the first year of the new Trust (2017/18). However, as part of the new Membership Framework (see below), it was agreed that actions should be taken over the three year period of the Framework to achieve a more active and representative membership. To this end, we undertook a full update of the membership database, contacting all those on the database (with the exception of the Bedford, Luton, Milton Keynes and Rest of England constituency area) to ask them to make contact if they wished to continue to be a member for EPUT specifically, for their up to date contact details and how they would like to be involved into the future. All members were asked to indicate from a range of options how they would like to be informed / involved, reflecting the levels of engagement outlined in our Membership Framework as follows:

Level 1 – Informed: One way communication (eg receive newsletters and updates, be advised of public meetings/membership events, vote in Governor elections)

Level 2 – Involved: In addition to level 1, share thoughts and ideas (eg attend meetings/ events, participate in surveys/consultations etc, participate in focus/discussion groups)

Level 3 – Influence: In addition to levels 1 and 2, stand for appointment as a Governor or become an active volunteer at the Trust.

A review of membership in the Bedford, Luton, Milton Keynes and Rest of England Constituency is to take place in Q2 2019/20.

Whilst the review of membership has resulted in a reduction in the overall number of members (as reflected in the table below), we are confident that this has resulted in a membership which wishes to be engaged with the work of the Trust to differing extents based on personal preferences which will shape the way we engage with our members into the future. We now intend to build on those relationships to maximise the value of membership on the provision of quality services by the Trust.

As at 31 March 2019, the Trust had 11,519 members as follows:

Table 38: Membership size and movements 2018/19

Membership Size and Movements 2017/18	
Public constituency	
At year start (April 1)	18,861
New members	27
Members leaving	13,594
At year end (March 31)	5,294
Staff constituency	
At year start (April 1)	6,482
New members	0
Members leaving	292
At year end (March 31)	6,190

A breakdown of the public membership is as follows:

Table 39: Breakdown of public membership as at 31 March 2019

Analysis of Public Membership 2017/18		
Public constituency		Number of members
Age (years)	0-16	1
	17-21	40
	22+	4,637
Ethnicity	White	4,034
	Mixed	104
	Asian or Asian British	427
	Black or Black British	281
	Other	18
Socio-economic groupings	AB	1,384
	C1	1,541
	C2	1,115
	DE	1,179
Gender analysis	Male	2,038
	Female	3,134

The analysis section of the above table excludes:

- 616 public members with no dates of birth;
- 430 members with no stated ethnicity;
- 75 members with no socio-economic grouping;
- 122 members with no gender.

General exclusions: suspended members and inactive members.

Membership Framework

The Trust recognises that the Council of Governors directly represents the interests of the members and the local communities it serves. The Trust believes that its members have an opportunity to influence the work of the Trust and the wider healthcare landscape, thereby making a real contribution towards improving the health and wellbeing of service users/patients and the quality of services provided.

The Membership Framework is one of six frameworks that underpin the Engagement Strategy that recognises the need to put service users and the public at the heart of our engagement. It has a direct link to engagement with our range of stakeholders and should be read in conjunction with the Communications, Patient Experience and Carers' Frameworks.

The Membership Framework outlines the Trust's vision for membership and priorities over the period 2018-2021 and includes the priorities to build an effective, responsive and representative membership body that will assist in ensuring the Trust is fit for its future in the changing NHS environment. It recognises that there will be a wide variation in the level of participation of our members and, therefore, provides a range of pathways from which choices can be made. Every effort will be made to be inclusive in the approach to involvement with the aim of the membership community reflecting the social and cultural mix of the Trust's constituencies.

The key priorities are to:

- encourage and maintain members with the aim of establishing a membership that is representative of the population the Trust serves;
- communicate effectively with members;
- develop an active membership including engagement with the public and key stakeholders.

The Council of Governors is responsible for the implementation of the Framework supported by the Trust Secretary Office. The framework was approved and endorsed by both the Council of Governors and the Board of Directors. An annual action plan has been developed to deliver the priorities which is monitored on a quarterly basis by the Council's Membership Committee. The Committee also reviews membership activities and representativeness through analysing the membership demographics, identifying plans to ensure a representative membership and promoting engagement from members and the wider community.
The Framework will be reviewed annually to ensure it remains meaningful and relevant as well as to assess progress and to identify where delivery of priorities may have not been achieved.

Engagement and recruitment of our members

The focus during 2018/19 has been to create a membership that wishes to be engaged with the Trust going forward and to re-invigorate the membership meetings that are held to encourage greater attendance. Over the coming year, we shall be using the improved membership information that is now in place following the review undertaken and evaluation of the new format meetings to increase the active engagement and involvement of our members.

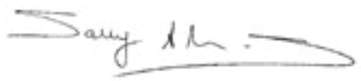
Active recruitment of new members to the Trust was not a priority during 2018/19. Local people who attended our meetings and those our Governors met through their attendance at patient and community forums in their local areas have been encouraged to become an EPUT member.

Our 'Your Voice' meetings are the primary method of engagement currently. These are chaired by Governors and supported by the Chief Executive and the Chair (or their deputies) as well as senior clinical staff based in the locality. The format of the meetings provides the opportunity for the public and members to hear about local services/issues/topics as well as the opportunity to ask questions of senior management in open forum. The opportunity is also given at all meetings for attendees to share their views on the future of the Trust and to receive updates on the action taken by the Trust following analysis of this feedback.

During 2018/19 two 'Your Voice' meetings were held, with another four held in early April 2019 following review of the format and content. The meetings in April 2019 were well attended, with higher attendance than the meetings held in spring 2018, and the feedback has been positive.
It is hoped that this increase in attendance will continue, reflecting our aim of increasing the engagement of our members.

Members are also kept up to date with developments at the Trust by:

- e-communications;
- receiving the members' newsletter, Our Voice, that provides up to date information and features on the Trust including service developments, information on issues relating to mental health, community services and learning disabilities, information about the Council of Governors, etc;
- visiting our website www.eput.nhs.uk ;
- using social media such as becoming a friend of the Trust on Facebook and/or following the Trust on Twitter;
- attending public meetings of the Board of Directors and Council of Governors;
- attending locality based patient/carer events; and
- attending the Annual Members' Meeting.



Sally Morris
Chief Executive
Essex Partnership University NHS FT
23 May 2019

> *Thank you for helping me pick up the pieces when I'd fallen apart. And for all of your happy smiles when I couldn't find my own. For this I will be eternally grateful.* ***The Lakes***

EPUT

QUALITY REPORT 2018/19

Executive Summary

We provide a range of different services, in different geographic areas, resulting in a complex document. To help readers navigate our Quality Report, a summary of content and where you can find specific information that you may be looking for is provided below.

Contents Page

PART 1

STATEMENT ON QUALITY FROM SALLY MORRIS, CHIEF EXECUTIVE OF EPUT

I am delighted to present this Quality Report for 2018/19, which shows how Essex Partnership University NHS Foundation Trust (EPUT) met our quality commitments for the past year – our second as a newly-merged organisation – and outlines our quality priorities in 2019/20.

Sally Morris,
Chief Executive

We identified five Quality Priorities for 2018/19. They were developed in line with the national quality goals; but, as a learning organisation, it was important to us that we took into account the issues raised with us directly. So we also included learning from complaints about our services, incidents, areas identified for improvement by the CQC and other feedback from people who use our services and their carers.

I am pleased to report that we achieved our quality priorities for last year. You can find more details about these and the work done to achieve them in this report. This is a testament to the skills and dedication of our staff; and, as Chief Executive, I am very proud of them. The improvements include:

- ensuring all mental health inpatients are also monitored for any deterioration in their physical health by using early warning scores;
- reducing the number of falls and avoidable pressure ulcers;
- improving good clinical recordkeeping by staff which is essential to support the delivery of high quality, evidence-based care;
- developing our innovative Trust Quality Academy by progressing established Quality Champions up to Gold Level so they can recruit and mentor new Quality Champions and by offering service users and carers Quality Champion training so they can help design and deliver quality improvement projects;
- working to ensure we identify all the significant learning from the statutory mortality review process and using this to improve services across the Trust.

When we merged in April 2017, we were clear that we are on a quality improvement journey. Our aim was to be rated as 'Good' in our first CQC comprehensive inspection, and to work towards being 'Outstanding' five years after merger. Our first CQC comprehensive inspection took place, unannounced, just a year after our merger. We were delighted that the Trust was rated as 'Good' overall, with our community health services and mental health services also achieving overall ratings of 'Good'. Fifteen of our core services were inspected and 11 of these achieved an overall rating of 'Good'. These are significant achievements for the Trust and our staff so soon after a major change process.

We also achieved 'Good' ratings in 59 of the 75 total domains inspected by the CQC and two 'Outstanding' ratings for 'Caring' in two core services. A 'Requires Improvement' rating was given overall for the Safe domain in mental health services and in 13 of the 75 total domains inspected, along with one 'Inadequate' rating for the Well-led domain in substance misuse services.

Inspectors were impressed by the extent to which the new values of the merged Trust had been embraced by everyone and displayed by all the staff they met. They also found that the Trust's senior managers were very visible in the core services and many members of staff told them that Board members were approachable, had visited their services and were willing to hear comments. As our aim is to be rated 'Outstanding' overall by 2022, it is particularly pleasing that the CQC found a number of examples of outstanding practice already across the Trust. This includes staff's interaction with patients, technology and innovation used to support patients and the preparation and support for patients to live successfully outside of hospital.

Rawreth Court and Clifton Lodge had their first inspections under the CQC's care home regime in 2018/19. While their overall ratings of 'Requires Improvement' is far from the outcome we would have wished, it is reassuring that both services are rated as 'Good' in regards to caring. The inspections identified several positive findings in both facilities and we were heartened that learning from the inspection at Rawreth Court was reflected in the Clifton Lodge inspection. We have a firm foundation to build on now to help ensure improved outcomes at the next inspections.

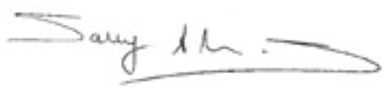
We know further work is required to raise quality in some areas of the Trust. We fully accept the CQC's findings in this regard and have used them to develop our quality priorities for 2019/20. But it's not all about what others tell us. I believe in checking personally, where possible and appropriate, that things are as they should be in the Trust. I make unannounced visits to services at any time of the day and night to see for myself the care being provided and hear directly from people using the services and the staff providing them. I hold regular open staff briefing sessions throughout the Trust and talk with our Members and other local people about their experiences of services at our 'Your Voice' meetings across Essex.

This report details many achievements of which the Trust and our staff can be justifiably proud. It also details our improvement plans for this current year. I hope you enjoy reading about them. I also hope you will understand how seriously we take our responsibility to provide quality services and how hard we work to continue to deliver services in a caring, compassionate and open way.

We have tried to make the report as easy to follow as possible. There are contact points at the end of the report – please do not hesitate to get in touch if you wish to know more about any of our quality improvements.

Statement of Accuracy

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



Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust

> *I'm really grateful to have been on a ward with such a good culture of care and concern for their patients. Thank you for keeping me in safe hands. I'm lucky to have had such a good team.* ***Kingswood Ward***

PART 2

OUR QUALITY PRIORITIES FOR IMPROVEMENT DURING 2018/19 AND STATEMENTS OF ASSURANCE FROM THE BOARD FOR 2018/19

What services did EPUT provide in 2018/19?

During 2018/2019, we provided hospital and community-based mental health and learning disability services across Essex as well as a small number of specialist mental health and/or learning disability secure services in Essex, Bedfordshire and Luton. We also provided community health services in South East Essex and West Essex as well as some specialist children's services Essex-wide.

How have we prepared this Quality Report?

This Quality Report has been prepared in accordance with the national legislation and guidance relating to the preparation of Quality Reports and Quality Reports in the NHS. The legislation and national guidance on Quality Reports and Accounts specifies mandatory information that must be reported within the Quality Report and local information that the Trust can choose to include; as well as the process that Trusts must follow in terms of seeking comments from partner organisations (Clinical Commissioning Groups, Healthwatch organisations, and Local Authority Health Overview and Scrutiny Committees) and the Council of Governors on their draft Quality Report as well as independent assurance from an external auditor.

This Quality Report has been collated from various sources and contains all the mandated information that is required nationally, as well as a significant amount of additional local information. It is set out in three sections in accordance with the national legislation and guidance. The report was considered in draft form by the EPUT Quality Committee and the Board of Directors. The draft report was also sent to Clinical Commissioning Groups, Healthwatch organisations, and Local Authority Health Overview and Scrutiny Committees and they were given 30 days in which to consider the content and provide commentary for publication in the final version. Clinical Commissioning Groups are required to provide a statement whereas the other partners are given the opportunity to provide a statement for inclusion should they wish to do so. The resulting statements are included at Annexe 1 of this Quality Report. The draft document was also sent to Local Authority Health and Wellbeing Boards for consideration and comment should they wish. The Lead Governor for EPUT also provided a statement, on behalf of the EPUT Council of Governors, which is included in Annexe 1.

The document was sent in draft form to the Trust's external auditors in April 2019, in order to provide independent external assurance in accordance with national guidance. This process has been completed and the external auditor's report is included at Annexe 3 of this Quality Report.

The EPUT Board of Directors approved the final version of the Quality Report 2018/19 and their statement of responsibilities in this respect is included at Annexe 2 of this report.

2.1 Key actions to maintain and/or improve the quality of services delivered in 2019/20

Quality Report

How have we developed our priorities for the coming year?

This section of the report outlines the annual key Quality Priorities identified by the Trust to improve the quality of our services in 2019/20. We have developed our Quality Priorities in line with national quality goals, which are based on patient safety, service user and carer experience and clinical effectiveness. In addition, we have incorporated quality improvement ideas along with themes arising from complaints and incidents, areas for improvement identified by the Care Quality Commission (CQC) and feedback from people who use our services and their families and carers.

2.1.1 Priority 1 - Continued reduction in harm

The Trust will aim to achieve 95% harm free care as measured by the national Safety Thermometer data collection. We will continue our journey towards harm free care aiming to decrease harm by 50% against current levels in the following areas with an ambition to move towards zero harm.

- Pressure Ulcers
- Avoidable falls
- Medication omission
- Physical health of mental health patients
- Early warning systems for deteriorating patients.

To achieve this, we will establish a working group to drive forward all aims as follows:

AREA	ACTIONS
Pressure Ulcers AIMS: 1) Develop a trajectory for a reduction in category 2 pressure ulcers 2) Zero category 3 and 4 pressure ulcers acquired as a result of omissions in care	• By April 2019 develop and embed RCA Pressure Ulcer Guidelines across all clinical services • By June 2019 have in place revised training programme incorporating educational videos • By September 2019 review all skin/pressure ulcer related data/information packs and ensure appropriate distribution
Avoidable Falls AIMS: 1) Aim for a 15% reduction in all falls 2) Reduce the number of falls resulting in a serious incident by 10% 3) Reduce the number of falls as a result of omissions in care by 50% against current performance	• By April 2019 review Falls Guidance and provide clarification regarding the requirement to complete a Falls Risk Assessment in people under the age of 65 • By July 2019 to introduce Falls: Supportive and Safe Observation Guidelines and measure outputs in relation to reduction in number of falls • By September 2019 implement a procedural guideline for Delirium • Continued participation in the National Audit of Inpatient Falls • By September 2019 to have Falls Champions in all inpatient areas • By October 2019 to review guidance in relation to the safe use of bedrails • By December 2019 hold a learning event for Falls Champions
Medication Omission AIMS: • To reduce the number of omitted doses by 50%	• Review the current data and develop an action plan to eliminate hotspots • Consider the use of ePMA and if appropriate develop a Business Case to support implementation

AREA	ACTIONS
Physical health of mental health patients AIMS: • To support nursing and support staff in the development of physical health competencies • To implement the competency framework	• By June 2019 develop a Physical Health Training programme based on the competency framework and the management of diabetes and CVD • By June 2019 to review the physical health audit to incorporate qualitative outcome measures and develop a baseline • By June 2019 the Physical Health Action Implementation Group will be reviewed to incorporate The Deteriorating Patient and Pressure Ulcers
Early warning systems for deteriorating patients	• For clinical staff to recognise the deteriorating patient through NEWS2 to ensure prompt intervention to treatment required Measures: • 100% of inpatient wards have implemented NWS 2 • 100% of inpatient wards have implemented the sepsis pathway • By September 2019, the physical health pathway (Annual Health Check) for community service users on care programme approach will be fully implemented.

Preparing medication for ward round

2.1.2 Priority 2 – Restrictive Practices

The Trust has agreed to adopt No Force First as its restrictive practice reduction programme following significant success as a strategy in other mental health inpatient environments. The impact of No Force First on wards has been shown to reduce conflict and restraint and associated work related sickness absence, with significant benefits for people using services and staff. Additionally, two wards have been selected to take part in a two year collaborative, working with Royal College of Psychiatrists on restrictive practices.

Through the Restrictive Practice Steering Group comprehensive and sustainable structures will be established to monitor, deliver and integrate the approach in clinical practice.

- By April 2019 we will have a system in place across all wards to comply with the requirements of the new national data set.
- By June 2019 all wards will be using Safety Crosses to monitor any incident and the type of restrictive practice that has occurred.
- By September 2019 all wards will have in place a debriefing protocol after incidents for both service users and staff to ensure individual and organisational learning takes place following incidents.
- By March 2020 we will implement the core strategies from the Reducing Restrictive Practice Guide across all inpatient areas. We will evaluate evidence of these strategies and their impact, and report to the Restrictive Practice Steering Group.
- By March 2020 we will reduce planned prone restraint (face down floor based restraint) by 20% as part of the longer term strategy to eliminate this practice completely.

2.1.3 Priority 3 – Suicide/Unexpected Deaths

We have identified the following priorities to ensure successful implementation and embedding of the Trust's Suicide Prevention Strategy within our services.

1) Suicide Prevention Safety Tools and communication
2) Suicide Prevention Learning Culture
3) Suicide Prevention Family and Carer Involvement.

The work programme for 2019/20 will incorporate the following.

- By August 2019 we will put in place a suicide prevention dashboard to track and monitor progress on the ten key parameters for safer mental health services.
- By September 2019 a rolling programme of training will be available to support our workforce to develop key competencies.
- By December 2019 we will produce a report on the effectiveness of the dashboard as a performance improvement tool, to support clinical decisions.
- By October 2019 our Suicide and Self-harm policy will be updated.
- During 2019/20 we will work to develop a strong integrated suicide plan with local stakeholders
- By December 2019 work in relation to developing a 'zero suicide app' will be in place and mechanisms agreed for evaluation.

2.1.4 Priority 4 – Collective Leadership

In order to operate as an outstanding organisation, we must work collectively with our staff, the people who use our services and our system partners to plan, deliver and evaluate the quality of care we provide, and the associated outcomes. Developing a just and learning culture and making continuous improvement everyone's business will support this. We have also identified the following priorities:

- By June 2019 two cohorts of senior leadership teams from across the system will have completed NHSI Transforming Change through System Leadership and have identified transformation change areas to drive forward change
- Locality hubs will be developed for system partners to collectively drive forward the transformation agenda
- All staff will be given the opportunity to undertake, develop and to work collectively with colleagues to implement quality improvements.
- We will embed collective leadership into organisational development frameworks to develop our teams

2.1.5 Priority 5 – Continuous Improvement

Our aim is to embed continuous improvement within the culture of the organisation and empower all staff, service users and carers to work together to enhance our services. To support this priority the work programme for 2019/20 will incorporate the following actions:

- By March 2020 all members of the Trust Board will undertake NHSI's Board level quality improvement programme
- We will develop quality improvement hubs across all Directorates to drive continuous improvement at a local level
- We will provide training to our Quality Champions, aiming to train a further 120 staff in quality improvement methodology
- We will develop 30 Gold level Quality Champions to provide coaching/mentorship to new recruits
- We will provide quality improvement awareness sessions and provide opportunities for service users and carers to take part in continuous improvement initiatives
- By September 2019 we will have in place a dashboard against all quality priorities.

2.1.6 Priority 6 – Effective Use of Technology

We will use technology effectively to better acquire, review, understand, analyse and exchange patient safety data and knowledge through the following work plan.

- Developing a dashboard for all quality priorities incorporating data from the new Patient Safety Incident Management System.
- Introducing the Perfect Ward app that makes quality inspections easy and more efficient (www.perfectward.com) and developing systems to respond to real time data alerts.
- Using ESR, safer staffing and safe care systems to gain assurance that staffing levels can support the delivery of organisational priorities.

2.1.7 Priority 7 – A Just and Learning Culture

We will develop a just and learning culture to embed our approach in responding to incidents and errors to protect staff and people that use our services. The following actions have been identified for 2019/20.

- By June 2019 we will embed elements of a just and learning culture into induction, leadership and quality champion training
- From July 2019, within one week of a serious incident, a copy of its 72 hour review will be shared with all members of the relevant teams
- We will publish good practice stories every month in order that we can extract the maximum possible learning from things that go well and things that do not go as expected.

2.1.8 Priority 8 – End of Life Care

We are committed to providing the very highest quality of care for people with advanced life threatening illnesses. They and their families should expect good end of life care, whatever the cause of their condition. All those identified as being at the end of their lives should have the opportunity to discuss, plan and identify their preferences for their care at end of life and their preferred place of death.

> *You were an amazing, motivating and supportive carer, who was worth her weight in gold throughout. Not just to the patient concerned, but to family members also supporting the situation*

Through the implementation of the End of Life Care Framework we will:

- implement a competency framework for staff, regardless of their grade, to enhance knowledge and skills for end of life care and care in the last days of life;
- work with systems and partners to create best approaches with regard to advanced care planning and individualised care plans;
- convene an End of Life Forum for clinical staff;
- expand the number of End of Life Care Champions.

2.2 Progress against the quality priorities we set for 2018/19

The Board of Directors considered the strategic context, their knowledge of the Trust and the feedback from staff and stakeholders during the planning cycle and identified five Quality Priorities for 2018/19.

RAG (**Red Amber Green**) ratings have been applied to provide an accessible method of understanding the levels of performance. RAG ratings should be used in conjunction with the actual levels of performance which are also quantified in the charts that follow.

RAG rated **RED** to indicate that performance has not met the target by a significant margin.	RAG rated **AMBER** to indicate that performance is close to target.	RAG rated **GREEN** to indicate that performance has met or exceeded the target %.

Quality priority: We will continue our journey towards our ambition of achieving harm free care in the following areas.

- Pressure Ulcers
- Falls
- Restrictive Practice
- Medication Omissions
- Early detection of Deteriorating Patient
- Unexpected death.

Data source: Datix

National Definition applied: Yes

Within this Quality Priority eight targets were set.

Why did we set this priority?

■ Pressure Ulcers

Pressure ulcers represent a major burden of sickness and reduced quality of life for people and their carers with the most vulnerable people being those aged 75+. Pressure ulcers are more likely to occur in people who are seriously ill, have limited mobility, cognitive impairment and nutritional deficiency. Pressure ulcers occur when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair blood supply. The presence of a pressure ulcer creates a number of significant difficulties psychologically, physically and clinically to patients, their families and their carers. They have a profound impact on a person's overall wellbeing and can be both painful and debilitating. Pressure ulcers can be serious and lead to life-threatening complications.

■ Falls

Across England and Wales, over 36,000 falls are reported from mental health units and 28,000 from community hospitals. They are the most commonly reported type of incident in community hospitals and the third most commonly reported type of incident in mental health hospitals.

Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. Hip fracture is the most common serious injury related to falls in older people. Thirty per cent of people who fracture their hip as a result of a fall will die within 12 months of the injury. Thirty per cent will not return to their pre-fracture level of function.

■ Omitted Doses

In 2007 a review of medication incidents by the National Patient Safety Agency (NPSA) identified that omitted and delayed medicines was the second largest cause of medication incidents reported to the National Reporting and Learning System (NRLS). The data highlighted that if delayed or omitted some medicines, such as anti-infectives, anticoagulants and insulin, could have serious or even fatal consequences. As a result, in 2010 the NPSA issued a Rapid Response Report aimed at reducing harm from omitted and delayed medicines in hospital.

2.2.1 Safety

Doses of medicines may be omitted for a variety of reasons, including:

- a valid clinical reason for not giving the medicine;
- the intention to prescribe a new or regular medicine is not carried through;
- the medication is not available on the ward or in the patient's home;
- the route of administration is not available (e.g. nil by mouth, loss of patency of an IV line);
- the patient is away from the ward or out when visited at home;
- poor communication between or within teams about the patient's needs;
- the patient refuses the medication.

■ No Force First

'No Force First' was originally an initiative within mental health in-patient units in the United States to dramatically reduce the number of, and ultimately eliminate dangerous restraint and seclusion events. It has a proven record of success in transforming healthcare environments and enhancing safety for service users and staff.

The key priorities for delivery are:

- developing leadership competencies towards organisational change;
- developing data to inform practice;
- building workforce competencies;
- implementing restraint restriction tools;
- developing patient roles within inpatient settings;
- reviewing debriefing techniques.

A 10% reduction was agreed across all work streams

During 2018/19 we have taken the following actions:

- We have strengthened membership of the Sign up to Safety Pressure Ulcer work stream with participation of tissue viability nurses and matrons from south east Essex and west Essex community health services to further support shared learning across the Trust.
- There is weekly reporting to the Executive Team on pressure ulcer prevalence including identifying any trends or themes and actions being taken forward to embed learning.
- Action plans for avoidable pressure ulcers are presented at Skin Matters meetings and monitored through the local quality and safety groups.
- Learning from root cause analysis undertaken for category three and four pressure ulcers is shared with teams.
- On-line pressure ulcer training has been reviewed and revised to reflect NHSI recommendations and is now mandatory.
- We participated in the National Stop the Pressure Day, holding events to engage the public
- Training on falls prevention has been strengthened.
- Work on falls prevention has been taken forward as part of the NHSI Falls Collaborative.
- We held a dedicated Falls Week in October.
- The Falls Guideline has been harmonised across the Trust.
- Standardised Falls Risk Assessment Tools are in use across all older adults wards.

2.2.1 Safety

- Communication of medication errors by service area via ward managers and matrons through Quality and Safety meetings and via the pharmacy weekly checklist.
- We implemented a system of checking all that all the medication charts have been signed before the staff on each shift leave.
- We introduced support through supervision where medication errors are repeated.
- We took forward the 'No Force First' approach with regard to restraint.
- We reviewed restraint training and implemented TASI training across all relevant areas.
- We used service user stories within restraint training.
- We signed up to a two-year collaborative on restrictive practices with RCP and NHSI.
- Performance in each of the above categories has been monitored during 2018/19 with the following reduction achieved at the time of writing against the organisational baseline:
  - Omitted doses : 375 in 2018/19 compared to 827 in 2017/18;
  - Prone restraint : 382 in 2018/19 compared to 407 in 2017/18 (6% reduction);
  - Avoidable PU : Three in 2018/19 compared to five in 2017/18 ;
  - Avoidable Falls : 10 in 2018/19 compared to nine in 2017/18.
- The Trust has consistently achieved or surpassed 95% harm free care from the 'Safety Thermometer' every month throughout the year.

Stop The Pressure information for Pressure Ulcer Week

2.2.1 Safety

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Achieve 95% harm free care through the national Safety Thermometer data collection	To date Safety Thermometer data indicates 95% or above for harm free care.	98.1%
2	Reduce the number of avoidable category three and four pressure ulcers acquired in our care	YTD there have been three avoidable three/four pressure ulcers compared to five in 17/18.	3
3	Reduce the number of avoidable falls that result in moderate or severe harm and a 15% overall reduction in falls	YTD there have been 13 falls resulting in a serious incident, of which five were avoidable. The figure for 2017/18 was 19, of which four were avoidable	13 5 avoidable 15% reduction achieved
4	Reduce the number of omitted doses of medication across our services	There were 375 omitted doses recorded up to end of March. If rates continue; EPUT (excluding Bedfordshire Community Services) has seen a 54.7% reduction in the number of omitted doses (2017/ 18 outturn = 827)	375
5	Implement 'No Force First' to reduce the number of restrictive practices including restraints	There is a plan to take this forward as part of the two-year Restrictive Practice collaborative.	
6	Roll out suicide prevention training to community mental health teams	Current training already open to community mental health teams - consideration to be given on increasing the uptake from this group.	Complete
7	Ensure that all staff working in adult inpatient services, crisis services, access and assessment, prison and IAPT receive recognised, appropriate suicide prevention training including those risks associated with physical health	Agreement secured for two part time dedicated trainers. As of January 2019, 452 colleagues have completed the Connecting with People training. In total, 780 colleagues have completed some form of suicide awareness training e.g. STORM or CwP. Online suicide awareness training is available to everyone through the Zero Suicide Alliance	Partially complete
8	Undertake audits to ensure all inpatients are monitored for physical health deterioration using early warning scores	The audit was presented to the Physical Health Action Implementation Group in February.	Complete

2.2.2 Clinical Effectiveness

Quality priority: Up-to-date clinical risk assessment and care plans have been a theme identified from our serious incident investigations. As a Trust we therefore want to ensure all care plans are produced in collaboration with the person using the service to meet their needs, are regularly reviewed and contain up to date information.

Data source: Audit

National Definition applied: Yes

Within this Quality Priority two targets were set.

Why did we set this priority?

Clinical record keeping is integral to professional practice. Good record keeping is a vital part of communication for clinical staff and is integral to promoting safety and continuity of care for service users. Staff should be clear about their responsibilities for record keeping in whatever format records are kept. Clinical records provide an account of individual considerations and the reasons for decisions and the use of this information is essential to supporting delivery of high quality, evidence based care

During 2018/19 we have taken the following actions:

- The practice development team has undertaken face to face training.
- We have undertaken records audits across CAMHS & LD, the Mother & Baby Unit, Secure Services, Mental Health Adult Wards and Mental Health Older People's wards in Q1 with a target to achieve 90% compliance by Q4.

	Baseline compliance (Q1)	Re-audit compliance (Q4)
CAMHS	85%	85%
Mother & Baby	91%	98%
MH Adults	80%	88%
Secure Services	79%	95%
Mental Health Older Adults	86%	89%
Total	**84%**	**91%**

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Undertake record keeping audits and achieve improvement compared to results from audits carried out in Q4 2017/18	Record keeping audits undertaken for inpatients as part of Matron toolkit. Annual audit complete.	Complete
2	Gather feedback from service users and their families about engagement and collaboration with their care plan to meet their needs and use it to make improvements as necessary.	Work continues in regards to gathering feedback. Format being reviewed in an attempt to increase the number of feedbacks received. Work continues to review work plan in alignment with national work.	Partially complete

2.2.3 Clinical Effectiveness

Quality priority: We will embed mortality review processes developed during 2018/19 in order to identify learning and take action

Data source: Local Audit

National Definition applied: Yes

Within this Quality Priority we set four targets.

Why did we set this priority?

The effective review of mortality is an important element of our approach to learning and ensuring the quality of services is continually improved. 'National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care' (National Quality Board March 2017) set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. Its aim was to help initiate a standardised approach that would evolve as national and local learning in respect of mortality review approaches increases.

During 2018/19 we have taken the following actions:

- The Mortality Review Policy was approved and is available from EPUT's website.
- A full report was presented to the Board of Directors in accordance with national requirements.
- We have published three Learning from Deaths reports.
- We have established processes for reviewing deaths in scope.
- We have had a review of deaths in the elderly and a review of LD deaths.
- Our policy on Mortality Review and Learning from Deaths was approved by the Board of Directors in September 2017, to be implemented from October 2017. We will undertake an audit on compliance with the policy after 12 months of its implementation at the end of Q3 2018/19.

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Provide quarterly reports on mortality to the Board of Directors	Reports are presented to the Board on a quarterly basis. The Q1 report was presented to September Board.	Complete
2	Complete thematic reviews of deaths in line with our Mortality Policy	Thematic reviews in progress with further ones being commissioned.	Complete
3	Identify trends and themes from case note reviews for action	Case note reviews currently being undertaken	Partially complete
4	Undertake audit of serious incident action plan implementation to ensure learning is embedded into practice	Audits of action plans continue following sign off of SI RCA's. The reports are submitted to Learning Oversight Subcommittee.	Complete

2.2.4 Patient Experience

Quality priority: We will strengthen engagement and involvement with service users, families and carers in relation to the mortality review process and the new clinical model (transforming services year 2)

Data source: Local Audit/Data Collection
National Definition applied: N/A

Within this Quality Priority we set three targets.

■ Quality Priority

We will strengthen engagement and involvement with service users, families and carers in relation to the mortality review process and the new clinical model (Transforming Services Year Two).

Milestones:

- Collate and analyse data collected from bereaved families and carers taken each quarter in respect of the Trust's level of engagement and involvement with them, to inform our processes and training for staff
- Have a protocol in place by end of Q3 for all co-production work with service users, families and carers including an evaluation method to inform our future processes in respect of the new clinical model
- Have trained a cohort of service users and carers to be Trust Quality Champions by the end of Q3

Why did we set this priority?

- To further achieve our commitment to encourage people to engage with us, feedback on our services and feel able to raise concerns.
- To further support the delivery of our strategic objective 'co-design and co-produce service improvement plans with system partners, including commissioners and service users' by involving service users and carers more to play a meaningful role not only in current services but also the future of Trust services.
- To enable us to monitor how effectively we involve bereaved families and carers by seeking their feedback appropriately so we can take action to improve processes.
- In recognition of the fact that every interaction we have is an engagement opportunity, and an opportunity to live our values of compassionate, empowering and open.

During 2018/19 we have taken the following actions:

- We have put in place questions to allow us to gain feedback from bereaved families at the conclusion of the serious incident process. This information is collated and used to inform our processes and training for staff.
- We have drafted a protocol for all co-production/engagement work with service users, families and carers including an evaluation form to gain feedback from the person with lived experience to help inform our future processes.
- We have implemented a training programme for service users and carers to become Trust Quality Champions.

2.2.4 Patient Experience

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Collate and analyse data collected from bereaved families and carers taken each quarter in respect of the Trust's level of engagement and involvement with them to inform our processes and training for staff	Mechanisms are in place for the collation and analysis of data. Family Liaison Officers are reminded of the need to pose the questions formulated by the Trust to families post meeting to present the final report with them.	Complete
2	Have a protocol in place by end of Q3 for all co-production work with service users, families and carers including an evaluation method to inform our future processes in respect of the new clinical model.	A protocol has been drafted ready for implementation when co-production projects are going to be taken forward. An evaluation form is also in place to gain feedback at the end of a project.	Complete
3	Have trained a cohort of service users and carers to be Trust Quality Champions by the end of Q3	Training has been run with some service users and carers. Some participants have expressed an interested in completing the Quality Champion Training. This will be scheduled in 2019/20.	Partially complete

2.2.5 Effectiveness

Quality priority: We will increase the number of staff and service users trained in quality improvement methodologies and involved in the implementation of quality improvement initiatives.

Within this Quality Priority four targets have been set.

Data source: Local Data Collection
National Definition applied: N/A

Has the priority been achieved?

AMBITION		YEAR END POSITION	
1	Provide Quality Champion training in all localities of the Trust with the aim to train a further 120 Quality Champions	Quality Champions training continues across all localities with an additional 50 Quality Champions undergoing training. A further four cohorts commenced in November 2019.	Complete
2	Develop 30 Gold level Quality Champions to provide coaching/ mentorship to new recruits	30 Gold level Quality Champions have been identified. The Quality team is working with the OD team to deliver both coaching and mentorship programmes in the autumn.	Complete
3	Provide quality improvement awareness sessions and provide the opportunity for service users and their carers to take part in training and quality improvement initiatives	Quality improvement has been incorporated into induction from August 2018. Access to quality academy awareness sessions circulated through communication systems. Service user / carer forums have commenced with individuals accessing training, forming part of current project teams.	Complete
4	Develop directorate quality improvement hubs to drive quality improvement at a local level	Forensic quality improvement hub under development with nine projects identified. Intention is to review in two months and roll out to other directorates.	Partially complete

2.3 Learning from Deaths

2.3.1 Background and context

The effective review of mortality is an important element of our approach to learning and ensuring the quality of our services continually improves. 'National Guidance on Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care' was published by the NHS National Quality Board in March 2017 and set out extensive guidance for Trusts in terms of approaches to reviewing mortality, learning from deaths and reporting information. Its aim was to help initiate a standardised approach that would evolve as national and local learning in respect of mortality review approaches increases.

During 2018/19 we have strengthened our approaches to mortality review in line with the national guidance. We take every death of people in our care very seriously. We expect our staff to be compassionate and caring at all times. The aim of reviewing the care provided to people who have died is to help improve care for all our patients by identifying whether there were any problems, understanding how and why these occurred and taking meaningful action to implement any learning. The reporting of mortality data is part of this review process. It is an evolving process across the whole NHS and continues to be challenging, both nationally and locally, to gather and analyse the data. The review of mortality and reporting of data will, therefore, continue to evolve over time to become more meaningful as we learn from our own experiences of doing this and those of other NHS Trusts.

As Trusts have been able to determine their own local approaches to undertaking mortality reviews and defining those deaths which should be in scope for review, mortality data is not comparable between Trusts. As such, we are using data locally to monitor the review of mortality and to assist in the ultimate aim of learning from deaths and improving the quality of services. Due to the nature of the services we provide, there will be a number of deaths that will be 'expected'. Nevertheless, we are always mindful that even if the person's death was 'expected', their family and friends will feel deeply bereaved by their loss, and we have strengthened our processes to support people who have been bereaved by a death of someone in our care. We have undertaken a review of a sample of these 'expected' deaths to identify any learning in terms of the quality of the care we provide to people at the end of their lives.

2.3.2 Explanatory notes

**** Please note, all figures stated in the section below relate to deaths 'in scope' for mortality review. Deaths 'in scope' are defined in the Trust's Mortality Review Policy as:***

- all deaths that have occurred within our inpatient services (this includes mental health, community health, learning disability and prison inpatient facilities);
- all deaths in a community setting of patients with recorded learning disabilities;
- all deaths meeting the criteria for a serious incident, either within our inpatient services or in a community setting;
- any other deaths of patients in receipt of our services, not covered by the above that meet the criteria for consideration for a Grade 2 case note review. These are identified on a case-by-case basis and include:
  - any patient deaths in a community setting which has been the subject of a formal complaint and/or claim by bereaved families and carers;
  - any patient deaths in a community setting for which staff have raised a significant concern about the quality of care provision;
  - any deaths of patients deemed to have a severe mental illness in a community setting. For the purposes of this policy, this is deemed to be any patient with a psychotic diagnosis (schizophrenia or delusional disorder) recorded on electronic clinical record systems that are recorded as having been under the care of the Trust for over two years.

- any deaths identified for thematic review by the Mortality Review Sub-Committee (including a random sample of 20 expected inpatient deaths per annum).

Figures are only stated for Q1 – Q3 of 2018/19. Q4 information will not be reported to the Board of Directors until June 2019. Information in relation to Q4 2018/19 will, therefore, be reported in the Trust's Quality Report for 2019/20. The reporting schedule was the same last year; and, therefore, information relating to Q4 2017/18 is also reported in this Quality Report.

At the time of preparing this Quality Report, the thematic reviews and expected inpatient death review sample for 2018/19 are in the process of being defined and commissioned and figures are therefore not included within the data below. Information in relation to thematic reviews of deaths occurring in 2018/19, including the random sample of 20 expected inpatient deaths, will therefore be reported in the Trust's Quality Report for 2019/20.

The figures contained in this section of the Quality Report are consistent with the agreed approach for reporting quarterly information to the Board of Directors and are reported as at 4 March 2019.

2.3.3 National Guidance Ref 27.1 - Number of deaths in scope for mortality review

2018/19 Q1 – Q3:
During 2018/19 (Q1 – Q3), * 172 of EPUT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Q1 = 59
Q2 = 53
Q3 = 60

Figures for the fourth quarter are not yet available at the date of preparing this Quality Report and will be reported in the EPUT Quality Report 2019/20.

2017/18 Q4:
The number of deaths within scope for mortality review in Q4 2017/18 was 76.

National Guidance Ref 27.2 Number of these deaths subjected to case record review/investigation

2018/19 Q1 – Q3:
By 4 March 2019, one Grade 2 case record review and 29 Grade 4 Serious Incident investigations have been carried out in relation to 30 of the Q1 – Q3 2018/19 deaths included above.
Note: in addition to the above, four case record reviews and 24 Serious Incident investigations are in progress.

The number of deaths in each quarter 2018/19 for which a case record review or an investigation was carried out (including those in progress) was:
Q1 = 14
Q2 = 21
Q3 = 23
The grade of review for 46 of the 172 deaths is under determination.

Figures for the fourth quarter are not yet available at the date of preparing this Quality Report and will be reported in the EPUT Quality Report 2019/20.

Explanatory note:
- **68** closed reviews at Grade 1 (do not fall within the category of case note reviews/investigations)
- **30** closed reviews at Grade 2 - 4 (case note review/investigation)
- **28** reviews in progress at Grade 2 - 4 (case note review/investigation)
- **46** final grade of review still under determination

Total = 172

2017/18 Q4:
By 4 March 2019, zero Grade 2 case note reviews and 23 Grade 4 Serious Incident investigations have been carried out in relation to 23 of the Q4 2017/18 deaths.
Note: in addition to the above, three case record reviews and zero Serious Incident investigations are in progress.

For the full year 2017/18, by 4 March 2010 five Grade 2 case note reviews and 88 Grade 3 Critical Incident Review / Grade 4 Serious Incident investigations have been carried out in relation to 92 of the total of 248 2017/18 deaths.
Note: in addition to the above, four case record reviews and zero Serious Incident investigations are in progress.

2.3.4 National Guidance Ref 27.3 - Deaths judged more likely than not to have been due to problems in care

2018/19 Q1 – Q3:
Five, representing 2.9%, of the patient deaths during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
- **2** representing 3% for the first quarter
- **3** representing 5.6% for the second quarter
- **0** representing 0% for the third quarter

Please note, 80 reviews are still in progress or a judgement in terms of problems in care is still to be made at the date of preparing this information.

Figures for the fourth quarter are not yet available at the date of preparing this Quality Report and will be reported in the EPUT Quality Report 2019/20.

2017/18 Q4:
Zero, representing 0%, of the patient deaths during Q4 2017/18 are judged more likely than not to have been due to problems in the care provided to the patient.
Please note, four reviews are still in progress/ a judgement in terms of problems in care is still to be made at the date of preparing this information.

The above judgements have been estimated using a tool designed locally by the Trust, based on the Royal College of Physicians Structured Judgement Review tool and methodology as there was no national methodology for mental health deaths. This tool is not based in any evidence based research. The Trust has recently devised an amended pro forma based on the methodology published by the Royal College of Psychiatrists in November 2018 and future judgements will use this tool.

2.3.5 National Guidance Ref 27.4 - Examples of learning derived from the review/investigation of deaths judged more likely than not to have been due to problems in care

The following are examples of learning derived from the investigation of deaths judged more likely than not to have been due to problems in care provided to the patient.

- Community Mental Health Teams should ensure continued communication from the team to the family about the progress of an Associated Mental Health Practitioner (AMHP) referral.
- Alerts to the Emergency Duty Service on Friday afternoons should be reinforced.
- Care plans and risk assessments should be updated taking in to consideration new risk factors identified.
- 48-hour follow-up calls should be completed according to patient risks and care plan and should:
  - address areas relevant to identified risk and should include a mental state examination unless contraindicated;
  - be documented by staff with access to the electronic records;
  - be documented contemporaneously.
- All contact with families should be recorded and information to be relayed in sensitive and appropriate language.
- Once a patient with the prison service has been assessed and discussed in the multi-disciplinary team meeting as requiring mental health support, they should have an identified key worker allocated within seven days and be followed up by the mental health team.

2.3.6 National Guidance ref 27.5 - action taken in consequence of the learning detailed above

We have taken the following actions as a result of the examples of learning detailed above.

- We have reviewed team processes for communicating with families about the progress of an AMHP referral.
- We have put in place processes for all Associated Mental Health Practitioner hubs to refer all outstanding work to the Emergency Duty Service at the end of each working day, including Fridays – categorising all into either high risk or non-urgent referrals.
- Staff attended Care Programme Approach (CPA) and clinical risk assessment training and monthly care plan audits were implemented.
- We reviewed the seven-day follow up procedure, reminded staff of the 48 hour protocol and implemented a 48 hour follow up template evidencing associated risk and care plan.
- A teaching session was delivered by a Consultant Psychotherapist to the Recovery and Wellbeing team on delivering sad news to families or carers.
- We developed a written procedure for the allocation of an identified key worker to patients within the prison service within seven days.

2.3.7 National Guidance Ref 27.6 – Impact of the actions described above:

The impact of the example actions described above is as follows.

- We strengthened our processes for keeping families informed of progress of AMHP referrals.
- We strengthened our processes for referral from AMHP hubs to the Emergency Duty Service at the end of each working day, including Fridays.
- We strengthened our care plan and risk assessment processes.
- We strengthened our 48 hour follow up processes.
- We enhanced our employee's skills in delivering sad news to families.
- We strengthened our processes for the allocating of identified key workers to patients within the prison service.

2.3.8 Learning from other deaths subjected to mortality review/investigation

We identify any appropriate learning from all mortality reviews undertaken and agree actions irrespective of whether the death has been judged as being more likely than not to have been due to problems in care provided to the patient. Examples of such learning include.

- Here must be clear recording of medical reviews with records of medication prescribed or changes to doses.
- All medical records must be available on the electronic patient record.
- All relevant previous mental health episodes should be sought and considered within the assessment to inform care and treatment planning.
- We should put in place contingency risk management plans where possible.
- We should put in place a process for communication sharing when a service user is under the care of more than one community team.
- If a patient cancels a clinical appointment, we should try to contact them in order to form a view on the clinical risk and develop an appropriate plan.
- Where consent is given for families/carers to be contacted, we should make contact with them regularly where appropriate.

In addition to the individual mortality reviews outlined in the sections above, during 2018/19 we undertook the following thematic reviews of deaths occurring in 2017/18

- expected inpatient deaths (10 in community health services and 10 in older peoples mental health services);
- deaths of clients receiving substance misuse services;
- deaths of clients receiving learning disability services;
- deaths classified as serious incidents.

The above reviews have resulted in a total of 169 deaths being subjected to overarching thematic review. We have also undertaken an audit of a random sample of seven deaths closed at Grade 1 review (desktop review).

We have shared the learning from these reviews with teams and our Mortality Review Sub-Committee overseeing its implementation. Examples of learning and actions taken as a result include.

- The principles of Advanced care planning, person centred care planning and discussions around preferred priorities of care should be actively applied in order to provide excellent end of life care to patients with advanced Dementia. The End of Life Care Plan template was reviewed to take account of the learning.
- We should develop proactive and collaborative partnerships between substance misuse services and physical and mental healthcare providers, including GPs, hospitals and CMHT, to ensure the sharing of all relevant information throughout an episode of care, for the benefit of individual patients and to improve integration of care.
- Review of Dual Diagnosis Policy and procedures and strengthening of processes to ensure high quality of care for dual diagnosis patients.
- We should consider ways of continuing to improve access to multi-disciplinary and multi-agency records, in order to reduce time spent retrieving Clinical and Medical records.
- We should continue our excellent work on the training of the Mental Capacity Act (MCA) for staff.

- We should consider a process of review for clients who have not been in contact with the service for a period of nine months or more. Consultants should be encouraged to complete the discharge process if they feel the client does not require any more medical intervention or support. A key element of the new Learning Disability (LD) Service Model is that there will be link workers who will provide 'soft contacts' for individuals who are not in regular contact with the local LD Service but who will require contact to ensure their safety.

2.3.9 National Guidance ref 27.7 – 27.9 - Mandated information that will be reported in 2019/20 Quality Report

We are unable to report on the following mandated information in the Quality Report 2018/19 and will report on this in the Quality Report 2019/20.

- The number of case record reviews or investigations finished in 2019/20 which related to deaths during 2018/19 but were not included in the Quality Report for that previous reporting period (i.e. Q4 information).
- An estimate of the number of deaths included above which we judge as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this (i.e. Q4 information).
- A revised estimate of the number of deaths during the previous reporting period taking account of the deaths referred to in the point above (i.e. Q4 information).

2.4 Whistleblowing

We hope to create an environment where our staff are able to speak up and raise concerns about poor practice without fear of victimisation. We want to encourage staff to express any concerns in a constructive way and to put forward suggestions in order to contribute towards the delivery of care and services to patients, service users and carers.

Our 'Raising Concerns policy and procedure' does not replace existing policies and procedures regarding grievance or complaints, or dealing with patient events as described in the 'Being Open and Duty of Candour policy' nor is it intended to replace the normal lines of communication between staff and their managers. Matters of concern should still be dealt with through normal management and/or clinical advisory channels, A 'standard' integrated policy was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS aimed at improving the experience of whistleblowing in the NHS. It is expected that the policy (produced by NHS Improvement and NHS England) is adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients and service users. Our approach and local process has, therefore, been integrated into the policy and provides more detail about how we will look into a concern.

If an individual raises a genuine concern under this policy, they will not be at risk of losing their job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully an individual into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action. Provided an individual is acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns.

We are committed to the principles of the 'Freedom to Speak up' review and its vision for raising concerns, and will respond in line with them.

We are committed to listening to our staff, learning lessons and improving patient care. On receipt the concern will be recorded and the individual will receive an acknowledgement within two working days. We will tell the individual who will be handling the matter, how to contact them, and what further assistance required. If required, we will write summarising the concern and setting out how we propose to handle it and provide a timeframe for feedback.

Individuals can raise concerns about risk, malpractice or wrongdoing in connection to any harm to the service we deliver. Just a few examples of this might include,but are by no means restricted to:

- unsafe patient care;
- unsafe working conditions;
- inadequate induction or training to staff;
- lack of, or poor, response to reported patient safety incident;
- suspicions of fraud (which can also be reported to our local counter fraud team);
- a bullying culture (across a team or organisation rather than individual instances of bullying).

How does the Freedom to Speak Up agenda support staff?

Freedom to Speak Up is a national agenda and an elected Principal Guardian is in place for EPUT. We have a number of mechanisms in place to enable staff to raise issues, for example the 'I'm Worried About' facility on the intranet and the 'Raising Concerns' policy and procedure. The Freedom to Speak Up Principal Guardian facilitates discussions between staff and management. Local Guardians are in place to support the Principal Guardian.

2.5 Annual Report on Safe Working of Junior Doctors 2018/19

2.5.1 Introduction

This section provides assurance that doctors in training are safely rostered and that their working hours are compliant with the terms and conditions of their contract.

2.5.2 Doctors in Training Data:

In north Essex the data for doctors in training is as follows:

Number of doctors in training (total inclusive of GP and Foundation)	71
Number of doctors in psychiatry training on 2016 terms and conditions	28
Total number of vacancies (average over reporting period)	19.5
Total vacancies covered by Locum Appointment for Service (LAS) and Medical Training initiative (MTI) (average)	10.5

In south Essex the data for doctors in training is as follows:

Number of doctors in training (total inclusive of GP and Foundation)	46
Number of doctors in psychiatry training on 2016 Terms and Conditions	28
Total number of vacancies (average over reporting period)	7
Total vacancies covered by LAS and MTI	3.25

2.5.3 Annual data summary:

In north Essex the data for doctors in training is as follows:

Trainees within the Trust								
Specialty	Grade	Q1	Q 2	Q 3	Q 4	Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
Psychiatry	CT1-3	30	32	32	33	**13**	880 hrs.	17 hrs.
Psychiatry	ST4-6	23	24	24	22	**13**	4120 hrs.	79 hrs.
Total		**53**	**56**	**56**	**55**	**26**	**5000 hrs.**	**96 hrs.**

Trainees outside the Trust overseen by the LET guardian								
Specialty	Grade	Q1	Q 2	Q 3	Q 4	Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
GP trainees	ST1	13	14	14	15	**4**	see note 1	see note 1
Foundation	FY1	12	10	12	12	**2**	see note 1	see note 1
Foundation	FY2	14	15	15	15	**1**	see note 1	see note 1

Note 1: There is a mixture of Foundation and GP trainees who work either four or six months rotation, so it is difficult to calculate hours uncovered as we do not have an electronic rostering system to capture data.

2.5.4 Agency Usage

We avoid using agency and rely on the medical workforce to cover at internal locum rates. We have only booked one locum to cover one overnight shift in this reporting period. The total number of shifts covered in reporting period:

North Essex Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies/Mat Leave/Sickness	217	217	1	2263.5	2263.5
Total	**217**	**217**	**1**	**2263.5**	**2263.5**

South Essex Locum bookings (internal bank) by reason*					
Reason	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies/Mat Leave/Sickness	84	84	0	1087.5	1087.5
Total	**84**	**84**	**0**	**1087.5.5**	**1087.5**

2.5.5 Issues Arising

There are vacancies at Core Trainee (CT) and Specialty Trainee (ST) level that has resulted in rota gaps throughout the year.

- **April 2018 – July 2018** - Three gaps at CT and 10 gaps at ST level
- **August – October 2018** - Seven gaps at ST level
- **November 2018 – January 2019** - Eight gaps at ST level
- **February – March 2019** - Five gaps at CT and nine at ST level

The gaps at CT level on the on-call rota are usually filled with existing doctors who are paid a locum rate. We generally avoid agency locums but used one, once during this reporting period. The gaps at ST level are usually left unfilled. There are no particular reasons or patterns observed for these gaps and recruitment is a national issue.

2.5.6 Actions taken to resolve issues

- We have advertised for LAS (Locum appointment for Service) doctors and currently there are 14 LAS and MTI (Medical Training Initiative) doctors who have filled the rota gap and gaps in service successfully.
- The CT doctors have been willing to fill the rota gap at NHS agency rate provided their working hours are still compliant as stated in the Junior Doctors Contract.
- Consultants while on call have stepped down to help with service provision duties if there are gaps at ST level.
- The Director of Medical Education (DME) and Clinical Tutors have attended BMJ career fairs in order to provide career advice to steer medical students towards psychiatry.

2.5.7 Key issues from host organisations and actions taken

There are no specific key issues within the Trust with regard to vacancy rates.

Junior Doctors have raised concerns about high work load at the Peter Bruff Assessment Unit at Colchester. This is being investigated by the Clinical Tutors and DME.

2.6 Statements of Assurance from the Board relating to EPUT 2018/19

2.6.1 Review of services

During 2018/19, EPUT provided and/or sub-contracted 149 relevant health services.

EPUT has reviewed all the data available to them on the quality of care in 149 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 94% of the total income generated from the provision of relevant health services by EPUT for 2018/19.

The data reviewed aimed to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. During 2018/19 monthly data quality reports were produced in a consistent format across all services. These reports monitor timeliness of data entry and data completeness. There has been excellent clinical engagement with a clear understanding of the importance of good data quality across the clinical areas. Further information about data quality is included in the data quality section below.

2.6.2 Participation in clinical audits and national confidential enquiries

Clinical audit is a quality improvement process undertaken by doctors, nurses, therapists and support staff that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change (NICE 2005). Clinical audit is a tool to assist in improving services; robust programmes of national and local clinical audit that result in clear actions being implemented to improve services are a key method of ensuring high quality.

We participate in all relevant National Clinical Audit Patient Outcome Programme (NCAPOP) audit processes and additional national and locally defined clinical audits identified as being important for the people who use our services.

During 2018/19 14 national clinical audits and one national confidential enquiry covered relevant health services that EPUT provides.

During that period EPUT participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that EPUT was eligible to participate in during 2018/19 are as follows:

- National Audit of Care at the End of Life (NACEL)
- National Sentinel Stroke National Audit Programme Round 5 (SSNAP) 2018/19
- National Audit of Cardiac Rehabilitation (NACR)
- National Asthma and COPD Audit Programme (NACAP)
- National Falls and Fragility Audit Programme - National Audit of Inpatient Falls (NAIF)
- National Audit of Intermediate Care – NHS Benchmarking
- National Diabetes Foot Care Audit Round 4 (NDFA)2018/19
- POMHUK Topic 16b Rapid Tranquilisation
- POMH UK topic 18a : Use of Clozapine
- POMH UK Topic 6d : Assessment of the side effects of depot antipsychotics
- POMH UK Topic 7f : monitoring of patients prescribed Lithium
- National Clinical Audit of Anxiety and Depression (NCAAD)
- NCAP EIP Spotlight Audit 2018/19
- Psychological Therapies Spotlight Audit

National Confidential Enquiries:

- CAMHS

The national clinical audits and national confidential enquiries that EPUT participated in during 2018/19 are as above.

The national clinical audits and national confidential enquiries that EPUT participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Audit (POMH = Prescribing Observatory for Mental Health)	No. of cases submitted as a % of the number of registered cases required by the terms of the audit/enquiry
National Audit of Care at the End of Life (NACEL)	MH services, WECHS and SEECHS participated. All relevant cases included in the Benchmarking Process
Sentinel Stroke National Audit Programme Round 5 (SSNAP) 2018/19	Data collection is on-going and continuous
National Audit of Cardiac Rehabilitation (NACR)	Data collection to be started from March 2019
National Asthma and COPD Audit Programme (NACAP)	Data collection to be started from March 2019
National Falls and Fragility Audit Programme - National Audit of Inpatient Falls (NAIF)	Data collection is on-going and continuous
National Audit of Intermediate Care – NHS Benchmarking	WECHS and SEECHS participated. All relevant cases included in the Benchmarking Process

The national clinical audits and national confidential enquiries that EPUT participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:	
Audit (POMH = Prescribing Observatory for Mental Health)	**No. of cases submitted as a % of the number of registered cases required by the terms of the audit/enquiry**
National Falls and Fragility Audit Programme - National Audit of Inpatient Falls (NAIF)	Data collection is on-going and continuous
National Audit of Intermediate Care – NHS Benchmarking	WECHS and SEECHS participated. All relevant cases included in the Benchmarking Process
National Diabetes Foot Care Audit Round 4 (NDFA) 2018/19	Data collection is on-going and continuous
POMH UK Topic 16b Rapid Tranquilisation	100% of required cases had information provided to national organisers
POMH UK topic 18a : Use of Clozapine	100% of required cases had information provided to national organisers
POMH UK Topic 6d : Assessment of the side effects of depot antipsychotics	100% of required cases had information provided to national organisers.
POMH UK Topic 7f : monitoring of patients prescribed Lithium	Data collection in progress.

The reports of eight national clinical audits were reviewed by EPUT in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided (examples only are listed)

SSNAP
- Team to ensure timely submission of complete data set to SSNAP as soon as possible
- Project Group to contact SSNAP regarding incorrect patient data allocation

NDFA
- Liaise with Podiatry team to send back the patient details to be entered to system.
- Use reminder email to collect data in a timely fashion to get back patient details
- To implement robust processes to record 12 and 24 week outcome.
- Look into appointment redesign for urgent referrals
- Review pending pilot of the Hot Foot tool currently being piloted via two GPs.

NCAP
- Mandatory annual checks in place for all patients with a diagnosis of psychosis
- Improvement in the compliance for the recording of physical health parameters

POMH
- Harmonise the depot practices and procedures in the Trust
- Medical staff to clearly describe the clinical reasoning at the basis of the decision initiating a long acting antipsychotic.
- Implementation of specific prompt to ward round template to improve adherence
- Implementation of side effect pro forma in Mobius (currently used in Remedy)
- Improve documentation of a care plan around the management of future episodes of disturbed behaviour within one week of administering RT
- Ensure a recent ECG (within the previous 12 months) has been undertaken & recorded prior to administering IM Haloperidol

EIP
- Options around setting up physical health clinics being explored, already in place in the east and now starting in the west. ECG and additional scales and BP machines now available to both teams Consideration being given to linking this in more with the medical review and how it can work in tandem
- All clinicians to use Dialog & QPR as outcome measures for all patients regardless of FEP. FEP clients to have this reviewed at CPA meeting after six months and following that at least yearly
- Care Coordinators to ensure patients are engaged with Psychology Department and Employment Advisors. Psychology and Employment to be advised of new First Episode referrals and participate in First Episode Groups
- Family Interventions training refresher to be held for care coordinators and system developed to capture interventions delivered
- Physical Health checks DNA'd to be offered a home visit
- Two psychologists to complete CBTp top-up training following funding by Health Education England.
- New EIP referrals are offered ABI clinic (Assessment Brief Intervention), where indicated for CBTp informed work
- Staff members to be trained in BFT when this becomes available

(Note: All national clinical audit reports are presented to relevant Quality and Safety Groups at a local level for consideration of local action to be taken in response to the national findings.)

The reports of 25 local clinical audits were reviewed by EPUT in 2018/19, and we have taken or intend to take the following actions to improve the quality of healthcare provided (examples only are listed)

- All inpatient areas complete physical health assessments including MUST and Waterlow as stated in session 4.0 (Assessment of all New Patients) of Clinical guideline on Physical Healthcare CG55
- Clinical leads should continue to monitor the completion of risk assessments and their content within clinical supervision in order to support staff to develop skills in the management of risk and to identify cases which may require escalation
- Ensure the actions taken box within the referral is completed in full, with the comments box to record the reasons behind a decision made that supports the rejection or allocation details recorded
- Admin staff to be asked to manage the appointments/arrange for new dates and referral letters to be sent if patient's current hospital is out of the local area
  - Feedback to groups to inform essential Trust work streams
  - Restrictive practices
  - Physical Health
  - Deteriorating patient
  - Falls
  - End of Life
  - Suicide Prevention

2.6.3 Clinical Research

We developed our priority clinical audit programme for 2018/19 following consultation with senior mental health and community health service managers to focus on agendas required to provide assurance that our services are safe and of high quality. A centralised Clinical Audit Department oversees all priority clinical audits, to facilitate clinicians to ensure high quality, robust audits and monitor and report on implementation of action plans post audit to ensure that, where necessary, work is undertaken to improve services. Learning from audits takes place internally via reports that are provided to individual senior and local managers, operational quality groups and centralised senior committees. The Trust also reports regularly to stakeholders such as Clinical Commissioning Groups about outcomes of audits relevant to services in their portfolios.

We offer opportunities for people using our services and staff alike to take part in research studies relevant to them which enables us to support the NHS to improve the current and future health of the population together with providing an evidence base for ongoing better healthcare. We are committed to being a research active organisation providing a balanced portfolio of interventional, observational, commercial and non-commercial studies across our specialty service areas delivered in Essex.

The total number of patients receiving and staff delivering relevant health services provided or sub-contracted by EPUT in 2018/19 that were recruited during that period to participate in research approved by a Research Ethics Committee and the Health Research Authority (HRA) was 924. This number of recruits was from participation in 33 research studies opened at the Trust in 2018/19, including the National Confidentiality Inquiry into Suicide and Homicide and Sudden Unexplained Death, by People with Mental illness (NCISH) which has recruited 79 participants in 2018/19.

We are aligned with the National Institute for Health Research (NIHR) Clinical Research Network (CRN) North Thames (NT), which provides regional support for researchers and funds a number of research delivery staff at the Trust to run studies on the NIHR CRN portfolio, a database of high quality peer reviewed clinical research studies meeting CRN eligibility criteria and expected to lead to significant changes in the NHS within five years. We were ranked nationally by the NIHR CRN as 29/70th highest recruiting Mental Health and Community Trust to portfolio studies for 2018/19.

We collaborate locally with Anglia Ruskin University, University of Essex, University of Hertfordshire, University of East Anglia and acute Trusts through University College London Partners (UCLP), the Eastern Academic Health Science Network (EAHSN) and the NIHR Collaborations for Leadership in Applied Health Research and Care North Thames (CLAHRC North Thames).

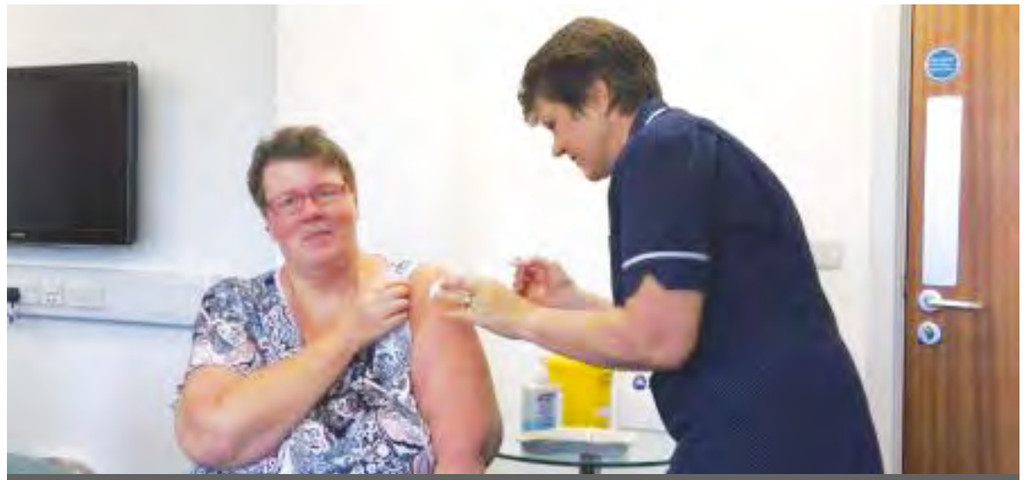
In late 2018 we took part in the NIHR CRN Patient Research Experience Survey (PRES), respondents rated their experience of taking part in research at EPUT at 4.32 out of 5 and 100% would consider participating in research again in the future.

The number of patients receiving relevant health services provided or sub-contracted by EPUT in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 293. [Overall recruitment including staff who participated was 924]

2.6.4 Goals agreed with commissioners for 2018/19

The CQUIN (Commissioning for Quality and Innovation) payment framework aims to support a cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner-provider discussions. It continues to be an important lever, supplementing Quality Reports, to ensure that local quality improvement priorities are discussed and agreed at Board level within and between organisations. It makes a proportion of the provider's income dependent on locally agreed quality and innovation goals.

A proportion of EPUT's income (2.5% of contract value) in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between EPUT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.



Chief Executive, Sally Morris, leads the flu campaign 2018

Our CQUIN programme for 2018/19 included schemes negotiated with commissioners across the areas in which we were commissioned to operate services. The CQUIN programme included a mix of local and national schemes and was valued at just under £6 million which represents 2.5% of contract value for the Trust. This compares to the 2017/18 CQUIN programme which represented 2.5% of contract value equating to £6.7 million. The current forecast achievement is £5,544,198.82.

Our CQUIN programme included
- staff health and wellbeing - staff survey;
- staff health and wellbeing - healthy food choices for staff;
- staff health and wellbeing - flu immunisations;
- improving the assessment of wounds;
- personalised care and support planning;
- physical health – cardio metabolic assessments;
- physical health part B - collaborating with primary care clinicians;
- improving services for people with mental health needs who present to A&E;
- transitions out of CYPMHS (Children and Young Persons Mental Health Services);
- preventing ill health by risky behaviours;
- community immunisation service (CIS);
- recovery college in secure services;
- reducing restrictive practices in secure services;
- discharge and resettlement;
- CAMHS inpatient transitions.

Our dedication to continually improving services endures; and teams have proven to be committed to and adept at managing resources to meet the stretching goals for quality improvement within the national CQUINs that have been set by commissioners in previous years as well as locally negotiated schemes. We anticipate teams will continue to ably meet the challenges for the coming year.

2.6.5 Stretching goals for quality improvement – 2019/20 CQUIN Programme (Commissioning for Quality and Innovation) for EPUT

Commissioners have incentivised us to undertake 12 CQUIN projects in 2019/20.

The value of our 2019/20 CQUIN scheme is £2,921,216 which equates to 1.25% of Actual Annual Contract Value, as defined in the 2019/20 NHS Standard Contract. In contrast to previous years, all are national CQUIN schemes.

The schemes agreed for 2019/20 are:
- staff flu vaccinations;
- alcohol and tobacco screening;
- alcohol and tobacco - tobacco brief advice;
- alcohol and tobacco - alcohol brief advice;
- 72hr follow up post discharge;
- mental health data quality - quality maturity index;
- mental health data quality – interventions;
- use of anxiety disorder specific measure IAPT;
- three high impact actions to prevent hospital falls;
- six month review for stroke survivors;
- healthy weight in adult secure mental health services;
- tier four CAMHS staff training.

Although these CQUINs are nationally mandated, the quarterly milestones Trusts are expected to meet on the journey to achieving the final CQUIN requirement are agreed locally.

This will support the need for different Trusts to work in different ways over the duration of the CQUIN, while working towards a common goal.

Essex Partnership University NHS Foundation Trust (EPUT) is required to register with the Care Quality Commission and its current registration status is registered with conditions. EPUT has the following conditions on registration in relation to Clifton Lodge and Rawreth Court (Nursing Homes):
- a requirement to have Registered Managers;
- a limitation on the number of beds provided by the services.

The Care Quality Commission issued EPUT with a Section 29A Warning Notice during 2018 in relation to healthcare services provided at HMP Chelmsford. The Warning Notice expired on 28 September 2018 following action taken by EPUT. Healthcare services at HMP Chelmsford were transferred to a new provider on 31 March 2019.

Essex Partnership University NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2018/19

2.6.6 What others say about the provider?

The Care Quality Commission completed five inspections during 2018/19:

Comprehensive Inspection (April – May 2018)

The CQC completed a comprehensive Inspection of our services in April and May 2018. The inspection was unannounced and was to review the quality of our services and to provide an initial rating following registration as a new provider in April 2017.

The final report confirmed we had achieved an overall rating of 'good' along with both community health services and mental health services also achieving an overall rating of 'good'. In addition, of the 15 core services inspected, 11 achieved an overall rating of 'good'. We achieved 'good' ratings in 59 of the 75 total domains inspected and a further two 'outstanding' ratings for 'caring' in two core services.

A 'requires improvement' rating was given overall for 'safe' in mental health services; in addition, we received 'requires improvement' ratings in 13 of the 75 total domains inspected and one 'inadequate' rating for the 'well-led' domain in substance misuse services.

The grid below shows our full ratings including the significant number of 'good' ratings as well as the areas which required further action to be taken:

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Mental health	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community health services for children and young people	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community health inpatient services	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community end of life care	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Good Jul 2018	Requires improvement Jul 2018
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Forensic inpatient or secure wards	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Child and adolescent mental health wards	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Wards for older people with mental health problems	Good Jul 2018	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Wards for people with a learning disability or autism	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community-based mental health services for adults of working age	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Mental health crisis services and health-based places of safety	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community-based mental health services for older people	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Community mental health services for people with a learning disability or autism	Good Jul 2018	Good Jul 2018	Outstanding Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018
Substance misuse services	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Inadequate Jul 2018	Requires improvement Jul 2018
Overall	Requires improvement Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018	Good Jul 2018

The CQC report confirmed that inspectors found a number of examples of outstanding practice across the Trust. This included staff's interaction with patients, technology and innovation used to support patients and the preparation and support for patients to live successfully outside of hospital.

The report described a number of positive areas and themes found in the inspection, including the following:

- Inspectors were impressed by the extent that our values had been embraced by everyone and were shown and modelled by all the staff met.
- We had worked at pace to harmonise policies and procedures to support staff following the merger. Senior staff saw leadership as fundamental to their role and the CQC saw that we embraced leadership values as being important at all levels of the organisation.
- Senior Managers were very visible in core services and many members of staff told the CQC that the Board members were approachable, had visited their services and were willing to hear comments.
- We had a robust governance framework and structure.
- We had taken significant steps to improve patient experience following previous CQC inspections.
- We ensured that actions had been prioritised based on risk, and the CQC saw significant work had been undertaken in the CAMHS inpatient and learning disability inpatient services; this had dramatically improved the environments for people using services.
- Leaders had oversight of safeguarding and incident reporting and shared lessons learnt.
- Compliance with mandatory training, supervision and appraisal was good.
- Staff and leaders cared for and supported each other.
- Staff felt listened to and supported.

The inspection report identified a number of issues which we needed to address. The key areas of concern that the CQC identified were:

- managing ligature risk;
- bed management;
- oversight of smaller services;
- deprivation of liberty;
- clinic room management.

As at the end of March 2019, a total of 300 individual actions have been reported as completed (97%) which confirms that we continue to make progress with the actions agreed to address the findings of the inspection.

HMP Chelmsford (June 2018 and October 2018)

The CQC completed an inspection of healthcare services provided at HMP Chelmsford by the Trust in week commencing 4 June 2018. The CQC undertook the inspection jointly as part of the overall inspection of the prison by HM Inspectorate of Prisons. The CQC noted improvements had been made with the Enhanced Nursing Service and Integrated Drug Treatment Service (IDTS), however, there were still a number of concerns we needed to address and as such the CQC issued the Trust with a Section 29A Warning Notice on the 27 July 2018.

In October 2018 the CQC undertook an unannounced focused inspection to review improvements made as a result of the Section 29A Warning Notice. This was to determine if the healthcare services we provided were meeting the legal requirements and regulations and that patients in the prison service were receiving safe care and treatment.

The CQC published a report on 6 February 2019 which confirmed that we had taken action in the majority of areas from the Warning Notice; however, there were three areas which required additional action to be taken to resolve. Overall the CQC acknowledged that a lot of progress had been made and commented that "it felt like a different place since the last inspection".

We completed a testing exercise at the end of March 2019 against the action plan developed as a result of the CQC inspection completed in June 2018 and the subsequent Section 29A Warning Notice. The testing was undertaken to confirm if the action taken had led to an improvement and had been maintained. The results of the testing confirmed the majority of actions tested had led to an improvement and had been maintained.

The contract to provide the healthcare aspect of the service ended on the 31 March 2019 and the commissioner appointed a new organisation to provide this service from the 1 April 2019. We continue to provide the IDTS service within the prison.

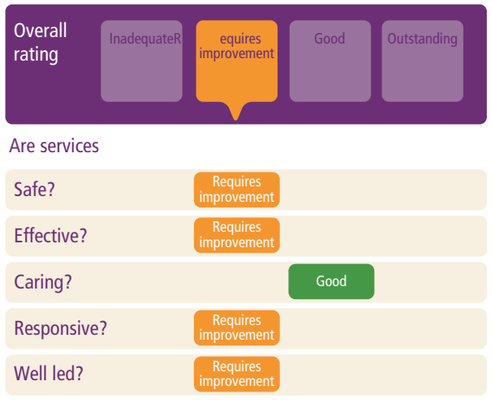
Nursing Homes (November 2018 and January 2019)

The CQC completed an inspection of our two nursing homes, Rawreth Court and Clifton Lodge. The purpose of the inspections was to provide the nursing homes with an initial rating following registration as nursing homes with the CQC in November 2017.

The CQC completed the inspection of our Rawreth Court in November 2018 and the final report provided the service with an initial rating of 'requires improvement'. We developed an action plan to address the concerns identified, and as of the end of March 2019 57% of the internal actions identified to address the requirement notice actions have been reported as completed. There are no actions which have passed the internally agreed timescales.

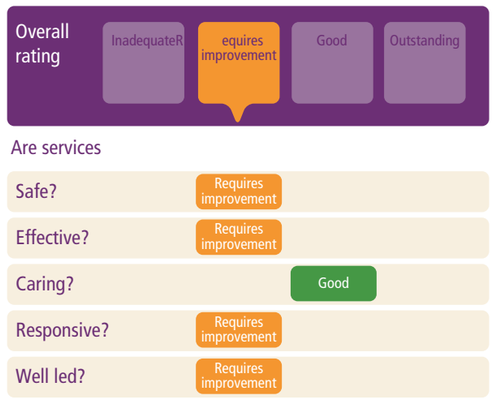
The CQC completed an inspection of Clifton Lodge in January 2019 which provided the service with an initial rating of 'requires improvement'. We developed an action plan to address the concerns identified and as of the end of March 2019 a total of 46% of the internal actions identified to address the requirement notice actions have been reported as completed. There are no actions which have passed internally agreed timescales.

Rawreth Court



We were so impressed with the unit and the staff there. The little touches like the street names, vintage style posters on the walls, door decorations (which I loved) and personalised boxes outside of the rooms really made it feel less like a nursing home and more like a community. I also have to say, the unit is absolutely spotless! I just wanted on behalf of my family, to let you know how pleased we all are with the care and environment at Rawreth Court and say thank you

Clifton Lodge



Thank you for all your kindness and understanding and for the unlimited care that you gave my dad at Clifton Lodge. You were all helpful and welcoming at any time of day. Some would say this is my job, but it takes a special person to be able to do the job you all do. Thank you.

2.6.7 Data Quality

Our ability to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for us to deliver safe, high quality care. The Board of Directors strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality also allows us to undertake meaningful planning and enables services to be alerted to any deviation from expected trends.

We have systems and processes in place for the collection, recording, analysis and reporting of data. Information systems have built in controls to minimise scope for human error or manipulation. There are corporate security and recovery arrangements in place. Roles and responsibilities in relation to service and data quality are clearly defined and where appropriate incorporated into job descriptions.

2018/19 has been a challenging year with the ongoing use of two mental health information systems inherited from the two former organisations (SEPT and NEP). We have undertaken considerable work to align data reporting across the organisation and to ensure that data definitions are interpreted and applied consistently. During 2018/19 Trust-wide reporting has been implemented to ensure that national data submissions accurately reflect our position.

Internal audit carried out a data quality audit on randomly selected KPIs across the Trust during February 2018 and advised there was 'satisfactory assurance' on the controls that were in place. Internal audit completed a further audit in Q3 2018/19 which has provided positive assurance on the controls in place.

We have assessed internal and external reporting requirements and reviewed data provision to ensure it is aligned to these needs. Data used for reporting is used for day to day management of the Trust's business. We use data to support decision making and take management action is address service delivery issues identified by reporting. Data used for external reporting is subject to verification prior to submission. We prepare and submit data returns on a timely basis and these are supported by an audit trail.

We have sought external independent assurance on the content of the Quality Report and of the quality of data that supported reporting of performance against three of the KPIs reported within it.

In addition to the changes above, the following key developments have taken place.

- The Information Assurance Framework has been revised to focus on the performance indicators outlined within the Single Oversight Framework. The assurance framework reflects the changes that were made to the Single Oversight Framework in November 2017.
- During 2018/19, a new IM&T strategy has been approved, which acknowledges the primacy of data quality and proposes practical steps to consolidate and improve it.
- Continued monthly monitoring of data quality across mental health and community health services patient data by Senior Management Teams, Executive Team and Finance and Performance Committee.
- Presentation of a regular Data Quality Report to the Information Governance Steering Sub Committee.
- In March 2019, a revised Data Quality Policy and Procedure was approved for use throughout the Trust.

EPUT achieved a Data Quality Maturity Index score of 98.9% for Q1 and 98.8% for Q2 compared to the NHSI Single Oversight Framework target of 95%.

EPUT's Information Governance Data Security and Protection Toolkit (DSPT) overall score for 2018/19 was compliant across all assertions.

Essex Partnership University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Essex Partnership University NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

- 99.4% for admitted patient care
- 100% for outpatient care
- N/A for accident and emergency care

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

- 99.2% for admitted patient care
- 99.9% for outpatient care
- N/A for accident and emergency care

We will be taking the following actions to improve data quality.

- Submission of additional fields within the Mental Health Services Dataset. As part of the implementation of new national datasets the Trust is undertaking intensive monitoring of all the data fields to ensure a high level of data quality is achieved.
- Increased number of Data Quality Audits to be undertaken by the Internal Audit function.

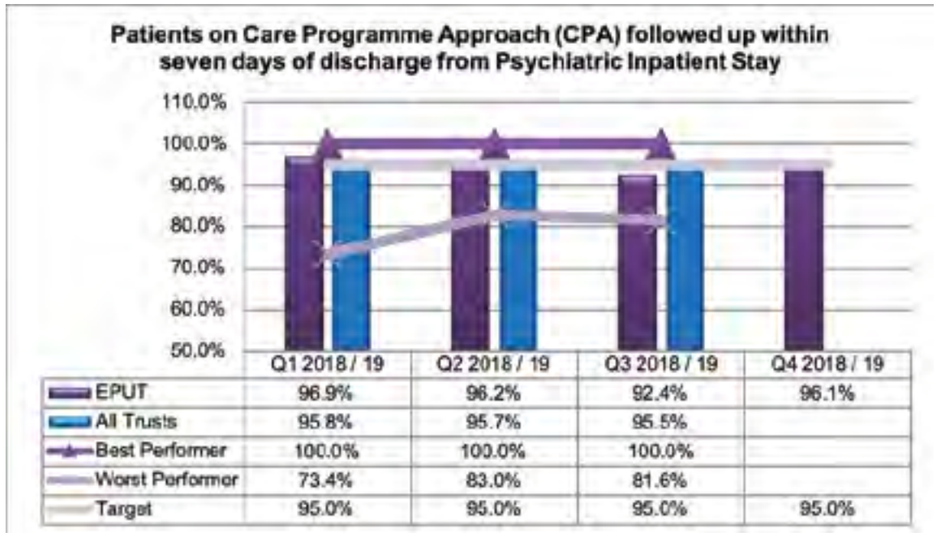
2.7 National Mandated Indicators of Quality

A letter from NHS Improvement dated 17 December 2018 accompanied by detailed guidance outlined the reporting and recommended audit arrangements for Quality Reports for 2018/19. The National Health Service (Quality Reports) Regulations 2010 had been previously amended to include changes of the mandatory reporting of a core set of quality indicators.

Those indicators relevant to the services we provided during 2018/19 are detailed below, including a comparison of our performance with the national average and the lowest and highest performers. The information presented for the four mandated indicators has been extracted from nationally specified datasets, and as a result, only available at a Trust-wide level.

2.7.1 Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay

Our ability to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for us to deliver safe, high quality care. The Board of Directors strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality also allows us to undertake meaningful planning and enables services to be alerted to any deviation from expected trends.



	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
EPUT	96.9%	96.2%	92.4%	96.1%
All Trusts	95.8%	95.7%	95.5%	
Best Performer	100.0%	100.0%	100.0%	
Worst Performer	73.4%	83.0%	81.6%	
Target	95.0%	95.0%	95.0%	95.0%

This indicator measures the percentage of patients that were followed up (either face to face or by telephone) within seven days of their discharge from a psychiatric inpatient unit.

This target has been met for quarters one and two, but we failed to meet the target in quarter three.

We investigated the dip in performance and found that in some cases staff were contacting the person who was discharged on the day of discharge. Under the national construct contact on the day of discharge is not counted as a seven day follow up.

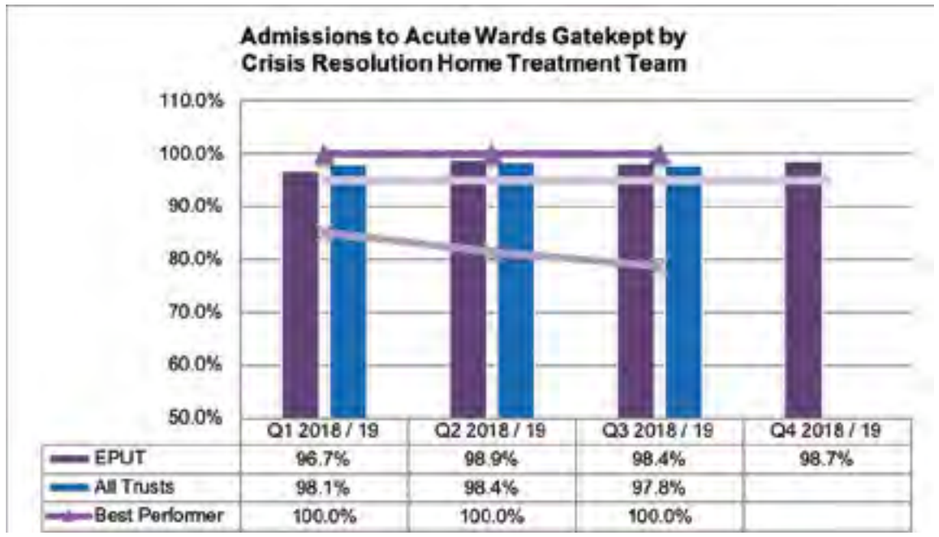
During Q4, we followed up 373 discharges within seven days out of a total 388 discharges, equating to a rate of 96.1%. The Q4 position is based on local data and will be updated upon receipt of the national data. The Q4 data for other organisations is not currently available but will be updated upon receipt.

We have taken the following actions to improve this indicator, and so the quality of our services.

- routinely monitoring compliance on a monthly basis including through use of dashboards
- disseminating identified learning across relevant services

Data Source: NHSD Strategic Data Collection Service (SDCS) – MHPrvCom via NHS Digital
National Definition applied: Yes

2.7.2 Admissions to acute wards gate kept by Crisis Resolution Home Treatment Team



	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
EPUT	96.7%	98.9%	98.4%	98.7%
All Trusts	98.1%	98.4%	97.8%	
Best Performer	100.0%	100.0%	100.0%	

This indicator measures the percentage of adult admissions which are gate kept by a crisis resolution and home treatment team.

This target has been met consistently during 2018/19.

During Q4, we gate kept 466 out of a total 472 admissions, equating to a rate of 98.7%. The Q4 position is based on local data and will be updated upon receipt of the national data in early May 2019. The Q4 data for other organisations is not currently available but will be updated upon receipt.

Data Source: NHSD Strategic Data Collection Service (SDCS) – MHPrvCom via NHS Digital
National Definition applied: Yes

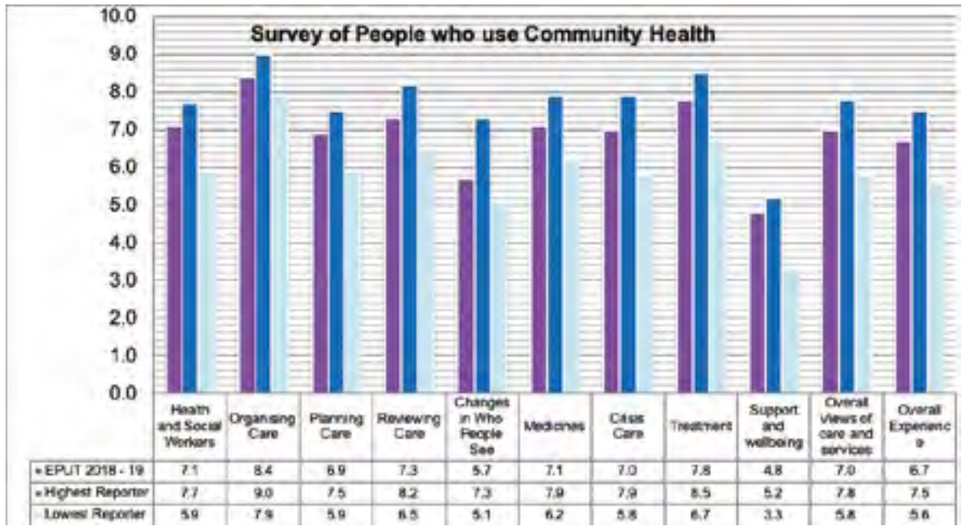
> *Thank you so much for all of your help and support during my admission, the nursing team always gave space to think and the number of coping strategies that I have learnt I will keep using and hopefully help to keep me out of hospital best wishes.* ***Galleywood Ward***

2.7.3 Patient experience of community mental health services

The Community Mental Health Patient Survey 2018 was sent to patients who received treatment from us. The 2018 survey of people who use community mental health services involved 56 providers of NHS mental health services in England (including combined mental health and social care trusts, foundation trusts and community healthcare social enterprises that provide mental health services). The survey is commissioned by the CQC and received responses from 12,796 people, a response rate of 28%.

Our 2018 report shows how we scored for each evaluative question in the survey, compared with other trusts. It uses an analysis technique called the 'expected range' to determine if the Trust is performing 'about the same', 'better' or 'worse' compared with most other trusts.

The questions are split into different domains and a summary of results is provided in the graph below:



	Health and Social Workers	Organising Care	Planning Care	Reviewing Care	Changes in Who People See	Medicines	Crisis Care	Treatment	Support and wellbeing	Overall views of care and services	Overall Experienc e
• EPUT 2018 • 19	7.1	8.4	6.9	7.3	5.7	7.1	7.0	7.8	4.8	7.0	6.7
• Highest Reporter	7.7	9.0	7.5	8.2	7.3	7.9	7.9	8.5	5.2	7.8	7.5
Lowest Reporter	5.9	7.9	5.9	6.5	5.1	6.2	5.8	6.7	3.3	5.8	5.6

The results of the 2018 Community Mental Health Patient Survey show that EPUT have scored 'about the same' as the England average across all sections in the graph above.

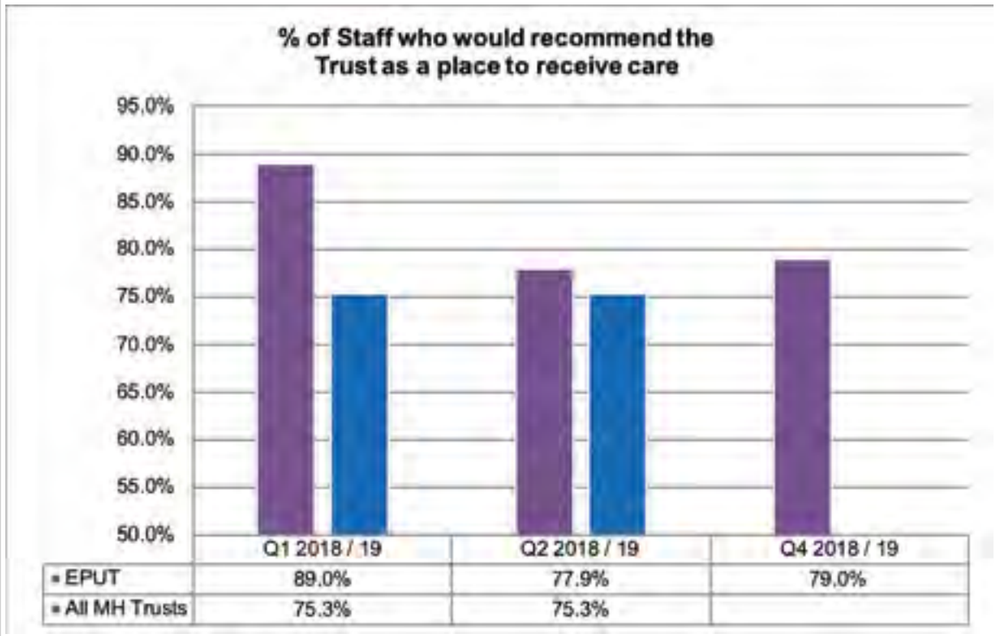
For one question we scored worse than average, 'Q17 Changes in who people see, what impact has this had on the care you receive?' An action plan has been developed and is in the process of being implemented.

Data Source: CQC Community Mental Health Services Survey
National Definition applied: Yes

2.7.4 Staff recommended score of the Trust as a place to receive treatment

The Friends and Family Test is available to staff to record whether they would recommend the Trust to their family or friends, either as a place to work or as a place to receive care.

Our staff were able to record their views from 1 April 2018 to 31 March 2019, although responses are not reported for Q3 as this coincides with the national NHS Staff Survey.



	Q1 2018 / 19	Q2 2018 / 19	Q4 2018 / 19
• EPUT	89.0%	77.9%	79.0%
• All MH Trusts	75.3%	75.3%	

The results of the 2018/19 SFFT show us as above average for the percentage of staff who would recommend the Trust as a place to receive care. We have taken the following actions to further improve this indicator, and so the quality of our services.

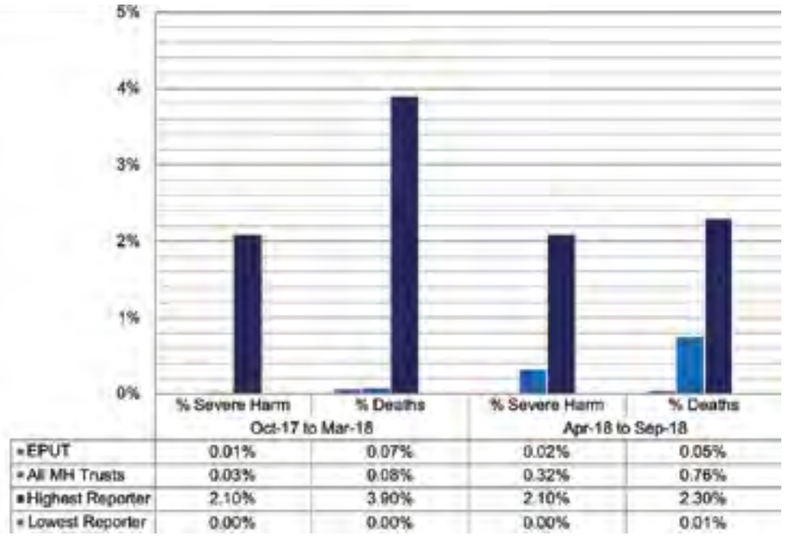
- SFFT link is regularly sent out to staff with an invitation to complete.
- SFFT is referred to as one of the key channels through which staff can report anonymously and confidentially.
- Paper versions of SFFT are taken to events and staff are asked to take them back to staff rooms and receptions.
- SFFT page has been created on the intranet for staff to access which has a link to the survey on it, the summary reports for Q1 and Q2, and further information/supporting publications regarding SFFT.
- SFFT link is also included on all staff engagement pages on the intranet so it is clearly visible and staff can access it easily when they want to give feedback.

Data Source: Staff Friends and Family Test (FFT) survey
National Definition applied: Yes

2.7.5 Patient safety incidents and the percentage that resulted in severe harm or death

Reporting Dates	1st October 2017 – 31st March 2018			1st April 2018 – 30th September 2018		
	All incidents	Severe harm	Deaths	All incidents	Severe harm	Deaths
EPUT	6,965	8	48	7,025	14	37

The graph below shows the percentage of all incidents we reported to the NRLS that resulted in severe harm and those which resulted in death.



	% Severe Harm	% Deaths	% Severe Harm	% Deaths
	Oct-17 to Mar-18		Apr-18 to Sep-18	
EPUT	0.01%	0.07%	0.02%	0.05%
All MH Trusts	0.03%	0.08%	0.32%	0.76%
Highest Reporter	2.10%	3.90%	2.10%	2.30%
Lowest Reporter	0.00%	0.00%	0.00%	0.01%

Patient safety data for period 1 April 2018 to 30 September 2018 was published in March 2019.

The national collection of patient safety incident data for period 1 October 2018 to 31 March 2019 is due to be completed by the end of May 2019 and reports are expected to be published in September 2019.

We consider that this data is as described for the following reasons
- nationally reviewed via the NRLS;
- benchmarking is against similar Trusts within our cluster group.

We have taken the following actions to improve this indicator, and so the quality of our services
- We have taken forward work to reduce the number of harms – details of some of this work are included throughout this report.
- We have agreed quality priorities for the coming year to specifically reduce incidents resulting in harm.
- There is close monitoring of quality improvement initiatives.
- Monthly Datix training for reporting staff and managers highlights the importance of reporting and to improve the quality of incident records.
- Closer monitoring of incidents is in place requiring manager approval to assist in reducing the length of time between the initial report and the data being uploaded to the NRLS.

Data Source: NRLS NPSA Submissions
National Definition applied: Yes

2.8 Implementing the Duty of Candour

The Duty of Candour is the requirement for all clinicians, managers and healthcare staff to inform patients (or, where appropriate, the patient's advocate, carer or family) of any actions which have resulted in, or could have resulted in, harm. It actively encourages transparency and openness and we have a legal and contractual obligation to ensure compliance with this standard. We have considered such openness and transparency to be vital in ensuring the safety and quality of our services and have continued to drive forward work in this area.

The Executive Directors have overall responsibility for ensuring the principles of Being Open: Duty of Candour policy and procedure and other associated policies are implemented across the organisation. Although Duty of Candour concentrates on incidents that are defined as causing moderate or severe harm, we are committed to being open with all patients and their families and carers in line with our Trust values. All our staff are encouraged to report all incidents based on our culture of a transparent, learning organisation and use the Datix Risk Management system to ensure a standardised approach.

All moderate, serious harm incidents and those identified for escalation are monitored on a weekly basis in a meeting held between the serious incident office and Clinical Risk Team with the Deputy Director of Nursing to review and ensure appropriate investigations are taken forward. For all moderate or severe harm, contact is made either with the patient or family members as appropriate and this is followed up in writing within 10 working days offering them the opportunity to participate in the investigation. This is monitored through the Serious Incident Office with weekly reporting to the Executive Operational Sub Committee as well as through performance reports.

Our Being Open: Duty of Candour Policy describes the process for acknowledging, apologising and explaining when things go wrong and outlines the professional, contractual and statutory Duty of Candour with which staff must comply to ensure that when cases of severe or moderate harm occur patients and relatives are fully informed and involved in the investigation process.

We have a mandatory Duty of Candour on-line course covering all staff with an overview course as a minimum for non-clinical staff, a more detailed course for clinical staff and even more detailed course for managers. The training provides staff with an understanding of the 'Being Open' process and the benefits of this. The aim is to support clinical staff to implement 'Being Open' knowledge within clinical practice and provides an overview of organisational and individual responsibilities as well as how to access and use Trust documentation. It emphasises that all staff have a responsibility to ensure that the principles contained with the policy and associated guidelines are followed in that they:
- must ensure that they report all patient safety events, complaints or claims to their line manager immediately;
- have responsibility to ensure that as part of continuing professional development they acquire, maintain and disseminate knowledge and skills to carry out where required the principles of 'Being Open';
- through clinical supervision and post event reviews, they can expect to receive support tailored to their individual need.

All the courses as a minimum cover:
- definitions;
- 10 key principles;
- process overview;
- benefits of 'Being Open'.
- responsibilities;
- level of response to different incident categories;
- documenting and recording;

This course is not required to be undertaken at regular intervals, but all moderate or severe harm incidents are monitored and further sessions can be given to individuals or teams via the serious incident office as well as advice to staff.

PART 3

REVIEW OF EPUT QUALITY PERFORMANCE DURING 2018/19

This part of the Quality Report is divided into four sections.

To enable readers to get an understanding of the Trust's performance in local areas, performance against indicators is detailed by locality area where it is possible to do so.

3.1 Examples of Quality Initiatives

Outlined below are some examples of quality improvements that have been achieved by EPUT services during 2018/19 to provide a flavour of the diversity of initiatives we are working on and the progress we are making in improving the quality of care we provide to our patients and users. Due to the diversity and capacity of services we provide, we only have room to include very brief details in this report - please do get in touch with us (contact details are at the end of this report) if you would like further details about any of the initiatives listed.

3.1.1 Mental Health Services

Specialist Services

Forensic Services

- Collaborative co-production with service users on Aurora Ward to reduce restrictive practice and sharing of risk management practices leading to greater choice for patients and fewer interventions from staff. This was recognised at the Trust's 2019 Quality Awards where service users attended to receive their award.
- Under the 'Fair Deal' Quality Initiative service users are participating in the delivery of training to staff, service groups and forums and delivering courses within our Recovery College. This both improves their vocational skills, confidence and self-esteem as part of their recovery pathway and provides an opportunity to be compensated for their expertise through an incentive programme.
- The service prioritises physical health care and has a diabetic lead nurse providing clinics to all patients with immediate needs, reducing the need for attendance at acute hospitals as well as providing advice on diet, lifestyle and self-management of medication. In addition all patients with long term conditions are placed on a register and monitored to ensure they are receiving rapid and appropriate support when required and screening at or above the level they would expect to receive in the community.
- To support and improve service user contact with their friends and family whilst in hospital, all patients are provided with mobile phones which can be used by them throughout the ward as a low cost alternative to traditional payphones increasing their sense of independence and choice. The removal of payphones also eliminates a known ligature risk.

Recovery College Graduation

Learning Disabilities Services

- The Health Facilitation Service supports the inpatient unit by assisting with appointments in acute facilities during inpatient stays and also visiting the unit every week to provide education to service users based on individual need, supported by inpatient staff and therapists.
- The Health Facilitation Service has continued to support mainstream health providers to make their services accessible to people with LD and this year have been involved in the development of a webinar to educate dental practices about the needs of people with LD and how to make reasonable adjustments. They have also worked alongside the diabetes service to develop a group tailored to the needs of people with LD and this has now been run successfully on two occasions.
- There are also plans for a Big Health Day to be run in the local area during LD Awareness Week where a whole day will be given to showing people with LD how to be healthy. This day will be fully interactive with events throughout the day promoting the benefits of staying healthy.

Health & Justice Service

- A female pathway has been developed within the Health and Justice Service, in order to be able to refer females to female only services, to offer female workers when requested and for females to be seen in family friendly environments. The anticipated benefits are greater engagement from females in treatment services, the ability to offer female support staff when requested and an increase in partnership working.
- A female Health and Justice Service flowchart has been produced and a directory of female specific services has been collated to further enhance the service offer for females.

> *With regards to the process of LeDeR and the issues faced with completing the reviews. He said he has been involved with the reviews since the programme started and feels that our health facilitation service do a brilliant job and he is very impressed with us all!*

Sally Morris cuts the ribbon to open the new De-escalation Suite at Byron Court

In-Patient Perinatal Service

- Rainbow Unit has a recovery corner within the activity room on the ward which has a 'handprint wall' where patients on the day of discharge have the opportunity to add their handprint; this has proven to be a very powerful source of support and instils hope in newly admitted patients. There is also a recovery board which houses notes, stories, poems or messages from patients to patients to demonstrate that recovery is possible.
- The therapy programme incorporates partner/carer invite and involvement as well as supporting 1:1 interactive therapy sessions between families such as dad's attendance at baby yoga classes.
- Each patient is given a welcome pack at the point of admission which they can add to throughout their stay with written outcomes from care reviews and care plans. The ward has now created a discharge pack which is created for each patient with a focus on non-clinical support and activities in their local area. These include group activities that they have enjoyed while on the unit or an area of interest they had discussed with a member of staff during their stay.

Child and Adolescent Mental Health Services

- Daily risk huddles have been initiated, which provide an opportunity for de-brief, reflection and open discussion in regards to risk. These huddles also incorporate the involvement of young people in regards to managing and maintaining safety on the wards.
- Young person led groups on the ward, in which they develop, lead and facilitate peer activities, developing confidence, sharing experience, and identifying skills.
- The use of Twitter to share practice and demonstrate safe and effective use of social media for young people. This allows the wards to connect with other CAMHS services and to learn and grow with the support of other services.

Perinatal Mental Health Service received Highly Commended in the national Positive Practice Awards

Drug & Alcohol Services (STaRS)

- STaRS have introduced a quality assurance tool across all sites providing weekly assurance and feedback relating to our key areas of activity.
- STaRS have led the redesign of the alcohol treatment pathway leading to clarity regarding the care co-ordination of these service users.

> *Thank you, really doesn't cut it, because what you have done for me has been life changing and you have given me the best present of all, the gift of being able to enjoy my daughter and give me the skills to be a good mum. It's still a long road, but I feel far better equipped to travel the ups and downs. I hope you all know the difference you made not just to individuals but families on a daily basis. So I hope you see now why thank you just doesn't cut it.*

Inpatient Mental Health Services

Adult Inpatients

- Mental Health Liaison Teams were developed towards Core 24 (Nice). Basildon and Southend acute hospitals are compliant following wave 1 funding. Colchester, Broomfield and Princess Alexandra acute hospitals are now ready for wave 2 funding.
- As part of the transformation work stream, there is now 24/7 Emergency/Urgent Response & Intensive Home Treatment provided. Any person experiencing a mental health crisis should receive a response from the liaison mental health service within a maximum of one hour of the service receiving a referral. Within four hours of arriving at an emergency department or being referred from a ward, any person experiencing a mental health crisis should have received the appropriate response or outcome to meet their needs and have an evidence based care package (informed by NICE) in place.
- High Intensity User Group was developed, working in partnership with ECC & MIND using ECC winter pressure funding. This is aimed at helping health and social care systems identify and support some of the most vulnerable people in our society by providing them with community based 1:1 coaching and mentoring to empower them to self-manage.
- In north east the Home First/Homelessness Project now has a part-time Band 7 post funded by Colchester Housing Borough Council. The national plan to end homelessness is aimed at ending rough sleeping, getting everyone housed, and preventing homelessness.
- An RTMS (repetitive transcranial magnetic stimulation) treatment for depression has been developed. This treatment was approved by NICE in 2015.
- ECT (electroconvulsive therapy) has been developed as a service to the private sector. This treatment is known to make changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses.

Older Adult Inpatients

Older Adult Inpatient Dementia/Functional Care Pathway (includes acute care decision making and gate keeping record prior to admission)

- Whilst home would always be the first option, mental health admission may not be avoidable. Prior to any admission it would be expected that there had been an assessment by the DISS team who would provide a clear rationale for admission including a clear and mutually agreed outcome. This ensures admissions are planned and purposeful. The inpatient services have developed clear assessment and treatment processes with timelines and there is an estimated date of discharge within 24 hours of admission. Length of stay is reduced and flows through the service improved.

Falls Prevention

- A Falls Focus Group has been established to look at a number of areas such as:
  - improving the ward environment by undertaking environmental audits with action plans and recommendations;
  - identifying falls champions for each ward with defined roles (both registered and unregistered staff);
  - planning falls champion training for the coming year;
  - eight staff training places identified and agreed through workforce development team on chair based exercise programmes in the summer of 2019, as a specifically targeted falls prevention programme;
  - increasing the high-low bed stock in the Trust.

Community Mental Health Services

Open Dialogue

- In Thurrock we are excited to have commenced a four week residential training in Peer Open Dialogue (POD). This is also associated with a year's research trial, which will consider how POD compares to 'Treatment as usual'. The trial is due to commence at the end of April 2019 and will last a year. This is closely associated with UCL, who will oversee the process.
- POD is seen as one of the new service user led and focused approaches to treatment for people suffering from severe and enduring mental health problems. It is also seen as an approach within Family Therapy. Professionals' focus is on facilitating family/significant others network meetings with the service user and whoever they identify as significant in their lives. In addition, the fidelity measurement criteria centres on continuity, responsiveness and minimising professional hierarchy, offering natural reflections from professionals to the network meeting.
- Research in Finland, where it originated has shown that patients who were under POD, needed significantly fewer admissions and in some cases; for example: patients with Psychosis, came off their medication and remained stable.

Thurrock First

- The Thurrock First service is an integrated community mental health, community health and social care service provided jointly by EPUT, North East London NHS Foundation Trust (NELFT) and Thurrock Council. It is recognised that people accessing services can present with complex conditions that cross the divide between healthcare (both mental and physical), and social care. The aim is to offer a single point of entry for each person to meet all their needs.
- Thurrock First strives to provide a high quality integrated adult health and social care information, advice and assessment service focused on prevention and signposting. In particular, it is the first point of telephone contact for adults living in Thurrock who want to talk to someone about adult social care, mental health, health problems that have been diagnosed and for which on-going care is needed, where to get help with other health problems and care that is available in the community.

> *I am writing this letter on behalf of our family to say a massive thank you to all the doctors, nurses and staff involved in our mother's treatment, care and recovery. From the top, the doctor and her team, through to the night staff, canteen staff and cleaners and particularly the nurses, all gave our mother the most amazing care, compassion and attention to bring our mum back to her old self. Sadly we only hear the bad bits from within the NHS, but the care and service our mum received from the NHS, on Beech Ward, was a shining example of the NHS at its very best.*

SIM (Serenity Integrated Mentoring) Mid Essex Project

- This model of care combines the best clinical care with compassionate but consistent behavioural boundary setting to reduce harm, promote healthier futures and reduce repetitive patterns of crisis from impacting 999 and other emergency care teams. Commencing in May 2018, SIM Mid Essex is a new programme, part of the national accelerator programme, led by a Project lead from Hampshire Constabulary. A trained police officer and mental health care co-ordinators work with the patient regularly to develop a shared care and response plan.
- The patient may have been referred to the programme to help find ways of coping that cause less risk to themselves and/or others. They may have been regularly detained by the police under Section 136 of the Mental Health Act, or frequently called 999 for an ambulance, attended A&E, or been admitted to a mental health ward on multiple occasions. The decision to offer the specific patient mentoring is made by the team consisting of representatives from mental health services, police, ambulance and the accident and emergency department. Mentoring can help the patient find new ways of coping so they are better able to manage their mental health. People who have used this programme have found it has improved their self-esteem, wellbeing and quality of life by addressing practical, social and emotional issues that can contribute to a mental health crisis. Frequency of detention under Section 136 is also reduced.
- A police mentor is an officer who is trained in mental health. The police mentor will meet with the patient and care co-ordinator (along with carers and/or family member, if the patient wishes) to help the patient reduce the risks they may be causing for themselves and/or others. Together they will take account of the patient's specific and individual needs particularly when responding if the patient is in crisis and help the patient stay safe and within the law. The police mentor and care co-ordinator work closely with the patient to better understand their personal needs when they are in crisis and co-produce their unique care and response plan. The police officer working with the patient will not to wear uniform but is a member of the NHS staff with an NHS identity badge, a police identity badge and full access to NHS buildings and patient's clinical records, meeting all governance requirements.

Sally Morris and Essex Police' Steve Worron pictured at launch of SIM (Serenity Integrated Mentoring)

Older people and dementia services

Accessible and responsive services

- Development of the West Essex Integrated Single Point of Access for all community and MH older people's and dementia services.
- North East Essex multi-agency dementia primary care pilot based around a cohort of four surgeries.
- EPUT older people's and dementia services aligned to primary care hubs/networks as part of locality integration initiatives.

> *My lovely dad who spent many weeks with you in your excellent care has sadly passed away. He is finally at rest from that terrible disease called dementia. You will remember how much he loved to sing and dance so the angels are set for one big party now. Thanks to every one of you for helping him in his last tormented months and helping him so much to get through each day without hurting anyone. Keep doing what Angels do on earth.*

Essex Dementia Team celebrate National Dementia Day 2019

SWIFT team

Enhanced integrated services to support care and treatment at home

- South East Essex Dementia Intensive Support Service and SWIFT admission avoidance collaborative.
- The Mid Essex Dementia Intensive Support Service is fully operational across the Mid system providing alternatives to admission. The service has continued to improve through this full implement stage reflecting the feedback from stakeholders.

End of life care for those with dementia

- The North East Essex Dementia services have been working with the St Helena's Hospice in their quality improvement initiative to deliver the gold standard framework for End of Life care for those with dementia.

North East Community Mental Health

Enhanced Mental Health Liaison Team

- The Mental Health Liaison Team received funding for additional staff to focus on periods of high activity and include an unregistered clinician to support the patient and carer in the referral experience. A steering group is ongoing involving a number of providers to consider improvement and governance of the service.

> *I would like to say a big thank you to the Swift Team who have attended me this week during a really horrible bout of illness. The nurses were excellent in every way and were so kind which gives one a lot of comfort when it's most needed. I think this is a wonderful scheme and keeps us oldies out of hospital, which is wonderful. Thank you all again for everything.*

GP Primary Care Pilot

- EPUT was approached to support a one day a week pilot in a local GP surgery in the NE which identified it required additional support with mental health referrals. A Band 7 Advanced Nurse Practitioner was mobilised to work with challenging cases within the surgery to support their GP colleagues. EPUT initiated a multi-disciplinary team meeting once a week where cases were discussed and subsequently seen by the primary care mental health worker. The pilot was so successful in terms on patient and GP feedback that a full time post was commissioned and now in post in Tendring and Colchester.

Social Care Leadership (Adult Mental Health)

Care Planning Scrutiny Panel

- This panel meets on a weekly basis to ensure there are fewer delays in provision of funded care and scrutinises all applications due to be submitted to Essex County Council's Social Care Funding Forum and the S117 Panels. The aim of the Scrutiny Panel is to ensure that all paperwork submitted to Essex County Council and the S117 panels is of the highest quality. It also ensures as far as possible that the applications are likely to be accepted and taken forward, thereby reducing delays in the provision of care. The Scrutiny Panel also provides very clear learning for staff via a robust feedback process.

Review and Recovery Team

- During 2018/19 the new Review and Recovery Team was launched in the north east of Essex, led by a Social Work Consultant in partnership with Peabody Housing, a local charity. The aim of this team is to ensure that high level support is provided to service users in this area when it is deemed appropriate for them to move on. The team is able to work with individuals intensively to ensure that their move from residential care into supported housing or their own tenancy is smooth and successful.

HeadsUp Service

The Trust successfully delivered the launch of the new HeadsUp Service, in partnership with Enable East and funded by the Big Lottery Fund and European Social Fund. HeadsUp works with people across Essex who have common mental health problems, such as anxiety and depression, and who are going through a period of unemployment. More than 90 people have already made the most of the project's free support, advice, practical tips and experiences to help with employability. A team of peer support workers give one-to-one support, while practical interactive workshops help to build skills and confidence. HeadsUp are assisted by a network of Essex-based businesses and organisations who share their guidance and expertise. Where relevant, they also help to secure employment or training for participants enrolled on the programme. HeadsUp has been shortlisted as a finalist in the 'Primary Care Initiative of the Year' category at the national HSJ Value Awards for its work supporting people back into employment.

Performance management of Section 117

- This process covers close monitoring of EPUT's performance in managing Section 117, by contacting all care co-ordinators and clinical managers on a monthly basis to let them know of all S117 reviews required to take place within the next three months as well as reminding them of any that are overdue. The aim of this process is to ensure that the Trust maintains a high performance in this area, thereby ensuring that service users receive a high level of care.

Partnering with Think Ahead

- EPUT has been supporting a second cohort of Think Ahead students. There are four Think Ahead social worker students based in north Essex, supported by two consultant social workers. Working in partnership with the Essex County Council, the Think Ahead students undertake placements in their children and family teams. EPUT also provides training on the national Think Ahead programme on Family Group Conferencing which has proved to be very successful over the last two years. This partnership will continue into its fourth year.

Connecting People

- Connecting People is an evidence-informed social intervention developed and evaluated in a series of studies led by the University of York that is taught on the National Think Ahead training programme for mental health social workers.
- Connecting People is underpinned by social capital theory and the recognition of positive social connections for the enhancement of physical and mental wellbeing. The primary aim of this intervention is to enhance the quality and diversity of service users' social networks. It adopts a logical, eight-step method of non-prescriptive and individualised care to facilitate movement towards improved social networks and social inclusion.
- EPUT have been taking part in a research study based on the psychosis service pathways working with the University of York, in collaboration with the McPin Foundation, University of Central Lancashire and the London School of Economics.
- The work undertaken within this pathway is highlighted by the National Collaborating Centre for Mental Health (NCCMH) as a positive practice example on the 'Positive Practice in Mental Health (PPiMH)' directory website.

Chaplaincy Volunteers

- Chaplaincy volunteers are active in Clacton and Colchester, Basildon and Epping. Recent trained volunteers have commenced visiting in the Derwent centre, Harlow, the first chaplaincy input at the Derwent Centre for almost two years and have been well received. The Linden Centre and Crystal Unit continue to be covered via the current service level agreement.
- Chaplaincy Volunteer training has continued to be provided. The latest course was held in the west at St. Margaret's Hospital, Epping. A waiting list is now being built up for the next training and it is hoped it can be held in south or the east.

Volunteer Chaplains celebrate their graduation

Psychological services

Dementia and Frailty Services (DFS)

- More individualised feedback has been developed with post diagnostic support (PDS), including an innovative PDS day workshop for all newly diagnosed people with dementia and their carers. These provide support and identify those families needing more complex support.
- A specialised group is provided for people with Mild Cognitive Impairment and a complex psychological therapy service for people with complex trauma and personality disturbance as expressed in later life.
- Intervention and supervision is provided to the UCL directed Pathfinder study for psychological therapy for people with cognitive impairment.
- A Tree of Life group exists to assist older people in both areas with complex psychological histories and current issues. In addition there is involvement in the EPUT Equality and Diversity programme with one psychologist seconded into the WRES initiative and one appointed as an equality champion.

Primary Care Interface and Integration

- Integration of Psychology and IAPT providers has been piloted in identified neighbourhoods in line with the development of a primary care facing mental health service. Collaborative care models of service delivery are being reviewed and scoped for local viability. Interventions include ACT and the Trauma Stabilisation Groups. This will enable the most accessible offer of interventions, with assigned governance, for those patients that typically represent the interface between primary and secondary care provision.

Knightswick Psychosis Project

- Having identified a low referral rate to psychological services for patients presenting with needs associated with psychosis, a locality psychologist has invested in developing a pathway to enhance access for this patient group. A scoping of unmet needs identified a need for interventions associated with paranoid delusional belief systems.
- Staff completed specialist training for a psychological programme targeting paranoid delusions. The 'Feeling Safe' programme offers potential for the upskilling of multidisciplinary team (MDT) staff to offer increased coping and resilience skills to patients with psychosis who have historically accessed a predominantly medically driven care plan. With the stabilisation of distress associated with delusions, there can be increased opportunities for the care plan to include social prescribing and goal attainment.

> *I would like to say a big thank you my IAPT counsellor who has been most helpful and supportive, the regular telephone therapy sessions have been a life line for me to talk through a lot of my health issues and difficult family challenges over the last 6 months. I am very appreciative of the support and guidance, I still have a few hurdles to get over, however, I do feel a lot more confident than I did six months ago.*

Secure Services

- An Understanding Risk Group has been implemented at Fuji (female medium secure ward) and Wood Lea Clinic (male LD low secure ward). This involved providing patients with psychoeducation around their risk and the risk factors associated with them reoffending. This supports patients to develop insight into their own offending behaviour, as well as empowering them to take greater responsibility of managing the risk they may present to others.
- Following the identification of the most effective interventions available for patients who have offended, psychologists have now attended Life Minus Violence (LMV) training. There is now an LMV programme underway at Brockfield House with patients attending two-hour group sessions three times a week.
- Psychologists within the team have attended training for the Fire-setters Intervention Programme for Mentally Disordered Offenders (FIP-MO). The FIP-MO programme has been run as two groups at Brockfield House (male and female groups) as well as in an individual format at Robin Pinto Unit. The group has found good outcomes so far as evidenced by pre- and post- standardised outcome measures.
- An Understanding Social Difficulties Group was implemented at Wood Lea Clinic to assist patients in understanding a diagnosis of autism and in supporting them to develop social skills.
- In response to the rehabilitation needs and difficulties reintegrating into the local community following lengthy hospital admissions, a Moving On group was designed and facilitated by psychology and OT on Forest Ward (male medium secure rehabilitation ward).
- Mindfulness Groups have been facilitated on wards for both patients and staff. This has been a means of staff learning techniques for their own wellbeing, as well as being able to use the techniques with patients. It has provided opportunities to model to patients the normality of anybody using mindfulness. This initiative has been launched on Robin Pinto Unit (male low secure ward) and Alpine and Lagoon (male medium secure wards).
- Mindfulness Based Cognitive Behavioural Therapy (MBCBT) has been implemented as a group on the male medium secure wards. This has been adapted to make it suitable for patients with severe and enduring mental health problems and is being facilitated jointly by psychology and OT.
- Rather than viewing DBT as an intervention to only be delivered to females with a diagnosis of EUPD, the wider implementations of the model were considered, including the use of DBT Skills Training to prisoners and young offenders. A DBT Skills Group was trialled with male low secure patients at Robin Pinto Unit. This new initiative had good outcomes in terms of reductions in anger, aggression and impulsivity.

The programme has also been adapted to enable patients to be referred to specific modules for skills training (taking two months each) instead of the full two-year programme, thereby enabling a wider pool of patients to access interventions most appropriate for their needs.

Sally Morris congratulates the Recovery College graduates

> *With love and thanks for your continued support and care for him.* ***Robin Pinto***

In-Patient Wards

- Assistant psychologists are now working under qualified supervision to provide activities, interventions and to improve observations after hours and on weekends.
- The pilot initiative planned to be established as a standard service offer, and should Clinical Associate Psychology apprenticeships become available, these will be considered suitable for evolving into apprenticeship training schemes to establish this as an ongoing offer. All groups have received extremely positive feedback from patients, with many ward staff also having commented on the positive impact their presence is having on the wards. In addition to this, the assistant psychologists also provided 'Visible and Available Psychology Times' (V&A) on the wards whereby patients or staff can seek informal psychological advice and support.
- Clinical Psychologists won a Quality Award for the innovative training they offered to Security Staff working on each Adult Inpatient Psychiatric Ward, on working with people with mental health problems.

Personality Disorder and Complex Needs (PD) developments

- A unique integrated and needs-led intervention service for people with Complex Needs (usually Personality Disorder, but also co-morbid conditions and trauma) has been piloted in South Essex as part of our Trust Service Transformation agenda.
- The PD lead for south east Essex has developed a project in conjunction with the CQUIN being led by the mental health liaison team. The project targets frequent attenders to A&E at Southend Hospital. High attenders are often identified as having a PD diagnosis and being care co-ordinated by a local RWT. The lead has worked up detailed case studies for this cohort, working with care co-ordinators to develop a psychological formulation that can offer insights into crisis profiles and the most appropriate whole system response across team provisions. In addition, they have delivered a focused skills training to identify care co-ordinators focusing on emotion regulation and distress tolerance.
- An Expert by Experience session was held to share the vision of the PD pathway developments, recruit opinions and engage consultation.
- An integrated Systems Training for Emotional Predictability and Problem Solving (STEPPS) initiative in south Essex has provided delivery as a partnership between IAPT providers and secondary care specialist mental health provision. This development will enhance access to psychological intervention for patients with a personality disorder, with the aim of reducing crisis presentations, reducing admissions and increasing recovery based goals and functioning.

GAS Goals outcome measure pilot

- In addition to standard outcome measures for specific symptoms and diagnoses, psychological services teams have piloted the use of Goal Attainment Scaling as an Outcome Measure. The GAS (Kirusek & Sherman, 1968) is a Clinician-Rated Outcome Measure (CROM), which measures the extent to which a patient's individual goals are achieved throughout the phase of an intervention.
- Psychological assessments inform a formulation of the presenting problem based on a clinical model framework. An intervention plan is then matched to patient needs, and personalised targets for intervention are set as goals. At the end of treatment, the extent of goal attainment is measured and used to provide feedback to the patient, to measure clinician progress and CPD needs, and to aggregate team outcome statistics. It assists in development and modification of intervention pathways and can be a behavioural and practical adjunct to quantitative clinical measures.
- Following a pilot, our commissioners have agreed to incorporate GAS into the care plan for every mental health service user, so outcomes will be established for every treatment episode. Service-specific outcomes (both qualitative, such as service user feedback sheets and quantitative, such as Patient-Rated measures), can easily be incorporated within the GAS framework. This way, services can still use any specific or specialist assessment and outcomes tools in conjunction with Goal Attainment Scaling, but the overall outcomes will be standardised using T-scores, and therefore be comparable from one service to another.

Specialist Psychotherapy Services

- Structured, time-limited group interventions have been introduced to reach more service users, including mentalisation-based and dialectic behavioural interventions over 18 months.
- Via joint assessment and discussion in the 'high intensity users' meeting, clients are identified as appropriate for more frequent psychodynamic psychotherapy. The increase in sessions is being monitored for value to the client and for the reduction on demands on other areas of the service. There is already some reduction in demands on the 'duty service' and care coordinators time.
- Psychotherapists provide training to multidisciplinary team staff, including 'Understanding our Patients' Behaviour' as well as topics such as: suicide, attachment, containment and trauma.
- A music therapist has introduced a 'Music Mirrors' project to enable memory links to embedded musical themes in patients with Dementia, amongst other innovative interventions on in-patient wards.

Team and staff support

- Team formulation forums provided by psychological services staff continue to be delivered across all MDT's. These include reflective practice sessions, case discussions and care plan development and identified training/teaching.

Staff support initiative following serious incidents or personal distress

Exposure to serious incidents (SIs) occurs for staff working in mental health services. Such experiences include the death of patients, serious patient injury, assaults on staff and patients causing harm to others. Any of these events can result in staff feeling overwhelmed by their emotional responses, which in turn can compromise resilience and performance and influence sickness absence.

- The Trust's psychological services developed a formal response plan for Psychological Services to take a lead in providing support to Trust employees affected by serious incidents. This is part of a strategic business plan targeting wellbeing and sustainability in conjunction with the NHS safety improvement and quality regime. A corresponding strategy is offered for consideration, embedded within the EPUT value system of being compassionate, empowering, and open. The proposal aligns to the EPUT investing in a safety culture that views openness as essential to better care, for both patients and staff.
- The identification and recruitment of psychological services designated clinicians who can step up in staff support roles, can provide governance and professional oversight to a robust workforce support strategy, is proposed. This clearly delineates staff support from investigatory processes and any HR procedures, promoting the propensity for openness and accessing assistance in a safe 'no blame' context. It hopes to be proactive in being workforce facing, to ensure team managers are also supported and enabled to respond to the support needs of their workforce in response to SI's.

ACT4NHS (Acceptance and Commitment Training) Staff Training

- EPUT has piloted Acceptance and Commitment Therapy-based training for staff, entitled ACT4NHS. The training aims to help staff identify and understand why they undertake certain tasks / functions during the process of their work, rather than just undertaking them in a task-orientated manner. It seeks to develop a level of psychological flexibility that enables staff to adapt to change, and manage the challenges of their daily work. By assisting staff to clarify their own individual life values, and measure the congruence of these against our organisational values, the aim is to enhance motivation and resilience, resulting in the provision of high quality care.

- ACT aims to:
  - highlight the ineffectiveness and costs of avoiding experiences that are difficult or unpleasant;
  - break down the literal content of thoughts and enable direct contact with difficult psychological content;
  - identify a sense of self that is distinct from and therefore not threatened by, psychological content;
  - promote contact with experiences in the here and now (thereby enhancing resilience and tolerance);
  - help clarify values which help to guide choices and emphasise what is important, and help distinguish them from goals and actions;
  - commit to actions that are linked to chosen values.

Allied Health Professions Mental Health

Closing the gap initiative

- This is an Allied Health Professions led initiative on managing the potential physical health risk to individuals on anti-psychotic medication and in particular in developing Type II diabetes by the engagement in a healthy lifestyle programme which incorporates education, exercise and meaningful activity & healthy eating. Initially developed on Cedar ward, this has been rolled out to other adult inpatient wards across Colchester, Chelmsford, Harlow and Basildon. The next phase is to introduce the initiative to community teams to sustain the progress made by service users once they are discharged from hospital and to support engagement with community resources.

Mindfulness

- Working in partnership with a range of professions and clinical groups, Trust leads have developed a broad range of mindfulness sessions and groups for both service users and staff. Staff sessions focusing of developing staff resilience also include brief sessions scheduled at lunch time which has proven popular with staff.

DBT

- Occupational therapists across adult community mental health teams in south Essex in partnership with psychological services have developed and facilitated a range of DBT focused skills training sessions to patients living in the geographic area. A systematic programme of training is being rolled out to ensure that occupational therapy staff across wider Essex and in particular, Colchester, Chelmsford and Harlow will also be delivering the same programmes to ensure parity.

Occupational Therapy Rotation for newly qualified staff

- Occupational therapy in mental health and learning disabilities has developed a robust and well-established rotational scheme of newly qualified Band 5 occupational therapists. The partnership includes Essex Partnership University NHS Foundation Trust (EPUT), Southend University Hospital NHS Foundation Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust and North East London NHS Foundation Trust to ensure that this includes acute care and specialities such as paediatrics. The scheme has been expanded to include Community health Services in EPUT, Essex County Council and acute hospitals in Colchester and Harlow.

Trust Occupational Therapists mark national OT Week

3.1.2 Community Health Services

West Essex Community Health Services

Integrated working with Essex County Council Adult Social Care

- West Essex Community Health Services are unique in terms of the operational leadership. The Director of Health and Care is responsible for both EPUT community services and Essex County Council Adult Social Care. The integrated leadership team work collaboratively to reduce hand offs and bureaucracy that delays and impacts on a patient's/carer's journey through the complex health and care system. It does this by:
  - supporting care home and domiciliary care providers to ensure that adults are able to remain in their own home environment wherever possible;
  - increasing understanding of both health and social care roles at the front line;
  - joint working across the collective occupational therapy workforce to avoid duplication;
  - collaborative joint decision-making to deliver person centred care, engaging with patients, family and carers to ensure the needs of the patents are achieved;
  - joint health and social care transfer of care planning for patients and carers from acute to community and home by reducing duplication of assessment;
  - reducing risk averse practice which increases length of stay by supporting effective safe discharge;
  - supporting difficult conversations with patients, family and carers regarding ongoing care and support.

Integration of Community Health and Specialist Dementia Frailty Services

- In 2018 the Harlow Specialist Dementia Frailty Team co-located with the Harlow Community Integrated Team based at Latton Bush. This first step with co-location has already supported improved communication and collaboration between clinicians which is a key enabler to support parity of esteem between physical and mental health needs for our patients.

Ongoing development of the Integrated Single Point of Access (SPA)

- Introduction of new telephone technology providing call waiting information for callers and recording of calls for audit and training purposes.
- Access to the EPUT contact centre for community nurses up to 23.00 hours 365 days per year and patients, and other health care professionals up to 24 hours.
- Therapists based in SPA to support effective triage of all therapy referrals, improving patient access to therapy support and preventing duplication.

Specialist Community Cardiac Team

- The team has expanded the heart failure service to include the provision of a dedicated Heart Failure Rehabilitation Exercise Programme. The aim of the programme is to empower patients with heart failure to self-manage their long term condition. The programme includes support to engage with physical exercise, management of medications, advice and guidance on diet and the impact of heart failure on everyday life.

The Trust marks Alzheimers Cupcake Day to raise awareness

Specialist Community Respiratory Team

Respiratory Clinician of the Day

- A clinician who will assess and review on the day referrals to the team, providing responsive and effective support to patients with respiratory conditions who are at high risk of an A&E attendance and/ or unplanned admission.

Respiratory Multidisciplinary (MDT) Team Co-ordinator

- MDT's have been established to support all patients discharged to ensure an appropriate care plan is developed with the patient to support self-management of their condition and prevent A&E and unplanned hospital admissions.
- The MDT Co-ordinator role requires effective system working across patient pathway with all respiratory clinicians, the patient and GP.
- Feedback from system partners and patients is very positive with other clinical pathways are considering a similar role.

> *I can honestly say the care and patient experience that was offered is beyond anything I have ever seen. All of the staff on the ward were fantastic and never once was anything too much trouble for them. There is no way I can repay the team except by saying thank you, thank you and thank you! They are an absolute credit to EPUT and the NHS!* ***Beech Ward, St Margaret's Hospital***

Empowering patients through technology

- My COPD App supports patients with Chronic Obstructive Pulmonary Disease with self-management of their condition.

West Essex Community Pain Service

- Provided by a multidisciplinary team (MDT) of professionals including specialist nurses, a psychologist, specialist physiotherapists, pharmacists and a pain consultant.
- Emphasis of the service is patient empowerment by supporting patients to gain the necessary skills to self-manage chronic pain.
- Provision of evidence based education and therapy sessions to support patients with shared decision making, development of personal goals.
- Supporting patients to understand the complexities of opioid medications. The service will support all patients who choose to reduce or discontinue their medications.

Harlow Integrated Community Team – development of a catheter clinic

The community nurses recognised the poor patient experience from current service provision and worked to:

- develop a community based clinic with appointment times for working age adults and non-housebound patients with in-dwelling catheters;
- provide a monthly service within an appropriate community clinic environment;
- improve the patient experience, effectiveness and efficiency of the service;
- extend the model of care across West Essex during 2019-20.

The service has to date received positive feedback from patients.

South East Essex Community Health Services

FNP (Family Nurse Partnership)

- The FNP team has continued to embed the use of the New Mums Star tool in personalising client care. The implementation of the Neglect clinical adaptation will enhance the work of the FNP team allowing testing and learning from new approaches. Both new and existing learning will be shared in knowledge and skills training with children's services partners. The team is committed to embedding team learning into their team meetings with a planned schedule for the year.

Speech and Language Therapy (SLT) – Paediatrics

- The continued rollout of the ABS delivery of a suite of programmes has been well received and extended the reach of the service in the target population. There is a positive impact on referral rates into the main service as a result of the preventative work undertaken by the ABS team.
- The use of Boardmaker Online (a subscription service) allows staff to upload general therapy resources via the account held for SLT on the Boardmaker Online website. Schools and parents can access the account with a unique username and password and print off as often as they like. This results in a saving on stationery and postage costs and can immediately make available items requested electronically. This is being extended into interactive activities which enables access when logging in via an iPad to target speech and language development over the coming year. The service will then be able to overview the amount of time these are accessed outside of direct therapy sessions to ensure that therapy targets are actually being practiced.

Palliative Care Service

- The Palliative Care Service supports patients and their relatives through the last year of life and provides care and support in the last days of life. The service maintains a Palliative Care Support Register, which is acknowledged as national best practice. The services also has a training arm to train front line staff (including those in care homes) to have confidence and better support patients in their last year of life. Additional developments have included new patient leaflets, undertaking carer surveys, an end of life competency framework and issuing a 'Red Folder' to all new patients with patient held information including advanced care plans.

> *Lovely to meet both of you yesterday, we really enjoyed it, very positive! Thank you so much for the idea sheets and activities, these are going to be very helpful.* ***SLT Paediatrics***

The Care Coordination Service

- In the last year the team has refined care plans which are now more personalised and goal based highlighting any areas which require support, showing the appropriate referrals that are made and states identified goals the patient wishes to achieve.
- The team have redesigned the way referrals are allocated, saving administration time. Internal referrals are now up and running, making the way in which SystmOne users refer easier and quicker.
- The care coordination team as a whole has unified paperwork and aligned working strategies/practices to provide the same quality service to the patient no matter the postcode.

The Castle Point and Rochford Team have two occupational therapists who are assessing and supporting frail patients who are frequent fallers.

South East Essex Care Coordination Service (Southend Team)

- The service works proactively with GPs within Southend to find patients who are vulnerable and at risk of decline and put in health and social care intervention before they hit crisis point.
- The service continues to maintain a strength base approach in developing an appropriate care package in a co-productive way. The team had expanded with 3.5 WTE Senior Health Care Assistants to support the service needs and ensure patients have continued support.

> *We lost both my husband's parents this year and the Palliative Care Team were involved on both occasions. My father-in-law died first and had quite a lot of involvement with your team member, who was excellent. My brother-in-law found it invaluable to have his help. Despite being out of area by the time my mother-in-law was also in need of palliative care. He stepped in to help. Once he became involved in her care, the contrast was incredible, thanks to him and all the team.*

Integrated Community Nursing Team

- Health Care Assistants (Band 3) were upskilled, trained and upgraded to deliver care to a Band 4 competency level. This has made our existing staff feel valued; feel supported into a nursing career pathway and helped the service respond better to the increasing district nursing demand.
- Quarterly staff development workshops saw over 150 staff from a variety of professional backgrounds participate in shared learning forums. Staff feedback from these workshops has been overwhelmingly positive, evidencing new learning and increased networking.
- A Practice Development Nurse position has supported district nurses in their day to day practice. The role supports newly qualified nurses to gain confidence working autonomously in the community and delivers tailored training to refresh or develop new nursing competencies.

The Leg Ulcer Service

- The Leg Ulcer Service provides holistic assessment and treatment for mobile patients with leg ulceration in clinic locations across the locality. Care is tailored to meet the individual's needs encouraging patient empowerment and involvement in their care to achieve desired outcomes.
- Assessment and on-going management is also provided through a 'well leg' monitoring service to help reduce risks of ulcer recurrence. All the nurses have extended knowledge and skills within the leg ulcer field.
- The Leg Ulcer Team continues to provide care at Southend Leg Club. This is a 'drop-in' centre held weekly with the support of volunteers to provide community-based treatment, health promotion, education and on-going care for people who are experiencing leg-related problems. Leg Club is held within a social setting to help foster peer support and tackle social isolation often linked to chronic health problems. Within the last year Southend Leg Club volunteers were recognised with an award from The Lindsay Leg Club Foundation for their continued work with Leg Club.

Workforce Development and Training – Quality Improvements 2018/19

Many of our quality improvements are concentrated on attracting a new workforce and creating development pathways for the existing staff.

Working with Schools and Colleges

- The Workforce Development and Training Department has been working closely with schools, colleges and Sustainability Transformation Partnerships (STPs) to increase engagement with school and college students. We are actively developing our talent pipeline by obtaining student details and offering work experience placements across the Trust and with our STP partners.

Further Development of Apprenticeship Programmes

- As part of the plan to develop our workforce, we have obtained Employer Provider Status enabling us to deliver health and care apprenticeships in-house. Whilst there are still many improvements to be made, we are very encouraged by the fact that the first learner to complete the programme and the End Point Assessment completed with a Merit. We feel that this demonstrates the quality of the training provided.

Application for approval to deliver as an Apprenticeship L4 L5 Higher National Diploma in Healthcare Practice England (Integrated Health and Social Care)

- This will enable in-house progression beyond the Level 3 programme mentioned above. This approval will enable us to deliver both L4 and L5 under Pearson's specifications in line with the Apprenticeship Standard for an Assistant Practitioner level 5. This will ensure high quality, consistent learning within the Trust, providing students with a clear line of development within the Trust and onward progression to a degree at Level 6. The delivery of the L4/5 course supports the Trust's 'grow your own' ethos and the recruitment and retention plan and is an exciting 'next step' for the Trust apprenticeship programme.

Development of Preceptorship Web media platform and Action Learning Sets

- As part of the Local Workforce Action Board, the Maximising Supply Group have been identifying ways in which to support, engage and reduce attrition in our newly qualified staff that are within their preceptorship year. As part of this we have the exciting development of a web-based media platform which is being created to allow for newly qualified practitioners across all areas to be able to access short experiential work placements in areas other than their own across the STP. This project has also identified the need for Action Learning Sets for the preceptees. The facilitators for which are currently being trained and venues identified. Action learning sets will also be supported with large scale seminar days on topics such as Quality Improvement and Leadership.

Improvements to Induction

- The aim of Corporate Induction is to introduce new starters to the Trust, providing information about its culture, values, policies, and essential information needed in daily work life. The impact of the information received is most effective if received in a timely manner, following starting with the Trust. The Induction and Mandatory Training Policy states that staff should attend Induction within two weeks of joining the Trust. In order to improve the relevance and usefulness of the content, and achieve the two week target, the training team have revised the programme so:
  - attendees are awarded seven competencies, which alleviate the need to complete e-learning for those subjects;
  - new starters are compulsorily booked on induction, and all mandatory training programmes;
  - the acquisition of the Linden Centre has enabled two Corporate Inductions per month, and further revision of programme will take place to improve the content.

I have just done my TASI training. I am very impressed by the manner and way this training was provided. These gentlemen have been absolutely amazing, funny, professional and the wealth of experience they provided is beyond valuable. I have been with the Trust for a while and have often dreaded this five day course but they made every minute and second of it worthwhile for me and I know I cannot speak for others but they made sure that everyone gave all they could and I could feel this every single day of the training. They managed to make me see and evaluate my practice in a totally different way and as a registered professional not only have they provided me with the techniques to use but also a totally different way of thinking and engaging with my colleagues, patients and other staff.

Their conduct, passion, effort and professionalism should be a recognised standard of practice and it would be a travesty if this isn't recognised.

Student Conference 2019

3.2 Overview of the quality of care offered in 2018/19 against selected indicators

As well as progress with implementing the quality priorities identified in our Quality Report last year, the Trust is required to provide an overview of the quality of care provided during 2018/19 based on performance against selected quality indicators. The Trust has selected the following indicators because they have been regularly monitored by the organisation. There is some degree of consistency of implementation across our range of services. They cover a range of different services and there is a balance between good and under-performance.

Patient Experience

3.2.1 Complaints

Data source: Datix
National Definition applied: only to K041-A submissions to the Department of Health

Complaints referred to the Parliamentary & Health Service Ombudsman

During 2018/19 a total of nine complaints were referred to the Parliamentary & Health Service Ombudsman (PHSO). Of these nine referrals, the PHSO decided not to investigate in four cases. The remaining five referrals are ongoing. During this year two cases, one received in 2016 and one in 2017 were concluded. The first was partially upheld, the Trust and Council were asked to review their procedures for carers' assessments and each organisation was asked to pay £750 for the impact the failings had had on the complainant. The complainant disagreed with the amount and was given a deadline by the PHSO to accept payment. This was not met and no payment was made. The second referral was upheld and the Trust was asked to pay £3,520 for avoidable distress and part payment of legal fees. There were several recommendations made to the Trust, an action plan has been completed and implemented to address these.

Complaints closed within timescales

The 'Percentage of Complaints Resolved within agreed timescales' indicator is a measure of how well the complaints-handling process is operating. The agreement of a timescale for the resolution of a complaint is identified in the NHS Complaints Regulations, but these do not stipulate a % target to be achieved. The Trust believes that commitments to complainants should be adhered to and aims for 100% resolution of all complaints within the agreed timescale with the complainant. This year the Trust has achieved 88.10% for complaints closed within agreed timescale.

Non-Executive Director Reviews

An important part of the complaints process is the independent reviews of closed complaints by the Non-Executive Directors (NEDs). The complaints are selected at random each month. The reviewer will take into consideration the content and presentation of the response, whether they feel the Trust has done all it can to resolve the complaint and if they think anything else could have been done to achieve an appropriate outcome. During 2018/19, the NEDs reviewed 54 complaint responses. The majority received a good or very good rating for how the investigation was handled and the quality of the response.

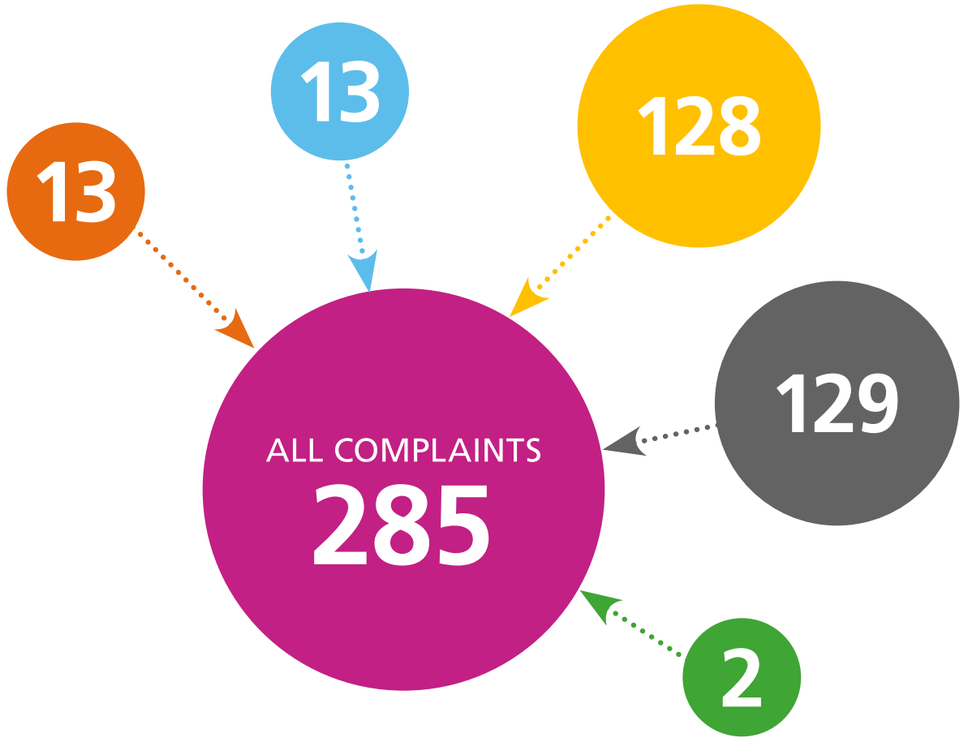
Patient Experience

Number of formal complaints received:

Performance Indicator	2018/19
Number of formal complaints received	**285**
Comprising:	
Total received Mental Health Services	259
Total received Community Health Services	26
Number of complaints withdrawn	**12**

*Please note: The figures stated in this section of the report (and those reported in the Trust's Annual Complaints Report) do not correspond with the figures submitted by the Trust to the Health and Social Care Information Centre on our national return (K041A). This is because the Trust's internal reporting (and thus the Quality Report and Annual Complaints Report) is based on the complaints **closed** within the period whereas the figures reported to the Health and Social Care Information Centre for national reporting purposes have to be based on the complaints **received** within the period*

Complaints Received by Locality



KEY:	
	EPUT TOTAL
	West Essex Community Health
	South East Essex Community Health
	South Essex Mental Health
	North Essex Mental Health
	Bedfordshire and Luton Forensic Mental Health

Patient Experience

Number of active complaints at year-end:

At year end, the number of active complaints was 55. All active complaints are on target to be responded to within their agreed timescale..

Number of complaints upheld / partially upheld:

A total of 300 complaints were closed during the year.

Performance Indicator	2018/19
Number of complaints upheld	24
Number of complaints partially upheld	201
Number of complaints not upheld	61
Totals	**286**

A total of 12 complaints were subsequently withdrawn by the complainant, one was not investigated due to consent being withheld and one was handled under Trust policy.

Patient Advice and Liaison Service queries and locally resolved concerns:

In addition, the Trust received a total of 956 Patient Advice and Liaison Service queries and 347 locally resolved concerns in 2018/19.

Nature of complaints received:

The top three themes for complaints for both mental health and community during 2018/2019 were dissatisfaction with treatment, staff attitude and communication. The top three themes for the Trust also apply nationally across the spectrum of health services. The table below shows the outcomes of the closed complaints for each of these three themes:

Top Three Complaint Themes 2018/19	Total Number of Complaints Received	Upheld	Partially Upheld	Total Upheld or Partially Upheld
Unhappy with treatment	42	2	28	30
Staff Attitude	53	6	34	40
Communication	39	5	29	34

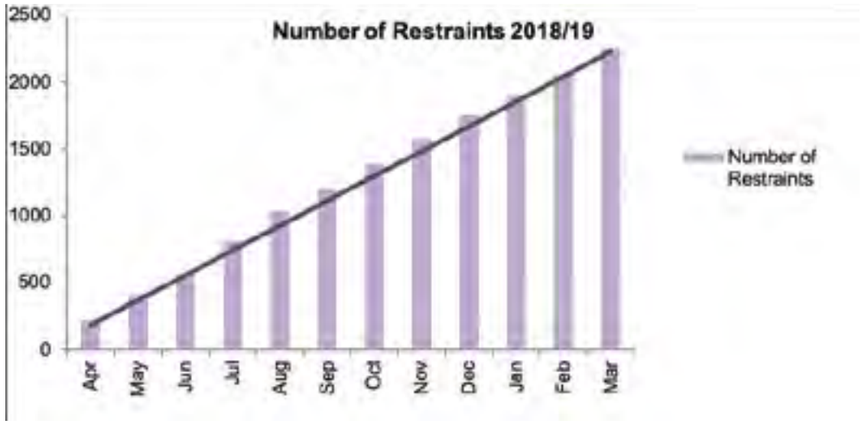
The category ‘unhappy with treatment’ covers a wide spectrum. In some cases, complainants had certain expectations; however, this was contrary to their clinical need. The Trust was, therefore, limited in providing solutions to these complaints.

3.2.2 Restraints

Restraints

EPUT monitors the use of restraints by inpatient ward on a monthly basis, including the reason for restraint and the type of restraint. The main reasons for restraint are self-harm, physical assault and anti-social behaviour. The most common types of restraint are patient standing and in a supine position. The use of prone position restraints are monitored in greater detail.

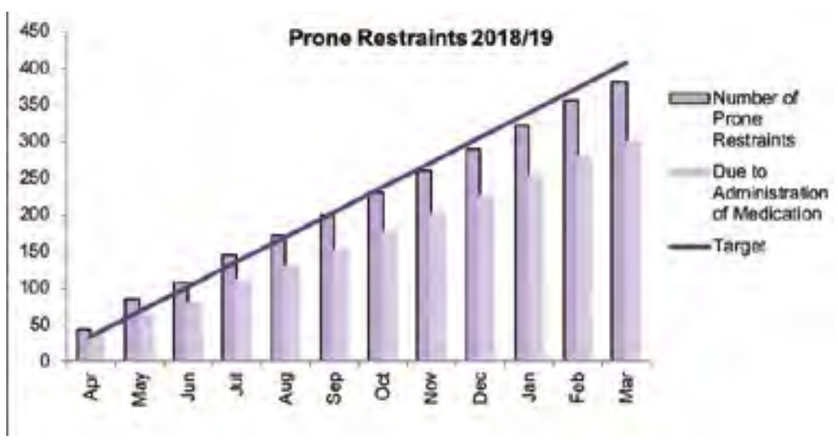
The total number of restraints in 2018/19 was 2251 this is a small increase compared to 2017/18 (2225). EPUT is also pleased to report that the rate of restraints per bed is lower than the national average but we did not achieve our internal stretch target of a 10% reduction.



Prone Restraints

The graph below shows the number of prone restraints undertaken by month and demonstrates that the majority of prone restraints take place to facilitate the administration of intra-muscular medication.

A reduction in the number of prone restraints is part of the Trust's Quality Priorities and is described in more detail in section 2.2.



3.2.3 Patient Environment

The Patient Led Assessment of the Care Environment (PLACE) Teams carried out assessments on the patient environment on 21sites from February – June 2018. No external validators accompanied the teams this year.

The Trust Board of Directors has ultimate responsibility for ensuring health services are provided within clean, safe and fit for purpose environments appropriate for health care.

EPUT achieved above the national average in four out of six categories. For Cleanliness we were +1.09%; for Facilities 1.46%; Dementia 0.12% and Disability 1.63%.

Although there are some areas of improvement and investment identified, overall the results must be considered as an improvement on the previous year.

	EPUT	England average (MH and LD trusts)	England average (All MH trusts)
Cleanliness	99.73%	98.64%	98.59%
Privacy, dignity and well being	89.18%	90.42%	90.08%
Food	90.03%	91.04%	91.29%
Facilities	96.70%	95.24%	95.26%
Dementia	87.46%	87.34%	87.20%
Disability	90.42%	88.49%	88.31%

3.2.4 Safer Staffing

The Trust monitors the actual levels of staffing compared to the established levels on a shift by shift basis across all its inpatient wards. The Trust has been above target all year. Twice daily sit rep calls are undertaken with all wards to review current staffing levels and risks.

3.2.5 Serious Incidents

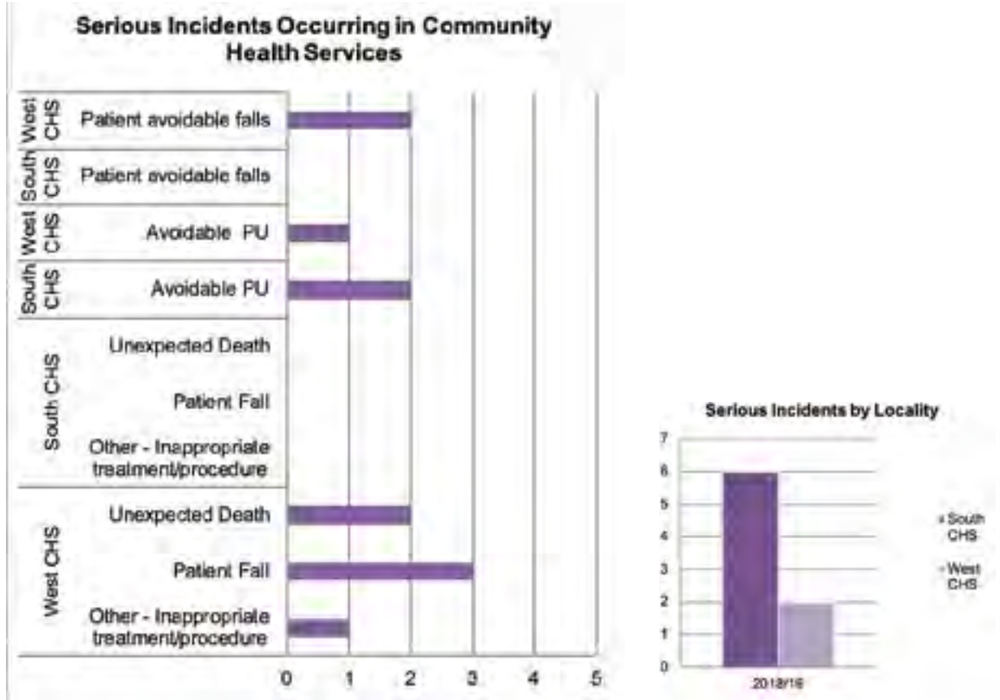
Data source: Datix
National Definition applied: EoE and Midland's definition applied

Monitoring of the number and nature of serious incidents, identification of learning and embedding learning back into clinical practice, is a key part of the Trust's patient safety systems.

The Trust reported six serious incidents in Community Health Services in 2018/19 compared to three during 2017/18 (excluding pressure ulcers).

Three of these incidents were falls leading to fractures. This is a slight increase compared to two last year. One of these incidents resulted in serious harm requiring surgical intervention. This is an increase compared to zero last year. Two of these incidents were unexpected deaths. This is an increase compared to one last year.

There were three avoidable pressure ulcers reported in 2018/19 and two avoidable patient falls.



Patient Safety

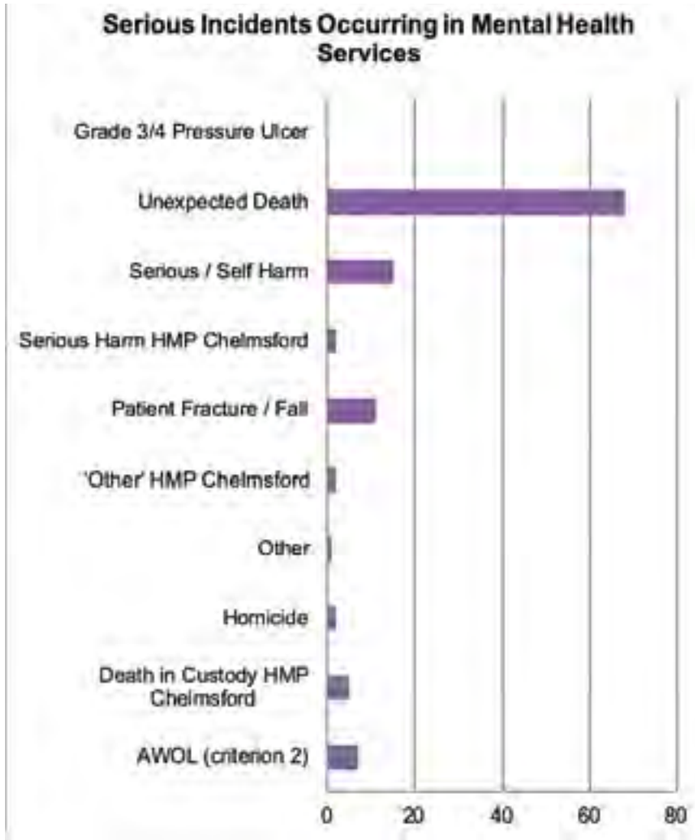
3.2.6 Serious Incidents

Data source: Datix
National Definition applied: EoE and Midland's definition applied

Monitoring of the number and nature of serious incidents, identification of learning and embedding learning back into clinical practice, is a key part of the Trust's patient safety. The Trust reported 113 serious incidents (SIs) in Mental Health Services in 2018/19 this is comparable to 112 reported in 2017/18.

The most common type of serious incident is an unexpected death. The Trust has unexpected death as a key priority for 2019/20. A commitment to suicide prevention training, implementing the Trust's suicide prevention strategy and learning from deaths are key to improvement. In addition to this, the Trust is strengthening their approach to family and care involvement and coproduction. Further details of suicide reduction can be found in the Quality Priorities section of this report.

The graph below shows that serious / self-harm and patient falls/fractures (occur mainly on older adult inpatient wards) are the two other most common form of serious incident.



Clinical Effectiveness

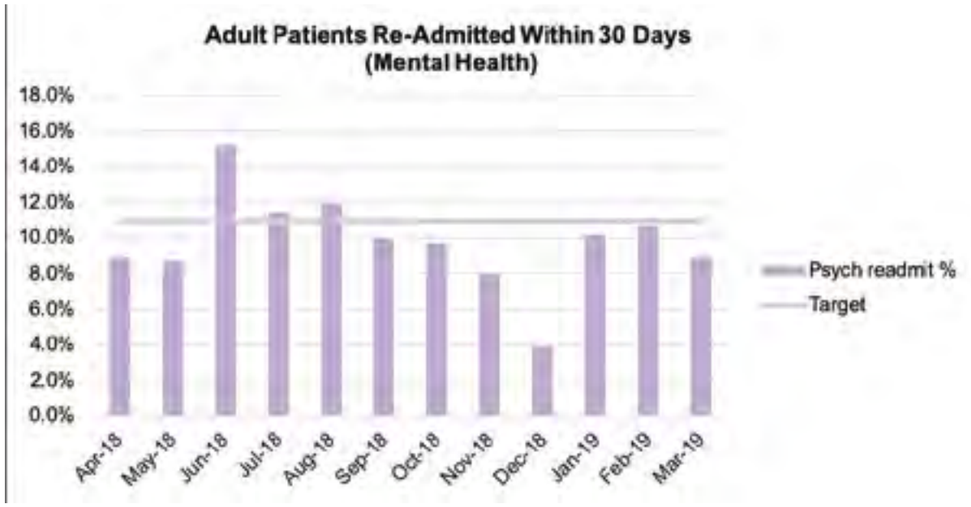
3.2.7 Readmissions

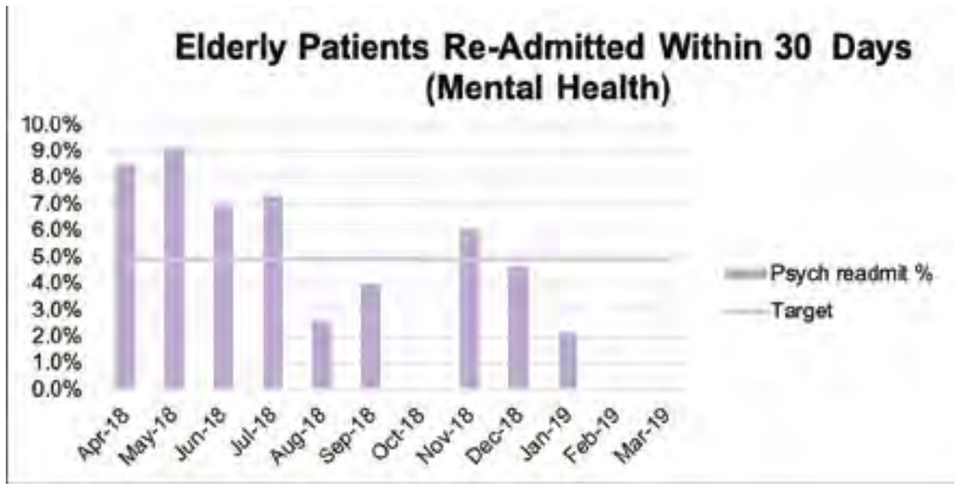
Data source: EPUT systems (IPM and Paris)
National Definition applied: Yes

The target % of Adults re-admitted within 30 days has been achieved for most months of the year with a slight spike in June 2018.

The target % of older people re-admitted within 30 days has not been achieved consistently during the course of 2018/19. Considerable improvement has been made since August 2018 ending the year with no re-admissions for February or March 2019.

In the graphs below, good performance is illustrated by levels of activity below the target line.

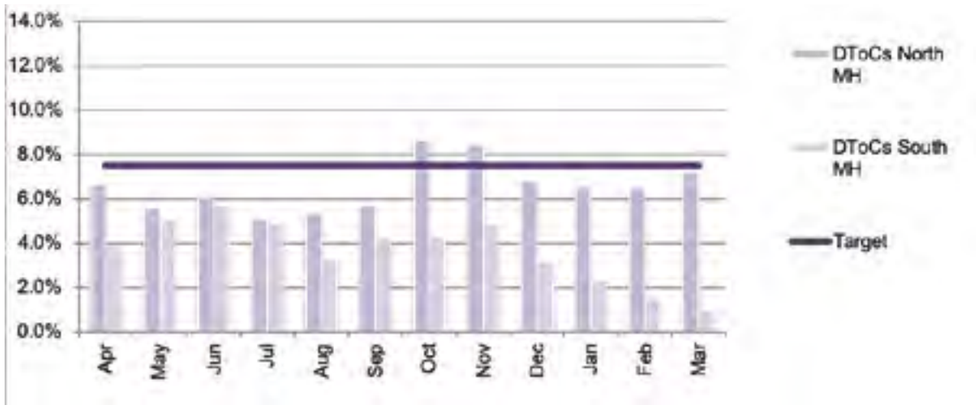




3.2.8 Delayed transfers of care

Data source: EPUT systems (IPM and Paris)
National Definition applied: Yes

Overall EPUT have been below benchmark across 2018/19. North MH Services were slightly above target in October and November.



Sheila Salmon and Sally Morris join the team for the official opening of the new Peter Bruff Mental Health Assessment Unit

3.3 Performance against key national priorities

In this section we have provided an overview of performance in 2018/19 against key national targets relevant to EPUT's services contained in NHS Improvement's (NHSI) Single Oversight Framework in accordance with the national guidance issued by NHSI for Quality Reports. Data for two indicators, 'Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay' and 'Admissions to acute wards gate kept by Crisis Resolution Home Treatment Team', have been reported in the mandatory indicator section (2.7) of this report.

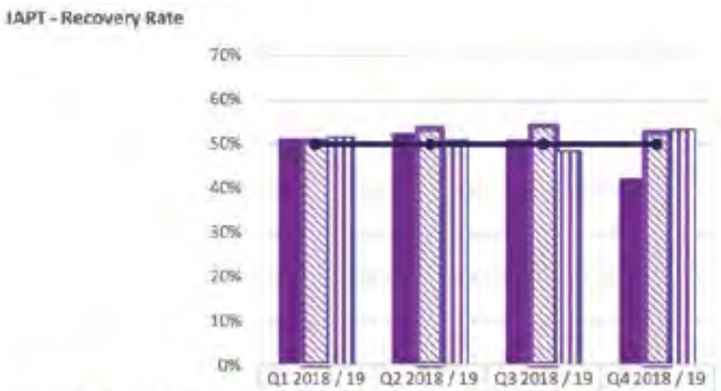
3.3.1 Out of Area Placements

This indicator was introduced in the November 2017 update to NHS Improvement's Single Oversight Framework. The indicator measures the number of days that patients have spent in in-patient facilities out of area. This has been proactively addressed in 2018/19, and there has been a significant reduction seen compared to 2017/18.

	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
EPUT	882.00	771.00	316.00	358.00
Target	1105.00	1105.00	1105.00	1105.00

3.3.2 Improving Access to Psychological Therapy Services – Recovery Rates

This indicator measures the percentage of patients discharged from IAPT services who have moved to recovery. The NHSI compliance threshold is 50%. IAPT services are commissioned from EPUT by three CCG's. Basildon and Brentwood fell below target in Q4. Q4 figures are local / provisional and will be updated with nationally published data when available.



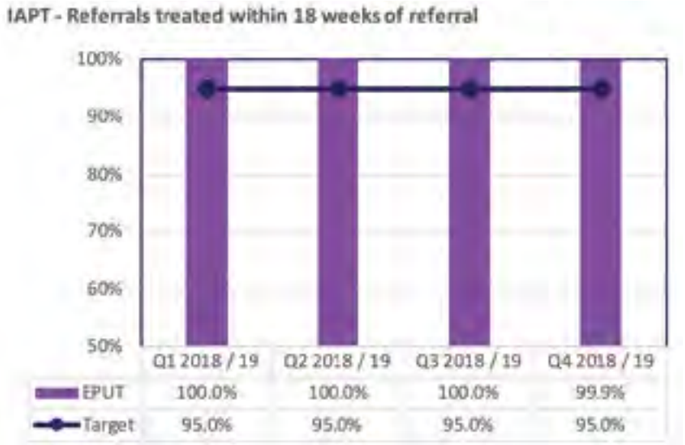
	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
Basildon & Brentwood	51.2%	52.5%	51.1%	42.3%
Castle Point & Rochford	50.5%	53.4%	54.3%	52.7%
Southend on Sea	51.5%	50.9%	48.4%	53.3%
Target	50.0%	50.0%	50.0%	50.0%

This indicator measures the percentage of referrals to IAPT services whose treatment commences within:

a) six weeks

b) 18 weeks

Compliance with both of these targets has been consistently achieved throughout 2018/19

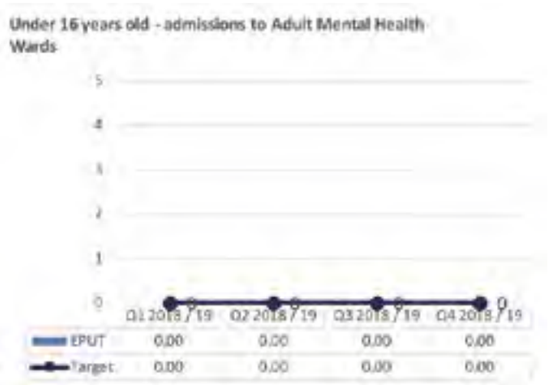


3.3.3 Early Intervention in Psychosis: Referrals treated within two weeks

This indicator measures the percentage of referrals for people with a first episode of psychosis treated within two weeks. Compliance with this target has been achieved consistently in 2018/19.

3.3.4 U16 Admissions to Adult Wards

This indicator measures the number of admissions of patients aged less than 16 years old to Adult Mental Health Wards. EPUT is pleased to report that no patients under 16 years old have been admitted to any of its Adult Wards



3.3.5 Cardio Metabolic Assessments

These indicators measure the percentage of adults with psychosis who have had a cardio-metabolic assessment, within three different settings

a) Inpatient wards

b) Early Intervention in Psychosis Service

c) Community services

The Service Improvement Team is currently working with relevant internal and external stakeholders to ensure that EPUT is working towards achieving the target levels of performance.

Cardio-Metabolic Assessment - Inpatients

	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
EPUT - Inpatients	43.4%	61.1%	68.3%	68.4%
Target	90.0%	90.0%	90.0%	90.0%

Cardio-Metabolic Assessment - Early Intervention in Psychosis

	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
EPUT - EIP	67.9%	78.8%	88.5%	90.8%
Target	90.0%	90.0%	90.0%	90.0%

Cardio-Metabolic Assessment - Community

	Q1 2018 / 19	Q2 2018 / 19	Q3 2018 / 19	Q4 2018 / 19
EPUT - Community	22.4%	32.0%	43.9%	56.4%
Target	65.0%	65.0%	65.0%	65.0%

3.4 Listening to our patients and service users

We believe that receiving and acting on feedback from our service users is crucial to maintain the high quality standards we have set ourselves and work continues to increase the feedback received. This section of our Quality Report outlines some of the ways in which we capture feedback from people who use our services together with some examples of changes we have made and outcomes resulting from that feedback. Information in terms of the results of the Friends and Family Test (FFT) is included in Section 3.2 of this report (local quality indicators).

■ Patient Survey Feedback

The Trust has in place a unified patient survey. This draws together the national NHS Friends and Family Test (FFT) and a further series of local questions around key areas we identified together with people who use our services. Surveys are sent to all patients who have recently been discharged, either from inpatient services or community caseloads as well as some patients who have chronic long term conditions to ensure they continue to receive a good service. Carers are also asked to complete the survey for those unable to fill it in themselves.

The Patient Experience Team provides services with regular reports which detail the results from the surveys for their teams. Managers review the content of these reports and discuss the feedback with their team or individual where appropriate, using it as an opportunity to reflect on practice and look for improvements. Managers are encouraged to use positive feedback to share and reinforce good practice, as well as encourage further participation in the survey.

Question	EPUT Scores 2018/19
To what extent did you feel you were listened to?	9.3
To what extent did you feel you understood what was said?	9.3
To what extent were staff kind and caring?	9.6
To what extent did you have confidence in staff?	9.4
To what extent were you treated with dignity and respect?	9.6
To what extent did you feel you were given enough information?	9.4
How happy were you with the timing of your appointments?	9.3
How would you rate the food?	7.3
To what extent would you say the ward/clinic was comfortable?	8.8
To what extent would you say the ward/clinic was clean?	9.3

A total of 5,451 responses were received to the Survey in 2018/19. The results of the answers to the local questions are detailed in the table above (figures denote average score out of 10).
The lowest scoring area with an average of 7.3 was food. The Patient Experience Team attends open inpatient meetings in order to listen to concerns from service users. An item that does feature in some meetings is food. When this occurs the Team contacts the Facilities department to discuss any issues brought forward. This has led to menu changes in some areas. In addition, the Facilities Department undertakes their own surveys and audits in relation to food to try and improve the patient's/service user's experience.

Thank you event for the Trust Volunteers

As outlined in section 2.7 the Trust also participates in the National Community Mental Health Survey. The Community Mental Health Patient Survey 2018 was sent to patients who received treatment from the Trust in September to November 2017 to complete and return. Full details of the responses can be located in section 2.7.

■ Other Key Patient Experience Engagement Activities

Your Voice:
The aim of these events is to give service users, carers, members of the Trust and Governors as well as the public a chance to speak directly to the Chief Executive about the services provided by EPUT. They are held across all localities and include different presentations from teams relevant to the locality. The events also provide an opportunity to update everyone on the Trust's planning process. Feedback from these events is generally positive although attendance does vary considerably from locality to locality.

Stakeholder Forums:
The purpose of these forums is to provide the opportunity for service users, carers and staff to discuss services in their area and share feedback with the Trust. Forums are chaired by a locality lead for the Trust who is supported by operational staff. In 2018/19 the Trust extended these forums to mid and west Essex. The forums have been well received by members of the public and attendance continues to grow. Some smaller forums were also held more as discussion groups, which included patients, carers and local voluntary organisations.

Service User Reference Group:
One of the Trust's strategic objectives is to involve service users and carers more to play a meaningful role not only in current services but also the future of Trust services. The service user and carer reference group set up to discuss the merger and engage on the mental health transformation work remains in place with the group receiving updates on developments from the leads. Many of the attendees continue to attend smaller working groups looking at specific service areas of the transformation. The Stakeholder Reference Group offers the opportunity for attendees to feedback to others on the discussion topics in the smaller working groups.

Training:
The Trust continues to involve both carers and service users at induction when they are invited to present with a member of the Patient Experience Team to share their lived experiences. This session is positively received by both attendees and volunteers. In addition, service users give talks at the mental health first aid training, service users and carers take part in some clinical staff interview panels. Service users also share their lived experiences with EPUT Health and Social Care Apprentices in the form of a workshop.

Co-production:
The Patient Experience Team is responsible for driving the Trust's work to support co-produced projects. One example is the creation of the Health and Social Care Apprentices Workshop which was co-produced with service users.

Open Inpatient Meetings:
As noted Open Inpatient Meetings are in place in a number of our inpatient wards. These meetings allow managers the opportunity to gather feedback from patients and service users to improve services. Good practice is also recorded in order that it can be cascaded as learning throughout the Trust. As much as possible we encourage patients/service users to lead the meetings.

Buddy Scheme:
The scheme seeks to empower both service users and our future healthcare workers by increasing understanding of mental health through true partnership-based work and education. It gives mental health nursing students an opportunity to engage with an identified service user who acts as a 'Buddy' in a series of structured meetings and provides an opportunity to learn from carers, gaining insight into their experience. The scheme encourages students to enquire with sensitivity and respect about service user and carer experiences of living with mental illness within the context of family, work and the wider community. The Buddy Scheme was expanded to include allied health professional students in 2018.

Outpatient Surveying:
These are conducted in order to increase FFT returns by service users who attend community based outpatient clinics and appointments. A member of the Patient Experience Team together with a volunteer, where appropriate, will proactively hand out FFT surveys for service users to complete on arrival or leaving the outpatient centres. The presence of a volunteer assists this as they can often engage with service users who may not wish to engage with someone from the Trust and are more comfortable talking to a person with lived experience.

Examples of actions we have taken/outcomes from service user feedback we have received

The table below details some examples of the 'You Said, We Did' feedback gathered by the services. These are actions we have taken / outcomes that have been achieved as a result of listening to feedback from our patients, service users and carers over the past year. The Patient Experience Team collects this information on a bi-monthly basis.

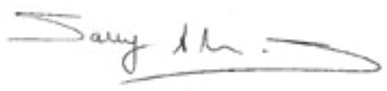
You Said	We Did
You requested that you had access to hot drinks all day not just at set times	We abolished the tea and coffee schedule and ensure that there is fresh hot water available to make drinks whenever you would like one
Patients felt the general environment was not very welcoming, cold or hot when in review appointments	In response we have redecorated, carpeted, supplied plants and have more visible information available. We are monitoring the centre temperature to ensure service user comfort
The Ladies Lounge could be more homely	We installed a television, painted the walls, took out the large tables and put in soft furnishings
We would like the garden to be tidier	An application for a volunteer gardener has been submitted to the Trust. As the weather improves garden projects will be offered as part of the OT programme
Refreshments in family room would be nice	Cold drinks and squash available in family room

CLOSING STATEMENT FROM SALLY MORRIS, CHIEF EXECUTIVE

I am proud to present our second Quality Report as EPUT. I am grateful to you for taking the time to read this report, and I hope it has been presented in a clear and useful way for you. I hope to be able to meet some of you at the Trust's open meetings in the forthcoming year and take forward any improvement suggestions you may have into next year's report.

In the meantime, if you have any questions or comments about this Quality Report please contact:

Faye Swanson
Director of Compliance and Assurance
Email: **faye.swanson@nhs.net**
Post: Essex Partnership University NHS Foundation Trust
The Lodge, Lodge Approach
Runwell, Wickford
Essex SS11 7XX



Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust
23 May 2019

ANNEXE 1 – Comments on the Quality Report

We sent the EPUT Quality Report to various external partners to seek their views on the content of the report. The responses received are outlined below for information – we thank them for taking the time to consider the information and for providing their comments.

EPUT Council of Governors' Statement on the Quality Report 2018/19

We have been invited to review the draft Quality Report for 2018/19. This has been undertaken by the Lead Governor co-ordinating thoughts and ideas from colleagues. This provides Governors with an opportunity to assure members of our Trust, via the Annual Report to Members that quality is at the heart of what EPUT does and will not be compromised. We have to ensure that the priorities which were set for 2018/19 have been met and are continuing to be taken forward.

The Board has identified patient safety, clinical effectiveness and patient experience as its priorities. The Governors take the view that without the highest level of patient safety, clinical effectiveness and patient experience these are not achievable. We have looked at what evidence there is to support the premise that patient safety is improving.

There are many measures for this and in general the Trust has shown that there have been significant improvements in most areas.

Omitted doses are down and the target set has been achieved. Avoidable pressure ulcers are also down with a significant reduction.

While overall falls are also down (by more than the 15% target set), avoidable falls are up slightly. We realise that this increase is probably not statistically significant but will be watching during this coming year that the downward trend is resumed.

We note that the number of prone restraints is now falling slightly by 6% (382 in 2018/19 from 407 in 2017/18). This is in line with national guidance and the 2015 Mental Health Act Code of Practice but, as was noted in our Statement last year, this still has some way to go to achieve the 'zero' target set by the Board. We note that most prone restraints are due to administration of medication. We raised the question last year as to whether there is a better way to persuade those who need this medication to take it voluntarily. We are hoping for more positive action in this area as probably the most likely route to reduce the prone restraint figures by a more significant amount.

The reduction in out of area placements continues, and we congratulate staff for achieving this. It has shown a significant improvement during the year and is recognised as being a major factor in a patient's recovery journey as well as reducing the cost to the Trust.

The Governors hold the view that the Trust Board engages in the processes relating to quality in the Trust, and treats quality as a top priority. We have attended the Trust stakeholder events, alongside service users and their carers, members of staff and senior staff from Local Authorities and Clinical Commissioning Groups, when time was spent considering the priorities for the coming year.

We also note that the Care Quality Commission undertook a full inspection following the first year of the new Trust's existence and congratulate the staff on achieving a remarkable score of 'Good' overall. This very helpful inspection provides an independent overview that the Trust continues to provide services of high quality.

We appreciate the good working relationship which exists between the Board (both Executive and Non-Executive Directors) and the Council and the regular attendance and input which we have received from Directors, whose standard of reports continues to be generally very high. We are also pleased that the Chief Executive, Sally Morris, uses the occasion of each of the Council meetings to address the Governors on an issue of interest. Her close involvement with the Council is much appreciated.

We have been pleased to continue, on your behalf, to undertake Quality Visits to a wide range of Trust facilities. These have enabled us to talk to staff as well as patients and to listen to any concerns there may be about quality. We can report that when these have been raised they have been immediately addressed.

A basic tenet for any NHS Foundation Trust is that a service user's physical condition should not be worsened by being in its care. We can give an assurance that the Quality Report is an honest commentary on the last year which shows a Trust which continues to be high performing, and the Board of EPUT have agreed a set of priorities which will continue to support the essential requirement that safety and quality comes first.

John Jones
Lead Governor
May 2019

EPUT Quality Report 2018/19

The draft Quality Report has been shared with the Chair, Councillors and co-opted members of the People Scrutiny Committee at Southend-on-Sea Borough Council, which is the health scrutiny committee. No comments were received. This should in no way be taken as a negative response.

Officers from the Trust attended the Scrutiny Committee meeting in October 2018 and Councillors scrutinised the issues concerning the relocation of the intermediate care beds to facilitate the St Luke's Primary Care Centre development and the recommendations relating to adult mental health beds. The Committee did not reach a specific conclusion and a number of concerns were raised which were addressed in the report considered at the Full Council meeting on 18th October 2018. At that meeting the Council resolved to support:-

(a) the creation of an additional 15-20 adult inpatient beds, to reduce the need for Southend residents having to be placed out of area;

(b) the request from Southend Clinical Commissioning Group (SCCG) and Essex Partnership University NHS Foundation Trust (EPUT) to defer consultation due to patient and staff safety issues, until the point of determining permanent moves;

(c) the establishment of a clinical group with the appropriate staff side representation to review and lead changes to enhance inpatient and community treatment, care and support going forward. This will include reviewing the options to bringing the Older People Organic Assessment beds back into South East Essex, with recommendations being completed by August 2019.

The Scrutiny Committee looks forward to the continued discussions with the Trust on this matter and will scrutinise the options and recommendations at the appropriate juncture.

Fiona Abbott
Principal Democratic Services Officer, Health Scrutiny Lead Officer & Statutory Scrutiny Officer
Legal & Democratic Services, Southend-on-Sea Borough Council

NHS
Southend
Clinical Commissioning Group

NHS Southend CCG
Southend-on Sea Borough Council
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17th May 2019

For the Attention of Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust
Via email: sally.morris4@nhs.net

Dear Sally

NHS Southend Clinical Commissioning Group welcome the opportunity to make comment on the annual Quality Account 2018/2019 prepared by Essex Partnership University Trust.

The CCG is pleased to see the Trust's commitment to an open and honest dialogue with the public regarding the quality of care delivered.

NHS Southend CCG note the following:

Quality Priorities
The CCG supports the five Quality Priorities for 2018/19, and that they were developed in line with the national quality goals and support the approach that as a learning organisation how you took into account the issues directly affecting the organisation.

The CCG were pleased to see that the 2018/2019 quality priorities were achieved. The areas relating to EPUT Community Health Services were discussed at the Quality Performance and Quality Meetings held between the CCG and Trust. The CCG where assured of the progress made.

The CCG also noted the improvements made within reducing the number of falls and avoidable pressure ulcers and can confirm that for this reporting period only one serious incident relating to pressure ulcers was reported during this period. The CCG was pleased to see the improvement made within management of falls which has resulted in reduction of incidents reported externally to the CCG.

The on-going work in developing Trust Quality Academy by progressing established Quality Champions up to Gold Level is recognised by the CCG as a good innovation and wish to commend the Trust on this development.

The on-going work the Trust has undertaken in management of complaints and incident including working to ensure significant learning from the statutory mortality review process is embedded back into the organisation and using this to improve services across the Trust was seen as a good achievement and welcome progression for the coming year.

Care Quality Commission
The Trust first CQC comprehensive inspection took place, unannounced, and reported in July 2018. The CCG was pleased to see that the Trust was rated as 'Good' overall, with community health services and mental health services also achieving overall ratings of 'Good'.
The CCG supports the forward view the Trust has identified in terms of the aim to work towards being rated as 'Outstanding' five years after the merger.

Rawreth Court and Clifton Lodge
The CCG noted that Rawreth Court and Clifton Lodge had their first inspections under the CQC's care home regime in 2018/19. Whilst the overall ratings for both sites were 'Requires Improvement' the CCG also supports the Trust view that this is far from the outcome wanted, and were also reassured that both services were rated as 'Good' in regards to caring.
The CCG are looking forward to working with the Trust during 2019/2010 to support further quality improvement within these facilities following the hand over from a commissioning perspective on April 1st 2019 from NHS Thurrock CCG (who were the incumbent Commissioning Lead for this service) to NHS Southend CCG.

End of Life
The CCG was pleased to see the work implemented regarding end of life care following the findings of the CQC report July 2018. The Trust is committed to the provision of the very highest quality of care for people with advanced life threatening illnesses. The actions highlighted which include:

- Implement a competency framework for staff, regardless of their grade, to enhance knowledge, skills for both end of life care and care in the last days of life
- Work with systems and partners to create best approaches with regard to advanced care planning and individualised care plans
- Convene an End of Life Forum for clinical staff
- Expand the number of End of Life Care Champions

The CCG acknowledges this is a large piece of work and welcomes seeing further improvement in this area once the above initiatives are embedded.

The CCG are able to confirm that throughout 2018-2019 the Trust continued development of integrated working has supported patients, family, carers and staff through:

- Increased understanding of both health and social care roles and taking opportunities to implement joint roles where this is delivers benefits.
- Joined up working across the collective occupational therapy workforce
- Collaborative approach to supporting our care home and domiciliary care providers to ensure that adults are able to remain in their own home environment wherever possible
- Joint decision making to deliver person centred care, engaging with patients, family and carers to ensure the needs of the patents are achieved
- Reduction in risk adverse practice which increases length of stay with safe discharge
- Supporting difficult conversations with patients, family and cares regarding ongoing care and support

The CCG supports that the Trust has reviewed the Integrated Single Point of Access but acknowledges that further work is needed to ensure that this service interfaces further with all services provided within the locality as more services become on line.

In regards to respiratory services the CCG welcomes the work taking place but recognises some of the challenges in sustaining this service. The CCG looks forward to reviewing the service in partnership as part of the integrated work stream.

Paediatric Speech and Language Therapist.
The CCG recognises the development work that is in place to further meet the needs of individuals within the geographical patch. Further work is needed to understand the potential gaps within this service and how this potentially affecting the patient. The CCG is committed to supporting improvement.

Community Nursing Services and Integrated Care
The CCG was pleased to see the training put in place to develop Health Care Assistants (Band 3) to deliver care to a Band 4 competency level, which has resulted in the workforce feeling, valued and also supported the District Nursing workload.

The support provided to GP practices and partners to promote a healthy walks programme in West Southend locality was also noted.

The CCG recognises the workforce challenges faced within Community and Integrated Care Services. It also supports the identified challenges highlighted within the account since the removal of national nurse training bursaries which have been highlighted as having some impact on workforce within some of the community nursing teams.

The CCG noted on reviewing the document that the following areas were not included within this year's accounts and would welcome consideration of these areas of work in the near future.

- The further development of the directory of services
- Further work on the activity data that evident the quality elements of the services provided.
- The positive and effective transition of its CICC services into their new premises which was felt to improve the quality outcomes and experience of the patient
- There was very little discussed in terms of the Trust work stream within safeguarding children and Adults. It would be helpful to understand the developments taking place in terms of the vulnerable groups.
- Infection control has some mention in the accounts but would welcome some further insight into the interventions and associated incidents.

In conclusion NHS Southend CCG has reviewed and endorses Essex Partnership University Trust Quality Account for 2018/19 as providing an accurate and balanced picture of the reporting period.

Yours sincerely

Dr Jose Garcia-Lobera
Chair

Tricia D'Orsi
Chief Nurse

NHS
Castle Point and Rochford
Clinical Commissioning Group

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17th May 2019

For the Attention of Sally Morris
Chief Executive
Essex Partnership University NHS Foundation Trust
Via email: sally.morris4@nhs.net

Dear Sally

NHS Castle Point and Rochford Clinical Commissioning Group welcome the opportunity to make comment on the annual Quality Account 2018/2019 prepared by Essex Partnership University Trust.

The CCG is pleased to see the Trust's commitment to an open and honest dialogue with the public regarding the quality of care delivered.

NHS Castle Point and Rochford CCG note the following:

Quality Priorities
The CCG supports the five Quality Priorities for 2018/19, and that they were developed in line with the national quality goals and support the approach that as a learning organisation how you took into account the issues directly affecting the organisation.

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The CCG noted on reviewing the document that the following areas were not included with this year's accounts and would welcome consideration of these areas of work in the near future.

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- Infection control has some mention in the accounts but would welcome some furthe insight into the interventions and associated incidents.

In conclusion NHS Castle Point Rochford CCG has reviewed and endorses Essex Partnership University Trust Quality Account for 2018/19 as providing an accurate and balanced picture of the reporting period.

Yours sincerely

Dr Sunil Gupta
Chair

Tricia D'Orsi
Chief Nurse

NHS
North East Essex
Clinical Commissioning Group

Response to the Quality Account for Essex Partnership University NHS Foundation Trust 2018-2019

North East Essex Clinical Commissioning Group (NEECCG) welcomes this Quality Account as a commitment to an open and honest dialogue with the public regarding the quality of care provided by Essex Partnership University NHS Foundation Trust for 2018-2019 and its quality improvement plans for the forthcoming year.

NEECCG is commenting on this Quality Account by virtue of its role as commissioner for mental health services for North East Essex. 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.

Though the CCG is commenting on a final draft version of the Quality Account, we are pleased to be able to assure accuracy of the content of the report in general. We have fed back our comments on accuracy on the draft report and anticipate that these changes will be made to the final published version.

The Trust's remit has predominantly been the provision of both hospital and community based mental health services; as well as learning disability; general community nursing; a community hospital in south Essex and services in Bedford and Suffolk. This heralded real opportunity to enhance and develop the implementation and sustainability of further quality improvements through the sharing of good practice and the alignment of quality standards for the benefit of patients.

It is pertinent you have used learning from previous years, including relevant feedback from staff and stakeholders to develop your key priorities for the forthcoming year relating to patient safety, clinical effectiveness and patient experience.

The introduction of 'National Guidance on Learning from Deaths' published in March 2017 saw new guidance relating to mortality review processes. In addition to good governance processes, underpinned by a new policy; to maximise opportunities for learning and improve services you have continued to strengthen local approaches in line with the mortality review guidance into 18/19.

You have participated in 14 national clinical audits and 1 national confidential enquiry. Data collections for NACR and NACAP commenced in March 2019 and POMH UK Topic 7f. We note that 8 national clinical audit reports have been reviewed with actions identified. In addition, 25 local audits were completed and identified some intended actions to improve quality of care to service users.

Your support for research has led to you joining the Clinical Research Network-North Thames and 924 people enrolled in 33 research studies, including the National Confidentiality inquiry into Suicide and Homicide and Sudden Unexplained death, by people with Mental Illness.

It is pleasing to note the level of success you have achieved with the commissioning for quality and innovation schemes (CQUINs). You have worked collaboratively with a variety of acute providers and the community Emotional Health and Well Being Service (EWMHS). This collaboration has led to the implementation of processes to improve patient experience and reduce attendances at Accident and Emergency Departments.

You received a number of unannounced visits by the Care Quality Commission which reviewed specific services. The inspection reports have been largely rated good, although they did identify some concerns relating to safe care and treatment, which remains 'requires improvement' and actions are ongoing.

The Trust narrowly missed the core quality indicator standard required by the regulatory framework for exceeding the 95% threshold for 7 day follow up of discharged patients with a dip in Quarter 3 to 92.3%. Local data suggest a recovery to 96.1% in Quarter 4 however to be confirmed once the national data is received. The 95% standard was exceeded however, for gate keeping of patients requiring admission by access and assessment teams.

It is particularly pleasing to see strengthened duty of candour responsibilities include mandatory Duty of Candour on-line training for all staff; improved governance processes; and the appointment of a Family Liaison Officer/Duty of Candour Lead.

The conclusion of the NHS North East Essex CCG is that Essex Partnership Trust's Quality Account 2018-19 provides a clear picture of your performance, improvements and future ambitions for improving quality and safety in your services. The CCG looks forward to working collaboratively with you as an integral partner in providing high quality healthcare services to the population of north Essex.

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

Statement from West Essex Clinical Commissioning Group

West Essex Clinical Commissioning Group is responsible for the commissioning of community and mental health services from Essex Partnership NHS Foundation Trust (EPUT) for the citizens of west Essex.

From October 2018 the mental health component of the contract (which had been managed by a different CCG on behalf of west Essex) returned to the direct administration of West Essex CCG.

EPUT provide services across Essex including community and mental health services. Where possible the information in the Quality Account has been divided by locality and type of care, this has helped us to identify elements of the account that are specific to west Essex patients.

The Quality Account for this year is a review of EPUTs performance in 2018/19. This is the second Quality Account of the merged organisation.

There is a significant section in the account explaining how the Trust is implementing and managing the National Guidance on Learning from Deaths. All the data which is now part of the requirement for quality accounts has been included. This section includes robust actions which EPUT are taking in relation to deaths "more likely than not to have been due to problems in care".

EPUT achieved the majority of sub elements within their quality priorities from last year. The elements which were partially complete at year end are either part of a 2 year plan or being maintained as a priority for 2019/20. We would like to congratulate the Trust on their work with bereaved families and their process for ensuring that co-production work with families and carers is carried out according to an agreed process.

In west Essex, EPUT have taken a key role in developing and delivering the Mental Health Liaison Service in the Emergency Department at The Princess Alexandra Hospital and have been instrumental in integrated care work for people with respiratory disease.

The Trust is working to embed quality improvement methodologies across the workforce. The inclusion of quality improvement as an essential element of induction for new staff demonstrates the Trusts clear commitment to the effective use of improvement science.

The CCG fully support EPUTs quality priorities for 2019/20, particularly their on-going commitment to reduction in harm and the suicide prevention strategy.

We are grateful that the Trust has included the governance arrangements for producing the quality account; this makes it clear to patients and families how this complex document has been created.

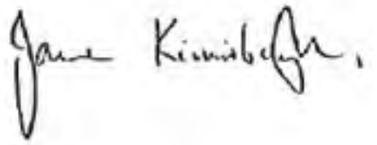
We confirm that we have reviewed the information contained within the Account and checked this against data sources where these are available; it is accurate in relation to the services provided.

The explanation by the Trust of why certain data sets are as they are has been fully explained.

We have reviewed the content of the Account: it complies with the prescribed information as set out in legislation, by the Department of Health and additional requirements identified for this year's account for example information on how staff can access a Freedom to Speak Out Guardian and the annual report on safe working of junior doctors.

Whilst the element of care that EPUT deliver for west Essex is only a proportion of their overall care provision, the account demonstrates clearly how care has been delivered by locality for both mental and community health. The account also shows how valuable local collaboration with EPUT continues to be for the west Essex system.

We believe that the Account is a fair, representative and balanced overview of the quality of care at the Trust.



Jane Kinniburgh
Director of Nursing and Quality
West Essex Clinical Commissioning Group.

May 2019

ESSEX PARTNERSHIP UNIVERSITY TRUST MID AND SOUTH ESSEX MENTAL HEALTH

CCG QUALITY REPORT

MANDATED SUMMARY STATEMENT

Mid and South Essex Sustainability and Transformation Partnership Response

The Clinical Commissioning Groups contracting with Essex Partnership University Trust for the provision of Community and Inpatient Mental Health Services welcomed the opportunity to review and comment on the Quality Report for Essex Partnership University Trust 2018/19. Thurrock Clinical Commissioning Group co-ordinated the response on behalf of Mid and South Essex Sustainability and Transformation Partnership (STP) who aim to commission safe, effective and responsive services that provides a positive experience for patients and carers.

Thurrock Clinical Commissioning Group received contractual transfer in February 2018 and has established a robust contractual relationship and vigorous governance arrangements to monitor quality and drive service improvement through the Clinical Quality Review Group and the Mental Health Partnership Board. These structures provide valuable forums through which organisational check and challenge can be undertaken. The organisations have the ambition to work collaboratively and gain assurances that ultimately drive enhancements to the quality systems and processes and improve treatment and care delivery for our CCG populations.

The Quality Report summaries EPUT achievements against the 2018/19 Trust quality priorities and identifies the 2019/20 priorities. It is notable that Essex Partnership University Trust is a relatively new organisation following the merger of South Essex Partnership Trust and North Essex Partnership Trust in April 2017. The Clinical Commissioning Groups would endorse that the Quality Report has been prepared in accordance with National Legislation and requirements. Essex Partnership University Trust is required to include in their Quality Reports the Trusts performance against National quality indicators. The Quality Report demonstrates this data has been included.

National Mandated Indicators of Quality (Mental Health Specific)

The National Mandated Indicators of Quality for 2018/19 are reported at a Trust wide level, which is wider than this STP contract.

The Trust achieved Q1 and Q2 performance for Patients on Care Programme Approach (CPA) followed up within seven days of discharge from psychiatric inpatient stay. The performance dipped slightly in Q3 2.6% below the target of 95%. Commissioner note that local data for Q4 indicates the trajectory has returned to an above target position. In the key domain of `Admissions to Acute Wards gate kept by Crisis Resolution and Home Treatment Team` the Trust reported above average concordance for this indicator and achievement in all four quarters and would reflect reporting throughout the year.

Commissioners acknowledge the results of the Survey of People who use Community Mental Health Services and the profile of `about the same` average score in most sections (between highest and lowest reporter). In the one section that was worse than average Commissioners note that EPUT has developed and is in the process of implementing an action plan.

The National Indicator for Staff Friends and Family Survey reports that EPUT are above Q1 and Q2 position for all Mental Health Trusts in the % of `Staff who would recommend the Trust as a place to receive care`. In order to provide transparency it would be helpful to include the actual data on number of responses from staff and a graph reflecting the response % to question would `staff recommend as a place to work`.

QUALITY PRIORITIES 2018/19

The Trust reported that they have performed well against the majority of their 2018/19 quality priorities and demonstrated strong performance in reducing the omitted doses of medication from 827 in 2017/18 outturn to 375 in 2018/19 data outturn which may reduce the potential and actual harm for patients and improve treatment outcomes. EPUT have acknowledged in the report that their internal ambition to achieve a 10% reduction in restraints was not achieved. EPUT are engaged with a National work stream to continue work on this patient safety initiative. The STP recognises the Trust performance in the delivery of quality priorities for 2018/19 and the positive reported effect this has had on delivery of safe and effective services.

We share the Trust's reported view that there are some key areas of work that require action to ensure that service users experience the best possible care and treatment promptly and in the most appropriate setting and the STP will continue to monitor progress, contractually review and take any required assurance action in 2019/20 to sustain safe, effective and responsive service delivery for the future.

Of the five Quality Priorities set by the Trust for 2018/19 the reported status is five quality priorities rag rated green with a range of ambitions partially complete. The Clinical Effectiveness – record keeping risk assessment and care plan priority for 2018/19 overall achieved the target of 90% against the audit criteria. Some of the practice areas did not achieve 90%, but it is noted that all practice areas either maintained or improved on their Q1 performance.

The Quality Priority section for 2018/19 identifies the following harm free work streams:

- Pressure Ulcers
- Falls
- Restrictive Practice
- Medication Omissions
- Early Detection of Deteriorating Patient
- Unexpected Death

A baseline for the above safety indicators are set out in the report on page 11 but this summary does not include the data for unexpected deaths. In the section reporting Serious Incidents (page 72/73) the unexpected death bar on the graph represents circa 70 unexpected deaths. As a safety priority domain commissioners would expect this data to be included in the report to qualify reporting against the 10% reduction set by EPUT for all work streams.

EPUT have included unexpected deaths as a key priority for 2019/20 and we support this commitment. Key to this work stream will be EPUT implementing the Suicide Reduction Plan on page 8. This reflects the Trust commitment to engage from Board to floor and with wider stakeholders in forging ahead with this crucial area of work. The Connecting With People evidenced-informed social intervention training programme underpinned by social capital theory is in the process of being rolled out in the Trust and it is positive to note that 452 staff have completed this training that is linked to suicide reduction.

Commissioners are cognisant of the progress that EPUT have achieved with embedding the Mortality Review process and adopting and adapting the Royal College of Psychiatrist Structured Review tool and methodology as best available evidence to support practice and decision making. The thematic reviews of deaths undertaken in 2017/18 demonstrate the Trusts engagement in learning from Deaths Culture and practice methodology.

The Clinical Commissioning Group would like to congratulate the Trust on the overall outcome of the comprehensive Care Quality Commission (CQC) inspection in April / May 2018. As a newly merged organisation the achievement of "Good" overall evidences a significant achievement by the Trust. We are satisfied that action plans were developed in response to the CQC inspection recommendations and that the Trust has continued work in year to raise the quality standards in the identified areas. Furthermore, the amalgamation of the CQC recommendations into developing the 19/20 quality priorities is warmly welcomed by commissioners.

The STP would like to commend the Trust on the results for the DQMI that achieved a Data Maturity Index score of 98.9% for Q1 and 98.8% for Q2 and evidences an excellent standard against the NHSI Single Oversight Framework target of 95%.

The STP have worked with Providers to implement a range of the Local Service Quality Improvements and Workforce Developments detailed in the Quality Report and view this section of the report as a reflection of the progress of EPUT as a relatively newly formed organisation of a journey of continuous quality improvement.

CQUIN

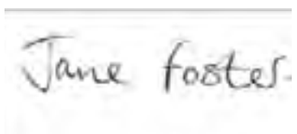
All South Essex Mental Health CQUINs were part of the contractual relationship for a minimum of the 2 year National CQUIN programme. The CQUINs were incentivised to provide system wide engagement and transformation. EPUT have worked with commissioners and other providers to undertake the ambitious transformations and build coalitions with key partners to deliver the Sustainability and Transformation Plans that are woven through the CQUIN programme. The CQUIN programme in 2018/19 did not attain the totality of the milestones. In order to achieve the full CQUIN programme in 2019/20 the pace of change, implementation and alliance building will need to be consistent and focused over the life of the delivery of the CQUIN schemes.

Essex Partnership University Trust continues to demonstrate a high level of commitment to improving patient and carer experiences of the organisation. It is positive to note a number of reported mechanisms for receiving real time feedback that have been established.

CONCLUSION

The Commissioners are aware that Essex Partnership University Trust have developed their Quality Priorities for 2019/20 in response to the National quality goals, which are based on patient safety, service user and carer experience and clinical effectiveness and triangulated this with the organisational themes arising from Serious Incidents and Complaints and areas identified for improvement by the CQC and commissioners would endorse this approach and support the Trust's chosen quality priorities for 2019/20. If this approach is aligned with a strong focus on quality assurance and quality control it will provide the framework and foundations for the organisation to work towards achieving the organisational aspiration of an `Outstanding` CQC rating within the next five years.

Overall the report is reflective of the commissioner knowledge of the Trust quality activities and aspirations. The STP and the Trust are undertaking a significant transformational work programme over the next two years and we look forward to continuing our strong alliance to strengthen the quality of commissioned mental health services in 2019/20 and beyond.



Jane Foster-Taylor
Chief Nurse

ANNEXE 2 – Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Reports) Regulations to prepare Quality Reports for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

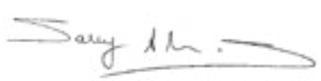
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance;
- 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 2018 to May 2019;
  - papers relating to quality reported to the board over the period April 2018 to May 2019;
  - feedback from commissioners received May 2019;
  - feedback from governors received 23 May 2019;
  - feedback from Overview and Scrutiny Committees received May 2019;
  - the Trust's complaints report (appertaining to 2018/19) published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated May 2018 and presented to the Board of Directors in May 2019;
  - the 2018 national patient survey published in November 2018;
  - the 2018 national staff survey published in March 2019;
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2019
  - CQC inspection reports dated 26 July 2018, 11 February 2019, 9 March 2019 and 13 March 2019;
- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Reports regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Professor Sheila Salmon
Chair
Essex Partnership University NHS FT
23 May 2019



Sally Morris
Chief Executive
Essex Partnership University NHS FT
23 May 2019

ANNEXE 3 – Independent Auditor's Report to the Council of Governors on the Annual Quality Report

22 May 2019

Council of Governors
Essex Partnership University NHS Foundation Trust
The Lodge
Lodge Approach
Runwell
Wickford
Essex
SW11 7XX

Dear Governors.

External Assurance on the Trust's Quality Report

We are pleased to present our findings following our review of the Essex Partnership University NHS Foundation Trusts (the Trust's) Quality Report for the year ended 31 March 2019.

The purpose of this report to the Council of Governors is to set out the work that we have performed, our findings and conclusions and any recommendations for improvement concerning the content of the Trusts Quality Report and our testing on mandated and local indicators as required by NHS Improvement.

We would like to take this opportunity to thank the employees of the Trust for their assistance during the course of our work

Yours faithfully

Associate Partner For and on behalf of Emst & Young LLP Enc

Limited assurance report on the content of the Quality Reports and mandated performance indicators

Independent auditor's report to the Council of Governors of Essex Partnership University NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Essex Partnership University NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of Essex Partnership University NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report) and certain performance indicators contained therein.

This report is made solely to the Trust's Council of Governors, as a body, in accordance with our engagement letter dated 29 September 2017. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our examination, for this report, or for the conclusions we have formed.

Our work has been undertaken so that we might report to the Council of Governors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from our appointment as the auditors to the Trust.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (page 70) Out of area placements (page 68)
- We refer to these national priority indicators collectively as the 'indicators'

Limited assurance report on the content of the Quality Reports and mandated performance indicator

Respective responsibilities of the directors and Emst & Young LLP

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'Detailed requirements for quality report' issued by NHS improvement
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018), which is supported by NHS Improvement's Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement,
- the Quality Report is not consistent in all material respects with the sources specified in Section 2.1 of the Detailed guidance for external assurance on quality reports 2018/19 and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports 2018/19

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance and consider the implications for our report if we become aware of any material omissions.

Limited assurance report on the content of the Quality Reports and mandated performance indicators

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - "Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ("ISAE 3000). Our limited assurance procedures included, but were not limited to:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the "NHS Foundation Trust Annual Reporting Manual 2018/19 to the categories reported in the Quality Report.
- reading the documents.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Report. The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19 and supporting guidance. The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Essex Partnership University NHS Foundation Trust

Limited assurance report on the content of the Quality Reports and mandated performance indicators

We read the other information contained in the quality report and consider whether it is materially inconsistent with the other information sources detailed in Section 2.1 of the Detailed guidance for external assurance on quality reports 2018/19'. These are:

- Board minutes for the period April 2018 to May 2019
- Papers relating to quality reported to the Board over the period April 2018 to May 2019
- feedback from commissioners, dated May 2019
- feedback from governors, dated May 2019
- feedback from Overview and Scrutiny Committee dated May 2019
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
- the latest national patient survey, published November 2018
- the latest national staff survey, published February 2019
- the Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019, and
- Care Quality Commission inspection report, published July 2018

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Essex Partnership University NHS Foundation Trust as a body, to assist the Council of Governors in reporting Essex Partnership University NHS Foundation Trust's quality agenda, performance and activities.
We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Essex Partnership University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing,

Limited assurance report on the content of the Quality Reports and mandated performance indicators

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Essex Partnership University NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement
- the Quality Report is not consistent in all material respects with the sources specified in EPUT Quality Report 2018/19, and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement

Enst & Young
Luton
28 May 2019

GLOSSARY

ADOS	Autism Diagnostic Observation Schedule
CAARMS	Comprehensive Assessment of At-Risk Mental States
CAMHS	Child and Adolescent Mental Health Service
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
CCQI	(Royal College of Psychiatry) College Centre for Quality Improvement
CHS	Community Health Services
CIPs	Cost Improvement and Income Generation Plan
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHT	Crisis Resolution Home Treatment
CRN NT	Clinical Research Network – North Thames
DAFNE	Dose Adjustment For Normal Eating
DHSC	Department of Health & Social Care
DTOC	Delayed Transfer of Care
DVT	Deep Vein Thrombosis
EEAST	East of England Ambulance Service NHS Trust
EIP	Early Intervention in Psychosis
EIS	Early Intervention Service
EPUT	Essex Partnership University NHS Foundation Trust
FEP	First Episode of Psychosis
FNP ADAPT	Family Nurse Partnership – Accelerated Design and Programme Testing
FRESH	Future, Recovery, Education, Skills, Hope (Recovery College)
FT	Foundation Trust
GP	General Practitioner
HEF	Home Enteric Feeding
HOSC	Health Overview and Scrutiny Committee
HRA	Health Research Authority
IAPT	Improved Access to Psychological Therapies
IOT	Intensive Outreach Team
IT	Information Technology
KLOE	Key Lines of Enquiry
KPI	Key Performance Indicator
LD	Learning Disabilities
LTC	Long Term Condition
MANTRA	Maudsley Model of Anorexia Nervosa Treatment for Adults
MDT	Multi-Disciplinary Team
MEWS	Modified Early Warning System
MHRA	Medicines and Healthcare Products Regulatory Agency
MHS	Mental Health Services
MHU	Mental Health Unit
MRSA	Methicillin Resistant Streptococcus Aureus – antibiotic resistant bacteria
MSK	Musculoskeletal
NCAPOP	National Clinical Audit Patient Outcome Programme
NCB	National NHS Commissioning Board
NELFT	North East London NHS Foundation Trust
NEP	North Essex Partnership University NHS Foundation Trust
NHS	National Health Service
NHSI	NHS Improvement (previously Monitor), the health sector regulator
NICE	National Institute for Health and Care Excellence.
NIHR	National Institute for Health Research
NIHR CRN	National Institute for Health Research Clinical Research Network
NPSA	National Patient Safety Agency
NRES	National Research Ethics Service
NRLS	National Reporting and Learning System
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PNIMH	Perinatal and Infant Mental Health champions
POMH UK	Prescribing Observatory for Mental Health UK
PRESCQIPP	Prescription Quality, Innovation, Productivity and Prevention
QIPP	Quality Innovation Productivity and Prevention
QNIC	Quality Network for Inpatient CAMHS
RAID	Rapid Assessment Interface and Discharge
RCA	Root Cause Analysis
REC	Research Ethics Committee
SEPT	South Essex Partnership University NHS Foundation Trust
SI	Serious Incident
SMI	Severe Mental Illness
SPoA	Single Point of Access
STaRS	Specialist Treatment and Recovery Service
STOMP	Stopping Over-Medication of People with a learning disability, autism, or both
STORM	Skills-based Training On Risk Management for suicide prevention
STP	Sustainability and Transformation Plan
SUHFT	Southend University Hospital NHS Foundation Trust
SUTS	Sign Up To Safety national campaign
TASI	Therapeutic and Safe Intervention
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
VLU	Venous Leg Ulcer
VTE	Venous Thromboembolism – blood clots

EPUT

ANNUAL ACCOUNTS 2018/19

Essex Partnership University NHS Foundation Trust

ANNUAL ACCOUNTS 2018/2019
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Statement of the Chief Executive's Responsibilities as the Accounting Officer of Essex Partnership University NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Essex Partnership NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Essex Partnership NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

- make judgements and estimates on a reasonable basis

- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements

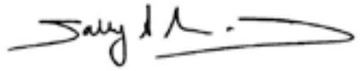
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance

- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and

- prepare the financial statements on a going concern basis.

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

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



Signed..... **Date: 23 May 2019**

Sally Morris
Chief Executive

ANNUAL GOVERNANCE STATEMENT FOR THE YEAR ENDED 31 MARCH 2019

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 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 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 Essex Partnership University NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As part of my role of providing leadership to the risk management process I am Chair of the Executive Operational Sub-Committee(EOSC), which is a Sub-Committee of the Finance and Performance Committee, a Standing Committee of the Board of Directors. This Committee and the Audit Committee are responsible for developing, maintaining and monitoring the risk management and assurance systems within the Trust. The Finance and Performance Committee and Quality Committee both received action plans linked to risks on the Board Assurance Framework and have an overview and scrutiny role in respect of these.

The Trust trains all staff in various aspects of risk management and ensures that where staff require specialist advice and training this is provided through attendance on specific courses and attendance at conferences. The Trust has in place an approved mandatory and essential training matrix in line with best practice requirements. Training and guidance is provided in various media formats to staff including e-learning, face-to-face, classroom environment, training and learning bulletins and seminars to ensure learning from good practice and experience is disseminated quickly and effectively.

The risk and control framework

The Risk Management and Assurance Framework details EPUT's risk management arrangements. It confirms accountability arrangements for individuals, including Executive Directors, risk specialists, managers and all staff. Risk Registers are in place at Board, Corporate and Directorate level together with an effective risk identification and assessment process to support these. Potential risks are identified and fed from a wide variety of sources including incidents, accidents, internal/external reviews, risk assessments, performance

information, claims, complaints and staffing trends.

The Framework outlines how risks are prioritised in a consistent manner through the organisation, including the potential consequence should the risk materialise and an assessment of the likelihood that the risk will materialise. The Framework details ways in which controls are identified, and how assurance is provided and evaluated. Risk appetite is defined by the identification of a target risk score, the level at which the risk becomes acceptable to the organisation. A risk appetite statement is included in the framework, which sets out principles that help define levels of acceptable risk. The Board has considered the application of risk appetite into its risk management processes in detail during the year and is using it in shadow form.

EPUT manages its most significant current and future potential risks through the Board Assurance Framework. Risks relating to quality during 2018/19 have included:

- Oversight and leadership of end of life care services
- Oversight and leadership of Substance Misuse Services
- Capacity of Quality Committee to deal with the quantum of issues and risks identified
- Embedding learning from incidents
- Taking the right action in relation to restraints
- Taking account of emerging guidance relating to dormitory accommodation
- Providing high quality services from safe premises
- Vacancy rates Trustwide in excess of EPUT benchmark target (and specifically at HMP Chelmsford)
- Bed occupancy levels in adult mental health in-patient services
- Consistently achieving in-patient shift fill rate targets

Risks relating to finance and/or performance in the same period have included:

- Fire safety systems and processes
- Assessing the potential implications of EU- exit
- Underperformance on contractual KPIs
- Achieving a reduction in agency spend
- Achieving efficiencies through CIPs
- Effective management of relationships with partners
- Implementing joint transformation of services
- Participating in the West Alliance on integrated pathways
- Potential for financial impact arising from HSE investigation into former NEP patient safety failings

Whilst some of the above risks were closed by year end, the following new risks have been identified for 2019/20:

- Maintaining a "good" CQC rating in the Well Led inspection during 2019/20
- Having the skills and capacity to deliver high quality services
- Embracing new and improved technology for innovation

Each potential risk is owned by an Executive Director. Action plans to mitigate risk are developed and approved by EOSC and scrutinised by Standing Committees of the Board of Directors. Movement of risks is monitored each month.

The Trust commissioned an independent third party well-led review in Quarter 4 in line with NHSI requirements. The findings of this review will be shared with the Trust at the end of May 2019 and recommendations to further develop the Trust's governance arrangements will be taken forward as appropriate.

The EPUT Quality Strategy continues to be implemented, supported by a Quality Academy and Quality Improvement (QI) process.

The Board of Directors and I fully support the continued development of a safety culture throughout the Trust. The health and safety of all service users, staff, carers and visitors is paramount. The Trust has provided clear procedures as well as resources for reporting and managing incidents and insists on a philosophy that promotes open and honest reporting. Trust staff have a duty to report all incidents to prevent harm in the future. Incident reporting is monitored via the Health, Safety and Security Committee. A system is in place to ensure weekly monitoring of moderate harm incidents and further investigation is undertaken as required. Issues are escalated to the Board or its Sub-Committees.

The Trust carries out all the necessary actions required to comply with its licence condition 4 (FT Governance) including a self-assessment against the Corporate Governance Statement and the licence conditions.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has in place policies, procedures and monitoring arrangements to support its duty to eliminate discrimination. Quality Impact Assessments and Equality Impact Assessment systems are in place to ensure that decisions are made fairly and representatively. Policy authors are asked to undertake an impact assessment where this has identified a potential risk to a protected characteristic group. Cost Improvement Programmes are subject to a Quality Impact Assessment (as set out in policy) and on-going monitoring to ensure that efficiencies do not adversely impact on the quality of service delivery.

Public stakeholders, including Clinical Commissioning Groups and Local Authorities are involved in managing key shared risks through well-established contract management and partnership committee structures that oversee the operational delivery of and potential threats to services delivered in partnership. In addition, the Council of Governors is advised of key risks that may have arisen or are likely to materialise, through regular meetings.

EPUT's workforce plan has been produced in consultation with service leads and is in line with the workforce aspirations and guidance set out in a number of national strategies including: The Five Year Forward View, Safer Staffing Guidelines, the NHS 10 year Plan and other related strategic documents.

Detailed trajectories for workforce change have been submitted to STP leads in response to the requirement to show how the workforce growth as set out in the Five Year Forward View will be achieved through a combination of innovation, recruitment and retention. The Trust has been working closely with NHSI as part of the recruitment and retention initiative and has submitted regular updates to its plans showing progress against targets. Internal governance is maintained through a number of forums including the monthly Workforce and Organisational Development Group, which reports through the Multi-Professional Education Group and the Quality Committee to the Executive Committee and Trust Board. The Workforce Transformation Group monitors the progress on workforce targets and workforce change.

All issues around workforce planning and development are covered through these committees. When detailed revisions of the workforce plan are required then service lead groups will be convened to explore new approaches and ideas. The introduction of new roles is explored at this level, with discussion around the implications of skill development and skill transfer. Recent examples are the pilots of the Trainee Nurse Associate and Physician Associate. These are being piloted in close consultation with service leads and regular monitoring of the impact. Workforce development, recruitment and retention plans are created with a view to ensuring the sustainability and security of supply. With this in mind, the Trust has promoted a skills based approach to planning where service, workforce and training plans are closely integrated and reviewed iteratively. In response to the changing workforce environment the Trust has created and maintained internal development pathways for nursing, offering a path from support worker to qualified status making use of the apprenticeship opportunities. It is intended to create similar pathways for therapy and psychology. The workforce plan is revised on a quarterly basis through circulation to leads and requests for updates.

The Trust meets requirements for safe staffing levels in mental health in-patient services by carrying out twice daily "sit rep" teleconference calls led by senior managers and the ward matrons. This call identifies ward staffing, reviews use of agency and bank staff as well as the ward dependency to enable identification of any areas of concern and to move staff if required. Community health inpatient services staffing levels are reviewed on a shift by shift basis and staff redeployed accordingly or obtaining additional staff above funded establishment to ensure patient safety. Establishment reviews are also undertaken and reported to the Board of Directors as per National Quality Board guidance. These establishment reviews utilise dependency tools by Keith Hurst and the Safe Care tool, but information is triangulated and professional judgement used to confirm recommendations.

EPUT is fully compliant with the registration requirements of the Care Quality Commission. There are conditions attached to the registration of two nursing homes that require having a registered manager in post). Internal inspection systems are in place to monitor compliance with CQC requirements in all Trust services. A system of regular quality visits by Non-Executive, Executive Directors and Governors is in place. During 2018/19 a comprehensive inspection was carried out by the CQC and the outcome was a 'Good' rating.

A joint inspection by CQC with HM Inspectorate of Prisons took place at HMP Chelmsford and a s29 Warning Notice was issued in respect of the healthcare services delivered by EPUT. The Warning Notice was closed in September 2018 as actions were completed and improvement acknowledged by a follow up CQC inspection. The CQC carried out inspections of two Nursing Homes under the social care inspection regime, both resulting in a rating of "Requires Improvement", for which an improvement place is in place and is being taken forward.

The Foundation Trust has published an up-to-date declaration of interests for Board level staff within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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, employers' 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.

EPUT has a Sustainable Development Management Plan which includes the good corporate citizen and adaptation reporting requirements, in accordance with guidance issued by the Sustainable Development Unit. The SDMP is currently being refreshed and the plan's principles are based on the requirements of the Climate Change Act which we have made steady progress against. The Trust does not report directly on sustainability issues but instead would provide any information requested by the NHS Sustainability Team who collate and report generally. No specific risk assessments have been undertaken from a property or Estates and Facilities perspective.

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

The EOSC has responsibility for overseeing the day-to-day operations of the Trust and for ensuring that resources are being used economically, efficiently and effectively. The Finance and Performance Committee scrutinises quality, clinical (including workforce) and financial performance each month and provides the Board with assurance that performance is acceptable or that risks are being managed.

The Trust's Audit Committee supports the Board and me as the Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements. The scope of the Audit Committee's work is defined in its terms of reference and encompasses all the assurance needs of the Board and Accounting Officer. The Audit Committee has engagement with the work of Internal Audit, External Audit and financial reporting issues. It is chaired by a Non-Executive Director.

Information Governance

Risks relating to data security are managed by the Director of ITT, Business Analysis and Reporting, in accordance with the Risk Management and Assurance Framework, Adverse Incident Policy and Procedure and the Information Governance and Security Policy. The Information Governance Steering Committee monitors controls in place to prevent data breaches and provides assurance reports on these to the Quality Committee. The initial action plan following the WannaCry attack, relating to cyber security was fully completed and signed off by the Audit Committee. NHS Digital was commissioned by the Trust to validate self-assessment against national standards. This identified 12 areas of high risk, of which only four remain. These will all be addressed in 2019/20.

During 2018/19, 0 information governance breaches were notified to the Information Commissioner's Office (ICO).

The Trust's Medical Director is the Caldicott Guardian, making sure that the personal information about those who use our services is used legally, ethically and appropriately, and that confidentiality is maintained. The Caldicott Guardian provides leadership and informed guidance on complex matters involving confidentiality and information sharing following the six Caldicott Principles.

The Trusts Executive Chief Finance Officer is the Senior Information Risk Owner (SIRO) responsible for understanding how the strategic business goals of the Trust may be impacted by any information risks and for taking steps to mitigate those risks. The Caldicott Guardian and SIRO work closely together when information risk reviews are conducted for assets that contain personal information.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on 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.

As Chief Executive Officer I have a personal commitment to quality in everything that we do and this is shared by our Chair and all members of our Board of Directors. EPUT has taken steps to assure the Board that the Quality Account/Report presents a balanced view of quality and that there are appropriate controls in place to ensure the accuracy of data that it contains. The Executive Director of Nursing has led the development of the Quality Report/Account and has supported the Board in determining the quality priorities that it contains. Robust systems are in place to monitor performance against the quality indicators, metrics and priorities set out in the Quality Account/Report in year and for ensuring that the Quality Account/Report is consistent with reports received in year.

The Quality Account/Report is circulated to our key stakeholders (commissioners, health overview and scrutiny committees and Healthwatch) and their comments on content are included in the final published version.

EPUT has a wide range of policies and procedures in place to ensure that the quality of care provided meets the standard expected by the Board of Directors and that services are compliant with legal, regulatory, contractual and best practice requirements. The robustness and integrity of policies and procedures is overseen by a policy controller within the assurance team.

There are plans, strategies and frameworks in place to continually improve the quality of services, for example our Quality Strategy and its implementation plan.

The Trust has systems and processes in place for the collection, recording, analysis and reporting of data. Information systems have built in controls to minimise scope for human error or manipulation. There are corporate security and recovery arrangements in place. Roles and responsibilities in relation to service and data quality are clearly defined and where appropriate incorporated into job descriptions. There is an Information Assurance Framework in place. Internal and external reporting requirements have been assessed and data provision is reviewed to ensure it is aligned to these needs. Data is used for day to day management of the Trust's business. Data is used to support decision making and management action is taken to address service delivery issues identified by it. Data used for external reporting is subject to verification prior to submission. Data returns are prepared and submitted on a timely basis and are supported by an audit trail.

Following the Data Quality audit in February 2018 which gave substantial assurance, Internal Audit conducted a further review of Data Quality in Q3 2018/19. The overall report conclusion confirmed that there was a moderate level of assurance in respect of design of and operational effectiveness of controls.

External independent assurance has been sought on the content of the Quality Account/Report and of the quality of data that supported reporting of performance against three of the KPIs reported within it.

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, the Strategy and Planning Committee, the Quality Committee and Finance and Performance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The following processes have been applied in maintaining and reviewing the effectiveness of the system of internal control:

- The Board of Directors met monthly in public during 2018/19 and received a report relating to finance, performance and quality inviting scrutiny and challenge
- A structure of Standing Committees beneath the Board provides a layered approach to monitoring, scrutiny and challenge of systems of internal control
- A comprehensive quality, assurance and risk structure is in place including a compliance team
- EPUT has a corporate governance development plan in place to ensure compliance with regulatory requirements
- Internal Audit conducted a review of the Trust's Corporate Governance Statement in March 2018. No recommendations for action were identified.
- There is a comprehensive programme of Internal Audit in place aligned to key areas of potential financial and operational risk. During the year 2018/19, 11 internal audits were undertaken. The outcome of two internal audits are yet to be finalised. The majority of audits provided moderate assurance in the design of controls and operational effectiveness. Two audits provided limited assurance for operational effectiveness (fire safety and cyber security), but it was Trust management that directed the internal auditors to assist in identifying improvements required in these areas and the majority of recommendations identified have been implemented in year.
- The Audit Committee has met regularly and carried out its responsibilities effectively in line with its terms of reference and the Audit Committee Handbook
- A Clinical Audit programme is in place to drive up quality standards. An annual report of results is produced and re-audit is undertaken if results require it
- An efficacy review was undertaken and implemented of the Standing Committees of the Board of Directors to ensure that they are meeting their Terms of Reference
- Internal Audit conducted a review of the Trust's Board Assurance Framework and Risk Management in March 2019. The report covers the following areas of risk maturity and EPUT's level of maturity is stated in brackets – Risk Governance (Managed), Risk Assessment (Managed), Risk Mitigation (Managed), Monitoring and Reporting (Enabled), Continuous Improvement (Managed). The Trust scores favourably against other Trusts audited – the highest for monitoring and reporting and the only Trust that has achieved 5 managed or enabled outcomes (BDO internal audit).

Conclusion

No significant internal control issues have been identified.

Signed..... **Date: 23 May 2019**

Sally Morris
Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Opinion

We have audited the financial statements of Essex Partnership University NHS Foundation Trust for the year ended 31 March 2019 which comprise Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Change in Taxpayers' Equity and the Statement of Cash Flows, and the related notes 1 to 29, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts.

In our opinion, the financial statements:

- give a true and fair view of the state of Essex Partnership University NHS Foundation Trust's affairs as at 31 March 2019 and of its income and expenditure and cash flows for the year then ended; and
- have been prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2018/19 and the directions under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

Key audit matters	• Risk of fraud in revenue and expenditure recognition including risk of misstatements due to fraud and error
Materiality	• Overall materiality of £6.1m which represents 2% of operating expenses

Key audit matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in our opinion thereon, and we do not provide a separate opinion on these matters.

Risk	Our response to the risk	Key observations communicated to the Audit Committee
Risk of fraud in revenue and expenditure recognition, including misstatements due to fraud and error (management override) Under ISA 240 there is a presumed risk that revenue may be misstated due to improper revenue recognition. In the public sector, this requirement is modified by Practice Note 10 issued by the Financial Reporting Council, which states that auditors should also consider the risk that material misstatements may occur by the manipulation of expenditure recognition. The manipulation of revenue or expenditure would occur through management override of control. As the manipulation of revenue or expenditure would occur through management override of control the two risks are inherently linked. We have therefore reported them together. We have concluded that due to the pressure on Essex Partnership University NHS Foundation Trust to achieve its financial forecast year end position there is a risk of manipulation to achieve this position. We believe this	In order to address this risk, we carried out a range of procedures, including: • Identifying, discussing with management and testing key accounting estimates for evidence of bias; these included the valuation of land and buildings, PFI models, and estimated accruals including any for Provider Sustainability Funding. • Identifying and testing provisions, included the pension provisions, redundancy provisions, dilapidation provision and the provision for the former Severalls Hospital site for evicence of bias. • Identifying and testing any contract disputes or challenges, using the Department of Health Agreement of Balances information, to ensure the Trust's reported position was supportable. • Testing non-NHS debtor and creditor balances and income and expenditure amounts to supporting evidence, including settlement in cash (where possible). • Testing revenue transactions posted to the last month of the year and the first month of the	Our testing has not identified any material misstatements with respect to revenue and expenditure recognition. Overall our audit work did not identify any material issues or unusual transaction which indicated that there had been any misreporting of the Trust's financial position. We have not identified any instances of inappropriate judgements being applied.

manipulation is possible through both income and expenditure transactions and areas of significant estimation. We have assessed that this risk is more likely to impact on non-NHS balances, as the agreement of balances exercise provides assurance over the intra NHS balances.	current year to ensure that they have been appropriately treated for year end financial reporting • Testing the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements • Confirming there were no significant unusual transactions.	

In the prior year, our auditor's report included a key audit matter in relation to valuation of land and buildings. In the current year, the Trust has not had a full revaluation, instead they have received a report from their expert valuer which confirms the change in valuation of land and buildings is not material. We have reviewed the output from the valuer and compared to independent data and concluded that we agree with this assessment. The valuation of land and buildings has therefore not been classified as a key audit matter in the current year.

In the prior year, our auditor's report also included a key audit matter in relation to merger accounting. In the current year, no merger accounting is required as this was dealt within in the prior year. Therefore this has not been classified as a key audit matter in the current year.

An overview of the scope of our audit

Tailoring the scope

Our assessment of audit risk, our evaluation of materiality and our allocation of performance materiality determine our audit scope for the Foundation Trust. This enables us to form an opinion on the financial statements. We take into account size, risk profile, the organisation of the Foundation Trust and effectiveness of controls, including controls and changes in the business environment when assessing the level of work to be performed. All audit work was performed directly by the audit engagement team.

Materiality

The magnitude of an omission or misstatement that, individually or in the aggregate, could reasonably be expected to influence the economic decisions of the users of the financial statements. Materiality provides a basis for determining the nature and extent of our audit procedures.

We determined materiality for the Trust to be £6.1 million (2018: £6.9 million), which is 2% (2018: 2%) of operating expenses. We believe that operating expenses to be one of the principal considerations for stakeholders in assessing the financial performance of the Trust.

During the course of our audit, we reassessed initial materiality and updated our calculation using the draft financial statements, this caused a small reduction in the materiality level used, falling from £6.9 million at planning to £6.1 million using the draft accounts. This had no impact on the scope of our audit.

Performance materiality

The application of materiality at the individual account or balance level. It is set at an amount to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality.

On the basis of our risk assessments, together with our assessment of the Trust's overall control environment, our judgement was that performance materiality was 75% (2018: 75%) of our planning

materiality, namely £4.5 million (2018: £5.2 million). We have set performance materiality at this percentage due to the Trusts' history of not having any material errors in the financial statements.

Reporting threshold

An amount below which identified misstatements are considered as being clearly trivial.

We agreed with the Audit Committee that we would report to them all uncorrected audit differences in excess of £0.3 million (2018: £0.3 million), which is set at 4.9% of planning materiality, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

We evaluate any uncorrected misstatements against both the quantitative measures of materiality discussed above and in light of other relevant qualitative considerations in forming our opinion.

Other information

The other information comprises the information included in the Annual Report set out on pages 1 to 79, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

We read all the financial and non-financial information in the Annual Report 2018/19 to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

We have nothing to report in this regard.

Opinion on other matters prescribe by the Code of Audit Practice issued by the NAO

In our opinion:

- the information given in the performance report and accountability report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the parts of the Remuneration and Staff report identified as subject to audit has been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2018/19.

Matters on which we report by exception

The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;

- We are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources as required by schedule 1D(1)(d) of the National Health Service Act 2006;
- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the Department of Health and Social Care's Group Accounting Manual 2018/19and is not misleading or inconsistent with other information forthcoming from the audit; or
- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

The Department of Health and Social Care's Group Accounting Manual 2018/19 requires us to report to you if in our opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the NHS Foundation Trust acquired in the course of performing our audit; or
- otherwise misleading.

We have nothing to report in respect of these matters.

Responsibilities of Accounting Officer

As explained more fully in the Accountable Officer's responsibilities statement set out on page ii and iii, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Auditor's responsibilities with respect to value for money arrangements

We are required to consider whether the Foundation Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This is based on the overall criterion that "in all significant respects, the audited body had proper arrangements to ensure it took

properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people".

Proper arrangements are defined by statutory guidance issued by the National Audit Office and comprise the arrangements to:

- Take informed decisions;
- Deploy resources in a sustainable manner; and
- Work with partners and other third parties.

In considering your proper arrangements, we draw on the requirements of the guidance issued by NHS Improvement to ensure that our assessment is made against a framework that you are already required to have in place and to report on through documents such as your annual governance statement.

We are only required to determine whether there are any risk that we consider significant within the Code of Audit Practice which defines as:

"A matter is significant if, in the auditor's professional view, it is reasonable to conclude that the matter would be of interest to the audited body or the wider public. Significance has both qualitative and quantitative aspects".

Our risk assessment supports the planning of sufficient work to enable us to deliver a safe conclusion on arrangements to secure value for money and enables us to determine the nature and extent of further work that may be required. If we do not identify any significant risk there is no requirement to carry out further work. Our risk assessment considers both the potential financial impact of the issues we have identified, and also the likelihood that the issue will be of interest to local taxpayers, the Government and other stakeholders.

Certificate

We certify that we have completed the audit of the financial statements of Essex Partnership University NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General (C&AG).

Use of our report

This report is made solely to the Council of Governors of Essex Partnership University NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.

Debbie Hanson
for and on behalf of Ernst & Young LLP
Luton
28 May 2019

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

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

FOREWORD TO THE ACCOUNTS

Essex Partnership University NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by Essex Partnership University NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

If you require any further information on these accounts please contact:

The Executive Chief Finance Officer
Essex Partnership University NHS Foundation Trust
Trust Head Office
The Lodge
Lodge Approach
Runwell
Wickford
Essex SS11 7XX

Telephone: 01268 366000

Signed:..... **Date: 23 May 2019**

Sally Morris
Chief Executive

Statement of Comprehensive Income for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	2	289,442	324,135
Other operating income	3	29,292	28,122
Operating expenses	5	(305,336)	(348,388)
Operating surplus/(deficit) from continuing operations		**13,398**	**3,869**
Finance income	9	787	560
Finance expenses	9	(3,084)	(3,317)
PDC dividends payable		(4,526)	(4,617)
Net finance costs		**(6,823)**	**(7,374)**
Other gains / (losses)		(1,025)	67
Gains / (losses) arising from transfers by absorption		-	203,203
Surplus / (deficit) for the year from continuing operations		**5,550**	**199,765**
Surplus / (deficit) for the year		**5,550**	**199,765**
Other comprehensive income			
Impairments		(30)	(20,940)
Revaluations		1,673	19,647
Remeasurements of the net defined benefit pension scheme liability / asset		752	1,507
Total comprehensive income / (expense) for the period		**7,945**	**199,980**

*Prior year technical net gain of £203,203k was recognised at start of new organisation, being the total of assets and liabilities transferred from predecessor organisations, in line with the Transfer by Absorption accounting policy note 1.28.

The notes on pages 6 to 51 form part of these accounts. All income and expenditure is derived from continuing operations.

Statement of Financial Position as at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	10	7,199	8,596
Property, plant and equipment	11	194,527	192,895
Investment property	12	18,145	18,105
Total non-current assets		**219,871**	**219,596**
Current assets			
Inventories	13	450	636
Receivables	14	20,839	27,079
Non-current assets held for sale / assets in disposal groups	15	550	968
Cash and cash equivalents	16	63,289	60,028
Total current assets		**85,128**	**88,711**
Current liabilities			
Trade and other payables	17	(34,738)	(41,361)
Borrowings	19	(2,793)	(2,951)
Provisions	21	(4,558)	(6,287)
Other liabilities	18	(1,564)	(1,392)
Total current liabilities		**(43,653)**	**(51,991)**
Total assets less current liabilities		**261,346**	**256,316**
Non-current liabilities			
Borrowings	19	(38,725)	(41,484)
Provisions	21	(13,186)	(13,102)
Other liabilities	18	(1,156)	(1,750)
Total non-current liabilities		**(53,069)**	**(56,336)**
Total assets employed		**208,277**	**199,980**
Financed by			
Public dividend capital		127,597	127,245
Revaluation reserve		62,813	62,326
Other reserves		(1,156)	(1,750)
Income and expenditure reserve		19,023	12,159
Total taxpayers' equity		**208,277**	**199,980**

The Financial statements on pages 2 to 3 were approved by the Board on 23 May 2019 and signed on its behalf by,

Signed:..... **Date: 23 May 2019**

Sally Morris
Chief Executive

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 - brought forward	**127,245**	**62,326**	**(1,750)**	**12,159**	**199,980**
Surplus/(deficit) for the year	-	-	-	5,550	**5,550**
Other transfers between reserves	-	(915)	(159)	1,076	-
Impairments	-	(30)	-	-	**(30)**
Revaluations	-	1,673	-	-	**1,673**
Transfer to retained earnings on disposal of assets	-	(240)	-	240	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	752	-	**752**
Public dividend capital received	352	-	-	-	**352**
Taxpayers' equity at 31 March 2019	**127,597**	**62,813**	**(1,156)**	**19,023**	**208,277**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Surplus/(deficit) for the year	-	-	-	199,765	**199,765**
Transfers by absorption: transfers between reserves	127,245	63,625	(3,032)	(187,838)	-
Other transfers between reserves	-	-	(225)	225	-
Impairments	-	(20,940)	-	-	**(20,940)**
Revaluations	-	19,647	-	-	**19,647**
Transfer to retained earnings on disposal of assets	-	(6)	-	6	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	1,507	-	**1,507**
Taxpayers' equity at 31 March 2018	**127,245**	**62,326**	**(1,750)**	**12,159**	**199,980**

Statement of Cash Flows as at 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		13,398	3,899
Non-cash income and expense:			
Depreciation and amortisation	11	6,299	6,743
Net impairments		100	3,993
Non-cash movements in on-SoFP pension liability		158	225
(Increase) / decrease in receivables and other assets		5,464	2,383
(Increase) / decrease in inventories		65	(16)
Increase / (decrease) in payables and other liabilities		(5,509)	6,914
Increase / (decrease) in provisions		(1,842)	753
Other movements in operating cash flows		26	21
Net cash generated from / (used in) operating activities		**18,358**	**24,885**
Cash flows from investing activities			
Interest received		328	54
Purchase of intangible assets		(469)	(94)
Purchase of property, plant, equipment and investment property		(6,439)	(6,279)
Sales of property, plant, equipment and investment property		334	1
Net cash generated from / (used in) investing activities		**(6,246)**	**(6,318)**
Cash flows from financing activities			
Public dividend capital received		352	-
Movement on loans from the Department of Health and Social Care		(2,121)	(2,614)
Capital element of PFI, LIFT and other service concession payments		(850)	(1,054)
Interest on loans		(241)	(326)
Interest paid on PFI, LIFT and other service concession obligations		(2,397)	(2,486)
PDC dividend (paid) / refunded		(3,902)	(4,851)
Net cash generated from / (used in) financing activities		**(9,160)**	**(11,331)**
Increase / (decrease) in cash and cash equivalents		**2,952**	**7,236**
Cash and cash equivalents at 1 April - brought forward		**60,028**	-
Cash and cash equivalents transferred under absorption accounting		309	52,792
Cash and cash equivalents at 31 March		**63,289**	**60,028**

NOTES TO THE ACCOUNTS

1. Summary of Accounting Policies and Other Information

1.1 General Information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Presentation of Financial Statements

When preparing the financial statements the Trust will in normal circumstances follow the standard format. However, where it is determined that the standard format is not representative in reflecting the true performance of the Trust, the presentation of the primary statements may be amended accordingly.

1.2.1 Accounting convention

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

1.3 Going concern

These accounts have been prepared on a going concern basis. For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

1.4 Income

1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard

retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4.3 Other income

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

1.5 Expenditure on Employee Benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

NEST Pension Scheme

A small number of employees are members of the NEST (National Employment Savings Trust) Scheme. NEST is a defined contribution scheme. This means that the contributions paid in by the employer, the employee and anyone else are invested and used to build up the employee's own pension pot in accordance with the Scheme's policies.

The contributions are managed by a trust, NEST Corporation, representing the employees and the employer shares no gain or loss on those funds. The employer is responsible only for its pension cost contributions and nothing else and does not bear the risks related to the plan rather those risks are borne by employees.

Employer's pension cost contributions are charged to operating expenses as and when they become due. The current year's contributions are in note 5.1 below.

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can

be identified and are recognised in the trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.6 Expenditure on Other Goods and Services

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

1.7 Property, Plant & Equipment

Recognition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administrative services
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- It is expected to be used for more than one financial year; and
- The cost of the item can be measured reliably and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- They form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

Tenant Improvements

Property, plant and equipment are capitalised where they are tenant improvements made on leased properties, that costs at least £5,000 and add value to the leased property such that it is probable that future economic benefits will flow to the Trust for more than one year over the remaining lease term.

Measurement

Valuation

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

Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Certain assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

When revaluing assets arising from a PFI project, this should be based on a value excluding recoverable VAT, reflecting the cost at which the service potential would be replaced by the PFI operator.

In accordance with HM Treasury requirements, Land and Building assets are valued every 5 years, with an interim valuation at the end of the intervening 3rd year. The District Valuer is a professionally qualified Valuer and works in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual'.

Properties in the course of construction for service or administrative purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses, as allowed by IAS23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future

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

Depreciation

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

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The Trust applies the following useful lives to property, plant and equipment assets. The lives applied to building assets are based on the latest valuations received from the district valuer.

Main Asset Category	Sub Category	Minimum Useful Life (in years)	Maximum Useful Life (in years)
Buildings - owned	Structure	T	68
	Engineering and installations	1	36
	External works	T	62
Buildings - PFI schemes	Structure	59	62
	Engineering and installations	23	28
	External works	41	44
Plant, machinery and equipment	Medical and surgical equipment	5	15
	Office equipment	5	5
	IT Hardware	5	10
	Other engineering works	5	15
Furniture and fitting	Furniture	10	10
	Soft furnishings	T	7
Motor vehicles		T	7

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease previously recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

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

Impairments

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

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

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

De-recognition / Assets Held for Sale

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.

1. management are committed to a plan to sell the asset;
2. an active programme has begun to find a buyer and complete the sale
3. the asset is being actively marketed at a reasonable price;
4. the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
5. the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the net sale proceeds and the carrying amount and is recognised in the income statement. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Depreciation ceases to be charged and the assets are not re-valued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated assets

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

Donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI Contract)

PFI transactions which meet the IFRIC12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on Statement of Financial Position' by the Trust. In accordance with IAS17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred. The finance cost is calculated using the effective interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

1.8 Intangible Assets

Recognition

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

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

The Trust does not have any internally-generated intangible assets.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful economic lives.

Amortisation

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

The Trust applies the following useful lives to amortise intangible assets to arrive at the assets residual value'

Main Asset Category	Sub Category	Useful Economic Life minimum (in years)	Useful Economic Life maximum (in years)
Intangible assets	Software	5	15

1.9 Investment Properties

Investment Properties are those assets which are held solely for the purpose of generating rental income or capital appreciation within the meaning of IAS 40. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

On initial recognition, Investment Properties are measured at fair value and are subsequently re-valued annually, with any gain or loss arising being dealt with in the Statement of Comprehensive Income, in accordance with IAS40.

The Trust currently has properties which are leased to housing associations, other NHS organisations and private tenants, following the decommissioning of the services that were previously rendered from these properties.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The trust as lessee

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Leases of land and buildings

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

1.10.2 The trust as lessor

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.11 Inventories

Inventories are stated at lower of cost and net realisable value.

1.12 Financial Instruments and Financial Liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables and contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

At the Statement of Financial Position date, the trust assesses whether any financial assets, are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

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

Provision for debtor impairment

A provision will be provided against the recovery of debts, where such a recovery is considered doubtful. Where the recovery of a debt is considered unlikely, the debt will either be written down directly to the Statement of Comprehensive Income, or charged against a provision to the extent that there is a balance available for the debt concerned, and thereafter charged to operating expenses.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.13 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 21 but is not recognised in the Trust's accounts.

Non clinical risk pooling

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

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an income of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Public dividend capital

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

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

1.17 Taxation

Essex Partnership University NHS Foundation Trust is a Health Service body within the meaning of s519AICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within the categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (s519 A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000pa. There is no tax liability arising in the current financial year.

1.18 Value Added Tax

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

1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury's FReM.

1.20 Capital commitments

For ongoing capital projects at the balance sheet date, the value of capital commitments will be based on the value of contracted work not yet completed at the balance sheet date. The value of the capital commitment is disclosed at note 23.

1.21 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients (see 'third party assets' above). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.22 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.23 Key Sources of Judgement and Estimation Uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Provisions

Provisions have been made in line with management's best estimates and in line with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

The Trusts post-employment benefits are rebased periodically subject to life expectancy assumptions as issued by Government Actuary Department. The real discount rate issued by the HM Treasury annually is also applied to the provision to determine the provision required as at the end of the financial year. The real discount rate applicable on 31 March 2019 was 0.29% (the previous year's rate was 0.10%). The total provisions relating to post-employment benefits as at the end of the financial year was £8,110k.

The Trust also holds a provision for its expense obligations in relation to the redevelopment of the former Severalls hospital site. This obligation is as a result of a joint Education Agreement and Highways (NAR3) Agreement that the Trust has with the Essex County Council along with Homes England building consortium, to provide financial support to the new housing development in terms of highways and schools. Whilst the obligation relating to the Education agreement has now been fulfilled, that which relates to the Highways Agreement is yet to be fulfilled. The Trust therefore maintains a provision of £6,344k with the expected timing of cashflow being over the next three years. The real discount rate applicable on 31 March 2019 was 0.76%.

Apart from the above provisions, the Trust has no other material provisions, or provisions which may change materially as a result of any underlying uncertainty.

Pensions

The valuations of the NHS Pensions Scheme liability and the Local Government Pension Scheme are carried out by the schemes' actuaries. These involve a degree of actuarial and financial assumptions and estimates.

Assumptions regarding valuation of Investment Properties, Land and Buildings

The Trust's Investment Properties, Land and Buildings are valued by the District Valuer. This involves a significant degree of judgement and estimation techniques and the results reflect the specialist professional assessment of the conditions within the external property market.

Assumptions regarding depreciation of Property, Plant and Equipment and Intangible Assets

The depreciation of Buildings is based on the value and life of the assets as periodically determined by the District Valuer.

The depreciation of other assets is based on the value and life of the assets in line with the accounting standard, IAS 16 *Property, Plant and Equipment*. The Standard requires that the useful life of an asset be reviewed regularly and, if expectations differ from previous estimates, any change is accounted for prospectively as a change in estimate under the Accounting Standard, IAS 8 *Accounting Policies, Changes in Accounting Estimates and Errors*.

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognized in the financial statements:

Consolidation of the EPUT Charity Accounts with the Trust Accounts

The accounting standards require consolidation of a group of entities under the control of a parent where there exists the power to govern the financial and operational policies of an entity so as to obtain benefits from its activities. As the Trust is a corporate trustee of the Essex Partnership NHS Foundation Trust General Charitable Fund, hence controls it, and the purpose of the Charities is to assist NHS patients, hence the Trust benefits from its activities, the requirements of the relevant accounting standards is normally applicable in the preparation of the Trust Accounts.

However, In line with IAS 1, *Presentation of Financial Statements*, specific disclosure requirements set out in individual accounting standards or interpretations need not be satisfied if the information is not material. The net assets of the Charity is about 0.5% of the Trust's total assets employed, and are therefore not considered to be material in the context of the Trusts wider accounts. As such, the Board of Directors have noted and approved that the Charities Accounts will not be consolidated into the main Trust Accounts for 2018/19. This will be subject to an annual materiality review each financial year.

1.24 Change in Accounting Estimate

The Trust reviews the useful lives of its non-current assets, including IT assets to identify assets where the expectations of the length of useful lives of the assets exceed previous estimates. Where this is the case, the carrying amounts of the relevant assets are adjusted as a result of the adjustment of their useful lives, in line with current expectations of the future benefits associated with the assets.

1.25 Operating Segments

Under International Financial Reporting Standards, operating segments are components of an entity that engage in separate revenue earning activities, have discrete financial information available, and whose results are reviewed regularly by the entity's chief operating decision maker. Activities or departments of an organisation that earn no or incidental revenues would not be operating segments.

Operating segments are reported in a manner consistent with the internal reporting to the Chief Operating Decision Maker of the Trust. The Chief Operating Decision Maker of the Trust is the Trust Board.

The Trust's activities constitute a single segment of healthcare activity provided wholly in the UK, are subject to similar risks and rewards and all assets are managed as one central pool. And this is consistent with the Trust's monthly financial report to the Trust Board.

1.26 Limitation of auditor's liability

In line with guidance from the Financial Reporting Council, the Trust's external auditor, Ernst & Young LLP, have limited their liability in respect of their external audit work. The limitation on auditors' liability for external audit work is £2m.

1.27 Accounting standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption, with IFRS 16 being anticipated for implementation in 2019/20.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The Trust's classification of some of its operating leases such as the leased vehicles will change to finance leases on adoption of this standard, however, the Trust does not expect the adoption of this standard to have a material impact on the 2019/20 accounts.
- IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not

therefore permitted. The Trust does not expect the adoption of this standard to have a material impact on the 2021/22 accounts.

- IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019. The Trust does not expect the adoption of this standard to have a material impact on the 2019/20 accounts.

1.28 Transfer by absorption

For functions that have been transferred to the trust from another NHS/local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS/local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the foundation trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

On the 1st of April 2018, the Bedfordshire Clinical Commissioning Group appointed the East London NHS Foundation Trust (ELFT) as the new provider for adult services and Cambridgeshire Community Services (CCS) as the new provider for children, acquired brain injury and neurological rehabilitation services.

The Trust has accounted for these transfers of functions in line with the above policy. The corresponding net assets/liabilities transferred recognised within income/expenses was nil with a cash receivable amount of £309k for the total net assets/liabilities transferred. There was no land/building transferred.

As a result of this transfer, the Trust's income base reduced by £41.7 million during 2018/19 and 1,069 staff have TUPE'd to the new providers as of 1st April 2018 which equates to an approximate annual pay cost of £29.4 million.

1.29 Prior Period Adjustment

Prior period adjustments may arise from a change in accounting policy or in correcting a material error.

Changes in accounting policies are only made when required by proper accounting practices or when the effect of the changes will provide more reliable or relevant information regarding the impact of transactions, other events and conditions on the Authority's financial position or financial performance.

Where a change is made, it is applied retrospectively (unless stated otherwise), by adjusting opening balances and comparative amounts for the prior period as if the new policy had always been applied.

Material errors identified in prior period amounts are corrected retrospectively by amending opening balances and comparative amounts for the prior period.

New or updated information may give rise to reclassifications between balances in the Statement of Financial Position, thereby leading to the restating of their opening balances under the new classifications. Where such reclassification is material, this is disclosed as a PPA.

1.29a During the financial year, the Trust made the following prior period adjustment:

Financial statement line item	As previously stated in 2017/18 audited year end return 31 Mar 2018 2017/18 £000	As restated in 2018/19 Opening Balances 31 Mar 2018 2017/18 £000	PPA 31 Mar 2018 2017/18 £000
Current liabilities			
Trade and other payables	(38,460)	(41,361)	**(2,901)**
Provisions	(6,287)	(6,287)	**0**
Non-current liabilities			
Trade and other payables	(8,039)	0	**8,039**
Provisions	(7,964)	(13,102)	**(5,138)**

The above PPA relates to the reclassification of the Trust's expense obligation regarding the redevelopment of the former Severalls hospital site, from Trade and other payables (Accruals) to Provisions, due to updated information regarding the levels of certainty around the timing of payment and potential value.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Cost and volume contract income	26,281	26,668
Block contract income	169,095	162,086
Clinical partnerships providing mandatory services (including S75 agreements)	4,153	9,207
Other clinical income from mandatory services	15,483	10,492
Community services income from CCGs and NHS England	65,619	99,826
Income from other sources (e.g. local authorities)	5,698	15,844
Private patient income	21	12
Agenda for Change pay award central funding	3,092	-
Total income from activities	**289,442**	**324,135**

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	41,706	42,604
Clinical commissioning groups	219,160	253,260
Department of Health and Social Care	3,092	-
Other NHS providers	4,412	2,849
Local authorities	18,260	22,783
Non-NHS: private patients	21	12
Non NHS: other	2,791	2,627
Total income from activities	**289,442**	**324,135**

Note 3 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	493	477
Education and training (excluding notional apprenticeship levy income)	7,571	6,337
Non-patient care services to other bodies	100	195
Provider sustainability / sustainability and transformation fund income (PSF / STF)	8,778	7,855
Income in respect of employee benefits accounted on a gross basis	779	864
Other contract income (Note 3.1)	8,791	7,968
Other non-contract operating income		
Charitable and other contributions to expenditure	29	36
Rental revenue from operating leases	2,751	4,388
Total other operating income	**29,292**	**28,122**

Note 3.1 Analysis of other contract income

	2018/19 £000	2017/18 £000
Catering	90	78
Pharmacy sales	38	24
Staff accommodation rental	65	72
Estates recharges (external)	2309	2226
IT recharges (external)	5288	4983
Other income not already covered (recognised under IFRS 15)	1001	585
Total other contract income	8791	7968

Note 4 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	771
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the 'provider license' and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below

	2018/19 £000	2017/18 £000
Income from services designated as commissioner requested services	289,421	324,123
Income from services not designated as commissioner requested services	21	12
Total	**289,442**	**324,135**

Note 5 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	3,813	4,638
Purchase of healthcare from non-NHS and non-DHSC bodies	5,021	4,433
Staff and executive directors costs	221,110	243,627
Remuneration of non-executive directors	171	157
Supplies and services - clinical (excluding drugs costs)	5,621	7,680
Supplies and services - general	7,657	8,646
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,007	4,752
Consultancy costs	2,499	2,066
Establishment	6,002	6,158
Premises	16,114	16,547
Transport (including patient travel)	3,972	4,837
Depreciation on property, plant and equipment	5,044	5,504
Amortisation on intangible assets	1,255	1,239
Net impairments	100	3,993
Movement in credit loss allowance: contract receivables / contract assets	782	
Movement in credit loss allowance: all other receivables and investments	-	2,199
Increase/(decrease) in other provisions	1,313	128
Change in provisions discount rate(s)	-	100
Audit fees payable to the external auditor		
audit services- statutory audit	67	66
Internal audit costs	106	181
Clinical negligence	1,765	1,635
Legal fees	(185)	1,245
Insurance	325	481
Research and development	561	536
Education and training	2,306	2,370
Rentals under operating leases	11,371	15,313
Redundancy	755	4,347
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,721	1,222
Car parking & security	770	527
Hospitality	40	37
Losses, ex gratia & special payments	55	23
Other services, eg external payroll	1,677	1,312
Other	(1,703)	1,569
Total	**305,336**	**348,388**

Note 6 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	170,690	187,575
Social security costs	15,502	17,368
Apprenticeship levy	753	910
Employer's contributions to NHS pensions	20,171	22,395
Pension cost - other	252	467
Other post employment benefits	(144)	(183)
Termination benefits	44	3,404
Temporary staff (including agency)	15,149	17,124
Total gross staff costs	**222,817**	**249,080**
Recoveries in respect of seconded staff	-	-
Total staff costs	**222,817**	**249,080**

There are no non pay benefits which are not attributable to individual employees.

Note 6.1 Retirements due to ill-health

During 2018/19 there were 3 early retirements from the Trust agreed on the grounds of ill-health (9 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £99k (£752k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 6.2 Director Remunerations and Staff Costs

The analysis of directors' remunerations and pension benefits for the year ended 31 March 2019 are in the Remuneration Report section of the Annual Report.

The analysis of staff costs, average staff numbers and staff exit packages for the year ended 31 March 2019 are in the Staff Report section of the Annual Report.

Note 6.3 Employee retirement benefit obligation

Note 6.3.1 Amounts recognised in the SoCI

	2018/19 £000	2017/18 £000
Current service cost	(252)	(301)
Net interest (expense) / income	(43)	(82)
Past service cost	-	-
Administration expenses	(7)	(5)
Total net (charge) / gain recognised in SOCI	**(302)**	**(388)**

Note 6.3.2 Principal actuarial assumptions

	31 March 2019 %	31 March 2018 %
Discount rate	2.40	2.55
Pension increases	2.40	2.30
Rate of increase in salaries	3.90	3.80

Note 6.3.3 Amount recognised in the Statement of Financial Position

	31 March 2019 £000	31 March 2018 £000
Present value of the defined benefit obligation	(18,288)	(18,252)
Plan assets at fair value	17,132	16,502
Net defined benefit (obligation) / asset recognised in the SoFP	**(1,156)**	**(1,750)**
Fair value of any reimbursement right	-	-
Net (liability) / asset recognised in the SoFP	**(1,156)**	**(1,750)**

Note 6.3.4 Change in benefit obligation

	31 March 2019 £000	31 March 2018 £000
Present value of the defined benefit obligation at 1 April	**(18,252)**	**-**
Prior period adjustment	-	-
Present value of the defined benefit obligation at 1 April - restated	**(18,252)**	**-**
Present value of the defined benefit obligation at start of period for new FTs	**-**	**-**
Transfers by absorption	-	(18,189)
Current service cost	(252)	(301)
Interest cost	(459)	(506)
Contribution by plan participants	(51)	(56)
Remeasurement of the net defined benefit (liability) / asset		
- Actuarial (gains) / losses	179	521
Benefits paid	547	279
Present value of the defined benefit obligation at 31 March	**(18,288)**	**(18,252)**

Note 6.3.5 Change in fair value of plan assets

	31 March 2019 £000	31 March 2018 £000
Plan assets at fair value at 1 April	16,502	-
Prior period adjustment		-
Plan assets at fair value at 1 April -restated	16,502	-
Transfers by normal absorption		15,157
Interest income	416	424
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets	573	986
- Actuarial gain / (losses)	-	-
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	-	-
Contributions by the employer	137	158
Contributions by the plan participants	51	56
Benefits paid	(547)	(279)
Business combinations	-	-
Settlements	-	-
Plan assets at fair value at 31 March	17,132	16,502

Note 6.3.6 Remeasurement in Other Comprehensive Income

	31 March 2019 £000	31 March 2018 £000
Return on funds assets in excess of interest	573	986
Change in financial assumption	(814)	521
Change in demographic assumptions	993	-
Remeasurement of the net assets /(defined liability)	752	1,507

Note 6.3.7 Projected pension expenses

	31 March 2020
Service cost	250
Net interest on defined liability	26
Administration expenses	7
Total	283
Employer contribusions	144
Total	144

Note 6.3.8 Sensitivity analysis

Adjustment to discount rate	**0.1%**	**0.0%**	**-0.1%**
Present valu total obligation	17,937	18,288	18,646
Projected cost	245	250	255
Adjustment to long term salary increase	**0.1%**	**0.0%**	**-0.1%**
Present valu total obligation	18,326	18,288	18,249
Projected cost	250	250	250
Adjustment to pension increases and deferred revaluation	**0.1%**	**0.0%**	**-0.1%**
Present valu total obligation	18,606	18,288	17,976
Projected cost	255	250	245
Adjustment to life expectancy assumptions	**+1 year**	**None**	**-1 year**
Present valu total obligation	18,912	18,288	17,665
Projected cost	258	250	242

Note 7 The Late Payment of Commercial Debts (interest) Act 1998.

There was a total interest payment of £91 relating to the late payment of commercial debts in the year ended 31 March 2019 (2017/18: £427).

Note 8 Operating leases

Lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	2,751	4,388
Total	**2,751**	**4,388**

	31 March 2019			31 March 2018
	Building £000	Other £000	Total £000	£000
Future minimum lease receipts due:				
- not later than one year;	1,733	444	2,177	2,215
- later than one year and not later than five years;	1,195	348	1,543	1,772
- later than five years.	700	-	700	792
Total	**3,628**	**792**	**4,420**	**4,779**

as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Essex Partnership University NHS Foundation Trust is the lessee.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	11,371	15,313
Contingent rents	-	-
Less sublease payments received	-	-
Total	**11,371**	**15,313**

	31 March 2019			31 March 2018
	Building £000	Other £000	Total £000	£000
Future minimum lease payments due:				
- not later than one year;	8,998	1,238	10,236	11,231
- later than one year and not later than five years;	5,418	906	6,324	5,313
- later than five years.	50,487	-	50,487	50,387
Total	**64,903**	**2,144**	**67,047**	**66,931**
Future minimum sublease payments to be received	-	-	-	-

Note 9 Finance income and finance expenditure

Note 9.1 Finance income

	2018/19 £000	2017/18 £000
Interest on bank accounts	371	136
Other finance income	416	424
Total finance income	**787**	**560**

Note 9.1 Finance expenditure

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	234	326
Main finance costs on PFI and LIFT schemes obligations	1,763	1,828
Contingent finance costs on PFI and LIFT scheme obligations	628	648
Total interest expense	**2,625**	**2,802**
Unwinding of discount on provisions	-	9
Other finance costs	459	506
Total finance costs	**3,084**	**3,317**

Note 10 Intangible assets

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	**17,272**	**176**	**17,448**
Transfers by absorption	-	-	-
Additions	410	-	**410**
Disposals / derecognition	(699)	(176)	**(875)**
Valuation / gross cost at 31 March 2019	**16,983**	**-**	**16,983**
Amortisation at 1 April 2018 - brought forward	**8,852**	**-**	**8,852**
Transfers by absorption	-	-	-
Provided during the year	1,255	-	**1,255**
Disposals / derecognition	(323)	-	**(323)**
Amortisation at 31 March 2019	**9,784**	**-**	**9,784**
Net book value at 1 April 2018	**8,420**	**176**	**8,596**
Net book value at 31 March 2019	**7,199**	**-**	**7,199**

Note 11 Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	48,541	132,000	1,140	6,895	5,027	388	11,591	2,653	209,235
Adjustment to brought forward balances	-	-	-	-	-	-	-	(468)	(468)
Transfers by absorption	-	-	-	-	-	-	(99)	-	(99)
Additions	-	4,280	-	48	52	-	1,281	-	5,641
Impairments	(30)	-	-	-	-	-	-	-	(30)
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	34	1,668	-	-	-	-	-	-	1,603
Reclassifications	(120)	6,184	-	(6,722)	-	-	323	-	(335)
Disposals / derecognition	-	-	-	(116)	(17)	-	(92)	-	(225)
Valuation/gross cost at 31 March 2019	48,425	144,032	1,140	105	5,062	388	12,984	2,185	215,322
Accumulated depreciation at 1 April 2018 - brought forward	-	-	-	-	3,253	335	10,099	2,653	16,340
Adjustment to brought forward balances	-	-	-	-	-	-	-	(468)	(468)
Transfers by absorption	-	-	-	-	-	-	(20)	-	(20)
Provided during the year	-	4,273	46	-	286	26	469	-	5,044
Impairments	-	-	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	(71)	-	-	-	-	-	-	(71)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(13)	-	(18)	-	(31)
Accumulated depreciation at 31 March 2019	-	4,202	46	-	3,539	361	10,451	2,185	20,794
Net book value at 1 April 2018	48,541	132,000	1,140	6,895	1,774	53	1,492	-	192,895
Net book value at 31 March 2019	48,425	139,830	1,094	105	1,523	27	2,523	-	194,528

Note 11.1 Property, plant and equipment financing

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
March 2019									
Owned - purchased	49,425	107,301	1,094	105	1,523	27	2,523	-	161,998
On-SoFP PFI contracts and other service concession arrangements	-	32,424	-	-	-	-	-	-	32,424
Owned - donated	-	105	-	-	-	-	-	-	105
NBV total at 31 March 2019	49,425	139,830	1,094	105	1,523	27	2,523	-	194,527

11.2 The analysis of revaluation of property plant and equipment

	2018/19 Total £'000	Revaluation Reserve Surplus £'000	Revaluation Reserve Impairment £'000	Operating Income Reversal of Impairment £'000	Operating Expenses Impairment £'000
Land	4	34	(30)	-	-
Building	1,639	1,639	-	-	-
Total	1,643	1,673	(30)	-	-

The above revaluation reserve surplus and impairment are mainly attributable to the revaluation of the Derwent Centre following the completion of major enhancement works to the building in July 2018, as well as the revaluation of the 72 London Road property prior to its reclassification as an investment property from April, 2018. These revaluations have been performed in line with the DHSC GAM and relevant accounting standards and carried out by the District Valuer.

11.3 Remaining Economic lives of Property, Plant and Equipment

Main Asset Category	Sub Category	Minimum Useful Life (in years)	Maximum Useful Life (in years)
Buildings - owned	Structure	6	67
	Engineering and installations	4	35
	External works	6	61
Buildings - PFI schemes	Structure	58	61
	Engineering and installations	22	27
	External works	40	43
Plant, machinery and equipment	Medical and surgical equipment	2	10
	Office equipment	0	0
	IT Hardware	1	5
	Other engineering works	1	10
Furniture and fitting	Furniture	0	0
	Soft furnishings	0	0
Motor vehicles		1	2

11.4 Assets under PFI contract

	2018/19 £000
Cost or valuation	
Cost/Valuation at 1 April	33,017
Additions during the year	166
Impairments	-
Revaluation	-
Cost/Valuation at 31 March 2019	**33,182**
Accumulated depreciation	
Cost/Valuation at 1 April	-
Provided during the year	(759)
Revaluation	-
Accumulated depreciation at 31 March 2019	**(759)**
Net Book Value at 1 April 2018	33,017
Net Book Value at 31 March 2019	**32,424**

EMI Homes – PFI

In 2004, two homes were opened for the provision of care for the Elderly Mentally Ill. The construction has been financed by a private finance initiative, between the legacy South Essex Partnership Trust (now Essex Partnership University NHS Foundation Trust) (the grantor) and Ryhurst (the operator), under a public private service concession arrangement.

The term of the arrangement is 30 years, over which the grantor will repay the financing received from the operator, ending in 2033. At the end of the financing period legal ownership will pass from Ryhurst to Essex Partnership University NHS Foundation Trust.

During the period of the arrangement the grantor will have full and sole use of the properties to provide the health care services as described above.

The operator is contracted to provide maintenance services of a capital and revenue nature over the period of the contract. No material capital expenditure is included in the contract arrangement.

Maintenance costs payable to the operator are subject to annual increases based on the Consumer Price Index (CPI).

There are no changes in the arrangement over the contract period.

Forensic Unit - PFI

In November 2009 a new forensic unit was opened to provide low and medium secure services. The construction of the new facility has been financed by a private finance initiative between the legacy South Essex Partnership Trust (now Essex Partnership University NHS Foundation Trust) (the grantor) and Grosvenor House (the operator), under a public private service concession arrangement.

The term of the arrangement, over which the grantor will repay financing received to the operator, is 29 years ending in 2037. At the end of the financing period legal ownership will pass from Grosvenor House to Essex Partnership University NHS Foundation Trust.

During the period of the arrangement the grantor will have full and sole use of the unit to provide health care services as described above.

The operator is contracted to provide maintenance services of a capital and revenue nature over the period of the contract.

Maintenance costs payable to the operator are subject to annual increases based on the Consumer Price Index (CPI).

There are no changes in the arrangement over the contract period.

Finance Leases

There were no assets held under finance leases and hire purchase contracts at the end of the reporting period and therefore there was no depreciation charged in the statement of comprehensive income.

Note 12 Investment Property

	2018/19	2017/18
	£000	£000
Carrying value at 1 April - brought forward	**18,105**	**-**
Transfers by absorption	-	15,914
Movement in fair value	(295)	511
Reclassifications to/from PPE	335	1,680
Carrying value at 31 March	**18,145**	**18,105**

The Trust's policy is to annually revalue its investment properties in accordance with accounting guidance. The revaluation provided by the District Valuer showed a decrease of £295,000 during 2018/19.

In April 2018, 72 London Road property was transferred from PPE to Investment Property

Note 13 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	159	150
Other	291	486
Total inventories	**450**	**636**

Note 14 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	22,674	-
Trade receivables*	-	14,921
Accrued income*	-	13,014
Allowance for impaired contract receivables / assets*	(4,301)	-
Allowance for other impaired receivables	-	(4,470)
Prepayments (non-PFI)	2,005	1,657
PDC dividend receivable	35	659
VAT receivable	365	1,212
Other receivables	61	86
Total current trade and other receivables	**20,839**	**27,079**

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 14.1 Allowances for credit losses

	Contract receivables and contract assets
	£000
Allowances as at 1 April 2018 - brought forward	**4,470**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-
New allowances arising	4,035
Reversals of allowances	(3,253)
Utilisation of allowances (write offs)	(951)
Allowances as at 31 March 2019	**4,301**

Note 15 Non-current assets held for sale

	2018/19 £000	2017/18 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**968**	**-**
Transfers by absorption	-	322
Assets classified as available for sale in the year	-	650
Assets sold in year	(318)	-
Impairment of assets held for sale	(100)	(5)
groups at 31 March	**550**	**968**

As at 1st April, 2018, the Trust had two properties held for sale, one of which was sold during the financial year i.e. No. 32 Thoroughgood Road, Essex. The Trust continues to hold the other property i.e. No. 4 The Glade, Bedfordshire for sale.

Note 16 Cash and cash equivalents

	2018/19 £000	2017/18 £000
At 1 April	**60,028**	**-**
Transfers by absorption	309	52,792
Net change in year	2,952	7,236
At 31 March	**63,289**	**60,028**
Broken down into:		
Cash at commercial banks and in hand	1,322	4,585
Cash with the Government Banking Service	61,967	55,443
Total cash and cash equivalents as in SoCF	**63,289**	**60,028**

Note 17 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	6,859	7,061
Capital payables	104	961
Accruals	20,338	25,304
Social security costs	2,721	2,832
Other taxes payable	1,946	2,056
Accrued interest on loans*		41
Other payables	2,771	3,106
Total current trade and other payables	**34,738**	**41,361**

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated

Note 18 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	1,564	1,392
Total other current liabilities	**1,564**	**1,392**
Non-current		
Net pension scheme liability	1,156	1,750
Total other non-current liabilities	**1,156**	**1,750**

Note 19 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	1,670	2,121
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,123	830
Total current borrowings	**2,793**	**2,951**
Non-current		
Loans from the Department of Health and Social Care	12,225	13,861
Obligations under PFI, LIFT or other service concession contracts	26,500	27,623
Total non-current borrowings	**38,725**	**41,484**

The Trust holds four single currency term loans from the Secretary of State for Health as follows:

	Amount Outstanding (Current) £000	Amount Outstanding (Non Current) £000	Interest Rate	Repayment Date
Loan 1	738	1,109	2.65%	March 2022
Loan 2	501	1,000	1.42%	March 2022
Loan 3	427	4,002	2.17%	March 2030
Loan 4	4	6,114	0.58%	March 2022
	1,670	**12,225**		

The Trust is responsible for ensuring that it is able to repay its borrowings and any associated interest charges

Note 20 On-SoFP PFI, LIFT or other service concession arrangements

Note 20.1 Imputed finance lease obligations

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**45,895**	**48,487**
Of which liabilities are due		
- not later than one year;	2,635	2,592
- later than one year and not later than five years;	10,443	10,871
- later than five years.	32,617	35,024
Finance charges allocated to future periods	(18,272)	(20,034)
Net PFI, LIFT or other service concession arrangement obligation	**27,623**	**28,453**
- not later than one year;	1,123	830
- later than one year and not later than five years;	4,264	4,420
- later than five years.	22,236	23,203
	27,623	**28,453**

Note 20.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**103,253**	**132,448**
Of which liabilities are due:		
- not later than one year;	5,054	4,931
- later than one year and not later than five years;	20,369	22,692
- later than five years.	77,830	104,825

Note 20.3 Analysis of amounts payable to service concession operator

	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**4,942**	**4,756**
Consisting of:		
- Interest charge	1,763	1,828
- Repayment of finance lease liability	830	1,058
- Service element and other charges to operating expenditure	1,227	1,138
- Capital lifecycle maintenance	-	-
- Revenue lifecycle maintenance	494	84
- Contingent rent	628	648
Total amount paid to service concession operator	**4,942**	**4,756**

Note 20.4 PFI commitment in respect of the service element

	31 March 2019 £000	31 March 2018 £000
Of which commitments are due		
Within one year	1,205	1,216
2nd to 5th year (including)	5,045	5,170
Later than five years	17,249	20,967
Total	23,499	27,353

Note 21 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Redundancy £000	Other* £000	Total £000
At 1 April 2018	**5,851**	**2,766**	**105**	**1,564**	**9,103**	**19,389**
Arising during the year	527	211	18	1,625	1,511	3,892
Utilised during the year	(463)	(153)	(24)	(534)	(1,939)	(3,113)
Reversed unused	(609)	(21)	-	(870)	(921)	(2,421)
At 31 March 2019	**5,306**	**2,803**	**99**	**1,785**	**7,754**	**17,747**
Expected timing of cash flows:						
- not later than one year;	303	163	99	1,785	2,205	4,558
- later than one year and not later than five years	1,191	847	-	-	5,546	7,384
- later than five years	3,812	1,793	-	-	-	5,805
Total	5,306	2,803	99	1,785	7,754	17,747

* Other provisions consist mainly of provisions for dilapidation costs of leased buildings, obligations in relation to the redevelopment of the former Severalls hospital site and onerous contracts.

The total value of clinical negligence provisions carried by the NHS Resolution on the Trust's behalf as at 31 March 2019 was £ 8,564,014 (2017/18: £29,378,727).

22 Movements on Reserves

	Total	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**72,735**	**62,326**	**(1,750)**	**12,159**
Surplus/(deficit) for the year	**5,550**	-	-	5,550
Transfers between reserves	**158**	(918)	-	1,076
Net impairments	**(30)**	(30)	-	-
Revaluations - property, plant and equipment	**1,673**	1,673	-	-
Transfer to retained earnings on disposal of assets	**0**	(240)	-	240
TAXPAYERS' EQUITY AT 31 MARCH 2019	**80,086**	**62,813**	**(1,750)**	**19,023**

23. Capital Commitments

The value of the capital commitments under expenditure contracts at 31 March 2019 was nil (2017/18: £588,056).

24. Events after the Reporting Period

24.1 Authorising Accounts for Issue

In accordance with IAS 10, the Trusts Annual Accounts were authorised for issue by the Chief Executive / Accounting Officer on 23 May 2019.

25. Contingencies

As at 31 March 2019, the Trust had contingent liabilities in respect of the liabilities to third parties scheme totaling £86,871 (2017/18: £75,466).

26. Related Party Transactions

Essex Partnership University NHS Foundation Trust is a body corporate established by the Secretary of State. The Independent Regulator of NHS Foundation Trusts ("Monitor") and other foundation trusts are considered related parties. The Department of Health and Social Care is regarded as a related party as it exerts influence over a number of transactions and operating policies of the Trust. During the year ended 31 March 2019 the Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department of those entities.

During the year and at the period end, the Trust had material transactions with other NHS bodies namely NHS Mid Essex CCG, NHS North East Essex CCG, NHS Thurrock CCG, NHS West Essex CCG, NHS Basildon and Brentwood CCG, NHS Castle Point and Rochford CCG, NHS Southend CCG, Health Education England, NHS England – Core, NHS England - East Local

Office, NHS England - East of England Specialised Commissioning Hub, Department of Health and Social Care.

During the year and at the period end, the Trust had material transactions with other public sector bodies namely Essex County Council, Southend-on-Sea Borough Council, Her Majesty's Revenue and Customs and NHS Pensions.

Other than those disclosed under note 28.1, during the year none of the Board Members, Governors or members of the key management staff or parties related to them has undertaken any material transactions with Essex Partnership University NHS Foundation Trust.

The Governors appointed to the Council of Governors may also be members of Boards and Committees of local stakeholder organisations. Local stakeholder organisations can nominate an individual as a Governor on the Council under the following arrangements:

Four Local Authority Governors, one each appointed by:

- Bedford Borough Council and Central Bedfordshire Council (joint appointment)
- Essex County Council
- Southend on Sea Borough Council
- Thurrock Council.

Three Partnership Governors appointed by partnership organisations, one each appointed by:

- Essex University and Anglia Ruskin University (joint appointment)
- CVS Essex
- Service Users & Carers Forum

Essex Partnership University NHS Foundation Trust is the Corporate Trustee of the Essex Partnership NHS Foundation Trust General Charitable Fund. During the year ended 31 March 2019, the Trust received income of £27,240 from the Charity for administrative services provided by the Trust on behalf of the Charity. The Trust did not receive any capital payments. All the members of the Corporate Trustee are also members of the Essex Partnership University NHS Foundation Trust Board.

26.1 Director's Interests

Professor Sheila Salmon is the Emeritus Professor of Health Services Development at the Anglia Ruskin University. The Trust total expenditure made to Anglia Ruskin University in the financial year was £109,691 for trainings, course fees, research studies, accommodation, room hire & catering. The trust total income received from Anglia Ruskin University in the financial year was £7,048 for student placement grant.

27. Financial Instruments

IFRS 7, Financial Instruments: Disclosures, requires disclosure of information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the entity is exposed at the end of the reporting period. Because of the continuing service provider relationship that the Trust has with the local Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. The Trust has limited powers to borrow or invest surplus funds and financial assets and

liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Credit risk

Over 90% of the Trusts income is from contracted arrangements with commissioners. As such any material credit risk is limited to administrative and contractual disputes.

Where a dispute arises, provision will be made on the basis of the age of the debt and the likelihood of a resolution being achieved.

Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from cash made available from prior year surpluses; and Public Dividend Capital funding that may be available from the Department of Health and Social Care to fund particular projects. The Trust has also funded two of its buildings through Private Finance Initiative scheme. Essex Partnership University NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Essex Partnership University NHS Foundation Trust is not, therefore, exposed to significant interest rate risk.

Foreign currency risk

The Trust has negligible foreign currency income and expenditure.

Note 27.1 Carrying values of financial assets

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	18,434	**18,434**
Cash and cash equivalents at bank and in hand	63,289	**63,289**
Total at 31 March 2019	**81,723**	**81,723**

	Loans and receivables £000	Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39		
Trade and other receivables excluding non financial assets	24,210	**24,210**
Cash and cash equivalents at bank and in hand	60,028	**60,028**
Total at 31 March 2018	**84,238**	**84,238**

Note 27.2 Carrying value of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	13,895	**13,895**
Obligations under PFI, LIFT and other service concession contracts	27,623	**27,623**
Trade and other payables excluding non financial liabilities	27,301	**27,301**
Provisions under contract	9,638	**9,638**
Total at 31 March 2019	**78,456**	**78,456**

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	15,982	**15,982**
Obligations under PFI, LIFT and other service concession contracts	28,453	**28,453**
Trade and other payables excluding non financial liabilities	38,505	**38,505**
Provisions under contract	5,633	**5,633**
Total at 31 March 2018	**88,573**	**88,573**

Note 27.3 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	34,181	47,069
In more than one year but not more than two years	3,710	2,759
In more than two years but not more than five years	15,921	12,717
In more than five years	24,644	26,008
Total	**78,456**	**88,573**

Note 28 Third Party Assets

The Trust held £186,629 (2017/18 £163,360) cash at bank and in hand at 31 March 2019 which relates to monies held by Essex Partnership University NHS Foundation Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

Note 29 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	57	16	54	43
Bad debts and claims abandoned	46	14	15	121
Total losses	**103**	**30**	**69**	**163**
Special payments				
Compensation under court order or legally binding arbitration award	1	1	1	8
Ex-gratia payments	36	47	11	15
Special severance payments	2	70	1	10
Total special payments	**39**	**118**	**13**	**32**
Total losses and special payments	**142**	**148**	**82**	**195**

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