



North Essex Partnership   
NHS Foundation Trust

# Annual Report and Accounts

1 April 2010 - 31 March 2011



Outstanding care  
*Transforming lives*





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Foundation Trust

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# From the Chairman and Chief Executive

To the people of Essex – Outstanding Care, Transforming Lives



This is our report to the people of Essex about what we do and how we do it – we provide mental health and substance misuse services. We treat about 23,600 people a year.

Mental health is the single largest cause of all illness in England. It is very common. Unlike many other conditions it is something that may need hospital care, community treatment, medications, talking therapies, and social support like assistance finding work. It is also an area where other people's attitudes (whether they're supportive or not; whether they discriminate or not) directly affect someone's prospects. Mental illness is the most stigmatised of all conditions, leading many to suffer in silence and in secret, something we are campaigning to end.

We are very well placed to deliver on all of these things. This is due to the enormous hard work our staff undertake. It is not acknowledged enough how hard staff work here, the pressure they are under, to deliver – but they do!

This Trust does a tremendous amount of good – lives saved, lives recovered and hope sustained and supported. We provide a huge amount of treatment. Last year we provided over 515,000 episodes of care, up by over 40,000 on the year.

- 60,000 day care places
- 127,000 occupied bed days in our hospitals
- 77,000 outpatient appointments
- 178,000 face to face meetings with patients in the community
- 70,000 telephone calls to patients about their care

The key point however is that all these things are provided to people. We want this Trust to be well known for the quality of its treatments and care – so much so that given a choice, people will choose to be treated here.

We are a well managed organisation, giving good value for money, though we do face tough and challenging times.

We've been a Foundation Trust since October 2007. We are part of the NHS as a Public Benefit Corporation, owned by our members, with the surplus we make reinvested into the services we provide. Our members – 2000 staff and 6500 public – through elected Governors – set our direction and hold us to account. In return we have some operational freedoms. All put together, this places us with the means and the skills to deliver outstanding care that transforms lives.

We want to thank every member of staff for their dedication, skills and care provided. We have some of the best staff anywhere in the NHS and all our success comes from their work and they make us who we are.

We also thank our Governors – all volunteers – who provide the link to our membership and the wider community; bringing their views and perspectives to bear.

In the pages that follow we mention some of the great things happening here – some have been recognised as best practice and something for others to emulate.

We deliver Outstanding Care that Transforms lives. We are North Essex Partnership.

The Annual Report and Accounts were approved by the Board of Directors on the 25 May 2011. The Quality Report was amended and assurance completed and the revised Annual Report and Accounts incorporating the amended quality report approved by the Board of Directors on 29 June 2011.

**Mary St Aubyn**  
Chairman

**Andrew Geldard**  
Chief Executive





# From The Lead Governor



We have completed another successful year and I want to thank everyone who has contributed to this success.

I hold the view that in a highly regulated health service our Governors - elected and appointed - provide some regulation by the local community; local views from members of the

Trust and the public, brought to bear in all the Trust does. This is how it should be. The Governors, all volunteers by the way, provide an extra dimension to this Trust and I want to thank each of them for their dedication to their task.

At times of big change in the NHS, local views must be taken into account and our Foundation Trust model has come into its own and I look forward to more involvement, and different ways for local people to be involved and I hope those readers of this report become members and join in!

The Board of Directors and the Council of Governors have worked extremely well together, a most successful partnership, which is the North Essex way.

**Dan Kessler**

# Statement of Directors Responsibilities

This statement is contained on page 77 as of the Financial Statements.

## Operational and Financial Review

The Chief Executive has responsibility for overseeing the day-to-day operations of the Trust. He exercises this responsibility through the Executive Management Team (EMT). EMT and the Board of Directors receive monthly reports detailing financial and other key performance indicators. The Board approves the quarterly compliance reports required by Monitor.

The governance documents of the Trust, which have been approved by the Board of Directors, include Powers Reserved to the Board, identifying the decisions which are required to be taken by the Board, and a Scheme of Delegation which has been drawn up by the Chief Executive and which identifies those decisions delegated to members of the Trust's management. The role and responsibilities of the Council of Governors are set out in the Code of Conduct for Governors, which has been agreed by the Board and the Council of Governors.

## Statement as to a going concern

The International Financial Reporting Standards require that the Board of Directors should assess and satisfy themselves that it is appropriate for the Annual Accounts of the Trust to be prepared on a 'going concern' basis. The Audit Committee of the Trust has reported to the Board on its assessment of that question, drawing as recommended, on the guidance published by Grant Thornton LLP, Chartered Accountants, which draws attention to the factors that might cast significant doubt on the 'going concern' assumption. Having considered the relevant factors outlined in the guidance, the Board of Directors agree with the Audit Committee's view, that there are no material uncertainties that might cast significant doubt upon the Trust's ability to continue as a 'going concern'.

## Who we are

We provide specialist mental health services across Essex and to parts of Hertfordshire and Suffolk. We have won service contracts (like managing Suffolk Community Healthcare) and this is good for staff and patients, generating more income for services and employment.

We are a large organisation (covering most of Essex, from the Central Line in west Essex, up from Epping

Forest into Harlow through to Uttlesford and Stansted Airport and across Essex from Chelmsford and Braintree to Colchester, Clacton and Harwich and south to Maldon and South Woodham Ferrers). We're a 'partnership' because social care staff are seconded to us from Essex County Council.

### We provide:

- Consultant Psychiatrist clinics (including in some GP surgeries)
- Psychology
- Hospital care for all ages – including a Mother and Baby unit and Intensive Care Units, day care and Partial Hospitalisation and Rehabilitation Services
- Crisis and Home Treatment
- Early Intervention in Psychosis
- Community Mental Health Teams
- Memory Assessment Services
- Child and Adolescent Services
- Specialist Eating Disorders Services
- Community Drug and Alcohol Services
- Prison and Criminal Justice Teams

We also won the contract to host NHS Community Health Services (like district nursing, health visitors and so on) in Suffolk.

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

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

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

Mental health care has been transformed. It is the unreported NHS success story of the last 10 years.

## Our vision

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





## Our commitments

### To individuals and families:

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

### To our staff:

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

### To our commissioners and key partners:

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

## Our values

### Our values underpin everything we do:

- promoting dignity, respect and compassion
- demonstrating openness, honesty and integrity
- building on individual strengths
- tackling stigma, promoting inclusion and valuing diversity
- listening, learning, and continuously improving to deliver quality and value

## No health without mental health

The Government produced its Mental Health Strategy – No Health Without Mental Health - on 2 February 2011.

At least one in four people experience a mental health problem at some point in their life and mental ill-health represents 23% of the total burden of ill health in the UK - the largest single cause of illness (compared to around 16% each for heart disease and cancer). Half of those with mental health problems first experience symptoms before the age of 14 and three-quarters before their mid-twenties. Depression is also the most common mental health problem in people aged over 65, with 13 -16% having sufficiently severe depression to require treatment.

The Government's six main objectives are that by 2014:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support with access to timely, evidence-based interventions and approaches that give people the

greatest choice and control over their own lives, in the least restrictive environment and human rights protected

5. Fewer people will suffer avoidable harm - people should have confidence that the services they use are the highest quality and at least as safe as any other public service
6. Fewer people will experience stigma and discrimination

## Mental Health Community Patient Survey

The independent survey of patients in mental health, carried out by the Care Quality Commission in 2010, showed a big improvement over the last survey in 2008. On the key topic of medication (listening, explaining and checking) the Trust had the best results of any mental health trust in the country.

The Trust improved in every area; rated better than other trusts on giving enough time to discuss conditions, patients being able to understand what is in their care plan and having the number of someone to call in a crisis.

The Trust scored in the top 20% in 29% of cases, 51% of answers were in the average 60% of Trusts, and the remainder were in the lowest 20%. Our scores improved by 54% in crisis care, 46% in care planning and 41% in care coordination.

There are areas where we can improve. We were marked lower than we would like (despite improvements) on helping people to find or keep work, helping people with benefits and helping people find accommodation.

## Pass it on

A campaign to encourage service users and staff to tell the Chief Executive what they think of our services was launched in January 2011. Staff and service users can write their comments on postcards and send them to the Chief Executive or email him directly.

North Essex Partnership NHS Foundation Trust

# Pass it on!

I'm Andrew, the Chief Executive.

Whatever your opinion, please tell me.

It might be something we did well or something we didn't so a change is needed.

If you think the Chief Executive needs to know, pass it on!



## Trust-wide Highlights

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

### Objective 1:

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

### Objective 2:

Being a model employer

### Objective 3:

Achieving good governance, inclusive involvement and excellent partnerships

### Objective 4:

Providing value for money

### Objective 5:

Expanding our business

We've met these objectives – for more detail, please see the Quality Report, but here are some highlights.

## Rainbow Mother & Baby Unit opens in Chelmsford

Simon Burns MP, Minister of State for Health and Priti Patel MP, opened our Mother & Baby Unit on 28 September 2010.

Having a baby can be a time of great joy but it can also be a time of stress and change for the body and mind, which in almost all parents creates changes in feelings and emotions. For many new mothers, mothers-to-be and fathers, this can lead to anxiety and depression. However some women require this more specialist service. We also work with women in early pregnancy who have been identified as having a high risk of developing severe mental illness following the birth.

The unit has five single inpatient en suite bedrooms. This allows mothers to continue caring for their babies during a vulnerable period, whilst receiving specialist treatment from our team.

Each bedroom has a cot, baby changing facility and the option for partners to stay, which encourages independence and parenting skills. However, if additional support is necessary, there are nursing staff on duty 24 hours a day.

### The key aims are:

- Stress management
- Relaxation

- Life style planning and organising
- Assertiveness
- Managing anger and irritability
- Interaction between mums and babies
- Building social support networks
- Effective time management to create a balance between work, leisure and self maintenance

We promote the use of Advance Statements - a way to write down people's preferences and as long as we are given a copy, we have to consider people's views. So if there is a particular medication they cannot take because of breastfeeding, writing it down in advance helps us with their care.

## Service user story

In 2007 I was admitted, together with my then two month old baby, onto the mother and baby unit in the Linden Centre in Chelmsford with severe post-natal depression. I had an enormous feeling of guilt with the post-natal depression. I had everything you could wish for; a gorgeous healthy baby, two other healthy children, a partner, a house, no financial worries and still I felt awful and unhappy. Family and friends found it very difficult to understand. I was very anxious and tearful, struggling to eat, and finding it difficult to cope with daily life. Although I was able to care for my baby, my mental state deteriorated rapidly and on advice of the doctor from the Crisis Team I volunteered to be admitted. I stayed for two and a half months. I think that the first step to recovery is to admit that something is not right.

I can still remember very well how it felt when I walked through the door with my baby. I had to go through the main acute psychiatric ward. I was very scared and felt very vulnerable. Once I was on the unit I felt quite safe but I knew I had to go through the main ward to get out, and also that my two older children had to do the same when they came to visit me and their little sister. I was also shocked and distressed when I was told that I was not allowed to sleep with my baby in the same room. Whenever she slept she was put in a separate locked room.

I was delighted to hear about the plans to develop a new mother and baby unit and being invited to help in its development. In view of my past experience, I am most pleased that the new unit has a separate entrance, so there is no need for patients and visitors to walk through the main acute ward, and also the units accommodate mothers and babies in the same rooms. Babies no longer need to be separated from the mothers when they sleep.

I am certain that the 'Rainbow Mother and Baby Unit' will provide an excellent service for the perinatal care for mothers and babies in Essex and surrounding counties,





Official Opening of The Mother & Baby Unit in Chelmsford by Andrew Geldard, Chief Executive, Priti Patel, MP, Simon Burns, MP and Mary St Aubyn, Chairman

and will provide a ray of light and a rainbow of colour, within the darkness of illness.

I am doing fine now. I feel much stronger in myself, and cope much better with stresses in daily life. My mood is lifted, and I can say I am enjoying life (most of the time).

And my two month old baby has now grown into a lively, happy and healthy three year old, who like all three year olds, is into everything!

## Service User and Carer Involvement

### Nothing about me, without me

Andrew Geldard says: This story shows how the Trust involves experts in our services – their expertise is based on their actual experience of care. The approach is absolutely right and work has continued in the last year to develop a strategy to make sure it is happening all round the Trust. Over 100 people attended the first event to consider a strategy in June 2010. A consultation document was agreed by the Board and substantial consultation has taken place up to April 2011. The strategy is expected to be approved by the Board in May 2011, with any amendment from the consultation incorporated.



Bedroom - Rainbow Mother & Baby Unit

## Colchester Integrated Acute Service

The Colchester Integrated Acute Service provides help to people in crisis, providing the first steps in a seamless care pathway.

The Service consists of a number of interventions around assessment and treatment and sign-posting to other non statutory agencies.

The Duty Team takes referrals from GP surgeries, other professionals and self referrals. Urgent referrals are seen the same day and non-urgent referrals are passed to the community teams and processed within 7 days of the referral meeting.

**Home Treatment team** – the team provide a crisis service in the service user's home, as an alternative to admission. People can be seen up to three times a day to offer support and treatment through a mental health crisis.

All service users on the case load of the team have the same physical monitoring as if admitted to the wards. All team members have been trained in physical health care monitoring. This is measured and reported weekly to the Clinical Manager.

The GP is asked about any medication or physical health problem. Medications reconciliation makes sure safe prescribing and monitoring of side effects is in place.

**Partial Hospitalisation** – this is the next step up from home treatment. Service users remain under the care of the acute service and can attend the inpatient unit as a day patient. This service is available seven days a week from 9am to 5pm.

**Inpatient Services** – this is the most intense form of intervention. All service users admitted to the wards are clerked in by a doctor and physical examination is carried out with blood screening to eliminate physical conditions that may be contributing to a presentation of an acute mental health crisis.

As a result of the integrated working, the physical health care of our service users is monitored throughout their care pathway and is subject to the same check and quality across the whole service, regardless of where the service is being delivered.

## Delirium Care

The Delirium Pathway gives specific guidance and support for acute hospitals in identifying and treating Delirium including at what stage a referral into secondary mental health services should be triggered. It advises appropriate physical health screening and subsequent care including suggested pharmacological guidance and also medication free interventions such as consideration of environmental and social factors that can be used to help treat delirium without the use of psychotropic medication.

The pathway also provides a client centred approach and involves carers by promoting use of the "This is me" form produced by the Alzheimer's Society, specifically for use when admission to general hospital is required.

The pathway supports collaborative management of Delirium in an acute setting where joint responsibility for the care is shared between Broomfield Hospital's Elderly Assessment Team who assess and treat simple cases of Delirium and the Enhanced Liaison Team who become

involved at the point when complex or unstable Delirium shows itself.

This pathway is totally new and is a truly collaborative approach to the management of Delirium, where relationships with acute hospitals have been developed and strengthened, achieving a shared approach across two organisations, to ensure the quality of interventions, whilst maximising the best outcomes for service users and carers.

An audit of referrals over a 3 month period to the team revealed that up to 15% of referrals could have avoided mental health services with improved education and systems to manage Delirium in hospitals.

Delirium occurs in 20% to 25% of hospitalisations annually. Investing in Mental Health services and interventions ultimately has a cost reduction benefit to PCTs and hospitals given the prevalence of Delirium at 20-25%.

The pathway has already been highlighted for use in the 'pan Essex' Dementia care pathways meeting to support the National Dementia Strategy, and enquiries have also been received from Colchester General Hospital to share the development of the Delirium Pathway in their service, as they too would like to develop work in this area.

We have developed links with the University of Essex to disseminate the work through to students and learners.

## CAMHS Eating Disorders Service

Eating Disorders like Anorexia can be life threatening and are certainly life changing problems. The number and complexity of these disorders has increased over the past few years and many patients have lengthy, ineffective treatment including an admission to hospital. It is not just individuals, but whole families that are affected. We developed a small group of staff who adopted an evidence-based approach to working with whole families to treat Anorexia. After one and a half years we have worked with a number of families and had no hospital admissions among the group treated using the new approach. As part of our treatment package we also use a pioneering new approach known as 'Multiple Family Group Therapy' where we work with 5 to 7 families together for initially 4 whole days followed by 6 follow-up whole days spread out over 9 months.

Following discussion amongst the CAMHS staff team we began a 6 month project to trial a different way of working. Relationships were developed with local paediatricians so we arranged to attend their monthly meeting. Parents were giving positive feedback to the





programme and some expressed a desire to meet other parents and we started a monthly parents group. The latest development has been to begin Multiple Family Group Therapy. We have now developed a specialist team of existing staff to ensure that this treatment approach is available to all CAMHS patients with eating disorders across the entire Trust.

This new way of working has improved safety, effectiveness and the patient experience. Having a standardised, comprehensive assessment procedure specifically designed for adolescent eating disorders and an enhanced review process enhances both safety and effectiveness.

All cases are reviewed at least every 12 weeks and we have been able to reduce treatment time from an average of 2.5 years to 9 to 12 months. We measure our clinical outcomes using both the Strength & Difficulties Questionnaire, Eating Attitudes Test (EAT-26) and we are part of a large national multi-site research project using Systemic Clinical Outcomes in Routine Evaluation that is specifically looking at change in family function.

Our method is characterised by bringing all family members together to tackle the problem, to focus upon family strengths and resources and we are intentionally disinterested in blame. We include friends of the young person in treatment to add to the knowledge sharing and draw on the power of peer relations (perhaps especially at lunchtime in school). Anonymised feedback said things such as “a life changing experience”, “inspirational”, “fantastic experience”, “the key to our girls getting their sparkle and life back” and “bonding with the other families was really positive”.

## CAMHS Crisis Outreach Service

Young people in mental health crisis in North Essex have access to a 24 hour consultation, assessment and 7 day a week crisis response and home treatment team, meeting DH targets and in accordance with NICE guidelines.

The service provides Crisis Assessment and Resolution to 11 to 18 year olds, with a mental health crisis. It is a specialised element of an ‘integrated model of care’ in CAMHS which also includes Community, Forensic and Inpatient Services.

The service is based on a psychosocial model and is nurse-led, able to provide a range of therapeutic interventions depending on the young person’s presentation.

- Crisis Outreach provide emergency assessments for

children and young people in North Essex, referred by A&E departments, General Hospital medical wards and Young People in community mental health services.

- Crisis Intervention may be over a 6 to 8 week period as an alternative to hospital admission, based on a home treatment and social inclusion model.
- Crisis Outreach clinicians will hold Care Co-ordination and/or provide a specialist intervention, alongside a plan of ongoing intervention in services within the CPA framework.
- The Crisis Outreach and Home Treatment team provides monitoring and support for North Essex young people in inpatient care placed out of county or in private/alternative provision.
- The Crisis Outreach and Home Treatment team also provides monitoring, assessment and support for young people with very complex needs who live outside of Essex either on an individual or block commissioning basis.

Crisis Outreach has received and been recognised by the QNI & Nursing Times Awards.

## Early Intervention in Psychosis (EIP) Service

### Physical Health Care Guidelines for Practitioners

We set the clinic up as our clients were not receiving adequate physical health care - there seemed to be a reluctance by primary care to provide physical health care for people using our mental health services. It made us do things differently. We decided that the best way to proceed was to hold a clinic in each location to be staffed by the team manager and the nurses who are licensed to prescribe medication for each team. Care Co-ordinators were encouraged to bring their clients along and stay with them while physical tests were conducted. This proved fairly successful where things are done differently and the patient receives the one stop – physical and mental health service.

One approach to improving the health of patients with schizophrenia, who can live up to 25 years less than the average citizen, is to improve the monitoring of physical health that occurs in psychiatric settings.

Medication for clients using an EIP service can bring unpleasant and potentially harmful side effects.

### So we make sure:

- All adult EIP clients are offered a physical health care check annually.
- Clients who accept these assessments, and for whom concerns are raised as a result, are offered further review and/or additional investigations.

- Clients' GPs are informed in writing of the results
- Clients are offered the opportunity to have an ECG prior to the commencement of anti-psychotic medication and a further ECG eight weeks after this medication has been started.

In addition to the physical investigations that this equipment allows, clients attending for a physical health review are questioned about a range of other factors. These include:

- dietary and caffeine intake
- alcohol and smoking history
- illicit drug use
- prescribed drug use/difficulties/side effects
- eyes
- dental health
- micturition/bowels
- sexual health history
- family history of any physical health problems.

If clients decline to have these checks, this is documented along with the date of the refusal, reason for it and future plan/strategy for monitoring the client's health.

People who are taking Clozaril (anti-psychotic medication) have their physical health monitored at the Clozaril clinics.

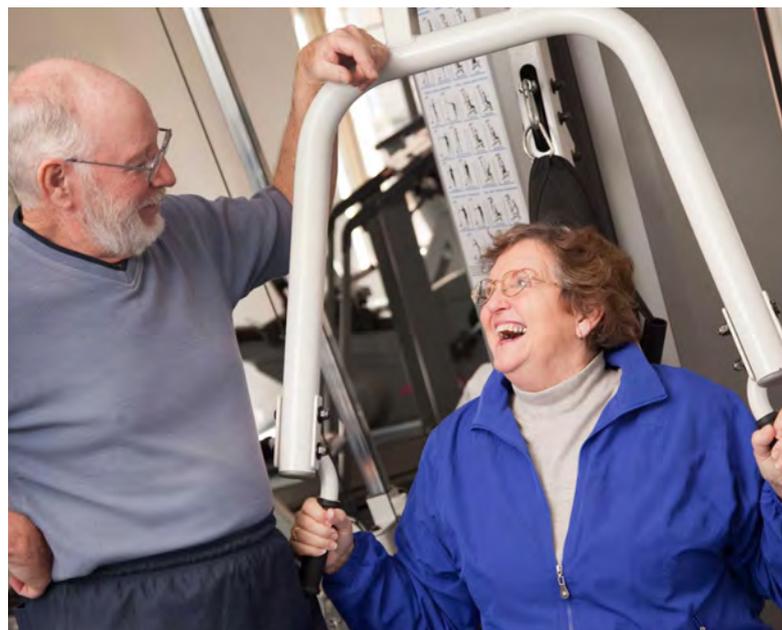
## Thinking Fit

Most older people diagnosed with memory problems go on to develop dementia, and in the absence of a cure, prevention appears the best health option. Good evidence shows that regular physical activity can halve the risk of dementia but most people miss out on this benefit because they are not active enough. The Thinking Fit study was set up to look at ways to delay the onset of dementia in those at risk of developing the condition. 128 patients are taking part in the study, recruited from the Trust's Memory Clinics. Successfully run in the West (Harlow, Epping) and about to move east to Chelmsford, this two-year, £500,000 project is funded by Essex County Council, sponsored by the Trust, and led by Consultant Psychiatrist, Dr Thomas Dannhauser.

Evidence indicates that much can be done to increase participation in healthy activities so that people at risk of dementia can reap the benefits. The ThinkingFit study will test new ways to make beneficial activities attractive and fun to older people, and useful for their cognitive health - their thinking.

Three types of activities are included in Thinking Fit: physical, social and computer-based brain training.

The physical activities mainly involve walking from home



because most people prefer this over attending a gym. Walking is supported by trained fitness instructors and the emphasis is on moderate, not strenuous, exercise. Heart rate monitors are used by participants to help them maintain the correct level of physical effort.

Social activities are good for mental health and making new friends is good brain exercise. Social group activities are provided by trained tutors in local facilities to make it easy for participants to attend - designed to be fun and engaging and details are kept secret to heighten the element of surprise that people enjoy.

The brain training activities use computers and can be enjoyed by people with no previous computer experience - computer tutors provide all the training and support required.

In order to make the Thinking Fit activities available to as many people as possible, they are provided at local community centres and in people's homes. People who participate from home have a fast internet connection and computer provided and they communicate with other participants using video conferencing. Alternatively, participants can attend a local Adult Continued Learning facility or library.

The response from participants that have completed the study so far has been overwhelmingly positive and the majority of participants have increased their activities as a result of their participation. The results will be published in late 2012.

Dementia research received 12 times less funding than cancer research, whilst dementia costs the country more than cancer and heart disease combined. Political efforts are underway to increase dementia research funding, in the meantime the ECC and NEPFT have demonstrated





their vision and commitment through funding and sponsorship of the Thinking Fit study that will help establish treatment and prevention strategies to deal with the looming dementia epidemic.

## Our staff - Celebrations of Achievement

270 people including governors, service users and staff attended the Celebration of Achievements awards on 17 November 2010 at King Edward Grammar School, Chelmsford.

Sally Mills-Lewis, lead commissioner for mental health services at NHS Mid Essex, and Dave Monk, BBC Essex presenter were the guests of honour.

Some of the winners were:



Winner of the Non-clinical Award Workforce Development



Winner of the Dave Monk Award, for an unsung hero Dick Mathias



Winner of the Clinical Award CAMHS Eating Disorders Team



Winner of the Chairman's Team Award Latton Bush Day Services



Winner of the Innovation Award Delirium Pathway



Winner of the R&D Award Dementia

## Patient Care Highlights by area

### Child and Adolescent Mental Health Services (CAMHS)

Toni Scales  
Area Director



We have successfully:

- Introduced a specialist CAMHS Eating Disorders service that now operates Trust-wide.
- Received Board approval for the building of a new CAMHS inpatient unit (which will expand existing services and offer a new source of income for the Trust).
- Employed two specialist CAMHS learning disability Staff.
- Formed a Clinical Board.
- Continued the success of Youth Matters, a Service User/Governor and clinician workstream.

#### CAMHS New Build

The planning approval of our new CAMHS unit on part of the old Severalls Hospital site is by far the biggest story of CAMHS. With building having commenced in Spring 2011, the purpose built unit will serve the young people of Essex, Suffolk, and further afield. The building is an innovative design and will house one of the UK's first Section 136 suite, designed specifically for young people (a section 136 suite is where people who are suspected by a police officer of suffering from a mental disorder can be taken from a public place to a secure place of safety for a Mental Health Assessment). The unit will house 25 beds – an additional 12 to the accommodation currently offered at Longview – giving additional scope for revenue.

**The unit has a scheduled opening date of Spring 2012**



#### North East Area

Jackie Liveras  
Area Director

This business model has been operational since 2010 – when Tendring and Colchester were brought together under the direction of Jackie Liveras, Area Director for North East. A successful

integration of the area means there is a more unified approach throughout the north east.

#### Achievements for the year for this area include:

- Successful integration of Colchester, Tendring and Halstead as one operational area.
- Development of a local Clinical Board, including service user representation.
- Older Adults Care Forum established.
- Consolidation of Adult Duty Service to reflect operational change.
- Merger of East and West Tendring Community Mental Health Teams to form a single operational group (now known as South Tendring CMHT).
- Review of Assertive Outreach Team and integration into Community Mental Health Teams.
- Successful series of GP engagement events launched.
- Rotation of staff introduced at the Landmere Centre, Clacton, to promote a single unit culture.
- Observation policy and award-nominated triage tool introduced to A & E department.
- Staff engagement lead appointed.
- Led a trustwide Service User and Carer Involvement workshop.

For 2011/12, there are plans to develop early discharge arrangements and extended working hours towards a 7 day service in both Defoe and Freeland Court Day Hospitals. Additionally, plans to review care pathways across both Adult and Older Adult Services for a more unified, integrated approach.

#### Capital investment plans include:

- A significant extension to the dining room – this will improve access, health and safety and the service user experience.
- King's Wood Centre has received funding for improvements to reception, including the introduction of Dementia sensitive signage in older adult units.
- Improvements to the physical environment at Peter Bruff.

#### West Essex

Harriet Carr-West  
Area Director, Lead for  
Early Intervention in  
Psychosis



The west area, includes Epping, Harlow and Uttlesford. The demographic for the area differs from England as a whole; it has slightly more older people and fewer 15-34 year olds. Men in Harlow have the lowest life expectancy in Essex. West Essex is quite diverse, including rural areas in Uttlesford





and Epping Forest deemed to suffer from poor access to services.

One of the key successes for our West area has been the development of the West Essex Clinical Board, based on the objectives of last years plan.

Plans for the area are exciting and include making good progress towards our Older Adult unit at St. Margaret's achieving Practice Development Unit status – which once achieved will recognise the good practice taking place at the unit.

**Throughout 2010-11, other achievements include:**

- Purchase of the freehold of the Derwent Centre
- Development of a performance monitoring tool (short listed in our Positive Practice Awards).
- A number of successful pilot schemes including paperless teams and a residential and nursing home liaison project in Epping Forest and Day Hospital outreach groups in Uttlesford.
- Demonstrably reduced length of stay in older adult wards through development of weekly care pathways
- Successful marketing of unfunded beds at Brian Roycroft unit (enabling attainment of income target for 2010-11).
- Chairman's Award given to Latton Bush Day Services after recommendation by people who use our services.

**Progressing West**

The Derwent Centre is a large 7,000 sq/m building on 0.74 hectares of land at the Princess Alexandra Hospital. Mental health services have operated from the building since the 1960s. A wide range of inpatient, community and administrative services operate from the building, serving west Essex. We need to update it because:

- The physical condition of the building has deteriorated in the last four decades, requiring modernisation
- The layout of the building is no longer appropriate for a modern therapeutic environment, and the needs of the various types of patient using the unit
- The wards should be single rooms with en-suite facilities.

The construction would be phased over a five year period as a majority of the work will need to be carried out whilst the building is fully operational.

The project design for the refurbishment of the building has now been finalised and presented to the project group for approval and a planning application will be made at the end of March 2011 after public and staff consultation events. Phase 1 works include the provision of the new 'bridge' construction into the garden along with works to the drop-in centre, internal improvement works

to Shannon house and a new car parking area outside Shannon House.

**Mid Essex**

Peter Flack  
Area Director



the last 12 months.

The Mid Essex services include inpatient facilities, Day Hospital Services, Community Support and Home Treatment teams and a range of specialist services, such as Eating Disorders, Outreach and Perinatal Services. The area has had some considerable success over

**These successes include:**

- The opening of the Rainbow Mother and Baby Unit, by MPs Simon Burns and Priti Patel
- The successful establishment of Mid Essex Clinical Board
- Practice Development Unit Accreditation achieved across Older Adult inpatient services
- Funding secured to continue the provision of Memory Assessment and Support Service to ensure the continued working partnership with the Alzheimer's Society
- Creation of Modern Matron/Clinical Manager post to cover Older Adult Services, thus allowing the Operational Service Manager to take a Trust wide strategic lead for Older Adult Services
- Establishment of Early Adopter GP-Led Commissioning Consortia.

The Clinical Board is now established and working well, with a range of staff as members which allows useful and productive discussion on important topics.

NHS Mid Essex has plans to establish a Crisis House in the area that will provide four beds and four safe spaces, providing an alternative to acute inpatient admission. The service will be for people of working age with severe mental health problems who are in crisis. Although the service will be managed and staffed by the third sector, access to beds will be through Mid Essex CRHT, offering a real alternative to acute inpatient admission. This a really good example of partnership working.

## Specialist Services



Steve Cook  
Area Director

These are very specialist services including Psychiatric Intensive Care Units, Rehabilitation, Alcohol and Substance Misuse Services, Prison Inreach services, and Learning Disability Services.

### Blood Borne Virus Pilot

Nationally, rates of HIV, Hepatitis B and Hepatitis C amongst intravenous drug users are 1.6%, 18% and 49% respectively. HIV and Hepatitis C have shown an increase over recent years. Action is required to increase awareness of Hepatitis C amongst health professionals, the public, high risk groups, and promotion of testing.

At the end of 2010 the PCT approached our services asking if we would pilot a Blood Borne Virus Service for 6 months, funded by the PCT, which we agreed to. This pilot started in January 2011.

We offer this service to our entire client group within the Colchester and Tendring area, i.e. Needle & Syringe Programme clients, and those in treatment with NEEDAS.

Each client is offered the Hepatitis B vaccination and the dried blood spot test for HIV, Hepatitis B and Hepatitis C, plus pre and post test discussion. If the result is positive we will refer the client to the appropriate service for treatment. If negative, we will offer the client harm reduction advice so they can remain negative. They will also be tested on a regular basis, checking that their status is still negative.

### Service user group

We have a service user group. This has been developed in conjunction with the Essex DAAT's Rhona Gilder (Carers, Users, Family Services Lead). Sheila Hicks, Changes Group Co-ordinator is facilitating this group which is held every three weeks.

### Christopher Unit

A new Associate Practitioner role has been created within the Psychiatric Intensive Care Unit Team. The appointee has a special interest in physical healthcare, sporting activities and health promotion.

### Shannon House

As part of the programme of improving our environments work is underway at Shannon House to improve safety and security; including new seclusion facilities, improving the staff base and better solutions to internal and external windows and doors, and redecoration of the courtyard areas.

Colchester Criminal Justice Mental Health has moved to

new premises at Herrick House to help provide premises for the new Eating Disorders Service at Northgate Centre in Colchester.

## Pharmacy Opens

A new pharmacy for mental health services was officially opened by North Essex Partnership on 27 January 2011 in Chelmsford.

The pharmacy, the first of its kind by North Essex Partnership will supply medicines by internal transport twice a day to the Trust's services across north Essex.

The Trust will be saving money by having its own pharmacy which is run by pharmacists and technicians employed by the Trust.

In addition to the pharmacy, North Essex Partnership has a new medications website which provides information for members of the public and health professionals about mental health conditions and medications.

The pharmacy was opened by Mary St Aubyn, Chairman, Andrew Geldard, Chief Executive, Judith Woolley, Associate Director of Pharmacy and Professor Stephen Bazire, Chief Pharmacist at Norfolk and Waveney Mental Health NHS Foundation Trust



## Former patient wins award

Angela Barnes, a Governor and former patient at North Essex Partnership NHS Foundation Trust is a winner of the national Mind Mental Health Media Awards.

"Anatomy of a mental illness" produced by BBC Radio 4, won the speech radio category and was amongst four other contenders for this award. The programme follows





the story of Angela Barnes, who was detained under the Mental Health Act after a psychotic episode in 2005. The programme traces Angela's experiences, speaking to her family and carers about the impact of bipolar disorder and her path to recovery. North Essex Partnership treated Angela during her illness and she has made a full recovery.



**Angela Barnes with presenters at the Mind Awards**

Angela Barnes said: "I am so pleased that I was allowed to be part of a much larger process to inform the general public about mental illness and its impact on the individual, and those around them. I most certainly didn't expect us to win as there were some really good contenders up against us, so when it was announced I was completely thrilled and amazed. I thank staff at North Essex Partnership for supporting me. Thank you also to Laurence Grissell of Radio 4, for the sensitive and brilliant way in which he told our story."

## Building for the Future

Through out this year, we have completed more than 700 capital projects. Here are some of the highlights.

### Thoroughgood Road

One of the Trust's premises at 32 Thoroughgood Road was identified as an ideal home for the Tendring CAMHS team who were resident at 25 West Avenue. The building was subject to a number of major improvements including complete redecoration, reflooring, rewiring and heating, along with some structural alterations to improve the overall layout of the building. A redundant detached garage at the property, which had been derelict for many

years, was converted into a play/therapy area to allow clinicians to work directly with some of the youngest CAMHS clients, in an environment suitable for sand and water play.

### Eating Disorders

The in house design team is currently working with Dr Zach deBeer, consultant Clinical Psychologist, to convert one of the blocks at the Northgate Centre in Colchester to a specialist Eating Disorders facility. This project is hot off the press and is currently on site with contractors, who are due to complete the project in early April. The new unit will have it's own kitchen facility, dining room, day room, treatment room, offices and consulting rooms, with a dedicated family therapy suite. The cost of the project is currently planned to be about £90,000.

### Energy Saver

The Trust has installed a 'Voltage Optimisation Unit' onto the main incoming electricity supply to the Linden and Crystal Centre. The existing supply voltage to these sites is at the high end of the permitted voltage range provided by the energy supplier. This unit reduces the supply voltage feeding these two sites to a lower level which will reduce the Trust's energy consumption and carbon output and reduce our energy bill. The installation costs are around £35,000 with a payback period of 3 to 5 years dependent upon settings, and if successful will be installed in other inpatient units as a Carbon Saving and Energy Efficiency investment scheme.

## Expanding our business

### Suffolk Community Services

In February 2011, North Essex Partnership NHS Foundation Trust was appointed as the interim host for Suffolk Community Healthcare (SCH), the community services arm of NHS Suffolk.

NEPFT was selected as the preferred partner and to be the interim provider of Universal Adult, Specialist Children's and certain Specialist Adult Community services for the period 1 April 2011 to 31 March 2012. This includes services such as District Nursing, Speech and Language Therapy and Podiatry Services.

Martin Royal, NHS Suffolk's director of corporate services, said: "In coming to this decision our priority has been ensuring the continued high quality of care for patients. NEPFT was chosen as their ethos is most closely aligned with what we want to achieve. People will still receive the same level of services in the same location and the constant work to improve services will continue."

# Quality Report

## Part 1 Statement on Quality From The Chief Executive of the NHS Foundation Trust

This is our third Quality Report and I am very pleased to be able to present it to the public. I am proud of the quality of care that we provide to people who use our services.

The year was our first as a Foundation Trust registered with the Care Quality Commission to undertake regulated activities. We have worked hard to evidence our compliance with the Essential Standards of Quality and Safety.

We cannot overestimate the importance of the need for people to feel safe with us, that our treatments and care work for people receiving our services, and how people feel about that treatment and care. Our Patient Experience Board has worked hard to develop and implement appropriate local patient surveys to ensure we are listening to what our patients have to say and take action where necessary to continuously improve our services. We have worked with Commissioners of our services to develop appropriate carer surveys again to make sure we are listening to people who look after service users in their own homes.

Our Quality, Risk and Patient Safety Department has continued to work as pro-actively as possible to ensure that serious incidents are not repeated, that reasons for complaints are not repeated and that we have learned from any mistakes we might make. We help our staff to recognise early warning signs of things going wrong so that these can be rectified and ultimately avoid serious incidents and complaints. We have a Risk and Governance Executive that provides assurance to the Trust Board on risk, quality and clinical governance. Our lead is the Medical Director and the Risk and Governance Executive is chaired by a Non Executive Director.

We have continued with area business units all contributing to the annual planning process with an emphasis on continuous quality improvement. Our Council of Governors has also been heavily involved in this and we have listened to what our Governors have had to say on quality. A number of our quality improvements for 2011/12 have been chosen taking account of what quality means to our Governors at this point in time with many changes on the horizon for the way services are commissioned, paid for and provided, in an increasingly difficult financial climate. In addition we report progress on our 2010/11 quality improvements as well as progress we have made against national targets and performance measures.

Our achievements during 2010/11 include the opening of the Rainbow Mother and Baby Unit, and our new in-house pharmacy building and service following through our five-year medicines management strategy. Our annual Celebration of Achievements in November demonstrated our continued commitment to acknowledge the excellent work, innovation, research, and achievements of our staff. We strive to be an exemplar employer and listen to what our staff have to say.

We have again requested assurance on our Quality Report from our Commissioners through the host Primary Care Trust and in addition asked for feedback from the Local Involvement Network and Health Overview and Scrutiny Committee. Discussions have taken place with our Lead Governor and a Governors' sub-group in developing quality improvements and choosing a measure for auditing. Our service user and carer workstream has completed a pilot of patient reported and carer reported outcome measures and we await the evaluation of this important work.

We have done very well in meeting the year's CQUIN (Commissioning for Quality Improvement and Innovation) targets for which we receive a financial reward and the 2011/12 CQUIN framework has been negotiated and agreed. Our quality improvements could not be achieved without our dedicated staff, whether they be directly involved in providing clinical services, or support those services in a corporate function.

We have successfully secured the management contract to host Suffolk Community Healthcare for 2011/12.

As always I am truly interested in what you all think of our services and welcome any comments about what you read in our Quality Account / Report or the experience you have with us.

To the best of my knowledge the information in this document is true and accurate.



**Andrew Geldard**  
Chief Executive





## Statement of Purpose

‘Outstanding care, transforming lives’

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

### **Our commitments:**

To individuals and families:

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

To our staff:

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

To our Commissioners and key partners:

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

### **Our Values**

Our values underpin everything we do:

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

With a workforce of over 2000 staff we currently provide mental health and substance misuse services to a population of one million people in north Essex, serving around 23,600 people each year. We also provide some services to people living in Suffolk, East Hertfordshire and south Essex – this includes specialist inpatient care. Our services are delivered in community, outpatient and inpatient settings.

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

## Strategic Objectives and Key Priorities

We have reaffirmed our five strategic objectives and set out eight associated key priorities and these are:

Strategic Objectives	Key Priorities
1. To provide high quality care that is effective, safe and as positive an experience as possible	<b>Effective</b>
	1. Improving access to, and accessibility of, services
	<b>Safe</b>
	2. Improving patient safety and general wellbeing, ensuring all care and other environments are appropriate, safe and therapeutic
	<b>Positive experience</b>
	3. Continuing to improve the experience of service users, families and carers, ensuring embedded systems for receiving and acting on feedback
2. To be a model employer	4. Creating positive experiences for staff within an efficient and effective workforce
3. To achieve good governance, inclusive involvement and excellent partnerships	5. Engaging widely with local communities and key stakeholders, developing productive partnerships with partner organisations and helping promote positive mental health
4. To provide value for money (economy, efficiency, effectiveness)	6. Ensuring an ongoing programme to ensure services are clinically and cost effective, use of estate is maximised and carbon footprint is reduced
	7. Realising development of, and benefits from, the Trust's information systems
5. To expand the business	8. Exploiting opportunities for growth and broader business development





## Terms of Authorisation

As a Foundation Trust we work within our terms of authorisation laid down by Monitor. Our schedule of goods and services can be found together with further information about our terms of authorisation through the following link:

<http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory/north-essex-partnership-nhs-foundation-trust>

## Regulated Activities

Our regulated activities are:

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

## Services and Locations

Our Directory of Services can be found as part of our Statement of Purpose on our Trust website ([www.nepft.nhs.uk](http://www.nepft.nhs.uk)). We have 25 locations registered with the Care Quality Commission and these are identified in the third column of the Directory.

# Part 2 Priorities For Improvement and Statements of Assurance From The Board

## Introduction

In part 2 we review the five priorities for improvement in last year's Quality Account / Report and what we achieved against those priorities during 2010/11. This is followed by our priorities for improvement in 2011/12.

All five of the priorities for 2010/11 are continued into 2011/12 but contained within three priorities for improvement. We have not retired priorities as we believe there is still work to do but the progress made has enabled the consolidation of the five 2008/09 and 2009/10 priorities into three for 2011/12. In addition we have consulted our Council of Governors, including staff Governors, and identified two further priorities for improvement for 2011/12. A further suggestion by the Council of Governors is included in an existing priority. The domains of quality are included in brackets in the 2011/12 section.

The priorities for improvement in 2011/12 have been approved by the Board of Directors at its meeting on Wednesday 27 April 2011. We will submit quarterly progress reports against our priorities through our Risk and Governance Executive, Commissioners Quality Assurance Group, and the Trust Board.

Part 2 also includes a number of statements of assurance from the Board relating to a review of services, our participation in national clinical audits, our learning from local clinical audits, our participation in clinical research, our goals agreed with Commissioners, our compliance with the Care Quality Commission Essential Standards of Quality and Safety, data quality, use of patient's valid NHS number, Information Governance Toolkit attainment levels, and clinical coding error rates.

## Review of 2010/11 priorities for improvement

### Developing systems and processes around Quality Accounts

- We have continued to develop our systems and processes around the Quality Report. Our Steering Group has updated its terms of reference and membership.
- We have developed patient safety measures outlining the impact of not meeting the standards and targets laid down, and ways of dealing with compliance and data quality issues.
- These measures have been developed across all individual inpatient areas and are reported and reviewed to our Risk and Governance Executive (RGE) monthly. The measures are:
  - Patient Safety
  - Risk management plan
  - Incident reporting (all)
  - Falls
  - AWOLS (Absent Without Leaves) (detained patients only)
  - Credits 4 Cleaning
  - Incidents of Infections and Control
  - Hand hygiene
  - Physical healthcare check
  - Drug errors
  - Pharmacy interventions
  - Specialist CPA (care programme approach) care plan in place
  - Specialist CPA care plan shared with service user
  - Complaints action plans
  - Patient Safety (staff measures)
  - Mandatory supervision
  - Safeguarding training
  - Hand washing training
  - Making Experiences Count training
  - CPA/Clinical risk training
  - Diversity training
  - ECCR (Ethical Care Control and Restraint) training
  - Manual handling training
  - Fire training
- The measures are designed to act as an 'early warning system' to RGE and also local teams and clinical boards who are able to feedback any actions required.

- Our service user and carer group has developed and piloted a set of patient reported outcome measures (PROMs) and carer reported outcome measures (CROMs) and this pilot is currently being evaluated.
- The PROMs relate to:
  - Feeling valued, treated with respect (process outcome).
  - Reducing and/or managing anxiety, depression or other symptoms of mental illness (change outcome).
  - Having choices, with access to information to make informed decisions (change outcome).
  - Feeling safe and secure in an environment which is conducive to health and wellbeing (change outcome).
  - Staying as well as you can be (quality of life outcome).
  - Access to support both preventively and in the longer term if required, rather than restricted to crisis times (quality of life outcome).
- The CROMs relate to:
  - Knowing support is available should a crisis occur (quality of life outcome).
  - Being listened to (process outcome).
  - Access to information to make informed decisions (change outcome).
  - Contact with other people (quality of life outcome).
  - Knowing someone will respond (change outcome).
  - Knowing someone will respond in a crisis (change outcome).
  - A local carer survey has also been developed with Commissioners and sent to over 500 carers.
  - We are improving the way incident reporting takes place, moving from paper to direct recording at ward level into a database.
  - We keep our staff informed about quality and audit through staff newsletters and through Clinical Boards.
  - We are currently evaluating an individual staff approach to quality developed by one of our Consultant Psychiatrists.
  - We have updated our Interim Quality Strategy and are developing a three-year strategy for consultation.

### Developing outcome measures

- We have implemented Health of the Nation Outcome Scales (HoNOS) and this is referred to in our Commissioning for Quality and Innovation (CQUIN) report later in part 2.

### Implementation of PROMs

- Implementation of PROMs will be dependant on the outcome of the evaluation of the pilot referred to above.

### The promotion of mental health

- A great deal of activity has taken place in relation to the promotion of mental health and recruitment of members. Our Governors have taken an active role in recruiting. The public constituency membership is 6536 (across 11 geographical districts) which shows an increase of 120 which is less than the estimated total we set last year of 7200. This reflects two things. The first, a slow down in the recruitment activity, with a new emphasis on quality rather than quantity, with Governors recruiting in their areas rather than through Trust-wide events. However we did recruit significantly, 737 new members. The Council had set an emphasis on community and member engagement with recruitment falling out of these strands of engagement activity. The other factor was a data cleanse, which showed 37 members had died and over 500 had left the area (some of the cleanse was also delayed from the previous year). This represented attrition of around 9% - almost double what was anticipated. That said, if the anticipated attrition rate of 5% had been reached we would have an additional 300 members, still less than the target.
- Our communications team have attended many events throughout the year, some with our Governors. Examples are the Tendring and Colchester Minority Ethnic Partnerships Black and Minority Ethnic festival, Chelmsford Wellbeing festival, and our own 'Get Moving' event; 130 members were recruited from these events alone. We have a Membership, Marketing and Public Relations Group that is chaired by a Governor and reports to the Council of Governors.
- Monthly reports from each Governor constituency outline progress and an analysis of representation. This helps us to identify where we need to recruit particular ethnic groups or age ranges to ensure our membership continues to reflect the communities. In rural areas we use local and mobile libraries to help promote membership.
- We have worked with large employers through the Mindful Employer team of voluntary organisations; we secured support from Virgin Active and Dorset Cereals for our public events. Community networks such as LINKs and CVS circulate material and generate support for our events. We work with Essex Libraries in holding events across the county.
- Our work engaging with 1,000 GPs includes encouraging them to join as members of the Trust.
- We have held member 'listening' meetings and produce a members newsletter; in addition Governors and stakeholders receive 'Building for the Future', about our capital projects, and a Governors' Update is issued at each Council meeting.
- Our Annual Public Meeting attracted 200 people.
- Various staff events have taken place: examples are a 'Liberating the NHS' consultation, three Clinical Conferences and our annual Celebration of Achievements.





- We have carried out anti-stigma work around mental health awareness in local schools with over 1000 students attending. Our 'no health without mental health' event resulted in positive publicity through live interviews on local radio.
- World Mental Health day was celebrated through our 'Go the extra mile' events in conjunction with Rethink, MIND, Virgin Active, LINKs and Time to Change, and the production of a DVD.
- Volunteering is encouraged through our 'Friends of' groups; there is now a Friends of the Landmere Unit (Clacton) and Friends of the Rainbow Unit (Mother and Baby).
- We have actively participated in 5QP which is a young person's involvement project.
- Our target for all inpatients receiving a physical health check is 100% and similarly for appropriate community patients. To this end a physical health care audit has been undertaken and an action plan drawn up so that we can move towards meeting our target. We continually seek to support the mental and physical healthcare needs of people who use our services long-term, especially where there are medication side effects to be considered. This has been included in the CQUIN framework for 2011/12.

### Improving medicines management

- We are very proud of our new Pharmacy based in Chelmsford, which means we are able to provide our own dedicated in-house pharmacy service focusing on the needs of our patients. This provides us with a robust infrastructure with which to move forward.
- We have purchased a medicines management software programme that will provide up-to-date dispensing of medication.
- By the end of the financial year we had already appointed more than a half of the proposed 22.5 pharmacy staff. This has been important in working towards a better pharmacy service for the purchase of drugs, dispensing, advice and management of medicines. We have ward/unit based clinical pharmacists and technicians as part of multi-disciplinary teams in each area of the Trust.
- We have developed a responsive transport and logistics system for pharmacy deliveries and some GPs are receiving deliveries of prescribed medicines for their patients to collect.
- Input to community units has been developed with a schedule of visits in place.
- A detailed audit and monitoring plan for medicines management and the medicines handbook is also in place.
- We now have an internal database of lithium patients.
- The Trust is proud to have come out top nationally in the community survey for medicines information provided to patients.
- Our Medicines Management Group identifies and prioritises areas for review.

## Priorities for improvement 2011/12

### Developing systems and process around Quality Accounts (incorporating development of outcome measures and any actions agreed from the PROMs and CROMs pilots) (Patient Safety/Clinical Effectiveness/Patient Experience)

We will:

- Develop further our patient safety measures and implement these in our community, outpatient and corporate areas.
- Incorporate patient experience and clinical effectiveness measures alongside the patient safety measures to develop a Quality Dashboard. Local areas are also keen to develop their own measures.
- Formalise outcome measures currently being used across the Trust, assess others for use, and develop new ones. We will also continue the implementation of HoNOS care clusters.
- Take forward any recommendations from the evaluation of the PROMs and CROMs pilot and feedback to service users and carers.
- Roll out the use of the database for incident reporting and pilot its use for serious incidents and complaints recording as well as compliance with the Essential Standards of Quality and Safety.
- Continue to involve, feed back and keep staff informed of developments in quality and audit, including three-year strategies for Quality and Clinical/Corporate Audit.
- Provide assurance to the Trust Board on Quality and Audit through our Risk and Governance Executive.

We will measure this quality improvement through:

- Evaluating the ongoing development, implementation, usefulness, robustness and analysis of the Quality Dashboard through feedback from teams, and the positive or other impact of this 'early warning system' on the level of serious incidents and complaints.
- Evaluating the use of care clusters and any other outcome measures that are formalised and/or developed/implemented.
- Our compliance with the Care Quality Commission Essential Standards of Quality and Safety.
- Monitoring progress against the action plans in our Interim Quality and Audit Strategies.
- Progress and assurance reports to the Risk and Governance Executive on quality, risk and patient safety.

We will submit quarterly progress reports to Risk and Governance Executive, Commissioners Quality Assurance Group, Council of Governors and the Trust Board.

## **The promotion of mental health (Patient Experience)**

We will:

- Continue with a robust campaign of community, staff and membership engagement through various media and forums. The Council of Governors approved a new membership strategy for 2011/12 and set modest increases for the coming years, but once again setting individual recruitment targets for each Governor. Allowing for an attrition rate of about 5% we will need to recruit 593 people in the coming year. The Membership, Marketing and Public Relations Work stream will monitor this.
- Acknowledge quality services through our annual Celebration of Achievements and encouraging teams to submit projects for external awards.
- Continue our development of 'Friends of...' groups.
- Reach out to young people through the schools campaign, youth groups and the youth involvement project.
- Engage with employers to work with us on mental health awareness and changing attitudes.
- Hold public events that increase public awareness about mental illness and how it can affect anyone.
- Hold constituency meetings on a regular basis.
- Maintain a membership that is representative of the local population.
- Continue to focus on the physical healthcare of people who use our services.

In addition our Council of Governors would like us to monitor and report progress against:

- The development and monitoring of an implementation plan about the Service User and Carer Involvement Strategy.

We will measure these quality improvements through:

- Meeting our membership targets including the diversity and representation across the area.
- Attendance and feedback at community and public events held throughout the year.
- Participation in and quality of our Celebration of Achievements and other external awards.
- The numbers of 'Friends of' groups including activity and feedback.
- Feedback from constituency meetings.
- Reporting on the implementation of the Service User and Carer Involvement Strategy and the level and variety of involvement by service users and carers in Trust activities.

We will submit progress reports quarterly to Risk and Governance Executive, Commissioners Quality Assurance Group, Council of Governors and the Trust Board.

## **Improving medicines management (Patient Safety/Clinical Effectiveness)**

We will:

- Build on the infrastructure in place for our in-house pharmacy through further recruitment and bringing the service up to full strength.
- Maintain or improve on our targets for reporting drug errors and pharmacy interventions.
- Develop competency frameworks and training for nurses on medicines management and for medical staff on prescribing.
- Develop a timetable of competency programmes for medicines safety awareness, secondary dispensing and prescribing of controlled drugs.

We will measure this quality improvement through:

- Successful recruitment of appropriately qualified pharmacy staff.
- Monitoring of reporting of drug errors and pharmacy interventions.
- Progress on competency frameworks and training, including awareness programmes.
- Feedback from nursing and medical staff.
- Compliance with Care Quality Commission Essential Standards of Quality and Safety.

We will submit progress reports quarterly to Risk and Governance Executive, Commissioners Quality Assurance Group, Council of Governors and the Trust Board.

## **Quality services through quality relationships (Patient Safety/Clinical Effectiveness/Patient Experience)**

We have emphasised to our Governors, through presentations and planning workshops, the importance of GP engagement in providing high quality services for our existing 'core' business and any future commissioned services through GPs or others. Our Governors, at these workshops, supported the importance of being prepared for the new and evolving commissioning market for high quality services. Action plans have recently been updated in discussion with local areas and GP engagement will continue to be a high priority for us in 2011/12.

Engagement will extend to any potential commissioner bodies. Quality of our services is especially important in terms of the 'any willing provider' or more recently termed 'any qualified provider' policy. This is still in development and details are awaited for mental health services but will entail commissioners developing a register of providers accredited to deliver a range of specified services within a community setting, and through a qualification process, meeting conditions of their licence with the Care Quality Commission. This means meeting the Essential Standards of Quality and Safety as well as Monitor's





compliance framework, providing safe, quality services to the contractual standards set by the NHS Commissioning Board.

GP and other potential commissioner engagement for quality includes:

- Good working relationships as partners in delivering quality healthcare.
- Raising awareness about the high quality services provided by this Trust.
- Maintaining staff commitment, motivation and morale to deliver high quality services and continuous quality improvements.

We will measure this quality improvement through:

- The development and success of a Commercial and Service Development team.
- Contracts won and/or services developed from Commissioners including GPs.
- Our status as a 'qualified' and/or 'willing' provider once the requirements are known.
- Feedback from our current Commissioners and potential Commissioners.
- Progress against our action plans.
- Feedback from our staff.
- Monitoring our reputation as a Trust providing high quality services, through the Care Quality Commission website, review reports and Quality and Risk Profiles.

We will submit progress reports quarterly to Risk and Governance Executive, Commissioners Quality Assurance Group, Council of Governors and the Trust Board.

### **Improving engagement and support of staff (Patient Safety/Clinical Effectiveness/Patient Experience)**

Quality relationships extend to staff. High quality services require high quality, motivated and engaged staff to deliver them. Recruiting, developing and retaining the right people are critical to our services. Developing and maintaining staff commitment, motivation and morale are vital during change, the current financial climate, and the changing pattern of commissioning. We want our staff to be part of the journey through this change, alongside those who govern, manage, develop and commission our services.

The annual national staff survey is a key marker of the way staff feel about our Trust and the services provided. A proportion of our staff is randomly selected to participate in the survey and generally our response rate is in line with national trends. We strive to be a model employer stating our commitments to staff and team as part of our vision and values. Our Governors rightly feel that responding appropriately to the staff survey is important.

The CQC essential standards of quality and safety include the following key outcomes:

- Outcome 12 (regulation 21) - Requirements relating to workers – people who use our services are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.
- Outcome 13 (regulation 22) - Staffing – people who use our services are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.
- Outcome 14 (regulation 23) - Supporting workers – people who use our services are safe and their health and welfare needs are met by competent staff.

We will measure this quality improvement through:

- Developing action plans and monitoring progress through a Staff Health and Wellbeing Strategy Group in direct response to the staff survey.
- Involvement of and supporting staff in evidencing CQC standards and preparing for planned reviews.
- Feedback from Staff Governors.
- National clinical audits related to staff.
- Feedback from Investors in People assessments.
- Monitoring of mandatory staff supervision and training.

We will submit progress reports quarterly to Risk and Governance Executive, Commissioners Quality Assurance Group, Council of Governors and the Trust Board.

### **Review of services**

During 2010/11 North Essex Partnership NHS Foundation Trust provided 28 NHS services across its three geographical areas. The entire list of our services by geographical area can be found in our directory of services at the link in part 1, statement of purpose.

NEPFT has reviewed all the data available to it on the quality of care in all 28 services covered by our three main block contracts that are subject to monthly quality assurance and contract monitoring processes. The income generated by the NHS services reviewed in 2010/11 represents 80% (£86m) of the total income generated from the provision of NHS services by NEPFT for 2010/11.

In addition the Board carried out detailed reviews on a number of services including Longview (CAMHS Tier 4), Trust wide Rehabilitation Services, north east Inpatient services, Trust wide Dementia services and trust wide Community Mental Health Teams. All data from the reviews is analysed and action plans in place and monitored throughout implementation and signed off as appropriate by RGE or Executive Management Team.



The Trust Board approved a new performance management framework, covering all key performance indicators (KPIs) for the Trust including inpatient and community services. These are included in the table in part 3 of this report.

Each month the Trust takes a critical view of an internal Quality and Risk Profile (QRP) sent to it by the Care Quality Commission encompassing information about all of our services. All areas identified as less than 'green' in the traffic lighted QRP are extracted into a rolling action plan and evidence is gathered to turn the action plan 'green'. Sometimes this will consist of more up-to-date information than is included in the QRP. We will also use evidence that is collected as part of our ongoing compliance with the Essential Standards of Quality and Safety. The evidenced action plan is sent back to the CQC through our lead assessor. This process is monitored through our Risk and Governance Executive (RGE).

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

The programme of national and local clinical and corporate audit is managed by the Quality and Audit Team and reviewed/monitored through a Quality and Audit group and exception reporting on limited assurance audits is made to the RGE.

The Trust has a schedule of 26 inpatient areas and 5 other areas participating in the productive ward series (Releasing Time To Care), the Creating Capable Team Approach, Practice Development Unit accreditation, AIMS accreditation, and/or the sustainability approach. This schedule runs from 2009 through to the end of 2011.

### **Participation in clinical audits**

During 2010/11 11 national clinical audits and 1 national confidential inquiry covered NHS services that NEPFT provides. During 2010/11 NEPFT participated in all national clinical audits and all national confidential enquiries.



The following tables outline the national audits and national confidential inquiry for which North Essex Partnership NHS Foundation Trust was eligible for during 2010/11, those that it participated in, whether the data collection was completed during the period, and the number of cases submitted to the audit, if applicable.

Eligible national audits for NEPFT	NEPFT participated in 100%	Data collection completed 2010/11	No. of cases submitted to audit as % no. of registered cases required by the terms of the audit
National audit of psychological therapies – depression and anxiety	Yes	Yes Reports still awaited	Mid = 12/13 = 92% North East = 47/47 = 100% West = 5/13 = 38.5%
Falls and bone health audit	Yes	Yes	Not applicable
National audit of depression	Yes	Yes Reports still awaited	100% - 40 cases
National organisational audit of the implementation of NICE public health guidance for the workplace by NHS Trusts	Yes	Yes	Not applicable
<b>Prescribing Observatory in Mental Health (POMH)</b>			
Topic 1 prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards	Yes	Yes	10 wards 137 patients
Topic 2 screening for metabolic side effects of anti-psychotic drugs (assertive outreach teams only)	Yes	Yes	2 AOTs 107 patients
Topic 5 benchmarking the prescribing of high dose and combination anti-psychotics on adult acute and PICU wards	Yes	Yes	3 to 10 wards (average 7) 26 to 134 patients (average 88)
Topic 7 monitoring of patients prescribed lithium	Yes	Yes	6 teams 104 patients
Topic 8 medicines reconciliation	Yes	Yes	17 teams 80 patients
Topic 10 use of antipsychotic medicine in CAMHS	Yes	Yes	6 teams 65 patients
Topic 11 prescribing of antipsychotics for people with dementia	Yes	Yes	Information not available
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (and its various constituent studies into sudden unexplained deaths and victims of homicide)	Yes	Yes	

## Learning/actions from national and local clinical audits

The reports of 1 national audit and 43 local clinical audits were reviewed by the Trust in 2010/11 through its Quality and Audit Group (QAAG), which reports to the Risk and Governance Executive. A total of 44 reports and action plans were received, reviewed and given a level of assurance at the QAAG. Each audit report has an action plan whose implementation is monitored by audit group and/or the most appropriate group working to the RGE. Some of the learning and actions from these audits are iterated in the table below.

Title/subject	Learning/actions
<b>National Audits</b>	
National falls and bone health audit in older people	Reviewing and revising policy Auditing compliance with policy Robust strategy relating to falls management Staff trained in awareness/management of falls risk factors Attendance at national workshops 'Fallers' moved to acute services promptly
National Audit of Depression	There have been some significant changes in practice nationally based on national results and it is anticipated that there will be changes following the receipt of our results
National organisational audit of the implementation of NICE public health guidance for the workplace by NHS Trusts	This is a benchmarking exercise and is work in progress. The report has been received and identifies the Trust as within the quartiles of partially or fully implemented guidance
<b>Local Audits</b>	
Mandatory supervision	Audit tool and process developed. Monitored through quality dashboard at Risk and Governance Executive
CPA and risk e-learning and training evaluation	Workshop and in-depth training course developed
Mystery Shopper	Implementation of Good Practice Guide
Monitoring serum levels and blood tests of patients on mood stabilisers	Awareness of NICE and Maudsley guidelines
Adherence to NICE CG28 Depression in Children and Young People	Diagnosis and severity recorded on CareBase Attendance of staff at CPA and CareBase training Outcome measures List and supply of self-help materials
Gap analysis of NICE CG78 Borderline Personality Disorder	Knowledge and understanding framework training for mental health professionals – two cohorts of 20 staff
Measuring compliance with NICE CG82 Schizophrenia	Clients offered the use of Advance Directives and recorded on CareBase Physical healthcare monitored and checked annually Sexual health included in assessment Therapies available appropriate to client and recorded on CareBase
NICE CG26 PTSD	CORE outcome measure used as standard 0.6wte Clinical Psychologist recruited to address issues in the action plan with CMHT staff
Audit proforma for learning disability protocol	All service users with LD flagged on CareBase Improvement in data collection Protocol taken on by new provider





Title/subject	Learning/actions
Infection control audits	New hand hygiene policy and revised simplified audit tool for hand hygiene audit Dress code policy updated to reflect 'bare below the elbows' Changes to the physical ward environments to meet infection control standards – enhanced cleaning audits Compliance with hand hygiene policy Training for support services supervisors, estates and other corporate departments in infection control
Child protection and vulnerable adults	ESAB and ESCB audit tools used for future audits Robust training plan implemented with courses held monthly OLM (oracle learning module) database implemented
Catering/cleaning questionnaire	Positive feedback
Physical healthcare monitoring	Developing CareBase to record when physical examinations are taking place Track and trigger monitoring Algorithm included in policy DNR form attached to policy ECT re-audited and protocol/policy reviewed Compliant with ECTAS
Nutritional audit	More patients having nutritional assessments More appropriate advice given about nutritional intake and supplements Staff more aware of importance of nutrition and monitoring Patients weighed more regularly
Manual handling	All patients on admission have manual handling needs assessment undertaken, regularly reviewed and updated as part of care plan Increased attendance at training

## Research

The number of patients receiving NHS services provided by NEPFT in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 54. This figure only includes patients recruited into NIHR portfolio trials, and not patients recruited to non-portfolio trials.

The key development in the Research and Development Department is the appointment of a Manager and represents a commitment by the Trust to develop its R&D functionality. R&D policies and the disbursement of legacy monies that the Trust has received are priorities for the department. The Clinical Studies Officer post, which will provide support to studies within the Trust area is currently being appointed to. The Trust Research prize has been revived and was awarded at the Celebration of Achievements awards in November.

Relationships continue with the Essex and Hertfordshire Comprehensive Local Research Network (CLRN) and other local mental health trusts in developing an agenda and portfolio of mental health and learning disability re-

search in Essex and Hertfordshire. The Trust has an R&D lead who is an executive team member on the Essex and Herts CLRN Board. A Consultant Clinical Psychologist in CAMHS has taken on the role of Chair of the Children's Health Local Speciality Group (LSG) for Essex and Hertfordshire.

The Trust continues to develop its research profile and presence. Trust based researchers are leading in the set up and execution of a number of national studies of neurodegenerative diseases. They are also involved with studies in a number of other areas of mental health such as people with psychosis, child and adolescent mental health and older adult mental health. In summary, the Trust remains a key player in the local R&D economy with a number of prominent researchers conducting and publishing regionally and nationally significant research regionally and nationally.

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

A proportion of NEPFT income in 2010/11 was conditional on achieving quality improvements and innovation goals agreed between the Trust and its Commissioners through

the Commissioning for Quality and Innovation payment framework. One element of a broader CQUIN target, namely the average length of stay reduction, was not achieved and negotiations are ongoing in respect of the £100,000 at stake (this is included in the overall figures below).

CQUIN main block conditional and received payment	£1,123,335
CAMHS conditional and received payment	£132,255
Low Secure Unit	£21,567
Total	£1,277,157

Further details of the agreed goals for 2010/11 and the following 12 month period are available electronically at <http://www.institute.nhs.uk/images/documents/wcc/PCT%20portal/CQUIN3/North%20Essex%20Partnership%20Mental%20Health%20CQUIN%202010-11%20Schedule%204%20final%20version.doc>

### Statements from the Care Quality Commission

North Essex Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is compliant.

The Trust was subject to a responsive review by the Care Quality Commission during the final quarter of the financial year. There were a number of triggers from information collected by the Care Quality Commission. As part of the responsive review the Trust submitted provider compliance assessments relating to four Essential Standards of Quality and Safety outcomes for all of its 25 registered locations (as defined by the CQC guidance). In addition unannounced visits were made to Trust Headquarters, Ardleigh Ward (Colchester), Henneage Ward (Colchester), Cedar Ward (Colchester) and Peter Bruff Unit (Clacton).

The formal review of compliance declared that the Trust was found to be compliant with the four outcomes with two minor concerns around care plans and safeguarding training, requiring improvement actions. In response the Trust has produced an action plan with Trust wide and local actions and this has been submitted to the CQC. Progress will be monitored by the Risk and Governance Executive and reported to the CQC who will satisfy themselves that the action plan has been implemented.

Service users who were interviewed during the visits by the CQC assessors said they felt safe as inpatients on the wards.

The Care Quality Commission has taken no enforcement action against the Trust during 2010/11.

### Data Quality

#### Statement on relevance of Data Quality and actions to improve Data Quality

We have taken or will be taking the following actions to improve data quality:

- The Director of Resources is the Executive Director with strategic responsibility for data quality.
- A Data Quality Policy has been approved and implemented; it has been communicated widely via e-mail, induction and IT training workshops, and staff news briefings.
- There is a framework of monthly performance monitoring and challenge by the Executive Management Team, which sets aside one morning each month to review in-depth the performance of the Trust, including data quality. This is reinforced with bi-monthly meetings in each of the six clinical areas, with the Director of Operations and Nursing, the Director of Resources and the Trust's Information Manager drilling down into team level data. This same data is aggregated and reported to the Board of Directors monthly.
- The Risk and Governance Executive monitors and manages significant data within the quality and safety arena.
- The Information Team routinely searches for data anomalies and inconsistent patterns to investigate and rectify. Reports are checked and validated before issue
- Actions identified in the external audit on data quality of the Quality Report have been completed.

#### NHS Number Validity and General Medical Practice Code

NEPFT submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage records in the published data which included the patient's valid NHS no. and General Medical Practice Code was:

Admitted patient care	98.5% NHS No.	97.5% GP Code
Outpatient care	100% NHS No.	100% GP Code

#### Information Governance Toolkit Attainment Levels

Information governance is to do with the way organisations handle personal information about patients and staff, and corporate information relating to finance and accounts. It provides a way for staff to deal consistently with the many rules and regulations, for example, the Data Protection Act 1998 and the Confidentiality NHS Code of Practice. The Toolkit is a performance tool pro-





duced by the Department of Health that sets all the rules and regulations into one framework allowing self-assessment of compliance with the law and central guidance. The level of compliance submission, by initiative, for March 2011 is:

Information governance management	93% (Green)
Confidentiality and data protection assurance	87% (Green)
Information security assurance	64% (Red)
Clinical information assurance	100% (Green)
Secondary use assurance	75% (Red)
Corporate information assurance	55% (Red)
Overall result	77% (Red)

Of the 45 requirements, 22 are considered as key and there is an expectation that the Trust must achieve compliance at level 2 or above for these, which it currently does:

Level 2	Significant compliance	12
Level 3	Full compliance	9
N/A	Not relevant to this Trust	1
Total		22

### Clinical Coding Error Rate

NEPFT was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

## Part 3: Review of Quality Performance Indicators

### Introduction

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

- Patient safety measures (measures that have been in place for three years and identified by the Risk and Governance Executive on behalf of the Trust Board). The rationale for these measures is the importance of patient safety; people need to feel safe while using our services and if they do not then this has the potential to impact on serious incidents and complaints.
- Clinical effectiveness measures – these measures include the key national priorities identified by the Department of Health Operating Framework; in addition there are a number of locally agreed performance

measures that came out of a performance management framework agreed by the Executive Management Team and the Trust Board. The rationale for these measures is to comply with national targets and to monitor our performance against a whole range of measures that impact on the quality of care we offer to our service users.

- Patient experience measures – Executive Directors, on behalf of the Trust Board, reviewed elements of the national patient survey results together with complaints and compliments. Over the past year local patient experience surveys have been developed and these will be included in our Quality Dashboard for 2011/12 and our Quality Report for 2011/12. The rationale for including these measures is that complaints is a gauge on how well we are doing and identifies potential areas for improvement. We also balance these with compliments received about the service, teams, and individuals that provide them.

We regularly involve stakeholders in planning workshops, which help to identify areas of concern that it may be appropriate to measure and monitor on a regular basis. Our Council of Governors represent a wide range of stakeholders from constituencies across the geographical area, service users and service user groups, carers and members of staff .

The Trust participates in the Audit Commission benchmarking survey of some 75% of mental health trusts in England. The survey shows that the Trust performs well in a range of productivity measures. For example:

- We have just below/at median number of available beds for adults and older adults.
- Adult bed occupancy per 100,000 which is above upper percentile performance.
- Adult occupied bed days per 100,000 – is between median and upper percentile.
- We have top quartile performance for low adult and other adult readmissions within 28 days.
- Older adult admissions per 100,000 is between median and upper percentile.
- Adult total DNAs (Did Not Attend) for new and first attendances improved from sixth lowest to second lowest.
- Second lowest DNA rate for older adults for new and first attendances.
- We have the lowest length of stay for adults and older adults.

### Performance of Trust against selected metrics

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

### Quality Dashboard – Patient Safety measures



The charts that follow are an extract from our Patient Safety Dashboard, which we have had in place for two years. We have been able to benchmark the figures over a two year period. We have developed clear targets for the reports within the dashboard. We use National Patient Safety Agency (NPSA) national reports for benchmarking.

The Patient Safety Dashboard is part of the patient safety element of our Quality Dashboard, which will in due course encompass all three quality headings of patient safety, patient experience and clinical effectiveness. The following is an extract from the monthly patient safety dashboard as at the end of March 2011.

The data sources are our local incident reports and the indicators are in line with NPSA requirements.



### Chart 1 - Mortality in care

This indicator measures mortality in care due to physical illness. For this indicator, we count people in our direct care as well as those who were known to us but may have died in the community.

'Unexpected deaths' are those where no life threatening physical illness has been known. People admitted with a serious, life-threatening, physical illness who, despite treatment for that physical illness, die in our care, are categorised as 'not unexpected deaths'. For clarity they are reported as 'expected deaths'.

### Mortality in care

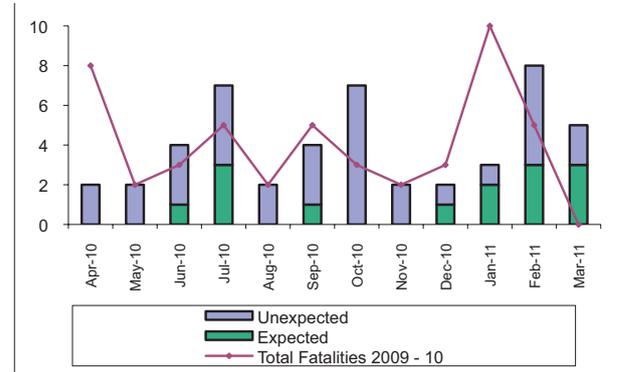


Chart 1

### Chart 2 – Total number of incidents

An incident in the Trust is any adverse event that has the potential to cause harm to an individual. There is proactive reporting of incidents in the Trust. It is imperative that incidents are reported if we are to continue to learn from events. (High level of reporting is actively encouraged nationally). The total number of incidents for the year is 5185 and this represents a significant fall from the previous year of 15%.

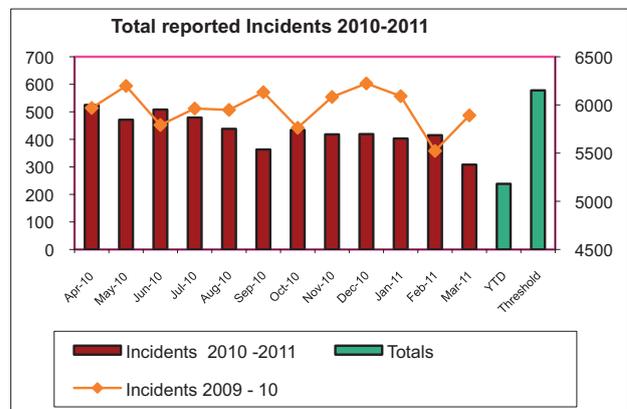


Chart 2

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

The full definition of a serious incident requiring investigation can be found in the East of England Serious Incidents Requiring Investigation Policy at the following link: [www.eoe.nhs.uk/downloadFile.php?doc\\_url=1285232270\\_NWVM\\_serious\\_incidents\\_policy.pdf](http://www.eoe.nhs.uk/downloadFile.php?doc_url=1285232270_NWVM_serious_incidents_policy.pdf)

There has been an increase of 3 reported serious incidents from the previous year but this is lower than 2008/09.

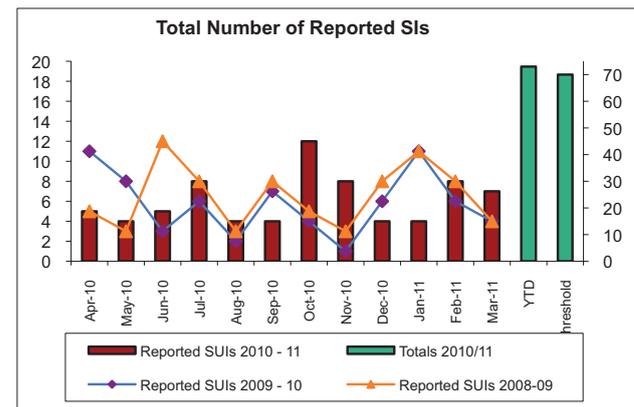


Chart 3

### Chart 4 – Falls

Once again we are reporting on falls instead of patient personal accidents, most of which are falls. This is both observed and unobserved falls reported by staff. Patient falls for the year have reduced significantly by 23%. This reduction over the last three years is represented by:

2008/09	1049
2009/10	876 (16% reduction)
2010/11	674 (23% reduction)

'Patient falls' was also included in the 2010/11 CQUIN framework agreed with the Commissioners and the target reduction was met.

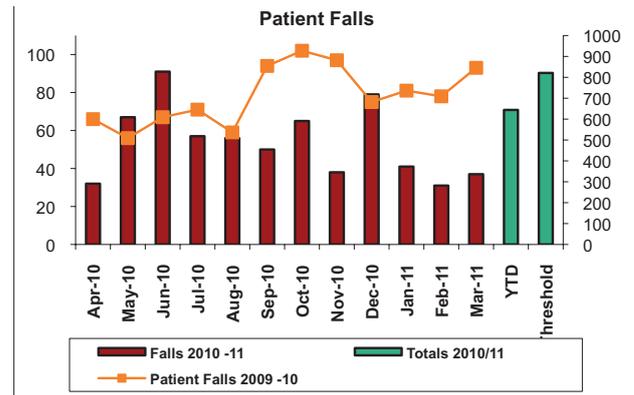


Chart 4

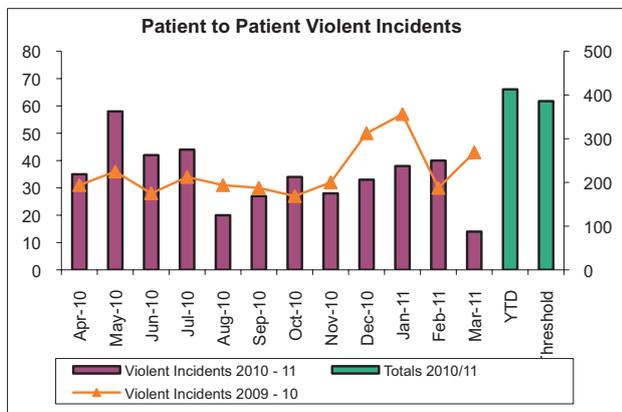


Chart 5

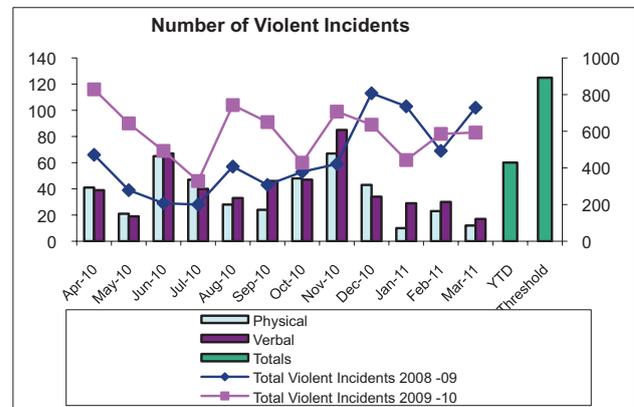


Chart 6

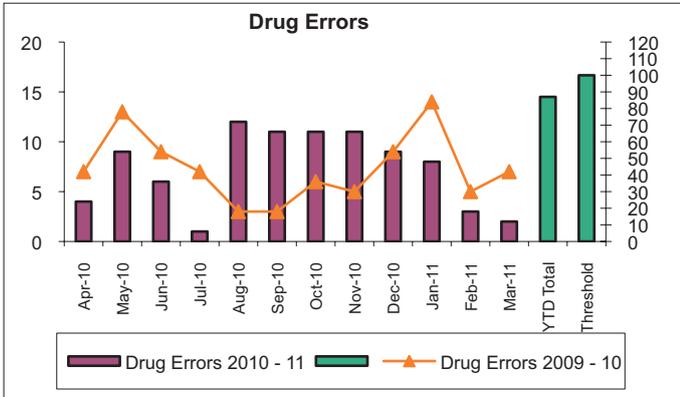
### Chart 5 – patient to patient violent incidents and Chart 6 – total number of violent incidents

Patient to patient violence incorporates aggression, harassment, actual assault and inappropriate behaviour towards another patient. Violence towards people and property is closely monitored and these two charts show the level of patient to patient violence/aggression that is being reported. It must be stressed that due to proactive reporting many of these incidents are verbal aggression rather than physical. Chart 6 relates to violence to property that has been damaged or verbal aggression towards staff. Patient to patient violence and harassment has increased slightly on last year. Violent incidents are slightly down on last year at 916 from 961. The number of physical assaults is down by 25%.

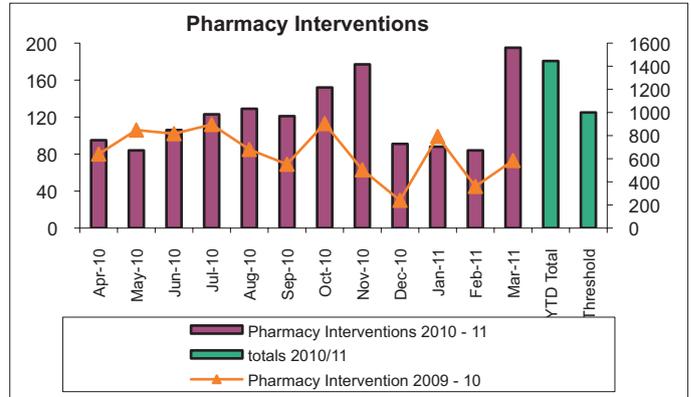




**Chart 7 and 8 – drug errors and pharmacy interventions**



**Chart 7**



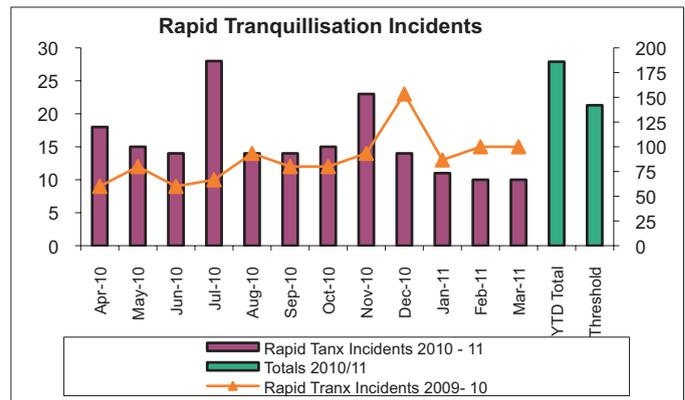
**Chart 8**

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

**Chart 9 – rapid tranquillisation incidents**

Rapid tranquillisation incidents are where medication in line with the protocol has been administered to control behaviour usually precipitated by violence/impulsivity. This chart looks at the number of rapid tranquillisations that have taken place. This level is low in the wider context of the number of violent incidents that have been reported in the Trust in the last year.

All of the above indicators are used by the Trust to support its drive for quality and achieve outstanding care, transforming lives.



**Chart 9**

## Clinical Effectiveness and other outcome measures

### National Targets, key priorities and regulatory requirements and primary indicators

The following indicators are collected from the data sources below and referenced in brackets in the table. In the key to data sources, the bracketed information refers to any nationally defined standards:

- (1) CareBase – patient database (nationally defined by Department of Health/ Care Quality Commission/ Monitor)
- (2) Acute Trusts (nationally defined as above)
- (3) Electronic staff records (nationally defined as above)
- (4) Infection control incident forms (nationally defined as above)
- (5) Local evidence (against Care Quality Commission standards)
- (6) Poppie database (in line with Drug Action Team requirements)
- (7) Electronic staff records (locally defined indicators)

Performance of Trust against selected metrics				
(data source – see legend above)	2010/11	2009/10	2008/09	Comment
No of people who received an assertive outreach service (1)	284	287	296	Target achieved - 277
Early intervention in psychosis (new cases) (1)	312	166	116	Target achieved - 103
Carer assessments (completed and declined) (1)	1724	(Completed only) 1439	2540	Target achieved - 1325
Crisis Resolution Home Treatment (gatekeeping) (1)	100%	1822 episodes of treatment	1771 episodes of treatment	Target achieved - 1595
4 hour wait for Accident & Emergency (Acute Trust target) (2)	N/A	2165 - 11	2271 - 17	Mental health breaches very low
Staff turnover (12 month average) (3)	8.3% (March 11)	12.23% (Feb 2010)	10.98%	Within expected tolerances
Sickness absence (in months) (3)	4.5%	5.09% (Feb 2010)	4.51%	Below NHS mean at year end
Inpatient data quality ethnic group (1)	99.96%	100%	100%	Excellent
Clients 18+ receiving a review (1)	96%	4199 - 67%	5016 - 70.4%	
Care Programme Approach 7 day follow up (1)	98.9%	99.2% CQC, 98.8% Monitor	97.8%	Excellent
Delayed transfers of care (1)	0.7% Monitor 0.07% CQC	0.3%	1.75%	Excellent -Monitor threshold of 7%
Admissions to inpatient services with access to CRHT (1)	N/A	99%	Q2 = 95%, Q3 =100% , Q4 = 97%	Excellent – well above Monitor threshold (90%)
18 week referral to treatment (Consultant led services) (1)	99.9%	100%	100%	Target achieved





Performance of Trust against selected metrics				
	2010/11	2009/10	2008/09	Comment
Methicillinresistant Staphylococcus aureus (MRSA) & Infections	N/A	38	20	Reduction of people with imported MRSA (coming from outside the organisation)
Core Standards (5)	N/A	100%	100%	
Essential Standards of Quality and Safety (5)	Compliant			
MHMDS data completeness (1)	99.52%			
Under 16 admissions (1)	0			
Detained patients AWOL (1)	0.06			
Monitor data completeness (1)	89.2%			
Inpatient discharges with a diagnosis recorded (1)	91.2%			
Problematic drug users in effective treatment (6)	91.4%			
5 week wait for 1st appointment (Consultant led services) (1)	82.4%			
18 week referral to treatment (non-Consultant led services) (1)	97.6%			
Under 18 admissions to an adult ward (1)	5			
Assertive Outreach caseloads (1)	284			
Inpatient re-admissions within 28 days of previous discharge* (1)	9.2%			Governor - chosen indicator for audit
Staff Vacancies (rolling position) (7)	384.9			
Staff Long term Sickness absence (7)	2.9%			
Staff Turnover excluding retirement (7)	6.2%			
Staff Leavers (7)	172.85			
Staff Leavers excluding retirement (7)	130.98			

\*Chosen and agreed by the Council of Governors to be included as a measure for 2011/12 and to be audited as part of the Audit Commission Quality Account/Report Audit.

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

### Patient experience measures

We have measured ourselves on the following patient experience measures. The data source for complaints and compliments is our local Respond database. The complaints data is nationally defined whilst the compliments is locally defined. The patient survey indicators are taken from the national community survey and are nationally defined questions. How we compared with other Trusts in this survey can be found on the Care Quality Commission website at <http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/communitymentalhealth-services.cfm>

	2010/11	2009/10	2008/09
<b>Complaints</b>	566	400	81
<b>Compliments</b>	273	173	222
<b>Patient Survey Q12</b> <b>Were the purposes of the medications explained to you?* (yes definitely &amp; yes to some extent)</b>	88%	97%	92%
<b>Patient Survey Q24</b> <b>Do you understand what is in your care plan?* (yes definitely &amp; yes to some extent)</b>	77%	87%	74%
<b>Patient Survey Q47</b> <b>Overall, how would you rate the care you have received from Mental Health Services in the last 12 months?* (Excellent, Very Good, Good)</b>	73%	82%	76%

\* Quality Health Community Mental Health Service Users Survey results

\*\* numbers reflect changes in national complaints policy Since the introduction of new Complaint Regulations on 1 April 2009, all concerns and complaints are now risk-scored into Low/Moderate/High and Extreme. Previously all low risk concerns were not recorded and therefore numbers of complaints has risen over the past two years due to the new process.

Although the total number of complaints has risen the number of those fully upheld remained similar. The number of complaints that were not upheld has risen considerably.

The total number of complaints has risen substantially in 2010/11 compared to the previous year. Clinical issues are still the highest number of complaints with a considerable rise in access to service issues. A new category has been added due to a number of complaints raised regarding funding and commissioning arrangements. There has been a reduction in the number of complaints made about staff attitude and privacy and dignity.

We welcome feedback – comments, compliments and complaints. We are a very large organisation with thousands of episodes of care delivered. We want to provide the best, but there will be occasions where people are not satisfied or are unhappy so we want to hear about it. We have many ways people can pass these on to team managers, reception staff, direct to the Chief Executive, or through the Patient Advice and Liaison Service.

People do not generally like to complain but other people can benefit from complaints where shortcomings in the service are highlighted.





## Statement of Directors' Responsibilities In Respect of The Quality Report

In preparing the Quality Report, the Directors are satisfied that the content of the Quality Report:

- meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010/11
- is not inconsistent with internal and external sources of information
- represents a balanced picture of the NHS Foundation Trust's performance over the period covered
- contains reliable and accurate performance information
- is subject to 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 (2 mandatory indicators and 1 Governor prescribed indicator will be subject to external audit and reported on by the end of June 2011)
- is robust and reliable and conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality.

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

..26 May 2011

..Chairman

..26 May 2011

..Chief Executive

## Statement from Primary Care Trust (Commissioners)

NHS Mid Essex on behalf of all three north Essex primary care Trusts are pleased to acknowledge the commitment that North Essex Partnership Foundation Trust makes to continuous, evidence based quality improvement across all services. Where there is still work to be done it is noted that the Trust will continue to work to achieve last year's priorities and this is particularly welcome. We remain committed to assisting you in driving the quality agenda through the quality incentive payments incorporated into the legal contract and working with you through the quality assurance group and other means.

Improving quality is everybody's business and the demonstration in your report that you are engaging with service users and carers through the development of outcome measures for example is reassuring. The same applies to the evidence you provide in the report around engagement with the public and with Trust Governors who have clearly influenced the quality account report. It is hoped that the initiation of 'Friends of' individual services is one that helps drive forward quality improvements at a local level. However the linkages between recruiting new members and promoting mental health, which is the section where recruitment is discussed, perhaps could be made clearer.

You also recognise and value the key role of staff, although the evidence of how engagement with staff is achieved could be strengthened. The focus on a new staff Health and Wellbeing strategy group is welcomed as it demonstrates a positive response to staff survey results. However, some key results of the national staff survey could have been included, with comparators, in order to provide a fuller picture. An on-going demonstration of robust engagement processes continues to be expected and it would have been of interest for you to have detailed the level of black minority and ethnic (BME) membership of the Trust. You stated in your previous report that the Trust had aspirations for to improve engagement with BME groups.

The Trust is commended on the development of new services, continuing to develop a dedicated pharmacy service, being involved and learning from clinical audits, improving data quality, reducing falls, reviewing services, responding to the findings of surveys and achieving against a myriad of performance targets. It is noteworthy that you have achieved positive reports after unannounced visits from the Care Quality Commission. Although not specifically mentioned in the report the Trust is also to be commended for improvements in prison health care and the developments for people with learning disabilities

Last year you commented on a welcome re-emphasis on research as this supports staff development as well as augmenting the mental health evidence base. NHS Mid Essex is delighted to see the appointment of research staff and a revival of the Trust's research prize. Information on what projects are undertaken and how they improved quality is welcomed.

In broad terms the presentation of information is sound. Some queries about detail may remain particularly for readers who are not familiar with your organisation. Examples include the lack of explanation for the increase year on year in rapid tranquilisation and the 'minor concerns' of the CQC 'around care planning and safeguarding'. In terms of accessibility to the report by the public your development of technological forms of dissemination is a positive development although those without access to the internet may find themselves at a disadvantage by your use of links. Information on how you are providing alternative methods of accessing information is welcomed. We refer the Trust to last year's comment regarding the possible development of an accessible language version as part of your publicity of the Accounts; this comment still stands.

In conclusion NHS Mid Essex (on the behalf of all north Essex PCT's) consider the Trust's Quality Accounts for 2010/2011 as providing an accurate and balanced picture of key performance indicators for the reporting period.

25th May 2011  
NHS Mid Essex on behalf of north Essex PCT's

## Statement from Essex Health Overview Scrutiny Committee

"Thank you for giving the Essex Health Overview Scrutiny Committee (HOSC) the opportunity to comment on the Trust's Quality Accounts.

I have agreed the following response with Committee members:

The Essex HOSC has had a relatively small number of contacts with the Trust over the last year. Essex is fortunate that the county has two of the most respected Mental Health Trusts in the country.

The Trust managers attended a countywide Away Day event arranged by the HOSC to look at (a) its strategic direction for the next three years; and (b) the 'big issues' in the health sector at present, and made a major contribution towards that debate.

The Trust has been fully involved in a major project the HOSC has been undertaking, looking at current and future provision for people with dementia. A Trust member has served on the Group overseeing the work and the Group visited the Crystal Centre at Broomfield, which is seen as a beacon service.

Graham Redgwell  
Secretary of Essex HOSC".

**LINKs were invited to comment but none have been received.**

### How To Provide Feedback On The Quality Account/ Report

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

Freephone 0800 169 1625

Andrew Geldard  
Chief Executive  
North Essex Partnership NHS FT  
Freepost  
RLXX-ZXRZ-ESZG  
Trust Headquarters, Stapleford House  
Stapleford Close, Chelmsford  
CM2 0QX

Email enquiries@nepft.nhs.uk

Website [www.nepft.nhs.uk](http://www.nepft.nhs.uk)  
[www.facebook.com/NorthEssexPartnership](http://www.facebook.com/NorthEssexPartnership)

Facebook  
[facebook.com/NorthEssexPartnership](http://facebook.com/NorthEssexPartnership)





## Independent Assurance Report to the Council of Governors of North Essex Partnership NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Council of Governors of North Essex Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of the content of North Essex Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the 'Quality Report').

### Scope and subject matter

I read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for my report if I become aware of any material omissions.

### Respective responsibilities of the Directors and auditor

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

I read the other information contained in the Quality Report and considered whether it is materially inconsistent with:

- Board minutes for the period April 2010 to May 2011
- Papers relating to Quality reported to the Board over the period April 2010 to March 2011
- Feedback from the Commissioners - NHS Mid Essex dated 25 May 2011
- Feedback from Governors - March and April 2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 1 May 2011
- The 2011 national patient survey
- The 2011 national staff survey
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2011
- Care Quality Commission quality and risk profiles dated April 2011.

I considered the implications for my report if I became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). My responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of North Essex Partnership NHS Foundation Trust as a body, to assist the Council of Governors in reporting North Essex Partnership NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and North Essex Partnership NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

### Assurance work performed

I conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). My limited assurance procedures included:

- Making enquiries of management;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents outlined above.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

### Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Mark Hodgson  
Officer of the Audit Commission  
Audit Practice  
Audit Commission  
3rd Floor  
Eastbrook  
Shaftesbury Road  
Cambridge  
CB2 8BF

Dated 29 June 2011

## Staff Survey

The independent survey of staff opinion collected by the Care Quality Commission shows that there are some areas that staff are not happy about.

Our four best scores include staff motivation at work, higher than the national average of Trusts; three are about staff safety and they are all higher than the national average.

There are 38 Key Findings. One finding is better than last year (staff having equality and diversity training), in 14 areas the results are down by small amounts.

- No issues in the best 20%
- 4 issues better than average
- 13 issues at the average
- 15 issues worse than average
- 6 issues in the worst 20%
- 1 issue improved since 2009
- 14 issues deteriorated since 2009

Key findings where the Trust is better than average

### Key findings where the Trust is better than average

Question	2009/10		2010/11		NEPFT Improvement/deterioration
	NEPFT	National Average	NEPFT	National Average	
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	27%	29%	25%	28%	-2%
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	99%	97%	98%	97%	-1%
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Question not comparable		16%	18%	N/A
Staff motivation at work	3.94	3.84	3.83	3.82	0.11





## Key findings where the Trust needs to improve

Question	2009/10		2010/11		NEPFT Improvement/ deterioration
	NEPFT	National Average	NEPFT	National Average	
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	76%	76%	68%	75%	-8%
Percentage of staff using flexible working options	Question not comparable		62%	67%	N/A
Support from immediate managers	3.89	3.78	3.70	3.80	-0.19
Percentage of staff suffering work-related injury in last 12 months	9%	8%	11%	8%	-2%
Percentage of staff suffering work-related stress in last 12 months	28%	30%	35%	31%	-7%
Impact of health and well-being on ability to perform work or daily activities	1.58	1.62	1.67	1.62	-0.09

## Key findings where the Trust has improved since 2009

Question	2009/10		2010/11		NEPFT Improvement/deterioration
	NEPFT	National Average	NEPFT	National Average	
Percentage of staff having equality and diversity training in last 12 months	26%	42%	38%	47%	+12%

## Key findings where the Trust has deteriorated since 2009

Question	2009/10		2010/11		NEPFT Improvement/deterioration
	NEPFT	National Average	NEPFT	National Average	
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	76%	76%	68%	75%	-8%
Quality of job design (clear job content, feedback and staff involvement)	3.55	3.40	3.37	3.42	-0.18
Work pressure felt by staff	2.99	3.02	3.07	3.01	-0.08
Trust commitment to work-life balance	3.69	3.58	3.60	3.59	-0.09
Support from immediate managers	3.89	3.78	3.70	3.80	-0.19





Question	2009/10		2010/11		NEPFT Improvement/deterioration
	NEPFT	National Average	NEPFT	National Average	
Percentage of staff saying hand washing materials are always available	71%	59%	59%	58%	-12%
Fairness and effectiveness of procedures for reporting errors, near misses or incidents	3.45	3.42	3.37	3.45	-0.08
Perceptions of effective action from employer towards violence and harassment	3.59	3.54	3.52	3.58	-0.07
Impact of health and wellbeing on ability to perform work or daily activities	1.58	1.62	1.67	1.62	-0.09
Percentage of staff reporting good communication between senior management and staff	41%	29%	31%	31%	1-0%
Staff job satisfaction	3.65	3.56	3.58	3.60	-0.07
Staff intention to leave jobs	2.46	2.58	2.54	2.55	-0.08
Staff recommendation of the Trust as a place to work or receive treatment	3.53	3.43	3.48	3.49	-0.05
Staff motivation at work	3.94	3.84	3.83	3.82	-0.11

## Equality and Diversity

The Trust Equality and Diversity group, chaired by the Director of Workforce and Development, is responsible for overseeing the delivery of the Trust's statutory duties and the actions set out in the Trust Single Equality scheme. In January 2011, the Trust reviewed its progress and updated its Single Equality Scheme as a first step towards implementing the NHS Equality Delivery Scheme.

Some of the key achievements were:

- Review and re-launch of an Equality and Diversity training programme.
- Completion of the improvement of the physical environment plan.
- Single sex ward/room facilities across the Trust.

The priorities for next year are driven by the requirement to comply with the Equality Act (2010). The act requires public sector bodies to eliminate discrimination, advance equality of opportunity and foster good relations between persons who share a relevant protected characteristic.

In order to meet the above requirements, the Trust is finalising its plan to engage with public, voluntary organisations and staff to inform the development of its equality objectives. The Trust will develop and publish its equality objectives by July 2011 based on the equality evidence and analysis arising from the extensive engagement process.

Table 1 shows a detailed breakdown of the profile of staff employed by the Trust by gender and ethnicity. Table 2 provides a breakdown of people currently receiving services from the Trust. These figures indicate that the staff profile is diverse and broadly represents the local population that it serves. It is acknowledged that data collection in respect of other protected characteristics as defined in the Equality Act could be improved and this will be addressed in the coming year.

Age Band	Headcount by Gender All Staff		Total
	Female	Male	
16 - 24	83	20	103
25 - 34	342	131	473
35 - 44	439	214	653
45 - 54	531	192	723
55 - 64	342	124	466
65+	53	29	82
<b>Trust Total</b>	<b>1790</b>	<b>710</b>	<b>2500</b>

Ethnicity	Headcount by Gender All Staff		Total
	Female	Male	
White	1410	412	1822
Mixed	28	18	46
Asian or Asian British	71	95	166
Black or Black British	189	122	311
Other	39	25	64
Not Stated	53	38	91
<b>Trust Total</b>	<b>1790</b>	<b>710</b>	<b>2500</b>

Age Band	Service Users by Gender			Total
	Female	Male	Un-known	
16 - 24	1811	1395	3	3209
25 - 34	1673	1422	2	3097
35 - 44	2084	1752		3836
45 - 54	1817	1412	1	3230
55 - 64	1201	1044	1	2246
65+	4899	2877	3	7779
<b>Trust Total</b>	<b>13485</b>	<b>9902</b>	<b>10</b>	<b>23397</b>

Ethnicity	Service Users by Gender			Total
	Female	Male	Un-known	
White	13078	9558	10	22646
Mixed	124	117		241
Asian or Asian British	113	98		211
Black or Black British	71	74		145
Other	69	37		106
Not Stated	15	8		23
<b>Unknown</b>	<b>15</b>	<b>10</b>		<b>25</b>
<b>Trust Total</b>	<b>13485</b>	<b>9902</b>	<b>10</b>	<b>23397</b>





# Sustainability Report

North Essex Partnership continues to make good progress in line with the Trust Board’s approved Carbon Management Plan (CMP) of December 2009. This three year carbon reduction plan has an objective for an overall 30% reduction in carbon emissions by the Trust. A number of low carbon initiatives were set out to achieve the target by use of various technologies, applications and policies.

The Trust is already using less energy and generating less carbon emissions since the baseline year of 2007 but maintaining this momentum will be increasingly challenging. The purpose of implementing a carbon management programme is to achieve the latest stringent NHS commitments. Using 2007/08 as the baseline year the Trust can and should reduce carbon emissions in its use of buildings by 30% before March 2015 and has achieved the 10% overall reduction by the end of 2010 (from 2007 baseline).

The Trust made significant reduction in energy consumption

- Oil (down by 6 percent)
- Gas consumption reduced (down by 10 percent)
- Use of electricity reduced (down by 15 percent)

A number of advances have been made since 2007/08, which have already reduced carbon emissions. Examples include the upgrading of boiler systems, investment in building management service controls and installing low energy lighting.

Here is some of the Trusts energy saving investments

### Herrick House and Northgate Centre - boiler replacements

Both schemes replaced old boilers and associated plant with modern condensing boilers to improve efficiency and reduce maintenance & energy costs.

### C & E Centre

Upgraded lighting in reception with more efficient luminaries and control to reduce energy costs.

### Lakes

Installation of more efficient luminaries and control to reduce energy costs in Abberton Centre corridors and waiting area.

### 1 Hospital Road

Replaced old boiler and associated plant with modern condensing boiler to improve energy efficiency and reduce maintenance and energy costs.

### 7 Oxford Road

Replaced old boiler and associated plant with modern condensing boiler to improve efficiency and reduce maintenance and energy costs.

### Peter Bruff Ward

Installation of Sunpipe light tubes to reduce use of lighting during daylight hours and improve energy efficiency.

### Linden Centre and 439 Ipswich Road

Replacement double glazed windows to improve energy efficiency.



87 staff at the Trust took part in energy-saving, eco-friendly “Smarter Driving” programme during Climate Week (21 March to 27 March 2011). The “smarter driving” programme aim to equip drivers with skills that will help them to drive in ways that produce less carbon emissions.

The new CAMHS building will have high levels of natural light, natural ventilation, ground source heat pump, solar thermal hot water system, photo-voltaic roof panels supplying electricity, sustainable surface water drainage systems, Smart Metering Systems for main services and Building Management System.





## Other disclosures in the public interest

Not upheld	23 (32%)
Partially upheld	27 (37%)
Fully upheld	18 (25%)
Not able to investigate	1 (1.5%)
Under investigation	4 (5%)
<b>Total</b>	<b>73</b>

### Issues raised

Clinical Issues	25 (34%)
Access to Service	20 (27%)
Communication	11 (15%)
Staff Attitude	9 (12%)
Privacy and Dignity	4 (5%)
Funding/Commissioning	2 (3%)
Data Breach	1 (1.5%)
Loss of property	1 (1.5%)
Others	0
<b>Total</b>	<b>73</b>

### Complaints

All learning is shared across the Trust through regular meetings with the Area Directors for dissemination to their Teams. Quarterly reports are shared at the area Clinical Boards. There are sample case scenarios published in the bi-monthly Trust magazine, Connections.

273 compliments were received in 2010/11 by the Making Experiences Count Team compared with 221 in the previous year.

## Patient Advice & Liaison Service (PALS)

492 low level enquiries were received by the Patient Advice & Liaison Service (PALS) compared to 344 in the previous year.

PALS Categories	
Information	261
Clinical issues	58
Access to services	31
Communication	30
Staff Attitude	15
Data breach	15
Appointments	12
Change of consultant request	11
Estates	9
Access to medical records	9
Bed shortages	6
Privacy & Dignity	1
Other	35
<b>Total</b>	<b>493</b>

# Foundation Trust Code of Governance

## Statement of Compliance with Code of Governance

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

The Board of Directors of the Trust supports and agrees with the principles set out in the NHS Foundation Trust Code of Governance, and to the best of its knowledge, information, and belief the Trust has complied with the Code throughout the year to the 31 March 2011, save in the following respect:

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

## Operation of the Board and Council of Governors

The Chief Executive has responsibility for overseeing the day-to-day operations of the Trust. He exercises this responsibility through the Executive Management Team (EMT). EMT and the Board of Directors receive monthly reports detailing financial and other key performance indicators. The Board approves the quarterly compliance reports required by Monitor.

The governance documents of the Trust, which have been approved by the Board of Directors, include Powers Reserved to the Board, identifying the decisions which are required to be taken by the Board, and a Scheme of Delegation which has been drawn up by the Chief Executive and which identifies those decisions delegated to members of the Trust's management. The role and responsibilities of the Council of Governors are set out in the Code of Conduct for governors which has been agreed by the Board and the Council of Governors.

## The Council of Governors

The Council is responsible for representing the interests of Trust members and partner organisations and for communicating information about the Trust, its vision and values and its performance to the members of the Trust

or stakeholder organisations which elected or appointed them. The Council of Governors must act in the best interests of the Trust and should adhere to its values and code of conduct. The minutes of meetings of the Council are considered at the following Board meeting in public. The Council is consulted on the development of forward plans for the Trust and approves the Trust's membership strategy.

The Council of Governors appoints and, if appropriate, removes the Chairman and other non-executive directors. The Council also decides the remuneration, allowances and other terms and conditions of office, of the Chairman and the other non-executive directors. The Council approves the appointment of the Chief Executive, appoints and, if appropriate removes, the Trust's auditor. In addition, the Council receives the Trust's annual accounts, any report of the auditor on them and the annual report.

The Council has had four regular meetings in public and an annual public meeting which took place in September 2010. Meetings are publicised in local newspapers and on the Trust website.

During 2010/11 the Trust had 45 governors, 28 of which were publicly elected to represent districts both in and outside of north Essex. There were 11 public constituencies: Braintree, Colchester, Chelmsford, Epping Forest, Harlow, Maldon, Tendring and Uttlesford (all in north Essex), plus south Essex, Suffolk and east Hertfordshire. There were five elected staff governors and 12 appointed Governors representing partner organisations.

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

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

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





### Names of Governors for 12 Months to 31 March 2011

Constituency or Appointing Organisation	First Name	Surname	Elected / Appointed Until
Elected	Suffolk	Moshud Ali	31/07/2013
Elected	Braintree	Mikey Henderson	31/03/2012
Elected	Braintree	Matthew Mills	31/03/2013
Elected	Braintree	Damian Pocknell	31/03/2013
Elected	Braintree	Valerie Sach	31/07/2013
Elected	Chelmsford	Mary Power	31/03/2013
Elected	Chelmsford	Steven Pruner	31/03/2013
Elected	Chelmsford	Cathy Trevaldwyn	31/03/2013
Elected	Chelmsford	Brian Winder	31/03/2013
Elected	Colchester	Annette Bright	31/07/2013
Elected	Colchester	Jayne Marshall	31/03/2012
Elected	Colchester	Russell Simmons	31/07/2013
Elected	Colchester	Harry Young	31/03/2012
Elected	Colchester	George Mooney	Resigned June 2010
Elected	East Hertfordshire	Michael Waller	31/03/2013
Elected	Epping Forest	Sheila Jackman MBE	31/03/2013
Elected	Epping Forest	Andrew Smith	31/03/2013
Elected	Epping Forest, and Deputy Lead Governor	Brian Spinks	31/03/2012
Elected	Harlow	David Bamber	31/03/2013
Elected	Harlow	Terrie Harris	31/03/2013
Elected	Maldon	David Pickles	31/03/2013
Elected	Maldon	David Williams	31/03/2013
Elected	South Essex	David Fairweather	31/03/2012
Elected	Tendring	Angela Barnes	31/03/2012
Elected	Tendring	Jan Giles	Ceased to be a governor in year
Elected	Tendring	James McQuiggan	31/07/2013
Elected	Tendring	Hugh Thompson	31/07/2013
Elected	Tendring, and Lead Governor	Dan Kessler	31/03/2013
Elected	Uttlesford	Pippa Ecclestone	31/03/2012
Elected	Uttlesford	Patrick Hamilton	31/03/2013
Elected	Staff - Medical	Sourangshu Acharyya	31/03/2013
Elected	Staff - Non Clinical	Linda Pearson	31/03/2013
Elected	Staff - Nursing	Nazir Shivji	31/03/2013
Elected	Staff - Other Clinical	Zach deBeer	31/03/2013
Elected	Staff - Social Care	Jo White	31/03/2013
Appointed	Alzheimers Society	Claire Lance	31/08/2013
Appointed	Anglia Ruskin Univesity	Sue Kerr	Resigned March 2011
Appointed	BBC Essex	David Monk	31/03/2013

### Names of Governors for 12 Months to 31 March 2011

Constituency or Appointing Organisation	First Name	Surname	Elected / Appointed Until	
Appointed	Colchester Mind	Clive	White	31/03/2013
Appointed	Essex County Council	Councillor Mick	Skeels	30/04/2013
Appointed	Essex Respite Association	Hazel	Ruane	31/03/2013
Appointed	HM Prison & YOI Chelmsford	Robert	Davis	31/03/2013
Appointed	Involving Essex	Ian	Griggs	Resigned March 2011
Appointed	NHS Mid Essex	David	Barron	31/03/2013
Appointed	NHS North East Essex	Pamela	Donnelly	Resigned October 2010
Appointed	NHS North East Essex	Tim	Young	30/11/2013
Appointed	Tendring & Colchester Minority Ethnic Partnership	Nick Ntiako	Brown	31/03/2013
Appointed	NHS West Essex	Qadir	Bakhsh	31/03/2013





### Governors attendance

		Meeting	AGM	Meeting	Meeting	Meeting	No of Meetings attended	Out Of	Notes
First Name	Surname	01/06/2010	08/09/2010	05/10/2010	07/12/2010	15/03/2011			
Sour-angshu	Acharyya	1	0	1	0	0	2	5	
Moshud	Ali	N/A	0	1	1	0	2	4	Elected July 2010
Qadir	Bakhsh	1	1	1	1	1	5	5	
David	Bamber	1	1	1	1	1	5	5	
Angela	Barnes	1	0	1	1	1	4	5	
David	Barron	1	0	0	1	0	2	5	
Annette	Bright	N/A	1	1	1	1	4	4	Elected July 2010
Nick Ntiako	Brown	1	0	1	0	1	3	5	
Robert	Davis	0	0	0	0	0	0	5	
Zach	deBeer	1	1	1	1	1	5	5	
Pamela	Donnelly	0	0	0	N/A	N/A	0	3	Resigned October 2010
Pippa	Ecclestone	1	1	0	1	1	4	5	
David	Fairweather	1	1	1	1	0	4	5	
Jan	Giles	1	N/A	N/A	N/A	N/A	1	1	
Ian	Griggs	0	0	1	1	0	2	5	Resigned March 2011
Patrick	Hamilton	1	0	1	1	1	4	5	
Terrie	Harris	1	0	0	1	0	2	5	
Mikey	Henderson	1	0	1	0	1	3	5	
Sheila	Jackman MBE	1	1	1	1	1	5	5	
Sue	Kerr	0	0	0	0	0	0	5	Resigned March 2011
Dan	Kessler	1	1	0	1	0	3	5	
Claire	Lance	N/A	0	0	1	0	1	4	Appointed August 2010
Jayne	Marshall	1	0	0	1	0	2	5	
James	McQuiggan	N/A	1	1	1	0	3	4	Elected July 2010
Matt	Mills	1	1	1	1	1	5	5	

Governors attendance									
First Name	Surname	Meeting 01/06/2010	AGM 08/09/2010	Meeting 05/10/2010	Meeting 07/12/2010	Meeting 15/03/2011	No of Meetings attended	Out Of	Notes
David	Monk	1	0	1	0	1	3	5	
George	Mooney	0	N/A	N/A	N/A	N/A	0	1	Resigned June 2010
Linda	Pearson	1	1	1	1	0	4	5	
David	Pickles	1	1	1	1	1	5	5	
Damian	Pocknell	1	0	1	0	1	3	5	
Mary	Power	1	0	1	1	1	4	5	
Steven	Pruner	1	1	1	1	1	5	5	
Hazel	Ruane	1	0	1	0	0	2	5	
Valerie	Sach	N/A	1	1	0	0	2	4	Elected July 2010
Nazir	Shivji	1	1	1	1	1	5	5	
Russell	Simmons	N/A	0	0	1	1	2	4	Elected July 2010
Mick	Skeels	1	0	0	0	1	2	5	
Andrew	Smith	1	1	1	1	1	5	5	
Brian	Spinks	1	1	1	1	1	5	5	
Hugh	Thompson	N/A	0	1	1	1	3	4	Elected July 2010
Cathy	Trevald- wyn	1	1	0	0	0	2	5	
Michael	Waller	1	1	1	1	1	5	5	
Clive	White	1	1	1	1	0	4	5	
Jo	White	1	1	1	0	0	3	5	
David	Williams	1	0	1	1	0	3	5	
Brian	Winder	1	1	1	0	1	4	5	
Harry	Young	1	1	1	1	1	5	5	
Tim	Young	N/A	0	N/A	0	0	0	3	Ap- pointed Novem- ber 2010





## The Board of Directors

The names of the Directors of the Trust are as follows:

Mary St Aubyn, DL	Andrew Geldard
Ray Cox	Geoff Scott
Charles Abel Smith	Paul Keedwell
John Gilbert	Rick Tazzini
Sarah Phillips OBE, DL	Malte Flechtner
Mark Simpson	Mike Chapman
	Lisa Anastasiou

The Chief Executive of the Trust is Andrew Geldard, who was appointed in July 2009. The other Executive Directors who are voting directors of the Trust are:

Dr Malte Flechtner – Medical Director  
 Paul Keedwell – Director of Operations and Nursing  
 Geoff Scott – Director of Strategy  
 Rick Tazzini – Director of Resources

The Chairman and Non Executive Directors of the Trust and the expiry dates of their terms of office are shown below. Each of them is an independent Non Executive Director. Details of the remuneration and pension and other benefits of the Directors are shown on pages 103-106.

Ray Cox is the Deputy Chairman and Sarah Phillips is the Senior Independent Director of the Trust. They were nominated by the Board at its meeting in February 2010 for indefinite terms, but always subject to review by the Board, and in the case of Ray Cox, also subject to formal appointment by the Council of Governors. This appointment was made at the Council's meeting on 2 March 2010.

## Chairman and Non Executive Appointments

Name	Role	End date of appointment
Mary St Aubyn, DL	Chairman	01 December 2012
Ray Cox	Non Executive Director and Deputy Chairman	30 November 2012
Charles Abel Smith	Non Executive Director	04 October 2013
John Gilbert	Non Executive Director	31 May 2014
Sarah Phillips	Non Executive Director and Senior Independent Director	30 November 2012
Mark Simpson	Non Executive Director	07 December 2012

These appointments may be terminated by the Council of Governors in accordance with the Trust's constitution. The balance of the membership of the Board is regularly considered by the Nominations Committee whose report appears on page 69.

## Profile of Board Members



### **Mary St Aubyn DL, Chairman**

Reappointed June 2010

#### Responsibilities:

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

#### Experience and Qualifications:

- Appointed Deputy Lieutenant of the County in 2004
- 1999-2001 Vice Chairman, Mid-Essex Hospitals NHS Trust
- 1996-1999 Vice Chairman, North Essex Health Authority
- 1993-1996 Non-Executive Director, North Essex Health Authority
- 1992-2005 magistrate in Chelmsford and Witham
- Member of the Parole Board at Her Majesty's Prison Highpoint



### **Andrew Geldard, Chief Executive**

Appointed July 2009

#### Responsibilities:

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

#### Experience and Qualifications:

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





**Dr Malte Flechtner, Medical Director**  
Appointed October 2007

Responsibilities:

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

Experience and Qualifications:

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



**Paul Keedwell,**  
**Director of Operations and Nursing**  
Appointed October 2007

- Responsible for all operational services - Adults of Working Age, Older Peoples' Services, Child and Adolescent Mental Health Services (CAMHS)
- Specialist Services, Psychology, Occupational Therapy
- Operation of the Mental Health Act
- Infection Control
- Mental Capacity Act
- Deprivation of Liberty Safeguards
- Nursing Leadership
- Safeguarding children and adults

Experience and Qualifications:

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



### **Geoff Scott, Director of Strategy**

Appointed October 2007

#### Responsibilities:

- Strategic service planning and organisational development
- Social work and social care leadership
- Communications
- Patient and public involvement
- Strategic lead for services for older adults

#### Experience and Qualifications:

- 2001 - 2007 Director of Development and Social Care, North Essex mental Health Partnership NHS Trust
- 1999-2001 Lead for Essex County Council on the project team and project board for the creation of the North Essex Mental Health Partnership NHS Trust
- 1996-2001 County Manager, mental health and substance misuse, Essex County Council, responsible for both commissioning and provision of relevant social care services
- 1980-1995 Various posts, Essex County Council, Social Services
- Four years management experience in the paints/coatings industry
- BSc (Hons) Polymer Science
- Certificate of Qualification in Social Work (CQSW)
- Diploma in Management Studies (DMS)



### **Rick Tazzini, Director of Resources**

Appointed November 2009

#### Responsibilities:

- Finance,
- Estates & Facilities,
- IT, Information
- Performance Management
- Procurement

#### Experience and Qualifications:

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





**Lisa Anastasiou, Director of Workforce & Development** (Non-voting Board member)  
Appointed March 2010

Responsibilities:

- Human Resources
- Medical Staffing
- Workforce Development
- Staff Engagement
- Occupational Health
- Equality & Diversity

Experience and Qualifications:

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



**Mike Chapman, Director of Commercial and Service Development** (Non-voting Board member)  
Appointed August 2010

Responsibilities:

- Commercial Development
- Marketing
- Commissioner Relationships
- Service Development
- Product Development
- Promoting Innovation
- Responding to Tender Opportunities

Experience and Qualifications:

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

## Non Executive Directors



**Charles Abel Smith**  
Reappointed October 2010

Responsibilities:

- Estates, financial controls, budgets and investment development
- Audit Committee
- Remuneration Committee
- Liaison with governors
- Assurance Framework implementation
- Sustainability

Experience and Qualifications:

- Currently Head of PPP Advisory with the consulting firm Arup. Clients include the National Audit Office which has appointed Arup as one of the eight strategic partners to assist in the preparation of Value for Money reports
- 1998-2005 Head of Public Private Finance with BNP Paribas with responsibility for arranging the funding for a wide range of PFI projects including major hospitals
- 1981-1998 Kleinwort Benson Ltd. Wide range of banking responsibilities including role as a director in the PFI Advisory Team.
- MA Geography, Cambridge University
- Certificate of Securities and Financial Derivatives



**Ray Cox**  
Reappointed December 2009

Responsibilities:

- Deputy Chairman
- Chairman of the Audit Committee
- Takes an overview for older adults' services
- Nominations Committee
- Liaison with governors

Experience and Qualifications:

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





**Sarah Phillips OBE, DL**  
Reappointed December 2009

Responsibilities:

- Senior Independent Director
- Chairs the Remuneration Committee
- Service User & Carer Experience
- Nominations Committee
- Takes an overview of CAMHS and specialist services
- Liaison with governors

Experience and Qualifications:

- Chairman, Multiple Sclerosis International Federation
- Chairman, Victim Support
- Awarded OBE in 2005 for services to disabled people
- Appointed Deputy Lieutenant of the County in 2005
- Commissioner of the Royal Hospital, Chelsea
- Sits on/chairs the Registration and Conduct Committees of the General Social Care Council
- 1998-2005 Chairman of the Multiple Sclerosis Society



**John Gilbert**  
Reappointed March 2011 for a further 3 years from June 2011.

Responsibilities:

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

Experience and Qualifications:

- Career includes director level posts with Essex County Council and various management and senior executive posts with Barclays Bank plc
- Member, Finance and Sustainability Committee, Scope
- Fellow of Royal Society for Encouragement of Arts, Manufacture and Commerce (FRSA)
- Fellow of Chartered Institute of Bankers
- BA (Hons) Economics, Durham



**Mark Simpson**  
Appointed December 2009

Responsibilities:

- Nominations Committee
- Charitable Funds Forum
- Liaison with Governors
- Special interest in marketing
- Assurance Framework Implementation

Experience and Qualifications:

- 2008 to date Marketing Director Ford Motor Company Limited
- 2004-2008 Marketing Communications Director Ford of Europe
- 2003-2004 Interactive Communications Manager Ford of Europe
- 2002-2003 Vehicle and Derivative Programming Manager, Ford of Europe
- 2000-2002 Regional Manager Lincoln Mercury
- 1998-2000 Global Commercial Vehicle Produce Marketing Manager Ford Motor Company
- BA in Marketing (Engineering)
- Masters Diploma in Marketing Management



**Dermot McCarthy, Trust Secretary**

Responsibilities:

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

Experience and Qualifications:

- BA (Hons) Modern English Studies
- Master of Business Administration



**James Purves, Legal Adviser to the Board**

Responsibilities:

Legal Advice to Board  
Support to Board of Directors, Council of Governors and Trust Secretary

Experience and Qualifications:

Solicitor and Legal Advisor



**Meetings of the Board of Directors  
Attendance Record**

			28/04/2010	26/05/2010	30/06/2010	21/07/2011	25/08/2010	29/09/2010	20/10/2010	24/11/2010	15/12/2010	26/01/2011	02/03/2011	30/03/2011	Attendance	Possible
Non Ex- ecutive Directors	Mary	St Aubyn	1	1	1	1	1	1	1	1	1	1	0	1	11	12
	Charles	Abel Smith	1	0	1	1	1	0	1	1	1	1	1	1	10	12
	Ray	Cox	1	1	1	1	1	1	1	1	0	1	1	1	11	12
	John	Gilbert	1	1	1	1	0	1	1	1	1	1	1	1	11	12
	Sarah	Phillips	1	1	1	1	1	1	1	1	1	1	1	1	12	12
	Mark	Simpson	1	1	0	1	1	1	1	0	1	1	1	1	10	12
Excutive Directors	Andrew	Geldard	1	1	1	1	0	1	1	1	1	1	1	1	11	12
	Dr Malte	Flechtner	1	1	1	0	1	1	1	1	1	1	1	1	11	12
	Paul	Keedwell	1	1	1	1	1	1	1	1	1	1	1	1	12	12
	Geoff	Scott	1	1	1	1	1	1	1	1	1	1	1	1	12	12
	Rick	Tazzini	1	0	1	1	1	1	1	1	1	1	1	1	11	12
Other Directors	Lisa	Anastasiou	1	1	0	1	1	1	1	1	1	1	1	1	11	12
	Mike	Chapman	1	1	1	1	1	1	1	1	1	1	1	1	12	12

**Attendance of Directors at Council of Governor's Meetings**

			Meeting	Meeting		Meeting	Meeting		
			01/06/2010	05/10/2010	AGM - 08/09/10	07/12/2010	15/03/2011	Attendance	Possible
Non Ex- ecutive Directors	Mary	St Aubyn	1	1	1	1	0	4	5
	Charles	Abel Smith	0	1	1	0	1	3	5
	Ray	Cox	1	1	1	1	1	5	5
	John	Gilbert	1	1	1	1	1	5	5
	Sarah	Phillips	1	1	1	1	1	5	5
	Mark	Simpson	0	1	1	0	1	3	5
					1				
Excutive Directors	Andrew	Geldard	1	1	1	1	1	5	5
	Dr Malte	Flechtner	1	1	1	1	1	5	5
	Paul	Keedwell	1	1	1	1	1	5	5
	Geoff	Scott	1	1	1	1	1	5	5
	Rick	Tazzini	1	1	1	1	0	4	5
Other Directors	Lisa	Anastasiou	0	1	1	1	1	4	5
	Mike	Chapman	1	0	0	1	1	3	5

# Audit Committee Report

## 1. Introduction

The Audit Committee is established by the Board with approved terms of reference. The Committee consists of three Non Executive Directors and it has met on 5 occasions during the year. The membership of the Committee and the number of meetings attended by each member are set out below.

Name	Role	Meetings attended
Ray Cox	Chairman	5/5
Charles Abel Smith	Non Executive Director	4/5
John Gilbert	Non Executive Director	5/5

This annual report which is in respect of the work of the Committee in 2010/11, follows guidance contained in the NHS Audit Committee Handbook, and is divided into six sections reflecting the key duties of the Committee.

## 2. Governance, risk management and internal control.

- The Committee reviewed and scrutinised various disclosure statements, including the Statement on Internal Control (SIC), the Head of Internal Audit Opinion, external audit opinion on the financial statements, and other appropriate assurances, and considers the SIC is consistent with these. Accordingly the Committee recommended Board approval of the SIC.
- The Committee and internal audit have reviewed the Board Assurance Framework, and consider it to be fit for purpose.
- The Committee reviewed the risk management system and the extent it is embedded in the organisation. Using evidence and assurance from the Risk and Governance Executive, the Committee is satisfied that adequate systems for risk management are in place and is confident that the ongoing work and focus of the executive on embedding it throughout the Trust will maintain and strengthen internal control.
- Following consideration of a detailed Internal

Audit report on the Standing Orders and Standing Financial Instructions in January 2010, the Audit Committee recommended approval of amendments to the Scheme of Delegation during the year and will review the Standing Financial Instructions again at its April 2011 meeting. The committee is planning a further review of the Standing Orders and the Scheme of Delegation early in 2011/12. The Committee is satisfied that appropriate controls and regulation for the conduct of business are in place.

- The Committee always includes a standing item on its meeting agenda to consider issues of a legal or regulatory nature.

## 3. Internal Audit

Throughout the year the Committee has worked effectively with Internal Audit to assess and strengthen internal control processes and levels of assurance. In particular the Committee has:

- Reviewed and considered the internal audit strategy, plans and programme of work. The Committee is satisfied internal audit plans and work are based on effective risk assessment and consultation with management, and has supported their approval.
- Considered all reports from internal audit and monitored the implementation of recommendations made. The Committee is assured that management action is appropriately monitored and managed.
- Received from the Internal Auditor regular performance indicators and is satisfied that the work of internal audit is efficiently and effectively carried out.
- The Committee is satisfied that based on advice from internal and external audit and management, the base number of days of internal audit work at 158 per year is adequate. An additional special item of 6 days work on claims management was also undertaken to support the NHS Litigation Authority submission.

## 4. External Audit

Throughout the year the Committee has worked effectively with External Audit. This is the first full year since the appointment of the Audit Commission which has been very successful and there are no significant issues arising. The External Auditor has direct access to the Chairman of the Trust, Chief Executive, and Director of Finance. The Audit Committee acts as their formal lines of





communication. The Committee has:

- Received regular updates and reports from external audit.
- Received the draft audit letter for 2009/10, and has been assured that appropriate action has been taken by management.
- Considered and reviewed the plans for auditing the 2010/11 accounts, and discussed topical auditing and accounting standards issues that have arisen.

## **5. Counter Fraud**

The activities of the local counter fraud specialist are provided by Deloitte. They report regularly to the Committee, on progress in the completion of the agreed annual plan for counter fraud work. Annually the Trust completes a qualitative assessment declaration, and this is used by the NHS Counter Fraud Service to assess the Trust's counter fraud arrangements. For the last year of review (2009/10), the assessment, which ranges from level 1 to 4, resulted in a level 2 being awarded. This means the Trust achieved adequate performance. The Committee was satisfied the assessment properly reflected the Trust's arrangements, and discussed proposals and plans for raising the assessment to level 3 for 2010/11.

## **6. Management**

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

An important part of the Committee's role is to challenge the assurance process when appropriate, and this is made more effective by the cooperation and participation of staff.

The Committee plays an important role in reviewing and scrutinising the annual financial statements prepared by the Director of Resources before submission to the board for adoption. The production of the accounts and the timing of the approval process are extremely challenging, requiring the highest levels of professionalism and commitment by the staff involved. Special meetings of the Committee are arranged as required to meet deadlines, and it is necessary for members of the Committee to have a ready understanding of the

accounting standards and other technical issues involved so that an assured recommendation is submitted to the board.

The Committee also keeps a brief and watchful eye on the Charitable Funds Accounts.

During the year the Trust introduced a revised Whistle Blowing Policy, and this was reviewed by the Committee as part of the approval policy. The Committee was satisfied the Policy has been implemented and is operating. Arrangements are in place to enable the Committee to receive periodic reports so that its effectiveness can be assessed.

## **7. Effectiveness of the Committee**

Each year the Committee undertakes a self assessment of its effectiveness and uses the check lists contained in the NHS Audit Committee Handbook and the Audit Commission publication 'Taking it on Trust'. This ensures the Committee maintains its compliance with good practice. Members of the Committee attend relevant seminars and other training opportunities, and the Chairman attends various regional audit Chair meetings to establish links and discuss issues and exchange ideas and practice.

## **8. Conclusion**

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

Signed Ray Cox, Chairman Audit Committee  
5 April 2011

## Nominations Committee Report

During the year 1 April 2010 to 31 March 2011 the Nominations Committee of the Board of Directors met on three occasions.

Name	Role	Meetings Attended	Notes
Mary St Aubyn	Chairman	3/3	
Ray Cox	Non Executive Director	2/3	Joined the committee in year
John Gilbert	Non Executive Director	1/3	Did not attend 2 meetings where his reappointment was under discussion
Sarah Phillips	Non Executive Director	3/3	
Mark Simpson	Non Executive Director	1/3	

The Nominations Committee consists of the above named Non Executive Directors. The duties of the Nominations Committee centre on keeping the size, structure, and composition of the Board of Directors under regular review and making recommendations to the Chairman of the Trust regarding the Executive Directors, and to the Council of Governors regarding the Non Executive Directors, for any change which the Committee may consider to be desirable.

The Committee met on 30 June 2010 in order to consider its recommendation in relation to the reappointment of a Non Executive Director, Charles Abel Smith, whose term of office was due to expire on 05 October 2010.

The general principles of the process which had been approved by the Council of Governors, were:

- an evaluation of Board skills by the Committee and of each Non Executive Director by the Chairman. She confirmed that Charles Abel Smith continued to be effective and committed to the role
- consideration by the Remuneration and Appointments Committee of the Council of Governors, of the Committee's findings, and the Chairman's report in order to decide whether to recommend to the Council of Governors whether Charles Abel Smith should be reappointed without a competitive process.

The Nominations Committee made a unanimous recommendation in favour of Charles Abel

Smith's reappointment to the Remuneration and Appointments Committee of the Council of Governors. The Council of Governors met on 05 October 2010 and after considering the Remuneration and Appointments Committee's recommendation that Charles Abel Smith should be reappointed, unanimously supported the appointment of Charles Abel Smith for a further 3-year term, commencing on 06 October 2011.

The Committee met on 24 November 2010 when it received a letter from John Gilbert regarding the role of Non Executive Director confirming that he would like to be considered for reappointment for a further term on expiry of his current term, on 31 May 2011. John Gilbert was not present at the meeting.

The Committee considered the processes and timescales relating to future appointment of Non Executive Directors. The Committee reviewed the job description for a Non Executive Director including feedback from members of the Remuneration and Appointments Committee (the 'RAC') of the Council of Governors. The job description was approved by the Council of Governors at its meeting held on 07 December 2010.

The Committee met on 26 January 2011 in order to consider its recommendation in relation to the reappointment of a Non Executive Director, John Gilbert, whose term of office was due to expire on 31 May 2011; John Gilbert was not present at the meeting.

The general principles of the process which had been approved by the Council of Governors, were:

- an evaluation of Board skills by the Committee and of each Non Executive Director by the Chairman. She confirmed that John Gilbert continued to be effective and committed to the role
- consideration by the Remuneration and Appointments Committee of the Council of Governors, of the Committee's findings, and the Chairman's report in order to decide whether to recommend to the Council of Governors whether John Gilbert should be reappointed without a competitive process.

The Nominations Committee made a unanimous recommendation in favour of John Gilbert's reappointment to the Remuneration and Appointments Committee of the Council of Governors. The Council of Governors met on 15 March 2011 and after considering the Remuneration and Appointments Committee's recommendation that John Gilbert should be reappointed, unanimously supported the appointment of John Gilbert for a further 3-year term, commencing on 01 June 2011.





# Remuneration Report

The Remuneration Committee members are:

Sarah Phillips  
Committee Chair

Charles Abel Smith  
Non Executive Director

Ray Cox  
Non Executive Director

The Remuneration Committee did not meet during the year. The work of the Committee receives professional support from the Director of Workforce and Development or her deputy.

Decisions on the remuneration of Executive Directors are made in the context of market rates e.g. salary benchmarking with other Foundation Trust's and NHS Trust's; the Trust's performance against its objectives and an individual's performance in their role. The Committee also considers whether other staff groups have received a pay award and the level of that award.

A formal policy detailing the approach to remuneration will be developed during the course of 2011/12.

All Executive Directors are employed on permanent contracts with notice periods as shown below. There are no provisions for early termination within the contracts nor do the contracts contain other details sufficient to determine the Trust's liability in the event of early termination.

There were no significant awards made to past Executive Directors during the course of 2010/11.

Name	Position	Contract Date	Notice Period
Lisa Anastasiou	Director of Workforce & Development	29/03/2010	3 Months
Mike Chapman	Director of Commercial & Service Development	06/02/2010	3 Months
Dr. Malte Flechtner	Medical Director	01/02/2005	3 Months
Andrew Geldard	Chief Executive	30/07/2009	6 months
Paul Keedwell	Director of Operations & Nursing	12/03/2010	3 Months
Geoff Scott	Director of Strategy	01/04/2001	4 Months
Rick Tazzini	Director of Resources	23/11/2009	3 Months

Details of payments made for retirements due to ill health are set out in note 8 to the Annual Accounts. Details of the salaries, benefits in kind and pension entitlements of Senior Managers are set out in note 9 to the Annual Accounts.

The Committee will be convened early in 2011/12 to consider issues including Executive Directors remuneration for 2011/12 and a review of the Remuneration Committee's terms of reference.

Andrew Geldard  
Chief Executive

## Membership Report

We have two constituencies – public and staff. We do not have a separate patient constituency. Patients are encouraged to join through the public membership work. The general responsibility for these tasks lies with the Membership, Marketing and Public Relations (MMPR) Governors' Workstream.

The public constituency membership as at 31 March 2011 was 6536 (across 11 geographical districts) which shows an increase of 120 which is less than the estimated total we set last year of 7200. This reflects two things. The first, a slow down in the recruitment activity, with a new emphasis on Governors recruiting in their areas rather than through Trust-wide events. However we did recruit significantly, 737 new members. The Council had set an emphasis on community and member engagement with recruitment falling out of these strands of engagement activity.

The other factor was a data cleanse, which showed 37 members had died and over 500 had left the area (some of the cleanse was also delayed from the previous year).

This represented attrition of around 9% - almost double what was anticipated. That said if the anticipated attrition rate of 5% had been reached we would have an additional 300 members, still less than the target.

The Council discussed this again in March 2011 with a new membership strategy that acknowledged the shortfall, but reiterated the approach to be taken (with more on engagement activity) and set modest increases for the coming years, but once again setting individual recruitment targets for each Governor. Allowing for an attrition rate of about 5% we will need to recruit 593 people in the coming year. The Membership, Marketing and Public Relations Workstream will monitor this.

### Staff constituency

About 100 staff members who left the Trust's employment became public members (this is now done automatically with the option to opt out). The staff constituency is 2,153 against the estimate made a year ago of 1,977. This growth is because of bank staff. It follows a major recruitment exercise to the new in-house bank in 2009/10. The staff membership total is expected to remain fairly stable over the coming year with a slight net reduction in overall establishment but slightly reduced turnover. As staff members leave the Trust's employment, if eligible, they automatically become public members subject to their option to opt out.

We believe that the current public constituency membership is within the tolerances of representativeness. However there are some shortfalls

where extra recruitment effort is required. We currently produce a monthly report for all Governors showing the latest membership and representative shortfalls. The Governors have been asked to give this some attention and MMPR will pursue this further.

### Gender

Membership is proportionate but with males a little underrepresented (by about 180, but a small improvement).

### Age

We are unrepresented in the under 16 category (however the eligible membership includes all young people under 16 and Trust membership is open to 14 year olds. However we do not know the proportion of this age band that is 14-15, however we would expect the current membership to be higher than it is; perhaps around 100.

We have run into some opposition from parents and schools about recruiting amongst this age group. We undertake considerable amount of activity in schools and colleges and this needs to be translated into members and we will be doing so over the period of the Plan (by also writing to parents when we attend schools). We will also encourage recruitment of patients and their families through our Child and Adolescent Mental Health Services (which is also in line with a new Trust Service User and Carer involvement strategy).

The age range 17-21 is at 4% of memberships and should be 6.6% (about 140 fewer) and this will be addressed through the recruitment strategy.

### Ethnicity

We are broadly representative here. Essex is 97% 'white' with other ethnic groups less than 1% each of the population. We have a representative membership for all groups except 'mixed'. However the numbers are small and keep us with the tolerance.

Overall numbers have increased but not significantly.

### Socio-economic status

This is the area where we need the most attention. The levels are proportionate to each other but underrepresented amongst C2 (at 1.8% of the membership when it should be 16%), with more work needed amongst D (7% and should be 15%) and Es (less so with E which is currently at 9.7%, should be 15%). (Note: C2 = Skilled manual workers, D = Semi-skilled and unskilled manual workers, E = Casual labourers, pensioners, unemployed).

- Explanation of future membership plan outlining steps taken in past 12 months to ensure representative membership in each constituency, and evaluation of outcome of these steps (reference table of analysis





- as appropriate), and
- Steps planned in next 12 months to ensure membership of each constituency is representative. Strategy must make reference to table of analysis of current membership.

The new Membership Strategy (approved at the March 2011 Board of Director's meeting) says; "Membership growth has been a challenge over the last year with the emphasis less on centrally organised events and more on the local level."

This additional responsibility on Governors, alongside their engagement work, also remains a challenge for some.

Nevertheless this strategy reaffirms that it is every Governor's responsibility to recruit new members, and sets a target of 20 per Governor per year. If this is achieved, 900 new members will be recruited – more than enough to reach any targets and to replenish the numbers lost through attrition.

This recruitment work should be an integrated part of engaging with current members and meeting the public (and experience shows that new members are often recruited at engagement events with current members). Even if this target was set for the public Governors only, this would still bring in 560 new members.

The new database and contract will enable us to analyse the membership returns in more detailed and specific ways. Reports will be sent to Governors regularly with this information to act on.

We have over 200 people who have filled out membership application forms but live outside the Trust's constituency boundaries, so are not counted as members.

#### **Proposals to monitor representativeness**

A new Service User and Carer Involvement Strategy has been developed with members, Governors and wider stakeholders. The final version is due to go to the May 2011 Board of Directors meeting. Service user/ carer Involvement will be offered to all members (with our magazine, MembersNews, proposed to change to accommodate this) so we will expect to see an increase in the number of patients and their families joining the Trust. Patients tend to be drawn disproportionately from the C2, D and E socio-economic categories.

The leader of the MMPR Workstream and the Trust Associate Director of Communications will attend meetings of each constituency Governors group to discuss representativeness and to lay plans to remedy it, within the guidelines set by Council as to how this will be done (i.e. in the area led by the Governors).

A Governor Development day in August 2011 is being set aside for this task (along with engagement) and the MMPR group will monitor it more closely and will make recommendations to the Council if changes are necessary.

New proposals include:

- Governors using the new Dementia DVD - about what the Trust services are and why the staff are so good - part of the National Dementia Strategy that explains to the public what dementia actually is and helps to raise awareness.
- Governors using the new Carers DVD.
- Governors using the DVD material from the Trust Celebration of Achievements awards (November 2010).
- Developing the 'Friends of...' groups for the Derwent Centre, Crystal Centre, Longview and Kings Wood. The Friends of the Landermere Centre is the most developed. One Governor has agreed to chair a Friends of the Mother & Baby Unit.
- Continuing the schools campaign and engaging youth groups.
- The youth involvement project (5QP).
- Continuing to seek an employer to work with the Trust around mental health awareness and changing attitudes.
- Christmas card campaigns in public shopping areas – to get people to sign cards, children to redecorate them and post them to service users (anonymously)
- Public events that increase contact between people with a mental illness and the general public (a major aim of the Time to Change campaign) around World Mental Health Day. We will consider a springtime public Get Moving event, possibly in Epping Forest, and ask Governors to work on the Heads Up campaign (with local hairdressers).
- At least two meetings a year to take place in each constituency, with the Chief Executive making a report to the members.
- Continuing our work with Essex Libraries with more Living Book events and possibly a poetry competition with the libraries.

## Business Review

### Financial Statements

This section provides a commentary on the Trust's financial performance. For the full financial statements please see Section 10.

The period 1 April 2010 to 31 March 2011 was the Trust's third full year as an NHS Foundation Trust. Our financial position continued to strengthen, producing a net operating surplus, before impairments, of £1.436million, which was £36,000 better than planned. The surplus was reinvested in the capital programme to enhance patient experience, quality and safety. After account is taken of the "technical" asset impairments of £5.177million, the recorded revenue position is a deficit for the year of £3.741million.

Based on our revenue performance and liquidity, we have retained a financial risk rating (FRR) level 4 and warranting 'significant assurance' in the Trust's internal audit. The Trust has achieved the financial targets set by the Board and performance requirements set by Monitor and the Care Quality Commission. The Board has agreed the Trust's financial plan for 2011/12

### Income

Total income for the year was £107.350m. Income of £87.363m was received from block contracts with the three north Essex Primary Care Trusts and Specialist Commissioners. Clinical partnership income of £7.020m included the Essex County Council section 75 agreement (£6.967m). Other protected non-clinical income of £1.692m included the Eastern Development Centre and Enable East (£0.040m).

### Spend

Operating spend, excluding PDC dividends totalled £108.776m. The sum comprised pay (£80.943m), non pay (£20.468m), impairment charges (£5.177m) and depreciation (£2.188m). Finance spend of £2.315m included PDC dividends of £2.144m.

### Financial Result

The financial result is that the Trust recorded a

technical deficit of £3.741 million. However, after account is taken of the £5.177 million of impairments in property asset values, the underlying Income & Expenditure surplus is £1.436 million compared to a plan of £1.400 million.

### External Auditors

The Audit Commission is the Trust's appointed external auditor for the three years through to 31 March 2012. The Trust incurred audit fees during the year of £70,000.

### Internal Auditors

Internal audit is overseen by the Audit Committee and by independent auditors, Deloitte LLP.

### Capital Developments

The capital programme for 2010/11 was managed within plan including the purchase of the Derwent Centre on the Princess Alexandra site in Harlow. During the year £7.654 million was spent on capital developments, mainly for the Derwent Centre, the new Pharmacy unit and system, refurbishment of clinical areas, IT and networks as well as on-going security and planning costs associated with the planned disposal of the Severalls Hospital site in Colchester.

The refurbishments included a new Mother and Baby Unit in Chelmsford, work on a new Eating Disorders Unit in Colchester, improvements to the Christopher Unit in Chelmsford, and various small refurbishment projects throughout the Trust.

In March 2011, building work began on a new CAMHS building in Colchester. This new facility is expected to be complete in 2011/12.

Plans are progressing for further strategic investment, including the replacement of the Trusts' clinical information system, and our mandatory services in low secure, the Derwent Centre and psychiatric intensive care.

### New contracts

For 2010/11, new service contracts were with commissioning partners for £0.4million investment to





expand services for children and adolescents in west Essex.

### Financial reporting

The Trust has continued to improve reporting to the board to include service-line activity, performance, quality and financial issues. Reference costing data was submitted to the Department of Health, improving the Trust's reference cost index or the fifth consecutive year to 93.7.

Work commenced in 2010/11 to introduce Health of the Nation Outcome Scales (HoNOS) and care clusters for service users. This work links, in due course to the future "payment by results" framework.

### Creditor payment

The Trust follows the Better Payment Practice Code. The Trust has delivered improvements in both the 30-day and 10-day targets.

#### Better Payment Practice Code – Measure of Compliance

Name	Year Ended 31 March 2011
Numbers	
Total Non-NHS Trade Invoices paid in the year	18,788
Total Non-NHS Invoices paid within target	16,968
Percentage of Non-NHS Trade Invoices paid within target	90%

Name	Year Ended 31 March 2010
Numbers	
Total Non-NHS Trade Invoices paid in the year	22,162
Total Non-NHS Invoices paid within target	18,545
Percentage of Non-NHS Trade Invoices paid within target	84%

The Better Payment Practice Code requires the NHS Foundation Trust to aim to pay all undisputed invoices by the later of:

- the due date;
- 30 days from the receipt of the goods or service;
- 30 days from the receipt of a valid invoice.

The above payment times are recorded using invoice receipt date to payment date, and include those invoices which have been disputed. The figures provided therefore show a lower percentage of invoices paid in accordance with the Better Payment Practice Code than would be the case if the disputed invoices were excluded. At present, there is no way of recording within the finance system those invoices which are disputed.

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

There are no amounts included within interest payable arising from claims under the above legislation.

No amounts of compensation were paid for debt recovery costs under the above legislation.

#### Counter fraud arrangements

The Trust is committed to providing and maintaining the highest standards of honesty and integrity in dealing with assets and uses best practice as recommended by the NHS Counter Fraud and Security Management Services, CFSMS. The policies and related materials are available on the trust's intranet and counter-fraud information is prominently displayed on the trust's premises.

Counter fraud specialist services are provided by Deloitte LLP. The trust's local counter-fraud specialist (LCFS) reports to the Director of Resources and performs a programme of work designed to provide assurance to the board in regard to fraud and corruption. The LCFS attends Audit Committee meetings at which she presents the programme and the results of her work. The LCFS gives regular fraud awareness sessions for the trust's staff. She investigates concerns reported by staff and, if they are substantiated, the trust takes appropriate criminal,

civil or disciplinary measures.

The Trust maintained its level “2” (evidence of a range of outputs) for the annual qualitative assessment for 2009/10 and 2008/09. The Trust expects to maintain this score for 2010/11, once the results of the qualitative assurance are known. Plans are in place to improve the score to “3” (performing well) for the financial year 2011/12.

### **Balance sheet and cash flow**

The Trust’s net worth decreased by £19.131million during the year, with total net assets standing at £69.603million at 31 March 2011. The Trust’s cash balances decreased by £0.907million during the period and had a £17.382million cash balance at year-end. The Trust drew down the remaining £4million of its £8million loan facility. The Trust was not required to call upon its £8.0million working capital facility during the year.

## **Outlook for 2011/12**

### **Revenue**

The NHS Operating Framework guidance for 2011/12 directs PCTs to pay providers, 2.5% for pay and price pressures including inflation, but to reclaim 4% for “efficiency”. This means that for 2011/12 our tariff price with the PCTs will be reduced by 1.5% - a cash reduction in income of £1.3million next year. National guidance states that providers can expect, “No better than flat cash for next three years”, which means at best a zero percent increase, but more likely further tariff reductions in future.

### **Capital**

The capital programme comprises three elements: operational capital (£2.2m), loan repayment (£1.0m) and strategic capital (£12.7m) The Board has approved the commencement of the new CAMHS facility in Colchester (£7.6m in 2011/12). There are four strategic business cases that have been prepared and are in a process of prioritisation for new IT systems, low secure, Derwent centre and psychiatric intensive care services. (£5.0m available in 2011/12).

### **Accounting policies**

The Financial Statements are prepared in accord-

ance with Monitor guidance and International Financial Reporting Standards. The Board of Directors has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the Financial Statements. Accounting policies for pensions and retirement benefits are in Note 1 of the Financial Statements.

### **Senior employees’ remuneration**

Details of senior employees’ remuneration, including pension entitlements, is disclosed in the annual accounts on pages 103 to 106.

### **Post balance sheet events.**

On 3 May 2011, the Trust entered into a 10year loan agreement, within the prudential borrowing limit, for £7million to fund the new CAMHS capital scheme.

During the year, the Trust entered into an agreement with Suffolk PCT to manage the Suffolk Community Services for one year, starting on 1 April 2011. This is not expected to have a material impact on the Trust during 2011/12.

### **Charitable Funds**

Registered Charity 1053509 is a charitable fund for the benefits of patients, research, training and staff welfare. The fund is administered by North Essex Partnership NHS Foundation Trust as the sole trustee. Full details can be obtained from the Director of Resources by writing to Trust headquarters.

The Trust’s Charitable Funds Forum has taken a pro-active role in 2010/11 The Forum then met 6 times during the year to assess the 38 bids received. Bids totalling £22,000 were approved all of which focused on improving the patient experience, including, flat screen televisions with Wii games, garden improvements, and a specialist piece of equipment for service users with dementia.





## Management Costs

Name	Year Ended 31 March 2011 £'000	Year Ended 31 March 2010 £'000
Management costs	7,118	8,216
Income	107,350	105,224
Management costs as a percentage of income	6.6%	7.8%

**Management costs are defined as those on the Department of Health website at [www.dh.gov.uk](http://www.dh.gov.uk)**

## Statement of the Chief Executive's Responsibilities as the Accounting Officer of North Essex Partnership NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed the North Essex Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of North 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 financial statements, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual, and in particular to:

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

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

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

Date: 25 May 2011



Andrew Geldard  
Chief Executive





## Statement of Directors' Responsibilities in Respect of the Accounts

The Directors are required under the National Health Service Act 2006 to prepare financial statements for each financial year. The Secretary of State, with the approval of the Treasury, directs that these financial statements give a true and fair view of the state of affairs of the NHS Foundation Trust and of the income and expenditure of the NHS Foundation Trust for that period. In preparing those financial statements, the Directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.

The Directors are 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 them to ensure that the financial statements comply with requirements outlined in the above mentioned direction of the Secretary of State. They are 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.

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the financial statements.

Each Director is not aware of any relevant audit information that has not been made available to the Auditors and has taken all steps that he or she ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's Auditor are aware of that information.

By Order of the Board

Date: 25 May 2011

Andrew Geldard  
Chief Executive

Date: 25 May 2011

Rick Tazzini  
Director of Resources

## Statement on Internal Control

### Scope of Responsibility

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

### The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of North Essex Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in North Essex Partnership NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

### Capacity to Handle Risk

North Essex Partnership NHS Foundation Trust has established a risk management framework in order to effectively manage risks within all areas of the Trust's operations.

The responsibility for overseeing the management of organisational hazards is defined within the Risk Management Strategy 2010-2014, as approved by the Board of Directors on 30 March 2011. The

Board of Directors retains strategic responsibility for the risk management agenda with operational responsibility being delegated to the Risk and Governance Executive. The Risk Register, which defines actions and sources of assurance, has been established and approved by the Board of Directors. Within this Trust wide approach, arrangements have been embedded to manage appropriate risks at a local level. The Risk Register is regularly reviewed, revised and submitted for approval to the Board of Directors.

The Board of Directors has adopted an Assurance Framework.

All staff within the Trust are included within the risk management process including the identification of risks and hazards at all levels of the Trust and participate in the risk assessment training programmes. Local Risk Registers have been developed as a result of this, with actions identified to mitigate those risks. Appropriate local risk management structures are being identified to ensure capacity exists to undertake assessments, identify hazards and to create and maintain local Risk Registers. As part of the Trust's training programme for managers and team leaders, training is provided to identify, prioritise and ultimately control operational hazards and reduce levels of risk to which staff, service users and visitors are exposed. The Risk & Governance Executive regularly reviews the Assurance Framework and this is submitted to the Board of Directors for approval.

### The Risk and Control Framework

The Risk Management Strategy sets out the Trust's approach to risk, including the ways in which risk is identified, evaluated and controlled.

The Board of Directors oversees the risk management agenda within the Trust receiving periodic updates from the Risk and Governance Executive. The Risk and Governance Executive has adopted an integrated approach to risk management.

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





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

Risk Registers are subject to annual and systematic review. This is assisting in embedding the risk management culture and activity throughout the Trust. The Risk Register details the sources of independent assurance. This document is subject to continuous review and is considered a live, dynamic management tool. The Trust actively uses the sources of independent assurance contained within this framework to underpin this Statement on Internal Control.

The Risk and Governance Executive is responsible for the monitoring of the framework. Where possible we update our stakeholders on our management of risk, paying particular attention to our Council of Governors who are constituted to represent the public in the constituencies we serve, as well as to reflect the views of our key stakeholders.

Information Security is fundamental to the operation of all NHS bodies including the North Essex Partnership NHS Foundation Trust due to the sensitive and confidential patient data it captures and the reliance on information systems to process, and transition of, any patient information.

The Trust has established an Information Governance & Security Steering Group to co-ordinate the review of the NHS Foundation Trust's information governance management and monitor the NHS Foundation Trust's information governance data security. This steering group reports directly to the Risk and Governance Executive. All staff are required to complete and successfully pass the relevant Information Governance training module supplied by the NHS Information Centre.

The Information Governance & Security arrangements take into account statutory arrangements and good practice. Information Governance provides a framework for managing information about patients and employees, with a particular emphasis on personal and sensitive information.

The Trust has reviewed its compliance with the CQC standards for quality and safety, Clinical Negligence Scheme for Trusts (CNST) and NHS Litigation Authority Risk Management Standards.

The Trust operates at Level 1 of the NHSLA Risk Management Standards for Mental Health Trusts.

The North Essex Partnership NHS Foundation Trust is meeting all the essential standards of quality and safety as reviewed by the Care Quality Commission in April 2011. The Trust is therefore compliant with the requirements of registration with the CQC.

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

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

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

## Review of Economy, Efficiency and Effectiveness of the Use of Resource

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

Additionally, the Board of Directors receives monthly finance and performance reports and approves the quarterly compliance reports, which are required by the independent regulator, Monitor.

Internal Audit conducts a review of the Trust's

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

## Annual Quality Report

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

Production of the Trust's Quality Report is governed and lead by the Risk & Governance Executive (R&GE), which reports into the Board of Directors. The Trust employs a comprehensive range of systems, reporting processes, training, data validity checks, as well as internal audit and limited assurance external audit. We have a team of Quality Accountants who manage the process for the Quality Account and reports directly to the R&GE. This approach provides the Board with the assurance that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data

## Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on

the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Risk and Governance Executive, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

During the year, Internal Audit issued 17 "final" audit reports and three "draft" reports. Six of the final audits resulted in "limited assurance" opinion, defined as "weaknesses in the system of controls are such as to put the system's objectives at risk". These were reported to the Executive Management Team for review and detailed action plans have been implemented to address these weaknesses. Plans have also been put in place to address other, less significant, weaknesses and ensure continual improvement in systems of internal control.

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

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit Opinion for the year ended 31 March 2011 is as follows:

"Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently."

The Internal Audit Plan in 2010/11 challenged a number of areas, and controls were further enhanced by management action.





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

i) The Board of Directors

The Board of Directors receives performance, safety, quality and financial reports at each of its meetings and receives reports of its Sub Committees to which it has delegated powers and responsibilities. The Board has reviewed the Assurance Framework and receives regular information from the Audit Committee and the Risk and Governance Executive. In 2010/11, the Board reviewed a number of significant policies and strategies during the period including Investment Policy, Single Equality Scheme, Policy and Procedure Writing Policy, Nursing strategy, Estates Strategy and Interim Quality Strategy.

Executive Directors have clear responsibilities for risk management within their area of control. Executive Directors also have corporate responsibility as Board members.

ii) Area and Assistant Directors

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

iii) The Audit Committee

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

iv) The Risk and Governance Executive  
Operational management of the risk management agenda sits with the Risk and Governance Executive, which has responsibility for implementing the Risk Management Strategy. The group is also responsible for developing the Trust's Clinical/ Practice Governance Strategy.

v) Internal Audit

Deloitte LLP was appointed 1 August 2004 to provide Internal Audit services, and re-appointed for a further three years in March 2009.

vi) Care Quality Commission (CQC)

In April 2011, the CQC reported the results of its review of compliance of North Essex Partnership NHS Foundation Trust that took place in February 2011. The CQC found that the Trust was meeting all the essential standards of quality and safety reviewed. The CQC suggested two areas for improvement action for "care and welfare" and "safeguarding".

The Trust has a "without conditions" registration from CQC dated 1 April 2010, demonstrating that the Trust meets the CQC's essential standards of quality and safety across the full range of services provided.

## Conclusion

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

Date: 25 May 2011

Andrew Geldard  
Chief Executive

# Independent auditor's report to the Council of Governors of North Essex Partnership NHS Foundation Trust

I have audited the financial statements of North Essex Partnership NHS Foundation Trust for the year ended 31 March 2011 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on pages **103 to 106**; and
- the table of pension benefits of senior managers and related narrative notes on page **103 to 106**.

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

## Respective responsibilities of the Accounting Officer and auditor

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

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

## Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements

are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

## Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of North Essex Partnership NHS Foundation Trust as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

## Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## Matters on which I report by exception

I have nothing to report in respect of the Statement on Internal Control on which I report to you if, in my opinion the Statement on Internal Control does not reflect compliance with Monitor's requirements.

## Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide external assurance over the Trust's annual quality report. I am satisfied that this work does not have a material effect on the financial statements.

Mark Hodgson  
Officer of the Audit Commission  
The Audit Commission's Audit Trust Practice  
3rd Floor, Eastbrook,  
Shaftesbury Road,  
Cambridge, CB2 8BF

26 May 2011





## Independent auditor's report to the Council of Governors of North Essex Partnership NHS Foundation Trust

Mark Hodgson  
Date: 29 June 2011  
Officer of the Audit Commission

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

I have considered the information given in the revised annual report of North Essex Partnership NHS Foundation Trust for the year ended 31 March 2011. The revised Annual Report replaces the original report approved by the Accounting Officer on 25 May 2011.

### **Respective responsibilities of the Accounting Officer and auditor**

The Accounting Officer is responsible for preparing the revised Annual Report. I am required to report to you whether the revised Annual Report is consistent with the financial statements.

#### **Basis of opinion**

My consideration has been directed on matters of consistency alone and not to whether the revised Annual Report complies with the requirements of Monitor's Annual Reporting Manual 2010/11.

### **Opinion**

In my opinion the information given in the revised Annual Report is consistent with the financial statements for the year ended 31 March 2011 which were approved by the Accounting Officer on 25 May 2011 and on which I gave an unqualified opinion on 26 May 2011.

### **Certificate**

In my report dated 26 May 2011, I explained that I could not formally conclude the audit on that date until I had completed the work to provide external assurance on the Trust's annual quality report. I have now completed this work. No matters have come to my attention since that date that would have a material impact on the financial statements on which I gave an unqualified opinion. I certify that I have completed the audit of the accounts of North Essex Partnership NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

# Foreword to the Financial Statements

These financial statements for the year ended 31 March 2011 are prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Date: 25 May 2011



Andrew Geldard  
Chief Executive





## North Essex Partnership NHS Foundation Trust Statement Of Comprehensive Income For the year ended 31 March 2011

	Note	2010/11		2009/10	
		£'000	£'000	£'000	£'000
<b>Operating Income</b>	3, 4		107,350		105,224
<b>Operating Expenses</b>	5		<u>(108,776)</u>		<u>(104,949)</u>
<b>Operating Surplus/(Deficit)</b>			<b>(1,426)</b>		<b>275</b>
<b>Finance Costs</b>					
Finance Income	10	69		72	
Finance Expense – Financial Liabilities	12	(196)		(108)	
Finance Expense – Unwinding of Discount on Provisions	23	(44)		(48)	
PDC Dividends Payable		<u>(2,144)</u>		<u>(2,493)</u>	
<b>Net Finance Costs</b>			<u>(2,315)</u>		<u>(2,577)</u>
Share of Profit/(Loss) of Associates/Joint Ventures Accounted For Using the Equity Method			-		-
Corporation Tax Expense			<u>-</u>		<u>-</u>
<b>Surplus/(Deficit) From Continuing Operations</b>			<b>(3,741)</b>		<b>(2,302)</b>
Surplus/(Deficit) of Discontinued Operations and the Gain/(Loss) on Disposal of Discontinued Operations			<u>-</u>		<u>-</u>
<b>SURPLUS/(DEFICIT) FOR THE YEAR</b>			<b><u>(3,741)</u></b>		<b><u>(2,302)</u></b>
<b>Other Comprehensive Income:</b>					
Share of Comprehensive Income From Associates and Joint Ventures			-		-
Revaluation Gains/(Losses) and Impairments on Intangible Assets			-		-
Revaluation Gains/(Losses) and Impairments On Property, Plant And Equipment			<b>(15,390)</b>		<b>(2,049)</b>
Revaluation Gains/(Losses) and Impairment Losses Arising From Classifying Non Current Assets as Assets Held For Sale			-		-
Additions/(Reductions) in 'Other Reserves'			-		-
Other Recognised Gains and Losses			-		-
Actuarial Gains/(Losses) on Defined Benefit Pension Schemes			-		-
<b>TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR</b>			<b><u>(19,131)</u></b>		<b><u>(4,351)</u></b>

The notes on pages 89 to 123 form part of these Financial Statements

# North Essex Partnership NHS Foundation Trust

## Statement of Financial Position as at 31 March 2011

	Note	31 March 2011		31 March 2010	
		£'000	£'000	£'000	£'000
<b>NON-CURRENT ASSETS</b>					
Intangible Assets	14		390		234
Property, Plant And Equipment	13		69,402		84,659
Investment Property			-		-
Investments In Associates (And Joint Controlled Operations)			-		-
Other Investments			-		-
Trade And Other Receivables	18		485		610
Other Financial Assets			-		-
Tax Receivable			-		-
Other Assets			-		-
<b>Total Non-Current Assets</b>			<b>70,277</b>		<b>85,503</b>
<b>CURRENT ASSETS</b>					
Inventories	17	84		-	
Trade And Other Receivables	18	2,226		2,256	
Other Financial Assets		-		-	
Tax Receivable		-		-	
Non-Current Assets For Sale And Assets In Disposal Groups		-		-	
Cash And Cash Equivalents	19	17,382		18,289	
<b>Total Current Assets</b>			<b>19,692</b>		<b>20,545</b>
<b>CURRENT LIABILITIES</b>					
Trade And Other Payables	20	(6,722)		(7,496)	
Borrowings	21	(978)		(445)	
Other Financial Liabilities		-		-	
Provisions	23	(734)		(302)	
Tax Payable		(1,504)		(1,468)	
Other Liabilities	22	(2,281)		(1,767)	
Liabilities In Disposal Groups		-		-	
<b>Total Current Liabilities</b>			<b>(12,219)</b>		<b>(11,478)</b>
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>			<b>77,750</b>		<b>94,570</b>
<b>NON-CURRENT LIABILITIES</b>					
Trade And Other Payables	20	-		-	
Borrowings	21	(6,355)		(3,333)	
Other Financial Liabilities		-		-	
Provisions	23	(1,792)		(1,997)	
Tax Payable		-		-	
Other Liabilities	22	-		(506)	
<b>Total Non-Current Liabilities</b>			<b>(8,147)</b>		<b>(5,836)</b>
<b>Total Assets Employed</b>			<b>69,603</b>		<b>88,734</b>
<b>TAXPAYERS' EQUITY</b>					
Minority interest			-		-
Public Dividend Capital			29,087		29,087
Revaluation Reserve			16,471		32,096
Other Reserves			-		-
Pensions Reserve			-		-
Income And Expenditure Reserve			24,045		27,551
<b>Total Taxpayers' Equity</b>			<b>69,603</b>		<b>88,734</b>

The financial statements on pages 84 to 123 were approved by the Board on 25 May 2011 and signed on its behalf by Andrew Geldard, Chief Executive



# North Essex Partnership NHS Foundation Trust

## Statement of Changes in Taxpayers' Equity

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£'000	£'000	£'000	£'000
<b>Taxpayers' Equity At 1 April 2009</b>	<b>20,575</b>	<b>35,193</b>	<b>28,805</b>	<b>84,573</b>
Surplus/(Deficit) For The Year	-	-	(2,302)	(2,302)
Revaluation Gains/(Losses) And Impairment Losses on Property, Plant and Equipment	-	(2,049)	-	(2,049)
Other Recognised Gains and Losses:				
Public Dividend Capital Received	8,512	-	-	8,512
Other Transfers Between Reserves	-	(1,048)	1,048	-
<b>Taxpayers' Equity At 31 March 2010</b>	<b>29,087</b>	<b>32,096</b>	<b>27,551</b>	<b>88,734</b>
<b>Taxpayers' Equity At 1 April 2010</b>	<b>29,087</b>	<b>32,096</b>	<b>27,551</b>	<b>88,734</b>
Surplus/(Deficit) For The Year	-	-	(3,741)	(3,741)
Revaluation Gains/(Losses) And Impairment Losses on Property, Plant and Equipment	-	(15,390)	-	(15,390)
Other Recognised Gains and Losses:				
Public Dividend Capital Received	-	-	-	-
Other Transfers Between Reserves (see Note 13)	-	(235)	235	-
<b>Taxpayers' Equity At 31 March 2011</b>	<b>29,087</b>	<b>16,471</b>	<b>24,045</b>	<b>69,603</b>

## North Essex Partnership NHS Foundation Trust

# Cash Flow Statement For The Year Ended 31 March 2011

		2010/11	2009/10
	Note	£'000	£'000
<b>Cash Flows From Operating Activities</b>			
Operating Surplus/(Deficit) From Continuing Operations		(1,426)	275
Operating Surplus/(Deficit) From Discontinued Operations		-	-
<b>Operating Surplus/(Deficit)</b>			
Depreciation and Amortisation		2,188	2,188
Impairments		5,177	3,842
(Increase)/Decrease in Inventories		(84)	-
(Increase)/Decrease in Trade and Other Receivables		350	(516)
Increase/(Decrease) in Trade and Other Payables		(510)	(480)
Increase/(Decrease) in Other Liabilities		45	285
Increase/(Decrease) in Provisions		227	(155)
Increase/(Decrease) in Tax Payable		36	70
Other Movements in Operating Cash Flows		(44)	115
		<u>5,959</u>	<u>5,624</u>
<b>NET CASH GENERATED FROM/(USED IN) OPERATIONS</b>			
<b>Cash Flows From Investing Activities</b>			
Interest Received		69	72
Purchase of Property, Plant and Equipment		(7,955)	(10,679)
Disposals of Property, Plant and Equipment		-	(70)
		<u>(7,886)</u>	<u>(10,677)</u>
<b>Net Cash Generated From/(Used In) Investing Activities</b>			
<b>Cash Flows From Financing Activities</b>			
Public Dividend Capital Received		-	8,512
Loans Received		4,000	4,000
Loans Repaid		(445)	(222)
Interest Paid		(196)	(108)
PDC Dividends Paid		(2,339)	(2,495)
		<u>1,020</u>	<u>9,687</u>
<b>Net Cash Generated From/(Used In) Financing Activities</b>			
<b>Increase/(Decrease) In Cash And Cash Equivalents</b>			
		<u>(907)</u>	<u>4,634</u>
<b>Cash And Cash Equivalents At 1 April 2010</b>	19	<u>18,289</u>	<u>13,655</u>
<b>Cash And Cash Equivalents At 31 March 2011</b>	19	<u>17,382</u>	<u>18,289</u>





## North Essex Partnership NHS Foundation Trust Notes to the Accounts for the year ended 31 March 2011

### 1 Accounting policies and other information

Monitor has directed that the Financial Statements of NHS Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trust Annual Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following Financial Statements have been prepared in accordance with the *2010/11 NHS Foundation Trust Annual Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the Financial Statements.

#### 1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the NHS Foundation Trust is contracts with Commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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

#### 1.2 Expenditure on Employee Benefits Short-term Employee Benefits

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

#### Pension costs

##### *NHS Pension Scheme*

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions)

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

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. Employer contribution rates are reviewed every four years following the Scheme valuation, and based on advice from the Scheme Actuary. An outline of these follows:

#### a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and Scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had, up to April 2008, paid 6%, with manual staff paying 5%. Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme, taking effect from 1 April 2008 his Valuation Report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the Scheme Actuary, Scheme contributions may be varied from time to time to reflect changes in the Scheme's liabilities.

## **b) Accounting valuation**

A valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

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

The valuation of the Scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

## **c) Scheme provisions**

In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

### **Annual Pensions**

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

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

### **Pensions Indexation**

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

### **Lump Sum Allowance**

For the 1995 section a lump sum is payable on retirement which is normally three times the annual pension payment.

### **III-Health Retirement**

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

### **Death Benefits**

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

### **Additional Voluntary Contributions (AVCs)**

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

### **Transfer between Funds**

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

### **Preserved Benefits**

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

### **Compensation for Early Retirement**

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

## **1.3 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.

#### 1.4 Property, Plant and Equipment Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Foundation Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the assets:
  - Individually have a cost of at least £5,000; or
  - form a group of assets which individually have a cost of more than £250 and collectively have a cost of at least £5,000, are functionally interdependent with broadly simultaneous purchase dates and are under single managerial control with anticipated simultaneous disposal dates; or
  - are furniture and equipment which forms part of the initial 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.

#### Measurement

##### Valuation

All Property, Plant and Equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value. Fair value is the lower of replacement cost and recoverable amount. The carrying value is reviewed for

impairment in the period if events or changes in circumstances indicate the carrying value may not be recoverable.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*. Valuations are carried out primarily on the basis of modern equivalent asset cost for specialised operational and non-specialised operational property. For non-operational properties, including surplus land, the valuations are carried out at open market value.

A full valuation was carried out and accounted for on 31 March 2011. The valuation was carried out by Montagu Evans, an independent organisation of Chartered Surveyors.

Assets in the course of construction are initially valued at cost. Where there is an indication that the initial cost is significantly different to the fair value of the asset when it is first brought into use, it is valued by professional valuers. Otherwise, the asset is valued as part of the next five or three-yearly valuation.

##### Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to Operating Expenses.

##### Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Freehold land is considered to have an infinite life and is not depreciated.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS Foundation Trust's professional valuers.

Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current value evenly over the estimated remaining life as follows:

Medical equipment and engineering plant and equipment	5 – 15 years
Furniture	10 years
Mainframe information and technology equipment	8 years
Soft furnishings	7 years
Office and information technology equipment	5 years
Set up costs in new buildings	10 years
Vehicles	7 years

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the NHS Foundation Trust, respectively.

#### *Revaluation gains and losses*

Revaluation gains are recognised in the Revaluation Reserve, except where, and to the extent that, they reverse revaluation decrease that has previously been 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 *Foundation Trust Reporting Manual*, impairments that are due to a loss of economic benefits or service potential in the asset are charged to Operating Expenses. A compensating transfer is made from the Revaluation Reserve to the Income and Expenditure Reserve of an amount equal to the lower of:

- i) The impairment charged to Operating Expenses; and

- ii) The balance in the Revaluation Reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in the 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 is recognised.

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

#### **De-recognition**

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

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

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

Property, Plant and Equipment which is to be





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

## 1.5 Intangible assets

### Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the NHS Foundation 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 NHS Foundation 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.

#### *Internally generated intangible assets*

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

Expenditure on research is not capitalised.

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

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

#### *Software*

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is

capitalised as an intangible asset.

### 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 fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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

### Amortisation

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

## 1.6 Government grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants, as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to Operating Income over the life of the asset in a manner consistent with the depreciation charge for that asset.

## 1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

## 1.8 Financial instruments and financial liabilities

### Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the

extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the NHS Foundation Trust becomes a party to the contractual provisions of the instrument.

#### **De-recognition**

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the NHS Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

#### **Classification and Measurement**

Financial assets are categorised as 'Loans and receivables.'

Financial liabilities are classified as 'Other Financial liabilities'.

#### **Loans and receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included within current and non-current assets. The NHS Foundation Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost.

#### **Other financial liabilities**

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost.

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

#### **Determination of fair value**

For financial assets and liabilities carried at fair value, fair value is the amount at which the asset or liability can be exchanged or settled.

#### **Impairment of financial assets**

At the Statement of Financial Position date, the NHS Foundation 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 cashflows of the asset.

The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

### **1.9 Leases**

#### **Operating leases**

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

#### **Leases of land and buildings**

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

### **1.10 Provisions**

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

#### **Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the





NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 23.

### **Non-clinical risk pooling**

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

### **1.11 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 24 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 24, 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.

### **1.12 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.

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid over 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 NHS Foundation Trust.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets; net cash held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility; and any PDC dividend balance receivable or payable. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

### **1.13 Value Added Tax**

Most of the activities of the NHS Foundation 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 tax is recoverable, the amounts are stated net of VAT.

### **1.14 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the financial statements since the NHS Foundation Trust has no beneficial interest in them.

However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *Financial Reporting Manual*.

### **1.15 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 that individual cases are 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 NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

### 1.16 Key judgements and estimates

The NHS Foundation Trust consider the key judgements and estimates within the financial statements are the calculation of provisions and accruals at year end. Details of the provisions can be found in note 23.

## 2. Operating Segments

The operating segments disclosed here are those significant segments reported upon internally to the NHS Foundation Trust Board of Directors. The NHS Foundation Trust does not allocate income to each healthcare segment.

Year Ended 31 March 2011					
	Income	Operating Expenditure	Operating Surplus/ (Deficit)	Net Surplus/ (Deficit)	Total Assets Employed
	£'000	£'000	£'000	£'000	£'000
Healthcare Activity	101,284	(102,920)	(1,636)	(3,951)	69,603
Eastern Development Centre/ Enable East Activity	6,066	(5,856)	210	210	-
<b>Total</b>	<b>107,350</b>	<b>(108,776)</b>	<b>(1,426)</b>	<b>(3,741)</b>	<b>69,603</b>

During the year 2010/11, income totalling £76,128,000 was received from Mid Essex PCT.

On 30 September 2010, Eastern Development Centre ceased to exist as a hosted arrangement. Enable East commenced on 1 October 2010 as a product and programme management service.

Year Ended 31 March 2010					
	Income	Operating Expenditure	Operating Surplus/ (Deficit)	Net Surplus/ (Deficit)	Total Assets Employed
	£'000	£'000	£'000	£'000	£'000
Healthcare Activity	99,394	(99,119)	275	(2,302)	88,734
Eastern Development Centre Activity	5,830	(5,830)	-	-	-
<b>Total</b>	<b>105,224</b>	<b>(104,949)</b>	<b>275</b>	<b>(2,302)</b>	<b>88,734</b>

During the year 2009/10, income totalling £74,964,000 was received from Mid Essex PCT.





### 3. Revenue from Patient Care Activities

Income from activities by income source:

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£'000	£'000
NHS Foundation Trusts	297	131
NHS Trusts	49	41
Strategic Health Authorities	485	232
Primary Care Trusts	88,804	87,012
Local Authorities	7,020	8,699
Department of Health	-	502
Non-NHS – Other	723	460
<b>Total Income from Patient Care Activities</b>	<b>97,378</b>	<b>97,077</b>

In 2010, £500,000 of Income from the Department of Health was income received by the Eastern Development Centre.

Income from activities by type of income:

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£'000	£'000
Block Contract Income	87,363	86,366
Clinical Partnerships Providing Mandatory Services (Including S75 Agreements)	7,020	8,694
Other Clinical Income from Mandatory Services	1,303	126
Other Non-Protected Clinical Income	1,692	1,891
<b>Total Income from Patient Care Activities</b>	<b>97,378</b>	<b>97,077</b>

£6,967,000 (2010: £7,683,000) of Income from Clinical Partnerships Providing Mandatory Services relates to Section 75 Agreements with Essex County Council.

£40,000 (2010: £1,002,000) of Income from Clinical Partnerships Providing Mandatory Services is income received by the Eastern Development Centre and Enable East.

#### Private Patient Income

In accordance with Section 44 of the NHS Act 2006, NHS Foundation Trusts must not exceed a pre-determined Private Patient Income (PPI) cap. The cap is based on the proportion of Private Patient Income received in 2002/03 or 1.5% of patient related income, whichever is greater.

North Essex Partnership NHS Foundation Trust PPI cap for the year ended 31 March 2011 is £1,461,000 (2010: £1,456,000). North Essex Partnership NHS Foundation Trust did not have any Private Patient Income during the year (2010: £nil).

#### 4. Other Operating Revenue

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£'000	£'000
Patient Transport Services	-	-
Education and Training	3,880	2,312
Research and Development	-	-
Charitable and Other Contributions to Expenditure	944	1,451
Non-Patient Care Services to Other Bodies	699	747
Income Generation	-	-
Rental Revenue	-	-
Grant Income	3,244	2,249
Other Revenue	1,205	1,388
<b>Total Other Operating Revenue</b>	<b>9,972</b>	<b>8,147</b>





## 5. Operating Expenses

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£'000	£'000
Services from Other NHS Foundation Trusts	951	660
Services from NHS Trusts	1,716	3,112
Services from Other NHS Bodies	1,859	1,116
Purchase of Healthcare from Non-NHS Bodies	295	68
Executive Directors' Costs (see Note 7)	2,436	2,560
Non-Executive Directors' Costs (see Note 7)	117	113
Staff Costs (see Note 7)	77,940	74,751
Drugs	1,772	1,828
Supplies and Services – Clinical (Excluding Drugs)	313	347
Supplies and Services – General	2,364	2,056
Establishment	2,705	2,727
Research and Development	-	-
Transport	845	809
Premises	3,957	3,964
Increase in Bad Debt Provision	62	51
Depreciation and Amortisation	2,188	2,188
Fixed Asset Impairments and Reversals (see Note 13)	5,177	3,842
Loss on disposal of Property, Plant and Equipment (see Note 11)	-	162
Audit Services - Statutory Audit	76	60
Audit Services - Audit-Related Regulators Reporting	13	-
Clinical Negligence	-	-
Eastern Development Centre Closedown Costs	214	-
Legal and Professional fees	884	975
Education and Training	440	653
Patient Travel and Activities	168	176
Grants	1,431	1,655
Other	853	1,076
<b>Total Operating Expenses</b>	<b>108,776</b>	<b>104,949</b>

Operating expenditure includes £5,856,000 relating to the Eastern Development Centre and Enable East.

There is no specified limit on auditor liability.

## 6. Operating Leases

Payments recognised as an expense:

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£'000	£'000
Minimum Lease Payments	<u>1,236</u>	<u>2,572</u>

Future minimum lease payments:

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£'000	£'000
On leases that expire:		
Not later than one year	478	492
Between one and five years	66	423
After five years	<u>19,440</u>	<u>89,944</u>
<b>Total</b>	<u><b>19,984</b></u>	<u><b>90,859</b></u>

Included within minimum lease payments on leases that expire after five years is £nil (2010: £74,085,000) relating to the Derwent Centre. On 30 April 2010, the NHS Foundation Trust purchased the freehold to the Derwent Centre.





## 7. Employee Costs and Numbers

### Employee Costs

	Year Ended 31 March 2011			Year Ended 31 March 2010
	Permanently Employed	Other	Total	Total
	£'000	£'000	£'000	£'000
Salaries and Wages	57,258	7,716	64,974	62,812
Social Security Costs	4,484	568	5,052	4,918
Termination Benefits	602	-	602	-
Employers' Contribution to NHS Pension Scheme	6,711	164	6,875	6,683
Other Pension Costs	-	692	692	799
Agency Costs	-	2,181	2,181	2,099
<b>Total</b>	<b>69,055</b>	<b>11,321</b>	<b>80,376</b>	<b>77,311</b>

Included within Employers' Contribution to NHS Pension Scheme is £119,889 for contributions to Directors' pensions.

### Average Number of Persons Employed

	Year Ended 31 March 2011			Year Ended 31 March 2010
	Permanently Employed	Other	Total	Total
	Number	Number	Number	Number
Medical and Dental Staff	125	-	125	123
Administration and Estates	431	58	489	475
Healthcare Assistants and Other Support Staff	388	368	756	747
Nursing, Midwifery and Health Visiting Staff	620	261	881	879
Scientific, Therapeutic and Technical Staff	83	3	86	75
Social Care Staff	-	120	120	136
Bank and Agency Staff	-	36	36	45
<b>Total</b>	<b>1,647</b>	<b>846</b>	<b>2,493</b>	<b>2,480</b>

The numbers included above are based on Whole Time Equivalents rather than headcount. Individuals on secondment from Essex County Council are included under the 'other' column, as they are not permanently employed by the NHS Foundation Trust.

## Exit Packages

Exit package cost band	Number of Compulsory Redundancies	Number of Other Agreed Departures	Total Number of Exit Packages by Cost Band
<£10,000	2	-	2
£10,001 - £25,000	4	-	4
£25,001 - £50,000	-	-	-
£50,001 - £100,000	3	1	4
£100,001 - £150,000	2	-	2
<b>Total</b>	<b>11</b>	<b>1</b>	<b>12</b>

### 8. Retirements Due To Ill Health

During the year ended 31 March 2011 there were three (2010: five) early retirements from North Essex Partnership NHS Foundation Trust on the grounds of ill health. The estimated additional liabilities of these ill health retirements are £314,000 (2010: £294,000). This information has been supplied by NHS Pensions. The cost of these ill health retirements will be borne by the NHS Business Services Authority – Pension Division.



## 9. Directors' Remuneration

Year Ended 31 March 2011										
Name and Title	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (to the nearest £100)	Annual real increase in pension at age of 60 (bands of £2,500)	Pension value at 31 March 2011 (bands of £5,000)	Annual real increase in related lump sum at 60 (bands of £2,500)	Lump sum value at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2010 £'000	Annual real increase in cash equivalent transfer value £'000	Cash Equivalent Transfer Value at 31 March 2011 £'000
M StAubyn, Chairman	40,001-45,000	-	100	-	-	-	-	-	-	-
C Abel Smith, Non-Executive Director	10,001-15,000	-	-	-	-	-	-	-	-	-
R Cox, Non-Executive Director and Deputy Chairman	10,001-15,000	-	400	-	-	-	-	-	-	-
J Gilbert, Non-Executive Director	10,001-15,000	-	400	-	-	-	-	-	-	-
S Phillips, Non-Executive Director	10,001-15,000	-	100	-	-	-	-	-	-	-
M Simpson, Non-Executive Director	10,001-15,000	-	-	-	-	-	-	-	-	-
A Geldard, Chief Executive	145,001-150,000	-	900	2,501-3,000	45,001-50,000	7,501-10,000	140,001-145,000	820	(50)	770
L Anastasiou, Director of Workforce and Development (4)	95,001-100,000	-	-	10,001-12,500	10,001-15,000	32,501 - 35,000	30,000 - 35,000	-	142	142
M Chapman, Director of Commercial and Service Development	95,001-100,000	-	1,000	2,501-5,000	25,001-30,000	12,501-15,000	85,001-90,000	440	15	455
M Flechtner, Medical Director (1)	190,001-195,000	-	400	2,501-5,000	20,001-25,000	7,501-10,000	65,001-70,000	378	12	390
P Keedwell, Director of Operations and Nursing	95,001-100,000	-	1,000	1-2,500	30,001-35,000	5,001-7,500	95,001-100,000	516	(30)	486
G Scott, Director of Strategy (2)	95,001-100,000	-	3,500	-	-	-	-	-	-	-
R Tazzini, Director of Resources (5)	110,001-115,000	-	600	55,001-60,000	55,001-60,000	-	-	7	442	449
A Mattin, Director of Operations (3)	1 - 5,000	-	-	-	-	-	-	548	-	-

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

During the year ended 31 March 2011, the Cash Equivalent Transfer values are calculated using Government Actuary Department factors based on indexation in line with the Consumer Price Index rather than the Retail Price Index, as was the basis for prior years. This has resulted in lower values than would have been reported under the previous indexation basis.

- (1) M Flechtner receives a salary for his role as Medical Director and a salary as a Consultant. The information in this table reflects his total salary for both positions.
- (2) G Scott is a member of the local Government Pension Scheme. This scheme is fully funded with all liabilities resting with the pension fund and not the employer.
- (3) A Mattin left on 6 April 2010. Pension figures for the period 1 April to 6 April 2010 are not available.
- (4) L Anastasiou was previously a member of the NHS Pension Scheme. The increases in value during the year reflect the value transferred across from her previous membership.
- (5) R Tazzini transferred assets into the NHS Pension Scheme from a different pension scheme. The increase in value during the year reflects the value transferred from a different pension scheme.

M Chapman and P Keedwell both held non executive directorships in other organisations during the year. No remuneration was received for those.



## Year Ended 31 March 2010

Name and Title	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (to the nearest £100)	Annual real increase in pension at age of 60 (bands of £2,500)	Pension value at 31 March 2010 (bands of £5,000)	Annual real increase in related lump sum at 60 (bands of £2,500)	Lump sum value at 31 March 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2009 £'000	Annual real increase in cash equivalent transfer value £'000	Cash Equivalent Transfer Value at 31 March 2010 £'000
M St Aubyn, Chairman	40,001-45,000	-	-	-	-	-	-	-	-	-
C Abel-Smith, Non-Executive Director	10,001-15,000	-	-	-	-	-	-	-	-	-
J Gilbert, Non-Executive Director	10,001-15,000	-	-	-	-	-	-	-	-	-
R Cox, Non-Executive Director	10,001-15,000	-	-	-	-	-	-	-	-	-
T Graily, Non-Executive Director (1)	1-5,000	-	-	-	-	-	-	-	-	-
S Phillips, Non-Executive Director	10,001-15,000	-	-	-	-	-	-	-	-	-
M Simpson, Non-Executive Director (2)	1-5,000	-	-	-	-	-	-	-	-	-
R Coleman, Chief Executive (3)	20,001-25,000	-	-	5,001-7,500	60,001-65,000	15,001-17,500	185,001-190,000	1,340	(1,407)	-
M Flechtner, Medical Director (4)	175,001-180,000	-	-	2,501-5,000	15,001-20,000	12,501-15,000	55,001-60,000	271	94	378
A Geldard, Director of Resources (5)	145,001-150,000	-	-	5,001-7,500	44,001-45,000	17,501-20,000	130,001-135,000	632	157	820
R Yeomans, Interim Director of Resources (6)	145,001-150,000	-	-	-	-	-	-	-	-	-
R Tazzini, Director of Resources (7)	40,001-45,000	-	-	1-2,500	1-2,500	-	-	-	7	7
C Moore, Director of Human Resources (8)	55,001-60,000	-	-	-	-	-	-	-	-	-
P Keedwell, Director of Operations and Nursing	95,001-100,000	-	-	1-2,500	25,001-30,000	2,501-5,000	85,001-90,000	446	47	516
A Mattin, Director of Operations (9)	95,001-100,000	-	-	1-2,500	30,001-35,000	2,501-5,000	95,001-100,000	476	49	548
R Waime, Director of Business Development (10)	100,001-105,000	-	-	-	-	-	-	-	-	-
M Chapman, Director of Business Development (11)	40,001-45,000	-	-	20,001-25,000	20,001-25,000	70,001-75,000	70,001-75,000	-	440	440
G Scott, Director of Strategy (12)	95,001-100,000	-	-	-	-	-	-	-	-	-

- (1) T Grailly left on 30 June 2009.
- (2) M Simpson was appointed on 8 December 2009.
- (3) R Coleman took early retirement on 30 April 2009.
- (4) M Flechtner receives a salary for his role as Medical Director and a salary as a Consultant. The information in this table reflects his total salary for both positions.
- (5) A Geldard was appointed Chief Executive on 29 July 2009.
- (6) R Yeomans appointment as Interim Director of Resources completed on 18 December 2009. All amounts are paid to a third party.
- (7) R Tazzini was appointed on 23 November 2009.
- (8) C Moore retired on 24 February 2010.
- (9) A Mattin left on 6 April 2010.
- (10) R Walne left on 7 October 2009.
- (11) M Chapman was appointed as Director of Business Development on 22 October 2009. He was employed prior to this, but the information above reflects only his remuneration as a Director.
- (12) G Scott is a member of the Local Government Pension Scheme. This Scheme is fully funded with all liabilities resting with the pension fund and not the employer.

M Chapman and P Keedwell both held non-executive directorships in other organisations during the year. No remuneration was received for these.





## 10. Investment Revenue

	31 March 2011	31 March 2010
	£'000	£'000
Interest Revenue:		
Bank Accounts	<u>69</u>	<u>72</u>
<b>Total Investment Revenue</b>	<u><b>69</b></u>	<u><b>72</b></u>

## 11. Other Gains and Losses

	31 March 2011	31 March 2010
	£'000	£'000
Gain/(Loss) on Disposal of Property/Plant and Equipment	<u>-</u>	<u>(162)</u>
<b>Total Other Gains and Losses</b>	<u><b>-</b></u>	<u><b>(162)</b></u>

## 12. Finance Costs

	31 March 2011	31 March 2010
	£'000	£'000
Interest on Loans	196	108
Interest on Late Payment of Commercial Debt	-	-
Other Interest Expense	<u>-</u>	<u>-</u>
<b>Total Finance Costs</b>	<u><b>196</b></u>	<u><b>108</b></u>

13. Property, Plant and Equipment

	Year Ended 31 March 2011										Total £'000	
	Land £'000	Buildings, Excluding Dwellings £'000	Dwellings £'000	Assets Under Construction £'000	Plant and Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture and Fittings £'000				
<b>Cost or Valuation</b>												
At 1 April 2010	35,518	46,340	959	2,968	1,623	488	2,894	1,991				92,781
Additions	1,099	4,363	14	1,207	135	29	478	172				7,497
Impairments Charged to Revaluation Reserve	(10,946)	(11,604)	(1,227)	-	-	-	-	-				(23,777)
Revaluations (through Revaluation Reserve)	1,247	7,052	88	-	-	-	-	-				8,387
Reclassifications	-	(385)	864	(1,013)	-	-	451	19				(64)
Disposals	-	-	-	-	-	-	-	-				-
<b>At 31 March 2011</b>	<b>26,918</b>	<b>45,766</b>	<b>698</b>	<b>3,162</b>	<b>1,758</b>	<b>517</b>	<b>3,823</b>	<b>2,182</b>				<b>84,824</b>
<b>Depreciation and Impairments</b>												
At 1 April 2010	654	2,623	56	-	1,092	440	2,273	984				8,122
Charged During the Year	-	1,613	58	-	108	8	208	128				2,123
Impairments Charged to Operating Expenditure	1,729	3,448	-	-	-	-	-	-				5,177
Reversal of Impairments	-	-	-	-	-	-	-	-				-
Reclassifications	-	-	-	-	-	-	-	-				-
Revaluation	-	-	-	-	-	-	-	-				-
Reclassified as Held for Sale	-	-	-	-	-	-	-	-				-
Disposals	-	-	-	-	-	-	-	-				-
<b>At 31 March 2011</b>	<b>2,383</b>	<b>7,684</b>	<b>114</b>	<b>-</b>	<b>1,200</b>	<b>448</b>	<b>2,481</b>	<b>1,112</b>				<b>15,422</b>
<b>Net Book Value</b>												
<b>At 31 March 2011</b>	<b>24,535</b>	<b>38,082</b>	<b>584</b>	<b>3,162</b>	<b>558</b>	<b>69</b>	<b>1,342</b>	<b>1,070</b>				<b>69,402</b>
<b>At 31 March 2010</b>	<b>34,864</b>	<b>43,717</b>	<b>903</b>	<b>2,968</b>	<b>531</b>	<b>48</b>	<b>621</b>	<b>1,007</b>				<b>84,659</b>

A charge for historic cost depreciation of £227,000 (2010: £1,048,000) is made to the Revaluation Reserve. This reflects the historic cost element of the depreciation charged on revalued assets in the Statement of Comprehensive Income. The charge is an adjustment to reserves (see Statement of Taxpayers' Equity). In 2010/11, Monitor issued revised guidance regarding the treatment of impairments between asset cost and depreciation. Impairments charged to Operating Expenditure are included within accumulated depreciation, other than those relating to Assets Under Construction, which are included within asset costs. Impairments charged to the Revaluation Reserve are included within asset costs. This treatment is derived from IAS 16, which states that: 'The accounts shall disclose, for each class of property, plant and equipment, the gross carrying amount and the accumulated depreciation (aggregated with accumulated impairment losses) at the beginning and end of the period. Monitor have interpreted this to mean that expensed impairments (and impairment reversals), other than those relating to Assets Under Construction, are included within accumulated depreciation. The NHS Foundation Trust's prior year figures have been restarted to reflect this change.



## 14. Intangible Assets

	Software	Total
	£'000	£'000
<b>Cost</b>		
At 1 April 2010	304	304
Revaluation	-	-
Reclassification	64	64
Additions Purchased	157	157
Disposals	-	-
<b>At 31 March 2011</b>	<b>525</b>	<b>525</b>
<b>Amortisation</b>		
At 1 April 2010	70	70
Revaluation	-	-
Impairments	-	-
Reversal of Impairments	-	-
Charged During the Year	65	65
Disposals	-	-
<b>At 31 March 2011</b>	<b>135</b>	<b>135</b>
<b>Net Book Value</b>		
<b>At 31 March 2011</b>	<b>390</b>	<b>390</b>
<b>At 31 March 2010</b>	<b>234</b>	<b>234</b>

All intangible fixed assets are purchased.

## 15. Impairments

	Tangible Assets	
	31 March 2011	31 March 2010
	£'000	£'000
Changes in Market Price	5,177	-
Other	-	3,842
<b>Total</b>	<b>5,177</b>	<b>3,842</b>

In 2011, a revaluation exercise was undertaken for all of the property owned by the NHS Foundation Trust. This resulted in:

- £5,177,000 of impairments being charged to the Statement of Comprehensive Income;
- £23,777,000 of impairments being charged to the Revaluation Reserve;
- an increase in value of certain assets totalling £8,387,000 being added to the Revaluation Reserve.

The total impact of the revaluation is therefore £20,567,000. The net movement to the Revaluation Reserve as a result of the revaluation carried out was £15,390,000.

In 2010, £3,060,000 of other impairments relate to the valuation of an asset which was brought into use during the year. The remainder relates to a piece of land purchased during the year, and some assets which are no longer used by the NHS Foundation Trust. There are additional impairments to assets contiguous with those impaired described above which were charged to the Revaluation Reserve during the year. The total charge to the Revaluation Reserve for reduction in the value of assets is £2,049,000.





## 16. Capital Commitments

Commitments under capital expenditure contracts at the Statement of Financial Position date were:

	31 March 2011	31 March 2010
	£'000	£'000
Property, Plant and Equipment	7,668	-

The above capital commitment relates to building work commenced on a new CAMHS building in Colchester. The CAMHS project was approved by the Board, and the contract awarded on 26 January 2011. The work began during March 2011.

## 17. Inventories

	31 March 2011	31 March 2010
	£'000	£'000
Materials	84	-

No inventories were held at 31 March 2010. During the year ended 31 March 2011, North Essex Partnership NHS Foundation Trust set up its own Pharmacy facility and now holds inventories for use throughout the NHS Foundation Trust.

During the year, the value of stock issued by the Pharmacy was £103,000.

## 18. Trade and Other Receivables

	31 March 2011	31 March 2010
	£'000	£'000
<b>Current Assets:</b>		
NHS Receivables	1,603	691
Other Trade Receivables	476	1,155
Provision for the Impairment of Receivables	(388)	(484)
PDC Receivables	197	2
Prepayments	241	324
Accrued Income	97	568
<b>Total Current Trade and Other Receivables</b>	<b>2,226</b>	<b>2,256</b>
<b>Non-Current Assets:</b>		
NHS Receivables	463	585
Other Trade Receivables	22	25
<b>Total Non-Current Trade and Other Receivables</b>	<b>485</b>	<b>610</b>
<b>Total Trade and Other Receivables</b>	<b>2,711</b>	<b>2,866</b>

The majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by the Government to buy NHS patient care services, no credit scoring of them is considered necessary.

All amounts are considered to be shown at fair value other than those trade receivables which are considered impaired. Impaired receivables are provided for fully.

## Provision for Impairment of Receivables

	31 March 2011	31 March 2010
	£'000	£'000
Balance at 1 April 2010	484	451
Increase in Provision	323	345
Amounts Utilised	(74)	(18)
Unused Amounts Reversed	(345)	(294)
<b>Total</b>	<b>388</b>	<b>484</b>

Impaired receivables are those past their due date where no agreement has been reached for recovery of the amount receivable.

## Receivables Past Their Due Date but Not Impaired

	31 March 2011	31 March 2010
	£'000	£'000
Up to three months	189	472
In three to six months	-	-
Over six months	24	36
<b>Total</b>	<b>213</b>	<b>508</b>

## Impaired Receivables Past Their Due Date

	31 March 2011	31 March 2010
	£'000	£'000
Up to three months	138	145
In three to six months	127	90
Over six months	123	249
<b>Total</b>	<b>388</b>	<b>484</b>





## 19. Cash and Cash Equivalents

	31 March 2011	31 March 2010
	£'000	£'000
Balance at 1 April 2010	18,289	13,655
Net Change in Year	(907)	4,634
<b>Balance at 31 March 2011</b>	<b>17,382</b>	<b>18,289</b>
Made up of:		
Cash with Office of Paymaster General	-	18,264
Cash with Government Banking Service	17,357	-
Commercial Banks and Cash in Hand	25	25
Current Investments	-	-
Cash and Cash Equivalents	17,382	18,289
Bank Overdraft	-	-
<b>Cash and Cash Equivalents as in Cash Flow</b>	<b>17,382</b>	<b>18,289</b>

## 20. Trade and Other Payables

	31 March 2011	31 March 2010
	£'000	£'000
<b>Current Liabilities:</b>		
Interest Payable	-	-
NHS Payables	2,102	2,592
Non-NHS Payables – Revenue	2,321	2,563
Non-NHS Payables – Capital	640	941
Accruals	1,659	1,400
<b>Total Trade and Other Payables</b>	<b>6,722</b>	<b>7,496</b>

Non-NHS Payables - Revenue includes £843,000 (2010: £835,000) outstanding pensions contributions at 31 March 2011.

## 21. Borrowings

	31 March 2011	31 March 2010
	£'000	£'000
<b>Current Liabilities</b>		
Bank Overdrafts	-	-
Loans from:		
Department of Health	978	445
Other Entities	-	-
Other	-	-
<b>Total Current Borrowings</b>	<b>978</b>	<b>445</b>
<b>Non-Current Liabilities</b>		
Bank Overdrafts	-	-
Loans from:		
Department of Health	6,355	3,333
Other Entities	-	-
Other	-	-
<b>Total Non-Current Borrowings</b>	<b>6,355</b>	<b>3,333</b>
<b>Total Borrowings</b>	<b>7,333</b>	<b>3,778</b>

Borrowings are made up of a single currency term loan from the Secretary of State for Health. The interest rate is 5.33% per annum, and the loan will be repaid in full by 30 September 2018. The NHS Foundation Trust is responsible for ensuring that the Prudential Borrowing Limit set by Monitor is not exceeded.

## 22. Other Liabilities

	31 March 2011	31 March 2010
	£'000	£'000
Deferred Income	2,281	1,767
Other	-	-
<b>Total Current Other Liabilities</b>	<b>2,281</b>	<b>1,767</b>
Deferred Income	-	506
Other	-	-
<b>Total Non-Current Other Liabilities</b>	<b>-</b>	<b>506</b>
<b>Total Other Liabilities</b>	<b>2,281</b>	<b>2,273</b>

£nil (2010: £1,617,000) of deferred income relates to the Eastern Development Centre.

£153,000 (2010: £172,000) relates to a capital grant which has been deferred to be credited to the Statement of Comprehensive Income at the same rate as the depreciation on the items purchased with the capital grant.



### 23. Provisions

	Current		Non-Current	
	31 March 2011	31 March 2010	31 March 2011	31 March 2010
	£'000	£'000	£'000	£'000
Pensions Relating to Former Directors	7	7	42	48
Pensions Relating to Other Former Staff	181	181	1,375	1,538
Legal Claims	49	69	-	-
Other	497	45	375	411
<b>Total</b>	<b>734</b>	<b>302</b>	<b>1,792</b>	<b>1,997</b>

	Pensions Relating to Former Directors	Pensions Relating to Other Former Staff	Legal Claims	Other	Total
	£'000	£'000	£'000	£'000	£'000
At 1 April 2010	55	1,719	69	456	2,299
Arising During the Year	-	-	31	452	483
Utilised During the Year	(7)	(197)	(17)	(45)	(266)
Reversed Unused	-	-	(34)	-	(34)
Unwinding of Discount	1	34	-	9	44
<b>At 31 March 2011</b>	<b>49</b>	<b>1,556</b>	<b>49</b>	<b>872</b>	<b>2,526</b>

#### Expected Timing of Cashflows:

Within One Year	7	181	49	497	734
Between One and Five Years	29	686	-	179	894
Between Five and Ten Years	13	385	-	174	572
After Ten Years	-	304	-	22	326
<b>Total</b>	<b>49</b>	<b>1,556</b>	<b>49</b>	<b>872</b>	<b>2,526</b>

Pension costs are calculated in accordance with NHS Pension Scheme rules, based on age, salary and length of service of employees. Other provisions relate to operational claims.

Expected reimbursement from Primary Care Trusts under back cover is £564,000 (2010: £690,000). This amount is included as an asset to the North Essex Partnership NHS Foundation Trust under Trade and Other Receivables (see note 18).

£5,823,661 (2010: £4,016,150) is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the North Essex Partnership NHS Foundation Trust.

## 24. Contingencies

### 24.1 Contingent Liabilities

	31 March 2011	31 March 2010
	£'000	£'000
Employment Claims	26	20
Public Liability Claims	-	2
<b>Total Contingent Liabilities</b>	<b>26</b>	<b>22</b>

Contingent Liabilities relate to eight (2010: seven) employment claims and zero (2010: one) Public Liability Claims.

The NHS Foundation Trust is in the process of disposing of the non-operational land and buildings at the Severalls site in Colchester. This is a major site for future residential development and the NHS Foundation Trust has entered into agreements with regards the road and education infrastructure with third parties.

The Trust entered into the following agreements in relation to the Severalls Hospital site:

Tripartite Agreement dated 20 March 2006 – Terminated 4 January 2011

Bipartite Agreement dated 25 January 2007

S106 Agreement dated 21 March 2006

NAR3 Agreement dated 4 January 2011

Education Funding Agreement dated 4 January 2011.

Legal advice has been obtained on the agreements to the effect that the Trust has no liability at this point in time that needs to be recorded in the accounts.

### 24.2 Contingent Assets

There are no contingent assets as at 31 March 2011 or as at 31 March 2010.





## 25. Lottery Fund

	31 March 2011	31 March 2010
	£'000	£'000
Deferred income brought forward	402	6
Grant income received in year	923	1,710
Project expenditure	(1,153)	(1,187)
Management expenditure	(135)	(127)
<b>Amount owed to Big Lottery Fund</b>	<b>37</b>	<b>-</b>
<b>Deferred income carried forward</b>	<b>-</b>	<b>402</b>

During the year, grants were received from the Big Lottery Fund to deliver “Well-being in the East”, a portfolio of projects which aims to increase physical activity and improve healthy eating and mental well-being throughout the East of England. The grant is restricted for this purpose. Less than 10% of the grant was incurred on the costs of managing the portfolio, with the remainder being disbursed to the portfolio’s projects. The portfolio commenced on 1 October 2007 and ended on 31 March 2011.

At 31 March 2011, there was unutilised grant income of £37,000 (2010: £402,000), of which £37,000 (2010: £13,000) relates to grants disbursed to projects but returned as unspent. All projects were closed by 31 March 2011, and the unutilised grant was returned to the Big Lottery Fund in April 2011.

## 26. Prudential Borrowing Limit

North Essex Partnership NHS Foundation Trust is required to comply with, and remain within, a Prudential Borrowing Limit. This is made up of two elements:

- i) The maximum cumulative long term borrowing limit. This is set by reference to the four ratio tests set out in Monitor's *Prudential Borrowing Code*. The financial risk rating set up under Monitor's *Compliance Framework* determines one of the ratios and therefore can impact on the long term borrowing limit.
- ii) The amount of any working capital facility approved by Monitor.

Further information on the *NHS Foundation Trust Prudential Borrowing Code* and *Compliance Framework* can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

North Essex Partnership NHS Foundation Trust had a Prudential Borrowing Limit of £28,200,000 in 2010/11 (2009/10: £26,700,000).

	2010/11	2009/10
	£'000	£'000
Maximum Cumulative Long Term Borrowing Limit set by Monitor	20,200	19,200
Working Capital Facility	8,000	7,500
<b>Prudential Borrowing Limit</b>	<b>28,200</b>	<b>26,700</b>

North Essex Partnership NHS Foundation Trust utilised £4,000,000 of the long term borrowing limit during the year (2010: £4,000,000) as a source of finance for capital schemes. The fixed interest rate is 5.33% per annum.

Long Term Borrowing Limit	2010/11	2009/10
	£'000	£'000
Maximum Cumulative Long Term Borrowing Limit set by Monitor	20,200	19,200
Long term Borrowing - Amounts Drawn Down	(8,000)	(4,000)
Long Term Borrowing - Repayments Made	667	222
<b>Long Term Borrowing Available</b>	<b>12,867</b>	<b>15,422</b>

	2010/11		2009/10	
	Actual PBL Ratios	Approved PBL Ratios	Actual PBL Ratios	Approved PBL Ratios
Minimum Dividend Cover	3.1	1	2.6	1
Minimum Interest Cover	34.4	3	29.6	3
Minimum Debt Service Cover	10.5	2	9.7	2
Maximum Debt Service to Revenue	0.6%	2.5%	0.6%	2.5%

Details of these calculations can be found at <http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/prudential-borro>





## 27. Financial Instruments

### 27.1 Financial Assets

	Loans and Receivables	Total
	£'000	£'000
NHS Receivables	1,725	1,725
Cash at Bank and in Hand	17,382	17,382
Other Financial Assets	432	432
<b>Total at 31 March 2011</b>	<b>19,539</b>	<b>19,539</b>
NHS Receivables	1,035	1,035
Cash at Bank and in Hand	18,289	18,289
Other Financial Assets	565	565
<b>Total at 31 March 2010</b>	<b>19,889</b>	<b>19,889</b>

All financial assets are held at book value. Book value is considered to be fair value.

### 27.2 Financial Liabilities

	Other Financial Liabilities	Total
	£'000	£'000
Borrowings	7,333	7,333
Other Financial Liabilities	7,223	7,223
<b>Total at 31 March 2011</b>	<b>14,556</b>	<b>14,556</b>
Borrowings	3,778	3,778
Other Financial Liabilities	7,496	7,496
<b>Total at 31 March 2010</b>	<b>11,274</b>	<b>11,274</b>

All financial liabilities are held at book value. Book value is considered to be fair value.

### 27.3 Financial Risk Management

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

During the year, North Essex Partnership NHS Foundation Trust adopted a new treasury management policy which allowed the NHS Foundation Trust to carry out its own treasury management operations. Prior to this, they were carried out by ASP Finance. Throughout the year, treasury management operations were within parameters formally stated in the NHS Foundation Trust's Standing Financial Instructions and Policies agreed by the Board of Directors. The NHS Foundation Trust's treasury activity is subject to review by the NHS Foundation Trust's internal auditors.

#### *Currency Risk*

The NHS Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The NHS Foundation Trust has no overseas operations. North Essex Partnership NHS Foundation Trust therefore has low exposure to currency rate fluctuations.

#### *Interest Rate Risk*

All of the NHS Foundation Trust's assets and liabilities carry nil or fixed rates of interest. North Essex Partnership NHS Foundation Trust is not therefore exposed to significant interest rate risk.

#### *Credit Risk*

The majority of the NHS Foundation Trust's income is from legally binding contracts with other public sector bodies. North Essex Partnership NHS Foundation Trust therefore has low exposure to credit risk. The maximum exposure as at 31 March 2011 is in receivables from customers as disclosed in Note 18.

#### *Liquidity Risk*

The NHS Foundation Trust's net operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. The NHS Foundation Trust largely funds its capital expenditure from funds made available from Government under an agreed Prudential Borrowing Limit. North Essex Partnership NHS Foundation Trust is therefore not exposed to significant liquidity risk.

### 27.4 Maturity of Financial Liabilities

	31 March 2011	31 March 2010
	£'000	£'000
In one year or less	8,201	7,941
In more than one year but not more than two years	978	445
In more than two years but not more than five years	2,935	1,335
In more than five years	2,442	1,553
<b>Total</b>	<b>14,556</b>	<b>11,274</b>





## 28. Post Balance Sheet Events

On 3 May 2011, North Essex Partnership NHS Foundation Trust entered into a loan agreement to borrow £7,000,000 as a source of finance to fund a capital scheme. The interest rate is fixed at 2.65% per annum. The loan is over ten years, with the final repayment due in September 2021. This is within the NHS Foundation Trust's Prudential Borrowing Limit.

During the year, North Essex Partnership NHS Foundation Trust entered into an agreement with NHS Suffolk to manage the Suffolk Community Healthcare Services for one year, starting 1 April 2011. This is not expected to have a material impact on the NHS Foundation Trust's financial statements for the year ended 31 March 2012.

## 29. Related Party Transactions

North Essex Partnership NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members, members of key management staff, Governors or parties related to them has undertaken any material transaction with North Essex Partnership NHS Foundation Trust.

During the year, North Essex Partnership NHS Foundation Trust had significant transactions with other bodies which fall under the Whole of Government Accounts.

	For the Year Ended 31 March 2011		As at 31 March 2011	
	Receipts from Related Party £'000	Payments to Related Party £'000	Amounts due from Related Party £'000	Amounts owed to Related Party £'000
Cambridgeshire and Peterborough NHS Foundation Trust	15	1,454	28	206
Colchester Hospital University NHS Foundation Trust	-	1,035	-	156
Mid Essex Hospital Service NHS Trust	206	745	11	33
The Princess Alexandra Hospital NHS Trust	32	1,188	35	26
East of England Strategic Health Authority	6,295	-	754	-
Mid Essex PCT	76,128	281	232	165
North East Essex PCT	257	1	246	143
Redbridge PCT	340	-	-	-
South East Essex PCT	1,592	-	-	-
Suffolk PCT	1,169	-	-	-
West Essex PCT	9,122	1,818	371	1,074
NHS Purchasing and Supply Agency	-	410	-	7
Essex County Council	7,508	-	-	-
Big Lottery Fund	944	-	-	37
HM Revenue and Customs	-	18,357	-	1,502
NHS Pensions	-	10,309	-	843



	For the Year Ended 31 March 2010		As At 31 March 2010	
	Receipts from Related Party	Payments to Related Party	Amounts Due From Related Party	Amounts Owed to Related Party
	£'000	£'000	£'000	£'000
Cambridgeshire and Peterborough NHS Foundation Trust	-	252	20	-
Colchester Hospital University NHS Foundation Trust	-	1,325	-	73
East of England Ambulance Services NHS Trust	-	878	49	-
Mid Essex Hospital Services NHS Trust	41	874	35	60
The Princess Alexandra Hospital NHS Trust	-	1,701	5	3
Department of Health	502	59	3,778	4
East of England Strategic Health Authority	1,332	14	202	-
NHS Mid Essex	74,964	7	358	22
NHS North East Essex	248	263	280	-
NHS Redbridge	334	-	-	-
NHS South East Essex	1,562	-	13	-
NHS Suffolk	1,255	73	-	-
NHS West Essex	7,911	1,106	(222)	-
NHS Business Services Authority	5	651	4	-
NHS Purchasing & Supply Agency	-	307	-	11
Essex County Council	8,369	-	303	-
Improvement East – Regional Partnership	870	75	-	-

### 30. Third Party Assets

North Essex Partnership NHS Foundation Trust held £283,257 cash at bank and in hand at 31 March 2011 (2010: £263,846) which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the financial statements.





### 31. Losses and Special Payments

There were 44 cases of losses and special payments (2010: 64 cases), totalling £142,000 (2010: £83,000). These amounts are disclosed on an accruals basis, excluding provisions for future losses.

There were no cases exceeding £250,000 during the current and preceding year.

	31 March 2011		31 March 2010	
	Number	£'000	Number	£'000
<b>Losses</b>				
Loss of Cash	14	3	25	20
Fruitless Payments	1	-	-	-
Bad Debts and Claims Abandoned	1	24	6	3
Damage to Buildings, Property, etc	<u>7</u>	<u>4</u>	<u>5</u>	<u>2</u>
<b>Special Payments</b>				
Compensation Under Legal Obligation	14	109	20	56
Extra Contractual to Contractors	-	-	-	-
Ex Gratia Payments	7	2	8	1
Extra Statutory and Regulatory	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

## Contact Us

We care about what you think. Whether you are a Foundation Trust member, a service user, a carer or a local resident, your opinions and comments are vital to us. Your feedback, whether good or bad, helps us improve the services we offer and develop new ones.

## By Post

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

**Tel:** (Switchboard) 01245 546 400

**Email:** [foundationtrust@nepft.nhs.uk](mailto:foundationtrust@nepft.nhs.uk)

**Website:** [www.nepft.nhs.uk](http://www.nepft.nhs.uk)

## Making Experiences Count

Contact our Customer Care Team if you want to compliment or make a complaint about our services.

Tel: 01245 546 400

## Members Queries

Contact our Foundation Trust Office with any membership comments or enquiries. You can also contact your Governor via the Foundation Trust Office.

**Tel:** 01245 546 443

## Patient Advice and Liaison Service

Contact PALS about any queries or concerns regarding our services.

Tel: 01245 546 433

## Emergencies

If you, or the person you are concerned about, are already being seen by our services and you feel emergency treatment is required, support is available from your local team at any time.

For people living in the following areas

Harlow, Epping Forest and Uttlesford:

01279 827 268

Chelmsford, Maldon and Braintree:

01376 308 100

Colchester and Tendring:

01206 287 303

## If you are not in contact with our services

If you, a friend or relative are experiencing mental health problems for the first time and need emergency treatment, you should contact your GP. To search for a GP in your area, visit [www.nhs.uk](http://www.nhs.uk)

