QUALITY ACCOUNT
2012 – 2013

South Essex Partnership University
NHS Foundation Trust
EXECUTIVE SUMMARY

We recognise that for organisations like ours, providing a range of different services, in different geographic areas, this document can be somewhat complex. To help readers navigate our Quality Account, a summary of content and where you can find specific information that you may be looking is provided below.

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A glossary of terms is provided at the end of the Quality Account in case we have used jargon which you are not familiar with. | Page No. |
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At SEPT, quality of service to our users is at the heart of everything we do

Everyone who uses the NHS rightly expects to receive care of the highest standard – quality care. Mostly, this means that services must be safe (do no harm), effective (do what they are meant to do) and people receiving the services find them acceptable and value them. At SEPT we work hard to ensure that the care we deliver is in line with these principles of quality as well as those outlined in the NHS Constitution and the national ‘Compassion in Practice Strategy’ (launched in December 2012). This strategy aims to build a culture of compassionate care for nursing, midwifery and care staff and is based around six values – care, compassion, courage, communication, competence and commitment. The vision aims to embed these values, known as the six C’s, in all nursing, midwifery and care-giving settings throughout the NHS and social care, to improve care for patients. Absolutely critical to achieving this is ensuring that we continue to recruit and retain a workforce that is well trained and motivated to always act in the best interest of patients who use our services and ensure that quality is at the heart of everything we do.

I am proud to present this Quality Account for SEPT, covering our first full year providing hospital and community-based mental health and learning disability services across Bedfordshire and Luton and South Essex as well as community health services in Bedfordshire, South East Essex and West Essex. The community health services we now provide in the above three locality areas are those services previously provided/hosted by Primary Care Trusts; such as District Nursing and Health Visiting services as well as a range of specialist services. Significant progress has been made this year with implementing integrated community health services teams so that care providers work together to provide seamless services to patients. In October 2012 SEPT, in partnership with Serco, took over responsibility for delivering NHS services in Suffolk under the name of SCH – Suffolk Community Healthcare. SEPT staff are responsible for delivering Podiatry, Speech and Language Therapy and Children’s services. This agreement is one of the first public / private sector agreements in the country between a service led organisation such as Serco and a leading NHS provider.

We are required by law to produce an annual Quality Account so that we can let you know how we did in terms of meeting our quality commitments for 2012/13 and what our quality priorities are for 2013/14. However, we see it as an opportunity to share more than that – this is an opportunity to demonstrate that SEPT is a transparent organisation and in the report we highlight our achievements and the areas where more work needs to be done.

Once you have read this Quality Account I hope you will be able to see for yourself how seriously SEPT takes quality in all its forms to ensure that we deliver services in a compassionate, dignified and respectful way. We believe that service users, staff and stakeholders are those best placed to tell us what constitutes the highest quality of service – we strive for and expect at all times the highest standards of care and we actively listen to users, staff and stakeholders to ensure we achieve this.

As you will no doubt be aware, the issue of quality of care within the NHS nationally has been brought to the forefront by the publication of the Francis Inquiry Report in relation to the care provided by Mid Staffordshire NHS Foundation Trust, which gained significant press coverage. We have analysed the outcomes of this report to ensure that we learn from the lessons and details of this work are included in Part 2 of this report.

To ensure that SEPT achieves this every time for every person who uses any of our services, we have several ways in which we can check that we are achieving a consistently high level of quality. The narrative and tables/graphs in this Quality Account are based on the information gathered through these various checks.

As a Foundation Trust, SEPT has a Council of Governors made up from elected members of our Trust as well as a Board of Directors both of which are led by the Chair of the Trust. The Boards ‘drive’ the Trust ensuring our staff are delivering services to the high standards we all aspire to and critically holding me and my executive team to account for the day-to-day running of the Trust. The Board of Directors receives monthly assurance on how we are getting on with meeting our goals and achieving desired outcomes. The
Board proactively ensures that we do not focus solely on national targets and financial balance, but also puts significant emphasis on the achievement of quality in our services. This approach ensures that performance is constantly monitored and any potential areas for improvement are addressed swiftly and remedied immediately. These Board of Director meetings are held in public 10 times each year which ensures that our operation is open and transparent and gives members of public the opportunity to understand our performance in more detail and to ask any questions they have.

What do others think of us?

We welcome the Care Quality Commission’s (CQC) unannounced visits to our services – which can take place at any time of the day or night – to assess how well we are meeting their 16 Essential Standards and Quality and Safety. The Care Quality Commission is the independent regulator of all health and social care services in England and their reports of these visits to our services are made public for everyone to read. We also invite other outside organisations to do announced or unannounced spot checks on these standards in our services too.

Public governors have undertaken a programme of visits to different services. Our commissioners also undertake announced and unannounced quality visits to our services to assess the quality of service being delivered and any remedial action required. Feedback from this external perspective has provided an incredibly useful insight into service quality from alternative perspectives and with ‘fresh eyes’ and has served to enable improvements to take place.

We in SEPT do not wait for inspections by the Care Quality Commission or other inspectors to ensure quality of services – we also undertake regular formal internal inspections of our services against the Care Quality Commission standards and identify any areas for quality improvement. The results and actions arising from these internal inspections are reported to the Board on a regular basis, and formal monitoring and follow-up undertaken to ensure that any necessary remedial actions are completed. Non-Executive Directors, Executive Directors, Governors and independent clinicians are also invited to visit our wards to review clinical care.

There is also an extensive programme of internal clinical audit in place, the results of which are detailed in Part 2 of this Quality Account.

We now have regular Clinical Quality Review Group meetings with each of our commissioners to which a detailed report is presented (containing information on quality performance indicators defined by our commissioners), enabling commissioners to monitor our quality performance and to require remedial action where necessary.

Ensuring that we receive and act on feedback from our service users is absolutely vital in driving up quality and we have taken a number of actions over the past year to increase the feedback we receive. These include the introduction of the ‘Friends and Family’ test across the organisation where we seek feedback from our service users and patients in terms of whether they would recommend the service they have received to friends or family. Details of the outcomes of this are included in Part 3 of this report. We have continued with our ‘mystery shopper initiative’ and I am delighted to have a willing group of ‘mystery shoppers’ who report back to me directly and confidentially about their direct and personal experiences of SEPT staff and services. We have grown our ‘mystery shopper’ group from 285 to 421 over the past year alone and continue to take actions to encourage more users to participate in this initiative. These individuals play a vital role in ensuring we continually improve the services we deliver and we have seen a really positive impact on changing practice as a direct result of this initiative.
What have we done well?

We have had an enormous amount of quality improvement success this year, having a great impact on outcomes for people who use our services. Unfortunately, I don’t have space here to talk about them all. We have however given some examples of quality improvements made over the past year in Part 3 of this report.

What do we need to do better?

Despite our successes, there are always areas where we can improve. Areas in which I am keen to see particular action are patient experience in mental health as measured by the national community mental health survey, complaints handling and response times, access to healthcare for people for a learning disability, reducing avoidable pressure ulcers and reducing harm from falls. Details of our priorities for 2013/14 are outlined in Part 2 of this report.

We can’t do it without our staff

I have always believed that SEPT recruits and retains the best staff in the business. They work incredibly hard – whether in Bedfordshire, Essex, Luton or Suffolk. Our staff take huge satisfaction from being able to deliver the best possible services – services of which we can all be proud and, most importantly, which staff would be happy for their friends and family to receive.

Whilst I am very proud of our staff, I am never complacent. We always need to be on the lookout for things that might not be going as they should be. As well as my willing group of ‘mystery shoppers’, I have personally visited a number of patients (randomly selected) over the past year either at home or elsewhere in order to listen first hand to their experiences of our services. I have found this to be an incredibly valuable experience and will continue these visits to seek feedback for the foreseeable future.

SEPT is proud to be a quality organisation, and I am proud to be the Chief Executive of our organisation. I hope you will agree when you read through this report.

Statement of Accuracy

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

Patrick Geoghegan OBE
Chief Executive
Professor of Mental Health and Social Care
Progress with the priorities for improvement for 2012/13 set out in the 2011/12 Quality Account of SEPT is set out in Part 3 of this document.

“Tough times and tough decisions to be made but staff and public engagement will help keep us focused on person centred care.” (Anonymous feedback received at stakeholder planning event 31 January 2013)

At SEPT we have a well established and well developed planning and engagement process for ensuring that our forward plans are developed as a result of listening to our stakeholders. This year was no different. Approximately 900 staff, service users, carers, governors, members and partners participated in planning events between December 2012 and March 2013 to consider the challenges we face and determine the priorities for 2013/14. Whilst we can’t claim that every single view or idea is reflected in our plans for the future we are confident that the themes of the feedback received has greatly influenced our quality improvement priorities and service developments for the next year.

Specifically our plans have been developed as a result of:

1. listening to the views of staff who attended five internal service planning events where the drivers affecting the Trust in the coming year were considered; objectives developed and areas in which the quality of services can be improved identified;
2. consultation at two stakeholder planning events held in south Essex and in Bedfordshire;
3. asking our governors and public Foundation Trust members in seven public constituency meetings across Bedfordshire and Essex to identify the activities that we need to start doing; those that we should carry on doing and those that we should stop doing in order to understand what a quality service looks like;
4. working with commissioners to identify action required to meet their expectations of a high quality service provider;
5. considering performance against national targets and priorities and identifying what action is required to ensure that services meet and where possible, exceed these;
6. making sure we are constantly taking action to deliver the rights and pledges contained in the NHS Constitution;
7. five Board of Director seminar session discussions about our forward plan;
8. feedback from attending service user and carer forums where we have open discussions with the public about our plans for the future; and
9. feedback sessions we have with partners such as Primary Care Trusts, Clinical Commissioning Groups, Local Authority colleagues and third sector on our plans for the future.

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

As a result of reviewing the outcomes from the various consultation processes, the Board of Directors has identified the key changes or actions that need to be made to continue to maintain and/or improve the quality of services delivered.

SEPT’s clinical and quality strategy is integral to and not separate from our overarching strategic vision. Clinical quality drives our vision “providing services that are in tune with you”.

2013/14 is going to be a challenging year. The SEPT Board of Directors is clear that the challenges faced should not distract us from concentrating on the number 1 priority, which is to ensure that our patients receive safe and effective services and have a positive experience of care provided by us.

Quality is a key driver in each of the four strategic priorities for SEPT and safety, experience and effectiveness is a theme that runs through each of our 12 corporate aims that will provide the framework for all of our activities in the coming year:
Strategic Priority 1: Delivering Quality Services That Are Safe and Effective

We will continue to make sure that we meet or exceed quality requirements consistently regardless of the external environment. This will require clear lines of accountability, with defined expectations and service standards, and empowerment of our workforce to deliver at all levels of the organisation.

Key aims that contribute to delivering this priority:
- Achievement of quality, regulatory and contractual standards that ensure the Trust remains compliant and meets patient expectation
- Implementation of timely Trust-wide systems for listening and responding to staff, patients, carers and local communities
- Development of outcome and efficacy measures and systems to evidence the impact of our services

Strategic Priority 2: Workforce Culture and Capacity

We need to continue to develop an organisational culture that reflects the increasingly diverse nature of SEPT’s service provision and builds on the values already in place. Clinical leadership and personal accountability will be key to ensuring delivery of the Trust’s objectives, as well as a commitment to ensure training and development is focused on ensuring that our workforce has the skills, knowledge and expertise required to deliver the strategy.

Key aims that contribute to delivering this priority:
- Alignment of workforce to principles and values contained in the NHS Constitution
- Leadership and accountability structures and systems strengthened from the Board to service delivery
- Action taken to ensure the 'right staff, with the right skills are in the right place at the right time'

Strategic Priority 3: Transforming Care

We will demonstrate our ability to respond to the current and future environment by working collaboratively to transform delivery of care. Plans will need to be clear, explicit, communicated and 'owned' by the clinical and support services to which they apply.

Key aims that contribute to delivering this priority:
- Delivery of required changes and improvements agreed in QIPP plans, CQUIN schemes and CIPs in partnership with CCGs, Local Authorities, the NCB and other partners
- Development of clear model and strategy to deliver integrated care provision
- Increased application of technology to improve patient care and experience and clinical and support service delivery

Strategic Priority 4: Clear Plans for Sustainable Services and Resources Used to Deliver Them

Developing sustainable services that can continue to be delivered and meet the requirements of the population they are aimed at during continual change will be a key priority for SEPT. There is not one answer to achieve this, but carefully made decisions, pursued opportunities and partnerships will enable us to add value to quality of service provision, improve care pathways, be more innovative in our approach and contribute to financial stability.

Key aims that contribute to delivering this priority:
- Development of clear service plans for clinical and support services that reflect local and national policy context
- Continued action taken to maximise efficient clinical service delivery and support service infrastructure
- Greater flexibility and responsiveness in our service offering pursued in all directorates.
2.2 Our quality priorities for 2013/14

The Board of Directors considered the strategic context, their knowledge of the Trust and the feedback from staff and stakeholders during the planning cycle and has identified five Quality Priorities for 2013/14. We believe that these priorities will deliver the improvements most often identified by our stakeholders and will lead to improved health outcomes for our patients and service users.

(EFFECTIVENESS) Quality Priority 1: Physical Healthcare

Physical healthcare assessment is a vital part of the holistic assessment within elderly mental health inpatient wards where a majority of the patients have complex physical and mental health needs. Through recent audits, it has been identified that the competency of staff in undertaking physical health assessments is not standardised across the Trust. By training staff and implementing competencies, there will be a standardised approach across the Trust and will also facilitate earlier detection in the deteriorating patient. This work will commence within the elderly inpatient areas where there is a larger proportion of patients with complex and multiple physical and mental health needs, but will then be rolled out wider.

Priority
- Improving competencies in monitoring, measurement and interpretation of vital signs within elderly mental health inpatient areas.

Target
- Development of competency framework for clinical staff
- Baseline audit and % improvement by March 2014

(SAFETY) Quality Priority 2: Pressure Ulcers

Avoidable pressure ulcers are seen as a key indicator of the quality of nursing care and preventing them happening will improve all care for vulnerable patients. Early risk assessment and prevention is therefore vital. All staff within clinical teams should be aware of this and undertake assessment of patients as they are admitted onto their caseloads or within an inpatient area. During 2012/13 SEPT had a priority to reduce the number of category 3 and 4 avoidable pressure ulcers to zero (which was a target set nationally and by the East of England Strategic Health Authority). All three community services have undertaken a number of areas work in relation to the themes resulting from root cause analyses and are now working to a standardised practice across the trust. Although we did not achieve the zero target, we made significant progress in reducing the number of category 3 and 4 avoidable pressure ulcers, achieving 95% of our ambition. We understand that this compares very favourably with the anticipated benchmark achievement for the East of England. The work undertaken needs to be sustained to continue to strive towards this target and we also need to reduce the number of avoidable category 2 pressure ulcers.

Priority
- To reduce the number of avoidable category 2, 3 and 4 pressure ulcers

Target
- To sustain and improve on the work undertaken during 2012/13 in reducing avoidable category 3 and 4 pressure ulcers towards the ambition of no avoidable category 3 and 4 pressure ulcers
- To identify a baseline for category 2 avoidable pressure ulcers and % improvement by March 2014 as agreed through CQUINs

(SAFETY) Quality Priority 3: Falls

Falls prevention is a complex issue crossing the boundaries of healthcare, social care, public health and accident prevention. Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year, with over 26,000 reported from mental health units and 28,000 from community hospitals. In February 2012 revised guidance from the NPSA on incidents resulting in long term harm led the Trust to review its serious incident reporting criteria. From that time this has seen the inclusion of inpatient falls resulting in long bone fractures that require surgical intervention to be reported as serious incidents. Falls prevention needs to consider the patients individual needs and the different environmental factors in different settings including home, care setting and hospitals. All of this needs to be reviewed, while balancing patient safety, independence and rehabilitation. During 2012/13, SEPT reported 1,593 falls, 31.77% of which resulted in low, moderate or severe harm. In total 18 falls resulted in severe harm, 15 of which were falls
resulting in long bone fractures that required surgical intervention, and therefore were reported as serious incidents.

Priority
- Reduce the level of avoidable falls resulting in harm

Target
- To identify how many of the 18 severe harm falls reported in 2012/13 were avoidable
- To agree a level of improvement on the 2012/13 outturn of avoidable falls, to be achieved by March 2014
- To achieve a 5% increase in the proportion of falls that result in no harm
- To increase reporting of no/minimal harm from falls

(EXPERIENCE) Quality Priority 4: Carers
The white paper ‘Caring for our future: reforming care and support’ published in July 2012 requires that the NHS “work with their local authority partners and local carers organisations to agree plans and budgets for identifying and supporting carers”’. This reinforces the requirements of the existing NHS operating framework for 2012/13 (DH - November 2011) which requires NHS commissioners to agree policies, plans and budgets to support carers with local authorities and voluntary organisations. More recently, the mandate for the NHS Commissioning Board was published in November 2012. In respect of carers, their needs are specifically referred to in the chapter on enhancing the quality of life for people with long–term conditions, which includes mental health. Paragraph 2.5 states: “the NHS Commissioning Board’s objective is to ensure the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment….the five million carers looking after friends and family members will routinely have access to information and advice about the support available—including respite care”

Part 2 of the NHS outcomes framework includes a section on health related quality of life for carers and performance indicators will be devised for publication at CCG, Local Authority and NHS Provider level.

The draft Care and Support Bill published in September, takes forward the existing local authority duty for assessment and review of carers needs. Subject to Parliament this would become law in April 2015.

There will therefore be a need for all community and mental health and seconded social care staff to be aware of their requirement to identify carers and sign post them to support services and for SEPT to continue to work collaboratively on carer support.

This quality account indicator will monitor numbers of staff undertaking training in 2013/14 against a baseline. This allows us to promote further understanding in the workforce of these new and forthcoming responsibilities for the NHS.

“Carers” in the context of this quality priority refers to family carers who support a relative who use health and social care services.

Priority
- To provide better support for carers by mental health and community health services

Target
- To increase the number of clinical staff trained to undertake the 3 R’s (Recognise, Record and Refer carers to appropriate services) by 324

(EXPERIENCE) Quality Priority 5: Improved Patient Experience
At an operational level there is a desire to increase the amount of feedback being received from patients to enable staff to be able to reflect on their practice based on direct feedback from patients in a way that the Francis Inquiry Report suggests is appropriate.

Moreover, from a strategic point of view, there is not currently a consistent approach to collecting patient feedback on services which brings difficulties in comparing like with like across the Trust. Upon this basis, it is considered sensible and logical to rationalise the survey work that is currently being undertaken into a standardised approach across the Trust.
Priority
- To promote continuous reflection and improvement on practice through regular patient feedback mechanisms
- To consolidate the use of the Friends and Family Test in services across the organisation (building on the 2011/12 Quality Account Priority in this area)

Target
- To introduce a patient and carer feedback and reporting system (including the NHS Friends and Family Test) across the organisation, enabling staff to receive regular commentary on their service from an end user perspective.

Each of the above five priorities will be monitored on a monthly basis by the Executive Directors of the Trust as part of the routine quality and performance report and the Board of Directors will be informed of any slippage against agreed targets. We will report on our progress against these priorities in our Quality Account for 2013/14.

2.3 Stretching goals for quality improvement – 2013/14 CQUIN Programme

Commissioners have incentivised SEPT to improve quality during 2013/14 via 55 programmes of work. This is a 20% increase in expectations compared to last year where SEPT was commissioned to deliver 43 programmes (and achieved 98% of these).

The overall programme is not only more challenging in terms of numbers, but commissioner expectations have increased. This year the programme is structured to improve services that give the greatest cause to concern to clinical commissioning groups GP leads and will have the biggest impact on improvement to quality and safety of SEPT’s services. Commissioners expect SEPT to be able to deliver quantitative service improvements where there can be no doubt of achievement measured both by patient satisfaction and improvement in clinical/quality outcomes.

Across all contracts/all locations SEPT is expected to:

- improve patient experience / patient rating of overall care measured by asking patients whether they would recommend SEPT services to their friends and family;
- measure staff rating of overall care by asking them (confidentially) whether they would recommend their service to their friends and family (commissioned by commissioners in Bedfordshire and West Essex);
- improve patient safety by continuing to reduce occurrence of pressure ulcers, falls, urinary tract infection in those with a catheter and VTE (furthermore, community services commissioners expect further reduction in category 2 pressure ulcers building on the reductions to category 2, 3 and 4 achieved in 2012/13) – mental health commissioners expect SEPT to commence measurement of and reduction to the prevalence of a further three categories of harm (self harm, medication errors and violence and aggression);
- focus on service improvements for patients and their carers either suffering from dementia, or not yet diagnosed – these incorporate improved services for carers, new services to identify patients not yet diagnosed and initiatives to reduce waiting times and improve access;
- focus on new services/service enhancements where the outcome is reduced dependence upon A&E/acute hospital services and care provided closer to home – Initiatives include working with service users in Essex identified as those that frequently attend A&E with a mental health need to identify support and treatment within the community – also in South East Essex development of integrated services for children and young people to avoid hospital admissions – within Bedfordshire, SEPT will work with at risk, high intensity users in their own homes to avoid potentially unnecessary admissions to hospital.

In Bedfordshire and Luton work will be undertaken to:

- continue to improve patient access to child and adolescent mental health services;
- improve treatment & outcomes for people currently on the Assertive Outreach Team caseload;
- implement a school ready health education check the outcome of which is to reduce health inequalities by early detection of developmental needs and health issues in children.
In West Essex commissioners have focused on:

- improvement to services for patients at end of life;
- improvements in the manner in which patients are assessed and reviewed for continuing health care needs.

South Essex commissioner’s priorities are:

- improvements to community services for patients with a learning disability addressing issues raised in the Michael report;
- improved access to mental health services for patients in crisis.

### 2.4 Learning lessons from the Francis Inquiry

SEPT’s Board of Directors, senior clinicians and other staff have carefully considered the recommendations contained within the Robert Francis Inquiry into the Mid Staffordshire NHS Foundation Trust. We have checked the recommendations against the work we are already doing in the Trust, and we are very pleased with the evidence which demonstrates the robustness of how we performance manage quality and other related issues within the Trust. We will now be doing more in-depth work on the recommendations of the report grouped under the key themes so we can continue to monitor how well we deliver high quality services within the Trust and ensure patients are at the heart of everything we do.

### 2.5 Statements of Assurance From The Board

#### 2.5.1 Review of services

**During 2012/13, SEPT provided and/or sub-contracted 175 relevant health services.**

*SEPT has reviewed all the data available to them on the quality of care in 175 of these relevant health services.*

*The income generated by the relevant health services reviewed in 2012/13 represents 99 per cent of the total income generated from the provision of relevant health services by SEPT for 2012/13.*

The data reviewed aimed to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Significant progress has been made this year in terms of data quality, completeness and consistency associated with community health services acquired in 2011/12. During 2012/13 monthly data quality reports have been produced in a consistent format across the three community areas. These reports monitor both timeliness of data entry and data completeness. Significant improvement in compliance has been achieved since the introduction of the reports and there has been excellent clinical engagement with a clear understanding of the importance of good data quality across the clinical areas. Similar issues in terms of data quality, completeness and consistency have been identified in terms of the Suffolk Community Services acquired in 2012/13 and these are similarly being addressed. This may have impeded the full review of all services, although Suffolk Services constitute a very small proportion of total SEPT services (2%).
2.5.2 Participation in clinical audits and national confidential enquiries

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

During 2012/13, 14 national clinical audits and two national confidential enquiries covered relevant health services that SEPT provides.

During 2012/13 SEPT participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SEPT was eligible to participate in during 2012/13 are as follows:

National clinical audits:
- National Audit of Schizophrenia
- POMH Topic 10b reaudit of use of antipsychotics in CAMHs
- POMH Topic 1f Reaudit of prescribing high dose and combined antipsychotics on adult acute wards
- POMH Topic 3c Reaudit of prescribing high dose and combined antipsychotics on PICU wards
- National audit of falls and bone health in older people (inpatient units)
- National Epilepsy 12 (2011/12)
- National audit of back pain management for NHS staff by occupational health services
- National Parkinson’s Disease audit (2011/12)
- POMH Topic 12a Baseline audit of prescribing for people with a personality disorder
- POMH Topic 2f Reaudit of screening for metabolic side effects of antipsychotic drugs
- POMH Topic 11b Reaudit of prescribing antipsychotics for people with dementia
- POMH Topic 13a Baseline audit of prescribing for ADHD
- Epilepsy 12 (2012/14)
- National Parkinson’s Disease audit (2012/13)

National confidential enquiries:
- Homicide and suicide
- Patient Outcome and Death Time to Intervene

The national clinical audits and national confidential enquiries that SEPT participated in during 2012/13 are as listed above.

The national clinical audits and national confidential enquiries that SEPT participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

<table>
<thead>
<tr>
<th>Audit (POMH = Prescribing Observatory for Mental Health)</th>
<th>Number of cases submitted as a percentage of the number of registered cases required by the terms of the audit / enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>POMH Topic 12a Baseline audit of prescribing for people with a personality disorder</td>
<td>28%. The choice of services included in the baseline audit resulted in a smaller than expected sample. In the reaudit scheduled for 2014/15, community mental health teams are to be audited.</td>
</tr>
<tr>
<td>POMH Topic 2f Reaudit of screening for metabolic side effects of antipsychotic drugs</td>
<td>92%</td>
</tr>
<tr>
<td>POMH Topic 11b Reaudit of prescribing antipsychotics</td>
<td>100%</td>
</tr>
</tbody>
</table>
Data was collected in March 2013 but not entered onto POMH systems until April 2013. Therefore at the time of compiling this Quality Account, the % data is not available.

SEPT has registered and is currently entering data. Data entry will continue until 2014/15.

The reports of 10 national clinical audits were reviewed by the provider in 2012/13 and SEPT intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>Audit Topic</th>
<th>Explanation of what the audit was examining and what the general aims were</th>
<th>Actions to improve the quality of healthcare provided</th>
</tr>
</thead>
</table>
| National Audit of Schizophrenia (NAS) | Ascertained compliance with implementation of relevant National Institute for Health and Clinical Excellence (NICE) guidance, and gained perceptions of service users and their carers about how these services are delivered. | • Links to be established with local hospital biochemistry/haematology labs to complete physical health monitoring  
• Enhance documentation to include reminders of monitoring of side effects and an annual physical review  
• All clinicians to be reminded of expected standards of practice/monitoring requirements for high dose and combination antipsychotic prescribing and to clearly document discussion with service users regarding decisions about choice of antipsychotic prescribes |
| POMH Topic 10b Re-audit of use of antipsychotics in CAMHs | Focused on the monitoring of side-effect and the use of antipsychotics in children and adolescents. It also collected data on aspects of psychiatric diagnosis, types of behavioural problem being treated and patterns of co-morbidity. The key aim was to ensure the mental and physical health of children and adolescents in the care of CAMHS Teams through the monitoring of side effects of antipsychotic drugs. | • Raise awareness with clinicians of the current gaps in practice when using antipsychotics and identify possible solutions to improve practice.  
• CAMHS’s consultants to consider researching and possible development of a Screening tool for monitoring extrapyramidal symptoms |
| POMH Topic 1f Reaudit of prescribing high dose and combined antipsychotics on adult acute mental health wards | Measured compliance with two key national standards:  
Standard 1: The total daily prescribed dose of antipsychotic is within SPC/BNF limits.  
Standard 2: Individuals are prescribed only one antipsychotics at a time.  
The main aim was to help services to ensure the mental and physical health of service users prescribed high dose or combination antipsychotics in the care of SEPT adult acute care wards. | • Implementation of the new Main Prescription Chart to Mental Health In-patient Wards to improve monitoring of PRN (as required) medication  
• Provision of feedback to doctors regarding their prescribing data to raise awareness of any areas of concern |
| POMH Topic 3c Reaudit of prescribing high | Measured compliance with two key national standards:  
Standard 1: The total daily prescribed dose of antipsychotic is within SPC/BNF limits.  
Standard 2: Individuals are prescribed only one antipsychotics at a time.  
The main aim was to help services to ensure the mental and physical health of service users prescribed high dose or combination antipsychotics in the care of SEPT adult acute care wards. | • Implementation of new Trust prescription charts on all Forensic Wards which alerts high dose prescribing |
| National Audit of falls and bone health in older people inpatient units | Conduct a local audit to ensure that Section 2 Appendix 2 High Dose or Combination Monitoring Forms have been completed where required. | • Conduct a local audit to ensure that Section 2 Appendix 2 High Dose or Combination Monitoring Forms have been completed where required. • Consultants on Fuji Ward to review all those patients on High Dose or Combination Antipsychotics and ensure written rationale for this prescribing is in place. • MORSE assessment completed on every patient on admission and reviewed weekly; following a fall or if patient’s condition deteriorates • Full physio assessment completed for all patients and care plan formatted – mobility status of patient discussed at handover and weekly MDT meetings and patient status board updated as necessary • Walking aids available 24/7 as stock held on site. If concerns about patients mobility capabilities arise then patient would be hoisted pending full physio assessment, a care plan will be formatted then changed following this assessment if appropriate • Observation chart in place for Glasgow coma scale (GCS) with clear recommendations outlined on form for duration of observation need. Training for GCS has been completed |
| National Epilepsy 12 (2011/12) | Facilitated health providers and commissioners to measure and improve quality of care for children and young people with seizures and epilepsies in order to continue improvement of outcomes for those children, young people and their families by comparing delivered care against recommended care using the 12 key indicators derived from the National Institute for Health and Clinical Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) guidelines. | • There should be evidence of descriptions of age of child/timing of the first episode as well as details of frequency of events and descriptions of developmental history or educational progress • Evidence of emotional or behavioural problems will be recorded • Children with epilepsy to have input by a consultant paediatrician with expertise in epilepsies by one year • Children who have epilepsy who are commenced on AEDs to have input by a consultant paediatrician with expertise in epilepsies by one year • Children with epilepsy who are commenced on AEDs are to be referred to an epilepsy specialist nurse for input by one year • An appropriate epilepsy syndrome or syndrome category classification should be given by one year • Children who have convulsive seizures to have an ECG by one year • Children with defined indications are given an MRI. • SEPT will be continuing with this audit process by providing data during 2012-14 and will expect to prepare a result comparing findings with this audit to show improvements where needed during 2014/15 financial year |
| National Audit of back pain | Measured how well occupational health (OH) services are managing | The Occupational Health services participating in this audit ceased provision of OH services to the |
| Management for NHS staff by NHS occupational health services (2011/12) | NHS staff in England who present to OH with back pain. 2011/12 was the first year that the Trust participated in this audit process. organisation at the end of 2011/12 and it was not therefore possible to develop an action plan. However, the findings from the audit report have been shared with the new service providers in order to help inform their service provision. | National Parkinson’s Audit (2011/12) | There were two service areas under review in this audit process: In neurological services a patient management audit to establish if the assessment and management of patients complied with National Institute for Health and Clinical Excellence (NICE) and National Service Framework for Long Term Neurological Conditions (NSF) guidelines. In Speech and Language therapy services the primary purpose of the audit was to establish if speech and language services currently provide assessment and interventions appropriate to the needs of people with Parkinson’s in line with the recommendations made in the NICE guidelines, NSF (National Service Framework) and RCSLT (Royal College of Speech and Language Therapy) Clinical Guidelines for Dysarthria and RCSLT Communicating Quality 3 standards for motor speech disorders and progressive neurological disorders. | • In Neurological services, Parkinson’s initial and follow up assessment to be amended to include question to introduce End of Life discussions. • In Speech and Language services recommendations were made that services made video or audio recordings of spontaneous speech and that service users should be explicitly asked about their difficulties with word finding and conversations. In addition, it was recommended that speech and language therapists carry out perceptual assessments to include respiration, phonation, resonance, articulation, prosody and intelligibility to acquire an accurate profile for analysis and should give particular attention to improvement of vocal loudness, pitch range and intelligibility. • SEPT has participated in the 2012/13 Parkinson’s audit with data already provided and are currently awaiting a report expected later in 2013/14 financial year, from which comparisons will be made with 2011/12 findings to indicate improvements that have taken place and any further improvements needed. | POMH Topic 12a Baseline audit of prescribing for people with a personality disorder | This quality improvement programme included a baseline clinical audit and re-audit 18 months later and was developed to ensure patients with a diagnosis of personality disorder are treated in line with best practice identified and extrapolated from NICE CG78 (2009), guidance for borderline personality disorder. | • A brief A4 page summary about the audit standards and the trust performance is to be drafted and circulated to all medical staff. • Team managers to be informed of the audit standards and the Trust performance, particularly the need to have a documented crisis plan and the involvement of patients in the development of the plan. | POMH Topic 2f Reaudit of screening for metabolic side effects of antipsychotic drugs | Aimed to improve the health of patients in the care of SEPT Assertive Outreach, Community Mental Health Teams and Depot/Clozapine Clinics through the monitoring of compliance with annual screening for metabolic side effects of antipsychotic drugs. | • A brief A4 page summary about the audit standards and the Trust performance to be drafted and circulated to all medical staff. • Services will ensure availability of tools for measuring height, weight and blood pressure in clinical settings. |
The reports of 82 local clinical audits were reviewed by SEPT in 2012/13 and SEPT intends to take the following actions (examples only) to improve the quality of healthcare provided.

A wide range of corporate and operational services in SEPT have carried out audits to inform their agenda and improve patient safety, efficacy and service delivery. Brief examples of some of the actions to be taken to improve services as an outcome of local clinical audits include:

**North and Mid Bedfordshire School Vision Screening Audit 2012** This audit evaluated whether the City Screener is an accurate and reliable form of vision screening for children aged 4-5 years old and to determine if it should be used across North and mid Bedfordshire/South Beds and Luton. Recommendations made as an outcome of the audit were to update the school nurse discharge guidelines and city screener procedures and for the City Screener to be implemented in south Bedfordshire.

**Essex Mental Health Services Audit on treatment and management in women of childbearing age with bipolar disorder (NICE Clinical Guideline 38)** This audit looked at how standards of practice measured against best practice identified in the NICE Clinical Guideline. A number of recommendations were made as a result of the audit, including developing a number of standardised templates to help clinicians in inpatient wards and outpatient clinics focus on the specific needs of female service users. A re-audit is planned to show if these recommendations have improved engagement with this NICE guideline in this area.

**Bedfordshire and Luton Mental Health Services spot check audit of admission and discharge profile documentation** This audit was requested by SEPT’s Council of Governors who had been provided with an audit report as part of information checking for the 2011/12 Annual Report and Quality Account. There were two rounds of spot checking the first of which in July continued to show some areas requiring development. However, the second round of re-audit in September 2012 found that improvements had been made in ensuring records were accessible and appropriately filed. To help continue improvement, the Records Department identified that further training about this for Trust staff might be helpful. There was evidence of the use of standardised admission protocols from the second re-audit, showing systems in the Trust had become more embedded. It was agreed that further work should continue to fully embed this process and that staff should be provided with information on requirements to standardise expectations about when discharge summaries should/should not be completed.

### 2.5.3 Clinical Research

As a demonstration of our commitment to research and development, SEPT in collaboration with the Postgraduate Medical Institute at Anglia Ruskin University has established a Health and Wellbeing Academy which will be responsible for overseeing research developments within the Trust. It is planned that the Academy will be launched in September 2013. Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. ‘Clinical research’ means research that has received a favourable opinion from a research ethics committee within the National Research Ethics Service (NRES). Information about clinical research involving patients is kept routinely as part of a patient’s record.

**The number of patients receiving relevant health services provided or sub-contracted by SEPT in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 384.**

The figure of 384 recruits is above the a local target for SEPT of 250 recruits for 2012/13 set by the National Institute for Health Research (NIHR) Comprehensive Local Research Network (CLRN).

### 2.5.4 Goals agreed with commissioners for 2012/13

The CQUIN (Commissioning for Quality and Innovation) payment framework aims to support the cultural shift towards making quality the organising principle of NHS services, by embedding quality at the heart of commissioner-provider discussions. It is an important lever, supplementing Quality Accounts, to ensure that local quality improvement priorities are discussed and agreed at Board level within and between organisations. It makes a proportion of the provider’s income dependent on locally agreed quality and innovation goals.
A proportion of SEPT’s income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between SEPT and any person or body they entered into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online http://www.sept.nhs.uk/Corporate/~/media/SEPT/Files/Reports/CQUIN Schemes 201314.ashx

Following negotiation with commissioners, SEPT launched a broad range of quality initiatives again under the CQUIN scheme during 2012/13 to increase the quality of service user care and experience. In total, the Trust was tasked with implementing a total of 43 schemes across mental health, learning disabilities and community health services within Bedfordshire, Luton and Essex. In addition, six schemes have been progressed within Suffolk services which SEPT became responsible for in October 2012. The total of SEPT’s income which was dependent on successful achievement of the CQUIN schemes for 2012/13 was just under £7 million. In 2011/12 this figure was £3,323,700.

Working with the Midlands & East Specialist Commissioning Group for forensic and secure indicators, as well as Community and Mental Health Commissioners in South and West Essex, Bedfordshire and Luton each new CQUIN scheme was designed with our patients and service quality in mind. Since its introduction in 2010/11, CQUIN has increased in importance for providers — increasing from 0.5 to 2.5 per cent of contract income in 2012/13.

Four CQUIN schemes were set nationally by the Department of Health:
- venous thromboembolism assessment — at least 90 per cent of adult inpatients should be assessed for risk of VTE
- patient experience — organisations should improve their scores based on the previous national inpatient surveys
- improving diagnosis of dementia — through identification of patients, dementia risk assessments, staff training and increased referrals to GPs
- incentivise use of the NHS safety thermometer (an improvement tool that allows the NHS to measure harm in four areas — pressure ulcers, urine infection in patients with catheters, falls and VTE)

We implemented a total of 23 CQUINs across the organisation under the above four national schemes. The remaining 20 CQUINs were set locally in discussion with the primary care trust organisations (replaced by clinical commissioning groups from 1 April 2013) based on local priorities. A selection of the projects negotiated locally included training initiatives that support staff to initiate conversations about healthy lifestyles with an opportunity to signpost to support service for giving up smoking, initiatives to help to smooth the transition as patients move from adolescent services into new services as young adults, through to the development of integrated community teams, aiming to promote sharing of patient information to help team working and reduce overlap as well as avoid gaps. The full list of projects is available here http://www.sept.nhs.uk/Corporate/~/media/SEPT/Files/Reports/CQUIN

The clinical and operational teams tasked with implementing the improvements have once again excelled – delivering 98% of the schemes (based on our self-assessment and expressed as a % of the financial value of the schemes) with clear evidence of improving quality for patients. Particular examples of which we are proud are:

Bedfordshire Community Health Services

GULP

This was the second year of a two year indicator designed to increase staff awareness of the importance of assessing patient’s hydration needs, and implement use of the Intelligent Fluid Management Bundle across community teams in Bedfordshire Community Services. Maintaining a regular intake of fluid helps patients to remain healthy, and this tool helps to identify service users who are less able to independently drink fluids.
Assessments using the tool indicate performance in excess of the target. At baseline in June 2012 there were 131 assessments, and a 30% improvement meant achieving an extra 39 patients. A total of 1902 assessments had been completed as of end of February, and we are awaiting March data.

**Bedfordshire & Luton Mental Health Services**

*Dementia*

Waiting times for memory assessment services have vastly improved as a result of this CQUIN. The aggregated waiting time for all four services was 22 weeks in Q1, this has reduced to 13.7 weeks in Q4 after commitment to caseload cleansing, review of clinic process with the advent of the new model and extra resource spent on employing a consultant and administration position to support the patients with longest waiting times to be seen as a priority.

Staff have worked hard to reduce waiting times for existing patients, whilst simultaneously introducing and embedding a new model. This will ensure that patients are seen more quickly, and with better follow up, an area focussed on for improvement following the patient/ carer service user survey performed in Q2 of the project.

**South East Essex Community Health Services**

*Personal Health Plan (PHP) for people living with Long-term conditions (LTC)*

Introduction of PHP has been a highly successful project that has exceeded its targets. To give an idea of the reach of this project;

- 93% of GP practices have a named champion to signpost people with LTC to PHP; this contributes to the sustainability of the project.
- 99% of people on the LTC register in respective PHP pilot practices were offered a PHP.
- 69% of all community health care teams have completed self-assessed, online PHP training. The training will still be available for new staff on OLM further increasing sustainability.

All champions raised in respective GP practices have also participated in PHP self-assessed training. PHP training has been offered to third sector organisations in SE Essex. This has included Castlepoint Association Volunteer Services, Southend Association Volunteer Services, LINKS, Southend Carer’s Group, Breatheasy Group and Patient Participation Groups. A communication plan has also been implemented to ensure that the PHP continues to be offered to people living with LTC.

The PHP website introduced during this project continues to be a useful tool for more independent patients and for those who receive assistance from community health teams.

**South Essex Mental Health Services**

*Prescribing*

This scheme aimed to support appropriate prescribing of antipsychotic medication for all patients, including those diagnosed with dementia who require medication to help manage psychological symptoms and behavioural disturbance. There were three parts to this scheme, all of which were fully achieved:

1) An audit of best practice prescribing guidance; 99.8% of antipsychotics prescribed are those contained within the Trust Formulary & Prescribing Guidelines (target 80%). Patient reviews with CPNs and sessional pharmacists in care homes continue. In total 431 care home residents reviewed during the project.

2) Training of Primary Care Physicians; Practice level training provided to 19 practices involving 101 participants. All requests for practice level training where fulfilled. All participants graded content as ‘relevant & useful’ and all that training was ‘good, very good or excellent’

3) Support for nurses and sessional pharmacists to review patients in care homes to improve prescribing practices; 83% of discharge notes complied with the necessary standard, representing more than the 50% improvement on baseline required by the CQUIN.

These three aspects have supported nurses, pharmacists and GP’s to achieve best practice in prescribing anti-psychotic medication.
South Essex CAMHs

Patient Revolution

The Trust received real-time feedback on the experience of patients in south Essex child and adolescent mental health services, and improvements to services were implemented based on feedback from patients. Further, positive reinforcement of good performance was shared with teams. 83% of respondents would now actively promote the service they had received from SEPT, as compared with 51% from the baseline data collection.

This scheme aimed to involve service users in reshaping the in-patient ward service and environment. Service users were asked to design an appropriate alternative question to help understand a child/young person's/parent/carers satisfaction with the service they have received. Present service users and carers were then asked on the day, or up to two days after discharge from the ward ‘How likely is it that you would recommend this service to friends and family?’

West Essex Community Health Services

Venous Thromboembolism (VTE)

Venous Thromboembolism (VTE) or blood clots are a significant cause of death, long term disability and chronic ill health. It was estimated in 2005 that there were around 25,000 deaths from VTE each year in hospitals in England and this has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS leadership Team. This is a common and often avoidable circumstance as low cost effective, preventative treatments are available.

This indicator was designed to ensure that all patients admitted for in-patient care at West Essex were assessed for risk of having a VTE so they may be more closely monitored, and treatment if required may be started earlier. This can reduce the number of patients affected, as well as deaths from VTE. Q1-4 performance has consistently exceeded the target for 98% patients to be assessed, and in fact performance has been exceeded such that 100% patients were assessed consistently for all 12 monthly submissions.

Secure and Forensic (including CAMHs Tier 4)

SEPT CAMHS Inpatient ward (Poplar Adolescent Unit) has a school unit on site with all inpatients well enough to leave the ward receiving 25 hours teaching per week plus additional structured activity. Work on this indicator was designed to ensure that the inpatient experience for school-age patients is age appropriate in the field of education, training and meaningful activity. 93% of CAMHS inpatients exceed threshold for Education, Training and Meaningful Activity set by specialist commissioners. This will better prepare patients for the rehabilitation phase of their treatment and enable timely discharge through the provision of these activities.

2.5.5 What others say about provider?

SEPT is required to register with the Care Quality Commission and its current registration status is 'Registered Without Conditions'.

The Care Quality Commission has not taken enforcement action against SEPT during 2012/13.

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

The CQC has undertaken a number of routine compliance reviews across a range of Trust services. Following each compliance review the CQC has provided a report outlining their findings. Where the CQC find non-compliance with a regulation (or part of a regulation), they state which part of the regulation has been breached by an organisation and make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact. The CQC define these as follows:
**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where there are areas for improvement for SEPT the CQC has identified minor concerns and associated improvement or compliance actions. None of the actions identified for SEPT had a significant impact on patient safety.

The following table summarises the reviews undertaken by the CQC during 2012/13. It should be noted that only the CQC can close a compliance action. To do this the Trust must have completed appropriate action to address the concern, audited implementation and provided the CQC with a report, including supporting evidence, outlining action taken and how this has improved patient outcomes, requesting that the CQC re-reviews compliance. The CQC can choose to come back and re-inspect or do a desk top review using evidence provided by the Trust.

<table>
<thead>
<tr>
<th>Registered Location</th>
<th>Date and nature of review</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basildon MHU</td>
<td>March 2013 Re-review of one standard from February 2011 inspection (Table-top review)</td>
<td>Compliant</td>
</tr>
<tr>
<td>Biggleswade Hospital</td>
<td>September 2012 Review of three standards (Inspection)</td>
<td>Compliant</td>
</tr>
<tr>
<td>Brockfield House</td>
<td>January 2013 Re-review of four standards from March 2011 (Inspection)</td>
<td>Compliant</td>
</tr>
<tr>
<td>Heath Close</td>
<td>March 2013 Re-review of one standard from February 2012 inspection (Table-top review)</td>
<td>Compliant</td>
</tr>
<tr>
<td>Rochford Hospital</td>
<td>December 2012 Re-review of four standards from March / July 2011 (Inspection)</td>
<td>Compliant with concerns from March / July 2011 Two additional minor concerns identified (see narrative below)</td>
</tr>
<tr>
<td>Thurrock Hospital</td>
<td>August 2012 Review of seven standards (Inspection)</td>
<td>Compliant with 3 Standards Minor Concerns with 4 standards (now compliant – see below)</td>
</tr>
<tr>
<td>Thurrock Hospital</td>
<td>March 2013 Re-review of four standards from August 2012 (Inspection - see above)</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

There are now just two minor concerns which are currently open with the CQC both of which are due to be completed in April 2013.

### 2.5.6 Data Quality

The ability for the Trust to have timely and effective monitoring reports, using complete data, is recognised as a fundamental requirement in order for the Trust to deliver safe, high quality care. The Board of Directors strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality also allows the Trust to undertake meaningful planning and enables services to be alerted of deviation from expected trends.
Significant improvements have been made during 2012/13 in terms of data quality and reporting within the acquired community services – thus enhancing the ability of services and of the Trust to monitor performance and take remedial action as necessary. Similar work is now being undertaken within Suffolk services to improve data quality and consistency of reporting with established SEPT systems.

The Trust issues routine Data Quality Reports to clinical staff for validation and any amendments identified are implemented.

**SEPT submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:**

1) which included the patient’s valid NHS Number was:
   - 99.4% for admitted patient care;
   - 100% for outpatient care; and
   - Accident and emergency care – Not applicable

2) which included the patient’s valid General Practitioner Registration Code was:
   - 100% for admitted patient care;
   - 100% for outpatient care; and
   - Accident and emergency care – Not applicable

**SEPT’s Information Governance Assessment Report overall score for 2012/13 was 74% and was graded Green (Level 2 (Satisfactory)).**

**SEPT was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.**

**SEPT will be taking the following actions to improve data quality:**

- The Trust is currently implementing a new Electronic Data capture system. An integral part of the implementation is that all new Electronic forms comply with the National Standard definitions and are programmed to ensure all mandatory data items are completed.
- The Data entry and Reporting procedures are being continually reviewed to ensure any changes are clearly documented.
- Routine Data Quality Reports are circulated for both Mental Health and Community Services, these highlight missing and out of date data fields. The Trust also monitors the timeliness of Clinical data being input onto the Information system. The target is all data is entered within one working day and is making great improvements in this area of data quality.
- As part of the implementation of new National Datasets the Trust is undertaking intensive analysis and monitoring of all the data fields to ensure a high level of data quality is achieved, which will result in the successful submissions for the new datasets below:-
  - Community Information Dataset
  - Improving Access to Psychological Therapies
  - Children and Young People’s Health Services
- Monthly Data Quality monitoring reports covering all services are made to the Board of Directors.
- A data quality assurance improvement framework is to be developed.

### 2.6 National Mandated Indicators of Quality

In the letter from the Department of Health (DoH) dated 29 January 2013, new reporting arrangements were introduced that impacted on the information trusts are required to report in future Quality Accounts. The National Health Service (Quality Accounts) Regulations 2010 have been amended to include the mandatory reporting of a core set of quality indicators. Those indicators relevant to the services SEPT provides are detailed below, including a comparison of SEPTs performance with the national average and also the lowest and highest performers. The information presented for the five mandated indicators has been extracted from nationally published data, and as a result, is only available at a Trust-wide level.
The above indicator measures the percentage of patients that were followed up (either face to face or by telephone) within seven days of their discharge from a psychiatric inpatient unit. A comparison with the national average demonstrates that, with the exception of quarter 3 2012/13, SEPT has been performing above the national average, and for all quarters have performed above the 95% target set by MONITOR, the regulator of NHS-funded health care services.

SEPT has taken actions to improve the percentage, and so the quality of its services, by routinely monitoring compliance with this indicator on a monthly basis and identifying the reasons for any patients not being followed up within seven days of their discharge. Any identified learning is then disseminated across relevant services. In addition a local indicator was established Trust wide in 2011/12 to monitor the percentage of follow ups that are provided face to face to ensure that at least 85% of those patients followed up have a face to face contact rather than a telephone call.

Data source: DoH Unify2 data collection – MHPvCom
National Definition applied: Yes
SEPT has consistently performed above the 95% target set by MONITOR, the regulator of NHS-funded health care services during 2012/13 with performance above the national average. SEPT’s performance for Q4, which demonstrates 100% of patients admitted to an acute psychiatric inpatient unit were gatekept by the Crisis Resolution Home Treatment Team (CRHT) prior to their admission, results in 99.9% achievement for the full year.

SEPT has taken actions to improve the percentage, and so the quality of its services, by routinely monitoring compliance with this indicator on a monthly basis and identifying the reasons for any patients not being gatekept by CRHT prior to their admission. Any identified learning is then disseminated across relevant services. With such positive performance achieved throughout 2012/13, in particular during quarters 3 and 4, SEPT will strive to maintain this level of performance during 2013/14 through maintenance of existing clinical processes.

Data source: DoH Unify2 data collection – MHPrvCom
National Definition applied: Yes
SEPT participates on an annual basis in the national staff survey for NHS organisations. Within the survey staff are asked to answer the question, "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust". Over the past two years the results have demonstrated that a higher proportion of staff from SEPT would agree with this statement than the national average for all NHS Trusts.

The full results of the 2012 Staff Survey were recently released and presented to SEPT’s Board of Directors in March 2013. As well as demonstrating agreement with the above question, the results also demonstrated a high level of engagement, motivation and job satisfaction. Whilst SEPT is pleased to see such positive results, there is still room for further improvements.

SEPT intends to take action to improve this percentage and the quality of its services by implementing the actions that are identified through the development of an action plan, which is currently under way and expected to be finalised in May 2013.

In addition to the development of an action plan, as reported in an earlier section of this report, more routine monitoring of staff views of overall care will be implemented during 2013/14 in Bedfordshire and West Essex as part of the CQUINs commissioned in these areas of the organisation.

**Data source:** National NHS Staff Survey Coordination centre / NHS Staff Surveys 2011 & 2012

**National Definition applied:** Yes
The community mental health service user survey is nationally conducted on an annual basis. The survey consists of a range of questions focusing on the care and treatment received by service users at various stages of care with SEPT community mental health services. The results demonstrate that there was a large improvement in patient experience between 2011 and 2012, however, SEPT's performance remained below the national average.

SEPT has taken the following actions to improve this percentage and the quality of its service:

- 15 'In Your Shoes' workshops held for service users offering them the opportunity to tell us what is good about the services they've received and what they think could be improved. The learning and feedback from these workshops is being translated into changes in practice
- Patient Experience Co-ordinators have been appointed to act as the link between service users and operational services, ensuring a more consistent approach to the sharing of patient feedback
- The Friends and Family Test (would you recommend this service to a friend of family member) was introduced, action plans were developed in response to the feedback received and implemented throughout 2012/13
- Continued recruitment of mystery shoppers who provide real time feedback about services, which is then passed to services for immediate action / improvement
- Commenced review of SEPTs Customer Care Strategy and our Vision and Values, the strategy will be completed and launched in 2013/14

As well as launching the new Customer Care Strategy, SEPT intends to continue to hold ‘In Your Shoes’ events during 2013/14 and will be completing further integration of patient surveys to enable improved benchmarking of performance, further learning from experience and ultimately, improvements in patient experience.

**Data source:** HSCIC / Community Mental Health Services Surveys  
**National Definition applied:** Yes
**Patient safety incidents and the percentage that resulted in severe harm or death**

<table>
<thead>
<tr>
<th>Reported Dates</th>
<th>1st October 2011 - 31st March 2012</th>
<th>1st April 2012 and 30th September 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation</td>
<td>All incidents</td>
<td>Severe harm</td>
</tr>
<tr>
<td>All UK &amp; Wales</td>
<td>612290</td>
<td>3678</td>
</tr>
<tr>
<td>SEPT</td>
<td>3057</td>
<td>69</td>
</tr>
</tbody>
</table>

*This figure decreased to 53 following publication due to the downgrading of the harm level for one incident*

The graph below shows the percentage of all incidents reported by SEPT to the NRLS that resulted in severe harm or death, compared to the rates of all UK & Wales NHS trusts, all Mental Health Trusts, and also includes the highest and lowest reported rates of all UK & Wales NHS trusts.

The rate of incidents reported as resulting in death are slightly above the national average, however, are below that of mental health trusts and significantly below the highest reported rates of death. The rate of incidents resulting in severe harm has shown a decline in the most recent data available (April – September 2012), however, remains above the national average. 78% of the severe harm incidents reported by SEPT during the period of 1 October 2011 to 30 September 2012 were pressure ulcers and a further 16% were slips, trips or falls.

As identified within the quality priorities for 2013/14, SEPT intends to take the following actions to improve this percentage and the quality of its services, by:

- reducing the level of avoidable falls, and the level of harm resulting from them;
- continuing improvements in the reduction of avoidable category 3 and 4 pressure ulcers.

In respect of the six months from 1 October 2012 to 31 March 2013, SEPT have reported 3756 Patient Safety Incidents, of which 42 (1.12%) resulted in severe harms and 16 (0.43%) resulted in deaths. This data has not yet been uploaded to the NRLS and so is subject to change as a result of data cleansing prior to submission.

**Data source:** NRLS NPSA Submissions 12/03/12, 12/09/2012 and 20/3/2013 and Datix.
**National Definition applied:** Yes
PART 3:
REVIEW OF OUR QUALITY PERFORMANCE DURING 2012/13

We want you to know how we’ve done over the past year in terms of delivering on those quality projects and initiatives we told you we hoped to achieve in our Quality Account last year. We also want you to know how we have performed against some key indicators of quality service which we also reported last year. We’ve included last year’s results as well as this gives you the opportunity to see whether we are getting better at quality or if there are areas where we need to take action to remedy. Where this is the case, we’ve included some information in terms of what we will be doing to improve.

This part of our Quality Account is divided into four sections, as follows:

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Progress against our quality priorities for 2012/13, outlined in our Quality Account 2011/12 (including historic and benchmarking data, where this is available, to enable you to compare our performance with other providers).</td>
</tr>
<tr>
<td>3.2</td>
<td>Examples of key achievements relating to quality improvement during 2012/13.</td>
</tr>
<tr>
<td>3.3</td>
<td>Performance against SEPT Trust wide and service specific quality indicators.</td>
</tr>
<tr>
<td>3.4</td>
<td>Performance against key national indicators and thresholds relevant to SEPT (from Appendix B of Monitor’s Compliance Framework - a document which sets out the approach Monitor will take to assess the compliance of NHS foundation trusts with their “Terms of Authorisation”) which have not been included elsewhere in this Quality Account. Appendix B of the Compliance Framework sets out a number of measures Monitor use to assess the quality of governance in NHS Foundation Trusts.</td>
</tr>
</tbody>
</table>

To enable you to get an understanding of the Trust’s performance in your local area, we have detailed performance against indicators by locality area where it is possible to do so.
Section 3.1: Progress against our quality priorities for 2012/13, outlined in our Quality Account 2011/12

Our Quality Account for 2011/12 identified five quality priorities for 2012/13 that aimed to deliver the improvements most often identified by our stakeholders as important. These priorities were taken forward in Bedfordshire, Luton and Essex and focused on enhancing the safety, experience and effectiveness of our services. Below is a summary of the progress made to date.

3.1.1 Safety

Quality priority: Eliminating avoidable pressure ulcers that are acquired in our care

We aimed to achieve zero avoidable grade 3 or 4 pressure ulcers acquired in our care by December 2012. We said we would start by reporting all grade 3 and 4 pressure ulcers that we identified but, by the end of the year we would only report those that were unavoidable and happened under our care. We also said we would increase the identification, and reporting, of all grade 2 pressure ulcers compared to 2011/12.

Data source: Datix
National Definition applied: Yes

During quarter 4, 1,031 category 3 and 4 pressure ulcers acquired in our care were reported, 6 were subsequently downgraded following investigation leaving 97. Of these, to date, seven have been identified as avoidable. Currently, we have achieved 93% of our target however there are a further 21 RCAs currently in progress, to identified if the pressure ulcers were avoidable.

All Category 3 or 4 Pressure Ulcers acquired in our care are reported as serious incidents and a detailed root-cause analysis (RCA) is undertaken to determine whether the pressure ulcer was avoidable or unavoidable. Each community service has a Skin Matters group to review RCAs before submission to the Executive Team for final sign off, and a trust-wide Pressure Ulcer meeting has been set up to share learning and review progress.

All three community services across the Trust are now working to standardised practices which include:
- all patients are assessed, using the Waterlow score, on admission to a caseload or inpatient bed
- preventative equipment is provided to all patients identified as ‘at risk’ (a Waterlow score over 15)
- learning from RCAs is shared with staff

Grade 2 Pressure Sores are all those acquired in SEPT care. These are not subject to RCAs to determine if avoidable or non-avoidable. The information demonstrates there has been an increase in reporting across all service evidencing the positive impact of the awareness raising work that has been undertaken across the Trust.
3.1.1 Safety  

**Quality priority:** Improving support provided to carers of patients and children in Community Health Services.

*We said that by March 2013 we would increase the number of carer’s assessments undertaken compared to a baseline audit during quarter 1 of 2012/13. We also said we would develop a community health service carers’ support system, plus training programmes.*

The Trust identified a two part quality improvement initiative, one part of which has proved difficult to take forward. The Trust set out to “increase numbers of carers assessments” of patients and children receiving community health services, however SEPT is not commissioned to carry out this service. Whilst unable to undertake carers assessments SEPT has been able to successfully progress the second part of the quality priority which was designed to improve carer support systems in community health services. Staff training on how to Recognise, Refer (for support) and Record carers (3Rs) for community staff was implemented alongside a number of other initiatives.

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3.1.2 Experience

**Quality priority:** Improving patient experience

*We said we would increase the percentage of patients who would recommend SEPT services to friends and family.*

SEPT introduced the Friends and Family Test in 2012/13, in line with an aspiration from the government for there to be one question that can be asked to all NHS patients in order to give a ‘tin-opener’ gauge of how well services are performing. This is already mandated across acute hospital services. SEPT is ahead of the curve in using the measure in mental and community healthcare settings. Patients (and their carers where relevant/appropriate) are asked:

“On a scale of 1 to 10, how likely is it that you would recommend this service to a friends or family member who needed similar care or treatment?” The responses are collated and a Net Promoter score is calculated. The lowest possible score is -100 and the highest score is +100.

**+69** is our Net Promoter score at the end of the year. This has improved from **+48** the baseline recorded in October 2012.

**+81** for Bedfordshire Community, **down** from the **+90** baseline (however, this score remains significantly high, with an average score of 9.5 out of 10 in Q4)

**+53** for Bedfordshire & Luton Mental Health, **improved** from the **+27** baseline

**+50** for South Essex Mental Health, **improved** from the **+32** baseline

**+83** for South East Essex Community, **improved** from the **+32** baseline

**+56** for West Essex Community, **improved** from the **+22** baseline

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3.1.3 Effectiveness

**Data source:** N/A

**National Definition applied:** N/A

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*278 staff received carer awareness training*

*We provided 20 carer information events and gave carer information to 931, carers, staff and members of the public*

*We facilitated Seven, eight-week carer, self- management courses wherein 323 carers attended*
3.1.1 Safety

Quality priority: Improving quality and personalisation of care plans.

We aimed to develop critical information standards that would evidence quality and personalised care planning. We were going to do this by conducting a baseline audit in quarter 1 so we could demonstrate a percentage improvement by March 2013.

Data source: SEPT Audit
National Definition applied: N/A

In order to benchmark personalisation in care plans across the organisation, critical information standards for measurement were identified and included in a range of audits as part of the Trust Priority Clinical Audit Programme 2012/13. Baseline audits were undertaken followed by a re-audit in March 2013.

The results of the audits are presented below and evidence that improvements have been achieved.

<table>
<thead>
<tr>
<th>Question</th>
<th>Baseline</th>
<th>Re-audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the health record include a signed care plan?</td>
<td>73%</td>
<td>80%</td>
</tr>
<tr>
<td>Are patient views clearly documented?</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Have patient quotes been included in the assessment and/or continuation sheets?</td>
<td>76%</td>
<td>81%</td>
</tr>
<tr>
<td>Does the care plan reflect all the care needs identified within assessment?</td>
<td>92%</td>
<td>96%</td>
</tr>
</tbody>
</table>

The improvements were achieved through the delivery of support via workshops commissioned from an external expert on care planning and one of our local universities. Additionally, we have supported staff in the development recording of personalised care plans through on-line training and 1:1 coaching.

Whilst we have demonstrated an improvement in all four standards, we recognise that further work is required to ensure that patients and their carers/families are active participants in decisions about them and are supported to make informed choices about their treatment and on-going care.

Electronic patient records are widely used in in domiciliary community health services with the paper copy being retained in the patient's place of residence. The standard to ensure the care plan is signed by the patient was difficult to measure in this instance, and, therefore, work will be undertaken to develop an appropriate template in which this information can be captured where records are electronic.

SEPT has been actively promoting the national strategy for nursing Compassion in Practice which enforces patient and service user "voice, choice and control". Additionally, the First Class Care campaign, which recognises that everyone who receives care is entitled to fundamental aspects of care in line with the Royal College of Nursing Principles Nursing Practice and Care Campaign, has been launched through a series of workshops. Staff are being issued with the First Class Care Handbook as an aide memoire for use in their day to day practice.

We will continue to provide support to front-line staff around the quality and personalisation of care plan in the form of coaching and workshops and will evaluate the impact on quality outcomes and personalisation for patients and service users in our care.
### 3.1.1 Safety

**Quality priority:** Improving handover of care; transfer of patients in and between services and discharge of patients to primary care

We said we would develop critical information standards and quality performance target for handover of care, transfer and discharge. We aimed to evidence improvement, by March 2013, through comparing performance against a baseline audit carried out in quarter 1 of 2013. We also promised improvement in the performance and quality of providing discharge summaries to GPs.

**Data source:** SEPT Audit

**National Definition applied:** N/A

Discharge and transfer of care are processes and not isolated events. They should be planned for at the earliest opportunity and ensure that service users and their carers understand and are equal partners in decisions relating to their care. Excellent communication and information sharing are required to ensure a smooth, effective, safe and prompt transition. In addition, the number of individuals caring for a patient during their hospital stay has increased and the need for comprehensive handover of information has become more important than ever. In order to benchmark transfer and discharge processes across services, critical information standards for measurement were identified and included in a range of audits as part of the Trust Priority Clinical Audit Programme. Baseline audits were undertaken and, in addition, observational audits of handover of care across in-patient areas were carried out to measure quality standards and performance expected for the safe and effective handover of care.

**Discharge and Transfer**

The baseline audit identified that all in-patient areas across mental health and community health services exceeded the Trust expectation of 90% compliance across all of the standards and therefore a decision was made to undertake a spot check during March 2013 across a random selection of 14 in-patient areas to ensure compliance was maintained. The checks confirmed Trust compliance of 90% with the exception of one area which provides long term continuing care.

**What Next?**

Whilst good areas of clinical practice were identified in the initial audit, the spot check undertaken found that there is still some work to be undertaken relating to discharge planning to ensure compliance is maintained. We will continue to ensure excellent communication and information sharing across all agencies, including colleagues in primary care so that all discharges from SEPT services are of the highest quality.

**Handover of care**

The baseline audit identified that handover in more than half of in-patient areas were unstructured and did not focus upon individual patient’s risk assessments. This was considered one of the priority areas for improvement. The other two standards identified as requiring action were the requirement for handover to be conducted free from non-emergency interruption and that the oncoming shift lead must ensure that the location of each patient is known.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Baseline</th>
<th>Re-audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of patient records to inform the clinical handover with a focus on risk</td>
<td>48%</td>
<td>75%</td>
</tr>
<tr>
<td>Clinical handovers will be conducted in an area free from non-emergency interruptions</td>
<td>35%</td>
<td>89%</td>
</tr>
<tr>
<td>Staff to check the location of each patient immediately following handover of each shift</td>
<td>No Evidence</td>
<td>87%</td>
</tr>
</tbody>
</table>

**What Next (Handover)** - The results of the re-audits on handover of care indicate that there has been significant improvement in the identified standards. Our priority is to ensure that this continues and in particular work to further improve the standards relating to safe and effective handover of care.
Section 3.2: Examples of key achievements relating to quality improvement during 2012/13

In our last Quality Account we set out an ambitious programme of quality objectives / service developments we planned to take to improve the quality of our services. Outlined below is a selection of the improvements that have been achieved during 2012/13.

**Trust wide**

- The implementation of a single point of access / single point of referral system in our Community Health Services, ensuring that the right person from the community health services team responds at the right time to referrals for support in the patient’s home that prevents admission to or facilitates discharge from hospital.
- Continued progress with the establishment of integrated adult care teams aligned to clinical commissioning groups and with social care provision across Bedfordshire, South East Essex and West Essex Community Health Services.
- Continued improvements in safeguarding arrangements as assessed by an Independent Auditor - “these results are impressive and demonstrate a very high standard of safeguarding work being achieved by SEPT.” “The turnaround seen this year in the performance of SEPT has been impressive and these cases demonstrated how improvements are being consolidated.”
- The implementation of new models of care in Learning Disability Services and the wider Trust Services as a result of the learning arising from the ‘Winterbourne Report’. This was a report which highlighted the poor, criminal and abusive practice by the staff employed in a residential setting for people with learning disabilities, Winterbourne View (not in any way connected with SEPT). The subsequent report that came out of the serious case review highlighted areas of concern with recommendations for organisations across the country to implement in order to ensure the safety and well-being of vulnerable people in their care. Within SEPT, the recommendations have been scrutinised by a Task and Finish Group and an action plan has been developed to give assurance to our Board that the poor practice found within Winterbourne will not be found in any service within SEPT.
- The personalisation approach to care was extended with Local Authorities across Bedfordshire, Essex and Luton.
- The achievement of continued improvements in end of life care – “by listening to patients, acknowledging their wishes and understanding them as people we hope to give them the time to come to terms with death and make any necessary preparations for the future whether that is where they’d like to die, who and what will be there or simply how their funeral will be. It’s all about giving them those important choices”. Laura Davis, End of Life Care Facilitator
- Launching of Activity Co-ordinators.
- The organisation of and participation in three mental health awareness events with the Sikh community and continued partnership working with other faith communities.
- The refreshing and launching of a Carer Strategy and the Carers Card.
- The implementation of all recommendations arising from a review of the Serious Incident process, ensuring all serious incidents are robustly investigated and any lessons learned are shared and implemented across the organisation.
- The harmonisation of pressure ulcer reporting and robust processes put in place to manage and reduce the incidences of pressure ulcers.
- Launch of ‘First Class Care’.
- The implementation of standardised Patient Notes and Care Planning documentation across Mental Health Services in the Trust.
- Significant progress in terms of achieving ‘Harm Free Care’ – a group has been established to review incidents in four areas of harm and to share good practice/learning across Trust, linking with safety thermometer data collection and pressure ulcer prevention. This is also monitored through serious incident reporting and reported to our Clinical Governance Committee.
• A new system has been implemented across the Trust to facilitate more effective monitoring of mandatory training completion and to address the provision of training, ensuring that staff maintain up-to-date training.
• Achievement of NHS Employers Equality and Diversity Partner status

**Bedfordshire and Luton**

• The implementation of a new sub-acute pathway in Bedfordshire Community Services which has been designed to prevent unnecessary admissions to general hospital and facilitate earlier discharges ensuring care closer to home provision and improved patient outcomes. This pathway includes a new 16 bedded sub-acute unit, integrated pathways between rehabilitation and enablement and the Rapid Intervention Team as well as the management of patients from care homes who have had frequent acute admissions.
• The opening of a short stay medical unit in Houghton Regis.
• Achievement by the Bedfordshire Community Services of Unicef Baby Friendly Accreditation.
• Strengthened links with GPs through the introduction of a named Mental Health Professional for each Practice.
• Completion of the Limetree redevelopment at Luton and Dunstable Hospital and transfer of the assessment and treatment inpatient service from Oakley Court.
• There have been a number of achievements in terms of Looked After Children (LAC) over the past 12 months including a review of the service for undertaking health assessments with multi-agency and service user involvement; training involvement and development / implementation of enhanced assessment document all of which are intended to achieve improvements in outcomes for children/young people to address known health inequalities for Looked After Children and young people leaving care. It is intended to continue to undertake work to develop these services over the coming year, including pathway development.

**South Essex**

• The establishment of a step up / step down in-patient facility aimed at preventing admission and facilitating discharge from acute hospital beds of people with dementia in South Essex Mental Health Services. This has been achieved through the redesign of existing service provision. The new model of service also provides patients with intensive rehabilitation to help people remain in their own homes for as long as possible.
• Brockfield House (forensic mental health in-patient services) was ranked third in the country in a Royal College of Psychiatrists Peer Review.

**West Essex**

• The establishment of an Early Supported Discharge Team for Stroke patients in West Essex Community Services to support more patients in their own homes who have suffered a stroke, thus reducing lengthy hospital stays.

**Suffolk**

• Introduction of a PASCOM audit in Podiatric Surgery allowing the collection of operative information for planning and performance reporting; implementation of computerised SystmOne record keeping.
• The service specification for Podiatry has been redrafted (awaiting agreement with commissioners) to allow the more robust focus being placed on those at greatest need.
• The service specification for adult speech and language therapy has been refocused to ensure that patients receive what they need when they need it.

Work is continuing to progress against a number of the priorities set out in the 2011/12 Quality Account and the key priorities for our 2013/14 quality work programme are set out in Part 2 of this report.
Section 3.3: Overview of the quality of care offered in 2012/13 against selected indicators

As well as progress with implementing the quality priorities identified in Quality Accounts last year, the Trust is required to provide an overview of the quality of care provided during 2012/13 based on performance against selected quality indicators. The Trust has selected the following indicators because they have been regularly monitored by the Board, there is some degree of consistency of implementation across our range of services, they cover a range of different services and there is a balance between good and under-performance. In 2011/12 a Patient Safety Incident indicator which focused on reporting rates and degree of harm was reported. This indicator has not been included this year following the introduction of a mandated indicator, available in section 2.6, that reports on the both the severity of and the number of incidents reported by the Trust.

Trust wide indicators

The KPI targets were established with the Commissioners: for C. Difficile and MRSA bacteraemia cases they must be solely attributable to the Trust and avoidable after investigation via root cause analysis (RCA).

<table>
<thead>
<tr>
<th>Infection Control Measure</th>
<th>Key Performance Indicator: Upper Limits</th>
<th>2012/13 Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cases of avoidable C.Difficile</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Cases of avoidable MRSA Bacteraemia</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Community Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cases of avoidable C.Difficile</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Cases of avoidable MRSA Bacteraemia</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

PATIENT SAFETY

Hospital Acquired Infections

**Data source:** Infection Control Nurses

**KPI data collection sheets**

**National Definition applied:** Yes

<table>
<thead>
<tr>
<th>Infection Control Measure</th>
<th>MH: Upper Limit</th>
<th>CHS: Upper Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper Limit</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Cases of avoidable C.Difficile</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cases of avoidable MRSA Bacteraemia</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
## PATIENT EXPERIENCE

### Complaints

<table>
<thead>
<tr>
<th>Data source: Datix</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Definition applied: Only to K041-A Submissions to the Department of Health</td>
</tr>
</tbody>
</table>

### Complaints referred to the Parliamentary & Health Service Ombudsman

At year-end a total of 17 complaints have been referred to the Parliamentary and Health Service Ombudsman, compared to last year’s figure of five complaints referrals. Of the five referrals last year, only one was investigated. Of the 17 complaints referred during 2012/13 10 have not been investigated and we are awaiting notification as to whether the remaining seven will be investigated or not. One complaint is still under investigation from 2011/12 for Bedfordshire and Luton Mental Health

### Complaints closed within timescales

The % of Complaints Resolved within Agreed Timescales indicator is a measure of how well the complaints-handling process is operating within the organisation. The agreement of a timescale for the resolution of a complaint is identified in the NHS Complaints Regulations, but these do not stipulate a % target to be achieved. This indicator is not part of the Compliance Framework, or part of any other national performance framework. Nevertheless, SEPT’s Executive Team considers that commitments made to complainants should be adhered to and agreed several actions to expedite and monitor the process of complaints resolution. A new local indicator has been introduced during 2012/13 to monitor the number of complaints resolved within 30 working days of receipt.

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All SEPT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Formal Complaints Received</td>
<td>483</td>
<td>433</td>
</tr>
<tr>
<td>Number of complaints closed in period</td>
<td>237</td>
<td>505</td>
</tr>
<tr>
<td>Complaints resolved within agreed timescale</td>
<td>172</td>
<td>381</td>
</tr>
<tr>
<td>% Complaints resolved within agreed timescale</td>
<td>73%</td>
<td>75%</td>
</tr>
<tr>
<td>Complaints upheld/partially upheld</td>
<td>127</td>
<td>286</td>
</tr>
<tr>
<td>Number of complaints withdrawn</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Number of complaints open at year end</td>
<td>112</td>
<td>56</td>
</tr>
<tr>
<td><strong>SEPT % Resolved within agreed timescales</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>73%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Clinical practice, which includes 'unhappy with care' and 'unhappy with treatment', was the largest cause for complaint across the Trust, with a total of 201 out of 433 complaints. It should be noted that in some instances a patient may report being unhappy with their care and treatment, however the treatment/care provided may have been provided in the best interest of the patient.

These complaints have been further split by locality and service.
PATIENT EXPERIENCE

Compliments

Data source: Datix
National Definition applied: N/A

Compliments are received on a daily basis and logged accordingly. A compliment of the week has been placed in Trust Today for some months now to encourage staff to share compliments with their colleagues throughout the Trust. A dedicated area on the intranet captures the content of all compliments and enables staff to view the positive comments received about colleagues and their services.

This year the Trust has received 3654 compliments.

It should be noted that the 2011/12 outturn for compliments was reported in last year’s report as 3863, this has subsequently increased to 3894. This increase occurred as a result of migration of compliments data from legacy systems in Essex community health services to SEPT systems. Following completion of the 2011/12 quality accounts, an additional 31 compliments were received. These compliments were migrated to SEPT’s system and included within this year’s report.

<table>
<thead>
<tr>
<th>Compliments Received</th>
<th>2011/12 Outturn</th>
<th>2012/13 Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfordshire &amp; Luton MH</td>
<td>264</td>
<td>651</td>
</tr>
<tr>
<td>Bedfordshire CHS</td>
<td>981</td>
<td>1214</td>
</tr>
<tr>
<td>South Essex MH</td>
<td>312</td>
<td>424</td>
</tr>
<tr>
<td>South East Essex CHS</td>
<td>2208</td>
<td>960</td>
</tr>
<tr>
<td>West Essex CHS</td>
<td>129</td>
<td>334</td>
</tr>
<tr>
<td>Suffolk CHS</td>
<td>N/A</td>
<td>71</td>
</tr>
<tr>
<td>SEPT</td>
<td>3894</td>
<td>3654</td>
</tr>
</tbody>
</table>
Rate of Complaints and Compliments

**Data source:** SEPT systems (Datix, SystmOne and Daily Diary Sheets)
**National Definition applied:** N/A

A comparison of complaints and compliments as a rate per 1,000 patient contacts demonstrates that the rate of compliments in each locality was greater than the rate of complaints received during 2012/13.

### Service Area

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Rate of Complaints (per 1,000 contacts)</th>
<th>Rate of Compliments (per 1,000 contacts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfordshire &amp; Luton MH</td>
<td>0.73</td>
<td>3.41</td>
</tr>
<tr>
<td>Bedfordshire CHS</td>
<td>0.09</td>
<td>2.69</td>
</tr>
<tr>
<td>South Essex MH</td>
<td>0.97</td>
<td>2.53</td>
</tr>
<tr>
<td>South East Essex CHS</td>
<td>0.04</td>
<td>1.27</td>
</tr>
<tr>
<td>West Essex CHS</td>
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<td>0.93</td>
</tr>
<tr>
<td>Suffolk CHS</td>
<td>0.05</td>
<td>1.09</td>
</tr>
<tr>
<td><strong>SEPT</strong></td>
<td><strong>0.22</strong></td>
<td><strong>1.83</strong></td>
</tr>
</tbody>
</table>
PATIENT SAFETY

Data source: Safety Thermometer
National Definition applied: Yes

Safety Thermometer (Harm Free Care)

A monthly census is taken of patients in our care which meet the national criteria for Safety Thermometer to measure four areas of harm. Censuses are taken in over 100 teams covering adult and older people wards and community teams, but excluding specialist services, on a monthly basis.

The areas of harm are:- Category 2 / 3 / 4 Pressure Ulcers (acquired in care or outside our care), Falls within 72 hours, Catheter Urinary Tract Infection (UTI) or Venous Thrombo-Embolism (VTE).

The graph below show the percentage of patients that were visited or were an inpatient on the census date, who had not acquired any of the four harms whilst in SEPTs care. During 2012/13 SEPT successfully achieved above the 95% target.

A Harm Free Care Group has been established and the group review the information obtained through the Safety Thermometer to inform its work.

The Safety Thermometer will continue to be used in a number of areas during 2013/14 however SEPT is also looking forward to piloting a new safety thermometer tool specific to Mental Health Services.
In this section of the report a selection of Key Quality Indicators are presented to show performance for the localities of Bedfordshire, South East Essex and West Essex over the past 12 months and where possible up to the past 24 months.

**Smoking Cessation**

**CLINICAL EFFECTIVENESS**

Smoking Cessation targets are aimed at contributing to the reduction of the number of smokers within the population. Indicators can include the number of patients referred to Smoking Cessation Services, the number of patients who attend Smoking Cessation Services and the number of patients who actually quit smoking.

In West Essex the number of patients who stopped smoking was below target at the end of March 2013, however demonstrates an improvement on the 2011/12 outturn.

In Bedfordshire the smoking referral target for 2012/13 was 300 and after being below trajectory early in the year, the services were able to successfully deliver the target. However, throughout 2012/13, the conversion rate has consistently been below the 40% target, and whilst the March 2013 position is yet to be confirmed, SEPT deem it unlikely that the target will be reached.

South Essex Community Health Services do not provide a smoking cessation service as the function was returned to the commissioners in 2010/11 and is currently delivered by Public Health.

Data source: Public Health services & Smoking Cessation database [Online]

National definition applied: Yes
There are two types of breastfeeding measure used within community services. The first is breastfeeding coverage, which is the number of babies aged 6-8 weeks with breastfeeding status recorded. The second is breastfeeding prevalence, which is the number of babies being breastfed at the 6-8 week check.

In Bedfordshire both the coverage and prevalence targets have been achieved, however of most note is the prevalence target which has improved significantly compared with 2011/12 figures.

In South East Essex Community Health Services both the coverage and prevalence targets were achieved.

Data source: SystmOne
National definition applied: Yes
18 week referral to treatment performance measures the length of time in weeks between referral into the service and the start of treatment. This is an important measure as it describes the length of time patients have had to wait for treatment.

Bedfordshire Community Health Services achieved consistently high performance throughout 2012/13, demonstrating maintenance of the strong performance achieved in 2011/12.

During 2012/13 South East Essex demonstrated some minor declines in performance, however in the latter 7 months were able to maintain strong performance, consistently delivering above the 95% threshold.

Following the positive work undertaken in West Essex during 2011/12 to improve waiting times, the services were able to maintain this positive performance during 2012/13 delivering over 95% throughout the year. In addition, an ambitious piece of work to reduce waiting times in Musculoskeletal services was completed during 2012/13 which led to a reduction to 11 weeks and finally to 8 weeks by the end of the year.

**Data source:** SystmOne

**National definition applied:** Yes
### Seven Day Post Discharge Follow Up - Face to Face

#### PATIENT SAFETY

A national target applies for all inpatients discharged from hospital to receive a follow up from mental health services within seven days of discharge. The national indicator states that the follow up can be completed face to face or by telephone. In 2010/11 a quality improvement target was introduced by SEPT to ensure that 85% of patients received a face to face follow up, effectively reducing the number of telephone follow ups and improving the quality of care provided.

The initiative was introduced initially in Bedfordshire and Luton, however, extended to South Essex in 2011/12. In 2012/13 both areas have demonstrated continued delivery of the 85% target, evidencing continuation of this positive quality initiative.

**Data source:** SEPT Systems (Care Plus and IPM)

**National definition applied:** Yes
Monitoring of the number and nature of SIs, identification of learning and embedding learning back into clinical practice, is a key part of the Trust’s patient safety.

The Trust reported 58 serious incidents (SIs) in Mental Health Services in 2012/13 compared to 39 during 2011/12.

On initial review the significant increase in the number of serious incidents reported year on year (19) is in the main as a result of fall/fracture incidents (15). The Trust took a decision to report these incidents from February 2012 under the NPSA definition of long term harm.

Work is underway to identify an annual baseline for falls/fracture incidents that would have met serious incident reporting criteria in 2011/12 to enable monitoring of any variances year on year. The Trust wide Falls Group monitors trends, themes and actions taken from slip, trip and fall incidents to identify work streams in relation to falls reduction.

Additional falls equipment has been purchased by Trust and is being disseminated to relevant wards.

There has been a reduction in the number of unexpected deaths reported in 2012/13 compared to those reported in 2011/12.

It should be noted that the 2011/12 outturn for serious incidents was reported in last year’s report as 41, this has subsequently decreased to 39. This decrease occurred when the Trust was informed by Her Majesty’s Coroner that two unexpected deaths were due to natural causes.

Data source: Serious Incident Database

National definition applied: EoE and Midlands definition applied
Readmission rates have been used extensively in the past to conduct national reviews into health-check arrangements, and as part of CQC cross-checking arrangements.

The Board of Governors selected readmissions as a local indicator reported in 2010/11 that would be subjected to independent testing by the Audit Commission in order to provide independent assurance on the quality of data used to report performance. The Audit Commission confirmed that the systems in place were sound. Some improvements to record management systems and development of admission and discharge profiles by clinical staff were identified and have been taken forward. The Trust target is based on a benchmark from 2007, however the NHS benchmarking club released a benchmark report in 2012, which demonstrated that the average readmission rate for adult services was 10% and for Older Peoples was 5%. So whilst performance has been above SEPTs internal target, it is noted that performance compares positively to national averages.

During Q1 and Q2 2012/13 an increase in adult emergency readmission rates in Bedfordshire was noted by SEPT, as a result an audit was completed by the Clinical Director aimed at reviewing each readmission and identifying any trends or learning. The audit found that each re-admission had causes specific to the individual case and it was not possible to identify any overall trends or themes that could be a source of learning for the organisation. SEPT continues to routinely monitor emergency readmissions and any unusual trends are investigated as required.

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### Adult Psychiatric Readmissions within 28 Days

<table>
<thead>
<tr>
<th></th>
<th>2011/12 Outturn</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfordshire &amp; Luton MH</td>
<td>4.45%</td>
<td>11.38%</td>
<td>9.78%</td>
<td>9.52%</td>
<td>7.66%</td>
</tr>
<tr>
<td>South Essex MH</td>
<td>6.80%</td>
<td>4.93%</td>
<td>7.08%</td>
<td>2.54%</td>
<td>2.40%</td>
</tr>
<tr>
<td>SEPT</td>
<td>5.82%</td>
<td>8.41%</td>
<td>8.75%</td>
<td>7.16%</td>
<td>5.69%</td>
</tr>
<tr>
<td>Target</td>
<td>6.00%</td>
<td>6.00%</td>
<td>6.00%</td>
<td>6.00%</td>
<td>6.00%</td>
</tr>
<tr>
<td>NHS Benchmark Club</td>
<td>10.00%</td>
<td>10.00%</td>
<td>10.00%</td>
<td>10.00%</td>
<td>10.00%</td>
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<thead>
<tr>
<th></th>
<th>2011/12 Outturn</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfordshire &amp; Luton MH</td>
<td>1.35%</td>
<td>5.40%</td>
<td>2.70%</td>
<td>2.60%</td>
<td>6.70%</td>
</tr>
<tr>
<td>South Essex MH</td>
<td>3.92%</td>
<td>0.80%</td>
<td>1.90%</td>
<td>2.90%</td>
<td>3.60%</td>
</tr>
<tr>
<td>SEPT</td>
<td>3.68%</td>
<td>2.20%</td>
<td>2.20%</td>
<td>2.80%</td>
<td>4.70%</td>
</tr>
<tr>
<td>Target</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
<td>2.00%</td>
</tr>
<tr>
<td>NHS Benchmark Club</td>
<td>5.00%</td>
<td>5.00%</td>
<td>5.00%</td>
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### Elderly Psychiatric Readmissions Within 28 Days

<table>
<thead>
<tr>
<th></th>
<th>2011/12 Outturn</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedfordshire &amp; Luton MH</td>
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<td>11.38%</td>
<td>9.78%</td>
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<td>4.93%</td>
<td>7.08%</td>
<td>2.54%</td>
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</tr>
<tr>
<td>SEPT</td>
<td>5.82%</td>
<td>8.41%</td>
<td>8.75%</td>
<td>7.16%</td>
<td>5.69%</td>
</tr>
<tr>
<td>Target</td>
<td>6.00%</td>
<td>6.00%</td>
<td>6.00%</td>
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<tr>
<td>NHS Benchmark Club</td>
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<td>10.00%</td>
<td>10.00%</td>
<td>10.00%</td>
<td>10.00%</td>
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</tbody>
</table>
Section 3.4: Performance against key national priorities

In this section we have provided an overview of performance in 2012/13 against the key national targets and indicators relevant to SEPT’s services contained in Monitor’s (NHS FT regulator) Compliance Framework. Data for two indicators, Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay and Admissions to acute wards gatekept by Crisis Resolution Home Treatment Team, have previously been reported under the mandatory indicator section (2.6) of this report. SEPT is pleased to report that compliance has been achieved across all indicators throughout 2012/13 with the exception of Access to Healthcare for People with a Learning Disability, details of which can be found on page 49.

People having a formal review within 12 months

This indicator applies to adults who have been on the Care Programme Approach for at least 12 months. The target set by MONITOR of 95% provides tolerance for factors outside the control of the Trust which may prevent a review being completed for all patients every 12 months. Compliance has continually been achieved in both South Essex and Bedfordshire and Luton.

Early Intervention Services: New Psychosis Cases

The MONITOR compliance threshold is to achieve 95% of contracted new cases of psychosis. In total SEPT has to achieve 149 new cases of psychosis per year, and this was significantly over achieved in 2012/13 with a total of 188 new cases being identified.
This indicator is calculated as the number of DTOCs due to either NHS or Social Care related issues for both mental health and learning disability services. The target established by MONITOR is less than 7.5% of patients should be Delayed Transfers of Care.

**Delayed Transfers of Care (DTOCs)**

These indicators measure the waiting times for patients who have commenced treatment and for those still waiting for treatment on non-admitted consultant-led pathways. The maximum waiting time is 18 weeks and the target for those who’ve commenced treatment is 95% and for those still waiting is 92%. Both targets have been consistently achieved throughout 2012/13.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
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<td>Maximum time of 18 weeks from point of referral to treatment</td>
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<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Target (waited)</td>
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<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
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<tr>
<td>Maximum time of 18 weeks – patients on an incomplete pathway</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Target (waiting)</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
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</table>

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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<tbody>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Target (waited)</td>
<td>95%</td>
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<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Maximum time of 18 weeks – patients on an incomplete pathway</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Target (waiting)</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
</tr>
</tbody>
</table>
West Essex Time spent in A&E

The A&E Clinical Quality indicators are only relevant to the Urgent Care Service that is provided in West Essex. This indicator measures the total time patients spend in A&E, the target is 4 hours or less and the threshold is 95%.

Data Completeness: Patient Identifiers

This indicator measures the % completeness of the Mental Health Minimum Dataset for patient identifier data items. The target for 2012/13 has reduced to 97% from the target of 99% in 2011/12.

Data Completeness: Patient Outcomes

Compliance has been achieved for each of the data fields that contribute to this indicator. The target for which is 50%
Throughout 2012/13 compliance has been maintained above the 50% target in all community health service areas.

Data Completeness - Community Care Referral to Treatment information

Compliance has been maintained above the 50% target throughout 2012/13.

Data Completeness - Community Care Referral Information

All community health service areas have maintained compliance with this indicator throughout 2012/13.

Data Completeness - Community Treatment Activity Information

Data Completeness - Referral to Treatment (Community Health)

Data Completeness - Referral Information (Community Health)

Data Completeness - Treatment Activity Information (Community Health)
This indicator seeks to respond to the recommendations made in MENCAP’s ‘Death by Indifference’ report. Trusts will be assessed on their responses to six questions on a scale of 1 to 4:

1. Protocols / mechanisms are not in place
2. Protocols / mechanisms are in place but have not yet been implemented
3. Protocols / mechanisms are in place and partially implemented
4. Protocols / mechanisms are in place and fully implemented

<table>
<thead>
<tr>
<th>Key Requirements:</th>
<th>SEPT Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identifies and flags patients with learning disabilities to ensure that pathways of care are reasonably adjusted to meet the health needs of patients?</td>
<td>3</td>
</tr>
<tr>
<td>2. Readily available and comprehensible information to patients with learning disabilities about the following criteria: Treatment options (including health promotion) Complaints, procedures, and Appointments</td>
<td>4</td>
</tr>
<tr>
<td>3. Provides support for family carers, including the provision of information regarding learning disabilities, relevant legislation and carers’ rights?</td>
<td>3</td>
</tr>
<tr>
<td>4. Includes training on learning disability awareness, relevant legislation, human rights, communication technique in their staff development and/or induction programmes for all staff?</td>
<td>3</td>
</tr>
<tr>
<td>5. Encourages representatives of people with learning disabilities into relevant forums, which seek to incorporate their views and interest in planning and development of health services?</td>
<td>4</td>
</tr>
<tr>
<td>6. Regularly audits its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?</td>
<td>4</td>
</tr>
</tbody>
</table>

A self-assessment of compliance with the 6 criteria has identified the need to assure ourselves that protocols are fully implemented within all services provided, and with the complexity and range of services that the Trust provides this has not been possible this year. A task and finish group has been established and will be responsible for ensuring full compliance is achieved in 2013/14.
As I said at the beginning of this report, I am proud to present the quality achievements of SEPT. Thank you for taking the time to read them. Whilst this report is an annual reporting requirement, we hope that we have presented the information in an open and useful way to enable everyone to understand SEPT’s performance. This is an annual requirement and I would be delighted to receive any ideas from readers as to how this report could be made more interesting or useful in future years – please do contact me if you have any ideas.

We report progress with quality goals to our Board of Directors on a regular basis. These meetings are open to members of the public to attend and I would urge you to come along and hear for yourself how we are doing. There is also an opportunity for members of the public to ask any questions they may have, and I would welcome this involvement from you. We also report more locally focused issues at our Public Member meetings where again I would encourage people to come and talk to the staff and managers responsible for care in their area – I can assure you that you will be made very welcome!

If you have any questions or comments about this Quality Report or about any service provided by SEPT, please contact:
Andy Brogan
Executive Director of Clinical Governance and Quality
SEPT
Trust Head Office
The Lodge
The Chase
Wickford
Essex SS11 7XX
Email: andy.brogan@sept.nhs.uk
Telephone: 01268 739654
ANNEX 1 – Comments on our Quality Account

We sent our Quality Account to various external partners to seek their views on the content of the report. The responses received are outlined below for information – we thank them for taking the time to consider the information and to provide their comments.

Bedfordshire and Luton Clinical Commissioning Groups
(Bedfordshire and Luton) - dated 24 May 2013

Statement from Bedfordshire and Luton Clinical Commissioning Groups to South Essex Partnership University NHS Foundation Trust Quality Account 2012 – 2013

Bedfordshire and Luton Clinical Commissioning Groups (CCGs) have received the Quality Account 2012/2013 from South Essex Partnership University NHS Foundation Trust (SEPT). The Quality Account was shared with Bedfordshire and Luton CCGs, and reviewed at the Patient Safety and Quality Committee and at Board level as part of developing our assurance statement.

The statement relates to the mental health partnership commissioned work covering Bedfordshire and Luton and also for the community services commissioned work in Bedfordshire. Bedfordshire and Luton CCGs acknowledge that SEPT cover a wide area but would like to have more local detail, with outcome based information to enable assessment of achievement within specific services for Bedfordshire and Luton.

Luton and Bedfordshire CCGs look forward to working with SEPT on local agendas including the development of service provision. Bedfordshire CCG values your continuing cooperation in the review of the Community Health Service looking at numbers of staff, skill mix and impact of the quality of service.

We have reviewed the information provided within the Quality Account and checked the accuracy of data submitted as part of SEPT’s contractual obligation. All data provided corresponds with data used as part of the ongoing contract monitoring process. This Account was easy to read and is well set out but is process driven with a lack of measurable outcomes.

Bedfordshire and Luton CCGs note that SEPT Mental Health achieved 91% of 2012/13 CQUIN (Commissioning for Quality and Innovation) and SEPT Community Health Services achieved 85% of the 2012/13 CQUIN.

Bedfordshire and Luton CCGs acknowledge that SEPT has unconditional registration with the CQC (Care Quality Commission).

The Francis Report and ongoing actions will form a key part of our assurance monitoring in 2013/14 and it is encouraging to see that Patrick Geoghegan, Chief Executive, is supportive in aiming to implement the recommendations.

Bedfordshire and Luton CCGs support SEPT’s rationale and indicators for 2013/14 and value continuing cooperation in working with SEPT to achieve good quality outcomes for the people of Bedfordshire and Luton.
NHS CPR CCG commentary on South Essex Partnership University NHS Foundation Trust (SEPT)

NHS Castle Point & Rochford CCG welcomes the opportunity to comment on the fourth annual Quality Account of South Essex Partnership University NHS Foundation Trust (SEPT), as a primary commissioner of mental health services across South Essex and community services in south East Essex. It is to be noted that this response is made on behalf of the four South Essex CCGs. Following the dissolution of the Primary Care Trusts from 1 April 2013 any monitoring and assurances for the quality of services will be undertaken by NHS CPR CCG and their GP colleagues.

To the best of NHS CPR CCG’s knowledge, the information contained in the Account is accurate and reflects a true and balanced description of the quality of provision of services.

NHS CPR CCG recognises the commitment of the Trust to ensure that patients receive safe and effective services with a positive experience in 2013/14, which they acknowledge will be a challenging year. It was also pleasing to see that quality was the key driver in each of the four strategic priorities.

NHS CPR CCG notes the strong priorities for patient safety and clinical effectiveness for 2013/14. They include improving the competencies in monitoring, measuring and interpretation of vital signs within elderly mental health inpatient areas by training staff and implementing competencies to ensure a standardised approach to facilitate earlier detection in the deteriorating patient. To reduce the number of avoidable grade 2, 3 & 4 pressure ulcers. This was in recognition that whilst they did not achieve zero tolerance in 2012/13 significant progress was made in reducing the number of 3 and 4 avoidable pressure ulcers, achieving 95% of their ambition.

The Trust will also be striving to reduce the level of avoidable falls resulting in harm by considering patients individual needs and the different environmental factors. This has been discussed with commissioners and plans have been agreed. A further priority will be to provide better support for carers by mental health and community health services by increasing the number of clinical staff trained to under the 3R’s. The final priorities relate to patient experience and involve the promotion of continuous reflection and improvement on practice through regular patient feedback mechanisms and the consolidation of the use of the Friends & Family Test in services across the organisation to build on the 2011/12 Quality Account Priority. NHS CPR CCG will be seeking assurance during 2013/14 with regard to these priorities through the Clinical Quality Review Groups providing support where appropriate.

NHS CPR CCG notes that the Trust recognises the challenge in achieving the 2013/14 CQUIN Programme. The priorities in South Essex are to improve community services for patients with learning disabilities to address the issues raised in the Michael Report and improve access to mental health services for patients in crisis.

NHS CPR CCG notes particularly the Trust’s focus on new services/service enhancements where the outcome is reduced dependence upon A&E acute hospital services for those service users with a mental health need. NHS CPR CCG will be seeking assurances that community teams will be strengthened to manage this.

NHS CPR CCG is particularly pleased to note the Trust’s commitment to undertake more in-depth work on the recommendations from the Winterbourne View and Francis Reports which is of great significance in the current climate within the NHS.
NHS CPR CCG was pleased to note the Trust’s participation with the national clinical audit programme and national confidential enquiries, and will monitor during 2013/14 that actions have been fully implemented to enhance patient safety, experience and for quality of care.

NHS CPR CCG congratulates the Trust in its commitment to ongoing research and development with its collaboration in establishing a Health and Wellbeing Academy to oversee research opportunities within the Trust.

NHS CPR CCG noted the Trust’s commitment to implementing the CQUINs for 2012/13, particularly the introduction of Personal Health Plans within South East Essex Community Services and that this project exceeded its targets. Other areas for recognition included a prescribing scheme which supported nurses, pharmacists and GP’s to achieve best practice in prescribing anti-psychotic medication across mental health services in South Essex and the implementation of the patient revolution scheme for South Essex CAMHs.

The Trust is registered with the CQC and its current registration is registered without conditions. There have been six routine compliance reviews undertaken by the CQC for facilities in South Essex. Two minor concerns were raised and NHS CPR CCG have sought assurance that actions have been put in place to address these.

NHS CPR CCG notes the Trust’s overall progress against the quality, patient safety and clinical effectiveness priorities for 2012/13, and specifically for South Essex:

- establishment of a step up/step down in-patient facility aimed at preventing admission and facilitating discharge from acute hospital beds of people with dementia in South Essex Mental Health Services
- Brockfield House (forensic mental health in-patient services) was ranked third in the country following a peer review

NHS CPR CCG will continue to support SEPT in monitoring its compliance with the statutory requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards to ensure that vulnerable adults are supported in making decisions relating to their care and treatment.

NHS CPR CCG continues to meet with SEPT on a monthly basis to gain assurance that quality, patient safety and experience is reported and monitored. Assurances on the quality of service provision will be monitored through a programme of announced and unannounced visits to strengthen quality assurance processes and to observe in real time the delivery of patient care. In our role as commissioners supported by our GP colleagues and the Quality Support Team assurances will continue to be sought.

NHS CPR CCG is fully supportive of all the priorities identified by SEPT in taking forward the patient safety, effectiveness, experience and involvement agenda and looks forward to working in partnership with the Trust in the forthcoming year.

**West Essex Clinical Commissioning Group**

**Statement of Endorsement**

West Essex Clinical Commissioning Group, as one of the commissioning organisations for SEPT, has been involved in reviewing the content of this Quality Account, ensuring that it reflects accurately the quality, safety and effectiveness of services provided. SEPT has also consulted with patient and public groups, staff and statutory bodies, taking into account their opinions.

The priorities and performance illustrated within the account for this year and last year accurately reflect and support both national and local priorities. West Essex Clinical Commissioning Group is pleased to endorse the publication of this account.

Siobhan Jordan
**Director of Nursing & Quality**
**West Essex Clinical Commissioning Group.**
Statement on SEPT’s draft Quality Account 2012/13

During 2012/2013 the Bedford Borough Council’s Adult Services and Health Overview and Scrutiny Committee invited SEPT, as providers of Community Health Services in Bedford Borough, to one meeting to discuss those services and a review of community beds.

At the Committee’s meeting held on 21 May 2013, the Committee considered SEPT’s draft Quality Account for 2102/2013. The Committee agreed that the priorities matched those of the public and that patients and the public had been involved in the production of the Quality Account.

In addition the Committee made the following comments:-

- The Committee welcomes and supports the successful joint working with Bedford Borough Council on work to prevent delayed discharges in Bedford
- The Committee is pleased to note that waiting times are being reduced for memory assessments
- The Committee very strongly supports SEPT’s work to listen to families and carers
- The presentational layout of the information within the draft Quality Account is slightly confusing and needs to include a separate geographical focus on all services in an individual area
- There is no reference to looked after children

(NOTE: Councillor Charles had disclosed a disclosable pecuniary interest in this item being a Non-Executive Director of SEPT and left the meeting during its consideration)


South Essex Partnership University NHS Foundation Trust Quality Account 2012-13

Comments from Luton Borough Council Scrutiny: Health and Social Care Review Group

The Luton Scrutiny: Health and Social Care Review Group (HSCRG) welcomes the opportunity to comment on South Essex Partnership University NHS Foundation Trust’s (SEPT) Quality Account 2012-13 and their quality priorities for 2013-14.

HSCRG is grateful for SEPT’s commitment to engage with the Council’s health overview and scrutiny process. Senior officers, including the Chief Executive, have attended a number of committee meetings during the year, along with senior officers from Luton Clinical Commissioning Group (CCG), to provide information on mental health services in Luton. HSCRG reviewed how those services were jointly funded with Bedfordshire, leading to concerns about disproportionally, a matter yet to be resolved.

SEPT’s Director of Mental Health Bedfordshire and Luton is also involved with the local officer network for health and social care and was party to an officer group supporting a scrutiny task & finish group reviewing discharge from hospital.

Members are content with SEPT’s overall reported achievement against its targets in 2012/13, and note the areas for improvement. They note particularly the reduction in complaints across the Trust from 483 in 2011-12 to 433 in 2012-13, and the significantly higher number of compliments received in Bedfordshire and Luton mental health (651 compared with 264) for the same periods, a good gauge of patients’ experience.

However, Members would prefer to see more Luton specific performance reporting in mental health, although conscious of the difficulty involved, given SEPT’s wide area of responsibility.

In conclusion, Members of the HSCRG are content with SEPT’s overall reported achievement against its targets in 2012/13 and support SEPT’s stated improvement priorities for 2013/14, focusing on safety, patients’ experience and effectiveness. They look forward to see the service continuing to meet the mental
health needs of the people of Luton, achieving positive outcomes in the forthcoming year and beyond, and maintaining its engagement with health overview and scrutiny.

Central Bedfordshire Health Overview and Scrutiny Committee - dated 23 May 2013

I can confirm there is no response to the Quality Account from Central Beds Health OSC.

Suffolk Health Scrutiny Committee - dated 7 May 2013

Please find below a statement for this year’s Quality Account, which was agreed by the Chairman and Vice-Chairman on behalf of the Suffolk Health Scrutiny Committee, prior to the county council elections which took place last week:

Due to the County Council elections this year, the Suffolk Health Scrutiny Committee was unable to meet to discuss the content of this year’s Quality Accounts during the timescales set by the Department of Health. In previous years, the Committee has not commented individually on providers Quality Accounts, as it has taken the view that it would be appropriate for Suffolk LINk to consider the documents and comment accordingly. The Committee is aware that the dedicated Quality Accounts Working Group established by Suffolk LINk has continued its work on Quality Accounts for 2012/13 and will be providing its views to the Healthwatch Board for formal ratification and submission to Suffolk providers.

The Committee has, in the main, been happy with the engagement of local healthcare providers in the work of the Committee over the past year, and is keen that these relationships continue to develop to ensure the best possible health services for the people of Suffolk. Consideration will be given to discussions with providers about how they are performing against their agreed targets, and potential scrutiny issues raised, when the Committee reconvenes in summer 2013.

Healthwatch Essex - dated 21st May 2013

Statement from Healthwatch Essex for Quality Account report 2012-2013

We recognise that Quality Account reports are a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public about the quality of service they provide. We fully support these reports as a means for providers to review their services in an open and honest manner, acknowledging where services are working well and where there is room for improvement.

We welcome the opportunity to provide a patient and public perspective on the Quality Accounts. As a newly-established organisation (we took on statutory responsibility on 1st April 2013), we are not in a position to comment retrospectively on the findings of the past year. We will, however, cooperate fully in the future production of these reports. We are an organisation which intends to provide comment rooted in evidence – be it ‘soft’ intelligence or more extensive, quantitative data. Following the Francis Report, we believe there is a significant challenge and opportunity for the whole health and social care system to look at how evidence relating to patient experience can be set on an equal footing with standard NHS data about performance and quality.

We share the aspiration of making the NHS more patient-focussed and placing the patient’s experience at the heart of health and social care. An essential part of this is making sure the collective voice of the people of Essex is heard and given due regard, particularly when decisions are being made about quality of care and changes to service delivery and provision.

Our wish is therefore that Healthwatch Essex works with its partners in the health and social care sector to engage patients and service users effectively and to ensure that their views are listened to and acted upon.

We look forward to working together in the production of Quality Accounts in the coming year and making sure that the voice and experience of patients and the public form an integral part of these documents. At a
time when the NHS is facing great change and financial challenge, patient experience and quality of care are more important than ever, and we welcome the opportunity to help shape the NHS of the 21st century.

Healthwatch Luton - dated 29 May 2013

South Essex Partnership University NHS Foundation Trust Quality Account 2012/13
Comments from Healthwatch Luton

It is extremely positive to see the new developments and changes that have taken place throughout the previous year and we are pleased to see SEPT developing new models and structures to ensure that patients and service users are receiving the quality of care that they deserve.

Last year we commented on the lack of localised data outlined in the Quality Accounts and it is good to see the inclusion of more localised information this year as SEPT provides a range of services through the region. Whilst this localised reporting is a step in the right direction, we consider there are some areas where this can be expanded upon to provide greater clarity.

It would be extremely beneficial if there could be further localised information detailed about the patient experience complaints data and serious incidents. For example, it has been mentioned that 17 complaints have been referred to the Parliamentary and Health Ombudsman and it would greatly assist us to understand how many stemmed from service users in Luton. Similarly, while there is a breakdown of the number of Serious Incidents by Locality, there is no additional information to outline what these entail. If information could be included to demonstrate the nature of serious incidents that have occurred in Luton, it will provide an opportunity for Healthwatch Luton and local stakeholders to further understand the activities and statistics specifically for Luton and will also provide an additional level of transparency to an already open and forthcoming organisation.

SEPT have included details of patient experience and staff surveys that provide valuable insight however it would be a positive step forward to also include survey results taken from relatives and carers of patients. We would hope that this can be considered for inclusion in future Quality Accounts.

Healthwatch Luton would like to commend SEPT for recognising the importance of providing carer awareness training. We would like to see this to continue to grow in the coming year and are happy to assist with this positive initiative.

It is clear that SEPT are committed to providing a high quality of services as evidenced by the positive performance against a range of national targets. There are areas that are in need of improvement including patient accidents and access to healthcare for people with learning disabilities. These have been identified as priorities for the coming year and we look forward to working with SEPT around these priorities.


SEPT Governors were invited to review the draft Quality Account for 2012/13 and feedback comments at two meetings arranged for this purpose on 6 May 2013. A number of Governors from across the Trust constituencies attended these meetings and the statement below is based on their comments and the additional emailed comments sent to the Lead Governor.

We have appreciated the keenness of the Trust Board to engage with them in all processes related to quality in the Trust, including our invitation to attend the Trust stakeholder events alongside service users and their carers, members of staff and senior staff from Local Authorities and Clinical Commissioning Groups, when time was spent considering the priorities for the coming year. Governors were also involved in meetings with the public and members across the Trust’s constituencies in Bedfordshire and Essex where sessions focused on identifying what activities the Trust should start, carry on and stop doing to understand what quality service looks like.

Governors believe that the strategic priorities are an excellent starting point for identifying the 2013/14 quality priorities, and in particular:
are pleased to see the inclusion of a focus on carer support as this has been something Governors has raised for the attention of the Board during the year;

appreciate there is focus on improvement to service user experience and involvement;

note that the Trust is starting to highlight priorities relating to quality improvements in community services as well as the interface between mental health and community services that is now possible as an outcome of the acquisition of community services during 2011/12;

have requested sight of the results of the Mystery Shopper Survey for the year, and what lessons are learned from this important ongoing piece of work;

are keen that patients contribute to and agree their care plan, and are therefore pleased to note the work planned to improve care plans electronic records which should contribute to an improved handover process;

are seeking an improvement in the completion of mandatory training;

believe that the high percentage of complaints which are upheld or partially upheld demonstrates an open culture within the Trust where mistakes are acknowledged.

We look forward to receiving the usual high standard of reports in relation to these quality priorities and also wish to express our appreciation for the regular updating of progress with improvement goals via reports in Board of Directors and Council of Governors meetings where there has always been a very visible presence of Directors willing and able to answer questions raised by us and other attendees.

Governors believe that it is essential to the success of SEPT that the Trust has strong leadership at all levels, and we look forward to working with the new Chief Executive and the Executive Directors for Bedfordshire, Essex and Suffolk services. We are particularly pleased at the high level of commitment shown by the Non-Executive Directors. We appreciate that Lorraine, as Chair, and Patrick, as the outgoing CEO, have made themselves available whenever possible to provide assurance and advice to Governors.

We feel that the Quality Account is an open and honest commentary on what has occurred in the last year and are pleased and reassured to see that this reflects quality services within community as well as mental health and learning disability services. We note that the number of complaints (particularly in Bedfordshire and Luton Mental Health) has risen significantly and that, although the severe harm percentage is reducing, it is still higher than the national average for all NHS and for all Mental Health Trusts. Whilst recognising that there can be a number of reasons for this (including better reporting), this is an area that Governors will be monitoring during the coming year.

Although we understand that within the Quality Account there are statutory statements and so some elements cannot change, we are pleased to note that the report is now more accessible and understandable, and will monitor that this approach continues during the coming year.

SEPT Governors have always enjoyed a good working relationship with the Board and SEPT staff and look forward to undertaking the enhanced role required under the Health and Social Care Act 2012. We consider the opportunity to comment on this Quality Account is an important link between the Board and the service users, providing as it does another chance publicly to assure the community which we serve that quality is at the top of the priorities for our Trust.
The Directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations 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) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;
- the content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to June 2013
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013
  - Feedback from the commissioners dated 24 May and 12 June 2013
  - Feedback from governors dated 8 May 2013 and 19 June 2013
  - Feedback from Local Healthwatch organisations dated 21 May and 29 May 2013
  - The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for period April 2012 to March 2013, received by the Board of Directors on 24 April 2013
  - The [latest] national patient survey 2012 received by the Board of Directors 27 September 2012
  - The [latest] national staff survey 2012 received by the Board of Directors March 2013
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated 20 June 2013
  - CQC quality and risk profiles dated March 2013
- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board:

NB: sign and date in any colour ink except black

...19 June 2013……Date………………………………………………Chairman

...19 June 2013……Date………………………………………………Chief Executive
We have been engaged by the Council of Governors of South Essex Partnership University NHS Foundation Trust to perform an independent assurance engagement in respect of South Essex Partnership University NHS Foundation Trust’s Quality Report for the year ended 31 March 2013 (the “Quality Report”) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:
► 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within 7 days of discharge from hospital (reported on page 23); and
► Admissions to inpatient services had access to crisis resolution home treatment teams (reported on page 24).

We refer to these national priority indicators collectively as the “indicators”.

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 issued by Monitor.
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
► the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
► the Quality Report is not consistent in all material respects with the sources specified below; and
► the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions. We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents listed below:
► Board minutes for the period April 2012 to June 2013;
► papers relating to Quality reported to the Board over the period April 2012 to June 2013;
► feedback from the Commissioners dated 24/05/2013 and 12/06/2013;
► feedback from local Healthwatch organisations dated 21/05/2013 and 29/05/2013;
► the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for period April 2012 to March 2013, received by the Board of Directors on 24/04/2013
► the latest national patient survey 2012 received by the Board of Directors 27/09/2012
► the latest national staff survey dated received by the Board in March 2013;
► Care Quality Commission quality and risk profiles dated March 2013;
► the Head of Internal Audit’s annual opinion over the trust’s control environment dated 21/05/2013; and
► any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the “documents”). Our responsibilities do not extend to any other information.
We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of South Essex Partnership University NHS Foundation Trust as a body, to assist the Council of Governors in reporting South Essex Partnership University NHS Foundation Trust’s quality agenda, performance and activities.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and South Essex Partnership University NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

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

► evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
► making enquiries of management;
► testing key management controls;
► limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
► comparing the content requirements of the **NHS Foundation Trust Annual Reporting Manual** to the categories reported in the Quality Report;
► reading the documents.

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

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the **NHS Foundation Trust Annual Reporting Manual**.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by South Essex Partnership University NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

► the Quality Report is not prepared in all material respects in line with the criteria set out in the **NHS Foundation Trust Annual Reporting Manual**;

► the Quality Report is not consistent in all material respects with the sources specified above; and

► the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the **NHS Foundation Trust Annual Reporting Manual**.

**Ernst & Young**

Ernst & Young LLP Cambridge 20 June 2013
<table>
<thead>
<tr>
<th><strong>GLOSSARY</strong></th>
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<tbody>
<tr>
<td><strong>BLPT</strong></td>
<td>Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust</td>
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<td><strong>BNF</strong></td>
<td>British National Formulary</td>
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<td><strong>CAMHS</strong></td>
<td>Child and Adolescent Mental Health Service</td>
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<td><strong>CIPs</strong></td>
<td>Cost Improvement and Income Generation Plan</td>
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<td><strong>CCG</strong></td>
<td>Clinical Commissioning Group</td>
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<td><strong>CPA</strong></td>
<td>Care Programme Approach</td>
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<td><strong>CQC</strong></td>
<td>Care Quality Commission</td>
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<td><strong>CPN</strong></td>
<td>Community Psychiatric Nurse</td>
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<tr>
<td><strong>CQUIN</strong></td>
<td>Commission for Quality and Innovation. This is shorthand for quality improvements agreed during the annual contracting negotiations between SEPT and its health commissioners.</td>
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<td><strong>DoH</strong></td>
<td>Department of Health</td>
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<td><strong>DTOC</strong></td>
<td>Delayed Transfer of Care</td>
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<td><strong>FT</strong></td>
<td>Foundation Trust</td>
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<td><strong>GCS</strong></td>
<td>Glasgow Coma Scale</td>
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<td><strong>HOSC</strong></td>
<td>Health Overview and Scrutiny Committee</td>
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<td><strong>IAPT</strong></td>
<td>Improved Access to Psychological Therapies</td>
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<td><strong>IT</strong></td>
<td>Information Technology</td>
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<tr>
<td><strong>KPI</strong></td>
<td>Key Performance Indicators</td>
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<tr>
<td><strong>Lean Working</strong></td>
<td>A process developed to help services evaluate their effectiveness and improve quality, care pathways and cost effectiveness.</td>
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<td><strong>LTC</strong></td>
<td>Long Term Condition</td>
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<tr>
<td><strong>MDT</strong></td>
<td>Multi-Disciplinary Team</td>
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<tr>
<td><strong>MRSA</strong></td>
<td>Type of bacterial infection that is resistant to a number of widely used antibiotics</td>
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<tr>
<td><strong>NCB</strong></td>
<td>National NHS Commissioning Board</td>
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<td><strong>NHS</strong></td>
<td>National Health Service</td>
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<td><strong>NICE</strong></td>
<td>National Institute for Clinical Excellence</td>
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<td><strong>NPSA</strong></td>
<td>National Patient Safety Agency</td>
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<td><strong>NRLS</strong></td>
<td>National Reporting and Learning System</td>
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<td><strong>NRES</strong></td>
<td>National Research Ethics Service</td>
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<td><strong>NSF</strong></td>
<td>National Service Framework</td>
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<tr>
<td><strong>OLM</strong></td>
<td>Oracle Learning Management – the Trust’s on-line training programme</td>
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<tr>
<td><strong>PASCOM</strong></td>
<td>Podiatric Audit surgery and Clinical Outcome Measurement</td>
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<tr>
<td><strong>PHP</strong></td>
<td>Personal Health Plan</td>
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<tr>
<td><strong>PICU</strong></td>
<td>Psychiatric Intensive Care Unit</td>
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<td><strong>POMH</strong></td>
<td>Prescribing Observatory for Mental Health</td>
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<tr>
<td><strong>PRN</strong></td>
<td>A shortened form of the Latin phrase <em>pro re nata</em>, which translates roughly as ‘as the thing is needed – means a medication that should be taken only as needed</td>
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<tr>
<td><strong>Quality Accounts</strong></td>
<td>All NHS provider organisations are required to produce a report on progress against quality targets in the preceding year and the indicators it wishes to use for the coming year.</td>
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<tr>
<td><strong>QIPP</strong></td>
<td>Quality Innovation Productivity and Prevention</td>
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<td><strong>RCA</strong></td>
<td>Root Cause Analysis</td>
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<tr>
<td><strong>SPC</strong></td>
<td>Summary of Product Characteristics (relating to BNF/pharmaceutical products)</td>
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<tr>
<td><strong>SEPT</strong></td>
<td>South Essex Partnership University NHS Foundation Trust</td>
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<tr>
<td><strong>SI</strong></td>
<td>Serious Incident</td>
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<td><strong>SIGN</strong></td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<tr>
<td><strong>UTI</strong></td>
<td>Urinary Tract Infection</td>
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<tr>
<td><strong>VTE</strong></td>
<td>Venous Thromboembolism – blood clots</td>
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