North East London NHS
NHS Foundation Trust

Annual Report and Accounts 2017-18




Best care by the best people

North East London NHS Foundation Trust Annual Report and Accounts 2017-18

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of the National Health Service Act 2006

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CHAIR'S STATEMENT

Welcome to the NELFT Annual Report for 2017/18. This document sets out all details of our performance, finances and governance arrangements for the previous financial year. As well as meeting our requirements in relation to openness and transparency, it also provides the opportunity to reflect on our progress as an NHS foundation trust delivering mental health and community health services to our local communities.

As you will know from the extensive coverage nationally, 2017/18 has been a challenging year for the NHS as a whole with unprecedented demands on services and significant financial pressures. This is all set against the challenge of delivering the priorities set out in the Five Year Forward View requiring even greater collaboration and integration across health economies.

As Chair of NELFT, I am very pleased to report that within this challenging environment, the Trust continues to improve in a number of key areas that translate to both a better patient experience and greater value for the tax payer. Our journey of improvement has many highlights when set against a number of national measures as highlighted below.

Due to the hard work and commitment of our staff we have been rated as 'Good' by our regulator, the Care Quality Commission (CQC), a marked improvement from their previous rating of 'Requires Improvement.' Our child and adolescent mental health inpatient service at Brookside has been rated as 'Outstanding', a remarkable demonstration of service led improvements given this service was rated 'Inadequate' just 18 months before.

In addition to improving our CQC rating we have also managed to maintain financial stability and a positive governance rating. All of this combined should assure our patients, staff and partners that we are an organisation delivering high quality care with upper quartile productivity that demonstrates continual improvement.

I know these achievements would not have been possible without strong leadership and the contribution of many. In particular, I wish to thank our executive management team, the wider Trust Board and senior leaders across the Trust. The support from all of our staff has been magnificent and coupled with that of our Council of Governors, partners and commissioners across North East London, Essex and Kent has been invaluable in helping us to deliver and sustain the improvements we have made.

I know the pressures on the NHS both locally and nationally will continue into the future and we will need to respond to these in a flexible way, supporting the integration agenda and ensuring that services are delivered to meet the needs of the whole person for the whole of their needs. This work includes minimising duplication and taking into account a patient's physical health, mental health and social care needs. We are in a strong position as a Trust to share innovations, collaborate with partners and drive up the quality of care in our local health economies. I am looking forward to the coming year and finding out what else it is possible for us to achieve, both as a Trust, and within our wider system role.

Joseph Fielder
Chair
22 May 2018

PERFORMANCE REPORT

The performance report includes an overview of the organisation, its purpose, key risks and performance during the year 2017/18, including an analysis of performance delivery. Full details in relation to performance are found in the Quality Report.

Performance Report – Overview

The service portfolio that constitutes NELFT has changed in this financial year with the acquisition of Kent and Medway Emotional Health and Wellbeing services for young people and all age Eating Disorder services across the same localities. These services now complement the London provision of community and mental health services and the Essex provision of community health services for the population in the South West of the county and Emotional Health and Wellbeing services for young people across the whole of Essex. The new services in Kent and Medway increases our geographic footprint significantly and enables us to support local communities with the implementation of new service models to improve care.

The anticipated financial and performance challenge of the year manifested itself with little surprise and our contracted agreements required every bit of our experience and resource to deliver. As well as delivering on our contractual targets our focus was on continuing to drive up the quality of what we do. We were able to deliver all of our contractual obligations with all of our commissioners within the financial envelope that we had planned for the year. Importantly all of our business was delivered within the standards expected or as specified in our contracts with commissioners.

The year was focused on our quality improvement journey following the disappointment of the previous year's CQC rating. Our comprehensive review by the CQC took place in late 2017 and NELFT is now rated as 'Good' overall whilst our Brookside services have completed the unprecedented journey from 'Inadequate' to 'Outstanding'. This revised rating demonstrates formal evidence of consistent progress in our journey to be the best and we continue to enjoy success in many specific areas of practice and performance. This was a year in which there were numerous national awards for services, individuals and teams within NELFT and we remain rightly proud of the progress that we are continuing to make.

NELFT services consistently perform to the very best benchmarks nationally and our friends and family tests reliably return favourable views from patients and carers where between 90 and 95% would recommend our services to their friends and family. This is a very high benchmark to maintain but it is consistent and supports improvements in our staff survey in which our response rate rose to 63%, benchmarking amongst the highest returns nationally. Notably some responses improved as much as 12 percentage points from the prior year and - whilst we should always acknowledge that we have more work to do - this is consistent objective evidence that NELFT is an organisation on a positive trajectory. Most critically NELFT is delivering this performance within a market in which the average performance indicators for comparable organisations are declining.

Our investment of time and commitment to our Quality Improvement (QI) Programme seems to have motivated a major cohort of our workforce and is generating huge energy across the Trust. The programme has only been in operation for 18 months and has already engaged more than 4000 of our workforce in different ways. Importantly it is becoming an embedded characteristic of the organisation and its culture, with a large number of QI projects being delivered by our staff.

The success of NELFT continues to attract the attention of other organisations seeking to learn. Areas of particular interest include our mental health acute care pathway, our Open Dialogue programme, our unique professional training programmes, our approach to agile working, our support to care homes and our use of technology to support young people to name but a few. Our QI programme is an important part of our commitment to our values as an organisation. It is equally

important in finding new ways to deliver care closer to home on the basis of patients' preferences. We anticipate this approach will continue to evolve as a successful model of care which NELFT will seek develop into the future consistent with the approach described in the Five Year Forward View.

Our financial challenge was always expected to be high and despite that being the case we have operated in accordance with our plans and the Trust has met its control total. For the financial year 2017/18 the total income was £370,897k and all aspects of our financial performance remained within expected margins. Quality performance metrics with the CQC framework and other governance considerations that contribute to our Single Operating Framework (SOF) were also delivered on plan. The SOF serves as the official rating framework for our regulator NHS Improvement. They have recently undertaken an assessment of our position and have segmented NELFT as a '1'. This segmentation denotes an organisation without need of official support from the centre and therefore one of the higher performers. This is perhaps the final piece of evidence demonstrating the improvement journey that NELFT has delivered during this year.

There have been accolades throughout the year and as well as a number of awards for the work that we do, the systems that we have developed and the services that we operate within the organisation. We have seen numerous publications citing our services as areas of good practice and we continue to focus on innovation and new ways of working to deliver national policy such as the Five Year Forward View. Our workforce initiatives to reduce our dependence on buildings and offices and optimise the money we spend on clinical services have made great progress. We have a growing number of staff who are working to our agile agenda with over 4,000 devices rolled out to support this innovation across the organisation.

Recruitment and retention of staff is without doubt one of the biggest challenges that we face. This is reflected in the wider public service market nationally but we have nonetheless seen continued improvement over the last year. Our performance indicators have improved significantly and our agency costs continue to reduce with a reduction in excess of 30% over the last two years. Work on health and wellbeing is also paying dividends and we have seen a consistent decline in sickness rates across the organisation. We have worked hard with NHSI over time to meet these challenging targets and NELFT is now quoted as a place of good practice in this arena.

We have invested significantly in health and wellbeing of our workforce and we are actively encouraging a healthy work life balance through the agility and flexibility agenda. This has been recognised in the engagement with the NHS Staff Survey and the uptake of activities across the Trust such as Staff Health and Wellbeing Week, local wellbeing activities and more opportunities for staff to connect with local leadership teams. We know that having an engaged, healthy workforce who feel valued is key to the delivery of high quality patient care and improves outcomes for patients.

Information about environmental matters are included in the Annual Governance Statement. Information about social, community, anti-bribery and human rights issues, including information about the relevant Trust policies, and the effectiveness of these policies is included in the Annual Governance Statement.

In March 2014 the Trust Board supported and approved the development of a Sustainability and Environmental Management Policy. Along with the Sustainability Development Management Plan (SDMP) this enables the Trust to focus and embed the sustainability agenda across its activities and assist the NHS in meeting its carbon reduction target in line with the NHS Carbon Reduction Strategy. The Policy has been reviewed and is being updated to reflect the Trust's progress and future sustainability plans.

The full account of our financial performance and all other accountability measurements are reported in detail within the body of this document with a guide to location in the contents table.

NHS Improvement's Single Oversight Framework

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

- Quality of Care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support and '1' reflects providers with maximum autonomy. NELFT has been placed in to segment '1'. This segmentation information is the Trust's position as at 31 March 2018. NHS Improvement has taken no enforcement action against the Trust. The detail of the Trust's financial metric scoring can be found below:

Area	Metric	2017/18 Q3 Score	2017/18 Q4 Score
Financial Sustainability	Capital service capacity	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	2	1
Financial controls	Distance from financial plan	1	1
	Agency spend	1	2
Overall scoring		**1**	**1**

Accounting Policies and Going Concern

The accounts were prepared under Trust Accounting Policies as approved by the Audit Committee which are in line with Foundation Trust accounting guidance as appropriate. They were prepared in line with IFRS as relevant to the NHS and as directed by HM Treasury and Monitor.

The Board is mindful of its duty to ensure the Trust is financially stable, not just for one year but over the medium term, to ensure the Trust remains a going concern. The Board has recently approved the 2018/19 Financial Plan which included a two year cash flow forecast alongside internal efficiencies required to remain sustainable. This shows that the Trust retains sufficient liquidity to manage its risk. The Directors have therefore been able to sign off the Going Concern concept for 2018/19.

The majority of the Trust's income is from health services and there is no material impact from any other income source that may have an effect on its provision of goods and services for the purposes of the health service in England.

Equality & Diversity Reporting

The Trust's Annual Equality & Diversity Report can be accessed at the following link:
http://www.nelft.nhs.uk/about-us-equality-and-diversity

Signed (on behalf of the Board of Directors)

John Brouder
Chief Executive
22 May 2018

ACCOUNTABILITY REPORT

Trust Strategy

The NHS continues to face a range of pressures that are impacting on the quality of care and bringing into question the long term future of many providers. The policy change that introduced Sustainability and Transformation Plans (STPs) is now providing a framework for bringing about further opportunities for integration and NELFT is using its strategy to streamline our effort to contribute to progressive change for the people we serve. We believe the best way to respond to these pressures is to change the way we provide care, to deliver the best services to patients across the whole care system, which will secure NELFTs long term future. Our strategy sets out our plan for the way we will deliver best care for patients and a sustainable future for NELFT.

Care needs to change

- Peoples' health in North East London, Essex and Kent is changing – more people are living longer and with more complex long term conditions, so need more care.
- Financial pressures mean big changes are needed, to guarantee patients receive high quality care.
- Organisations across the care system need to work together to change the way care is provide.
- The Five Year Forward View clearly seeks to move away from dependency on hospital beds and provide more integrated out of hospital care.

We provide good care in NELFT

- Patients say we consistently give high quality care, proving the skill and dedication of our hard working staff.
- The CQC says we provide good care.
- Our track record of providing care in new ways, such as in mental health, is way ahead of many other organisations.

More care should be at home and in the community

- Care at home or in the community is an affordable, safe and effective alternative to inpatient care in hospital.
- We will actively work with partners in health, social care and the third sector to put in place better care, so people spend less time in hospital and attend less often.
- We'll work with others to improve health and lives.
- The changes needed to bring about this transformation in patient care will play a big part in tackling the stresses and pressures in the care system. They will also mean change for our staff, patients and the care organisations we work with.
- We will actively work with partners to develop, promote and implement this affordable, high quality and innovative out-of-hospital care that patients prefer, bringing about big improvements in the health and lives of people, families and communities.

We want to provide the best care

- We believe that the best care is delivered by the best people, improving the health and lives of people, families and communities.

- We believe everyone in NELFT plays a part in making the care we deliver is the best and we value our staff making sure they have the skills and capabilities to deliver the best care and by making NELFT a great place to work.
- NELFT consistently performs highly and has high patient satisfaction. We are a financially sound, well run Trust

We want the organisation to grow and be sustainable

- Although much is changing in the NHS and public services, we still have an active strategy at NELFT designed to strengthen the organisation to continue growth to agreed limits. We will do this by expanding our business but only in areas where we benchmark in the upper quartile or in geographically adjacent locations.
- We know that growth in an increasingly challenged financial climate requires innovative thought and leadership and collaboration with our strategic partners.
- We need to identify areas of waste and inefficiency and eliminate them where possible, ensuring that provision of the highest quality patient care is maintained.

How do we see our role?

- We have identified several key roles in our strategy to fit the demands of modern services.
- We are renowned for setting new standards.
- We are frequently market leaders and transformers.
- We are the out of hospital innovator and coordinator.
- We are competent in delivering new treatment design solutions.
- We are the thought leader.
- We are the innovator.
- We are a collaborator.

We believe that continued development of these specific areas of expertise and experience position us at the forefront of modern and progressive care and service development for public services. We are currently refreshing our strategy ‘Good to Best’ and we will aspire to ensure that NELFT continues to deliver a high quality care and treatment experience to all of the people that we serve and that we maintain our position as a high performing successful organisation.

Most importantly we seek to make a real and positive difference to the health and wellbeing of the people that we serve.

NELFT at a glance

Our Values

- **P**eople first
- **P**rioritising quality
- **P**rogressive, innovative and continually improving
- **P**rofessional and honest
- **P**romoting what is possible – independence, opportunity and choice

Approximately 6000 staff across
210 sites (including bank and agency staff)
Serving a population of **4.3m**

CQC Rating – Good
Friends & Family Test – 94% would recommend us to family and friends
Complaints – 469
Compliments – 3499

Financial Metric – 1 (1 being ‘best’ and 4 being ‘worst’)
Turnover – £371m

Patient Experience

Our latest Friends and Family Test shows that 94% of respondents would be extremely likely or likely to recommend our services. Further information relating to patient care and experience activities can be found in the Quality Report.

		How likely is it that you would recommend this service to friends and family if they needed similar care or treatment?			
Survey name		**Date**	**Survey returns**	**Would recommend**	**Would not recommend**
NELFT Overall					
Overall		Q4 2016/17	3842	94%	2%
		Q1 2017/18	3821	93%	2%
		Q2 2017/18	3915	94%	1%
		Q3 2017/18	3646	93%	2%
		Q4 2017/18	3458	94%	1%
Community Services		Q4 2016/17	2812	95%	1%
		Q1 2017/18	2512	96%	1%
		Q2 2017/18	2609	96%	1%
		Q3 2017/18	2407	97%	1%
		Q4 2017/18	2189	96%	1%
Mental Health		Q4 2016/17	1030	92%	3%
		Q1 2017/18	1309	88%	4%
		Q2 2017/18	1306	89%	3%
		Q3 2017/18	1239	87%	3%
		Q4 2017/18	1269	89%	3%

Improved CQC rating to 'Good'

In August, October and November 2017 we were re-inspected by the Care Quality Commission and had our first Well Led review which assesses the Trust's leadership, governance and organisational culture. The CQC are the independent regulator of health and social care in England. The CQC monitor, regulate and inspect health and social care services to ensure that fundamental standards of quality and safety are met. This includes inspecting services to see if they are safe, effective, compassionate and of a high quality. Findings are published nationally and include performance ratings to help patients and service users choose care.

The Trust was inspected and measured against five key questions/domains and a summary table of results can be found below:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive?

- Are they well-led?

The Provider Quality report was published on 18 January 2018 with an overall rating of 'Good'. This shows a marked improvement on the overall 'Requires Improvement' rating received following the April 2016 comprehensive inspection and follow up visit in October 2016 and demonstrates the dedication and commitment of staff to improving services.

This is also a significant step towards the Trust's overall ambition to achieve an 'Outstanding' rating.

Overall, four out of five CQC domains received a Good rating for Caring, Effective, Responsive and Well Led, and a Requires Improvement rating for Safe. Areas for improvement identified under the Safe domain have resulted in Requirement Notices with 'must do' actions in relation to three regulations as follows:

- Regulation 12: safe care and treatment
- Regulation 17: good governance
- Regulation 18: staffing

Actions are being managed through a risk management approach and regular updates are provided to Board monthly.

Monthly updates on areas of improvement identified by the CQC are available as part of our public Board papers: http://www.nelft.nhs.uk/about-us-board- papers

The table below shows the ratings for each core service provided by the Trust.

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Child and adolescent mental health wards	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Community health inpatient services	Requires improvement	Good	Good	Good	Good	Good
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for older people	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Good	Good	Outstanding ☆	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good

	Safe	Effective	Caring	Responsive	Well led	Overall
Mental health crisis services and health-based places of safety	Good	Requires improvement	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Requires improvement	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Good	Good

Awards and recognition

NELFT staff, teams and services continue to lead the way nationally and we are delighted to acknowledge some of the great successes we have experienced this year.

Cavell Nurses' Trust Awards - Excellence in Care for Older People Individual
NELFT Nurse Consultant Geraldine Rodgers has been honoured by the charity Cavell Nurses' Trust for her passion and commitment to supporting elderly patients.

ENEI Awards ceremony - Employee Network Group 2017 – Public Sector
The Trust won the award for the 'Employee Network Group 2017 – Public Sector' in July 2017.

Patient Safety Awards - Patient Safety in Community
Our Significant 7 project was the winner of the Patient Safety in Community award for work supporting care home staff with delivery of physical healthcare for elderly patients.

Allocate Awards - Workforce 2.0 Award for Leadership
The Trust's HR Systems team won the Workforce 2.0 Award for Leadership.

Nursing Times - Technology and Data in Nursing category for the My Mind app
The team behind the My Mind app won in the Technology and Data in Nursing category.

Queen's Nursing Institute - Queen Elizabeth the Queen Mother Award for Outstanding Service
Liz Alderton, a district nurse, received the Queen Elizabeth the Queen Mother Award for Outstanding Service from the Queen's Nursing Institute.

AF Association - Healthcare Pioneers – Showcasing Best Practice in AF winners
NELFT and the North East London Local Pharmaceutical Committee were one of the 'AF Association Healthcare Pioneers 2018 – Showcasing Best Practice in AF' winners. The award was for the project: Health Foundation Quality Improvement Improving Physical Health Care for patients with psychosis (PHCP) through collaborative working with local community pharmacies.

Inclusive Top 50 UK Employers - Placed at number 19 of the Most Inclusive Employers
NELFT has been placed at number 19 in this year's Inclusive Top 50 UK Employers. NELFT was the only Trust in the south east of England to make the Top 50 and one of only two NHS organisations in the Top 20.

Internal staff recognition
The Trust runs a Make a Difference staff recognition scheme internally and in 2017/18 there were over 150 individuals and teams recognised. At the end of March 2018 a staff awards event took place where the following staff were announced as overall category winners for the year:

Outstanding Achievement or Contribution Award
Caroline Game (End of Life Care Facilitator)

Leadership Award
Wellington Makala (Deputy Integrated Care Director – Acute and Rehabilitation Directorate)

Team or Department Award
The Safeguarding Administration Team

Excellence Award
Kaylea Kirby (Administration and Support Worker)

Care and Compassion Award
Giedrius Gencas (Legal Services Manager)

Improvement to Services Award
Lynne Denison (Healthcare Support Worker)

Working in Partnership Award
Infection Prevention and Control Team

Quality Improvement Award
Patrick Onyema (Healthcare Support Worker)

Infection Prevention and Control Award
Sultana Ali (Flu Vaccination Promoter)

NELFT Lifetime Achievement Award (to mark NHS70)
Lindsay Royan (Clinical Psychologist)

DIRECTORS' REPORT

The Board of Directors is responsible for the Trust's strategic direction, day-to-day operations and performance. Their powers, duties, roles and responsibilities are set out in the Trust's Constitution (Annex 6) and include:

- Setting the Trust's strategic aims and ensuring that financial resources and staff are in place for the Trust to meet its objectives.
- Review management performance
- Provide active leadership of the Trust within a framework of risk assessment and control
- Ensure the quality and safety of healthcare services, education, training, development and research and apply the principles and standards of clinical governance set out by NHS regulators
- Ensure the Trust is compliant with its Terms of Authorisation, Constitution, mandatory guidance, relevant statutory requirements and contractual obligations
- Regularly review the performance of the Trust in these areas against regulatory requirements and Trust objectives.

Composition of the Board of Directors as at 31 March 2018:

Joseph Fielder	Chair *(M)*
John Brouder	Chief Executive *(M)*
John Roome	Vice Chair and Independent Non-Executive Director *(M)*
Brian Hagger	Senior Independent Director *(M)*
Liz Delauney	Independent Non-Executive Director *(F)*
Mark Friend	Independent Non-Executive Director *(M)*
Amanda Lewis	Independent Non-Executive Director *(F)*
Sultan Taylor	Independent Non-Executive Director *(M)*
Dr Caroline Allum	Executive Medical Director *(F)*
Bob Champion	Executive Director of Workforce & OD *(M)*
Stephanie Dawe	Chief Nurse and Executive Director of Integrated Care (Essex and Kent) *(F)*
Barry Jenkins	Executive Director of Finance and Commercial Development *(M)*
Jacqui Van Rossum	Executive Director of Integrated Care (London) *(F)*

For profiles of Directors please log on to: https://www.nelft.nhs.uk/about-us-our-board

(M = male, F = Female)

Balance and appropriateness of the Board of Directors

The make-up and balance of the Board has been reviewed. The Board has also had the opportunity to review the appropriateness of current appointments. Three Executive members of the Board have clinical backgrounds, two are business graduates and all executive members have extensive experience in the provision of broad ranging healthcare services. Several members have experience in both the commissioning and provider arm with equal experience in regulating functions or organisations. The non-executive membership has extensive and current experience within the NHS, public services, not for profit organisations, business services, legal practice, commercial banking, information technology and global investments. Most have held office with specific briefs for governance, risk management and strategic planning as well as major investment decision making analysis.

The integrated Board has a strong culture of challenge and a dynamic approach to business development but maintains the discipline of broader horizon scanning and vigilance in the field of

governance. The non-executives continue to bring a richness of experience and a wealth of knowledge that has been inspirational to the organisation. The Board has been able to take entrepreneurial decisions but within a system of governance and objective risk management. The Board has overseen a period of successful change and development in the organisation with tangible benefits to both patients and staff.

The Board has a track record of delivery but continues to relate high level functions and proposals for change to improving the patient experience. The Board has demonstrated a clear balance in its membership through extensive debate and development.

Executive Director contract start dates are listed below:

Name	Contract Start Date
John Brouder (Chief Executive)	4 August 2009
Barry Jenkins (Executive Director of Finance)	9 February 2015
Caroline Allum (Executive Medical Director	1 April 2016
Stephanie Dawe (Chief Nurse and Executive Director of Integrated Care (Essex & Kent)	1 April 2007
Bob Champion (Executive Director of Workforce & OD)	1 September 2015
Jacqui Van Rossum (Executive Director of Integrated Care (London)	1 July 2010

Terms of office of **Non-Executive Directors** who served during 2017-18 are listed below:

Name	Term of Office
Joseph Fielder (Chair)	1 April 2016 – 31 March 2019
John Roome (Vice Chair)	1 January 2016 – 31 December 2018
Brian Hagger (Senior Independent Director)	01 December 2005 – 31 May 2018
Marjorie Woodward (NED)	1 June 2016 – 31 May 2017
Liz Delauney (NED)	01 May 2017 – 30 April 2020
Mark Friend (NED)	1 March 2016 – 28 February 2019
Amanda Lewis (NED)	1 November 2016 – 31 October 2019
Sultan Taylor (NED)	01 April 2017 – 31 March 2020

Appointment and Removal of the Chair or other Non-Executive Directors

The Council of Governors at a General Meeting of the Council of Governors shall appoint or remove the Chair of the Trust and other Non-Executive Directors.

Appointment

- The Remuneration Committee of the Board of Directors will identify the balance of individual skills and experience it requires at the time a vacancy arises and, accordingly, draw up a job description and person profile for each new appointment.

- Suitable candidates will be identified by the Board of Directors which may, if the Board considers it appropriate in particular circumstances, engage an external organisation that is recognised as an expert in this field, to assist it in this process

- The Remuneration Committee of the Board of Directors, on expiry of the initial non-executive directors current terms of appointment (or a period of 12 months from appointment as a Director of this Foundation Trust, whichever is the greater) and on any subsequent vacancy,

shall consider whether to recommend to the Council of Governors to reappoint the retiring non-executive director or Chair, taking into account the most recent appraisal of the director. If the Council of Governors does not so appoint, or if the individual does not wish to continue, or if the Committee does not consider the reappointment appropriate, then the Board of Directors shall be asked to identify suitable new candidates in accordance with the procedure outlined above.

Removal

- Removal of the Chair or other Non-Executive Directors shall require the approval of three-quarters of the Members of the Council of Governors.

- A resolution to remove the Chair or a non-executive Director (such person in either case being referred to in this paragraph as the 'Reviewee') may only be proposed if a notice in writing, signed by not less than one quarter of the members of the Council of Governors, has first been sent to the Chair or (if the Reviewee is the Chair), to the next most senior Non-Executive Director (such person in either case being referred to in this paragraph as the 'Senior NED') of the intention, reasons and supporting evidence

- The Senior NED shall then notify the Reviewee and the Council of Governors of the proposal and the nature of the allegation and shall invite the Reviewee to give their account of the matter.

- The Reviewee shall have the right to prepare a written response to be sent to the members of the Council of Governors in advance of the meeting and at the meeting itself the Reviewee shall have the right to address the Council of Governors in relation to the proposal for his removal but shall not be entitled to attend the rest of the meeting or to witness the proposal, the deliberations of the Council of Governors or their subsequent vote on the matter. In taking their decision, the Council of Governors shall take into account the most recent appraisal of the Reviewee and any report or recommendation on the matter received from the Senior NED.

Well Led Review CQC

In 2017, the CQC undertook a Well Led review of NELFT. The key lines of enquiry into each of the eight elements of the NHS Improvement and the CQC Well Led Framework (2017) concluded that there was sufficient evidence and assurance that the Trust had meet the 'Good' rating requirements.

Within Element Two, the CQC made just one regulatory compliance recommendation relating to the development of a formal corporate strategy that communicates NELFT vision and links all NELFT strategies. This work is well underway and on target for completion within 2018.

Other recommendations were made across all eight elements the Board has responded and on target to complete the necessary actions by the 31 July 2018. A more detailed report is available Board papers: http://www.nelft.nhs.uk/about-us-board-papers

As NELFT grows and the boundaries of the organisation change through integration, the governance arrangements and our implementation of the Well Led Framework and will require us to constantly review the eight elements and key lines of enquiry that ensure we remain a 'Good' well led organisation.

Attendance Record

Board of Directors – Attendance Record 2017-18														
		Note	April	May	Jun	Jul	Sep	Oct	Nov	Jan	Feb	Mar	**Attendance**	**Out of**
Joseph	Fielder	a	1	1	1	0*	1	1	1	1	1	1	9	10
Liz	Delauney			1	1	1	1	1	1	1	0	1	8	9
Mark	Friend		1	1	1	1	1	1	1	1	1	0	9	10
Brian	Hagger	b	1	1	1	1	0	1	1	1	1	1	9	10
Amanda	Lewis		1	1	1	1	1	1	1	1	1	0	9	10
John	Roome	c	1	1	1	1	1	1	1	1	1	1	10	10
Sultan	Taylor			1	1	1	1	1	1	1	1	1	9	9
Marjorie	Woodward		1	1									2	2
John	Brouder		1	1	1	1	1	1	1	1	1	1	10	10
Caroline	Allum		1	1	1	1	1	1	1	1	1	1	10	10
Bob	Champion		1	1	1	1	1	1	1	1	1	1	10	10
Stephanie	Dawe		1	1	1	1	1	0	1	1	1	1	9	10
Barry	Jenkins		1	1	1	1	1	1	1	1	1	1	10	10
Jacqui	Van Rossum		1	1	1	1	1	1	1	1	1	1	10	10

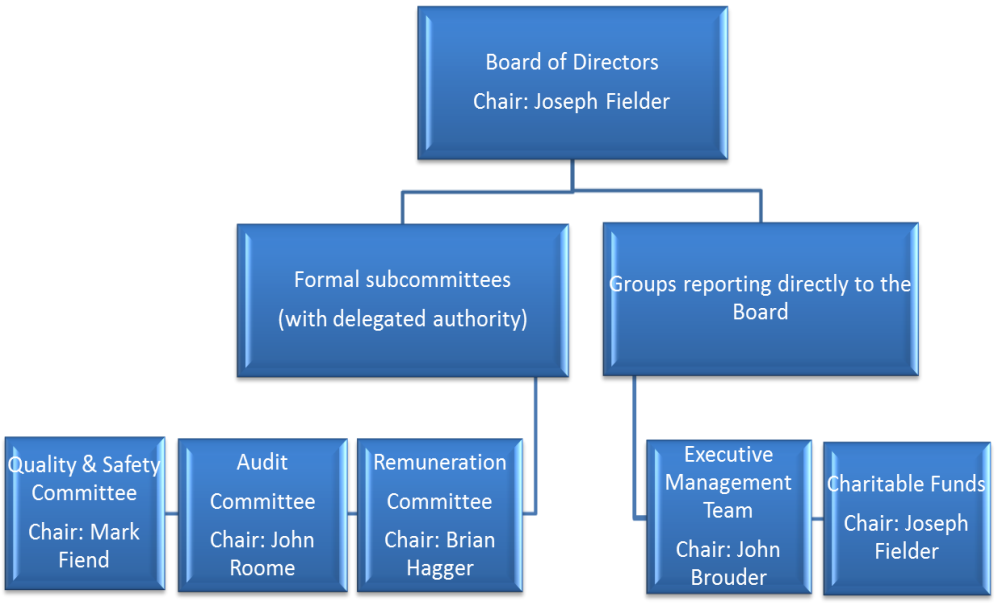
Notes:

a Chairman *denotes to ill health

b Senior Independent Director

c Vice Chairman

Committee structure at 31 March 2018



Board Committee Membership

Audit Committee – 5 meetings in 2017/18
John Roome (NED Committee Chair) Brian Hagger (NED) Mark Friend (NED) Amanda Lewis (NED) Sultan Taylor (NED)
Remuneration Committee – 3 meetings in 2017/18
Brian Hagger (NED Committee Chair) attended all meetings Joe Fielder (Chair) attended two meetings John Roome (NED) attended all meetings Mark Friend (NED) attended one meeting Amanda Lewis (NED) attended all meetings Sultan Taylor (NED) attended all meetings Liz Delauney (NED) attended all meetings
Quality & Safety Committee
Mark Friend (NED and Chair) Liz Delauney (NED) Sultan Taylor (NED) John Brouder (Chief Executive) Stephanie Dawe (Chief Nurse & Executive Director of Integrated Care, Essex & Kent) Jacqui Van Rossum (Executive Director of Integrated Care, London) Caroline Allum (Executive Medical Director) Alison Garrett (Director of Nursing, Quality Governance)

Audit Committee Report

The Audit Committee is a non-executive committee of the Trust Board with delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial non-clinical internal controls, which supports the achievement of the Trust's objectives.

The principal purpose of the committee is to assist the Board in discharging its responsibilities for monitoring the integrity of the Trust's accounts. In addition it reviews the adequacy and effectiveness of the Trust's systems of risk management and internal controls and monitors the effectiveness, performance and objectivity of the Trust's external auditors, internal auditors and local counter fraud specialist. Within this remit, it also had responsibility for the oversight of the whistleblowing procedures within the Trust.

The members of the Audit Committee are listed on page 24 and include three independent Non-Executive Directors. The Chair of the committee is a qualified accountant and three members of the committee have recent or relevant financial experience. Committee membership has been stable throughout the year, with the Chair and membership all being in place for the full year.

External audit

There was one non-audit service provided by KPMG during the year relating to the Quality Accounts.

Internal audit and counter fraud services

The Board uses external parties to deliver the internal audit and counter-fraud services:

BDO LLP provides the internal audit service. This service covers both financial and non-financial audits according to a risk-based plan agreed with the Audit Committee, Quality & Safety Committee and Executive Management Team.

The Trust's separate counter fraud service is provided by TIAA who provide fraud awareness training and carry out reviews of areas at risk of fraud and investigate any reported frauds. No significant fraud was uncovered in the past year.

Internal controls

In addition to routine work on the financial and risk controls operating in the Trust, through the internal audit plan the Committee focused on controls relating to Workforce risks, IT risks and Quality and Safety Risks. The Committee is made aware of issues arising from the Quality & Patient Safety Committee through the Chair of that Committee and has also invited the Chief Nurse to join the Committee on a regular basis to ensure the link is robust. The Committee has had sight of a detailed schedule of recommendations and the Trust's progress against actions put in place to achieve those recommendations.

Financial reporting

The Committee reviewed the Trust's accounts and Annual Governance Statement. To assist this review it considered reports from management and from the internal and external auditors to assist our consideration of: the quality and acceptability of accounting policies, including their compliance with accounting standards;

- key judgements made in preparation of the financial statements;
- compliance with legal and regulatory requirements
- the clarity of disclosures and their compliance with relevant reporting requirements;

Significant financial judgements and reporting for 2017/18

The organisation's going concern status has been specifically discussed with the External Auditors in relation to the financially challenging environment the Trust faces. The Audit Committee has discussed and agreed the audit risks facing the Trust the most significant of which relates to the valuation of land and buildings for the year to 31 March 2018. The Audit Committee has been assured by the Head of Internal Audit Opinion on the Trust's internal control environment and approach to identifying, assessing and mitigation planning to risks.

Ensuring external auditors' independence

Any engagement of the external auditors in relation to non-audit work is approved by the Executive Director of Finance in conjunction with the Executive Team. This policy complies with all relevant auditing standards and follows industry practice in terms of defining prohibited work and setting out the approval and notification processes all non-audit work should be subject to. The external audit work plan and any additional non-audit work is agreed annually by the Audit Committee. The Audit Committee believes that in this way the external auditors' independence is ensured.

Remuneration Committee

The power to appoint the Chief Executive and other executive directors sits with the Remuneration Committee of the Board. The Remuneration Committee consists of the Trust Chair and all Non-Executive Directors (NEDs) and is chaired by the Senior Independent Director. The committee meets when necessary (but not less than twice a year) and its duties and responsibilities include to:

- Determine the terms of service and salary arrangements for Executive Directors and those other Senior Managers who are not subject to Agenda for Change and ensure they are fairly rewarded for their individual contribution to the organisation (having regard to affordability and to the provisions of any national arrangements, if appropriate);

- Monitor and evaluate the performance of individual Executive Directors and Senior Managers (where appropriate, in the role of a 'grandparent');

- Determine and oversee non-contractual arrangements such as termination and other severance payments and agreements, taking account of national guidance, where appropriate.

- Determine and approve the terms of service and contractual arrangements for any proposal that an individual earns more than:

    - £120 per hour
    - £750 per day
    - £142,500 per annum

    (such sums to be gross amounts fully inclusive of any expenses, benefits in kind, etc.)

- Determine and approve any benefits in kind such as relocation packages for Executive Directors and Senior Managers, performance related pay, any other bonuses or allowances (not to include lease cars or any other salary sacrifice benefits).

All Executive Directors have permanent contracts of employment with the Trust.

Appraisal process for the Chair and Non-Executive Directors

The appraisal process is a key part of the performance framework and ensures that the skills and knowledge of the Board are regularly reviewed. The Council of Governors evaluates the performance of the Chair and Non-Executive Directors via the following process:

- The Chair holds 1:1 appraisal meetings with each NED, taking into account the views of fellow Board members and Governors if appropriate
- The Chair's appraisal is sent to the Senior Independent Director who holds a 1:1 meeting with the Chair to feed back the report and agree objectives for the coming year
- The Nominations/Terms of Service Committee of the Council of Governors considers the final reports regarding Chair and NED appraisal
- The Nominations/Terms of Service Committee make recommendations to the Council of Governors on reappointment or removal
- The Council of Governors receives a report from the Nominations/Terms of Service Committee at a formal meeting and approve or reject the recommendations
- If it has not been possible or practical to hold a separate meeting of the Nominations/Terms of Service Committee of the Council of Governors then a meeting of the Council of Governors will consider the appraisal report and recommendation for reappointment or removal.

Registers of Interests

The Trust holds registers of interests for Directors and Governors. These are available to the public and can be accessed by contacting Lauren MacIntyre, Head of Corporate Affairs on 0300 555 1300 or lauren.macintyre@nelft.nhs.uk. The Register of Interests for Directors is approved annually by the Board.

Statements of Compliance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

In terms of the better payment practice code, NELFT has achieved the following:

- Non-NHS creditors – 69% paid within 30 working days (up from 55%)
- NHS creditors – 42% paid within 30 working days (down from 57%)

The Trust has paid no interest under the Late Payment of Commercial Debts Act 1998

All directors confirm at the time of approving the report

- As far as the directors are aware there is no relevant audit information of which the Trust's auditor is unaware and
- The directors have taken all the steps they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establishing that the Trust's auditor is aware of that information.

Signed:

John Brouder
Chief Executive
22 May 2018

STAFF REPORT

Our approach to staff engagement

The end of this business year marks the second anniversary of the implementation of our 'Best People' strategy. During this time, the document has undergone one refresh and is subject to further review in the wider context of the imminent publication of the Health Education England strategy for the whole health and social care workforce. We have continued on our journey of putting people first and have invested strongly in consolidating pathways into careers with NELFT; reducing reliance on costly agency workers; improving the leadership of the organisation and improving retention through embedding a range of health and well-being activities within our business as usual.

We also continued on our journey of culture change, through positive engagement with our workforce at all levels and reducing prejudicial and discriminatory practices even further. This is evidenced in our outstanding national staff survey results, which saw an unprecedented 63% response rate from a full census and many findings moving dramatically into more positive ratings. Key positive themes emerged around our colleagues feeling listened to by senior management and being able to influence decision that affect their working lives.

We have been and remain absolutely committed to continue to develop and embed formal and informal engagement methods, including establishing engagement and wellbeing ambassadorial roles in all localities that are representative of all staff groups and give a strong voice to our workforce in influencing our direction as an organisation. We have focused on the following themes for targeted action:

Recruitment Strategy

We continued to develop our position as employer of choice, with the context of the wider provider alliance and STP agenda, by holding a number of targeted recruitment campaigns within local communities, further and higher education establishments, professional bodies' conferences and more recently with the armed forces. A dedicated team now reviews every vacant post with line management to establish the most appropriate way of attracting the best candidates and we have a well-established "Talent Pool" of job applicants who are held in reserve following successful interviews. By utilising technology effectively and streamlining systems and processes, we have reduced the time to fill vacancies to an average of 43 days.

Retention and Wellbeing

We have invested strongly in examining data around colleagues leaving and better understand the reasons and how we may work together to avoid this. We have developed workshop programmes to help colleagues plan for retirement, which includes options such as retire and return, or deferment. The health and well-being of our workforce has also been a major priority, with 40 wellbeing and engagement ambassadors operating across the Trust and every locality producing a sustainable calendar of events and activities designed to improve everyone's working lives.

Flexible Working

Flexible and agile working have really taken off over the past year, with over half of the workforce equipped and facilitated to work agilely. This is steadily enabling us to move away from traditional ways of working that were constrained by space in premises and static technology. Working flexibly enables our staff to undertake a range of options such as part time, term time and Bank work. We support colleagues to consider options that are mutually agreeable and support line managers to be more enlightened in their approach to leading their teams, based on trust and productivity.

Career Pathways

In order to develop a sustainable talent pipeline for the future, we continue to work creatively internally and with external partners to explore entry level options to career pathways, such as volunteering and apprenticeships. We have worked closely with education providers to develop clinical apprenticeships and other vocational routes to becoming healthcare professionals. We also pride ourselves in the conversion rate from healthcare studies students to substantive employees, as well as return to practice nurses and other health care professionals.

Leadership and Talent Management

Investment continues in the leadership of the organisation, with routine and ad hoc development programmes available through our comprehensive training and CPD portfolio. A programme for senior non-clinical and medical managers has been run successfully, as has a second cohort of the Calibre Programme to help staff with disabilities exploit their development potential. Further investment in a new combined learning management, appraisal, supervision and revalidation tool, will revolutionise our approach to talent management.

Off payroll disclosures:

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2018 of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	1
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018 of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	1
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior	0

officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	

Non-Executive Directors:

Title	First Name	Last Name	Gender	Role	Start Date In Position
Ms.	Liz	Delauney	Female	Non-Executive Director	01/06/2017
Mr.	Mark	Friend	Male	Non-Executive Director	01/03/2015
Mr.	Brian	Hagger	Male	Non-Executive Director	01/12/2005
Mrs.	Amanda	Lewis	Female	Non-Executive Director	01/11/2016
Mr.	John	Roome	Male	Non-Executive Director	01/01/2015
Mr.	Sultan	Taylor	Male	Non-Executive Director	01/04/2017

Staff Policies

The Trust has policies in place that detail how the organisation applies full and fair consideration to a number of different workforce issues including equality and diversity, consultation and the management of organisational change, whistleblowing, health and safety and counter fraud and corruption. The key policies can be found at the following link: http://www.nelft.nhs.uk/about-us-policies

Workforce breakdown:

Group	Male	Female
Board members	**8**	**5**
Band 7 and above	**252**	**967**
Band 7 and below	**624**	**3644**

Sickness absence:

Average FTE 2017/2018	**0.88**
Total FTE Days Lost	**69227.24**
Average Sick Days Per FTE	**10.66**
FTE Days Available	**1,960,598**
Total Calendar Days Lost	**80,359**

Sickness absence data published by the Department of Health is consistent with Trust metrics and at 10.66 days lost per Full Time Equivalent (FTE) staff member, is slightly higher than last year. NELFT has however benefited from consistently applied efforts to better manage sickness absence and demonstrate a trend that shows absence reducing to nearer target levels.

STAFF SURVEY

	2017/18		2016/17		Trust improvement/ deterioration
Response rate	**Trust**	**Benchmarking Group (trust type) average**	**Trust**	**Sector Average**	
	63%	45%	38%	44%	Improvement of 25%

Top 5 ranking scores from 17/18 (comparison)	2017/18		2016/17	Trust improvement / deterioration
	Trust	Benchmarking Group (trust type) average	Trust	
Communication between senior management and staff is effective	48%	41%	37%	Improvement of 11%
Senior managers act on staff feedback	39%	32%	28%	Improvement of 11%
The team I work in often meets to discuss the team's effectiveness	76%	69%	73%	Improvement of 3%
Senior managers here try to involve staff in important decisions	41%	35%	32%	Improvement of 9%
I know who the senior managers are here	91%	85%	87%	Improvement of 4%

Bottom 5 ranking scores from 17/18 (comparison)	**2017/18**		**2016/17**	**Trust improvement / deterioration**
	Trust	**Benchmarking Group (trust type) average**	Trust	
Satisfaction with my level of pay	28%	32%	31%	Deterioration of 3%
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	26%	22%	22%	Deterioration of 4%
On average how many additional unpaid hours do you work per week for this organisation, over and above your contracted hours?	64%	61%	69%	Improvement of 5%
Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	84%	87%	83%	Deterioration of 1%
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	58%	56%	60%	Improvement of 2%

FTC form for accounts for periods ending 31 March 2018

4. EMPLOYEE COSTS AND NUMBERS(WTE)

4.1 Employee expenses

	2017/18			2016/17
	Total	Permanent	Other	Total
	£000	£000	£000	£000
Salaries and wages	198,688.00	198,688.00	0.00	191,297.00
Social Security Costs	19,675.91	19,675.91	0.00	18,366.75
Employer contributions to NHSPA	24,089.95	24,089.95	0.00	23,428.71
Pension Cost - other contributions	26.29	26.29	0.00	5.28
Termination benefits	0.00	0.00	0.00	0.00
Apprentice Levy	988.81	988.81	0.00	0.00
Agency/contract staff	22,249.85		22,249.85	27,342.00
	265,718.80	243,468.95	22,249.85	260,439.74

4.2 Average number of employees

	2017/18			2016/17
	Total	Permanent	Other	Total
Medical & Dental	364.42	292.57	71.85	302.85
Ambulance Staff	0.00	0.00	0.00	
Administration & Estates	1,534.62	1,491.03	43.59	1,269.01
Healthcare assistants and other support staff	674.77	674.77	0.00	474.69
Nursing, midwifery and health visiting staff	2,398.81	2,115.36	283.45	2,157.96
Nursing, midwifery and health visiting learners	0.00	0.00	0.00	
Scientific, therapeutic and techinical staff	1,283.42	1,184.47	98.95	1,230.99
Social care staff	0.00	0.00	0.00	
Other	32.61	32.61	0.00	6.00
Total	6,288.65	5,790.81	497.85	5,441.50

Total expenditure for 2017/18 financial year on consultancy costs was £138,000.

Note 4.4 Reporting of other compensation schemes - exit packages 2016/17 Note that columns D, F, H and J are entered in £000 Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	*Cost of compulsory redundancies £000s	Number of other departures agreed Number	Cost of other departures agreed £000s	Total number of exit packages Number	Total cost of exit packages £000s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £000s	Subcode	Expected Sign
<£10,000	1	3	5	9	6	13			400	+
£10,001 - £25,000	4	73	1	21	5	94			410	+
£25,001 - 50,000	4	147	3	114	7	260			420	+
£50,001 - £100,000	5	330	0	0	5	330			430	+
£100,001 - £150,000	1	106			1	106			440	+
£150,001 - £200,000					0	0			450	+
>£200,000					0	0			460	+
Total	**15**	**659**	**9**	**144**	**24**	**803**	**0**	**0**	470	+

Signed:

John Brouder
Chief Executive
22 May 2018

REMUNERATION REPORT

The Remuneration Committee is assisted by the Executive Director of Workforce & Organisational Development. Remuneration policy for the Trust's most senior managers (Executive Directors who are members of the Board) is to ensure remuneration is consistent with market rates for equivalent roles in Foundation Trusts of comparable size and complexity, while taking into account the performance of the Trust, comparability with employees holding national pay and conditions of employment, pay awards for senior roles elsewhere in the NHS and pay/price changes in the broader economy, any changes to individual roles and responsibilities and overall affordability. The committee refers to the annual Foundation Trust Network Board salary survey together with publicly available information about trends within the NHS and broader economy.

Performance is assessed in relation to both organisational performance against agreed objectives and external measurements including regulatory information, and individual performance against annual personal objectives and contribution to the performance of the organisation. It is the current policy of the committee not to award any performance related bonus or other performance payment to executive directors.

Where appropriate, non-pay terms and conditions of employment of senior managers are consistent with NHS contractual arrangements applying to the majority of NHS Employees under 'Agenda for Change'. Senior manager's contracts of employment have no set term but are subject to continuing satisfactory performance. Contracts can be terminated by either party with a notice period for the Chief Executive of six months, and three months in the case of other senior managers. Contractual early termination payments are in accordance with NHS national terms and conditions. No significant award or compensation has been paid to any former senior manager in the past year.

I confirm that the voting membership of the Board of Directors constitute the senior managers in accordance with the NHS Foundation Trust Code of Governance.

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found on page 36 of the annual report.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

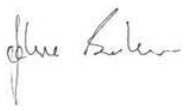
The banded remuneration of the highest-paid director in North East London NHS Foundation Trust in the financial year 2017-18 was £190-195K (2016-17 was £190-195K). This was 6.67 times (2016-17:6.58 times) and the median remuneration of the workforce, which was £28778.76 in 2017-18 (£29,179.33 in 2016-17)

In 2017/18 one employee received remuneration in excess of the highest paid director (2016-17:three employees). Remuneration ranged from 192K to £212K (2016-17:£194k to £236K).

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

In 2017/ 18 there were 16 employees earning in excess of £142.5K and in 2016/17 there were 18 employees earning in excess of £142K.

Signed:



John Brouder
Chief Executive
22 May 2018

Salary entitlements of senior managers

Name		2017-2018						2016-2017						Ref
		Salary and Fees	All Taxable Benefits	Annual Performance related bonus	Long-term Performance related bonus	All Pension related benefits	TOTAL	Salary and Fees	All Taxable Benefits	Annual Performance related bonus	Long-term Performance related bonus	All Pension related benefits	TOTAL	
John Brouder (1)(4)	Chief Executive Officer	180-185	8200	0	0	0	190-195	180-185	8200	0	0	0	190-195	1
Barry Jenkins (1)	Director of Finance	140-145	0	0	0	42.5-45	185-190	140-145	0	0	0	52.5-55	195-200	2
Jacqueline Van-Rossum (1)	Exec.Dir.Intgd Care (London) &Transformation	120-125	0	0	0	22.5-25	145-150	120-125	0	0	0	35-37.5	155-160	3
Bob Champion (1)	Director of HR	110-115	0	0	0	0	110-115	110-115	0	0	0	0	110-115	4
Stephanie Dawe (1)(3)	Exec.Dir.Integrated Care(Essex)&Chief Nurse	100-105	0	0	0	30-32.5	130-135	120-125	0	0	0	35-37.5	155-160	5
Caroline Ann Allum (1)	Executive Medical Director	150-155	0	0	0	52.5-55	205-210	150-155	0	0	0	327.5-330	480-485	6
Joseph Fielder (1)	Chair	45-50	0	0	0	0	45-50	45-50	0	0	0	0	45-50	7
Sultan Ashmall Taylor (1)	Non Executive Director	15-20	0	0	0	0	15-20	0	0	0	0	0	0	8
Amanda Lewis (1)	Non Executive Director	15-20	0	0	0	0	15-20	0-5	0	0	0	0	0-5	9
John Roome (1)	Non Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15 - 20	10
Mark Friend (1)	Non Executive Director	15-20	0	0	0	0	15-20	10-15	0	0	0	0	10-15	11
Marjorie Woodward (2)	Non Executive Director	0-5	0	0	0	0	0-5	15- 20	0	0	0	0	15 - 20	12
Brian Hagger(1)	Non Executive Director	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20	13
Maria Elizabeth Delauney (2)	Non Executive Director	10-15	0	0	0	0	10-15	0	0	0	0	0	0	14

Band of Highest paid Directors total remuneration 000's	**190-195**	**190-195**
Median Total Remuneration	**£28,779**	**29,179**
Ratio	**6.67**	**6.58**

Notes :

1. Indicates that the post holder has been in post whole year
2. Indicates that the post holder has been in post part year only
3. From December 2017 Stephanie Dawe has been on secondment as a Chief Nurse at Provide. NELFT invoice Provide monthly for the two days Stephanie is at Provide per her Secondment agreement. Initially, Stephanie fell within the 120-125k bracket. The total invoiced to Provide YTD was 21k. This has had the effect of re-categorising Stephanie into the 100-105k bracket.
4. Trust paid for the rent(8.2K) of the accomodation for the Chief Executive Officer in the financial year 2017-18.

All directors were appointed by formally constituted appointments panels in consultation with the North East London Strategic Health Authority and are on the same normal employment contract basis as other staff, giving six months' notice by either party in the case of the Chief Executive, and three months' notice for other Executive Directors.

Pension Benefits of senior managers 2017/18

Name and title	Real increase in pension at NPA (bands of £2500) £000	Real increase in lump sum at NPA (bands of £2500) £000	Total accrued pension at NPA at 31 March 2018 (bands of £5000) £000	Lump sum at NPA related to accrued pension at 31 March 2018 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Real Increase in Cash Equivalent Transfer Value £000
Barry Jenkins	0-2.5	0	65-70	0	688	615	67
Jacqueline Van-Rossum	0-2.5	2.5-5	55-60	165-170	1,113	1022	80
Bob Champion (No Pension)	0	0	0	0	0	0	0
Stephanie Dawe	0-2.5	2.5-5	15-20	55-60	382	332	47
Caroline Allum*	2.5-5	0-2.5*	40-45	105-110	760	723	30
Ref:	1	2	3	4	5	6	7

* Negative Banding

During the year the Trust received updated information from NHS Pensions regarding the prior year pension benefits for Caroline Allum, we have therefore amended our prior year figures to reflect this updated information. The revised prior year figures have been audited during 2017/18.

GOVERNORS AND MEMBERS

The statutory duties of the Council of Governors include to:

- Appoint and, if appropriate, remove the Chair;
- Appoint and, if appropriate, remove the other Non-Executive Directors;
- Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors;
- Approve the appointment of the Chief Executive;
- Appoint and, if appropriate, remove the NHS foundation trust's auditor;
- Receive the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report; and
- Hold the Non-Executive Directors to account for the performance of the Board.

In addition, in preparing the Trust's forward plan, the Board of Directors must have regard to the views of the governors.

Composition of the Council of Governors

The Council of Governors comprises 30 members. 16 are elected to represent public constituencies, 7 are elected to represent staff constituencies and 7 are appointed by partner organisations. Elected members serve three year terms. If a governor resigns during that three year term, the person with the next highest number of first preference votes will take up the position for the remainder of that term. The Lead Governor is Stephen King, public governor for the Basildon constituency. The Deputy Lead Governor is Mark Egalton, public governor for the Havering constituency. The Council of Governors had four vacancies at 31 March 2018.

The Council is required to meet a minimum of three times a year. Three formal meetings were held in the period from 1 April 2017 – 31 March 2018 and the Annual General Meeting was held on 26 September 2017. The attendance record for the three formal meetings appears below:

Constituency type	Constituency	Name	26.07.17	25.10.17	28.03.18	Attendance (Actual)	Attendance (Possible)	Term of Office Expiry
Public	Barking & Dagenham	Christine Brand	1	1	0	2	3	30 June 2020
Public	Barking & Dagenham	Karen Jordan-Nicholls	1	1	1	3	3	30 June 2020
Public	Barking & Dagenham	Anthony McKernan	1	1	0	2	3	30 June 2020
Public	Basildon	Stephen King[1]	1	1	1	3	3	30 June 2020
Public	Brentwood	Tim Barrett	0	0	0	0	3	30 June 2020
Public	Havering	Mark Egalton[2]	1	1	0	2	3	30 June 2020
Public	Havering	Geoffrey Farmer	1	1	1	3	3	30 June 2020
Public	Havering	Bukola Folayan	1	1	1	3	3	30 June 2020
Public	Redbridge	Indu Barot	1	1	0	2	3	30 June 2020

[1] Lead Governor

[2] Deputy Lead Governor

Constituency type	Constituency	Name	26.07.17	25.10.17	28.03.18	Attendance (Actual)	Attendance (Possible)	Term of Office Expiry
Public	Redbridge	Stephen King	0	0	0	0	3	30 June 2020
Public	Redbridge	Clive Myers	1	1	1	3	3	30 June 2020
Public	Thurrock	Colin Brennan	1	1	1	3	3	31 May 2018
Public	Waltham Forest	Chris Casey MBE	0	0	0	3	3	30 June 2020
Public	Waltham Forest	Neil Collins	1	1	0	2	3	30 June 2020
Public	Waltham Forest	Fatima Khasimi	1	1	0	2	3	30 June 2020
Public	Rest of England	Jogga Singh Teidy	1	1	0	2	3	31 May 2018
Staff	Barking & Dagenham	Mandy Orwell	0	0	1	1	3	30 June 2020
Staff	Basildon & Brentwood	Gary Townsend	0	0	0	0	3	31 August 2019
Staff	Corporate Services	Alison Garrett	1	1	1	3	3	30 June 2020
Staff	Havering	Susan Pateman	1	1	1	3	3	31 August 2019
Staff	Redbridge	Shirley Baah-Mensah	0	0	0	0	3	31 August 2019
Staff	Thurrock	Rumbidzai Mugezi	1	1	0	2	3	30 June 2020
Staff	Waltham Forest	Bethanne Willingham	0	0	1	1	3	30 June 2020
Nominated	LBBD	Andrew Hagger	0	0	0	0	3	
Nominated	LBH	Barbara Nicholls	0	0	1	1	3	
Nominated	LBR	Caroline McClean	0	0	0	0	3	
Nominated	LBWF	Vacancy						
Nominated	NEL Sector	Vacancy						
Nominated	NHS SW Essex	Vacancy						
Nominated	Essex CC	Vacancy						

Nominations/Terms of Service Committee

The Trust has established the Nominations and Terms of Service Committee of the Council of Governors which is responsible for matters including the appointment, re-appointment and terms and conditions of the Chair and Non-Executive Directors. As at 31 March 2018 the Governor membership of the committee is as follows:

- Stephen King (Public, Basildon and Lead Governor)
- Mark Egalton (Public, Havering and Deputy Lead Governor)
- Geoff Farmer (Public, Havering).
- Clive Myers (Public, Redbridge)

Appointments

At its meeting held on 25 October 2018 the Council of Governors re-appointed two Non-Executive Directors:

- Brian Hagger (Senior Independent Director) was reappointed as a Non-Executive Director for the period 01 December 2017 to 31 May 2018.
- Amanda Lewis was reappointed as a Non-Executive Director for the period 01 November 2017 to 30 November 2019.
- There were no new appointments made by the Council of Governors in 2017/18.

Following the end of Brian Hagger's final term of office as a Non-Executive Director a new appointment will be made. The procedure is planned to include a selection panel with representation from the Nominations and Terms of Service Committee, the Council of Governors, the Chair, a Non-Executive Director and the Equality and Diversity Manager. A recommendation will be brought from the Nominations and Terms of Service Committee to the full Council of Governors.

Governor activity

The Council receives regular reports on NELFT's performance and works collaboratively with NELFT to ensure good governance. Governors are invited to attend three statutory meetings per year, plus NELFT's Annual General Meeting and are also invited to regular governor information forums. The meetings and forums provide structured opportunities to hear feedback from, and to question senior staff including the Chief Executive, executive directors and non-executive directors and to raise issues including those brought to them by constituents. The forums in particular offer opportunities for governors to develop their knowledge about NELFT and NHS structures.

We hold an annual joint Board/Governor strategy workshop which provides an opportunity for governors to give their views and those of members of the public on the trust's forward plans, objectives, priorities and strategies. In addition Governors received a presentation on refreshing the Trust's Strategy in March 2018.

Governors are given the opportunity to review and comment on the NELFT Quality Account and the Annual Report and Accounts at their Council of Governors meetings and via requests for feedback on the Quality Account. The final Accounts and Report are presented to Governors at the Annual General Meeting usually held in September.

Internal Care Quality Commission (CQC) Inspections and PLACE Assessments

As part of their role, governors take part in mock CQC inspections and PLACE assessments and form part of a team made up of senior clinicians and management staff to check on the quality of the services we provide. On such visits governors may be tasked with speaking to patients about their experience and perception of the quality of care, responsiveness and friendliness of staff, cleanliness of rooms and toilets, quality of food, facilities for visitors and information about further treatment or arrangements for going home.

Council of Governor Elections

In June 2017 we were advised of the outcome of elections which resulted in 18 public and staff governors taking up roles on the Council of Governors.

Governors are provided with learning opportunities as well as ongoing support in their roles. The learning programme for governors includes access to NHS Providers' core skills and specialist module training courses to support their understanding of the governor role and the statutory duties involved. We also held two externally facilitated workshops to enable new governors to discuss and learn about their statutory duties and to explore with our Communications Team how best to engage with member and the public.

Council of Governor Meetings

These meeting are held in public at Trust Headquarters and NELFT members are welcome to attend. Meeting dates are listed on the Trust website and further details can be requested from the Head of Corporate Affairs, Lauren MacIntyre, lauren.macintyre @nelft.nhs.uk 0300 555 1300.

Membership

NELFT's membership is comprised of public and staff members. Members of the public are eligible to be part of the following constituencies, depending on where they live: Barking & Dagenham, Havering, Redbridge, Basildon, Brentwood, Thurrock, Waltham Forest and Rest of England. Membership is open to any individual who:

- Is over 11 years of age
- Is entitled under the constitution to be a member of one of the public constituencies as detailed above, or one of the staff constituencies.

As well as receiving regular information about NELFT and feeding back their experiences and ideas, NELFT members can nominate themselves as potential governors and get to vote for their preferred representative during the Council of Governors elections.

Membership Numbers

At 31 March 2018 the Trust had 10,130 public members and 5,634 staff members, making a total of 15,756 members. The Trust has put its focus on engagement with current members rather than recruitment of new members and will continue to do so throughout 2018/19.

Representation

NELFT's membership currently has a good match for most protected characteristics; however we are under-represented in terms of young people, certain BME groups, notably the gypsy and Arabic population, and people who identify as LGBT. The membership office has introduced a rolling programme of targeted recruitment sessions at relevant community and public events to address these gaps. We will regularly review our achievement to target and introduce additional recruitment methods where required.

Recruitment

Public membership has remained consistent over the past few years and to maintain this we offer the following membership registration opportunities:

- Membership information at partner events where we have stalls
- Membership information available at our own events
- An online membership form
- Social media promotion of membership
- Membership promoted via word of mouth by NELFT staff and public governors
- NELFT volunteers encouraged to sign up via their volunteer application forms
- Link to online form in our quarterly stakeholder briefings
- Service users of partner organisations provided with membership information at events and via their websites and newsletters.

Membership Engagement

We are always looking for new ways to better involve members in the Trust and the Communications team has been focusing on the following areas:

- Establishment of an events calendar and fundraising events
- Improved social media activity for people that can't physically attend events e.g. livestreaming events/ conferences, and creation of an online community.
- Revamp web pages on website – one stop shop for people to access information about membership and events

We continue to promote our membership through the following channels:

- Securing increased coverage of our work in local news media
- Development of information on the NELFT website, enabling visitors to find out more about membership and governance at NELFT
- Increased use of social media drawing upon our Twitter followers and Facebook friends to promote membership, upcoming events and opportunities to join our Council of Governors
- Staff governors promoting their role including the opportunity to submit articles for the quarterly stakeholder briefings
- Increased external and internal written promotion including governors' photographs, constituencies and contact details on website and intranet.

Get in contact

We are happy to answer any questions you have about membership or governance at NELFT. Please contact us on the details below.

Membership Office
FREEPOST RRLE/EKUZ-YRXZ
CEME Centre – West Wing
Marsh Way
Rainham
Essex
RM13 8GQ

Tel: 0800 694 0699

Email: membership@nelft.nhs.uk
Website: http://www.nelft.nhs.uk

Signed

Joseph Fielder
Chair
22 May 2018

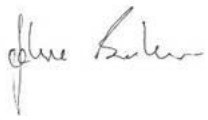
John Brouder
Chief Executive
22 May 2018

STATEMENTS AND ACCOUNTS 2017/18

STATEMENT OF COMPLIANCE WITH THE FOUNDATION TRUST CODE OF GOVERNANCE

North East London NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust fully supports these requirements and no areas have been identified as non-compliant with the Code.

Signed:



John Brouder
Chief Executive
22 May 2018

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF NORTH EAST LONDON NHS FOUNDATION TRUST

The National Health Service Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which requite North East London NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of North East London NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- Prepare the financial statements on a going concern basis.

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

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

Signed:

John Brouder
Chief Executive
22 May 2018

NORTH EAST LONDON NHS FOUNDATION TRUST
ANNUAL GOVERNANCE STATEMENT 2017/18

For the period 1 April 2017 – 31 March 2018

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance. The system of internal control is based on a process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of NELFT, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in NELFT for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust's Risk Management Policy makes it clear that, whilst I have overall responsibility for risk, leadership for specific risk management areas have been delegated to individual Directors:

- The Chief Nurse and Executive Director of Integrated Care (Essex) has delegated responsibility for quality and risk management, including the Care Quality Commission Regulation and compliance with the Fundamental Standards, the risk register, risk assurance, claims management, Central Alerting System, medical devices, health and safety, local security management and the management of clinical governance, including complaints, serious incidents and compliance with coroner's regulations;
- The Chief Nurse and Executive Director of Integrated Care (Essex) has responsibility for the management of risks associated with operations in the Essex health economy, and also responsibility for Infection Prevention and Control (including Flu Pandemic readiness) and the Safeguarding of Children and Adults;
- The Executive Director of Integrated Care (London) has responsibility for the management of risks associated with operations in London health economies;
- The Executive Director of Finance has responsibility for managing the development and implementation of systems of financial and commercial risk;
- The Executive Medical Director is the Trust's Caldicott Guardian and has responsibility for information governance. This individual is the Trust's Senior Information Risk Owner;
- Under the leadership of the Chief Executive Officer, the Estates Director has responsibility for the buildings, plant and non-medical devices used by Trust staff, and has particular responsibilities for Fire safety, security, waste management, and environmental management;
- The Executive Director of Workforce & Organisational Development has responsibility for risk management regarding employees, staffing, workforce development and equalities;

- Integrated Care Directors have responsibility for local risk management systems and controls; and
- Associate Medical Directors, the Directors of Nursing and Professional Leads have responsibility for the systems of clinical risk management at locality level.

The Board, managers and staff are committed to the principles of risk management that apply throughout clinical and non-clinical areas of the Trust. The Risk Management Policy is reviewed every three years by the Board of Directors, as a minimum and is designed to assist individuals in identifying and determining risk activities so that resources can be targeted to reduce risk. The policy details the Trust's framework for setting objectives providing assurance and managing risk with the intended purpose of embedding a consistent culture of accountability for the management of risk. Ultimate responsibility rests with the Board of Directors and staff are trained to be "safety aware" and to identify, assess and record risks in their own areas.

The system of risk management within the Trust is a critical constituent of the internal control framework and this is monitored and developed through the Board, Audit Committee and Quality and Safety Committee, supported by the governance system through each tier of the organisation to ensure appropriate action and shared learning. This is supported by a Head of Risk Assurance within the department of Quality and Patient Safety.

The Trust has an established process of learning and sharing good practice through the three tiers of governance at practice, operational and strategic levels. Products of assurance are managed through a cycle of business at each level and trends and themes are identified and reported through to the Board, Audit Committee and Quality and Patient Safety Committee. This is supported by a framework of learning from incidents, clinical audit, quality improvement programme and development and a robust research and development infrastructure.

The Trust is committed to ensuring a safety culture where staff have a constant and active awareness of risk management and are able to learn. This is supported by a robust organisational development framework to improve staff capability. Staff are supported to report all safety incidents and concerns. The Trust has implemented the Duty of Candour regulatory requirements to ensure the culture remains open and transparent. Equality Impact Assessments are undertaken on all policies and training is provided on incident reporting and management. The Trust considers lessons to be learnt from national inquiries, and ensures any relevant local action is taken forward.

The Trust has a range of mechanisms to facilitate close working with key partners including the performance management of contracts by commissioners, regular attendance at Local Authority Scrutiny Committees, Health and Wellbeing Boards (where applicable), Local Safeguarding Boards, Service User and Carer Groups, Health Watch, and meetings with Chief Officers and Directors of Social Care.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit (HoIA) provides an annual opinion, based on and limited to the work performed, on the overall adequacy and effectiveness of the organisations risk management, control and governance processes. This is achieved through a risk based plan of work, agreed with management and approved by the Audit Committee. Their work has been increasingly skewed towards clinical rather than financial audits and the Audit Committee ensures that the annual plan contains the right balance.

The Head of Internal Audit has given the following opinion for the year ending 31 March 2018:

As the internal auditors of NELFT we are required to provide the Audit Committee, and the Director of Finance with an opinion on the adequacy and effectiveness of risk management, governance and internal control processes, as well as arrangements to promote value for money.

In giving our opinion it should be noted that assurance can never be absolute. The internal audit service provides NELFT with moderate assurance that there are no major weaknesses in the internal control system for the areas reviewed in 2017/18. Therefore, the statement of assurance is not a guarantee that all aspects of the internal control system are adequate and effective. The statement of assurance should confirm that, based on the evidence of the audits conducted, there are no signs of material weaknesses in the internal control framework.

In assessing the level of assurance to be given, we have taken into account:

- All internal audits undertaken by BDO LLP during 2017/18
- Any follow-up action taken in respect of audits from previous periods for these audit areas
- Whether any significant recommendations have not been accepted by management and the consequent risks
- The effects of any significant changes in the organisation's objectives or systems
- Matters arising from previous internal audit reports to NELFT
- Any limitations which may have been placed on the scope of internal audit – no restrictions were placed on our work.

The risk and control framework

o Identification and evaluation of risk

Systems are in place to ensure the identification, analysis, quantification and recording of individual risks, and the consequences of their potential impact, and these form the basis of the Trust's risk register. Risk Registers are maintained at each level in the organisation with the assurance that the risks are being managed appropriately being monitored through the tiers of governance. The Trust ensures that risks are managed at each level and in each locality and within corporate services. The Board Assurance Framework is reviewed by the whole Executive Management Team and Board of Directors who discuss and set the Trust's appetite for BAF risks.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust and as professionals working to professional codes of conduct. The Board of Directors, through the Risk Management Policy and Incident Reporting Policy, promotes open and honest reporting of incidents, risks and hazards. This is supported by a range of policies with which staff are required to comply. There are formal mechanisms for engaging with partner organisations, service users and the wider public and these mechanisms contribute to internal Business Planning and Performance Management processes.

The Trust has a robust approach to managing information governance and data security. The Trust has submitted its March 2018 IG submission within the Information Governance Toolkit version 14.1, achieving a score of 72% and a status of green (satisfactory), based on reaching the level 2 and above targets required to meet compliance set by the DOH/NHSI on all the requirements

o Quality Governance arrangements

The Trust has reviewed the requirements of the Quality Governance framework and has an effective assurance system in place. The monitoring of specific elements of the framework is conducted via the Quality & Patient Safety committee of the board and the Performance Executive group. The committees review governance and performance dashboards on a monthly basis which contain indicators relating to all statutory and regulatory requirements. The Board reviews the Strategic CQC Quality Improvement Plan monthly which contains detailed actions on CQC recommendations such as care planning, risk assessments, falls prevention, incident reporting, information governance and environmental awareness.

- **CQC Registration**

Assurance on compliance with CQC registration requirements is reported and monitored regularly via the three tiers of governance (i.e. Quality & Patient Safety Groups reporting to the Quality & Patient Safety Committee which reports to the Board).

Regular quality and performance reports, quality account and exception reports go to the Board to ensure that members are informed of key quality issues relating to patient experience, patient safety and clinical effectiveness.

- **Principal risks to compliance with the NHS foundation trust condition 4 (FT governance)**

Compliance with the NHS Foundation Trust condition 4 requires trusts to 'apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate as a supplier of healthcare services.'

The principal risk to non-compliance with this condition is for the Trust to fail to establish effective board and committee structures with a clear purpose and terms of reference for each committee and well defined lines of accountability throughout the organisation.

The Trust mitigates this risk by having a three-tiered system of governance in place that ensures quality and performance reporting requirements are mirrored from board subcommittee level down to a local level with information flowing both ways.

The board subcommittee structure is well established. Each committee has a non-executive chair and at least two other non-executive members who provide scrutiny and rigorous challenge to executive committee members about Trust performance. Committees all have terms of reference which are reviewed annually by the board as well as a regularly reviewed cycle of business. Risk, trends and themes are analysed at each committee. The Trust uses dashboard-style reports so that areas of non-compliance can be quickly identified.

Regular progress reports from internal and external auditors on both financial and clinical systems provide assurance that the Trust continues to take action set out in the corporate governance statement over the financial year.

- **Other major risks**

The following risks have been identified as key to the organisation:

Clinical (current risk)
Following a CQC comprehensive inspection in April 2016, the Trust received an overall 'requires improvement' rating. The CQC quality report identified enforcement and requires improvement notices consisting of 137 recommendations. A Strategic CQC Improvement Group was established and an improvement plan developed with a completion date of 30 June 2017.

Risk: If there is not meaningful monitoring and audit of the improvements made there is a risk of reduced safety occurring

Mitigation: Time limited project group established to deliver improvement plan outcomes.

Clinical (current risk)

Risk: If there is an insufficient number of staff in key clinical areas then the ability of staff to provide the best care is compromised

Mitigation: Improvement in recruitment and retention procedures being managed through the Well Led action plan and close monitoring of agency spend and procedures to mitigate the quality risk.

Risk: If services are provided from poor accommodation then this will have a negative impact on the staff and patient experience and the ability of staff to provide the best care

Mitigation: Implementation of the Estates Strategy with opportunities for acceleration under review.

Business (future risk)

Risk: If the Trust is unable to establish effective stakeholder relationships then reputation will suffer along with the ability to influence stakeholders and commissioners, retain business and seek new business

Mitigation: Stakeholder Engagement Plan in place and briefings developed. More structured approach being taken to customer relationship management. Engagement in STPs across the Trust's geographic footprint.

Risk: If the Trust loses new and current business to competitors then reputation and ability to compete in the market will suffer along with the ability transform services in response to patient need

Mitigation: Development and implementation of the Commercial Strategy and monitoring of practice improvement and transformation plans.

- **The Board Assurance Framework**

The Risk Management Strategy describes the arrangements for embedding risk management in the activities of the organisation through explicit processes for identifying, assessing and responding to risks and incidents. The Board Assurance Framework is reviewed by the Board of Directors and Executive Management Team on a monthly basis with an intensive review into a specific domain which is then noted at the Board meeting.

The Audit Committee supports the effective management of risk within the Trust through:

- Assessment of relevant internal and external audit work on systems of control;
- Assuring the effectiveness of external and internal audit and counter fraud services;
- Ensuring that the scope of internal audit provides adequate coverage and review of fundamental systems;
- Commenting on the nature and scope of the external audit plan; and
- Reviewing the annual financial statements before submission to the Board, focusing particularly on: changes in, and compliance with, accounting policies and practices, major judgmental areas; and significant adjustments resulting from the audit

Assurance mechanisms within the Trust are supported by:

- Review of reports completed by internal audit with action and review on agreed risk areas;
- Report on risk management, control and review processes, commissioned from internal audit;
- Preparation for the inspection and report from the Care Quality Commission;
- Recommendations from clinical audits;
- Recommendations and guidance from NHS Improvement and/or the Department of Health;

- Health and Safety Executive assessment and reports;
- Quality and Performance Reviews by local commissioners.

Relationship with Stakeholders

The interests of service users, carers and stakeholders are embedded in our values, and demonstrated in our ways of working. We have strengthened our learning processes, utilising the systems of governance, to improve the quality of our service.

The Trust has a continuing positive relationship with stakeholders and staff through the delivery of key objectives and delivering performance against contracts. This is supported through regular meetings at a strategic and operational level. There is an on-going strategic partnership working strategy and plan that is monitored by the Executive Team and Board. The stakeholder engagement strategy and media plan have also been reviewed.

Compliance with NHS Pension Scheme regulations

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

External Standards

Following a CQC re-inspection and Well-led review in August and October/November 2017, an overall Good rating was received. Overall, four out of five CQC domains received a Good rating for Caring, Effective, Responsive and Well Led, and a Requires Improvement rating for Safe. Areas for improvement identified under the Safe domain have resulted in Requirement Notices with 'must do' actions in relation to three regulations, Regulation 12: safe care and treatment, Regulation 17: good governance and Regulation 18: staffing. Actions are being managed via a risk management approach with monthly reports to Board.

Equality, Diversity and Human Rights

The Trust has all the necessary controls in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with, including published statutory equality schemes.

Carbon Reduction Delivery Plans

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

Information Governance

The Trust has reported two Level 2 Information Governance incidents to the ICO. One incident has resulted in no enforcement notice or fines from the ICO. The other is currently with the ICO for any recommendations or actions. Both incidents were thoroughly investigated, patients were informed, lessons learned and actions put in place.

- **Annual Quality Report**

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

The Trust has put in place an Information Assurance Framework which is monitored through the Data Quality Action Group. The development of the Quality Account involves consultation with a wide group of internal and external stakeholders including governors, service users, Health Watch, Overview and Scrutiny Committees and commissioners.

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

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

The Trust has robust processes in place for managing resources including regular reviews between operational/clinical leads and finance managers and regular scrutiny by executive leads. The programme of internal and external audit approved each year includes a number of financial and clinical audits, the outcomes of which provide the Trust with valuable insight into the effectiveness of systems.

I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Executive Management Team, the Audit Committee and the Quality & Safety Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by the final report of external and internal auditors, the CQC improvement plan following comprehensive inspection in April 2016 and internal management reports and other key reports.

Internal audit methodology is based on four assurance levels in respect of their overall conclusion as to the design and operational effectiveness of controls within the system reviewed. The assurance levels are based on IA giving either "substantial", "moderate", "limited" or "no". The four assurance levels are designed to ensure that the opinion given does not gravitate to a "satisfactory" or middle band grading. Under any system we are required to make a judgement when making our overall assessment.

BDO concluded the Risk Management Maturity Assessment in January 2018 where it was concluded that overall the Trust have a Defined Risk Management process and it is achievable to achieved a Managed position within the next 6-9 months. There are good practices taking place and the key focus areas are to identify disconnects between divisional and BAF risks and that there is a shared understanding of how this works as the review identified disparities in views on how risk is escalated across the Trust. Critically to be fully Managed the Trust should refresh the Board Assurance Framework in line with the recommendations made.

The review has identified a good willingness across the Trust to invest more time into risk management and this is very important to sustain. By continuing to do this BDO believe the Trust can improve the good position it has particularly divisionally and move closer to a stronger risk management framework.

The recent Internal Audit report considered by the Audit Committee provided the Trust with substantial assurance for 1 audit, moderate assurance for 3 audits and limited assurance on 5 audits – Sign Up to Safety, Recruitment & Retention (including agency spend), Health Roster, Mental Health Act Compliance and Temporary Staffing Costs and approvals. Detailed action plans have been developed to address issues identified by audit.

Conclusion

I can confirm that no significant control issues have been identified in the 2017/18 financial year.

Signed:

John Brouder
Chief Executive
22 May 2018

OPERATING AND FINANCIAL REVIEW SUMMARY

For 2017/18 the Trust approved a plan to achieve both a use of financial resources score of 2 (where 1 is the highest and 4 the lowest) and a continuing operations surplus £3.9m, the latter having been set to comply with a £3.4m control total agreed with our regulators. Given that both these objectives were exceeded, with a use of financial resources score of 1 and a final continuing operations surplus of £11.7m, 2017/18 has been another successful year for the Trust.

After allowing for the impact of the revaluation of our land, buildings and IT assets the Trust is reporting an Income and Expenditure deficit of £20.6m, which is summarised below:

NORTH EAST LONDON FOUNDATION TRUST				
Summary Income & Expenditure Position				
For the Year Ending 31st March 2018				
	Annual Budget	**Actual**	**Variance to date**	**Actual last year**
	£	**£**	**£**	**£**
Income	362,435	370,897	8,462	356,058
Expenditure (incl. Reserves)	(349,267)	(351,001)	(1,734)	(346,153)
EBITDA	**13,168**	**19,896**	**6,728**	**9,905**
Depreciation	(4,470)	(4,697)	(227)	(3,445)
PDC	(3,260)	(2,633)	627	(2,846)
Interest Payable	(1,105)	(1,109)	(4)	(1,162)
Interest Receivable	102	116	14	136
Gain on Asset Sale	500	93	(407)	111
Continuing Operations (Control Total)	**4,935**	**11,666**	**6,731**	**2,699**
Impairment	-	(32,229)	(32,229)	(1,697)
Reversal of previous years impairments	-	-	-	25
Total I&E Position	**4,935**	**(20,563)**	**(25,498)**	**1,027**

Income

Overall income increased by £14.8m (4.2%) in 2017/18 to stand at £370.9m. This included £7.7m of NHS Sustainability and Transformation funding. A significant proportion of the Trusts remaining income (94.6%) comes through contracts held with NHS and local authority commissioners. Following a successful tender new NHS Contracts for the provision of all age Eating Disorders and Children's and Adolescent Mental Health Services across Kent have started. Additionally, for 2017/18 NHS Contracts were held with the four North East London Clinical Commissioning Groups, the two Clinical Commissioning Groups covering South West Essex, NHS England and West Essex CCG as lead commissioner for Children's and Adolescent Mental Health Services for Essex. Services were also commissioned by four North East London Borough Councils, Essex County Council and Thurrock Council.

Expenditure

As part of the planning process cost reduction schemes and initiatives totalling £16.0m were required to deliver the 2017/18 financial plan. Additionally, £2.7m of cost reductions were not achieved and a further £0.4m only achieved non recurrently in 2016/17, making a total requirement for 2017/18 of £19.1m. In the year total cost reduction of £16.4m (86.0%) were achieved. Headline expenditure increased in the year by £4.9m (1.4%) to £350.9m.

Approximately 75% of our expenditure relates to pay, including the use of medical and nursing temporary staff employed either through the in house bank or agencies. Expenditure on agency and locum staffing is monitored externally and the Trust has been set an annual expenditure target of £21.9m. Total expenditure on temporary staffing this year is below that of last year, with cumulative agency and locum expenditure being £22.2m (inclusive of £2.3m expenditure incurred on the recently acquired Kent service).

Other non-pay costs include drugs, the cost of premises and the cost of clinical placements sub contracted to NELFT by its mental health commissioners.

Financing Costs

In preparing this set of accounts, the Trust appointed a new external valuer to undertake a full revaluation of its land and buildings. Based upon this assessment and the re-classification of some premises from non specialised to specialised, the total net value of land and buildings has been reduced by £18.5m, resulting in an impairment of £24.7m and a revaluation reserve adjustment of £6.2m. Additionally, the Trust has also appointed an external valuer to assess the value of its IT assets giving rise to a further impairment of £7.5m. Taken together with the impact of new capital works, the value of the Trust's assets has reduced from £140.8m to £113.0m.

The above reduction in the Trusts asset values has contributed to a lower PDC charge this year of £2.6m.

Depreciation of the Trust assets was £4.7m for the year 2017/18.

Capital Expenditure

The total Capital expenditure in the year was £8.7m of which £2.0m related to ligature works and a further £2.7m being spent on the Waltham Forest Hub development which is scheduled to complete in 2019.

Cash and Borrowing

Foundation Trusts retain cash surpluses to invest in future developments and manage risk. At March 2018 the Trust had a cash balance of £49.2m. The Trust has an outstanding PFI liability of £8.1m and a finance lease of £2.6m as at 31st March 2018.

Accounting Policies and Going Concern

The accounts were prepared in accordance with the Trust Accounting Policies which are in line with Foundation Trust accounting guidance as appropriate. They were prepared in line with IFRS as relevant to the NHS and as directed by HM Treasury and NHS Improvement.

The Board is mindful of its duty to ensure the Trust is financially stable, not just for one year but over the medium term, to ensure the Trust remains a going concern. The Board has recently approved the 2018/19 Operating Plan which included a cash flow forecast alongside internal efficiencies required to remain sustainable. This shows that the Trust retains sufficient liquidity to continue in operational existence and to provide the current services for the foreseeable future. The Directors have therefore been able to sign off the Going Concern concept for 2018/19.

Barry Jenkins
Executive Director of Finance
22 May 2018

NHS Foundation Trust accounts template

Inputs

MARSID	NELONDON
Name of Foundation Trust	North East London NHS Foundation Trust
Date of year end (dd/mm/yyyy)	31/03/2018
Start of current year (dd/mm/yyyy)	01/04/2017
Comparative year end (dd/mm/yyyy)	31/03/2017
Start of comparative year (dd/mm/yyyy)	01/04/2016
Year for financial reporting (20XX/YY)	2017/18
Year for comparative year (20XX/YY)	2016/17
Year for year end (20XX)	2018
Year for comparative year (20XX)	2017
Opening Year (20XX)	2016
Next financial year (20XX/YY)	2018/19
Date of approval of financial statements (dd/mm/yyyy)	22/05/2018

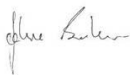
North East London NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

Foreword to the accounts

North East London NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by North East London NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Name	**John Brouder**
Job title	**Chief Executive and Accounting Officer**
Signed	
Date	**22nd May 2018**

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	348,464	338,200
Other operating income	4	22,433	17,858
Total operating income from continuing operations		**370,897**	**356,058**
Operating expenses	6	(387,927)	(351,270)
Operating (deficit) / surplus from continuing operations		**(17,030)**	**4,788**
Finance income	9	116	136
Finance expenses	10	(1,109)	(1,162)
PDC dividends payable		(2,633)	(2,846)
Net finance costs		**(3,626)**	**(3,872)**
Gains on disposal of non-current assets	12	**93**	111
(Deficit) / surplus for the year		**(20,563)**	**1,027**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(18,964)	(741)
Revaluations	14	25,228	1,611
Total comprehensive (expense) / income for the period		**(14,299)**	**1,897**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Property, plant and equipment	14	113,068	140,818
Trade and other receivables	17	46	62
Intangible assets	13	1,754	-
Total non-current assets		**114,868**	**140,880**
Current assets			
Trade and other receivables	17	29,215	20,807
Non-current assets for sale and assets in disposal groups	15	4,050	-
Cash and cash equivalents	18	49,946	51,681
Total current assets		**83,211**	**72,488**
Current liabilities			
Trade and other payables	19	(48,007)	(48,162)
Other liabilities	20	(4,248)	(3,889)
Borrowings	21	(508)	(455)
Provisions	24	(4,403)	(4,969)
Total current liabilities		**(57,166)**	**(57,475)**
Total assets less current liabilities		**140,913**	**155,893**
Non-current liabilities			
Borrowings	21	(10,184)	(10,693)
Provisions	24	(3,729)	(3,901)
Total non-current liabilities		**(13,913)**	**(14,594)**
Total assets employed		**127,000**	**141,299**
Financed by			
Public dividend capital		60,363	60,363
Revaluation reserve		38,368	33,138
Income and expenditure reserve		28,269	47,798
Total taxpayers' equity		**127,000**	**141,299**

The financial statements on pages 4 - 7 were approved by the board of directors on 22nd May 2018 and signed on its behalf

Signature

Name John Brouder

Position Chief Executive

Date 22 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017	**60,363**	**33,138**	**47,798**	**141,299**
Deficit for the year	-	-	(20,563)	**(20,563)**
Transfers between reserves	-	(1,034)	1,034	**-**
Impairments	-	(18,964)	-	**(18,964)**
Revaluations	-	25,228	-	**25,228**
Taxpayers' equity at 31 March 2018	**60,363**	**38,368**	**28,269**	**127,000**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016	**60,363**	**32,921**	**46,118**	**139,402**
Surplus for the year	-	-	1,027	**1,027**
Transfer between reserves for impairments	-	(653)	653	**-**
Impairments	-	(741)	-	**(741)**
Revaluations	-	1,611	-	**1,611**
Taxpayers' equity at 31 March 2017	**60,363**	**33,138**	**47,798**	**141,299**

Statement of Cash Flows for the period ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating (deficit) / surplus		(17,030)	4,788
Non-cash income and expense:			
Depreciation and amortisation	6	4,697	3,445
Net impairments	7	32,229	1,672
(Increase) in receivables and other assets		(7,773)	(2,982)
(Decrease) in payables and other liabilities		(206)	(7,652)
Increase/(decrease) in other liabilities		359	(234)
(Decrease) in provisions		(742)	(1,424)
Net cash generated from/(used in) operating activities		**11,534**	**(2,387)**
Cash flows from investing activities			
Interest received		122	137
Purchase of intangible assets		(354)	-
Purchase of property, plant and equipment		(8,284)	(6,328)
Sale of property, plant and equipment		93	409
Net cash generated (used in) investing activities		**(8,423)**	**(5,782)**
Cash flows from financing activities			
Capital element of finance lease rental payments		(175)	(153)
Capital element of PFI payments		(281)	(257)
Interest paid on finance lease liabilities		(352)	(374)
Interest paid on PFI obligations		(753)	(777)
PDC dividend paid		(3,285)	(2,660)
Net cash generated (used in) financing activities		**(4,846)**	**(4,221)**
(Decrease) in cash and cash equivalents		**(1,735)**	**(12,390)**
Cash and cash equivalents at 1 April		**51,681**	**64,071**
Cash and cash equivalents at 31 March	18	**49,946**	**51,681**

Notes to the Accounts

1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going Concern

The Trust's accounts have been prepared on the basis that the Trust is a "going concern". This means that the Trust's assets and liabilities reflect the ongoing nature of the Trust's activities. After making enquiries, the Directors have a reasonable expectation that North East London NHS Foundation Trust has adequate resources to continue in operational existence and to provide the current services in the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.2 Income Recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable in the normal course of business. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.3 Expenditure on employee benefits

Short Term Employee Benefits

IAS 19 sets out the requirements for accounting for short term employee benefits, post-employment benefits and termination benefits.

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018 is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2018 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

National Employment Savings Trust

In 2013/14, the Trust implemented auto-enrolment for eligible employees in the National Employment Savings Trust (NEST), which is a scheme set up under the Pensions Act 2008. NEST is regulated by The Pensions Regulator the UK regulator of workplace pension schemes.

NEST is a defined contribution, off Statement of Financial Position scheme. The number of employees auto enrolling into NEST in 2017/18 is 142 (20 in 2016/17). The value of employer's contributions in 2017/18 is £26.29k (£5.3k in 2016/17).

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property Plant and Equipment

Property, plant and equipment are recognised as an asset if it is probable that future economic benefits associated with the asset will flow to the entity and the cost of the asset to the entity can be measured reliably.

1.5.1 Capitalisation

Assets are capitalised:

- where they are capable of being used for a period which exceeds one year.
- individually have a cost of at least £5,000; or
- they form a group of assets which individually have a cost of more than £250, collectively have a cost of
- it is held for use in delivering services or for administrative purposes; or
- the cost of the item can be measured reliably.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.5.2 Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

A full revaluation of Land, buildings and IT assets was undertaken at 31st March 2018 by the External Valuers in accordance with the Royal Institution of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect fair value, with a desktop review of land and buildings conducted over the last 4 years .

Fair values are determined as follows:

- land and non-specialised buildings – market value for existing use;
- specialised buildings – depreciated replacement cost. Land and Buildings will be also measured at fair value in accordance with IFRS 13, when they are surplus to requirements, not in use and not expected to be brought back into use the fair value would be considered from the perspective of a buyer who will not take the entity's considerations into account.
- the Trust undertakes a full revaluation of land and buildings every five years with an interim every three years. However in the event of volatile circumstances and unforeseen changes, revaluation frequency will be increased.

1.5.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.5.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Assets are depreciated on current cost evenly over the estimated life of the asset. The Trust applies the following useful lives to assets on acquisition:

Asset	Economic Life
Vehicles	7 years
Furniture	10 years
Soft Furnishing	7 years
Soft Furnishing	7 years
Office and IT equipment	5 years
Mainframe IT equipment	8 years
Short life medical equipment	5 years
Medium Life Medical Equipment	10 years
Long Life Medical Equipment	15 years
Buildings	60 years

1.5.5 Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and excesses are charged to operating expenses.

Decreases in asset values and impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of the impairment charged to operating expenses and the balance in the revaluation reserve attributable to the asset before impairment.

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

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.5.6 De-recognition of non-current assets

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

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

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

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

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

1.6 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.6.1 The Trust as lessee

Finance leases

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.6.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.7 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.8 Intangible assets

An intangible asset is defined as an identifiable non-monetary asset without physical substance, (IAS 38) which is capable of being sold separately from the rest of the Trust's business or arising from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to the Trust and where the cost of the asset can be measured reliably.

1.8.1 Software

Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairment previously recognised in operating expenses now netted off expenditure and not treated in income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter treated as non- operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other non-comprehensive income'.

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

1.8.3 Amortisation

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

The Trust depreciates software licenses over the range of 3 to 5 years.

1.9 Financial instruments and financial liabilities

1.9.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

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

1.9.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.9.3 Loans and receivables

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

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

1.9.4 Financial liabilities

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

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability

1.9.5 Determination of fair value

Fair value is determined from market prices, independent appraisals and discounted cash flow analysis as appropriate to the financial asset or liability. Where required, cash flows are discounted at the Treasury's discount rate.

1.9.6 Classification and measurement

Financial assets are categorised as “fair value through income and expenditure”, loans and receivables.

Financial liabilities are classified as “fair value through income and expenditure” or as “other financial liabilities”.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at ‘fair value through income and expenditure’ is impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

1.9.7 Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’. When items classified as ‘available-for-sale’ are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in ‘Finance Costs’ in the Statement of Comprehensive Income.

1.10 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that it will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.
Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016-17: positive 0.24%) in real terms.

1.10.1 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in the Notes to the Accounts at note **25.**

1.10.2 Non-clinical risk pooling

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

1.10.3 Joint ventures

Joint ventures are separate entities over which the Trust has joint control with one or more other parties.
The Trust does not currently have any Joint Ventures.

1.11 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods.

1.11.1 Critical judgements in applying accounting policies

The following are critical judgements, apart from those involving estimations which management have made in the process of applying the Trust's accounting policies and that have the most significant impact on the financial value recognised in the financial statements:

An assessment of the Trust's Private Finance Initiative (PFI) scheme was made in 2009-10 and determined that the PFI scheme in respect of Chapters House, Goodmayes hospital, should be accounted for as an On Statement of Financial Position asset under IFRIC 12.

Land, buildings, dwellings and IT assets to the value of £112M are shown in the accounts and this constitutes the most significant accounting estimate, based on a full revaluation undertaken by two separate External Valuers. (Montagu Evans and DVS Property Specialist). The net impact of the revaluation is shown below:

	£000
Impairment charged to Revaluation Reserve	(18,964)
Impairment charged to I&E	(32,229)
Upward revaluation	25,228
Net Impact	**(25,965)**

1.11.2 Provisions

Assumptions around the timing of the cash flows relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Trust and from external advisers regarding when legal issues may be settled.

1.12 Accounting Standards Issued but not yet adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

Accounting Standards	Published by IASB	Financial year for which the change first applies	Effect on Trust for the year ended 31 March 2018
IFRS 9 Financial Instruments	Jul-14	Application required for Accounting periods beginning on or after 1 January 2018	No effect
IFRS 15 -Revenue from Contracts with customers	May-14	Application required for accounting periods beginning on or after 1 January 2018	No effect
IFRS 16 Leases	Jan-16	Applies to annual reporting periods beginning on or after 1 January 2019	No effect
IFRIC 22-Foreign Currency Transactions and advance consideration	Dec-16	Application required for accounting periods beginning on or after 1 January 2018	No effect
IFRIC 23-Uncertainty over Income Tax Treatments	Jun-16	Applies to annual reporting periods beginning on or after 1 January 2019	No effect

* This reflects the EU -adopted effective date rather than the effective date in the standard.

1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in the notes where an inflow of economic benefits is probable.

Contingent liabilities are not recognised but are disclosed in the notes unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent assets and liabilities arising in the year are disclosed at note **25.1**

1.15 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the actual cost of capital utilised by the Trust, is payable over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the actual average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cleared balances in GBS and National Loan Fund deposits, excluding cash balance held in GBS account that relate to a short-term working capital facilities ,(iii) any PDC dividend balance receivable or payable.

The dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.16 Taxation

1.16.1 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16.2 Corporation tax

The Trust is a Health Service body within the meaning of s519A Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within the categories covered by this. There is a power for the Treasury to apply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to the provision of health care and where the profits there from exceed £50,000 per annum. There is no tax liability arising in the current financial year.

1.17 Third party assets

North East London Foundation Trust held cash and cash equivalents which relate to monies held by the Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts. The Third Party Assets as at 31st March 2018 is £45K (£510K in the year ended 31 March 2017).

1.18 Losses and special payments

Losses and Special Payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories which govern the way each individual case is handled.

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

Losses and Special Payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

2 Operating Segments

As the Trust is based on a Borough Directorate Structure to reflect the commissioning arrangement it reports to the Board (Chief Operating Decision Maker) as a whole entity. Accordingly, no segmental information is provided in these accounts.

3 Operating income from patient care activities

3.1 Income from patient care activities (by nature)

	2017/18 £000	2016/17 £000
Mental health services		
Cost and volume contract income	10,419	406
Block contract income	139,037	130,884
Clinical partnerships providing mandatory services (including S75 agreements)	1,472	1,469
Clinical income for the secondary commissioning of mandatory services	3,847	3,748
Other clinical income from mandatory services	2,794	1,501
Community services		
Community services income from CCGs and NHS England	136,826	138,177
Community services income from Local Authority	52,377	59,688
Other services		
Other clinical income	1,692	2,327
Total income from activities	**348,464**	**338,200**

3.2 Income from patient care activities (by source)

	2017/18 £000	2016/17 £000
NHS England	17,025	16,083
Clinical commissioning groups	271,899	255,577
NHS Foundation Trusts	557	477
NHS Trusts	1,767	1,237
Local authorities	56,218	60,651
Department of Health	-	722
NHS other	-	328
NHS injury scheme	152	558
Non NHS: other	846	2,567
Total income from activities	**348,464**	**338,200**

3.3 Overseas visitors (relating to patients charged directly by the NHS Foundation Trust)

No overseas visitor are invoiced directly, however the Trust invoices our host CCG where overseas visitors use the Trusts services. This income which was £655k in 2017/18, is included under income from patient care activities.

3.4 Income from activities arising from commissioner requested services

Under the terms of its provider license, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18 £000	2016/17 £000
Income from services designated (or grandfathered) as commissioner requested services	340,131	330,624
Income from services not designated as commissioner requested services	8,333	7,576
Total	**348,464**	**338,200**

4 Other operating income

	2017/18 £000	2016/17 £000
Research and development	2,131	2,063
Education and training	8,086	8,851
Education and training - notional income from apprenticeship fund	10	-
Non-patient care services to other bodies	285	1,188
Sustainability and Transformation Fund income	7,723	3,938
Rental revenue from operating leases	784	776
Rental revenue from finance leases	180	-
Other income	3,234	1,042
Total other operating income	**22,433**	**17,858**

5 Operating leases

5.1 North East London NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where North East London NHS Foundation Trust is the lessor.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	784	776
Total	**784**	**776**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
Not later than one year;	784	855
Later than one year and not later than five years;	-	855
Total	**784**	**1,710**

5.2 North East London NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where North East London NHS Foundation Trust.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	12,257	3,052
Total	**12,257**	**3,052**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
Not later than one year;	3,216	3,181
Later than one year and not later than five years;	6,729	8,731
Later than five years.	997	1,868
Total	**10,942**	**13,780**

All of the lease arrangements are in relation to the rental of building for the provision of services except for Pegasus total bed management contract of Community Health Services (CHS) which is for the lease of beds. All operating lease rentals are charged to operating expenses on a straight- line basis over the term of the lease.

6 Operating expenses

	2017/18 £000	2016/17 £000
Services from NHS foundation Trusts	1,155	1,511
Services from NHS Trusts	350	1,060
Services from CCGs and NHS England	56	167
Purchase of healthcare from non NHS bodies	2,863	4,072
Remuneration of non-executive directors	202	157
Staff and executive directors costs	265,719	260,440
Supplies and services - clinical	11,720	12,404
Supplies and services - general	731	1,048
Establishment	6,279	6,597
Premises - business rates collected by local authorities	1,009	811
Research and development-non staff	17	-
Transport	1,013	688
Premises	29,693	35,949
(Decrease) / Increase in provision for impairment of receivables	(392)	790
Drug costs	4,822	4,510
Depreciation on property, plant and equipment	4,697	3,445
Net impairments	32,229	1,672
Audit fees payable to the external auditor		
Audit services - statutory audit	74	74
Other auditor remuneration (external auditor only)	10	63
Clinical negligence	510	364
Legal fees	641	1,655
Consultancy costs	138	174
Internal audit costs	74	78
Training, courses and conferences	1,866	4,508
Education and training - notional expenditure funded from apprenticeship fund	10	-
Patient travel	13	16
Redundancy	-	(1,167)
Operating lease expenditure (net)	12,257	3,052
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI) on IFRS basis	1,212	1,182
Insurance	64	43
Other services, e.g. external payroll	4,091	4,717
Losses, ex gratia & special payments	9	2
Other	4,795	1,188
Total	**387,927**	**351,270**

6.1 Auditor remuneration exc. VAT

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
Financial Statements Audit	59	59
Whole of Government Accounts	2	2
Audit related assurance services	8	8
All other assurance services	-	44
Total	**69**	**113**

6.2 Limitation on auditor's liability

Our contract with our external auditors provides for a limitation of the auditor's liability to a maximum aggregate of £500k.

7. Impairment of assets

	2017/18 £000	2016/17 £000
Impairments charged to the operating expenses - Note 7 (a)	32,229	1,672
Impairments charged to the revaluation reserve - Note 7 (b)	18,964	741
Total impairments	**51,193**	**2,413**

Note 7 (a)

	£000
Impairment	34,098
Impairment reversal	- 1,869
Impairments charged to the operating expenses	**32,229**

Note 7 (b)

	£000
Impairments charged to the revaluation reserve	18,987
Reversal of impairments credited to the revaluation reserve	-23
Impairments charged to the revaluation reserve	**18,964**

8 Employee costs

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	198,688	191,297
Social security costs	19,676	18,367
Apprenticeship levy	989	-
Employer's contributions to NHS pensions	24,090	23,429
Pension cost - other	26	5
Temporary staff (including agency)	22,250	27,342
Total staff costs	**265,719**	**260,440**

8.1 Retirements due to ill-health

	2017/18		2016/17	
	£000	Number	£000	Number
Early retirement due to ill health	174	6	106	2

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

9 Finance Income

Finance income represents interest received on assets and investments in the period.

	2017/18 £000	2016/17 £000
Interest on bank accounts	116	136
Total	**116**	**136**

10 Finance expense

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Interest on Finance leases Obligations	352	374
Unwinding of discount on provision (Others)	4	11
Main finance costs on PFI and LIFT schemes obligations	753	777
Total	**1,109**	**1,162**

11 Better Payment Practice Code - Measure of Compliance

	2017/18 Number	2016/17 Number
Total Non-NHS Trade invoices paid in the year	35,952	61,926
Total Non-NHS Trade invoices paid within target	24,690	34,256
Percentage of Non-NHS Trade invoices paid within target	69%	55%
Total NHS Trade invoices paid in the year	1,532	1,624
Total NHS Trade invoices paid within target	647	933
Percentage of NHS Trade invoices paid within target	42%	57%

12 Profit on Disposal of Non Current Assets

	2017/18 £000	2016/17 £000
Profit on disposal of non-current assets	93	409
Loss on disposal of non-current assets	-	(298)
Net profit on disposal of non-current assets	**93**	**111**

This £93k represents overage from previous year sale. There has been no disposals arising in 2017/18

13 Intangible Assets

	Software licenses	Total
	£000	£000
Valuation/gross cost at 1 April 2017	**-**	**-**
Additions	354	**354**
Reclassifications	1,400	**1,400**
Gross cost at 31 March 2018	**1,754**	**1,754**
Net book value at 31 March 2018	**1,754**	**1,754**

As a result of a revaluation of its IT assets at 31 March 2018, it came to the attention of the Trust that one of these assets held as Asset Under Construction (AUC) in the previous year and becoming operational in the year should be classed as an intangible asset. Accordingly, the asset has now been reclassified as intangible.

14 Property, Plant and Equipment

14.1 Property, Plant and Equipment 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2017	**41,980**	**80,583**	**10,055**	**428**	**40**	**15,194**	**1,625**	**149,905**
Additions	-	2,821	5,329	-	-	205	-	**8,355**
Additions - leased			7					**7**
Impairments	(10,049)	(16,564)	-	-	-	(7,485)	-	**(34,098)**
Impairments charged to the revaluation reserve	(11,552)	(7,435)						**(18,987)**
Reversal of impairments credited to operating expenses	12	1,857	-	-	-	-	-	**1,869**
Reversal of impairments credited to the revaluation reserve	-	23	-	-	-	-	-	**23**
Revaluations	972	21,521	-	-	-	(9,133)	-	**13,360**
Reclassifications	-	8,243	(14,415)	-	-	4,772	-	**(1,400)**
Transfers to/ from assets held for sale	(3,840)	(210)	-	-	-	-	-	**(4,050)**
Disposals / derecognition	-	-	-	-	-	-	-	**-**
Gross cost at 31 March 2018	**17,523**	**90,839**	**976**	**428**	**40**	**3,553**	**1,625**	**114,984**
Accumulated depreciation at 1 April 2017	12		-	428	39	7,213	1,395	**9,087**
Provided during the year	-	2,723	-	-	1	1,920	53	**4,697**
Revaluations	(12)	(2,723)	-	-	-	(9,133)	-	**(11,868)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**428**	**40**	**-**	**1,448**	**1,916**

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
NBV total at 31 March 2018								
Owned	15,075	73,866	976	-	-	3,553	177	**93,647**
Finance leased	588	2,613	-	-	-	-	-	**3,201**
On-SoFP PFI contracts and other service concession arrangements	1,860	14,360	-	-	-	-	-	**16,220**
NBV total at 31 March 2018	**17,523**	**90,839**	**976**	**-**	**-**	**3,553**	**177**	**113,068**

The £25,228m shown in the Statement of Comprehensive Income (page 4) is the sum of the two revaluation figures indicated(£13,360m + £11,868m)

The Trust has undertaken a full revaluation of its Land, Buildings and IT assets at 31 March 2018 as shown below:

	Land & Building	IT Assets
Name of the valuer	Montagu Evans	DVS
Qualification	RICS	RICS

14.2 Property, Plant and Equipment 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2016	**40,733**	**83,523**	**12,319**	**428**	**40**	**9,310**	**1,625**	**147,978**
Additions	494	1,248	3,282	-	-	1,357	-	**6,381**
Impairments	(10)	(731)	-	-	-	-	-	**(741)**
Reclassifications	-	-	(5,546)	-	-	5,546	-	**-**
Revaluations	763	(3,457)	-	-	-	-	-	**(2,694)**
Disposals / derecognition	-	-	-	-	-	(1,019)	-	**(1,019)**
Gross cost at 31 March 2017	**41,980**	**80,583**	**10,055**	**-**	**-**	**15,194**	**-**	**149,905**
Accumulated depreciation at 1 April 2016	12	-	-	428	39	7,175	1,342	**8,996**
Provided during the year	-	2,633	-	-	-	759	53	**3,445**
Impairments	-	1,697	-	-	-	-	-	**1,697**
Reversals of impairments	-	(25)	-	-	-	-	-	**(25)**
Revaluations	-	(4,305)	-	-	-	-	-	**(4,305)**
Disposals / derecognition	-	-	-	-	-	(721)	-	**(721)**
Accumulated depreciation at 31 March 2017	**12**	**-**	**-**	**428**	**39**	**7,213**	**1,395**	**9,087**

Note Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
NBV total at 31 March 2017								
Owned	38,131	63,676	10,055	-	1	7,981	230	**120,074**
Finance leased	1,296	3,024	-	-	-	-	-	**4,320**
On-SoFP PFI contracts and other service concession arrangements	2,541	13,883	-	-	-	-	-	**16,424**
NBV total at 31 March 2017	**41,968**	**80,583**	**10,055**	**-**	**1**	**7,981**	**230**	**140,818**

15 Non-current assets held for sale 2017/18

	Land £000	Buildings excl. dwellings £000	Total £000
At 1 April 2017	**-**	**-**	**-**
Assets classified as available for sale in the year	3,840	210	**4,050**
At 31 March 2018	**3,840**	**210**	**4,050**

Asset Held for sale

The following assets are held for sale for the reasons below:

Naseberry court - This building was not fit for purpose and all its service has been transferred to Goodmayes site.
Greenthorne - The community mental health team at this site has been relocated to Thorpe Coombe.
Aveley clinic – This facility is no longer used for clinical or administrative purpose.

As a result, all the above facilities have become vacant and have no alternative use and the Board has decided to dispose of it as it is surplus to its estate requirements. As the process of disposal is already underway and is likely to be sold within the next 12 months, the assets have been reclassified as “Asset Held for Sale”, at its fair value.

16 Inventories

There were no inventories at the year ended 31 March 2018 (nil as at 31 March 2017).

17 Trade and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	17,008	16,519
Provision for impaired receivables	(1,012)	(1,404)
Prepayments	3,392	2,779
Accrued income	6,491	217
Interest receivable	-	6
PDC dividend receivable	625	-
VAT receivable	1,209	1,277
Other receivables	1,502	1,413
Total current trade and other receivables	**29,215**	**20,807**
Non-current		
Other receivables	46	62
Total non-current trade and other receivables	**46**	**62**

17.1 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April	**1,404**	**847**
Increase in provision	779	790
Amounts utilised	-	(233)
Unused amounts reversed	(1,171)	-
At 31 March	**1,012**	**1,404**

17.2 Analysis of impaired receivables

	31 March 2018 Trade and Other receivables	31 March 2017 Trade and Other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	49	-
30 - 60 Days	29	119
60 - 90 days	11	2
90 - 180 days	100	365
Over 180 days	823	918
Total	**1,012**	**1,404**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	7,843	2,991
30 - 60 Days	3,462	4,138
60 - 90 days	1,039	752
90 - 180 days	1,961	1,588
Over 180 days	5,639	2,954
Total	**19,944**	**12,423**

18 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**51,681**	**64,071**
Net change in year	**(1,735)**	(12,390)
At 31 March	**49,946**	**51,681**
Broken down into:		
Cash at commercial banks and in hand	766	58
Cash with the Government Banking Service	49,180	16,623
Deposits with the National Loan Fund	-	35,000
Total cash and cash equivalents as in SoCF	**49,946**	**51,681**

18.1 Third party assets held by the NHS Foundation Trust

North East London NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	45	510
Total third party assets	**45**	**510**

19 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Receipts in advance	2	78
Trade payables	26,157	22,630
Capital payables	690	612
Social security costs	5,468	4,995
Other payables	1,203	490
Accruals	14,487	19,330
PDC dividend payable	-	27
Total current trade and other payables	**48,007**	**48,162**

20 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Other deferred income	4,248	3,889
Total other current liabilities	**4,248**	**3,889**

21 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Obligations under finance leases	201	174
Obligations under PFI contracts	307	281
Total current borrowings	**508**	**455**
Non-current		
Obligations under finance leases	2,371	2,573
Obligations under PFI contracts	7,813	8,120
Total non-current borrowings	**10,184**	**10,693**

22 Finance leases

Trust as a lessee

Obligations under finance lease where North East London NHS Foundation Trust is the lessee:

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**4,086**	**4,613**
of which liabilities are due:		
Not later than one year;	527	527
Later than one year and not later than five years;	2,109	2,109
Later than five years.	1,450	1,977
Finance charges allocated to future periods	(1,514)	(1,866)
Net lease liabilities	**2,572**	**2,747**
of which payable:		
Not later than one year;	201	174
Later than one year and not later than five years;	1,140	996
Later than five years.	1,231	1,577
	2,572	**2,747**

There have been no significant lease arrangements during the year end 31 March 2018.

23 Imputed finance lease obligations

The Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI liabilities	**14,472**	**15,506**
Of which liabilities are due		
Not later than one year	1,034	1,034
Later than one year and not later than five years	4,135	4,135
Later than five years	9,303	10,337
Finance charges allocated to future periods	(6,352)	(7,105)
Net PFI obligation	**8,120**	**8,401**
Not later than one year	307	281
Later than one year and not later than five years	1,537	1,407
Later than five years	6,276	6,713

23.1 Total on-SoFP PFI commitments

The Trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Commitments in respect of the service element of the PFI or other service concession arrangement	21,900	23,111
Of which liabilities are due:		
Not later than one year	1,243	1,212
Later than one year and not later than five years	5,287	5,158
Later than five years	15,370	16,741

23.2 Total future payments committed in respect of PFI or other service concession arrangements

	31 March 2018 £000	31 March 2017 £000
Consisting of:		
Not later than one year	2,807	2,739
Later than one year and not later than five years	11,949	11,657
Later than five years	32,997	36,095
Total amount paid to service concession operator	**47,753**	**50,491**

24 Provisions for liabilities and charges analysis

	Current		Non-Current	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Provisions relating to other staff	309	309	3,729	3,901
Other legal claims	103	110	-	-
Redundancy	3,471	3,108	-	-
Other	520	1,442	-	-
	4,403	**4,969**	**3,729**	**3,901**

	Pensions	Other legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**4,210**	**110**	**3,108**	**1,442**	**8,870**
Arising during the year	126	70	3,471	520	**4,187**
Utilised during the year	(302)	(6)	(928)	(260)	**(1,496)**
Reversed unused	-	(71)	(2,180)	(1,182)	**(3,433)**
Unwinding of discount	4	-	-	-	**4**
At 31 March 2018	**4,038**	**103**	**3,471**	**520**	**8,132**
Expected timing of cash flows:					
- not later than one year;	309	103	3,471	520	**4,403**
- later than one year and not later than five years;	1,236	-	-	-	**1,236**
- later than five years.	2,493	-	-	-	**2,493**
Total	**4,038**	**103**	**3,471**	**520**	**8,132**

25 Clinical negligence liabilities

	31 March 2018	31 March 2017
	£000	£000
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of the Trust	3,053	1,607

25.1 Contingent assets and liabilities

	31 March 2018	31 March 2017
	£000	£000
Contingent liabilities - NHS Litigation Authority legal claims	(82)	(72)

26 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	-	1,476

27 Events After the Reporting Period

There are no events after the reporting period that require disclosure.

28 Financial instruments

28.1 Financial risk management

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in its activities.

The Trust's Treasury management operations are carried out by the Finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Credit Risk

Because of the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the debtors note.

Liquidity Risk

The Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. The Trust is not, therefore exposed to significant liquidity risks.

Interest Rate Risk

All of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore exposed to significant interest rate risk.

28.2 Financial assets

	Loans and receivables	Total
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non-financial assets	23,235	**23,235**
Trade and other receivables (excluding non-financial assets) - with other bodies	754	**754**
Cash and cash equivalents at bank and in hand	49,946	**49,946**
Total at 31 March 2018	**73,935**	**73,935**

	Loans and receivables	Total
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non-financial assets	12,250	**12,250**
Cash and cash equivalents at bank and in hand	51,681	**51,681**
Total at 31 March 2017	**63,931**	**63,931**

28.3 Financial liabilities

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Obligations under finance leases	2,572	**2,572**
Obligations under PFI, LIFT and other service concession contracts	8,120	**8,120**
Trade and other payables excluding non-financial liabilities	17,235	**17,235**
Trade and other payables (excluding non-financial liabilities) - with other bodies	30,772	**30,772**
Total at 31 March 2018	**58,699**	**58,699**

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Obligations under finance leases	2,747	**2,747**
Obligations under PFI and other service concession contracts	8,401	**8,401**
Trade and other payables excluding non-financial liabilities	48,162	**48,162**
Provisions under contract	4,660	**4,660**
Total at 31 March 2017	**63,970**	**63,970**

	31 March 2018	31 March 2017
	£000	£000
In one year or less	58,699	64,415
Total	**58,699**	**64,415**

28.4 Fair values of financial assets

	Book value	
	£000	£000
Non-current trade and other receivables excluding non-financial assets	46	46
Total	**46**	**46**

28.5 Fair values of financial liabilities

	Book value	Fair value
	£000	£000
Non-current financial liabilities	3,729	3,729
Total	**3,729**	**3,729**

29 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses:				
Theft, fraud etc.	4	1	1	-
Overpayment of Salary	7	8	3	-
Total losses	**11**	**9**	**4**	**-**
Special payments				
Ex-gratia payments	-	-	7	2
Total special payments	**-**	**-**	**7**	**2**
Total losses and special payments	**11**	**9**	**11**	**2**

The amounts stated above are reported on an accruals basis but exclude provision for future losses.

30 Related parties

North East London Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the Year ended 31 March 2018, none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust. The Trust has engaged in transaction with Provide CIC but immaterial in value

The value of material transactions with related parties is as shown below:

	Receivables		Payables	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Related parties as defined by NELFT are as follows:				
Department of Health	19	-	-	27
Barking &Dagenham CCG	2,405	629	-	-
Havering CCG	1,371	833	-	161
Redbridge CCG	1,686	666	-	-
Waltham Forest CCG	1,310	265	-	25
Basildon &Brentwood CCG	639	424	56	240
Thurrock CCG	525	222	-	-
Barking, Havering and Redbridge University Hospitals NHS Trust	764	-	755	-
Other NHS Bodies	8,537	9,175	4,358	5,748
Total	**17,256**	**12,214**	**5,169**	**6,201**

	Income		Expenditure	
	2017/18 £000	2016/17 £000	2017/18 £000	2016/17 £000
Department of Health	1,902	1,358	2	95
Barking & Dagenham CCG	58,911	59,649	-	128
Havering CCG	55,125	55,362	-	190
Redbridge CCG	45,883	44,332	-	247
Waltham Forest CCG	60,849	55,575	162	200
Basildon & Brentwood CCG	14,943	17,665	-	240
Thurrock CCG	7,889	7,718	-	-
Barking, Havering and Redbridge University Hospitals NHS Trust	1,124	-	989	-
Other NHS Bodies	58,894	44,759	15,082	16,096
Total	**305,520**	**286,418**	**16,235**	**17,196**

30.1 Related parties

	Receivables		Payables	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Local Authority Bodies is as follows:				
Barking & Dagenham Council	621	116	159	17
Havering Council	751	624	-	390
Redbridge Council	1,573	1,267	53	64
Waltham Forest Council	278	459	-	216
Essex County Council	1,056	1,469	783	-
Thurrock Council	417	246	74	8
Others	118	55	15	397
Total	**4,814**	**4,236**	**1,084**	**1,092**

	Income		Expenditure	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Local Authority Bodies is as follows:				
Barking & Dagenham Council	6,650	6,747	29	429
Havering Council	5,023	3,729	267	466
Redbridge Council	6,406	7,023	81	766
Waltham Forest Council	7,006	7,611	56	202
Essex County Council	12,690	16,970	-	-
Thurrock Council	17,866	18,082	91	65
Others	577	489	492	603
Total	**56,218**	**60,651**	**1,016**	**2,531**

31 NON CONSOLIDATION OF CHARITABLE FUND ACCOUNTS

NELFT is the corporate trustee to North East London Community Health Care Charity (Charity Registration No: 1048931). The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

Prior to 2013/14, the FT ARM permitted the NHS foundation trust not to consolidate the charitable fund. From 2013/14 this dispensation is no longer available and NHS foundation trusts therefore need to consolidate any material NHS charitable funds which they determine to be subsidiaries.

The charitable fund account for the year ended 31 March 2018 has an income of £15K expenditure of £87K and net assets of £277k at this date. As these values are not material to the Trust's overall results, the Trust has opted not to consolidate the accounts under IAS 27. Further information on the charity and its accounts can be found at the Charity Commission website at: http://www.charity-commission.gov.uk/

KPMG

Independent auditor's report

to the Council of Governors of North East London NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of North East London NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity, Statement of Cash Flows, and the related notes, including the accounting policies in Note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: financial statements as a whole	£7.1m (2016/17:£6.8m) 1.9% (2016/17:1.8%) of total income from operations

Risks of material misstatement		vs 2016/17
Recurring risks	Valuation of land and building assets	◀▶
	Valuation and existence of income and receivables	◀▶

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters (unchanged from 2017/18), in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Land and Buildings (£108.4m; 2016/17: £122.5m) *Refer to page 10 (Audit Committee Report), Note 1 (accounting policy) and Note 12 (financial disclosures)*	**Valuation of Land and Buildings:** Land and buildings are required to be held at fair value. Assets which are held for their service potential and are in use should be measured at their current value in existing use. In accordance with the adaptation of IAS16 this is interpreted as market value for non-specialised assets and as market value in existing use for specialised assets. Market value in existing use is interpreted as the modern equivalent asset value, being the cost of constructing an equivalent asset at today's cost. Trusts may determine that an equivalent asset would be constructed at a different site or make assumptions about the amount of space required. These should be realistic assumptions about the location and size of site required. It is also necessary to consider whether there is any indication of impairment. Impairment could occur as a result of loss of market value due to conditions in the market or due to deterioration in the value in use of the asset, either because of its condition or because of obsolescence. Valuations are inherently judgemental, therefore our work is focused on whether the valuers methodology, assumptions and the underlying data used to arrived at those, are appropriate and correctly applied during the valuation exercise North East London NHS Foundation Trust had a full valuation of its land and buildings undertaken at the 31 March 2018. The Trust engaged Montagu Evans to undertake the full revaluation exercise which included the measurement of all Trust buildings. The revaluation exercise resulted in a £24.4m decrease in the value of land and a £10.3 million increase in the value of buildings compared to the prior year.	Our procedures included: — **Review of the Trust's valuer:** We assessed the scope, qualifications and experience of Montagu Evans, North East London NHS Foundation Trust's valuer and the overall methodology of the valuation performed to identify whether the approach was in line with industry practice and the valuer was appropriately experienced and qualified to undertake the valuation. — **Review of asset records:** We considered the accuracy and completeness of the estate base data provided to the valuer to complete the valuation to ensure it accurately reflected the Trust's estate. — **Methodology choice:** We assessed the overall methodology of the valuation performed to understand whether the approach was in line with industry practice. — **Accuracy of assumptions:** We considered the revaluation basis and benchmarks used by the valuer. We engaged our property team experts to undertake an assessment of the revaluation. — **Application of the valuation:** We considered the accuracy of the accounting treatment applied by the Trust when recognising revaluation gains and losses on individual assets. **Our results** We found the resulting valuation of land and buildings to be balanced.

2. Key audit matters: our assessment of risks of material misstatement

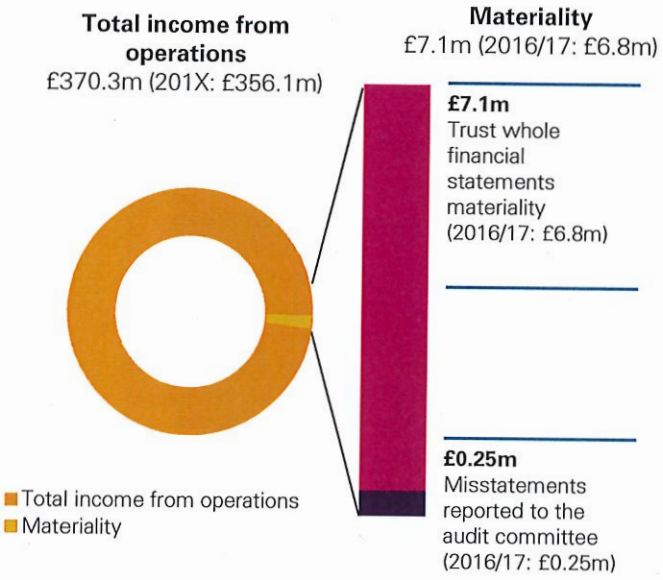
	The risk	Our response
Income and Receivables Income: (£370m; 2016/17: £356m) Receivables: £28.6m; 2016/17 £20.9m) *Refer to page 11 (Audit Committee Report), Note 1 (accounting policy) and Note 3, 4 and 15 (financial disclosures).*	**Valuation and Existence of Income and Receivables** Of the Trust's reported total income, £289 million (2016/17 £272m) came from the commissioners (Clinical Commission Group and NHS England). CCGs and NHS England make up 78% of the Trust's income. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then commissioners are able to impose fines, reducing the level of income achievement. In 2017/18, the Trust have recognised Sustainability and Transformation Funding from NHS Improvement. This was received subject to achievement of defined financial and operational targets on a quarterly basis. The Trust was allocated £7.7m of transformation funding, of which £5.4m was additional, bonus funding made available at year end due to the achievement of those targets. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £250,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. The Trust reported total income of £21.8m (2015/16: £14 million) from other operating activities. Much of this income is contracted from NHS and non-NHS bodies under contracts that indicate when income will be received; on delivery, milestones, or periodically. Some sources of income require independent confirmations which can impact the amount the Trust will receive.	Our procedures included: — **Contract agreement:** We agreed a sample of commissioner and local authority income balances to the signed agreements in place. We assessed the contract variations identified and sought explanations as to the cause of these variances. — **Agreement of balances:** We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers. Where there were mismatches we challenged management's assessment of the level of income they were entitled to and the receipts that could be collected. In doing so we examined supporting correspondence for any formal disputes or arbitration for consistency with the accounting treatment within the financial statements. — **Sustainability and Transformation Funding**: We assessed the Trust's calculation of performance against the financial and operational targets used in determining receipt of Sustainability and Transformation Funding to determine the amount the Trust qualified to receive. We agreed the amounts recorded in the accounts to our calculation. — **Provision for impaired receivables:** We considered the basis upon which provisions for non-NHS debt have been made. We tested the assumptions taking into account both past performance and circumstances specific to the financial year end. — **Income recognition:** We tested income transactions that spanned the financial year end to assess whether the income had been recognised in the correct financial period. **Our results** We found the resulting estimates made by the Trust in relation to NHS income and receivables to be balanced.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £7.1 million (2016/17: £6.8 million), determined with reference to a benchmark of total income from operations (of which it represents approximately 1.9%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.25 million (2016/17: (£0.25 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Rainham, Essex.



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 46, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of North East London NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Fleur Nieboer

for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants

15 Canada Square, Canary Wharf, London, E14 5GK

25 May 2018

KPMG

NELFT NHS
NHS Foundation Trust
Best care by the best people

NELFT NHS Foundation Trust

Quality Account

2017/18

PART A

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Foreword

Welcome to our Quality Account, indeed welcome to another year of learning and development for us as we seek to learn from our past in order to build a better future. I signed off my foreword last year with a statement of confidence that we would continue to grow, to learn and to improve the experience of the people that we serve in both our patient and staff cohorts. The reflective test now of course should be to determine what the evidence is one year on to show that we have delivered on that ambition.

The year has been no less challenging that we anticipated for all public services. There are major changes afoot and integrated care and STPs have dominated much of our thinking and development time.

Despite that, we have continued to grow our service portfolio and this has been a year in which we acquired the child and adolescent mental health services for young people in Kent and Medway. New acquisitions notoriously take a lot of work but the learning and improvement processes that we put in place for the Essex services have served us well in the early days. I am confident that we will do an equally good job in driving up the standards for the services in Kent in the way that we have done for Essex.

The Board has remained grounded throughout the year and at every meeting a patient journey is shared for learning and discussion. We have heard some interesting stories from patients this year, good and bad, but each is a reminder of our purpose and an opportunity to improve. We have seen our patient and carer Friends and Family Test maintaining high scores and we have seen the highest ever return on our Staff Survey with many of our scores improving dramatically.

Most importantly we have seen our overall ratings with the CQC move from 'Requires Improvement' to 'Good'. Our rating for our Brookside services has moved to 'Outstanding'. The latter rating has generated a real spike in energy both locally and nationally. Most recently Brookside was featured as the national monthly blog for the NHS Confederation (February 2018). No other service has ever completed this journey from 'Inadequate' to 'Outstanding' and it is unlikely that they would ever do so in such a short timescale. As part of the KPMG audit this year they have highlighted some data quality issues around the home treatment team's record keeping. We have already responded to this and an action plan has been put in place that will be overseen by the executive integrated care director, London to ensure timely compliance.

Several individuals, teams and services have been acclaimed with national awards throughout the year and we have made real progress in developing our Quality Improvement Programme which has touched more than four thousand of our staff this year. This programme has generated enormous energy and may be the single most influential initiative of our recent history. It has spawned countless improvement projects and will certainly feature prominently into our future ambition.

This has also been a year in which we have made major progress in delivering the support and investment for agile working and we now have several thousand staff working to this agenda and doing so very successfully. This element of our strategic effort seeks to reduce our dependence on buildings and increase the percentage of our income spent on direct

clinical services. We have made real progress on this objective throughout the year and will continue to pursue this initiative and optimise the gain.

Our workforce plans have been a major focus for development too and like many other initiatives that we have delivered, our practices in this arena are seen to be the standard that regulators seek to share with other providers. We have seen significant reduction in our agency costs and our efforts are clearly bringing benefits in the use of agency staff, sickness levels and presence.

Our many development opportunities for nursing have attracted national attention too, not least our Rotational Nurse Programme and of course our Care Certificate Training Programme. These, along with other NELFT innovations, are featured in the Health Education England Conference as nationally significant programmes. This is something we should be very proud of but is of course just one element of the development of our quality programme this year

I am enormously proud of what we have achieved in terms of quality this year and we continue to see our performance in areas such as the workforce race equality standard (WRES) used as a target for other organisations. Our recent launch of our rainbow lanyard campaign continues to build on our efforts to become a truly inclusive and equal opportunity employer. We have invested a lot of time and effort in staff engagement and staff health and wellbeing. It is my hope that all of these initiatives will continue to bear fruit such that we see a consistent improvement in the experiences of the people that we serve as an organisation.

For many critics of the NHS these investments may be perceived to be wasteful but for NELFT it is our clear ambition to continue to invest to drive up the quality of user experiences and to continue to do that within our budgets and business plan. We aspire to be the best and whilst the pursuit of the best in terms of quality is our primary interest, we would also seek to ensure that we do so within a highly disciplined business model so that the people we serve can be equally confident that their money is being spent effectively, wisely and in a predictably efficient business model.

Whatever we achieve as an organisation only becomes possible through the professional commitment, dedication and enthusiasm of an amazing workforce. I would like to take this opportunity to say a heartfelt thank you to everyone in the organisation for their individual contributions. We are only making progress because of what you bring to our services day after day in often challenging circumstances. Thank you.

John Brouder
Chief Executive
22 May 2018

To the best of my knowledge the information presented to you in this document is accurate and provides a fair representation of the quality of service delivered within the organisation.

Statement from the chair

The biggest achievement and indicator of the quality of our services over the past year has been the Care Quality Commission (CQC) rating of 'Good'. It has been a pleasure to be a part of the trust's journey from 'Requires Improvement' to 'Good' and this is a chance for me to thank our staff for their hard work, dedication and commitment to improving the quality of the care we provide to our local communities. That is fundamentally why we are here and we must continue to work on any areas that require improvement and bring those to our minimum standard of 'Good'.

As well as recognising the efforts of our staff who directly deliver services to our patients, and the support services that enable them to do that so effectively, I would also like to acknowledge the work of the trust board and senior leadership team who have led the trust on our improvement journey. It has truly been a trust wide approach to delivering against our CQC improvement plan as well as managing all of our business as usual objectives and performance targets. Throughout this time it has been good to see our staff putting patients at the heart of what they do and to see our staff engagement and survey response rates improve so markedly this year. That is a vital and positive indicator for me as Chair given it is widely understood that engaged and empowered teams typically provide better care to patients.

Our CQC rating is a reason for us all to be proud but we must not be complacent. There is always more we can do to improve the care we deliver to our patients, their carers and families. As such our NELFT Quality Improvement Programme is an important part of our journey to continuously learn and improve. We will continue to keep our emphasis on our Quality Improvement Programme as it provides us all with a recognised methodology and consistent approach to improving quality and I have been delighted by the numbers of staff that have engaged and are progressing through the training cohorts and tiers. This is something we can all be part of across NELFT and I am looking forward to seeing how this progresses over the coming year. My view is that NELFT people are improving people in every possible sense.

I believe that delivering best care to individuals and our communities for the whole of their needs, for the whole of their lives, is an important part of our forward vision and that will call on all of us to increasingly collaborate across traditional boundaries to deliver the best, efficient and most seamless services we can. This will be challenging, calling for new ways of working among all parties so that we get the best outcomes for all the patients we serve, seeing the bigger picture and this broader fundamental system requirement.

Finally, I applaud all of our teams for the many quality and other awards you have achieved in the past year and I urge you to continue to be the leaders, innovators and champions of improvement that I see evidenced every day in our trust.

Joseph Fielder
Chair
22 May 2018

Statement from the chief nurse and executive director of integrated care (Essex)

Key to our success and achievement are our people; particularly as we continuously respond to the changing needs of the health of our communities, the remarkable and welcome improvement in the life expectancy of older people, along with a changing social and financial landscape.

The introduction of the CQC fundamental standards back in 2015 provided the framework we needed to monitor, review and transform the way we deliver care. With a greater focus on safety and quality at our Board, we have ensured all our services are provided by caring staff, despite the increasing pressure and demand they face.

As Chief Nurse I am immensely proud of the achievements we have made following our CQC re-inspection in October 2017 and the challenging plans we have set for ourselves for the next year. What continues to inspire me is the way our staff constantly achieve new heights when put to the test. Our adolescent in-patient unit for children and young people with mental health concerns, Brookside, moved from inadequate to **outstanding** in just 18 months. No other unit across the country has achieved this level of performance. With movement in all our service ratings we ended the year with **GOOD** from the CQC. Our challenge now is to move the remaining services to outstanding and with the **best people delivering the best services** across NELFT, I remain optimistic.

The Quality Account provides us with a platform to achieve this and sets out a number of areas that we must focus on. These have been influenced and identified by our patients, governors, staff and partner organisations; by listening to their views and comparing ourselves with others we ensure we focus on what matters to the people we serve.

The Quality Account is a vital snapshot of our achievements and whilst it shows areas where we have progressed well, there are clearly areas where further improvement is still needed.

For the coming year our priorities are aligned to the CQC as follows:

- **Safety**

Ensuring all our patients and staff are protected from avoidable harm

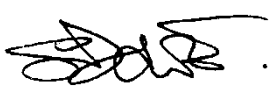
- **Effective**

Ensure all our patients receive evidence based treatments that achieves and supports good outcomes

- **Responsive**

Ensure all our patients receive care and treatment organised to meet their needs

We welcome all opportunities to provide feedback on the services we provide and the delivery of the fundamental standards. If you have used our services and wish to get involved in their further development we would be delighted to work with you.



Stephanie Dawe

Chief Nurse and Executive Director of Integrated Care (Essex and Kent)
22 May 2018

Welcome to this year's Quality Account. We hope you find it an informative and useful read.

What is a Quality Account?

Annually all NHS healthcare providers are asked to write a report about the quality of services they provide. This is called the Quality Account.

The Quality Account enables us to engage with patients, service users, staff, stakeholders, partner organisations and the public in an open and transparent way. We look forward, identifying our key priorities for the year ahead and look back, showing the improvements we have made in the last year to improve the quality of care that we provide.

NELFT's Quality Account is split into two parts, part A and part B.

- Part A
  Will provide an introduction to NELFT
  Look at our awards
  Look forward at our priorities for improvement in the coming year
  Look back on our progress outlined in Quality Account 2016/17
  Look at how we performed in the annual staff survey

- Part B
  Will provide detailed information regarding our statements of assurance from the board
  Inform you of our progress with audit and data quality
  Show performance data against our core indicators
  Provide an appendix, glossary and useful contact numbers list

Quality Account governance arrangements

The chief nurse and executive director of integrated care (Essex) has overall responsibility for the NELFT Quality Account. Production of the Quality Account is the responsibility of the director of performance and business intelligence.

Leads of our services are engaged in working with clinical and operational staff to deliver our key priorities. Progress reports on each of our priorities are reported to each locality leadership team on a bi-monthly basis and to our quality and safety committee, which is chaired by a non-executive director, every 6 months.

In addition, our Quality Senior Leadership Team oversees the Quality Account process and receives a formal update report once a quarter. This information is then reported to the executive management team, which reports to the NELFT board.

Data quality is assured through NELFT's data quality action group and through audit processes (both internal and external).

How to provide feedback on this Quality Account

We hope that you enjoy reading this year's Quality Account.

If you would like to give us feedback on our Quality Account 2017/18, please contact:

Name: Julie Price, director of performance and business intelligence

Email: julie.price@nelft.nhs.uk Tel: 0300 555 1201 ext. 59854

Address: NELFT NHS Foundation Trust
CEME Centre
Marsh Way
Rainham, Essex RM13 8EU

Our services

NELFT is a growing organisation serving a population of 4.3 million across north east London, Essex, and Kent. We employ in excess of 6,000 staff and have an annual turnover in excess of £355 million.

NELFT provides mental health and community services for people living in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest and people living in Essex; since October 2107, we have also delivered mental health and emotional wellbeing services for children and young people in Kent and Medway. We deliver these services in a range of settings including hospitals, health centres, GP practices and people's own homes. We work closely with a range of partners to ensure the best care is provided for our patients and service users.

Our values

NELFT has a core set of values outlining what is important to our staff and the people who use our services:

- **People first**
  We remember that patients, service users and carers are our top priority, and treat others how we would like to be treated
- **Prioritising quality**
  We provide the best service possible, following best practice and national developments
- **Progressive, innovative and continually improving**
  We listen and continually improve our services for the benefit of our patients, service users and carers
- **Professional and honest**
  We work to create relationships based on honesty, respect and trust, and meet the highest standards of professionalism and confidentiality
- **Promoting what is possible – independence, opportunity and choice**
  We help people achieve the best quality of life possible, giving them the information and support they need

NELFT awards and achievements

Following the Care Quality Commission (CQC) Well-Led Review late in 2017 NELFT was awarded the new overall CQC rating of 'Good' as this reflects the improvements we have made over the last 18 months to move from our previous 'Requires Improvement' rating.

Brookside, our child and adolescent mental health unit has been rated 'Outstanding' by the CQC, a huge improvement following a rating of 'Inadequate' the previous year.

- **Cavell Nurses' Trust Awards - Excellence in Care for Older People Individual**

NELFT Nurse Consultant Geraldine Rodgers has been honoured by the charity Cavell Nurses' Trust for her passion and commitment to supporting the elderly patients she cares for at a prestigious awards ceremony in Central London

- **ENEI Awards ceremony - Employee Network Group 2017 – Public Sector**

NELFT won the award for the 'Employee Network Group 2017 – Public Sector' at ENEI Awards ceremony held on Tuesday July 11 at the Law Society in London

- **Patient Safety Awards - Patient Safety in Community**

We are delighted to be the winner of the Patient Safety in Community award announced at the national Patient Safety Awards event on 4 July

- **Allocate Awards - Workforce 2.0 Award for Leadership**

NELFT won an award at the Allocate Awards on Tuesday October 17. The trust's HR Systems team won the Workforce 2.0 Award for Leadership at this year's ceremony, which was held at the Hilton Deansgate in Manchester

- **Nursing Times - Technology and Data in Nursing category for the Mind Fresh app**

A NELFT team won at the Nursing Times Awards on Thursday November 3. The team behind the Mindfresh app won in the Technology and Data in Nursing category, and were chosen above 10 other healthcare organisations for the coveted prize

- **Queen's Nursing Institute - Queen Elizabeth the Queen Mother Award for Outstanding Service**

Liz Alderton, based at Harold Hill Health Centre, received the Queen Elizabeth the Queen Mother Award for Outstanding Service from the Queen's Nursing Institute

- **AF Association - Healthcare Pioneers – Showcasing Best Practice in AF winners**

NELFT and North East London Local Pharmaceutical Committee has been announced as one of the 'AF Association Healthcare Pioneers 2018 – Showcasing Best Practice in AF' winners. The award was for the project: Health Foundation Quality Improvement Improving Physical Health Care for patients with psychosis (PHCP) through collaborative working with local community pharmacies

- **Inclusive Top 50 UK Employers - Placed at number 19 of the Most Inclusive Employers**

NELFT has been placed at number 19 in this year's Inclusive Top 50 UK Employers. The award was announced on Thursday November 30 and saw NELFT as the only trust in the south east of England to make the Top 50 and one of only two NHS organisations in the Top 20

- **EMN showcased at NHS Providers conference**

The NELFT Ethnic Minority Network strategy was successfully selected to be part of the NHS Providers Showcase at their annual national conference in Birmingham

- **NELFT projects shortlisted for the Health Business Awards**

The trust was recognised for the Mindfresh App, with a nomination in the Healthcare IT category, as well as being shortlisted for a Patient Safety Award for the Significant 7 Training Package, run in collaboration with BHR Clinical Commissioning Group

Significant 7 is an early warning tool and associated training designed for care home staff. The training and tool were created by NELFT and BHR CCG. Over the past two years Geraldine Rodgers, project lead of Significant 7, has overseen several projects in four geographical locations with the aim of ascertaining if this tool could help care staff spot deterioration of their residents earlier. The results have been very encouraging, with a marked reduction in Accident and Emergency admissions, reduction in falls and pressure ulcers with an increased confidence in staff who use the tool daily.
In July last year Significant 7 was shortlisted for two awards and won the National Patient Safety Award in the community category. The project has also been accepted as a poster presentation at the Autumn British Geriatric Society Conference in London at the end of November and commended for a Healthy Business Award for Patient Safety in December 2018.

- **Dementias 2018 awards**

The Dementia Crisis Support Team (DCST) in Basildon, Brentwood and Thurrock, presented a poster at the Dementias 2018 Conference in London. The conference took place on February 9/10 and the DCST were the delighted to be recipients of the 'Best Poster' award

- **Health Education England highlights the work of NELFT's Aubrey Keep Library**

The Aubrey Keep Library received national recognition recently when Health Education England reviewed four case studies for their Impact Case Studies Quality Group. The case studies were added to the HEE Impact Case Studies Database, which is a national database of case studies of library impacts

- **The Journal of Wound Care Awards**

In March 2018 the Tissue Viability Team was highly commended for their innovative work to prevent pressure ulcers

2.1 Priorities for improvement 2017/18

Development of our quality priorities for 2017/18

Continuous improvement remains a top priority for NELFT and we always look to develop meaningful quality indicators that can be monitored, reported and scrutinised by all.

In last year's Quality Account, we focused on the outcome of NELFT's April 2016 Care Quality Commission (CQC) inspection. The CQC is the independent regulator of health and social care in England. The CQC monitor, regulate and inspect health and social care services to ensure that fundamental standards of quality and safety are met. This includes inspecting services to see if they are safe, effective, compassionate and of a high quality. Findings are published nationally and include performance ratings to help patients and service users choose care.

The trust was inspected and measured against five key questions/domains:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive?
- Are they well-led?

NELFT was inspected again in October 2017 and we are delighted to report that our rating was upgraded from 'requires improvement' to 'good' This is a real reflection of the dedication and hard work of all of our staff in providing good quality and safe patient care. It also demonstrates that the priorities in our Quality Account 2016/17 helped focus all our teams on improving quality and safety for our patients. The table below provides a summary of our latest inspection results:

	Safe	Effective	Caring	Responsive	Well led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Child and adolescent mental health wards	Good	Good	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Community health inpatient services	Requires improvement	Good	Good	Good	Good	Good
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for older people	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Good	Good	Outstanding ☆	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Requires improvement	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Requires improvement	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Good	Good

In January 2018, following the CQC inspection, NELFT was rated as 'outstanding' in 4 inspected service areas, 'good' in 56 inspected service areas and 'requires improvement' in only 10 inspected service areas, resulting in an overall rating of 'good'. This means we moved from a position of 48 services areas achieving 'outstanding' or 'good' in our previous CQC inspection, to 60 services in the latest inspection. Whilst we are delighted with the progress made, we wish to continue improving in the domains of safe, effective and responsive to ensure our programme of work is fully embedded.

We are particularly proud of achieving 'good' in all service areas for the caring domain and that is a strong endorsement of our value of 'people first'.

During both the April 2016 and October 2017 inspections, the CQC spoke to 265 patients and service users or their relatives and carers. They collated feedback from 339 patients, carers and staff using comment cards. The CQC also carried out 15 interviews with staff and attended 65 multi-disciplinary meetings which included care reviews, and attended 25 focus groups that were attended by staff, governors, trade unions, BME network members and non-executive directors. NELFT has used the feedback from this wide ranging group of NELFT stakeholders to help us shape our quality priorities both for the past year and for the coming year. The inspection process takes account of all the views received and helps us to understand where people both within and external to the organisation wish us to improve.

NELFT's achievement of a 'good' rating from the CQC shows that the work we needed to do in the past year has been successfully undertaken. We are pleased with the progress we have made with the ambitious targets we set in last year's Quality Account, however, we feel more work is required to ensure that the new ways of working are fully embedded with all our services and staff. For that reason, we are continuing with the same priorities for our Quality Account in this coming year, but have set ourselves the challenge of more stringent targets.

Brookside child and adolescent inpatient unit

One area that deserves special mention is our children and adolescent inpatient unit: Brookside. Back in April 2016, following the CQC comprehensive inspection, our child and adolescent mental health ward Brookside was rated inadequate. Brookside was an 18 bedded inpatient mental health unit for young people also providing a 4 bedded high dependency unit, providing 24 hour specialist care for those experiencing an acute mental health crisis and requiring inpatient care.

Following the inspection NELFT undertook an extensive refurbishment and recruitment programme in Brookside. An action plan was co-produced with service users, clinicians and managers as part of the process, and the unit implemented all recommendations to improve quality of care.

Brookside reopened in September 2016 with a transformed model of care providing greater treatment options for young people at home. We were delighted to welcome the CQC back for a re-inspection in October 2016 to inspect the ward which reopened as a 15 bedded unit. The unit was then rated 'good' across all five domains. In the most recent CQC review in August 2017 the ward, together with the young people's home treatment team (YPHTT), has been rated as 'outstanding in the caring and well led domain, leading it to achieve an overall 'outstanding' rating. The CQC acknowledged this as was an unprecedented improvement by the service.

The innovative model, developed by the clinical team in agreement with NHS England and local commissioners, provides both acute inpatient beds and a YPHTT. The YPHTT is a 24/7 service designed to support young people in their own homes and ensures the maintenance of social networks, schooling and family connections.

Priority 1 – Safe

Aim:

To ensure that care plans and risk assessments are consistent across the trust to deliver safe and effective patient care. Standardising care plans to ensure they contain the five elements of care:

- Consent and capacity
- Social situation
- Collaborative
- Risk assessment
- Recovery focused

Our Quality Improvement (QI) team has been leading a QI Collaborative: the Quality Improvement Accelerator Care planning (QIAC). The QIAC is based on the Institute of Healthcare Improvements (IHI) Breakthrough Series Collaborative methodology.

Staff attend QI training and are taught QI methodology that they apply to projects in their own service areas, focussing on developing the five elements of care planning. This programme has seen some very positive results and good engagement with clinicians. During 2017/18 45 teams have registered for the QIAC programme, with 15 teams having graduated.

Alongside the QI work, NELFT has been updating its electronic patient record systems (EPR), namely RiO and SystmOne, to enable care planning to be consistently and accurately recorded by all clinicians in to patient records.

This has taken some planning and preparation in order to ensure both EPRs can accurately capture the information across the numerous care disciplines – a challenge, as many of our patients are being seen by several of our clinical services simultaneously and it is important for us to be able to track the correct care plan against the correct referral in to a service. The updates in RiO have been completed and training was rolled out to clinicians during quarter 3 17/18.

SystmOne is more challenging in the way the records are constructed so work is therefore still ongoing to resolve the recording, with a roll out planned for quarter 1 2018/19.

The Chief Nurse introduced a quality dashboard that is reported monthly across the organisation, from Board and Executive Management Team, down through the management and team layers throughout the trust. Included in this dashboard are indicators to demonstrate the progress of consistent care planning across NELFT services. This year we have further developed the quality dashboard, including more indicators from quarter to quarter. A task and finish group has led the programme of work and the quality dashboard is now routinely used in all locality quality leadership team meetings.

We want to continue with this programme of work to ensure our systems accurately record, and clinicians consistently enter, details of care plans and risk assessments in to our EPRs so that we can accurately monitor (via the quality dashboard) that they are in place for all patients and of a high quality, including the five elements of care.

Goal 1

1. To ensure that by quarter 4 2018/19 75% of care plans and risk assessments are completed and recorded in our electronic patient record systems (EPR) and that all staff will be aware and deliver care in accordance with the plans and level of risk

Area applicable to:

We will continue with embedding:

- Acute wards for adults of working age and psychiatric intensive care unit
- Wards for older people with mental health problems
- Child and adolescent mental health wards
- Community mental health services for adults of working age
- Community mental health services for older people

Additionally we will apply the target to:

- Emotional wellbeing mental health services in Essex
- Children and adolescence mental health services (CAMHS) in London

What do we expect to achieve?

1. Clinical risk assessment training to be made mandatory for all staff where applicable, achieving compliance rate of 85% and above by quarter 4 2018/19:
   Trajectory: Q1 15% Q2 45% Q3 65% Q4 85%
   This is the Governor selected indicator for external audit.

2. Care plans and risk assessments are monitored and updated when needed and recorded on EPR systems:
   Trajectory: Q1 10% Q2 25% Q3 50% Q4 75%

<u>Baseline data</u>

1. Acute wards for adults of working age and psychiatric intensive care unit 77.52%
   Wards for older people with mental health problems 77.94%
   Child and adolescent mental health wards 71.05%
   Community mental health services for adults of working age 48.00%
   Community mental health services for older people 57.55%

Training is due to commence for Emotional wellbeing mental health services in Essex and CAMHS in London in quarter 1 2018/19.

2. Acute wards for adults of working age and psychiatric intensive care unit 37.26%
   Wards for older people with mental health problems 16.67%
   Child and adolescent mental health wards 28.70%
   Community mental health services for adults of working age 10.65%
   Community mental health services for older people 8.35%
   Emotional wellbeing mental health services in Essex 24.79%
   Children and adolescence mental health services (CAMHS) in London 4.06%

How progress will be monitored and measured:

- Through monthly mandatory training records
- Through monthly monitoring of the quality dashboard

How progress will be reported:

- Reported monthly through locality leadership team meetings
- Reported monthly to Quality Senior Leadership Team (QSLT)

Goal 2

1. To implement a system for monitoring and frequently auditing risk assessments ensuring consistency across services using QIAC methodology

Area applicable to:

We will continue with embedding:

- Community health services for adults

Additionally we will apply the target to:

- Emotional wellbeing mental health services in Essex
- Children and adolescence mental health services (CAMHS) in London

What do we expect to achieve?

1. To carry out an audit reviewing risk assessments in the clinical notes of patient records, achieving a compliance rate of 75% completed and recorded on our electronic patient record systems across those applicable teams listed below by the end of quarter 4 2018/19

Baseline data

During 2017/18 15 teams graduated from the QIAC programme. Their risk assessment audits of those participating services demonstrated a compliance in community health of 87% (cohort 1) and 84% (cohort 2). Our goal this year will encompass teams across the whole of community health services for adults and additionally emotional wellbeing mental health services in Essex and CAMHS in London. No QIAC audits have taken place in these children's mental health services.

How progress will be monitored and measured:

- Through audit using the QIAC quality improvement care planning audit tool

How progress will be reported:

- Reported monthly through locality leadership team meetings
- Reported quarterly through Quality Senior Leadership Team (QSLT)

Goal 3

1. For patients over the age of 65 to automatically receive a falls risk assessment on admission to hospital.

Area applicable to:

We will continue with embedding:

- Older adult's mental health wards

Additionally we will apply the target to:

- Community inpatient wards across London and Essex

What do we expect to achieve?

1. A falls risk assessment to be completed for every patient who meets the threshold on admission to the older adult mental health ward or community inpatient wards

Baseline data

NELFT older adult mental health wards reported 100% compliance in quarter 4 2017/18, a level we want to maintain.

NELFT community inpatient wards in London and Essex do not currently have a method of recording this data electronically. Work is underway to roll out an EPR solution so currently there is no baseline data.

How progress will be monitored and measured:

- Through quarterly clinical audit and reporting of incidents
- Through weekly clinical data audit and managed through supervision and staff team meetings

How progress will be reported:

- Reported monthly through locality leadership team meetings
- Reported monthly to Quality Senior Leadership Team (QSLT)

NELFT's performance regarding the completion of risk assessments and care planning has been measured in our annual record keeping audit. For each service trust-wide, a sample of records is audited helping us to understand our compliance in certain areas of patient notes. The audit looks at the quality of our record keeping, from data capture through to the quality of clinical notes.

The data below gives an overview of our performance in regards to care plans and risk assessments for 2016 and 2017. During this time, services used both paper and electronic means for recording information. The trust now primarily uses electronic patient record systems.

A total of 1,995 records were audited in 2016/17 and 2,127 records in 2017/18. Not all patients audited required a care plan or risk assessment to be completed. The data below shows the percentage of care plans and risk assessments that were carried out against the percentage of people who these were applicable to. This demonstrates where improvements have been made and where we aim to improve.

Is there evidence that an up to date risk assessment has been undertaken on the patient's needs where required?

Electronic		**Paper**	
2016	**2017**	**2016**	**2017**
85.0%	94.18%	89.04%	100%

Is there evidence of a current care plan/treatment plan/treatment programme/goal setting agreed with the client or patient for this latest episode of care?

	Electronic Records		**Paper Records**	
	2016	**2017**	**2016**	**2017**
Adult	92.0%	92.54%	93.93%	95.45%
Child / Young Person	86.0%	85.79%	80.92%	83.33%

The electronic recording of care plans for children and young people has remained static. This is because NELFT has acquired new contracts in the past year for children and young people's services across Kent and Medway. Much training has been undertaken to ensure new staff understand how to capture data on NELFT systems and we expect the compliance rate to improve in future.

Has a discussion taken place regarding end of life care planning?

Paper and Electronic Records	
2016	**2017**
73.08%	72.00%

We have noted a slight fall in compliance. On investigation, this relates to how data is captured and in some cases staff were recording 'unknown' in the electronic patient record, which was unclear. As a result, fresh guidance has been issued to clinical teams to ensure they are aware of how to record the data in future.

Has an individualised care plan for the last days of life been agreed?

Paper and Electronic Records	
2016	**2017**
50%	83%

Data taken from NELFT clinical record keeping audit 2017

Priority 2 - Effective

Goal 1

1. That 85% of patient care plans include the 5 elements of care planning - consent and capacity, social situation, collaborative, risk assessment, recovery focused

2. Using the QIAC audit tool to measure quality of care plans to ensure 85% contain the five elements of care by end quarter 4 2018/19

Area applicable to:

We will continue with embedding:

- Acute wards for adults of working age and psychiatric intensive care unit
- Child and adolescent mental health wards
- Community mental health services for adults of working age

Additionally we will apply the target to:

- Emotional wellbeing mental health services in Essex
- Children and adolescence mental health services (CAMHS) in London

What do we expect to achieve?

1. Care plans include the 5 elements of care planning by the end of quarter 4 2018/19 Trajectory: Q1 10% Q2 35% Q3 60% Q4 85%

Baseline data

NELFT achieved 78% compliance (QIAC cohort 1) and 79% compliance (QIAC cohort 2) for quarter 4 2017/18 in:

- Acute wards for adults of working age and psychiatric intensive care unit
- Child and adolescent mental health wards
- Community mental health services for adults of working age

There is currently no baseline data for emotional wellbeing mental health services in Essex and CAMHS in London as QIAC audits were not undertaken previously for these services.

How progress will be monitored and measured:

- Through monthly audit of the quality of care plans ensuring they contain the 5 elements of care, using the QIAC quality improvement care planning audit tool

How progress will be reported:

- Reported monthly through locality leadership team meetings
- Reported monthly to Quality Senior Leadership Team (QSLT)

Goal 2

1. All care plans for mental health patients are recovery orientated and reflect the personal views and preferences of patients

Area applicable to:

We will continue with embedding:

- Acute wards for adults of working age and psychiatric intensive care unit
- Child and adolescent mental health wards
- Community mental health services for adults of working age

Additionally we will apply the target to:

- Emotional wellbeing mental health services in Essex
- Children and adolescence mental health services (CAMHS) in London

What do we expect to achieve?

1. That staff work collaboratively with patients to include their preferences and views in their care plan.

   Trajectory: Q1 25% Q2 50% Q3 75% Q4 100%

Baseline data

NELFT achieved 86% compliance (QIAC cohorts 1 and 2) for 'recovery focused care plans' and 92% compliance (QIAC cohort 1) and 96% compliance (cohort 2) for 'collaborative care plans' for quarter 4 2017/18 in:

- Acute wards for adults of working age and psychiatric intensive care unit
- Child and adolescent mental health wards
- Community mental health services for adults of working age

There is currently no baseline data for emotional wellbeing mental health services in Essex and CAMHS in London as QIAC audits were not undertaken previously for these services.

How progress will be monitored and measured:

- Through monthly audit of the quality of care plans ensuring they include personal preference of patients using the QIAC quality improvement care planning audit tool.

How progress will be reported:

- Reported monthly through locality leadership team meetings.
- Reported monthly to Quality Senior Leadership Team (QSLT)

Priority 3 – Responsive

Aim:

To ensure that where appropriate, referrals to treatment (RTT) waiting times are achieved.

In September 2017 NELFT was contracted to provide the Young Persons Wellbeing Service (YPWS) Medway and Children/Young People Mental Health Services (CYPMHS) Kent. During the transfer of patients to our services, it became apparent that a number of young people had been waiting for either assessment or treatment for longer than the national target of 18 weeks. Additionally, some young people had been waiting over a year for their treatment. NELFT wants to ensure the waiting lists are dealt with as quickly as is possible to allow young people access to care.

Goal 1

1. To ensure that all young people who have waited in excess of 52 weeks for assessment and/or treatment are seen by the appropriate clinical team by end quarter 3 2018/19 (dependent on the allocation of additional resources by commissioners)

Area applicable to

- Kent and Medway

What do we expect to achieve?

2. By the end of quarter 3 2018/19, no young person will be awaiting assessment or treatment for more than 52 weeks (dependent on the allocation of additional resources by commissioners)
   Trajectory: Q1 15% seen Q2 55% seen Q3 100% seen

<u>Baseline data</u>

Awaiting assessment:		Awaiting treatment:	
East Kent	17	East Kent	108
West Kent	4	West Kent	36
Medway	2	Medway	17

The benchmark is the national target for waiting times, set out as follows:

NHS Constitution standard sets out that more than 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral.

Nationally reported data as at the end of March 2017 shows 90.3% of patients waiting to start treatment (incomplete pathways) had been waiting up to 18 weeks (so 92% has not been met).

How progress will be monitored and measured:

- Through daily MIDAS dashboards
- Through weekly and monthly progress reports provided by the performance team

How progress will be reported:

- Monthly through department patient and quality safety group meetings
- Monthly through locality leadership team meetings

Goal 2

1. To ensure that all young people who have waited for an attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD) assessment to have been assessed by a specialist clinical team by end quarter 3 2018/19

Area applicable to:

- East Kent

What do we expect to achieve?

1. By the end of quarter 3 2018/19 every young person needing an ADHD or ASD assessment will have been clinically reviewed.
   Trajectory: Q1 15% seen Q2 55% seen Q3 100% seen

Baseline data

In September 2017 NELFT inherited the waiting lists for ASD/ADHD assessments from previous providers; we have worked closely with clinical teams and commissioners to verify data in order to understand the extent of the waiting list. The current number of young people waiting over 18 weeks for ASD/ADHD assessment totals 916.

How progress will be monitored and measured:

- Through weekly and monthly progress reports provided by the performance team

How progress will be reported:

- Monthly through department patient and quality safety group meetings
- Monthly through locality leadership team meetings

Priority 4 – Well led

Goal 1

1. To ensure that all staff are continually up to date with mandatory training, including mental health act training where applicable

Area applicable to:

- NELFT wide

What do we expect to achieve?

1. To achieve a compliance rate of 85% and above for all mandatory training by the end of quarter 4 2018/19
   Trajectory: Q1 70% Q2 75% Q3 80% Q4 85%

Baseline data

Whilst the trust is currently achieving 85.09% (as at April 2018) across all mandatory training disciplines as a combined total, the compliance in Kent and Medway services is 48.82% Our aim is to achieve 85% compliance in Kent and Medway while maintaining 85% compliance in all other areas.

How progress will be monitored an0 measured:

- Measured through monthly training compliance reports and MIDAS

How progress will be reported

- Monthly through department patient and quality safety group meetings
- Monthly through locality leadership team meetings
- Reported monthly to Performance Senior Leadership Team (PSLT)

Goal 2

1. To ensure that teams have access to MIDAS to support their management of services

Area applicable to:

- East Kent, West Kent and Medway CYPMH services

What do we expect to achieve?

1. 100% of managers to have received MIDAS training by the end of quarter 4 2018/19 Trajectory: Q1 20% Q2 50% Q3 85% Q4 100%

Baseline data

No MIDAS training has been undertaken with managers in Kent and Medway as at quarter 4 2017/18.

How progress will be monitored and measured:

- Through review of business intelligence training records

How progress will be reported:

- Quarterly through locality leadership team meetings

Goal 3

1. Continue to develop an effective performance analytical tool which provides the executive management team with forecasting information and highlights any risks or areas of underperformance

Area applicable to:

- NELFT wide

What do we expect to achieve?

1. To develop a BI dashboard, to complement the quality dashboard, which demonstrates key measures for the CQC domains of 'effective' and 'responsive' across all core services

2. Pilot to be completed by the end of quarter 1 18/19

3. The BI dashboard will enable effective monitoring of outcomes and benchmarking of services NELFT wide

How progress will be monitored and measured:

- Presentation to Clinical Executive team, Executive Management Team (EMT) and Communities of Practice (COP) meetings

How progress will be reported

- Through quarterly updates to Performance Senior Leadership Team (PSLT) and EMT

Governors' Indicator

This year, the governors have selected clinical risk training as the indicator to be audited by KPMG, as this complements the priorities set out in the Quality Account.

The audit will test that the compliance reporting methodology and reporting via Quality Account updates is accurate.

The current NELFT performance for clinical risk training is: 56.44% which relates only to:

- Acute wards for adults of working age and psychiatric intensive care unit
- Wards for older people with mental health problems
- Child and adolescent mental health wards
- Community mental health services for adults of working age
- Community mental health services for older people

How do our priorities impact on patient safety, clinical effectiveness and patient experience?

Patient safety will be enhanced through:

- Comprehensive care plans and risk assessments being completed for patients and recorded on EPR ensuring continuity of, and safe, care
- Monitoring and auditing clinical risk across services, ensuring consistency of standards being applied
- Falls assessments being completed for all patients over 65 on admission to hospital

Clinical effectiveness will be enhanced through:

- Staff being up to date with mandatory, mental health act and clinical risk assessment training
- Care plans containing the five elements of care planning:
  consent and capacity; social inclusion; collaborative; risk assessment; recovery focused
- Care plans reflecting the personal views and preferences of patients.

Patient Experience will be enhanced through:

- Services having an effective means to monitor service efficiency, including waiting times, through the MIDAS performance management tool
- Patients will wait a maximum of 18 weeks to be treated
- Care plans will be recovery orientated and reflect the personal views and preferences of patients, ensuring their voice is heard and care is tailored to their individual needs.

In last year's Quality Account, we also included a review of the friends and family test for improving the patient experience. This was to ensure that feedback collated is appropriately disseminated through the organisation and used to inform service delivery. Having reviewed the process (please refer to **Progress against each of our 2016/17 priorities** below), we are satisfied that the feedback and learning is indeed disseminated throughout NELFT and so we have not included the workstream in this year's Quality Account. Instead, we have selected another indicator for the Quality Account 2017/18 that directly impacts patient experience: patient waiting times. This is a national indicator and our focus in the coming year is the waiting times for our newly acquired services in Kent, where young people have been waiting longer than they should be. This workstream requires particular targeted attention to ensure we improve the patient experience.

2.2 Statements of assurance from the board

The statements of assurance from the board for our trust are in part B of this document. Please therefore refer to part B where you will see information regarding our registration, participation and progress in these areas.

3.0 Progress against each of our 2016/17 priorities

Considerable progress has been achieved against our targets for 2016/17 and our achievements are noted below.

Last year NELFT's priorities focused on:

- Safe
- Effective
- Responsive
- Well led

Priority 1: Safe

Goal 1

1. To ensure that 85% of care plans and risk assessments are completed where applicable, and that staff will be aware and deliver care in accordance with the plans and level of risk

Applicable to:

- acute wards for adults of working age and psychiatric intensive care unit
- wards for older people with mental health problems
- child and adolescent mental health wards
- community mental health services for adults of working age
- community mental health services for older people

What we achieved:

By When	Q1	Q2	Q3	Q4
By end Q3	99.4	100% of audited sample	Data not available QI Team introducing Life system in Q3 so data will be available in Q4	100% of audited sample Risk Assessment **Cohort 1** - 81% **Cohort 2** - 86%

Goal 2

1. To implement a system for monitoring and frequently auditing risk assessments ensuring consistency across services

Applicable to:

- Community health services for adults

What we achieved:

By When	Q1	Q2	Q3	Q4
Review policy by end Q1	Under review	Sign off 11/08/2017	Data not available QI Team introducing Life system in Q3 so data will be available in Q4	QIAC: **Cohort 1** - 81% **Cohort 2** - 86% Community teams: **Cohort 1** - 87% **Cohort 2** - 84%
Carry out audit achieving 85% compliance by end Q3	N/A	N/A		

We are pleased with the progress made and are now seeing consistently high results in audit results. To ensure we continue with the embedding of this work, the priority remains in the Quality Account 2017/18.

Goal 3

1. For patients over the age of 65 to automatically receive a falls risk assessment on admission to hospital

Applicable to:

- Older adults mental health wards

What we achieved:

By When	Q1	Q2	Q3	Q4
50% reduction in falls by end Q4	N/A	N/A	N/A	Not achieved 38%
A falls risk assessment complete for all admissions	N/A	100%	100%	100%

Falls prevention work continued on the older adult mental health wards through quarters 1 to 4. As well as the trust-wide Falls Steering Group attendance, the wards carry out a quarterly table top exercise to review falls and themes. This is a multi-disciplinary team (MDT) and reviews each fall incident to ensure the post falls protocol has been followed and as re-assessment of risk was undertaken. The MDT also considers themes such as medication; behaviour; activity planning to address restlessness and agitation; environmental risks and vision and observation levels. This learning is shared across the three older adult mental health wards.

A Stop Falls poster campaign was launched in January 2018 and the post fall huddle (a get together with staff and the patient to discuss what happened and how to prevent reoccurrence) was also launched which helps influence the falls risk re-assessment. Each patient on the older adult wards had a falls risks assessment completed on admission and the post falls protocol initiated for every patient. There are falls champions identified on each ward. The falls champions are working with the occupational therapist to review all the falls risk assessments of patients to check there are no obvious changes in risk factors that may predispose patients to falls.

There was a significant reduction in falls for quarter 2 and quarter 3 indicating a downwards trajectory but a significant increase in falls in quarter 4. This is partly attributable to one particular patient on Stage Ward whose risk of falling could not be fully mitigated despite a ward case review and initiation of a management plan.

To ensure continued improvement, this priority remains in the Quality Account 2017/18.

Priority 2: Effective

Goal 1

1. That 85% of patient care plans include the 5 elements of care planning – consent and capacity, social situation, collaborative, risk assessment, recovery focused

Applicable to:

- Acute wards for adults of working age and psychiatric intensive care unit
- Child and adolescent mental health wards
- Community mental health services for adults of working age

What we achieved:

By When	Q1	Q2	Q3	Q4
All care plans to include 5 elements by end Q1	63.9% achieved	**Cohort 1** 84% achieved **Cohort 2** 64% achieved	Data not available QI Team introducing Life system in Q3 so data will be available in Q4	**Cohort 1** - 78% **Cohort 2** - 79%
Lead identified for each area by April 17	18 out of 19	19/19		100%
Leads to attend 6 fortnightly half-day learning programme	9/18 50%	10/19 53%		**Cohort 1 & 2:** N/A formal learning sets complete

This work has taken longer than originally anticipated Since quarter 2, we have seen very positive signs of improvement but more work is needed. To ensure we continue with the embedding of this work, the priority remains in the Quality Account 2017/18.

Goal 2

1. All care plans for mental health patients are recovery orientated and reflect the personal views and preferences of patients.

Applicable to:

- Acute wards for adults of working age and psychiatric intensive care unit
- Child and adolescent mental health wards
- Community mental health services for adults of working age

What we achieved:

By When	Q1	Q2	Q3	Q4
Audit to show staff working collaboratively with patients to reflect preferences Broad range of recovery goals written into care plans	74.2% achieved	**Cohort 1** 73% achieved **Cohort 2** 68% achieved	Data not available QI Team introducing Life system in Q3 so data will be available in Q4	**Recovery Focussed** **Cohort 1** - 86% **Cohort 2** - 86% **Collaborative** **Cohort 1 -** 92% **Cohort 2 -** 96%

To ensure we continue with the embedding of this work, the priority remains in the Quality Account 2017/18.

Priority 3: Responsive

Goal 1

1. To ensure an effective system of monitoring waiting times is embedded across NELFT for all patients attending outpatient type services

Applicable to:

- NELFT wide

What we achieved:

By When	Q1	Q2	Q3	Q4
Where MIDAS monitoring tool newly rolled out ensure service leads trained by end Q1 Where applicable services will effectively manage RTT using MIDAS	100% complete	Achieved	Achieved	Achieved

Priority 4: Well led

Goal 1

1. To ensure that all staff are up to date with mandatory training, including clinical risk assessment and mental health act training where applicable

Applicable to:

- Nelft wide

What we achieved:

By When	Q1	Q2	Q3	Q4
85% compliance by end Q4	89.23%	88.15%	85.37%	89.09%

Goal 2

1. To ensure that teams have access to MIDAS to support their management of services

Applicable to:

- Older adult wards

What we achieved:

By When	Q1	Q2	Q3	Q4
85% of older adults managers to have received MIDAS training by end Q2	100%	Acheived	Acheived	Achieved
MIDAS to be rolled out to 75% managers NELFT - wide by end Q4		76%		78%

Although the goal was to train manager on older adult wards, the MIDAS training programme has achieved 78% compliance across managers NELFT-wide.

Goal 3

1. To develop an effective performance analytical tool which provides the executive management team with forecasting information and highlights any risks or areas of underperformance

Applicable to:

- Nelft wide

What we achieved:

By When	Q1	Q2	Q3	Q4
Pilot to be complete by end Q1 Heatmap to show areas of best practice Heatmap to provide forecasting to help identify risk	Complete	N/A Pilot was shared with Exec and senior managers Following feedback further development is underway with COPs	New approach - feedback from pilot suggested and approach should be 'responsive' and 'effective' for Core services. Currently presenting to COP's to agree approach.	Performance board report PowerBI prototype - work in progress

This goal changed after quarter 1 when the feedback to the pilot phase suggested a different approach should be adopted. A new development has been underway, following extensive consultation across NELFT, and a pilot will be tested in April 2018.

Governors' selected local indicator 2016/17: Friends and Family Test

The Friends and Family Test asks the following 5 questions each month of a minimum of 5 patients or carers in each of our services:

- How likely is it that you would recommend this service to friends and family if they needed similar care or treatment?
- Did you find it easy to get care, treatment or support from this service?
- Did staff introduce themselves to you?
- Did the service you received meet your expectations?
- Did you feel you were involved in your care as much as you would have liked?

Goal 1

Evaluate:

- That the collection and collation methods we use for 5 x 5 are sound
- That patient feedback is appropriately disseminated throughout the organisation and action is taken if needed
- That the demographics of respondents are representative of the communities that we serve

What we learned:

Whilst our auditors, KPMG, were able to undertake some sampling and cross checking of data to our monthly performance reports to commissioners, they were unable to provide a comprehensive opinion on the process used by NELFT to gather the 5x5 feedback from patients as the system primarily relies on telephone calls to patients seeking feedback. We use this method as it is more engaging with patients and has a higher response rate than if

we were to use paper or electronic methods. The qualitative data collected through the telephone calls allows for immediate learning and action by teams. Improvement outcomes as a result of patient feedback are reported to Quality and Safety Committee and Board on a quarterly basis, then disseminated to back to teams through DPQSGs. Monthly posters of results are circulated and teams have timely access to their own data through MIDAS to discuss as team meetings.

The results of NELFT Friends and Family Test for 2017/18 are:

		How likely is it that you would recommend this service to friends and family if they needed similar care or treatment?			
Survey name		**Date**	**Survey returns**	**Would recommend**	**Would not recommend**
NELFT Overall					
Overall		Q1 2017/18	3821	93%	2%
		Q2 2017/18	3915	94%	1%
		Q3 2017/18	3646	93%	2%
		Q4 2017/18	3458	94%	1%

Annual staff survey

Each year, NHS England requires NHS providers to complete a staff survey. This survey gives our colleagues the opportunity to feedback about their experience of working in the trust. From the survey results, we will then put together local improvement plans to help better the staff experience of engagement and well-being. The information taken from the survey also enables us to review our performance against other similar NHS providers and how we compare nationally.

We value the feedback from our staff and this survey is one of numerous ways of gauging their opinions. We pride ourselves on an open and honest culture that embeds the trust values in everything that we do.

This has been another challenging year for the trust in terms of continuing uncertainty about the potential changes the sustainability transformation plan agenda may bring, as well as the impact of the CQC re-inspection and subsequent report. We have worked tirelessly over the past year to act upon the findings of the previous survey, which yielded some very disappointing results and to act upon the recommendations contained within its management report. A communications plan was developed to share the results across the organisation and ensure that all staff had the opportunity to participate in making improvements to their working lives. We engaged thoroughly and positively throughout the whole workforce to demonstrate that we had listened to what they had to say and had acted upon their wishes. Our colleagues said that they wanted a shorter, more user friendly survey, that was available online and we delivered that. Our colleagues also said that they wanted to see a greater connection between senior leadership and front line staff. This initiated a programme of engagement events across all directorates and localities and a whole range of health and well-being orientated activities accessible to all.

As a result of all of the engagement work undertaken across the organisation, the 2017 survey received an unprecedented 63% response rate from a full census. The vast majority

of responses to the questions showed a significantly positive shift from the previous year, many of which benchmarked in the top 20 percentile nationally. The results and recommendations have been disseminated across the organisation much earlier than in previous years and locality leadership teams are already working on action plans to both celebrate the success and prioritise areas for further development.

The key positive findings and also the ones that showed the most statistically significant improvement were:

1. Communications between senior management and staff were highly rated, as was confidence in senior managers acting on staff feedback and involving them in decision making
2. Staff felt safe in raising concerns to management and felt confident that management would act positively to concerns when raised
3. Staff reported that when they reported concerns, they were treated fairly, that the organisation took appropriate measures to learn from incidents and that the learning was shared widely in the spirit of quality improvement
4. There was also a significant increase in the number of staff reporting that they would recommend the trust to friends or family for treatment

The areas that showed a less positive result and as such are now subject to comprehensive trust-wide action plans were:

1. An increase in the numbers of staff reporting being affected by musculoskeletal problems
2. An increase in the numbers of staff reporting dissatisfaction with pay
3. An increase in the number of staff reporting being affected by work related stress

A full copy of our annual staff survey results can be found on the National NHS Staff Survey Co-ordination Centre website www.nhsstaffsurveys.com

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Quality Account

2017/18

PART B

Welcome to part B of the Quality Account.

As outlined in part A, part B provides statements of assurance from the board regarding the review of our services. We highlight our contributions to data quality and clinical audit and provide some detailed information in our appendices. Should you wish to provide feedback on our Quality Account, please refer to part A where our contact details for feedback are provided.

2.2 Statement of assurance from the board

During 2017/18 NELFT provided and/or subcontracted 111 relevant health services (provided across multiple localities). NELFT has reviewed all the data available to them on the quality of care in 111 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by NELFT for 2017/18.

Participation in national clinical audit and confidential enquiries

To meet the expectations of the NHS Constitution, NELFT has in place an Annual Clinical Audit programme aimed at continuously improving the quality of care, safety, and standards provided by its services. The programme is designed to monitor compliance with relevant national standards, including NICE, and ensure a robust system of quality assurance reporting. The programme for 2017/18 included both local and national clinical audits, as well as confidential enquiries.

Clinical audit is undertaken to review systematically the care the trust provides to patients against best practice standards. NELFT utilises participation in national clinical audit programmes and confidential enquiries as a driver for improvements in quality. Participation in audits like these not only provide opportunities for comparing practice nationally, they play an important role in providing assurance about the quality of our services. The trust is committed to ensuring that all clinical professional groups participate in clinical audit.

During the period 2017/18, NELFT participated in 9 (100%) national clinical audits and 2 (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 NELFT was eligible to participate in during 2017/18 are listed in appendix 2a. The national clinical audits and national confidential enquiries that NELFT participated in during 2017/18 are listed in appendix 2a. The national clinical audits and national confidential enquiries that NELFT participated in, and for which data collection was completed during 2017/18, are listed in appendix 2a 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.

The number of patients receiving relevant health services provided or sub-contracted by NELFT in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1,347.

Learning from national clinical audits

National Clinical Audits are designed as a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria

and the implementation of change. Its purpose is to engage all healthcare professionals from across the UK in a systematic monitoring process of their clinical practice. The aim is to support and encourage quality and deliver better outcomes in the care we provide to our patients and service users.
National audit participation by the trust also includes receiving benchmarked reports on our performance, with the aim of improving the care provided. National audits are related to some of the most commonly-occurring conditions. Data for these audits are supplied by local clinicians to provide a national picture of care standards for a specific condition. On a local level, National Clinical Audits and Patients Outcome Programme (NCAPOP) audits provide local trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvements for patients. Our trust actively participates in these audits and will continue to use these reviews to improve the quality of care we provide to our end users.

The reports of 8 national clinical audits and one confidential enquiry were reviewed by NELFT in 2017/18. This included national audits for which data was collected in earlier years with the resultant report being published in 2017/18. NELFT intends to take the actions detailed in appendix 2b to improve the quality of healthcare provided.

The trust has a demonstrable and clear process that supports shared learning and improvement from national clinical audit findings as follows:

- The trust produces a local summary and SMART action plan based on the findings of the national audit
- National and local trust findings are shared across service teams to identify gaps in performance, and this information is used to produce a trust wide action plan to improve the quality of its services.
- Implementation of the action plan is monitored by the trust's clinical audit team via the trust's robust Clinical Audit Action Plan Tracker **(CAAPT**)
- Progress of action implementation is discussed locally in the specialty clinical audit group meetings on monthly or bimonthly basis
- Progress and completion status of actions against the CAAPT are reported to the trust's Quality and Safety Committee **(QSC**) on a quarterly basis.
- The Head of Clinical Audit & NICE provides quarterly reports to the trust's Quality & Safety Committee, which includes a summary of national audit findings relevant to the trust, identifying emerging themes or areas requiring action for improving the quality of service provided by the trust. Thus providing assurance to the leadership that quality improvement of care, standards and safety is continuous.

Learning from local clinical audits

A snap shot of 24 local clinical audit reports were reviewed by NELFT in 2017/18 and where areas that require improvement were flagged up, the findings were placed into SMART action plans, with designated action completion dates. These actions may vary, from improving the quality of documentation, to the issuing of new guidelines or amending relevant policies. These findings and smart plans are then shared with service leads, who in turn would share with their staff, to learn from the findings and in so doing improve the quality of healthcare provided by NELFT.

Our clinicians are strongly encouraged and supported to set up local relevant in-depth audits as a follow up to national audit findings, based on local quality and safety priorities. The reports of 24 local clinical audits were reviewed and actions agreed by the services. These audits cover various services provided by NELFT and details are provided in appendix 2c.

Care Quality Commission (CQC) and Clinical Audit

The CQC uses clinical audits as one of the quality improvement processes or cycle of events that helps ensure patients receive the right care and treatment. Care and services are measured against evidence-based standards and changes are implemented to narrow the gap between existing and best practice. At NELFT, clinical audit is a continuous cycle that is continuously measured with improvements made after each cycle. Examples of clinical audit improvements can be found in appendix 2c.

The CQC (November 2017) inspection report acknowledges the improvements made in the management of patients prescribed high dose antipsychotic therapy, stating that:

"*The pharmacist ensured that patients on high dose antipsychotics were identified, and prompted the medical team to ensure that all associated monitoring was completed.*"

From 4 – 8 December 2017, the trust celebrated its 3rd annual trust-wide Clinical Audit Awareness Week. It was a great opportunity to share local and national clinical audit findings, including outcomes from clinical audits implemented in the trust to address concerns and implement change. The event was very well attended and it was an informative week. To date, the number of Clinical Audit Champions (CAC) stands at 800 across the trust, fully trained and improving the quality of patient care and safety trust wide using the clinical audit process.

Clinical audit remains an established quality improvement (QI) activity in NELFT, demonstrating ongoing, continuous improvements in the quality of care that the trust provides. The CQC had in their previous (2016) inspection report acknowledged that:

"*The trust used a number of nationally recognised tools and audits to measure and improve the outcomes of patients and people using their services*."

"*Staff participated in clinical audit to measure and improve on practice. The trust had completed a number of national and local audits in areas such as use of family intervention therapy, national asthma audits and prescribing of combined oral contraceptives. The findings of these were used to make improvements to the services. For example, in the older people community mental health, teams participated in clinical audits, such as the national clinical audit for antipsychotic medication. The last audit identified the need to improve recording and teams had developed new templates for this."*

NICE compliance in NELFT

One of the requirements of the Care Quality Commission is for all healthcare organisations to consider nationally agreed guidance when planning and delivering treatment and care. Implementing NICE guidance can help patients, carers and service users receive care in line with the best available clinical evidence and cost-effectiveness. This also enables people to be accountable for their care, knowing how they will be cared for in a consistent evidence-based way, thus building patients' confidence in the trust.

NELFT has a robust and efficient process of NICE guidance dissemination in place that ensures monthly review, and determination of the applicability of each NICE guideline to our services. Immediately after publication, each NICE guidance is assessed for their relevance to the trust by the clinical / service leads. Further, there is a highly efficient operational process in place, which ensures that all relevant NICE Baseline Assessment Tools and guidelines are made available to the appropriate service leads monthly. All these processes and systems are in place to monitor the level of NICE compliance within services. Each year, the trust undertakes a range of audits specific to NICE guidance, which are included in the annual Clinical Audit programme. This practice also helps us monitor and measure our services against national guidance, to ensure compliance is being maintained.

CQUIN targets 2017/18

Commissioning for quality and innovation (CQUIN) is a payment framework enabling commissioners to award excellence by linking a proportion of the income they give to providers such as NELFT to the achievement of national and local quality improvement goals.

A proportion of NELFT income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between NELFT and any person or body that they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available on request from:

Performance and business intelligence team

Email: julie.price@nelft.nhs.uk

Tel: 0300 555 1201

Address: NELFT NHS Foundation Trust, CEME Centre, West Wing, Marsh Way, Rainham, Essex RM13 8GQ

The total amount of income in 2017/18 conditional upon the achievement of quality improvement and innovation goals was £4.1m. The monetary total for achievement of goals in 2016/17 was £5.5m.

Registration with the Care Quality Commission (CQC)

NELFT is required to register with the Care Quality Commission (CQC) and its current registration status is that it is registered to carry out the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Personal care - this is a new regulated activity in relation to the acquisition of the reablement service
- Treatment of disease, disorder or injury

Following NELFT's comprehensive inspection during April 2016, an extensive improvement plan was implemented across three core services. The CQC has re-inspected a number of core services including a well led review during October – November 2017. Overall NELFT is now rated by the CQC as good. In particular one core service was initially rated as inadequate by the CQC, however this core service is now rated as outstanding.

NELFT has not participated in any special reviews or investigations by the CQC during the reporting period and the CQC has not taken enforcement action against NELFT during 2017/18.

NHS number and general medical practice code validity

NELFT submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

99% for admitted patient care

98.4% for outpatient care

97.4% Accident and Emergency

which included the patient's valid General Medical Practice Code was:

100% for admitted patient care

99.9% for outpatient care

99.9% Accident and Emergency

Information governance assessment report

NELFT's information governance assessment report overall score for 2017/18 was 72% and was graded green (satisfactory on all requirements).

Clinical coding error rate

NELFT was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Audit – areas for improvement

NELFT will be taking the following actions to improve data quality:

All staff receives training on electronic recording systems prior to being given access. E-learning packages have been developed to provide more timely and efficient access to systems and support the face to face learning that is available.

The data quality / information governance mandatory e-learning programme that is now an annual requirement has been revised to include further guidance around registration of death and associated record management, synchronisation of records and recording of diagnosis, particularly within inpatient records applicable to Secondary Uses Service

submissions. Specific guidance has been developed and circulated regarding recording of Diagnosis to support accurate and complete recording of Diagnosis by all staff.

A data quality responsibilities document was developed and circulated to staff detailing that they each have an individual responsibility to ensure that they complete all of their required mandatory training and that they are aware of the key trust policies that influence their role assisting in promoting and producing good quality data.

Data quality prompts were developed and implemented within the electronic patient records highlighting missing high priority information such as demographics and equalities data. The results of the annual record keeping audit have identified improvements in these areas.

The 2017/18 annual healthcare records audit included an increased focus on the assessment of data quality practices and those areas that impact on them. More use was shown of electronic systems for recording activity and clinical information as well as increased access via mobile devices. This information informs an action plan for improvement of data quality and record keeping across the trust which is reviewed by the trust on a regular basis.

Data quality issues are identified and reported on monthly, highlighting areas where improvement is required. The use of data quality information to support individual teams and individual practitioners is an area of development that will further support progress in completing the minimum required data. Data quality information is available to all staff through both the clinical activity reports and performance dashboards produced on the business intelligence tool, MIDAS.

Maintenance and improvement of data quality across both clinical and corporate services is a function of the Data Quality Action Group who report to senior leadership team monthly via the Chairperson. The group identify priorities to target in the coming financial year, review the impact to financial performance in regards to data quality issues and agree the annual healthcare records audit, corporate records audit and information governance toolkit clinical coding audit.

Information assurance framework assessment and spot checks are agreed each year to monitor the quality and accuracy of our reported data against source data.

In addition to the above, NELFT continues to monitor the capture and quality of information submitted as part of datasets and commissioned activity.

Learning from Deaths

Numbering from NHSi detailed requirements guidance	Prescribed information	Form of statement
27.1 *Provided by Performance from EPR*	The number of its patients who have died during the reporting period including a quarterly breakdown of the annual figure	During 2017/18, 7756 of NELFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period. This represents 1.88% of NELFT's caseload for 2017/18. Q1 1587 Q2 1707 Q3 2458 Q4 2004
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	Further information can be found on the NELFT website at https://www.nelft.nhs.uk/about-us-incident-reporting NELFT was not required to collect the data in this way prior to 01/09/2017 and therefore 7 months of data only is available. Within NELFT all unexpected deaths are reviewed against the serious incident framework through a systematic case review. Those that meet the criteria are investigated under the serious incident investigation policy. NELFT concerns itself with other levels of investigation including, local internal, safeguarding, LeDer and CDOP. The trust has clearly defined the criteria in which clinical case reviews will be undertaken in its incident reporting policy (addendum) A structured framework for clinical reviews by mental health trusts are still in development. The trust has met the requirement to undertake reviews and publish findings on its public website, 31/03/2018, 50 case record reviews. It is too early to suggest learning themes from the clinical case reviews. The trusts serious incident investigation process is well established and has provided learning opportunities and quality improvements. Although not all serious incidents found gaps in care, there are always opportunities to learn. 30 serious incident investigations have been carried out in relation to 7756 of the deaths included in item 27.1. Within NELFT, case record reviews are managed separately to serious incidents and therefore 0 cases of a death were subjected to both a case record review and a serious incident investigation.

27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	26 representing 0.30% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. Data was not collected in quarter 1 in this way. Quarter 1: data not collected Quarter 2: 0 (September data only) Quarter 3: 11 cases Quarter 4: 15 cases We are unable to provide percentages by quarter as the total number of deaths was provided as an annual figure only. These numbers have been estimated using the Confidential Enquries of Stillbirths and Infant Deaths (CESDI) methodology and the Serious Incident Framework 2015. It is anticipated that the trust will adopt an approved and tested structured framework for mental health in 2018.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	Of completed serious incident investigations, the following themes consistently arose : • Deterioration of physical health • Missed early opportunities to identify Sepsis • Breakdown of communication between family and staff • Lack of a national EPR clinical record system
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	Actions include: Introduction of electronic NEWS recording across the inpatient wards to support early detection of deterioration in health accompanied by training for all staff. A Sepsis training programme for all staff and a Sepsis awareness initiative through the Harm Free Care group. Facilitated team discussions to improve communications between family and staff following investigation findings. Where there is evidence of domestic abuse this needs to be raised in line with the policy and risks and managed accordingly. Support for carers, offering of carers assessment and signposting to support individual risk assessments to take account of carers stress

27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Audits of patient records and NEWs recording and actions are demonstrating the staff are more aware of the need for early intervention. Where there is evidence of domestic abuse this needs to be raised in line with the policy and risks and managed accordingly. Support for carers, offering of carers assessment. Signposting to support individual risk assessments to take account of carers stress
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	Data not available for 2016/17 or April – August 2017
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	The trust undertook thematic review of a number of community mental health unexpected deaths associated with self / suspected suicide that had occurred in a specific service, over a specific period of time. It was not possible to conclude that any of the deaths were due to problems in care. All mental health inpatient deaths are investigated as serious incidents.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	Data not available for 2016/17 or April – August 2017

2.3 Reporting against our core indicators 2017/18

NHS Improvement requires foundation trusts to report on a set of quality indicators through the single oversight framework (SOF)

Indicator	Measure	National Average	NHS trust Highest	NHS trust Lowest	NELFT 2016/17	NELFT 2017/18
The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	Percentage	95.4%	100%	69.2%	95.8%	97.63%
The percentage of admissions to acute wards for which the Crisis Revolution Home Treatment Teams (HTT) acted as a gatekeeper during the reporting period	Percentage	98.5%	100%	84.3%	98.5%	94.6%
The percentage of patients aged: i. 0 -15 ii. 16 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	Percentage				5.8% (1 of 17) 5.13% (201 of 3917)	11.76% (4 of 34) 5.0% (178 of 3525)
The trusts 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	Number	7.60	8.10	6.41	7.8	8.0
Patient safety incidents	Number Rate per 100,000 population	**Q1/2** 3160	**Q1/2** 7384	**Q1/2** 12	8033 286.89	**Q1/2 Q3/4** 4141 TBC 192.60 (full year effect)
Patient safety incidents that resulted in severe harm or death	Number Percentage	**Q1/2** 33 1.29%	**Q1/2** 172 8.3%	**Q1/2** 2 0.4%	32 0.4%	**Q1/2 Q3/4** 36 TBC 0.87% TBC

Core Indicator Assurance of data in table in 2.3 above

The percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	NELFT considers that this data is as described for the following reasons: NELFT continue to perform strongly against the CPA follow up; there are robust systems and processes in place to monitor performance. The close working across the acute care pathway between wards and our home treatment teams enables timely follow up. NELFT has taken the following actions to improve this indicator, and so the quality of its services, by: All locality directorate areas are now responsible for monitoring CPA follow up for patients discharged directly back to a community team hence this is now closely managed and reported locally.
The percentage of admissions to acute wards for which the Crisis Revolution Home Treatment Teams (HTT) acted as a gatekeeper during the reporting period	NELFT considers that this data is as described for the following reasons: Following KPMG audit in April 2017, a number of actions were taken to improve the quality of recording and reporting. This has resulted in greater assurance of the data. NELFT has taken the following actions to improve this indicator, and so the quality of its services, by: providing data capture capability in NELFT EPR (RiO) rather than a stand-alone system (Care Map); Performance team providing quarterly reports to ensure compliance; clearer understanding between clinical and performance teams of terminology to ensure correct reporting criteria. These actions, completed during 2017, should result in improved results for 2018.
The percentage of patients aged: i. 0 -15 ii. 16 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	NELFT considers that this data (in table above) is as described for the following reasons: the numbers of patients readmitted are low and so are individually reviewed and discussed at directorate monthly meetings to ensure correct data recording. NELFT has taken the following actions to improve this indicator, and so the quality of its services, by: reviewing each case individually with the ward managers and responsible assistant director. Readmission rates for 16 and over remains very low. For young people aged under 16, NELFT has transformed the model of care, providing greater treatment options for young people at home. The acuity of inpatients is therefore greater and this has led to the increase in readmissions when compared with last year. Each case continues to be individually scrutinised.
The trusts 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	NELFT considers that this data (in table above) is as described for the following reasons: this is a CQC commissioned survey carried out by an independent contractor. The data is in the public domain on the CQC website http://www.cqc.org.uk/provider/RAT/survey/6

	NELFT has taken the following actions to improve this indicator, and so the quality of its services, by rolling out a Quality Improvement Accelerator Care planning (QIAC) programme to ensure patients are actively involved in decisions about their own care.
Patient safety incidents Patient safety incidents that resulted in severe harm or death	NELFT considers that this data is as described for the following reasons: this data is published nationally by NHS Improvement. The data is taken from the National Reporting and Learning System (NRLS) which is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care. NELFT has taken the following actions to improve this indicator, and so the quality of its services, by • delivering training to our new staff in Kent • setting up regular training sessions in Trust headquarters • the publication of newsletters which provide guidance on what to report, how to report and the proper codes to use for the most frequently reported incidents • a screen saver for all staff • the introduction of Datix champions • the roll out of Datix quality dashboards. Datix dashboards contain up to date information on incident numbers, types and reporting patterns. These are now available at every level within the organisation. This means that teams can see all this information in one place which helps to identify areas for improvement and good practice • Feedback is automatically given to staff who report incidents. This feedback includes the result of the investigation and any lessons learned NELFT intends to take the following actions to improve this number and so the quality of its services by • Continuing to review the data quality standards set by NHS Improvement for uploads to the NRLS. This includes making sure the coding of the harm matches the definitions provided by NHS Improvement • Supporting teams who require help in identifying, reporting and reviewing incidents

NELFT performance indicators for 2016/17 and 2017/18

Indicator	Measure	Target	National Average	NHS trust Highest	NHS trust Lowest	NELFT 2016/17	NELFT 2017/18
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Percentage	92%	90.4%	100%	68.1%	100%	99.1%
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	Percentage	95%	84.6%	100%	63.7%	98.3%	99.1%
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (audited by KPMG)	Percentage	50%	60.2%	96%	4%	76%	82.1%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient wards b) Early intervention psychosis services Community mental health services (people on care programme approach)							TBC**
Improving access to psychological therapies (IAPT) a) Proportion of people completing treatment who move to recovery (from IAPT dataset) b) Waiting time to begin treatment (from IAPT minimum dataset): i) Within 6 weeks of referral (audited by KPMG) ii) Within 18 weeks of referral) Admissions to adult facilities of patients under 16 years old	Percentage Number	50% 75% 95%	51% 89.4% 98.7%	67% 100% 100%	21% 10% 38%	50% 98.9% 100%	50.5% 97.7% 100% 0
Inappropriate out-of-area placements for adult mental health services (bed days)	Number (whole year data)						38 34 in Feb 18 4 in Mar 18

**Awaiting confirmed data from Royal College of Psychiatry

Appendix 1

Quality Account Glossary

Care Programme Approach (CPA) - The term ‘care programme approach’ describes the framework for supporting and coordinating effective mental health care for people with severe mental health problems in secondary mental health services

Care Quality Commission (CQC) - The care quality commission is the health and social care regulator for England. The CQC looks at the joined up picture of health and social care. Their aim is to ensure better care for everyone in hospital, in a care home and at home. They provide the essential standards for quality and safety against which organisations must demonstrate compliance

Clinical audit - Clinical audit is a process that has been defined as a quality improvement process that seeks to improve service user care and outcomes through systematic review of care against explicit criteria and the implementation of change

Clinical Commissioning Groups (CCGs) - CCGs commission the majority of health services, including emergency care, elective hospital care, maternity services, and community and mental health services, since the implementation of the Health and Social Care Act 2012 on 1st April 2013. There are 211 CCGs, each commissioning care for an average of 226,000 people

CQUIN (Commissioning for Quality and Innovation) -The CQUIN payment framework was introduced in 2009 to make a proportion of providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of care. The framework helps make quality part of the commissioner-provider discussion everywhere. The framework has been designed based on feedback from partners in the NHS

Early Intervention in Psychosis (EIP) - A clinical approach to those experiencing symptoms of psychosis for the first time

Home Treatment Team (HTT) – provide acute home treatment for adults whose mental health crisis is so severe that they would otherwise have been admitted to hospital.

MUST - The ‘Malnutrition Universal Screening Tool’ (‘MUST’) was developed by the Malnutrition Advisory Group in 2003. It is supported by many governmental and non-governmental organisations including the British Dietetic Association (BDA), the Royal College of Nursing (RCN) and the Registered Nursing Home Association RNHA) and is the most commonly used screening tool in the UK

NELFT (North East London NHS Foundation Trust) - a community and mental health services trust serving the health needs of residents in south west Essex, Havering, Redbridge, Waltham Forest and Barking & Dagenham

National Institute of Clinical Excellence (NICE) - NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health

National Clinical Audits and Patient Outcome Programme (NCAPOP) - audits are commissioned and managed on behalf of NHS England by the Healthcare Quality Improvement Partnership (HQIP)

NHS Improvement (NHSi) – Since 1st April 2016 Monitor and the NHS Trust Development Authority have merged. They now operate under the name of NHS Improvement

STP - sustainability and transformation plan – is a new planning framework for NHS services. STPs are intended to be a local blueprint for delivering the ambitions NHS bodies have for a transformed health service, which is set out in a document called Five Year Forward View

Quality Improvement Programme – Quality improvement refers to bringing about changes that improve patient experiences and support staff to deliver person centred care that is better, safer, more effective and more efficient using a range of specific tools and methods. Quality improvement is an approach which enables everyone to get involved in improving quality.

WIZE-up - a free and confidential drug and alcohol service for young people under 18 (including young offenders) and families in Thurrock.

Appendix 2a

National clinical audit and confidential enquiries – eligibility and participation

National clinical audits and enquiries	Status	Cases submitted
National Audit of Intermediate Care (NAIC)	**NELFT sites registered for audit participation** • Bed based services ○ Waltham Forest: Ainslie Unit ○ Redbridge: Foxglove & Japonica wards ○ Thurrock Community Hospital: Mayfield Ward ○ Brentwood Community Hospital: Thorndon Ward • Home based services ○ Waltham Forest: Community Rehabilitation Team ○ London & Essex: Intensive Rehabilitation Services *The NAIC Summary report - England 2017* has been published. Evidence from the audit demonstrates that intermediate care works with more than 91% of service users either maintaining or improving their level of independence in undertaking activities of daily living, during their episode of care. Individual service reports are due for publication in March 2018. UK wide reports are due for publication in May 2018.	227 bed based intermediate care services 134 home based intermediate care services
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) Pulmonary Rehabilitation Work stream	**NELFT pulmonary rehabilitation [PR] sites registered for audit participation** • Barking & Dagenham • Havering • Redbridge • Waltham Forest The national supplementary report was published December 2017. Findings indicate that many such 'sicker', potentially more disabled patients – who may have substantial rehabilitation needs – are not being referred to and/or assessed by PR programmes.	Cases submitted: • Barking & Dagenham - 8 (53% of eligible patients) • Havering - 46 (84% of eligible patients) • Redbridge - 22 (81% of eligible) • Waltham Forest - 58 (112% of eligible patients)

Sentinel Stroke National Audit Programme (SSNAP)	**NELFT sites registered for audit participation** • Redbridge: King George's Hospital inpatient rehabilitation team • Dagenham: Grays Court Nursing Home Quarterly reports for the data collection period August - November 2017are due to be published in March 2018.	Cases submitted: Redbridge: 32 Dagenham: 27
National Diabetes Foot care audit (NDFA)	The 3rd Annual report will include all foot ulcers where the first assessment took place prior to 31 March 2017 and is due to be published in March 2018. Data submission is ongoing for the fourth annual report 2017/18.	100% of eligible cases
UK Parkinson's audit	**NELFT sites registered for audit participation** • Harold Wood: Long Term Conditions Centre Data has been submitted for consecutive patients seen during May to September 2017. Patient Reported Experience Measure (PREM) questionnaires have been handed to up to 50 consecutive patients. Individual service reports are due for publication in March 2018 and UK wide reports are due for publication in May 2018.	100% of eligible cases
National Epilepsy 12 audit (Round 3)	**NELFT sites registered for audit participation** • Harold Wood: Children's Service • Waltham Forest: Paediatric Epilepsy Service (Specialist Community Paediatrics) Epilepsy12 Project Board is defining the methodology and dataset for the third round of the audit. Data entry is scheduled to start spring 2018.	

POMH-UK audit Topic 1g & 3d - Prescribing high dose and combined antipsychotics	Data for eligible patients was collected by NELFT teams, over the period 01/02/17 – 28/02/17.	Trust teams: 5 Total submissions: 128 [Acute/PICU = 113 Forensic = 15]
POMH-UK audit Topic 17a - Use of Depot/ LA Antipsychotic injections for relapse prevention		Trust teams: 13 Total submissions: 235 [Inpatient wards = 48; Community MHS = 187]
POMH-UK QIP Topic 15b: Prescribing valproate for bipolar disorder	Data has been submitted to POMH-UK The national report is due for publication in the first quarter of 2018/19.	
Child Health Clinical Outcome Review Programme National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Mental Health Conditions in Young People	Prospective data was collected in March 2017. National report is due for publication in April 2018	5 cases
Mental Health Clinical Outcome Review Programme National Confidential Inquiry into Suicide and Homicide for people with mental illness (NCISH) 2017/18	The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) is a project which examines all incidences of suicide and homicide by people in contact with mental health services in the UK.	100% of eligible cases

Appendix 2b

National clinical audit and confidential enquiry - Requirements and actions taken

National audit of Intermediate Care (NAIC)

This the third year that NELFT has participated in the audit where the focus of the audit has been to look at services which support usually frail, elderly people accessing intermediate care at times of transition, when stepping down from an acute hospital episode or preventing the patient being admitted to secondary or long term care. These services are a crucial part of the solution to managing increasing demand in the health and social care system. The audit shines a light on intermediate care and provides a stocktake of current service provision.

National and NELFT outcomes:

- Nationally, mental health workers rarely are included in MDT's
- Where NELFT was comparable the community bed provision NELFT has positive benchmarking with safe Occupancy and *Average Length of Stay* on average lower than 21 Days

Actions taken:

- Review of transdisciplinary working
- Strengthen the MDT approach

National Chronic Obstructive Pulmonary Disease (COPD) (Pulmonary Rehab (PR) Work stream)

The core aim of the programme is to drive improvements in the quality of care and services provided for COPD patients. The pulmonary rehabilitation audit 2017/18 will be running a snapshot audit of organisation and resources of pulmonary rehabilitation services, as well as a snapshot audit of clinical care

Actions in place following the previous round of the national audit:

- **Patient Referral**
  - Improve PR profile amongst referrers and local population
  - Review PR provision v capacity
  - All PR services to review reasons for failure of clients to complete PR and develop flexibility to encourage patients to compete programmes.
  - Improve data recording to specifically include: MRC breathlessness score

- **Structure and content of programmes**
  - Review frequency and duration of programmes, with regard to outcome success, capacity, demands and resources.
  - Review appropriateness of the exercise capacity measures currently used against quality assurance of technical standards.
  - Review exercise content of programmes to emphasise "exercise" as an appropriate outcome measures.
  - Consider a case for individualised prescription and mid-programme re-assessment to amend exercise prescription dependant on staff capacity.

- **Programme resources and staffing**
  - Determine local capacity and local demands for both chronic stable referrals and those post-hospital discharges.
  - Development of referral pathways for post-exacerbation PR with development of provision of services to meet the capacity and flexibility required to meet the local demands.
  - Review of Standard Operating Procedure to be agreed, incorporating local policies on treatment venues including patient transport facilities, equipment requirements, safety systems including risk assessment of venues and emergency treatment arrangements and provision of safe including skill mix, seniority and competencies.

- **Education & patient information**
  - Review the format, content and quality of each education session within programmes and their relevance to the COPD Assessment Test questionnaire.
  - Review use of alternative outcome tools to reflect local PR service success / benefits.
  - All areas to review the "on-going exercise plans" provided on discharge, and to consider a tracking process to confirm the engagement in this by clients.

Sentinel Stroke National Audit Programme (SSNAP)

The Sentinel Stroke National Audit Programme (SSNAP) is a national rolling audit programme which started in December 2012. It aims to improve the quality of stroke care by auditing stroke services against evidence based standards, and national and local benchmarks.

It is a national audit for which stroke services across England, Wales and Northern Ireland providing acute care, rehabilitation, or 6 month review follow-up, are asked to participate and provide routine continuous data on every stroke admission/ stroke patient accessing their services.

The aims of the audit are:
- To benchmark services regionally and nationally
- To monitor progress against a background of organisational change to stroke services and more generally in the NHS
- To support clinicians in identifying where improvements are needed, planning for and lobbying for change and celebrating success and to empower patients to ask searching questions.

National and NELFT outcomes:
- Based on demographics of the boroughs covered by NELFT, the average age of those referred to the service is higher than the national average. With increasing age there is also the increased likelihood of co-morbidities and potential for lower 'baseline' function and subsequent outcome functional level post stroke.
- The Modified Rankin Scale (mRS) on discharge from inpatient services to Community Rehabilitation Service (CRS) reported on SSNAP illustrates that a large percentage of patients coming into the service have a higher level of disability compared to national statistics, with approximately 60% having moderate to severe disability on referral to the service compared to approximately 35% nationally.
- During the audited SSNAP period 76% of patients seen by the CRS either demonstrate an improvement or maintain their ability, when scored against the mRS

Actions taken:

- Action taken to improve communication between Barking, Havering & Redbridge University Hospital Trust (BHRUT) and NELFT in order to obtain a full list of stroke patients admitted and discharged from our neighbouring acute trust. Trust is currently receiving a list of stroke patients discharged directly from the ward. The named contact links are to be further strengthened when Stroke Nurse is in post
- 6 month review clinic appointment booking is currently being reviewed. Data from SSNAP is being used to help identify patients requiring their 6 month review to ensure these are booked and completed in a timely manner as well as patient list sent from BHRUT.

National Epilepsy 12 audit (Round 2)
Epilepsy 12 was established in 2009 and has the continued aim of helping epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies.

Actions taken:
- Regular Epilepsy training and guideline awareness sessions
- Update and re-launch 'First seizure guideline' which should be available to paediatric doctors
- Teaching sessions in Emergency Department and within Whipps Cross paediatric department and Specialist children's service around the 'First seizure guideline'

Round 3 of the Epilepsy 12 audit has an expanded scope, and aims to:
- Continue to measure and improve care and outcomes for UK children and young people with epilepsies.
- Include all children and young people with a new onset of epilepsy
- Enable continuous patient ascertainment
- Use a pragmatic and concise dataset
- Incorporate **NICE Quality Standards**, Mental Health, Educational and Transition metrics
- Obtain approval to include patient identifiers to allow local real-time individual and service dashboard elements within the audit reporting **platform.**

National Diabetes Foot Care Audit (NDFA)

The National Diabetes Foot care Audit (NDFA) enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease. The National Diabetes Foot care Audit (NDFA) is a continuous data collection audit.

National Diabetes Foot care Audit (NDFA) looks at the following key areas:
- Structures: are the nationally recommended care structures in place for the management of diabetic foot disease?
- Processes: does the treatment of active diabetic foot disease comply with nationally recommended guidance?
- Outcomes: are the outcomes of diabetic foot disease optimised?

NELFT outcomes:
- The audit findings showed that NELFT Podiatry is better than the national average for the healing rates of diabetic foot ulcers at both 12 weeks (65.7 per cent of the ulcer episodes the patient was reported to be alive and ulcer-free, compared to 44.8 per cent nationally) and 24 weeks (64.8 per cent of the ulcer episodes the patient was reported to be alive and ulcer-free at 24 weeks, compared to 58.3 per cent nationally).

Actions taken:

- The process of data collection reviewed to capture more eligible patients, including domiciliary patients

Prescribing Observatory for Mental Health – UK (POMH-UK) audit prescribing topics in mental health services

The national Prescribing Observatory for Mental Health (POMH-UK aims to help specialist mental health trusts / healthcare organisations improve their prescribing practice. POMH-UK, with its member organisations, identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes (QIPs). Organisations are able to benchmark their performance against one another and identify where their prescribing practice meets nationally agreed standards and where it falls short. Wide participation in QIPs creates a picture of prescribing practice nationally.

- **POMH UK audit Topic 16a - Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour**

NELFT achieved 97% compliance with the requirement for documented evidence of a debrief being undertaken within 24 hours where patients had been administered IM medication (compared to 42% for the total national sample).

The **SMART action plan** in place includes:

- Reinforcing the requirement for documenting physical health monitoring of patients administered RT
- Reinforcing the requirement for documented evidence of a recent ECG or a risk-benefit statement where patients refuse an ECG
- Requirement for improving the quality of care plans so that they include post-RT discussions with the patient for management of future episodes of acutely disturbed behaviour

- **POMH UK audit Topic 1g & 3d - Prescribing high dose and combined antipsychotics**

Areas of good practice in NELFT, showing continuous quality improvements in patient safety outcomes include:

- Number of patients prescribed high dose antipsychotic(s) continues to fall, demonstrating improved compliance with the recommendation/standard that patient's antipsychotic dose should be within SPC/BNF dose limits.
- Number of patients prescribed a single antipsychotic has increased, demonstrating improved compliance with the recommendation/standard that patient's should only receive one antipsychotic at a time
- Physical health monitoring and assessment for NELFT was above the total national sample [TNS]: NELFT compliance range 83% - 97% (TNS 66% - 95%)

The **SMART action plan** in place includes:

- Care plans, for patients on antipsychotic therapy, to have a clear treatment plan which reflects the patient's antipsychotic therapy, including high dose prescribing.
- The requirement for responsible clinicians to ensure junior medical colleagues document physical health in the patient's electronic records using the updated ward round template on RIO, with the aim of achieving 100% compliance with all indicated physical health parameters.

- **POMH UK audit Topic 17a - Use of Depot/ LA Antipsychotic injections for relapse prevention**

NELFT achieved 94% compliance with standards to reviewing patient's antipsychotic medication at least annually (compared to 80% for the total national sample)

The **SMART action plan** in place includes:

- Further improvements for the documentation for assessment of side effects
- Requirement for improving the quality of care plans so that they include a clinical plan

National Confidential Inquiry into Suicide and Homicide for people with mental illness (NCISH), Annual Report 2017

Patient suicides having fallen in recent years, particularly in England and Scotland. During 2005-2015, 28% of suicides in the UK general population were in mental health patients, although this figure is slightly higher in Scotland and slightly lower in Wales.

Similar falls are also apparent in specific patient groups that have been of concern. There has been a downward trend in the number of suicides by patients recently discharged from hospital in England and Scotland: there were 230 post-discharge deaths in the UK in 2015, down from 299 in 2011. A similar fall is found in suicides by patients who were non-adherent with drug treatment in the month before death, in England down from 160 in 2010 to 110 in 2015. These downward trends have occurred despite more patients being treated by mental health services.

Suicide by mental health in-patients continues to fall but the longstanding downward trend has slowed. In the 5 years after 2005, in-patient suicide numbers in the UK fell by 39%; in the 5 years after 2010, the fall was 10%. In England the equivalent in-patient suicide rates, i.e. taking into account the number of admissions, were similar: 31% and 14%. In recent years there has been an average of 114 suicides by in-patients in the UK per year, including 89 in England.

Actions taken:

- The 2017 NCISH report has been shared with the MHS Community of Practice AMD for onward dissemination
- An action plan is to be developed for the trust, taking into consideration key findings highlighted in the 2017 national report, as well as the key findings highlighted in the 2016 report, which includes prompt [2-3 days] follow up of patients discharged from services

Appendix 2c

Pharmacy: Medicines Management audits

- **Controlled Drugs (CDs) audit:** The CDs audit is carried out by pharmacy staff quarterly across all NELFT sites and services where CDs are used. The audit findings have shown that there has been an overall improvement in compliance with the NICE-derived standards for the safe and secure handling of CDs. A more robust action plan tracking system was introduced during 2017: *CD Action Plan Tracker* (CDAPT) which has strengthened the process for sharing and following up on actions arising out of the quarterly audits – resulting in an improvement in the compliance with the CD standards.

- **Medicines Reconciliation audit:** Effective Medicines Reconciliation is an essential component of clinical governance, ensuring patient safety through the safe and appropriate use of medicines for each individual patient, on admission and during transfer of care. The annual audit has shown that there has been an overall improvement in compliance with the NICE-derived standards for *Medicines Optimisation*. On overall reduction in the time taken to resolve MR queries has been attributed the increased use of Summary Care Records (SCR) by the pharmacy team. SCR access is to be made available for all relevant NELFT staff to further improve the timely completion of the medicines reconciliation process

- **Antimicrobial audit:** The annual antimicrobial audit is carried out as part of the national Antimicrobial Stewardship programme. Standards are derived from the NICE guideline on Antimicrobial Stewardship**.** The annual audit has shown that there has been ongoing, continuous improvement from 2012 to 2017 for the requirement of completion of allergy status for patients, clinicians providing an indication and duration for the prescribed antibiotic. The pharmacy team take the lead for ongoing monitoring on patients prescribed antibiotics, to maintain compliance with the principles of antimicrobial stewardship

- **Acute & Rehabilitation Directorate**
  - **Rapid Tranquillisation and Acuphase (pharmacy-led local RAC re-audit):** RAC audits on the monitoring of patients prescribed rapid tranquillisation medication and Clopixol Acuphase were implemented in the Trust following a CQC inspection in August 2017. Improvements have been made in the documentation for recording ECG and providing a rationale for patients prescribed Clopixol-Acuphase. New guidance on the *Safe use of Clopixol Acuphase* has been developed, together with an action plan, both of which have been shared across the Acute & Rehabilitation Directorate.

  - **High dose antipsychotic prescribing (pharmacy-led local RAC re-audit):** The high dose antipsychotic monitoring audits, carried out for inpatient wards, have shown continuous improvements in compliance with the trust's policy on High Dose Antipsychotic Prescribing, which includes highlighting patients on high dose antipsychotic therapy and completing documentation on physical health monitoring.

A collaborative approach between the pharmacists, medical and nursing staff has ensured that patients on high dose antipsychotic therapy continue to be identified, ensuring the physical health monitoring form is completed for these patients and that there is ongoing review of patient's on high dose antipsychotic therapy, thereby ensuring that there is safe prescribing of high dose antipsychotics.

- **EWMHS [Emotional Well-being and Mental Health Services] for young people - FP10 Prescriptions audit**: This audit measured the trust's compliance with NHS Security Management Service Security of Prescription Forms Guidance. Sites audited all kept their FP10 prescription pads locked and only issued FP10 prescription pads to authorised staff. The audit findings have been shared with the service managers and consultants within the EWMHS service. The trusts process on the safe and secure handling of FP10 prescriptions has been shared with staff.

- **Community Recovery & Assertive Outreach Services:** The WHITE zone criteria is being refined to include only patients in Acute Services. An alternative zone/code is in the process of being created (to WHITE) for patients in planned long-stay specialist admissions. Creating a new zone is being considered for patients with Non-clinical and Social Needs so as not to over burden to AMBER zone.

- **Improving access to psychological therapies (IMPART):** The service policy of offering top up sessions and continued telephone skills coaching to all client that complete treatment is being clarified. Actions are in progress to review and revise method of relaying what is available to clients post discharge and number of top up sessions typically offered to clients who will be having them with someone who was not their original therapist. Ways to improve availability of therapists are reviewed to client who have been discharge and want skills coaching and/or top up sessions. The approach to taper discharge is being reviewed, in particular, discussing if the therapist needs to exercise some initiative in contacting the patient initially post discharge. The Complaints process information sheet used with clients is in the process of being reviewed to create a more user friendly and colourful version together with the Niggles, Grizzles and these will be posted up in the main building.

- **Children Targeted Services:** Services are ensuring that transfer in and out of records are managed in timely fashion and all staff working within the Health Visiting team are aware of the transfer in and out process. Actions are in progress to reduce waiting list for Autism Spectrum Disorder (ASD) assessments and improving the documentation of findings on physical examination including looking for any signs of Self harm or physical injury. Examination for Neurocutaneous stigmata using Woods Lamp (NICE recommendation) is being reviewed. Follow up appointments after diagnosis of ASD are being booked to ensure that parents and the child get adequate support to meet any challenges after diagnosis has been given. Patient satisfaction surveys are to be encouraged to ensure that the level of care provided to the patients is fit for purpose.

- **Psychological Services:** Clinicians are prompted to ask about driving status of patients. Driving status is recorded on the first appointment assessment pack and care plan letters. The self-help pack includes information on sleep hygiene and medication. Pittsburgh Sleep Quality Index (PSQI) is used as an outcome measure to assess sleep in assessment stage. Clients are asked if managing sleep difficulties are important to them. Junior doctors running physical health clinic will be recording height and weight on

growth chart on RiO. They will also be required to obtain blood results of the patients who had bloods done elsewhere and document them on RiO (they should be able to log results retrospectively). All doctors will be given access to CYBER lab. A copy of the Physical Health pro-forma will be kept in each of the clinic consultation rooms. Template has been designed for first assessment that has a prompt for driving status to ensure that this information is captured more consistently and a section is to be included on the care plan letter template for driving status to improve adherence to guidelines and ensure members of the team use the agreed care plan template containing prompt for driving status when documenting contact with the patients.

- **Long Term Conditions Services:** The rationale for sending letters, and risks of not sending them, has been discussed with relevant stakeholders and an effective timescale (3 weeks) has been agreed. The Community Cardiac Service continues to improve documentation of assessments and investigations carried out by the service. Yearly review of anticoagulation therapy is to be added to the Clinic Consultation checklist as a prompt to document this effectively.

- **Nutrition and Dietetics Service (N&D):** Head & Neck patients are contacted to book home visits if there is no room in a clinic within the first 2 weeks. All head and Neck referrals are endeavoured for triage on the day referred (actions in progress).

- **Universal Children Services:** Team leaders and band 6 nurses have developed a new system for transferring records starting with the initial task requesting records to transfer out within 14 days. They support the training of the admin staff to follow process for transferring out universal caseload records, which involves recognition of child's records which are not routine universal service. The transfer out of records is actioned within 2 weeks and this is monitored on an ongoing basis. A designated member of staff has been appointed to review the tasks weekly and ensure transfers out are actioned

- **Acute & Rehabilitation Directorate:** Direct entry into RiO is being implemented instead of using paper records at Home Treatment Teams to ensure a plan is put in place for patients on admission. Staff education on prescription and circulation of common maximum dose cards to duty doctors are in progress.

- **Acute & Rehabilitation Directorate: 'As Required' prescribing practice:** Weekly teaching sessions are to be held in the wards on "as required prescribing".

- **Older Adults Mental Health & Memory Service:** GP's are educated about the importance of cognitive testing.

- **Child Health Services:** Discussions are in progress to set up a specific clinic for initial assessments of neurodevelopment issues and staff are to be trained accordingly. A collaborative working relationship and joint consultations / work with Paediatricians has been suggested and is being explored further.

- **Specialist Stroke Services:** The importance of MUST screening tool is to be highlighted in care homes as part of CQC guidelines. Patients are weighed on admission and a weekly weight record is maintained. Named Nurses are allocated to review, audit and maintain documentation to ensure the MUST tool is completed as required at the time of

taking weight. System has been improved to better meet the needs of the staff to improve compliance. MUST screening guide and staff support are to have easy access and visibility.

- **Falls prevention Services:** Initial Falls Assessment Template has been introduced and is mandatory as a part of initial falls assessment where all assessments and their outcome have to be recorded in a timely manner. Band 4 and above have completed the MUST training.

- **School Nursing Services**: Engagement with schools are now diarised and carried out earlier in the academic year to enable the timetabling of the workshop. Engagement with Sexual Health Service and Wize-Up are also made earlier in the academic year to enable staff to commit to dates. Pupil evaluation forms are completed following sessions.

- **Children Services:** Administration staff will access the Transfer In folder on RiO and disseminate the appropriate information to the named practitioner to ensure that transfer in and out records are managed in timely fashion.

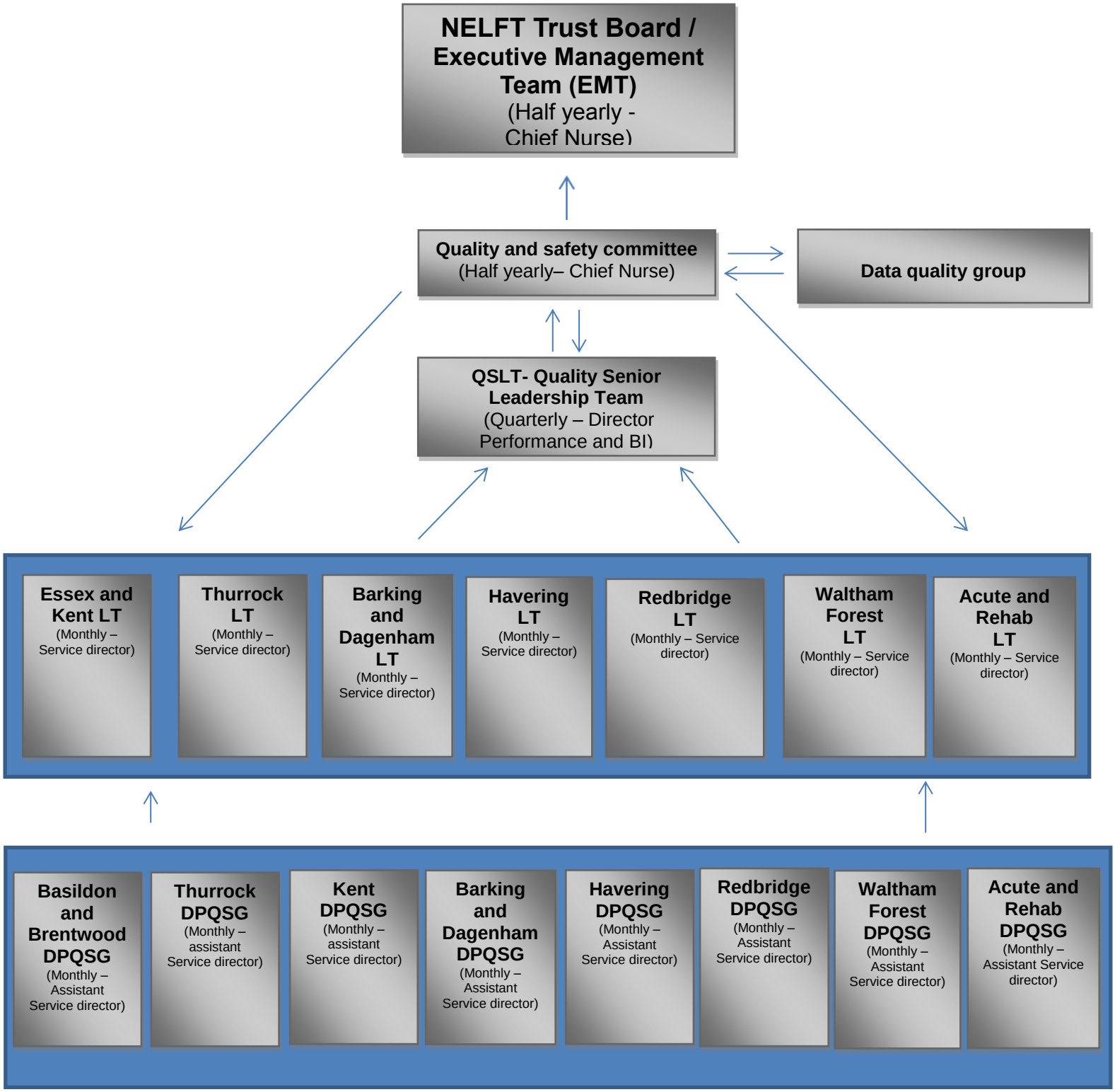
- **Early Intervention in Psychosis [EIP] Service:** Consistency of when carers are being offered early intervention has been reviewed. Database has been amended to record number of times the intervention has been offered to ensure it is done more than once, if necessary. Service users who choose not to engage in the sessions are being contacted to consider potential barriers to uptake. The Service has linked in with the inpatient acute wards and an easy to understand glossary of key terms that carers may encounter both in EIP and the wards have been created to ensure they have some information about psychosis and the CWI to provide to First Episode Psychosis (FEP) carers (this is also included in the introduction pack). There is now training across EIP and acute wards to ensure that learning is shared.

- **Intermediate Care Medical Team:** Documentation of indication in notes and drug charts is being discussed with doctors & ward managers to improve compliance with sending of MSU before starting antibiotics.

- **A&E Liaison (Whipps Cross), Waltham Forest:** Recording of referral reasons correctly on SNOMED is being progressed. More educational events will be organised. Actions are on-going to achieve 90% of referral and discharge letters sent within two weeks and a standard of 85% of response times across all units.

Appendix 3

Quality Account governance structure



LT – Local leadership team meeting

DPQSG – Directorate performance, quality & safety group

Local improvement priorities/leads
Patient and service user involvement

Appendix 4

Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

NHS North East Essex Clinical Commissioning Group

North East Essex Clinical Commissioning Group
Aspen House
Stephenson Road
Colchester
CO4 9QR

Tel: 01206 918747
www.neessexccg.nhs.uk

19 April 2018

By E Mail only to julie.price@nelft.nhs.uk

Julie Price
Director of Performance and Business Intelligence
North East London NHS Foundation Trust
CEME Centre, Marsh Way
Rainham
Essex RM13 8EU

Dear Julie

Thank you for providing a draft copy of your Quality Account for 2017/8 for comment by North East Essex CCG.

As you are aware the Services provided in Essex Emotional Wellbeing and Mental Health Services form just one part of your portfolio and as such do not feature heavily in your account. The lead commissioner role for this service rests with West Essex Clinical Commissioning Group and accordingly I shall feedback to them.

I have taken the opportunity to read the account and my following comments relate to an account that is still in progress of finalisation.

Please consider the following:

- This is a public facing document and ease of reading is of prime consideration. So please explain the acronyms that are used as well as providing an explanation of terms such as "White Zone".
- Proof read to ensure that all references to contract years are accurate.

The Care Quality Commission report published in January this year was very pleasing as the Trust achieved an overall rating of Good. This is obviously a testament to the hard work of the Trust and your staff.

Kind regards

Yours sincerely

Lisa Llewelyn

Lisa Llewelyn
Director of Nursing and Clinical Quality

Chief Officer: Samantha Hepplewhite

Chairman: Dr Hasan Chowhan

Dear Julie

Thank you for asking Healthwatch Havering to comment on your Quality Account.

Can I begin by congratulating the staff of the Trust in their continued commitment to delivering excellent care. It is also great to note that this commitment to care has resulted in a very successful year for the team where the showcasing of their work has received national recognition and the winning of many prestigious awards.

We found the overall report to be well balanced and the goals for this year ones which felt really reflected a further step forward in improving patient care. Your organisation has continued to grow and now delivers services across a range of populations. Of particular note under the section 'Safe' Goal 3 - aiming to develop the model to include over 65 for falls assessment in the community in-patient service in London and Essex, 'Effective' - ensuring 95% of care plans include the five elements of care by end of quarter 2.08/19 extended to emotional wellbeing mental health services in Essex and CAMHS in London and 'Responsive' - extending and developing the children's services in Medway and East Kent.

For Havering specifically, we would like to congratulate your team on the success of Brookside , a stunning turnaround of service and environment - well done!

best

Anne-Marie Dean

Chairman
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Clinical Commissioning Group

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020 3688 2628

Stephanie Dawes
Chief Nurse and Executive Director of Integrated care
NELFT NHS Foundation Trust

1 May 2018

Dear Stephanie

RE: **Waltham Forest Clinical Commission Group Response to North East London NHS Foundation Trust Draft Quality Accounts 2017/18**

Waltham Forest Clinical Commissioning Group (WF CCG) welcome the opportunity to review the Quality Accounts provided by North East London Foundation Trust (NELFT) which set out an overview of the quality of care provided by the Trust during 2017/18 and the priorities for 2018/19.

The Quality Account opens with a wealth of achievements and awards received across NELFT celebrating the successes of teams, individuals and the organisation as an employer. It is clear that the executive team are proud of the achievements of the staff throughout the year.

Following a challenging 2016/17 and the Trusts Care Quality Commission (CQC) rating of "requires improvement" it is clear that the Trusts Quality Improvement action plan and commitment to the Quality Account local improvement indicators have delivered the requisite improvements. WF CCG is pleased that the CQC report published January 2018 rewarded the hard work and dedication of staff with an improved rating of "good" and most especially that the further work on the Brookside unit resulted in a rating of "outstanding".

NELFT continue to align their local improvement indicators with the CQC fundamentals standards of care, carrying on from those set in 2017/18. The CCG is keen to support the ongoing development of the quality dashboard as these will support NELFT's commitment to drive up the quality and experience for the patients and move the Trusts services to "outstanding".

However whilst the continuance of local indictors supports sustainable improvement, there are a number of areas where NELFT could be more challenging in the targets set, for example the completion of risk assessments target is 10% lower than set last year at 75%. The quality improvement continuum to "outstanding" requires a balance of embedding but also ongoing ambition and NELFT indicators could be more ambitious.

NELFT have had a number of challenges in relation to referral to treatment times and WF CCG would have appreciated a local quality indictor that supported improvement for its residents.

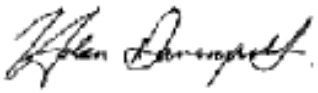
Review of achievements against the 2017/18 indicates the progress with supporting data. Of the 9 indicators 4 were achieved and 5 not achieved. Falls reduction was 38% against a target of 50% but the account clearly highlights the work undertaken to reduce falls and note that there was significant success in quarters 2 and 3.

The annual staff survey supports the reason why NELFT were placed 19 in the top 50 UK employers. It is clear that staff feedback is valued and this has resulted in good communications and staff being confident to raise concerns and issues.

WF CCG have reviewed the content of the draft Quality Account comparing the content and format as mandated by NHS Improvement requirements for Foundation Trusts 2017/18 and the Account demonstrates compliance. The final Quality Account will have in place information and data for the newly required section "Learning from Deaths" which will provide the reader with assurance of NELFT's investigation processes and organisational learning.

WF CCG would like to thank NELFT for requesting input into the draft Quality Accounts and to give comment on the quality improvements both made and planned for the coming year. We look forward to working in partnership to achieve the "Outstanding" rating that our residents deserve.

Yours sincerely



Helen Davenport
Director of Nursing, Quality and Governance

Dr Anwar Khan
Waltham Forest Chair

Kent and Medway NHS
NHS and Social Care Partnership Trust

Trust Headquarters
Farm Villa
Hermitage Lane
Maidstone
Kent
ME16 9PH

Tel 01622 724133

10 May 2018

NELFT Communications and Julie Price
c/o email

Dear Colleague

Re: NELFT Foundation Trust Draft Quality Account Report 2017/18

Thank you for forwarding you Quality Account 2017/18 to KMPT requesting feedback on the document.

I note that you require brief feedback and this feedback is on behalf of Kent and Medway NHS and Social Care Partnership Trust. I have read your Quality Account with interest. As we are a Kent and Medway based Trust I specifically looked at your overall performance in Quality and specifically your goals in relation to Kent and Medway Services. It was particularly pleasing to see that you achieved outstanding in caring, well led and overall for your Child and Adolescent Mental Health Wards.

I read with interest the description of MIDAS. MIDAS is described as a performance reporting tool to help integrate, validate and present data from multiple systems. Managers can see there Teams performance in difference areas for example, appraisal compliance and mandatory training. They can also look at the activity that is happening within the Team to ensure that all patients are seen and they receive the right treatment in a timely fashion. MIDAS helps managers to performance manage their services and enables the Trust to extract data from a central source which can then be shared with Commissioners. This is particularly interesting as I noted the plan in goal was to "ensure that Teams have access to MIDAS to support the management of Services applicable to East Kent, West Kent and Medway CYPH Services.

I was also pleased to note the inclusion of a goal "to ensure that all young people who have a wait in excess of 52 weeks for assessment and/or treatment are seen by the appropriate Clinical Team by end quarter 3 2018/19 (dependant on the allocation of additional resource for Commissioner) applicable to Kent and Medway with an ambition that by the end of quarter 3 2018/19 no young person will be awaiting assessment/treatment for 52 weeks and that this will be monitored by your daily MIDAS board with weekly or monthly progress reports to your performance team and reported in your patient and quality safety meetings and locality leadership team meetings. It will be good to see the ambition stepped up on waiting times.

I was also please to note the goal to ensure that all young people who have waited for a attention deficit hyperactivity disorder or autistic spectrum disorder assessment to be assessed by a specialist clinical team by the end of quarter 3 2018/19 applicable to East Kent.

Wishing you a successful year and success in your quality goals.

Yours sincerely

Professor Catherine Kinane
Executive Medical Director

Families & Homes Directorate
Deputy Chief Executive: Linzi Roberts-Egan

Waltham Forest

Waltham Forest Town Hall, Forest Road, Walthamstow, London E17 4JF

Stephanie Daw
Chief Nurse & Executive Director of Integrated Care
CEME Centre, West Wing,
Marsh Way,
Rainham, Essex.
RM13 8GQ

Date: 14th May 2018

Dear Stephanie

London Borough of Waltham Forest Response to North East London NHS Foundation Trust Draft Quality Account Report 2017/18

The London Borough of Waltham Forest (hereafter LBWF) welcomes the opportunity to comment on the Annual Quality Account prepared by North East London NHS Foundation Trust (NELFT) which sets out the overall performance of the trust in 2017/18 and priorities for 2018/19.

We are pleased that NELFT has received a 'good' CQC rating in the past 12 months. Whilst we recognise that a number of quite significant challenges remain we welcome the evidence of continuous progress towards improvement and the Trust's commitment to continuing this throughout 2018/19 and look forward to working with NELFT to deliver further improvements.

In relation to these challenges, LBWF have identified the following considerations that we would wish to see addressed within the 2018/19 plan. We expect that many of that these considerations will be familiar to senior leaders in NELFT having previously been raised by LBWF in a range of fora. We would therefore request that they are highlighted in next year's quality account to ensure that progress towards resolution is made.

Though overall the trust has received a 'good' rating we believe there are areas where further improvements are required but the account doesn't provide sufficient detail as to how this will be achieved. Specifically, we feel that there is a need for greater focus around acute wards for working age adults and psychiatric intensive care units given that this service has been rated as requiring improvement across all domains. Additionally, whilst we see that goals for the coming year do seek to enhance the rating / quality within the 'safe' domain we would wish to see a greater exploration of how this improvement may be achieved and the areas of focus, especially given the significance of this domain for service users.

The account highlights a number of areas where goals for 2017/18 have not been achieved. We would expect the Quality Account to outline the factors that prevented these goals from being achieved, subsequent learning and what has been improved / changed in order to ensure achievement in 2018/19. Furthermore we would expect to see that any goals not achieved are revised given they represent important issues around quality of care and ensuring that care delivered is safe. Specifically we are concerned that the target for 85% of patient care plans to include the five elements of care planning was missed last year (effective goal 1) and would seek to understand from the account, haste is required to achieve that target this year.

From the account it is clear that whilst significant progress has been made in a number of areas there is a need for the Trust to be more ambitious and set more challenging targets in order to maximise the benefits to patients. For example in regards to 'safe' goal one, whilst we welcome the attempt to standardise and ensure a consistent patient record is held electronically the 75% goal is not sufficiently challenging, especially given that this target was achieved in all four quarters of 2017/18. We would therefore like to see a plan to achieve 100% of this goal as well as a review of all goals where similar characteristics exist to make them more challenging or provide a justification where targets are already being achieved as to why there is not opportunity for further enhancement.

To deliver the 2018/19 priorities we believe that NELFT will need to work more effectively with its partners. LBWF welcomes the opportunity to deliver upon the shared priorities highlighted in this account however in order for this approach to be effective there is a requirement for NELFT to ensure it delivers consistent engagement / partnership working. Disappointingly we are continuing to identify issues around communication of decision-making and communication with service users which we believe must be improved over the course of the next 12 months. We wish to highlight a specific issue relating to CAMHS threshold changes where the Trust did not effectively communicate with LBWF leading to incorrect information being issued to service users. We believe that through enhanced partnership working we can address these issues for 2018/19 and would seek the Quality Account be updated to reflect this priority.

We have concerns over the quality of some of the data that is produced by the Trust and / or data being readily available to partners. We would wish to highlight specific issues around the measurement of Adults and Children's Mental Health as well as some partner data which is either not being recorded or there are inaccuracies. We believe that there are opportunities for the Trust to work more closely with partners to quality assure data / information. In future years, we believe there is the opportunity to use this enhanced data in order to develop more localised ambitions and goals for LBWF, similar to those highlighted for Kent services in this report. We believe that doing this would add significant value to the quality of information we receive and overall will lead enhanced evidence-led decision making across the sector and better outcomes for service users. LBWF would be glad to work with the Trust to develop these proposals going forward.

LBWF would like to thank NELFT for requesting input into the draft quality accounts and to give comments on the quality improvements made thus far and those planned for the coming year. We welcome the opportunity to work with NELFT to address the comments we have outlined above in order to develop a stronger health care system which delivers enhanced outcomes for service users and their families.

Yours sincerely

Linzi Roberts-Egan
Deputy Chief Executive

Havering
LONDON BOROUGH

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Thursday 17th May 2018

www.havering.gov.uk

By Email:
Julie.price@nelft.nhs.uk

Dear Sir / Madam,

I am writing on behalf of the London Borough of Havering with regard to the Trust's Draft Quality Account Report 2017/18.

The Report demonstrates that the Trust has a comprehensive range of quality improvement processes and made significant progress over the course of year in many areas. However, based solely on the information contained in the report, I would suggest that Trust considers the following issues: -

The outcome and patient experience of care are key measures of service quality. With this in mind, it is noticeable that the majority of quality measures reported relate to the process of care. We would strongly recommend that the Trust develops and publishes more information reflecting the voice of the patient and patient outcomes.

The Report makes clear that the Trust is an increasingly large and complex organisation providing services over a wide area to a variety of diverse communities. As a result, there is the real possibility that the average quoted for the Trust as a whole may not reflect the experience of residents in the London Borough of Havering. Therefore we would suggest that the Trust provides assurance for each individual geographic area that the information stated in the report reflects the state of services available to that community.

It is evident that CQC continues to have reservations regarding the quality of some services however the structure of the report does not assist the reader to identify whether the proposed priorities for future action are relevant and or likely to be effective. For example to aid understanding and transparency, it would assist if the actions proposed under the Safe theme were linked to the weaknesses identified by CQC such that 6 out of 15 areas were rated as 'require improvement' (Table on p11). Likewise, it's not clear whether the actions listed will address the issues that resulted in acute wards for adults of working age and psychiatric intensive care being rated as 'require improvement'.

Havering
Making a Greater London

Finally, fantastic and commendable improvement has been achieved with regard to the Brookside Unit – however it would be reassuring to see evidence that the Trust Board has also considered, understood and addressed the weaknesses in governance procedures that failed to identify problems with the Unit that were revealed by the CQC inspection.

Yours Sincerely,

Barbara Nicholls (Director of Adult Services)
and
Mark Ansell (Acting Director of Public Health)

NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

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Ilford
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Barking and Dagenham, Havering and Redbridge CCGs (BHR CCGs)
Commissioner Statement 2017/18

North East London NHS Foundation Trust (NELFT)

NHS Barking and Dagenham Clinical Commissioning Group welcomes the opportunity to review the Quality Account (the Account) for North East London NHS Foundation Trust (NELFT) and to provide this statement.

This statement has been prepared in collaboration with Havering and Redbridge CCGs and colleagues from the North and East London Commissioning Support Unit.

We confirm that we have reviewed the information contained within the Account and checked this against data sources, where these are available to us as part of existing contract assurance and monitoring processes, and can confirm that we believe it is accurate in relation to the services provided by the Trust.

We have noted the number of examples provided within the Account which attest to the Trust's achievements in improving the quality of care and patient experience during 2017/18.

The CCG congratulates the Trust on its remarkable achievement which has seen the Trust's overall ratings with the CQC improve from '*Requires Improvement*' to '*Good*', and the rating for Brookside Child and Adolescent inpatient services moved to '*Outstanding*'. The CCG recognises and commends the commitment by all employees in delivering the significant quality improvement programme the Trust has undertaken to achieve this rating.

The CCG acknowledges the efforts of the workforce team to improve recruitment and retention and the ongoing reduction in agency costs. This work has ensured a stable and committed workforce which the CCG recognises leads to an improvement in the quality of care for patients and their families.

The CCG would also like to congratulate the Trust on winning a number of national awards. Specifically NELFT has been placed at number 19 for Inclusive Top 50 UK Employers, and the achievement in the Patient Safety Awards of the Patient Safety in Community Team, which won the Patient Safety in Community award. The CCG believes that these awards provide a helpful insight into the organisational culture of NELFT.

The CCG would like to commend NELFT on its improvements in relation to Clinical Audit and improving clinical effectiveness and patient safety.

Civic Offices, New Road, Grays
Essex RM17 6SL
17 May 2018

Stephanie Dawe
Chief Nurse and Executive Director of Integrated Care
NELFT NHS Foundation Trust
CEME Centre
West Wing
Marsh Way
Rainham
Essex
RM13 8GQ

* Response provided by email

Dear Stephanie,

North East London Foundation Trust draft Quality Account Report 2017/18.

I am writing to provide feedback on your draft quality account 2017/18 on behalf of Thurrock Council, as requested on 17 April 2018.

Thurrock Council's Adult's Health and Housing Directorate works in partnership and alongside North East London Foundation Trust (NELFT) delivering a number of key community based health and wellbeing services.

Specifically, Thurrock delivers a joint Reablement Service, Rapid Response Assessment Service and 'Thurrock First', a single point of contact service. All of these services are delivering good quality care and support to Thurrock residents. Thurrock First is a relatively new joint service that has been successfully launched and continues to go from strength to strength.

Ongoing commitment to working in partnership can be seen in a number of key areas including:

- Sharing an integrated Director post between the two organisations;
- The forthcoming development of an 'Alliance Agreement' of provider services in Thurrock which includes the Council, NELFT and other local partners; and
- NELFT's consistent attendance at key operational and strategic delivery fora, such as Thurrock Health and Wellbeing Board.

Strategically, the Council and NELFT continue to work very closely together on our New Models of Care pilot, a place based, whole systems transformation programme beginning in two districts in Thurrock.

The partnership continues to mature, remains highly collaborative and is built upon a track record of previous delivery of innovative and effective service development.

Yours sincerely

Roger Harris
Corporate Director, Adults Housing and Health

NHS BASILDON AND BRENTWOOD & THURROCK CCGs COMMENTARY ON NORTH EAST LONDON FOUNDATION TRUST 2017/18 QUALITY ACCOUNT

NHS Basildon and Brentwood and Thurrock CCGs welcome the opportunity to comment on the annual Quality Account prepared by North East London NHS Foundation Trust (NELFT).

As lead Commissioner for the south west Essex Community Services contract and to the best of NHS Basildon and Brentwood 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.

The CCGs note that there are some omissions in the data submitted, related to the new national requirement to report Learning from Deaths, following the publication of the National Quality Board framework in March 2017. The CCGs anticipate that this more detailed review will be included within the final version of the quality account.

HIGHLIGHTS FROM 2017/18

The CCGs commend the Trust's hard work in achieving an overall rating of 'Good' from 'Requires Improvement following the CQC's 'Well Led Review' in 2017. In addition the CCG can confirm that there has been significant work to review and re-design their service provision in line with the Sustainability and Transformation Partnerships, in collaboration with the CCGs and other health providers across the economy.

NELFT have achieved some significant successes during 2017-18. Firstly winning the award for inclusiveness as employers. This was also demonstrated in their improved Staff Survey for 2017 when they achieved an unprecedented 63% response rate being benchmarked in the top 20% nationally in many key areas.

Secondly, winning the Patient Safety in the Community award for the work with the patient safety programme to reduce pressure ulcer incident and embed the learning from these incidents is a significant achievement and we offer our congratulations on these successes.

PRIORITIES FOR 2018/2019

The CCGs note that for Community Health Services (adults), the Trust aims to continue to embed the system for monitoring and auditing risk assessments, which was introduced in Q4 of last year.

We are pleased to see that last year's priority to undertake robust falls risk assessments on admission to hospital will now be rolled out to community inpatient wards in Essex. This target will be for all patients over 65 who meet the required threshold to have a fall assessments automatically on admission.

The CCGs note that the NELFT wide goal to achieve mandatory training compliance of 85% and above by Q4 had already been achieved in Q4 17/18 and support NELFT to maintain and improve this achievement in 2018/19.

The NELFT wide development of an effective analytical tool to highlight risks of underperformance will be an asset to improving service delivery.

PARTICIPATION IN CLINICAL AUDITS

The CCGs are pleased to note that together with local audits, NELFT participated in 100% national clinical audits and 100% of the national confidential enquiries that it was eligible to participate in. The CCGs welcome the actions identified by the Trust to improve the quality of healthcare provided following the audits.

The CCGs recognise that the Trust has included reference to NICE in this Quality Account and stated that all processes and systems are in place to ensure NICE compliance within services.

PROGRESS AGAINST 2016/17 PRIORITIES

Priority 1: Safe

Goal 2 – The CCGs are pleased to see progress made in the implementation monitoring and auditing of risk assessments to ensure consistency across the Trust. The Trust are now seeing consistently high results and will continue to embed the work.

Priority 3: Responsive

Goal1 – The Trust should be commended on their achievement across all 4 quarters in effectively monitoring waiting times.

Priority 4: Well Led

Goal 1 – As previously mentioned, the CCGs note that compliance for mandatory training NELFT wide has been consistently above their 85% target.

The CCGs acknowledge that the auditor's evaluation of the Governors selected local indicator, Friends and Family Test, highlighted that they were unable to provide a comprehensive opinion on the process used by NELFT to gather the 5x5 feedback by patients. However, we are pleased to note the sustained high recommendation rate.

Assurance

The lead CCG formally monitors and gains assurances about the standards of practice within the Trust through the Clinical Quality Review Group. This group meets monthly and consists of Executives from the provider and senior members of the CCG and associates to the contract. The overarching purpose of the group is to provide assurance to the CCGs regarding the delivery of clinical quality at NELFT by having an overarching view of quality standards within the Trust.

The CCGs agree with the key priorities for improvement to be undertaken during 2018/19 and are committed to working collaboratively with the Trust to support the continually improve of patient safety and quality of care.

Appendix 5 2017/18 Statement of directors' responsibilities for the Quality Report

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.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

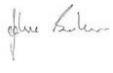
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period 01/04/17 to 18/05/18
    - papers relating to quality reported to the board over the period 01/04/17 to 18/05/18
    - feedback from commissioners dated 19/04 -17/05/2018
    - feedback from governors dated 04/04/2018
    - feedback from local Healthwatch organisations dated 02/05/2018
    - feedback from Overview and Scrutiny Committee awaited (requested 17/04/2018)
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/03/2017
    - the [latest] national patient survey 15/11/2017
    - the [latest] national staff survey 06/02/2018
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 24/04/2018
    - CQC inspection report dated 18/01/2018
- 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
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the Board

Date 22 May 2018 Signature  Chairman

Date 22 May 2018 Signature  Chief Executive

Appendix 6 Auditors limited assurance report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORTH EAST LONDON NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of North East London NHS Foundation Trust NHS Foundation Trust to perform an independent assurance engagement in respect of North East London NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within six weeks of referral

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

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 NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); 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 Requirements for external assurance for quality reports for foundation trusts 2017/18.*

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:

- Board minutes and papers for the period 1 April 2017 to 18 May 2018;
- papers relating to quality reported to the board over the period 1 April 2017 to 18 May 2018;
- feedback from commissioners, dated 19 April 2018 to 17 May 2018;
- feedback from governors, dated 04 April 2018;
- feedback from local Healthwatch organisations, dated 02 May 2018;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey dated 15 November 2017
- the national staff survey dated 06 February 2018
- Care Quality Commission Inspection, dated 18 January 2018; and
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 24 April 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of North East London NHS Foundation Trust as a body, to assist the Council of Governors in reporting the 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 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 North East London NHS Foundation Trust for our work or this report, except 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 indicator;
- 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; and
- 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 affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the

measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by North East London NHS Foundation Trust.

Basis for adverse conclusion

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on pages 3 to 4 of part A of the Trust's Quality Report, the Trust currently has concerns with accuracy and completeness of the data concerning the early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral indicator.

When calculating the indicator performance the Trust considers each case in the reporting period and manually classifies it as compliant, non-compliant or exempt. Our testing over a sample of these cases found a number of cases to have been mis-classified. As a result the completeness and accuracy of the numerator and denominator cannot be confirmed, as the error rate was 8/25 cases in our sample.

Further during the course of our testing insufficient supporting evidence was available to support the classification of 3/25 cases reviewed. As a result we are unable to form an opinion on the accuracy of the classification of these cases.

As a result of these issues we have concluded that we are unable to test sufficiently the early intervention in psychosis indicator for the year ended 31 March 2018.

Adverse conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for adverse conclusion' section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 in the Guidance; and
- the indicator in the Quality Report subject to limited assurance (improving access to psychological therapies (IAPT): waiting time to begin treatment (from IAPT minimum dataset): within six weeks of referral) has not been 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 Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
15 Canada Square, Canary Wharf, London, E14 5GL

25 May 2018

Useful contact numbers

Trust secretary

Trust Head Office

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Tel: 0300 555 1200

Email: communications@nelft.nhs.uk

Service user advice and liaison service

If you require information, support or advice, you can call us on the numbers below:

Borough/ Directorate	Name	Extension
Essex	Linda Morcombe/ Chris Jones	0300 555 1201 Ext 52708
Kent	Linda Morcombe/ Chris Jones	0300 555 1201 Ext 52708
Thurrock	Linda Morcombe	0300 555 1201 Ext 52708
Barking & Dagenham	Sheila Wright	0300 5551201 Ext 65075
Havering	Lisa Askew	0300 555 1201 Ext 66234
Redbridge	Jenny Cook	0300 555 1201 Ext 54422
Waltham Forest	Bernadette Duffy	0300 555 1200 Ext. 68502
Acute and Rehabilitation	Sharon Clennell	0300 555 1201 Ext: 65408

Accessibility

If you require this report in another language or in a different format, eg. large print, easy read, braille or audio, please contact:

Harjit Bansal

Equalities & diversity manager

Email: harjit.bansal@nelft.nhs.uk

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