North East London NHS
NHS Foundation Trust

Annual report and Accounts
2018-19

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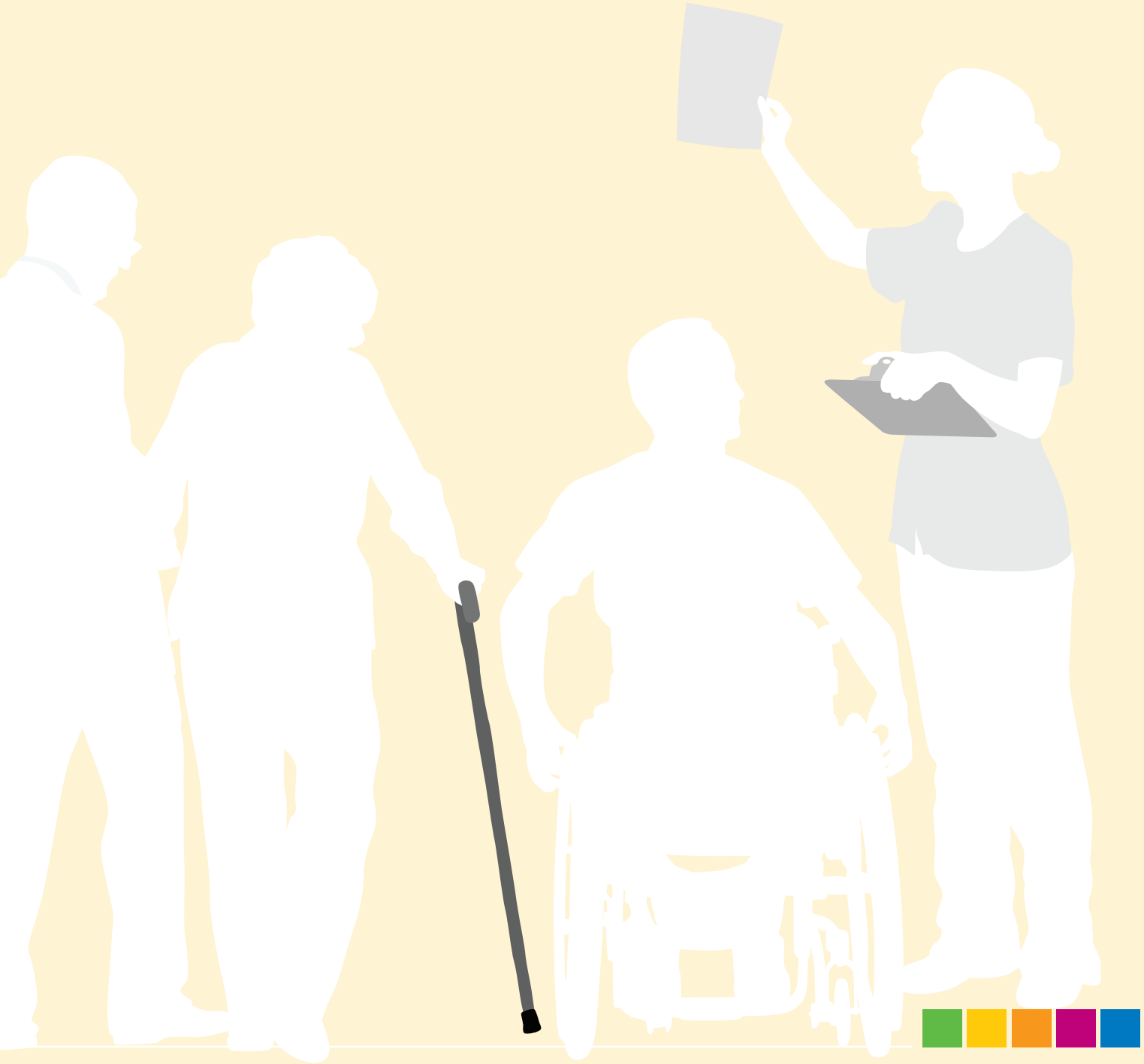
NELFT NHS Foundation Trust Annual Report and Accounts 2018-19

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



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CHAIR'S STATEMENT

Welcome to the NELFT Annual Report for 2018/19 and what has been another year of sustained high delivery and continued progress towards our vision of delivering the best care by the best people. We are emerging from this past year having maintained our Care Quality Commission (CQC) rating of 'Good' and delivered once again on our financial and statutory commitments. We have extended our service reach and footprint with the addition of services for young people in Barnet, in addition to our existing service provision in North East London, Essex and Kent. Where we take these services on, we are establishing a reputation for real improvement, addressing issues with waiting times and improving the quality of care being provided. In addition to our high achievements in patient care and in exceeding our financial control total, we have continued to develop and improve on our 'workforce and people' agenda where high staff engagement, lower agency spend, innovation, creativity and quality improvement are rapidly becoming the way we do things in NELFT. We are rightly proud of these successes but are also actively sharing this best practice whilst remaining open to learning and improvement from elsewhere.

Whilst we continue to perform at a high level as a Trust, we work within a number of highly challenged and complex health economies where we do our excellent work against a backdrop of clinical skill shortages, increasing demand and very tight financial constraints. The fact that we do so well despite these constraints is testament to the hard work and dedication of everyone who works in NELFT. Increasingly, our success will also depend on our ability to both lead and work within new models of care, across our growing geographic footprint, in new transformational and collaborative ways. In order to deliver on the commitments in the NHS Long Term Plan we must increasingly lead and share best practice across all of the local 'care systems' we operate within, working in true partnership with other providers.

We are ready and playing our part in developing more holistic and integrated care pathways that deliver even better outcomes and value. This is particularly true as we support the wider work we do in multiple Integrated Care Systems and Sustainable Transformation Partnerships with our colleagues in acute and primary care. Our endeavour and efforts are continuing to converge; we constantly seek opportunities to collaborate, working at greater scale and aggregation to the benefit of our patients, their carers and families. This past year we have played a key role in the strategic work carried out in Barking & Dagenham, Havering and Redbridge (BHR) with our Integrated Care Partnership Board, and in the developments that extend beyond that in terms of our strengthening relationships and joint working with our commissioners and fellow providers through our Provider Alliance. We have worked with partners in Waltham Forest to support work towards the Integrated Care System and have led the way with the End of Life Care Pathway work. We are an integral partner in the Thurrock Alliance, supporting and delivering on the Better Care Together programme. These partnerships, whether formal or informal, are bringing together all health service providers with a far greater emphasis on the common good that we can generate through our closer working and shared ambition to improve care for the communities we serve.

The breadth of change, the increasing need for collaboration, and the benefits we can unlock in working more closely together represent just some of the challenges and potential opportunities we face in the coming year. The Long Term Plan provides further expectations and challenge but the foundations we continue to build both within NELFT and across the wider 'systems' will serve us well in delivering against these in 2019/20.

There is, and will continue to be, an increasing emphasis on self-help and prevention and that means we must become even more engaged in the community and with our membership as a Foundation Trust. That approach will ensure that we build health and wellbeing into our communities from infancy and continue that through to longer and more fulfilling lives that contain respect, dignity and inclusion for all. All of this will ensure our communities thrive and are part of a healthy and more sustainable future.

I am proud and privileged to be the Chair of NELFT, your Chair, and I thank all of you, our patients, staff, governors, stakeholders, partners and well-wishers for the successes of the past year and in anticipation of your support and renewed efforts in the coming twelve months to maintain our journey of progress and improvement.

Signed:

Joseph Fielder
Trust Chair
21 May 2019

CHIEF EXECUTIVE'S STATEMENT

As in many of our previous annual reports, we are citing further development and change in the business portfolio of NELFT as we have been joined by services for young people in Barnet and taken over the running of the Urgent Care Centre at Whipps Cross Hospital. We have also extended some of our influence and expertise through back office functions and find ourselves to be in high demand from organisations seeking development in IT systems for example. As reorganisation of contracted care models and the new NHS evolves we will also take the opportunity to extend our expertise to facilitate that broader development and collaboration wherever we can appropriately do so.

As is the case with all other public services this period of austerity has tested the whole organisation to an unprecedented level. Despite the very tough round of contractual negotiation that started the year we have met our financial plan. The details of our financial performance is outlined later in this report but it should be noted that NELFT continues to deliver its contractual obligations in full and to the standards specified in contractual agreements. Importantly, despite the real pressure on financial resourcing we have continued to develop our approach to quality improvement and the many other programmes designed to improve our patient experience.

We have committed ourselves to become the employer of choice because we know that positive staff experience translates into better patient experience. To support that ambition we have continued to invest in staff health and wellbeing activities across the organisation and we have a robust network in place to ensure that this continues to develop and evolve in a way which supports our ambition. A great deal of our work this year was designed to respond positively to what our staff said and was based on our staff survey last year which was amongst the very highest in the country in terms of return rates. I am pleased to note that that position has been maintained this year and of course feedback from that return now provides the intelligence on which we will build into our plans for the time ahead.

Our staff experience remains a priority because recruitment and workforce is where we see our highest risks as an organisation. Our staff experience therefore - and of course retention - remain amongst our most important objectives. Making NELFT an employer of choice is critical and our position on diversity, engagement and compliance with the Workforce Race Equality Standards remains the best in the country as it has done for the past three years. Maintaining this status strongly supports both recruitment and retention and this continues to be a high priority in the development of our culture and values.

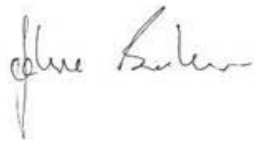
Getting the work life balance for staff right is another important element of our ambition and flexible working remains a priority for all of us. Our roll-out of agile working and supporting technology continues. In addition we have continued our commitment to using quality improvement as a key mechanism to engage staff in improving what we do across the organisation. We are now on our tenth cohort and several thousand of our staff are either in training or involved in one of our quality improvement projects. This has proved to be a strong motivator for the engagement and involvement of staff in improving much of what we do as an organisation.

NELFT always prides itself on its ambition to be the best and to ensure that we continue to benchmark against the very best nationally. We continue to stand out in many areas such as our acute care pathway in mental health, our Child and Adolescent Mental Health

Services (CAMHS), our innovative models in community care, major improvements for patients in areas such as our phlebotomy service in Waltham Forest, developing fit for purpose environments for our patients (Brookside, Thorpe Coombe to name just two), our Ethnic Minority Network and more generic functions such as agile working. Our position at the forefront of providers has continued this year with several awards which have been noted within the Accountability Report below.

The Long Term Plan for the NHS now sets out a different focus for organisations and partnerships where we concentrate more on collaboration and less on competition. NELFT is ready to embrace these new ways of working and use them to continue our ambition to be the very best and support the best people to deliver the best care.

Signed:



John Brouder
Chief Executive
21 May 2019

PERFORMANCE REPORT

North East London NHS Foundation Trust was formed in 2008 under the Health and Social Care (Community Health and Standards) Act 2003.

NELFT provides an extensive range of integrated community and mental health services for people living in the London Boroughs of Barking & Dagenham, Barnet, Havering, Redbridge and Waltham Forest and community health services for people living in the south west Essex areas of Basildon, Brentwood and Thurrock. We provide an Emotional Wellbeing Mental Health Service for children and young people across the whole of Essex. We are the provider of all age eating disorder services and child and adolescent mental health services across Kent and Medway.

With an annual income of £389 million, we provide care and treatment for a population of circa 4.3 million. We employ approximately 6,000 staff who work across 210 bases in London, Essex, Kent and Medway.

The performance report includes an overview of the organisation, its purpose, key risks and performance during the year 2018/19, including an analysis of performance delivery. Full details in relation to performance are found in the Quality Report.

PERFORMANCE REPORT – OVERVIEW

In last year's Performance Report we stated that we had acquired Kent and Medway emotional health and wellbeing services for young people and all age eating disorder services across the same localities. We continue to work with our partners to reduce waiting times and deliver a new and improved model of care for young people who require mental health support, as well as people who need to use our eating disorder services. Last year we also acquired paediatric therapy services in Barnet. As a large Trust both geographically and in terms of the array of services we provide, NELFT never underestimates the challenges our workforce faces in delivering the best possible care to the communities we serve.

As a Trust we have a large number of key performance indicators (KPI's), quality indicators, CQUINs and targeted information requirements that we are contracted to report on a monthly and quarterly basis to commissioners and NHS England. A number of those KPI's have financial penalties set against them if we fail to meet the target. All indicators are monitored internally through the governance cycle and signed off in this process before being reported externally. We have flex and freeze in place to allow for data to be refreshed before resubmission and on those targets missed we exception report and put action plans in place. For quarter 4 2018/19 we are reporting over 85% compliance for all KPI's across all contracts. The 15% of indicators that missed KPI targets in year did not result in financial penalties. However remedial action plans were put in place with a review on data processes and data quality. We also have many non-contractual indicators that we monitor, setting ourselves high standards to ensure people come first in the services we provide.

The financial and performance challenges each year continue to prove that our contracted agreements require 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.

NELFT was inspected in October 2017 and we were delighted to report that our rating was '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. In January 2018 NELFT was rated as 'outstanding' in four inspected service areas. We moved from a position of 48 service areas achieving 'outstanding' or 'good' in our previous CQC inspection, to 60 services in the latest inspection. We are continuing to use the CQC domains to continue the good work and measure our achievements, future goals and indicators.

NELFT services consistently perform to the very best benchmarks and we publish chosen indicators, which are measured against local trusts and nationally, on the website quarterly. Our patient feedback via friends and family tests has returned in our latest responses, that only 0.013% would not recommend our services, reflecting continued favourable views from patients and carers who would recommend our services to their friends and family. Our staff survey response rate remained high at 61%, benchmarking amongst the highest returns nationally. NELFT benchmarked in the top 10 percentile of response rates for the second successive year. The vast majority of responses to the questions showed either a positive shift from the previous year, or remained the same. The results and recommendations have been disseminated across the organisation and directorate leadership teams are already working on action plans to both celebrate the successes and prioritise areas for further development. 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 Programme continues to motivate a major cohort of our workforce and generates interest across the Trust. The Quality Improvement Team has launched a new quality improvement website, NQIP (NELFT Quality Improvement Programme), where you can find out more about the work, training and resources. It is an embedded characteristic of the organisation and its culture, with a large number of quality improvement projects being delivered by our staff.

The success of NELFT continues to advance whilst supporting the NHS Long Term Plan. We are involved in the North-East London Sustainability and Transformation Partnership and we are one of the leading organisations within the Barking, Havering and Redbridge Provider Alliance, jointly with our acute partner Barking, Havering and Redbridge University Hospitals NHS Trust and the GP Federations. The focus of the Provider Alliance has been on developing the frailty pathway to improve outcomes for patients, supporting Care City, our innovative partner, in the roll out of the new Atrial Fibrillation Pathway as well looking at ways for both health and social care providers across Clinical Commissioning Groups (CCGs) to provide more integrated care in the community. Across Essex we are linked in with the Mid and South Essex Sustainability and Transformation Partnership and supporting the work to relieve pressure on the acute care providers and look at how we can support more care in the community.

Areas of particular interest include our Thurrock First pathway. This is a joint approach of social care, health and mental health pathways, which joins three providers with a single point of access to direct calls to the appropriate area of response. We continue with mandatory training and our unique professional training programmes, our agile working initiative, our support to care homes and our use of technology to support young people in monitoring their improvement whilst in our care.

It is equally important in finding new ways to deliver care closer to home on the basis of patients' preferences, care complexities and the ability for staff to agile work. We anticipate this approach will continue to evolve as a successful model of care which NELFT will seek to 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 2018/19 the total income was £389m and all aspects of our financial performance remained within expected margins.

Quality performance metrics within the CQC framework and other governance considerations that contribute to our Single Operating Framework were also delivered on plan. The Single Oversight Framework serves as NHS Improvement's official rating framework and on this NELFT is segmented as a '1'. This segmentation denotes an organisation without need of official support from the centre and therefore one of the higher performers.

There have been a number of awards for our work throughout the year. Once again NELFT has been included in a number of 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. 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 around 6000 staff who are working to our successful agile agenda with devices rolled out to support this innovation across the organisation.

Recruitment and retention of staff continues to be the biggest challenge 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 spend continues to reduce from last year by 16%.

Work on health and wellbeing is also paying dividends and we have seen a consistent decline in sickness rates across the organisation. We have invested significantly in the 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.

The Trust Board 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.
Information about anti-bribery and human rights issues, including information about the relevant Trust policies and the effectiveness of these policies, is included within the Annual Governance Statement.

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 potential 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. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

This segmentation information is the Trust's position as at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and Use of Resources

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

Area	Metric	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	1	2	2	3	1	1	2	2
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E margin	1	1	1	3	1	2	2	2
Financial controls	Distance from financial plan	1	1	2	1	1	1	1	1
	Agency spend	2	2	1	1	2	1	1	1
Overall scoring		**1**	**1**	**1**	**2**	**1**	**1**	**1**	**1**

ACCOUNTING POLICIES AND GOING CONCERN

Information on the above is included within the Operating and Financial Review Summary.

EQUALITY AND DIVERSITY REPORT

The Equality, Diversity and Inclusion Team are within the Executive Director of Workforce and Organisational Development's portfolio. The team works across the organisation to ensure compliance and implementation of various equality and diversity frameworks, including:

- The Equality Act 2010.
- Workforce Race Equality Standards.
- Gender Pay Gap.
- Accessible Information Standards.
- Equality Delivery System2 (EDS2).
- Sexual Orientation Monitoring Standards.
- Disability Confident Standards.

The team has delivered on the following in 2018/19:

- Partnership working: sharing good practice and collaborating with other trusts, local authorities and voluntary sector organisations both locally and nationally.
- Events: Equality, Diversity and Inclusion Conference, Ethnic Minority Staff Network Conference, International Women's Day celebrations, Diwali celebrations and various other key events.
- Employee Engagement: Supporting the staff networks in place, which include the Ethnic Minority Staff Network, Disability Staff Network, LGBT+ Staff Network,

Dyslexia and Specific Learning Disabilities Forum, Hearing Impairment Group, WoMen's Network and the Just Us Peer Support Group.

- Patient Engagement: Using the Equality Delivery System (EDS2) to engage with patients on improvements to service delivery, particularly across the nine protected characteristics.
- Training and Development: Ensuring staff compliance with mandatory training for equality and diversity which is currently 95%. The delivery of the Calibre Programme (a leadership programme for staff with disability) has now had its third cohort of staff. In addition to this, a specific training programme has been delivered to meet the changing demographical needs of the population that the Trust serves.
- Health and Wellbeing: The team is involved in running training and awareness sessions for staff to support them at work, e.g. pregnancy and maternity, menopause, dementia.
- Policy development: The development of various cultural guidelines to support staff to work with various diverse communities. The team has specifically focused on developing guidelines as a result of various events, e.g. Menopause at Work, How to Access "Access to work".
- Data: The team has put a lot of work into ensuring that all systems in NELFT currently report on diversity monitoring for patients and for staff.
- External Recognition: The team has presented its work and good practice on the Workforce Race Equality Standards (WRES) to various forums and trusts across England. The national WRES team are currently working with Trust to have this work published so that it can be shared nationally. NELFT's team was shortlisted for a diversity award in Manchester and the Ethnic Minority Staff Network achieved an outstanding award at the Trust's Annual General Meeting.

Challenges for the team

- Facilitating increasing practicalities of consistently recording equality monitoring data for patients, with regard to religion, disability, sexual orientation and transgender and gender reassignment.
- Managing increasing demands on a small team to support the diverse spectrum of staff networks.
- Managing increasing demands on a small team to monitor equality and inclusivity of patient engagement.
- Managing the logistical complexities of engaging with patients and the public due to the geographical areas that NELFT covers.
- Ensuring equitable access to funding for specialist training and various awareness events.

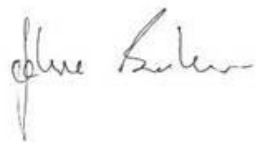
Key objectives for 2019/2020

- Supporting the Ethnic Minority Staff Network to develop and implement an action plan for reducing bullying and harassment for black and minority ethnic staff and ensuring diverse interview panels.
- Implementing the reporting requirements relating to gender pay gap and preparing to meet the ethnicity pay gap reporting requirements.
- Delivering on the Workforce Disability Equality Standards, due to be published in August 2019.

- Securing funding for a specialist training programme.
- Delivering on the LGBT+ Allies Scheme.
- Launching the Disability Staff Network Strategy.
- Improving diversity monitoring for patients.
- Improving access to interpreting and translation services across Essex and Kent.

For additional information: https://www.nelft.nhs.uk/about-us-equality-and-diversity

Signed (on behalf of the Board of Directors)



John Brouder
Chief Executive
21 May 2019

ACCOUNTABILITY REPORT

TRUST STRATEGY

Building on our previous strategy 'From Good to Best', published in 2015, we have refreshed the NELFT corporate strategy with input from staff and stakeholders. Our refreshed strategy highlights the key challenges faced by the Trust and our approach to addressing these challenges over the coming years.

We still want to deliver on our role as thought leader, partner, innovator and integrator, as set out in our strategy. Our staff and our partners are key to enabling us to achieve this.

Our aims

- Over the next five years we will ensure our CQC rating is 'Good' and move towards 'Outstanding' across the five CQC domains.
- We want NELFT to be the NHS employer of choice and will achieve this by engaging with and developing our people.
- We will make best use of our resources and grow our financial turnover, in line with our commercial framework.

Our strategic objectives

Sustainability and Transformation Partnerships and Integration

We will lead and support integrated working and care delivery across the three main Sustainability and Transformation Partnership footprints we work within (East London Health and Care Partnership, Mid and South Essex Sustainability and Transformation Partnership and Transforming Health and Social Care in Kent and Medway).

Best Care

We will focus on integrating physical and mental health with a focus on patient centred outcomes. We will look to standardise care and reduce variation across our services so we are delivering the best care consistently to patients no matter which local community they are part of.

Best People

We will focus on developing our leadership competency and capacity across the Trust ensuring we have staff with a range of skills and experience to deliver the Best Care.

Finance

We will maintain a strong governance rating and a sustainable turnover. We will use our commercial framework, business intelligence system and our estates rationalisation programme to enable the delivery of our strategy.

Identity

We will ensure our staff and partners are able to identify with NELFT and tell our story. We will actively seek feedback from staff, patients and partners in order to understand what people think about the Trust and use that feedback to make improvements.

NELFT AT A GLANCE

Our vision

NELFT will actively shape, develop and deliver, integrated, locality based care for the populations we serve.

Our purpose

To improve the health and wellbeing of the populations we serve.

Our mission

To deliver the Best Care by the Best People

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

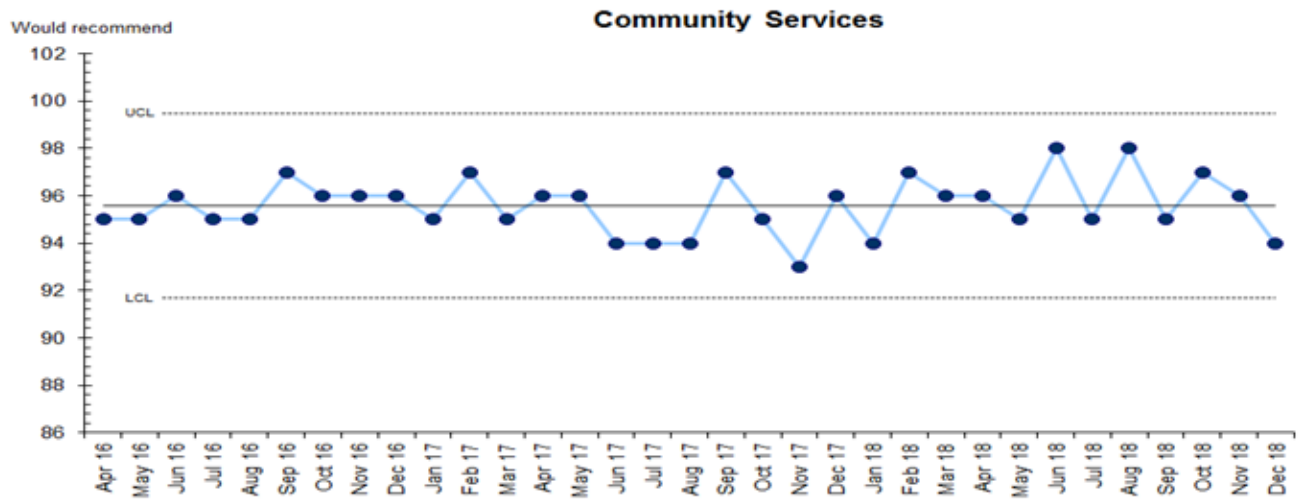
Approximately 6000 staff across 210 sites (including bank and agency staff)
Serving a population of 4.3m

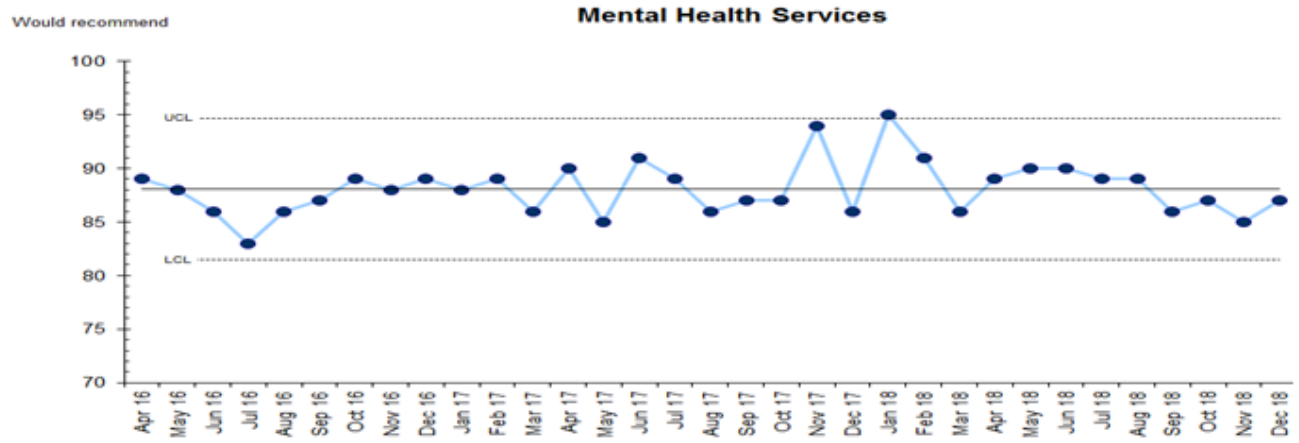
CQC Rating – Good
Friends & Family Test – 95% would recommend us to family and friends
Complaints – 490
Compliments – 4674

Financial Metric – 1 (1 being ‘best’ and 4 being ‘worst’)
Turnover – £389m

Patient Experience

Our Friends and Family Test shows that on average 96% of respondents would recommend our community services and 88% would recommend our mental health services.





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.

Brookside wins Royal College of Nursing Award

The team at Brookside, our child and adolescent inpatient unit and the children's home treatment team won the Royal College of Nursing Mental Health Practice Award for the work they have undertaken to transform services for young people.

Brookside Receives Accreditation From the Royal College of Psychiatrists.

Brookside, our young people's mental health inpatient unit, has been awarded an accreditation by the Royal College of Psychiatrists.

Emotional Wellbeing and Mental Health Services Moving Minds Premiere

Young people who use our Emotional Wellbeing and Mental Health Services in Essex attended a London premiere of their film 'Safe Space', highlighting mental health stigma. The film was made as part of the Moving Minds project with Into Film.

Coping Through Football

Our Coping Through Football project, in partnership with Leyton Orient, celebrated 10 years of success at an event at Wembley Stadium. The project was also highlighted as part of a national report evaluating the positive impact of football on mental health and was showcased at an event at the House of Commons.

Queens Nurse Award

Sue Burke, Acting Head of Integrated Community Services in Basildon and Brentwood has been given the prestigious title of Queen's Nurse by The Queen's Nursing Institute.

Royal College of Nursing Nurse Awards

The Royal College of Nursing nominated two NELFT nurses for the prestigious Nurse Awards. Geraldine Rodgers (Associate Director of Nursing, Clinical Effectiveness and Fellow for Older People) was shortlisted in the Nursing Older People category and Rebekah Bewsey (Modern Matron) for the Mental Health Practice award.

Significant 7 shortlisted for prestigious Royal College of Nursing Nurse Award

Geraldine Rodgers and the Significant 7 Project, set up to support care home staff to improve the physical health care of older people, was shortlisted for a prestigious Royal College of Nursing Nurse Award.

Waltham Forest Memory Service commended by the Royal College of Psychiatrists

NELFT's Memory Service in Waltham Forest received an accolade from the Royal College of Psychiatrists. The service has been awarded a Sustainable Mental Health Service Commendation.

Health Initiative of the Year Chemist and Druggist Awards

The work of a collaborative project across Barking and Dagenham, the Physical Health Care for patients with Psychosis (PHCP) Project, was shortlisted in the Health Initiative of the Year for this year's Chemist and Druggist Awards.

Perfect Ward App

The work the Trust has undertaken with the Perfect Ward App implementing the new online audit tool across both inpatient and community services has generated significant interest and culminated in a short film in partnership with the Perfect Ward.

Inclusive Companies awards

Our Head of Equality and Diversity, Harjit K Bansal, was nominated for the Diversity Champion Award and our Ethnic Minority Network was nominated for the Outstanding Diversity Network Award.

NHS70 Women Leaders

Four NELFT staff members were recognised as inspirational women leaders as part of NHS70 celebrations. The following members of staff were recognised as inspirational leaders across the NHS in London:

- Carrie-Ann Wade, Director of Communications and Engagement
- Laura Stuart-Neil, Lead for Allied Health Professionals and Quality Improvement
- Lindsay Royan, Head of Psychological Services
- Sujaa Arokiadass, Associate Medical Director

NELFT Finance department achieves NHS Future Focused Finance Level 1

The NHS Finance Leadership Council awarded NELFT Future Focused Finance Level 1 accreditation. Currently, only NHS Improvement and NELFT have this level of accreditation in London.

The Healthy Workplace Charter

We are pleased to announce that we have now attained 'Achievement level' in the Healthy Workplace Charter. The Healthy Workplace Charter is a set of standards that organisations meet in order to receive an official accreditation (and award). The Charter is backed by the Mayor of London and provides clear and easy steps for employers to make their workplaces healthier and happier.

DIRECTORS' REPORT

The general duty of the Board of Directors, its composition and the director appointment process and disqualification criteria are all outlined within the main body of the Trust's Constitution. Furthermore, Annex 5 contains the Standing Orders for the practice and procedure of the Board of Directors. https://www.nelft.nhs.uk/about-us-publications

In line with this document, the general duty of the Board of Directors is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

More specifically, the Board of Directors is collectively responsible for:

- Setting the strategic direction of the organisation – ensuring there are clear strategic objectives in place and overseeing their delivery
- Monitoring performance of the NHS Foundation Trust
- Promoting and Upholding the Trust's mission, vision and values
- Ensuring the Trust has sound systems of good governance and is compliant with its Constitution and Standing Orders, Provider Licence and any other statutory and regulatory requirements

Composition of the Board of Directors as at 31 March 2019

Joseph Fielder, Trust Chair *(M)*
Sultan Taylor, Vice Chair and Independent Non-Executive Director *(M)*
Mark Friend, Senior Independent Director and Independent Non-Executive Director *(M)*
Liz Delauney, Independent Non-Executive Director *(F)*
Amanda Lewis, Independent Non-Executive Director *(F)*
David Bowen, Independent Non-Executive Director *(M)*
John Brouder, Chief Executive *(M)*
Caroline Allum, Executive Medical Director *(F)*
Bob Champion, Executive Director of Workforce & Organisational Development *(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)*

(M = male, F = female)

For profiles of Directors, please visit: https://www.nelft.nhs.uk/about-us-our-board

Balance, completeness and appropriateness of the Board of Directors

The make-up and balance of the Board of Directors has been reviewed. The Board has also had the opportunity to review the appropriateness of current appointments. Cycles of Business have been further developed and amended in line with best practice and both the Remuneration Committee and Nominations Committee review a Board Skills Matrix.

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 and technology. 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. Non-executive members 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 make 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 improve the patient experience. The Board has demonstrated a clear balance in its membership through extensive debate and development.

Executive Director contract start dates (for those who served during 2018-19)	
Name	**Contract Start Date**
John Brouder, Chief Executive	4 August 2009
Barry Jenkins, Executive Director of Finance and Commercial Development	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 & Organisational Development	1 September 2015
Jacqui Van Rossum, Executive Director of Integrated Care (London)	1 July 2010
Non-Executive Director Terms of Office (for those who served during 2018-19)	
Name	**Term of Office**
Joseph Fielder, Trust Chair	01 April 2016 – 31 March 2019 Reappointed 01 April 2019 – 31 March 2022
John Roome, Vice Chair and Non-Executive Director	01 January 2015 – 31 December 2018 Vice Chair until 31 December 2018
Sultan Taylor, Vice Chair and Non-Executive Director	01 April 2017 – 31 March 2020 Appointed as Vice Chair from 24 January 2019
Brian Hagger, Senior Independent Director and Non-Executive Director	01 December 2005 – 31 May 2018 Senior Independent Director until 31 May 2018
Mark Friend, Senior Independent Director and Non-Executive Director	01 March 2015 – 28 February 2016 Extended 01 March 2016 – 28 February 2019

	Reappointed 1 March 2019 – 28 February 2022 Appointed Senior Independent Director from 01 June 2018
Liz Delauney, Non-Executive Director	01 May 2017 – 30 April 2020
Amanda Lewis, Non-Executive Director	01 November 2016 – 31 October 2019
David Bowen, Non-Executive Director	01 June 2018 – 31 May 2021

Patient care

Learning and service improvements as a result of patient experience survey feedback and complaints are reported to the Board on a quarterly basis. Learning from complaints is also accessible on NELFT's website: www.nelft.nhs.uk/patients-carers-visitors-learning-from-complaints

Specific examples of service improvements this year were:

- The planned development of instructional videos for parents in paediatric physiotherapy services
- The introduction of customer service assistants in phlebotomy clinics to support people in navigating the electronic kiosks
- Young people in Emotional Well-being Mental Health Services (EWMHS) have helped to improve the waiting areas through an art project to make them feel more user friendly
- Barking and Dagenham services have ensured that chaperone posters are displayed in all clinics so that attendees are aware they can request a same sex chaperone if needed

On a monthly basis we collate and report on both local and national targets and key indicators. These are monitored through our tight governance process and where targets are missed there is a process to agree and sign off action plans. For transparency we put trajectories in place to monitor progress against any targets that are slipping or not being met. As a Trust we look at all indicators by the CQC domains to ensure the best patient care is in the forefront of our daily working practice. All other targets related to quality indicators (both external and internal) are reviewed monthly. We work closely with our local commissioners on service development, data quality and improving the patient journey.

Also as a Trust we give our services and teams the tools to be able to monitor their own progress whether that is the team's performance or whether that is against indicators i.e 18 weeks referral to treatment. Within the published Quality Report we show areas that need improvement within the Trust and then our achievements against those areas. This is shared with all of our stakeholders, before being uploaded and circulated.

Stakeholder Relations

Mid and South Essex

We are a key partner in the Thurrock Alliance working with commissioners and providers across Thurrock to deliver integrated care. We are actively working as part of the Better Care Together Thurrock Programme to implement new ways of working across health and

social care services to improve outcomes for local communities. This work is in partnership with the local authority and the voluntary sector, as well as our other NHS partners.

Find out more about the Better Care Together Thurrock programme at: www.nelft.nhs.uk/better-care-together-thurrock

We are working with our colleagues at Essex Partnership University Trust and Basildon and Thurrock University Hospitals NHS Foundation Trust to support improvements to the patient journey in relation to urgent and emergency care. We are looking at how we can reduce barriers to delivering effective care across all organisations to improve patient outcomes.

We are supporting the implementation of a Citizen's Panel and this will be critical going forward to seek views of patients and residents.

Find out more about the Mid and South Essex Sustainability and Transformation Partnership at: www.nhsmidandsouthessex.co.uk/

Kent and Medway

We are working with commissioners and providers across the Kent and Medway Sustainability and Transformation Partnership to support improvements to the care pathways that we are involved in delivering – children's mental health services and all age eating disorder services.

The main focus is on the reduction of waiting times for young people and their families in accessing assessment and treatment. We are working with commissioners to look at ways to improve this.

We are also working with partner organisations to share knowledge and expertise in the delivery of IT services.

Find out more about the Kent and Medway Sustainability and Transformation Partnership at: www.kentandmedway.nhs.uk/stp/

North East London

Across Barking and Dagenham, Havering and Redbridge (BHR) work is taking place to move towards an integrated care system. We are a key partner in the BHR Provider Alliance and John Brouder, our Chief Executive, is one of the co-chairs. The BHR Provider Alliance brings together the NHS and local authority to look at how we can deliver improved health and care services for local communities. The BHR Provider Alliance works in partnership with the Joint Commissioning Board and Integrated Care Partnership Board to agree priorities.

We are working with BHR Clinical Commissioning Groups and Barking, Havering and Redbridge University Hospital NHS Trust to deliver the system-wide financial recovery plan. This is governed through the BHR Financial Recovery Board and has been put in place to address the significant financial challenges across the BHR health economy. In order to meet the challenge, clinical transformation will be supported in order to deliver services in different ways to improve outcomes for patients and deliver best value for money.

In Waltham Forest we are working closely with partners in the council and BARTS Health NHS Trust to further integrated care and ensure care is provided closer to home. A Memorandum of Understanding has been agreed between partners and a governance system established within the Better Care Together Board framework. This work includes the transformation of: community services to promote ageing well; end of life services; and urgent care.

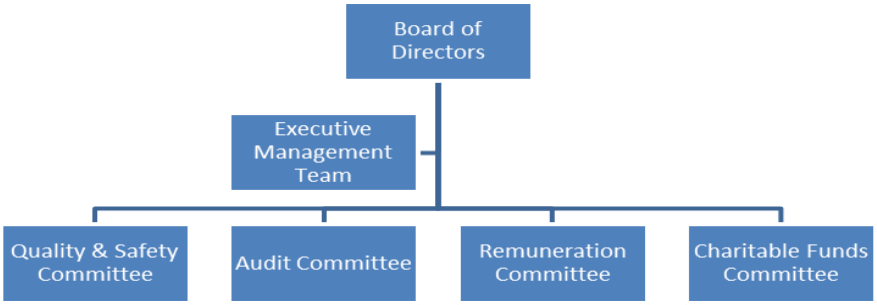
Board of Directors Attendance Record

Board of Directors – Attendance Record 2018-19														
		Note	April	May	Jun	Jul	Sep	Oct	Nov	Jan	Feb	Mar	Attendance	Out of
Joseph	Fielder	a	X	X	X	X	X	X	X	X	X	X	10	10
Liz	Delauney		X	X	X	X	X	X	X	X	X	X	10	10
Mark	Friend	b	X	X	X	X		X	X	X	X	X	9	10
Brian	Hagger	b	X	X									2	2
Amanda	Lewis		X	X	X		X	X	X	X	X	X	9	10
John	Roome	c	X	X	X	X	X	X	X				7	7
Sultan	Taylor	c	X	X	X	X	X	X	X	X	X	X	10	10
David	Bowen				X	X	X	X	X		X	X	7	8
John	Brouder		X	X	X	X	X	X	X			X	8	10
Caroline	Allum		X	X	X	X	X	X	X	X	X	X	10	10
Bob	Champion		X	X	X	X	X	X	X	X	X	X	10	10
Stephanie	Dawe		X	X	X	X	X		X	X	X	X	9	10
Barry	Jenkins		X	X	X	X	X		X	X	X	X	9	10
Jacqui	Van Rossum			X		X	X	X	X	X	X	X	8	10

Notes:

a	Chairman
b	Senior Independent Directors
c	Vice Chairman

Committee Structure at 31 March 2019



Board Sub-Committee Membership

Audit Committee	Attended
John Roome (Committee Chair until 31 December 2018)	4/4
Mark Friend (Interim Committee Chair from 1 January 2019)	5/5
David Bowen (Non-Executive Director)	2/3
Amanda Lewis (Non-Executive Director)	4/5

Remuneration Committee	Attended
Joe Fielder (Trust Chair/ Committee Chair)	3/3
John Roome (Vice Chair until 31 December 2018)	2/2
Sultan Taylor (Vice Chair from 24 January 2019)	2/3
Mark Friend (Senior Independent Director)	3/3
Liz Delauney (Non-Executive Director)	3/3
David Bowen (Non-Executive Director)	2/3
Amanda Lewis (Non-Executive Director)	3/3

Quality and Safety Committee	Attended
Mark Friend (Committee Chair)	9/12
Sultan Taylor (Vice Chair)	11/12
Liz Delauney (Non-Executive Director)	10/12
John Brouder (Chief Executive)	7/12
Stephanie Dawe (Chief Nurse and Executive Director Integrated Care for Essex and Kent)	10/12
Jacqui Van Rossum (Executive Director Integrated Care for London)	9/12
Caroline Allum (Executive Medical Director)	9/12
Alison Garrett (Director of Nursing, Quality Governance)	11/12

Charitable Funds Committee	Attended
David Bowen (Committee Chair)	2/2
Joseph Fielder (Trust Chair)	2/2
Sultan Taylor (Vice Chair)	1/2
John Brouder (Chief Executive)	2/2
Barry Jenkins (Executive Director of Finance and Commercial Development)	2/2
Stephanie Dawe (Chief Nurse and Executive Director of Integrated Care for Essex and Kent)	2/2
Jacqui Van Rossum (Executive Director Integrated of Integrated Care for London)	2/2

Audit Committee Report

The Audit Committee is constituted as a standing committee of, and accountable to, the Board of Directors. The Committee is authorised by the Board of Directors to act within its Terms of Reference but shall not have executive powers other than those delegated within the Terms of Reference.

The purpose of the Audit Committee is to independently and objectively:

- Monitor the integrity of the Trust's financial statements.
- Oversee compliance with corporate governance standards.
- Assist the Board of Directors in its oversight of risk management and the effectiveness of internal control.
- Review financial, corporate governance and risk management assurance processes.
- Oversee external and internal audit functions.
- Monitor the effectiveness, performance and objectivity of the Trust's External Auditors, Internal Auditors and Local Counter Fraud Specialist.

External Audit

With the exception of the Quality Report Audit, there were no other non-audit services provided for the year end 31 March 2019.

Ensuring External Auditors' Independence and Effectiveness

Any engagement of the external auditors in relation to non-audit work is approved by the Executive Director of Finance and Commercial Development in conjunction with the Executive Management Team. This 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 are agreed annually by the Audit Committee. The Audit Committee believes that this ensures the independence of the external auditors.

Committee members and attendees annually complete an Audit Committee self-assessment. This asks members whether the Committee considers the independence, objectivity and effectiveness of external auditors. It also includes some questions regarding the work of the External Auditors such as whether they inform the committee of key developments and issues at key stages of their audit. The Audit Committee receives four progress reports from External Auditors throughout the year, agrees the Audit Plan and Non-Executive Directors meet privately with External Auditors annually.

KPMG, the Trust's current External Auditor was re-appointed in September 2015 for the 31 March 2016 year-end audit. The re-appointment followed a formal tender procurement process. At 31 March 2019, KPMG's length of tenure as NELFT's External Auditor was 10 years, although the Audit Team has changed regularly. Prior to the expiry of this contract, a sub-committee of the Council of Governors will be formed to lead the appointment process with support from the Audit Committee. The total value of external audit services at 31 March 2019 was £81k, exclusive of VAT.

To ensure the external auditors have remained independent, the Audit team members have rotated in line with professional requirements.

Internal Audit

NELFT contracts BDO LLP to provide its internal audit service. This service covers both financial and non-financial audits, in line with a strategic and operational plan that is approved by the Audit Committee. The plan is developed with Executive Directors and is set within the context of a multi-year approach to internal audit planning, such that all areas of key risks are looked at over a three year audit cycle. The plan is then reviewed annually to ensure any newly identified risks and opportunities are captured.

Counter Fraud Service

From 1 June 2018 the Trust's Counter Fraud Service has been provided by East London NHS Foundation Trust (ELFT). Prior to this it was provided by TIAA. The Trust has a dedicated full time Local Counter Fraud Specialist (LCFS). The role of the LCFS is to assist in creating an anti-fraud and anti-bribery culture within the Trust; to deter, prevent and detect fraud and bribery; to investigate any suspicions that arise; to seek to apply appropriate sanctions; and to seek redress in respect of monies obtained through fraud and bribery.

In 2018/19 the focus was on increasing the level of fraud awareness and reporting across the Trust and, as such, an intensive publicity campaign and training programme was delivered Trust wide. A comprehensive Fraud Risk Assessment was carried out to identify risk areas where resources need to be targeted. A programme of pro-active reviews commenced as a result.

The Audit Committee receives regular progress reports from the LCFS during the course of the year and also receives an annual report. The Committee reviewed the levels of fraud reported and detected and the arrangements in place to prevent, minimise and detect fraud and bribery. No significant fraud was uncovered in the past year.

Internal Controls and Risk

In addition to routine work on the financial controls operating in the Trust, through the Internal Audit Plan the Committee focused on risks and associated controls relating to quality and safety, workforce, estates, governance, procurement and business development. The Committee received progress reports to ensure full oversight of all recommendations resulting from internal audits, and the associated implemented action plans.

The Audit Committee continues to receive updates regarding the performance and business of the other Board sub-committees to ensure the link between committees is robust. It also receives assurance from the Data Quality Group and has reviewed clinical and corporate risks rated 15+ since January 2019.

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 for assurance 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 2018/19

The Trust is engaged in the provision of healthcare, with £367.8m of its income related to patient care activities and £20.9m from other sources. Other income included education and training (£9.0m), Provider Sustainability Fund (£6.9m), Research and Development (£2.6m) and rent for shared occupation (£0.6m).

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 Trust has applied judgements in the valuation of land and buildings, IT, intangibles and provisions. These have been fully discussed with the auditors and are fair statements.

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.

Remuneration Committee

The Remuneration Committee is constituted as a standing committee of, and accountable to, the Board of Directors. Its main purpose is to identify and appoint candidates to fill Executive Director positions and to determine and oversee the remuneration and other conditions of service for Executive Directors and other Senior Managers. The membership of the Committee comprises of all Non-Executive Directors, and is chaired by the Trust Chair, or in his/ her absence, the Senior Independent Director.

The Committee meets at least twice annually and its specific responsibilities include:

- Reviewing the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board of Directors
- Giving consideration to succession planning for Executive Board members
- Identifying and appointing to Executive Director posts when they arise and approving their other significant commitments and interests
- Ensuring Executive Directors are Fit and Proper Persons
- Giving consideration to Executive Director continuation in office including suspension or termination and compensation commitments
- Determining the Terms of Service for Executive Directors and Senior Managers who are not subject to Agenda for Change terms and conditions
- Monitoring Executive Director objectives and performance
- Determining and approving the terms of service and contractual arrangements for any off payroll engagement when an individual earns more than:

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

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 Trust's performance framework and ensures that the skills, knowledge and competency of the Board of Directors are regularly reviewed. The Council of Governors, with support from its Nominations Committee, evaluates the performance of the Trust Chair and Non-Executive Directors through the following process:

- Non-Executive Director appraisals: The Chair holds 1:1 appraisal meetings with each Non-Executive Director, taking into consideration the views of Board members and Governors, where appropriate.
- Chair appraisal: The Senior Independent Director and Lead Governor request feedback from the Board of Directors and Council of Governors. The Senior Independent Director holds a 1:1 appraisal meeting with the Trust Chair to discuss performance and agree objectives for the coming year.
- The Nominations Committee considers the appraisal reports for the Trust Chair and Non-Executive Directors.
- The Nominations Committee provides feedback and recommendations to the full Council of Governors.
- The Council of Governors refers to the appraisals when making decisions regarding the extension of the Terms of Office for the Trust Chair and Non-Executive Directors.

Registers of Interests

The Trust holds registers of interests for Directors, Decision-Making Staff and Governors which detail any potential conflicts of interest that may arise. These are available to the public through the Trust website https://www.nelft.nhs.uk/about-us-our-board and https://www.nelft.nhs.uk/about-us-governors and can also be accessed by contacting Lauren MacIntyre, Head of Corporate Affairs on 0300 555 1300 or lauren.macintyre@nelft.nhs.uk. Board members and Governors are actively given the opportunity to declare interests on appointment and on an annual basis thereafter, as well as at the beginning of each meeting. Registers of interests are presented annually at the public Board of Directors and Council of Governors meetings.

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:

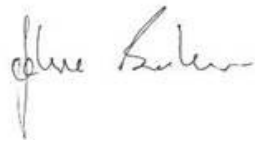
- Non-NHS creditors – 75% paid within 30 working days (up from 69%)
- NHS creditors – 50% paid within 30 working days (up from 42%)

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
- The directors have taken all of the steps they ought to have taken as a director in order to make themselves aware of any relevant audit information and to ensure that the Trust's auditor is aware of that information.

Signed:



John Brouder
Chief Executive
21 May 2019

STAFF REPORT

Our approach to staff engagement

This year marks the third anniversary of the implementation of our workforce and organisational development 'Best People' strategy. The strategy has undergone two refreshes and is currently subject to further review as we wait for developments with the Health Education England strategy for the whole health and social care workforce. We have sustained our journey of living the Trust values and have invested strongly in the engagement with our workforce and enhancing their health and wellbeing. We have continued to consolidate pathways into careers with NELFT; continued to reduce reliance on costly agency workers by streamlining substantive recruitment and increasing the staff bank; better developed the leadership of the organisation and improved retention through continuing to embed a range of health and wellbeing activities within our business as usual.

Our journey towards culture change, by engagement with our workforce at all levels and reducing prejudicial and discriminatory practices even further, continues at pace. This is evidenced in our second successive year of outstanding participation in the national staff survey, which saw a continuation of a >60% response rate. Key positive themes were consolidated around our colleagues feeling listened to by senior management, further reductions in experiencing violence, harassment or discrimination and recognition for the positive action we are taking on health and wellbeing.

The Joint Negotiating and Consultative Committee meets bi-monthly and the agenda for meetings reflects a Trust update and opportunities for discussion of performance against objectives and key performance indicators. The Trust workforce reporting dashboard is shared and staff side members contribute to any actions arising from performance monitoring. The Trust also supports over 150 staff in network ambassadorial roles, who are able to influence policy and decision making in all directorates. Such roles include ambassadors for the Ethnic Minority, LGBT+ and Disability Staff Networks; Health and Wellbeing, Workplace Contacts and more recently – Freedom to Speak Up. These roles, as well as our commitment to partnership working with our trade union colleagues continue to reflect the demography and geography of the Trust and ensure that the voice and opinions of our workforce are heard and responded to.

The Joint Negotiating and Consultative Committee and Joint Local Negotiating Committee for medical staff, are formally established bodies for negotiations and consultation on any matters that affect the workforce. Every change management process involves consultation with affected parties and recent audit activity shows that the Trust's approach to staff consultations is suitably fair, open and transparent.

We remain resolute in our efforts to consolidate improvements in the following areas:

Recruitment Strategy

A key theme of our refreshed objectives is to aim to be the NHS employer of choice within our geography. We continued to develop our position as employer of choice, with the context of the wider Provider Alliance and Sustainability and Transformation Partnership 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 continually 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. The recruitment and on-boarding experience of new starters continues to be positive and the average time to fill for vacancies is 45 days.

Retention and Wellbeing

This is an area of enormous commitment in time, energy and modest financial investment. We have robust data on leavers and an appreciative enquiry approach to exploring reasons for colleagues to do so. This year’s retention efforts have focused on career pathway development and the introduction of a competency framework to support newly qualified healthcare professionals to take their next step within the organisation, rather than having to leave. Health and well-being remains a major priority, with a programme of activities embedded in business as usual across all directorates. We now host 90 well-being and engagement ambassadors across the Trust, as well as ambassadorial roles associated with all three staff networks, prevention of bullying and harassment and freedom to speak up.

All employment policies are agreed in partnership between the leadership and staff side representatives of the Trust. The Management of Attendance Policy covers the issue of disability before and during employment, as well as guidance on reasonable adjustments. As a result of work undertaken with the Disability Staff Network, the Trust now has four specialist Disability Ambassadors, who have subject matter expertise around workplace adjustments, contractual obligations and technological support for staff with disabilities.

Health and safety and occupational health performance are discussed at the Joint Negotiating and Consultative Committee, Strategic Workforce Group and the Strategic Health and Wellbeing Group.

Flexible Working

With over 85% of the workforce equipped and trained to work agilely, we remain at the forefront of such ways of working within the NHS. We continue to support working flexibly in accordance with personal circumstances and have a good balance between full time, part time and bank workers.

Career Pathways

We continually review the levels at which people can enter employment with NELFT and can demonstrate a strong track record of converting volunteers and service users into employees and supporting personal and professional growth. A competency programme to take healthcare professionals from Band 5 to Band 6 is under development and a career co-ordinator role has been agreed to manage this going forward. Apprenticeships remain a challenge, with less traction being gained in clinical roles, though the Apprentice Nurse Associate scheme has yielded good results so far.

Leadership and Talent Management

We continue to invest internally and externally generated funding in developing our leaders at all levels. Senior leadership team members successfully completed a programme in

association with the NHS Leadership Academy and a third cohort of the Calibre Programme was run to help staff with disabilities maximise their developmental potential. Further investment in our new combined learning management, appraisal, supervision and revalidation system (STEPS) has revolutionised our compliance with mandatory training and streamlined the other processes.

Off payroll disclosures:

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

Number of existing engagements as of 31 March 2019 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 2018 and 31 March 2019, 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 2018 and 31 March 2019 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 2018 and 31 March 2019:

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

Non-Executive Directors:

Title	First Name	Last Name	Gender	Role	Start Date In Position
Ms.	Liz	Delauney	Female	Non-Executive Director	01/05/2017
Mr.	Mark	Friend	Male	Non-Executive Director	01/03/2015
Mr.	Brian	Hagger	Male	Non-Executive Director	01/12/2005 to 31/05/2018
Mrs.	Amanda	Lewis	Female	Non-Executive Director	01/11/2016
Mr.	John	Roome	Male	Non-Executive Director	01/01/2015 to 31/12/2018
Mr.	Sultan	Taylor	Male	Non-Executive Director	01/04/2017
Mr	David	Bowen	Male	Non-Executive Director	01/06/2018

Staff Policies:

The Trust has policies in place, developed in partnership with our trade union colleagues, that detail how the organisation applies full and fair consideration to a number of different workforce issues including: equality, diversity and inclusion (EDI); 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

Commitment to the equality, diversity and inclusion agenda is evidenced in the growth of our staff networks and our substantial compliance with the Workforce Race Equality Standards (WRES) and our emerging strength in supporting whistleblowing with the appointment of the Freedom to Speak Up Guardian.

Workforce breakdown:

Group	Male	Female
Board members	7	5
Band 7 and above	325	1,253
Band 7 and below	632	3,616

***This excludes Medic and those staff with a personal salary (non-agenda for change)**

Sickness absence:

Average FTE 2017/2018	4,985.46
Total FTE Days Lost	82,876.87
Average Sick Days Per FTE	16.62
FTE Days Available	1,819,692.43
Total Calendar Days Lost	97,321

Our sickness absence levels, which are slightly above target, continue to mirror sector, regional and national trends. We continue to invest in the efficacy of our occupational health service as well as the physical and emotional health and well-being of our workforce.

Staff Survey

	2018/19		2017/18		Trust improvement/ deterioration
Response rate	**Trust**	**Benchmarking Group (trust type) average**	**Trust**	**Sector Average**	
	61.1%	48%	63%	45%	Deterioration of 1.9%

Most improved scores	2018/19		2017/18	Trust improvement/ deterioration
	Trust	**Benchmarking Group (trust type) average**	**Trust**	
Satisfaction with recognition for good work	63%	62%	57%	Improvement of 6%
Organisation treats staff involved in error, near misses or incidents fairly	59%	58%	54%	Improvement of 5%
Satisfaction with extent to which organisation values work	50%	47%	45%	Improvement of 5%
Staff given feedback about changes made in response to reported errors/ near misses/ incidents	67%	62%	62%	Improvement of 5%
Would recommend organisation as a place to work	61%	60%	56%	Improvement of 5%

Most declined scores	2018/19		2017/18	Trust improvement/ deterioration
	Trust	**Benchmarking Group (trust type) average**	**Trust**	
Staff reporting physical violence at work	80%	86%	87%	Deterioration of 7%
Staff experiencing musculoskeletal problems as a result of work activities	30%	23%	26%	Deterioration of 4%
Staff receiving regular updates on patient/ service user experience feedback in directorate/ department	60%	60%	63%	Deterioration of 3%
Number of additional paid hours worked per week over and above contracted hours	22%	23%	20%	Deterioration of 2%

Below are some of the Trust wide actions agreed to respond to these areas:

You Said	We Will
• Improved links between staff and senior managers • Improve staff confidence in the incident reporting process	**Improve staff engagement and involvement** • Review current staff engagement events across the Trust and explore opportunities to improve the process, with greater senior managers involvement • Provide guidance, information and talks on incident reporting to support staff with the process.
• Staff to be better supported by managers, particularly with complex tasks • Involve staff in decisions/changes in their area of work	**Promote effective relationship management** • Amend content of the team leads leadership programme to include delegation, communication skills, trust and staff involvement in decision making • A commitment to ensuring that an assessment of the impact of all system changes on staff is carried out
Focus health and wellbeing initiatives to address issues relating to : • Physical health problems • Work related stress	**Develop and promote staff health and wellbeing initiatives** • Roll out an Employee Assistance programme across the Trust • Ensure all line managers are aware of and utilising the direct physiotherapy referral form • Develop and pilot an musculoskeletal awareness checklist • Provide stress management/mindfulness opportunities in all directorates
• Reduce incidence of bullying and harassment	**Reduce bullying and harassment** • Promote the Bullying and Harassment e-learning module ensuring all staff are supported to complete it • Undertake a thematic review of bullying and harassment cases across the trust • Roll-out and embed Workplace Ambassadors across the Trust

Trade Union Facility Time from 1 April 2018 to 31 March 2019

Relevant Union Officials	
Number of employees who were 'relevant union officials' during the 12 month period	**32**
Full time equivalent employee number	**4,878**

Percentage of time spent on facility time	
Percentage of time spent by these relevant union officials on 'facility time'	
0%	**15**
1-50%	**17**
51-99%	**0**
100%	**0**

Percentage of pay bill spent on facility time	
Total cost of facility time	**£32,048**
Total pay bill	**£280,715,114**
Percentage of the employer's total pay bill spent on facility time	**0.011%**

Paid trade union activities	
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?	**100%**

FTC form for accounts for periods ending 31 March 2019

5. EMPLOEE COSTS AND NUMBERS(WTE)

Note 5.1 Employee Expenses

	2018/19			2017/18
	Total £000	Permanent £000	Other £000	Total £000
Salaries and wages	210,239	210,239	0	198,688
Social security costs	20,990	20,990	0	19,676
Apprenticeship levy	1,056	1,056	0	989
Pension cost - employer contributions to NHS pension scheme	24,962	24,962	0	24,090
Pension cost - other*	14	14	0	26
Temporary staff - agency/contract staff	23,244	0	23,244	22,250
	280,505	**257,261**	**23,244**	**265,719**

5.3 Average number of employees

	2018/19			2017/18
	Total wte	Permanent wte	Other wte	Total wte
Medical and dental	400	304	96	365
Administration and estates	1,525	1,486	39	1,535
Healthcare assistants and other support staff	680	680		675
Nursing, midwifery and health visiting staff	2,348	2,089	259	2,398
Scientific, therapeutic and technical staff	1,450	1,356	94	1,283
Other	43	43		33
	6,446	**5,958**	**488**	**6,289**

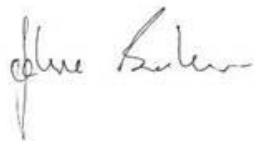
Total expenditure for 2018/19 financial year on consultancy costs was £117k.

Compensation Schemes:

Note 6.1 Reporting of other compensation schemes - exit packages

Exit package cost band	Number of compulsory redundancies No.	Cost of compulsory redundancies £000	Number of other departures agreed No.	Cost of other departures agreed £000	Total number of exit packages No.	Total cost of exit packages £000
<£10,000	1	6	0	0	1	6
£10,000 - £25,000	3	51	0	0	3	51
£25,001 - £50,000	5	171	1	40	6	211
£50,001 - £100,000	1	56	2	158	3	214
>£100,000	0	0	0	0	0	0
Total	**10**	**284**	**3**	**198**	**13**	**482**

Signed:



John Brouder
Chief Executive
21 May 2019

REMUNERATION REPORT

The Remuneration Committee is assisted by the Executive Director of Workforce & Organisational Development with advice on procedures and benchmarking of pay and conditions of service. The 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 NHS Providers Board Salary Survey and NHS Improvement benchmarking data, 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 the accounts and details of senior employees' remuneration can be found below. 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 2018/19 was £190-195K (2017-18 was £190-195K). This was 7.0 times (2017/18 6.7 times) the median remuneration of the workforce, which was £26,152 in 2018/19 (£28,779 in 2017/18).

In 2018/19 three employees received remuneration in excess of the highest paid director (2017/18 three employees). Remuneration ranged from 185K to £212K (2017/18 £192k to £212K).

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 2018/19 there were 16 employees earning in excess of £142.5K and 16 employees in 2017/18.

Salary entitlements of senior managers

Name	Title	2018-2019 Salary and Fees (bands of £5,000)	All Taxable Benefits	All Pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
John Brouder (1)(4)	Chief Executive Officer	180-185	9,200	0	190-195
Barry Jenkins (1)	Executive Director of Finance & Commercial Development	145-150	0	0-2.5	145-150
Jacqueline Van-Rossum (1)(5)	Executive Director of Integrated Care (London)	125-130	0	0	125-130
Bob Champion (1)	Executive Director of Workforce & OD	115-120	0	0	115-120
Stephanie Dawe (1)(3)&(6)	Chief Nurse and Executive Director of Integrated Care (Essex & Kent)	130-135	0	2.5-5	135-140
Caroline Allum (1)	Executive Medical Director	150-155	0	12.5-15	165-170
Joseph Fielder (1)	Chair	45-50	0	0	45-50
Sultan Taylor (1)	Non Executive Director	15-20	0	0	15-20
Amanda Lewis (1)	Non Executive Director	15-20	0	0	15-20
John Roome (2)	Non Executive Director	20-25	0	0	20-25
Mark Friend (1)	Non Executive Director	20-25	0	0	20-25
David Bowen(2)	Non Executive Director	10-15	0	0	10-15
Brian Hagger(2)	Non Executive Director	0-5	0	0	0-5
Liz Delauney (1)	Non Executive Director	15-20	0	0	15-20

Name	Title	2017-2018 Salary and Fees (bands of £5,000)	All Taxable Benefits	All Pension related benefits (bands of £2,500)	TOTAL
John Brouder (1)(4)	Chief Executive Officer	180-185	8,200	0	190-195
Barry Jenkins (1)	Executive Director of Finance & Commercial Development	140-145	0	42.5-45	185-190
Jacqueline Van-Rossum (1)(5)	Executive Director of Integrated Care (London)	120-125	0	22.5-25	145-150
Bob Champion (1)	Executive Director of Workforce & OD	110-115	0	0	110-115
Stephanie Dawe (1)(3)	Chief Nurse and Executive Director of Integrated Care (Essex & Kent)	120-125	0	30-32.5	150-155
Caroline Allum (1)	Executive Medical Director	150-155	0	52.5-55	205-210
Joseph Fielder (1)	Chair	45-50	0	0	45-50
Sultan Taylor (1)	Non Executive Director	15-20	0	0	15-20
Amanda Lewis (1)	Non Executive Director	15-20	0	0	15-20
John Roome (2)	Non Executive Director	15-20	0	0	15-20
Mark Friend (1)	Non Executive Director	15-20	0	0	15-20
David Bowen(2)	Non Executive Director	0-5	0	0	0-5
Brian Hagger(2)	Non Executive Director	15-20	0	0	15-20
Liz Delauney (1)	Non Executive Director	10-15	0	0	10-15

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. Since December 2017 Stephanie Dawe has been on secondment as Chief Nurse at Provide CIC for which a contribution of 50% of the basic salary is received.
4. Trust paid for the rent of the accommodation for the Chief Executive Officer in the financial year 2018-19.
5. As per NHSBSA instruction, where the calculation results in a negative figure, zero has been submitted in "All pension related benefit" column.
6. There have been no Annual or Long Term performance related bonus payments in either 2017/18 or 2018/19. Stephanie Dawe is in receipt of a responsibility allowance which the Remuneration Committee has agreed to backdate from December 2018 to December 2017. This backdated payment was not made in 2018/19 and is not reflected in the above analysis.
7. 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.

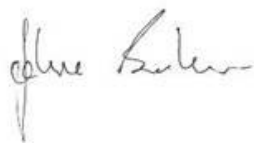
Band of Highest paid Directors total remuneration 000's	**190-195**
Median Total Remuneration	**£31,586**
Ratio	**6.11**

Pension Benefits of senior managers

Name	Real increase in pension at NPA (bands of £2,500)	Real increase in lump sum at NPA (bands of £2,500)	Total accrued pension at NPA at 31 March 2019 (bands of £5,000)	Lump sum at NPA related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value After deduction
Barry Jenkins	0-2.5	0	65-70	0	840	688	109
Jacqueline Van-Rossum	0-2.5	0*	55-60	165-70	1,259	1,113	94
Stephanie Dawe	0-2.5	2.5-5	15-20	55-60	456	382	43
Caroline Allum	0-2.5	0*	45-50	105-10	891	760	87

* *Where calculation results in a negative figure we have disclosed zero*

Signed:



John Brouder
Chief Executive
21 May 2019

GOVERNORS AND MEMBERS

Statutory Duties

Statutory duties for NHS Foundation Trust Council of Governors as provided by the National Health Service Act 2006:

- Appoint and, if appropriate, remove the Chair.
- Appoint and, if appropriate, remove the other Non-Executive Directors.
- Decide the remuneration and allowances and other terms and conditions of office of the Chair and the other Non-Executive Directors.
- Approve (or not) any new appointment of a Chief Executive on recommendation from the Chair and Non-Executive Directors.
- 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 at a general meeting of the Council of Governors.

Statutory duties for NHS Foundation Trust Council of Governors as amended by the Health and Social Care Act 2012:

- To hold the Non-Executives Directors individually and collectively to account for the performance of the Board of Directors.
- To represent the interests of the members of the organisation as a whole and the interests of the public.
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution.
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions.
- Approve amendments to the Trust's Constitution, following consultation with the Board of Directors.
    i. Where there has been an amendment to the Constitution which relates to the powers, duties or roles of the Council of Governors, at least one governor must attend the next Annual Members' Meeting and present the amendment to members.
- Approve significant transactions in line with the Trust's Constitution.

Fulfilling the Council of Governors statutory duties

Statutory Duty	Action during 2018/19
Appoint and, if appropriate, remove the Chair and Non-Executive Directors	Non-Executive, David Bowen, was appointed by the Council of Governors in May 2018. The Council of Governors began the process for the recruitment of a Non-Executive Director in Common and Audit Chair in November 2018. The Council of Governors appointed Sultan Taylor, as Vice Chair in January 2019. The Council of Governors re-appointed Trust Chair, Joe Fielder and Senior Independent Director, Mark Friend.
Decide the remuneration and allowances and other terms and conditions of office of the Chair and the other Non-Executive Directors	The Council of Governors agreed the Remuneration and allowances of the Trust Chair and Vice Chair at a formal meeting in July 2018. The Council of Governors agreed the Remuneration and allowances of the Non-Executive Director in Common/ Audit Chair in January 2019.
Approve (or not) any new appointment of a Chief Executive on recommendation from the Chair and Non-Executive Directors	Not applicable for 2018/19.
Appoint and, if appropriate, remove the NHS Foundation Trust's Auditor	Not applicable for 2018/19.
Receive the NHS Foundation Trust's Annual Accounts, any report of the auditor on them, and the Annual Report at a general meeting of the Council of Governors	The Council of Governors received the Annual Report, Annual Accounts and Auditor's Report at a formal Council of Governors meeting in September 2018
To hold the Non-Executives Directors individually and collectively to account for the performance of the Board of Directors.	The Council of Governors: • Reviewed the appraisals of the Trust Chair and Non-Executive Directors • Received the Board of Directors evaluation of effectiveness results • Received the Board of Directors meeting agendas and minutes • Asked a question at every Board of

	Directors meeting • Chose a quality indicator • Received presentations from Non-Executive Directors at each formal Council of Governors' meeting • Received the Non-Executive Director roles and responsibilities matrix • Were invited to comment on the Trust's Strategy and Forward Plan • Received updates from the Trust Chair at every Council of Governors meeting and Governor Development and Information Forum
To represent the interests of the members of the organisation as a whole and the interests of the public.	• Held quarterly Council of Governor meetings in Public • Held an Annual General Meeting in September 2018 • Submitted articles for the quarterly stakeholder briefings • Developed a governor email address for members to contact: governors@nelft.nhs.uk • Updated governor biographies and photographs on the website alongside contact details • Organised member events including a talk from a clinician
Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution	Not applicable for 2018/19.
Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions	Not applicable for 2018/19.
Approve amendments to the Trust's Constitution, following consultation with the Board of Directors.	The Council of Governors commented on, and then approved, a revised Trust Constitution in January 2019.

Approve significant transactions in line with the Trust's Constitution	Not applicable for 2018/19. Definition reviewed as part of the Constitution revision.

Composition of the Council of Governors

NELFT has 32 governors in total which is broken down in the following way:

- 25 elected governors (17 public governors, 8 staff governors)
- 7 appointed governors from partner and stakeholder organisations

Elected members serve a three year term, at which point they may be re-elected.

Four formal Council of Governors meetings were held in the period from 1 April 2018 – 31 March 2019 on: 26 April 2018, 26 July 2018, 27 September 2018 and 24 January 2019 and the Annual General Meeting was held on 27 September 2018. These meeting were held in public at the Trust Headquarters and NELFT members were able to attend. Meeting dates are listed on the Trust's website and further details can be requested from the Head of Corporate Affairs, Lauren MacIntyre, lauren.macintyre@nelft.nhs.uk 0300 555 1300.

The attendance record for the four formal meetings appears below:

NAME	CLASS OF GOVERNOR	DATE ELECTED	DATE(S) OF RE-ELECTION/ RE-APPOINTMENT	CURRENT TERM ENDS	MEETINGS ATTENDED
**Mark Egalton	Public, Havering	May 2014	June 2017	June 2020	4 out of 4
Bukola Folayan	Public, Havering	June 2017	-	June 2020	2 out of 4
Fatima Khasimi	Public, Waltham Forest	June 2017	-	June 2020	2 out of 4
Teddy Jogga Singh	Public, Rest of England	May 2015	April 2018	April 2021	4 out of 4
*Stephen King	Public, Basildon	June 2011	June 2014 June 2017	June 2020	3 out of 4
Christine Brand	Public, Barking and Dagenham	June 2013	June 2017	June 2020	4 out of 4
Clive Myers	Public, Redbridge	June 2017	-	June 2020	4 out of 4
Geoff Farmer	Public, Havering	May 2014	June 2017	June 2020	4 out of 4
Kevin McNamara	Public, Thurrock	April 2018	-	April 2021	3 out of 4
Colin Brennan	Public, Thurrock	May 2015	-	May 2018 – Term finished	1 out of 1
Tim Barrett	Public	June 2017	-	June 2020	0 out of 3

				– Stepped Down	
Karen Jordan-Nicholls	Public, Barking and Dagenham	June 2017	-	June 2020	4 out of 4
Indu Barot	Public, Redbridge	June 2017	-	June 2020	2 out of 4
Barbara Nicholls	Local Authority Appointed, Havering	April 2016	April 2019	April 2022	3 out of 4
Chris Rice	Local Authority Appointed, Barking and Dagenham	November 2018	-	November 2021	1 out of 1
Joe McDonnell	Local Authority Appointed, Waltham Forest	October 2018	-	October 2021	0 out of 1
Christopher Whitbread	Local Authority Appointed, Essex County Council	July 2018	-	July 2021	0 out of 3
Renata Wojciechowska	Staff, Redbridge	June 2017	-	June 2019	3 out of 4
Kiki Vratchovaska	Staff, Thurrock	July 2018	-	July 2021	1 out of 3
Mandy Orwell	Staff, Barking and Dagenham	June 2017	-	June 2020	3 out of 4
Alison Garrett	Staff, Corporate Services	June 2017	-	Stepped Down	2 out of 2
Susan Pateman	Staff, Havering	April 2013	August 2016	August 2019 – Stepped Down	1 out of 2
Gary Townsend	Staff	August 2016	-	August 2019 – Stepped Down	0 out of 3

*Stephen King is currently the Trust's Lead Governor
** Mark Egalton is currently the Trust's Deputy Lead Governor

Current Vacancies Include:
Public – 1 Barking and Dagenham, 1 Redbridge, 1 Brentwood, 2 Waltham Forest, 1 Kent.
Staff - 1 Basildon and Brentwood, 1 Havering, 1 Waltham Forest, 1 Corporate Services, 1 Kent.
Appointed - 1 Thurrock Unitary Authority (added in 2019 revision of Constitution), 1 Kent County Council (added in 2019 revision of Constitution), 1 Redbridge Local Authority.

The following individuals ceased serving as elected Governors during 2018-2019: Tim Barrett, Colin Brennan, Alison Garrett, Susan Pateman and Gary Townsend.

Director attendance at Council of Governors meetings:

Name	Position	Meetings Attended
Joe Fielder	Trust Chair	April, July, September, January
Mark Friend	Senior Independent Director	July
Sultan Taylor	Vice Chair	July, January
Liz Delauney	Non-Executive Director	January
Amanda Lewis	Non-Executive Director	April
David Bowen	Non-Executive Director	September
John Brouder	Chief Executive	July, September
Stephanie Dawe	Chief Nurse and Executive Director Integrated Care, Essex and Kent	September, January
Barry Jenkins	Executive Director of Finance and Commercial Development	April, September

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

In line with the Trust Constitution and statutory duties, the Council of Governors shall appoint or remove the Trust Chair and other Non-Executive Directors at a General Meeting of the Council of Governors.

Appointment of the Chair or other Non-Executive Directors

In line with the Council of Governors Terms of Reference, the Council of Governors may not delegate any of its functions or powers to any committees or sub-committees but it may appoint committees or sub-committees to advise and assist it in carrying out its functions.

Nominations Committee

The Nominations Committee is a standing committee of, and accountable to, the Council of Governors. It assists the Council of Governors in its duty to appoint Non-Executive Directors by:

- Reviewing the Board Skills Matrix, specifically looking at the balance of skills, knowledge, experience and diversity of the Non-Executive Directors.
- Reviewing the results of the Board of Directors evaluation of effectiveness.
- Reviewing the required time commitments of the Non-Executive Directors.

- Considering Non-Executive Director succession planning taking into account the objectives of the Trust and the views of the Board.
- Ensuring leadership needs of the Trust are kept under review at Non-Executive Director level to ensure the Trust's ability to operate effectively in the health economy.
- Agreeing a clear process for recruiting Non-Executive Directors, ensuring an open and transparent approach.
- Approving the role description with reference to the gaps in the Board Skills Matrix. Ensuring time commitment is clearly indicated.
- Ensuring that potential Non-Executive Directors are "Fit and Proper" Persons in line with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5.
- Ensuring potential Non-Executive Directors disclose other significant commitments and business interests that could result in a conflict of interest before appointment.
- Receiving reports on behalf of the Council of Governors on the process and outcome of appraisal for the Chair and Non-Executive Directors.
- Making recommendations to the Council of Governors on reappointment of any Non-Executive Director at the conclusion of their specified terms of office. Giving due regard to their performance and ability to continue to contribute to the Board in the light of knowledge, skills and experience required.
- Providing recommendations to the Council of Governors on remuneration and allowances for the Chair and Non-Executive Directors.

At 31 March 2018, the Governor membership of the committee was:

- Stephen King (Public, Basildon and Lead Governor)
- Mark Egalton (Public, Havering and Deputy Lead Governor)
- Geoff Farmer (Public, Havering).
- Clive Myers (Public, Redbridge)
- Renata Wojciechowska (Staff, Redbridge)
- Kevin McNamara (Public, Thurrock)

Removal of the Chair or other Non-Executive Directors

In line with the Trust Constitution, the removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the Members of the Council of Governors currently holding office.

Governor Induction and Development

As well as their formal meetings, Governors are invited to attend an induction day and six Governor Development and Information Forums each year. 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. Part of the forums are reserved for developmental activities, which are aligned to the CQC's well-led key lines of enquiry and informed by the governor self-evaluation of collective effectiveness. As well as internal support, governors are given the opportunity to attend NHS Providers courses to aid their understanding of the governor role and their ability to carry out their statutory duties.

Patient-Led Assessments of the Care Environment (PLACE) Assessments

As part of their role, governors take part in PLACE assessments and form part of a team made up of patients, senior clinicians and management to check on the quality of the services NELFT provides. On such visits governors may be tasked with speaking to patients about their experience, the condition, cleanliness and accessibility of the care environment, the quality of food, facilities for visitors and the accessibility of information.

Council of Governor Elections

During the year, there were two elections to fill vacancies in Thurrock's staff constituency and public constituency. Work also commenced to contact any governors with poor attendance to see whether they wished to continue as a governor, and if so, what support could be offered. This included alternating the time of formal meetings to ensure that they were inclusive and accessible to all governors, regardless of circumstances. Elections were also streamlined to occur annually with a formal induction event taking place soon after governors were formally in post.

As part of the Constitution review, some of the appointing organisations were changed and two constituencies were added: Kent staff and Kent public.

Due to the above pieces of work, the Council of Governors had 14 vacancies at 31 March 2019. The Trust met with election companies in February 2019 to commence the election process and fill vacant seats. Results for these elections will be declared in June 2019.

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, Kent and the Rest of England.

Membership is open to any individual who:

- Is over 16 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.

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 2019 the Trust had 10,120 public members and 6,152 staff members, making a total of 16,272 members.

Membership 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. We are also looking at ensuring representation across new geographies (Kent and Barnet).

Membership 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.
- Development of the Trust website to make it more user friendly
- Work with the Council of Governors to support locality events
- Refresh of the database following contact with all public members regarding GDPR

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
- Trust 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.

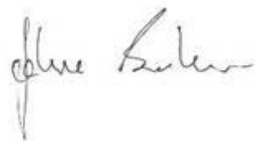
Please contact us on the details below.

Membership Office
FREEPOST RRLE/EKUZ-YRXZ
CEME Centre – West Wing
Marsh Way
Rainham
Essex
RM13 8GQ
Tel: 0800 694 0699

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

Signed:

Joseph Fielder
Trust Chair
21 May 2019



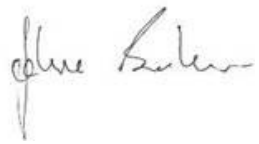
John Brouder
Chief Executive
21 May 2019

STATEMENTS AND ACCOUNTS 2018/19

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
21 May 2019

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 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.

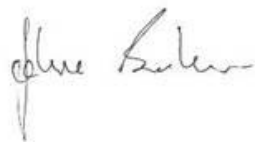
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance 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
21 May 2019

NORTH EAST LONDON NHS FOUNDATION TRUST
ANNUAL GOVERNANCE STATEMENT 2018/19

For the period 1 April 2018 – 31 March 2019

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of North East London NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in North East London NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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 and Kent) has delegated responsibility for quality and risk management. This includes: regulation and compliance with the CQC's Fundamental Standards, the risk register, risk assurance, claims management, the Central Alerting System, medical devices, 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 and Kent) has responsibility for the management of risks associated with operations in the Essex and Kent health economies, 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 the London health economy;
- The Executive Director of Finance has responsibility for managing the development and implementation of systems of financial and commercial risk and information governance. This individual is the Trust's Senior Information Risk Owner.
- The Executive Medical Director is the Trust's Caldicott Guardian and is responsible for risk management regarding medical staffing, education and revalidation and mortality.
- The Executive Director of Workforce & Organisational Development has responsibility for risk management regarding employees, staffing, workforce development and equalities;
- 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;
- Under the leadership of the Chief Executive Officer, the Head of Corporate Affairs has responsibility for risk management regarding corporate governance, freedom to speak up, health and safety and local security management (although the Chief Nurse is Security Management Director)
- Under the leadership of the Chief Executive Officer, the Director of Communications has responsibility for risk management regarding communications, identity and reputation.
- The Integrated Care Directors have responsibility for local risk management systems and controls;
- The Associate Medical Directors, the Directors of Nursing and Professional Leads have responsibility for the systems of clinical risk management at locality level.

The Board of Directors, 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 at least every three years by the Board of Directors 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.

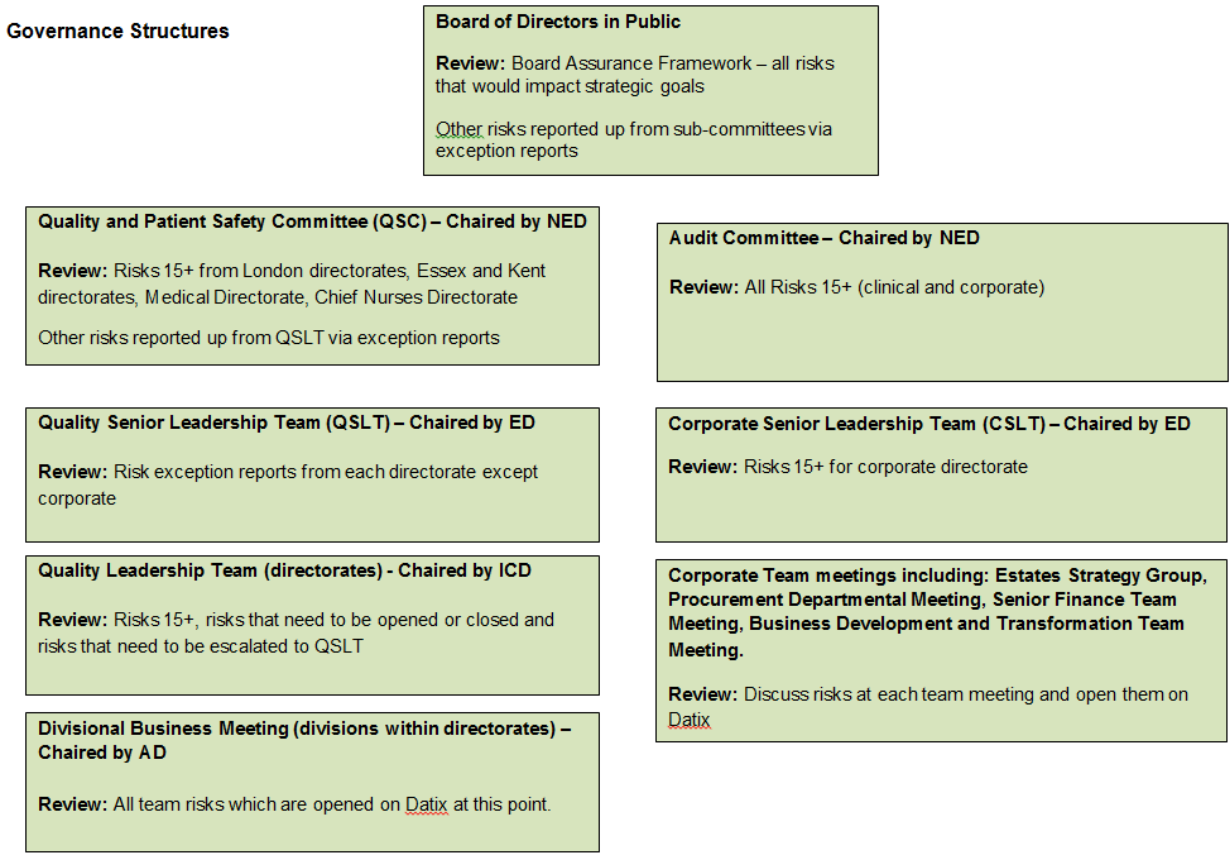
Risk management training is provided via e-learning which is available to all staff via the STEPS system. In addition there is a webinar which can be accessed via the intranet. There are also a variety of guidance notes, from a detailed step by step guide through the local risk management system, to an easy to follow two-page overview. The Head of Risk Assurance also provides training to groups and individuals as required.

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 of Directors, Audit Committee and Quality and Safety Committee which are supported by the governance systems (below). This year, the Audit Committee enhanced its risk oversight role, by including the review of all 15+ clinical and corporate risks within its Terms of Reference and Cycle of Business. As well as this, it 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

The Quality and Safety Committee also reviews risks at each monthly meeting. It looks at the risks within all operational services and the Chief Nurse and Medical Director's portfolios. This includes risks that impact patient and staff safety, patient experience, quality governance, clinical effectiveness, clinical audit, pharmacy and NICE compliance.

Each tier of the risk governance framework ensures appropriate action is taken and learning is shared. 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 of Directors, Audit Committee and Quality and Safety Committee. This is supported by a framework of learning from incidents, clinical audit, quality improvement programmes and a robust research and development infrastructure. At a strategic level, individuals have been given the opportunity to attend the

NHS Providers Risk Management Training. One Non-Executive Director and the Head of Corporate Affairs attended this training, and provided feedback regarding best practice at a Board Development Workshop and Non-Executive Director Away Day.

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 enquiries, and ensures any relevant local action is taken forward.

The Trust has a Gifts, Hospitality and Conflicts of Interest Policy which is in line with NHS England's publication "Managing Conflicts of Interest in the NHS" which was published in February 2017. This provides clear guidance to staff who may be offered gifts and hospitality as part of their role and also explains the Trust process with regard to declaring and managing any potential conflicts of interest.

The Trust has also developed a Slavery and Human Trafficking Statement in line with the Modern Slavery Act 2015. This statement outlines NELFT's actions to understand modern slavery and human trafficking risks and the effective systems and controls that have been implemented to address these. This statement can be found on the Trust's website.

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 provides an annual opinion, based on and limited to the work performed, on the overall adequacy and effectiveness of the organisation's 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.

The Head of Internal Audit has given the following opinion for the year ending 31 March 2019:
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 2018/19. 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 2018/19.
- 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.

During the year, the Trust's internal auditors flagged areas whether further assurance could be obtained and made recommendations in the following areas:

- Fire safety – specifically:
    - Improve training to ensure it is site-specific
    - Create a way to ensure fire warden presence is known at any given site
- Corporate Governance – specifically:
    - Refresh and publish overall strategy – ensuring objectives and key performance indicators identified and linked with Board Assurance Framework
    - Ensure all corporate risks are on the risk management system
    - Incorporate monitoring key performance indicators into Executive Management Team meetings
- National Early Warning Score (NEWS) compliance – specifically:
    - Update NEWS2 policies, procedures and guidance
    - Ensure training records are centralised and maintained
    - Improve compliance with NEWS tool

All recommendations are updated and reviewed at each Audit Committee in the Internal Audit Follow Up Report. All outstanding recommendations are also taken to the Executive Management Team meeting on a monthly basis to ensure that action plans are developed and implemented.

The risk and control framework

- **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. These areas form the basis of the Trust's risk registers which are maintained at each level in the organisation. Assurance that risks are being managed effectively in both corporate and clinical services is gained through the governance structures in place.

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.

- **Risk Appetite and Board Assurance Framework**

In December 2018, the Board of Directors reviewed and defined its risk appetite, tolerance levels and target scores. This is within the Board of Directors Cycle of Business, scheduled on an annual basis.

The Board Assurance Framework was also developed further and was aligned to the Trust's strategic objectives and risk appetite. This is reviewed and updated by the Executive Management Team on a monthly basis, before being presented at the Board of Directors meeting in public.

The key risks within the Board Assurance Framework and their mitigations are below:

Risk	Mitigations
Treatment time If people are waiting too long for treatment then their health condition may deteriorate	**Preventative Controls:** Mock Inspection Programme Monthly reports to Quality Safety Committee (QSC) and Board of Directors Completion of zoning and risk assessments are key to maintaining patient safety **Recovery Controls:** Clinical Risk policy High Risk Reporting protocol. The above included in a operational recovery plan which will include clear trajectories based on risk management, clinical harm reviews, additional temporary staffing and a review of system and processes to ensure effective use of capacity and demand to ensure safe patient care. Risk registers closely reviewed and updated. Close scrutiny of above via internal governance process from front line service to Board.
CQC Non Compliance If NELFT is non-compliant with CQC regulations and fundamental standards then the Trust will not provide the best care	**Preventative Controls:** Mock Inspection Programme Perfect Ward Audits Monthly reports to Quality Safety Committee (QSC) and Board of Directors **Recovery controls:** CQC internal action plans worked up locally and monitored via the internal governance process

	Risk register is monitored/ updated Themes taken forward to ensure improvements via established quality groups
Staff safety If staff do not feel safe at work the vacancy rates will increase and impact on patient safety and quality	**Preventative Controls:** Implementation of positive and proactive work. Police liaison forums and police presence; taking action. Update of Managing Violence at Work Policy Installation of CCTV on Mental health inpatient units Development of an Employee Assistance Programme **Recovery Controls:** Staff advised to inform Police of incidents Merseycare is visiting Acute and Rehabilitation Directorate in June 2019 to advise on additional work/initiatives that we could undertake to reduce violence and aggression
Medical staffing If there are insufficient clinical staff, including medical staff numbers then the Trust will need to rely on agency staff leading to a lack of continuity of care and patients not receiving the best care. Medical staff vacancies in Kent services in particular are causing service delivery Issues	**Preventative Controls:** Monthly vacancy and recruitment activity reporting. Fortnightly agency review group meetings Half yearly report to Quality and Safety Committee on workforce development activities Task and finish group established to look at targeted resourcing campaigns; closer liaison with locum agencies and increase in campaigning to employ bank doctors. **Recovery Controls:** Commission external agency to undertake large scale recruitment campaign. Specification being drafted between Procurement and Integrated Care System, with Senior Leadership Team input.

Leaving the European Union

As required by the Department of Health and Social Care the Trust has undertaken business continuity risk assessments to ensure any gaps in controls are addressed in preparation for an exit of the EU. An EU Exit Working Group provides the forum for risk assessment and planning and response to occurrences respectively with oversight provided

by the Board. Tests of Business Continuity and Incident Management Plans against EU Exit risk assessment scenarios have been undertaken and Risk Assessments and Business Continuity Arrangements have been reviewed against the following preparedness areas as advised by the Department of Health and Social Care:

- Supply of medicines and vaccines
- Supply of medical devices and clinical consumables
- Supply of non-clinical consumables, goods and services
- workforce
- reciprocal healthcare
- research and clinical trials
- data sharing, processing and access.

EU Exit Workforce Implications

In order to plan effectively for the UK exit from the EU, a steering group was established, both to meet the internal planning requirements and to manage arrangements to notify NHS England as to the organisation's readiness for whatever happens. The group also committed to scope our workforce implications. In doing this, we have identified the members of staff of EU origin and whilst the numbers fluctuate month on month, we have seen a steady year on year increase overall in our EU workers. Broadly the data shows the following:

a) We currently have approximately 250 colleagues of EU origin (Excluding the 80 + Irish citizens, who we have discounted as their status will remain protected under the 1923 Common Travel Area Agreement).

b) The most common nationalities are: Polish (37), Greek (22), Spanish (21), German (18), Romanian (14), French (13) and Portuguese (12). All other nationalities are in single figures.

c) The distribution between Directorates is as follows: Essex & Kent (57), Waltham Forest (52), Havering (31), Barking and Dagenham & Barnet (30), ARD (25), Redbridge (24) and the remainder in corporate services.

d) Analysis of main staff groups shows the following: Psychology and Psychological Therapies (49), Nursing – all groups (37), Health Care Assistants and Support Workers (33), Doctors – all groups (27), Physiotherapists (27), Occupational Therapists (11) and other assorted roles in single figures.

During Quarter 4 2018/19 and Quarter 1 2019/20, we wrote to all of our colleagues of EU origin expressing our support for their continuing employment with NELFT and applications for settled status should they wish to do so. We also held three open access workshop sessions delivered by our legal advisors DAC Beachcrofts, to provide helpful information on the implications of staying or leaving. Whilst the sessions were not very well attended, feedback from recipients of letters was very positive, as was that received from participants in the workshops. The steering group has now suspended activity

pending further negotiations on exit.

- **Quality Governance arrangements and Performance Information**

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 and Safety Committee of the Board. The Audit Committee further receives a report from the Data Quality Group providing assurance and scrutiny of the quality and safety indicators.

- **CQC Registration**

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

Regular quality and performance reports, the 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.

After CQC inspections, a report is also taken to the Board of Directors which reviews recommendations and progress against their associated action plans.

- **Data Security Risks**

The Trust submitted its Annual Data Security Toolkit submission at the end of March 2019, and has met 90 out of the 100 mandatory requirements and is working towards the remaining 10 with an action plan in place.

- **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 Trust has a Scheme of Delegation which outlines matters that must be reserved for the Board of Directors, and those that may be delegated to a sub-committee or Executive Director. The board sub-committee 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 regarding Trust performance. An Integrated Performance Report is also presented to the Board of Directors and Executive

Management Team on a quarterly basis. This report contains indicators relating to all statutory and regulatory requirements.

Committees all have their own Terms of Reference which outline the responsibilities, accountabilities and reporting lines of the committee and a cycle of business, to ensure the duties are fulfilled. Both of these documents are reviewed annually by the Committee and Board of Directors. Risk, trends, themes and exceptions are analysed at each committee.

Regular progress reports and recommendations from internal and external auditors on both clinical and non-clinical areas ensure that the Trust's governance systems are fit for purpose and effective, as well as providing assurance of the validity of the Trust's corporate governance statement.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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

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

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

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.

The Trust has recently refreshed its five year workforce and organisational development strategy that sets out short, medium and long-term plans to support the best people in delivering the best care. The strategy was approved by the Trust Board and the priorities and objectives are subject to ongoing Board scrutiny via workshop sessions and through regular reporting to the Quality and Safety Committee (QSC). These measures, as well as compliance with Health Education England approved workforce planning methodologies, assure the Board that staffing processes are safe, sustainable and effective. We deploy our resources effectively in all operational areas, using rostering technology and in accordance with National Quality Board guidance and recommendations. We continually review our skill mix and staffing levels to ensure the right people in the right place at the right time. Our recruitment processes will ensure that our staff are fit for purpose and our retention strategy will be focused on positively engaging with our workforce and promoting their health and well-being. Our management of temporary staffing solutions will focus on best value and high quality staff and we will use evidence from staffing activities to continually improve our practices. As well as monthly Board reporting and regular reports to the QSC, we will produce an annual governance statement that describes how we comply with the 'Developing Workforce Safeguards' recommendations.

NHS Improvement's Well-led Framework

In line with NHS Improvement's Well-led Framework, the Trust commissioned an external well-led review in 2016, and is due to commission another in the latter part of 2019.

The CQC also assessed whether the Trust's services were well-led in January 2018 and provided the Trust with a "good" rating in this area. The Trust is receiving its next CQC well-led inspection in June 2019.

Both reports, noted positive areas of practice, as well as areas for improvement. From this, action plans were developed and implemented. As well as these, more extensive internal reviews took place in relation to the Trust's quality governance in 2017/18 and the Trust's corporate governance in 2018/19.

To provide further assurance regarding the Well-led Framework, the Board of Directors annual self-assessment of effectiveness, was aligned to the CQC's well-led key lines of enquiry. Resulting action plans were produced and results informed the Board Development Workshop schedule which also aligned to the Well-led Framework.

Particular areas of development and improvement within the Well-led Framework across 2018/19 included:

- Trust Strategy
- Freedom to Speak Up activity
- Board service visits and their feedback mechanism
- Risk, risk appetite and Board Assurance Framework
- Trust Constitution and corporate and quality governance procedures

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

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.

The Board receives a finance report at every meeting, which provides an update on the Trust use of resources, in line with the single oversight framework.

Information Governance

There were no level 2 information governance incidents reported for 2018/19.

There were no serious incidents relating to information governance.

Annual Quality Report

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

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

Through the year a number of data quality issues have emerged and been highlighted at the Quality and Safety Committee. In order to address these concerns a number of sub-groups have been established reporting through the Data Quality Action Group which now have a line of reporting through to the Audit Committee.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality and safety committee and 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 the external and internal auditors and internal management reports and other key reports.

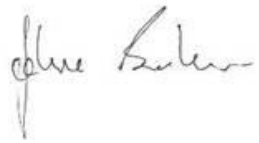
Internal audit methodology is based on four assurance levels in respect of their overall conclusion as to the design and operational effectiveness of controls within the system reviewed. The assurance levels are based on internal audit giving either "substantial", "moderate", "limited" or "no". The four 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.

Each Audit Committee reviews the internal audit recommendations, and the progress made against each of these recommendations by management. This ensures that any gaps in control are responded to in a timely manner. These recommendations are also scrutinised by the Executive Management Team, and those relating to clinical services, by the Quality and Safety Committee.

Conclusion

I can confirm that no significant control issues have been identified in the 2018/19 financial year.

Signed:



John Brouder
Chief Executive
21 May 2019

OPERATING AND FINANCIAL REVIEW SUMMARY

Financial Performance 2018/19

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 £3.5m, the latter having been set to deliver the 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 £8.2m, 2018/19 can be seen as another successful financial 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 surplus of £8.2m, which is summarised below:

	2018/19 £000	**2017/18 £000**
Operating income from patient care activities	367,843	348,464
Other operating income	20,874	22,433
Operating Expenses	(386,157)	(387,927)
Operating surplus / (deficit) from continuing operations	**2,560**	**(17,030)**
Finance income	331	116
Finance expenses	(1,175)	(1,109)
PDC	(2,069)	(2,633)
Net finance costs	**(2,913)**	**(3,626)**
Gain on Asset Sale	4,151	93
Surplus / (deficit) for the year	**3,798**	**(20,563)**

Add back impairment included within operating expenses	4,397	32,229
Adjusted financial performance surplus / (deficit) including PSF	**8,195**	**11,666**

Income

When taken together income from patient and other activities increased by £17.8m (4.8%) in 2018/19 to stand at £388.7m. This included £6.9m of NHS Provider Sustainability funding. A significant proportion of the Trusts remaining income (88.5%) comes through block contracts held with NHS and local authority commissioners.

Following a successful tender a new NHS Contracts for the provision of Children's Therapy Services started during the year. Additionally, for 2018/19 NHS Contracts continue to be held with the four North East London Clinical Commissioning Groups; the two Clinical Commissioning Groups covering South West Essex; NHS England; West Essex CCG (as lead commissioner for Children's and Adolescent Mental Health Services for Essex); and

the Clinical Commissioning Groups in Kent for the Children's and Adolescent Mental Health Services and all age Eating Disorder services provided. 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 £11.9m were required to deliver the 2018/19 financial plan. Additionally, £4.1m of cost reductions were not achieved in 2017/18, making a total requirement for 2018/19 of £16.0m. In the year total cost reductions of £15.3m (95.7%) were achieved of which £5.1m is non recurrent.

Headline operating expenses reduced in the year by £1.8m (0.5%) to £386.2m. When the impact of impairments are excluded underlying operating expenses increased by £26.1m (7.3%). This reflects increased pay costs arising from additional patient activity and the impact in 2018/19 of the three year Agenda for Change pay award alongside increased premises investments relating to newly commissioned services and to facilitate estates rationalisation and agile working.

Including the use of medical and nursing temporary staff employed either through the in house bank or agencies 74.4% of expenditure is pay related. 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 at £23.2m this year is slightly higher than both the expenditure cap and last year (£22.2m).

Operating expenses also includes drugs, the cost of premises and the cost of clinical placements sub contracted to NELFT by its mental health commissioners.

Financing Costs

The Trust's accounting policy requires a full revaluation every five years with an interim one every three years for all its land and buildings. In 2017/18 the Trust undertook a full revaluation exercise of all its land and buildings whereby each site was visited, measured and assessed by our independent valuer.

In the past 12 months the Trust has assets which have been subjected to change such as refurbishment or extension (but which may or may not affect the carrying value of the asset), change of use or vacated assets that can be disposed of. As a result a number of specific assets have been subjected to a desktop review in order to provide an updated value assessment. As a consequence of this targeted review the Trusts Asset value has reduced by £10.3m.

The above reduction in the Trusts asset values has contributed to a lower PDC charge this year of £2.1m.

Depreciation of the Trust assets was £6.2m for the year 2018/19.

Capital Expenditure

The total Capital expenditure in the year was £15.3m of which £1.7m related to ligature works and a further £8.7m 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 2019 the Trust had a cash balance of £48.6m. The Trust has an outstanding PFI liability of £7.8m and a finance lease of £2.4m as at 31 March 2019.

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.

NELFT adopts a stringent financial planning process that seeks to identify and make provision for all known financial cost pressures. As part of the 2019/20 financial planning process an assessment was made of the possible risks that might impact upon the achievement of our financial targets with the key risks being:

- Achievement and contribution towards the North East London STP wide control total.

- Failure to achieve CQUIN and Key Performance Indicators where under the existing contract format 1.25% of the contract value relates to the achievement of CQUINs and where financial penalties can be applied for failing to achieve against Key Performance Indicators.

- Delivery of the cost improvement programme.

- Impact of service decommissioning – at the time of preparing the plan it was known that some of our commissioner's plans included unidentified QIPP which may result in the further reduction in and / or decommissioning of services.

In order to mitigate the materialisation of these and other financial risks, financial performance is integral to the Trust's approach to performance management. A monthly Project Management Office meets to ensure that all key projects are on line, including the delivery of cost improvements and efficiency savings. Furthermore, on a monthly basis each risk will be re-assessed for both likelihood and impact and a probability score calculated.

In addition to the proactive management of projects and cost improvement programmes through the Project Management Office, although not financially factored into this plan and difficult to quantify, the Trust would be expecting to see financial upsides arising through;

- The continued impact of agency and temporary staffing controls.

- The improved recruitment and retention of staff reducing the reliance on temporary staff.

To assist with the mitigation of any adverse internal financial variances that cannot otherwise be managed through the proactive management of other budgets, a contingent reserve is provided for within the financial plan.

The Financial Plan approved for 2019/20 by the Board seeks to deliver a Continuing Operating Surplus of £3.4m (0.9%) which is consistent with the agreed Control Total.

Contracts for next year have been signed of which in excess of 75% (by value) do not terminate until after 31 March 2020.

The Trust will be starting the year with a strong positive cash position which based on the expected movements summarised below it is expecting to maintain with a forecast cash balance at the end of the year £41.7m:

	2019/20 £000
Opening cash balance	48,639
EBITDA	14,385
Interest receivable	240
Interest payable	(995)
CAPEX	(25,000)
Sale of assets	4,043
Capital repayment - PFI and Finance leases	(565)
PDC dividend payment	(1,850)
Movement in debtors	3,843
Movement in Creditors	(1,063)
Closing cash balance	**41,677**

In addition to the delivery of their agreed control total Trust's financial standing is also assessed through a use of financial resources. Based on the current planning assumptions the plan is to achieve an overall score of 1 (where 1 is the highest score) made up against each of the component parts as follows:

	Measure	**Rating**
Debt servicing	2.77 times	**1**
Liquidity	4 days	**1**
I&E Margin	0.9%	**2**
Variance in I&E Margin as a % of Income	0.00%	**1**
Agency Spend	0.00%	**1**

Overall Use of Resources	**1**

Taking the above issues into account the Directors have been able to confirm the Trust is a going concern for the 12 month period from the date of approving the 2018/19 accounts.

Signed:

Barry Jenkins
Executive Director of Finance
21 May 2019

NHS Foundation Trust accounts template

Inputs

MARSID	NELONDON
Name of provider	North East London NHS Foundation Trust
Provider status	FT
Date of year end (dd/mm/yyyy)	31/03/2019
Start of current year (dd/mm/yyyy)	01/04/2018
Comparative year end (dd/mm/yyyy)	31/03/2018
Start of comparative year (dd/mm/yyyy)	01/04/2017
Year for financial reporting (20XX/YY)	2018/19
Year for comparative year (20XX/YY)	2017/18
Year for year end (20XX)	2019
Year for comparative year (20XX)	2018
Opening Year (20XX)	2017
Next financial year (20XX/YY)	2019/20
Date of approval of financial statements (dd/mm/yyyy)	21.05.2019

North East London NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

North East London NHS Foundation Trust -Annual accounts for the year ended 31

Foreword to the accounts

These accounts, for the year ended 31 March 2019, have been prepared by North East London NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Name **John Brouder**

Job title **Chief Executive and Accounting Officer**

Signed 

Date **21-May-19**

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	367,843	348,464
Other operating income	4	20,874	22,433
Operating expenses	6	(386,157)	(387,927)
Operating surplus / (deficit) from continuing operations		**2,560**	**(17,030)**
Finance income	9	331	116
Finance expenses	10	(1,175)	(1,109)
PDC dividends payable		(2,069)	(2,633)
Net finance costs		**(2,913)**	**(3,626)**
Gains on disposal of non-current assets	12	4,151	93
Surplus / (deficit) for the year		**3,798**	**(20,563)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(9,057)	(18,964)
Revaluations	14	3,133	25,228
Total comprehensive income / (expense) for the period		**(2,126)**	**(14,299)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	13	1,703	1,754
Property, plant and equipment	14	111,818	113,068
Trade and other receivables	17	83	46
Total non-current assets		**113,604**	**114,868**
Current assets			
Trade and other receivables	17	31,443	29,215
Non-current assets for sale and assets in disposal groups	15	300	4,050
Cash and cash equivalents	18	48,639	49,946
Total current assets		**80,382**	**83,211**
Current liabilities			
Trade and other payables	19	(45,459)	(48,007)
Borrowings	21	(565)	(508)
Provisions	24	(5,274)	(4,403)
Other liabilities	20	(3,917)	(4,248)
Total current liabilities		(55,215)	(57,166)
Total assets less current liabilities		**138,771**	**140,913**
Non-current liabilities			
Borrowings	21	(9,620)	(10,184)
Provisions	24	(4,265)	(3,729)
Total non-current liabilities		(13,885)	(13,913)
Total assets employed		**124,886**	**127,000**
Financed by			
Public dividend capital		60,375	60,363
Revaluation reserve		27,987	38,368
Income and expenditure reserve		36,524	28,269
Total taxpayers' equity		**124,886**	**127,000**

The financial statements on pages 4 - 7 were approved by the Board of Directors on 21 May 2019 and signed on its behalf

Signature: 

Name: John Brouder

Position: Chief Executive

Date: 21 May 2019

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018	60,363	38,368	28,269	127,000
Surplus/(deficit) for the year			3,798	3,798
Transfers between reserves	-	(2,485)	2,485	-
Impairments	-	(9,057)	-	(9,057)
Revaluations	-	3,133	-	3,133
Transfer to retained earnings on disposal of assets	-	(1,972)	1,972	-
Public dividend capital received	12	-	-	12
Taxpayers' equity at 31 March 2019	**60,375**	**27,987**	**36,524**	**124,886**

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
Surplus/(deficit) for the year	-	-	(20,563)	(20,563)
Transfers between reserves for Impairments	-	(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 Cash Flows Statement of Cash Flows for the period ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		2,560	(17,030)
Non-cash income and expense:			
Depreciation and amortisation	**6**	6,238	4,697
Net impairments	**7**	4,397	32,229
(Increase) / decrease in receivables and other assets		1,594	(7,773)
Increase/(decrease) in other liabilities		(331)	359
Increase / (decrease) in payables		(2,970)	(206)
Increase / (decrease) in provisions		1,286	(742)
Net cash flows from / (used in) operating activities		**12,774**	11,534
Cash flows from investing activities			
Interest received		331	122
Purchase of intangible assets		(1,511)	(354)
Purchase of PPE and investment property		(13,325)	(8,284)
Sales of PPE and investment property		3,858	93
Net cash flows from / (used in) investing activities		**(10,647)**	**(8,423)**
Cash flows from financing activities			
Public dividend capital received		12	-
Capital element of finance lease rental payments		(200)	(175)
Capital element of PFI, LIFT and other service concession payments		(307)	(281)
Interest paid on finance lease liabilities		(327)	(352)
Interest paid on PFI, LIFT and other service concession obligations		(727)	(753)
PDC dividend paid		(1,886)	(3,285)
Net cash flows from / (used in) financing activities		**(3,435)**	**(4,846)**
Increase / (decrease) in cash and cash equivalents		(1,308)	(1,735)
Cash and cash equivalents at 1 April 2018		49,946	51,681
Cash and cash equivalents at 31 March 2019	**18**	**48,639**	**49,946**

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 2018/19 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 has prepared its financial statements on a going concern basis as the directors have a reasonable expectation that:

- It will provide the same level of services for the foreseeable future at the year end 2018/19 75% of its contracts for income are signed;
- It has achieved a Surplus of £8.2m before impairment in the year;
- It starts the new financial year with a healthy cash balance of £48m;
- Its Current assets exceeds its current liabilities both at 31st March 2019 and in its operating plan;
- It has achieved a Use of Resources (UoR) rating of 1 at 31 March 2019 and planning to have the same rating for 2019/20;
- Its Financial Plan approved for 2019/20 by the Board will deliver a Continuing Operating Surplus of £3.4m, consistent with the agreed Cor

1.1 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. 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.

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

Revenue from Local Authority Contracts

As with revenue from NHS contracts the Trust is contracted to provide health care services to Local authorities. A performance obligation relating to an agreed set of activity that satisfied both parties is agreed with a fixed amount received monthly. A small element of the overall contract is linked to Key Performance Indicators which are monitored on a monthly basis. Where under achievement is likely the contract price is reduced to reflect this and the income would be reduced accordingly.

Revenue from CQUIN

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract. The Trust therefore accounts for the whole of this income in the relevant accounting year, unless there clear indication that the targets won't be met.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. Once notification of monthly income due to NELFT, the same amount is accrued for and the full amount is normally settled the following month. There is therefore no requirement to provide for unsuccessful compensation claims and doubtful debts in line with IFRS 9.

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.

Other income

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

1.2 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.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional cost is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

a) Accounting valuation

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 valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019 is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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 2018/19 55 (2017/18 was £142k). The value of employer's contributions in 2018/19 is £2k (2017/18 was £26.29k)

1.3 Expenditure on other goods and services

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

1.4 Property, plant and equipment

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.

1.4.1 Capitalisation

Assets are capitalised where:

- They are capable of being used for a period which exceeds one year.
- Individually they have a cost of at least £5,000;
- They form a group of assets which individually have a cost of more than £250, collectively have a cost of
- They are held for use in delivering services or for administrative purposes;
- The cost of the individual 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 lives.

1.4.2 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.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of Investment properties or assets held for sale.

A full revaluation of property, plant and equipment are performed every five years with an interim desktop valuation every three years to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period.

Current values in existing use are detemined as follows:

- Land and non-specialised buildings at market value for existing use
- Specialised buildings at depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment , transport equipment, furniture and fittings and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short use full lives or low values or both, as this is not considered to be materially different from current value in existing use.

A desktop review of eight properties was undertaken at 31st March 2019 by the External Valuer, Montague Evans and a valuation was undertaken for one of the Trust's IT assets completed in the year by the District Valuer, both in accordance with the Royal Institute of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect fair value.

The assets selected for valuation were based on the following:

- Newly completed asset;
- Assets subjected to extensive refurbishment or extension;
- Change of use of an asset;
- Vacated or partly vacated assets.

1.4.3 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.

1.4.4 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
Office and IT Equipment	5 Years
Mainframe IT Equipment	10 Years
Short Life Medical Equipment	5 Years
Medium Life Medical Equipment	10 Years
Long Life Medical Equipment	15 Years
Buildings	60 Years

1.4.5 Revaluation and impairment

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where and to the extent that they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

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

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

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of :

- The impairment charged to operating expenses.
- The balance in the revaluation reserve attributable to that asset before the impairment.

Extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

Derecognition

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 abandon 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 useful life is adjusted. The asset is derecognised when scrapping or demolition occurs.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) 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 and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

1.5 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.

1.5.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

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.

1.5.2 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.

1.6 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.

1.7 Intangible Assets

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

1.7.1 Software

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

1.7.2 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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

1.7.3 Amortisation

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

The Trust depreciates software licenses over 10 year period.

1.8 Financial instruments and financial liabilities

1.8.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics (ONS).

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

1.8.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

1.8.3 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under PFI and/or lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

1.8.4 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12 month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.8.5 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

1.8.6 Loans and receivables

Loans are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability.

1.9 Provisions

1.9.1 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.

1.9.2 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.

1.9.3 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.

1.10 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 estimated and the 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.

1.10.1 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.

Private Finance Initiative (PFI)

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.

Provision for impairment of receivables

Due to the implementation of IFRS 9, management are required to use their judgement to stratify and classify debtors in order to draw conclusions about the collectability of the debt and therefore the appropriate level of bad debt provision that should be applied to each class of debtor.

Impairments and estimated asset lives

The Trust is required to review property, plant and equipment for impairment. In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives.

Valuations of land and buildings

The Trust adopts a policy of undertaking a full revaluation of its estate every five years with an interim desktop valuation every three years. Non-specialised buildings are valued under an Existing Use Basis and specialised buildings are valued using a Depreciated Replacement Cost, considering the cost of a Modern Equivalent Asset. Valuations are based on a range of assumptions including optimal floor space and land size of a Modern Equivalent Asset. See Note 1.4 for further details.

Key sources of estimation uncertainty

Management has made the following critical judgements in the process of applying the entity’s accounting policies which may have a significant effect on the amounts recognised in the accounts:

- The use of estimated asset lives in calculating depreciation and amortisation (See Note 14 and 17);
- The valuation basis used for specialised and non-specialised assets and the use of Gross Internal Area(GIA);
- Provisions for early voluntary retirement pension contributions and injury benefit obligations are estimated using expected life tables and discounted at the pensions rate of 2.9% nominal (0.10% 2017/18 in real terms).

Included in the receivables and payables balances are a number of accruals, prepayments and accrued income. These may inevitably require an element of estimation. Where estimates have been applied, the Trust group has adhered to guidance stipulated in the Group Accounting Manual.

1.10.2 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.

1.11 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 as at 31 March 2019
IFRS 16 Leases	Jan-16	Applies to annual reporting periods beginning on or after 1 January 2019	No Effect
IFRS 17-Insurance Contracts	May-17	Application required for Accounting periods beginning on or after 1 January 2021	No Effect
IFRIC 23-Uncertainty over Income Tax Treatments	Jun-16	Application required for Accounting periods beginning on or after 1 January 2019	No Effect

1.12 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

1.13 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:

- Donated assets;
- 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;
- 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.

1.14 Taxation

1.14.1 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.

1.14.2 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.

1.15 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 2019 is £46k (£45K in the year ended 31 March 2018).

1.16 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).

1.17 Foreign Exchange

The functional and presentational currency of the Trust is sterling.

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)

	2018/19 £000	2017/18 £000
Mental health services		
Cost and volume contract income	11,652	10,419
Block contract income	155,029	139,037
Clinical partnerships providing mandatory services (including S75 agreements)	1,417	1,472
Clinical income for the secondary commissioning of mandatory services	3,481	3,847
Other clinical income from mandatory services	2,187	2,794
Community services		
Community services income from CCGs and NHS England	136,432	136,826
Income from other sources (e.g. local authorities)	53,443	52,377
All services		
Private patient income	5	-
Agenda for Change pay award central funding	3,757	-
Other clinical income	440	1,692
Total income from activities	**367,843**	**348,464**

3.2 Income from patient care activities (by source)

	2018/19 £000	2017/18 £000
Income from patient care activities received from:		
NHS England	17,168	17,025
Clinical commissioning groups	292,470	271,899
Department of Health and Social Care	3,855	-
NHS Foundation Trust	96	557
NHS other	436	-
Local authorities	51,818	56,218
Non-NHS: private patients	5	-
NHS Trust	1,532	1,767
Injury cost recover scheme	152	152
Non NHS: other	311	846
Total income from activities	**367,843**	**348,464**

3.3 Overseas visitors (relating to patients charged directly by the provider)

No overseas visitor are invoiced directly, however the Trust invoices our host CCG where overseas visitors use the Trusts services. This income which was £464k in 2018/19. This is included under income from patient care activities.

3.4 Income from activities arising from commissioner requested services

	2018/19 £000	2017/18 £000
Income from services designated as commissioner requested services	361,424	340,131
Income from services not designated as commissioner requested services	6,419	8,333
Total	**367,843**	**348,464**

4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development	2,561	2,131
Education and training (excluding notional apprenticeship levy income)	8,281	8,086
Non-patient care services to other bodies	693	285
Provider sustainability and transformation fund income (PSF / STF)	6,876	7,723
Other (recognised in accordance with IFRS 15)	1,803	3,234
Education and training - notional income from apprenticeship fund	71	10
Rental revenue from finance leases	182	180
Rental revenue from operating leases	407	784
Total other operating income	**20,874**	**22,433**

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.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	407	784
Total	**407**	**784**

	2018/19 £000	2017/18 £000
Future minimum lease receipts due:		
Not later than one year;	407	784
Total	**407**	**784**

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.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	6,139	12,257
Total	**6,139**	**12,257**

	2018/19 £000	2017/18 £000
Future minimum lease payments due:		
Not later than one year;	6,961	3,216
Later than one year and not later than five years;	20,714	6,729
Later than five years.	24,407	997
Total	**52,082**	**10,942**

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

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	2,515	1,561
Purchase of healthcare from non-NHS and non-DHSC bodies	5,139	2,863
Staff and executive directors costs	280,505	265,719
Remuneration of non-executive directors	210	202
Supplies and services - clinical (excluding drugs costs)	8,549	11,720
Supplies and services - general	814	731
Drug costs	4,727	4,822
Consultancy costs	117	138
Establishment	7,071	6,279
Premises	42,125	29,693
Transport	849	1,013
Depreciation on property, plant and equipment	6,003	4,697
Amortisation on intangible assets	235	-
Net impairments	4,397	32,229
Movement in credit loss allowance: contract receivables / contract assets	(875)	-
Movement in credit loss allowance: all other receivables and investments	(137)	(392)
Increase/(decrease) in other provisions	792	-
Premises - business rates collected by local authorities	957	1,009
audit services- statutory audit	88	74
other auditor remuneration (external auditor only)	10	10
Internal audit costs	72	74
Clinical negligence	572	510
Legal fees	3,037	641
Insurance	47	64
Research and development	12	17
Education and training	2,145	1,866
Rentals under operating leases	6,139	12,257
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	1,242	1,212
Education and training - notional expenditure funded from apprenticeship fund	71	10
Transport - other (including patient travel)	13	13
Losses, ex gratia & special payments	111	9
Other services	5,920	4,091
Other	2,685	4,795
Total	**386,157**	**387,927**

6.1 Auditor remuneration exc. VAT

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
Financial Statements audit	73	61
Audit-related assurance services	8	8
Total	**81**	**69**

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

	2018/19 £000	2017/18 £000
Impairments charged to operating surplus: (Note7a)	4,397	32,229
Impairments charged to the revaluation reserve (Note 7b)	9,057	18,964
Total net impairments	**13,454**	**51,193**

Note 7 (a)

	2018/19 £000	2017/18 £000
Impairment	7,112	34,098
Impairment reversal	(2,715)	(1,869)
Impairments charged to the operating expenses	**4,397**	**32,229**

Note 7 (b)

	2018/19 £000	2017/18 £000
Impairments charged to the revaluation reserve	9,453	18,987
Reversal of impairments credited to the revaluation reserve	(396)	(23)
Impairments charged to the revaluation reserve	**9,057**	**18,964**

8 Employee costs

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	210,239	198,688
Social security costs	20,990	19,676
Apprenticeship levy	1,056	989
Employer's contributions to NHS pensions	24,962	24,090
Pension cost - other	14	26
Temporary staff (including agency)	23,244	22,250
Total gross staff costs	**280,505**	**265,719**

8.1 Retirements due to ill-health

	2018/19		2017/18	
	£000	Number	£000	Number
Early retirement due to ill health	160	3	174	6

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.

	2018/19 £000	2017/18 £000
Interest on bank accounts	331	116
Total finance income	**331**	**116**

10 Finance expense

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

	2018/19 £000	2017/18 £000
Interest expense:		
Finance leases	327	352
Main finance costs on PFI and LIFT schemes obligations	727	753
Total interest expense	**1,054**	**1,105**
Unwinding of discount on provisions	121	4
Total finance costs	**1,175**	**1,109**

11 Better Payment Practice Code- Measure of Compliance

Better payment practice code	2018/19		2017/18	
	Number	£'000	Number	£'000
Non NHS				
Total bills paid in the year	26,973	175,572	35,952	235,713
Total bills paid within target	20,281	156,483	24,690	138,815
Percentage of bills paid within target	**75.20%**	**89.10%**	**68.70%**	**58.90%**
NHS				
Total bills paid in the year	1,490	37,402	1,532	38,921
Total bills paid within target	744	20,176	647	15,823
Percentage of bills paid within target	**49.90%**	**53.90%**	**42.20%**	**40.70%**
Total				
Total bills paid in the year	28,463	212,974	37,484	274,634
Total bills paid within target	21,025	176,659	25,337	154,638
Percentage of bills paid within target	**73.90%**	**82.90%**	**67.60%**	**56.30%**

12 Profit on Disposal of Non Current Assets

	2018/19 £000	2017/18 £000
Gains on disposal of assets	4,151	93
Total gains / (losses) on disposal of assets	**4,151**	**93**

This relates to the disposal of Nasebery and Greenthorne.

13 Intangible Assets

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	1,754	-	1,754
Additions	-	1,511	1,511
Reclassifications	184	(1,511)	(1,327)
Valuation / gross cost at 31 March 2019	**1,938**	**-**	**1,938**
Provided during the year	235	-	235
Net book value at 31 March 2019	**1,703**	**-**	**1,703**

14.3 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019							
Owned - purchased	13,558	64,037	9,375	3	4,280	124	91,377
Finance leased	732	2,463	-	-	-	-	3,195
On-SoFP PFI contracts and other service concession arrangements	3,300	13,441	505	-	-	-	17,246
Net book value at 31 March 2019	**17,590**	**79,941**	**9,880**	**3**	**4,280**	**124**	**111,818**

14.4 Property, plant and equipment financing - 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018							
Owned - purchased	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
Net book value at 31 March 2019	**17,523**	**90,839**	**976**	**-**	**3,553**	**177**	**113,068**

A desktop review of eight properties was undertaken at 31st March 2019 by the External Valuer, Montague Evans and a valuation was undertaken for one of the Trust's IT assets completed in the year by the District Valuer, both in accordance with the Royal Institute of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect fair value.

14.1 Property, Plant and Equipment 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018	17,523	90,839	976	428	40	3,553	1,625	114,984
Additions	-	-	13,747	-	-	-	-	13,747
Impairments	-	(4,680)	(2,432)	-	-	-	-	(7,112)
Reversals of impairments	66	2,649	-	-	-	-	-	2,715
Revaluations	-	1,475	32	-	3	-	-	1,510
Impairments charged to the revaluation reserve	(36)	(9,417)						(9,453)
Reversals of impairments credited to the reserve	37	359						396
Reclassifications	-	2,195	(2,443)	-	-	1,575	-	1,327
Valuation/gross cost at 31 March 2019	**17,590**	**83,420**	**9,880**	**428**	**43**	**5,128**	**1,625**	**118,114**
Accumulated depreciation at 1 April 2018	-	-	-	428	40	-	1,448	1,916
Provided during the year	-	5,102	-	-	-	848	53	6,003
Revaluations	-	(1,623)	-	-	-	-	-	(1,623)
Accumulated depreciation at 31 March 2019	**-**	**3,479**	**-**	**428**	**40**	**848**	**1,501**	**6,296**
Net book value at 31 March 2019	**17,590**	**79,941**	**9,880**	**-**	**3**	**4,280**	**124**	**111,818**
Net book value at 1 April 2018	**17,523**	**90,839**	**976**	**-**	**-**	**3,553**	**177**	**113,068**

14.2 Property, Plant and Equipment 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 - restated	41,980	80,583	10,055	428	40	15,194	1,625	149,905
Additions	-	2,821	5,336	-	-	205	-	8,362
Impairments	(21,601)	(23,999)	-	-	-	(7,485)	-	(53,085)
Reversals of impairments	12	1,880	-	-	-	-	-	1,892
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)
Valuation/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**

15 Non-current assets held for sale 2018/19

	Land £000	excl. £000	Total £000
At 1 April 2018	3,840	210	4,050
Less assets sold in year	(3,750)	0	(3,750)
Balance as at 31 March 2019	**90**	**210**	**300**

16 Inventories

There were no inventories at the year ended 31 March 2019 (nil as at 31 March 2018).

17 Trade and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables	22,638	17,008
Capital receivables	4,042	-
Accrued income		6,491
Allowance for impaired contract receivables / assets	(2,429)	-
Allowance for other impaired receivables	(968)	(1,012)
Deposits and advances	-	-
Prepayments (non-PFI)	3,879	3,392
PDC dividend receivable	442	625
VAT receivable	1,307	1,209
Other receivables	2,532	1,502
Total current receivables	**31,443**	**29,215**
Non-current		
Other receivables	83	46
Total non-current receivables	**83**	**46**

Accrued income is shown as Nil in 2018/19. As per GAM the requirement, for Porvider Sustainbility Fund (PSF) income outsatnding to be shown under a different heading "contract receivables " under Trade and Other Receivables.

17.1 Provision for impairment of receivables

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	31 March 2019 £000	31 March 2018 £000
At 1 Apr 2019	1,012	-
Increase in provision	3,397	1,404
Amounts utilised	(517)	779
Unused amounts reversed	(495)	(1,171)
Balance as at 31st March 2019	**3,397**	**1,012**

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.

	2018/19 £000	2017/18 £000
Balance as at 1 April 2018	49,946	51,681
Net change in year	(1,307)	(1,735)
Balance as at 31 March 2019	**48,639**	**49,946**
Broken down into:		
Cash at commercial banks and in hand	74	766
Cash with the Government Banking Service	48,565	49,180
Total cash and cash equivalents as in SoCF	**48,639**	**49,946**

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 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 2019 £000	31 March 2018 £000
Bank balances	46	45
Total third party assets	**46**	**45**

19 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	22,141	26,157
Capital payables	1,112	690
Accruals	15,295	14,487
Receipts in advance and payments on account	-	2
Social security costs	5,775	5,468
Other payables	1,136	1,203
Total current trade and other payables	**45,459**	**48,007**

20 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	3,917	4,248
Total other current liabilities	**3,917**	**4,248**

21 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Obligations under finance leases	229	201
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	336	307
Total current borrowings	**565**	**508**
Non-current		
Obligations under finance leases	2,142	2,371
Obligations under PFI, LIFT or other service concession contracts	7,478	7,813
Total non-current borrowings	**9,620**	**10,184**

22 Finance leases

Trust as a lessee

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

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities	**3,559**	**4,086**
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.	923	1,450
Finance charges allocated to future periods	(1,188)	(1,514)
Net lease liabilities	**2,371**	**2,572**
of which payable:		
Obligations under finance leases	229	201
Later than one year and not later than five years;	1,306	1,140
Later than five years.	836	1,231
	2,371	**2,572**

There have been no significant lease arrangements during the year end 31 March 2019

23 On-SOFP- PFI

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**13,439**	**14,472**
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	8,270	9,303
Finance charges allocated to future periods	(5,625)	(6,352)
Net PFI, LIFT or other service concession arrangement obligation	**7,814**	**8,120**
Of which liabilities are due:		
Not later than one year	336	307
Later than one year and not later than five years	1,679	1,537
Later than five years	5,799	6,276

23.1 Total on-SoFP PFI commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**44,945**	**47,753**
Of which liabilities are due:		
Not later than one year	2,877	2,807
Later than one year and not later than five years	12,386	11,949
Later than five years	29,682	32,997

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

	31 March 2019 £000	31 March 2018 £000
Consisting of:		
Not later than one year	1,273	1,243
Later than one year and not later than five years	5,558	5,287
Later than five years	13,826	15,370
Total amount paid to service concession operator	**20,657**	**21,900**

24 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2018	4,038	103	3,471	520	8,132
Arising during the year	145	68	2,513	3,080	5,806
Utilised during the year	(300)	(40)	(1,896)	(333)	(2,569)
Reversed unused	(180)	(49)	(1,575)	(147)	(1,951)
Unwinding of discount	121	-	-	-	121
At 31 March 2019	**3,824**	**82**	**2,513**	**3,120**	**9,539**
Expected timing of cash flows:					
Not later than one year;	309	82	2,513	2,370	5,274
Later than one year and not later than five years;	1,236	-	-	750	1,986
Later than five years.	2,279	-	-	-	2,279
Total	**3,824**	**82**	**2,513**	**3,120**	**9,539**

	Current		Non -Current	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Pensions - Early departure costs	309	309	3,515	3,729
Legal claims*	-	103	-	-
Equal pay (including agenda for change)	82	-	-	-
Redundancy	2,513	3,471	-	-
Other	2,370	520	750	-
	5,274	**4,403**	**4,265**	**3,729**

25 Clinical negligence liabilities

	31 March 2019 £000	31 March 2018 £000
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of the Trust	4,812	3,053

25.1 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(50)	(82)
Gross value of contingent liabilities	**(50)**	**(82)**

26 Contractual capital commitments

There are no Capital Commitments for year ended 31 st March 2019. (Nil balance in 2017/18).

27 Events After the Reporting Period

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

28 Financial instruments

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 2019 are in receivables from customers, as disclosed in note 17.

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.

28.1 Financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Loans and receivables £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9			
Trade and other receivables excluding non financial assets	25,898	-	25,898
Cash and cash equivalents	48,639	-	48,639
Total at 31 March 2019	**74,537**	**-**	**74,537**

Impact of IFRS 9 On Financial Assets

	Loans and receivables £000	Assets at fair value through the I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39			
Trade and other receivables excluding non financial assets-with DHSC	23,235	-	23,235
Cash and cash equivalents	49,946	-	49,946
Trade and other receivables excluding non financial assets-with Non-DHSC	754	-	754
Total at 31 March 2018	**73,935**	**-**	**73,935**

28.2 Financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Obligations under finance leases	2,371	2,371
Obligations under PFI, LIFT and other service concession contracts	7,814	7,814
Trade and other payables excluding non financial liabilities	39,684	39,684
Total at 31 March 2019	**49,869**	**49,869**

Impact of IFRS 9 On Financial Liabilities

	Other financial liabilities £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
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 (other bodies)	30,772	30,772
Total at 31 March 2018	**58,699**	**58,699**

28.3 Fair values of financial assets

	Book value £000	Fair Value £000
Non-current trade and other receivables excluding non-financial assets	83	83
Total	**83**	**83**

28.4 Fair values of financial liabilities

	Book value £000	Fair Value £000
Non-current financial liabilities	4,265	4,265
Total	**4,265**	**4,265**

29 Losses and special payments

	2018/19		2017/18	
	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.	9	27	4	1
Overpayment of Salary	13	84	7	8
Total losses and special payments	**22**	**111**	**11**	**9**

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

30 Initial application of new IFRS

30.1 Application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

30.2 Application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

31.1 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 2019, 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 and Cavendish square Group but immaterial in value,in addition the Trust has a Chair in common with Barking, Havering and Redbridge University Hospitals NHS Trust.

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

	Receivables		Payables	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Related parties as defined by NELFT are as follows:				
Department of Health	110	19	-	-
Barking &Dagenham CCG	1,103	2,405	-	-
Havering CCG	845	1,371	-	-
Redbridge CCG	3,953	1,686	-	-
Waltham Forest CCG	253	1,310	2	-
Basildon &Brentwood CCG	301	639	-	56
Thurrock CCG	3	525	-	-
Barking, Havering and Redbridge University Hospitals NHS Trust	264	764	476	755
Provide CIC	63	-	-	-
Other NHS Bodies	7,740	8,537	3,837	4,358
Total	**14,635**	**17,256**	**4,313**	**5,169**

	Income		Expenditure	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Department of Health	3,855	1,902	-	2
Barking & Dagenham CCG	56,656	58,911	-	-
Havering CCG	54,851	55,125	-	-
Redbridge CCG	49,027	45,883	-	-
Waltham Forest CCG	65,395	60,849	2	162
Basildon & Brentwood CCG	14,945	14,943	37	-
Thurrock CCG	8,209	7,889	-	-
Barking, Havering and Redbridge University Hospitals NHS Trust	819	1,124	1,214	989
Provide CIC	63	-	-	-
Other NHS Bodies	73,872	58,894	14,895	15,082
Total	**327,692**	**305,520**	**16,148**	**16,235**

31.2 Related parties

	Receivables		Payables	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Local Authority Bodies is as follows:				
London Borough of Barking & Dagenham	395	621	1	159
London Borough of Havering	651	751	2	-
London Borough of Redbridge	779	1,573	4	53
London Borough of Waltham Forest	1,816	278	44	-
Essex County Council	1,058	1,056	1,683	783
Thurrock Council	-	417	15	74
Others	78	118	70	15
Total	**4,777**	**4,814**	**1,819**	**1,084**

	Income		Expenditure	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Local Authority Bodies is as follows:				
London Borough of Barking & Dagenham	6,314	6,650	9	29
London Borough of Havering	6,230	5,023	126	267
London Borough of Redbridge	5,867	6,406	147	81
London Borough of Waltham Forest	5,544	7,006	199	56
Essex County Council	12,120	12,690	-	-
Thurrock Council	15,259	17,866	57	91
Others	483	577	585	492
Total	**51,817**	**56,218**	**1,123**	**1,016**

32 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 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 accounts for the year ended 31 March 2019 has an income of £3K, expenditure of £17K and net assets of £310k 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: https://www.gov.uk/government/organisations/charity-commission

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 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and 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 2019 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 2019 and the Department of Health and Social Care Group Accounting Manual 2019.

Overview	
Materiality: financial statements as a whole	£7.6m (2018: £7.1m) 2% (2018: 1.9%) of total income from operations

Risks of material misstatement		vs 2018
Recurring risks	Valuation of land and buildings	▼
	Total operating income	◄►
	New: Accrued expenditure and provisions recognition	▲

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.

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 three key audit matters (2017-18: 2), 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
Valuation of Land and Buildings (£97.5 million; 2018: £108.4m) *Refer to page 61(Audit Committee Report), Note 1.4 (accounting policy) and note 14 (financial disclosures)*	**Subjective valuation: 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 The Trust undertook an impairment assessment and identified eight land and building assets for a desktop valuation at the 31 March 2019. The revaluation exercise resulted in a £67k increase in the value of land and a £10.3m decrease in the value of buildings compared to the prior year.	Our procedures included: - **Assessing valuer's credentials:** We assessed the independence, objectivity and capabilities of the valuer and the terms under which they were engaged by management; - **Test of detail:** We considered the accuracy of the underlying data provided by the Trust and used by the valuer as the basis of their valuation. We reconciled the data to that used in the prior year and investigated the cause for any changes; - **Methodology choice:** We assessed the reasonableness of the assumptions adopted during the valuation exercise particularly regarding GIA data and use of the building. Through inquiries with the Trust we identified any buildings for which the primary use of the building had changed during the financial year (specialised, non-specialised, surplus) and ensured these changes have been considered during the valuation exercise. - **Test of detail:** We considered the impairment assessment completed by management regarding assets not selected for external revaluation and considered its reasonableness. In doing so we drew on national benchmarks. - **Methodology choice:** We considered the revaluation basis and benchmarks used by the valuer. We engaged our property team experts to undertake an assessment of the revaluation. - **Test of detail:** We considered the appropriateness of the accounting treatment applied by the Trust when recognising revaluation gains or losses on individual assets. **Our findings** Following a revision to the Trust's initial valuation assumptions we found the resulting valuation of land and buildings to be balanced.

	The risk	Our response
Total Operating Income (£388.7 million; 2018: £370.9 million) *Refer to page 61 (Audit Committee Report), Note 1.1 (accounting policy) and notes 3 and 4 (financial disclosures).*	**Subjective estimate** Of the Trust's reported total income, £309.6m (2017/18 £288.9m) came from the commissioners (Clinical Commission Group and NHS England). CCGs and NHS England make up 80% 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. This results in estimates being required at the year end. 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. Discrepancies between the submitted balances from each party can result in adjustments being made to yearend balances. The recognised £6.9 million of income from the Provider Sustainability Fund. Receipt of this income is contingent on achievement of quarterly financial targets agreed with NHS Improvement. The availability of these funds can act as an incentive for management to make adjusts to its position to ensure these targets are met. The Trust reported total income of £20.9m (2017/18: £22.4m) 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 the following tests of details: — **Test of detail:** We inspected supporting documentation for variances over £300,000 arising from the Agreement of Balances exercise to critically assess the Trust's assessment of its achievement of contract KPIs and accounting for disputed income. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising income from Commissioners — **Test of detail:** We assessed the Trust's calculation of performance against the financial and operational targets used in determining receipt of Provider Sustainability Funding to determine the amount the Trust qualified to receive. We agreed the amounts recorded in the accounts to our calculation; and — **Test of detail:** We tested income transactions that spanned the financial year end to assess whether the income had been recognised in the correct financial period. **Our findings** We found the estimate of total operating income to be reasonable. (2018: reasonable)

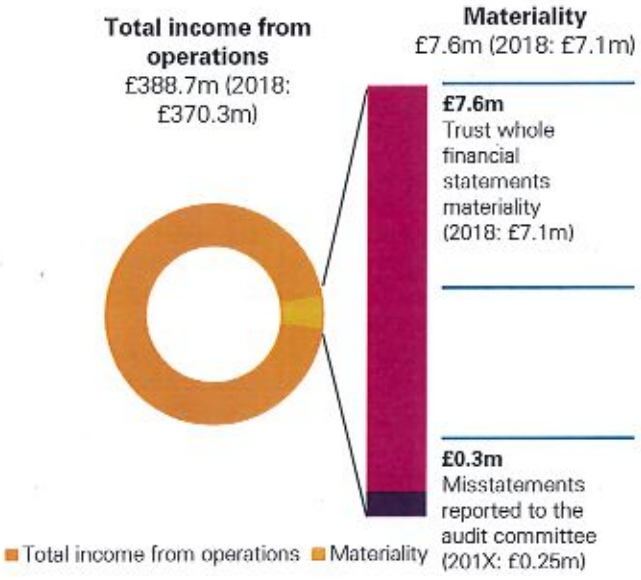
	The risk	Our response
Accrued expenditure and provisions recognition **NHS and Non-NHS Accruals** (£15.3 million; 2018: £14.5m) *Refer to page 61 (Audit Committee Report), note 1.10 (accounting policy) and note 19 (financial disclosures).* **Total Provisions** (£9.5 million; 2018: £8.1m) *Refer to page 61 (Audit Committee Report), page 1.9 (accounting policy) and note 24 (financial disclosures).* **Provision for doubtful debts** (£3.4 million; 201m: £1.0) *Refer to page 61 (Audit Committee Report), note 1.1 (accounting policy) and note 17.1 (financial disclosures).*	**Effects of irregularities** In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay expenditure at year-end, as well as the completeness of the recognition of provisions or the inappropriate release of existing provisions The Trust agrees a target for its financial performance with NHS Improvement for 2018-19, achievement of which entitled it to Provider Sustainability Funding. There may therefore be an incentive to defer expenditure, or recognise commitments at a reduced value in order to achieve the control total agreed with NHS Improvement.	Our procedures included: – **Test of detail:** We tested expenditure transactions that spanned the financial year end to assess whether the expenditure had been recognised in the correct financial period. – **Test of detail:** For a sample of accruals recognised at the financial yearend we assessed the appropriateness of the existence of the accrual and the reasonableness of the accrual valuation. – **Test of detail:** We confirmed the basis upon which the provision for doubtful debt had been made. We tested the assumptions taking into account both past performance and any circumstances specific to the year ended 31 March 2019. – **Test of detail:** For a sample of year-end provisions we assessed the appropriateness of the recognition of the provision balance and assessed the assumptions used by management in valuing the provision. **Our findings** We found the resulting recognition of accrued expenditure to be balanced and provisions to be cautious. (2018 accruals and provisions: balanced)

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £7.6 million (2017/18: £7.1 million), determined with reference to a benchmark of total income from operations (of which it represents approximately 2%). We consider total 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 £0.3 million (2017/18Y:(£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

The Accounting Officer has prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement on Page 59 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's 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, and we did not identify going concern as a key audit matter.

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 2018/19.

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 2018/19, 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.

KPMG

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 59 the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: 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 their 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.

Our risk assessment did not identify any significant risks

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
London
28 May 2019

KPMG

NELFT NHS
NHS Foundation Trust
Best care by the best people

NELFT NHS Foundation Trust

Quality Report

2018/19

PART A

Contents

Foreword

Welcome to our Quality Report, indeed welcome to another year of continuous learning and improvement in an ever complex health economy. As a large Trust both geographically and in terms of the array of services we provide, I never underestimate the challenges our workforce faces in delivering the best possible care to the communities we serve.

The year has been no less challenging than we anticipated for all public services. As a Trust our geographic footprint places us within six Sustainability and Transformation Plan (STP) regions, with three of these STPs requiring a lot of input and resource to ensure that NELFT services are at the forefront of improving the patient experience within the localities.

We are heavily involved in the NEL STP and one of the leading organisations within the BHR Provider Alliance, jointly with our acute partner BHRUT and the GP Federations. The focus of the Provider Alliance has been on developing the frailty pathway to improve outcomes for patients, supporting Care City, our innovative partner, in the roll out of the new Atrial Fibrillation Pathway as well as looking at ways for both health and social care providers across Barking and Dagenham, Havering and Redbridge to provide more integrated care in the community. Our Child and Adolescent Mental Health Services at Brookside continue to be recognised nationally for both the innovative service model and their improvement journey from a CQC “Inadequate” rating to a rating of “Outstanding”.

Across Essex we are linked in with the Mid and South Essex STP and supporting the work to relieve pressure on the acute care providers and look at how we can support more care in the community. We are working hard in Thurrock with our social care partners to change the model of social care support and working with GPs to support the development of a new model of primary care provision.

In Kent and Medway we continue to work with our partners to reduce waiting times and deliver a new and improved model of care for young people who require mental health support, as well as people who need to use our eating disorder services. This is a challenging area of delivery both in terms of staffing and demand but we are determined, with the support of partners, to make improvements in this area.

In all of these areas we are leading the way in terms of innovation, collaboration and partnership. I am grateful to all our partners and stakeholders across our patch who support us to constantly strive to improve outcomes for patients.

We have continued to seek opportunities to grow our service portfolio and in the last year we have acquired services for young people in Barnet. This is part of our work to deliver high quality outcomes for patients in areas where we can make improvements.

All of these priorities and complexities in terms of integration, innovation and improvement have been captured in our refreshed corporate strategy which sets out a direction of travel for the Trust going forward. Thank you to everyone who was involved with this work. Our Trust Board will be monitoring progress each quarter and it is great to have a suite of strategies (including Best People – our workforce strategy and Best Care – our clinical strategy) that all work with each other to support our vision to actively shape, develop and deliver, integrated, locality based care for the populations we serve.

None of this work would be possible without a dedicated and committed workforce who are open to continuous learning and new ways of working. I am pleased that so many of our staff have shared their views not only via the NHS Staff Survey and Friends and Family Test but

also through engagement in a number of initiatives across the Trust. At a time when recruitment is a national issue for the NHS and Brexit holds a lot of uncertainty for staff, I know it is crucial to support the health and wellbeing of those who work in NELFT. Our staff health and wellbeing programme has grown considerably throughout the year with over 90 ambassadors throughout the Trust and activities happening across all the localities to help staff focus on their health and wellbeing. All the evidence indicates that staff who feel valued and engaged in their workplace and are well supported deliver better quality outcomes for patients so this is crucial to us as an employer.

We have continued to make progress across the equality and diversity agenda and we are now one and we were the first Trust in the country to meet all of the national Workforce Race Equality Standards (WRES). We are focused on ensuring we support all protected characteristics and are learning from the success with our Ethnic Minority Network and strategy to apply a similar approach in other areas.

The year has seen further efforts to support the open and transparent culture within the Trust, making us a safe place for people to learn, improve and raise concerns. We have appointed a dedicated Freedom to Speak Up Guardian who has undertaken a large programme of staff engagement across the Trust. Staff, as well as patients and carers, being able to voice concerns and issues is crucial for us to be able to improve the quality of the services we provide.

We have continued our focus on quality improvement via the NELFT QI Programme and now have more than 3500 staff trained at various levels and 200 projects being delivered. We have tailored some of this work to areas of improvement highlighted by the Care Quality Commission to ensure we are focusing efforts in the right place. An example of this would be our Care Planning Quality Improvement Collaborative, looking to improve the quality of patient care plans.

Our CQC rating remains “Good” and I am proud that we receive positive feedback from patients, carers and staff about their experiences of our organisation. We will have our next CQC well-led review in 2019/20 and my hope is this reflects the work that has taken place both clinically and with the Governance review that has taken place across the Trust.

Whatever we achieve at NELFT is only possible because of the professional commitment, dedication and enthusiasm of our 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.

Signed:

John Brouder
Chief Executive
21 May 2019

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 Trust Chair

In this year's statement I want to start by thanking everyone in NELFT for all your hard work and dedication in supporting our patients in so many positive ways. This is at the heart of our purpose as a Trust to support the wellbeing and health of all our local communities by delivering the very best care we can. The challenging improvement goals we set ourselves in last year's Quality Report are to be continued during 2019/20, to ensure we push forward in all domains of safety and quality. There are real challenges in the availability of capital, funding pressures, shortages of skilled clinicians and more, and yet we continue to excel and exceed most expectations.

I am particularly proud of our work to improve staff engagement and support diversity. We are the first Trust to achieve the Workforce Race Equality Standard (WRES) across all categories, with our work being acknowledged externally. We have increased our staff engagement which I see as fundamentally important to value our staff and improve patient care. Also of note we have initiated a pioneering initiative 'Reverse Mentoring' where our frontline operational staff work directly with Board members acting as their mentors. This is part of the delivery of our Ethnic Minority Strategy.

As well as working to change the landscape for ethnic minority staff working in NELFT, the Trust has been working hard across all protected characteristics. Achievements of note include the first draft of our Disability Staff Network Strategy and disability staff champion training, the launch of our LGBT+ Rainbow Lanyard Scheme and the start of our Women's Network, working with both women and men across the Trust to improve career opportunities and experiences in the work place. There is more to be achieved over the coming year but I am heartened by how much is happening to improve the working lives of our staff.

In order to meet system challenges, we are breaking new ground in collaboration and integrated working and to facilitate the transformation of services to be even more patient centric and efficient. Importantly to support this work we are building ever stronger relationships with our commissioners, colleagues in local government and with our regulators. There is a real sense of NELFT as a leader and innovator within an emerging Integrated Care System for Barking & Dagenham, Havering and Redbridge (BHR). Similarly, as 'chair in common' at BHRUT I see the strongest ever links between both of our trusts and an environment of common purpose to work together to serve our patients in holistic care pathways that also serve to ensure we are as sustainable as we can be under available funding schemes.

In London we are working hard in Waltham Forest with partners on a range of projects from improving the urgent care response to integrating the end of life care provision for patients. We see tremendous progress continue in Essex and Kent with our emotional wellbeing services for young people as we look to improve the access to and quality of care for this group of patients and their families. In keeping with our focus on improving services for children and young people we have also successfully transferred specialist children's services in Barnet to the Trust.

We are working in three main Sustainability and Transformation Partnerships (STPs) in North East London, Mid and South Essex and Kent and Medway and we have some involvement in as many as six. I particularly want to thank and praise our Board of Directors,

both executive and non-executive colleagues, who have had to increase their commitments to meet the demands of this expanding field of work. This sense of leadership in care provision, with its associated innovation, improvement and transformation, ensures that we continue to grow our service base and organisation by delivering that which we are best at. I would also like to thank our Council of Governors who voluntarily give up their time and make significant contributions to the Trust, by representing the views of our patients and local population.

Beyond our front line services, we have back office expertise that sees NELFT supporting other provider trusts and commissioners in areas such as Procurement, IT, Estates and Quality Improvement (QI). Our journey with QI in the past two years has been truly amazing, with over 3500 staff having had an introductory awareness session and over 200 trained to Facilitator or Mentor level. Staff from other organisations have enrolled onto our training and have also adopted principles of some of our care planning collaborative work. I am particularly proud that the majority our QI projects are targeting direct improvements to patient outcome and/or experience.

My final comment here must be an ongoing appeal to the passion we have in NELFT to learn and improve. We make mistakes sometimes and get things wrong occasionally and when that happens we must be humble and transparent in accepting that and in recommitting ourselves to our mission and the delivery of the best care by the best people. If we listen to and respect our patients, our colleagues and the tax payers that fund our work for the good of all, acting on what we hear, then we can be certain we are adding value and are truly improving care in our workplaces.

I thank you and all our stakeholders for your support and wish you every success in 2019/20.

Signed:

Joseph Fielder
Trust Chair
21 May 2019

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

As a Trust we are continually looking to respond to the changing needs of the health and social care economies we work within, both locally and further afield. We are fully engaged with work across the STP footprints within which we sit and our priorities for service improvement are aligned to these as well as the delivery of the NHS Long Term Plan.

Key to our success and achievement going forward is integration and collaboration. This is something we have already been supporting with various partnerships across London, Essex and Kent and will continue to build on over the coming year. As well as improving the quality of care we provide, we want to improve outcomes for our patients and this is so often linked to the patient's journey through the health and care system. We can only make improvements and operate more efficiently through co-production and working together with our partners.

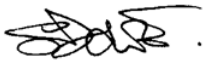
The introduction of the CQC fundamental standards back in 2015 provided the framework we needed to monitor, review and transform the way we deliver care. We continue to use this framework to assure our Board on issues of safety and quality, particularly in light of the increasing pressure and demand on our services. I am proud of our CQC Good rating and I know all our staff work hard to continue to deliver high quality services. That's not to say we can't improve the services and care we provide to our patients and communities. As such, I am equally proud, if not more so, to say we have a workforce that is dedicated to continuous learning and improvement.

The Quality Report 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 Report 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. As with previous years we have sought to set ourselves challenging improvement priorities in order to achieve the best outcomes for the people we serve. This year, whilst we have struggled to achieve a number of stretch targets, our Non-Executive Directors, through the process of scrutiny, have ensured we continue to push forward in all domains of safety and quality. Through this process, along with service visits and manual audits, we identified some weaknesses in data collection as opposed to practice which we will tackle into 2019/20.

We welcome all opportunities to receive 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.

Signed:



Stephanie Dawe
Chief Nurse and Executive Director of Integrated Care (Essex and Kent)
21 May 2019

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

What is a Quality Report?

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

The Quality Report enables us to engage with service users, carers, 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 Report is split into two parts, part A and part B.

- Part A
  Provides an introduction to NELFT
  Looks at our awards
  Looks forward at our priorities for improvement in the coming year
  Looks back on our progress outlined in Quality Report 2017/18
  Looks at how we performed in the annual staff survey

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

Quality Report governance arrangements

The chief nurse and executive director of integrated care (Essex) has overall responsibility for the NELFT Quality Report. Production of the Quality Report 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 six months.

In addition, our quality senior leadership team (QSLT) oversees the Quality Report 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 Report

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

If you would like to give us feedback on our Quality Report 2018/19, please contact:

Name: Jacky Hayter, Director of Performance and Business Intelligence

Email: jacky.hayter@nelft.nhs.uk

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

Our services

NELFT is a growing organisation serving a population of 4.9 million across north east London, Essex, and Kent. We employ in excess of 6,000 staff and have an annual turnover in excess of £380 million.

NELFT provides mental health and community services for people living in the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, Essex, Kent and Medway. Since September 2018 we have also delivered integrated therapy services to children in the London borough of Barnet. 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

NELFT Attains Achievement Level In The Healthy Workplace Charter

We are pleased to announce that we have now attained 'Achievement level' in the Healthy Workplace Charter.

Brookside Receives Accreditation

Brookside, our young people's mental health inpatient unit, has been awarded an accreditation by the Quality Network in CAMHS which is overseen by the Royal College of Psychiatrists (RCPsych).

Improvements to Waltham Forest blood test service leads to more patients being seen

We are delighted to announce that our new community blood testing service in Waltham Forest has been praised in a review by local NHS commissioners.

Sue Burke gains prestigious Queens Nurse award

Sue Burke, Acting Head of Integrated Community Services in Basildon and Brentwood has been given the prestigious title of Queen's Nurse (QN) by The Queen's Nursing Institute (QNI).

NELFT nominated for two awards at the 2018 Inclusive Companies awards

Our equality and diversity manager, Harjit K Bansal and EMN network nominated for Outstanding Diversity Network Award and Diversity Champion Award.

Brookside wins RCNi Award for Mental Health Practice Award

NELFT staff members recognised as inspirational women leaders as part of NHS70 celebrations

We are delighted to announce four of our staff have been recognised as inspirational women leaders across the NHS in London.

Significant 7 shortlisted for prestigious RCNi nurse award

Geraldine Rodgers and the Significant 7 project, set up to support care home staff to improve the physical health care of older people, have been shortlisted for a prestigious RCNi nurse award.

NELFT Finance department achieves NHS Future Focused Finance Level 1

The NELFT Finance department received an accolade recently from the NHS Finance Leadership Council (FLC). The Council awarded NELFT Future Focused Finance Level 1 accreditation. Currently, only NHS Improvement and NELFT have this level of accreditation in London. The accreditation was launched in December 2016 and aims to demonstrate the organisation's commitment to the development of finance skills across the workforce.

Waltham Forest Memory Service commended by the Royal College of Psychiatrists

NELFT's Memory Service in Waltham Forest has received an accolade from the Royal College of Psychiatrists. The service has been awarded a Sustainable Mental Health Service Commendation.

Two NELFT nurses have been nominated for the prestigious Nurse Awards

The Royal College of Nursing has nominated two NELFT nurses for the prestigious Nurse Awards. Geraldine Rodgers (Associate Director of Nursing, Clinical Effectiveness and Fellow for Older People) has been shortlisted in the Nursing Older People category and Rebecca Bewsey (Interim Young Persons Home Treatment Team Manager) won the Mental Health Practice award.

Collaborative project in Barking and Dagenham has been shortlisted for an award

A project in Barking and Dagenham has been nominated for an award. The work of the Physical Health Care for patients with Psychosis (PHCP) project has been shortlisted in the Health Initiative of the Year for this year's Chemist and Druggist Awards.

NELFT receives Healthy Workplace recognition for staff health and wellbeing initiatives

NELFT is delighted to announce that the Trust has achieved the London Healthy Workplace Charter Accreditation at commitment level. The Healthy Workplace Charter is a set of standards that organisations meet in order to receive an official accreditation (and award). The Charter is backed by the Mayor of London and provides clear and easy steps for employers to make their workplaces healthier and happier.

NELFT's John Brouder has been included in the HSJ list of Top Chief Executives 2018

The Health Service Journal (HSJ) published their annual list of Top 50 NHS Trust Chief Executives on Monday 12 March. The list this year featured NELFT's Chief Executive John Brouder.

Waltham Forest healthy child project received a UNICEF Baby Friendly Initiative certificate

NELFT Health Visiting Waltham Forest together with our partners, HENRY and the Lloyd Park Children's Centres, received a UNICEF Certificate of Commitment to the Baby Friendly Initiative (BFI) at the 'Celebrating two-year olds' partnership event held at the Paradox Centre, Chingford on Wednesday 17 January.

A NELFT team has been shortlisted for the Journal of Wound Care Awards 2018

The work of a NELFT team has been highlighted with the shortlisting in a category at this year's JWC Awards. The Journal of Wound Care Awards ceremony will take place at Banking Hall in London on Friday 2 March.

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.

Inaugural 'NELFT's Got Talent' show a huge success

NELFT celebrated its inaugural talent show, NELFT's Got Talent, celebrating the creative talent of our colleagues. Presented by the NELFT communications team to a packed house of colleagues from across London, Essex, Kent and Medway, attendees were indulged with great entertainment from singers, a ukulele player, an aerial hoop performer, a variety of dancers including traditional Indian dancing and body popping.

2.1 Priorities for improvement 2019/20

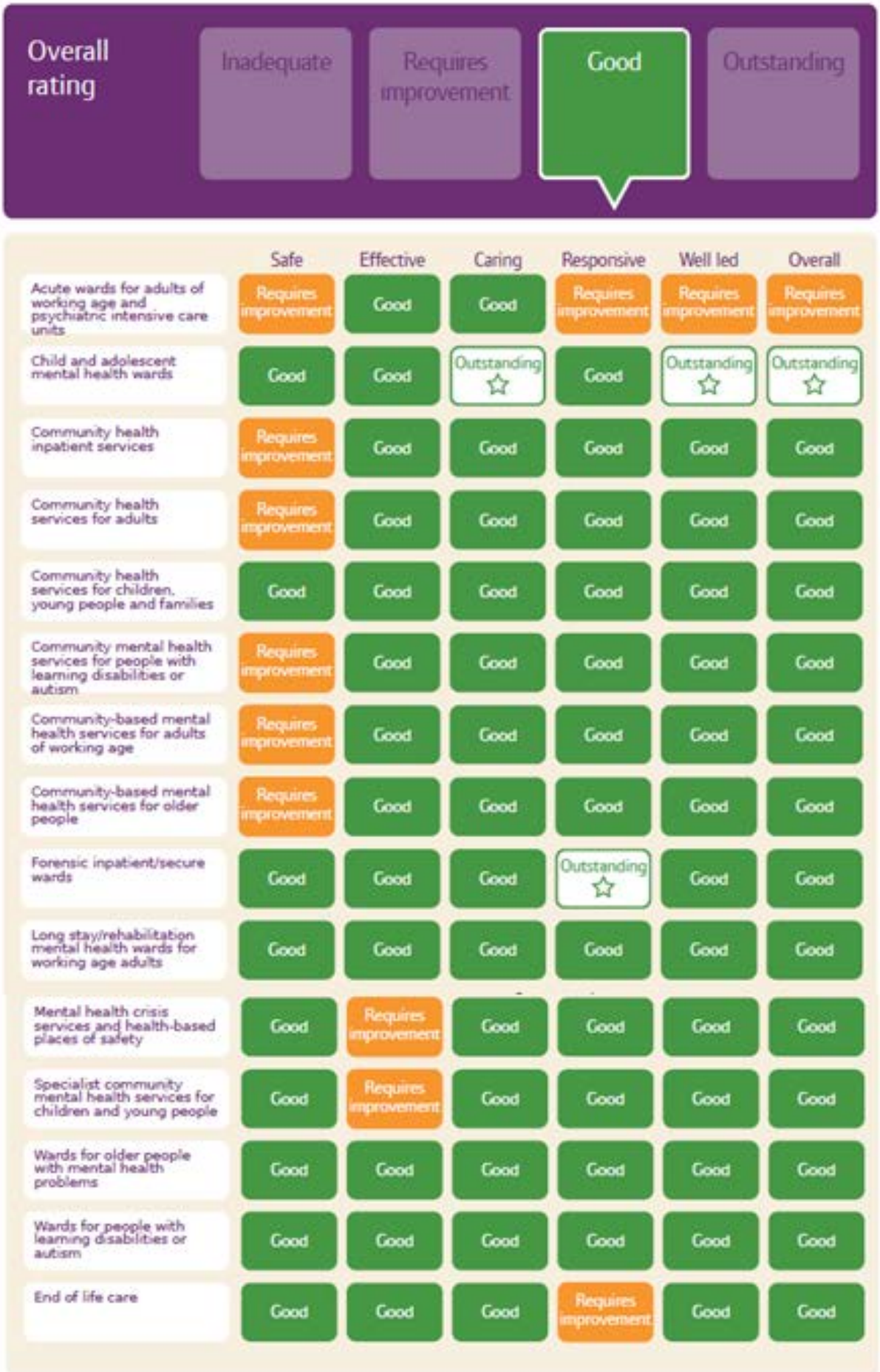
Development of our quality priorities for 2019/20
Continuous improvement remains a top priority for NELFT and we always look to develop meaningful quality indicators that can be monitored, reported and scrutinised by all.

In last two years' Quality Reports, we focused on the outcomes of Care Quality Commission (CQC) inspections. 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?

In January 2018 NELFT was rated as 'outstanding' in four inspected service areas. 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. It also demonstrates that the priorities in our Quality Report helped focus all our teams on improving quality and safety for our patients. We are continuing to use the CQC domains to continue the good work and measure our achievements, future goals and indicators. The table below provides a summary of our latest inspection results:


Overall rating
Inadequate
Requires improvement
Good
Outstanding
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

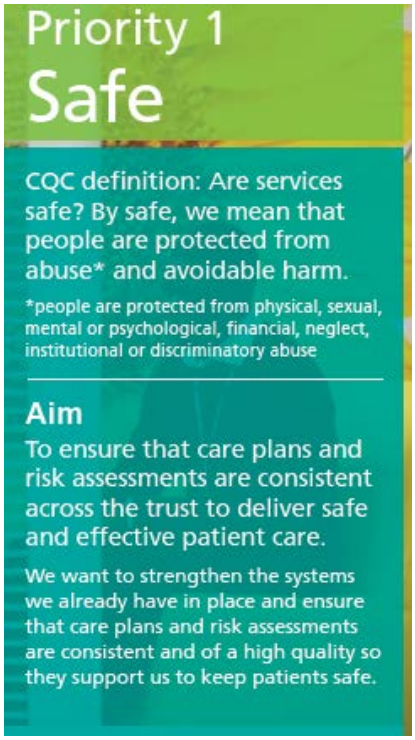
We are about to have a CQC Well Led Inspection and the organisation has to provide information and data to assist the inspection. As we have been focussing on our domains of safe, effective, caring, responsive and well led as an organisation we were in a position to provide the necessary requirements to support the visit. Since last year's Quality Report we are pleased with the continued progress we have made with the ambitious targets set; however, as we did not meet all the targets we will continue to monitor them again this year to finalise the embedding of certain indicators. We have also added new priorities for 'looking forward' this year, these include Safeguarding Supervision, Staff Appraisals and monitoring Violence and Aggression training, using our staff survey results to monitor how many staff members report this in their working day.

As an organisation we like to look forward and be proactive in our approach to improving patients' health and wellbeing, so in the coming year we are looking at how poor mental health impacts on physical health and could lead to worsening of some conditions. Also how poor physical health can negatively impact on mental health. We already have a service that supports those service users with Long Term Conditions with our Clinical Health Psychology Service. The aim would be to look at primary and secondary drivers to eradicate the mortality gap for people with serious mental illness in NELFT. The drivers will be across Health via monitoring, early referral, diet, exercise, primary care and early year's health. In Social Care it will viewed through employment, education and housing amongst a few drivers.

To update on last year's special mention regarding Brookside NELFT's adolescent mental health inpatient unit for 12-18 year olds. Over the last three years the unit has undergone an extensive environmental refurbishment and modernisation of the service offered. Praise and congratulations were given by the Mayor of Barking and Dagenham to the team on this transformation and the subsequent CQC rating of 'Outstanding'. Also the unit was subsequently awarded the 2018 RCN Mental Health Practice Award and has recently been accredited by the Quality Network for Inpatient CAMHS (QNIC). Now, the Brookside unit is leading nationally in its model of inpatient care and is sharing good practice with other organisations.

In the following pages, we describe NELFT's quality priorities for the coming year

Priority 1 – Safe



Aim:

To ensure that care plans and risk assessments are consistent across the trust to deliver safe and effective patient care. This involves 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 continues to produce positive results and good engagement with clinicians. During 2018/19 more team members have registered for the QIAC programme and we have seen some re-joining.

The Quality Improvement work has continued, supported by the development of a peer audit tool that teams can use to identify their own progress and ensure that the NELFT 5 elements of care planning are being implemented.

Care planning and risk assessment is also monitored with individual clinicians through monthly supervision and this is done looking at live caseloads in the electronic patient records.

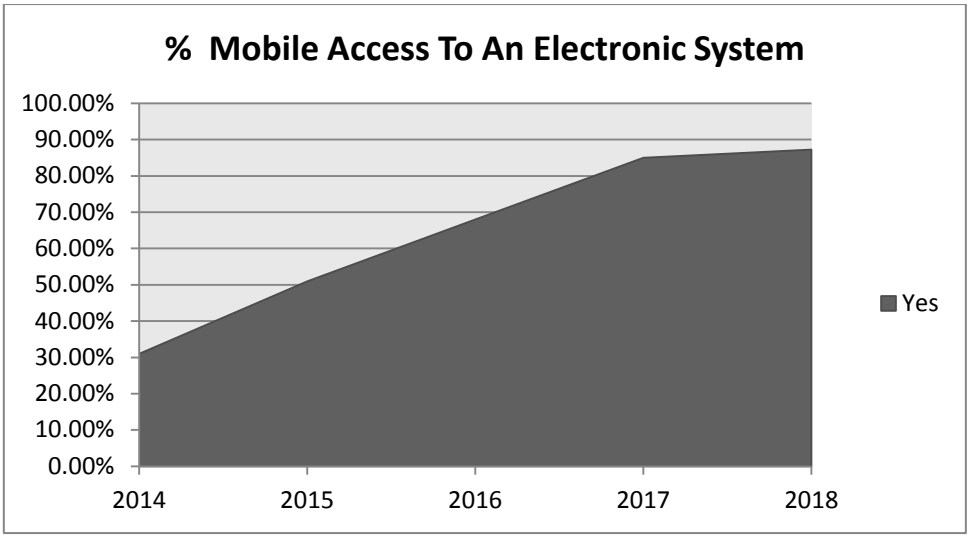
Alongside the QI work, NELFT has updated its electronic patient record systems (EPR), namely RiO and SystmOne, to enable care planning to be consistently and accurately recorded by all clinicians into patient records. Compliance and engagement with the systems has been monitored throughout the year. The Clinical Effectiveness Team have implemented training sessions across NELFT to ensure that the correct information is captured and that care planning continues to be recorded consistently. The Clinical Risk Assessment Training, which became mandatory for all clinicians in 2017, is now fully compliant across the organisation.

The Quality and Safety Committee have received monthly updates on work regarding care planning and clinical risk assessments, the data has been provided by the Performance Team directly from the electronic patient records. Alongside this a manual audit took place in December 2018 and this has enabled work to be focussed in specific areas to support staff to further improve.

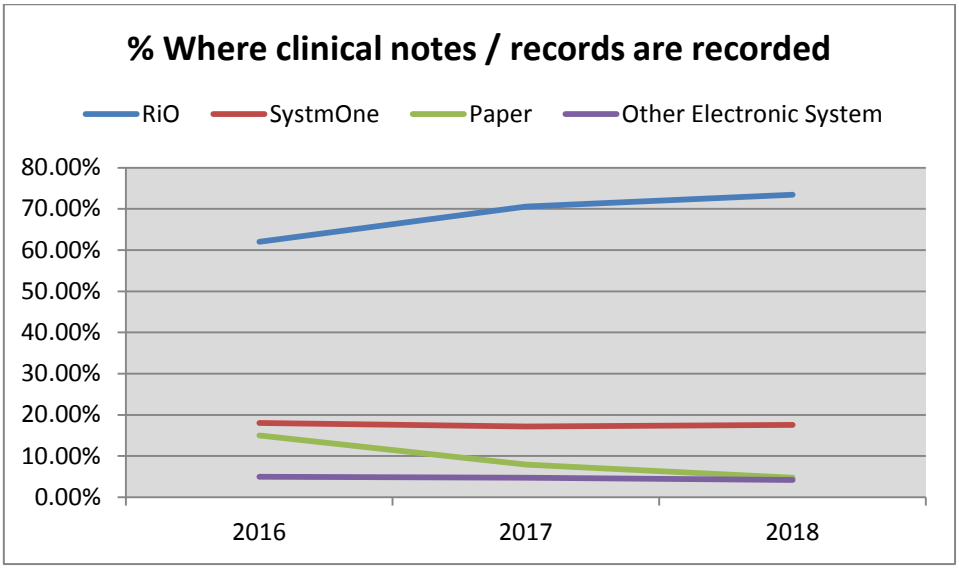
NELFT's performance regarding the completion of risk assessments and care planning has been measured in our annual record keeping audit. For each service trust-wide, a sample of records is audited helping us to understand our compliance in certain areas of patient notes. The audit looks at the quality 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 assessment from 2014 to 2018. During this time, services used both paper and electronic means for recording information. The trust now primarily uses electronic patient record systems and is increasing its deployment of agile devices to access these systems.

Mobile access to an electronic system?	2014	2015	2016	2017	2018
Yes	31.00%	50.96%	68.00%	85.00%	87.25%
No	69.00%	49.04%	32.00%	15.00%	12.75%



Where do you record your clinical notes / record?	2016	2017	2018
RiO	62.00%	70.53%	73.48%
SystmOne	18.00%	17.20%	17.59%
Paper	15.00%	7.90%	4.73%
Other Electronic System	5.00%	4.73%	4.21%



A total of 1,995 records were audited in 2016/17, 2,127 records in 2017/18 and 2360 in 2018/19. Not all patients audited required a care plan or risk assessment to be completed.

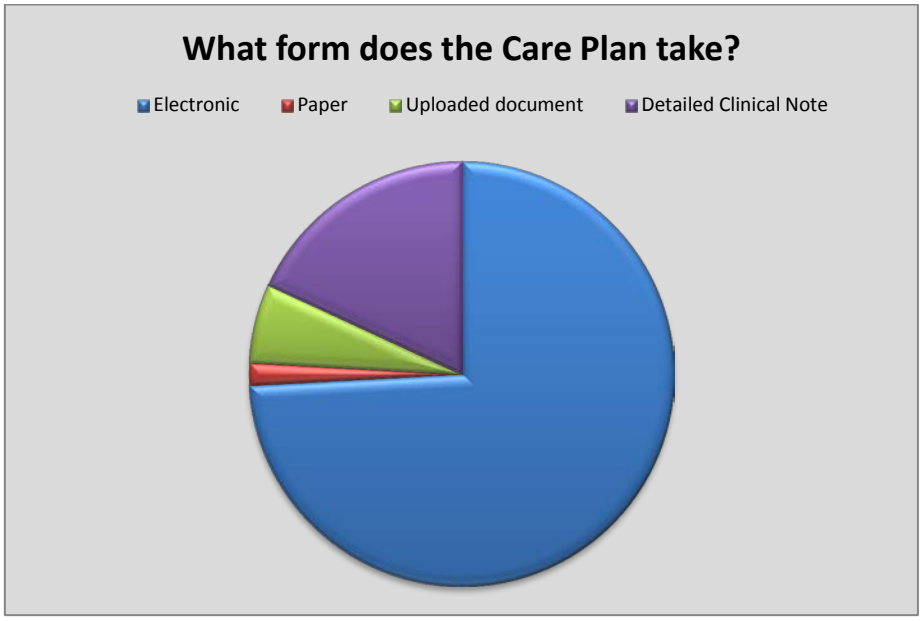
The data below shows the percentage of care plans and risk assessments that were carried out against the percentage of people who these were applicable to. This demonstrates where improvements have been made and where we aim to improve.

Is there evidence that an up to date risk assessment has been undertaken on the patient's needs where required?					
Electronic			**Paper**		
2016	**2017**	**2018**	**2016**	**2017**	**2018**
85.0%	94.18%	95.43%	89.04%	100%	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			**Paper**		
	2016	**2017**	**2018**	**2016**	**2017**	**2018**
Adult	92.0%	92.54%	92.82%	93.93%	95.45%	95.70%
Child / Young person	86.0%	85.79%	84.57%	80.92%	83.33%	84.78%

*The electronic recording of care plans for adults has remained fairly static while in children has reduced slightly. NELFT has acquired new contracts in the past year for children and young people's services in Barnet where, in some services, a high percentage of paper records were used. 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.

What form does the Care Plan take?	
Electronic	74.13%
Paper	1.73%
Uploaded document	6.00%
Detailed Clinical Note	18.13%



Has a discussion taken place regarding end of life care planning? Paper and Electronic Records		
2016	**2017**	**2018**
73.08%	72.00%	67.74%

Has an individualised care plan for the last days of life been agreed? Paper and Electronic Records		
2016	**2017**	**2018**
50%	83%	48.39%

It should be noted that this is a small sample of approximately 30 patients year on year which equates to 1.3% of the records audited.

*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.

In addition, the NELFT EoLc strategic priorities this year includes improving inputting, capturing and recording EoLc specifically regarding preferred priorities of care/ death and care planning for the last days of life.

**Data taken from NELFT clinical record keeping audit 2018*

Goal 1

1. To ensure that by quarter 4 2019/20 75% of care plans and risk assessments are completed and recorded in our EPR systems 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
- 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 and risk assessments are monitored and updated when needed and recorded on EPR systems achieving compliance rate of 75% and above by quarter 4 2019/20:

Trajectory: Q1 25% Q2 35% Q3 50% Q4 75%

Baseline Data

Area		Q4
Trajectory		75%
Adult PICU	Risk Assessments	Data not available
	Care Plans	
MHS wards for older adults	Risk Assessments	93.9%
	Care Plans	11.1%
Children and adolescent mental health wards	Risk Assessments	55.3%
	Care Plans	13.2%
Community-based mental health service for adults of working age	Risk Assessments	68.8%
	Care Plans	15.4%
Community-based mental health services for older people	Risk Assessments	61.2%
	Care Plans	10.5%
EWMHS services in Essex	Risk Assessments	77.3%
	Care Plans	24.9%
CAMHS in London (excluding inpatients)	Risk Assessments	50.5%
	Care Plans	14.9%

How progress will be monitored and measured:

- 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 continue 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
- 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 2019/20

Baseline data

Area	
Target	75%
Achieved on average	55%

During 2018/19 there were 2 cohorts of QIAC training.

Our goal this year continues to be to encompass teams across the whole of community and 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 and recorded on an EPR.

Area applicable to:

We will continue with embedding:

- Older adult's mental health wards
- 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

During 2018/19 NELFT undertook a programme of work to roll out an EPR solution for recording this data electronically. During this time, it has become apparent that the data quality needs to be improved. Data suggests that compliance has dropped to 81% as at quarter 4. Therefore a new trajectory has been agreed to encourage working towards better data quality and compliance.

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)

Priority 2 - Effective

Goal 1

1. That 85% of patient care plans include the five elements of care planning - consent and capacity, social situation, collaborative, risk assessment, recovery focused - using the QIAC audit tool, by the end of quarter 4 2019/20

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
- 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 five elements of care planning by the end of quarter 4 2019/20
   Trajectory: Q1 10% Q2 35% Q3 60% Q4 85%

Baseline data

NELFT achieved an average of 70% for 2018/19 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
- CAMHS London

There is currently no baseline data for emotional wellbeing mental health services in Essex 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 five 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
- 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 an average of 68% compliance for ‘recovery focused care plans’ and 77% compliance for ‘collaborative care plans’ for quarter 4 2018/19 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
- CAMHS London

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

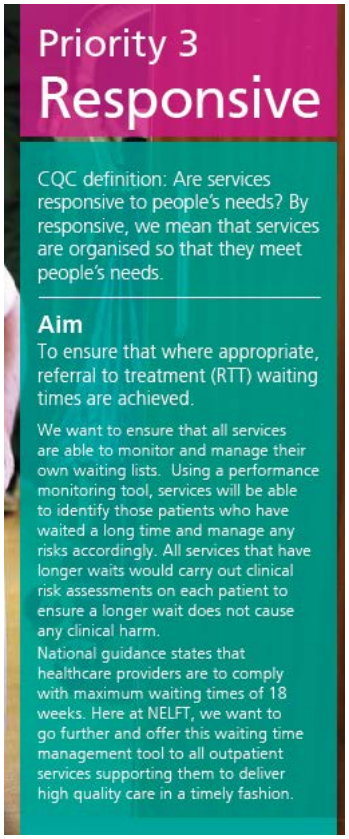
How progress will be monitored and measured:

- 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.

We are continuing to monitor the Young Persons Wellbeing Service (YPWS) Medway and Children/Young People Mental Health Services (CYPMHS) Kent. There are still a number of young people waiting for either assessment or treatment for longer than the national target of 18 weeks. Additionally, some young people are still waiting over a year for their treatment. NELFT remains focussed on ensuring the waiting lists are dealt with as quickly as possible to allow young people access to care.

Goal 1

1. To ensure that more than 92% of the young people who are waiting for assessment and/or treatment are seen by the appropriate clinical team by end quarter 2 2019/20 (dependent on the allocation of additional resources by commissioners)

Area applicable to

- Kent and Medway (excluding ADHD and ASD waiters)

What do we expect to achieve?

1. By the end of quarter 2 2019/20, no young person will be awaiting assessment or treatment for more than 18 weeks (dependent on the allocation of additional resources by commissioners)

Baseline data

As at the end of Quarter 3 2018/19 there were 1376 children (excluding ADHD and ASD waiters) waiting over 18 weeks to begin treatment.

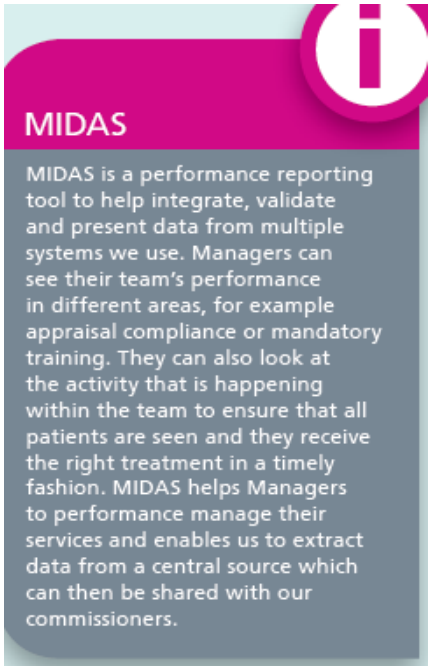
As an average, those children seen and started treatment within 18 weeks was 78.46%.

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

NHS Constitution standard sets out that patients on incomplete pathways should have been waiting no more than 18 weeks from referral to the time of their first treatment or intervention. Incomplete pathways, often referred to as waiting list times, are the waiting times for patients waiting to start treatment, as at the end of each month.
The incomplete waiting time standard was introduced in 2012 and states that the time waited must be 18 weeks or less for at least 92% of patients on incomplete pathways.

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 92% or more of the young people waiting for an attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD) assessment are waiting less than 18 weeks to be assessed by a specialist clinical team by end quarter 4 2019/20

Area applicable to:

- Kent and Medway

What do we expect to achieve?

1. By the end of quarter 4 2019/20 more than 92% of the young people waiting for treatment will be waiting less than 18 weeks for an ADHD or ASD assessment.

   Trajectory: Q1 30% under 18wks
   Q2 50% under 18wks
   Q3 75% under 18wks
   Q4 92% under 18wks

Baseline data

By the end of quarter 3 2018/19, there were 1816 young people waiting over 18 weeks. At the end of quarter 3 2018/19 we had 26.8% waiting under 18 weeks. Funding has been agreed with commissioners to employ additional resource and trajectories are in place.

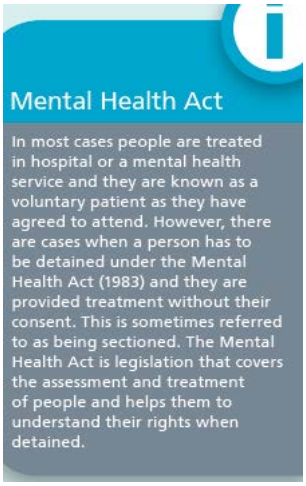
How progress will be monitored and measured:

- 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

Appraisals and Personal Development Plans

Appraisals are incredibly important for both a human resource management tool and an individual performance management process. Appraisals can have a significant influence on the Trust's culture, employee engagement, staff morale, and therefore staff productivity. If a member of staff feels valued then they transfer that value to other staff members and service users. If staff understand their role, objectives, benefits and purpose then they have a focus to drive forward for their own development and this will impact on the Trust's values. A good appraisal system and the joint approach for personal development plans also aid retention of key and committed staff. NELFT has launched a new appraisal and mandatory training system called STEPS, to support evaluation and learning.

1. To increase the percentage of staff with an up to date appraisal and Personal Development Plan

Area applicable to:

- NELFT wide

What do we expect to achieve?

1. To work towards a compliance of 85% of staff having an up to date appraisal and Personal Development Plan.

Baseline Data

NELFT's Trust wide (all services, including corporate teams) appraisal compliance as at the end of December 2018 was 77.99%

How progress will be monitored and measured:

- Through monthly reporting via the performance team.
- Line Managers using MIDAS, a performance reporting tool that integrates, validates and presents data.

How progress will be reported

- Through monthly reporting to Leaderships Teams, Senior Leadership Teams and the Executive Management Team, via the governance cycle in place within the trust.

Goal 2

Violence and Aggression in the workplace

Levels of violence against staff working in mental health trusts remain much higher than other types of trusts within the NHS. A health service journal paper analysis suggested that there are 200 reported physical assaults on NHS staff every day in England. Violence and aggression is a concern in most health care settings and can be directed from both patients, visitors and colleagues. Repeated exposure to violent and aggressive behaviour can have a highly negative effect on staff morale and performance. It can leave staff feeling vulnerable, and undervalued. The trust also has policies covering Violence and Aggression and is part of the Health and Safety mandatory training module. So NELFT are committed to support staff with training in Violence and Aggression and there are four questions in our staff survey relating to physical violence and four questions relating to harassment, bullying or abuse.

1. As a Trust we wish to support and encourage our staff to be open and honest to report any violent or aggressive behaviour, whether experienced or witnessed. We would therefore like to increase the % of reporting such behaviour

Area applicable to:

- NELFT wide

What do we expect to achieve?

1. Use of staff survey results to understand the areas reporting physical violence, harassment, bullying or abuse, where improvement can be made.

2. To work towards a compliance of 85% of staff completing Prevention and Management of Violence and Aggression Training.

Baseline Data

- Percentage of staff/colleagues reporting most recent experience of violence
  In 2016/17 staff survey 87%
  In 2017/18 staff survey 83%
- Current validated training position is 78.23% for Prevention and Management of Violence and Aggression.

How progress will be monitored and measured:

- Through monthly reporting via the performance team and using MIDAS, a performance reporting tool that integrates, validates and presents data.
- Staff survey findings and the review of Datix incidents.

How progress will be reported

- Through monthly reporting to Leaderships Teams, Senior Leadership Teams and the Executive Management Team, via the governance cycle in place within the trust.

Governors' Indicator

This year, the governors have selected Safeguarding Children: safeguarding supervision uptake and compliance. Percentages of staff receiving: 1:1 and group supervision effectiveness should be >90% and maintained at that level.

This indicator will look at the percentages of staff receiving 1:1 and group supervision.

Safeguarding supervision is embedded within the organisation and has clear evidence for improving the outcomes for vulnerable children, young people and their families. Continuing professional development and supervision underpin the delivery of high quality care. NELFT acknowledges that an effective supervision structure will benefit children because it will have a direct impact on the quality of the work practitioners undertake. NELFT is committed to ensuring that both supervisors and supervisees are clear about their roles, responsibilities and accountabilities in the protection of vulnerable children, young people and their families.

Supervision is essential to help practitioners to cope with the emotional demands of work with vulnerable children and their families.

Safeguarding supervision is a process whereby an appropriately qualified, experienced supervisor, either a Named Nurse Safeguarding Children, Specialist Nurse for Safeguarding Children and/or professionals who have completed the NSPCC Supervisors training course or other recognised course, meets regularly with staff members to reflect upon their safeguarding practice and review cases. It is also an opportunity to raise any concerns or identify areas in which improvements can be made.

We seek to ensure that the individuals we provide services to, are effectively safeguarded against abuse, neglect and discrimination, are supported to achieve their potential and are treated with dignity and respect in all aspects of care.

The current NELFT performance for safeguarding supervision compliance (as at 31.03.2019 based on Q4) is:

Locality	1:1 Compliance	Group Compliance
Acute & rehab	90%	90%
Barking & Dagenham	91%	96%
Basildon, Brentwood & Thurrock	100%	97%
EWMHS	90%	93%
Havering	90%	85%
Redbridge	88%	92%
Waltham Forest	90%	96%

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
- Falls assessments being completed for all patients over 65 on admission to hospital, regardless of reason for admission
- Effective supervision promotes good standards of practice and the delivery of a high quality service

Clinical effectiveness will be enhanced through:

- 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
- All staff have the relevant and up to date mandatory training completed
- Safeguarding supervision provides a process of professional learning and support to enable practitioners to develop their knowledge and competencies

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.
- The delivery of a high quality service
- To ensure that practice is soundly based and consistent

During 2019/20 we will continue to monitor the indicator that directly impacts patient experience: patient waiting times. This is a national indicator and our focus again in the coming year is the waiting times for our children's mental health services in Kent, where young people have been waiting longer than they should be. This work stream continues to require 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. Part B can be found at https://www.nelft.nhs.uk/about-us-publications

Progress against each of our 2018/19 priorities

Considerable progress has been achieved against our targets for 2018/19 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 by quarter 4 2018/19 75% of care plans and risk assessments are completed and recorded in our EPR systems and that all 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
- EWMHS Services in Essex (additional area for 2018/19)
- CAMHS in London – Excluding inpatients (additional area for 2018/19)

What we achieved:
*N/A – No data available

Area		Q1	Q2	Q3	Q4
Trajectory		10%	25%	50%	75%
Adult PICU	Risk Assessments	Not currently recording on EPR			
	Care Plans	Not currently recording on EPR			
MHS wards for older adults	Risk Assessments	7.9%	18.6%	100%	93.9%
	Care Plans	N/A	1.5%	3.6%	11.1%
Children and adolescent mental health wards	Risk Assessments	5.1%	8.1%	33.3%	55.3%
	Care Plans	12.2%	5.4%	17.2%	13.2%
Community-based mental health service for adults of working age	Risk Assessments	36.4%	35.8%	58.9%	68.8%
	Care Plans	11.4%	11.9%	14.2%	15.4%
Community-based mental health services for older people	Risk Assessments	36.7%	39.1%	51.4%	61.2%
	Care Plans	6.0%	5.7%	7.1%	10.5%
EWMHS services in Essex	Risk Assessments	24.1%	27.6%	83.7%	77.3%
	Care Plans	15.4%	19.2%	23.6%	24.9%
CAMHS in London (excluding inpatients)	Risk Assessments	28.7%	30.1%	41.1%	50.5%
	Care Plans	6.2%	6.5%	9.9%	14.9%

Goal 2

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

Applicable to:

- Community health services for adults
- CAMHS in London

What we achieved:

Area	18/19
Target	75%
Compliance of audited electronic patient records Achieved on average:	55%

The data includes new teams that joined in the second half of the year. When new teams join the QIAC there is an initial phase of learning sets, this can lead to lower recording compliance whilst learning embeds.

To ensure we continue with the embedding of this work, the priority remains in the Quality Report for the coming year.

Goal 3

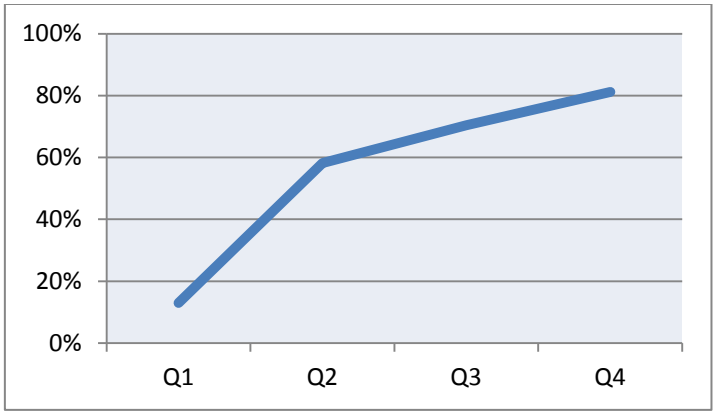
1. For patients over the age of 65 to automatically receive a falls risk assessment on admission to hospital and recorded on an EPR.

Applicable to:

- Older adults mental health wards
- Community inpatient wards in London and Essex (additional for 2018/19)

What we achieved:

Area	Q1	Q2	Q3	Q4
Target				100%
Patients over the age of 65 to automatically receive a falls risk assessment on admission to hospital and recorded on an EPR	13%	58%	70%	81%



Electronic Patient Records (EPR) were newly rolled out to the community inpatient wards in London and Essex in 2018/19.

Using EPR has shown data quality compliance is lower than we would expect. Therefore, this will remain a priority in the Quality Report for the coming year.

Priority 2: Effective
Goal 1

1. That 85% of patient care plans include the five elements of care planning - consent and capacity, social situation, collaborative, risk assessment, recovery focused, using the QIAC audit tool, by the end of quarter 4 2018/19

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
- EWMHS services in Essex (additional for 2018/19)
- CAMHS in London (additional for 2018/19)

What we achieved:

Area	Q4
Target compliance by the end of quarter 4	85%
All care plans to include 5 elements by end Quarter 4	70%

We have seen some positive signs of improvement but more work is needed.

Through 2018/19 we saw favourable compliance with quarter 1 results being at 84%, but by quarter 4 there is an overall small drop. During quarters 3 and 4 we have seen new teams joining and some teams re-joining having acknowledged that they need to refocus on care planning. In most cases this is due to staffing changes and the requirements to reinforce the importance of care planning and its procedures. For others, they are being more stringent with their audits and are scrutinising more closely. Of the teams joining and re-joining, across the five elements, there is significant percentage increase in compliance for each element.

To ensure we continue with the embedding of this work, the priority remains in the Quality Report for the coming year.

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
- EWMHS services in Essex (additional for 2018/19)
- CAMHS in London (additional for 2018/19)

What we achieved:

	Q1	Q2	Q3	Q4
Recovery Focussed	81%	77%	70%	68%
Collaborative	87%	83%	75%	77%

NELFT achieved an average of 68% compliance for 'recovery focused care plans' and 77% compliance for 'collaborative care plans' for quarter 4 2018/19. The drop in quarters 3 and 4 is reflective of new teams joining and the re-joining of some teams due to a change in staffing and more stringent auditing, highlighting a need for refreshed training and focus.

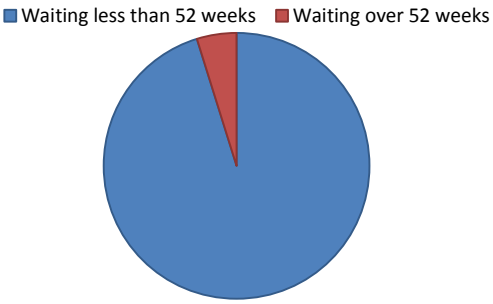
To ensure we continue with the embedding of this work, the priority remains in the Quality Report for the coming year.

Priority 3: Responsive
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)

Applicable to:

- Kent and Medway



What we achieved:

By end Q3 no young person will be awaiting assessment or treatment for more than 52 weeks	95 ach

As at the end of quarter 3, 4.83% of the children waiting have been waiting over 52 weeks. Of those waiting for neuro development treatment 36% of the waiters at the end of quarter 3 have been waiting over 52 weeks.

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

Applicable to:

- East Kent

What we achieved:

Area	Q3
Target compliance by the end of quarter 3	100%
By end Q3 every young person needing an ADHD or ASD assessment will have been clinically reviewed	50.5%

As at the end of quarter 3, an average of 50.5% of children on the neurodevelopment pathway of those seen, were seen within 18 weeks.

Funding has been agreed with commissioners to employ additional resource and trajectories are in place.

This will remain a priority in the Quality Report for the coming year.

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

Area applicable to:

- NELFT wide

What we achieved:

Area	Q1	Q2	Q3	Q4
Target compliance by the end of quarter 4				85%
Staff up to date with mandatory training including clinical risk assessment & MHA	88.88%	88.42%	90.85%	91.08%

Overall NELFT compliance for mandatory training has met and exceeded target.
Kent and Medway staff compliance had been noted as particularly low in the past. In 2018/19 Kent and Medway achieved a compliance rate of 99.65% at the end of quarter 3.

Goal 2

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

Applicable to:

- East Kent, West Kent, and Medway CYPMH Services

What we achieved:

Area	Q1	Q2	Q3	Q4
Target compliance by the end of quarter 4				100%
Percentage of teams have access to MIDAS to support their management of services	87%	82%	94%	100%

We are delighted to report that this goal has been achieved. We will continue to offer training to new staff and to offer support to all staff in the use of MIDAS.

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

Applicable to:

- NELFT wide

What we achieved:

Business Intelligence are continually developing the analytical tool and are now in the position to distribute licences to publish data internally for analysts and teams to start using and viewing data. This process will be rolled out in Q1 2019/20.

Governors' selected local indicator for 2018/19: Clinical Risk Training
The governors selected clinical risk training as the indicator to be audited by KPMG, as this complements the priorities set out in the Quality Report.

The audit was aimed to test the compliance reporting methodology and reporting via Quality Report updates is accurate.

The existing NELFT performance for clinical risk training was 56.44% which relates to the following services:

- 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

During the course of 2018/19 NELFT has significantly increased compliance, as at the end of quarter 4 we are pleased to have achieved 91.14%.

Annual staff survey

Each year, NHS England requires MHS service provider organisations to facilitate the completion of a staff survey. This survey gives our colleagues the opportunity to feedback about their experience of working in the Trust, across a range of indicators. From the survey results, we then put together Trust-wide and local improvement plans to help better the staff experience of engagement, health and well-being. The information taken from the survey also enables us to review our performance against other similar NHS organisations as well as how we compare nationally.

We value the feedback from our colleagues and this survey is one of numerous ways of gauging their opinions. We continue to pride ourselves on an open and honest culture that embeds the Trust values in everything that we do and demonstrates that we actively listen to our staff and act upon their opinions.

This has been yet another challenging year for the Trust in terms of its collaborative input into multiple integrated care systems, the impending CQC well-led review and managing resources effectively. We have worked tirelessly over the past year to act upon the findings of the last year's survey, which yielded some very encouraging results and demonstrated unprecedented levels of workforce engagement and enthusiasm of colleagues to influence the leadership of the organisation. 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. We repeated the more user friendly online questionnaire and introduced a bespoke survey for our Bank Workers as a further commitment to our inclusivity. We also built upon the embedding of engagement and well-being matters as agenda items for all team meetings and have centrally co-ordinated a range of activities on a

regular events calendar in each Directorate. These activities include Yoga, massage therapy, mindfulness and mental health first aid.

Building on the engagement work undertaken across the organisation, the 2018 survey attracted an impressive 61% response rate from a full census; which benchmarked in the top 10 percentile of response rates for the second successive year. The vast majority of responses to the questions showed either a positive shift from the previous year, or remained the same. 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 following response areas showed a plus 5% or more improvement from last year:

- The recognition I get for good work.
- The extent to which my organisation values my work.
- My organisation treats staff who are involved in an error, near miss or incident fairly.
- We are given feedback about changes made in response to reported errors, near misses and incidents
- I would recommend my organisation as a place to work.

The following response areas showed a 3% or more deterioration from last year:

- The last time you experienced physical violence at work; did you or a colleague report it?
- I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams).

This latest survey is memorable in that it demonstrates year on year commitment from the Trust to ensure that colleagues feel safe in having their say and confident in that we will act upon their opinions.

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

Quality Report Glossary

ADHD	Attention deficit hyperactivity disorder	Attention deficit hyperactivity disorder (ADHD) is a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness
ASD	Autism Spectrum Disorder	Autism Spectrum Disorder (ASD) is a term used to describe a number of symptoms and behaviours which affect the way in which a group of people understand and react to the world around them. It's an umbrella term which includes autism, Asperger syndrome and pervasive developmental disorders.
BFI	Baby Friendly Initiative	The initiative is a global effort for improving the role of maternity services to enable mothers to breastfeed babies for the best start in life. It aims at improving the care of pregnant women, mothers and newborns at health facilities that provide maternity services for protecting, promoting and supporting breastfeeding (Definition source: Wikipedia)
BHR	Barking and Dagenham, Havering and Redbridge	Refers to the geographical areas of Barking and Dagenham, Havering and Redbridge
BHRUT	Barking, Havering and Redbridge University Hospitals Trust	Barking, Havering and Redbridge University Hospitals NHS Trust is an NHS trust which runs King George Hospital in Goodmayes and Queen's Hospital in Romford. It also operates many clinics at a number of sites in the nearby area including Barking Hospital and Brentwood Community Hospital.
BI	Business Intelligence	Business intelligence comprises the strategies and technologies used by enterprises for the data analysis of business information. BI technologies provide historical, current and predictive views of business operations (Definition source: Wikipedia)
CAMHS	Child and Adolescent Mental Health Service	CAMHS is used as a term for all services that work with children and young people who have difficulties with their emotional or behavioural wellbeing
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
COP	Community of Practice	
CQC	Care Quality Commission	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

CYPMHS	Children and Young People's Mental Health Service	Kent CYPMHS provides emotional wellbeing and mental health advice and support for young people and their families across Kent
EMT	Executive Management Team	
EPR	Electronic Patient Record	Electronic Patient Record refers to the electronic capture and storage of patient health information
EWMHS	Emotional Wellbeing and Mental Health Service	Emotional Wellbeing and Mental Health Service (EWMHS) provides emotional wellbeing and mental health advice and support for young people and their families across Southend, Essex and Thurrock
FLC	Finance Leadership Council	
HEE	Health Education England	The function of Health Education England is to provide national leadership and coordination for the education and training within the health and public health workforce within England.
HSJ	Health Service Journal	Health Service Journal is a news service which covers the British National Health Service, healthcare management and health policy.
HTT	Home Treatment Team	The Home Treatment Team provide acute home treatment for adults whose mental health crisis is so severe that they would otherwise have been admitted to hospital.
IHI	Institute of Healthcare Improvements	
LGBT	Lesbian, Gay, Bisexual, Transgender	
NEL	North East London	Refers to the geographical area of north east London
NELFT	North East London NHS Foundation Trust	NELFT is a community and mental health services trust serving the health needs of residents in Essex, Havering, Redbridge, Waltham Forest and Barking & Dagenham, Barnet, Kent and Medway
PSLT	Performance Senior Leadership Team	
QI	Quality Improvement	Improving quality is about making healthcare safer, effective, patient centred, timely, efficient and equitable
QIAC	Quality Improvement Accelerator Care	
QN	Queen's Nurse	The title of Queen's Nurse is available to nurses who have worked in the community for at least five years and who are committed to learning and leadership
QNI	The Queen's Nursing Institute	The Queen's Nursing Institute is a charity that works to improve the nursing care of people in their own homes in England, Wales, and Northern Ireland.

QNIC	Quality Network for Inpatient CAMHS	The network aims to demonstrate and improve the quality of inpatient child and adolescent psychiatric in-patient care through a system of review against the QNIC service standards
QSLT	Quality Senior Leadership Team	
RCPsych	Royal College of Psychiatrists	The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry
RTT	Referral To Treatment	Referral to Treatment or RTT is the term used to describe the amount of time that a patient has waited from the point of referral to the time that they receive treatment
STP	Sustainability and Transformation Partnership	Sustainability and Transformation Partnership 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
WRES	Workforce Race Equality Standard	The Workforce Race Equality Standard is a requirement through the NHS standard contract. It focusses on supporting the system to understand the nature of the challenge of workforce race equality and to enable people to work comfortably with race equality.
YPWS	Young Peoples Wellbeing Service	The Young Persons' Wellbeing Service provides emotional wellbeing and mental health advice and support for young people in Medway, Kent

NELFT NHS
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Quality Report

2018/19

PART B

Welcome to part B of the Quality Report.

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 Report, please refer to part A where our contact details for feedback are provided.

2.2 Statement of assurance from the Board

During 2018/19 NELFT provided and/or subcontracted 294 relevant health services (provided across multiple localities). NELFT has reviewed all the data available to them on the quality of care in 294 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by NELFT for 2018/19.

Freedom to Speak Up

NELFT has a full time Freedom to Speak up Guardian who has been actively promoting the Freedom to Speak Up role and process within the organisation.

In order to embed the role and encourage staff to raise their concerns, information has been provided through the following mechanisms: weekly newsletters, computer screen savers, information stalls, monthly presentations at the staff induction, posters, leaflets and attendance at team meetings and other engagements.

The Trust has seen a significant increase in the number of staff members approaching the Freedom to Speak Up Guardian, showing that a Freedom to Speak Up culture is being embedded successfully within NELFT.

A Freedom to Speak Up Policy is available on NELFT's Intranet and explains the process of raising concerns. To ensure an open and transparent culture within NELFT, executive and non-executive Freedom to Speak Up leads have been identified. A strategy is being developed and Freedom to Speak Up champions are being recruited.

The concerns that staff may raise are (this list is not exhaustive):

- unsafe or unprofessional patient care
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor response to a reported patient safety incident
- physical abuse
- abuse of power, position or authority
- suspicions of fraud, theft or bribery
- bullying or harassment across a team
- concerns about service provision or the conduct of NELFT staff

Staff may raise concerns openly, confidentially or anonymously. There is a range of individuals who can be approached by staff raising concerns: line managers, senior

managers, the Freedom to Speak Up Guardian, a Union representative, the Human Resources department, the Safeguarding Team, a member of the Senior Leadership Team or an external organisation listed in the policy. Staff may raise concerns in writing, through the Freedom to Speak Up email address or on the phone, and may also request to have a private meeting off site.

Individuals receiving the concern are responsible for informing the staff member about the actions planned and the timescales; ensuring that feedback is provided. Staff members are also invited to share their feedback on the process of raising concerns.

The Freedom to Speak Up Policy assures staff that if a concern is raised, the person who raised it will not be at risk of losing their job or suffering any form of reprisal as a result. The Policy states that NELFT will not tolerate the harassment or victimisation of anyone raising a concern, nor will it tolerate any attempt to bully staff into not raising concerns. Any such behaviour is a breach of NELFT's values and, if upheld following investigation, could result in disciplinary action. Staff members are encouraged to contact the Freedom to Speak Up Guardian if they feel that they have been victimised or any harm has come to them following raising a concern.

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 2018/19 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 2018/19, NELFT participated in 14 (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 Trust also participated in 7 CQUIN audits which covered relevant health services that NELFT provides.

The national clinical audits and national confidential enquiries that NELFT was eligible to participate in during 2018/19 are listed in appendix 2a. The national clinical audits and national confidential enquiries that NELFT participated in during 2018/19 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 2018/19, 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 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1,967.

Learning from national clinical audits

National Clinical Audits are designed to measure healthcare practice on specific conditions against accepted standards, providing patients, the public and clinicians with a clear picture of the standards of healthcare being achieved for specific specialities. 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.

NELFT intends to continue to improve the processes for monitoring the recommendations and outcomes of National Audits and Confidential Enquires by ensuring:

- National clinical audits and national confidential enquiries continue as on-going components to the development of the Annual Clinical Audit Programme. Priority will be assigned to all national and mandatory audits and approved at Board for review, thus maintaining our gold standard 100% participation rate with these studies.
- Local level audit summary reports for national clinical audits to be completed with recommendations and action plans, encouraging shared learning
- Performance outcome and updates for all national audits are presented at senior Quality Safety Committee Meetings (QSC) and corporate level meetings ensuring the Trust is involved and aware of national audits undertaken in the Trust.
- Clinical and senior leadership to remain integral to ensure national audit completion and reflection.

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 14 national clinical audits and 2 confidential enquiries were reviewed by NELFT in 2018/19. This included national audits for which data was collected in earlier years with the resultant report being published in 2018/19. 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 Clinical Audit & Effectiveness Manager 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 110 local clinical audit reports were reviewed by NELFT in 2018/19 out of which 38 audits have been completed (35%) to date. These completed audit reports were reviewed by NELFT in 2018/19 and 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 38 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.

From the 10th – 14th December 2018, the Trust celebrated its 4th annual Trust-wide Clinical Audit Awareness Week (CAAW). 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 1392 across the Trust, fully trained and improving the quality of patient care and safety Trust wide using the clinical audit process. This figure captures data up until January 2019.

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 2018/19

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 2018/19 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 2018/19 and for the following 12 month period are available on request from:

Performance and business intelligence team

Email: jacky.hayter@nelft.nhs.uk

Address: NELFT NHS Foundation Trust, CEME Centre, West Wing, Marsh Way, Rainham, Essex RM13 8GQ

The total amount of income in 2018/19 conditional upon the achievement of quality improvement and innovation goals was £7.1m. The monetary total for achievement of goals in 2017/18 was £6.8m.

Registration with the Care Quality Commission (CQC)

NELFT has been a Foundation Trust since 1st June 2008.

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

Overall NELFT is now rated by the CQC as good.

There is a Well-led CQC visit due in March 2019. All requested information has been supplied.

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 2018/19.

NHS number and general medical practice code validity

NELFT submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

99.8% for admitted patient care

100% for outpatient care

95.6% Accident and Emergency

which included the patient's valid General Medical Practice Code was:

99.9% for admitted patient care

99.9% for outpatient care

99.0% Accident and Emergency

Information Governance Assessment Report

NELFT's progression in regards to the new Beta Version of the Data Security and Protection Toolkit is currently at 83 out of the 100 mandatory requirements for 2018/19

Clinical coding error rate

NELFT was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

Audit – areas for improvement

NELFT will be taking the following actions to improve data quality:

All staff receive 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. New starters to the Trust undergo appropriate systems training and mandatory training as part of the new streamlined induction process during their first two weeks of employment. This is maximising compliance.

The data quality / information governance mandatory e-learning programme is now an annual requirement and the training programme 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. Further work around recording of Diagnosis is being undertaken with Community staff.

Both the Record Keeping and Data Quality policies are currently under review and will include guidance around areas identified within the annual healthcare records audit.

The 2018/19 annual healthcare records audit included an increased focus on the assessment of data quality practices, risk 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 which is reviewed by the Data Quality Action Group (DQAG) on a regular basis.

Data quality prompts have been expanded within the electronic patient records to include missing high priority information including mandatory dataset and families information. The results of the annual record keeping audit have identified improvements in these areas. PC login messages have also been used to inform all staff of their record keeping and data quality responsibilities.

Data quality issues are identified and reported to Localities on a monthly basis, highlighting areas where improvement is required (at both Locality and Team level) to 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.

Data quality has been key in our RTT workstream and the 3 C's (Care Plans, Clinical Risk Assessments and Clinical Harm Reviews) ensuring that data is correct to support clinical quality and patient safety.

Work is also taking place with NELFT's EIP Teams to ensure an improvement in data quality, including a review of the electronic patient record templates to support accurate recording of clinical processes.

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 assessments 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

<table>
<tr><th>Numbering from NHSi detailed requirements guidance</th><th>Prescribed information</th><th>Form of statement</th></tr>
<tr><td>27.1</td><td>The number of its patients who have died during the reporting period including a quarterly breakdown of the annual figure</td><td>During 2018/19, 7399 of NELFT patients died. (of which 29 number were neonatal death, and 22 were people with learning disabilities and 441 had a severe mental illness)

This represents 1.29% percent of NELFT’s caseload for 2018/19.

This comprised the following number of deaths which occurred in each quarter of that reporting period:

<table>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>TOTAL</td><td>2030</td><td>1813</td><td>1555</td><td>2001</td></tr>
<tr><td>Of which:</td><td colspan="4"></td></tr>
<tr><td>Neonatal</td><td>5</td><td>6</td><td>10</td><td>8</td></tr>
<tr><td>Stillbirths</td><td colspan="4">NELFT unable to provide this due to the nature of the services the Trust provides</td></tr>
<tr><td>Learning disabilities</td><td>10</td><td>5</td><td>3</td><td>4</td></tr>
<tr><td>Severe mental illness</td><td>97</td><td>126</td><td>96</td><td>122</td></tr>
</table>
</td></tr>
<tr><td>27.2</td><td>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.</td><td>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. All unexpected deaths that are not subject to any of the above investigations are subject to a review by NELFT’s Mortality Review Group.
In 2018/19 63 serious incident investigations have been carried out in relation to 7399 total of the deaths included in item 27.1.

The number of deaths in each quarter for which an investigation was carried out was:
10 in the first quarter
22 in the second quarter
15 in the third quarter
16 in the fourth quarter</td></tr>
<tr><td>27.3</td><td>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</td><td>11 serious incidents representing 0.15% 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.

54 Case reviews using the Confidential Enquires of Stillbirths and Infant Deaths (CESDI) methodology identified that 0 deaths were more likely than not to have been due to problems in the care provided to the patient.</td></tr>
</table>

<table>
<tr><td></td><td>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.</td><td>In 8 of the cases suboptimal factors were identified during the case reviews but were unlikely to have contributed to the fatal outcome.

A total of 33 serious incidents were reviewed and scored using the CESDI methodology. A total of six were excluded as they had been deescalated as a serious incident during the investigation process. The scoring of an additional seven has been deferred until the outcome of the coroner's inquest where it was not possible to determine a cause of death at the stage the serious incident investigation concluded. A remaining 15 investigations are still under investigation and will be CESDI scored at the conclusion stage. From this review the number of serious incidents and percentage of patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided were assessed as the following:

<table>
<tr><th>Quarter</th><th>CESDI score of 2</th><th>CESDI score 3</th><th>Total</th></tr>
<tr><td>Q1</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>Q2</td><td>4</td><td>3</td><td>7</td></tr>
<tr><td>Q3</td><td>1</td><td>0</td><td>1</td></tr>
<tr><td>Q4</td><td>Investigations ongoing</td><td>Investigations ongoing</td><td>Investigations ongoing</td></tr>
</table>

These numbers have been estimated using the Confidential Enquires of Stillbirths and Infant Deaths (CESDI) methodology and the Serious Incident Framework 2015. A score of 2 represents suboptimal care - different care MIGHT have made a difference (possibly avoidable death)
A score of 3 represents suboptimal care WOULD REASONABLY BE EXPECTED to have made a difference (probably avoidable death)

All deaths where the CESDI score was 2 or 3 have an accompanying robust action plan in place to ensure learning is embedded and in addition these were subject to a Coroners review.</td></tr>
<tr><td>27.4</td><td>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.</td><td>• Improving how we work in partnership and listening to the voice of carers and relatives
• Improving recording of formal risk assessments
• Improving recording of Next of Kin details in patient records
• Improving adherence to policy and guidance</td></tr>
<tr><td>27.5</td><td>A description of the actions which the provider has taken in the reporting period, and proposes to take following the</td><td>• Following the National Quality Board Guidance for NHS trusts on working with bereaved families and carers, a task and finish group has been set up to review the support provided to families and carers following bereavement. The findings and recommendations are due in March 2019.</td></tr>
</table>

	reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	• Following the publication of NHS Resolution - Learning from suicide related claims the Serious Incident team are completing a benchmarking exercise against the findings and the review is planned for completion in March 2019 and an action plan will be developed against any shortfalls identified. • The Acute and Rehabilitation Directorate undertook an SI learning event on 14th November; two recent Serious Incident investigation cases were presented and discussed. There were approximately 150 practitioners in attendance and they examined the learning from the investigation including the root causes and the care and service delivery issues identified. • The Children & Young People Community of Practice undertook a learning event in November that included a focus on the learning from Kent & Essex CYP Suicide report, and Mental Health Transition.
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 carer's 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.	9 case record reviews and 14 investigations were completed between January 2018 and 31st March 2018 which related to deaths which took place before the start of the reporting period.
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	In 2017/2018, of the 5 patient deaths that were investigated that occurred before the reporting period, 0 were judged to be more likely than not to have been due to problems in the care provided to the patient. 3 of the 5 Investigations did identify care and service delivery issues which may have contributed which represents 0.039% of the deaths. This number has been estimated using the serious

	provided to the patient, with an explanation of the methods used to assess this.	incident RCA investigation.
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.	There were no deaths during the previous reporting period 2017/18 which the provider judges as a result of investigation were more likely than not to have been due to problems in the care provided to the patient

In 2017/18, 26 of the deaths reviewed or investigated during that year were judged to be more likely than not to have been due to problems in the care provided to the patient. This represented 0.30% of the deaths that occurred during that financial year. In addition, 9 case record reviews and 14 investigations that related to deaths that took place during 2017/18 were completed after 31st March 2018. Of these, following an SJR and then a subsequent judgement, 3 deaths were judged to be more likely than not to have been due to problems in the care provided to the patient. Therefore, of all the deaths that occurred in 2017/18 and which were reviewed or investigated, a total of 29 deaths were judged to be more likely than not to have been due to problems in the care provided to the patient. This represents 0.37% of the patient deaths that occurred during 2017/18.

2.3 Reporting against our core indicators 2018/19

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 2017/18	NELFT 2018/19
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	95.5% (as at Q3)	100%	81.6 % (Q3)	97.63%	95.78%
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Teams (HTT) acted as a gatekeeper during the reporting period	Percentage	97.8% (As at Q3)	100%	78.8% (Q3)	94.6%	96.42%
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				11.76% (4 of 34) 5.0% (201 of 3917)	5.56% (2 of 36) 4.86% (166 of 3417)
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	Not available	7.7	5.9	8.0	7.2
Patient safety incidents	Number Rate per 100,000 population	**Q3/4 2017/18** 3147	**Q3/4 2017/18** 8134	**Q3/4 2017/18** 11	**Q1/2** 4199 **Q3/4** 4545 275	**Q1** 2375 **Q2** 2381 **Q3** 2472 **Q4** 2271 299
Patient safety incidents that resulted in severe harm or death	Number	**Q3/4 2017/18** 18	**Q3/4 2017/18** 138	**Q3/4 2017/18** 0	**Q1/2** 40 **Q3/4** 46	Q1 12 Q2 12 Q3 12

						Q4 9 Q1 0.50% Q2 0.49% Q3 0.48% Q4
	Percentage	0.6%	3.9%	0.0%	0.95% 1.01%	0.40%

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 consistently works to closely monitor this indicator, and the quality of its services, by: continuing to improve data capture in NELFT EPR (RiO). The Performance team provide monthly reports to ensure compliance; clearer understanding between clinical and performance teams of terminology to ensure correct reporting criteria.
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 is as described for the following reasons: the numbers of patients readmitted remain 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	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

care worker during the reporting period	contractor. The latest survey findings were published in November 2018. The data is in the public domain on the CQC website http://www.cqc.org.uk/provider/RAT/survey/6 NELFT continues 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 in the Training and Development Centre at CEME, using the computer suites so staff can access the system as part of their training • The publication of quarterly newsletters which provide guidance on what to report, how to report and the proper codes to use for the most frequently reported incidents. The newsletters also share what has been learnt from incidents • A screen saver for all staff with the key message of 'if in doubt, report it'. • The development and embedding of the use 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 • All new starters receive information on incident reporting and how this contributes to everyone's safety as part of their induction 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

	National Reporting and Learning System. This includes making sure the coding of the harm matches the definitions provided by NHS Improvement • Visiting teams to help them in identify, report and review incidents • Develop a Datix User Group which will share how we can make it easier for staff to report incidents • Scope the use of mobile devices for incident reporting

NELFT performance indicators for 2017/18 and 2018/19

Indicator	Measure	Target	National Average	NHS trust Highest	NHS trust Lowest	NELFT 2017/18	NELFT 2018/19
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Percentage	92%	88.8%	100%	73.9%	99.1%	100%
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	Percentage	95%	91.7%)	100%	59.4%	99.1%	99.6%
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%	Jan 19 Ave 77%	100%	0%	82.1%	81.7%
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**	Audit taking place in Q4 results not availabl e until June 2019
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)	Percentage	50% 75%	51.9% 89.2%	88% 100%	29% 13%	50.5% 97.7%	50.77% 98.94% 99.96%

ii) Within 18 weeks of referral Admissions to adult facilities of patients under 16 years old	 Number	95%	99.1%	100%	36%	100% 0	 1
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	1816

Appendix 1
Quality Report Glossary

CAAPT	Clinical Audit Action Plan Tracker	
CAAW	Clinical Audit Awareness Week	
CAC	Clinical Audit Champions	
CCG	Care Quality Commission	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
CESDI	Confidential Enquiries of Stillbirths and Infant Deaths	CESDI is an ongoing UK enquiry which assesses the risks of death in late foetal life and infancy, and identifies risks attributable to suboptimal clinical care
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
CPA	Care Programme Approach	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
CQC	Care Quality Commission	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
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
Datix		Datix is the Trust wide web based incident and risk management system. It is used to report and manage incidents, to manage risks on the risk register and to manage complaints, concerns and compliments
DQAG	Data Quality Action Group	
EIP	Early Intervention in Psychosis	A clinical approach to those experiencing symptoms of psychosis for the first time

HTT	Home Treatment Team	The Home Treatment Team provide acute home treatment for adults whose mental health crisis is so severe that they would otherwise have been admitted to hospital.
IAPT	Improving Access to Psychological Therapies	IAPT is a programme that began in 2008 with the direct objective to improve access for people with anxiety and depression to evidence based psychological therapies such as Cognitive Behavioural Therapy (CBT)
NCAPOP	National Clinical Audits and Patient Outcome Programme	audits are commissioned and managed on behalf of NHS England by the Healthcare Quality Improvement Partnership (HQIP)
NELFT	North East London NHS Foundation Trust	NELFT is a community and mental health services trust serving the health needs of residents in Essex, Havering, Redbridge, Waltham Forest, Barking & Dagenham, Barnet, Kent and Medway
NHSi	NHS Improvement	Since 1st April 2016 Monitor and the NHS Trust Development Authority have merged. They now operate under the name of NHS Improvement
NICE	National Institute of Clinical Excellence	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health
QI	Quality Improvement	Improving quality is about making healthcare safer, effective, patient centred, timely, efficient and equitable
QIAC	Quality Improvement Accelerator Care	
QIP	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.
QSC	Quality Safety Committee	This NEFLT committee is to assure the Board that the Trust's quality governance model is robust and effective in identifying emerging risk and that there is leadership, governance and effective culture to improve the delivery of high quality person centred care
RTT	Referral To Treatment	Referral to Treatment or RTT is the term used to describe the amount of time that a patient has waited from the point of referral to the time that they receive treatment
SOF	Single Oversight Framework	The Single Oversight Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'

Appendix 2a

National clinical audit and confidential enquiries – eligibility and participation

Title of audit	Management body	Participation	If completed, number of cases/records or % submitted
National Audit of Intermediate Care (NAIC) Assessment of progress in community services aimed at maximising independence and reducing use of hospitals and care homes.	NHS Benchmarking Network	**Bed based services** • Redbridge: Foxglove & Japonica wards • Brentwood Community Hospital: Thorndon Ward • Waltham Forest: Ainslie Unit • Thurrock Community Hospital: Mayfield Ward **Home based services** • Waltham Forest: Community Rehabilitation Team • London & Essex: Intensive Rehabilitation Services Provider bespoke report published November 2018	226 bed based intermediate care services 124 home based intermediate care services Community hospitals were asked to complete the Service User Questionnaire (SUQ) for up to 50 consecutive referrals. 28 forms were returned for NELFT (56%). (NELFT Bespoke Report Dec 2018)
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD) Pulmonary Rehabilitation Work stream (PR) Continuous clinical audit which comprises of three parts: a continuous clinical audit of service provision and delivery of pulmonary rehabilitation, a snapshot audit of the organisation and resourcing of services, and an accreditation scheme	Royal College of Physicians (RCP)	NELFT pulmonary rehabilitation [PR] sites registered for audit participation • Barking & Dagenham • Havering • Redbridge • Waltham Forest • BB & Thurrock Organisational data collection delivered between 1st April 2019 – 1st July 2019 for both Asthma and COPD Continuous data collection - to run from March 2018 – February 2021 For Patients assessed from 1st March 2019 and discharged by 31st August 2019, records are to be completed by 11th October 2019 on the national audit web tool	Ascertainment rate not available as audit not yet due. Audit to commence March 2019
National Diabetes Foot care audit (NDFA) To enable the podiatry service to measure performance against NICE guidance and peer units, and monitor adverse outcomes for people with diabetes who develop diabetic foot disease	NHS Digital	The 4th Annual report will include all foot ulcers where the first assessment took place prior to 31 March 2018 and report to be published spring 2019. Participating services - Waltham Forrest and Barking & Dagenham. The NDFA audit is a continuous data collection audit. Currently gathering data for the 5th Annual report 2019-20	100% of eligible cases
National audit of Care at the End of Life (NACEL) The audit focuses on the quality and outcomes of care experienced by	NHS Benchmarking Network	Audit commissioned over 3 years with the first data collection to take place in 2018. Trust site overview Adult Mental Health – submission 1 Community Mental Health – submission 1	4 cases submitted NACEL office is distributing a survey for participants to

those in their last admission in acute, community and mental health hospitals throughout England and Wales.		Hospital site overview Adult Mental Health – submission 1 Community Mental Health – submission 1 Organisational level data Case note audit data June – Oct 18 Carer reported measure data Data validation and analysis – October - December 2018 Report publication due January – February 20-19 NELFT Bespoke Dashboard report (for first round of submission) Community and Mental Health published February 2019	provide feedback on the 1st iteration of the audit at present Awaiting info re submission from the national office
UK Parkinson's Audit The UK Parkinson's Audit outlines the state of Parkinson's services, and highlights areas for improvement.	Parkinson's UK	Continuous audit NELFT has registered for participation. Audit data submission deadline is the 31st of October 2019	Ascertainment rate not available as audit not yet due. Audit to commence February 2019
National Epilepsy 12 audit (Round 3) Audit continues to measure and improve care and outcomes for UK children and young people with epilepsies. Enables continuous patient ascertainment with the use of pragmatic and concise dataset.	Royal College of Paediatrics & Child Health (RCPCH)	3 year programme. Organisational data submitted The first clinical audit report for data collected for patients within Cohort 1 will be published in March 2020.	National Organisational report published Jan 2019. Continuous clinical audit data collection ongoing until Oct 2020
National Clinical Audit of Psychosis (NCAP) (EIP services) Year One: Core audit The core audit examined care being provided to people with a psychosis by inpatient and outpatient services using the core audit standards, based on the 2014 NICE schizophrenia guidelines.	Royal College of Psychiatrists (RCPsych)	The CCGs covered are Redbridge, Waltham Forest, Havering, Barking & Dagenham Adults 16 years and older who are being cared for by adult services in the community or as inpatients. Number of eligible patients for North East London NHS Foundation Trust is 2055	192 community patients 8 Inpatients selected randomly by RCPsych Returns for NELFT was 189 (95%approx) out of an expected 200
National Clinical Audit of Anxiety and Depression (NCAAD): Core audit on inpatient wards The Audit will focus on the following areas for improvement based on the NAPT findings: •Access, •Waiting times, •Training	Royal College of Psychiatrists (RCPsych)	Awaiting National report and recommendation estimated for publication between January – April 2019 A retrospective audit of service users admitted to an inpatient mental health service for anxiety and/or depression Data collection for round 4 closed National report publication due spring 2019	Awaiting info from the national audit office regarding data submission
National Clinical Audit of Anxiety and Depression (NCAAD):	Royal College of Psychiatrists (RCPsych)	The Psychological Therapies Spotlight Audit will focus on the following areas for improvement based on the NAPT findings	All eligible cases submitted for WF Psychological

Psychological Therapies Spotlight Audit		Commenced August 2018 Publication of report	Services Adult Psychotherapy Service has submitted 9 out of 28 eligible cases Havering MAP service has submitted 30 out of 35 eligible cases In addition, a total of 18 Therapist Questionnaires and 20 Service User Questionnaires (SUQ) have been submitted. (Figures provided by the national audit office)
POMH-UK audit Topic 16b – Rapid Tranquilisation This audit focuses on the re-audit for QIP 16: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour	Royal College of Psychiatrists (RCPsych)	Data entry by NELFT teams, over the period 1st March – 31st May 2018	Trust teams: 16 Total submissions: 21 By Adult Acute Services (POMH Trust Specific report published Oct 2018
POMH-UK audit Topic 18a – Prescribing Clozapine The aim of this baseline audit is to monitor patients prescribed clozapine, including physical health monitoring, in line with NICE guidance	Royal College of Psychiatrists (RCPsych)	Data entry by NELFT teams, over the period 1st June – 31st July 2018 and submitted to POMH UK National report to be published January 2019 followed by the NELFT specific report published February 2019	Trust teams: 13 Total submissions: 62
POMH-UK audit Topic 6d Assessment of the side effects of depot antipsychotics. The aim of the audit is to measure Trust compliance with NICE guidance:	Royal College of Psychiatrists (RCPsych)	1. Antipsychotic side effects should be monitored routinely and regularly (NICE 2002, 2009) 2. People receiving depot preparations should be maintained under regular clinical review, particularly in relation to the risks and benefits of the drug regimen (NICE 2002, 2009) 3. The side effects associated with antipsychotic drugs should be 'assessed using standardised methods and validated rating scales' (Clinical Standards Board for Scotland 2001).	Participating teams for Redbridge: 4 Total submissions: 70 Participating teams for Barking & Dagenham: 4 Total submissions: 28
POMH-UK audit Topic 7f Monitoring of patients prescribed lithium This audit aims to measure the Trusts compliance with NICE standards for the	Royal College of Psychiatrists (RCPsych)	The audit has consistently identified gaps between evidence-based recommendations and clinical practice in relation to the biochemical monitoring of patients who are receiving maintenance treatment with lithium. NHS Trusts UK wide have collected and	A total of 54 cases have been submitted for NELFT

monitoring of patients prescribed lithium, including physical health monitoring.		entered data during February to March 2019.	
Sentinel Stroke National Audit Programme (SSNAP) 18/19 The audit aims to continuously monitor the prospective national audit programme which monitors stroke services against evidence based standards to improve care. Data is collected using the SSNAP online collection tool.	Royal College of Physicians (RCP)	Participating services • Community Rehab Service (CRS) • ESD • Stroke 6 months reviews (Havering & B&D) Period April – June 2018 – 65 CRS cases submitted, 62 cases for 6 month review All patients with a primary diagnosis of stroke coded as I-61, I-63, I-64 should be submitted to SSNAP. The minimum age for patient submission to SSNAP is 16.	Data submission (London) April – June 2018 65 cases submitted July – Sept 2018 Data submission (Essex) During the periods Dec 2017- June 18 196 patients were referred due to stroke
Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Mental Health Conditions in Young People – Continuous audit The aim of the audit is to identify the remediable factors in the quality of care provided to young people treated for mental health disorders; with specific reference to 1. Depression and anxiety 2. Eating disorders and Self harm.	NCEPOD	Currently the report publication for previous audit is still delayed	Data is not being collected in 2018/19 as detailed by national body
Mental Health Clinical Outcome Review Programme: National Confidential Inquiry into Suicide and Homicide for people with mental illness (NCISH) 2018/19 The audit aims to monitor people with Mental Illness (NCISH). The National Inquiry will help NELFT by supporting health professionals, policymakers, and service managers with the evidence and practical suggestions they need to effectively implement change.	NCEPOD	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. Publication of National report received October 2018	100% of eligible cases

Appendix 2b

National clinical audit and confidential enquiry - Requirements and actions taken

National audit of Intermediate Care (NAIC)

NELFT has participated in The National Audit of Intermediate Care (NAIC) which is now in its seventh iteration. The audit focuses on the care and support of usually frail, older people, at times of transition between different services in the health and care system, for example, when stepping down from acute hospital care or preventing them being admitted to longer-term care, until they really need to. 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.

A total of 124 provider organisations participated, supplying data for 469 intermediate care services. This comprised of 226 bed based services, 124 home based services, 53 re-ablement services and 66 crisis response services. In total, 11,707 service user questionnaires and 5,039 patient reports experience measures were returned.

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
- Service user experience of intermediate care - In NAIC 2018, 99% of people felt they had been treated with dignity and respect. (NAIC Provider Bespoke Report England Nov 2018)
- On average, 91% of service users were in receipt of harm free care.
- The Community Hospitals project evidences the improvement in service user dependency via the collection of a clinical standardised outcome measure. The Modified Barthel Index (MBI) clinical outcome measure is collected on admission and discharge to assess the change in dependency of the service user. In 2018, the mean score on admission was 52.0 and on discharge is 70.2, giving an average improvement in score of 18.2.

Actions taken:

- Review of transdisciplinary working
- Strengthen the MDT approach

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) (Pulmonary Rehab Audit (PR) Work stream) (NACAP)

The National Asthma and COPD Audit Programme aims to drive improvements in the quality of care, services and clinical outcome for patients with asthma and COPD. The pulmonary rehabilitation audit 2018/19 will be running a snapshot audit of organisation and resources of pulmonary rehabilitation services, as well as a snapshot audit of clinical care. Registration for this work stream opened in September 2018; however this is a continuous clinical audit of service provision and delivery, with a biennial snapshot audit of service organisation and resource in March 2019.

Multiple participating sites have registered to participate in the audit which is:

- Havering
- Redbridge
- Barking & Dagenham
- Waltham Forest

Data collection period for clinical audit components is March 2019. Data collection is reported in three phases. For Patients assessed from 1st March 2019 and discharged by 31st of August 2019 - Records to be completed by 11th October 2019 on the national audit web tool.

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:

- Previous audit outcomes demonstrated 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).

- Fourth annual report to be published 9th May 2019. Currently gathering data for 5th annual report 2019 – 20

Data collection period for clinical audit components is March 2018/19. **No data can be provided at present.**

National audit of Care at the End of Life (NACEL)

A three year project which focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. The scope of the audit will include the following elements:

- A case note review of inpatients in hospital in the last few days and hours of life

- An organisational level audit covering service models, activity, workforce, finance quality and outcomes

- The development and administration of an innovative Carer Reported Experience Measure

- The development and administration of a Staff Reported Measure, and

- Topics for periodic, time-limited 'spotlight' audits *(NHS Benchmarking Network, 2019)*

Data collection period is now complete and currently data is being validated and analysed. Report publication due January – February 2019, therefore outcomes and actions cannot be reported.

UK Parkinson's Audit

Audit aims to provide a clear picture of the state of Parkinson's services, showcasing good practice but highlighting many areas for improvement. It was the first to include a Patient Reported Experience Measure (PREM), giving people with Parkinson's a stronger voice in rating the services they receive. UK wide reports to be published May 2018 for 2017 audit.

No planned data collection during 2018/19 financial year (1st April – 31st March 2019). Audit to recommence in 2019/20. Data collection 1st May – 30th of September 2019. Deadline for submission 31st October 2019.

National Epilepsy 12 audit (Round 3)

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. Round 3 commenced in 2017 when the audit was recommissioned as part of National Clinical Audit and Patient Outcomes Programme (NCAPOP). 148 Health Boards and Trusts with a paediatric epilepsy service across England and Wales submitted data to the organisational audit.

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.**

Outcomes from National Organisational report (Jan 2019)

It is encouraging that this report shows incremental improvements in some areas of paediatric epilepsy service provision, including:

• Overall numbers of epilepsy nurse specialists

• Overall numbers of paediatricians with expertise and

• The number of specific clinics for children and young people with epilepsies

Key Recommendations:

- All Health Boards and Trusts to ensure they have sufficient defined general paediatricians with expertise in epilepsies to correctly diagnose epilepsy and provide appropriate ongoing management for all children with epilepsy.
- All Health Boards and Trusts to ensure that when rescue medication is prescribed for use by parents and carers of children at risk of prolonged epileptic seizures that training and individualised emergency care plans are provided.
- Health Boards and Trusts to ensure provision of sufficient follow up epilepsy clinic capacity. Where appropriate, children with epilepsy currently in a general paediatric clinic should be identified and streamed through designated epilepsy clinics.
- Health Boards and Trusts to agree referral pathways to tertiary paediatric neurology services. Referral processes should ensure that after referral ongoing shared care is maintained. Referral pathways should also be clear to ensure appropriate timely referral for epilepsy surgery evaluation, ongoing complex epilepsy management or both.
- Health Boards and Trusts to consider whether Vagus Nerve Stimulation (VNS) review and programming could be achieved more locally via satellite specialist neurology/ epilepsy clinics.
- Commissioners, Health Boards and Trusts to ensure that ongoing epilepsy care should include mental health assessment, diagnosis and treatment alongside management of seizures.
- Health Boards and Trusts to formally agree transition pathways from paediatric to adult services. Local arrangements should define how this is achieved for different young people with epilepsies with different associated problems, for example children and young people with an intellectual disability or neurodisability.
- Optimisation of services and understanding of need as key to improving epilepsy management
- National initiatives are to be developed with the aim towards improving care and services, specifically for children with epilepsy (e.g. the NICE guidelines for the diagnosis and management of adults and children with the epilepsies (2004, 2012))
- Epilepsy Training courses developed by the British Paediatric Neurology Association
- Incremental improvements in some areas of paediatric epilepsy service provision, including:
    - overall numbers of epilepsy nurse specialists
    - overall numbers of paediatricians with expertise and
    - the number of specific clinics for children and young people with 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’ to be implemented.

National Clinical Audit of Psychosis (NCAP) (EIP Services)

NCAP is the next phase in the development of the National Audit of Schizophrenia, extended to include both inpatient and community care provided for people with a broader group of severe mental health problems. NCAP will measure provision of care against standards based on NICE Clinical Guideline CG178 and Quality Standard QS80 Psychosis and Schizophrenia in adults. Key areas of performance will include the assessment and treatment of physical health, health promotion, prescribing practice, use of evidence-based psychological treatments and access to services at times of crisis.

The CCGs covered are Redbridge, Waltham Forest, Havering, Barking & Dagenham
The audit looked at adults 16 years and older who are being cared for by adult services in the community or as inpatients. Number of eligible patients for NELFT was 2055. 192 community patients and 8 Inpatients selected randomly by Royal College of Psychiatrists (RCPsych) Returns for NELFT was 189 (95%approx) out of an expected 200.

Outcomes and findings for NELFT:

- Performance was above average on majority of indicators
- Use of polypharmacy (for patients not on Clozapine) is significantly higher than in many trusts.

Key Recommendations/ Areas for improvement:

- Provision of written information about current antipsychotic
- Intervention for smoking, abnormal glucose control and elevated blood pressure
- Rationale documented where high dose is prescribed
- Patients offered family intervention
- Record that patient was involved in the prescribing decision
- Record of discussion of benefits and adverse effects
- Medication adherence has been investigated
- Patients involved in work or study related activity outside the home

National Clinical Audit of Anxiety and Depression (NCAAD): Core audit on inpatient wards

The core audit includes the following key performance areas:

- Access
- Comprehensive assessment and care planning
- Availability of appropriate psychopharmacological and psychological treatment
- Crisis planning
- Follow up and community care
- Service user outcomes.

This is a retrospective audit of service users admitted to an inpatient mental health service for anxiety and/or depression.

Data collection period for the core audit was June to September 2018; the local reports to trusts are to be published in Spring 2019.

National Clinical Audit of Anxiety and Depression (NCAAD): Psychological Therapies Spotlight Audit

This audit is a follow-up to the National Audit of Psychological Therapies (NAPT). The Psychological Therapies Spotlight Audit will focus on the following areas for improvement based on the NAPT findings:

- Access
- Waiting times
- Training and supervision of therapists
- Measuring and monitoring service user outcomes
- Provision of the NICE recommended therapies of an appropriate modality and for a sufficient duration

All eligible cases have been submitted for WF Psychological Services.

Adult Psychotherapy Service has submitted 9 out of 28 eligible cases

Havering MAP service has submitted 30 out of 35 eligible cases

In addition, a total of 18 Therapist Questionnaires and 20 Service User Questionnaires (SUQ) have been submitted. (Figures provided by the National Audit Office)

Data entry period closed on 31st January 2019.

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 clinical component of SSNAP collects a dataset for every stroke patient, including acute care, rehabilitation, 6-month follow-up and outcome measures in England, Wales and Northern Ireland.

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, celebrating success and to empower patients to ask searching questions.
- To provide hospitals, commissioners, patients and the public with an unprecedented level of insight into the performance of stroke services.

National and NELFT outcomes:

Community Rehab Services (CRS)

- Based on demographics of the boroughs covered by NELFT, the average age of those referred to the service is higher for CRS for the 65-74 age range, 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 70% having moderate to severe disability on referral to the service compared to approximately 40% nationally.
- During the audited SSNAP period 80% of patients seen by the CRS either demonstrate an improvement or maintain their ability, when scored against the mRS.
- 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.

6 month review findings

- The findings show that locally, most patients post stroke are suitable for a 6 month review
- 100% of 6 month reviews locally are completed face to face
- 36.8% of those screened were identified as requiring support. 85.7% of these have received psychological support locally compared to 66.6% nationally.
- Significant improvement noted in Mood/Behaviour and cognitive screening as part of the 6 month reviews. Pro-formas for relevant assessments are now on RIO and since the SSNAP result of 2016 (for the same period) screening for this has increased from 35% to 61.3%
- Contact has been made with the Stroke Association to streamline 6 month review processes across BHR economy.
- Meeting/ discussions have held to compare stroke review forms of Havering/B&D and Redbridge and share with Stroke Strategy groups

Communication between BHRUT and NELFT

- NELFT is now receiving a list of stroke patients discharged directly from BHRUT wards.
- Stroke discharge summaries are to be obtained directly from BHRUT of patients referred rather than via GP.

Actions taken:

- Psychological support - Lack of psychology is a known identified gap within the current stroke pathway and identified funding resourced for a 0.2wte neuro psychologist to sit within the stroke pathway. Successful candidate due to start in January 2019

- 6 month review - Proposed changes submitted to leadership to the stroke reviews in Havering and Barking & Dagenham. As a result all stroke reviews will be completed via home visits ensuring efficiencies within the review system.
- Stroke Nurse appointed substantively

- NELFT has increased their working relationship with NELFT's Consultant Clinical Neuropsychologist in providing, not only support and intervention to patients but also support to staff.

- Boroughs participating in the audit (Havering, Barking & Dagenham) have been working on enhancing 6 month review process to ensure a more streamlined, equitable service is provided

- Locally, regular stroke standards meetings held across the stroke pathway to monitor and identify actions to continue to enhance adherence to National Stroke Standards.

- First meeting of Stroke forum held in October 2018 (to be held 4 x years) to increase joint working across neuro psychology and stroke services within NELFT.

POMH UK audit Topic 16b - Rapid tranquillisation (RT) in the context of the pharmacological management of acutely-disturbed behaviour

During March to May 2018, 54 specialist Mental Health Trusts or healthcare organisations within the UK participated in this re-audit of rapid tranquillisation. Data was received for 2392 episodes of acutely-disturbed behaviour involving patients in acute adult, psychiatric intensive care or low, medium or high secure wards, under the care of 358 clinical teams.

The standards are derived from NICE Guideline NG10: Violence and aggression: short-term management in mental health, health and community settings.

Participation level
6 clinical teams and 21 episodes were submitted by NELFT at re-audit 2018.

Performance against practice standard 1
1a In NELFT for 80% of episodes, IM medication was administered for which there was a prompt debrief and the standard was met within 72 hours

1b In NELFT for 30% of episodes where IM medication was administered for which there was documented evidence that within a week of the episode, the patient's written care plan addressed the management of any future episodes of acutely-disturbed behaviour.

1c In NELFT for 10% of episodes where IM medication was administered for which there was documented evidence that within a week of the episode, the patient's written care plan acknowledged their preferences and wishes for the management of future episodes of acutely-disturbed behaviour

Performance against practice standard 2

In NELFT for approx. 70% of episodes where intramuscular haloperidol was administered for which there was documented evidence of a recent ECG for the patient.

Performance against practice standard 3

3a In NELFT for 30% of episodes, where IM medication was administered, for which the mental and behavioural state of the patient was assessed (allowing for a BARS rating) at least once in the hour following the period of rapid tranquillisation.

NELFT % of episodes there was at least one documented test:
Pulse rate, Blood Pressure & Temperature = 20%
Respiration rate = 55%

3b Physical health measures recorded in the hour following rapid tranquillisation for episodes involving not-at-risk and at-risk patients
Standard was met for 15% of episodes with patients not at risk

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 18a Prescribing Clozapine (Baseline audit).

The aim of this baseline audit is to monitor patients prescribed clozapine, including physical health monitoring, in line with NICE guidance QS80.

The data collection period was June to July 2018, a total of 74 cases have been submitted for NELFT with 16 participating teams.

NELFT specific outcomes and findings
Treatment target
- Documented discussion with the patient, family and/or carers about potential benefits and side effects – 70%

- Performance against Practice Standard 1 - Pre-treatment screening should include physical examination, with assessment of the cardiovascular system

- Documented pre-treatment measures of blood pressure, pulse rate, body weight, plasma lipids, plasma glucose, and a general physical examination in patients treated with clozapine for less than 18 weeks: Trust sub-sample n=18

Standard met for:
Blood Pressure – 100%
Heart/ Pulse Rate – 100%
Body weight/BMI/ Waist circumference – 80%
Plasma lipids – 80%
Plasma glucose – 65%
General physical examination – 70%

- Performance against Practice Standard 3 - Monitoring in the first two weeks of treatment should include at least daily assessment of temperature, blood pressure and pulse

- Documented daily measures of temperature, pulse rate and blood pressure in the first 2 weeks of clozapine treatment in patients treated with clozapine for between 2 and 18 weeks: Trust sub-sample N=15

Standard met for:
Temperature – 90%
Pulse rate – 95%
Blood Pressure – 95%

- Performance against Practice Standard 6 - Patients established on clozapine treatment for more than a year should have an annual medication review, taking account of therapeutic response and recognised side-effects

- Documented blood pressure, pulse rate, body weight, plasma lipids, plasma glucose, and a general physical examination in the past year in patients treated with clozapine for more than 1 year: Trust sub-sample N=48

Standard met for:
Blood Pressure – 90%
Body weight/BMI/ Waist circumference – 90%
Plasma lipids – 45%
Plasma glucose – 50%
General physical examination – 45%

The national report published in early 2019.

NELFT specific report published February 2019

POMH-UK audit Topic 6d Assessment of the side effects of depot antipsychotics.

The aim of the audit is to measure Trust compliance with NICE guidance CG178 & QS80:
1. Antipsychotic side effects should be monitored routinely and regularly (NICE 2002, 2009)
2. People receiving depot preparations should be maintained under regular clinical review, particularly in relation to the risks and benefits of the drug regimen (NICE 2002, 2009)
3. The side effects associated with antipsychotic drugs should be 'assessed using standardised methods and validated rating scales' (Clinical Standards Board for Scotland 2001).

The data collection period was 3 Sep to 31 Oct 2018.
The data entry period was 1 Nov to 30 Nov 2018, a total of 98 cases have been submitted for teams and services across NELFT.

The National report is due for publication in April 2019.

POMH-UK audit Topic 7f - Monitoring of patients prescribed lithium

This re-audit will measure Trust compliance with NICE Guidance CG185 standards for the monitoring of patients prescribed lithium, including physical health monitoring. Participation in national POMH-UK audits benchmarks the Trust against other similar trusts.

NHS Trusts UK wide are collecting data at present, the data collection period is February to March 2019. Total number of cases submitted for NELFT is 54. The national report is due for publication in July 2019.

Child Health Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Mental Health Conditions in Young People – Continuous audit

No planned data collection during 2018/19 financial year (1st April – 31st March 2019). Audit to recommence in 2019/20

National Confidential Inquiry into Suicide and Homicide for people with mental illness (NCISH), National Annual Report 2018

The 2018 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) which is commissioned by the Healthcare Quality Improvement Partnership (HQIP) provides findings relating to people who died by suicide or were convicted of homicide in 2006-2016 across all UK countries. Additional findings are presented on sudden unexplained deaths under mental health care in England and Wales. *(NCISH, 2018)*

NCISH key themes derived from national report

- 28% people who died by suicide had contact with mental health services in the previous 12 months
- Inpatient care – Services should make sure wards are a safe place for you to recover
- Young people – A wide range of professionals should be able to help you if you are in crisis
- Recent self-harm - Everyone should get a good assessment after self-harm
- Woman - Services need to recognise why women can be at risk of self-harm and suicide

Actions taken:

- The 2018 National NCISH report has been shared with the AMD for Community of Practice adult mental health and Learning Disability Lead for onward dissemination
- Local level summary and report to be developed for the Trust, taking into consideration key findings

Appendix 2c
Pharmacy: Medicines Management audits

Mental Health Act (MHA) T2/T3 Spot check audit (re-audit)

This is a re-audit to measure compliance with standards for the accurate completion of the Consent to Treatment s58 forms T2 and T3.

Outcomes and Areas of Improvements:

- High dose antipsychotic was documented and covered under the forms in 100% of cases compared to 90% in the previous audit.

Actions undertaken:

- Re-education for Nurses in regards to the importance of the T2, T3 and S62 forms to be attached to medicine card
- Ensuring the right phrase 'either an approved clinician or a SOAD' is deleted appropriately on T2 form by the consultants
- Ensuring medication listed on the T2 or T3 form by the consultants, including when required (PRN) is solely for the treatment of mental health disorder
- Ensuring all medication for mental health disorder on the medicine card is listed on the T2 or T3 form by the consultants

Assessing compliance with VTE risk assessments and prescribing of appropriate anticoagulation across NELFT Community Health Service inpatient wards

The aim of the audit is to review the adherence and application of the Trust guidelines for the assessment and pharmacological prevention of venous thromboembolism (VTE)

Outcomes and Areas of Improvements:

- Where VTE prophylaxis was not prescribed, 100% of patients had a reason documented as to why.
- 92% of VTE risk assessments were completed within 24 hours of patient admission
- 86% of prescribed pharmacological VTE prophylaxis was prescribed in accordance with Trust guidelines.

Actions undertaken:

- To consider making the templates for the London and Essex risk assessments as harmonised as possible.
- To ensure nursing and pharmacy staff are more vigilant in identifying non-completed risk assessments.
- To achieve an improvement in the number of risk assessments completed within 24 hours
- Prescribers to improve awareness and application of Tinzaparin dosing guidelines
- To align dosing parameters in Trust guidelines with dosing guidelines in the Tinzaparin memorandum.
- To ensure all prescribers are aware of the dosing parameters outlined in the Tinzaparin memorandum, in particular how to prescribe according to renal function and weight.

Annual Antibiotic Audit:

- The annual antibiotic audit is carried out as part of the national Antimicrobial Stewardship programme. Standards are derived from the NICE guideline NG15 Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use and Quality Standard QS121 Antimicrobial Stewardship. The pharmacy team implemented a programme of RAC (rapid audit cycle) audits to monitor compliance. Four RAC cycles were completed and there has been sustained improvement.

Outcomes and Areas of Improvement:

- 100% Compliance was maintained with Standard 2
- 100% of patients were on antimicrobial therapy within the appropriate Formulary

Actions undertaken:

- Doctors to ensure that the allergy box, duration and indication are completed on the patient's medicines chart/EPMA/EPR.
- Pharmacists and nursing staff to continue to support the doctors in ensuring that the allergy box, duration and indication are completed on the patient's medicines chart/EPMA/EPR.
- Annual re-audit cycles are to be continued to ensure standards are maintained in line with the Trust's Formulary.

Antimicrobial prescribing in the community for NELFT CHS and MHS NMPs

The audit aims to provide assurance that NELFT community Non-Medical Prescribers (NMPs) are compliant with local initiatives:

- Issue a "treating your infection" leaflet to patients to support the prevention of antimicrobial resistance agenda where appropriate;
- Provide assurance that where the above leaflet is not issued or re-enforced, there is good clinical reasoning for not doing so;
- Provide assurance that where an antibiotic is prescribed, it is in line with local formularies;
- Ensure that where a non-formulary antibiotic is prescribed, there is good clinical reasoning for doing so;
- Formulary prescribing should account for the majority of prescribing that takes place;
- To determine percentage of patients having samples tested before antibiotics are started.

Outcomes and Areas of Improvement:

- Two of the three standards achieved last year were achieved again this year at 100%
- Six out of the nine standards set this year were achieved at 100%
- 100% of patients appropriate for re-enforcement of leaflet information already issued to them, had it re-enforced
- 100% compliance with local formularies
- 100% of patients had their drug history checked for previous antibiotic usage
- 100% of patients with UTIs already having the leaflet have it re-enforced where appropriate
- 100% of patients having their UTI symptoms correctly interpreted for antibiotic initiation
- 100% of patients having their Urine dipstick results correctly interpreted for antibiotic initiation

Actions undertaken:

- To raise awareness of reporting and UTI Leaflet
- To redesign of audit tool - Add male/female question for UTIs
- To raise awareness of broad spectrum antibiotic prescribing

- **Community Recovery & Assertive Outreach Services:** The WHITE zone criteria are 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. The re-audit has demonstrated significant improvements in the White Zone of which 57% of clients experiencing face-to-face contact compared to 37% in the baseline audit 2017, however the proportion of clients not seen but contacted by telephone dropped from 24% in 2017 to 11% in the re-audit 2018.

- **Improving access to psychological therapies (IMPART):** People with a personality disorder (PD) diagnosis or PD traits require inpatient mental health care and it is important that they receive the support they need. IMPART service users who have received inpatient mental health care, to be recruited and interviewed for the study focusing on eliciting from the services users their thoughts, perceptions and views about their experiences with inpatient mental health care with a focus on what they found helpful and/or unhelpful. IMPART to provide training and consultation to inpatient staff. Information sheets and leaflets will be made available supporting staff members in dealing with service users on wards.

- **Children Targeted Services:** Referral process, client experience and journey into and through the Autism Spectrum Disorder (ASD/C) service to be improved ensuring faster referral services. Areas of delay and inaccuracy identified so that the flow can be improved, including improved efficiency, as well as improved client and referrer experience. Best practice guidelines were reviewed (e.g. NICE, Autism Act) and specific criteria created to compare to referrals into the service. Surveys are being created for clinicians who are making referrals and for clients to gain understanding of their experiences of the referral process.

- **Long Term Conditions Services:** Cognitive Stimulation Group has been implemented with the aim to improve the well-being of people with early stages of dementia. The pre and post measure scores suggest that the content of the cognitive stimulation group has been effective in helping the mental well-being of participants with early stage dementia.

- **Nutrition and Dietetics Service (N&D):** Training programmes on the dysphagia programme to be further adjusted to place greater emphasis on texture modified diets to improve participant knowledge of target areas pre and post training. Changes will include jargon free training and training which is made more accessible to non-native English speakers. Training sessions will be shorter and target more specific areas of dysphagia management; visual aids are incorporated to describe the difference between the texture modified diets and to aid explanation of aspiration. More time will be allocated to the explanation of risk feeding; and training to be offered on a cyclical basis to account for staffing levels and staff turnover.

- **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 admin staff to follow the process for transferring out universal caseload records, which involves recognition of a 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. All staff working within Health Visiting Teams to be made aware of the transfer in and out process.

- **Acute & Rehabilitation Directorate:** 'Readiness to Discharge' (RTD) is described as the estimate of a patient's ability to leave a service and the perception of being prepared or not prepared for discharge (Steele & Sterling, 1992). Development of a checklist to be designed to identify areas relevant to RTD which will capture information such as; DBT skills, goal achievement, reductions in behaviour targets, better understanding of difficulties, perceived loss of support, fears associated with coping alone, the future, dependency on a mental health service and the environment and personal views around endings. This will act as a reminder for therapists to address these aspects in sessions with clients.

- **Older Adults Mental Health & Memory Service:** Older Adults Home Treatment Team (OAHTT) staff to complete forms for every patient admitted including the admissions after MHA assessments.

- **Older Adults Mental Health & Memory Service:** The Young onset dementia network collaborative group have written a care pathway to guide services along with creating a GP decision making tool for young onset dementia. 100% of dementia diagnoses are now being followed up six monthly by memory advisors.

- **Child Health Services:** Look After Children (LAC) Health Service to continue to work with the Local Authority and Universal Services to identify reason in the delay of Review Health Assessment (RHA) timeliness and to improve the processes to reduce these delays. Training packages are revised to include the importance of achieving timeliness discussion on oral health with carer, health promotion activity, appropriate reference to Strength and Difficulties Questionnaire (SDQ) and for allowing the voice of the child throughout the RHA. Specialist LAC Nurses to continue to quality assure all RHAs using the updated tool.

- **Children Services:** Autism Spectrum Disorder (ASD) pathway leads (medical and therapy leads) identified to provide strategic leadership and drive improvements in the diagnostic process of Autism Spectrum Disorder (ASD) assessments and establishing the profile of the child's strengths, skills, impairments and needs, translating this into post diagnosis intervention.

- **Early Intervention Service:** A business case is currently being developed to improve access to psychological services for patients with voice disorders across boroughs of Barking & Dagenham, Havering and Redbridge.

- **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.

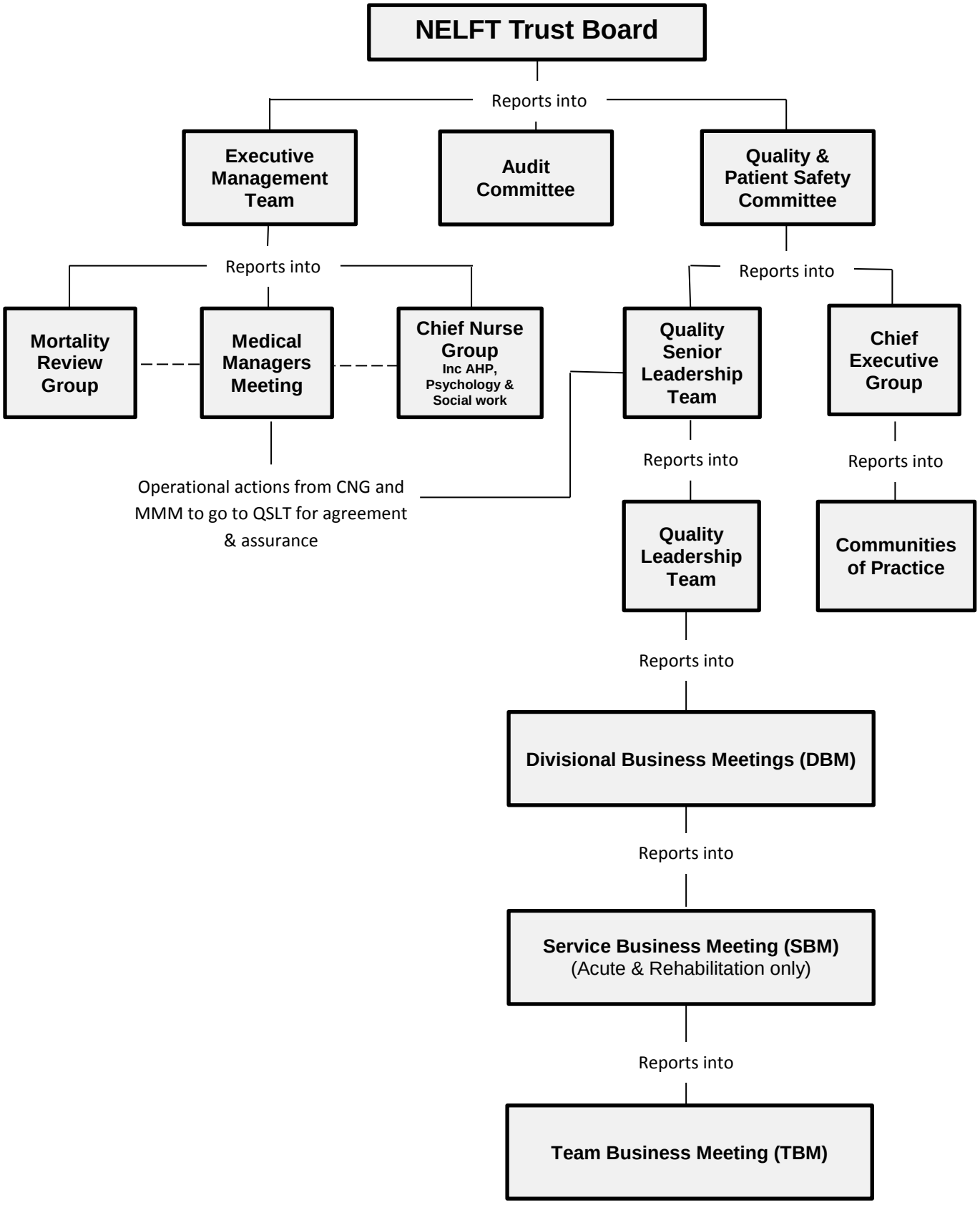
- **A&E Liaison:** Further training delivered and provided to the Psychiatric Liaison Service and Out-of-hours staff regarding the completion of risk assessment proformas.

- **Access & Assessment:** Clients on initial medical assessment have their allergy status checked and documented in their progress notes. This increased from 27% to 62%, shifting the compliance from red zone to amber zone. All clinicians who incorporated allergies as a sub-heading into their proformas were documenting allergy status 100% of the time.

- **Patient Experience & Effectiveness:** Dementia Crisis Support Team (DCST) demonstrated compliance of 42% with DCST standard of assessing within 4 days from referral to initial assessment and discharge within 6 weeks. The DCST's overall aim is to be able to assess in a shorter period of time, improving patient experience, therefore further reducing hospital admissions and team figures for 'over stay'.

- **Patient Experience & Effectiveness:** All care co-ordinators encouraged to complete a questionnaire regarding reasons they struggle to see clients face-to-face once a week in the audited zones. This will help to identify key factors such as caseload or clients not attending meetings. Documentation to be improved to ensure all client contacts are captured on RiO.

Appendix 3
Quality Report governance structure



Appendix 4
Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

NHS BASILDON AND BRENTWOOD & THURROCK CCGs COMMENTARY ON NORTH EAST LONDON FOUNDATION TRUST 2018/19 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.

Commissioners in Mid and South Essex remain pleased with the delivery of services to our population and the constructive partnership that exists between CCG officers and our colleagues at the Trust

HIGHLIGHTS FROM 2018/19

Commissioners commend the Trust's hard work in maintaining an overall CQC rating of 'Good' and outstanding in four areas including child and adolescent and forensic in-patient ward areas. It is also noteworthy that the former unit was subsequently awarded the 2018 RCN Mental Health Practice Award.

The Trust should be commended for the great work being undertaken to ensure a culture of inclusiveness including the achievements in meeting the Workforce Race Equality Standard and LGBT initiatives.

PRIORITIES FOR 2019/20

The use of QI methodology to deliver the safety priority, ensuring that care plans and risk assessments are consistent across the trust is a good development that will support sustainability.

The effectiveness priority two, ensuring care plans are complete and recovery focused will contribute to patient care and outcomes and is also welcomed by commissioners.

Commissioners note the effectiveness priority three is not applicable the Mid and South Essex STP.

The fourth priority, well led, focusses on the Trusts most important asset, the staff. Commissioners support the focus on appraisals and development plans, tackling violence in the workplace.

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.

PROGRESS AGAINST 2018/19 PRIORITIES

Commissioners note the following:

Priority 1 Safe

Goal 1 – The Trust achieved the goal to ensure 75% of risk assessments are recorded for EWMHS in Essex

Goal 2 – Implementing a system for monitoring and auditing risk assessments did not achieve the goal of 75% for community health services for adults

Goal 3 – Completion of falls assessment made good progress but failed to reach the 100% target.

Priority 2 Effective

(Not applicable to Mid and South Essex STP)

Priority 3: Responsive

(Not applicable to Mid and South Essex STP)

Priority 4: Well Led

Goal 1 – Commissioners note that compliance for mandatory training NELFT wide has been consistently above their 85% target.

Goal 2 – The Trust achieved the goal of supporting management through effective use of business intelligence.

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 2019/20 and are committed to working collaboratively with the Trust to support the continually improve of patient safety and quality of care.

Havering Healthwatch Limited

Dear John

Thank you for sending the Quality Account.

The report reads well, and it is good to see transparency regarding what has been achieved and what is a goal that still needs to be achieved. As is often the case when you begin a new contract and take on a service which requires some realignment and a dependency on former records, particularly when these are paper records, the movement to electronic data systems which is essential to good patient care and clinical monitoring can take time. However, again progress is being demonstrated.

We particularly support the new priorities of Safeguarding supervision and monitoring Violence and Aggression training and the use of the staff survey to help identify and support staff.

The continued drive to ensure care plans include the five elements of care planning – consent and capacity, social situation, collaborative, risk assessment, and recovery focused are at the centre of the work. To continue to embed this for in- patients across adults, child and adolescent and psychiatric intensive care bed.

Again, it was very pleasing to see so many staff, two full pages, congratulated nationally and given awards for their work. Healthwatch Havering would like to congratulate you and recognise all staff for the hard work and dedication that they have show to patients, families and friends in our borough.

We wish you well with you CQC Well Led Inspection.

Best,

Anne-Marie Dean

Chairman

Havering Healthwatch Limited - A company limited by guarantee - Registered in England & Wales no.08416383

Registered Office and postal address: Queen's Court, 9-17 Eastern Road, Romford RM1 3NH

Telephone 01708 303300 (24hr voicemail)

https://www.healthwatchhavering.co.uk

Via email on jacky.hayter@nelft.nhs.uk
Ms Stephanie Dawe
Chief Nurse and Executive
Director of Integrated Care
NELFT NHS Foundation Trust
CEME Centre – West Wing
Marsh Way
Rainham Essex
RM13 8GQ

Members Suite
Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Direct Dial: 03000 416512
Email: HOSC@kent.gov.uk
Date: 20th May 2019

Dear Stephanie

Quality Accounts

Thank you for offering Kent County Council's Health Overview and Scrutiny Committee the opportunity to comment on NELFTs draft Quality Account. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

Given the number of Trusts which will be looking to KCC's HOSC for a response, and the window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Please be assured that the decision not to comment should not be taken as any reflection on the quality of the services delivered by your organisation and as part of its ongoing overview function, the Committee would appreciate receiving a copy of NELFTs Quality Account for this year once finalised.

Kind regards

Sue Chandler
Chair, Health Overview and Scrutiny Committee
Kent County Council

NHS
West Essex
Clinical Commissioning Group

Statement from West Essex Clinical Commissioning Group

West Essex Clinical Commissioning Group is responsible for the commissioning of the Emotional Wellbeing and Mental Health Service (EWMHS) from North East London NHS Foundation trust (NELFT). The service provides early intervention, support and mental health services for children and young people living in all of Essex.

During 2018/19 NHS West Essex CCG carried out quality visits to the EWMH services throughout Essex, along with the standing monthly quality and contract review meetings and continuous informal dialogue with the Trust, Commissioners are able to comment on the information provided within the quality account.

NELFTs priorities from 18/19 were broadly achieved, and had specific EWMHS components. These priorities and their application within the service are being carried forward into a second year to work on the areas where further improvement can be made and to consolidate progress from year one.

The Trust is adding the following priorities for 2019/20; staff appraisals, addressing staff safety/ monitoring violence and aggression training and the Board of Governors priority covers the uptake and compliance with child safeguarding supervision in all localities.

Commissioners are completely supportive of the continuation of last year's priorities in the EWMHS service, particularly where there are improvements that can be delivered.

We confirm that we have reviewed the information contained within the draft account and checked this against data sources where these are available; it is accurate in relation to the services provided. Some data in relation to required information is still being collated (so is not included in this draft) and will be added to the final version.

The Quality Account requirement for the inclusion of specific information to demonstrate the organisations learning from deaths has been included in detail and the Trust has identified learning from their review of patient deaths during the year.

NELFT have clearly stated the process for staff to be able to speak up through their Freedom to Speak up Guardian, the themes of issues being raised and how these are being managed.

Currently the Trust have not included a statement/report regarding junior doctors safety with regard to any rota gaps and plans for improvement to reduce these gaps, which was a requirement for this year's account. We are confident this will be added to the final version.

The Trust has explained the governance process in relation to the production of the Quality Account and how readers can give feedback.
The structure of the account, Part A and Part B make it easy to navigate and understand.

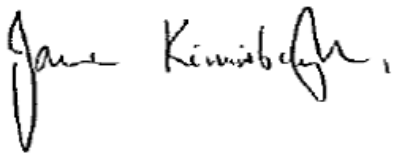
The information on national and local audits with the detail of how NELFT have responded to national reports is particularly comprehensive and provides assurance that the Trust process for learning from national reports is robust.

We would be grateful if NELFT would review whether the views of children and young people could specifically be sought in preparation for the 2020/21 priorities.

Dr Rob Gerlis, Chair
Andrew Geldard, Chief Officer

NHS
West Essex
Clinical Commissioning Group

Commissioners will continue to work collaboratively with NELFT to ensure sustained and embedded improvements within community mental health services for children in Essex.



Jane Kinniburgh
Director of Nursing and Quality
West Essex Clinical Commissioning Group.

May 2019

London Borough of Waltham Forest – Health Scrutiny Committee

Feedback on NELFT NHS Foundation Trust Quality Account 2018/19

The Health Scrutiny Committee is pleased to see the Trust's focus on continuous learning and improvement and its commitment to integrated care, as set out in the new Corporate Strategy.

In 2018/19 the Health Scrutiny Committee reviewed Child and Adolescent Mental Health Services (CAMHS) and the access to mental health services experienced by homeless people in the borough. These reviews were supported by the Trust's staff throughout the year, who provided us with their time and input.

The review of Waltham Forest CAMHS was prompted in April 2018 by an increase in waiting times and a rise in the thresholds for support. The Committee recognises that this had a detrimental impact on children and their families. The Health Scrutiny Committee received a number of updates from the Trust from October 2018 to April 2019 detailing access to CAMHS and the actions taken to address the issues identified. We are pleased to hear that the Trust has been successful in securing additional funding to increase capacity and that waiting times have decreased as a consequence. The Committee is also pleased to note that Priority 1 for of the Quality Account is to improve performance in regards to care plans and risk assessment, including that of CAMHS across London. The Committee will continue monitoring the situation closely to support children and adolescents in Waltham Forest receive the mental health services they need, including prevention services.

As part of its Themed Review report into Health Outcomes for People who are Homeless, the Committee received input from the Trust noting that "there are no systems in place within mental health services to monitor homelessness and individuals throughout the care pathway who are homeless". The Committee would like to express its concern regarding the lack of specific support offered to homeless patients with their mental health needs. The Committee has included a recommendation in its themed review report regarding inreach housing support for all mental health inpatients.

The Committee would like to congratulate the Trust on its 2017 CQC 'Good' rating and on having four service areas rated as 'Outstanding' in 2018. It particularly notes the overall 'Outstanding' rating of child and adolescent mental health wards at the last inspection. The improvement priorities for 2019/20 – focused on safety, effectiveness, responsiveness and leadership – build on the outcomes of the inspection and are a positive step in continuous improvement.

In addition to the CQC inspection and 19/20 priorities, the Committee would like to emphasise the positive outcome of NELFT's performance against the Single Oversight Framework. The Trust has demonstrated it performs strongly against most indicators, having set out future actions to improve its performance further.

The Committee applauds the Trust's efforts in improving its compliance, performance and capacity over the last year, and it looks forward to hearing how the Trust's improvement priorities will continue supporting its service users in 2019/20.

THURROCK COUNCIL

We continue to work very closely with NELFT as key partners in the Thurrock Alliance. We have signed off a Memorandum of Understanding (MoU) between all organisations across the NHS and the Council during 2018/19 which clearly laid out how we would continue to work together jointly to improve services locally and not hide behind organisational boundaries. We see this as a significant step on our integration journey that lays out how we will all be working together much more closely over the next 3 – 5 years.

Roger Harris
Thurrock Council
Civic Offices
New Road
Grays
Essex RM17 6SL

Healthwatch Kent response to the North East London NHS Foundation Trust Quality Account

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

This takes up a large amount of time, so we have taken the decision to prioritise our resource on making a difference to services rather than reading Quality Accounts.

However, we'd like to support the Trust by setting out the areas we have worked together on in the past year:

- In 2016 we published a reported detailing feedback from over 300 people about the Children & Adolescent Mental Health service. Our recommendations were then incorporated into the new service specification which NELFT are now delivering against. We've met with them to understand how they are progressing our recommendations.
- We've met with key staff members to keep updated about the service and understand the challenges.
- Following the recent Ofsted report on services for children with special educational needs, we will be working with NELFT as part of the resulting action plan.
- We will shortly be publishing a report detailing the feedback we've heard about autism services. We look forward to working with the Trust on our recommendations.
- We will continue to share what we are hearing about NELFT services with the Trust.

We look forward to continuing our constructive working relationship with the Trust in the next year.

Healthwatch Kent May 2019

Appendix 5
2018/19 Statement of directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Reports) Regulations to prepare Quality Reports for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period 19/05/2018 to 21/05/2019
    - papers relating to quality reported to the Board over the period 19/05/2018 to 21/05/2019
    - feedback from commissioners dated 17/04/2019 to 17/05/2019
    - feedback from governors dated 17/05/2019 and 20/05/2019
    - feedback from local Healthwatch organisations dated 23/04/2019 and May 2019
    - feedback from Overview and Scrutiny Committee 08/05/2019 and 20/05/2019
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2018 national patient survey 22/11/2018
    - the 2018 national staff survey 26/02/2019
    - the Head of Internal Audit's annual opinion over the Trust's control environment 23/04/2019
    - CQC inspection report dated 18/01/2108
- 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 Reports regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the Board

Date 21.05.2019 Signature  Trust Chair

Date 21.05.2019 Signature  Chief Executive

Useful contact numbers

Trust Head Office
CEME Centre
Marsh Way, Rainham, Essex RM13 8GQ
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 & Kent	Linda Morcombe	0300 555 1201 Ext 52708
Barking & Dagenham	Sheila Wright	0300 555 1201 Ext 65075
Havering	Lisa Askew	0300 555 1201 Ext 66234
Redbridge	Jenny Cook	0300 555 1201 Ext 54422
Waltham Forest	Bernadette Duffy	0300 555 1201 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
Head of Equality, Diversity and Inclusion
Email: harjit.bansal@nelft.nhs.uk
Tel: 0300 555 1200 ext. 64231

Trust membership

Members get information on local health services and shape how these develop. Members can also stand as governors and take part in key activities. Membership is free. For more information contact NELFT on tel. 0800 694 0699

Careers

For the latest information on vacancies at NELFT please visit our website at www.nelft.nhs.uk

You can follow us for news and upcoming events for our users and members:

on twitter.com/NELFT

on www.facebook.com/NELFTNHS

on LinkedIn www.linkedin.com/company/north-east-london-nhs-foundation-trust

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 to perform an independent assurance engagement in respect of North East London NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority 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
- inappropriate out-of-area placements (IOAP) for adult mental health services

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 2018/19* ('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 Guidance.

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 19 May 2018 to 21 May 2019;
- papers relating to quality reported to the board over the period 19 May 2018 to 21 May 2019;
- feedback from commissioners, dated 17 April 2019 to 17 May 2019;
- feedback from governors, dated 17 May 2019 to 20 May 2019;
- feedback from local Healthwatch organisations, dated 23 April 2019 and May 2019;
- feedback from Overview and Scrutiny Committee, dated 08 May 2019 and 20 May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2018 national patient survey, dated 22 November 2018

- the 2018 national staff survey, dated 26 February 2019;
- Care Quality Commission Inspection, dated 18 January 2018
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 23 April 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the 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 and the Inappropriate Out of Area placements indicator.

When calculating the performance for both indicators the Trust considers each case in the reporting period and manually classifies it as compliant, non-compliant or exempt. For both indicators 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 7/13 cases in our sample for EIP testing and 11/27 cases in our sample for IOAP testing.

As a result of these issues, we have concluded that the EIP and IOAP indicators for the year ended 31 March 2019 have 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.

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 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

28 May 2019

If you would like this information in Braille, large type, in another format or in another language, please ask a member of staff. (English)

Bu bilgileri büyük yazı tipinde Körler Alfabesinde, başka bir biçimde ya da başka bir dilde okumak isterseniz lütfen bir görevliye danışın. (Turkish)

Nëse këtë informacion do e dëshironit në Braille, font më të madh, në format tjetër apo gjuhë tjetër, ju lutem pyesni një anëtar të personelit. (Albanian)

Se desejar obter esta informação em Braille, num tipo de letra maior, noutro formato ou noutro idioma, por favor peça a um membro do pessoal. (Portuguese)

আপনি যদি এই তথ্যটি ব্রেইলে, বড় হরফে, অন্য ফরম্যাটে বা অন্য ভাষায় পেতে চান, অনুগ্রহ করে, কর্মীদলের একজন সসদস্যকে তা জানান। (Bengali)

در صورت تمایل به دریافت این اطلاعات به صورت بریل، چاپ درشت، یا سایر فرمت‌ها یا زبان‌ها، لطفاً درخواست خود را با یکی از کارکنان ما مطرح کنید. (Farsi)

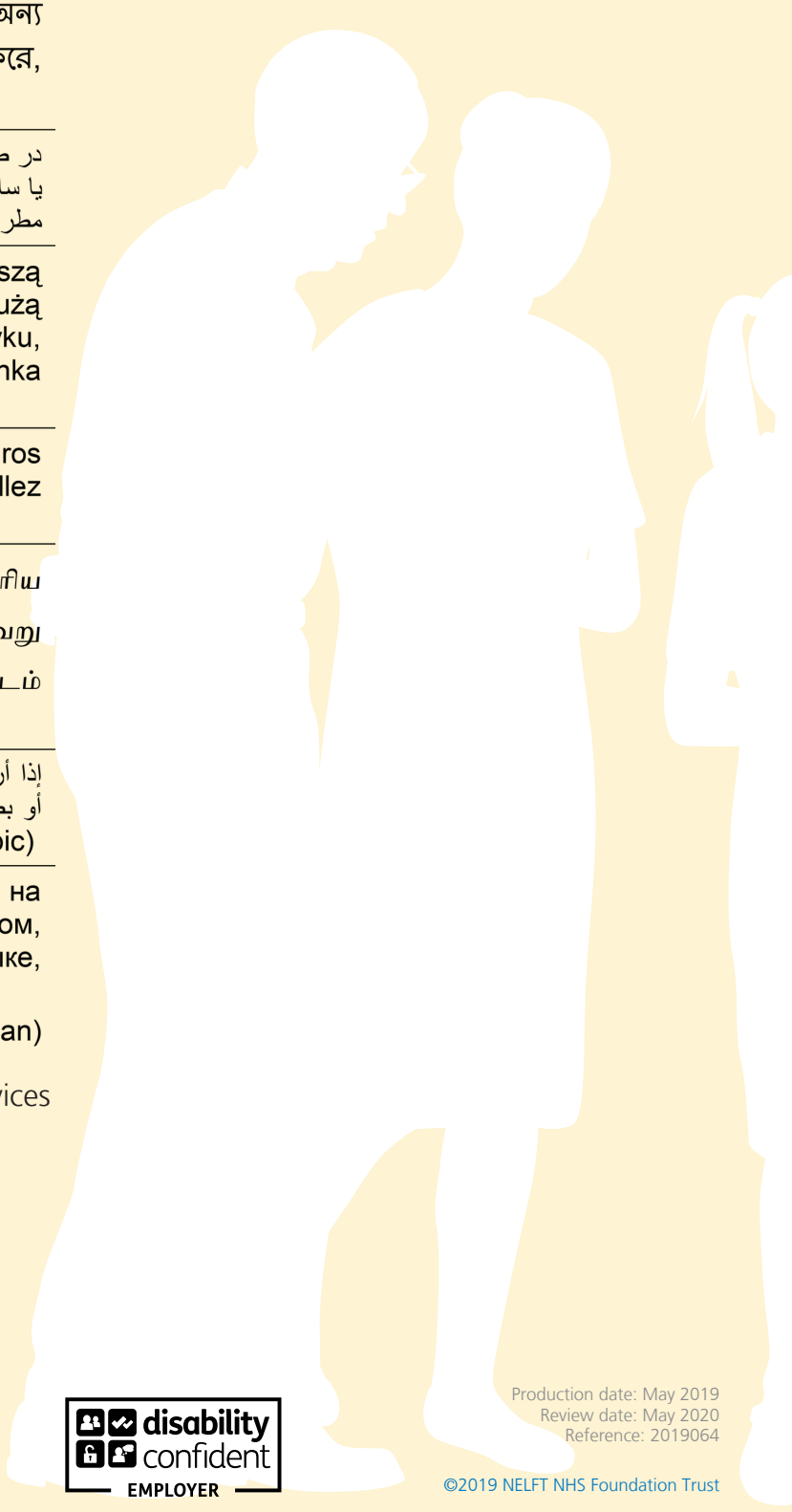
Jeżeli chcieliby Państwo uzyskać niniejszą informację zapisaną w alfabecie Braille'a, dużą czcionką, w innym formacie lub w innym języku, prosimy zwrócić się w tej sprawie do członka personelu. (Polish)

Si vous souhaitez obtenir ces informations en gros caractères Braille ou dans une autre langue, veuillez le demander à un membre de l'équipe. (French)

நீங்கள் இத்தகவலை ப்ரெய்லியில், பெரிய எழுத்துகளில், வேறு ஃபார்மேட்டில் அல்லது வேறு மொழியில் பெற விரும்பினால், ஊழியரிடம் கேளுங்கள். (Tamil)

إذا أردت الحصول على هذه المعلومات بطريقة برايل، أو بحروف كبيرة، أو بصيغة أو لغة أخرى، يرجى طلب ذلك من أحد أعضاء فريق العمل. (Arabic)

Если вы хотите получить эту инфрормацию на языке Брайля, напечатанную крупным шрифтом, в другом формате или на другом языке, пожалуйста, обратитесь к любому сотруднику. (Russian)



NELFT provides community and mental health services for people of all ages in Essex and the London boroughs of Barking and Dagenham, Havering, Redbridge and Waltham Forest, as well as Barnet and Kent and Medway.

NELFT NHS Foundation Trust
CEME Centre – West Wing, Marsh Way,
Rainham, Essex RM13 8GQ.

Tel: **0300 555 1200**

www.nelft.nhs.uk

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