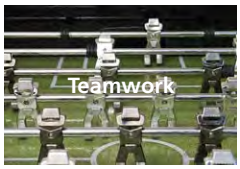
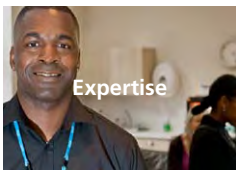
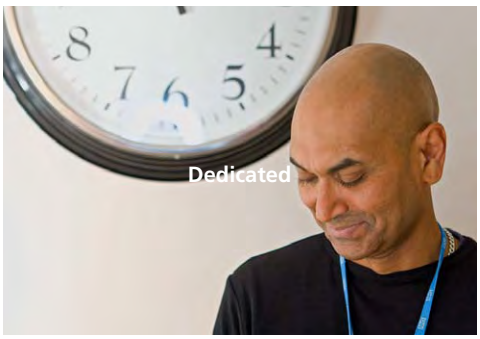
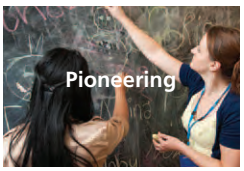
East London NHS
NHS Foundation Trust



East London NHS Foundation Trust Annual Report and Accounts 2012/13







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East London NHS Foundation Trust
Annual Report and Accounts 2012–13

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Foreword by Dr Robert Dolan, Chief Executive

The London 2012 Olympics and Paralympics proved to be a magnificent global event which influenced many of our activities last year. With our partners, we were keen to ensure we were ready for the predicted influx of 500,000 people and had strategies in place to ensure that services could run as normal.

The proximity of London 2012 presented an opportunity for us to focus on sport and exercise, to encourage and increase participation in fitness activities, to improve physical and mental health wellbeing. Staff developed activity programmes to really engage service users in becoming healthier. As an added incentive, the Trust purchased 446 Paralympic Games tickets with monies from our Charitable Trust Fund, to enable service users to attend a Paralympic event at one of the London 2012 venues to give them the experience of a lifetime.

A number of staff and service users were involved in the opening and closing ceremonies or were volunteers. They infected us with their enthusiasm and stories of meeting elite athletes, rehearsals and friendships made.

We were delighted to have the opportunity to join up with Richmond Borough Mind in June to jointly provide the Richmond Wellbeing Service. This was our first venture outside of East London and it has enabled us to build on the experience we have gained as an IAPT (Improving Access to Psychological Therapies) pilot in Newham and share our expertise more widely.

A key area of change for the Trust has been in the development of services for older people. In May, we opened Columbia Ward, a specially designed inpatient Dementia Assessment unit for East London. We linked up with Kingston University Dementia Design group who have expertise in designing interiors to meet the needs of people who are confused or disorientated. Centralising inpatient services has enabled us to establish an intensive therapeutic programme to help us fully assess inpatients and plan for their on-going care.

In Newham, we have pooled expertise by merging two continuing care services to provide an integrated health care unit for older people with complex physical and mental health needs. Dementia Services in Newham were singled out for praise at an international dementia conference by Care Services Minister, Paul Burstow. And in Tower Hamlets, Dementia Services received a Local Government Chronicle Award for moving from having one of the lowest rates of dementia diagnosis to now having one of the highest.

In Newham, we have further developed a range of options to support residents in getting well and staying well. The Telehealth Care System is now a mainstream approach which engages patients with a long term condition to self-monitor and self-manage their care with the support of health professionals. Virtual Wards can offer intensive care at home to avoid hospital admission and commence a programme of rehabilitation in the patient's home. The Hospital In-Reach Team can intervene to reduce length of stay in hospital and hand the care of patients over to the Virtual Ward team.

In Newham, our Podiatry were Services praised by Diabetes UK for offering the best foot care in England for people with diabetes with one of the lowest rates for minor and major amputations – a high risk for people with diabetes. The Trust has also introduced a Specialist Diabetic Service for people with a mental health diagnosis and diabetes to improve their health outcomes.

There have been several developments in services to support young people and their families. In Newham, a multi-agency triage service has been introduced as a one-stop point of contact for professionals or members of the public to request support for a vulnerable child. The School Nursing team and Immunisation team in Newham achieved an HPV immunisation rate of 91.2%, the third highest in the country. CAMHS in City and Hackney are involved in national research to determine the best approach to reducing incidents of self-harm in teenagers. And we were successful in a joint bid to provide cognitive behavioural therapy to young people in Tower Hamlets and City and Hackney.

The Unit for Social and Community Psychiatry run by the Trust in collaboration with Queen Mary, University of London, became a World Health Organisation (WHO) Collaboration Centre. Officially opened in March 2013 by Professor Dame Sally Davies, the Chief Medical Officer at the Department of Health, the unit is one of just 18 mental health WHO Collaborating Centres in Europe and the only one specially designated for mental health services development. The unit will link research undertaken in East London to international work to benefit service development locally and in Europe.

This has been a significant year for technological developments in the Trust. We have focused on providing staff with the technology they need to work in any setting and have access to the systems and information they need to do their work. Many community staff now have laptop computers or tablets to record information as they go. (We issued our one hundredth laptop computer to a community mental health nurse in April.) Additionally, the introduction of Dragon Digital Dictation has revolutionised the way staff work and the time taken to produce written information, such as letters to service users and GPs and notes for our electronic records. Digital Pens are enabling health visitors in Newham to write their notes manually in the patient's home and download the information back at the office thus saving valuable time. These initiatives mean that staff have more therapeutic time to spend with service users and carers.

Improving quality has been a major focus for the Trust this year. We have been closely monitoring what service users say about our services; the number of incidents and complaints; if we are meeting our user-led standards; and the outcomes of care given. This is to bottom out what we need to do to truly improve the care and experience of those who use our services, and the support given to families and carers.

The Trust was successful in attaining Level 3 in the NHS Litigation Authority Risk Management Standards. We are the only mental health and community services trust in the country to meet this standard. It means the Litigation Authority has found our processes to be of high quality and that our work on safety is having an impact.

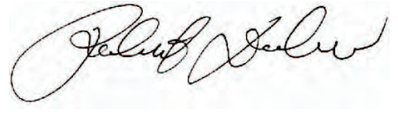
A number of our mental health services have been assessed under the accreditation schemes run by the Royal College of Psychiatrists, with many attaining an 'Excellent' rating. The Care Quality Commission has visited all our inpatient services and assessed these to be meeting all requirements. The assessments are extremely thorough and involve talking to inpatients and relatives on the telephone, as well as checking records and making their own observations.

To support our drive to improve quality, we have developed multidisciplinary staff training programmes with a difference. Actors are involved in a training programme to provide realistic scenarios for staff to refine their skills based on real incidents which have occurred. And in another setting, a computerised simulation dummy is helping mental health staff to refresh their skills and knowledge about physical conditions. Apprentice programmes are underway for junior nursing staff to develop leadership skills and expertise to move into more senior roles.

The Trust has also rolled out training to community based staff on the use of Automated External Defibrillators to improve the success rate after cardiac arrest in the event that someone collapses on Trust premises. Having competent, confident and able staff is key in driving up quality.

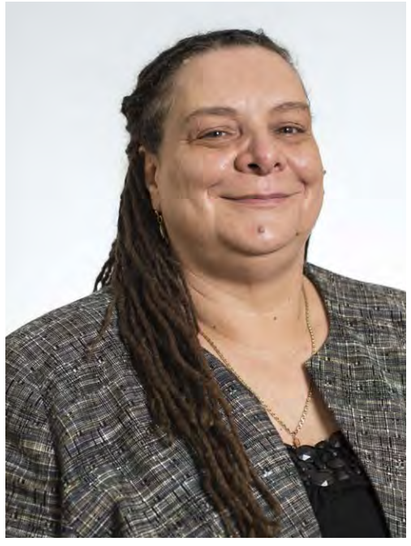
Listening to those who use our services will tell us if we are getting it right, where we are not and what we need to do to achieve this.

I was delighted to welcome Marie Gabriel, our new Chair, who started in the Trust in October. Passionate and dynamic, she has already had a positive impact on the Trust. She has met with staff, service users, governors, members, our volunteers and partners to establish a relationship and seek views about Trust services. I look forward to working alongside Marie in the coming years as the Trust evolves and grows to meet future challenges.



Dr Robert Dolan
Chief Executive

Statement by Marie Gabriel, Chair



I am delighted that my first Chair's report announces another year of great achievement at East London NHS Foundation Trust. This includes securing both national and international recognition for our work. For example, our Newham-based Unit for Community and Social Psychiatry became a World Health Organisation, (WHO) Collaborating Centre for Mental Health Services Development – one of only two in the country.

We have continued to deliver service improvements and develop new initiatives as we strive to be a Trust with the highest levels of service user and staff satisfaction. I have met many of our staff in their work place, and at events, and have been truly impressed by their unyielding commitment to quality improvement and obvious dedication to a true partnership with service users and carers. Also apparent is their resolute determination to increase efficiency and productivity. The Trust is full of remarkable people doing remarkable things every day and for this reason I am proud to say that most of the success stories in this report belong to them. I wholeheartedly thank all our staff, including our clinicians, for their hard work.

Critical to the governance of the Trust is our Council of Governors and the members who elect them. I have found our Council of Governors to be well informed, focused in debate and vigorous in their scrutiny of the Trust. Together with our members, our Council has made many innovative suggestions and been critical in ensuring that our priorities and strategies are truly informed by service users, carers, staff and the local community. I was able to witness first-hand the impact their contribution had on both our carers strategy and our annual plan priorities. I know that our resulting decisions are made more effective by their efforts. I am also proud that their input is having a national impact through their work with the Care Quality Commission. I take this opportunity to thank all the governors, including those who have departed this year, and would particularly like to thank the Deputy Chair for being so welcoming and challenging.

This year there has been a strong emphasis on building productive partnerships, especially with the new organisations emerging from the national NHS restructuring. Locally, we have been actively engaged with all health and social care partners in progressing integrated care. We have also been building partnerships beyond the NHS. For example with the third sector and with business identifying ways in which we can, together, improve care and organisational effectiveness. I thank all partners for their openness and willingness to participate in our joint endeavours.

Of course our key partnership is with our service users and their carers, who we recognise as equal partners in care. We are known for our service user engagement and continuously work with them to consider how they can be further involved in the planning, delivery and evaluation of Trust services. I have been particularly impressed by Florid and our work to employ our service users within the Trust. I thank all our service users and carers for their willingness to engage so purposefully in our work. This year we have had a specific focus on improving carers' engagement. In collaboration with our CCGs, (Clinical Commissioning Groups) we are developing CQUINs (*Commissioning Quality and Innovation* Framework) to enhance the support to all our carers, including young people. We are anticipating great results in the year to come.

It has been an inspirational six months for me and a successful 12 months for the Trust. As I look forward, there remain unprecedented challenges given the current economic climate; the bedding in of new NHS arrangements; and the continuous need to meet the demands of a growing and diverse population. These challenges and the creative energy of our service users, carers and staff are what keep things interesting and exciting for the Board of Directors. I am truly looking forward to the next 12 months!

Marie Gabriel
Chair

Directors' Report/Operating and Financial Review

Background Information
East London NHS Foundation Trust (formerly East London and The City University Mental Health NHS Trust) was originally formed in April 2000. In April 2007, the Trust was awarded University status in recognition of the extensive research and education undertaken in the Trust. On 1 November 2007, the Trust was authorised to operate as an NHS Foundation Trust under the National Health Service Act 2006.

In February 2011, the Trust integrated with community health services in Newham. We are now a trust which provides mental health and community health services.

The Trust's headquarters are in Tower Hamlets.

The Trust provides a wide range of community and inpatient services to children, young people, adults of working age, older adults and forensic services to the City of London, Hackney, Newham and Tower Hamlets. Forensic Services are also provided to Barking and Dagenham, Havering, Redbridge, Richmond and Waltham Forest. The Trust provides some specialist mental health services to North London, Hertfordshire and Essex. The specialist Forensic Personality Disorder service serves North London and the specialist Chronic Fatigue Syndrome/ME adult outpatient service serves North London and the South of England. Our specialist Mother and Baby Psychiatric Unit receives referrals from London and the South East of England.

The East London areas served by the Trust are the most culturally diverse and deprived areas in England and therefore provide significant challenges for the provision of mental health services. The Trust's local services are provided to a population of 710,000 in East London and the Trust's forensic services are provided to a population of 1.5m in North East London.

The Trust's 2012/13 income was £259m. The Trust's services operate from 64 community and inpatient sites and have over 735 general and specialist inpatient beds. The Trust employs approximately 3,700 permanent staff.

The seven main inpatient areas in our localities are:

City and Hackney
City and Hackney Centre for Mental Health
Homerton Row
London E9 6SR

Newham
Newham Centre for Mental Health
Glen Road
London E13 8SP

Tower Hamlets
Tower Hamlets Centre for Mental Health
275 Bancroft Road
London E1 4DG

The Coborn Centre for Mental Health
Cherry Tree Way
Glen Road
London E13 8SP

Community Health Newham
East Ham Care Centre
Shrewsbury Road
London E7 8QP

Forensic Services:
John Howard Centre
12 Kenworthy Road
London E9 5TD

and

Wolfson House
311-315 Green Lanes
London N4 2ES

A range of services is also provided through community teams, home treatment teams, crisis resolution teams, rehabilitation teams and assertive outreach services. The Trust aims to provide people with alternatives to admission, where appropriate, to provide treatment, care and support outside a hospital setting.

The Trust's postal address is:
Trust Headquarters
EastONE
22 Commercial Street
London E1 6LP

Tel: 020 7655 4000
Website: www.eastlondon.nhs.uk

Trust Vision, Strategic Objectives and Service Developments

Trust Vision

The Trust vision is to provide high quality community-orientated health care to local communities. The Trust will do this in partnership with service users, their carers and families and statutory and voluntary organisations.

In 2011/12 the development of new priorities and measures of quality and satisfaction represented a fundamental shift in the Trust strategy and a move away from the existing wide range of 'output' focused performance measures. The Trust agreed three main priorities as a framework for delivery of the annual plan:

- Improving service user satisfaction
- Improving staff satisfaction
- Maintaining financial viability

The Trust decided to keep the same framework for delivery of its priorities for 2012/13, due to the initial success and the need for a sustained approach in order to bring about the improvements required. This view is supported by the Council of Governors.

The Trust wishes to be viewed as one of the highest performing trusts in the country and the provider of choice for mental health and community services in East London.

The Trust is committed to early and effective engagement with the Council of Governors to ensure that it meets the needs of local communities and can be held to account for the quality of services provided.

The Trust intends to work closely with Clinical Commissioning Groups in East London and its local authority partners to ensure that a high quality integrated health and social care system is commissioned and delivered.

Strategic Objectives

To deliver our service and business plans over the next five years, the Trust will:

- Ensure the meaningful participation of service users, their carers and families in the shaping, delivery and evaluation of their care and the future direction of our services
- Improve the quality of our community and inpatient services
- Develop a highly skilled, motivated and culturally capable workforce
- Maximise learning opportunities for all staff, provide high quality teaching and training, and remain a centre of excellence for research
- Make the best use of our resources, improve performance and develop the quality of information and IT systems
- Develop existing and new partnerships to promote social inclusion for all our service users to reduce health inequalities and encourage healthy lifestyles and choices
- Continue the emphasis on avoiding the need for hospital admission and extending the options for out-of-hospital care.

Service Developments

The Trust's ambitious five-year service strategy aims to ensure continuous and sustained service improvement in all areas and the development of more community-based services that promote independence, choice and recovery. It will also create clear community and inpatient pathways and modernisation of our inpatient services. The Trust will work with statutory and non-statutory partners to address social inclusion and health inequalities and improve health and well-being. The Trust will also develop more responsive services to primary care and work alongside GPs to deliver improved care pathways between primary care and secondary mental health services.

Service developments over the next five years will focus on:

- Improving services and support to GPs and primary health care teams
- Developing high quality community services that promote independence and recovery as well as more choice for service users
- Increasing access for service users to employment, education and training opportunities, physical healthcare services and ensuring that we provide culturally appropriate services
- Improving our inpatient services so that service users can access the best type of service at the right time
- Providing modern and fit-for-purpose environments and buildings for both service users and staff
- Ensuring that there are good information systems in place so that clinicians and service users can access the right information at the right time.

During the past year the Trust has made good progress in addressing the above areas, providing an excellent foundation for taking forward the Annual Plan for 2013/14.

Operating Review/Achievements and Improvements

Research: East London Connects to the World

Dame Sally Davies, Chief Medical Officer at the Department of Health, formally opened the WHO Collaborating Centre for mental health services development.

The Newham-based unit was established in 1997 and is one of 18 WHO Collaborating Centres in the field of mental health in Europe and the only one specifically designated for mental health services development in the world.

Achieving such status means the Unit – part of Queen Mary, University of London – will play a key role in supporting the development of international mental health policies and the implementation of the European Mental Health Action Plan.

Research at the Unit has already delivered benefits to the local population through improvements to clinical services. This has included the establishment of novel services and treatments such as a model day hospital, body psychotherapy, computer-mediated approaches for clinicians to communicate with patients in the community, and training modules for psychiatrists about how to engage with patients with psychosis.

Olympics – Planning and Communicating

The London 2012 Olympics and Paralympics were a triumph for the country and the City. As a key NHS trust providing services in all the host boroughs, this global event was a local event for us and we were keen that services users and staff benefited and felt involved.

There was also a need for extensive planning to ensure that services continued to function during the Games. With a predicted 500,000 people travelling to the area daily, the Trust needed to have strategies in place that prepared it for all eventualities. We worked closely with partner organisations to share information and expertise, and plan and communicate.

We needed to ensure we had adequate supplies of food, linen, and medication and that staff had the necessary parking permissions. We also employed technology to use staff time well.

A car sharing scheme was introduced and a fleet of Trust bicycles purchased to offer a greener option for staff to get to work and carry out home visits. In preparation, all staff were asked to explore an alternative route to their workplace and trial it before the Olympics began.

Leaflets were distributed to all Trust sites to advise service users that services would continue as usual during the Olympics and details were published in local papers and on the Trust website.

Inspiring Participation in Exercise, Sporting and Social Activities

Trust staff embraced the opportunity to increase participation in sport and social activities to build on existing programmes and capitalise on the enthusiasm of London 2012. This included an extensive range of activities with all age groups from inter-ward Table Tennis Olympic tournaments, Wii Olympic Sport tournaments, ten pin bowling trips, canoeing, rock climbing, tennis, sports days, parachute games, egg and spoon races, football games, street dancing and much more.

Art and craft groups produced Olympic torch designs, t-shirts, decorated Trust sites and even made an Olympic countdown clock. An Olympic sound track was produced by service users in City and Hackney, and in Newham the Day Opportunities service made replica Olympic torches and took part in the Newham Show parade.

Being Part of London 2012

Staff and service users were involved in London 2012 in a myriad of ways. Volunteering opportunities were promoted a year in advance, resulting in a number of staff and service users becoming Games Maker volunteers and over 40 staff being involved in the opening and closing ceremonies.

"When I found out that the Olympics were coming to London and Newham in particular, I knew I was going to be a part of it! I had a great time being a Games Maker! It was a really good experience!

I met lots of lovely volunteers, and met lots of athletes and other officials from around the world! At times I found it exhausting and challenging. Being part of something so historic and positive has helped me feel more confident."

Vanessa Isidore, Service user and Games Maker

"I volunteered to take part in the London 2012 Olympic ceremonies as I live and work in East London and wanted to give something back to the community and NHS. What better way than to volunteer.

The homage that Danny Boyle paid to the UK and the NHS was touching and has continued to unite many of the volunteers that were involved who are carrying on the good work started."
Marica Wainner, Executive Assistant, People Participation

The Trust purchased 446 tickets from the Charitable Trust Fund for a range of Paralympics events to present to service users who had been involved in projects relating to improving mental and physical health wellbeing. The tickets provided a unique opportunity to witness a Paralympics event up close and to be part of the summer of sport.

"It brought tears to my eyes and those 10 minutes in front of 80,000 spectators and goodness knows how many worldwide via TV have changed and inspired me. Everyone has equal worth regardless of any physical, mental or sexual difference, we are all human."
Sipho Malinga, Volunteer Performer and Senior Nurse Practitioner

The Legacy for East London

The Trust has ensured that the interests of service users have been represented in discussions about new accommodation opportunities in the London 2012 Athletes Village.

A new sports and exercise project, a partnership between the Trust and the University of East London, has been established since London 2012 to measure and evaluate the benefit of exercise on mental health wellbeing. Students from the Psychology department and the Sports and Exercise faculty have been working with service users in the Trust as part of their coursework.

The Trust's Occupational Therapists are using the momentum of the Olympics and Paralympics to inspire service users to use exercise as a long-term strategy to manage and maintain good physical and mental health.

"I have a strong belief in the positive effects sport and exercise can have on people's mental health and wellbeing. I see my role as an exciting opportunity to try and increase participation as a result of the Olympics and deliver a long lasting legacy."
Hannah Mellor, Olympic Legacy Development Worker

Strengthening the Care of Older People

There have been many developments in the past 12 months to restructure services for older people, bring together expertise and ensure families have the right support according to their needs.

Continuing Care

In Newham, a continuing care service for people with advanced dementia moved from Custom House to East Ham Care Centre. The unit provides care to older people with complex physical health needs. It means the borough now has an integrated physical and mental health care facility for older people.

In Tower Hamlets, our continuing care ward for people with advanced dementia, moved to a more homely environment at The Green in Bethnal Green. The Green is on the ground floor and most residents have their own room with en-suite facilities. There is a large garden which all residents can enjoy.

Columbia Ward

The Trust opened a new, specially designed ward to provide a centralised inpatient dementia assessment unit for East London. The new unit was formally opened by Professor Alistair Burns, National Clinical Director for Dementia at the Department of Health. We linked up with Kingston University Dementia Design Group to create an environment that would meet the specific needs of people who might be confused or disoriented.

The unit is bright and airy with a homely feel. We chose colour schemes to add to the ambiance of the unit and pictures have been hung in strategic areas to orientate older people. For example, a big picture of a fruit bowl has pride of place in the dining area and signals that it is where meals are taken.

Centralising inpatient services on one site has enabled us to develop a single specialist experienced team and establish

an intensive rehabilitation programme with greater availability of therapeutic interventions and activities.

The in-patient assessment aims to provide an accurate diagnosis and develop a management plan to enable individuals to return home with treatment and practical support. If this is not possible, and there are concerns about safety and wellbeing, the team will work with the patient and their carers to consider alternative care options.

Talking about Older People's Care

Staff have been getting out and about to talk to people and raise awareness of dementia services at events and in supermarkets.

Health and care workers in East London came together on 26 November to share ideas, approaches and innovation in the care of older people. The event was organised by the Trust, Barts Health NHS Trust and Homerton University NHS Trust.

The key note speakers were Amanda Waring, a campaigner for improvements in the care of older people, and Professor David Oliver, the National Clinical Director for Older People's Services at the Department of Health. Other speakers included Professor Julienne Meyer, Professor of Nursing at City University and staff leading the way in a range of specialties from each trust.

Amanda Waring spoke movingly of the experiences of her mother who had become unwell and needed hospitalisation. Some of the more negative experiences prompted her to start a movement to highlight the need for considered nursing care in hospitals.

The conference provided food for thought for the participants and provided opportunities to hear about good practice in other services.

ECT Service Accredited

The Tower Hamlets Electroconvulsive Therapy (ECT) service was accredited as 'Excellent' by the Royal College of Psychiatrists in February 2012 following an extensive assessment process. The service is run jointly with Barts Health and provides ECT to all age groups across East London.

Adult Mental Health Services

Improving and Maintaining Standards

The Home Treatment Teams in Tower Hamlets and City and Hackney were awarded accreditation by the Royal College of Psychiatrists.

The Home Treatment Team provides care to individuals and their family in their own home as an alternative to inpatient psychiatric admission. This multi-disciplinary team also offers community alternatives such as the Crisis House, which is run in partnership with the voluntary sector.

The Home Treatment Teams work towards recovery and help service users develop strategies to prevent relapse. Both teams have been involved with the national accreditation pilot, alongside only eight other Home Treatment Teams across the UK.

Diabetes Care in Mental Health Services

In September 2012, the Trust initiated a Diabetes Specialist Service for mental health care inpatients. This new service covers all three East London boroughs and is led by a Diabetes Specialist Nurse based in the community service in Newham.

The service aims to improve the overall management of diabetes. It is also seeking to improve the knowledge and skills of staff to support people with diabetes when they are admitted to one of our mental health units.

Personalisation

The Trust has been working in partnership with the City of London and the London Boroughs of Newham, Tower Hamlets and Hackney to support service users in applying for personal budgets to get the support that they want.

Personalisation aims to give people more control over their own lives and the freedom to select services they feel will support them. Service users can now access services they choose to suit their own lifestyles.

Training has taken place to ensure staff are able to support service users and know the application process for their respective borough.

Bed Occupancy Rates

The Trust has a range of alternatives to hospital admission such as home treatment teams, supported hostel care and, in Newham, the Acute Day Hospital to provide treatment and care to individuals when they are acutely ill. But sometimes, a hospital admission is the best option for the individual. When this happens, it is important that there is a bed available for them.

The number of patients admitted to our wards has been high over the last 12 months. The Trust has been looking at processes to help us better manage inpatient beds to ensure that when people are admitted they have their own bed and do not experience too much disruption. We will be piloting a Triage Ward in Newham in the coming months to see if this can help address our bed management better.

Richmond Wellbeing Services Opens for Business
On 1 June the Trust, in partnership with Richmond Borough Mind, took over the running of IAPT Primary Care Psychological Therapies and Primary Care Mental Health Liaison in Richmond. (IAPT stands for Improving Access to Psychological Therapies.)

The new Richmond Wellbeing Service is for people who experience depression, anxiety, sadness, anger, extreme shyness, obsessive behaviour, phobias, relationship difficulties or other psychological issues which are holding them back in their lives. The Richmond Wellbeing Service offers group workshops, counselling, self-help courses, a range of talking therapies and computer-based therapies.

PICUs are 'Excellent' Early Achievers
Crystal Ward at the Newham Centre for Mental Health and Bevan Ward at the City and Hackney Centre for Mental Health received an 'Excellent' in the Royal College of Psychiatrists AIMS accreditation process for Psychiatric Intensive Care Units. The accreditation for Psychiatric Intensive Care Units (PICU) has recently been introduced, so Crystal Ward and Bevan Ward were early achievers of this programme.

The Accreditation for Inpatient Mental Health Services (AIMS) is designed to improve the quality of care in inpatient mental health wards.

Improving Mental Health in the Vietnamese Community
The City and Hackney Psychology BME Access Service collaborated with the Vietnamese Mental Health Service (VMHS), to offer a series of motivational interviewing groups to members of the Vietnamese community experiencing problems with gambling.

The VMHS identified gambling to be a significant problem for many of their service users and the wider community. The British Gambling Prevalence Survey (2010) shows that 0.9% of the population experience problem gambling, and that this has increased since 2007.

Gambling awareness groups were set up to provide a safe space for group members to share their experience of the impact of gambling on their lives and to consider whether they would like to make steps towards change.

In February, the VMHS launched Recipes of Life, a colour booklet written in English full of easy-to-prepare recipes from the Vietnamese cuisine. Recipes of Life integrates talking therapy with healthy cooking and eating sessions, providing an easy and culturally relevant way for people to talk about health, wellbeing, resilience and recovery. Telling the stories associated with their favourite recipes helps put people in touch with their strengths and resources and those of their families, communities and culture.

Quality Accounts 2012/13
Operating Review/Achievements and Improvements

Forensic Services

User-Led Employment Projects
Following last year's successful launch of the service user-run café at the John Howard Centre, a number of other employment projects have been set up which aim to utilise service user skills and provide meaningful routes into employment and vocational training. Projects include event catering, horticulture and landscaping, graphic design and print and picture framing. Unlike previous employment schemes these projects have been set up as social enterprises. The projects have created paid employment for significant numbers of service users. The café and catering project alone has generated over of £16,000 turnover in its first six months of operation.

Successful Royal College of Psychiatry (RCP) Peer Review
2012 saw the Forensic Service achieve its most successful set of peer reviews ever. The RCP peer review is an intensive review of service quality across a range of areas including patient focus, clinical and cost effectiveness, accessible and responsive care, security and patient environment. The Forensic Service was highly commended for its clinical provision and high level of patient involvement. The results for both our forensic inpatient sites, John Howard Centre and Wolfson House, put us amongst the top performing secure services in the country.

Improving Primary Healthcare
Individuals detained under the Mental Health Act in England and Wales experience some of the poorest physical health outcomes in the UK. Significant investment has been put into developing primary healthcare services in our forensic units with a particular focus on targeting chronic health related conditions such as diabetes, high cholesterol levels, obesity and hepatitis. Our GP-led primary healthcare service now provides patients with a full physical health assessment on admission and an annual health check. 2012/13 has also seen the introduction of a specialist diabetic nurse service and enhancements to our foot health and dental services.

Improving our Ward and Clinical Environments
During 2012 we opened up Westferry Ward; a high quality, purpose built, 10-bedded psychiatric intensive care unit (PICU) at the John Howard Centre. PICU's provide care and treatment for the most distressed and unwell patients, often at the point of admission. The light and spacious design of Westferry Ward provides a care environment where patients can be treated safely and humanely in order to achieve effective recovery from acute psychosis.

Developing our Forensic Learning Disability Services
The range and quality of inpatient services for forensic learning disability service users in the UK has historically been poor. This often meant that service users were detained in inappropriate hospital placements far away from family and friends. In early 2012 we opened Woodbury Ward, a 12-bedded specialist low secure ward with a view to providing a local inpatient service. The quality of the unit's patient and therapeutic environments has contributed to successful outcomes in relation to safe and timely patient discharges.

The Care Quality Commission assessors visited Woodbury Ward in January and found that it met all the essential standards of quality and safety. As part of their inspection they spoke with the inpatients on the ward, observed how people were being cared for, talked with staff, and checked records. Additionally, they undertook telephone discussions with relatives or other professionals who were not able to meet with them during the visits.

Focus on Technology to Improve Care

The Trust has focused this year on using technology to make life easier for staff, reduce the time taken to record information and free them up to care for service users.

Mobile Working
In common with many organisations, the Trust needs to balance the requirements of a mobile workforce and challenges faced as a result of staff needing access to various Trust applications, securely, from their personal devices. To help achieve this we organised workshops/awareness events for particular technologies including: a mobile clinical solution for access to electronic records system (RiO) and other clinical applications such as voice recognition; iPads to provide mobile access to email and paperless meetings; Digi pens to remove the need for multiple data entry onto paper forms and into clinical systems; and access to email and shared documents from personal mobile phones.

Laptops and Remote Working
The Trust has issued portable laptop computers to care co-ordinators in community health teams and a range of psychiatrists, speech and language therapists, district nurses and staff in some specialist teams.

Digi Pens
These are being rolled out to community staff to help improve efficiency. Digi pens enable staff to write in ink on paper records but, at the same time, the pen also stores information which can be later downloaded.

"Seeing a number of patients in the same day in different locations and providing records for two organisations was a challenge. However, with the introduction of the new Digi pens life changed for the better. Clinical notes are now stored confidentially on the pen and no paper is transported around. Notes can be uploaded in moments. It means we have prompt access to patient notes and therefore can spend more time with people."
Melanie King, Team Manager, Older Adult Psychiatric Liaison Team

Dragon Digital Dictation
Dragon Digital Dictation is software that uses voice recognition technology to convert speech into typed text without the need for keying. Over 100 care co-ordinators and 10 psychiatrists are now using this technology. It means they can update notes more efficiently and provide information to service users and other health care professionals more quickly.

More Reliable Remote Access
As part of our preparations for London 2012 the Trust made significant investment in increasing both the capacity and reliability of a remote access service so that staff had access from home.

Videoconferencing
Videoconferencing has been introduced at ten sites across the Trust. The service allows staff to access videoconferences from internet-enabled computers and hand held devices such as an iPad. A new web-based IT training solution has been implemented for Trust staff that also saves time and travel costs.

Community Services

High Level of Patient Reported Satisfaction
The collection of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) was extended to eight services. A carers questionnaire was introduced at East Ham Care Centre, where PROMs and PREMs are now collected from all wards.

PREM information from four touch screens at health centres is displayed on large posters next to the screens. A leaflet to distribute with appointment letters encourages patients to use the touch screens.

A directorate-wide PROM and PREM report is generated, which is discussed at the Community Health Newham (CHN) Quality and Assurance Group. The report is issued to services to enable feedback on the results, to promote a local discussion and to bring about improvements.

Overall, the PREM results indicate a high level of satisfaction with the quality of patient services. The PROMs for the Virtual Ward and Extended Primary Care Team show that patients rate these service interventions as effective.

Outstanding Foot Care for People with Diabetes
Newham was praised by Diabetes UK for offering the best foot care in England for people with diabetes. According to Diabetes UK's audit, the Foot Health Team at Community Health Newham apply 'outstanding' foot care standards in the treatment of diabetics.

Newham was the only healthcare organisation in the country to score in the top quarter for every single foot care criteria in the audit, including delivery of foot examinations and the number of minor and major amputations carried out. Some of the worse performing PCTs carried out eight times more amputations in people with diabetes than Newham.

Conversation Partner Scheme (CPS)
The Speech and Language Team in Newham has established a CPS for people with a communication disability who are socially isolated. This uses volunteers trained jointly with the Trust's Volunteer Coordinator and the team. Volunteers visit people referred to the scheme in their homes for a period of 12 weeks, on a weekly basis, and receive supervision from Speech and Language Therapists.

Telehealth Launch
Sir John Oldham, National Lead for Quality and Productivity at the Department of Health, launched Telehealth in Newham at an event in December 2012 that was jointly hosted by Newham Clinical Commissioning Group and the Trust.

Over 120 GPs, health and social care staff in Newham attended. Sir John Oldham commended services in Newham for the progress made in integrating health systems for patients.

Newham is pioneering the use of technology enabling patients to take charge of their own health monitoring by using their mobile phone, TV or computer. This promotes independence, helps avoid periods of illness and hospital admissions. It also enhances the support GPs and community staff can give to people with long-term conditions such as diabetes, chronic obstructive pulmonary disease, hypertension and cardiac problems.

Terry Munro is a long term user of the Telehealth system.

"I get up every morning, take my blood pressure and blood sugar level and it helps me know how I am doing. Telehealth is a fantastic help to me and I think everybody who needs it should have it."

Intensive Support at Home
Virtual Wards provide patients, who might otherwise be admitted into hospital, with intensive care and support in their own home. It also helps enable people to leave hospital as soon as possible.

The Trust has four Virtual Ward teams in Newham who work closely with local GPs to support acutely ill patients along with their families. Like a regular ward, the team holds daily meetings with professionals involved with the patient to monitor progress and identify new interventions to assist recovery.

Virtual Ward Doctors have access to EMIS, the GP record system.

The Hospital In-Reach Team works alongside the Virtual Ward and has an important role reducing admissions, length of stays and looking into why individuals were admitted into hospital. The team looks at what steps are needed to discharge patients home and actions to keep them well.

Films for Parents
Newham Health Visitors Odilia Gamor and Krystal Mesmain starred in a series of films for parents on the NHS Choices website. The short two-minute films cover a range of topics and offer advice to parents about childcare. Parents and health experts talk about issues and provide practical advice about the day-to-day care and management of babies and toddlers.

The films are available on the NHS Choices website: www.nhs.uk
You can access news about health visiting in Newham via Twitter on @HVingNewham

"The focus of the films was the role health visitors play in reducing parental anxiety and their friendly approach to put parents' minds at rest and to reassure. There is a lot to learn when you become a parent and these films are an easy way to get reliable information and feel more confident in caring for young children."

"The experience was fantastic and, as I love my job, this will market our service to the whole country and showcase the help and support we can offer families."
Odilia Gamor, Health Visitor

Children's Triage Service
A multi-agency triage service has been introduced in Newham to provide a single point of contact for professionals or members of the public requesting support or protection for vulnerable children. Two health visitors are based with police officers and social care professionals. A full-time team reviews referrals for children and operates a streamlined approach to: information sharing and decision making; avoiding duplication of services and a delay in families receiving services.

If you are concerned about the safety or wellbeing of a Newham child you can make a request for support or protection by logging on to www.newham.gov.uk/triage. In an emergency situation, eg. if a response is needed within an hour, tel: 0203 373 4600.

Physiotherapy
Newham's Physiotherapy Service has seen some exciting developments. The Muscular Skeletal (MSK) Out-patients Physiotherapy Team offers highly skilled services comprising specialist Musculoskeletal Assessment, Diagnosis and Treatment including Manual Therapy (Joint Mobilization/ Manipulation and Soft Tissue Techniques), Acupuncture, Electrotherapy, Taping, Chronic Pain Management and Peripheral Joint Injections.

The team exceeded the NHS waiting list target of 18 weeks to offer a less than four week waiting time. A Saturday clinic now takes place to give people better access to the service and includes a female-only clinic. Satellite Clinics have been introduced in a number of GP surgeries to provide a service closer to where patients live and to further facilitate accessibility to physiotherapy. A self-referral pilot took place at two local GP surgeries. This scheme enables individuals to directly refer themselves to the MSK team by completing a self-referral form from their GP reception or following a consultation with a GP where physiotherapy is indicated.

Immunisation Team goes to War on TB
The Newham Immunisation team achieved 91% Tuberculosis (TB) immunisation coverage for infants 0-12 months old in 2011-12. The team is responsible for delivering the Bacillus Calmette–Guérin (BCG) vaccine or TB vaccination programme in the borough.

Newham has the highest rate of TB in London, remaining at over 90/100,000 for the last ten years. As a consequence, the borough operates a universal Neonatal BCG policy in line with Department of Health guidance. Newham also offers a catch up BCG service for at risk children up until aged 16.

The team vaccinate neonates in Newham University Hospital and at eight community BCG clinics in locations across the borough. They vaccinate approximately 40% of children born in the hospital. The parents of children who miss the hospital service, or are born in other hospitals, are contacted by the immunisation team when they register the child's birth.

HPV Immunisation
Most women will have an HPV infection at some time during their life, usually without even knowing it. But some types of HPV are known to increase the risk of developing particular cancers. So in 2008, immunisation against HPV was introduced in the UK for girls. HPV vaccine is given to girls aged 12-13 years and takes place in schools, as part of the standard immunisation schedule.

In Newham, the School Nursing Service and the Immunisation team achieved an HPV immunisation rate of 91.2% putting them in the top third nationally.

Sickle Cell Support
The Newham Sickle Cell Service held its third conference in October 2012 attended by 200 people. Dr Paul Telfer, Consultant Haematologist from the Royal London Hospital and Dr Nimze Gadong, Consultant Paediatrician from Newham University Hospital, spoke about chelation therapy, bone marrow transplant and the genetic treatments of the future.

Newham Council Employment Services spoke about how they could support people with chronic blood conditions into employment. There were a range of talks and workshops from key organisations able to provide families with a wealth of information and signpost to services who can support them.

Specialist Services

Alcohol Services in Hackney
The City and Hackney Alcohol Recovery Centre (ARC) used Alcohol Awareness Week (19-25 November) to raise awareness in local media about their service.

ARC offers an open access service; access to group work; one-to-one key working; medical physical and psychiatric input; community detoxification and relapse prevention medications; and psychological interventions and referral to inpatient detox and residential rehabilitation.

ARC has a liaison team on hospital wards, homeless shelters and other community settings who can offer advice and information. They also help local people to access wider services at ARC. Those individuals physically dependent on alcohol and aiming for abstinence can be referred for detox and rehabilitation. Friends and families can get support through Drop In, a family support group, and over the phone.

You can contact ARC on tel: 020 8985 3757 or visit at 17-20 Tudor Grove, London, E9 7QL.

Self-Harm Intervention
Child and Adolescent Mental Health Services in City and Hackney are joining other services across the country to research the role of family therapy when a young family member has had episodes of self-harm. The SHIFT Research project is being run by the University of Leeds and focuses on adolescents aged 11-17 years who have engaged in at least one previous episode of self-harm. The trial will involve 832 participants from centres in Yorkshire, Greater Manchester and London and will undertake a randomised controlled trial of family therapy versus treatment for young people seen after second or subsequent episodes of self-harm. The research will evaluate which approach reduces repetition of self-harm and brings about an improved quality of life for the young person.

Support through Socialising
The Tower Hamlets Specialist Addiction Unit has hosted evening events to extend engagement with friends and families of service users. Addiction recovery like mental health recovery can be a long journey for the individual and those around them, so a strong support network makes a great difference to the chances of recovery. But there is a need to reduce stress among friends and family members of people with drug and alcohol problems.

These events are part of a programme to work with the social networks of service users to provide an informal space for people to come together and find support. Additionally, a Friends and Family evening group is being introduced. This is an evidenced-based intervention focusing on improving coping mechanisms.

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Claire McKenna, Service Manager and Senior Nurse, said:

"We've been part of the Quality Network since 2003 and have been striving for excellence in everything we do. The award and the rating make us very proud of our work but more importantly, this programme has been immensely helpful in ensuring we provide the best care possible for our young inpatients at all times."

Mental Health Unit for Young People Rated 'Excellent'
The Coborn Centre for Adolescent Mental Health was rated 'Excellent' by the Quality Network for Inpatient CAMHS (Children and Adolescent Mental Health Services). 'Excellent' is the highest level achievable in the accreditation. The Coborn Centre for Adolescent Mental Health provides person and family-centred care for young people aged 12 to 18 years old with complex and severe mental illness.

The Quality Network for Inpatient CAMHS (QNIC) is a national accreditation and inspection programme led by the Royal College of Psychiatrists. Their assessment visit to the Coborn Centre included reviewing questionnaires filled in by both service users and staff, and in-depth discussions with the team and inpatients. They also inspected services and wards and scrutinised a large amount of evidence submitted by the team.

Summer School at the Coborn
A Summer School took place from 6-10 August for young people admitted to the Coborn Centre for Adolescent Mental Health.

Newham-based visual arts organisation Rosetta Art Centre (www.rosettaarts.org) promote arts engagement in an accessible and therapeutic way. Rosetta Art Centre was successful in securing funding for this pilot project.

The project used self-reflective journals as an alternative way to express and communicate experience and emotions. They enabled young people to talk more easily about themes and emotions communicated in the journals in pictures.

The week culminated in an exhibition and celebration of the young people's creative achievements.

New Psychological Therapies for Young People
The Trust was successful in a joint bid to provide a new therapy to young people in Tower Hamlets and City and Hackney. The nationally-recognised Improving Access to Psychological Therapies (IAPT) service is a collaboration between the Trust, the local Clinical Commissioning Groups, the local authority and the acute hospitals.

The initial focus of the Children and Young People's (CYP) IAPT Project has been on extending training to staff and service managers in Child and Adolescent Mental Health Services and embedding evidence-based practice across services. This is to ensure that the whole service, not just the trainee therapists, use session by session outcome monitoring.

Children and young people have been engaged at a national level to help steer the project, and each of the IAPT sites is committed to working with children and young people locally, listening to their wishes and preferences.

Development of MST service
Multi-systemic Therapy (MST) is an intensive outreach service working with young people and their families, who are at risk of going into custody or care. The service works primarily with young people involved with youth offending services, or those showing significant anti-social behaviour at home, at school or in the community. The MST service has demonstrated excellent outcomes and is now being extended to other boroughs.

Improving Quality

Making High Quality Care Our Priority

The Trust launched its ideas for a new quality strategy as part of NHS Change Day on 13 March. The day brought staff together from all corners of the Trust to share ideas about how we can improve the quality of care we provide. As a result, a new approach was proposed to support and empower front-line staff to make changes and improvements aimed at improving quality of care. The goal is to provide the highest quality mental health and community care in England by 2020. This will require a culture change and fundamental re-think of the way that we provide care, how we engage and support staff to improve the care provided, and prioritise those areas of work that have greatest value to service users and carers.

A number of projects have been under way over the last year as part of the Harm Free Care programme. The work has focused on reducing medication errors, falls and physical violence on inpatient wards. Examples include improving the identification of blood-borne diseases within City and Hackney, an initiative piloted on Joshua Ward, which has won a physical health Beacon Award and reducing the levels of physical violence on inpatient wards in Tower Hamlets through locally led improvement ideas.

Trust Achieves Highest Level in NHSLA Assessment

The Trust was successful in obtaining Level 3 (the highest level) of the NHS Litigation Authority risk management standards. The only mental health and community services trust in the country to do so.

The Trust was assessed against 50 standards in five domains: governance, learning from experience, competent and capable workforce, safe environment and clinical risk. The assessment also included visits to the Newham Centre for Mental Health and the East Ham Care Centre. This means that the Litigation Authority found the Trust has high quality processes in place, reducing risk to service users.

British National Formulary Available at the Touch of a Button

An online version of the British National Formulary (BNF) is available to staff on all Trust computers. The BNF is a one-stop shop to go to for validated, up-to-date information about medication. It includes a guide to the dosage, side effects and contra indications of every drug available.

Defibrillators in Position

A programme to improve the success rate in resuscitation after cardiac arrest was rolled out across the Trust. The use of an Automated External Defibrillator (AED) can mean the difference between life and death and can be found in public places such as shopping centres, airports, train stations and sports centres, with local staff trained in their use.

Defibrillators are now located in 30 community sites across the Trust. Staff have received training so that they know how the equipment works and feel confident to use it. AEDs can be used safely even by non-clinical people who witness an arrest or who are nearby and can respond more quickly than the ambulance service. Every minute is critical in this situation and the use of AEDs has been responsible for saving many lives.

High Fidelity Simulation to Improve Physical Healthcare Management

A computer controlled simulation dummy has helped staff to improve safety and care of service users and patients. The Trust has introduced this simulation training for multidisciplinary clinical teams to practice their management of key medical emergencies. Sim Man, a medical simulation device with computer controlled simulation technology, enables staff to refresh and refine their skills, learn new procedures, practice to improve their skills and optimise clinical outcomes.

Although this is a commonly used approach to learning in acute physical healthcare services, the Trust is one of the first of its type to adopt it. This innovative approach was shortlisted as a finalist for the 2013 Patient Safety Awards.

Serious Incident Simulation Training

A six-month series of in-house multi-disciplinary simulation sessions based on actual serious incidents were attended by 144 staff.

Involving all levels of clinical staff working in multi-disciplinary teams, the project aims to:

- See simulation training embedded in the clinical training programme and introduced as an additional means of learning from serious incidents
- Help prevent serious incidents and/or improve the management of serious incidents when they occur
- Promote learning in multi-disciplinary teams and highlight the importance of team working and communication.

Staff have appreciated the opportunity to improve their skills in a safe environment, and have demonstrated greater awareness of the factors that are related to serious incidents.

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Energy and Sustainability Measures

Water Savings

We continue to work with our water saving specialist ADSM to ensure year-on-year savings. We have installed washroom controls and other water-saving measures across our sites, and act quickly in the event of a water leak. Last year, the Trust was refunded over £10,000 from Thames Water thanks to the work of ADSM.

Smart Meters

We continue to monitor and analyse our energy usage thanks to installed smart meters that provide half-hourly data reads. We will install Smart Meters to our water meters to ensure accuracy and continued savings.

Insulating our Plant Rooms

We have installed flange and valve insulation across inpatient sites. This reduces energy waste at source. Saving wasted heat has helped to significantly reduce the Trust's carbon emissions and will bring year on year savings estimated at £8,000.

Staff Awareness

To raise staff awareness of energy issues, the Estates and Facilities department has promoted a greener approach in staff communications.

Improving the Environment

The Trust has undertaken a number of refurbishments over the year to improve facilities for service users.

In the John Howard Centre four additional bedrooms were added to the Millfields Unit as part of a full refurbishment. Morrison Ward was also fully refurbished and now has a new anti-ligature shower and en-suite facilities throughout. The Trust has completed phase one of installing new anti-ligature, high security 'Save-Vent' windows to over 60 locations.

In Hackney, a new sensory room was developed in the Mother and Baby Unit to provide a relaxing, calming environment for women. Work took place on Bevan Ward, the Psychiatric Intensive Care Unit, to upgrade the seclusion room. This involved the introduction of an additional observation room and new anti-ligature sanitary fittings, CCTV and a two-way communication system.

Quality Accounts
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Executive Summary

The Quality Accounts Report is an important tool for strengthening accountability for quality within our organisation.

The purpose of the Quality Account Report is to enable the Trust to be transparent and accountable for its performance. It also provides an opportunity to engage with our key stakeholders and staff in improving the quality of the services we provide.

This report reflects back on the year from April 2012 to March 2013 and provides information for the Trust priorities for 2013/14. In that time the Trust has significantly improved the measurement of service user satisfaction so that we are better able to use this information to make improvements to our services.

The Trust has identified key areas for improvement and has plans in place to monitor and report on progress.

The suggested priorities for the 2013/14 Quality Accounts Report focus attention and resources on achieving a maximum of quality improvement over a prolonged period. The Trust priorities cut across all areas of healthcare provision and are intended to improve clinical effectiveness, patient experience and patient safety.

The priorities address the levels of satisfaction experienced by users of our services and the staff providing them.

This Quality Account Report reflects our determination to develop our understanding and measurement of quality as experienced by users of our services and the staff working in our services. Our ambition is to deliver continuous quality improvement in all our services.

Part 1. Statement on Quality

1.1 Statement on Quality from Dr Robert Dolan, Chief Executive

The Trust has intensified its focus on improving the quality of care across all services. Our priorities for 2012/13 were a continuation of the priorities developed the previous year. These were reviewed and appraised by the Trust Governors and service user groups and it was agreed to build on the progress made.

A proportion of the Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the Trust and East London and the City Alliance for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. This constituted 2.5% of the Trust's total income and the Trust was successful in achieving these goals.

The summer of 2012 was a unique time for us, with the London 2012 Olympics and Paralympics taking place in East London. Planning for the London 2012 Games provided an opportunity to focus upon emergency planning and resilience issues and to work more closely with local partner agencies. We were able to provide services as usual throughout these events and optimise the opportunities presented by the proximity of the games to increase the uptake of sport and exercise by service users and staff in the Trust.

As part of our commitment to developing an Olympic legacy and increasing service user participation in health and wellbeing activities, the Trust has employed an Olympic Legacy Development Worker to work with the University of East London and Queen Mary, University of London and introduce a range of wellbeing and exercise programmes for service users across adult services.

This year, there has been a greater emphasis on ensuring that feedback from service users and carers is central to all our activities. The monitoring of our user-led standards audits helps us to understand what is happening, and the results are very encouraging. The use of Patient Reported Outcome and Experience Measures (PROMs and PREMs) has been extended within community health services in Newham. They have been used extensively in community nursing to measure the quality of care and the impact on outcomes as perceived by patients and carers. The feedback has been extremely useful, so this approach is now being rolled out to other services such as foot health, speech and language therapy and other nursing teams.

It is vital that we do not only gather feedback about the quality of our services, but that we act on it and reassess whether the interventions introduced have improved the quality of the service or if further or different action is needed. Improving the quality of all our data remains a key aim for the Trust, and a plan is in place to achieve this.

The publication of the Francis Report in March highlighted the importance of having robust systems to measure quality and also the importance of listening – to service users and to staff. We have continued to encourage a culture within all our services where staff feel recognised and supported, but also where poor performance is challenged and managed appropriately.

In March 2013, the Trust held a staff event "Making High Quality Care our Priority" to launch a Trust wide programme aimed at reducing harm, reducing risk and improving quality. A number of projects are underway which are already showing some promising results.

Additionally, the Trust was successful in attaining level 3 in the NHS Litigation Authority assessment, making East London NHS Foundation Trust the only mental health and community health trust in the country to achieve this.

Being a centre of excellence for research is one of the key strategic objectives of the Trust. The aim of the research is to provide evidence that contributes to the worldwide evidence base and, directly or indirectly, leads to improvements in healthcare. This was taken another step forward with news that the Unit for Social and Community Psychiatry has been designated as a World Health Organisation Collaborating Centre for Mental Health Services Development. This will assist knowledge and understanding around quality, not just in East London but worldwide and we are proud to drive this agenda forward.

1.2 Statement on Quality from Dr Kevin Cleary, Medical Director

Never before has the NHS had such scrutiny of the quality of care it is providing to patients and service users. The events which have unfolded in Mid-Staffordshire have shocked patients, staff and the public, leading to some fundamental questioning of how we monitor and deliver care to our community.

How could a Trust have lost sight so dramatically of the needs of its patients and have been blinded to what was happening in their own hospital? What can we do to make sure it never happens here in East London?

Firstly, quality needs to be embedded in the very core of everything we do in relation to the service users, patients and families that we care for. We need to be constantly asking ourselves if what we are doing is improving the patient experience, the clinical effectiveness of our treatment and its safety? These are not questions which should only be asked by senior managers, but by all of our staff within the organisation. For this reason, we have simplified the structure of our quality committees and organised them around these three core elements. We have also for the first time had a governor sitting on the Trust quality committee to provide some outside challenge to the executive group about the work we undertake.

Secondly, we need to provide a clear understanding to our staff of what we believe is important for them to focus on in relation to quality. There has been a lot of press commentary on organisations being too focussed on targets and that we should move away from targets as if they are the cause of problems in the NHS. I believe this to be an oversimplification of the problem. Targets can be useful if they are embedded in a strategy of quality improvement; if you cannot measure something, you cannot improve it. Too often, however, the target is the quality improvement strategy and this means that the triad of effectiveness, safety and experience are forgotten. We have worked hard with our commissioners to ensure that we are focussed on fewer quality indicators, so that staff and service users, have a clear agreed idea of what we are wanting to improve and are not chasing a multitude of disconnected issues. This really is a situation where less is absolutely more.

Thirdly, we need to listen more. We need to strengthen and support the voice of our service users and patients at all levels in ensuring the care we offer lives up to our core values of compassion and quality. We need to listen to our staff and provide an open space to allow everyone to suggest ways in which we can improve the quality of care we provide. Our executive directors are now visiting three front-line teams each week to hear directly about the quality of care we provide and what we can do to improve. In addition, we will shortly be setting up Listening to Improve forums across the organisation to ensure everyone has the opportunity to raise ideas that could improve quality.

Finally we need to move away from the annual short term planning around quality and have a coherent narrative that spans at least five years. The very best healthcare organisations plan well into the future about what they are working on to improve. This allows the organisation to stretch itself to achieve really difficult aims. Knowing that you will be working on a quality agenda for five years changes the mind set on what is achievable and produces a much stronger bottom-up agenda – the sort that is going to be sustainable and effective. We have been consulting with our staff, service users and governors about a longer-term quality improvement strategy that will be a real stretch for us as an organisation and will mean working with partners across the whole of the pathway as we have never done before. I am confident that this type of quality focus will ensure that we continuously and relentlessly improve the care we provide to our local community and this is what matters, above all else.

2.1 The Population Served by East London NHS Foundation Trust (ELFT)

The Trust provides services across four boroughs in east London: Hackney, The City of London, Newham and Tower Hamlets, as well as IAPT services in Richmond. The areas of East London are culturally diverse with significant levels of mental and physical health need. East London is exclusively inner-city urban, with high levels of immigration, socio-economic deprivation and health inequalities.

The area is also densely populated and has a relatively young population. Ethnicity data indicates that the East London area has the largest black and minority ethnic (BME) population (49%) in the UK. The BME population nationwide is eight per cent. By contrast, Richmond upon Thames is one of the least ethnically diverse and least deprived areas in the country and the least deprived in London.

Figure 1. ELFT population (incl. Richmond) by ethnicity

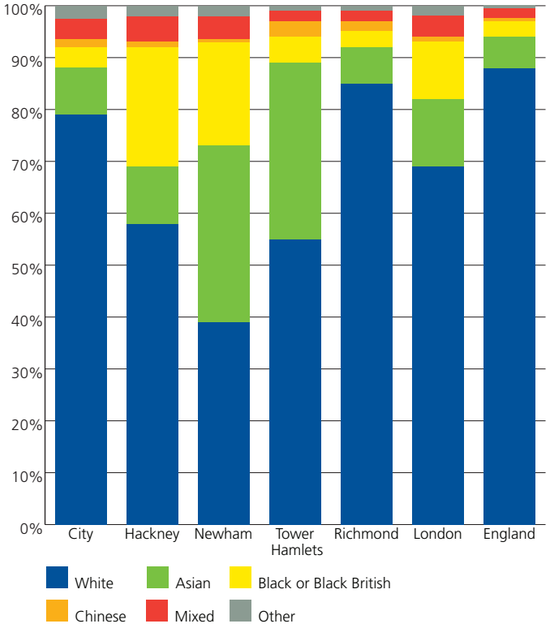
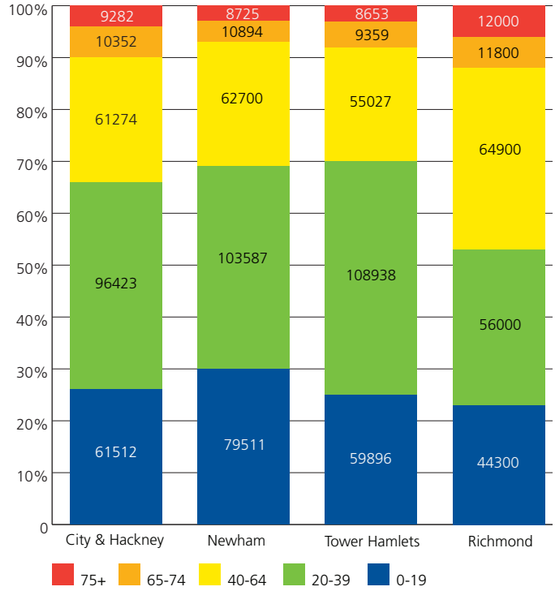


Figure 2 shows that the boroughs in East London have a very young population, with a high proportion of adults aged 20-39 years. The proportion of older people is therefore much smaller than the national average. The population of Richmond is different and the largest proportion of people are aged 40-64 years.

Figure 2. ELFT population (incl. Richmond) by age group



London's population is estimated to grow by 810,000 from 7.56 million in 2007 to 8.1 million by 2016. The population served by the Trust is expected to increase overall by 25% (178,000 people), with 31% in Newham (80,900), 35% in Tower Hamlets (78,200), and 8% in City & Hackney (18,900). The population projections suggest a rise in the total population of Richmond upon Thames to 212,000 in 2018.

There are a number of implications for Trust services. Many of the severe mental illnesses, such as schizophrenia and bipolar disorder first present in early adulthood. There will therefore be a disproportionately higher number of new diagnoses of these conditions, which will require significant service input to establish treatment. The large working age population offers a substantial opportunity to improve mental health through the workplace and, similarly, to prevent poor mental health triggered by workplace factors, such as stress.

However, levels of economic inactivity among the working age population vary markedly across East London, with particularly high levels in Tower Hamlets. Consequently, a high proportion of children are born into poverty. The area has some of the highest child poverty levels in the country.

In spite of this, the Trust has demonstrated that it is performing well compared to others in terms of inpatient efficiency with, for example low length of stay, lower readmission rates and fewer delayed transfers of care. Compared to the level of morbidity, we have one of the lowest levels of investments for one of the most deprived areas of the country.

IAPT in Richmond upon Thames

IAPT is a primary mental health service which provides high quality care and treatment for people aged over 18 years with an identified mental health problem in a community setting. The service provides support to GPs treating and managing patients in Richmond practices. It has two elements: enhanced mental health support and psychological therapies in line with Improving Access to Psychological Therapies (IAPT). The two are integrated and have a single point of access. The overall primary mental health service also provides a gateway to specialist mental health services and works closely with specialist mental health services as well as other community based services.

The enhanced mental health support element provides a range of interventions to support people with mental health problems in the community whilst also working closely with GPs. In line with national directives, enhanced support is provided to GPs to care for those people who have been engaged with specialist mental health services but are stabilised to the extent that they can be discharged back to primary care. This includes those with long-term mental health conditions such as diagnoses (ICD-10*) of schizophrenia, bipolar disorder, schizoaffective disorder, recurrent depression, and chronic neurotic, stress related and somatoform disorders.

The psychological therapies element is evidence-based stepped care (i.e. clients receive the least intensive intervention necessary to treat their condition and can step up to a more intensive intervention if appropriate) provided by qualified psychological therapists in line with DH IAPT and NICE guidelines. The service provides evidence-based psychological therapies to the adult population of Richmond suffering from mild to severe depression and anxiety disorders, based on IAPT stepped care framework and the recovery approach. They also support and participate in the mental health assessment processes where necessary.

Estimated prevalence of mental health problems in Richmond

Using national estimates on prevalence as outlined in the 2007 psychiatric morbidity survey, the estimated number of people experiencing mental health problems in Richmond upon Thames is just over 31,000.

The population of the London Borough of Richmond is expected to increase over the next ten years. This will have an impact on the future demand for all services including mental health services. Table 1 provides estimates of what this increase might look like in terms of common mental health disorders and indicates that the number of people experiencing any common mental health disorder could increase from 31,073 in 2013 to 36,406 in 2023. Numbers with common mental disorders are therefore estimated to increase by over 17% over the next ten years.

Table 1: Estimated increase in the number of people in Richmond experiencing common mental health disorders, 2013 – 2023

	Est. prevalence in adults aged 16+ years	Number in 2013	Est. number in 2023
Mixed anxiety and depressive disorder	9.0%	14,490	16,974
Generalised anxiety disorder	4.4%	7,084	8,298
Depressive episode	2.3%	3,703	4,338
All phobias	1.4%	2,254	2,646
Obsessive compulsive disorder	1.1%	1,771	2,075
Panic disorder	1.1%	1,771	2,075

Source: 2007 Adult Psychiatric Morbidity Survey and ONS Sub National Population Projections
NB. 2013 numerator = 161,000; 2018 numerator = 179,900; 2023 numerator = 188,600.
*(ICD-10 Classification of Mental and Behavioural Disorders)

2.2 Review of Services

East London NHS Foundation Trust provides a wide range of community and mental health services to the City of London, Hackney, Newham and Tower Hamlets. Forensic services are also provided to Barking & Dagenham, Havering, Redbridge and Waltham Forest, as well as community health services in Newham. This year the Trust has also provided psychological therapies to people in Richmond upon Thames (South West London) in partnership with the mental health charity Mind.

During 2012/13 the Trust sub-contracted one NHS service. The Trust has reviewed all the data available to them on the quality of care in this service.

The income generated by the NHS services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for this period.

Mental Health Services

Trust service provision includes community and inpatient services for children, young people, adults of working age and older adults who live in the City of London, Hackney, Newham and Tower Hamlets. The Trust has a large and well-established Child and Adolescent Mental Health Service (CAMHS) and provides a range of psychological therapies services.

The Trust provides Forensic Services to the four local boroughs, as well as the North East London boroughs of

Barking and Dagenham, Havering, Redbridge and Waltham Forest and other specialist mental health services to North London, Hertfordshire and Essex. The specialist Chronic Fatigue Syndrome/ME adult outpatient service also serves North London and the South of England.

The Trust's local services are provided to a population of 710,000 in East London and the Trust's Forensic Services are provided to a population of 1.5 million in North East London.

As of June 2012, the Trust has provided Primary Mental Health services in Richmond. These services are part of the Increasing Access to Psychological Therapies (IAPT) model, developed in Newham. As a consequence, 33 new staff are providing psychological services across multiple sites in the Richmond area.

Community Health Newham Services

Community Health Newham has been a fully integrated part of the Trust for over two years (since 1st February 2011). The Community Health Newham (CHN) Directorate is responsible for improving the health and wellbeing of the people of Newham through healthcare services in community settings. CHN has a key role in delivering personalised services that promote and enhance people's independence and well-being.

As a consequence of this integration, the Trust now employs an additional 900 staff and provides community health services from 33 sites, including an inpatient facility of 78 beds at the East Ham Care Centre for continuing care, respite care and intermediate care service users. Some of these sites are also used by mental health services.

2.3 Participation in Clinical Audits

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

The reports of five national clinical audits and one national confidential enquiry were reviewed by the provider in 2012/13 and East London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. The Trust develops specific action plans for each audit which are managed through the Clinical Effectiveness Committee.

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

The national clinical audits and national confidential enquiries that East London NHS Foundation Trust participated in during 2012/13 are as follows:

Description of National Audit	Submitted to
National Sentinel Stroke Audit	Royal College of Physicians Stroke Audit Team Clinical Standards Department – Clinical Effectiveness and Evaluation Unit Royal College of Physicians of London
National Audit of Intermediate Care	NHS Benchmarking, 3000 Aviator Way Manchester Business Park Manchester M22 5TG
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness	Centre for Suicide Prevention Psychiatry Research Group School of Community-Based Medicine University of Manchester 2nd Floor, Jean McFarlane Building Oxford Road Manchester M13 9PL
National Audit of Schizophrenia	Royal College of Psychiatrist 4th Floor, Standon House 21 Mansell Street London E1 8AA
National Audit of Cardiac Rehabilitation	Department of Health Sciences Area 4, Seebohm Rowntree Building University of York York YO10 5DD
Primary Prevention of Cardiovascular Disease Audit	British Heart Foundation Greater London House 180 Hampstead Road London NW1 7AW

The Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) also undertakes a range of external and peer review programmes. The Trust participates in a wide range of improvement projects as outlined below:

CCQI Programme	Participation by the Trust	% of cases submitted
Service accreditation programme		
ECT clinics	1 ECT clinics	100
Working age adult wards	14 wards	100
Psychiatric intensive care units	4 PICUs	100
Older people mental health wards	4 wards	100
Memory services	3 services	66
Psychiatric liaison teams	2 teams	100
Service quality improvement networks		
Inpatient child and adolescent units	1 unit	100
Child and adolescent community mental health teams	1 team	33
Therapeutic communities	1 community	100
Forensic mental health services	1 service	100
Perinatal mental health inpatient units	1 units	100
National Audit of psychological therapies (NAPT)	**1 team**	**100**
POMH TOPIC	**Number of patients**	
Prescribing antipsychotic medication in people with dementia	261	100
Prescribing high-dose and combination antipsychotics: acute/ PICU, rehabilitation/complex needs, and forensic psychiatric services	432	100
Supplementary audit report: Screening for metabolic side effects of antipsychotic drugs	77	100
Multisource feedback for psychiatrists (ACP 360)	**157 enrolments**	**28 in total**

The reports of nine local clinical audits were reviewed by the provider in 2012/13 and East London NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. The Trust develops specific action plans for each audit which are managed through the Clinical Effectiveness Committee.

Audit Priority	Lead Committee	Directorate
CPA and Risk Assessment Audit	Clinical Effectiveness Committee / CPA Group	All
Record Keeping Audit	Clinical Effectiveness Committee / Health Records Development Group	All
Medication Audits – Prescribing, Administration and Rapid Tranquilisation	Clinical Effectiveness Committee / Medicines Committee	All
Infection Control Audit	Clinical Effectiveness Committee / Infection Control Committee	All
Inpatient Standards Audit	Clinical Effectiveness Committee / Service Delivery Board	All inpatient units
Mental Health Act (including Consent to Treatment)	Clinical Effectiveness Committee / Mental Health Act Committee	All
Community Treatment Orders	Clinical Effectiveness Committee / Mental Health Act Committee	All community teams
Prescribing antipsychotic medicines for people with dementia (POM UK)	Quality Committee / Medicines Committee	MHCOP teams
High dose prescribing audit (POM UK)	Quality Committee / Medicines Committee	All

2.4 Research

Being a centre of excellence for research is one of the key strategic objectives of East London NHS Foundation Trust. To achieve this objective, the Trust collaborates closely with academic partners, such as Queen Mary, University of London, and City University, and concentrates on research that improves the delivery of healthcare in East London. Research in the Trust is linked to the specific local context, reflects national priorities, and plays a leading role internationally.

The aim of the research is to provide evidence that contributes to the worldwide evidence base and directly or indirectly, leads to improvements in healthcare. To achieve this,

research has to be of high quality and receive recognition on an international level.

One manifestation of this goal has been the designation of the Unit for Social and Community Psychiatry as a World Health Organisation Collaborating Centre for Mental Health Services Development. It was formally opened as such by Prof. Dame Sally Davies, the Chief Medical Officer for the Department of Health. A joint venture co-funded by the Trust and Queen Mary, the unit is based at the Trust's Newham Centre for Mental Health. This new designation makes it one of just 18 WHO Collaborating Centres in the field of mental health in Europe and the only one in the world specifically designated for mental health services development. The Unit now forms part of a small network of selected centres involved in writing the European Mental Health Action Plan. The status links research and service development in East London with the WHO, which is intended to be of mutual benefit.

The work of the research groups has influenced public and professional debates on policy and clinical issues in mental healthcare at local, national and international levels. The impact of our research on policy and practice can sometimes be rather indirect and difficult to distinguish from the effects of other contributions to the same debates. In other areas, however, it is possible to identify some direct impact of our research on health services and policy. Some examples are:

- Our research on novel non-verbal therapies included several exploratory randomised controlled trials which all showed an effectiveness of the new interventions, i.e. music therapy and body psychotherapy. This research has not only influenced the NICE guidelines (which state that "arts therapies", an umbrella term for non-verbal therapies, are the only type of treatment which can claim effectiveness in improving negative symptoms in schizophrenia), but also led to a local initiative for funding and implementing non-verbal therapies in East London.
- Although the EPOS programme is still on-going it has already had outputs with an impact on practice. We showed that the DIALOG scale has good psychometric properties for assessing subjective quality of life and treatment satisfaction. Although the main intention of the DIALOG intervention is to improve outcomes, there has been a great interest of services and the UK expert group for assessing outcomes in patients with psychosis to use the DIALOG scale because of its brevity and easy application.
- Since the DIALOG+ intervention has been fully completed, i.e. with the new software and the additional guide for addressing patients' concerns, local commissioners have been most interested and intend to make its implementation a requirement for service funding, once the current trial is completed.
- Findings from a pilot trial of peer support for patients discharged from hospital suggest benefits for patients (emotional and practical support, interaction and socialisation, mutual sharing and mentoring) and peer support workers (increased confidence, sense of achievement, new skills and recovery insights). These and other findings have informed the further development of peer support services in the Trust and elsewhere.
- Our research demonstrating the importance of patients' initial subjective response to treatment had a direct impact on the priorities of East London NHS Foundation Trust. The Trust made it an explicit objective to focus on and improve patients' initial experiences in both in- and outpatient treatment.
- The research on training clinicians in communication about psychotic experiences of patients has already shown to improve clinicians' confidence in communicating with challenging patients. As a result, developed and tested training method has been widely adopted in training schemes in East London.

The number of participants from the East London NHS Foundation Trust recruited in 2012/2013 to take part in research included on the National Institute of Health Research (NIHR) Portfolio was 457.

In every calendar year since 2007, our involvement in research has resulted in over 100 publications, thus helping to improve patient outcomes and experience across the NHS.

Further information regarding the research undertaken across the Trust, including a list of on-going and previous research is available: http://www.eastlondon.nhs.uk/rande/

2.5 Goals Agreed with Commissioners for 2012/13

Use of the CQUIN Payment Framework

A proportion of East London NHS Foundation Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between the Trust and East London and the City Alliance for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. In 2011/12 this constituted 1%; in 2012/13 2.5% of the Trust's total income will be conditional on successful achievement of the CQUINs.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available electronically on the website: http://www.eastlondon.nhs.uk/ or on request from the Trust Secretary.

The table opposite summarises the Trust's final position on delivery of 2012/13 Mental Health CQUIN targets.

Quality Accounts 2012/13
Part 2. Priorities for Improvement

Table 1. Mental Health CQUINs and Trust performance

2012/13 Mental Health CQUIN Indicators	2012/13 Q4 Target	Trust Performance
1. Improve the physical health and medicines reconciliation of patients with mental health problems		
CQUIN 1a – Ensure that the clinical teams share the CPA registers with the patients' GP practice via NHS.net accounts and provide the GPs with the diagnosis information and care cluster needed to update their Serious Mental Illness register	Yes/No	Yes
CQUIN 1b – 95% of patients to have a complete set of mental and physical health high mortality ICD-10 codes based on a snap shot of activity based on end of Q2 and end of Q4 (50%) data	95%	97.3%
Coronary Heart Disease		96.6%
Chronis Obstructive Pulmonary Disease		97.6%
Diabetes		97.2%
Obesity		97.8%
CQUIN 1c – Ensure that 75% of service users on CPA with diabetes, CHD, COPD, hypertension and/or obesity have either completed a physical health check with their GP or that there is recorded evidence of an outreach attempt to facilitate it through a letter to GPs based on NHS Spine information.	75%	81.9%
CQUIN 1d – The Trust must demonstrate medicine reconciliation in care plans within 72 hours of admission. Achievement of this indicator will be measured through an audit of care plans. This indicator applies to all acute inpatient services including services for adults and older adults.	90%	100%
CQUIN 1e – Trust to send agreed discharge notification to GP by NHS.net email account or safehaven fax within 1 week of discharge for 90% of patients. As based on NHS Spine information.	90%	100%
CQUIN 1f – Trust to send GP a CPA review outcome letter/or copy of care plan by either NHS.net email account, safehaven fax or letter within two weeks of CPA review for 75% of patients. Patients who are not registered with a GP as per NHS Spine information at the time of the review will be excluded.	75%	90.8%
2. Supporting individuals to identify their own objectives within the care planning process and developing recovery orientated practice within the organisation.		
CQUIN 2a – Mental health trusts can demonstrate organisational progress in implementing recovery orientated practice.	Yes/No	Yes
CQUIN 2b -Trust will be required to demonstrate that 50% of all care plans for service users in care clusters 11 – 14 on CPA adult and older adult services show evidence of collaborative care planning and contain two personal recovery goals.	50%	64.6%
ß. Improving dementia care and prescribing in Mental Health Trusts		
CQUIN 3a – Trust to demonstrate participation in the 2012 POMH-UK audit of antipsychotic prescribing for people with a primary or secondary diagnosis of dementia as identified on RiO according to London audit standards and share results with NHS London	Yes/No	Yes

CQUIN 3b – 90% of all those under the care of the Trust with a primary or secondary diagnosis of dementia and who are on antipsychotics to: 1. Have a review of their prescription at least 3 monthly (in accordance with NICE guidelines) and that review is documented in clinical records, *and* 2. within two weeks of the review, trusts to have sent a letter to GP and families/carers (where consent is explicitly given) detailing information on the on-going prescribing and monitoring arrangements for antipsychotics	90%	98%
CQUIN 3c – A local sustainable quality improvement plan is developed and agreed with local CCGs and commissioners by the end of Q2 and activity is taken forward, with an interim* report being prepared for the CCG/Lead Commissioners in Q4 (this should also be shared with the London office of the National Commissioning Board (successor body to NHS London, taking over from 1 April 2013). **commissioners and providers should agree in the course of the year the date for the final report, which we would recommend be March, 2014*	Yes/No	Yes
CQUIN 3d – Trust to demonstrate that for 90% of discharges of patients with dementia the information required has been provided to the patient's GP and family/carer where appropriate within 2 weeks.	90%	93.8

4. Improve the physical health of users of mental health service by providing smoking cessation support

CQUIN 4a –Trust to implement a comprehensive programme of training in smoking cessation for staff so that at least a third of professional staff have been trained in a recognised brief intervention protocol.	33%	51%
CQUIN 4b – Smoking status of service users recorded in at least 75% of electronic patient records.	75%	93.3%
CQUIN 4c – At least 2% of service users on CPA are involved in agreeing and adopting a care plan intervention for smoking cessation.	2%	15%

5. Improve the recording of data by using the NHS Safety Thermometer

CQUIN 5a – Completion of NHS Safety Thermometer	Submission of quarterly dataset	Yes

2012/13 CQUIN targets for Forensic Services, Child and Adolescent Mental Health Services, Newham Talking Therapies and Community Health Newham have been met. The full report is available upon request from the Trust secretary.

Quality Accounts 2012/13
Part 2. Priorities for Improvement

2.6 What Others Say about the Trust

Care Quality Commission (CQC)

East London NHS Foundation Trust is fully compliant with the Care Quality Commission

Statements from the Care Quality Commission (CQC)
East London NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without any conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2012/13.

There were no relevant special reviews or investigations by the CQC during the reporting period. Below are quotes from the unannounced inspections of inpatient services at the Forensic Services Directorate undertaken in 2012/13:

CQC Compliance Report – Forensic Services

- Clissold, Woodbury, Butterfield and Hoxton wards at Wolfson House
- West Ferry ward, a psychiatric intensive care unit, at the John Howard Centre

"We checked that practice on seclusion and restraint in the Forensic Services Directorate was in line with national guidelines and the trust's own policy and procedures."

"Patients told us they had been involved in their care planning. We saw evidence of multidisciplinary team working and positive interaction between staff and patients on the wards. Seclusion was used rarely on most of the low secure wards in Wolfson House. We observed that staff were concerned to protect patients' dignity and privacy when they were held in seclusion. The seclusion facilities for Wolfson House and West Ferry ward conformed to national guidelines to protect people's dignity, rights and their safety."

"Staff teams were supported to care for patients. Staff received training and support on the appropriate use of seclusion and restraint. Staff on one ward said they were experiencing staffing pressures. The trust was recruiting to fill two vacancies on this ward."

"We reviewed a range of records, including the seclusion records, and found these to be accurate and up to date."

Trust Response
The CQC report was disseminated across the Trust and discussed at the Service Delivery Board, Quality Committee and Assurance Committee. The Trust submitted action plans in response to the improvement actions requested by CQC.

Further information
http://www.eastlondon.nhs.uk/about_us/care_quality_commission.asp

NHSLA Level 3 Assessment

East London NHS Foundation Trust is the only mental health and community health trust in the country to reach level 3.

The assessment took place over two days on 16-17 January 2013. Two assessors reviewed the 50 individual risk management standards. This included reviews of evidence, interviews with key staff, testing of policy ratification and circulation and a visit to the Newham Centre for Mental Health and the East Ham Care Centre.

Two standards tested were specific to Community Health Newham services (screening and VTE), and the Trust was required to demonstrate that other standards were applied and monitored in Community Health Newham.

The NHSLA confirmed that the Trust successfully achieved Level 3 status, with a score of 48/50.

The long-term implementation of NHSLA standards should help to reduce risk and improve quality and safety of Trust services on a sustainable basis.

Organisation Readiness Self-Assessment (ORSA)

The self-assessment questionnaire has been approved by the Review of Central Returns Steering Committee – ROCR

The ORSA is a process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are up-to-date and fit to practice and compliant with the relevant professional standards. Revalidation will have 2 elements, re-licensing and re-certification.

Since autumn 2009, any doctor who wants to practice in medicine in the UK not only has to be registered with the GMC, but also has to hold a license to practice.

Organisational Readiness Self -Assessment is a questionnaire that aims to:

- Ensure designated bodies understand what is needed for revalidation and identify and prioritise areas for development
- Inform the England Revalidation Delivery Board and the GMC regarding progress towards implementation in England
- Contribute towards the Secretary of State's assessment of readiness for revalidation in 2012.

2.7 Data Quality

The Trust's Information Governance (IG) framework, including Data Quality (or "Information Quality Assurance") policy and responsibilities/management arrangements are embedded in the Trust's Information Governance and Information Management and Technology Security Policies.

Information Quality Assurance:

- The Trust established and maintains policies and procedures for information quality assurance and the effective management of records
- The Trust undertakes or commissions annual assessments and audits of its information quality and records management arrangements
- Data standards are set through clear and consistent definition of data items, in accordance with national standards
- The Trust promotes information quality and effective records management through policies, procedures, user manuals and training.

The Trust's Commissioners, Trust Board and Information Governance Steering Group receive regular reports on data quality/completion rates against agreed targets. The IG Steering Group receives and reviews performance on data quality benchmarked across London and nationally – including the use of the national data quality dashboard.

To support action and improvement plans, Directorate Management Teams receive a range of cumulative and snapshot data quality reports from the Trust's Information Management team. These show missing or invalid data at ward, team and down to individual patient level. Data validity and accreditation checks are undertaken annually in line with the IG Toolkit national requirements and an annual audit of clinical coding is undertaken in line with the IG Toolkit national requirements.

East London NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data taken from local RiO data as of 31st January 2013:

- which included the patient's valid NHS number was: 98% for inpatient mental health, 98.4% for community mental health, 99.1% for CAMHS, 99.2% for CHN and 96.4% for Addiction services
- which included the patient's valid General Medical Practice Code was: 98.9% for inpatient mental health, 95.9% for community mental health, 98.6% for CAMHS, 96.8% for CHN and 90.9% for addictions services.

The Trust has implemented the following actions to improve data quality:

- Continuing deployment of 'RiO Clinical' across mental health services
- Monthly performance management meetings
- Expansion of RiO community systems
- Migration of CAMHS legacy system to RiO
- Major initiatives to embed captured PbR clusters.

2.7.1
Information Governance Toolkit attainment levels

East London NHS Foundation Trust Information Governance Assessment Report overall score for 2012/13 was 88%. The Trust failed to achieve Level 2 for Requirement 112 (national mandatory information governance training) resulting in a 'Not satisfactory' rating.

2.7.2
Clinical coding error rate

East London NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.

2.8 Trust Priorities for 2013/14

In 2013/14 the Trust is continuing to implement the long-term priorities and measures of quality and satisfaction developed as a result of the collaborative work undertaken with partner and stakeholder groups in 2010/11. The Trust will maintain the focus on these three key areas to ensure continuity and consistency:

- Improving service user and carer satisfaction
- Improving staff satisfaction
- Maintaining financial viability

In spite of significant challenges, the Trust has directed considerable resources to improve these key priorities and we intend to build on this momentum. The challenge for the year ahead is to keep all areas of quality (patient safety, clinical effectiveness and patient experience) central to the care and treatment we provide

2.9 Quality Indicators for 2013/14

The Trust monitors quality in a number of ways, including through designated Board committees, robust performance management processes, internal scrutiny, self-assessment and feedback from service users and carers.

A revised set of indicators will enable the Trust to better monitor the quality of service delivery within the annual plan and through the in-year monitoring process.

They are grouped into the categories of:

- Patient safety
- Clinical effectiveness
- Patient experience

The quality indicators will provide a renewed emphasis on service user focused measures for quality. This work will allow the Trust to measure real aspects of recovery and experience and improve performance.

Much of the work the Trust undertakes to improve the quality of the services we deliver is in partnership with external organisations and stakeholder groups. We hope to continue this positive experience in the future.

In addition to the nine quality indicators set out below, a range of initiatives will be undertaken over the next 12 months in the following areas:

The Quality Indicator priorities 2013/14

Quality indicator	Category
1. a. % of patients on CPA for whom we have met or exceeded their planned number of visits per month b. % of patients with a primary diagnosis of schizophrenia on enhanced CPA whose care plan addresses three of the following: i. Mental State Examination ii. Psycho-education iii. Employment (including education) iv. Relationships v. Housing vi. Activity c. % of patients on CPA whose carer has been contacted by the care co-ordinator	Patient experience; Clinical effectiveness
2. Percentage of young people in contact with Community CAMHS Teams who have shown improvement as measured by CORC outcome measures	Patient experience; Clinical effectiveness
3. All medication errors involving high risk medication, anticoagulants and Methadone to be defined as never events • The Trust target for 2013/14 is zero events	Clinical effectiveness; Patient safety
4. Expand the current real-time data collection process to include Learning Disability and MHCOP services and increase local ownership of touch screens as indicted by the local development and analysis of questions and data.	Patient experience;
5. Percentage of all patients with diabetes with a physical health care plan that specifies targets for glycaemic control • 80% of mental health inpatient nursing and support workers to have experiential training with the Diabetic Nurse Specialist	Patient safety; Clinical effectiveness
6. Undertake regular focused surveys of staff to better understand their perception of issues across the Trust • A set of core questions concerning engagement, involvement and morale • Repeat questions would act as a pulse-point indicator by which to measure incremental outcomes to initiatives • Additional questions based on a theme would be asked at each quarterly point e.g. quality of appraisals, stress, career development, opportunities for research etc.	Patient experience
7. Each clinical team to develop one quality initiative to improve patient satisfaction	Patient experience; Clinical effectiveness; Patient safety
8. Ensure a high percentage of patients receive adequate antipsychotic prescribing monitoring • Medicines reconciliation of all patients on admission and subsequent review of medicine charts by pharmacy staff • Annual POMH-UK audits for high dose and combination prescribing • Quarterly audit of high dose antipsychotic prescribing	Patient experience; Clinical effectiveness
9. Develop partnership with local organisation(s) which promote physical and mental wellbeing • Work in partnership with our primary care colleagues to understand the barriers and facilitators to better physical health care for mental health service users in the community • The focus will be on improved monitoring of outpatients on the Serious Mental Illness (SMI) Register	Patient experience; Clinical effectiveness; Patient safety

2.10 Special Focus across the Trust

2.10.1
Preparation and Planning for the Olympics

The Trust provides services in three of the six London boroughs that hosted the London 2012 Games (Newham, Tower Hamlets, and Hackney). Barts and The London and Homerton Hospital were designated healthcare providers for the Games. The planning strategy for the Games outlined by NHS London SHA in their Games Planning Pack was 'business as usual' with no closure of services. No additional funding was allocated. No services were disrupted during either of the Games and the Trust met the expectation of 'business as usual'.

Planning for the London 2012 Games was a positive experience for the Trust. In addition to the key planning assumptions for the London 2012 Games, the Trust had to reflect upon its preparedness for responding to emergency incidents to ensure it is capable of responding effectively and is resilient enough to continue to carry out its core functions under extremely challenging conditions. It was also necessary to assure its partner agencies that it was able to do this. A detailed emergency preparedness assurance exercise was carried out with NHS London and this provided the opportunity to ensure our emergency planning was fit for purpose and to test its practical application. The Trust is now in a much more confident position in terms of responding to a major incident.

Planning for the Games also provided an opportunity to work more closely with local partner agencies. It brought different groups of staff together internally and helped to create new and different relationships between staff of different agencies. It also provided an opportunity to think about new ways of working in the future and to learn lessons from the planning and exercising programmes which staff engaged in.

Key points from the experience are:

- Increased knowledge and awareness of emergency planning and business continuity issues across the organisation and among a wide range of roles and staff groups
- Refreshed and meaningful business continuity plans for all services
- Greater appreciation of close partnership working
- New relationships at different levels between partnership agencies
- Greater knowledge and understanding of partnership agencies.

There was wide participation from staff across the organisation in the planning meetings, as well as in locally established meetings. We were able to sign off our detailed plan before the Games started and it was generally felt that planning had been detailed and well-co-ordinated to the point that no outstanding planning issues were identified. The planning and delivery for the Games illustrated the range of ideas, commitment and collaboration that is possible both within the Trust and with partner agencies, and this is something which we acknowledge and celebrate. A commitment to 'business as usual' and to our service users was evident throughout the process.

2.10.2
Olympic Legacy

As part of its commitment to developing an Olympic legacy and increasing service user participation in health and wellbeing activities, East London NHS Foundation Trust has employed an Olympic Legacy Development Worker. The aim is to work with the University of East London and Queen Mary University to introduce a range of wellbeing and exercise programmes for service users across adult services. The aim is to have these students providing health and wellbeing activities across adult acute inpatient wards and the Alcohol Recovery Centre (ARC). These will be delivered through student placements on the adult acute inpatient wards and community teams. The students will be undertaking undergraduate or masters level degrees in relevant areas, such as heath and exercise, sports development, coaching and positive psychology. One of the objectives is to support service users to identify activities based in the community that they would like to access once discharged and set goals with students on how to achieve this. The programmes started in February 2013 in order to coincide with the academic needs of the university students.

Prior to starting the project, the Trust ran a series of focus groups with service users and staff to ask what the priorities were and how the process should be implemented. Both groups felt that physical activity was 'extremely important'. A key component of the pilot project is the evaluation of the intervention. As such, the process involves collecting feedback from service users, students and staff throughout the process. This information will be used to inform any future developments.

A physical health programme has been implemented as part of the abstinence group within the ARC service. Students are providing tailored support plans and coaching sessions to service users at Kings Hall sports centre. They then provide short education sessions covering topics such as benefits of exercise for alcohol recovery, exercise and coping with negative moods and identifying and overcoming barriers.

All inpatient sessions are co-facilitated with Occupational Therapy (OT) staff with the aim of developing this to provide one-to-one coaching and goal setting sessions. In addition to the sessions in adult services, there are also weekly dance sessions provided by one of the students at the Coborn Centre (inpatient CAMHS ward). There is also a four week Yoga trial being implemented on the inpatient wards in each of the boroughs, and a chair-based exercise trial due to take place on the older adult functional wards in the future.

Future developments

- Queen Mary Students will be delivering workshops across inpatient and community teams covering nutrition, cancer screening, sexual health and dental care. These are starting at the end of June
- The sports team in forensics are looking into the costing and feasibility of becoming an accredited centre for a Level 2 Gym Instructor qualification. This would be provided by the Trust staff to train service users. These qualifications would enable service users to seek employment in the health and fitness industry once discharged
- Working with Barry McGuigan Boxing Acdemy (BMBA) for service users and staff to attend health activation days based on a boxing intervention on 26 June. The Community Recovery and Rehabilitation Team have confirmed 20 service users from Tower Hamlets
- Funding has been approved so far in Hackney and Tower Hamlets to get eight staff trained as 'community activators' with YMCAfit. This is to train more staff to run physical health groups and link in with community facilities effectively. Staff can then act as the leads for the boroughs and feedback to the trust-wide Sports/Physical Health Committee. The first one of these will be 10 June.

2.10.3
Dementia – Local Government Chronicle/ Local Government Association Awards 2013

In March 2013 the Tower Hamlets Dementia Partnership received the LGC Award for Health and Social Care ahead of sevn other shortlisted services from across the country.

The East London NHS Foundation Trust, in conjunction with the London Borough of Tower Hamlets, the Clinical Commissioning Group and the Alzheimer's Society, are the key members of the Tower Hamlets Dementia Partnership. Winning the award was recognition for all the hard work staff have put in to develop a coherent and integrated pathway for dementia across health and social care in Tower Hamlets.

The process began three years ago with the development of a Joint Strategic Needs Assessment. At this time service users expressed the view that services were fragmented. They battled to obtain a referral for specialist assessment, numbers on the primary care dementia register were low and community engagement was poor. A project board was set up to develop and restructure services with the explicit aim to harness the opportunities that an integrated approach would bring.

As a key member of the partnership, East London Foundation Trust has developed and redesigned services to provide a coherent community pathway and give the service user the best possible experience. The Trust now has a Diagnostic Memory Clinic, Community Dementia Team, Dementia Liaison Service in the Royal London Hospital, liaison to GP practices, to the Community Virtual Wards and to care homes. It also commissions the Alzheimers Society to provide Dementia Advisors.

The judges recognised the way the partnership has

targeted new investment and redirected significant resources from inpatient services into new community services, and the profound impact the pathway has had on the service user and carer experience. Referrals to the Memory Clinic have doubled in the last year. The number of people receiving a dementia diagnosis in the Royal London has dramatically increased and those being coded with dementia in primary care has increased by 20%. This makes Tower Hamlets the most improved borough in the country for diagnosing dementia.

2.10.4
International Nursing Award

This award is for nurses whose international work has made a difference to the healthcare of people outside the UK, or for nurses who, as a result of working abroad, have introduced new nursing practises within the UK. Entries are accepted from nurses who have been or are currently working in the UK health service. Nurses may nominate themselves, their team or be nominated by a colleague.

Cerdic Hall is a Primary Care Mental Health Liaison Nurse at East London NHS Foundation Trust. Cerdic has developed services for mental health patients in Uganda, where patients often face stigma, exclusion and even violence. By pioneering patient involvement, care has now improved dramatically.

2.10.5
Volunteering

Since its inception two years ago, the Volunteer Programme has gone from strength to strength, basing itself on good practice in volunteer management and by providing a quality recruitment and training process. The Trust Volunteer Coordinator has acted as mentor/adviser to two London NHS Foundation Trusts and others around the country on the programme model.

The volunteers reflect the diversity of the community the Trust serves and is inclusive of service users with mental health and physical disabilities. A young deaf Somalian woman became a volunteer and attended the compulsory training

Photo left to right: Cecilia Anim, Deputy President, Royal College of Nursing, Jane Cummings, Chief Nursing Officer for England, Cerdic Hall, Primary Care Mental Health Liaison Nurse, East London NHS Foundation Trust, Fiona Phillips, Host

with two signers, a learning experience for all – including the signers, who commented on their new learning and understanding of mental health.

Volunteers are placed across the entire Trust, and a new development began in community health where volunteers were placed to befriend service users with aphasia following a stroke. These service users are now becoming volunteers themselves and assist the team that supports the befrienders.

Staff regularly provide feedback on the quality of the volunteers and their knowledge and skills following the training. Sarah Dove, education head at the Coborn Centre for Adolescents in Newham commented, *"The volunteers feel part of the staff team and are so committed, enthusiastic and bring new ideas to the work we are undertaking."*

Over 80 roles have now been developed in a wide range of departments and this number is set to grow further in the new financial year. Volunteers are enhancing the activities staff are bringing to our service users. They also gain experience, skills and knowledge. A majority of those who have left the Trust to move on also gained employment within the NHS. For further information on our volunteer programme contact the Trust Volunteer Coordinator ann.lacey@eastlondon.nhs.uk.

Nadia Essa, a volunteer on the March 2013 training programme, wrote

"I just wanted to drop you a quick email to say thank you very much for such a great three days of training. I thoroughly enjoyed your way of teaching especially through storytelling and getting us thinking instead of just feeding us information. It was really inspiring to be there with such lovely people. Thank you!!!"

2.10.6
Selection Days

Historically, the Trust used a traditional interview format to recruit nurses. It focused on the person's clinical skills and used scenarios to determine how they would manage a range of situations lasting, at the most, 45 minutes. The interview panel did not have the time to really get to know the candidate or to fully explore their values, beliefs and an understanding of their emotional literacy.

Two years ago the nursing directorate reviewed its recruitment process and considered how best to recruit an emotionally literate, compassionate, resilient and mindful workforce. The concept of selection days, which focused on values, beliefs, emotional intelligence and also tested literacy and numeracy, was introduced.

These selection days are facilitated by the Deputy Director of Nursing, supported by service users, Borough Lead Nurses, Matrons, PINs and Clinical Practice Leads this ensures continuity and shared expectations relating to the quality of nurses we recruit.

All shortlisted candidates are invited to a selection day where a range of individuals and group exercises are used to test values and beliefs, comparison, their ability to reflect, self-regulate and understand the impact their behaviour and actions can have on others. We test their ability to listen, hear, process, formulate, narrate and use their own life experiences to demonstrate thinking, feelings and behaviours.

In addition to this, debates focusing on topical issues such as racism, homophobia, and female genital mutation are used to complement the exploration of the candidates' values, beliefs and their ability to articulate their views.

All qualified nurses are expected to complete a drug calculation test, and all candidates complete a literacy test. If candidates are successful in all three components of the selection day, they will be invited to an individual interview which will focus on clinical skills or skills specific to the job they are applying for.

Band 6 Apprentices

Selection days not only enable the Trust to recruit staff who are able to care for patient compassionately and creatively but also allow us as an organisation to clearly define our own values and expectations and our commitment to ensuring the service user is at the centre of everything we do.

The feedback from staff, service users and their carers has been positive and is evidenced on service user satisfaction questionnaires, carers' comments and through preceptorship, supervision and mentoring programmes.

2.10.7
Band 6 Apprenticeship Programme

The Band 6 Clinical Practice Lead role is often considered the most challenging. Staff moving from a Band 5 staff nurse into the Band 6 role often describe feeling unprepared and overwhelmed, and they struggle to meet the demands of being a lead clinician and junior manager.

Thinking about the concept of succession planning, and the need to develop potential and to retain quality staff, an Apprentice Band 6 programme was developed. This is a 20 day programme, staggered over a nine month period and broken into three key components: Clinical, Leadership and Management.

Quote by Daisy Tate
(Staff Nurse Band 5)

"This was a brilliant day! It was informal and although I was nervous to begin with, I quickly relaxed and really felt able to be myself and as though it was my personality that was important rather than being able to recite law by rote. It also felt more real to our actual job – it's our relationships with our service users that are important and that's what came through.

I've been on other selection days and the ELFT day was so much more realistic to actual practice. On the others, it was my knowledge that counted rather than my personality and at ELFT, although knowledge was important, who I was far outweighed it. I was also far more nervous in the SLAM/UCLP process as it was a constant knowledge test and there was no respite from formal testing. Although the ELFT day was a test from start to finish, it was far more authentic."

Quality Accounts 2012/13
Part 2. Priorities for Improvement

Clinical
This component includes two days recovery training focusing on Recovery in Practice, The Art of Engagement and Recovery Care Plans. Physical Health Training, Women's Needs, Rapid Tranquilisation, CPA, Family work, Risk, Understanding the Relationship between the Ward and the World are also part of this programme.

Leadership
This component includes a five-day leadership programme which looks at leading oneself, leading others and influencing and developing others. Two days 'Clear as Mud' looks at how nurse leaders work through the myriad of problems they face and uses experiential learning to explore their relationship with staff and others. A number of sessions explore leadership styles, personal strengths and the ability to lead and follow.

Management
This component introduces the Apprentice Band 6s to the 'Bigger Picture' and gives them an understanding of Governance, Commissioning, the role of the Executive Board and the National Picture. There is also Core Staff Management training.

Throughout the course, there are structured support groups, action, learning sets and recovery reflection groups to support the learning. After each component, there are individual assessments focusing on how each person can put learning into practice and whether they meet the desired competences. They will have the opportunity to supervise a member of staff, shadow and hold the duty senior role nurse under supervision and have a two week placement of their choice.

Each apprentice is allocated a mentor/coach who will support, challenge, assess them and be their critical friend throughout the course. They will also be given some project work to complete, which they will present to the Executive Board, service and Clinical Directors and the Borough Lead Nurse at the end of the programme.

When they have completed the programme successfully, they will become Apprentice Band 6 Nurses. They will be supported in securing substantive Band 6 posts within a year of completion. The majority of the sessions are facilitated by staff working for the Trust, who utilise the wealth of experience and expertise we have in our organisation.

This programme is still running, but will be evaluated by all involved when completed.

Quote from Aaron Barham, Band 6 Apprentice

"The Band 6 training programme has enabled me to learn some new skills and consolidate others. It shows that the Trust is investing in their staff and their development and by doing so, shows the commitment to providing an excellent service to all our clients.

The programme is an exciting opportunity for all of us involved."

Quote from Mark Pattison, Band 6 Apprentice

"I joined East London Foundation Trust because of their strong work ethic, the high standard of care offered to patients and their determination to invest in their staff by offering a platform for continued professional development.

True to their word the Band 6 training was offered and I was luckily enough to get on the programme. Being offered a place on the Band 6 apprentice has been an incredible opportunity and one that has offered me more training and experience than I could ever have wished for. The training offered to us has been worlds away from anything I have come across before and is undoubtedly creating a higher calibre of nurse.

The training we are receiving is up to date, evidence based and from individuals who are experts in their respected fields. The faith which East London NHS Foundation Trust has shown us by heavily investing in the future of our nurses is incredibly inspiring. I'm constantly learning new skills and as a result of the vast training I have received from the programme I have been offered a Band 6 post which I now feel I'm ready for due to the apprenticeship.

I'm proud to say I'm part of East London NHS Foundation Trust and the investment it has shown its staff through this course has been incredible."

2.10.8
Hope Wall Project
As hope is one of the key factors in recovery, we have decided to utilise the power of hope in a Trustwide project. The Hope Wall Project is a coproduction involving Band 3 and 4 ward-based staff, service users, the Deputy Director of Nursing and the People Participation Lead.

The main aim is to capture people's hopes in a variety of ways and to use those as potential starting points for individual recovery. Also the sharing and discussion of these hopes would be invaluable for making meaningful connections with each other.

The idea is that the Band 3 and 4 staff will lead and drive forward the Hope agenda on their particular wards. We have held a number of meetings where we all come together to discuss ideas and solutions to any potential barriers. We also had excellent exchanges on how we all have powerful hopes of our own.

Different Solutions
There have been a wide range of activities/approaches to this work.

- Hope-based discussion groups
- Hope Walls (people publishing their hopes in a dedicated space on the ward
- Art-based sessions with a hope focus (e.g. cutting out hope related pictures from magazines and formulating a hope-based plan)

Outcomes
There will be an event on the 7th July to showcase this work where service users and the staff will present their particular projects. This will then highlight how working with Hope will be taken forward.

We also want to look at how this work can be captured in one place (a book, website etc.) so it can be used as a training tool for the future.

Part 3. Review of Quality Performance 2012/13

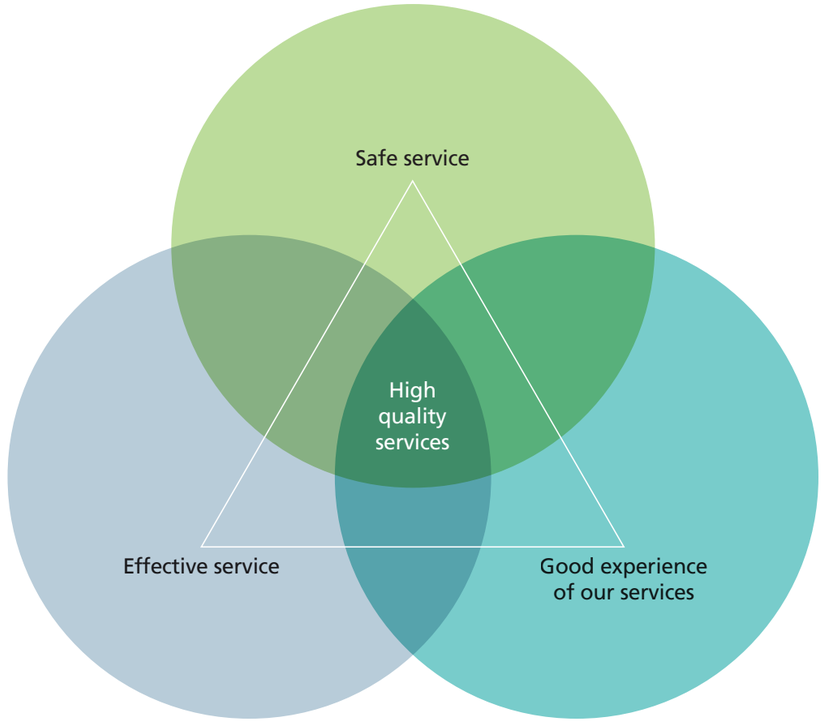
3.1 Review of Quality Performance 2012/13

3.1.1
Review of Priorities for 2012/13
Our quality strategy underpins everything we do and enables us to set targets and monitor their impact. In addition to the national clinical targets, we have developed quality indicators covering patient safety, clinical effectiveness and patient experience.

We have continued to encourage a culture within all our services where staff feel recognised and supported, but also one where poor performance is challenged and managed appropriately.

This quality report will detail the key achievements and a summary of progress across indicators. Each indicator is described in respect of improvements achieved during the year, and the identification of further improvements required during 2013/14.

The quality indicators set out below were developed in partnership with our key stakeholders, such as service users, carers and representative groups across the four boroughs and cover those three main domains. By focusing our time and resources on these priorities, the Trust has been able to achieve each of the targets. This is why we have chosen to maintain this focus for 2013/14.



The Quality Indicator priorities 2012/13

Priority	Category	Target	Status
1. All Adult & Older Adult Community Teams to increase the % of caseload receiving face-to-face contact per month	Patient experience; Clinical effectiveness	**80%**	92%
2. Percentage of young people in contact with Community CAMHS Teams who have shown improvement as measured by CORC outcome measures	Patient experience; Clinical effectiveness	**80%**	84%
3. Amount of time care co-ordinators working in Adult and Older Adult services are in contact with patients as a proportion of their working week.	Patient experience	**Establish baseline**	Yes (22%)
4. An increase in the % of patients with enhanced CPA with a crisis plan and risk assessment up-to-date	Patient experience; Patient safety	**90%**	97%
5. Reduce the total number of medicine errors of three high-risk medications (Insulin, Lithium and Clozapine).	Patient safety; Clinical effectiveness	**<3%**	2.85%
6. Increase the % of patients who have had their medicines reconciled within 72 hours of admission	Patient safety; Clinical effectiveness	**90%**	96%
7. Consolidation of real time satisfaction measures for service users across services	Patient experience	**Process**	**Touch screens** CHN 5 MH 8 **Digipens** CHN 16 MH 22
8. Percentage of all patients with diabetes with a physical health care plan that specifies targets for glycaemic control.	Patient experience; Clinical effectiveness; Patient safety	**Establish baseline**	Yes
9. Increase the proportion of staff who report having well-structured appraisals in the last 12 months.	Patient experience; Clinical effectiveness	**51%**	54%
10. Each Clinical team to develop one quality initiative to improve patient satisfaction	Patient experience; Clinical effectiveness; Patient safety	**Yes/No**	*Yes

* A list of initiatives is available upon request

The quality Indicators are developed as a means of making the greatest improvement to the quality and safety of services based on what the Trust and key stakeholders believe are the Trust priorities. Although the Trust has maintained a focus on improving patient and carer satisfaction, staff satisfaction and maintaining financial viability, the individual areas of focus, and corresponding indicators, change every year. As such, it is not always possible to provide historical or comparative data.

Quality Accounts 2012/13
Part 3. Review of Quality Performance 2012/13

In addition to fulfilling all the quality priorities set out over the previous year, the Trust has met all Care Quality Commission (CQC) and all Commissioner targets.

Monitor Assurance

East London NHS Foundation Trust has a range of Monitor targets on which we report throughout the year. The targets outlined below are tested by external monitors to provide assurance that the data provided are reliable. Two are statutory, one is locally defined.

The figures below show the trust has exceeded all national targets. As set-out in section 2.7, the trust has data quality arrangements in place which ensure the Trust's Commissioners, Trust Board and Information Governance Steering Group receive regular reports on data quality/ completion rates against agreed targets. The IG Steering group receive and review performance on data quality benchmarked across London and nationally – including the use of the national data quality dashboard.

Monitor targets	Target 2012/13	Actual 2012/13	ELFT 2011/12
1. CPA inpatient discharges followed up within 7 days (face to face and telephone)	95%	**98.1%**	96.4%
2. Patients occupying beds with delayed transfer of care – Adult and Older Adult	7.5%	**1.75%**	0.7%
3. The total number of patient safety incidents, including the percentage of such incidents that resulted in severe harm or death			
Total incidents reported		8064	7130
Incidents identified as 'patient safety incidents' (as per NPSA definition)		2631	2332
Of which resulted in severe harm or death		7 (0.3%)	9 (0.4%)

The number of 'patient safety incidents' indicator has been published for the first time. It is reliant on staff reporting incidents and there is a degree of clinical judgement regarding the classification of harm associated with any incident. The trust benchmarks itself against other trusts in order to review and improve reporting practice.

The Trust is keen to increase the reporting of incidents, but reduce the patient experience of harm. The Trust are supporting this by seeking to develop whole system measures of quality, which would allow us to better understand whether we are improving the quality and safety of our services over time.

In parallel, the Trust is looking at developing a more continuous and rounded view of system safety, incorporating a continuous measure of adverse incidents (using trigger tools), complaints, serious incidents, voluntary reporting of incidents, mortality, and other indices.

The table below details each of the Trust's Monitor Indicators for the last two reporting periods. The data are presented as end of year ('year to date') figures.

Monitor Targets	Target 2012/13	Actual 2012/13	Period used 2012/13	ELFT 2011/12
Mental Health Patients occupying beds with delayed transfer of care – Adult & Older Adult (Only CAMHS excluded)	7.5%	1.75%	YTD 2012/2013	Monitor Definition changed 12/13 – year figure including social care 1.2%
Admissions made via Crisis Resolution Teams (end of period)	95%	98.8%	YTD 2012/2013	99.0%
Number of adult CPA patients meeting with care-coordinator in past 12 months	95%	98.1%	YTD 2012/2013 derived using in date care plans	98.5%
Access to healthcare for people with a learning disability – report compliance to CQC	Completion of self-assessment and declaration	19	Current	17 – sourced from TB Compliance Report
Newly diagnosed cases of first episode psychosis receiving Early Intervention Services	176	299	YTD 2012/2013	320
Completeness of Mental Health Minimum data set – PART ONE	97%	99.1%	Q4 2012/2013 provisional	99.0%
Completeness of Mental Health Minimum data set – PART TWO	50%	92.2%	Q4 2012/2013 provisional	88.7%
Referral to treatment time within 18 weeks (non-admitted patients)	95%	100.0%	YTD 2012/2013	100%
Maximum time of 18 weeks from point of referral to treatment (patients on incomplete pathways)	92%	100.0%	YTD 2012/2013	New Indicator 2012/13
A&E Clinical Quality – Waiting time in A&E	95%	96.3%	YTD 2012/2013	99.6%
MRSA bloodstream infections – reported instances	0	0	YTD 2012/2013	0
Reduction in Clostridim Difficile – reported instances	0	0		0
Monitor Targets – Community Information Data Set (CIDS – Data Completeness)				
Community Referral to treatment information	50%	100.0%	Q4 2012/2013	100%
Referral information	50%	74.7%	Q4 2012/2013	79.8%
Activity information	50%	96.3%	Q4 2012/2013	80.0%

28 Day Re-admission rates

ELFT considers that these percentages have reduced for people 15 years of age and over due to the concerted effort teams have made to ensure assessments and discharges are as thorough as possible. The increased rate in re-admission rates for people under 15 years of age is due to the small sample size.

Presented below are the percentages for the last two reporting periods.

ELFT has taken the following actions to improve these percentages, and so the quality of its services, by increasing staff training and ensuring clinical decisions are based on multi-disciplinary input, levels of community support are high and patients have greater access to Community Mental Health Teams (CMHT).

Total discharges

Period	Number of clients (0 to 14)	% of clients (0 to 14)	Number of clients (15 or over)	% of clients (15 or over)	Discharges
2011/12	0	0	270	8.1	3332
2012/13	1	7.1%	262	7.6	3468

Presented below are the discharges based on Split Cohort for discharges for the last two reporting periods

Based on Cohort Age (0 to 14)

Period	Number of clients (0 to 14)	Discharges	% of clients (0 to 14)
2011/12	0	16	0
2012/13	1	14	7.1%

Based on Cohort Age (15 and Over)

Period	Number of clients (15 or over)	Discharges	% of clients (15 or over)
2011/12	270	3316	8.1%
2012/13	262	3454	7.6%

Good Quality Care across the Trust

The Trust participates in a range of additional activities designed to improve the quality of the care and treatment we provide.

The information in the following section comes from various sources, both from internal process and external review.

Performance Framework 'Ready Reckoner'

The DoH originally published the 'Performance Framework' in April 2009. It was subsequently revised with effect from April 2012. Its aim is to 'provide a dynamic assessment of the performance of NHS providers and commissioners against minimum standards'.

The process is linked to the regulatory and performance management roles of the CQC, Monitor and SHA. The purpose of the NHS Performance Framework is to identify poor performance continually, using a series of indicators from the following domains:

- Finance
- Quality of Service derived from:
  - Integrated Performance Measures Operational Standards and Targets
  - CQC Registration status
- User experience.

The framework is underpinned by indicators in each domain, and a weighted scoring system, to determine performance thresholds.

The process operates using the following principles:

- Measured monthly, reported quarterly
- Results published in the DoH publication 'The Quarter'
- Monthly communication of results relating to operational standards and targets to SHA.

The table below contains the Trust scores (Sept 2012) for each selected question and related domain.

	National threshold	London threshold	ELFT	BEH	C&I	CNWL	NELFT	Oxleas	SLaM	SWstG	WL
Domains Passed	-	-	4	4	3	4	2	4	3	2	3
Access & waiting	**66.2**	**68.0**	69.6	66.9	67.3	67.3	65.5	76.7	65.8	67.5	64.9
(Q22)	**81.2**	**82.2**	84.2	79.9	83.9	80.8	83.5	81.6	83.0	80.2	82.4
(Q36)	**48.1**	**53.8**	55.1	54.0	50.7	53.8	47.5	71.8	48.6	54.9	47.4
Safety, quality, coordinated care	**68.7**	**73.1**	73.4	69.7	74.0	75.6	69.1	75.3	75.2	72.3	73.0
(Q16)	**72.5**	**78.6**	83.4	74.2	77.7	81.9	69.9	79.5	79.9	79.2	82.2
(Q23)	**81.1**	**82.0**	81.7	78.7	85.0	81.8	83.0	81.7	82.4	82.5	81.0
(Q30)	**69.0**	**79.1**	77.2	75.6	81.0	83.0	77.0	84.4	78.0	77.5	77.7
(Q42)	**46.1**	**52.6**	51.4	50.5	52.4	55.6	46.4	55.7	60.5	50.0	51.3
Better info, more choice	**65.7**	**67.3**	66.1	67.3	67.3	68.3	70.0	68.3	69.7	62.3	66.8
(Q10)	**69.0**	**71.7**	75.5	70.6	71.5	70.5	70.9	68.6	72.8	71.4	73.7
(Q23)	**62.2**	**67.3**	66.3	67.0	70.3	67.6	72.5	75.5	65.5	57.0	64.5
(Q25)	**68.5**	**70.2**	65.6	71.4	71.3	72.4	72.1	69.7	76.3	65.9	67.1
(Q26)	**56.2**	**60.1**	57.1	60.1	56.3	62.7	64.4	59.5	64.1	54.8	61.9
Building closer relationships	**82.5**	**83.6**	82.6	83.2	81.8	84.6	82.5	86.0	85.1	81.9	84.5
(Q5)	**82.3**	**83.2**	82.1	83.3	82.9	83.9	82.6	86.0	83.8	80.5	84.3
(Q6)	**79.5**	**81.1**	79.1	81.5	78.3	83.0	81.6	81.1	83.6	79.9	81.7
(Q7)	**90.7**	**90.9**	88.6	92.6	86.9	92.6	91.1	92.5	91.0	90.1	92.2
(Q8)	**79.7**	**81.5**	81.4	80.6	79.9	82.4	81.1	83.9	82.3	79.4	82.1
(Q21)	**76.6**	**81.2**	82.0	77.9	80.9	80.9	76.0	86.4	84.8	79.8	82.3

Mental Health Benchmarking Update

The Trust has continued its participation in benchmarking activities via the NHS Benchmarking Club and submitted data to both the Inpatient and the Community Services Surveys during 2012.

The club comprises a majority of Mental Health Trusts in England and has been in place for the last four years. Its aims are to help identify best in class performance for particular services and facilitate improved performance and decision making for all members through comparative analysis.

The findings are summarised below:

Inpatient Mental Health Services

The survey presents the Trust as having high service need and provision:

- Relatively high bed number and occupied bed day provision for both adult and older adult services
- High admission rates for (weighted) population served in adult services
- A high proportion of patients assigned to psychosis related adult services.

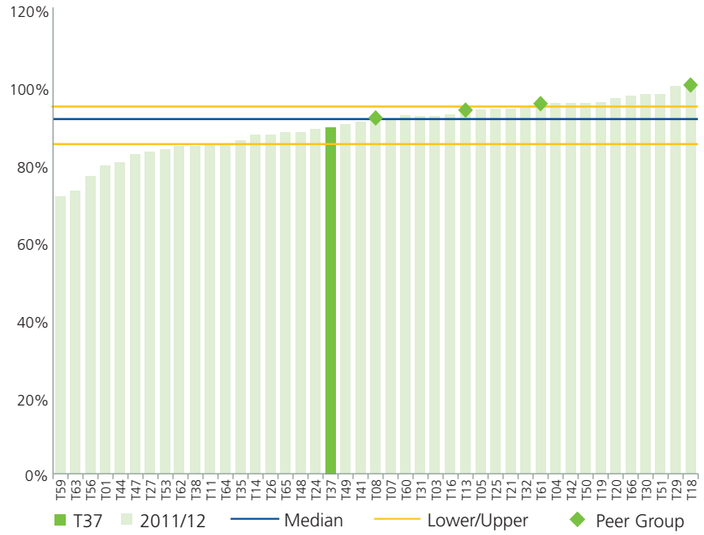
Community Mental Health Services

The survey presents the Trust as having high service need and provision:

- Generic CMHT and Assertive Outreach caseloads that are amongst the highest reported
- High proportions of the catchment population that are on CPA
- High referral rates to CMHTs
- Relatively high patient contact rates across a range of community team types
- High inpatient admission levels and CRT referral rates for CMHT patients.

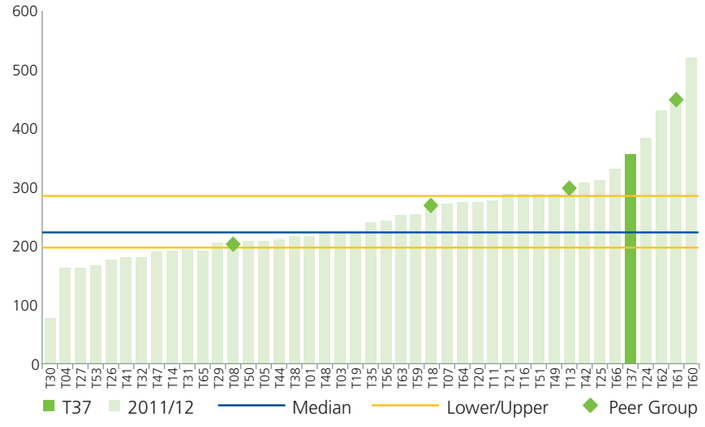
Analysis of bed occupancy data for adult acute beds reveals a median occupancy rate of 91% across participants (figure 1). The range in occupancy is relatively low with lower quartile at 85% and upper quartile at 95%. Five trusts report occupancy levels of less than 80% and three trusts report occupancy at 100% or over. ELFT (T37) reports occupancy levels at 89%. This position is reported for occupancy excluding leave.

Figure 1. Adult acute occupancy rates (excluding leave)



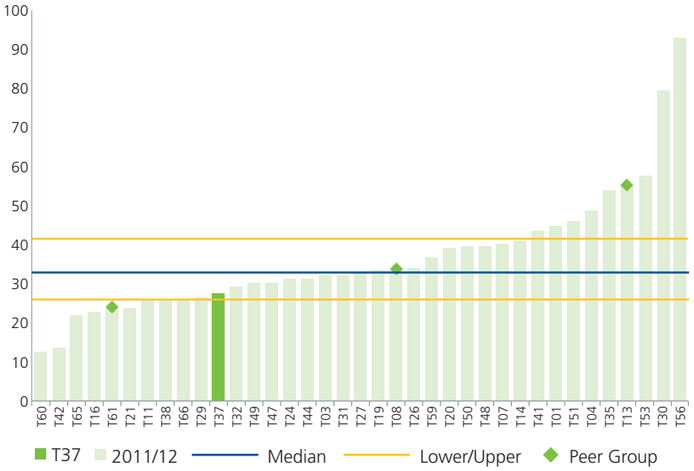
The number of admissions to acute adult beds has been benchmarked per 100,000 registered population. This reveals a range of utilisation across the NHS. Key determinants of the number of admissions will include local needs, the number of beds provided by each trust, and the length of stay of patients and availability of beds for new admissions. This is profiled below in figure 2 and shows a median position of 234 admissions per 100,000 working age adult population. ELFT has circa 330 admissions per 100,000 head of population.

Figure 2. Adult acute – Admissions per 100,000 head of population



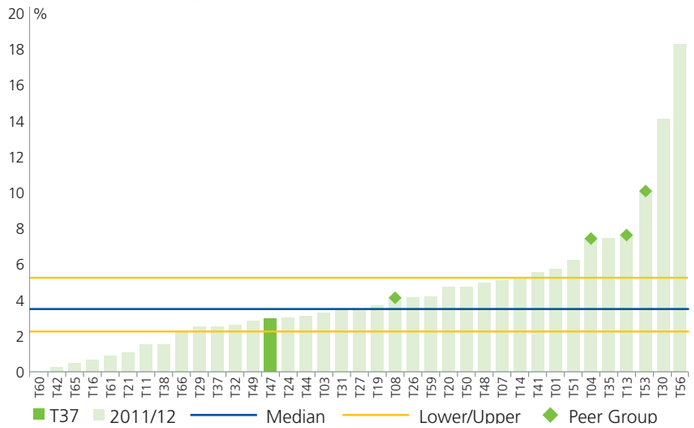
Average length of stay for adult acute admissions is a key performance measure for mental health providers. Mean length of stay is 32 days across the participating trusts. The range reported is interesting with outliers identified at both ends of the spectrum that require validation by participants (figure 3). Length of stay is influenced by a number of variables including the acuity of the caseload, extent of delayed transfers of care, and ability to hand patients over to community based services. Trusts with fewer beds tend to have greater pressure on length of stay due to potentially higher acuity levels in patients that are admitted to beds.

Figure 3. Mean average length of stay (including outliers, excluding leave)



Data on delayed transfers of care shown in figure 4 reveals a median position of around 3.5%. This is presented as the % of total bed days lost due to delayed transfers. Delays are for patients who are appropriate to be discharged and can be delayed due to a number of reasons including waiting for a bed or place elsewhere or alternative packages of care to be agreed and put into place. ELFT level of 3.5% is below the median.

Figure 4. Adult Acute – delayed transfers of care (numbers of bed days lost divided by the number of occupied bed days)



Care Programme Approach (CPA)

The CPA is the framework through which care and treatment is delivered for a large proportion of the Trust's service users. The table below shows that for the vast majority of services users on CPA their care plans are kept up to date. However, the proportion of service users on CPA who are seen every month is below the level we would hope to achieve. Increasing contact time is one of the Trust's priorities for the year ahead.

Indicator	Target	Actual Performance
CPA patients – care plans in date (documents 12 months old)	95%	97.8%
CPA patients – care plans in date (documents 6 months old)	95%	89.2%
% CPA patients seen per month – face to face only	90%	90.4%

Safeguarding Adults and Children

The Trust works with around 16,000 adult mental health service users at any one time. Many of these are parents, pregnant women, grandparents, stepparents or in contact with children. Over 25% of our service users will be subject to the Care Programme Approach.

Child and Adolescent Mental Health Services (CAMHS) received 4,370 referrals during the year. CAMHS had 43,539 total contacts with approximately 4,082 children and young people on CAMHS caseloads.

The following information should demonstrate how good performance in training compliance in health and safety areas leads to fewer staff safety incidents and therefore reduces the potential for personal injury claims. This is vital for improving patient safety, clinical effectiveness and patient experience, the Trust's priorities.

CPA Audit Tool – Safeguarding Children Standards

Four of the standards in the CPA audit tool relate to safeguarding children. Once it is known that the service user has children, the Safeguarding Children Audit Tools applies. These are to ensure children are identified at the outset.

'Safeguarding Children Level 1' training compliance

The Trust continues to ensure that all staff attend relevant mandatory training courses. The target set by the CQC for all levels is 80%.

Safeguarding Children Level 1

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	2,306	90.0%
2011/12	3,592	3,404	94.8%
2012/13	3,653	3,454	**94.55%**

'Safeguarding Adults' training compliance

The Trust is about to embark on a major training programme around safeguarding adults to ensure that all our staff have the appropriate training to manage this agenda.

'Safeguarding Adults' training compliance

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	1,018	80.6%
2011/12	3,592	2,913	81.1%
2012/13	3,580	2,978	**83.18%**

Health & Safety

The Trust has a comprehensive action plan that addresses the requirements of H&S legislation and security management services directions. The plan covers all aspects of training and regulatory compliance.

Incident data

Total	Fire	Moving and handling	Falls (non-clinical)	Smoking in an un-authorised area	Total
2010/11	106*	8	66	123	303
2011/12	146**	14	96	157	413
2012/13	122***	16	75	171	384

*32 actual fires **42 actual fires *** 34 actual fires

'Health and Safety' training compliance

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	1,331	52.0%
2011/12	3,592	2,969	82.7%
2012/13	3,653	2,627	71.9%

'Manual Handling' training compliance

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	2,237	87.3%
2011/12	2,901	2,684	92.5%
2012/13	3,653	3,451	94.5%

'Fire Safety (including fire marshal)' training compliance

Total	Number of staff	Number of staff attended	% compliance
2010/11	2,562	2,401	93.7%
2011/12	3,592	2,665	74.2%
2012/13	3,653	2,434	66.6%

Medicines Management

Medicines management is a high risk area of activity. We therefore pay specific attention to medication errors of all types and have recently introduced an e-learning package for all staff who administer medication.

Incident data

	Prescribing error	Dispensing error	Administration error	Chart not signed	Medication availability	Other	Total
Total	24	34	124	6	5	48	241

Medicines incidents continued to be reported via the Trust DATIX system and discussed at Medicines Safety Groups. Measures then are taken to minimise risk and repetition of incidents.

Training Compliance

All clinical staff receive medicines safety training. This increases awareness of how to minimise risks around the prescribing, dispensing and administration of medicines.

Quality Accounts 2012/13
Part 3. Review of Quality Performance 2012/13

Medicines Safety

	Number of staff	Number of staff attended	% compliance
Total	1421	1176	82.76%

The Trust has also developed an e-learning programme for nurses for the safe administration of medicines. Nurses are given protected time to complete the training.

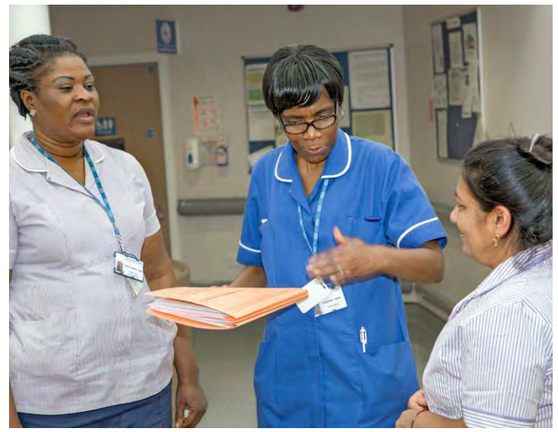
Safe administration of medicines (e-learning)

	Total number of nurses completing e-learning package (in 12/13)
Total	421 (23)

Medicines Reconciliation

The Trust's target is that over 90% of patients' medicines are to be reconciled by pharmacy staff within 72 hours. This is a directive from the NPSA, NICE and also a CQUIN target for the Trust. Reconciliation of medicines on admission ensures that medicines are prescribed accurately in the early stages of admission. It involves checking that that the medicines prescribed on admission are the same as those that were being taken before admission and involves contacting the patient's GP.

Medicine Reconciliation	
Directorate	Complete (%)
City and Hackney	92.7%
MHCOP	97.5%
Newham	93.1%
Tower Hamlets	96.4%
Trust Total	**95.9%**



Drug Savings

The trust has reduced expenditure of medicines by 19% in 2012/13. This was achieved through several initiatives, including:

- Reduced waste
- Managed entry of new drugs
- Centralised procurement
- Use of generic medicines.

Service User-Led Standards Audit

This is a summary of findings from the Service User-Led Standards Audit for Quarter 2 (July to September 2012). The audit collects information across ten service user developed standards by asking two questions per standard.

The data are presented as 'mean scores' for each directorate against the standards listed below.

1. Service users can access ward staff at all times and feel treated with dignity and understanding.
2. Service users are provided with information and guidance on how to complain and feel able to raise concerns without fear.
3. The religious, spiritual and cultural needs of every service user are respected and accounted for.
4. Service users are provided with information (written) and guidance (verbal) about medications, including potential side effects.
5. Service users are involved in important decisions about care planning and discharge.
6. Service users have regular access to therapeutic groups and activities that enhance their wellbeing.
7. Service users receive regular, quality 1:1 time with their allocated named nurse.
8. Service users are informed of their rights in regard to the Mental Health Act 1983 and accessing clinical notes.
9. Service users are provided with information and advice on practical matters, such as housing and benefits.
10. On admission, service users receive a Welcome Pack containing useful information.

Survey scale used by Service Users

1	2	3	4	5	N/A
No	Rarely	Sometimes	Often	Yes	Don't know
Never	Slightly	Moderately	Very	Always	Not applicable
Not at all	Disagree	Neither	Agree	Extremely	
Strongly disagree	Poor	Fair	Good	Strongly agree	
Very poor				Excellent	

Trust wide data for all mental health wards as measured in Quarter 2 (2012/13)

Standard	1	2	3	4	5	6	7	8	9	10	Mean
C&H	4.0	2.8	2.8	3.4	3.4	3.9	3.0	2.9	2.7	2.6	3.2
Newham	4.3	3.1	3.3	3.3	3.1	3.5	2.5	3.1	2.7	2.4	3.1
Tower Hamlets	4.1	3.0	3.4	3.4	3.2	4.1	2.2	2.7	3.2	2.5	3.2
John Howard Centre	4.5	4.3	3.7	3.9	3.9	4.1	3.7	4.0	4.2	3.2	4.0
Wolfson House	4.5	4.0	4.5	4.1	3.7	4.2	3.6	4.2	3.9	3.9	4.1
TRUST	**4.3**	**3.4**	**3.5**	**3.6**	**3.5**	**4.0**	**3.0**	**3.4**	**3.3**	**2.9**	**3.5**

CQC – Community Patient Survey (2012)

We use national survey formats to find out about the experience of service users when receiving care and treatment from the Trust. In April 2012, a questionnaire was sent to 850 service users. Responses were received from 209 service users at East London NHS Foundation Trust.

The Trust's scores are compared against scores from other trusts nationally. This takes into account the number of respondents from each trust, as well as the scores for all other trusts. This makes it possible to identify which scores we can confidently say are 'better' or 'worse' than the majority of other trusts.

ELFT user ratings have increased in three of the nine domains. It is noticeable that the gains made in last year's (2011) survey were maintained, in particular around Talking Therapies. The overall rating (6.5) is up on last year's overall rating (6.3).

Against 2010 data, it is possible to see steady progress across a number of domains, for example health and social care from 8.2 in 2010 to 8.4 in 2012. Similarly, talking therapies (6.5 to 7.1), care co-ordinator (8.3 to 8.5), care plan (6.3 to 6.5),

How this score compares with other trusts		Based on patients' responses to the survey, this trust scored
8.4/10	Health and social care workers	About the same
6.8/10	Medications	About the same
7.1/10	Talking Therapies	About the same
8.5/10	Care Coordinator	About the same
6.5/10	Care Plan	About the same
7.3/10	Care Review	About the same
7.1/10	Crisis Care	About the same
5.6/10	Day to Day Living	About the same
6.5/10	Overall	About the same

Community Health Newham (CHN) – Patient Reported Outcome and Experience Measures (PROM and PREM)

Over the last year, PREMs and PROMs have been collected from a wide range of services and for the vast majority of people using those services.

Number of questionnaires completed:

- Extended Primary Care Team (EPCT) – 1731
- Virtual Ward (VW) – 765
- Specialist Nursing Services – 1089
- Specialist Therapies Services – 2492
- Health Centres:
  - Appleby – 60
  - West Ham Lane – 24
  - Lord Lister – 25
- Annual Patient Surveys:
  - Adults – 2077
  - Children's Services – 341

New Services for PROMs and PREMs:

During 2012/13 more services started to collect PROMs/PREMs data. Below are a list of them:

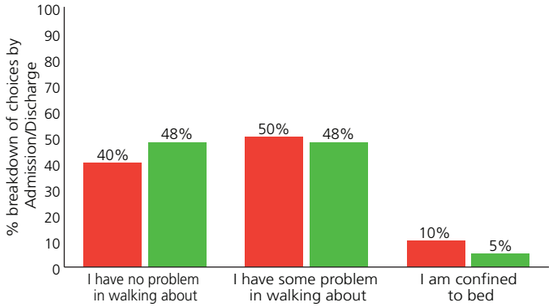
- Sally Sherman Ward
- Diabetic Nursing Service
- Foot Health
- Telehealth
- Speech and Language Therapy
- Tissue Viability

For the purpose of the Quality Accounts Report presented left is data from a few selected service areas. A full report covering all areas of CHN service provision is available upon request from the Trust Secretary.

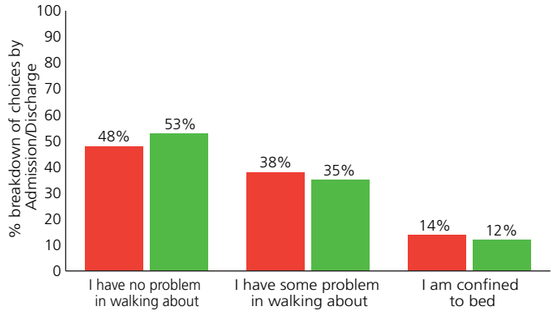
For both Extended Primary Care Teams (EPCT) patients reported that interventions had been effective and that the experience had been very good.

West Locality – EPCT
PROMs April 2012 – March 2013

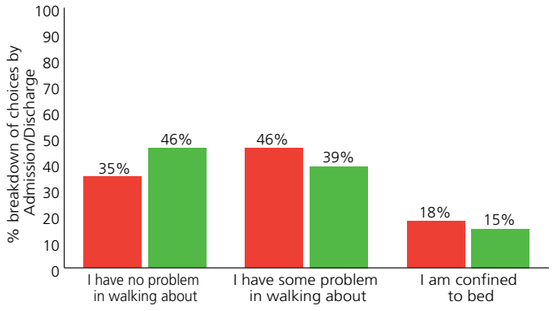
EPCT – Mobility



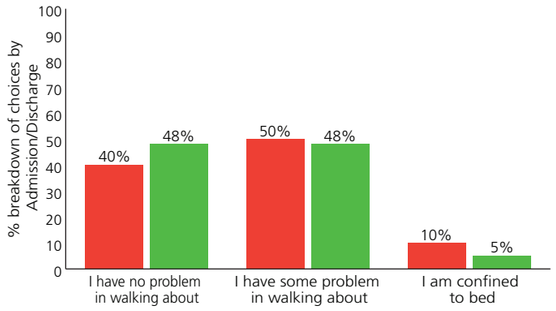
EPCT – Self-Care



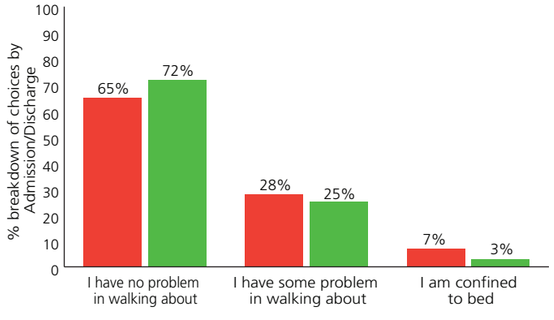
EPCT – Usual Activities

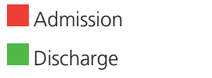


EPCT – Pain/Discomfort



EPCT – Anxiety/depression





EPCT West
PREMs April 2012 – March 2013
For all five questions, patients have reported improvements.

Patient experience shows a very positive result, with only a very small percentage reporting problems around trust and confidence in the professional they saw.

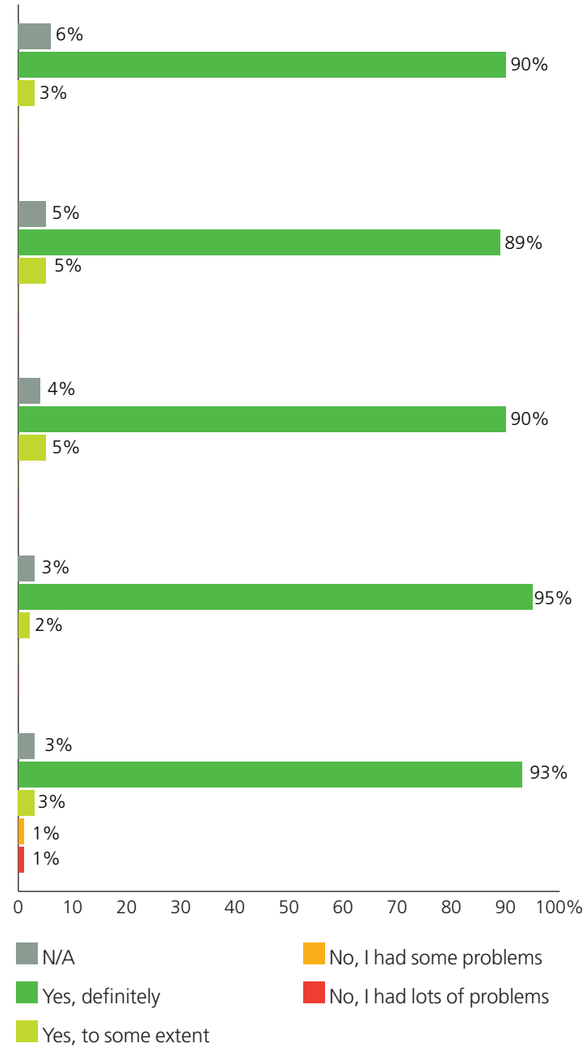
Were you involved as much as you wanted to be in discussions about you/your child's care and treatment today?

When you had an important question to ask this person, did you get answers that you could understand?

Did this person give you information you could understand about you/your child's care, treatment or condition?

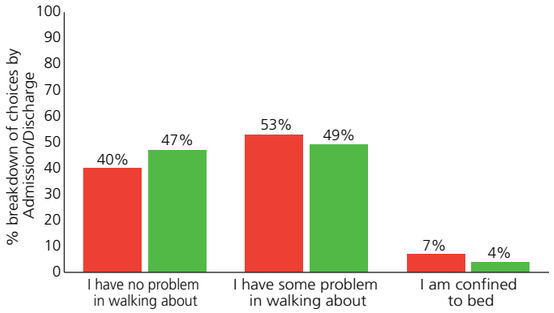
Did this person treat you with respect and dignity?

Did you have trust and confidence in the professional that saw you today?

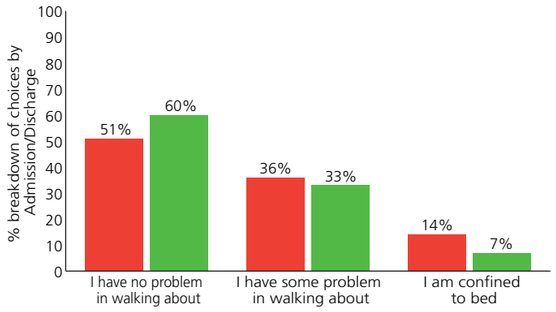


East Locality – EPCT
PROMs April 2012 – March 2013

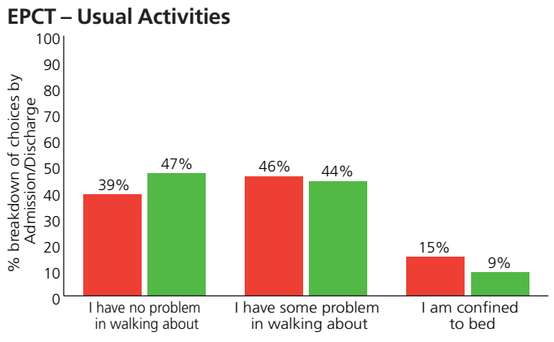
EPCT – Mobility



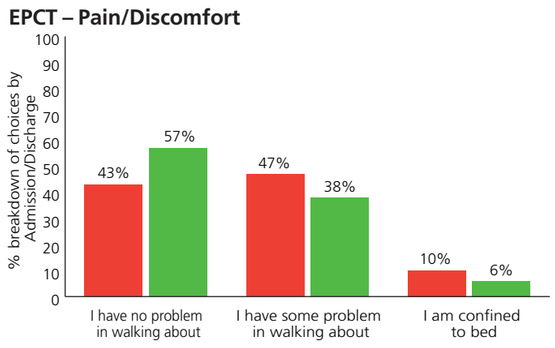
EPCT – Self-Care



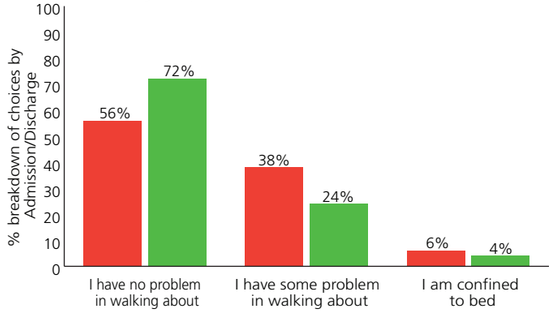
EPCT – Usual Activities



EPCT – Pain/Discomfort



EPCT – Anxiety/depression



EPCT East
PREMs April 2012 – March 2013

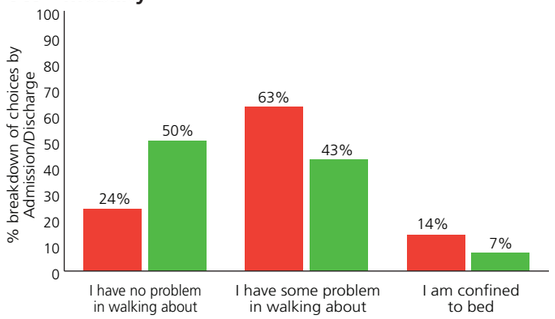
For Extended Primary Care Team EAST, patients reported improvements for all five questions on discharge.

Overall this is a very positive patient reported experience for all questions, with a small percentage of problems reported.

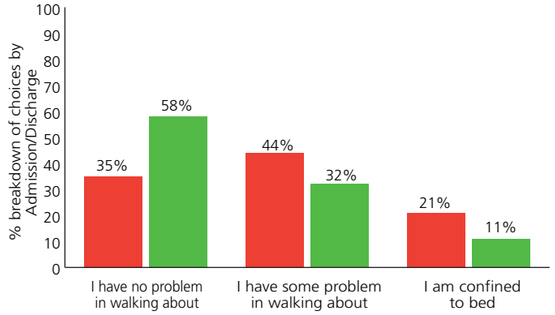
For the four Virtual Wards (VW), patients on the whole reported that interventions had been effective. The fact that there is a trend that patients report to be confined to bed at discharge from the VW can be linked to the complexities surrounding management of chronic conditions in the community setting.

North West – VW
PROMs April 2012 – March 2013

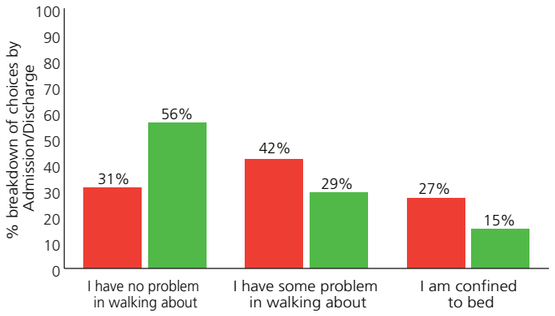
VW – Mobility



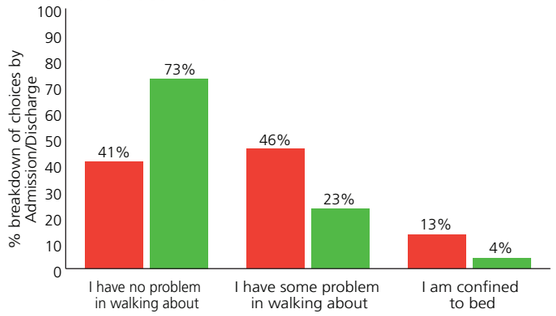
VW – Self-Care



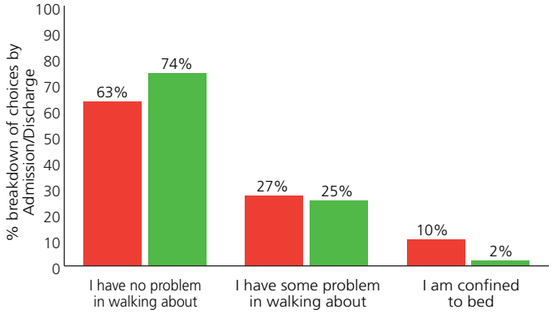
VW – Usual Activities



VW – Pain/Discomfort

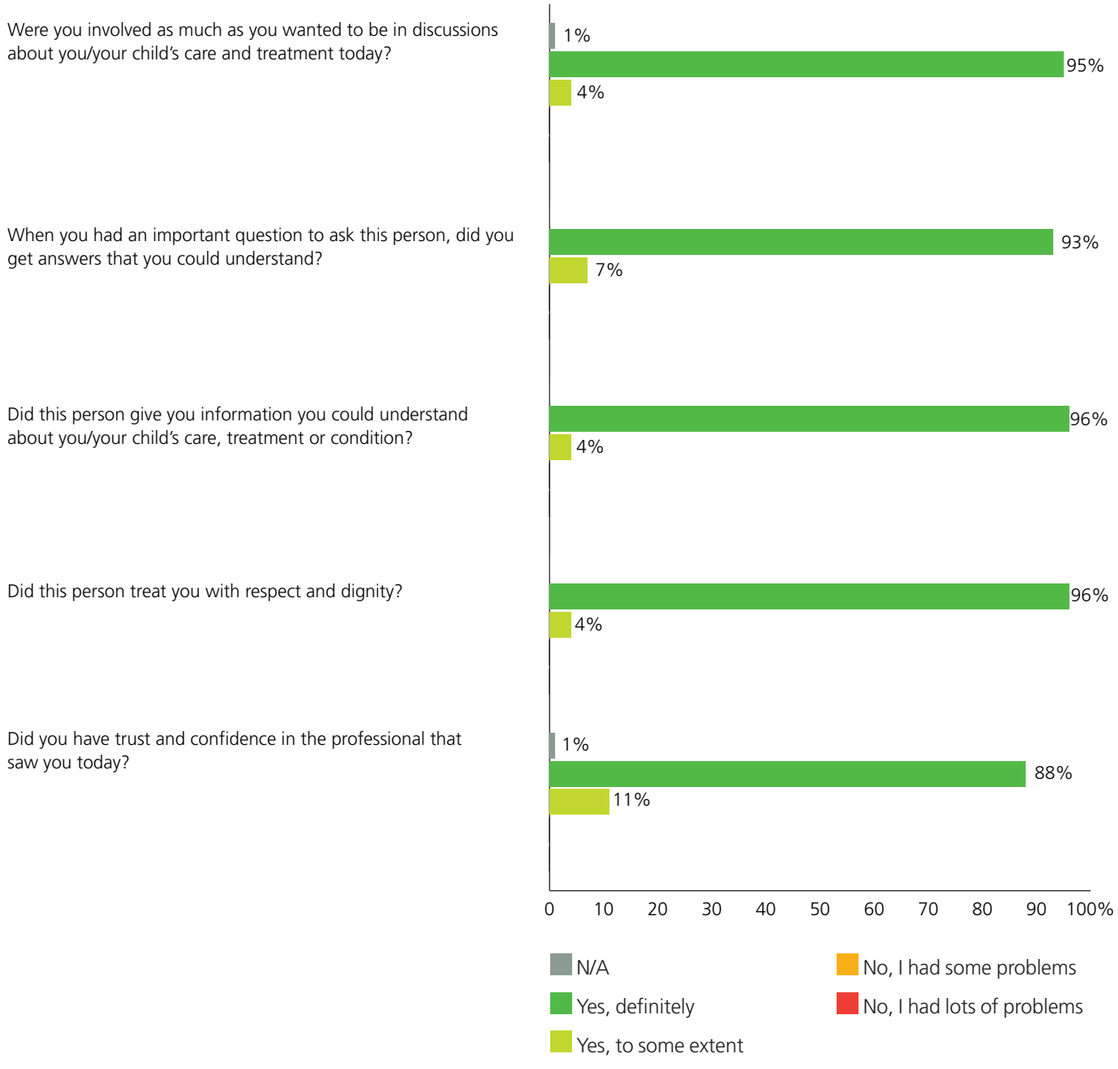


VW – Anxiety/depression



VW North West
PREMs April 2012 – March 2013
For North West VW, patients reported improvements for all five questions on discharge.

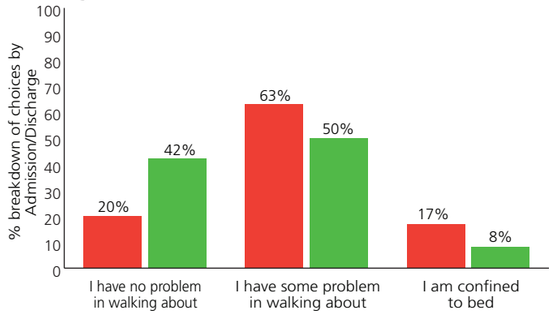
Very positive patient reported experience. Patients in the NW VW experienced no problems throughout their journey.



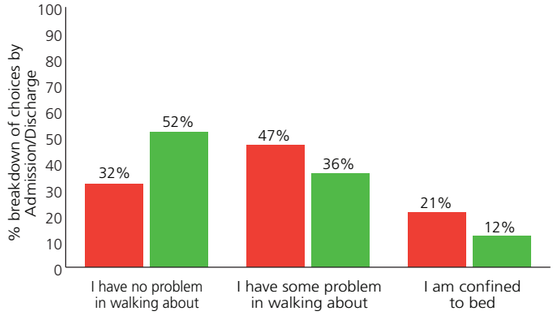
Cazaubon Ward
Specialist Nursing
PROMs April 2012 – March 2013

The PROMs results for the Cazaubon Ward are worth noting in that patients reported no 'Pain/Discomfort' and 'Anxiety/Depression' at discharge and for all other questions show significant improvements.

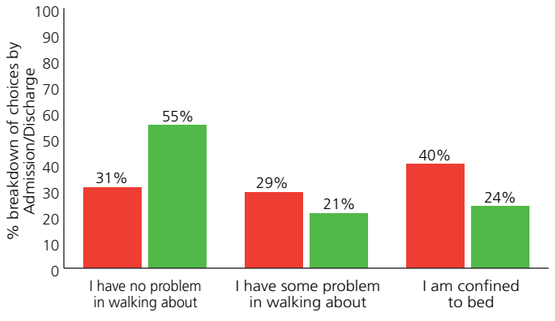
Mobility



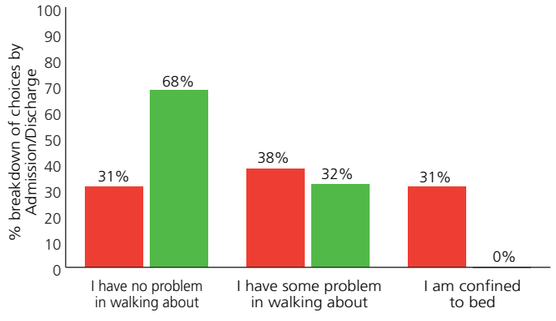
Self-Care



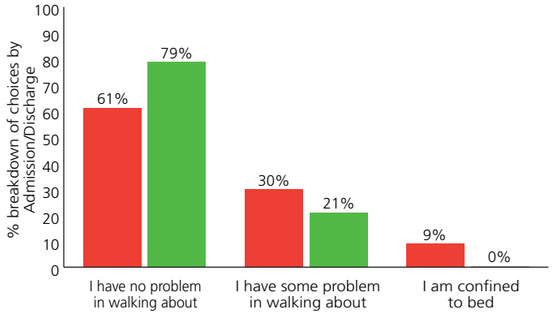
Usual Activities

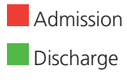


Pain/Discomfort



Anxiety/depression





Cazaubon Ward
Specialist Nursing
PREMs April 2012 – March 2013

Patients have reported significant improvements across all five questions.

Patient experience for Cazaubon Ward, though more on the positive side than negative leaves room for improvement, especially on the communications side of the patient's journey.

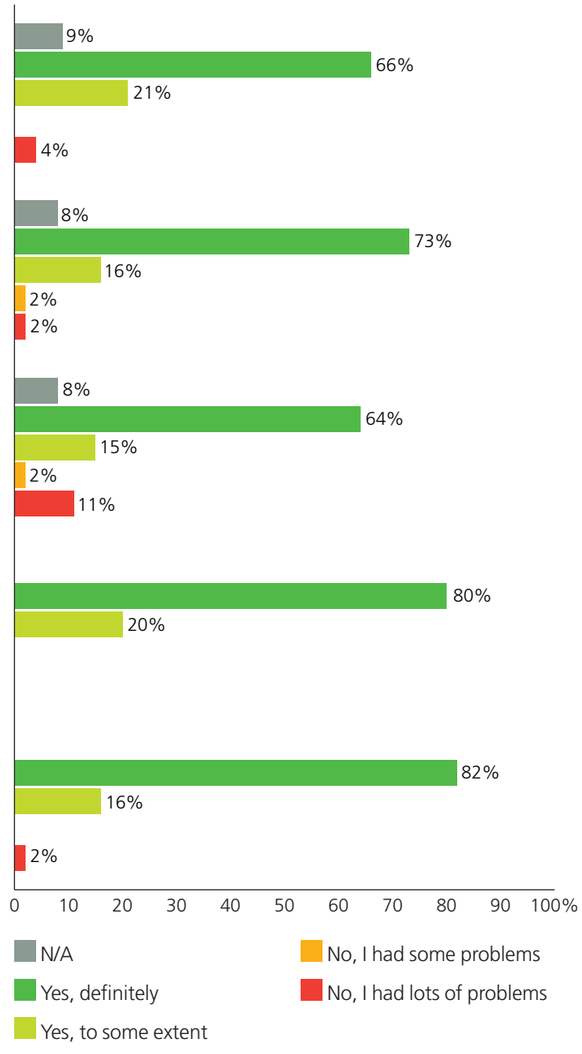
Were you involved as much as you wanted to be in discussions about you/your child's care and treatment today?

When you had an important question to ask this person, did you get answers that you could understand?

Did this person give you information you could understand about you/your child's care, treatment or condition?

Did this person treat you with respect and dignity?

Did you have trust and confidence in the professional that saw you today?



NHS Staff Survey 2012

The results are collated by the NHS Staff Survey Coordination Centre and Quality Health (the external appointed organisation).

The Trust is keen for staff to participate. Their feedback is extremely important in helping to shape the actions the Trust will take in order to create a work environment that is both rewarding for staff and safe for our service users.

By completing the survey, staff also helped to raise £6,290 for ten charities based in Newham, Tower Hamlets and Hackney.

The Trust achieved a 37% response rate, a slight decrease from 2011. NHS Trusts across London have seen a decrease in response rates. However, despite a lower response rate, the Trust has made significant progress in areas which were highlighted as areas for improvement.

Most noticeably, the top five ranking scores where the Trust compares most favourably with other mental health/learning disability trusts are:

- Number of staff having well-structured appraisals
- Staff feeling satisfied with the quality of work and patient care they are able to deliver
- Support from immediate managers
- Ability to contribute towards improvement at work
- Good communication between senior management and staff.

The Trust's overall staff engagement scores were above the national average. Response rates from key factors such as staff motivation at work, staff recommending the Trust as a place to work or to receive treatment, and staff's ability to contribute towards improvements at work were all better than the average.

Key findings for the Trust benchmarked against other mental health / Learning Disability Trusts

Staff pledge: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services				
	Question number(s)	Our Trust in 2012	Average (median) for mental health trusts	Our Trust in 2011
KF21. % reporting good communication between senior management and staff	Q11a-d	37	30	-
KF22. % able to contribute towards improvements at work	Q7a, 7b, 7d	77	71	71
Staff satisfaction				
KF23. Staff job satisfaction	Q8a-g	3.74	3.67	3.56
KF24. Staff recommendation of the trust as a place to work or receive treatment	Q12a, 12c-d	3.64	3.54	3.52
KF25. Staff motivation at work	Q5a-c	3.87	3.84	3.83

The Trust's score on staff job satisfaction was among the highest 20% of the Trusts of a similar function.

These improvements were only achieved because of the commitment to delivering the best available care to our service users.

Staff also highlighted a number of areas which the Trust needs to address. These include discrimination at work, increasing the availability of hand washing materials, increasing the reporting of errors, near misses or incidents and increasing the Trust commitment in providing equal opportunities for career progression and promotion. Additionally, a higher number of staff than the previous year indicated that they work extra hours and the number of staff who received health and safety training in the last 12 months had reduced.

Next Steps

The actions from the 2011 NHS Staff Survey have been delivered throughout 2012. The main focus last year was the delivery of training and development that addressed key themes such as reducing stress, bullying and harassment, appraisals and supervision and job satisfaction.

The Trust strives to continuously improve on the areas that are important to the staff. The actions addressing the concerns outlined by staff in the 2012 NHS Staff Survey have been agreed by the Trust Board.

A Trust-wide action plan and local action plans will focus on: effectively communicating and disseminating the improvements made as result of feedback from the staff survey; Improving the quality of appraisal and job relevant training, learning and development linked to appraisals; tackling the issue of hand washing and ensure materials are available to staff; discrimination and equal opportunity issues and witnessing and reporting potentially harmful errors, near misses or incidents. The plans will be monitored by the Workforce Committee.

Quality Accounts 2012/13
Part 3. Review of Quality Performance 2012/13

Complaints and Patient Advice and Liaison Service (PALS)

Between 1 April 2012 and 31 March 2013, the Trust received 438 formal complaints. This is 23 less than the previous year, representing a 5% decrease. It should be noted that some people have made more than one complaint. The total number of complainants is therefore somewhat less at 316.

The majority were either from male service users, or their relatives and carers, who accounted for 62% of complainants. Their complaints outstrip female service users by 5:1. In terms of age, the Trust receives proportionately fewer complaints about service users aged over 60 years. We also receive disproportionately few complaints from members of the Asian community.

Of complaints to date, the Trust has replied to 375, and 73% of complainants received a full written response, either within the Trust's target timescale of 25 working days or an extended timescale agreed with the complainant. A further seven complaints were withdrawn by complainants. We are confident that once we have completed this year's (12/13) complaints, we will achieve our performance target of 75%.

Many complainants took up the offer of a meeting with staff to ensure their concerns were clearly understood and to discuss how these might best be resolved. It is the experience of the complaints team that this is the best means of ensuring complaints are resolved to the complainant's satisfaction.

Subject of Complaints

Typically, most complainants will raise more than one issue in their complaint, and there were 805 subjects identified within the 438 complaints. The top subject for the year 2012/13 was communication / information (written or oral) accounting for 16%. This covers clinical information – such as how decisions about care / medication are explained to service users, their relatives and carers – both verbally and in writing. It also includes issues to do with information contained in reports, Mental Health Act (MHA) documentation. Patients have the right to access their patient records, and when they do, may come across information which they disagree with, or which gives other cause for concern. Other subjects include attitude of staff, medication, alleged lack of support in the community and access to services.

Of complaints responded to date, 105 complaints have either been upheld, or partly upheld, accounting for almost 40% of complaints.

On receipt of complaints, we grade them. High risk complaints comprise complaints where there is an allegation of abuse or exploitation, or allegations that care / lack of care have led to physical injury or some other harm. High grade complaints are managed under a slightly different process. In some cases we may feel it is more appropriate for the case to be managed under the Serious Incident (SI) procedure and we can refer it to a formal Committee (comprising Director of Nursing and Medical Director) for them to consider instituting a Serious Untoward Incident (SUI). In any event, we report periodically to that Committee on all high graded complaints we have received and their outcome. Last year we received 58 such complaints which were graded high, representing 13% of the caseload. By March 2012, eight out of 58 were either upheld partly or in full.

Parliamentary and Health Service Ombudsman (PHSO)

Since 2009, there has been a two tier procedure in place. If complainants are unhappy, they can go to the Ombudsman for their case to be reviewed. The Ombudsman's office reviews the complaints file / patient records and reaches a view on whether the complaint has been dealt with appropriately. If they feel it has not, their office may investigate. Since 2009, the Ombudsman has only investigated one of the Trust's complaints and in that case, did not uphold. This was in 2010.

Last year, we knew of 27 Trust cases that the Ombudsman reviewed. We know that nine have definitely been closed. Of the remaining cases, some are still open. Others have almost certainly been closed, but we have not been notified. From 1 January, the law changed so that Trusts will be provided with a copy of the Ombudsman's outcome letters to complainants. This will help us better understand the basis of any of their decisions and hopefully help inform future practice.

Accessibility to the complaints procedure remains a priority. The Trust has a Freephone number which is advertised on posters displayed in all service areas, and a Freepost address. The Trust also has a complaints leaflet which provides information on the complaints procedure, as well as details of organisations which can provide independent advice and support to service users, their relatives and carers who wish to complain. There are also laminated cards with this information by phone boxes on the wards.

3.2 An Explanation of Which Stakeholders Have Been Involved

The Trust has consulted with a range of stakeholders during this process and the feedback can be seen in the following sections.

The Trust has a long history of working collaboratively with our service user and carer groups, the Trust Governors and local stakeholder groups.

Indeed, there is significant service user and carer participation in all of the Trusts key overview and reporting mechanisms, e.g. the bi-monthly Quality Committee, Patient Participation Committee and the Patient Experience Committee meetings.

3.3 Statement from Lead Commissioning CCG – Newham

Newham Clinical Commissioning Group

Commissioners Statement for East London Foundation Trust 2012/13 Quality Accounts

NHS Newham Clinical Commissioning Group has reviewed the information contained within the Trust's Quality Account for 2012/2013.

We confirm that we have reviewed the information contained with the Account and checked this against data sources where this is available to us as part of existing contract/ performance monitoring discussions.

We have taken particular account of the identified priorities for improvement by the Trust and how this work will improve the quality and safety of health services for the populations they serve.

ELFT have a clearly articulated vision and long term, strategic approach to quality measurement and improvement, which includes patients, carers, staff and Board members. The Trust's three quality priorities were developed in 2010/11 with the involvement of stakeholders and this year they have identified a number of quality indicators to indicate how well they are achieving their three strategic objectives.

Priorities have been chosen to reflect the Trust's strategic priorities and each is mapped to a quality domain (patient experience, clinical effectiveness or safety)

There is a substantial focus on staff engagement for 2013/14:

- Senior staff visiting front line teams;
- The making High Quality Care Our Priority Programme;
- Listening to improve forums;
- Five-year objectives to improve quality.

Use of Commissioning for Quality and Innovations (CQUIN) measures is good and shows an integrated approach to quality across the Trust. The Trust has an excellent record on national and local audits and has participated in 100% of national audits. It also has a clear internal audit programme. We welcome the substantial section on research and note that the Trust has recently been awarded WHO status for its Unit for Social and Community Psychiatry.

We believe more could be done to detail how quality priorities will be monitored and we will be working with the Trust through 2013/14 to strengthen this area. Overall the report could be more granular and look at Borough specific teams and quality improvement in more detail. Community services are an area we would like to see more focus on in the coming year and there could be more Borough specific data, for example relating to complaints and patient and staff experience with results separated into mental health and community services.

The quality indicators relating to safety could be strengthened and described in more detail. We will be working with the Trust to focus on Serious Incident management and embedding learning from these over the next year.

We have reviewed the content of the Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair, representative and balanced overview of the quality of care at ELFT. We have discussed the development of this Quality Account with ELFT over the year and have been able to contribute our views on consultation and content.

This Account has been reviewed within the CCG and by colleagues in the NHS North and East London Commissioning Support Unit (CSU).

Overall we welcome the vision described within the Quality Account, agree on the priority areas and we will continue to work with the Trust to continually improve the quality of services provided to patients and support to carers.

Dr Zuhair Zarifa
Chair of NHS Newham Clinical Commissioning Group

Quality Accounts 2012/13
Part 3. Review of Quality Performance 2012/13

3.4 Statement from City and Hackney CCG

City and Hackney Clinical Commissioning Group

NHS City and Hackney Clinical Commissioning Group Commissioners Statement for East London Foundation Trust 2012/13 Quality Accounts

NHS City and Hackney Clinical Commissioning Group (CCG) are responsible for the commissioning of health services from East London Foundation Trust (ELFT) mental health trust on behalf of the population of the City of London and London Borough of Hackney.

The CCG welcomes the opportunity to provide this statement on ELFT's Quality Account. We confirm that we have reviewed the information contained within the Account and checked this against data sources where this is available to us as part of existing contract/ performance monitoring discussions and is accurate in relation to the services provided. We have taken particular account of the identified priorities for improvement for ELFT and how this work will enable real focus on improving the quality and safety of health services for the population they serve.

ELFT have a clearly articulated vision and long term, strategic approach to quality measurement and improvement from top down to bottom up, including staff, patients and carers and Board members. The Trust's three quality priorities were developed in 2010/11 with the involvement of all stakeholders and each year the Trust agrees a number of quality indicators to stretch themselves and indicate how they are achieving the three strategic objectives. Priorities have been chosen to reflect the Trust's strategic priorities but no detail but no detail has been provided on why each quality indicator has been chosen. However each is mapped to a quality domain (patient experience, clinical effectiveness or safety).

There is a substantial focus on staff engagement for 2013/14:

- Senior staff visiting front line teams;
- The making High Quality Care Our Priority Programme;
- Listening to improve forums;
- Five-year objectives to improve quality.

Use of commissioning for Quality and innovations (CQUIN) measures is good and shows an integrated approach to quality across the Trust. The Trust has an excellent record on national and local audits and has participated in 100% national audits. It also has a clear internal audit programme. We welcome the substantial section on research and note that the Trust has been awarded WHO status for its Unit for Social and Community Psychiatry this year.

We believe more could be done to detail how quality priorities will be monitored and we will be working with the Trust through 2013/14 to strengthen this area. Overall the report could be more granular and look at Borough specific teams and quality improvement in more detail. Community services are not covered in much depth but the detail is probably is probably proportionate to spend. There could be more Borough specific data i.e. complaints and staff and patient survey results and action plans and results separated into mental health and community services, perhaps an area for development next year. We would be particularly interested to see the Trust work towards improving its service user led standards audit results, noting that five out of 10 standards were rated 'poor' in 2012/13 and Did Not Attend (DNA) rates could be improved across a proportion of services and further benchmarking is required in this area to allow effective quality performance management in 2013/14.

The quality indicators relating to safety are the weakest (e.g there is a priority for staff to introduce one quality initiative to improve patient experience and this is classified as a patient safety priority) and could be strengthened. We will be asking the Trust to include information about Serious Incident management and timelines of completing actions from these and embedding learning.

We have reviewed the content of the Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair, representative and balanced overview of our quality of care at ELFT. We have discussed the development of this Quality Account with ELFT over the year and have been able to contribute our views on consultation and content.

This Account has been reviewed within the CCG and by colleagues in the NHS North and East London Commissioning Support Unit (CSU).

Overall we welcome the vision described with the Quality Account, agree on the priority areas and will continue to work with ELFT to continually improve the quality of services provide to patients.

Dr Clare Highton
Chair
NHS City and Hackney Clinical Commissioning Group

3.5 Statement from Tower Hamlets Healthwatch

Healthwatch Tower Hamlets
Room 12, Block 1 (Trust Offices)
Mile End Hospital, Bancroft Road
London E1 4DG
www.healthwatchtowerhamlets.co.uk

Healthwatch Statement from Tower Hamlets and Hackney

This Quality Account was considered by members of Healthwatch Tower Hamlets. In their opinion it is a fair reflection of the range and the quality of healthcare services provided by the Trust.

We are pleased the Trust is taking a long term strategy for improving the quality of services for users and that they intend to maintain a focus on the three key areas of improving user and carer satisfaction, improving staff satisfaction and maintaining financial viability. This reflects priorities previously raised by users and the local community and also enables us to clearly follow the progress of improvement.

It is reassuring to see the positive achievement of the Commissioning for Quality and Innovation (CQUIN) targets. We realise that these are set by the commissioners but it would be good to understand how users and carers have an input into setting the CQUIN targets. For instance is their likely to be a target for measuring progress in relation to integrated care across the Trust and their primary, acute and social care partners as well as the voluntary and community sector?

Has there been research into a likely rise in demand for services across the Trust as a result of the welfare reforms?

It would be good to see some data on the waiting times for accessing services as we have had anecdotal reports of long waiting times particularly in accessing talking therapies.

Staff

Very reassuring to see an improvement in staff survey results and the Trust seems to have some positive programmes to address staff training. However we are still receiving comments from users about a minority of staff who patients consider to be rude or not fit for purpose.

I noticed if an inpatient was 'aware' of what was happening around them all the nurses would be nice to them and treat them well. However if the patient was not aware of what was happening to them then the nurses would treat them badly...

There is some concern that staff do not reflect the communities of the borough in which they operate. User groups have indicated that they feel there is a need to undertake a more focused education and recruitment campaign within target key communities to encourage young people to enter the mental health profession. Is this something that could be undertaken with similar campaigns being undertaken by Barts Health? We have also had anecdotal comments that BME staff do not progress within the organisation and get disgruntled and leave.

The percentage of staff: experiencing harassment, bullying or abuse from other members of staff; experiencing discrimination at work; and reporting they will probably look for work in another trust in the next 12 months; had all been areas of concern highlighted in previous years but we don't see any reporting in this account. Is there a plan to increase the response rate of staff?

Is there a plan to survey patients who have now been discharged from secondary to primary care?

Service User-Led Standards Audit

Why is this just quarter 2? Concerns around City and Hackney with five poor.

Taken together with the subject of complaints there does seem to be an issue regarding communication and information. Is there a particular problem with users being provided with Welcome Pack s on the ward?

Quality Accounts 2012/13
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3.6 Statement from Tower Hamlets Overview and Scrutiny Panel

A request for a statement was sent to Tower Hamlets Overview and Scrutiny Panel 21 May 2013. Unfortunately, no response was received prior to the submission date (28 June 2013).

3.7 An Explanation of any Changes Made

East London NHS Foundation Trusts welcomes the feedback received from Newham CCG, City and Hackney CCG and Tower Hamlets Healthwatch. We have worked with all of our stakeholders to develop a Quality Accounts Report which is a fair and balance review of the quality of the services the Trust provides. We will continue to collaborate in the development of key quality priorities and the evaluation of our services against these goals.

3.8 Feedback

If you would like to provide feedback on the report or make suggestions for the content of future reports, please contact the Trust Secretary, Mr Mason Fitzgerald, on 020 7655 4000. A copy of the Quality Accounts Report is available via: East London NHS Foundation Trust website (http://www.eastlondon.nhs.uk/) and NHS Choices website (http://www.nhs.uk/Pages/HomePage.aspx)

3.9 2012/13 Statement of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period; April 2012 –May 2013
  - Papers relating to Quality reported to the Board over the period; April 2012 – May 2013
  - Feedback from governors dated; March 2013
  - The trusts complaints which constitute part of the 'Integrated Governance Report' reported Quarterly to the Trust Board; May 2013
  - The national patient survey; September 2012
  - The national staff survey; February 2013
  - The Head of Internal Audit's annual opinion over the trust's control environment dated; March 2013
  - Care Quality Commission quality and risk profiles dated; February 2013
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

Date.....Chairman

Date.....Chief Executive

Glossary

Term	Definition
Admission	The point at which a person begins an episode of care, e.g. arriving at an inpatient ward.
Assessment	Assessment happens when a person first comes into contact with health services. Information is collected in order to identify the person's needs and plan treatment.
Black and minority ethnic (BME)	People with a cultural heritage distinct from the majority population.
Care Co-ordinator	A care co-ordinator is the person responsible for making sure that a patient gets the care that they need. Once a patient has been assessed as needing care under the Care Programme Approach they will be told who their care co-ordinator is. The care co-ordinator is likely to be community mental health nurse, social worker or occupational therapist.
Care pathway	A pre-determined plan of care for patients with a specific condition
Care plan	A care plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy. (see Care Programme Approach).
Care Programme Approach (CPA)	The Care Programme Approach is a standardised way of planning a person's care. It is a multidisciplinary (see definition) approach that includes the service user, and, where appropriate, their carer, to develop an appropriate package of care that is acceptable to health professionals, social services and the service user. The care plan and care co-ordinator are important parts of this. (see Care Plan and Care Co-ordinator).
Care Quality Commission (CQC)	The Care Quality Commission is the independent regulator of health and social care in England. They regulate care provided by the NHS, local authorities, private companies and voluntary organisations.
Case Note Audit	An audit of patient case notes conducted across the Trust based on the specific audit criteria outlined by CQC.
Child and Adolescent Mental Health Services (CAMHS)	CAMHS is a term used to refer to mental health services for children and adolescents. CAMHS are usually multidisciplinary teams including psychiatrists, psychologists, nurses, social workers and others.
CAMHS Outcome Research Consortium (CORC)	CORC aims to foster the effective and routine use of outcome measures in work with children and young people (and their families and carers) who experience mental health and emotional wellbeing difficulties.
Community care	Community care aims to provide health and social care services in the community to enable people to live as independently as possible in their own homes or in other accommodation in the community.
Community Health Newham (CHN)	Community Health Newham provides a wide range of adult and children's community health services within the Newham PCT area, including continuing care and respite, district nursing and physiotherapy.
Community Mental Health Team (CMHT)	A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and the community.
Continuing Care	The criteria for assessing long term care eligibility
DATIX	Datix is patient safety software for healthcare risk management, incident reporting software and adverse event reporting.
Discharge	The point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan. (see Care plan)
East London NHS Foundation Trust (ELFT)	East London NHS Foundation Trust provides a wide range of community and inpatient mental health services to the City of London, Hackney, Newham and Tower Hamlets. Forensic Psychiatric Services are also provided to Barking & Dagenham, Havering, Redbridge and Waltham Forest. Community Health Services are provided in Newham.
General practitioner (GP)	A family doctor who works from a local surgery to provide medical advice and treatment to patients registered on their list
Mental health services	A range of specialist clinical and therapeutic interventions across mental health and social care provision, integrated across organisational boundaries.
Multidisciplinary	Multidisciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.
Named Nurse	This is a ward nurse who will have a special responsibility for a patient while they are in hospital.
National Institute of Health Research (NIHR)	The goal of the NIHR is to create a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
National Institute for health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
(NCI / NCISH)	The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI / NCISH) is a research project which examines all incidences of suicide and homicide by people in contact with mental health services in the UK.
Patient Advice and Liaison Service (PALS)	The Patient Advice and Liaison Service offers patients information, advice, and a solution of problems or access to the complaints procedure.
PbR	Payment by Results
Prescribing Observatory for Mental Health (POMH-UK)	POMH-UK is an independent review process which helps specialist mental health services improve prescribing practice.
Primary care	Collective term for all services which are people's first point of contact with the NHS. GPs, and other health-care professionals, such as opticians, dentists, and pharmacists provide primary care, as they are often the first point of contact for patients
Primary Care Trust (PCT)	Formerly the statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions
Quality Accounts	Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.
RiO	The electronic patient record system which holds information about referrals, appointments and clinical information.
Service user	This is someone who uses health services. Other common terms are patient, service survivor and client. Different people prefer different terms.
Serious Mental Illness (SMI)	Serious mental illness includes diagnoses which typically involve psychosis (losing touch with reality or experiencing delusions) or high levels of care, and which may require hospital treatment.

Financial Review
2012/13

Introduction

The accounts have been prepared in compliance with the accounting requirements of the 2012/13 NHS Foundation Trust Annual Reporting Manual (the FReM) agreed with HM Treasury and issued by the Foundation Trust regulator, Monitor. The Trust has complied with cost allocation and charging requirements set out in HM Treasury guidance.

Overview

This section describes the financial performance for year ended March 2013; this is measured by the Financial Risk Rating (FRR) developed by Monitor, our independent regulator, which compares key financial metrics consistently across all Foundation Trusts. The rating reflects the likelihood of a financial breach of the Trust's terms of authorisation with a rating of 5 reflecting the lowest level of financial risk and a rating of 1, the highest. This is the sixth year as a Foundation Trust. During the course of the year, the Trust maintained a FRR of 4 for all the four reporting quarters, exceeding the planned FRR of 3.

The national operating framework required the Trust to achieve a 4% cash releasing efficiency saving. This equated to approximately £9.6m. The Trust achieved savings of £7.8m in year, and made up the shortfall through obtaining increased income. The Trust implemented a number of strategies to minimise the impact on front line services as a result of the savings requirement including adopting a whole systems review approach in a number of service areas, cost reductions and negotiating better deals with our suppliers.

Additionally, the Trust was required to achieve further savings of £1.5m by our local commissioners. This was achieved through a jointly agreed plan that consisted of a combination of additional efficiencies and decommissioning of some services.

The table below summarises and contrasts our performance for 2012/13, including comparative information for 2011/12.

	2012/13 £'M		2011/12 £'M	
Operating income	259.0		257.0	
Operating Expenditure	241.1		(241.5)	
EB/TDA	**17.9**		**16.4**	
Depreciation and Impairments	(9.6)		(6.2)	
Operating Surplus / (Deficit)	**8.3**		**10.2**	
Net Finance Cost	(2.0)		(1.6)	
Dividend	(3.1)	(5.1)	(3.3)	(4.9)
Net Surplus / (Deficit)	**3.2**		**5.3**	
Revaluation gains / (losses) and impairment loss	0.7		5.0	
Total Comprehensive Income / (Expense) for the year	**3.9**		**10.3**	

The Trust is required to make an assessment of the valuation of its assets annually. The valuation is performed by professional valuers, who have to apply prescribed rules and methodologies. The impact of the valuation can result in impairment loss or a revaluation gain which has to be accounted for accordingly in the accounts.

Income

The Trust received £259m of income. The profile of the source of income has not materially changed from 2011/12. The table below provides an analysis of the income as reported in the accounts.

	£m	%
Income from Activities		
NHS Trusts	1.8	0.7%
Primary Care Trusts	242.3	93.0%
Foundation Trusts	0.2	0.1%
Local Authorities	5.0	1.9%
Sub-total	249.3	95.7%
Other Operating Income		
Education and Training	6.5	2.5%
Research and Development	2.4	0.9%
Other Income	2.4	0.9%
Sub-total	9.7	4.3%
Total Income	**259**	**100.0%**

Best part of the total income (90%) was from block contracts with the local East London Primary Care Trusts and Specialist Commissioners for Forensic and CAMHS tier IV services.

In addition, interest earned from cash held was £0.3m.

Expenditure Analysis

Analysis of the operating spend is shown in the table below with comparative figures for 2011/12. Staff pay costs account for 72% of the total operating spend. This is consistent with the nature of the services we provide and is comparable with other Trusts providing similar services.

	2012/13		2011/12	
	£m	%	£m	%
Services from NHS Bodies	18.8	8%	19.7	8%
Services from Non-NHS Bodies	8.5	3%	9.6	4%
Staff Salary	174.3	71%	174.3	72%
Establishment	3.5	1%	2.9	1%
Supplies and Services	10.2	4%	10.9	5%
Drugs	3.1	1%	3.5	1%
Premises and Transport	10.6	4%	9.3	4%
Other	15.9	6%	11.3	5%
Sub-Total	**244.9**	**100%**	**241.6**	**100%**
Depreciation	5.6		4.6	
Impairments	4.0		1.6	
Sub-Total	**9.6**		**6.3**	
Total	**254.5**		**247.8**	

Capital

The Trust delivered a capital programme of £5.4m. £5.1m. This included upgrades of clinical areas (£3.8m), purchase of furniture/equipment (£0.2m), IT Hardware/Software upgrades (£1.4m).

Monitor risk rating
The overall risk rating is determined by our performance against five headings, with each carrying its own weighting. The table below summaries the five headings, the weighting each carries and the score that determines the risk rating from "1" to "5".

Risk Rating	5	4	3	2	1	Weighting
Underlying performance	11%	9%	5%	1%	<1%	25%
Achievement of plan	100%	85%	70%	50%	<50%	10%
Net return after financing	3%	2%	-0.5%	-5%	< -5%	20%
IS surplus margin	3%	2%	1%	-2%	< -2%	20%
Liquidity metric	60	25	15	10	<10	25%

Underlying Performance
The underlying performance is measured by EBITDA (Earnings Before Interest, Taxes, Depreciation and Amortization) margin which was 6.8% compared to plan of 5.2%. This gives an EBITDA margin rating of "3" which is consistent with the plan. The "underlying performance" rating carries a 25% weighting towards the overall financial risk rating.

Achievement of plan
The actual EBITDA was £17.9m compared to plan of £13.1m. This gives a rating of "5" against this target. The "achievement of plan" rating carries a 10% weighting towards the overall financial risk rating.

Net Return after financing
The return on assets was 4.6% which gives a rating of "5", compared to plan rating of "3". The Net Return after financing metric carries a 20% weighting towards the overall financial risk rating.

Income and Expenditure Surplus Margin
The surplus margin is the net surplus before impairments as a percentage of the operating income. The actual was 2.7% compared to plan of 1.0%. This gave a rating of "4", against a plan of "3". The surplus margin carries a 20% weighting towards the overall financial risk rating.

Liquidity
The liquidity rating measures our ability to pay our creditors from our liquid assets. It also takes into account the working capital facility available to the Trust and excludes any cash payment in advance by the commissioners. The metric is defined as the number of day's worth of the Trust's operating expenditure that its liquid assets will cover. The actual liquidity days metric was 39 days compared to plan of 25 days. The overall rating for liquidity was "4" consistent with the plan. The liquidity rating carries a 25% weighting towards the overall financial risk rating.

Overall Summary
The Trust has exceeded the financial risk rating against the plan submitted to Monitor. This has been achieved by working to and achieving an internal plan which was more challenging than the plan submitted to Monitor.

The table below summaries the overall risk rating compared to plan:

Risk Rating Measure	Plan	Actual	Weighting
Underlying Performance	3	3	25%
Achievement of Plan	5	5	10%
Net Return after financing	3	5	20%
Surplus Margin	3	4	20%
Liquidity	4	4	25%
Weighted Average Rating	**3.45**	**4.05**	**100%**

Borrowing
The Trust's borrowing capacity is fixed by its Prudential Borrowing Limit (PBL) and was set by Monitor at £51.8m. In addition, it is permissible for the Trust to have a Working Capital Facility (WCF) of up to £13.4m; at the end of March 2013, the Trust had a WCF of £13.4m. The WCF did not need to be used.

Accounting Policies and Going Concern
The Trust is required to comply with Monitor's NHS Foundation Trust Annual Reporting Manual. For 2012/13, the accounting policies contained in the manual follow the International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts.

As an NHS Foundation Trust, the Directors and the Trust's Auditors are aware of the need to review annual results in context of ensuring that the Trust has sufficient resources to run services in the foreseeable future. This provides an assurance for the going concern concept. The Directors have assessed future financial risk and have factored in such risks within the Trust's annual plan for 2013/14. The Directors are satisfied that the Trust has adequate resources to fund the operational performance in the foreseeable future and have therefore been able to sign off the going concern concept for 2012/13 accounts. The auditors have given an unqualified opinion on the financial statements.

Monitor's Quarterly Monitoring Arrangements

The ratings assigned by Monitor the independent regulator of NHS Foundation Trusts, are shown below. The Trust has consistently achieved a finance risk rating of 4, and a governance rating of green, over the last two years.

Table 5: Performance against Monitor's Compliance Framework

Area:	Rating key:	2011/12 Year-end Performance:	2012/13 Year-end Performance:
Financial Risk	Assessed on a scale of 1-5, with 1 = high risk, and 5 = low risk	4	4
Governance Risk	Green = low risk Amber = medium risk Red = high risk	Green	Green

Board Assurance Framework
The Trust has a Board Assurance Framework that is used as a risk register to monitor the Trust's objectives and any risks to achieving them. The framework is updated on a regular basis and reviewed by the Assurance Committee and Trust Board, in order to ensure that appropriate action is taken to mitigate such risk. The effectiveness of the Board Assurance Framework is assessed on an annual basis by the Trust's Internal Auditors, and a substantial assurance opinion was provided in 2012/13.

Our Workforce

The Trust's Workforce Strategy
The Trust recognises that providing high quality inpatient and community-orientated health care to local communities requires a highly skilled and motivated workforce. The Trust considers its staff to be the most prized asset and the Trust's Workforce Strategy reflects this belief:

- To become the Mental Health Provider of Choice and the Mental Health Employer of Choice for East London
- To develop a highly skilled, motivated and culturally capable workforce
- To maximise learning opportunities for all staff, provide high quality teaching and training, and remain a centre of excellence for research.

Recruitment, Selection and Retention
The Trust has seen an overall reduction in vacancy rates in most areas and turnover is similarly decreasing, leading to some professions nearing capacity. The focus has moved towards managing our internal talent and ensuring that we are securing the clinical and leadership skills needed for the future. Successful initiatives have been rolled out, such as the Band 6 Apprentice Programme for nurses and the recruitment of a number of Band 5 associate nurses as part of the strategy to 'grow our own'. All professional groups, including administrators, have assessed roles and structures to ensure there continues to be development opportunities for staff at all levels.

A number of workforce redesign initiatives have been implemented following reviews into whether changes in skill mix and ways of working can lead to efficiencies and improvements in quality of service. New posts have been designed and piloted, such as Social Therapists and Assistant Practitioners. These are now fully embedded and working effectively within multi-disciplinary teams.

The Trust continues to recruit high quality applicants to posts and has used a number of different strategies to attract applicants to 'difficult to recruit' posts, including building links with domestic and overseas students and joint selection processes with Local Authorities. Innovative selection processes have been developed, such as assessment days to recruit nursing staff, to identify applicants with the necessary competence and aptitude to deliver quality services to our patients.

The Trust has also reviewed the use of recruitment and retention premia and has agreed a proposal to pay this for Health Visitors, where there remains an acute skills shortage.

The recruitment service has made considerable steps in streamlining processes to provide an effective and efficient service to our directorates. A number of important initiatives have been introduced including the on-line CRB checking service which has reduced the time spent obtaining disclosures

so that the average number of days is now two. The Recruitment and Selection Policy was updated to meet the NHSLA Employment Checks Minimum Data Set and a number of good practice recommendations were implemented, including keeping a central record of professional registration numbers for agency staff.

The recruitment service is now working to a new redeployment protocol that gives staff, whose job is at risk, the priority over external applicants in cases where their skills match a new vacancy. The new process enables us to meet our obligations in finding suitable alternative employment for redeployed staff whilst minimising the impact to services of holding back vacancies.

Managing Change

The Trust has successfully delivered a number of programmes to achieve efficiency savings over the past year, with changes made to team structures, staffing structures and new ways of working introduced. A number of staff that were displaced were supported to find suitable alternative employment and redundancies were kept to a minimum. Staff were supported throughout the change process via the Employee Assistance Programme and with careers counselling. Practical support was offered for developing interview skills and CVs.

Staff Engagement, Recognition and Wellbeing

The Trust held the third Staff Engagement roadshow to promote the results and recommendations of the staff survey. This included a revised staff benefits booklet.
The Trust has built on the success of the Appreciative Inquiry Programme of workshops and used the findings to develop a quality appraisal and supervision process which has now been embedded in the organisation. Staff appraisal forms were amended to meet the dual aims of ensuring staff feel supported and valued, while at the same time meeting objectives closely aligned to both business goals and personal development plans.

Staff Recognition Initiatives

As part of its commitment to recognise staff contribution, the Trust introduced the Team of the Month Award in October 2012. This was in addition to the Employee of the Month Award that saw 51 winners in 2012.

The Trust also continued to reward exceptional employee achievements with its second Annual Staff Award, attended by a record 800 people. It showcased excellent delivery of care which helped inspire others. Categories were:

- Manager of the Year Award
- Employee of the Month Award
- Team of the Year Award
- Trainee/Student Health Professional of the Year Award
- Chief Executive Award
- Chair's Award

Health and Well-being Initiatives

In 2012 the Trust approved the new Health and Well-Being Strategy and its action plan to adapt a cohesive approach to promoting workplace health and well-being. There was a stronger focus on physical health supported by the following initiatives:

- A 'physical activity week'
- Smoking cessation surgeries
- Workshops to support staff on nutrition, reducing stress and health MOTs
- Encouraged uptake of the Cycle to Work Scheme to promote physical activity
- Continued subsidising of yoga/Pilates classes (currently attended by 113 staff members)
- Fresh fruit deliveries to all inpatient wards across the Trust
- 288 sessions of free massage delivered.
- Stress Management

In addition to the above initiatives, the Trust undertook an annual stress survey in line with the Health and Safety Executive' (HSE) and is currently delivering on the HSE's Management Standards, ensuring compliance and reduction of stress amongst staff. These included:

- Workshops for employees to build resilience against stress
- Management training to help managers recognise signs of stress in their teams
- The distribution of a Managing Stress leaflet with positive tips to tackle stress.

Learning and Development

The Trust's Learning and Development department has recently achieved compliance in relation to standards to meet NHSLA Level 3. This required a number of new and good practice measures being introduced, including:

- Updating the TNA so that mandatory training is compliant with regulations
- Putting a system in place to ensure local induction is carried out and that evidence of this is collected
- Ensuring all bank staff receive a local induction
- Updating the mandatory and statutory training and induction policies
- All actions from the NHSLA being monitored via the bi-monthly Workforce Committee to help ensure that the Trust remains compliant.

The Trust continued to invest in developing clinical competency and capacity and has focused on the development of senior and clinical leadership. Structured work programmes were planned and delivered with the Trust Board, the Executive Team and Directorate Management Teams to ensure that the focus is always on quality (patient experience, clinical effectiveness and patient safety), whilst sustaining the organisation's viability (activity and finance). Development work was facilitated by an external consultant and covered areas such as risk awareness, business development and market opportunities, organisational development and annual planning.

Leadership training was delivered to all Band 8, 7 and 6 Nurses in Inpatient Units and the Trust continues to deliver the well-received Management Development Programme Forty managers have now successfully completed the programme.

Equality

A number of initiatives have been delivered under the Trust's Equalities Programme. Delivery is monitored by a newly created Single Equality staff network group, 'Going for Gold'. These include:

- All new employees now receiving diversity training as part of their corporate induction, including targeted training for managers and doctors.
- Written guidance made available for employees responsible for undertaking equality impact analysis.
- The Trust became a Stonewall Champion in June 2012 and has begun to deliver against an ambitious plan to become a top 100 employer on the Workplace Equalities Index.
- This Dignity at Work Policy and all Employee Relations policies were updated to comply with the new Equalities Act.
- Two popular diversity events this year including a pre-Olympics celebration of cultural diversity.

Category	Staff 2012/13 (WTE)	%
Age		
17-21	10	0.30%
22-35	1079.16	32.23%
36-50	1475.44	44.06%
51-65	763.76	22.81%
66+	20.34	0.61%
Ethnicity		
White	1355.37	40.47%
Mixed	106.73	3.19%
Asian or Asian British	469.2206	14.01%
Black or Black British	1110.29	33.16%
Other	95.66	2.86%
Not Stated	214.44	6.40%
Gender		
Male	1061.32	31.69%
Female	2287.39	68.31%
Trans-Gender	0	0%

Category	Staff 2012/13 (WTE)	%
Disability		
Yes	16.2	0.48%
No	229.85	6.86%
Undefined	3102.65	92.65%

In 2013/14 the Trust's Workforce Strategy will continue to aim to achieve the following:

- Recruit and retain culturally competent and highly skilled staff
- To develop critical thinkers and a motivated workforce
- To continue striving to be the Employer of Choice for East London
- To facilitate new ways of working to ensure that the best use of highly trained professionals is being made
- To improve workforce design and planning to ensure the right workforce capacity which is aligned to the directorates and service users' needs
- Address current national shortage of Health Visitors and District Nurses.

Equality and Diversity

The Equality function is part of the Directorate of Nursing and has a specific focus on improving the Trust's equality performance at patient and service user levels.

A series of road shows were organised to introduce to service, clinical and borough directors a renewed focus on equality, and more specifically what supporting services could do to help integrate equality considerations with the delivery of patient care. The visits also gave everyone the opportunity to identify key equality priorities across patient service areas.

An enhanced equality analysis tool has been developed to improve the process of taking into account equality factors for service redesign, policy development and organisational change. The tool is supported by a new equality and diversity library resource organised by: age, gender reassignment, disability, race, religion or belief, sexual orientation, pregnancy and gender.

'Going for Gold' is a new advisory forum inspired by the London 2012 Olympic Games and Paralympic Games. The forum will help the Trust understand and improve its performance with regards to equality, diversity and inclusion and is organised three times a year. Stakeholders include service users, carers, HealthWatch organisations (formally called Local Involvement Networks), local community and voluntary sector organisations and Trust staff, including clinical and borough directors The forum is expected to evolve and become part of a Social Inclusion Board that reports to the Trust Board.

The Trust's second annual Patients Equality Report was published this year, highlighting areas of good practice in advancing equality across the Trust, together with equality data from the Trust's patient information systems. The Trust is working to improve the quality and clarity of data collected to further improve equality performance. A pilot to monitor equality related patient/service user experience using the data has been established in Newham and the results will inform the pilot as it is rolled out across the Trust.

Two trustwide equality events celebrated the cultural diversity of East London with a variety of performing arts. Performers included members of the Trust in the Harmony Community Choir along with service users.

The Trust now has an equality champion at Board level to help ensure improving equality is always considered as part of governance arrangements and is aligned to organisational values and priorities.

People Participation

East London Foundation Trust has a People Participation Team working throughout the Trust. Their role is to ensure that service users and carers are involved in the running of the Trust and that the Trust puts service users at the heart of all of its work.

The team has, in the last year, introduced a new Carers Strategy, a set of standards for ward rounds and set up a forum to review the quality of the food on the wards. Many of these initiates originate from the local working together groups, which are a feature of each directorate and provide a forum for service users and carers to work together with staff to discuss local issues and suggest local solutions.

The team works closely with the membership office to ensure that governors and members work alongside service users and carers, ensuring the people of East London can be involved and get the very best service that the Trust can offer.

Quality Accounts 2012/13
Financial Review

Daily Void 2013

NEWS FLASH: THE DAILY VOID HAS AN EXCLUSIVE ON PATIENT EXPERIENCE IN ELFT, READ ALL ABOUT IT!

PATIENT EXPERIENCE IS GETTING EVERYWHERE!

EXCLUSIVE

The Void can exclusively reveal that the East London Foundation Trust has a People Participation Team working throughout the Trust. Their role is to ensure that service users and carers are involved in the running of the Trust and that the Trust puts service users at the heart of all of its work.

We understand that the team have, in the last year, introduced a new Carers Strategy, a set of standards for ward rounds and set up a forum to review the quality of the food on the wards, many of these initiates originate form the local working together groups which are a feature of each directorate and provide a forum for service users and carers to work together with staff to discuss local issues and suggest local solutions.

The team works closely with the membership office to ensure that governors and members work alongside service users and carers to ensure all the people of East London can be involved and get the very best service that the Trust can offer.

CELEB NEWS:
RENE DESCARTES TO APPEAR ON 'STRICTLY'
"I THINK I HAVE TO DO IT"

Mystery woman confesses to the Void !

"I used to want to be alone until I discovered People Participation, now I get involved in the running of the Trust I feel more confident in myself and I look forward to meeting other people"
FIND OUT INSIDE WHO THE MYSTERY WOMAN IS.

WIN AN ALL EXPENSES PAID HOLIDAY TO SUN-KISSED CROYDON
See inside for details

Board of Directors

Purpose
The Board of Directors is collectively responsible for the strategic direction of the Trust, its day-to-day operation and overall performance. The powers, duties, roles and responsibilities of the Board are set out in the Board's Standing Orders.

The main role of the Board is to:

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

Composition of the Board of Directors
The composition of the Board of Directors as at 31 March 2013 was as follows:

Marie Gabriel	Chair
Dr Robert Dolan	Chief Executive Officer
Nicola Bastin	Vice Chair and Senior Independent Director
Mary Elford	Non-Executive Director
Alan Palmer	Non-Executive Director
Professor Stefan Priebe	Non-Executive Director
Kingsley Peter	Non-Executive Director
Clyde Williams	Non-Executive Director
Jitesh Chotai	Director of Finance
Dr Kevin Cleary	Medical Director
Dr Navina Evans	Director of Operations
John Wilkins	Deputy Chief Executive/Director of Performance and Business Development
Professor Jonathan Warren	Director of Nursing

Baroness Molly Meacher, Chair, resigned from the Trust as of 11 September 2012. Ms Marie Gabriel was appointed by the Council of Governors to replace her, and commenced in post on 1 October 2012.

Non-Executive Directors
The power to appoint and remove the Chair and Non-Executive Directors in a foundation trust is vested in the Council of Governors.

The terms of office are as follows:

Name:	Expiry of term:
Marie Gabriel	1 October 2015
Nicola Bastin	1 November 2013
Professor Stefan Priebe	1 November 2013
Kingsley Peter	1 November 2013
Clyde Williams	1 November 2013
Alan Palmer	1 January 2016
Mary Elford	1 January 2015

Attendance Record
During the course of the year, the Board of Directors has met on a monthly basis (except in August and December). All meetings are held in public, and are followed by a meeting held in closed session. The attendance record of meetings for the Board of Directors for the year ended 31 March 2013 is as follows:

Trust Board Director	Number of meetings	Total number of attendances
Baroness Molly Meacher	4	4
Marie Gabriel	5	5
Dr Robert Dolan	10	8
Nicola Bastin	10	9
Professor Stefan Priebe	10	10
Kingsley Peter	10	9
Alan Palmer	10	10
Clyde Williams	10	9
Mary Elford	10	10
Jitesh Chotai	10	10
Dr Kevin Cleary	10	9
Dr Navina Evans	10	10
John Wilkins	10	10
Jonathan Warren	10	10

In addition to Board meetings, the Chair meets regularly with the Non-Executive Directors prior to Board meetings. The full Board also has a development programme, including away-day sessions, and both Executive and Non-Executive Directors attend a number of committee meetings.

Performance Evaluation
The Trust has processes in place for an annual performance evaluation of the Board, its Directors and its committees in relation to their performance over the 2012/13 financial year. The main components of this are:

- The Board has an ongoing development programme in place and conducted a performance evaluation in July 2011, facilitated by an independent assessor
- The Chair conducts individual performance evaluations of the Non-Executive Directors and the Chief Executive, as well as Executive Directors, in relation to their duties as Board members
- The Senior Independent Director conducts a performance evaluation of the Chair
- The Chief Executive conducts performance evaluations of the Executive Directors.

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

Balance, Completeness and Appropriateness of the Membership of the Board of Directors
The current Board of Directors comprises seven Non-Executive Directors (including the Trust Chair) and six Executive Directors (including the Chief Executive). The structure is compliant with the provisions of the NHS Foundation Trust Code of Governance.

Taking into account the wide experience of the whole Board of Directors, as well as the balance and completeness of the membership, the composition of the Board of Directors is considered to be appropriate.

Register of Directors' Interests
Under the terms of the Trust's Constitution, the Board of Directors are individually required to declare any interest which may conflict with their appointment as a Director of the Trust, as well as any related party transactions that occurred during the year. A copy of the register is available from the Trust Secretary.

Director's Remuneration
The responsibility for setting the remuneration packages of the Executive Directors falls to the Appointments and Remuneration Sub-Committee, details of which are found below. Full details of the Directors' remunerations are set out in the Accounts section.

The remuneration of the Trust Chair and Non-Executive Directors is the responsibility of the Council of Governors Nominations Committee which makes recommendations to the Council of Governors.

Audit Committee

Composition of the Audit Committee
The members of the Audit Committee as at 31 March 2013 are as follows:

Alan Palmer	Chair
Kingsley Peter	Non-Executive Director
Mary Elford	Non-Executive Director

Attendance Record
During the course of the year, the Audit Committee met six times. The attendance record of meetings for the Audit Committee for the year ended 31 March 2013 is as follows:

Committee members	Number of meetings	Total number of attendances
Alan Palmer	6	6
Kingsley Peter	6	5
Mary Elford	6	6

How the Audit Committee Discharges its Responsibilities
The purpose of the Audit Committee is to provide one of the key means by which the Trust Board ensures that effective internal financial control arrangements are in place. In addition, the Committee is tasked with providing a form of independent check upon the executive arm of the Trust Board. The Committee operates in accordance with terms of reference set by the Board of Directors which are consistent with the NHS Audit Committee Handbook and the Foundation Trust Code of Governance. All issues and minutes of these meetings are reported to the Trust Board.

In order to carry out its duties, Committee meetings are attended by the Director of Finance and representatives from Internal Audit, External Audit and Counter Fraud. The Committee directs and receives reports from these representatives, and seeks assurances from Trust officers. The main functions of the Committee are set out below.

Annual Accounts
The Audit Committee reviews and scrutinises the draft annual accounts through questioning of the external auditors and Trust officers and recommends their adoption by the Board.

Internal Audit
The Trust's Internal Auditors for 2012/13 were Deloitte LLP. Internal Audit provides an independent appraisal service to provide the Trust Board with assurance with regards to the Trust's systems of internal control.

The Audit Committee considers and approves the Internal Audit Plan and receives regular reports on progress against the plan, as well as an Annual Report. The Committee also receives and considers internal audit reports on specific areas.

External Audit
The Trust's External Auditors for the period 1 April 2012 to 31 March 2013 were KPMG.

The main responsibility of External Audit is to plan and carry out an audit that meets the requirements of Monitor's Audit Code for NHS Foundation Trusts. Under the Code, External Audit is required to review and report on:

- The Trust's accounts
- Whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

The External Auditors also review the content of the Trust's Quality Accounts.

The Audit Committee reviews the External Audit Annual Audit Plan at the start of the financial year and receives regular updates on progress. The Committee also receives an Annual Audit Letter.

KPMG's remuneration for 2012/13 was £58,103 excluding VAT.

Prior to KPMG's appointment as the Trust's external auditor, the Trust commissioned KPMG to carry out non-audit work for the Trust. The Trust paid KPMG £32k for this work.

Auditor's Reporting Responsibilities
KPMG reports to the Council of Governors through the Audit Committee. Their report on the Trust's financial statements is based on its examination conducted in accordance with UK Generally Accepted Accounting Practices and Monitor's Financial Reporting Manual. Their work includes a review of the Trust's internal control structure for the purposes of designing their audit procedures.

Counter Fraud
Local Counter Fraud Services (LCFS) are provided by Parkhill Audit Agency. The role of the LCFS is to assist in creating an anti-fraud culture within the Trust; to deter, prevent and detect fraud; to investigate any suspicions that arise; to seek to apply appropriate sanctions; and to seek redress in respect of monies obtained through fraud.

The Audit Committee receives regular progress reports from the LCFS during the course of the year and also receives an annual report.

The Trust's Counter Fraud service has received a rating of 4 (excellent – the highest possible rating) from the NHS Counter Fraud Service.

Relationship with the Council of Governors
In an NHS Foundation Trust, the Council of Governors is vested with responsibility for the appointment of the Trust's External Auditors, and will consider recommendations from the Audit Committee when doing so.

The Council of Governors appointed KPMG as the Trust's external auditors in July 2012 following a formal tender exercise.

Appointments and Remuneration Sub-Committee

Purpose
The Appointments and Remuneration Sub-Committee has the responsibility to review the structure, size and composition of the Board of Directors and make recommendations for changes where appropriate. The Committee is also responsible for leading the recruitment and appointment process for Executive Directors, reviewing reports on their annual performance evaluation, and for reviewing and agreeing the remuneration levels of the Executive Directors.

Composition of the Appointments and Remuneration Sub-Committee
The members of the Appointments and Remuneration Sub-Committee as at 31 March 2013 are as follows:

Marie Gabriel	Chair
Dr Robert Dolan	Chief Executive Officer
Nicola Bastin	Vice Chair and Senior Independent Director
Mary Elford	Non-Executive Director
Alan Palmer	Non-Executive Director
Professor Stefan Priebe	Non-Executive Director
Kingsley Peter	Non-Executive Director
Clyde Williams	Non-Executive Director

The Director of Human Resources, Mary Foulkes, attends Committee meetings as an advisor.

Attendance Record
During the course of the year, the Appointments and Remuneration Sub-Committee met three times. The attendance record of meetings for the Committee for the year ended 31 March 2013 is as follows:

Committee member	Number of meetings	Total number of attendances
Baroness Molly Meacher	2	2
Marie Gabriel	2	1
Dr Robert Dolan	3	1
Nicola Bastin	3	3
Alan Palmer	3	2
Professor Stefan Priebe	3	3
Kingsley Peter	3	1
Clyde Williams	3	2
Mary Elford	3	3

More information is set out in the Remuneration Report.

Other Board Committees

Assurance Committee
Chaired by a Non-Executive Director, the Assurance Committee has responsibility for managing the Board Assurance Framework (high level risk register). The Committee assesses, oversees and strategically manages and directs all aspects of the Trust's corporate and clinical governance risks.

Finance, Business and Investment Committee
This committee is chaired by a Non-Executive Director, and is attended by two other Non-Executive Directors, the Chief Executive and the Director of Finance. Its main role is to scrutinise all financial reports, all issues with a material financial impact (including proposed service and capital developments) and cash investment policy.

Quality Committee
The Quality Committee has responsibility for ensuring that the Trust's statutory duty of quality under the Health Act 1999 is discharged, and it approves and monitors quality improvement plans and workstreams. The Quality Committee maintains a sub-committee structure that assists it in ensuring that the Trust is meeting all Care Quality Commission essential standards and other governance targets.

Mental Health Act Sub-Committee
The Mental Health Act Sub-Committee is chaired by a Non-Executive Director and ensures that the statutory duties of the Trust Board under the Mental Health Act 1983 and subsequent amendments are exercised reasonably, fairly and lawfully.

Public Participation Committee
The Public Participation Committee was established to assist the Trust Board in meeting its duty to consult with service users and the public, and its remit and membership has been reviewed in order to support the work of the Council of Governors. Membership includes the Trust Board Chair, a Non-Executive Director, service user representatives from across the Trust, a carer representative, governors and members of the Trust's Executive Team. This Committee discusses issues regarding patient experience and involvement, and gives service user and carer representatives a direct link to the Trust Board.

Council of Governors

Purpose
The Council of Governors comprises 45 members, 27 of which are elected to represent public constituencies, nine who are elected as staff representatives and nine appointed partnership organisation members.

Trust Governors have a responsibility to represent their members' and partner organisations interests, particularly in relation to the strategic direction of the Trust, and to provide a steer on how the Trust should carry out its business in ways consistent with the needs of its members and the wider population.

Governors do not undertake operational management of the Trust but do challenge the Board of Directors, acting as the Trust's critical friend and collectively holding the Board to account for the Trust's performance to help shape the organisation's future direction.

Duties
The formal powers and duties conferred on the Council of Governors by the National Health Services Act 2006, Standing Orders of the Council of Governors and the constitution are as follows:

- To appoint, remove and decide the terms of office of the Chair and other non-Executive Directors
- To approve the appointment of the Chief Executive by the Non-Executive Directors
- To appoint or remove the auditor at a general meeting of the Council of Governors
- To be consulted on forward planning by the Board of Directors
- To receive the annual report and accounts, and the report of the auditor on them, at a general meeting of the Council of Governors
- To decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors
- To inform Monitor if the Trust is at any risk of breaching its terms of authorisation where these concerns cannot be resolved locally

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

The Council of Governors receive and consider relevant information on clinical and operational matters, the Trust's Annual Plan, and other appropriate information, in order to fulfil their duties.

The respective powers and roles of the Board of Directors and the Council of Governors are set out in their Standing Orders.

Some of the key features of the relationship between the two bodies are:

- Executives and Non-Executive Directors attend each Council of Governor Meeting
- Summaries of Council of Governor meetings are reported to the Board of Directors
- A Senior Independent Director attends Council of Governor meetings and is available to meet with Governors on a one-to-one basis to discuss any issues or concerns a Governor may have
- The Deputy Chair of the Council of Governors works with the Chair to ensure that the two bodies cooperate effectively
- The continuation of the role of Assistant Deputy Chair has ensured consistency of this work in the absence of the Deputy Chair
- Council of Governors continue to have an open invitation to attend all Trust Board meetings
- Membership Meetings held in relation to the Trust's Annual Plan are attended by Governors, Executive Directors and the Chair.

The Health and Social Care Act 2012 places great emphasis on local responsibility and accountability. Foundation Trust governors have an integral role to play in this respect and accordingly have been given new powers which have increased the scope of their responsibilities and ensure they have more influence than before, especially in relation to financial matters.

In light of the Act a number of requirements are placed on the Board of Directors to empower governors by:

- Holding open board meetings
- Before holding a board meeting the board must send a copy of the agenda to the Council of Governors

- As soon as practicable, after holding a meeting, the board must send a copy of the minutes to the Council of Governors
- The Trust must ensure that Governors are equipped with the skills and knowledge they need to undertake their role.

Additional Duties:

- Significant transactions must be approved by more than half of the members of the Council of Governors voting
- Governors must be satisfied that the earning of private patient income will not significantly interfere with their Trust's principal purpose of the performance of its functions (NHS work) and must notify the board of their decision on this
- Where an amendment is proposed to the constitution in relation to the powers or duties of the council at least one Governor must attend the next Annual Members Meeting and present the proposal. The Trust must also give its members the chance to vote on such amendments to the constitution

Governor	Term	No of meetings out of six unless otherwise stated
Tower Hamlets		
Ashek Ali	November 2012 – 2015	1(3)
Terry Cowley	November 2012 – 2015	3(3)
Nassar Hosein	September 2010 – 2013	4
Faizul Islam	October 2009 – October 2012	2(3)
Gordon Joly	November 2012 – 2015 (2nd Term)	6
Ala Miah	February 2012 – 2015	1(1)
Marybel Moore	October 2009 – October 2012	2(3)
Dinah Morley	September 2010 – 2013 (2nd Term)	6
Peter Nichol	September 2010 – 2013 (2nd Term)	3
Saleha Rashid	September 2010 – August 2012	0(2)
Stephen Tabone	November 2012 – December 2012	1(1)
Newham		
John Barfield	November 2012 – 2013 (2nd Term)	6
Julie Kennedy	May 2011 – October 2012	1(3)
Ajith Lekshmanan	November 2012 – 2015	3(3)
Norbert Lieckfeldt	November 2012 – 2015	3(3)
Shannon O'Neill	September 2010 – 2013 (2nd Term)	5
Manji Patel-Vekaria	September 2010 – 2013	6
Chinedu Udonsi	September 2010 – August 2012	2(2)
Edith Weston	March 2011 – 2013	4
Ernell Diana Watson	November 2012 – 2015	3(3)
Malcolm Williamson	October 2009 – July 2012	2(2)
Community Health Newham		
Susan Weston Browne	April 2011 – November 2012	1(3)
Asmat Khan	April 2011 – October 2013	6
Zahida Khan	April 2011 – October 2013	5
Carol Ann Leatherby	April 2011 – October 2013	6
Hackney		
Brizlall Boodhoo	August 2011 – October 2013	5
Eric Cato	November 2012 – October 2015	2(3)
Katherine Corbett	November 2012 – October 2015	2(3)
Kofoworola David	November 2012 – 2015 (2nd Term)	2
Chloe Desouza	November 2012 – 2016	3(3)
Anne-Marie Farrugia	October 2009 – October 2012	3(3)
Matt Jones	October 2009 – October 2012	0(3)
Stuart Maxwell	September 2010 – September 2012	1(3)
Ike Oze	November 2012 – 2015	3(3)
Clarissa Rocke-Caton	September 2010 – 2013 (2nd Term)	6
Other London Boroughs		
Reverend Brian Sallery	September 2010 – March 2013	1(5)
City of London		

Governor	Term	No of meetings out of six unless otherwise stated
Gerald Hine	September 2010 – 2013	6
Staff		
Ruth Benbow	September 2010 – 2013	3
Josephine Dolan	November 2012 – 2016	1(3)
Margaret Minoletti	November 2013 – 2016	2(3)
George Paton	October 2009 – October 2012	2(3)
John Peers	September 2010 – 2013 (2nd Term)	2
Julian Ruse	November 2012 – 2015	3(3)
Betsy Scott	November 2011 – 2013	3
Basseer Somally	September 2010 – 2013 (2nd Term)	6
Uduak Ukpeh	March 2010 – 2012	0(3)
Staff CHN		
Dr Sandra Baum	November 2012 – 2016	2(3)
Bibi Sajida Khan	April 2011 – October 2013	5
Jenny Noschese	April 2011 – May 2012	1(1)
Appointed		
Will Huxter	Appointed June 2011	3
Charlene McLean	Appointed July 2011	2
Kolil Miah	Appointed September 2011	3
Virginia Rounding	Appointed December 2011	2
Stephen Stansfield	Appointed Novermber 2007	4
Bill Turner	Appointed July 2011 – July 2012	1(1)
Sahdia Warraich	Appointed November 2007	4
Amy Whitelock	Appointed August 2012	2(4)

Governor Expenses

There was a total of £716 of expenses claimed by governors for 2012/13 financial year. All expense claims are made and processed in line with Trust policy. Records of individual expense claims were not maintained by the Trust for 2012/13, but a system is now in place for 2013/14.

Membership

Membership Statistics – Please see below:

	Trust Public Members	Percentage of total public membership*	East London & The City population	Target percentage of population in the Trust's catchment area*
City of London	47	0.61	12,551	1.75
Hackney	2,191	28.59	221,433	30.86
Newham	3,329	43.44	238,818	33.28
Tower Hamlets	2,096	27.35	244,844	34.12
Other Areas	1,113			
Total in catchment	**7,663**		**717,646**	
Total including Other Areas	**8,776**			
Staff Membership	**4,140**			
Total Trust Membership	**12,916**			

*The percentage of public members in the Trust's catchment area is determined by excluding members in 'Other Areas'

The Trust has a membership base of 8,776 as at 31 March 2013.

Eligibility requirements

The Trust has two main membership groups:

Public

All members of the public aged 12 years or older and living in the City of London, Hackney, Newham or Tower Hamlets are eligible to become members of the Trust. Residents of any other London borough aged 12 years or older can also join the Trust. The Trust does not have a separate membership group for service users or carers – both service users and carers make up a vital part of the public membership group.

Staff

All Trust staff are automatically part of the staff membership group provided they are on a permanent contract or on a fixed-term contract of at least 12 months duration. Staff can opt out of membership if they wish. Trust bank staff and staff who are seconded from partner agencies and have been in post or are on contracts longer than 12 months were invited to sign up as members of the staff group.

Members are similar to demographic proportions to the population served by the Trust. Whilst the Trust wishes to maintain a membership which adequately represents the local population, we also aim to support the continued development of our membership and its involvement and influence.

Our focus in 2012/2013 has been on the effective engagement of our current membership and development of active members. The Trust will however continue to focus on membership recruitment in areas where it is under-represented.

But significant membership growth is not our primary aim. Creating a more active and representative membership with increased engagement is our main aim, and to see an increased turnout at elections.

There will be an on-going review of membership per public constituency to ensure that they are representative in terms of locality, age, gender, and ethnicity. We seek guidance and support from the Trust Lead on Equality and Diversity where needed.

Membership Involvement

The Trust recognises that not all members want to be involved to the same extent or in the same way in Trust activities. Levels of membership engagement range from members wanting to be kept up to date on Trust developments to those who attend focus or local groups and/or the Annual Members Meeting and Annual Plan Consultation events and may consider standing for election to the Council of Governors.

A focus group of public members, the "Working Lunch Group", continues to meet quarterly and are chaired on a rotation basis by a trust member. Of significance is this group's involvement in the redesign of the members' area of the new Trust website.

Trust members continue to receive the membership newsletter – 'In Your Trust' and receive regular bulletins for election briefing sessions and events.

The membership team now holds a stall at every staff induction to encourage staff that membership is a trust wide activity and newly recruited Trust volunteers are encouraged to show their support to the trust and join as members.

Annual Members Meeting

Held at Stratford Town Hall on 11 September 2011, this event drew a large number of members who engaged in lively group discussions on a selection of topics and heard from key note speakers. An election briefing Session was held at this event for forthcoming elections. Art work from members was displayed as a changing slide show at the beginning of the event. Many members then joined the Annual General Meeting which followed afterwards. Over 70 members attended the Annual Members Meeting.

Annual Plan Consultation Event and Meeting

12 February 2013 and 5 March 2013

Over 150 people attended these events. Key emerging themes will be used to inform the trust's Annual Plan. Members had the opportunity to meet their governors, speak directly to Borough Directors and pose key questions to senior staff.

Other Membership Events

Over 2012/2013 the membership team coordinated and ran separate events, meetings, and engagement sessions for members and the recruitment of new members. Some of these included:

- Chair Recruitment Event
- Election Briefing Session
- Talk given at Alzheimer's Society Tower Hamlets
- Talk given to local Stroke Association Group
- Stroke Awareness Day Event
- Carers Event
- World Mental Health Day events in Hackney and Tower Hamlets
- Bangladeshi Mental Health Awareness Day
- Student Nurse Induction Sessions- talks given on membership

How to contact Council of Governors

Governors can be contacted via email, post or telephone through the Membership Office. Information about staff representatives and public representatives for each local area of the Trust is available on the Trust website. Staff governors details are also available on the staff intranet. Details of Council of Governor Meetings, which are open to the public, are also published on the trust's website.

In May 2012 the Membership Office moved but is still to be found on 1st floor of Trust Headquarters. The contact details are as follows:

Membership Office
1st Floor, Trust Headquarters
22 Commercial Street
London
E1 6LP
Freephone: 0800 032 7297

Volunteer Report

We have now completed the second year of the Trust's volunteer programme and it has been a year of considerable growth and success. The number of volunteers has grown by almost 80% to a total of 485 people being involved for some, if not all of the year. The number of services where volunteers have been placed has also increased and we now offer 98 different volunteering roles across the Trust. This number is set to increase in the early part of 2013 the next financial year.

All volunteers have to participate in a compulsory training programme Training is available every day of the week, including weekends. Trust staff responsible for the volunteers recruitment process in their departments are well supported. This includes help with initial applications and other relevant administration tasks including DBS checks (previously known as CRB). These are now completed online, leading to a reduction in time spent on this process and the speedier recruitment of volunteers.

Additional training was introduced this year in the form of workshops for specific topics to match specific volunteer roles. These workshops have included dementia, befriending, walk leading and customer service. These new workshops compliment basic training given and have proved very successful. They will be added to as new volunteer roles are identified.

We have a very diverse group of volunteers that reflect the community the Trust serves. Our surveys, exit interviews and focus groups feedback has shown that 96% of volunteers stated that training they received was of great benefit to them in building skills and knowledge. 89% stated great satisfaction in the recruitment and placement procedure and 42% of those who have left the programme did so because they had gained employment within the NHS mental health services thanks to the experience they gained from volunteering.

Public Interest Disclosures

The Trust strives to be a responsible member of the local community, and information regarding its performance in this area, as well as other matters of public interest, are set out below.

Trust Policies Relating to the Environment

The Trust has implemented a number of strategies and processes regarding environmental matters. This includes an Environmental Policy Statement that sets out the Trust's commitment to manage environmental risks and reduce our environmental impact. The Trust has developed strategies regarding waste, energy and green transport.

Private Finance Initiative (PFI)

In 2002 a 30-year contract commenced with G H Newham Ltd for the construction, maintenance and operation of facilities management services for the Newham Centre for Mental Health.

The Trust extended the PFI contract to provide for the expansion and reprovision of the Coborn Centre for Adolescent Mental Health – the Trust's specialist child and adolescent inpatient service.

The Trust is committed to making a payment of £4.994m for the combined scheme during 2012/13 compared to £4.817k in 2011/12.

Health and Safety at Work

The Director of Nursing is the Executive Director lead for Health and Safety matters and is supported by the Estates Department, Assurance Department, Security Nurse Manager and local Health and Safety leads. A Safety Committee meets regularly to discuss implementation of legislation and current health and safety issues.

The Trust is provided with Occupational Health services through agreements with local Primary Care Trusts and a private provider.

Equal Opportunities

An equal opportunities employer, the Trust is accredited with the Two Ticks Disability Symbol and has achieved the 'Positive about Disabled People' status. The Trust has an Equal Opportunity Policy in place.

Consultation

Previously established staff consultation arrangements continue to operate through the Joint Staff Committee which is chaired by a Non-Executive Director and is attended by staff-side and management representatives. Local Joint Staff Committees have been set up in the directorates. The Trust also continues to consult with the Local Overview and Scrutiny Committees.

The Trust consulted with staff, the Council of Governors and membership regarding its Annual Plan for 2013/14. More information regarding this, and other public and patient involvement activities, is set out elsewhere in this Annual Report.

Compliance with the Better Payment Practice Code

Details of compliance with the Better Practice Payment Code are set out in Note 9 of the accounts.

Freedom of Information Act

The Trust complies with the Freedom of Information Act 2000 which came into force on 1 January 2005. Details of the Trust's publication scheme and how to make requests under the Act are on the Trust's website www.eastlondon.nhs.uk. All requests for information received during the year have been handled in accordance with the Trust's policy and the Act.

Security of Data

The Trust has continued to ensure that information provided by service users and staff is handled appropriately and kept safe and secure. The Trust is required to report any data related incidents that would be classed as Serious Untoward Incidents, such as the loss of paper or electronic files.

The Trust has reported one data related incident during 20012/13 that would be classed as a Serious Untoward Incident.

Information governance risks

Risks to information including data security are managed and controlled by the Trust in a robust way. The Trust has a nominated Caldicott Guardian (Medical Director), who is also the executive director lead for Information Governance, and is supported by key staff within the *Assurance Directorate* and directorate leads. Policies are in place which are compliant with NHS guidelines, and incident reporting procedures are in place and utilised by staff. An Information Governance Steering Group forms part of the Trust's *Quality* Framework. The Trust Board receives reports on compliance with the Information Governance Toolkit.

Counter Fraud

The Trust engages Parkhill Audit Agency to provide the Local Counter Fraud service, and reports on counter fraud activity are submitted to the Trust's Audit Committee. The Trust's Counter Fraud Policy was updated during the course of the year. Further details are set out in the report on the Audit Committee.

Trust Auditors

The Trust's Auditors are KPMG. Further details are set out in the report on the Audit Committee.

Remuneration Report

For the purposes of this report the disclosure of remuneration to senior managers is limited to Executive and Non-Executive Directors of the Trust.

Trust Board Appointments and Remuneration Sub-Committee

Details relating to the purpose and composition of the Appointments and Remuneration Sub-Committee are set out in the Appointments and Remuneration Sub-Committee pages of this report.

Remuneration Policy

Executive Directors' salaries are decided by the Appointments and Remuneration Sub-Committee taking into account the requirements of the role, benchmarking information, individual and Trust performance, and the financial circumstances relating to the Trust performance and those relating to the Trust as a whole. Individual performance bonuses are not paid to Executive Directors. No individual is involved in any discussion or decision regarding their own pay level.

Contractual Arrangements

All Executive Directors have permanent contracts of employment with the Trust. Executive Directors are required to give three month notice to terminate their employment contracts.

Non-Executive Directors are appointed for fixed terms. The dates of appointments are listed below:

Executive Director	Post	Date of Appointment
Dr Robert Dolan	Chief Executive	11 September 2006
John Wilkins	Deputy Chief Executive/Director of Performance and Business Development	1 November 2007
Jitesh Chotai	Director of Finance	1 April 2009
Dr Kevin Cleary	Medical Director	1 June 2011
Dr Navina Evans	Director of Operations	1 February 2012
Jonathan Warren	Director of Nursing	1 August 2010

Salaries and Allowances

The remuneration (and pension) arrangements for both Executive and Non-Executive Directors including the Chairman are set out in section 6.1-6.3 within the accounts section of this report.

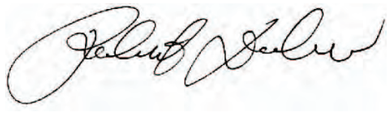
The remuneration of the Chairman and Non-Executive Directors is reviewed by the Council of Governors Nominations Committee and set by the Council of Governors. There was no compensation paid to any past or current members of the Board of Directors during the year.

Dr Robert Dolan
Chief Executive

Statement of Compliance with the NHS Foundation Trust Code of Governance

The NHS Foundation Trust Code of Governance was published by Monitor on 29 September 2006 and updated on 1 April 2010. The purpose of the Code is to assist NHS Foundation Trusts in improving their governance practices. It is issued as best practice advice, but imposes some disclosure requirements. This Annual Report includes all the disclosures required by the Code.

The Trust Board of Directors support and agree with the principles set out in the NHS Foundation Trust Code of Governance. The Trust is compliant with all provisions of the Code.



Dr Robert Dolan
Chief Executive

As far as the directors are aware, all relevant information has been made available to the auditors. The directors have also taken necessary steps in their capacity as directors and are unaware of any relevant information not being disclosed or brought to the attention of the auditors.

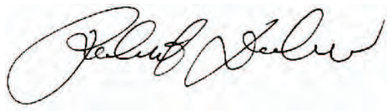
Audited Annual Accounts

For the year ended 31 March 2013

Foreword to The Accounts

These accounts, for the year ended 31 March 2013, have been prepared in accordance with paragraphs 24 and 25 of schedule 7 to the NHS Act 2006.

Signed:



Dr Robert Dolan
Chief Executive

Date: 29 May 2013

Annual Accounts
For the year ended 31 March 2013

Annual Governance Statement 2012/13

1 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.

2 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 against the achievement of the organisationís policies, aims and objectives of East London NHS Foundation Trust, and 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 East London NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

The Trust Board are accountable to the Independent Regulator (Monitor) for performance and control issues, and submits quarterly monitoring returns and exception reports to Monitor in accordance with the Monitorís Compliance Framework.

3 Capacity to handle risk
The Trust has a Risk Management Strategy and operational policies approved by the Trust Board. Leadership is given to the risk management process through a number of measures, including designation of Executive and Non-Executive Directors to key committees within the Trust's Healthcare Governance Framework structure. The Director of Nursing has delegated responsibility for ensuring the implementation of the Assurance Framework, and is assisted by the Director of Governance & Corporate Planning, who leads and manages the Trust's Assurance Department. All directors have responsibility to identify and manage risk within their specific areas of control, in line with the management and accountability arrangements in the Trust. Directorates have identified leads for risk management.

The Assurance Department provides support to directorates and departments on all aspects of effective risk assessment and management. The Department maintains the Trust's incident and risk reporting system, and risk registers. The Department also has a vital role in training, which is given to staff on induction and regular training opportunities are provided to staff at all levels, including root cause analysis training.

The Assurance Department is responsible for the dissemination of good practice and lessons learned from incidents or near misses. Good practice is disseminated within the Trust through information sharing, cascading of information via the groups and committees included in the Healthcare Governance Framework, maintenance of the incident register and consequent learning from such incidents.

4 The risk and control framework
Key elements of the Risk Management Strategy
Attitude to, and management of, risk is embedded within the Trust ís Risk Management Strategy. The strategy and related procedures set risk management activities within a broad framework within which the Trust leads, directs and controls its key functions in order to achieve its corporate objectives, safety and quality of services, and in which it relates to patients, staff, the wider community and partner organisations. The Trust has a Board Assurance Framework in place which provides a structure for the effective and focused management of the principal risks to meeting the Trust's key objectives. The Board Assurance Framework is fully mapped to Care Quality Commission standards.

The Board Assurance Framework enables easy identification of the controls and assurances that exist in relation to the Trust's key objectives and the identification of significant risks. High-level risk is assessed and monitored within the Assurance Committee, with more detailed risks being assessed and monitored by committees and groups within the Healthcare Governance Framework. Key issues emerging from this assessment and monitoring include a review of balance between absolute and acceptable risk, quantification of risks where these cannot be avoided, implementation of processes to minimise risks where these cannot be avoided and learning from incidents. These issues are cascaded throughout the Trust via directorate representative and multi-disciplinary attendance at committee and group meetings.

The Board Assurance Framework is reported to the Board on a quarterly basis, and red rated risks are reported to each meeting.

The Trust has quality governance arrangements in place. The Medical Director is the Board executive lead for quality. The Trust has a Quality Strategy and the Trust Board receives a regular report on quality issues. The quality of performance information is assessed through the Information Governance Toolkit and through the annual Quality Accounts audit. Assurance is obtained on compliance with CQC registration

requirements through the role of the Assurance Committee, the performance framework, and from the Trust's own schedule of unannounced visits to services.

Information Governance risks
Risks to information including data security are managed and controlled by the Trust in a robust way. The Trust has a nominated Caldicott Guardian (Medical Director), who is also the executive director lead for Information Governance, and is supported by key staff within the Information Management & Technology Directorate and directorate leads. Policies are in place which are compliant with NHS guidelines, and incident reporting procedures are in place and utilised by staff. An Information Governance Steering Group forms part of the Trust's Healthcare Governance Framework and the Trust Board receives reports on compliance with the Information Governance Toolkit.

Embedding risk management in the activity of the organisation
Risk management is embedded throughout the Trust's operational structures, with emphasis on ownership of risk within the directorates and a supporting role by the Assurance Department.

Directorates are responsible for maintaining their own risk register, which feed into the Trust's corporate risk register. The local risk registers are reviewed at Directorate performance meetings that are held on a quarterly basis. The Director of Governance & Corporate Planning receives risk registers from Directorates, as well as copies of committee and sub-group meetings throughout the Trust. Directorate representatives attend key committees of the Healthcare Governance Framework, ensuring formal channels of reporting, wide staff involvement, and sharing of learning. The implementation of incident and other risk related polices and procedures throughout the organisation ensure the involvement of all staff in risk management activity.

Involvement of public stakeholders
Risks to public stakeholders are managed through formal review processes with the Independent Regulator (Monitor) and the local commissioners through joint actions on specific issues such as emergency planning and learning from incidents, and through scrutiny meetings with Local Authorities' Health & Overview Scrutiny Committees. The Council of Governors represents the interests of members and has a role to hold the Board of Directors to account for the performance of the Trust.

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

The Trust received unannounced visits by the Care Quality Commission in July 2012 and December 2012. Both visits resulted in the Trust being assessed as fully compliant with CQC standards.

NHS Pension Scheme
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.

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

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

Report of the Mid Staffordshire NHSFT public inquiry
The Trust has set up a working group, led by the Medical Director, to consider the findings and recommendations of the Report of the Mid Staffordshire NHSFT public inquiry. The working group includes representatives from the Council of Governors, and will make recommendations to the Trust Board for action to be taken.

5 Review of economy, efficiency and effectiveness of the use of resources
As Accounting Officer, I have responsibility for ensuring economy, efficiency and effectiveness of the use of resources. Performance in this area is monitored by the Trust Board on a regular basis. The Trust Board discusses and approves the Trust's Annual Plan, taking into account the views of the Council of Governors. The Annual Plan includes the annual budgets. Throughout the year, the Trust Board receives regular finance and performance reports, which enable it to monitor progress in implementing the Annual Plan and the performance of the organisation, enabling the Board to take corrective action where necessary, and ensure value for money is obtained.

I am also supported by the work of internal audit, who, in carrying out a risk-based programme of work, provide reports on specific areas within the Trust and make recommendations where necessary. The work of Internal Audit, and the progress of implementing their recommendations, is overseen by the Trust's Audit Committee.

6 Annual Quality Report
The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form

and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Medical Director is the executive director lead for the Quality Report.

The Quality Report contains two main areas of information; details of the Trust's quality priorities for 2013/14, and performance against quality indicators for 2012/13.

The quality priorities for 2013/14 have been developed in conjunction with senior clinicians and managers, the Council of Governors and user groups. They form part of the Trust's Annual Plan for 2013/14 which has been prepared in line with Monitor requirements, and agreed by the Trust Board.

There are controls in place to ensure that the Quality Report is an accurate statement of the Trust's position. Information regarding the Trust's performance is produced by the Trust's performance management systems, and is regularly reported to the Board and performance management meetings throughout the year. The Trust's Performance Management Framework has been reviewed by Internal Audit and has received a substantial assurance opinion.

7 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 Internal Audit, 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 the Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Auditís opinion confirms that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2012/13 Annual Governance Statement and provides substantial assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. In addition, the Head of Internal Audit opinion also confirms that reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisationís objectives, and that controls are generally being applied consistently.

The effectiveness of the system of internal control is guaranteed by ensuring clear duties and accountability are allocated to each part of the Healthcare Governance Framework, and to individuals within the framework.

The Board receives the Board Assurance Framework on a quarterly basis, and receives a report on red rated risks at each meeting, receives reports from the Assurance Committee and from the Audit Committee, and notes minutes from key committees and groups within the framework. Reports submitted to the Board identify risk and are linked to the Board Assurance Framework, where relevant.

The Audit Committee is accountable to the Board for reviewing the establishment and maintenance of an effective system of internal control and risk management. It approves the annual audit plans for internal and external audit activities, receives regular progress reports and individual audit reports, and ensures that recommendations arising from audits are actioned by executive management. The Audit Committee receives the minutes of the Assurance Committee.

The Trust has a Counter Fraud service in place, in line with the Secretary of Stateís Directions on Fraud and Corruption and the Counter Fraud and Corruption Manual. The Audit Committee receives regular reports from Counter Fraud services.

The Assurance Committee has delegated responsibility for the Board Assurance Framework, and meets on a quarterly basis to review and update the Board Assurance Framework. There is shared membership between the Audit and Assurance Committees via Internal Audit, the Director of Finance, the Associate Director of Governance and the Chair of the Assurance Committee. The Assurance Committee receives the minutes of the Audit and Quality Committee.

The Quality Committee integrates the processes of clinical governance and risk management. It receives reports from working groups, and reviews risk with the chairs of such groups. It approved the clinical audit plan and receives and discusses individual clinical audit reports, ensuring that appropriate action is being taken to address areas of under-performance. Internal audit have given a substantial assurance opinion on the Trust's Clinical Audit arrangements. Executive Directors chair committees, with managers from various disciplines and from various services participating in the groups. The Quality Committee reports to the Assurance Committee, and also has links to the Service Delivery Board.

Internal Audit services are outsourced to Deloitte LLP, who provide an objective and independent opinion on the degree to which risk management, control and governance support the achievement of the organisationís agreed objectives. Individual audit reports include a management response and action plan. Internal Audit routinely follows up action with management to establish the level of compliance and the results are reported to the Audit Committee.

Directors ensure that key risks have been identified and monitored within their directorates and the necessary action taken to address them. Directors are also directly involved in producing and reviewing the Board Assurance Framework, and attend the Audit and Assurance Committees to report on risk within their areas of control.

The interests of patients, clients and other stakeholders

is given authority by inclusion of representatives on various groups of the Trust where possible and appropriate, as well as the role of the Council of Governors.

The Trust's regular reporting to Monitor provides additional assurance with regard to the Trust's governance arrangements and compliance with the Terms of Authorisation.

In January 2013, the Trust was awarded Level 3 of the NHS Litigation Authority Risk Management Standards for Mental Health and Learning Disability services, which provided substantial assurance regarding our governance processes.

The net result of these processes is that risk is assessed systematically, with internal reviews ensuring checks and balances, a local chain of reporting which ensures follow through of recommendations and actions, and wide staff involvement ensuring effective communication throughout the Trust.

Internal Control Issues

The Trust's Internal Auditors have given limited assurance opinions in the following areas:

- Health & Safety
- Mental Health Act
- Non-Clinical Contracting and Service Level Agreements
- Procurement
- Mobile Working and Remote Access

Action plans have been put in place to address the issues raised, and implementation is monitored by the Audit Committee.

The Trust's Board Assurance Framework (as of 31 March 2013) has four red rated risks:

- Increased demand causing over occupancy on inpatient wards and lack of female Psychiatric Intensive Care Unit capacity
- Serious incidents which affect reputation with stakeholders and regulators and result in loss of public confidence
- Health visitor services capacity in Community Health Newham
- Lack of robust partnership arrangements which threaten the development of sustainable service plans.

A summary of the action taken and current position is set out below:

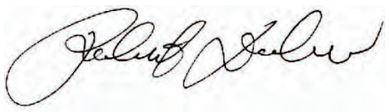
- Clinical Commissioning Groups have recently confirmed that they will fund a triage ward in Newham Adult Mental Health services on a pilot basis for 18 months, in order to alleviate bed pressures. The Trust has also recently expanded its female Psychiatric intensive Care Unit capacity.
- Inpatient and Community service project boards monitor the quality and safety of services and ensure that action is taken following incidents. The Trust's Serious Incident Committee and Quality Committee discuss findings of serious incident reviews and ensure that learning is shared and action taken.
- The Trust is in discussion with Clinical Commissioning Groups regarding the additional investment required to meet the new national strategy for health visiting services.
- The Trust welcomes the authorisation of local Clinical Commissioning Groups and is developing its relationships with them in order to ensure that sustainable service plans are implemented in East London.

8 Conclusion

The Trust has an effective system of internal control, and the specific internal control issues detailed above are being addressed through robust action plans.

The Audit Committee, Assurance Committee and Trust Board will continue to monitor these areas closely and agree additional action as required.

Signed:



Dr Robert Dolan
Chief Executive

Date: 29 May 2013

Independent Auditor's Report to the Council of Governors of East London NHS Foundation Trust

We have audited the financial statements of East London NHS Foundation Trust for the year ended 31 March 2013 on pages 99 to 133. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

This report is made solely to the Council of Governors of East London NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. 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 auditorís report 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.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officerís Responsibilities on page 98 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practiceís Boardís Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trustís circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of East London NHS Foundation Trustís affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directorsí Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, 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 are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of East London NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Signed:

Neil Thomas for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London
E14 5GL

Date: 29 May 2013

Statement of the Chief Executive's Responsibilities as the Accounting Officer

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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed East London NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of East London NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

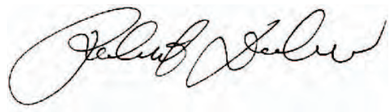
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him to ensure that the 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 Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed:



Dr Robert Dolan
Chief Executive

Date: 29 May 2013

Statement of Comprehensive Income
For the year ended 31 March 2013

	NOTE	2013 £000	2012 £000
Operating Income from continuing operations	3	**258,975**	257,938
Operating Expenses of continuing operations	4	**(250,683)**	(247,785)
Operating Surplus/(Deficit)		**8,292**	10,153
Finance Costs			
Finance Income – interest receivable		**297**	342
Finance Expense – PFI and finance lease interest payable		**(2,334)**	(1,873)
PDC Dividends payable		**(3,077)**	(3,288)
Net Finance Costs		**(5,114)**	(4,819)
Surplus/(Deficit) For The Year		**3,178**	5,334
Other comprehensive income			
Revaluation gains/(losses) and impairment losses property, plant and equipment	12.1	**660**	4,977
Total Comprehensive Income/(Expense) for the Year		**3,838**	**10,311**

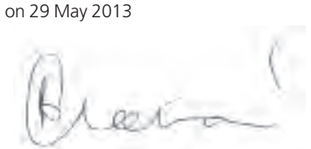
The notes on pages 104 to 133 form part of these accounts.

Statement of Financial Position
as at 31 March 2013

	Note	2013 £000	2012 £000
Non-Current Assets			
Intangible assets	**11**	**332**	116
Property, plant and equipment	**12**	**145,164**	148,925
Total non-current assets		**145,496**	149,041
Current Assets			
Inventories	**14**	**187**	221
Trade and other receivables	**15**	**11,491**	8,341
Cash and cash equivalents	**17**	**41,939**	46,238
Total current assets		**53,617**	54,800
Current Liabilities			
Trade and other payables	**18**	**36,686**	47,814
Borrowings	**19**	**459**	490
Provisions	**20**	**3,162**	209
Total current liabilities		**40,307**	48,513
Total Assets Less Current Liabilities		**158,806**	155,328
Non-Current Liabilities			
Borrowings	**19**	**20,740**	20,813
Provisions	**20**	**224**	273
Total non-current liabilities		**20,964**	21,086
Total Assets Employed		**137,842**	134,242
Financed By (Taxpayers' Equity)			
Public dividend capital		**76,938**	76,854
Revaluation reserve		**23,099**	23,503
Other reserves		**–**	(1,808)
Retained earnings		**37,805**	35,693
Total Taxpayers' Equity		**137,842**	**134,242**

The financial statements on pages 99 to 133 were approved by the Board on 29 May 2013 and signed on its behalf by:

Dr Robert Dolan
Chief Executive



Jitesh Chotai
Director of Finance

Statement of Changes in Taxpayers' Equity 2012/13

	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Retained Earnings £000	Total £000
Taxpayers' Equity as at 1 April 2012	76,854	23,503	(1,808)	35,693	**134,242**
Total Comprehensive Income for the year		660		3,178	**3,838**
Public Dividend Capital received	84				**84**
Public Dividend Capital repaid					**0**
Transfer of realised profits/(losses) to the revaluation reserve					**0**
Reduction in the donated asset reserve due to depreciation					**0**
Reduction in the donated asset reserve due to impairment					**0**
Transfer of excess depreciation over historic cost depreciation		(1,064)		1,064	**0**
Other transfers between reserves			1,808	(2,130)	**(322)**
Taxpayers' Equity as at 31 March 2013	**76,938**	**23,099**	**0**	**37,805**	**137,842**

Statement of Changes in Taxpayers' Equity 2011/12

	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Retained Earnings £000	Total £000
Taxpayers' Equity as at 1 April 2011	76,854	18,356	(1,808)	30,529	123,931
Total Comprehensive Income for the year		4,977		5,334	10,311
Public Dividend Capital received					0
Public Dividend Capital repaid					0
Transfer of realised profits/(losses) to the revaluation reserve					0
Reduction in the donated asset reserve due to depreciation					0
Reduction in the donated asset reserve due to impairment					0
Transfer of excess depreciation over historic cost depreciation		170		(170)	0
Other transfers between reserves					0
Taxpayers' Equity as at 31 March 2012	**76,854**	**23,503**	**(1,808)**	**35,693**	**134,242**

Statement of Cash Flows
For the year ended 31 March 2013

	NOTE	2013 £000	2012 £000
Operating surplus/(deficit) from continuing operations		**8,292**	10,153
Non-cash income and expenses			
Depreciation and amortisation		**5,574**	4,615
Impairments	**4**	**6,416**	4,670
Reversals of impairments	**4**	**(2,407)**	(3,038)
(Increase)/decrease in trade and other receivables	**15**	**(2,840)**	10,542
(Increase)/decrease in inventories	**14**	**34**	19
Increase/(decrease) in trade and other payables	**18**	**(2,915)**	4,106
Increase/(decrease) in other liabilities	**18**	**(6,470)**	6,819
Increase/(decrease) in provisions	**20**	**2,904**	(15)
Net Cash Generated From/(Used In) Operations		**8,588**	37,871
Cash flows from investing activities			
Interest received		**284**	339
Purchase of intangible assets	**11**	**(285)**	(55)
Purchase of property, plant and equipment	**12**	**(6,836)**	(8,411)
Net cash generated from/(used in) investing activities		**(6,837)**	**(8,127)**
Cash flows from financing activities			
Public dividend capital received		**84**	–
Capital element of PFI and finance lease payments		**(426)**	(458)
Interest element of PFI and finance lease payments		**(2,334)**	(1,873)
PDC dividend paid		**(3,374)**	(3,502)
Net cash generated from/(used in) financing activities		**(6,050)**	(5,833)
Increase/(decrease) in cash and cash equivalents		**(4,299)**	23,911
Cash and cash equivalents at 1 April 2012		**46,238**	22,327
Cash and cash equivalents at 31 March 2013		**41,939**	46,238

Accounting Policies and Other Information

1 Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared on a going concern basis 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 at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the requirements to report "earnings per share" or historical profits and losses. After making enquiries, the directors have a reasonable expectation that East London NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the Accounts.

1.2 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 the 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 to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The judgements and key sources of estimation uncertainty that have a significant effect on the material amounts recognised in the Accounts are detailed below:

- Asset valuations are provided by independent, qualified valuers. Valuations are subject to general price changes in property values across the UK. Asset values might vary from their real market value when assets are disposed of.
- Determination of useful lives for property, plant and equipment – estimated useful lives for the Trust's assets are based on common, widely used assumptions for each asset type except where specialist information is available from professional bodies. The Trust reviews these lives on a regular basis as part of the process to assess whether assets have been impaired.
- Provisions for pension and legal liabilities are based on the information provided from NHS Pension Agency, NHS Litigation Agency and the Trust's own sources. Pension provision is based on the life expectancy of the individual pensioner as stated in the UK Actuarial Department most recent life tables which change annually. All provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

1.3 Revenue

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

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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

1.4 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

Retirement benefit costs

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.5 Other expenses

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.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

a) it is held for use in delivering services or for administrative purposes;
b) it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
c) it is expected to be used for more than one financial year;
d) the cost of the item can be measured reliably; and
e) the item has a cost of at least £5,000; or
f) Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
g) Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

a) Land and non-specialised buildings – market value for existing use
b) Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. From 1 April 2008, HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. The Trust commissioned independent valuers, Montagu Evans, to carry out a full valuation of land and buildings using the modern equivalent asset methodology at 31 March 2013.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

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.

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when:

a) it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; and
b) the cost of the asset can be measured reliably; and
c) the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

a) the technical feasibility of completing the intangible asset so that it will be available for use
b) the intention to complete the intangible asset and use it
c) the ability to sell or use the intangible asset
d) how the intangible asset will generate probable future economic benefits or service potential
e) the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
f) the ability to reliably measure the expenditure attributable to the intangible asset during its development

Valuation

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.8 Depreciation, amortisation and impairments

Freehold land, properties under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.9 Revenue government and other grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS 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.

1.10 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

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.

Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

1.11 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI asset is recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.13 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.

1.14 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the following discount rates from HM Treasury:

Short term (up to 5 years): -1.8%
Medium term (5 to 10 years): -1.0%
Long term (over 10 years): 2.2%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursement will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.15 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. The contribution is charged to expenditure. 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 at note 27.

1.16 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to 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.

1.17 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that arises from past events that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed where the likelihood of a payment is probable.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.18 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: Financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. The fair value of the financial assets has been determiend as the transaction price.

Financial assets at fair value through income and expenditure

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.19 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:
a) The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and
b) The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability. The fair value of the financial liabilities has been determiend as the transaction price.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.20 Corporation tax

The Trust's activities relate to the provision of goods and services relating to healthcare authorised under s519A Income and Corporation Taxes Act (ICTA) 1988. On this basis the Trust is not liable for corporation tax.

1.21 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.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting

exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 31 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

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 cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.25 Losses and special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

1.26 Private patient income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The 2012 Act now obliges foundation trusts to ensure that the income they receive from providing goods and services for the NHS (their principal purpose) is greater than their income from other sources. The Trust did not receive any private patient income in the current period.

1.27 Limitation of auditor's liability

In line with guidance from the Financial Reporting Council, the auditors have limited their liability in respect of their audit (or any other work undertaken for the Trust). The engagement letter dated 17 September 2012, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1.0m in aggregate in respect of all services.

2 Segmental analysis

A business segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are different from those of other business segments. A geographical segment is engaged in providing products or services within a particular economic environment that is subject to risks and returns that are different from those of segments operating in other economic environments.

The directors consider that the Trust's activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all assets are managed as one central pool.

3 Operating income from continuing operations

	2013 £000	2012 £000
Income from Activities		
Strategic Health Authorities**	**–**	142
NHS Trusts**	**1,825**	3,037
Primary Care Trusts**	**242,323**	238,863
Foundation Trusts**	**159**	348
Local Authorities	**5,048**	3,532
Department of Health**	**–**	37
	249,355	245,959
Other Operating Income		
Education and training	**6,514**	6,223
Research and development	**2,346**	2,148
Other income*	**760**	3,608
	9,620	11,979
Total Operating Income from Continuing Operations	**258,975**	257,938

* Other income includes revenues received from a variety of sources in relation to activities not directly linked to core activities as well as ad hoc schemes and projects none of which is individually significant.
** Denotes income received for the provision of mandatory services as per the Trust's terms of authorisation (£244,307k for 2013, £242,427k for 2012). All other income is categorised as income from non-mandatory services (£16,333k for 2013, £15,511k for 2012).

4 Operating expenses of continuing operations

	2013 £000	2012 £000
Services from NHS Foundation Trusts	**4,767**	4,835
Services from NHS Trusts	**3,006**	3,248
Services from PCTs	**10,990**	11,594
Purchase of healthcare from non NHS bodies	**8,493**	9,635
Executive directors' costs	**1,114**	1,152
Non executive directors' costs	**149**	143
Staff costs	**173,051**	173,034
Drug costs	**3,149**	3,482
Supplies and services – clinical	**2,598**	2,925
Supplies and services – general	**7,621**	7,029
Establishment	**3,509**	2,898
Research and development	**2,959**	2,655
Transport	**1,051**	957
Premises	**9,161**	8,350
Provision for impairment of receivables	**839**	(18)
Depreciation and amortisation	**5,574**	4,615
Impairments of property, plant and equipment	**6,416**	4,670
Reversal of impairments of property, plant and equipment	**(2,407)**	(3,038)
Audit services – statutory audit	**70**	80
Other Auditors Remuneration	**38**	–
Clinical negligence	**602**	536
Other services, eg external payroll	**934**	886
Redundancy costs	**1,613**	2,769
Other	**5,386**	5,348
Total Operating Expenses of Continuing Operations	**250,683**	247,785

5 Operating leases

The Trust has 14 lease arrangements, of which 2 have been assessed in accordance with IAS17 as finance leases (see Note 21) and 12 as operating leases. All of the lease arrangements are in relation to the rental of buildings.

	2013 £000	2012 £000
Payments recognised as an expense		
Minimum lease payments	1,197	1,474
Total	**1,197**	1,474

	2013 £000	2012 £000
Total future minimum lease payments		
Payable:		
Within one year	1,159	1,460
Between one and five years	1,729	1,897
After five years	144	250
Total	**3,032**	3,607

6 Salary and pension entitlements of senior managers

6.1 Remuneration

Name and Title	2012/13 Salary* (Bands of £5,000) £000	2012/13 Other Remuneration* (Bands of £5,000) £000	2012/13 Bonus** (Bands of £5,000) £000	2011/12 Salary* (Bands of £5,000) £000	2011/12 Other Remuneration* (Bands of £5,000) £000	2011/12 Bonus** (Bands of £5,000) £000
Baroness Molly Meacher Chair (to 12/09/2012)	20-25	-	-	45-50	-	-
Marie Gabriel Chair (from 01/10/2012)	20-25	-	-	-	-	-
Dr Robert Dolan Chief Executive	190-195	-	-	205-210	-	-
John Wilkins Deputy Chief Executive and Director of Performance & Business Development	120-125	-	-	115-120	-	-
Jitesh Chotai Director of Finance	120-125	-	-	120-125	-	-
Dr Navina Evans Director of Operations	155-160	15-20	40-45	20-25	5-10	5-10
Dr Kevin Cleary Medical Director	180-185	-	40-45	145-150	-	25-30
Professor Jonathan Warren Director of Nursing & Quality	105-110	-	-	105-110	-	-
Nicola Bastin Non Executive Director	15-20	-	-	15-20	-	-
Alan Palmer Non Executive Director	10-15	-	-	10-15	-	-
Kingsley Peter Non Executive Director	10-15	-	-	10-15	-	-
Clyde Williams Non Executive Director	10-15	-	-	10-15	-	-
Professor Stefan Priebe Non Executive Director	10-15	-	-	10-15	-	-
Mary Elford Non Executive Director	10-15	-	-	0-5	-	-
Band of highest-paid director	190-195			205-210		
Median total remuneration	34,810.92			33,751.76		
Ratio	5.6			6.1		

*Salary and Other Remuneration are inclusive of Bonus
**Bonus refers to Clinical Excellence Awards, which are given to recognise and reward the exceptional contribution of NHS consultants, over and above that normally expected in a job, to the values and goals of the NHS and to patient care

There were no payments for golden hellos, compensation for loss of office, benefits in kind or performance related bonuses for any of the senior managers
See also note 7.3
Between 13/09/2012 and 30/09/2012 Nicola Bastin deputised as Trust Chair, this did not attract any additional remuneration

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6.2 Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £5,000) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000) £000	Cash Equivalent Transfer value at 31 March 2013 £000	Cash Equivalent Transfer value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value £000
Jitesh Chotai Director of Finance	0 - 2.5	0 - 5.0	45 - 50	140-145	913	860	8
Dr Kevin Cleary Medical Director	2.5 - 5.0	5.0 - 10.0	40 - 45	120 - 125	767	658	75
Dr Navina Evans Director of Operations	7.5 - 10.0	25.0 - 30.0	60 - 65	180 - 185	1086	860	181
Professor Jonathan Warren Director of Nursing & Quality	2.5 - 5.0	5.0 - 10.0	30 - 35	90 - 95	504	425	57
John Wilkins Deputy Chief Executive and Director of Performance & Business Development	0 - 2.5	5.0 - 10.0	30 - 35	100 - 105	694	606	56

Pension benefits apply to Executive Directors only as Non-Executive Directors do not receive any pensionable remuneration.

The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The Government Actuary Department factors for the calculation of Cash Equivalent Transfer Value assume that benefits are indexed in line with CPI, which are expected to be lower than RPI that was used previously.

The Trust contributed a total of £91,182 to Executive Director Pensions in 2012/13.

6.3 Reporting related to the review of Tax Arrangements of Public Sector Appointees (unaudited)

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arm's length bodies published information in relation to the number of off payroll engagements at a cost of over £58,200 per annum that were in place on 31 January 2012. The tables below report the number of engagements in place as at 31st January 2012 (Table 1) and the number of new engagements between 23rd August 2012 and 31st March 2013 for more than £220 per day and for more than six months (Table 2).

Table 1 – Off Payroll engagements at a cost of over £58,200 per annum that were in place as at 31 January 2012

No. in place on 31st January 2012	6
No. that have since come onto the Trusts Payroll	0
No. that have been re-negotiated/re-engaged, to include contractual clauses allowing the Trust to seek assurance as to their tax obligations	5
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the department to seek assurance as their tax obligations	0
No. that have come to an end	1
Total	**6**

Table 2 – For all new off payroll engagements between 23rd August 2012 and 31st March 2013, for more than £220 per day and more than 6 months

No. of new engagements	15
No.of new engagements which include contractual clauses giving the right to request assurance in relation to income tax and National Insurance	5
No. for whom assurance has been accepted and received	9
No. that have been terminated as a result of assurance not being received	1
Total	**15**

7 Staff costs and numbers

7.1 Staff costs

	2013 £000	2012 £000
Salaries and wages	**140,532**	141,696
Social security costs	**13,062**	12,750
Employer's contributions to NHSPA	**16,108**	16,129
Agency/contract staff	**4,463**	3,611
Total	**174,165**	174,186

7.2 Average number of persons employed

	2013 Total Number	2012 Total Number
Medical and dental	**277**	270
Administration and estates	**749**	763
Nursing, midwifery and health visiting staff	**1,613**	1,628
Scientific, therapeutic and technical staff	**577**	592
Bank and agency staff	**477**	424
Other	**2**	2
Total	**3,695**	3,679

7.3 Median remuneration multiplier

The banded remuneration of the highest-paid director in East London NHS Foundation Trust in the financial year 2012/13 was £190,000 – £195,000 (2011/12, £205,000 – £210,000). This was 5.6 times (2011/12, 6.1 times) the median remuneration of the workforce, which was £34,811 (2011/12, £33,752).

In 2012/13, no employees (2011/12, 0) received remuneration in excess of the highest-paid director. Remuneration ranged from £12,776 to £183,052 (2011/12 £13,460 to £180,452).

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

The movement in the multiplier from 6.1 in 2011/12 to 5.6 in 2012/13 is primarily as a result of the full year effect of the Chief Executive's remuneration, reflecting the cost to the Trust, being reassessed by the remuneration committee part way through the financial year ending March 31st 2012.

There has been no significant movement in the median remuneration between the two years.

7.4 Retirements due to ill-health

During 2012/13 there were 6 (2011/12, 6) early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £357k (2011/12, £508k). The cost of these ill-health retirements will be borne by NHS Pensions.

8 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. Employer's pension cost contributions are charged to operating expenses as and when they become due.

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) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2013, is based on detailed membership data as at 31 March 2010 updated to 31 March 2013 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

9 Better Payment Practice Code – measure of compliance

	2013 Number	2013 £000
Total Non-NHS trade invoices paid in the year	**32,386**	**63,510**
Total Non-NHS trade invoices paid within target	**29,799**	**57,332**
Percentage of Non-NHS trade invoices paid within target	**92%**	**90%**
Total NHS trade invoices paid in the year	**1,045**	**28,430**
Total NHS trade invoices paid within target	**981**	**27,910**
Percentage of NHS trade invoices paid within target	**94%**	**98%**

	2012 Number	2012 £000
Total Non-NHS trade invoices paid in the year	33,191	58,960
Total Non-NHS trade invoices paid within target	31,073	53,416
Percentage of Non-NHS trade invoices paid within target	94%	91%
Total NHS trade invoices paid in the year	942	24,270
Total NHS trade invoices paid within target	876	23,444
Percentage of NHS trade invoices paid within target	93%	97%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

10 Late Payment of Commercial Debts (Interest) Act 1998

There are no amounts included within other interest payable arising from claims made under this legislation.

11 Intangible assets

11.1 Intangible assets 2012/13

	Software licences £000
Gross cost at 1 April 2012	777
Additions purchased	285
Gross cost at 31 March 2013	**1,062**
Amortisation at 1 April 2012	661
Charged during the year	69
Amortisation at 31 March 2013	**730**
NBV Purchased at 31 March 2013	**332**
NBV Total at 31 March 2013	**332**
Useful economic life	
- Minimum useful economic life	**3**
- Maximum useful economic life	**3**

11.2 Intangible assets 2011/12

	Software licences £000
Gross cost at 1 April 2011	722
Additions purchased	55
Gross cost at 31 March 2012	777
Amortisation at 1 April 2011	510
Charged during the year	151
Amortisation at 31 March 2012	661
NBV Purchased at 31 March 2012	116
NBV Total at 31 March 2012	116
Useful economic life	
- Minimum useful economic life	3
- Maximum useful economic life	3

12 Property, plant and equipment

12.1 Property, plant and equipment 2012/13

	Land £000	Buildings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	**Total £000**
Cost or valuation at 1 April 2012	27,549	115,507	1,843	2,442	35	7,173	4,227	158,776
Additions purchased	0	2,260	894	535	0	1,168	236	5,093
Reclassifications	0	1,613	(1,842)	0	0	229	0	0
Impairments charged to revaluation reserve	1,499	(839)	0	0	0	0	0	660
Revaluation surpluses	6	(7,670)	0	0	0	0	0	(7,664)
Disposals	0	0	0	0	0	0	0	0
Cost or Valuation at 31 March 2013	**29,054**	**110,871**	**895**	**2,977**	**35**	**8,570**	**4,463**	**156,865**
Depreciation at 1 April 2012	0	963	0	1,205	35	4,241	3,407	9,851
Charged during the year	0	3,940	0	352	0	902	311	5,505
Reversal of impairments	(6)	(2,401)	0	0	0	0	0	(2,407)
Impairments recognised in operating expenses	0	6,416	0	0	0	0	0	6,416
Revaluation surpluses	6	(7,670)	0	0	0	0	0	(7,664)
Disposals	0	0	0	0	0	0	0	0
Depreciation at 31 March 2013	**0**	**1,248**	**0**	**1,557**	**35**	**5,143**	**3,718**	**11,701**
Net book value								
- Owned at 31 March 2013	29,054	79,946	895	1,420	0	3,427	745	115,487
- Finance Leased at 31 March 2013	0	762	0	0	0	0	0	762
- PFI Contracts at 31 March 2013	0	27,207	0	0	0	0	0	27,207
- Donated at 31 March 2013	0	1,708	0	0	0	0	0	1,708
Total at 31 March 2013	**29,054**	**109,623**	**895**	**1,420**	**0**	**3,427**	**745**	**145,164**
Useful economic life								
- Minimum useful economic life		30		3		5	3	
- Maximum useful economic life		90		15		8	12	
- Protected assets at 31 March 2013	29,054	109,623	0	0	0	0	0	138,677
- Unprotected assets at 31 March 2013	0	0	895	1,420	0	3,427	745	6,487
Total at 31 March 2013	**29,054**	**109,623**	**895**	**1,420**	**0**	**3,427**	**745**	**145,164**

12.2 Property, plant and equipment 2011/12

	Land £000	Buildings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	**Total £000**
Cost or valuation at 1 April 2011	30,028	97,305	13,637	1,898	35	6,028	4,174	153,105
Additions purchased	0	5,929	1,614	500	0	1,145	10	9,198
Reclassifications	0	13,068	(13,155)	44	0	0	43	0
Impairments charged to revaluation reserve	(2,645)	7,394	228	0	0	0	0	4,977
Revaluation surpluses	166	(8,189)	(481)	0	0	0	0	(8,504)
Disposals	0	0	0	0	0	0	0	0
Cost or Valuation at 31 March 2012	**27,549**	**115,507**	**1,843**	**2,442**	**35**	**7,173**	**4,227**	**158,776**
Depreciation at 1 April 2011	0	4,674	0	938	35	3,566	3,046	12,259
Charged during the year	0	3,161	0	267	0	675	361	4,464
Reversal of impairments	(166)	(2,872)	0	0	0	0	0	(3,038)
Impairments recognised in operating expenses	0	4,189	481	0	0	0	0	4,670
Revaluation surpluses	166	(8,189)	(481)	0	0	0	0	(8,504)
Disposals	0	0	0	0	0	0	0	0
Depreciation at 31 March 2012	**0**	**963**	**0**	**1,205**	**35**	**4,241**	**3,407**	**9,851**

	Land £000	Buildings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	**Total £000**
Net book value								
- Owned at 31 March 2012	27,549	79,351	1,843	1,237	0	2,932	820	113,732
- Finance Leased at 31 March 2012	0	2,266	0	0	0	0	0	2,266
- PFI Contracts at 31 March 2012	0	30,966	0	0	0	0	0	30,966
- Donated at 31 March 2012	0	1,961	0	0	0	0	0	1,961
Total at 31 March 2012	**27,549**	**114,544**	**1,843**	**1,237**	**0**	**2,932**	**820**	**148,925**
Useful economic life								
- Minimum useful economic life		30		3		5	3	
- Maximum useful economic life		90		15		8	12	
- Protected assets at 31 March 2012	27,549	114,544	0	0	0	0	0	142,093
- Unprotected assets at 31 March 2012	0	0	1,843	1,237	0	2,932	820	6,832
Total at 31 March 2012	**27,549**	**114,544**	**1,843**	**1,237**	**0**	**2,932**	**820**	**148,925**

13 Finance leases

13.1 Net book value of assets held under finance lease 2012/13

	Buildings £000	PFI Contracts £000	**Total £000**
Cost or valuation at 1 April 2012	4,227	30,966	35,193
Revaluation surpluses	(1,757)	(3,758)	(5,515)
Cost or Valuation at 31 March 2013	**2,470**	**27,208**	**29,678**
Depreciation at 1 April 2012	–	–	–
Charged during the year	1,097	583	1,680
Impairments recognised in operating expenses	660	3,175	3,835
Revaluation surpluses	(1,757)	(3,758)	(5,515)
Depreciation at 31 March 2013	**–**	**–**	**–**
Net book value			
- Purchased at 1 April 2012	2,266	30,966	33,232
- Donated at 1 April 2012	1,961	–	1,961
Total at 1 April 2012	**4,227**	**30,966**	**35,193**
Net book value			
- Purchased at 31 March 2013	762	27,208	27,970
- Donated at 31 March 2013	1,708	–	1,708
Total at 31 March 2013	**2,470**	**27,208**	**29,678**

13.2 Net book value of assets held under finance lease 2011/12

	Buildings £000	PFI Contracts £000	**Total £000**
Cost or valuation at 1 April 2011	4,400	26,402	30,802
Revaluation surpluses	(1,218)	(954)	(2,172)
Impairments charged to revaluation reserve	1,045	5,518	6,563
Cost or Valuation at 31 March 2012	**4,227**	**30,966**	**35,193**
Depreciation at 1 April 2011	612	477	1,089
Charged during the year	606	477	1,083
Revaluation surpluses	(1,218)	(954)	(2,172)
Depreciation at 31 March 2012	**–**	**–**	**–**
Net book value			
- Purchased at 1 April 2011	1,893	25,925	27,818
- Donated at 1 April 2011	1,895	–	1,895
Total at 1 April 2011	**3,788**	**25,925**	**29,713**
Net book value			
- Purchased at 31 March 2012	2,266	30,966	33,232
- Donated at 31 March 2012	1,961	–	1,961
Total at 31 March 2012	**4,227**	**30,966**	**35,193**

Quality Accounts 2012/13
Notes to the accounts

14 Inventories

	2013 £000	2012 £000
Movements in pharmacy stock for the year:		
Balance at 1 April 2012	**221**	240
Purchased during year	**2,221**	2,753
Issued during year	**(2,255)**	(2,772)
Balance at 31 March 2013	**187**	221

15 Trade and other receivables

	2013 £000	2012 £000
Amounts falling due within one year:		
NHS receivables	**6,714**	4,714
Other trade receivables	**2,585**	763
Provision for impaired receivables	**(1,175)**	(941)
Prepayments and accrued income	**1,399**	2,337
Other receivables	**1,968**	1,468
Sub Total	**11,491**	8,341
Total	**11,491**	8,341

16 Provision for impaired receivables

	2013 £000	2012 £000
Balance at 1 April 2012	**(941)**	(1,369)
Written off during year	**605**	410
Unused amounts reversed	**–**	671
Provided in year	**(839)**	(653)
Balance at 31 March 2013	**(1,175)**	(941)

17 Cash and cash equivalents

	2013 £000	2012 £000
Balance at 1 April 2012	**46,238**	22,327
Net change in cash and cash equivalent balances	**(4,299)**	23,911
Balance at 31 March 2013	**41,939**	46,238
The above balance at 31 March 2013 was held at:		
Government banking service	**41,827**	46,103
Commercial banks and cash in hand	**112**	135
Total	**41,939**	46,238

18 Trade and other payables

	2013 £000	2012 £000
Amounts falling due within one year:		
NHS payables	**1,522**	4,490
Other trade payables	**10,332**	8,040
Capital payables	**472**	2,215
Other payables	**440**	228
Accruals	**15,578**	18,457
Deferred income	**2,053**	8,523
Taxes and social security payables	**6,289**	5,861
Sub Total	**36,686**	47,814
Total	**36,686**	47,814

19 Borrowings

	2013 £000	2012 £000
Amounts falling due within one year:		
Current part of finance leases	**189**	182
Current part of PFI contracts	**270**	308
Sub Total	**459**	490
Amounts falling due after more than one year:		
Finance leases	**75**	264
PFI contracts	**20,665**	20,549
Sub Total	**20,740**	20,813
Total	**21,199**	21,303

20 Provisions

	Pensions – other staff £000	Legal claims £000	Other £000	Total £000
Balance at 1 April 2012	316	166	–	482
Utilised during the year	(46)	(166)	–	(212)
Arising during the year	–	138	2,978	3,116
Balance at 31 March 2013	**270**	**138**	**2,978**	**3,386**
Expected timing of cashflows:				
Not later than one year	46	138	2,978	3,162
Later than one year and not later than five years	184	–	–	184
Later than five years	40	–	–	40
Total	**270**	**138**	**2,978**	**3,386**

£3,977k is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the Trust.

21 Finance leases

The Trust has the following leases which are deemed to be finance leases:
York House, 411 Barking Road, London, E6 8AL
15 Homerton Row, London, E9 6ED

A lease is deemed to be a finance lease where substantially all of the risks and rewards of the lease contract are carried by the Trust. An asset and a liability are recognised in the Statement of Financial Position. The asset is shown at current Market Value and is depreciated over the term of the lease. The liability is shown at an amount equivalent to the present value of future lease payments and is reduced by apportioning lease payments between capital and interest elements over the term of the lease.

	Minimum lease payments		Present value of minimum lease payments	
	2013 £000	2012 £000	**2013 £000**	2012 £000
Within one year	**193**	193	**189**	182
Between one and five years	**75**	268	**75**	264
After five years	**–**	–	**–**	–
Less future finance charges	**(4)**	(15)		
Present value of minimum lease payments	**264**	446	**264**	446

22 PFI contracts on-Statement of Financial Position

The Trust has the following PFI contract which is deemed to be on-Statement of Financial Position:
Newham Centre for Mental Health & Coborn Centre for Mental Health

A PFI contract is deemed to be on-Statement of Financial Position where substantially all of the risks and rewards of the contract are carried by the Trust. An asset and a liability are recognised in the Statement of Financial Position. The asset is shown at depreciated replacement cost and is depreciated over the term of the contract. The liability is shown at an amount equivalent to the present value of future lease payments and is reduced by apportioning lease payments between capital and interest elements over the term of the contract.

	Minimum lease payments		Present value of minimum lease payments	
	2013 £000	2012 £000	**2013 £000**	2012 £000
Payable:		(restated)		(restated)
Within one year	**2,568**	2,568	**270**	245
Between one and five years	**10,273**	10,273	**1,386**	1,256
After five years	**44,013**	46,580	**19,279**	19,678
Less future finance charges	**(35,919)**	(38,242)		
Present value of minimum lease payments	**20,935**	21,179	**20,935**	21,179

The PFI contract has 30 years concession period, commencing 20 April 2002, for the PFI partner to initially carry out the design and construction of the works and subsequently to provide a fully serviced facility. At the expiry of the contract period the Trust may negotiate a new agreement with the company for the continuation of the services. Subject to this, the agreement shall terminate and the Trust is under no obligation to pay compensation of any kind to the company. The Trust has granted a 30 year head lease to the PFI partner.The PFI partner has granted a 30 year underlease to the Trust to occupy the facilities.

Historically, the accounting entries for the PFI scheme have been based on the original financial model provided by independent advisors at the inception of the contract. During 2013, this model has been updated to reflect actual market conditions, particularly with regard to the inflationary uplift percentage applied to the unitary payments. This has resulted in a restatement of the opening PFI liability, which has been treated as a transfer between reserves.

Commitments in respect of the service element of the PFI:	**2013 £000**	2012 £000
Payable:		(restated)
Within one year	**2,581**	2,426
Between one and five years	**12,473**	11,672
After five years	**84,705**	88,088
	99,759	102,186

23 Prudential borrowing limit

	2013 £000	2012 £000
Maximum cumulative long term borrowing set by Monitor	**51,800**	54,300
Working capital facility agreed by Monitor	**13,400**	13,400
Total prudential borrowing limit	**65,200**	67,700
Actual borrowing in the period – long term – PFI & finance leases	**20,740**	20,813
Actual borrowing in the period – working capital	**0**	0

East London NHS Foundation Trust is required to comply and remain within a prudential borrowing limit.

This is made up of two elements:
1) The maximum cumulative amount of long-term borrowing. This is set by reference to four ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.
2) The amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation trusts.

Financial Ratios	Actual ratio 2013	Approved PBL Ratios 2013	Actual ratio 2012	Approved PBL Ratios 2012
Minimum dividend cover	5.9	> 1.0	5.1	> 1.0
Minimum interest cover	7.8	> 3.0	8.9	> 3.0
Minimum debt service cover	7.8	> 2.0	8.9	> 2.0
Minimum debt service to revenue	1%	< 3%	1%	< 3%

24 Capital commitments

At the year end capital commitments not provided for in these Accounts amounted to £3,209k (2011/12, £998k). This amount relates to property, plant and equipment as part of capital projects which are expected to be completed in 2013/14.

25 Subsequent events

On 1 April 2013 five properties transferred from Newham Primary Care Trust under sections 300 and 301 of the Health and Social Care Act 2012. This follows the dissolution of PCTs on 31 March 2013. The book transfer value of these assets was £5,737k. The Trust has instructed a qualified valuer to undertake a full valuation of these properties during the first quarter of the financial year ending 31 March 2014.

26 Contingencies

	2013 £000	2012 £000
Contingent liabilities	**49**	53
Amounts recoverable against contingent liabilities	**–**	–
Net value of contingent liabilities	**49**	53

Contingent liabilities relate to cases being managed by NHS Litigation Authority

27 Clinical negligence

The Trust belongs to the Clinical Negligence Scheme for Trusts (CNST) and pays an annual insurance premium to the NHS Litigation Authority (NHSLA). Under the terms of this agreement, since 1 April 2002, financial responsibility for clinical negligence claims transferred to the NHSLA and the liability for claims is provided for in their Accounts. At 31 March 2013 the NHSLA were providing £3,977k against thirty three claims on behalf of the Trust.

28 Related party transactions

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

During the time period which these Accounts relate to, none of the Board members, the Members Council or members of key management staff or parties related to them has undertaken any material transactions with the Trust.

Professor Stefan Priebe, Non Executive Director, is the Professor of Social and Community Psychiatry at Queen Mary University of London. The Trust received £140k income for services provided and expended £909k for services received.

Ms Mary Elford, Non Executive Director, is a Council Member at Queen Mary University of London. The Trust received £140k income for services provided and expended £909k for services received. Ms Mary Elford is also a Lay Advisor to the Department of Health. The Trust received £689k income for services provided and expended £254k for services received

The Department of Health is regarded as a related party. During the period, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income 2013 £000	Expenditure 2013 £000	Receivable 2013 £000	Payable 2013 £000
NHS London	6,683	2	1	–
City & Hackney Teaching PCT	50,931	3	527	–
Newham PCT	101,677	10,664	2,923	433
Tower Hamlets PCT	39,388	1,445	268	3
NHS Croydon	41,812	–	271	–
Homerton University Hospital NHS Foundation Trust	171	3,961	1	14
Barts Health NHS Trust	1,683	3,073	309	871
NHS Litigation Authority	–	602	–	–
Kingston PCT	597	–	112	–
NHS Business Services Authority	–	111	–	66

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Newham, Hackney and Tower Hamlets Local Authorities in respect of joint enterprises.

The Trust has not received revenue or capital payments from any charitable sources.

29 Financial instruments

The fair values for each class of financial assets and financial liabilities together with their carrying amounts shown in the Statement of Financial Position are as follows:

	Carrying amount 2013 £000	Carrying amount 2012 £000	**Fair value 2013 £000**	Fair value 2012 £000
Cash and cash equivalents (note 17)	**41,939**	46,238	**41,939**	46,238
Trade and other receivables (note 15)	**10,092**	6,004	**10,092**	6,004
Total financial assets	**52,031**	52,242	**52,031**	52,242
Trade and other payables (note 18)	**14,589**	14,787	**14,589**	14,787
Accruals (note 18)	**15,578**	18,457	**15,578**	18,457
Capital creditors (note 18)	**472**	2,215	**472**	2,215
Borrowings (note 19)	**21,199**	21,303	**21,199**	21,303
Provisions (note 20)	**3,386**	482	**3,386**	482
Total financial liabilities	**55,224**	57,244	**55,224**	57,244
Total financial instruments	**(3,193)**	(5,002)	**(3,193)**	(5,002)

30 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

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 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.

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.

Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The most significant exposure to credit risk is in receivables from customers, as disclosed in Trade and other receivables (note 15).

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament . The Trust also largely finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Credit quality of financial assets and impairment losses

The aging of trade receivables at 31 March 2013 was:

	Gross 2013 £000	**Impairment 2013 £000**	**Carrying amount 2013 £000**
0 - 3 months	**5,289**	**(599)**	**4,690**
3 - 6 months	**210**	**(154)**	**56**
6 + months	**427**	**(422)**	**5**
Total	**5,926**	**(1,175)**	**4,751**

	Gross 2012 £000	Impairment 2012 £000	Carrying amount 2012 £000
0 - 3 months	3,333	(258)	3,075
3 - 6 months	903	(283)	620
6 + months	540	(400)	140
Total	4,776	(941)	3,835

31 Third party assets

The Trust held £1,092k cash at bank and in hand as at 31 March 2013 (£1,139k as at 31 March 2012) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the Accounts.

32 Losses and special payments

There were 38 cases (year ended 31 March 2012, 42 cases) of losses and special payments totalling £152k approved during the year ended 31 March 2013 (year ended 31 March 2012, £78k). There were no clinical negligence, fraud cases, personal injury cases, compensation under either legal obligation cases or fruitless payment cases where the net cash payment exceeded £100k.

33 Redundancy costs

The Trust made the following redundancy payments during the year:

	Compulsory Redundancies 2013 Number	**Other Redundancies 2013 Number**	Compulsory Redundancies 2012 Number	Other Redundancies 2012 Number
Redundancy package cost band				
Less than £10,000	**3**	**–**	6	–
£10,001 - £25,000	**2**	**–**	24	–
£25,001 - £50,000	**5**	**–**	28	–
£50,001 - £100,000	**7**	**–**	20	–
£100,001 - £250,000	**5**	**–**	–	–
	22	**–**	78	–
	£000	**£000**	£000	£000
Total cost	**1,613**	**–**	2,769	–

34 Staff sickness absence

	2013 Number	2012 Number
Days lost (long term) *	**33,079**	36,191
Days lost (short term)	**15,673**	16,890
Total days lost	**48,752**	53,081
Total staff years	**3,360**	3,356
Average working days lost	**14.5**	15.8
Total staff employed (headcount)	**3,618**	3,619
Total staff employed with no absence (headcount)	**1,417**	1,971
Percentage of staff with no absence	**39.2%**	54.5%

* long term sickness is defined by DoH as over 20 consecutive working days

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