Performance report

September 2021

Title	Performance report
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Accountable Executive director	Dr Amar Shah, Chief Quality Officer

PURPOSE OF THE REPORT

To provide assurance to the Board on overall performance of the organisation, in delivery of the Trust strategy.

KEY MESSAGES

The performance report provides a strategic overview of performance on four key themes (safety; access and responsiveness; effectiveness and outcomes; children and young people). Each theme includes a small number of Trustwide measures, together with a narrative to describe progress, challenges and actions. The appendix contains our system performance dashboard, with measures related to population health, quality of care and value for each of the key populations that the Trust serves. This helps us understand performance for each population that we serve, and to better understand internal variation. Narrative to explain unusual variation is contained in the overview of performance within the relevant theme.

Where are we doing well, and what have we learned?

Despite increase in demand across many of our community-based services, the average waiting times for assessment and treatment remain stable for many services, including CAMHS, and are reducing for Perinatal services. Community Health services continue to main responsive district nursing and rapid response services.

Many teams have begun to start working through the backlog of cases that have not yet been seen. This causes a paradoxical increase in the average waiting time data, as seen for memory services, autistic spectrum disorder assessments and community health services such as the East London musculoskeletal and diabetes clinics. This is a positive signal that we are beginning to work through assessments for those that have been waiting a long time in the backlog, despite the apparent deterioration in the average waiting times data.

The levels of inpatient violence and use of restraints appears to be decreasing, and whilst pressure ulcers of grade 2-4 remain stable but higher than pre-pandemic, the numbers of moderate to severe graded pressure ulcer incidents remain low. This reflects the positive impact of a range of strategies that teams have implemented.

Most services continue to report a high level of satisfaction through our Patient-reported Experience Measures (PREM). Patient-Reported Outcome Measures (PROM) show some signs of positive changes in paired Dialog scores during the pandemic across a range of quality of life measures. The report contains more details about how we are addressing the most frequent areas of dissatisfaction highlighted by service users through the Dialog outcome scale – employment, mental health and physical health.

KEY MESSAGES (continued)

Where are we identifying challenges, and what are we doing about it?

We have longer waiting lists and backlogs for assessment and treatment in many community-based services. Some teams have now begun to tackle the backlog, which is seen paradoxically as a deterioration in their average waiting time for assessment. All teams have access to data to manage their waiting lists and caseloads. Data quality continues to complicate our understanding of the true picture of waiting lists. Local performance teams are supporting services to re-establish the standard practices around caseload management that were often de-prioritised during the acute phases of the pandemic. There is now a consistent set of principles across the Trust around how we triage referrals and manage waiting lists to ensure people are safe while waiting to be seen. Services with longer waits than usual have developed recovery plans, which are monitored closely within directorate management teams and within our internal performance structures. Our progress with managing waiting times and backlogs is reviewed every three months at Quality Assurance Committee.

There has been a notable drop in the percentage of service users receiving follow-up contact within 72 hours of discharge, an important and evidence-based suicide-prevention intervention. In most cases this was due to service users not engaging with teams and technical challenges with our clinical systems. We have been transitioning to a new way of recording follow-up contact, so that we are able to report nationally on this measure. The transition is likely to be a temporary contributing factor in the performance deterioration. Directorates have been applying their quality improvement approach to develop and test new ideas to engage meaningfully with service users following discharge. There is a weekly Trustwide group which oversees implementation of this standard, and the adoption of the new recording practices. Further training and support are being provided across all our mental health directorates.

Executive Summary

Strategic priorities this paper supports (please check box including brief statement)

Improved population health	☒	The performance report describes our progress and impact on specific themes that relate to our strategic priorities, such as children and young people, safety, access and outcomes. The system dashboard contains key measures related to population health, quality of care and value for the main populations that the Trust serves, with narrative to explain any unexpected variation.
Improved patient experience	☒	
Improved staff experience	☒	
Improved value	☒	

Committees/meetings where this item has been considered

Date	Committee and assurance coverage
Various	Various aspects of this report are submitted to the Service Delivery Board and Quality Assurance Committee. Some of the performance information also submitted to commissioners and national systems.

Implications

Impact	Update/detail
Equality Analysis	Some of the metrics in this report are designed to improve equalities by ensuring access to services and good outcomes. Analysis of the experience of different groups is undertaken as part of the Trust's inequalities work stream.
Risk and Assurance	This report and supporting appendices cover performance for the period to the end of July 2021 and provides data on key compliance, NHS Improvement, national and contractual targets.
Service User/Carer/Staff	This report summarises progress on delivery of national and local performance targets set for all services.
Financial	The performance summary will escalate the areas where targets have not been met or areas of noncompliance against the main contracts and could pose a financial risk to the Trust.
Quality	Metrics within this report are used to support delivery of the Trust's wider service and quality goals.

Introduction: How this report is structured

Summary of organisational performance

The narrative section is organised around a small number of key themes (safety; access and responsiveness; experience and outcomes; children and young people). Each section contains 3-5 indicators aggregated at Trust level, together with a summary of current performance (progress, issues and actions).
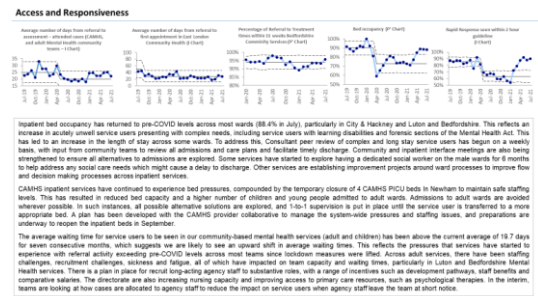

Key indicators related to the performance theme

Narrative describing current performance – including progress, challenges and actions

Appendix 1 – System performance dashboard

This dashboard demonstrates our impact on key measures of population health, quality of care and value for the main populations that the Trust services. Highlighted arrows draw attention to areas where we are seeing change (improvement, deterioration or instability)
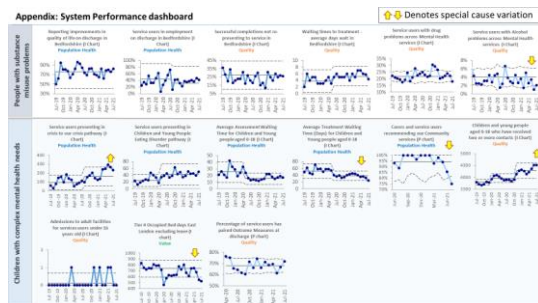
Each row contains the measures related to a population that we serve

Highlighted arrows to show areas where we are seeing instability, with assurance of actions provided in the initial narrative

Appendix 2 - What is our performance against national assurance indicators?

This provides the Board with assurance of our performance against the measures that form the new System Oversight Framework within the NHS
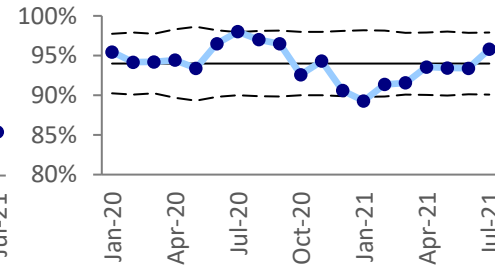
Access and Responsiveness

Average number of days from referral to assessment – attended cases (CAMHS, and adult Mental Health community teams – I Chart)
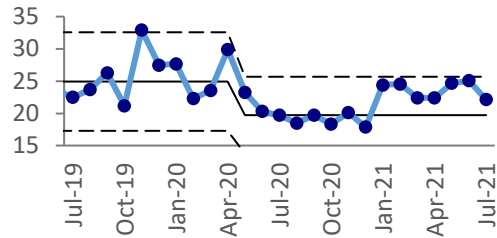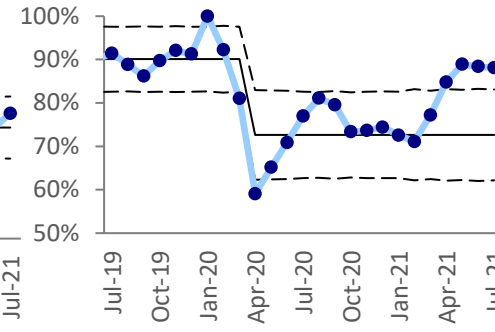
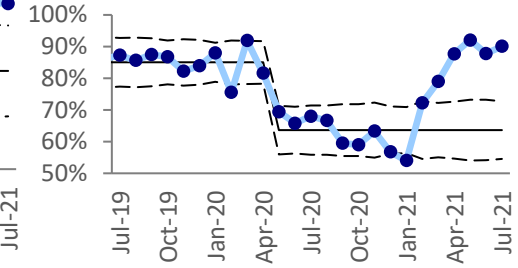**Average number of days from referral to first appointment in East London Community Health (I Chart)**
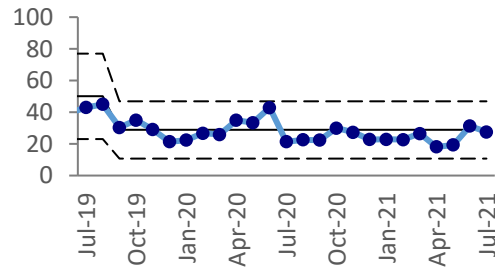
Percentage of Referral to Treatment times within 11 weeks Bedfordshire Comminity Services (P' Chart)

Bed occupancy (P' Chart)

Rapid Response seen within 2 hour guideline (I Chart)

Inpatient bed occupancy has returned to pre-COVID levels across most wards (88% in July), particularly in City & Hackney and Luton and Bedfordshire. This reflects an increase in acutely unwell service users presenting with complex needs, including service users with learning disabilities and forensic sections of the Mental Health Act. This has led to an increase in the length of stay across some wards. To address this, Consultant peer review of complex and long stay service users has begun on a weekly basis, with input from community teams to review all admissions and care plans and facilitate timely discharge. Community and inpatient interface meetings are also being strengthened to ensure all alternatives to admissions are explored. Some services have started to explore having a dedicated social worker on the male wards for 6 months to help address any social care needs which might cause a delay to discharge. Other services are establishing quality improvement projects around ward processes to improve flow and decision making processes across inpatient services.

CAMHS inpatient services have continued to experience bed pressures, compounded by the temporary closure of 4 CAMHS PICU beds In Newham to maintain safe staffing levels. This has resulted in reduced bed capacity and a higher number of children and young people admitted to adult wards. Admissions to adult wards are avoided wherever possible. In such instances, all possible alternative solutions are explored, and 1-to-1 supervision is put in place until the service user is transferred to a more appropriate bed. A plan has been developed with the CAMHS provider collaborative to manage the system-wide pressures and staffing issues, and preparations are underway to reopen the inpatient beds in early October.

The average waiting time for service users to be seen in our community-based mental health services (adult and children) has been above the current average of 19.7 days for seven consecutive months, which suggests we are likely to see an upward shift in average waiting times. After a period of reduction in waiting times during the initial waves of the pandemic, this would reflect a return to the waiting times pre-pandemic. Many services are now seeing referral volume exceed pre-COVID levels. In Bedfordshire and Luton mental health, there are plans to address recruitment challenges by trying to recruit our long-term agency staff to substantive roles, with a range of incentives such as development pathways, staff benefits and comparative salaries. The directorate are also increasing nursing capacity and improving access to primary care resources, such as psychological therapies. In the interim, teams are looking at how cases are allocated to agency staff to reduce the impact on service users when agency staff leave the team at short notice.

Access and Responsiveness

Across East London, mental health services are working with primary care networks to see and support people within primary care through the community mental health transformation programme. This will improve service user experience and release capacity to manage rising demand for those with more complex needs.

Psychological Therapy Service waiting times for assessment remain stable, and treatment waiting times continue to decrease. As highlighted previously, this reflects the positive impact of service redesign and new online treatment pathways that have started to become embedded across teams and the emerging primary care network psychological therapy pathways. Perinatal service assessment waiting times have improved in July, with 89% of service users being seen within 28 days.

Early intervention services (EIS) have seen a reduction in the percentage of service users commencing treatment within 2 weeks of referral. This is mainly due to the exclusion of video and telephone contacts in the national definition. If all contact methods were included, most EIS services would meet the national 56% target. However, there has also been an increased volume of referrals, particularly in City and Hackney and Luton & Bedfordshire. City & Hackney has reported the highest referral activity in the country. This has meant that most services have been managing caseloads above national EIS standards, further compounded by staffing challenges, including vacancies, sickness, and maternity leave. All services are undertaking a demand and capacity review with the support of the performance team in order to better understand and address these continued pressures.

Older people's memory services have seen an increase in assessment waiting times. This is expected, as the service has reopened routine care pathways (paused during the pandemic) and have begun assessing those service users waiting for the longest, thereby causing average waiting times for those seen in the month to rise. There is also evidence of increased prevalence of dementia locally and nationally during the pandemic, and referral activity in some localities has almost doubled over the last 18 months. All memory services are developing recovery plans to effectively manage waiting lists and backlogs, working with GPs, acute providers, and commissioners to improve pathways and secure additional investment to increase workforce capacity to meet national quality standards.

Community Health district nursing responsiveness remains stable across Luton and Bedfordshire, and East London. Community rapid response is being delivered successfully against the new national 2-hour standard, despite increased referral pressures from acute hospitals and staffing challenges. In East London, average waiting times to initial assessment remains low for Foot Health, Speech and Language Therapy, and Continence services. In Bedfordshire, average waiting times for assessment and treatment remain stable for Continence, Speech and Language therapy, Foot Health, and Wheelchair services.

CAMHS waiting times remain stable, but they have experienced significant increase in referrals across community and crisis services which is likely to adversely impact waiting times in the coming months.
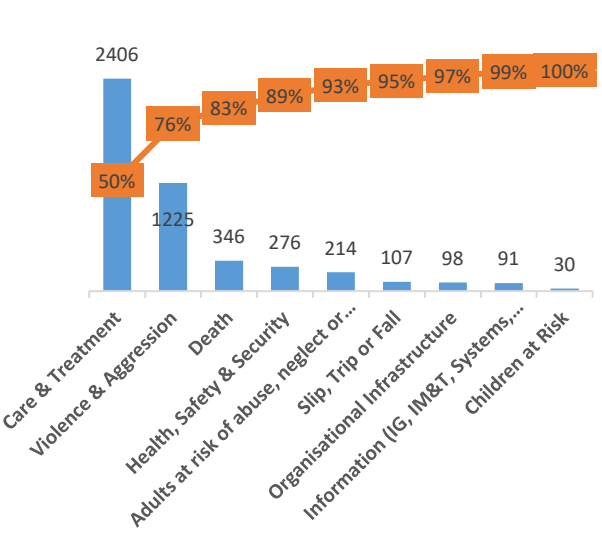
In addition to the standard performance measures that we report on locally and nationally, which is based on the waiting time for those who have been seen in the month, there is a cohort of service users who have yet to be seen and are waiting for assessment. This cohort has grown during the pandemic in many services, creating a backlog. The primary services affected by this are Adult and Older Adult Community Health Teams, Learning Disabilities, Psychological therapies, CAMHS, Memory Services, Autism and ADHD services, IAPT, and a small number of Community Health services.

Over the past few months, these services with backlogs of service users awaiting assessment have been undertaking a review of their waiting lists. Initial findings of the review suggest that some long waits related to data quality issues, such as referrals not being closed, contacts not being recorded correctly, where the service user moved out of area and the referral had not been updated on our clinical system, and transitions between services where someone remains on the caseload but does not need to be seen until they have been formally transferred. Some of the long waits identified in our systems have been found to be due to service users not responding to invitations to attend appointments, service users being admitted following referral to a community team, service users being open to multiple teams and receiving care in another team, and delays with booking appointments. All services are being supported to go methodically through the entire waiting list, particularly focusing on those who have been waiting extended periods for assessment, to identify whether the wait is genuine or a data quality error.
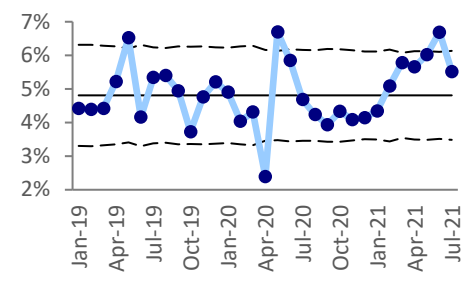
All ELFT community-based teams have systems in place to triage referrals based on need and risk and to monitor and manage their waiting lists. All services have access to data that enables them to monitor caseload, waiting times and referrals. Services with longer waits and backlogs than normal are completing recovery plans using standardised Trust templates. We have now developed some standard principles to ensure that all community-based teams have systems and processes in place to prioritise and triage referrals in a consistent way, and to ensure that we are monitoring and preventing the risk of harm for those that are awaiting assessment and/or treatment. There is regular oversight of waits, demand, access and backlogs within directorate management meetings and through our internal performance management systems. A deep dive report on waiting times for service users not yet seen has been presented to the Quality Assurance Committee in September to highlight services with the longest waiting times and backlogs along with the plans services have put in place to deliver improvement. Updates will continue to be provided to Quality Assurance Committee on this topic every 3 months.

Safety

### Categories of safety incidents June and July 2021 (Pareto)

Care & Treatment 2406 (50%)
Violence & Aggression 1225 (76%)
Death 346 (83%)
Health, Safety & Security 276 (89%)
Adults at risk of abuse, neglect or... 214 (93%)
Slip, Trip or Fall 107 (95%)
Organisational Infrastructure 98 (97%)
Information (IG, IM&T, Systems,... 91 (99%)
Children at Risk 30 (100%)

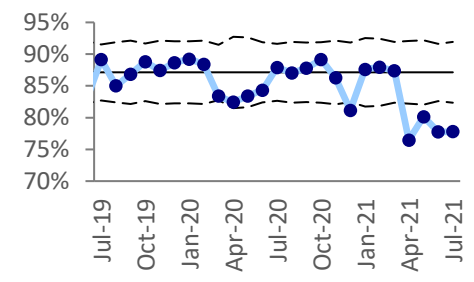### Percentage of all safety incidents resulting in Harm (P Chart)

Rate of physical violence incidents per occupied 1,000 bed days (P Chart)
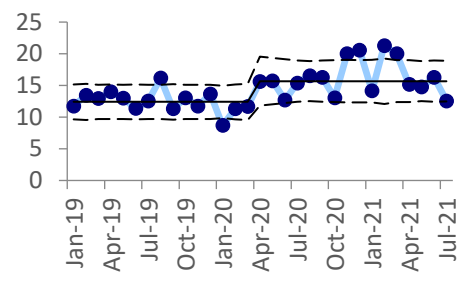
Number of Grade 2, 3 or 4 pressure ulcers (I Chart)
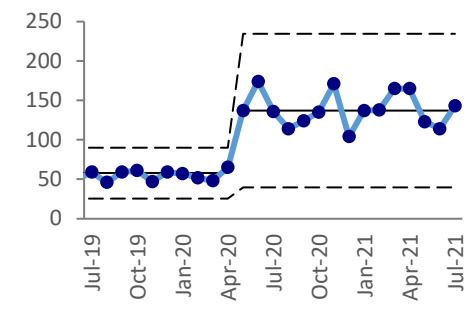
Percentage of service users followed-up within 72hours of discharge (p chart)

Whilst the total number of grade 2, 3 and 4 pressure ulcers remains higher than pre-pandemic, the number of moderate to severe (grade 3-4) pressure ulcers continues to stay low. This has been attributed to the comprehensive plan in place to manage pressure ulcers, which has included delivering training and awareness sessions to increase vigilance and awareness, fortnightly pressure ulcer meetings in London and Bedfordshire community nursing teams supported by the tissue viability service, and proactive monitoring and reporting of level 2 pressure ulcers by services have helped prevent deterioration in pressure ulcer conditions.

The Pareto chart above shows the distribution of reported incidents by category during June and July. This highlights that 50% of all reported incidents related to care and treatment and 26% related to violence and aggression. The main care and treatment themes included service users declining COVID swabs, adverse reaction to vaccinations, admission of Children & Young People onto Adult wards due to bed shortages, wound and catheter care, medication refusals and errors, service users declining care plan and assessments, or self-isolation advice, challenging behaviour requiring increased supervision, and Rapid Response Team interventions to deescalate conflict.
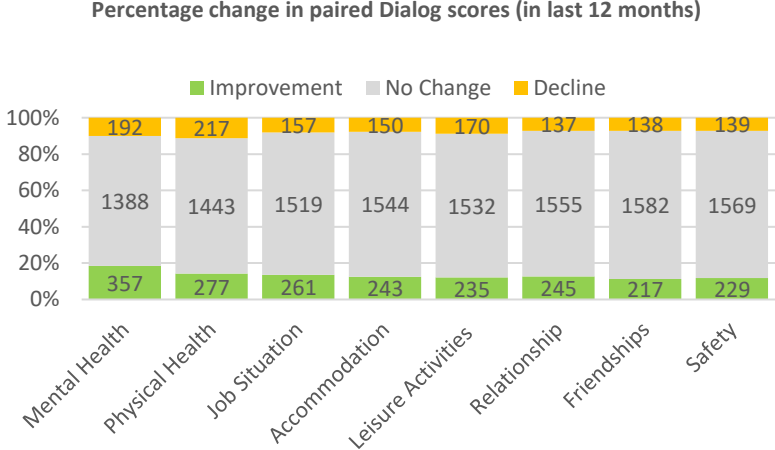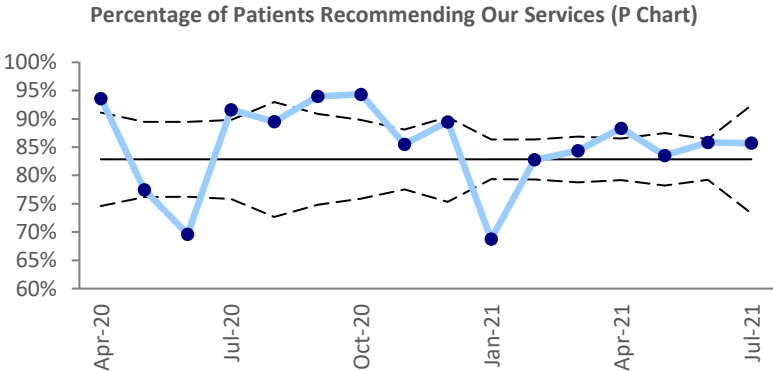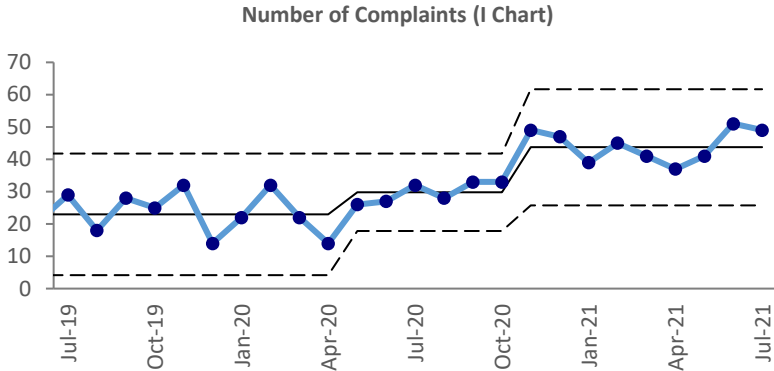
The chart for safety incidents resulting in harm shows an increase in recent months. The increase is related to incidents of self-harm across a number of wards; however, the vast majority of these are recorded as having caused no injury. The increase in safety incidents in Coborn that contributes to this, compounded by staffing challenges, led to the decision to close the 4-bed PICU area temporarily in order to maintain patient safety and quality of care. All services have processes in place for reviewing incidents and disseminating learning to staff, such as monthly newsletters, quarterly learning lessons workshops, and team governance meetings.

Safety

The Trust-wide rate of violence and aggression incidents across inpatient services has shown signs of reduction. Services have introduced several initiatives to address ward safety issues that appear to be having a positive impact, such as stabilising the workforce, ensuring restrictive practices are proportionate and appropriate, and increasing multidisciplinary input and engagement in decision-making processes around treatment and safety. Some services have reported that as staffing pressures have started to ease, the levels of violence & aggression and restraint use have also decreased. Some services have begun to see a reduction in the use of seclusion and rapid tranquillisation within patient services due to the use of quality improvement to test and implement 'Covid Safety Bundles.' This involves interventions designed to de-escalate potential harm and keep staff and service users safe and well. All our ward management teams have processes to actively manage acutely unwell service users, such as daily 'Time to Think' safety huddles, which are well established across all our wards and form part of our quality control system to manage safety issues such as violence and restraints. Ward teams frequently review care plans to ensure they remain effective. They also identify any themes relating to a particular service user or a group of service users and proactively take steps to reduce risk, such as spreading complex and challenging service users across multiple wards and promoting activities to maintain a therapeutic environment.

Our compliance against the 72-hour standard for post-discharge contact has fallen below the national 80% target over the past three months. Local investigation of cases where we have not managed to follow-up someone within 72 hours highlight factors including service users not engaging with multiple follow-up attempts within the 72 hours, some service users not having telephone or alternative contact medium, and data entry errors by staff in recording a positive contact. In a small number of cases, follow-up contact was not offered promptly. There were also instances where the newly established primary care networks (PCN) had successfully contacted service users, but this was not captured in the reports. The data systems have now been updated to include all PCN contacts. A small number of services reported technical issues with our clinical systems freezing and preventing appointments from being recorded successfully. A review of this issue was conducted, and the preliminary findings suggest that it was due to certain PCs and laptops that required a software update. There is a Trust-wide 72-hour Safety and Wellbeing Steering Group which meets weekly to review progress, share learning, and help improve post-discharge follow-up care. The steering group has supported services to test and implement a new way of capturing follow-up contact in order to meet the national reporting requirements in a more robust way. Most services have started to transition to the new system in the past two months. The transition to this new way of scheduling and recording follow-ups is likely to have contributed to a temporary reduction in performance as staff adjust to new systems and processes. Services anticipate the performance will improve once the new system is fully embedded and staff become more familiar with new recording practices and procedures.

Experience and Outcomes

Number of Complaints (I Chart)

Percentage of Patients Recommending Our Services (P Chart)

Percentage change in paired Dialog scores (in last 12 months)

	Improvement	No Change	Decline
Mental Health	357	1388	192
Physical Health	277	1443	217
Job Situation	261	1519	157
Accommodation	243	1544	150
Leisure Activities	235	1532	170
Relationship	245	1555	137
Friendships	217	1582	138
Safety	229	1569	139

The number of complaints continues to remain stable with an average of 43 complaints per month, although higher than pre-pandemic. The percentage of service users who would recommend our services to friends and family remains stable with an average of 83%, although with fewer responses than usual during July. Services continue to work with People Participation and quality assurance leads to increase feedback through various mediums, such as focus groups, telephone conversations, complaints and compliments, to help services continuously learn and make improvements. The quality report contains an analysis of themes arising from complaints and service user feedback over the past year.

Across IAPT services, the percentage of positive comments to the Patient Experience Questionnaire (PEQ) remains relatively stable, suggesting that service users do not feel that virtual therapy has provided a worse experience than face-to-face. However, some individuals would prefer face-to-face contact, and services have increased the offer of on-site treatments from July 2021 to make this available for those who prefer it. Service users, carers and parents across Dementia and Newham Specialist Children and Young People's Services, and Learning Disabilities have also reported high satisfaction levels.

The outcome chart above for Dialog data shows us the percentage of service users (with two Dialog scores at different points in time in the last year) who have demonstrated a positive or negative change across a range of quality of life measures. It should be noted that the overall number of paired measures (within the past 12 months) remains lower than expected, and the above data does not measure satisfaction levels, only positive or negative changes in scores. Therefore, some service users who have reported no change may be very satisfied, and others may be unsatisfied. Conversely, those who have reported a decline in scores may still be within the satisfied threshold. Over time, we will be supporting greater use of Dialog in clinical care to assess satisfaction with a range of outcomes, and also extend the ways in which we utilise Dialog data to understand whether we are making a difference to the factors that influence people's quality of life.

The Dialog chart shows that 11.8% of service users overall have reported an improvement in the past year, with 81% of service users reporting no change and 7.2% reporting a decrease. As highlighted in previous Board reports, there has been a shift towards greater concerns about employment, followed by mental health and physical health issues during the pandemic. Services have reported that this reflects the current social and economic impact caused by the pandemic on our populations, particularly as a

Experience and Outcomes

result of business closures, potential loss of the Government furlough scheme, social isolation, breakdown in family relationships, domestic violence, and general uncertainty and anxieties about the future. Services have been working closely with local authorities and other partners to address socio-economic issues, for example, collaborating with local employment agencies, drug and alcohol services, and accommodation providers to deliver care in an integrated way. Many of these services have recently restarted offering face-to-face clinics within our community teams. This will help service users engage more quickly and strengthen engagement, particularly for those who do not feel comfortable with digital solutions. A number of group interventions that were temporarily stopped during the pandemic, such as walking and physical activities clubs, have now restarted.

The Trust set up an Employment steering group 18 months ago, chaired by the medical director for London and supported by Public Health and People Participation. There is a strong representation on the group from service users. The group has developed service user led Gold Standards for all of our Individual Placement and Support (IPS) services and is developing employment and training support materials for service users. As part of our anchor organisation work, we have established five social value metrics for our contractors, one of which is to increase employment opportunities and training for service users. The recent contract for our new website will be the first to implement this social value statement.

As services have started to return to normal, more emphasis is being placed on completing lifestyle assessments and supporting service users with emerging health and wellbeing needs. The Trust has established a trust-wide Quality of Life and Outcomes steering group to oversee and monitor the implementation of Dialog and Trialog across all services, so that good clinical care is delivered consistently in an empathetic way and focused on co-production and the strengthens and capabilities of service users.

40% of service users in community perinatal teams should have two or more outcome measures (Core-10) completed, in line with national quality standards (CQUIN) for this year. Although the CQUIN has not yet commenced due to the pandemic, the services have been working to embed the use of outcomes and have exceeded the standard. Further work will be undertaken to identify key themes that are emerging and any gaps that need to be addressed by services to improve care and treatment. The services are continually monitoring the percentage of women that are seen from minority communities, which is currently stable at an average of 40% from Black, Asian and Minority Ethnic (BAME) communities. Recent evidence shows poorer outcomes for women from minority backgrounds and services are working to ensure services are accessible for all women.

The percentage of service users achieving recovery across IAPT services has been maintained during the pandemic. A similar pattern is evident in the proportion of service users achieving reliable improvement. The percentage of service users from BAME backgrounds appears to have increased recently. The number of referrals have increased sharply in February and remain higher than pre-pandemic levels.

There has been a decrease in the number of patients on the end-of-life pathway. This could be due to significant number of deaths within the community and hospital settings, so it may be that more patients on the register have died. This may also reflect the fact that some GP surgeries have not held the usual Gold Standards Framework meetings during COVID, potentially resulting in fewer patients being registered with the Palliative Care Hub. The Specialist Palliative Care Team continue to identify the surgeries who do not have these meetings, and are meeting with their practice managers to encourage them to commence, with escalation to the CCG if necessary.
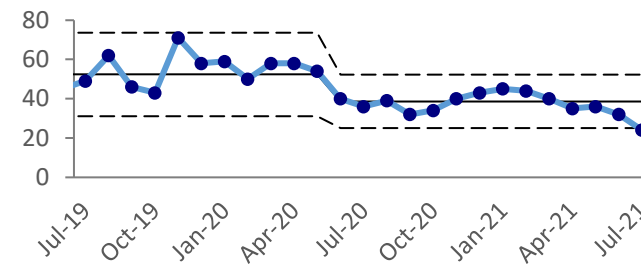
Children and Young People

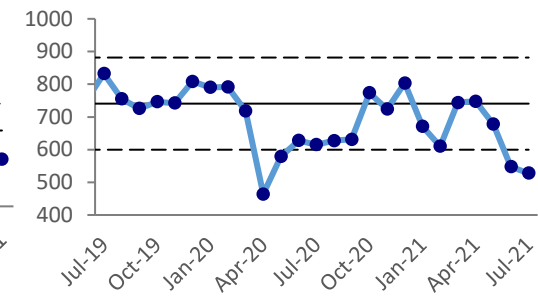**Service users presenting in crisis to our crisis pathway (I Chart)**
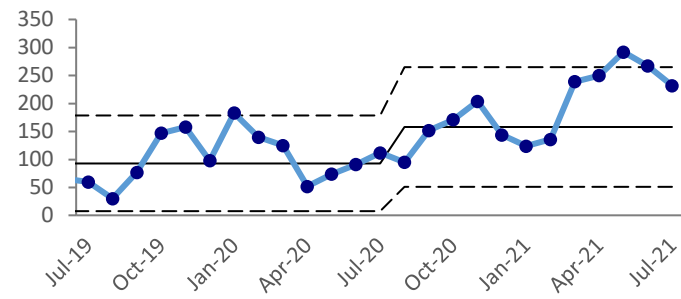
Average Assessment Waiting Time for Children and Young people aged 0-18 (I Chart)
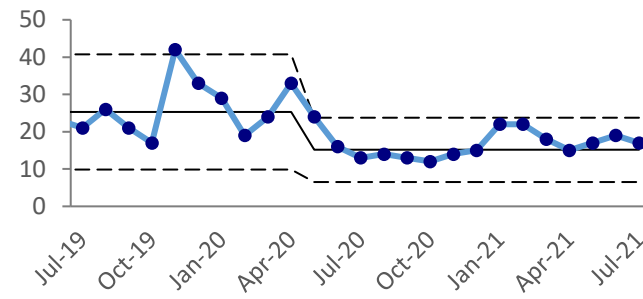
Average Treatment Waiting Time (Days) for Children and Young people aged 0-18 (I Chart)

Tier 4 Occupied Bed days East London excluding leave (I chart)

The number of presentations to crisis services and referrals to community teams remains high. Although referrals did reduce during July and August, an increase is expected when schools re-open in September. Services have also reported an increase in the levels of complexity and higher levels of risk of harm. It is believed that the rise in demand is related to the impact of school closures, lack of routine and structure, reduced access to emotional and therapeutic support, and increased stress on children and families. This is putting pressure on capacity in community services and strengthening the case for integrated system-wide working. Crisis services have expanded during the pandemic and are now operating 7 days a week from 9 am-9 pm (East London cover is 24/7 since 1 August 2021).

Further investment is planned to extend the cover and expand capacity to provide intensive community support, follow-up, and admission avoidance. It is predicted that demand for services will continue as long-term effects of the pandemic emerge, however, crisis presentations should stabilise. Linked with increased referrals is a broader system issue relating to thresholds for accessing care across community partnerships which have become tighter, particularly in City and Hackney, causing more pressures on CAMHS services. Services work closely with stakeholders, staff, and young people to ensure their needs are appropriately managed using all forms of support available within the wider system. CAMHS services have adopted the iThrive framework and QI methodology to ensure access is timely and relevant to the stage of each young person's journey.

The average assessment waiting time across the services remains stable, and there has been a further decrease in average waiting times for treatment. While this is positive, it only reflects waiting times for those that have been seen. The numbers of children and young people presenting across the urgent pathway have impacted those waiting for an assessment who are categorised as low or no risk. Services are monitoring this closely and have developed recovery plans where waiting lists and backlogs are the largest. Newham and City and Hackney have developed recovery plans to address waiting list backlogs over the next 12 months. City & Hackney is working closely with Homerton hospital to establish a Single Point of Entry (SPE) that will reduce unnecessary waits for service users. This will also enable teams to divert appropriate Tier 2 referrals back to alternative services, reducing the management of inappropriate referrals and releasing capacity. In addition, the service is planning on running a waiting list initiative to assess families on Saturdays (with 3-5 staff) to reduce assessment waiting times. Newham is involved in establishing a Multi-Agency Collaborative (MAC) program that aims to support those waiting and potentially provide a brief intervention (Mentoring, support, Groups) that may reduce the need for CAMHS input. In addition, 5 additional staff members will be recruited in the next few months to help reduce the waiting list backlog.

Children and Young People

Since February, the average waiting times for children and young people to access the Autistic Spectrum Disorder (ASD) pathway have increased. This correlates with the current recovery plan to address the assessment waiting list backlog, with those waiting the longest for an assessment being prioritised for an appointment. The Specialist Children & Young People's Service holds weekly multidisciplinary meetings to review the longest waiting and most complex cases to prioritise and put plans in place. Families waiting for assessment are made aware of a variety of available supports, including monthly online parent workshops led by occupational therapy, a helpline, and resources through the SCYPS YouTube channel. As part of the one-year recovery plan, the ASD pathway has been redesigned to provide an equitable service across all ages, ensuring that information is gathered at the point of referral to ensure that service entry criteria are met and to continue building a clinical picture of the child in liaison with education settings, before assessment. It is expected that appointments would have doubled from normal levels by the end of October. Generally, there has been an increase in referrals in Newham, which has been worsened by COVID and reduced social interactions that have adversely impacted children and young people.

Appendices

Appendix 1: System Performance dashboard - overview

People with substance misuse problems

Measure	Domain	Average	Variation
Service users reporting improvements in quality of life on discharge in Bedfordshire	Population Health	76%	
Service users in employment on discharge in Bedfordshire	Population Health	43%	
Percentage of successful completions not re-presenting to service in Bedfordshire	Quality	27%	
Waiting times to treatment - average days wait in Bedfordshire	Quality	5.3	
Percentage of service users with drug problems across Mental Health services	Quality	21.7%	
Percentage of service users with Alcohol problems across Mental Health services	Quality	4%	⬇️

Children with complex mental health needs

Measure	Domain	Average	Variation
Service users presenting in crisis to our crisis pathway (monthly)	Population Health	158.1	⬆️
Service users presenting in Children and Young People Eating Disorder pathway (monthly)	Population Health	42.9	
Average Assessment Waiting Time (days) for Children and Young people aged 0-18	Population Health	15.1	
Average Treatment Waiting Time (days) for children and young people aged 0-18	Population Health	38.6	⬇️
Carers and service users recommending our Community services	Quality	94.7%	⬇️
Children and young people aged 0-18 who have received two or more contacts (caseload)	Quality	4279.9	⬆️
Admissions to adult facilities for services users under 16 years old (monthly)	Quality	0.1	
Tier 4 Occupied Bed days East London excluding leave (in month)	Value	740.5	⬇️
Percentage of service users has paired Outcome Measures at discharge	Quality	68%	

Dementia

Measure	Domain	Average	Variation
Average wait (in weeks) from referral to diagnosis -18 week target	Quality	15.8	
Percentage of service users offered on-going post diagnostic support - 6 months after diagnosis	Population Health	95.5%	
Percentage of patients receiving diagnosis of mild cognitive impairment	Quality	10.6%	⬇️
Average waiting time (in days) from referral to assessment	Population Health	104.9	⬆️
Percentage satisfaction with service, service users and carers	Quality	91.3%	

Children with complex health needs

Measure	Domain	Average	Variation
Percentage with complex neuro disability receiving a clinical review within past 12 months	Population Health	52.4%	⬆️
Percentage of service users and parents satisfied with services – Friends and Family Test	Quality	98.4%	
Average weeks waited from Autism Spectrum Disorder referral to first appointment	Quality	43.4	⬆️
Children receiving ASD diagnosis within 2 or less appointments	Value	34.6%	

People receiving end of life care

Measure	Domain	Average	Variation
Service users on End of Life Pathway (end of month)	Population Health	1,392	⬇️
Service Users referred to Continuing Healthcare as a fast track in month in East London (monthly)	Population Health	78.9	
Percentage of service users with Care Plan in place (advanced) in East London	Quality	53.7%	⬆️
Percentage of service users with Care Plan in place (advanced) in Bedfordshire	Quality	90.4%	
Percentage of service users who died in their preferred place of death	Value	83.7%	⬇️

People who are frail or who have multiple long term conditions

Measure	Domain	Average	Variation
Percentage of service users who have recorded a positive experience	Quality	98.6%	
Average waiting time in weeks for urgent referrals to district nursing / rapid response East London	Quality	0.3	
Number of Grade 2, 3 or 4 pressure ulcers (monthly)	Quality	136.9	
Promoting independent living - discharged within 6 wks. Bedfordshire	Quality	93.8%	
Number of inappropriate referrals into Intermediate Care - Bedfordshire	Value	26%	

People with common mental health problems

Measure	Domain	Average	Variation
Percentage of service users moving into recovery	Population Health	54.6%	
Percentage access by minority groups	Population Health	33.2%	⬆️
Percentage of positive comments to PEQ	Quality	93.6%	⬇️
Average wait times to (in weeks) to assessment chart	Quality	0.7	
Average wait times to treatment (in weeks) from assessment	Quality	6.7	
Number of service users entering treatment (in month)	Value	2,475	⬆️

People with a learning disability

Measure	Domain	Average	Variation
Average waiting times for new referrals seen (in weeks) for assessment	Population Health	5.9	
Percentage of service users that would recommend this service	Quality	91.9%	
Occupied bed days used in month by service with Learning Disability (Monthly)	Quality	92	
Number of specialist out of area inpatient placements (Monthly)	Value	0.1	

People with Severe Mental Illness

Measure	Domain	Average	Variation
Percentage of SMI service users completing annual physical health checks	Population Health	8.6%	⬇️
Percentage of service users receiving Individual Placement Support – IPS	Population Health	12.4%	
Percentage of service users in employment	Population Health	6.2%	
Service users receiving NICE concordant care within 2 wks of referral (EIS services – face to face)	Population Health	68.7%	
Percentage of service users in settled accommodation	Population Health	46.8%	
Percentage of service users followed-up within 72hours of discharge	Quality	87.1%	⬇️
Percentage of Inpatient service users with paired outcome measures showing improvement.	Quality	28.3%	⬆️
Psychological Therapy Service average wait times to (in weeks) to 1st assessment in East London	Quality	6.5	
Psychological Therapy Service average wait times to (in weeks) to treatment in East London	Quality	17.5	
Number of restraints reported per occupied 1,000 bed days (monthly)	Quality	25.3	
Rate of physical violence incidents per occupied 1,000 bed days (monthly)	Quality	15.6	⬇️
Bed occupancy	Value	72.6%	⬆️

Woman who are pregnant or new mothers

Measure	Domain	Average	Variation
Number of service users seen in the month from minority communities	Population Health	41.3%	
Number of service users accessing community perinatal services per month	Population Health	191	
Percentage of community perinatal service users seen within 28 days	Quality	86.6%	
Percentage of patients undertaking Core10 showing improvement	Quality	53.7%	
Percentage of Service Users not attending their initial appointment	Value	18.2%	

Stable Long Term Conditions (East London)

Measure	Average	Variation
Average weeks waited for initial appointment with the foot health team	5.1	
Average weeks waited for face to face appointment with the Diabetes Service	3.6	⬆️
Average weeks waited for initial appointment with the MSK and Physiotherapy teams	3.5	⬆️
Average weeks waited for initial appointment with the Continence Service	17.4	
Rapid Response contacts within 2 hour guidelines	63.6%	⬆️

Stable Long Term Conditions (Bedfordshire)

Measure	Average
Percentage of referral to treatment times within 11 weeks with the Continence Service	95%
Percentage of referral to treatment times within 11 weeks with the Speech and language therapy	80%
Percentage of referral to treatment times within 11 weeks with the Wheelchair Service	61%
Percentage of referral to treatment times within 11 weeks with the podiatry team	84%
Percentage of referral to treatment times within 11 weeks with Physio	99.6%

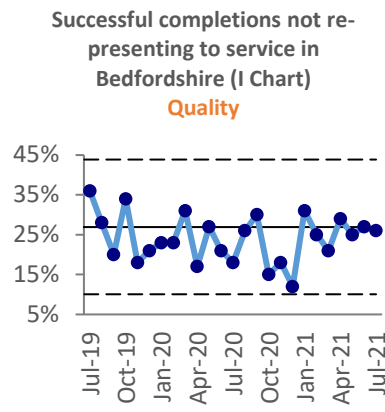# Appendix 1: System Performance dashboard

⬆️⬇️ Denotes special cause variation

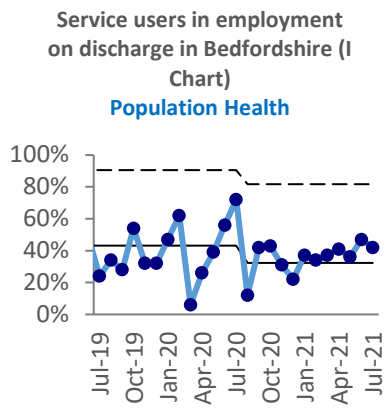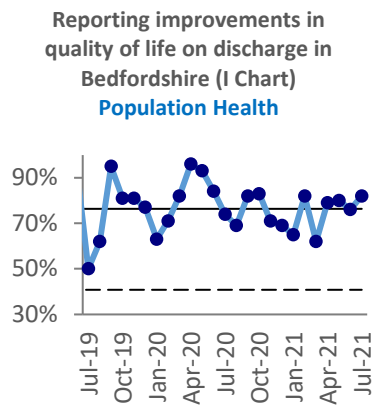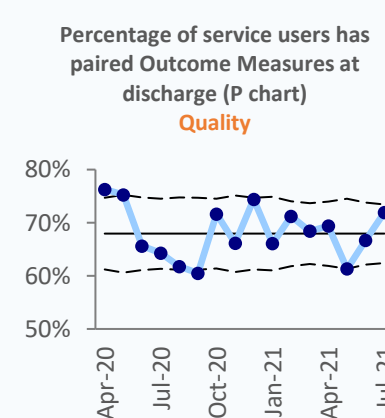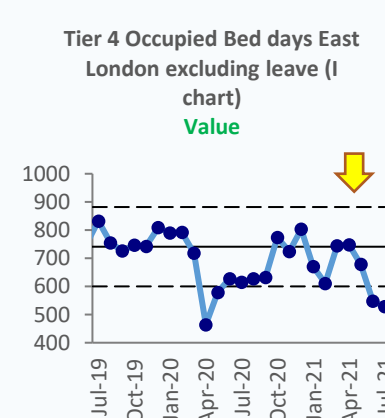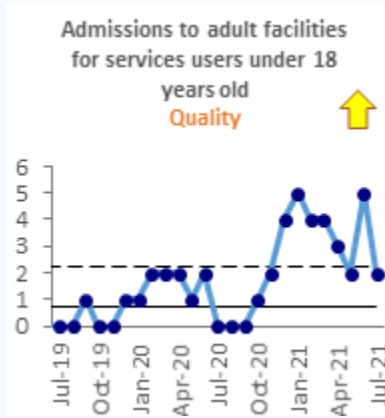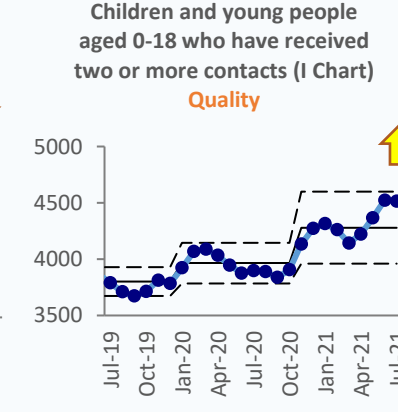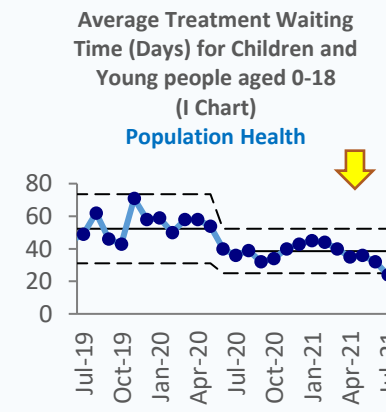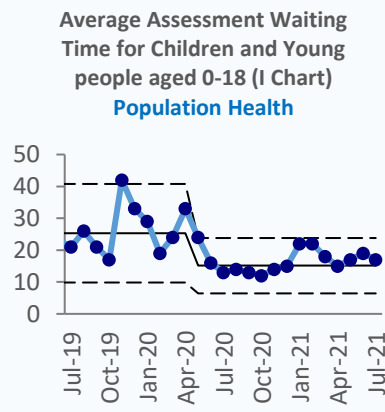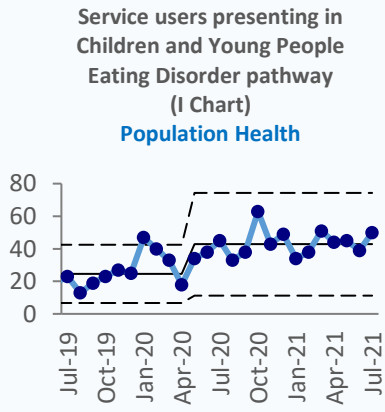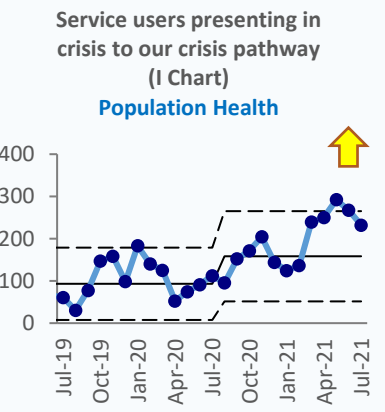## People with substance misuse problems

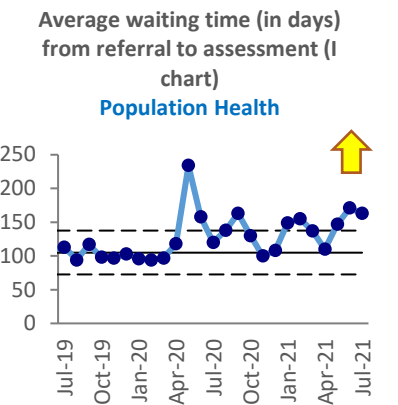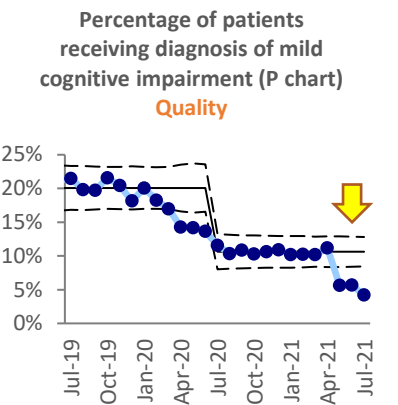**Reporting improvements in quality of life on discharge in Bedfordshire (I Chart)**
Population Health

Service users in employment on discharge in Bedfordshire (I Chart)
Population Health

Successful completions not re-presenting to service in Bedfordshire (I Chart)
Quality

Waiting times to treatment - average days wait in Bedfordshire (I Chart)
Quality

Service users with drug problems across Mental Health services (I Chart)
Quality

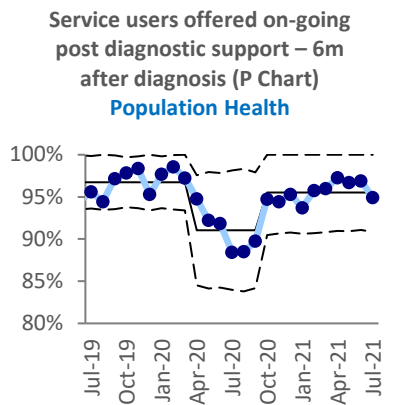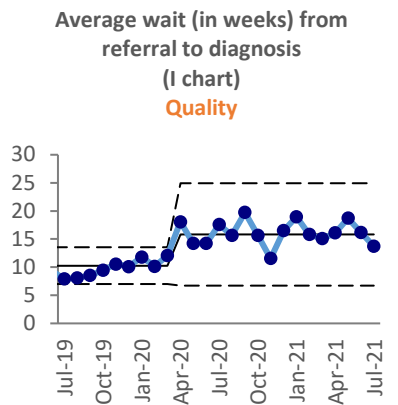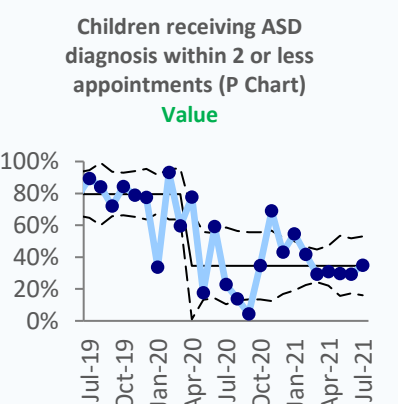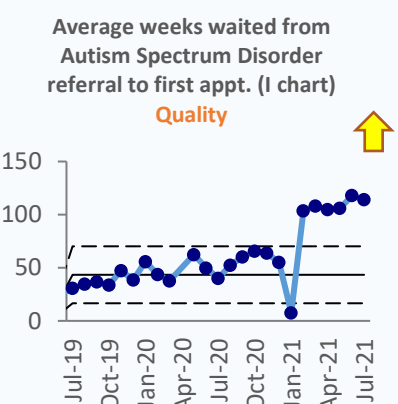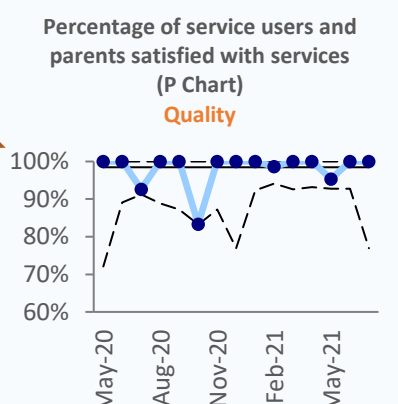**Service users with Alcohol problems across Mental Health services (I Chart)**
Quality

Children with complex mental health needs

Service users presenting in crisis to our crisis pathway (I Chart)
Population Health

Service users presenting in Children and Young People Eating Disorder pathway (I Chart)
Population Health

Average Assessment Waiting Time for Children and Young people aged 0-18 (I Chart)
Population Health

Average Treatment Waiting Time (Days) for Children and Young people aged 0-18 (I Chart)
Population Health

Carers and service users recommending our Community services (P chart)
Population Health

Children and young people aged 0-18 who have received two or more contacts (I Chart)
Quality

Admissions to adult facilities for services users under 18 years old
Quality

Tier 4 Occupied Bed days East London excluding leave (I chart)
Value

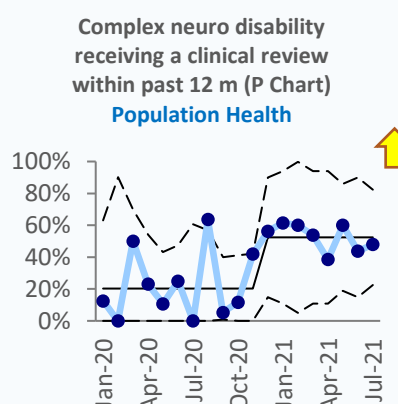**Percentage of service users has paired Outcome Measures at discharge (P chart)**
Quality

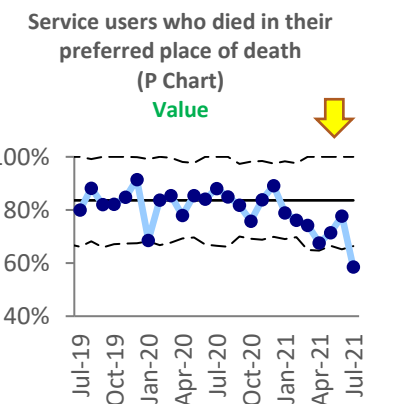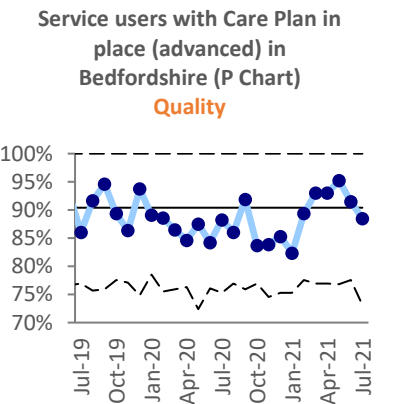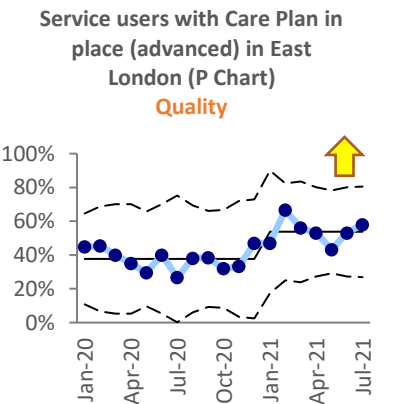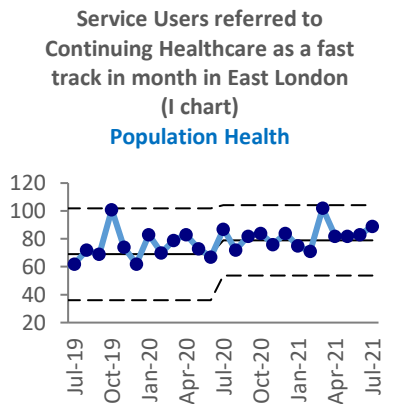# Appendix 1: System Performance dashboard

⬆️⬇️ Denotes special cause variation

People with dementia

Average wait (in weeks) from referral to diagnosis (I chart)
Quality

Service users offered on-going post diagnostic support – 6m after diagnosis (P Chart)
Population Health

Percentage of patients receiving diagnosis of mild cognitive impairment (P chart)
Quality

Average waiting time (in days) from referral to assessment (I chart)
Population Health

Percentage satisfaction with service, service users and carers (I chart)
Quality

Children with complex health needs

Complex neuro disability receiving a clinical review within past 12 m (P Chart)
Population Health

Percentage of service users and parents satisfied with services (P Chart)
Quality

Average weeks waited from Autism Spectrum Disorder referral to first appt. (I chart)
Quality

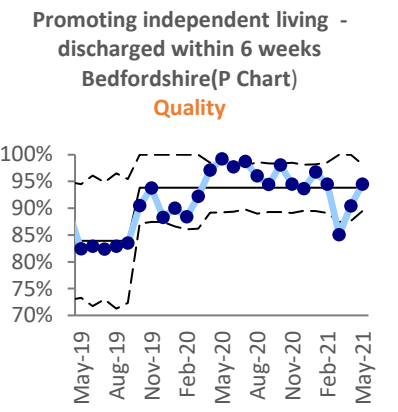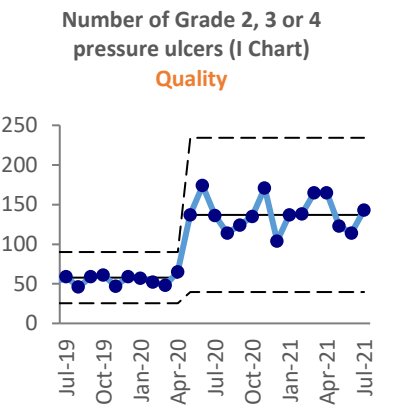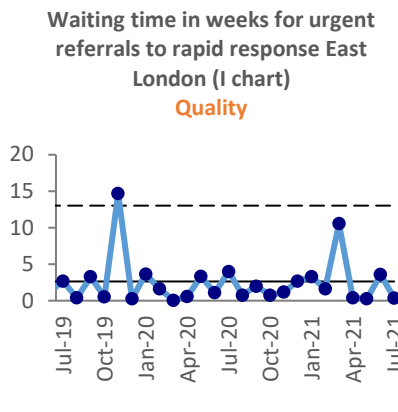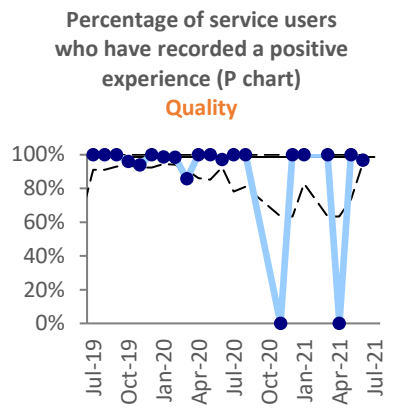**Children receiving ASD diagnosis within 2 or less appointments (P Chart)**
Value

People receiving end of life care

Service users on End of Life Pathway (I chart)
Population Health

Service Users referred to Continuing Healthcare as a fast track in month in East London (I chart)
Population Health

Service users with Care Plan in place (advanced) in East London (P Chart)
Quality

Service users with Care Plan in place (advanced) in Bedfordshire (P Chart)
Quality

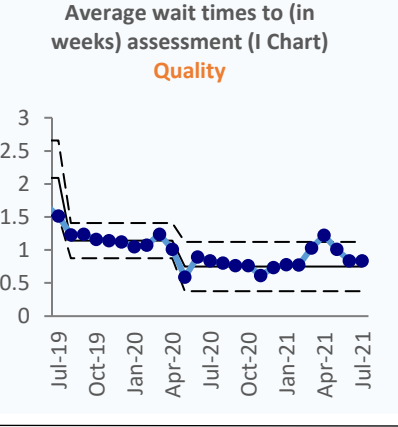**Service users who died in their preferred place of death (P Chart)**
Value

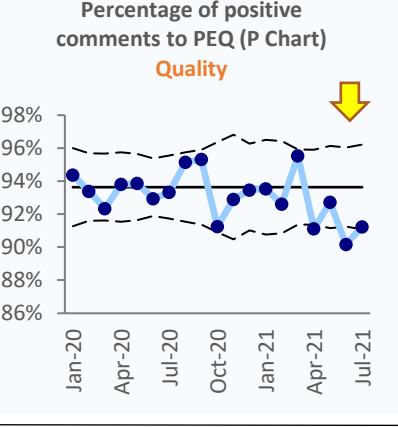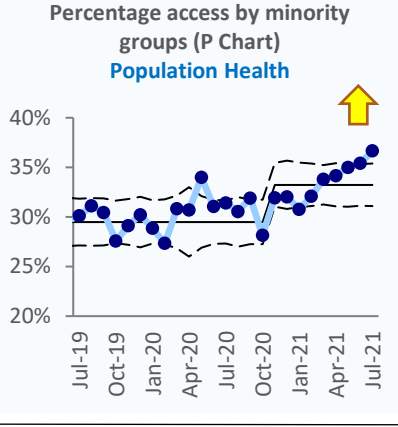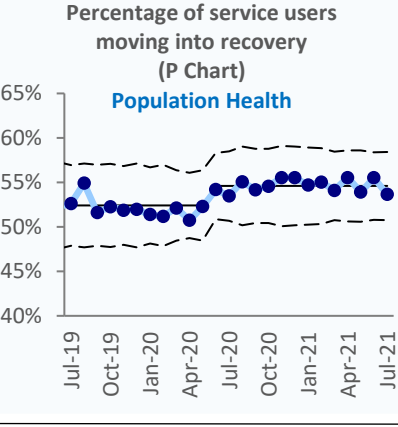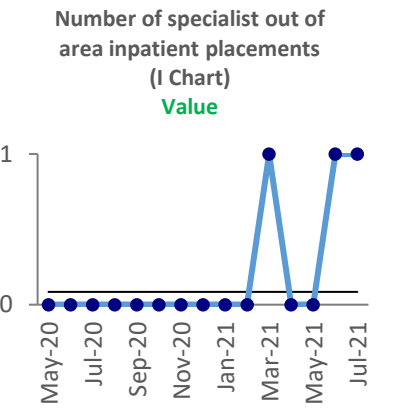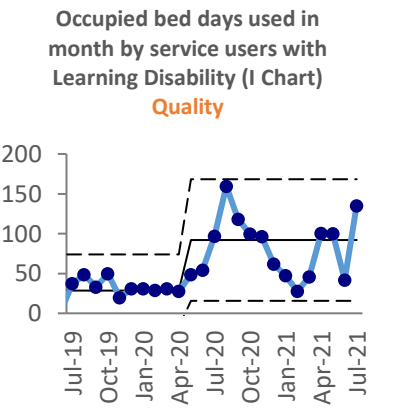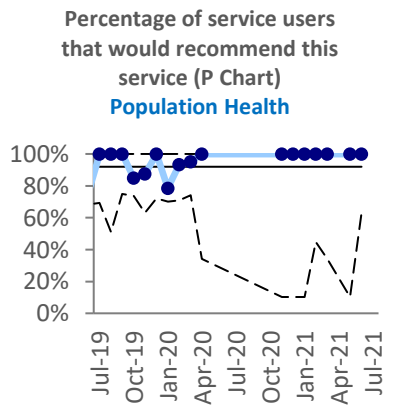# Appendix 1: System Performance dashboard

⬆️⬇️ Denotes special cause variation

People who are frail or have long term conditions

Percentage of service users who have recorded a positive experience (P chart)
Quality

Waiting time in weeks for urgent referrals to rapid response East London (I chart)
Quality

Number of Grade 2, 3 or 4 pressure ulcers (I Chart)
Quality

Promoting independent living - discharged within 6 weeks Bedfordshire(P Chart)
Quality

Number of inappropriate referrals into Intermediate Care - Bedfordshire (P Chart)
Value

People with common mental health problems

Percentage of service users moving into recovery (P Chart)
Population Health

Percentage access by minority groups (P Chart)
Population Health ⬆️

Percentage of positive comments to PEQ (P Chart)
Quality ⬇️

Average wait times to (in weeks) assessment (I Chart)
Quality

Average wait times to treatment (in weeks) from assessment (I Chart)
Quality

Number of service users entering treatment (I Chart)
Value ⬆️

People with a learning disability

Average waiting times for new referrals seen (in weeks) for assessment (I chart)
Population Health

Percentage of service users that would recommend this service (P Chart)
Population Health

Occupied bed days used in month by service users with Learning Disability (I Chart)
Quality

Number of specialist out of area inpatient placements (I Chart)
Value

Appendix 1: System Performance dashboard
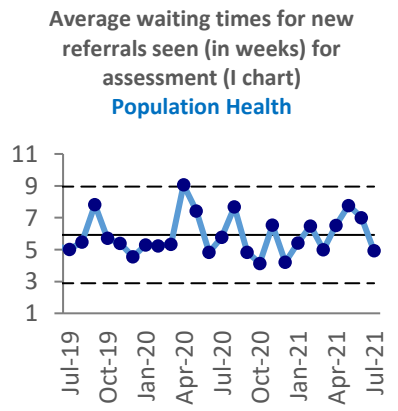
⬆️⬇️ Denotes special cause variation

People with Severe Mental Illness

Percentage of service users receiving Individual Placement Support (P chart)
Population Health

Percentage of service users in employment (P chart)
Population Health

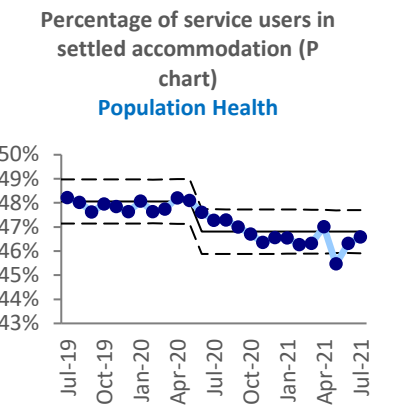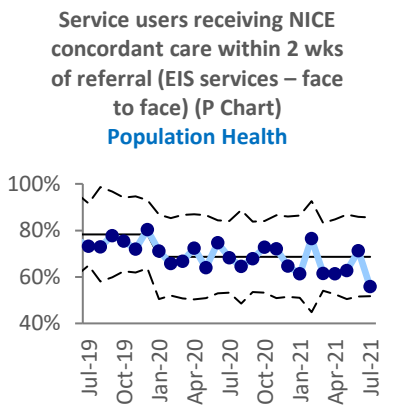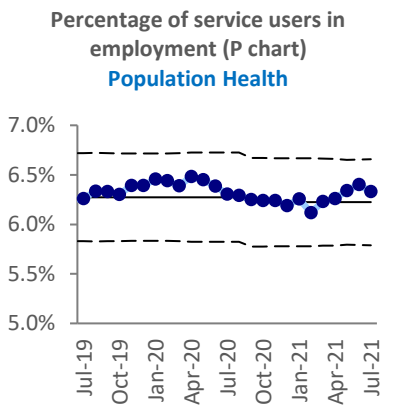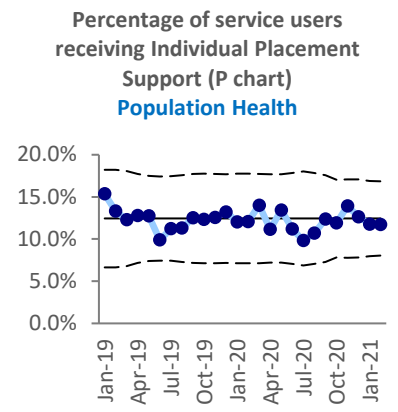**Service users receiving NICE concordant care within 2 wks of referral (EIS services – face to face) (P Chart)**
Population Health

Percentage of service users in settled accommodation (P chart)
Population Health

Percentage of service users followed-up within 72hours of discharge (p chart)
Quality

Inpatients with paired outcome measures showing improvement (P Chart)
Quality

PTS average wait times to (in weeks) to 1st assessment in East London (I chart)
Quality

PTS average wait times to (in weeks) to treatment in East London (I chart)
Quality

Rate of physical violence incidents per occupied 1,000 bed days (P Chart)
Quality

Number of restraints reported per 1,000 occupied bed days (P Chart)
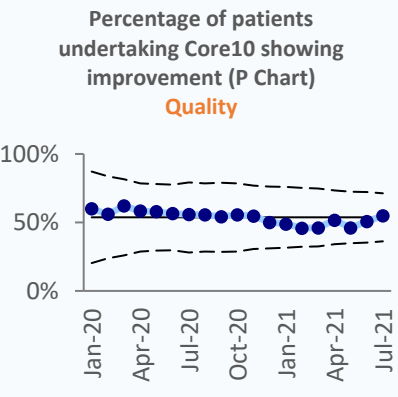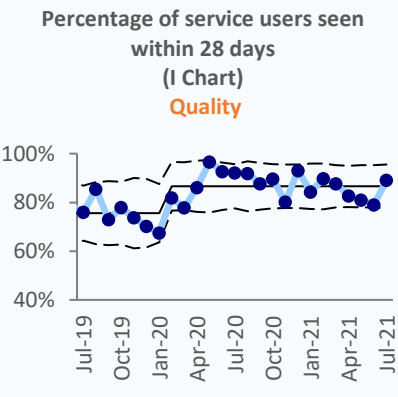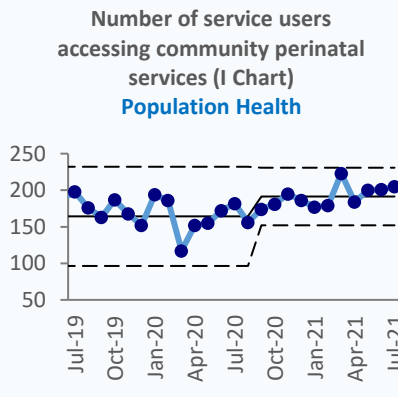Quality

Bed occupancy (P' Chart)
Value

Woman who are pregnant or new mothers

Service users seen in the month from minority communities (P Chart)
Population Health

Number of service users accessing community perinatal services (I Chart)
Population Health

Percentage of service users seen within 28 days (I Chart)
Quality

Percentage of patients undertaking Core10 showing improvement (P Chart)
Quality

Percentage of Service Users not attending their initial appointment (P Chart)
Quality

Appendix 1: System Performance dashboard

People with stable long term conditions (East London)

Average weeks waited for initial appointment with the foot health team (I Chart)

Average weeks waited for face to face appointment with the Diabetes Service (I chart)

Average weeks waited for initial appointment with the MSK and Physiotherapy teams (I chart)

Average weeks waited for initial appointment with the Continence Service (I Chart)

Rapid Response seen within 2 hour guideline (I Chart)

People with stable long term conditions (Bedfordshire)

Referral to treatment times within 11 weeks with the Continence Service (I chart)

Referral to treatment times within 11 weeks Speech and language therapy (I chart)

Referral to treatment times within 11 weeks Wheelchair Service (I chart)

Referral to treatment times within 11 weeks with the podiatry team (I chart)

Percentage of referral to treatment times within 11 weeks with Physio (I chart)

Appendix 2: Regulatory Compliance – System Oversight Framework (SOF)

NHS England and NHS Improvement have published a new approach to NHS System Oversight in June 2021 to align with the vision set out for Integrated Care Systems. The table below provides a summary of the new indicators relevant to the Trust and current status. Some of the measures remain undefined so will be clarified over time. There are currently no areas of concern to bring to the Board's attention.

No.	SOF Oversight Theme	Responsible Services	Measure	Comments
1	Quality, access and outcomes	Mental Health	NHS Long Term Plan metrics for mental health which include access measures for CYP, Perinatal, IAPT, EIS, Employment support, physical health checks, crisis and acute care, liaison services, criminal Justice and Adult inpatients	Key national Mental Health LTP metrics have been included in relevant population measures. There are a few areas that are in development and will be included in future reports.
2	Quality, access and outcomes	Community Services	2-hour urgent response activity	No concern
3	Quality, access and outcomes	Community Services	Discharges by 5pm	Further guidance is being sought to clarify the scope of this measure and how it should be reported.
4	Quality, access and outcomes	Primary Care Services	Access to general practice – number of available appointments and proportion of the population with access to online GP consultations	No concern
6	Quality, access and outcomes	Primary Care Services	Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	Further guidance is being sought to clarify the scope of this measure and how it should be reported.
7	Preventing ill health and reducing inequalities	Primary Care Services	National public health indicators including monitoring of vaccinations, cervical screening, diabetes, cardiac high risk conditions, and weight management, Learning disability physical health checks	No concern
8	Quality, access and outcomes	Corporate Services	CQC rating, hospital level mortality indicator, Potential under-reporting of patient safety incidents, National Patient Safety Alerts not completed by deadline, MRSA, Clostridium difficile infection, E. coli bloodstream infections, VTE risk assessments	No concern
9	People	Corporate Services	Quality of leadership, staff survey perceptions of leadership & career progression, people promise, health and wellbeing, bullying and harassment experience, flexible working opportunities, staff retention and sickness, flu vaccination uptake, proportion of female senior leaders and from BAME backgrounds, and ethnicity coding.	Data with regard to people is now contained within the people report. The measures related to people for the SOF are not yet clear, and the intention will be to include these in the people report once this is possible.
10	Finance	Corporate Services	New indicators include underlying financial position, run rate expenditure, and overall trend in reported financial position	Further guidance is being sought to clarify the scope of these measures and how they should be reported. Data and assurance related to financial performance is now included in the separate finance report.