Integrated Performance Report

July 2021

East London NHS Foundation Trust

Report to the Trust Board – Executive Summary 22 July 2021

Purpose of the Report: To provide assurance to the Board on overall performance of the organisation, including financial performance, in delivery of the Trust strategy.

Title	Integrated Performance report
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Accountable executive directors	Dr Amar Shah, Chief Quality Officer Steven Course, Chief Finance Officer

Summary of key issues

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

Waiting times for CAMHS and most mental health services remain stable, and community health services have continued to maintain responsive district nursing and rapid response services. Access to psychological therapy services and talking therapies continues to remain stable and waiting times remain below pre-COVID levels. Whilst average waiting times remain low for many services, this measure is based on the wait for those who have been seen. Many services have developed a backlog during the pandemic due to the closure of some services or prioritising urgent referrals. The quality report contains a deeper dive into the processes in place across different service types to understand and manage the waits for assessment and treatment. The quality improvement section of the quality report outlines how many of these services are utilising QI to support them to improve flow, with the results that can be achieved through this approach. All services with longer waits and backlogs are completing a standardised backlog recovery plan, which is monitored through our internal performance management system. Many of our teams are working with system partners in developing plans to manage increased demand, for example our CAMHS crisis service and eating disorder pathway. Quality assurance committee discussed the topic of waits and backlogs in June 2021, and will be receiving a three-monthly update on progress.

Most services have reported a high level of satisfaction through our Patient-reported Experience Measures (PREM). The number of service users successfully contacted within 72 hours of discharge from an inpatient setting continues to remain high, and above the national target.

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

We have seen an increase in safety issues, such as community-acquired pressure ulcers, violence and restraint within inpatient settings. There is a comprehensive plan around pressure ulcers which will be coming to the quality assurance committee in September. This includes pressure ulcer facilitators working alongside clinical teams to build increased vigilance, awareness and reporting interventions; training using virtual platforms (including for temporary staff); two-weekly pressure ulcer meetings in London and Bedfordshire community nursing teams supported by the tissue viability service; benchmarking exercise with community services in Cambridgeshire and an inner city community Trust; and a collaborative QI project with Barts Health which will restart in August following a delay due to the pandemic.

Summary of key issues (continued)

All services are working on the factors that are related to the increase in conflict within our inpatient mental health services, including staffing and restrictions that are in place to limit infection risk. All inpatient units have Time to Think structures, which are part of our quality control system around inpatient safety issues such as violence and restraint. This structures bring together staff and service users to understand the factors related to incidents of violence and restraint, and develop change ideas that we can then test using quality improvement. The work on violence and restraint reduction will be presented to quality assurance committee in September as part of a deeper dive.

Are there any other important issues to highlight?

Services continue to highlight challenges with recruitment and some services have no option but to employ agency staff to fill roles on a temporary basis while they attempt to recruit to permanent vacancies.

In terms of financial performance, the operating surplus (EBITDA) to the end of May 2021 is £1,787k compared to a planned operating surplus of £2,935k. The net position amounts to deficit of £1,148k (-1.3%) compared to a planned net deficit of zero (0.1%) before accounting adjustments. The year-to-date net deficit is worse than planned, by £1,148k. The cash balance of £122.8m as of the end of 31st May 2021.

Executive Summary

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

Improved patient experience	☒	
Improved health of the communities we serve	☒	
Improved staff experience	☒	
Improved value for money	☒	

Committees/meetings where this item has been considered

Date	Committee and assurance coverage
Various	Various sections of this report are submitted to the Service Delivery Board, Finance Business and Investment Committee and other Trust committees. 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 and population health task and finish group.
Risk and Assurance	This report and supporting appendices cover performance for the period to the end of May 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

This report provides assurance to the Trust Board on organisational performance, finance and delivery of our strategy. It seeks to demonstrate how the Trust is improving the quality of life for all we serve. The image below illustrates the structure for this report.

1

Are we impacting on outcomes for the populations that we serve?

The paper is organised around the key populations that we serve. For each population, there is a summary of key measures (**population health**, **quality**, **value**) for us to track consistently over time. These measures include national indicators related to Long Term plan delivery

2

What does the data tell us?

This provides the Board with narrative related to the key measures for each population, particularly focused on areas where we are seeing change (improvement, deterioration or instability)

3

What are the key projects that we are undertaking to improve outcomes for each population?

This provides the Board with a summary of progress against key projects within our annual plan that aim to improve outcomes for the population

4

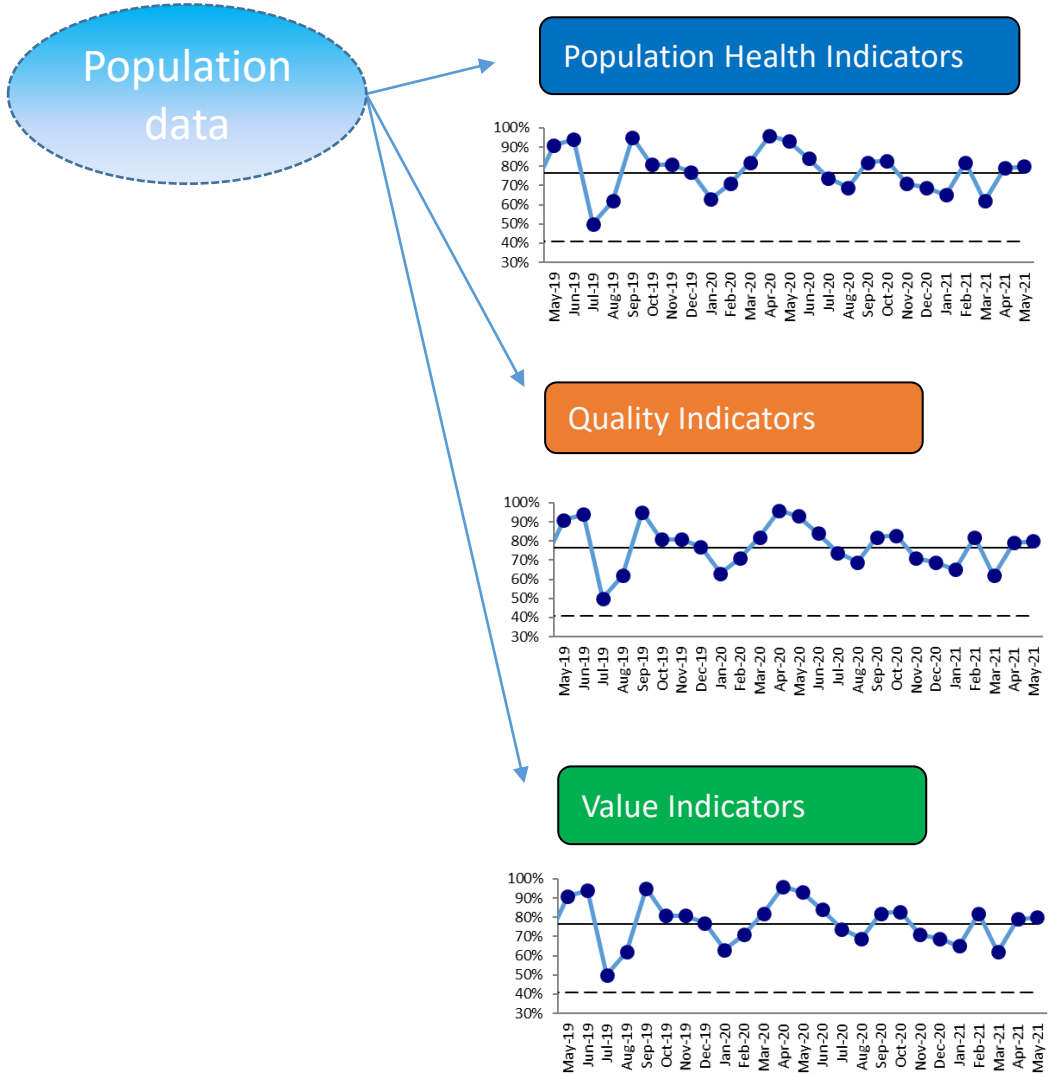
How is the Trust performing in terms of finances?

This provides the Board with assurance on financial performance

5

What is our performance against the 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



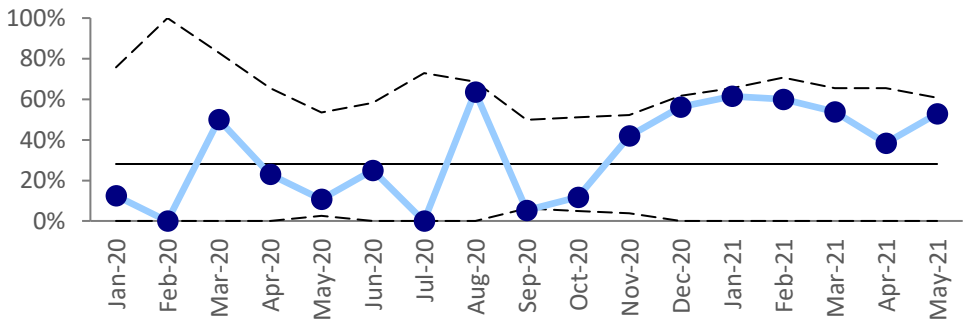
The main populations that we serve

Slides	Population
7-10	Children with complex health needs
11-14	Children with complex mental health needs
15-17	People receiving end of life care
18-23	People who are frail or who have multiple long term conditions
24-26	People with a learning disability
27-30	People with common mental health problems
31-33	People with dementia
34-38	People with serious mental illness
39-41	People with substance misuse problems
42-44	Women who are pregnant or new mothers
45-49	People with stable long term conditions
50-52	Finance
53	System Oversight framework

Children with complex health needs

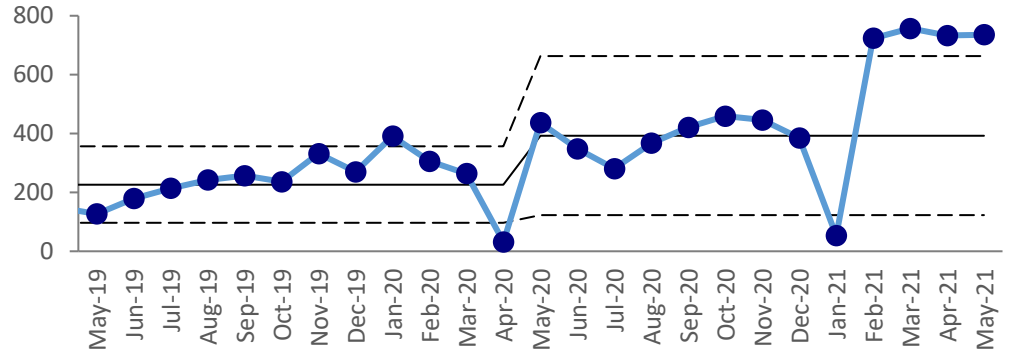
Percentage of Children and Young People with complex neuro disability receiving a clinical review within past 12 months (p chart)

Population Health



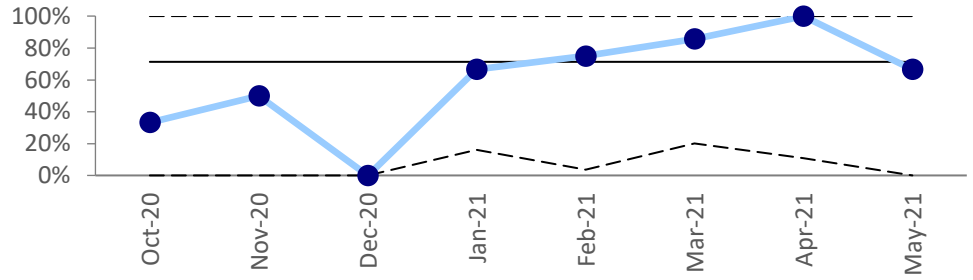
Average days waited from ASD referral to first appointment (I chart)

Quality



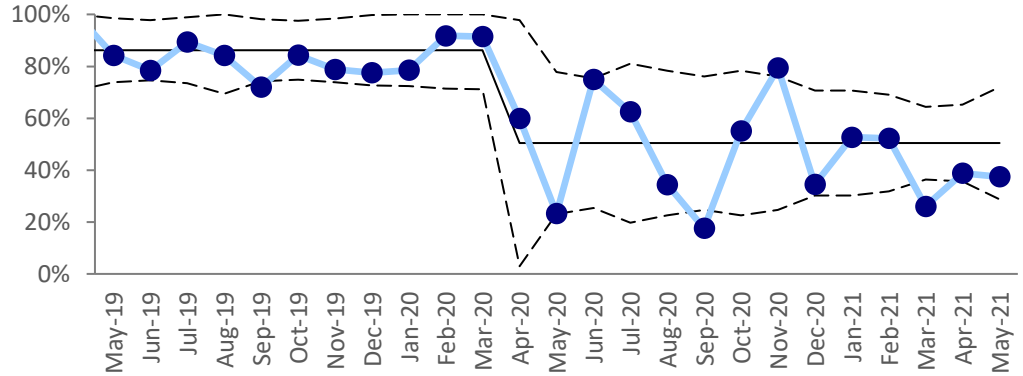
Percentage of unaccompanied asylum seekers receiving the integrated health and mental health assessment in the month (p chart)

Population Health



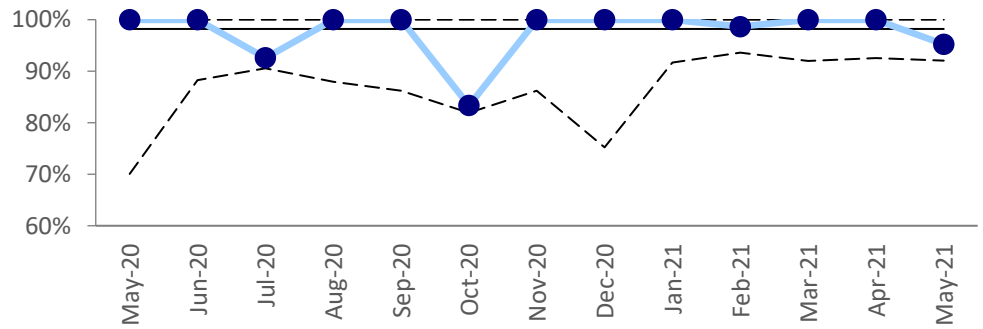
Percentage of children receiving ASD diagnosis within 2 or less appointments (p chart)

Value



Percentage of service users and parents satisfied with services – Friends and Family Test (p chart)

Quality



Children with complex health needs - Comments

What does the data tell us?

The indicators for this population focuses on children and young people with disabilities and complex healthcare needs within the London Borough of Newham.

Our population health indicators highlight that 53% of children with neuro-disabilities received a clinical review within 12 months in May, which is relatively stable over the last 6 months, and an improved performance from 2020. A consultant-led team is now in place and pathway reviews are commencing in the team to improve flow and access to services, starting initially with the autism spectrum disorder (ASD) pathway. Statutory services such as Looked After Children, Education Health Care Plans and safeguarding appointments need to be prioritised, which impacts on capacity for other work.

The percentage of unaccompanied asylum seekers receiving an integrated mental health assessment demonstrates is currently at 67%. Work to support this population is based on a research project designed to improve access for vulnerable service users. Funding has been agreed to extend the Mental Health Practitioner role until the end of the financial year. There are also discussions with CCG's as to whether this could be extended across North East London due to the benefits it provides this vulnerable group.

Our quality indicators highlight that on average 95.2% of parents and service users are satisfied by the Newham Specialist Children and Young People's Services which provide a range of community health and mental health services in the borough. Most services have reported receiving positive feedback via our Patient Reported Experience Measures and also compliments.

The average waiting times for children and young people with ASD to access services have significantly increased above normal levels since February. This correlates with work on addressing the backlog for assessment, as the service has now commenced a 1-year backlog recovery plan, with those waiting the longest being prioritised for assessment. Therefore, the data from February demonstrates that the average waiting times for those seen for assessment in the month, was significantly longer than normal. As part of the recovery plan, the service has commenced a redesign of the ASD clinical pathway to provide an equitable service across all ages, and has received additional investment which has enabled the recruitment of four new clinicians and two administrators. There has been an increase in referrals in Newham which has been worsened by COVID, suspension of face-to-face contact, and reduced social interactions that have adversely impacted children with ASD.

Our value indicator highlights that only 38% of children and young people were diagnosed within two appointments. This links to the above narrative about the backlog plan to prioritise the cases waiting longest, many of which have already had more than two appointments. The service anticipates this to rise to pre-COVID levels once the recovery plan has been delivered.

Children with complex health needs - Projects

Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people. A brief description of each project is provided along with a progress update.

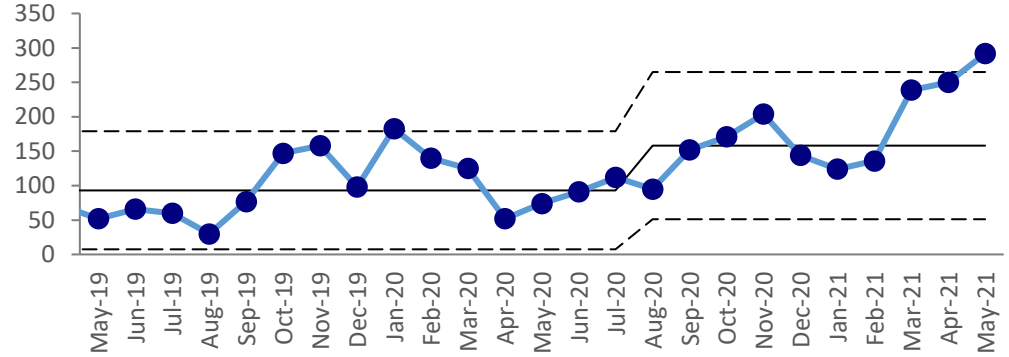
Project	How will this impact on outcomes, experience and/or value	Progress Update
Autism spectrum disorder (ASD) assessments – improving care and waiting time	Bringing our care in line with National Institute for Health and Care Excellence (NICE) guidance for Autism assessments via service redesign. Stage 2 integration with Child and Adolescent Mental Health Services (CAMHS) neurodevelopment team for seamless service provision and improved experience of care	Multidisciplinary Team established, funding agreed, recruitment in progress, streamlining of processes in progress
Specialist Children & Young People's Services (SCYPS) Special educational needs and disabilities (SEND) Plan	Plan to ensure compliance with statutory reforms - quantify Education and Health Care Plan (EHCP) assessment need across all teams	SCYPS special needs Board established, working group with clinical Commissioning Group (CCG) and Local Authority (LA) commencing. A data review is underway to identify gaps and develop appropriate plans.
Quality assure the Dietetic service and identify issues/risks/areas for improvement	Improve outcomes for children with dietetic needs by benchmarking current provision against other localities	External review completed which identified the need for additional capacity to support home enteral tube feeding for children. Additional staff recruited, and liaising with CCG for funding.
Transition pathways	Improve outcomes and transition experiences for children with complex needs/learning disability and Children & Young People (CYP) with long term conditions (LTC) managed within the acute setting	Roald Dahl charity nurse recently in post, Transitions working group up and running again to help support service users with complex needs.
Develop Single Point of Access (SPOA) referral system	Improved information at the point of referral and improved multidisciplinary team triage will improve experience for referrers and patients	The service is in the early design stage of reorganising resources and planning changes needed
SCYPS service user involvement plan	Develop an active and innovative people participation plan which aims to improve service user involvement and overall experience of care	People Participation Lead recruited and is in the process of meeting with teams and service users to develop plan
Establish Specialist School Nursing Service	To integrate nursing care within specialist school setting for improved health outcomes	Agency nurses have scoped the service and the full service proposal is now being finalised. We are expecting confirmation of funding imminently and will then move towards substantive recruitment ready for implementation in the first term of 21-22 academic year.

Children with complex health needs - Projects

Project	How will this impact on outcomes, experience and/or value	Progress Update
Research Strategy	Improve overall population health outcomes for children with complex health needs by embedding research in all areas of SCYPS and build on the evidence base for care	A survey has been completed to gain information about the experience and needs for our service users to inform the research priorities
Develop joined-up therapy care plans for children with complex needs	Improved communication and coordinated services within integrated care plans will improve outcomes and experience for service users	An initial planning meeting has taken place for a multidisciplinary pathway within therapies. This identified the need to link with Paediatrics as the next step.
Patient reported outcome measures (PROMS)	Implement PROMS across all services – measuring and monitoring outcomes leads to improvements in outcomes and overall care	Scoping of different PROMS used across services is underway, goal-based outcomes presented at clinical governance meeting

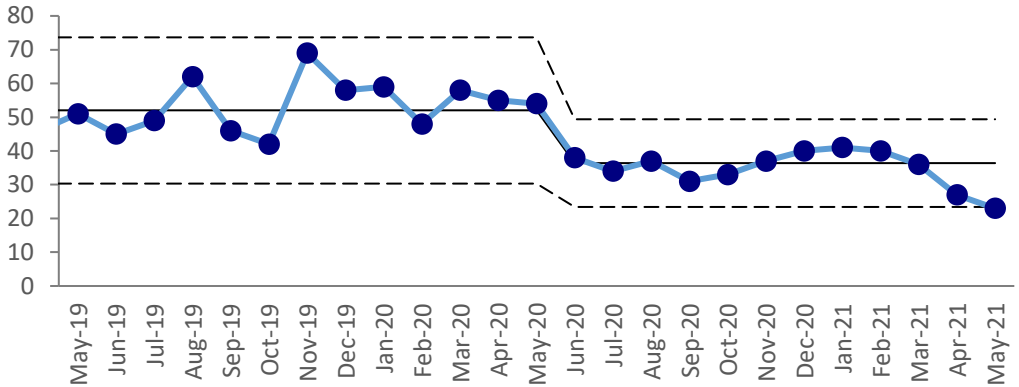
Children with complex mental health needs

Number of service users presenting in crisis to our crisis pathway (I chart)



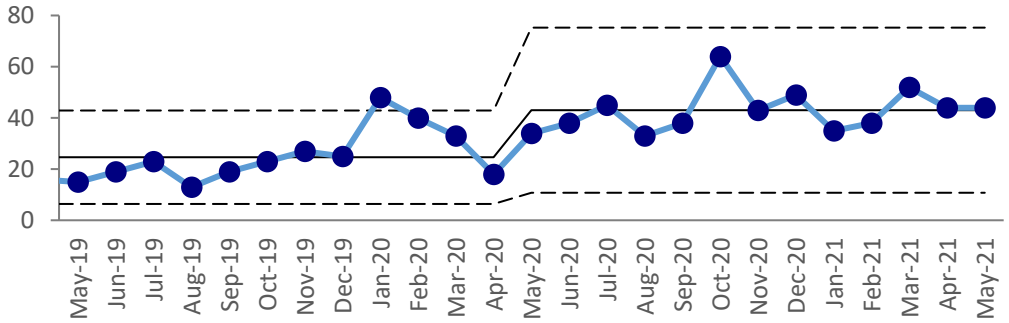
Population Health

Average Treatment Waiting Time for children and young people aged 0-18 (I chart)



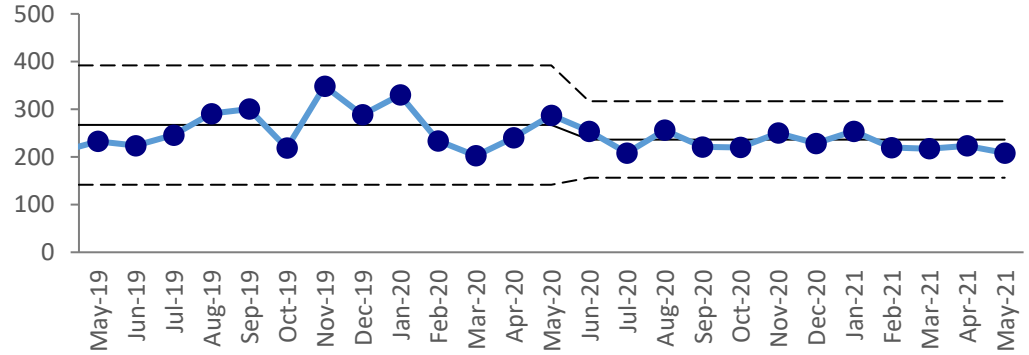
Quality

Number of service users presenting in the Children and Young People Eating Disorder pathway (I chart)



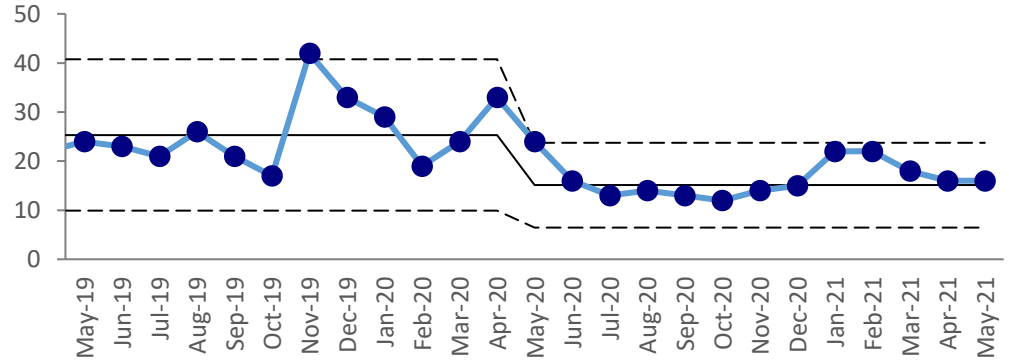
Population Health

Average length of time in treatment at point of discharge (in days) (I chart)



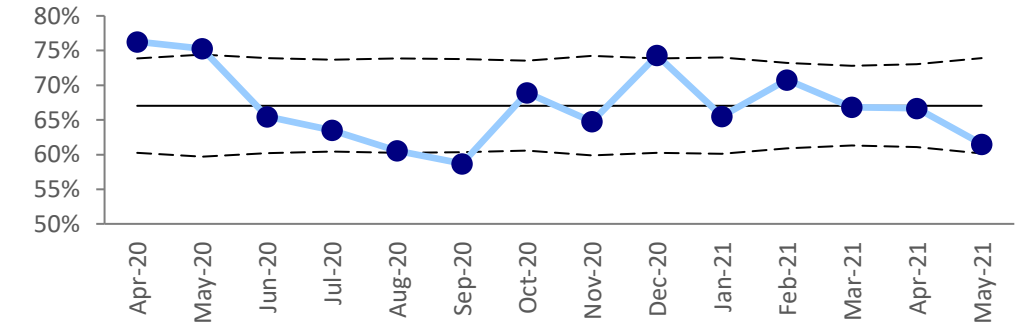
Quality

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



Quality

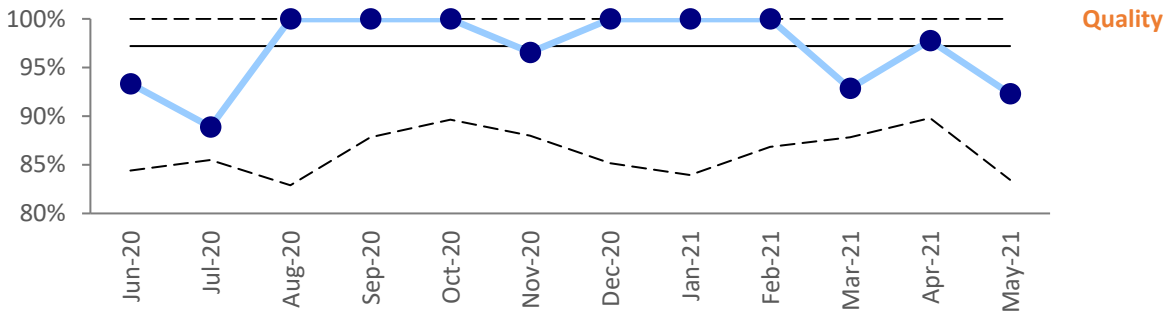
Percentage of service users with paired Outcome Measures at discharge (P chart)



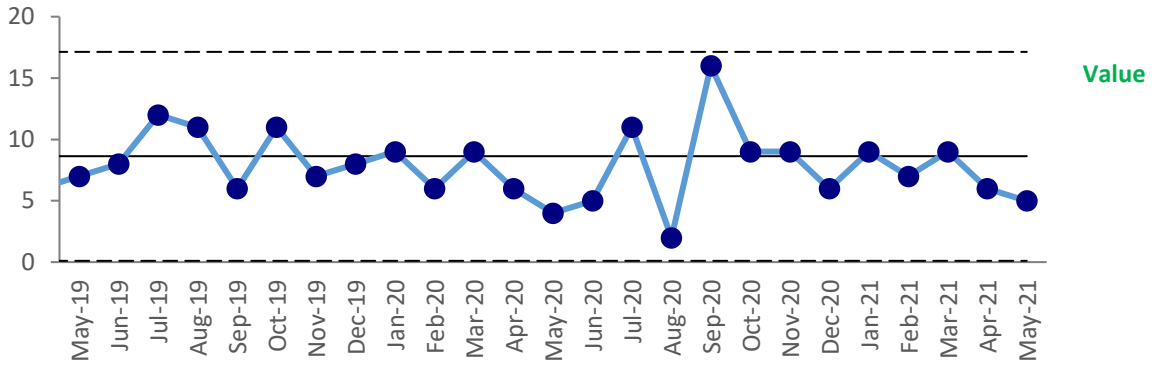
Population Health

Children with complex mental health needs

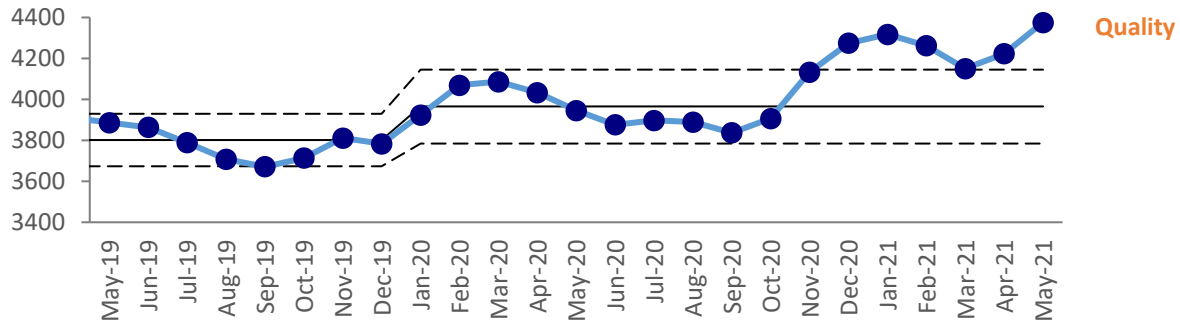
Percentage of carers and service users recommending our Community services (P chart)



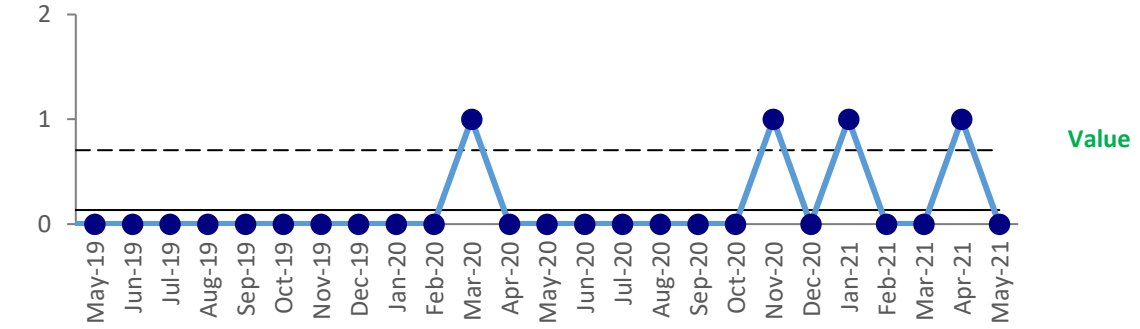
Number of service users admitted into Tier 4 (Inpatient) East London(I chart)



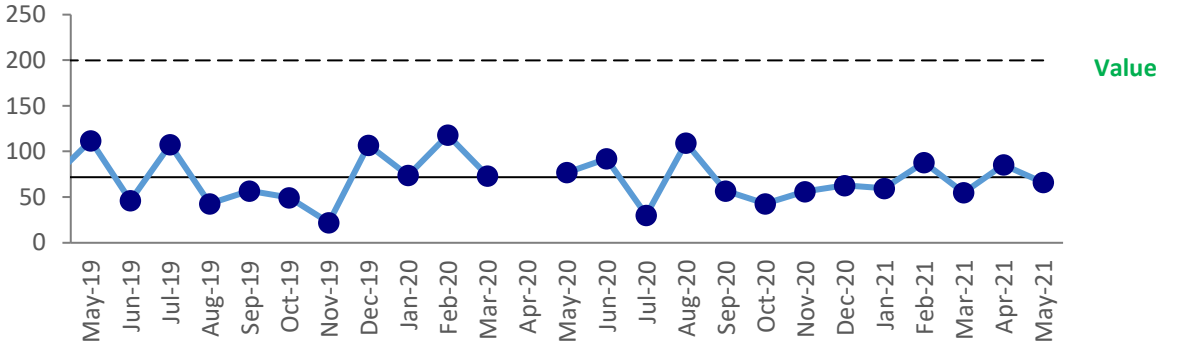
Total number of individual children and young people aged 0-18 accessing community CAMHS (two or more contacts in the past year) (I chart)



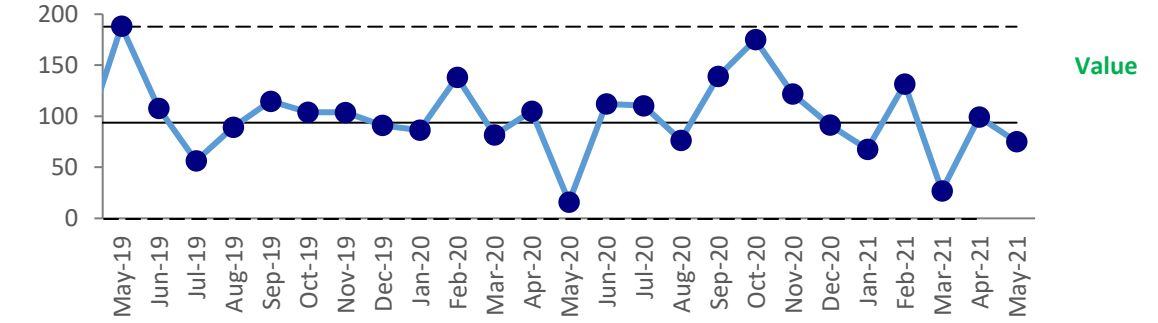
Admissions to adult facilities of service users under 16 years old (I Chart)



Average length of stay in Tier 4 (Inpatient PICU) East London (I chart)



Average length of stay in Tier 4 (Inpatient Acute) East London (I chart)



Children with complex mental health needs

What does the data tell us?

The indicators for this population focus on Children and Young People (CYP) with emotional, behavioural, and mental health difficulties across East London, Bedfordshire and Luton.

Our population health indicators highlight an increase in crisis presentations since 2019, and this has continued into 2021 due to the effects of the pandemic. This reflects a 35% increase in crisis presentations across East London, 79% in Bedfordshire, and 176% in Luton. The number of referrals has increased, as has the level of acuity and complexity. This experience is consistent with national trends. Crisis services have expanded during the pandemic, and are now operating 7 days a week from 9am-9pm. Further investment is planned to extend cover and expand capacity to provide intensive community support, follow up and admission avoidance.

Referrals to Eating Disorder services have also risen during this period with Bedfordshire increasing by 157%, Luton by 137%, and East London by 65%. Business cases have been developed for the expansion of Eating Disorder services to meet this demand. CAMHS referrals have also increased, particularly in City & Hackney, Bedfordshire and Luton. However, CAMHS waiting times for assessment and treatment are shorter than pre-pandemic. This is due to the changes services have made to maintain access through remote working and shifting to a virtual delivery model where possible. It is believed that the increase in demand is related 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 real pressures on capacity in community services and strengthening the case for integrated system wide working. For example, services are working with Homerton Hospital to develop a Single Point of Access for CAMHS services and the voluntary sector to utilise resources efficiently and adopting an integrated, person-centred approach (utilising the Thrive model) to direct young people to the most appropriate service. This is already in place in Bedfordshire and developing in Luton. Similarly, pressures on A&E and acute paediatric services are requiring services to work within each local area to improve crisis pathways, admission avoidance, joint working with children's social care to support young people in crisis in the most appropriate environment, whether that is in their home, social care placement, paediatric or CAMHS inpatient bed. It is predicted that demand for services will continue as long-term effects of the pandemic emerge, however crisis presentations should stabilise.

Our quality indicators highlight that satisfaction levels remain stable, with 97.2% recommending our services. Our value indicators highlight that admissions to Tier 4 beds and the average length of stay for general acute and PICU beds have remained broadly stable. However, the number of admissions of children and young people into adult inpatient wards, although low, has increased in frequency over the past few months. This reflects the wider system pressures across all community and inpatient pathways. Admissions to adult wards are avoided wherever possible and the CAMHS and adult teams work closely to support young people in the best way possible whilst working to transfer to a more appropriate setting or facilitate discharge to the community.

Children with complex mental health needs - Projects

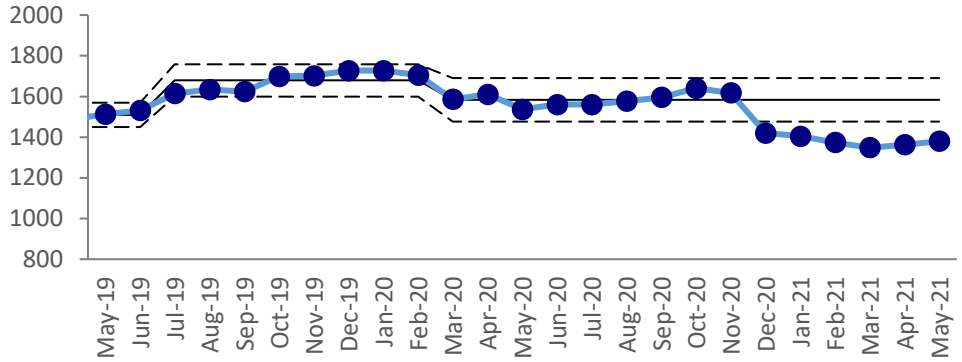
Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people. A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
Improving access to Crisis and Eating Disorder	Increasing capacity and developing crisis services towards national ambition for 24/7 all age crisis services, establishing efficient crisis pathways as per national commissioning standards to be more response to increasing demand Developing eating disorder services in line with NHS Long Term Plan and local priorities to improve access and experience for service users.	Crisis services expanded during Covid in Bedfordshire and East London – expanding hours to 7/7, 9am-9 pm. Further investment is planned to extend cover and expand capacity to provide intensive community support and follow up and admission avoidance. Business cases have been developed for the expansion of Eating Disorder service to meet referral pressures.
Integrated Care with Local Authority	Strengthening existing partnership working and removing silo working, strengthening single point of access and collaborative working within place-based system. Services are also developing an integrated schools offer in each place in conjunction with Education and partner agencies.	Services are working to implement place-based integrated discharge hub meetings and have progressed well with establishing joint working with expansion in Mental Health Support Teams across in Bedfordshire, Luton and East London. The emphasis across local systems is on developing an integrated schools age offer, with the development of a communities of practice programme in BLMK and North East London. The North East London (NEL) Integrated Care System conference led by Children and Young People will set the transformation agenda – “all about me – for the benefit of everyone“
Tier 4- managing bed base and reinvestment in community services	Working with the North Central East London (NCEL) CAMHS Collaborative and Bedfordshire Luton and Milton Keynes (BLMK) system to promote integrated proactive working, support admission avoidance, managing surge in demand through proactive community redesign and joining up interventions such as regional funding for new Bedfordshire Day Care service, CCG investment for Crisis/core CAMHS capacity, Local Authority investment in intensive community support.	Work is under way across London region and in BLMK with system partners . Utilising ICS structures to promote integration and transformation of bed capacity and flow.
BLMK CAMHS Tier 4 unit	Currently no local CAMHS inpatient provision in BLMK. Children and Young people always placed out of area, with delays in accessing care, disconnection from family, school and local services, and longer length of stay. Local provision will improve experience, quality of care and outcomes.	NHSE confirmed funding for interim unit - Project plan in place, weekly meetings, implementation ongoing – scoping site options.

People receiving end of life care

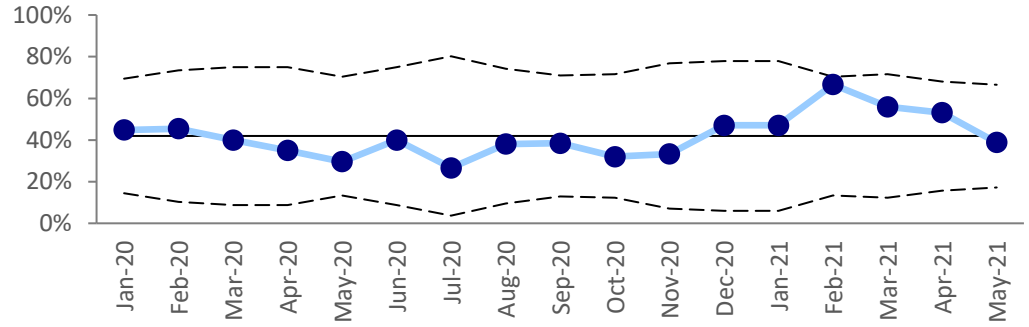
Number of service users on End of Life (EOL) pathway in East London and Bedfordshire (I chart)

Population Health



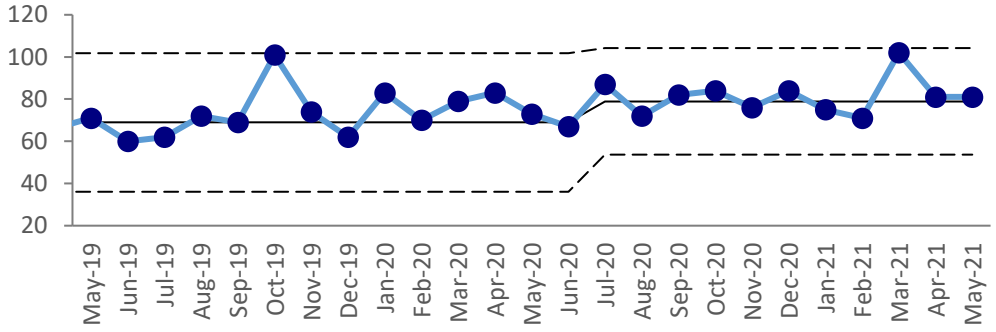
Percentage of service users with EOL Care Plan in place (advanced) in East London (P chart)

Quality



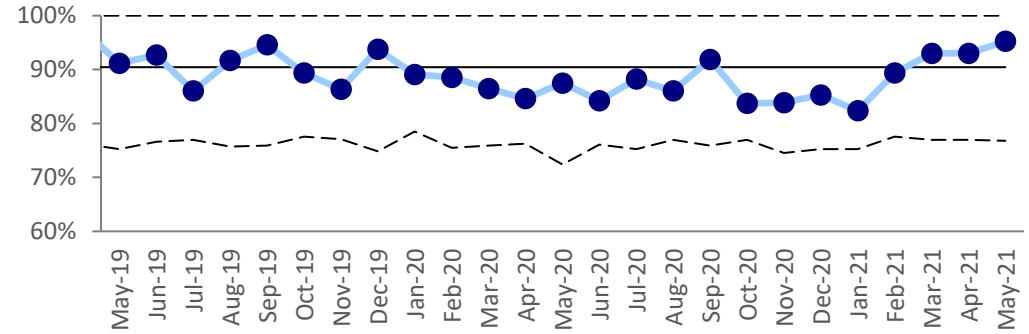
Number of Service Users referred to Continuing Healthcare as a fast track in East London (I chart)

Population Health



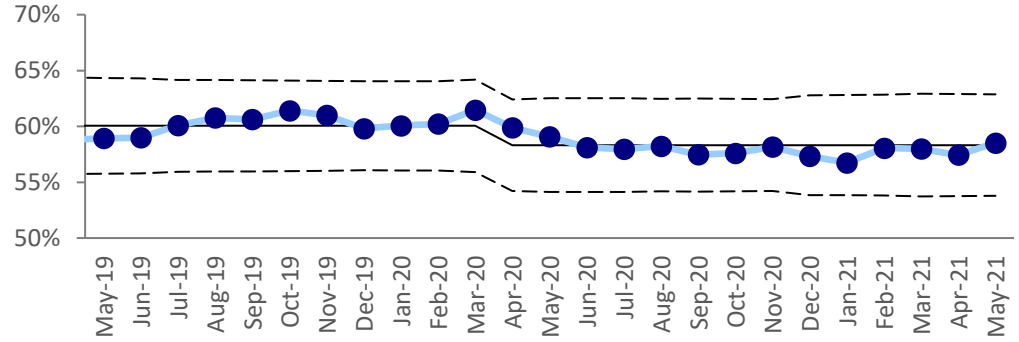
Percentage of service users with EOL Care Plan in place (advanced) in Bedfordshire (P chart)

Quality



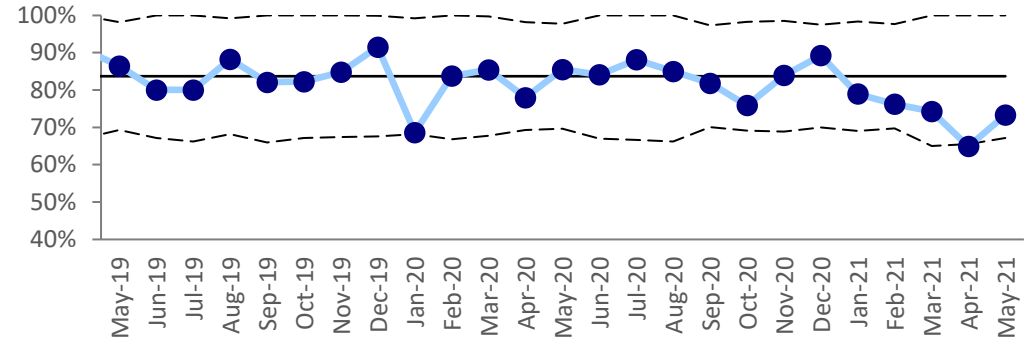
Percentage of patients with cancer diagnosis in Bedfordshire (P chart)

Population Health



Percentage of service users who died in their preferred place of death in East London & Bedfordshire (P chart)

Value



People receiving end of life care

What does the data tell us?

The indicators for this population focus on service users nearing end of life or in the advanced stages of a terminal illness. The Trust provides services in conjunction with third sector providers who provide access and care for people at end of life across East London and Bedfordshire.

Our population health indicators highlight that the number of service users entering the end of life pathway has decreased below normal levels in the past few months. In East London, figures are low compared to Bedfordshire. It is believed that this is due to under reporting and services are exploring new ways of capturing activity on our clinical systems and establishing reports to monitor activity. In Bedfordshire, the number of service users on an end of life pathway has decreased from 1513 in May 2020 to 1380 in May 2021, with a peak in January 2021 of 1727. The decrease correlates with a rise in the number of deaths in the community. Bedfordshire specialist palliative care and district nurses teams have been providing support to service users and their families and enabling people to die in their preferred place.

The percentage of patients with a cancer diagnosis in Bedfordshire on the end-of-life pathway remains consistent with an average of 57%. This measure helps us ensure parity and equity across the service, and that we are supporting individuals with a range of conditions (such as multiple sclerosis, motor neurone disease, dementia and end-stage heart failure), with end of life care.

The number of service users referred to the Continuing Healthcare (CHC) team has increased during the pandemic but remains stable. The service continues to work with a variety of external agencies, specifically independent nursing care homes in Newham to enhance their skills in observation to enable them to identify deterioration in service user condition and liaise closely with GP's and the CHC team to coordinate effective care.

Our quality indicators show high completion of end of life care plans in Bedfordshire (93%) but lower completion in East London (53%). These plans are necessary to deliver personalised care and improve the experience of service users and families. Services in Newham and Tower Hamlets are in the process of reviewing and introducing a new care plan template that is simpler for staff to complete, and easier for service users to understand.

Our value indicator highlights that an average of 83.7% of service users on the end of life pathway are dying in their preferred place, although there are signs of a possible reduction, particularly in East London. Local investigation of instances where service users did not die in their preferred place of death highlights recording errors and other factors such as unplanned acute admissions unrelated to the palliative diagnosis. The preferred place of death is identified as part of the care planning process. During Covid, more patients have identified their preferred place of death as their home. Tower Hamlets performance is lower than Newham but work is underway to simplify care plans, along with training arranged by the Advanced Care Planning coordinator to improve compliance. In Bedfordshire, wider partnership arrangements are in place with the East of England Ambulance Service to ensure processes are in place with the palliative care hub for service user wishes to be honoured.

People receiving end of life care - Projects

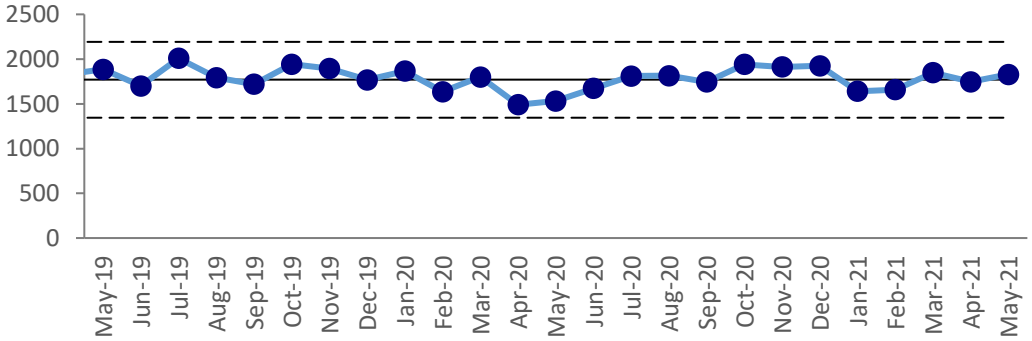
Below are the main projects under way to improve population health outcomes, experience of care and value for this population, aligned to what matters most to this group of people. A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
Electronic Palliative Care Coordination System (EPACCS) - Bedfordshire	Electronic system which enables all users on the Trust clinical system (SystmOne) to quickly review key decisions made by the patient and family regarding advanced care planning to improve quality of care	The system has been implemented and a review is currently being conducted to guide future developments and monitor impact on quality of care
Improving quality of care through establishing Palliative Care training programmes - Bedfordshire	Specific training programmes have commenced, initially by Specialist Palliative Care Team and now taken over by Palliative Care lecturer practitioner. Courses available for registered and unregistered staff covering key aspects of caring for the palliative and dying patient and their families	Rolling programmes are now in place and staff feedback is very positive.
Standardised Single Referral form - Bedfordshire	Work has commenced to implement a Bedford Luton Milton Keynes (BLMK) referral form for hospices and community palliative care services on one form. The aim is that this will reduce the time for referring clinicians and enable teams to know which other services are involved in the patient's care	A draft of the new referral form has been created and is under review by all stakeholders. Once the draft form is agreed, a pilot will be initiated to improve the referral process and the quality of referrals to community services.
Improving coordination of Palliative Care at Home through case discussion - Bedfordshire	A meeting was set up weekly during COVID for staff to discuss referrals to the palliative care at home 'fast track' service. This is attended by ELFT palliative care team, palliative care at home nurses, hospice teams and continuing healthcare teams	Multiagency forums are now in place. This has enabled the identification of patients who may require this service and robust conversations around their care provision
Improving Advanced Care Planning for those on the end of life pathway – Tower Hamlets	We are currently building our Advance Care Planning team, with an aim to identify patients who are in the last 12 months of life. This will enable us to more proactively identify and support people to die in a place of their choosing.	A number of new staff have been recruited into the service to support service users, including those with learning disability, to die in a way that meets their wishes. Services have received very positive feedback about the service and continue to recruit into remaining vacancies within the service to reach full complement of staff in the coming months.

People who are frail or who have multiple long term conditions

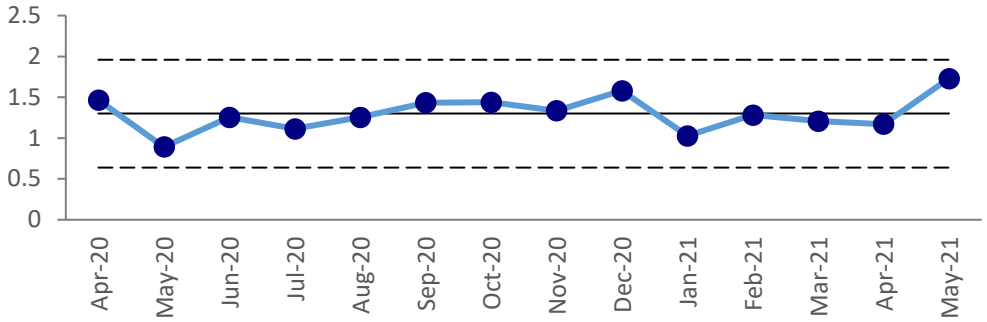
Number of referrals to Rapid Response community services (I chart)

Population Health



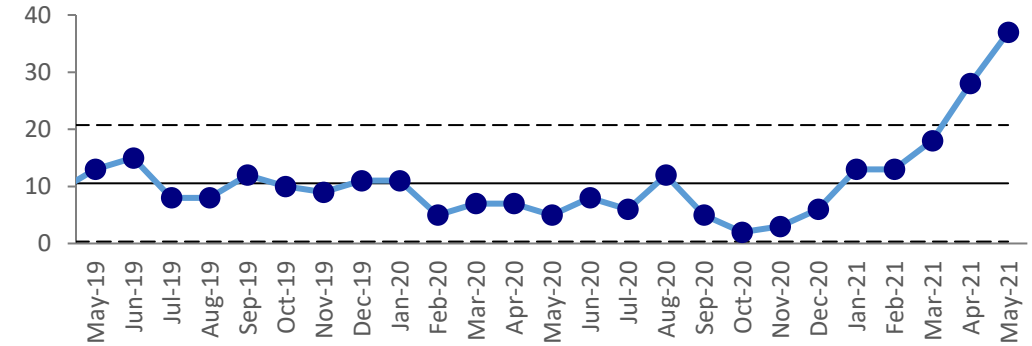
Average waiting time in days for urgent referrals to district nursing / rapid response – East London (I chart)

Quality



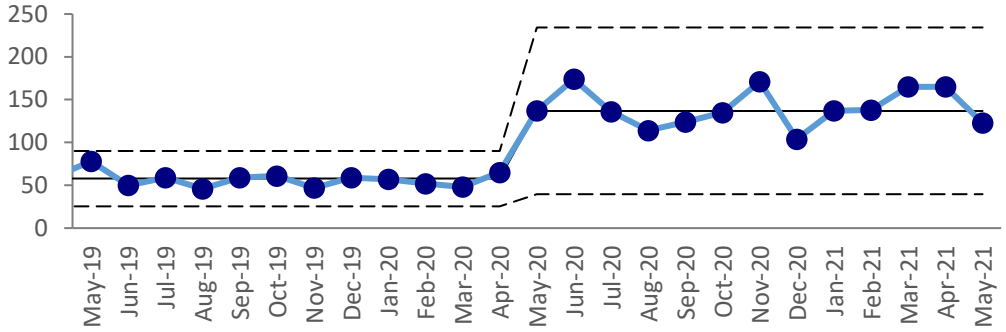
Number of referrals to the falls service – East London (I chart)

Population Health



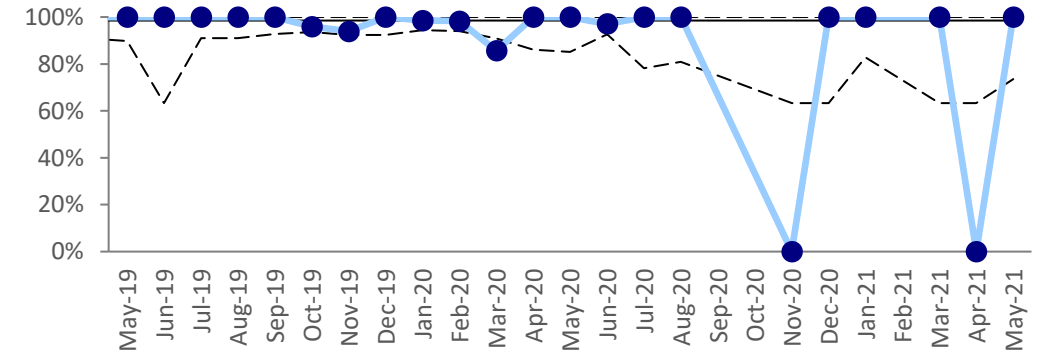
Number of Grade 2, 3 or 4 pressure ulcers (I chart)

Quality



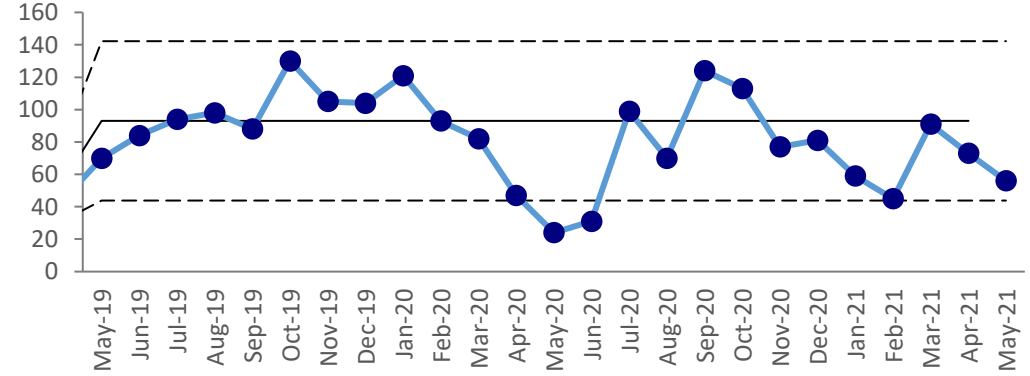
Percentage of service users who have recorded a positive experience (P chart)

Quality



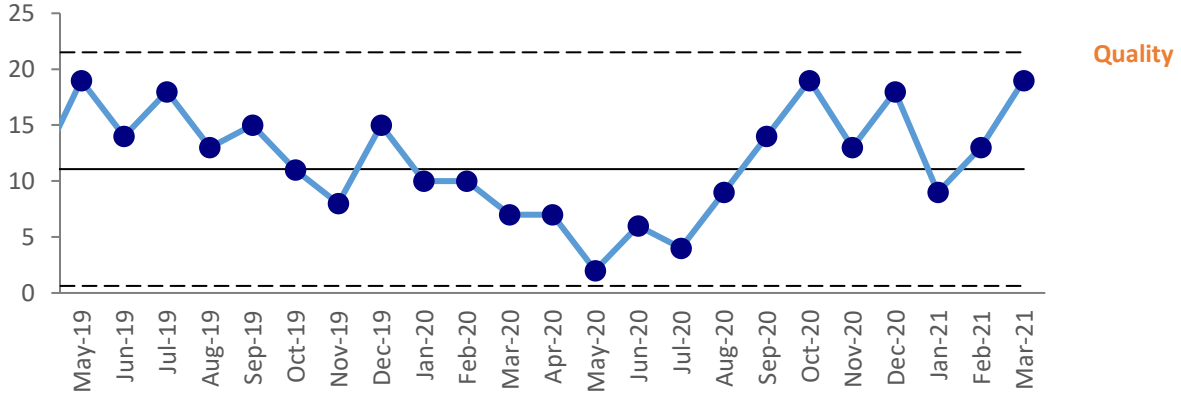
Number of GAS (Goal Attainment Scaling) Assessments – East London (I chart)

Quality

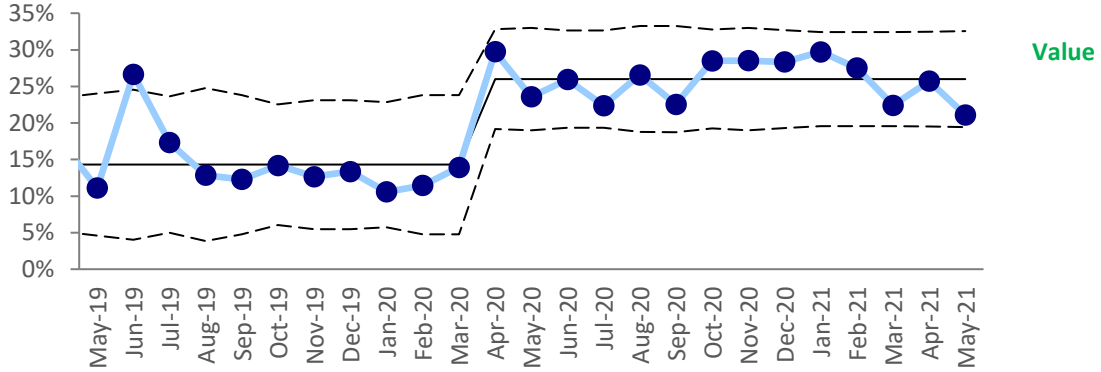


People who are frail or who have multiple long term conditions

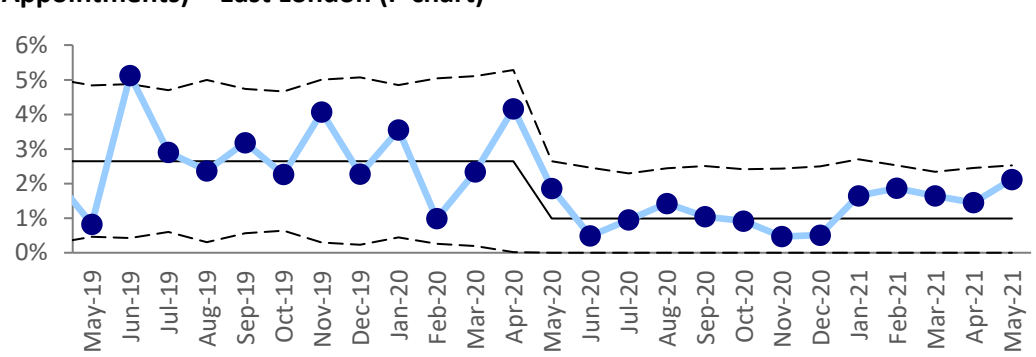
Promoting independent living - discharged from the service after 6 weeks with no ongoing care and support needs - Bedfordshire (I chart)



Number of inappropriate referrals into intermediate care – Bedfordshire (I chart)



Percentage of service users offered an appointment who don't attend (First Appointments) – East London (P chart)



People who are frail or who have multiple long term conditions

What does the data tell us?

The indicators for this population focus on service users living with frailty or multiple long-term conditions. The NHS Long Term Plan makes a commitment to support this population through new urgent community response and recovery services, investment in care homes, and helping service users to age well.

Our population health indicators highlight that referrals to Rapid Response services remain stable. These teams play an important role in preventing avoidable admissions to hospitals and all services have received investment to enhance the provision of care to include a new 2-hour response offer. This will ensure that eligible service users are quickly and appropriately supported at home or in the community. Services across East London have already started to deliver this standard, whilst services in Bedfordshire are in the implementation phase of delivery.

The number of referrals of frail service users to our Falls Team in East London has increased significantly since April 2021. This coincides with when the dedicated Falls Team was created on our clinical system, and it is believed that this has led to more accurate recording of falls referrals, as previously this activity was logged under different teams with varying levels of accuracy. From July, the service will be required to see service users who have had a fall and require help within 60 minutes.

Our quality indicators highlight that average times for rapid (2 hours) and urgent (24 hours) community care referrals remain stable with the majority of service users being seen within the respective timeframes. Investigation of referrals that were not seen within these timeframes highlighted factors such as referrers not sending referrals to the team in a timely manner, poor communication, or recording errors. Pathways continue to be strengthened through multiagency interface meetings and local Partnership Boards to ensure continuous learning and improvement. Patient experience feedback has reduced during the pandemic (hence the widening control limits), and this will be an area of focus over coming months, to re-introduce routine feedback in ways that pose no infection risk.

The GAS score (Goal Attainment Scale) relates to Tower Hamlets therapy services and is an outcome measure that scores the extent to which goals are achieved during the course of intervention. The service is performing well in recording this based on their current caseload numbers. Across community services, different outcome measures are used by different teams and work is underway to develop a uniform outcomes framework that can enable us to learn from variation across services.

The number of pressure ulcers remains stable following an upward shift in the number of reported cases in April 2020. The pressure ulcer facilitators and lead nurse for tissue viability, supported by the director of nursing, will be leading a plan to reduce community acquired pressure ulcers. The plan will be presented to the Quality Assurance Committee in September, and involves a range of interventions. These include pressure ulcer facilitators working alongside clinical teams to build increased vigilance, awareness and reporting interventions; training using virtual platforms (including for temporary staff); two-weekly pressure ulcer meetings in London and Bedfordshire community nursing teams supported by the tissue viability service; benchmarking exercise with community services in Cambridgeshire and an inner city community Trust; and a collaborative QI project with Barts Health which will restart in August following a delay due to the pandemic. Teams have highlighted that due to lockdown, some service users have been less mobile and active, particularly those service users that are housebound, and other service users have declined visits due to fears about the virus. This meant that routine surveillance was not always possible. East London has fewer numbers of pressure ulcer cases compared to Bedfordshire, where category 2 cases are higher but category 3 and 4 ulcers remain low. This demonstrates that although numbers may be higher, the skin lesions have not deteriorated and are being managed well. It should also be noted that Bedfordshire routinely has higher pressure ulcer activity due to its large population size and significantly more residential homes compared to London boroughs.

People who are frail or who have multiple long term conditions

What does the data tell us?

In Bedfordshire, the number of service users supported to live independently through rehabilitation started to decrease during the early phase of the pandemic, but since July 2020 it has increased and remains stable with an average of 11 service users living independently each month. This reflects the fact that the service was initially unable to meet the demand from acute providers discharging service users from hospital beds during the first ware of the pandemic. However, the service was able to redirect resources to support individuals and enable independent living.

Our value indicator for East London highlights non-attendance across Extended Primary Care Teams (EPCTs), physiotherapy, and occupational therapy teams. This shows that the percentage of service users who do not attend their appointments has improved and remains at 1%. It is believed this is related to the positive uptake of digital consultations which has provided service users with greater choice and flexibility to engage with services, as well as effective local practices such as contacting service users before appointments. In Bedfordshire, the value indicator measures the number of inappropriate referrals from acute hospitals to the Bedfordshire community services, which has increased from an average of 12.7% to 28.4% during the pandemic. The Integrated Discharge Hub has been introduced to provide multi-disciplinary discharge planning support to facilitate a smooth transfer into community care. The Hubs bring together the local authorities of Luton, Bedford Borough, Central Bedfordshire, and Milton Keynes, as well as community NHS services and the voluntary sector. The virtual Integrated Discharge Team responds to referrals to identify a suitable pathway within the hour and hospital staff are informed of the patient's discharge destination. As COVID restrictions lift, staff within the integrated discharge hub will review patients on the wards to ensure smooth transition into the community and reduce the number of inappropriate referrals.

People who are frail or who have multiple long term conditions - Projects

Below are the main projects under way to improve population health outcomes, experience of care and value for this population, aligned to what matters most to this group of people. A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
Rapid Response Fast Falls – East London	Looking to improve the response time of service users who have fallen and improve the clinical outcome of the service user as well as reducing unnecessary admission to hospital.	This service has recently been launched offering a response within 30-60 minutes of a call. Recent review of performance data highlights high response rates within designated timeframes.
Integrated Discharge Hub – East London	The role of the service by assisting the discharge of service users from the ward will lead to better clinical outcomes for the patients, and a better discharge experience. This will also reduce the length of unnecessary time spent in an acute care setting.	The service has relocated the team to Royal London Hospital and implemented twice-daily multidisciplinary team calls with partners. The service has also developed a new referral form with partners to coordinate care more effectively.
Safety Huddles and Care Coordination – East London	To create an integrated approach to supporting some of our most vulnerable, high-risk patients and a shared, collaborative approach towards safeguarding	The safety huddle is being tested in the South East extended primary care team on a monthly basis. Details of all cases for discussion/review are shared in advance to enable the allocated social worker to attend. Initial feedback is positive and it has enabled attendees to build connections and relationships, leading to improved communication outside the safety huddle meetings. The terms of reference are currently being reviewed to help strengthen the care co-ordination and the role of Care Navigation within the huddle.
Older Persons Clinic – East London	Reviewing and streamlining the pathway will improve the experience of the service user and reduce time to assessment and intervention	The assessment form and pathway between the older persons clinic and our community teams has been streamlined, in order to improve access. In addition, services have formalised the inter-referral process between our community teams and outpatients clinic to provide easier access to consultants where a need is identified.

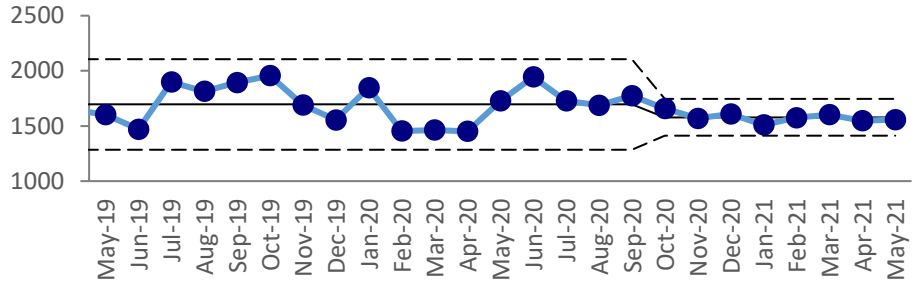
People who are frail or who have multiple long term conditions - Projects

Project	How will this impact on outcomes, experience and/or value	Progress Update
Triple Aim Quality Improvement (QI) project focused on Adults living in Newham who have a body mass index over 40 (bariatric) and are housebound (Newham)	Looking to improve the quality of life, and what matters to housebound bariatric adults in Newham.	This is a QI Project which is progressing well. The team are in the process of collecting and analysing data to support the project and measure the impact it is having on service user experience and outcomes.
Safeguarding Discharge	Joint project between Newham University Hospital NHS Trust , London Borough of Newham and East London NHS Foundation Trust to improve the recognition of Safeguarding and improve Discharges	This project is in the scoping phase. Initial discussion have taken place and future meetings have been arranged to developed a plan.
Hospital Avoidance (Bedfordshire)	Project with Complex care (Care Home provision) and Matron service to demonstrate the impact of the service in preventing hospital admissions.	Review underway to map the future of the service. Template being created within clinical record to reflect hospital avoidance within the service.
Implementing national 2 Hour Response target for urgent referrals (Bedfordshire)	Urgent Community 2-Hour response is designed to meet the care needs of adults who are experiencing a deterioration of health or who require support to optimise their independence.	The service is in the process of being established and our clinical system is being configured to support national and local reporting
Intermediate Care rehabilitation (Bedfordshire)	To improve the way we are able to record and report activity and improvement in patient outcomes.	Work has commenced with our clinical system (SystmOne) to ensure accurate reporting so that teams can monitor outcome measures more effectively to demonstrate the value of the service.

People with a learning disability

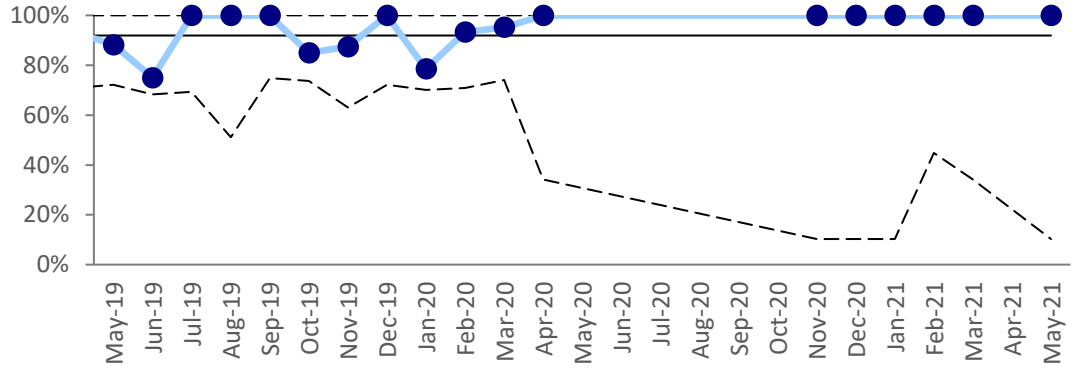
Total number of successful contacts made each month by LD teams (I chart)

Population Health



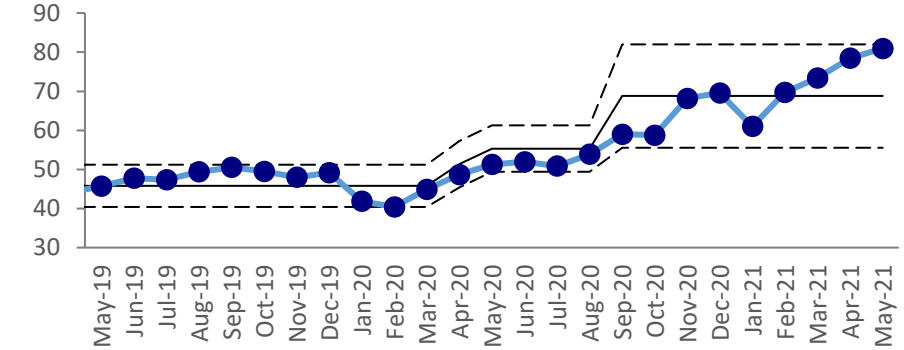
Percentage of people satisfied or very satisfied with the service received (P chart)

Quality



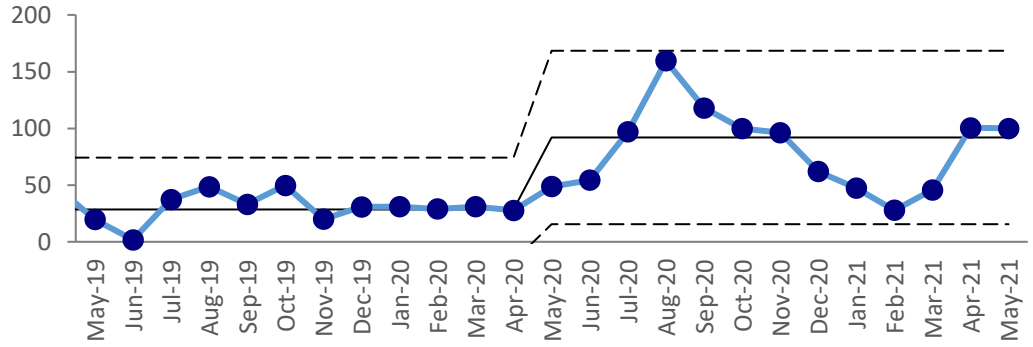
Average waiting times for new referrals seen (in days) for assessment in East London (I chart)

Quality



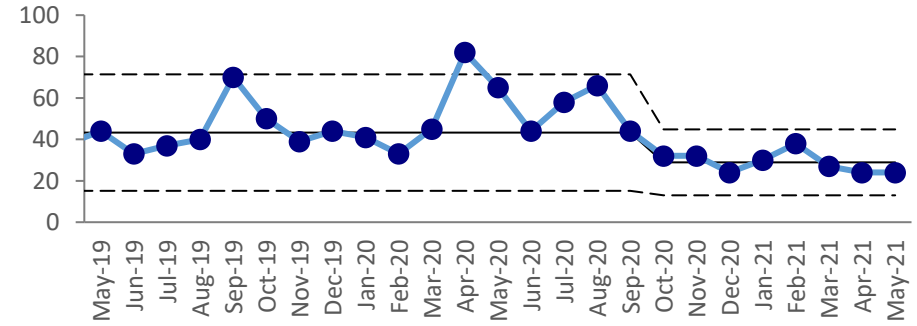
Occupied bed days utilised each month for people with dual diagnosis of learning disability and mental illness (I chart)

Quality



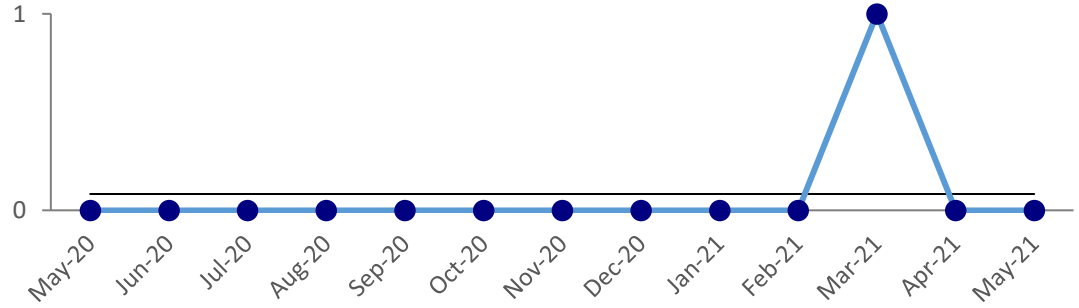
Average waiting times for new referrals seen (in days) for assessment in Bedfordshire and Luton (I chart)

Quality



Number of specialist out of area inpatient placements (run chart)

Value



People with a learning disability

What does the data tell us?

The indicators for this population focus on service users with learning disabilities. During the pandemic period, this particular population faced significant risks and experienced high mortality rates.

Average waiting times for assessment have reduced across Luton and Bedfordshire to an average of 29 days but increased across East London services to an average of 69 days. In Luton & Bedfordshire, the service is meeting its local 18-week waiting times target. Waiting times have reduced partly due to the single point of entry and the Intake and Assessment Function, which is managed by a virtual multidisciplinary team to carry out first appointments. This model proved effective in the first wave of the pandemic and subsequent waves to ensure that the holistic needs of service users were assessed in a timely way including individual risks related to COVID.

Average waiting times are higher in Tower Hamlets than Newham. The Tower Hamlets service is broadly achieving its local 42-day assessment target. It is important to note that Tower Hamlets is an integrated service with social care, whereas Newham is a purely health-delivered service. This means that their targets are different and also how the activity is recorded differs across multiple clinical systems. This can impact on the interpretation of waiting times across services. Cognitive assessments were placed on hold during the acute phases of the pandemic due to the challenges of carrying out these assessments using Personal Protective Equipment (PPE), and these have now gradually restarted. There remains a backlog for transition assessments for service users moving between children and adult services. Where possible and appropriate, virtual consultation has been utilised to facilitate assessment. However, virtual engagement is challenging with service users who are non-verbal or where digital access is more difficult. This has impacted the number of successful contacts made each month with service users. Where clinically appropriate, face-to-face appointments have continued to support the management and assessment of complex and high-risk cases. As the teams have started working through the backlog of assessments, this is now impacting on waiting times, as those seen in-month will have been waiting longer than pre-pandemic. All of our learning disability services are also utilising quality improvement to work on demand, capacity, and flow across all services.

Our quality indicators highlight that 100% of service users would recommend learning disability services. However, all the teams acknowledge that different approaches are required to engage our service users to offer feedback. The accessible version of the service user feedback form is due for review and services will be working with the newly appointed People Participation Lead for Learning Disability to consider additional ways to engage with the people we serve.

Our value indicators highlight that there has been an increase in inpatient bed days, particularly relating to the periods following the most acute phases of the pandemic. However, out-of-area placements remain low across the learning disability teams and in line with national expectations. This is due to proactive welfare calls and engagement with service users, and all the changes teams have made to adapt and improve care.

People with a learning disability - Projects

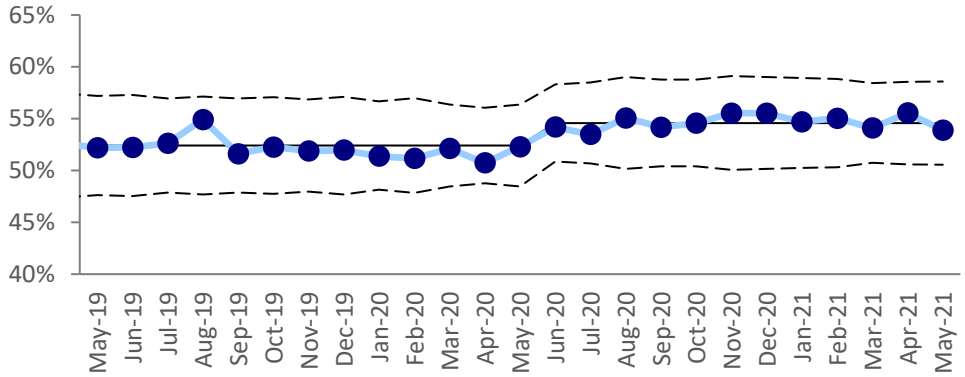
Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people. A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
YouTube Project	Newham Learning Disability Service have initiated a Trustwide project to create a YouTube channel.	This is now available for clients and carers and has accessible information about a range of health topics (including Coronavirus), and specific team information relating to the Newham Learning Disability team and what support is available. Continuing to engage with service users to further develop the channel.
STOMP (Stopping over-medication of people with a learning disability, autism or both, with psychotropic medicines)	First phase of an audit on use of antipsychotics. To further explore use of Positive Behaviour Support plans, alternative approaches to care, ethnicity in relation to those cases where there is use of psychotropic medication.	This has been shared within the Tower Hamlets QI forum and will form part of the STOMP workstream across all services in the Learning Disability Learning Network
Preparing for adulthood	Improve transition for children and young people with complex needs/learning disability and children with long term conditions managed within an acute setting	Roald Dahl charity nurse recently in post, transitions working group restarted following closure due to the pandemic. The service is now supporting service users moving between children and adult services to maintain good outcomes
Improving Access to Treatment in the Newham LD Team	Improving the process of triage, initial screening assessments and allocation to treatment pathways will improve access to the right treatment, at the right time, that is person centered.	The project has run five tests of change, including the formation of a Triage team. Measuring outcomes have been challenging due to the uneven flow of referrals through the COVID period.
Race and inequalities project (Luton and Bedfordshire, Newham)	The project aims to improve the quality of experience for service users with learning disability from ethnic minority groups	The service People Participation lead is working across Luton and Bedfordshire and Newham initially to share learning and best practice. They will be supporting the Learning Disability Network to share feedback and best practice across all services in the coming months.
Triple Aim QI project	The aim of the project is to improve the quality of life for services users on antipsychotic medication without diagnosis of Serious Mental Illness	This was a project which started before the pandemic and has recently relaunched in June. The project group is evaluating some of the initiatives that were introduced during the past 12 months.

People with common mental health problems

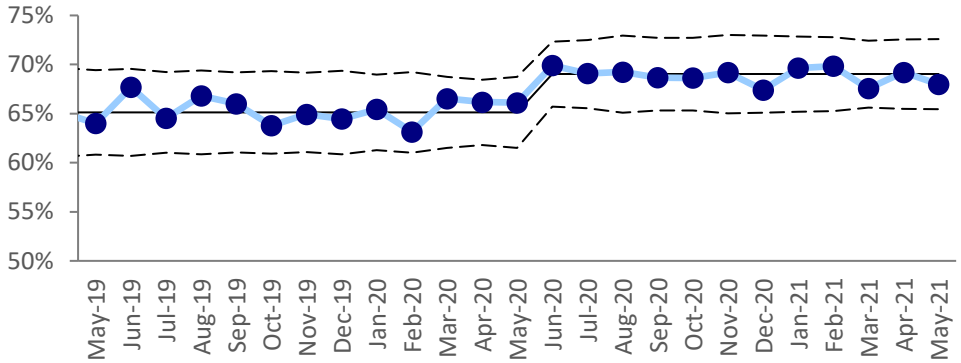
Percentage of service users moving into recovery (P chart)

Population Health



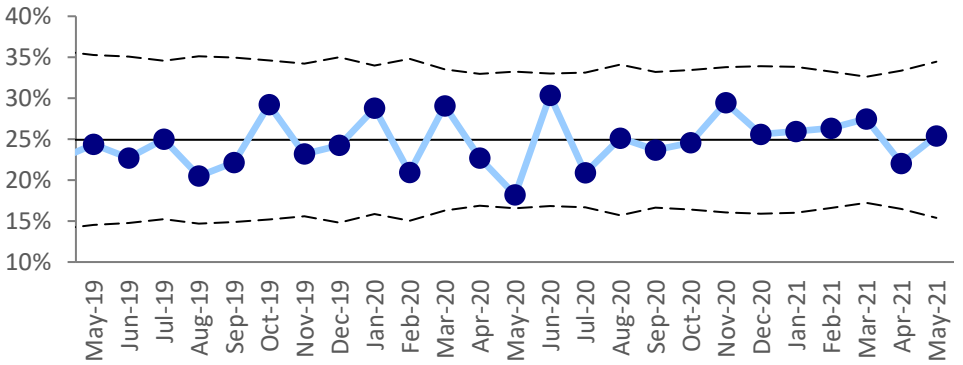
Percentage of service users showing reliable improvement (P chart)

Quality



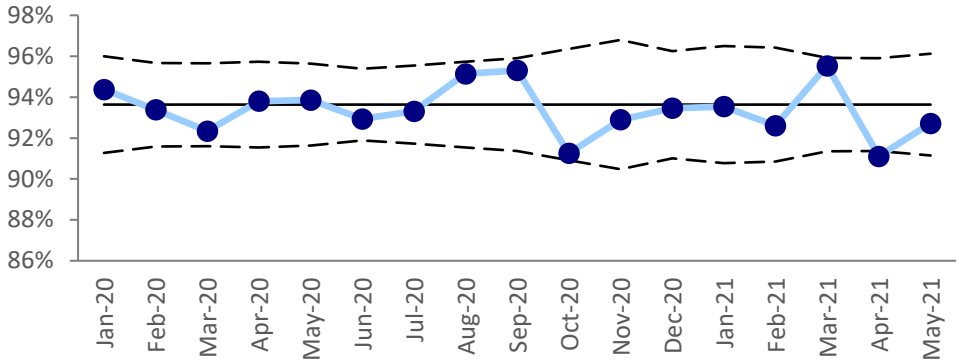
Percentage employed at end of treatment of those unemployed at start (P chart)

Population Health



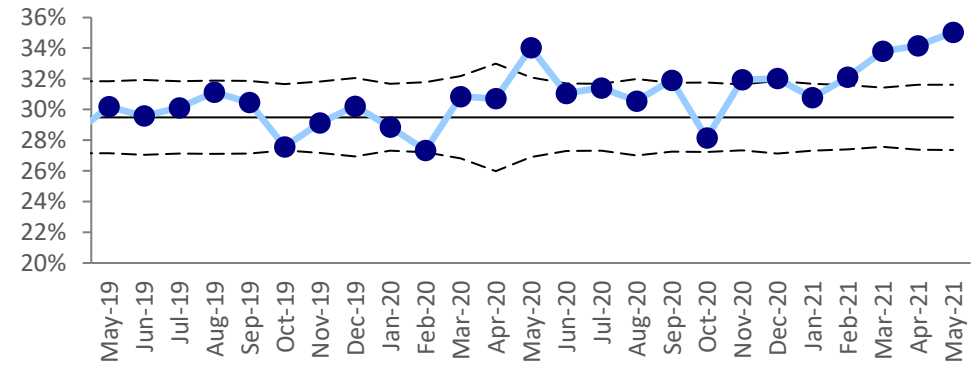
Percentage of positive comments to PEQ (P chart)

Quality



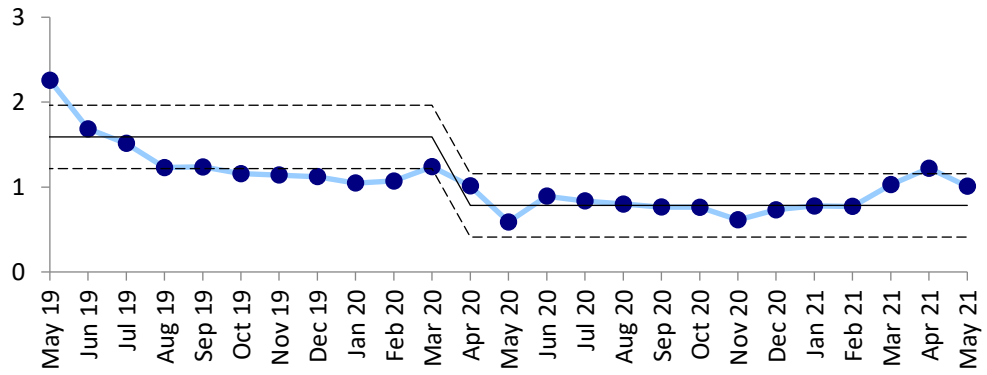
Percentage access by minority groups (P chart)

Population Health



Average wait (in weeks) for assessment (I chart)

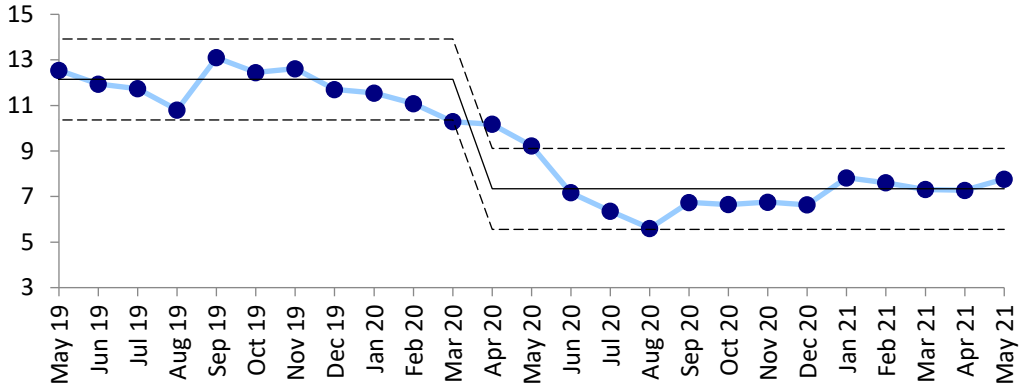
Quality



People with common mental health problems

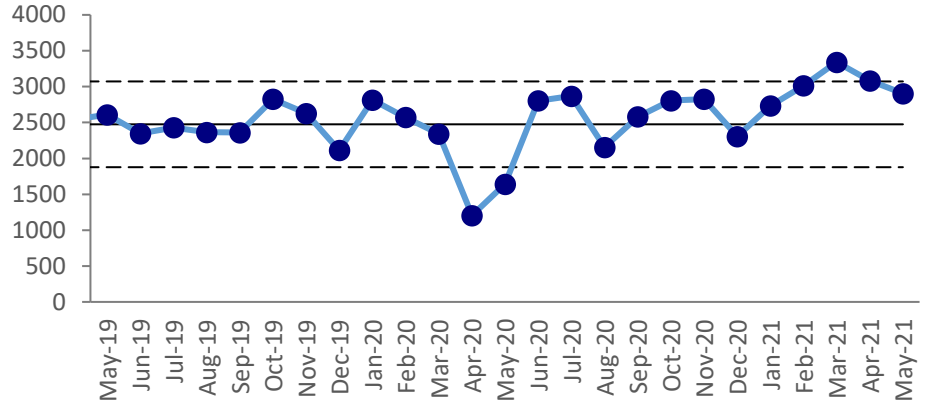
Average wait (in weeks) for treatment (I chart)

Quality



Number of service users entering treatment (I chart)

Value



People with common mental health problems

What does the data tell us?

The indicators for this population focus on service users with common mental health problems such as stress, depression, and anxiety disorder who are supported by our Improving Access to Psychological Therapies (IAPT) services across Richmond, Newham, Tower Hamlets, and Bedfordshire

Our population health indicators highlight improvement in the percentage of service users achieving recovery, which 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 Black, Asian, and Minority Ethnic (BAME) backgrounds appears to have increased, with several months above the upper control limit and a strong likelihood of an upwards shift being confirmed in the next few months. The number of referrals have increased sharply in February and remain higher than pre-pandemic levels.

The percentage moving from unemployment into work remains stable, although it appears there is a chance that we will see a small upwards shift as the most recent run of 5 months has all been above the long-term average. This is a very positive result given the negative impact on the employment market caused by the pandemic.

Our quality indicators highlight that average waiting times for assessment decreased during the pandemic but now appear to be increasing modestly while remaining well below the national 6-week standard. Average waiting time for treatment improved significantly during the pandemic but in recent months has started to rise, although remains lower than the 90 days (13 week) target. This is largely due to a combination of high demand and recruitment difficulties, especially in Bedfordshire.

The percentage of positive comments to the Patient Experience Questionnaire (PEQ) remains relatively stable, which suggests that service users do not feel that remote therapy has given them a worse experience than face-to-face. However, some individuals would prefer face-to-face contact and the services are planning to increase the offer of on-site therapies from July 2021 to make this available for those who prefer it.

Our value indicator highlights that the number of service users entering treatment was particularly high in both February and March which has put pressure on waiting times for assessment, particularly in Tower Hamlets.

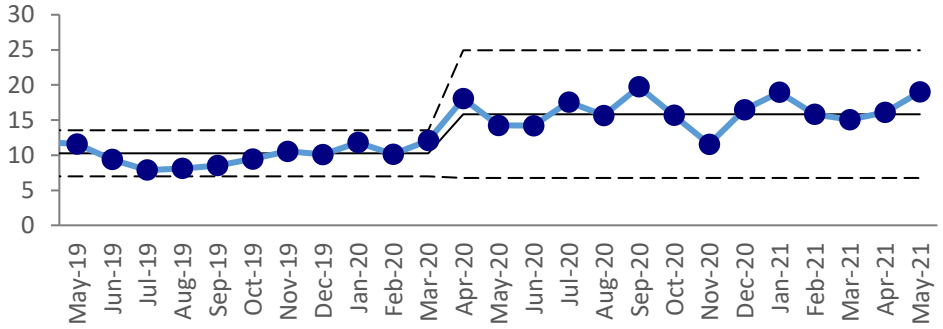
People with common mental health problems - Projects

Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people.
A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
Reducing drop-out rates in Bedfordshire Wellbeing service and Tower Hamlets	Clearer communication with service users will support them to engage better with services	Continuing to test change ideas as part of a QI project on this topic
Improving the Patient Experience Questionnaire feedback process	Improving the process will help to gather more feedback with more useful information to help us improve services	Team formed, working on specific aim statement
Improving recovery rate for low intensity therapies in Richmond	Reducing early drop-out and offering step-up where needed will deliver better overall recovery rate	Successful improvement in recovery rate through improving attendance and stepping-up non-recovered service users. Continuing to monitor to ensure we sustain the progress
Triple Aim QI project – reducing health inequalities in Bedfordshire	Improving access for Asian men over 40 will address several factors of inequality	Currently conducting the three-part data review, seeking input from current and recent service users from target population segment, in order to understand needs and assets that can inform the development of change ideas

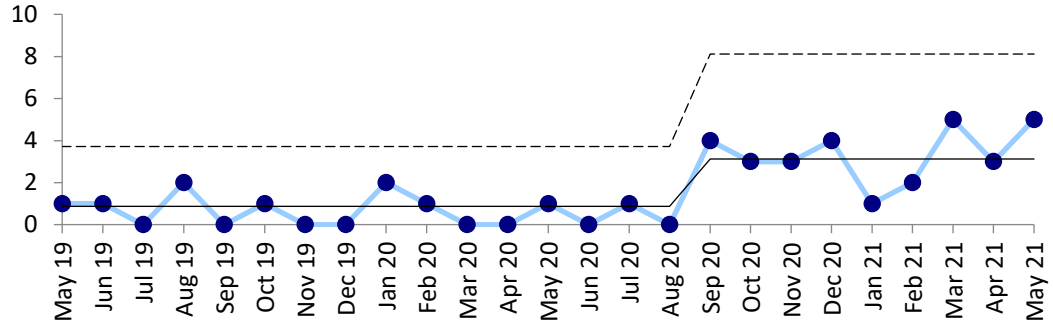
People with dementia

Average wait (in weeks) from referral to diagnosis -18 week target (I chart)



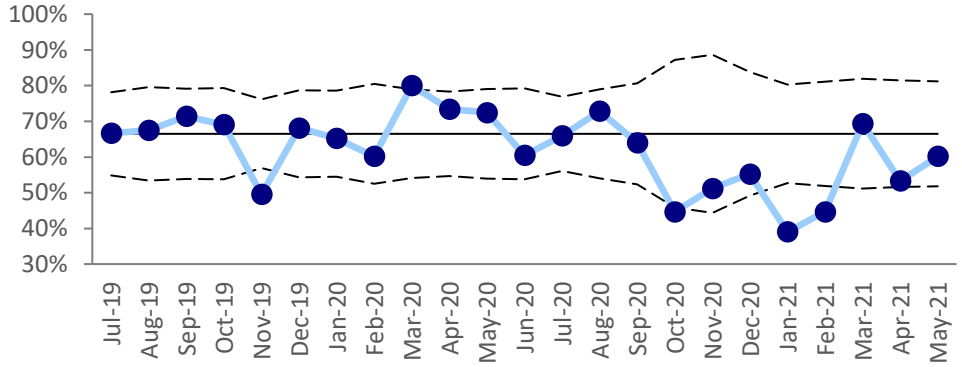
Quality

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



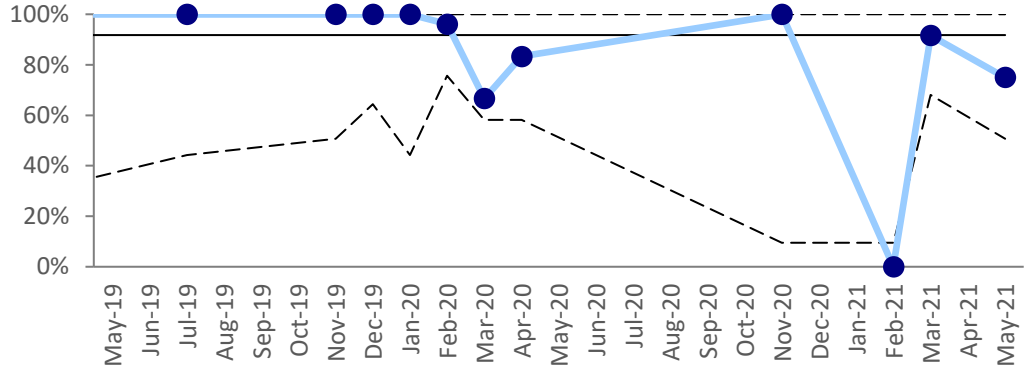
Quality

Percentage of service users offered on-going post diagnostic support - 6 months after diagnosis (P chart)



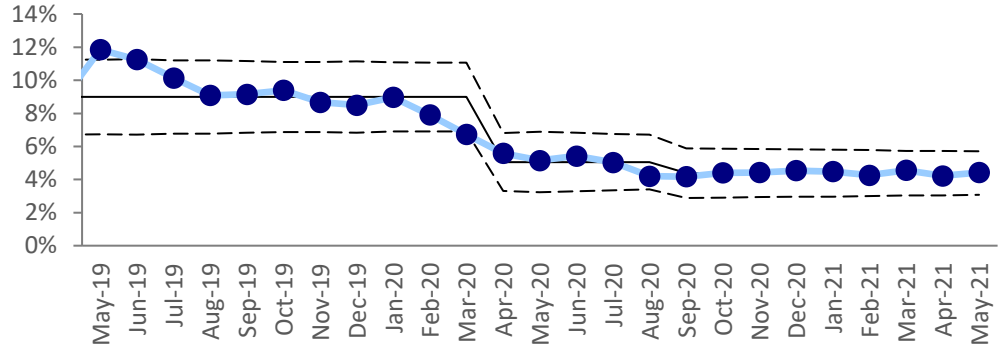
Population Health

Percentage satisfaction with service, service users and carers (p chart)



Quality

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



Quality

What does the data tell us?

The indicators for this population focus on older people suffering from dementia. The NHS Long Term Plan makes a clear commitment to this population, which entails timely and accurate diagnosis, post-diagnostic support, crisis intervention, and reducing the need for inpatient admissions.

Diagnostic services and community mental health teams looking after patients with dementia have suffered significant disruption during the pandemic due to the high risk to patients, the restrictions on care home visits, and the challenges of digital communication with this population. Additionally, conducting cognitive diagnostic assessment for suspected dementia patients remotely is extremely challenging. Services have managed to maintain the referral to diagnosis target (18 weeks) with an average 15.8 week wait. However, waiting times to diagnosis have gone up during the pandemic. There is a significant backlog that is being addressed in all areas through redesign of service pathways, discussions with commissioners and additional funding to support service recovery.

Long-term post-diagnostic support for dementia patients reduces the burden of care and provides support for patients and families when needed. There is variability between services based on commissioning and investment levels, but the data highlights that 66.5% of service users are receiving contact at least once within 6 months of diagnosis. The data highlights there were several months where the figure was lower which was due to the closure of routine services during the acute waves of the pandemic.

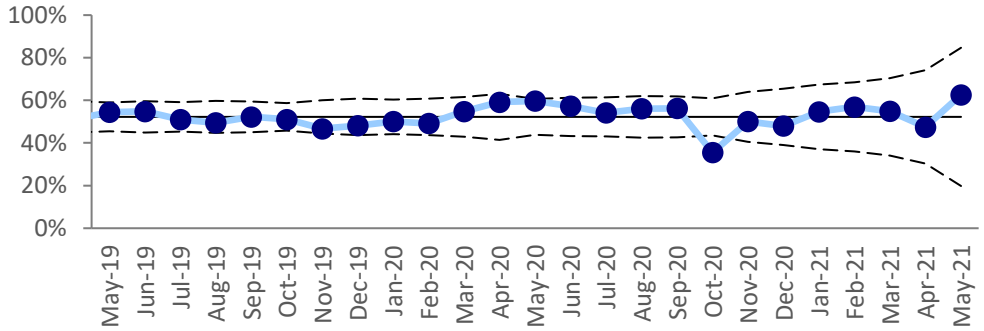
People with dementia - Projects

Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people. A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
Review of Hackney Dementia Service	Evaluate the current strengths and weaknesses of the service model and make necessary improvements to pathways, balancing the offer of digital and face-to-face contact, managing the backlog and waiting list	The service is currently revaluating the admin processes throughout the diagnostic pathway, which will help to improve waiting lists and access. Extra medical time will be used over the next few months to reduce waiting time and improve diagnostic rate, particularly in relation to mild cognitive impairment recall. The service is also exploring starting cognitive stimulation therapy group as soon as possible.
Development of memory services – Tower Hamlets	Review the development of memory services in relation to national service development expectations, post diagnostic support & national accreditation standards. Agree future models of care, community mental health provision and resources across the pathway.	The service has secured additional interim funding to increase nurse resource in the team. As part of the recovery plan, the service is continuing to review the post-diagnostic offer and has been able to reintroduce cognitive stimulation therapy. The service is also currently developing the role of the post-diagnostic nurse to increase capacity for ongoing support.
Improving Dementia Care – QI Project Central Bedfordshire	The aim of the QI project in Central Bedfordshire is to reduce the time from referral to diagnosis. The service has disparities with the population size and resources and has been working with Commissioners to secure additional funding. This project will support the improvement of dementia diagnosis rates in Central Bedfordshire.	The service has recently secured funding from the CCG for 12 months to support the project. The project team has developed a process map and driver diagram. The team has identified some change ideas and is planning on testing these in the coming months, including working closely with primary care to offer GPs virtual consultation clinics and provide in-reach support and advice to improve the pathway to diagnosis. The service will also have identified psychology assistants to support the assessment model as in Luton and Bedford.

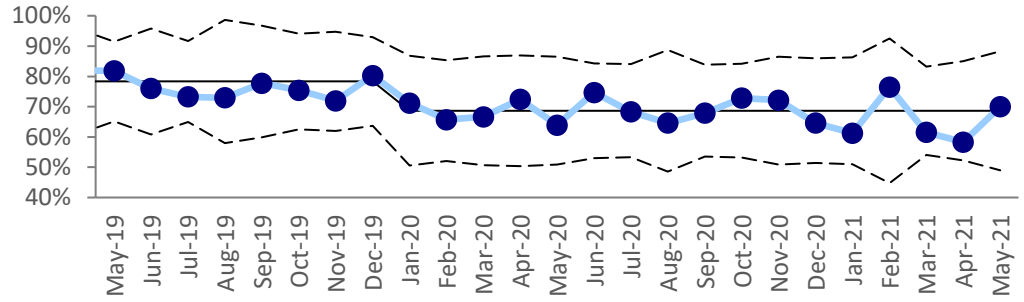
People with serious mental illness

Percentage of SMI service users completing annual physical health checks (P chart)



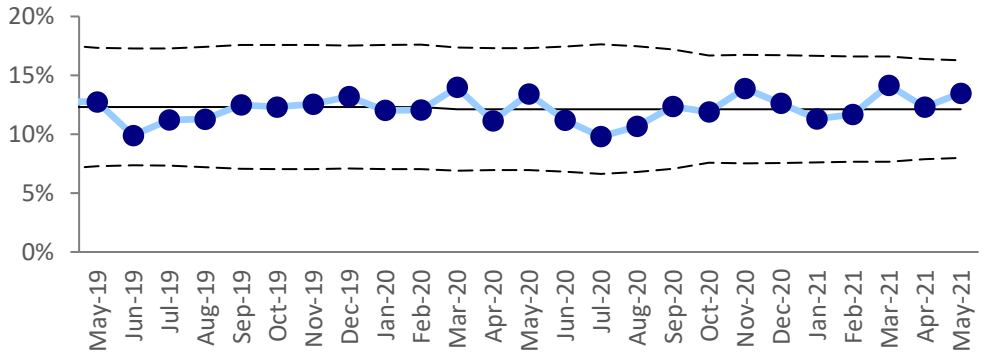
Population Health

Percentage of service users receiving NICE concordant care within 2 weeks of referral to EIS services – Face to face contacts only (P chart)



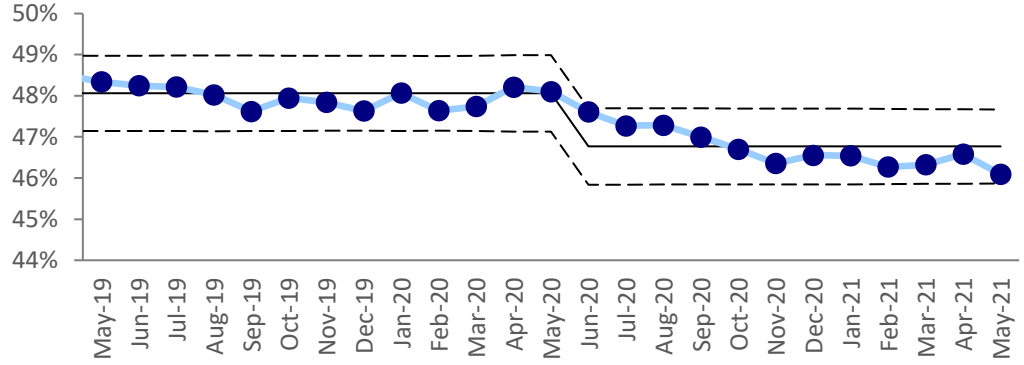
Quality

Percentage of service users receiving Individual Placement Support - IPS (P chart)



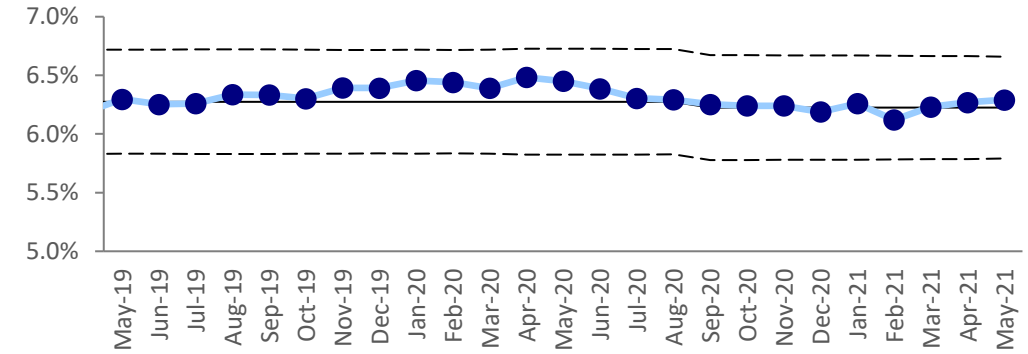
Population Health

Percentage of service users in settled accommodation (P chart)



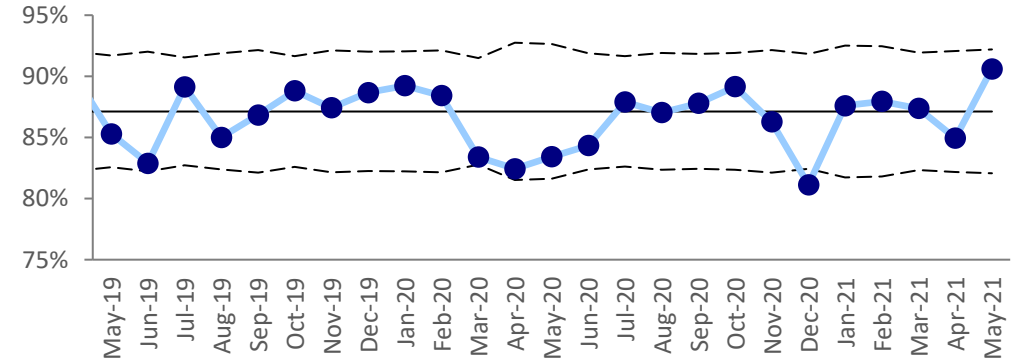
Population Health

Percentage of service users in employment (P chart)



Population Health

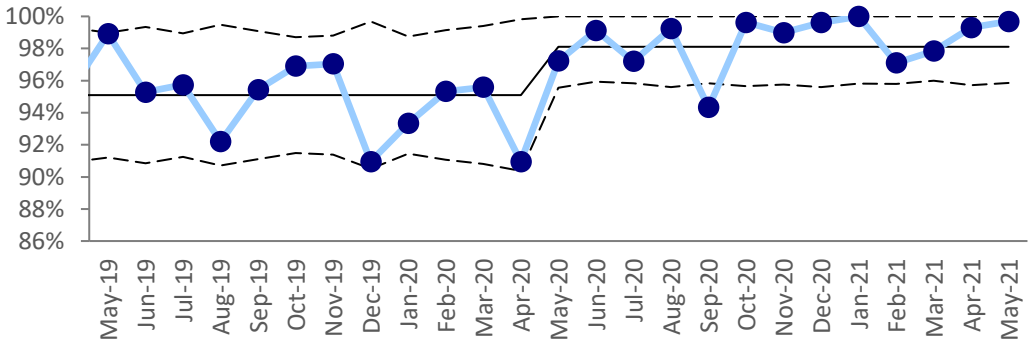
Percentage of service users followed-up within 72 hours of discharge (P chart)



Quality

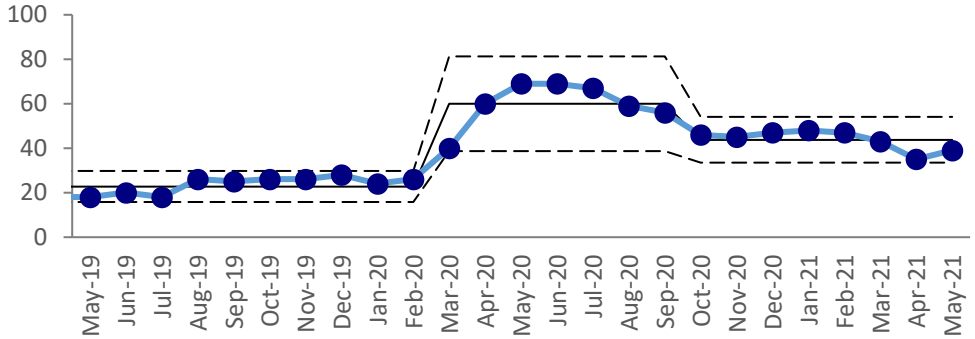
People with serious mental illness

Percentage of service users with paired outcome measures (DIALOG) (P chart)



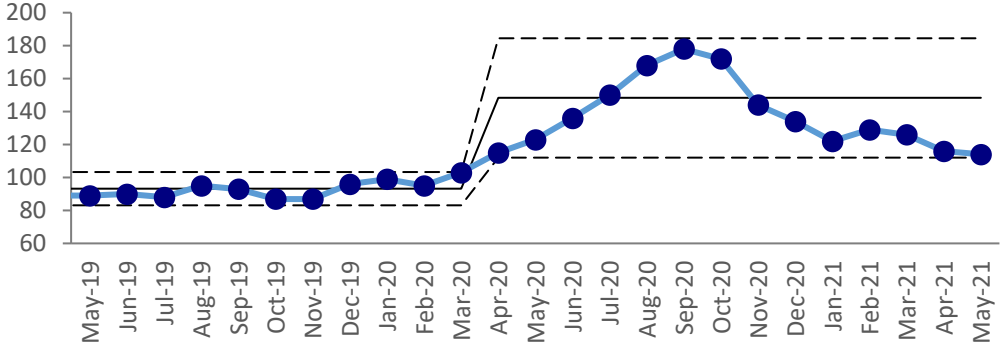
Quality

Psychological Therapy Service (PTS) average wait times (in days) to 1st assessment in East London (I chart)



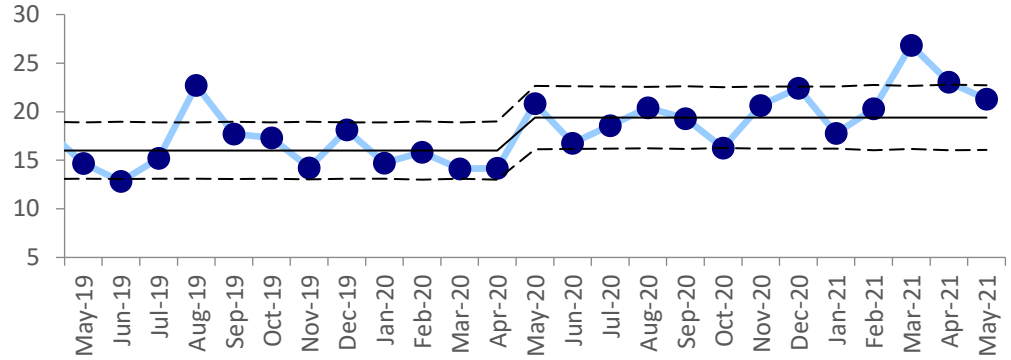
Quality

Psychological Therapy Service (PTS) average wait times (in days) to treatment in East London (I chart)



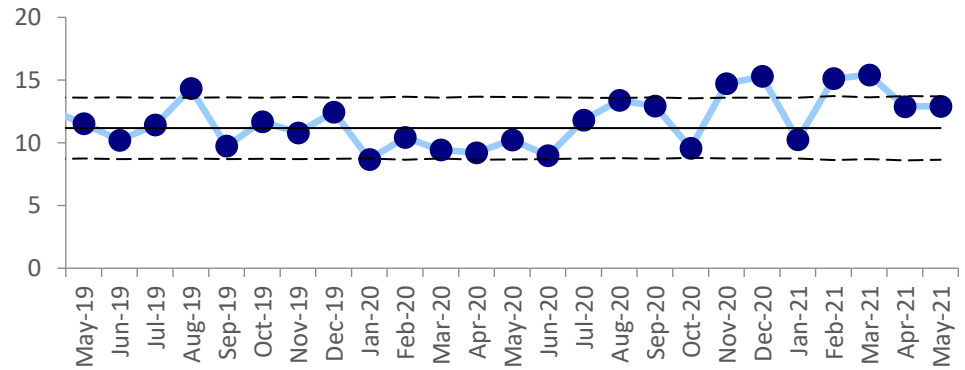
Quality

Rate of restraints per 1,000 bed days (U chart)



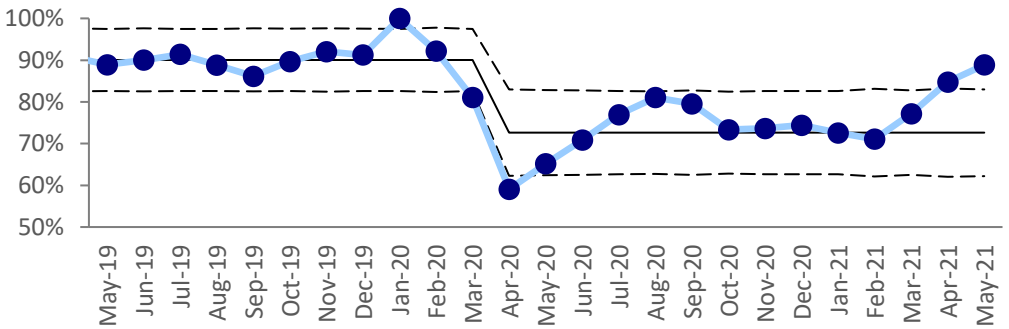
Quality

Rate of physical violence per 1,000 bed days (U chart)



Quality

Bed occupancy (Mental Health & Community Health) (P' chart)



Value

What does the data tell us?

The indicators for this population focus on service users with serious mental illness, behavioural or emotional disorders resulting in severe functional impairment that significantly limits an individual's quality of life. Some of the indicators also focus on service users who have been unwell enough to require inpatient care.

Our population health indicators highlight that the percentage of service users with serious mental illness within our services who have received annual physical health checks remains stable, with an average of 52.2% reviewed annually. Initiatives in both primary and secondary care are being mobilised to improve this across East London and Bedfordshire and Luton. Services have started to train existing staff to complete physical health checks, and are recruiting physical health staff to provide dedicated capacity to complete annual checks across primary care and secondary care and maintain accurate primary care registers. This is based on the successful model in City and Hackney. It should be noted that annual physical health checks are largely carried out in primary care based on their individual registers, which they are responsible for maintaining and monitoring. At the present time, the Trust does not have routine access to this information, however, work is underway to explore this further to accurately progress against this standard.

Performance against the adult mental health early intervention services (EIS) waiting times target for service users to receive NICE-compliant treatment within two weeks of referral continues to fluctuate, and in May was above the national 65% target. Since the onset of the pandemic, EIS services have seen an increase in referrals, congruent with the national picture. The increased number of referrals and restrictions on face-to-face contact have both contributed to an increase in waiting times. Across all services, contact will be attempted within the first 7 days, and usually within 48 hours, but for those that require a more assertive approach to engagement with multiple contact attempts, such cases can fall outside of the 2-week standard. Despite these challenges, most services have maintained access times through offering telephone or virtual contact. However, the national indicator only includes face-to-face contacts at this point.

The percentage of service users in employment and those receiving Individual Placement Support (IPS) to enter employment remains stable, with an average of 6.3% and 12.1% respectively. There are a number of employment initiatives underway across the Trust to support service users, including working closely with the Department of Work & Pensions and the Job Centre to create opportunities and offering benefits guidance. The percentage of service users in settled accommodation has seen a downward shift during the pandemic. This partly reflects the impact of the pandemic and also changes in the way the indicator is reported to meet national reporting guidelines which requires the status to be updated every 12 months. Service leads are working to ensure records are updated in a timely manner.

Our quality indicators highlight that follow-up within 72 hours of discharge from hospital remains stable and above the national 80% target. DIALOG is an outcome measure that collects information from service users across a range of domains (mental, physical, social) to measure quality of life. The percentage of service users with paired outcome measures (DIALOG) has been improving and remains consistently high with over 95% of service users having two or more completed outcome assessments to help measure change over time. We will aim in future to move towards looking at improvement in DIALOG scores.

What does the data tell us?

Psychological Therapy Service waiting times for assessment remain stable and treatment waiting times continue to decrease. This reflects the positive impact of service redesign and new online treatment pathways that have started to take shape and become embedded across each borough. Further work is underway across all services to integrate psychological therapy pathways with newly established Primary Care Networks to proactively manage flow and demand pressures.

The rate of restraints and physical violence across inpatient services have been higher than usual during recent months. There are several interacting factors that have influenced this increase, from restrictions put in place to manage Covid transmission, impact on staffing and a greater reliance on temporary staffing. This has been most acute in our forensic services (LD wards in particular) and CAMHS inpatients - through both waves these services saw increases in violence and the associated use of restrictions to contain this – such as restraints, seclusion and long term segregation. The strategy to improve this has several elements which all inpatient services are working on, which include stabilising staffing, ensuring that our covid precautions are proportionate and reflect the easing of restrictions within general society (as far as is practical and safe), and greater multidisciplinary involvement and engagement in considering plans for individuals and groups around safety on the ward. Each inpatient team has a forum (Time to Think) to discuss and learn from each other about conflict and containment and how to manage and reduce this with service users. There will also be an increase in training capacity through 2021 for MAPA training (the training for de-escalation and physical holding skills) and ensuring we are compliant with the Restraint Reduction Network national standards. This work will be monitored by the directors of nursing and reporting to the quality assurance committee in September.

Our value indicator highlights that bed occupancy has increased over the past 4 months, reaching 88.9%. This reflects the wider pressures faced by community and inpatient services and is consistent with national trends. Periods of relative low occupancy coincide with peaks in COVID transmission rates and that demand for mental health crisis care is rising. The Trust is working closely with our two Integrated Care Systems to help manage flow and cope effectively with demand. Inpatient services utilise regular bed management meetings and strengthen community care pathways to reduce local admission pressures.

People with serious mental illness - Projects

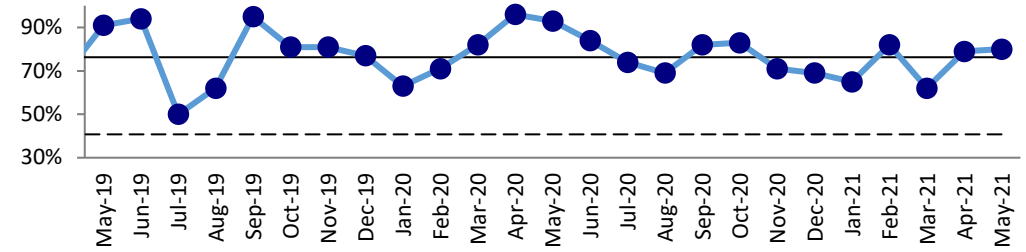
Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people. A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
Loneliness project	Our service users have told us that they feel socially isolated and want support in this area to improve the quality of their lives. Therefore by exploring ways we can enhance social connections we can improve outcomes for service users	Programme has begun and loneliness groups have been established across ELFT. Over the next few months the service will monitor and gather feedback from service users to support improvement.
Trust wide employment programme	Employment will support the service user recovery process	Service users are in the process of developing their own standards of what good employment support looks like, to help shape next steps. Focus on Improving Access to Psychological Therapy (IAPT), and helping service users enter or remain in employment is key to this initiative.
Community mental health transformation	Our services will be delivered in partnership with primary care colleagues, adult social care and the VCSE, enabling us to act more locally, swiftly and appropriately depending on complexity of need. Waiting times will decrease, more holistic advice and support will be provided and services will be outcomes focused with DIALOG as our primary measure	Formal consultation with ELFT staff concluding in June 2021, which will set new expectations in terms of primary care network mental health team structure and place of work in communities. In City & Hackney, all eight neighbourhood mental health teams are up and running. The transformational approach has an increased focus on the social factors that impact on mental health - social isolation, poor housing, poverty, poor physical health. As a consequence there is a lot of emphasis on connecting people to resources in their communities, setting up support groups and a range of new neighbourhood based activity groups such as cycling clubs, football, gardening, and cooking.
Inpatient improvements (Newham)	The experience of inpatient care will be significantly improved in Newham via the Newham Improvement plan and the 14 workstreams within it.	Driver diagram and QI approach agreed. Each workstream has allocated leads. Teams meeting virtually weekly. Service user and staff co-production a key priority.

People with substance misuse problems

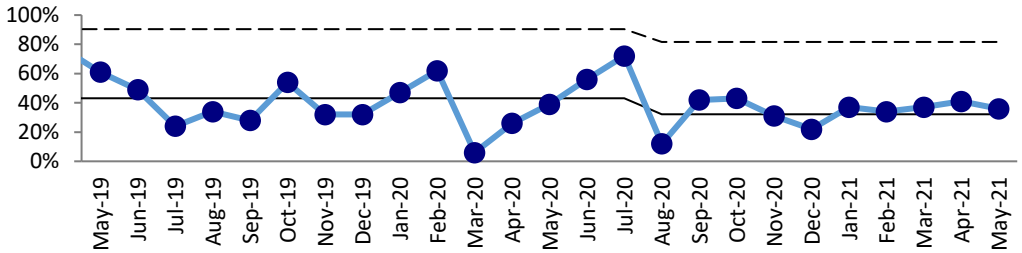
Percentage of service users reporting improvements in quality of life on discharge in Bedfordshire (I chart)

Population Health



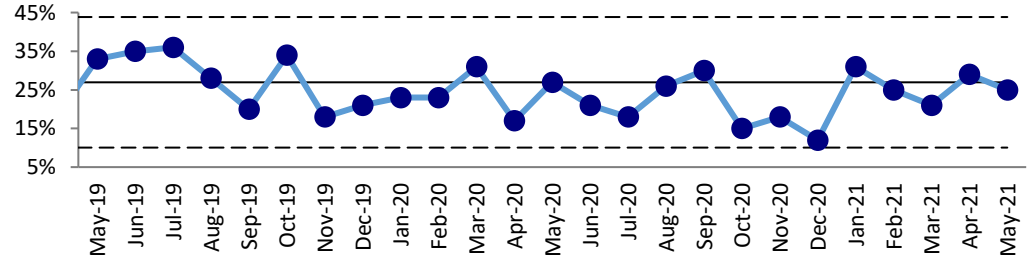
Percentage of service users in employment on discharge in Bedfordshire (I chart)

Population Health



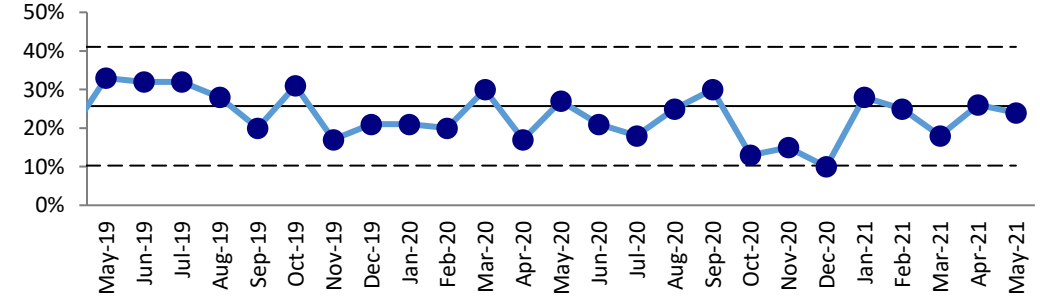
Percentage of service users completing treatment in Bedfordshire (I chart)

Quality



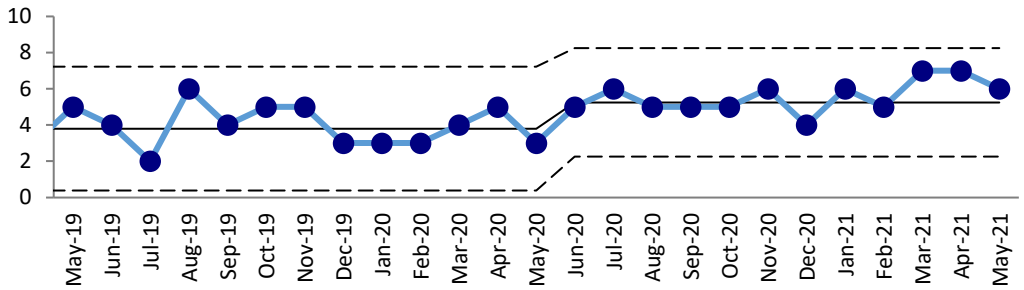
Percentage of successful completions not re-presenting to service in Bedfordshire (I Chart)

Value



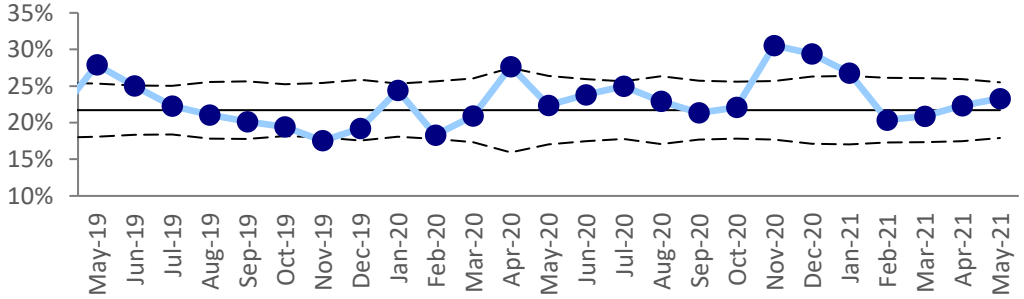
Waiting times to treatment - average days wait in Bedfordshire (I Chart)

Quality



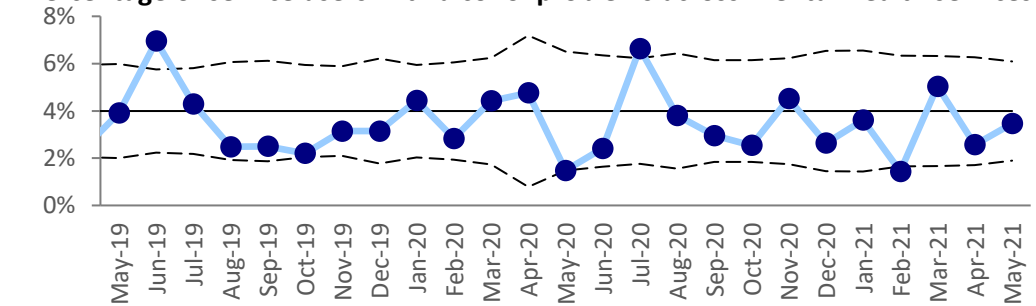
Percentage of service users with drug problems across Mental Health services (P chart)

Quality



Percentage of service users with alcohol problems across Mental Health services (P chart)

Quality



People with substance misuse problems

What does the data tell us?

The indicators for this population focuses on service users with drug and alcohol misuse across mental health services, and Bedfordshire where the Trust provides the Addictions Path 2 Recovery (P2R) service. The P2R service provides drug and alcohol advice, treatment, and support to adults whose lives are affected. It is an integrated service with a range of expertise available in one place including one-to-one appointments, group work, family appointments, physical health review with a nurse, prescribing for opiate use, medically assisted detoxification from alcohol, and referral and support to access other services.

Our population health indicators highlight that the percentage of service users reporting improvements in quality of life has remained stable, and the percentage of service users entering employment on discharge has decreased from 43.1% to 32.9% during the pandemic. The lack of social interaction, employment opportunities, and inability to engage in new activities during COVID has been a barrier to service users remaining abstinent.

Our quality indicators highlight that successful completion of treatment within addictions services has remained stable. There were periods where completion rates dropped during the pandemic due to reorganising service delivery and diverting routine capacity to manage urgent and complex cases. However, completion rates have remained within the top quartile nationally. Non-opiate and alcohol completions have improved again in the last three months as short treatment interventions have been re-established. Average waiting times have also increased which is due to increased demand and referrals into treatment. The service has recently completed a full review of the referral and assessment system and pathway aimed at changing processes to ensure easier and faster access, including supporting service users to self-care through accessing digital platforms (MyCarePath). As these changes get fully embedded the service is expecting waiting times to decrease.

Our value indicators highlight that the percentage of service users re-presenting to the Addiction service after completing treatment continues to fluctuate within normal variation with 24% of service users returning in May.

The quality indicators show that across mental heath services an average of 4% of service users are at risk of alcohol abuse and 21% of service users are current users of drugs - of these, the key substances are cannabis (45%), crack cocaine (12%), powder cocaine (9%) and heroin (7%). As part of physical health monitoring, all services are making referrals to local addiction services and working to integrate pathways so that staff from addiction services in-reach into our inpatient units and community teams to provide timely interventions collaboratively.

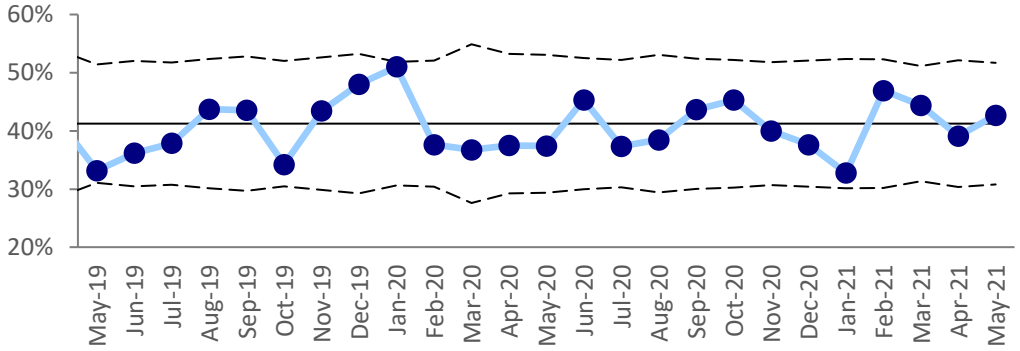
People with substance misuse problems - Projects

Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people.
A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
Increasing digital access – Implementing MyCarePath website service QI project	MyCarePath is an online application that allows service users to manage their own care, and provide increased digital access and allow more service users to enter treatment from the comfort of their own home.	MyCarePath has now been launched, posters designed, Self help packs written and printed to promote this new service. The service will be closely monitoring the uptake of the new service offer in the coming months.
Development of Dual Diagnosis Pathways	Care pathways across ELFT are being strengthened to improve the experience of care for service users with mental health and alcohol and drug misuse problems. This aims to reduce duplication for service users, increase joint planning and improve coordination of care	A protocol is in place to help service users coordinate effective discharge plans through one service. There are established forums and weekly referrals meeting to share information and coordinate support for service users open to multiple services. Processes are also in place to facilitate joint care plan reviews for over 200 service users with dual diagnosis.
Criminal Justice Expansion	Increase provision for service users in the criminal justice system to provide treatment instead of going to prison	This is a new initiative and recruitment is underway to support implementation of new pathways that will offer better care for service users in the criminal justice system.
Rough Sleepers Expansion	This is an expansion of the current service to support homeless service users by providing an in-reach service, bringing multiple services to the central rough sleepers hub to offer joined up multidisciplinary care tailored to service user needs.	The service has recently been established with temporary staff whilst permanent recruitment is completed. There is evidence of positive impact of this service in year 1 with supporting service users to access housing and support with both physical health and mental health needs.

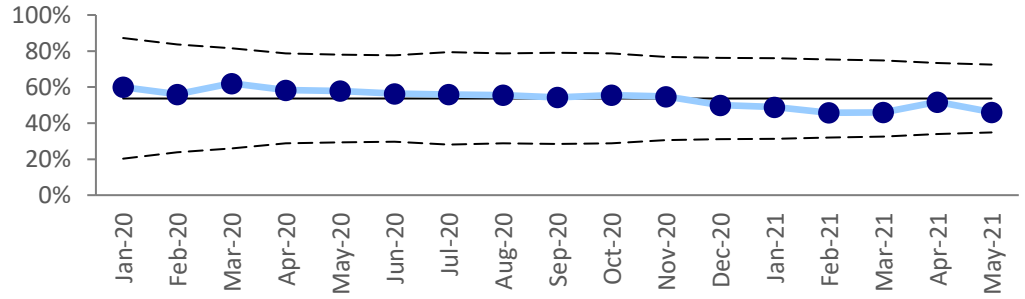
Women who are pregnant or new mothers

Percentage of service users seen in the month from minority communities (P chart)



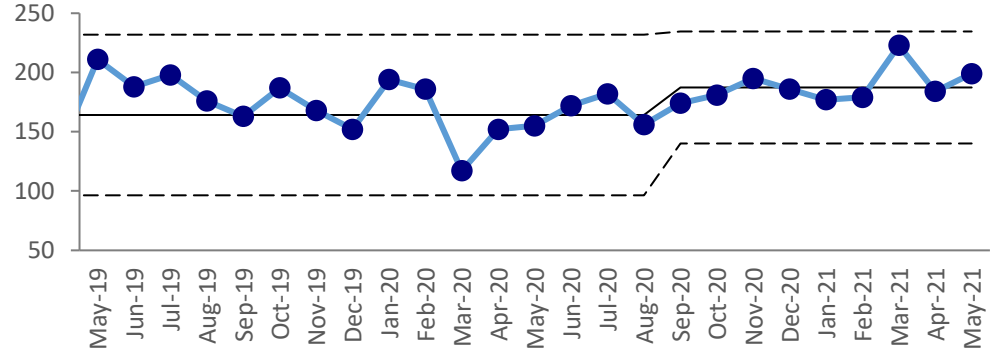
Population Health

Percentage of patients undertaking Core10 showing statistically significant improvement (P chart)



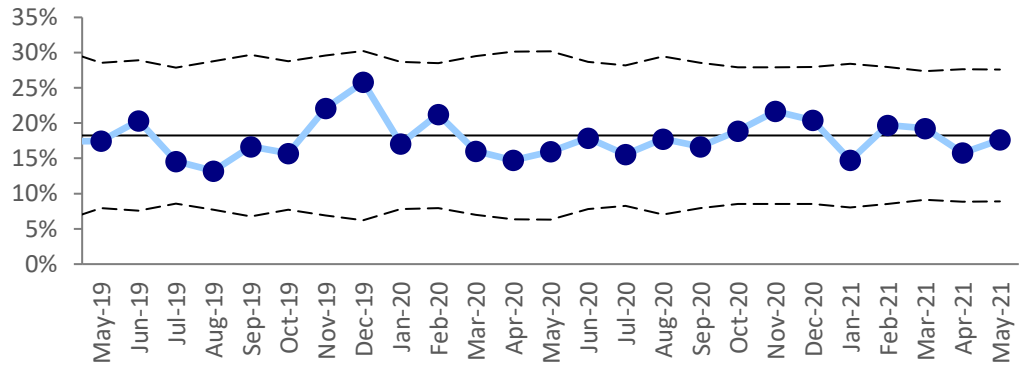
Quality

Number of service users accessing community perinatal services (I chart)



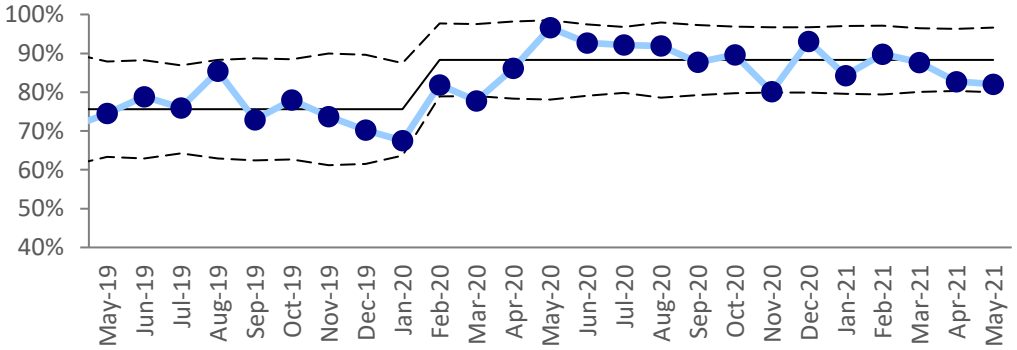
Population Health

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



Value

Percentage of community perinatal service users seen within 28 days (P chart)



Quality

Women who are pregnant or new mothers

What does the data tell us?

The indicators for this population focus on women with mental health problems, who are planning pregnancy, pregnant, or who have a baby up to one year old across East London, Luton and Bedfordshire.

Our population indicators highlight that the percentage of women from minority ethnic backgrounds accessing services continues to fluctuate with an average of 47% of service users coming from BAME communities. Our services closely monitor the number of women that are seen who are from minority communities to ensure access levels are representative of local communities. The perinatal services are all aware of the recent data showing poorer outcomes for women from minority backgrounds and are working to improve services to ensure they are accessible for all women.

The number of service users accessing community perinatal services is projected to steadily rise, as set out in the NHS Long Term Plan. Plans to increase access were affected by COVID, which is reflected by the steep reduction in referrals during March 2020, but activity has since continued to increase and now remains stable. It is expected that the teams will see a steady increase over this year to meet the 8.6% access rate target as set out by NHS England. The Bedfordshire & Luton Integrated Care System Mental Health Programme is currently developing a plan to support recovery against the target. Service leads have been working creatively to increase access through digital and group appointments to maximise existing resources. New Maternal Mental Health Services are being developed for 2021/22 which will support plans to increase access.

Our quality indicators highlight that the percentage of service users seen within 28 days has seen an improvement with an average of 88% seen within this timeframe. Services have reported that this is due to the positive uptake of virtual appointments.

As part of clinical quality incentives (CQUIN), 40% of service users in community perinatal teams should have two or more outcome measures (Core-10) completed. Although the CQUIN has not been implemented yet, the teams have been working towards this in preparation for later in the year.

Our value indicators highlight that outpatient non-attendance remains stable and does not appear to have changed with the introduction of video appointments. Services continue to utilise patient feedback to understand reasons for non-attendance and exploring ways to make improvements such as re-establishing text reminder services that were paused during the pandemic.

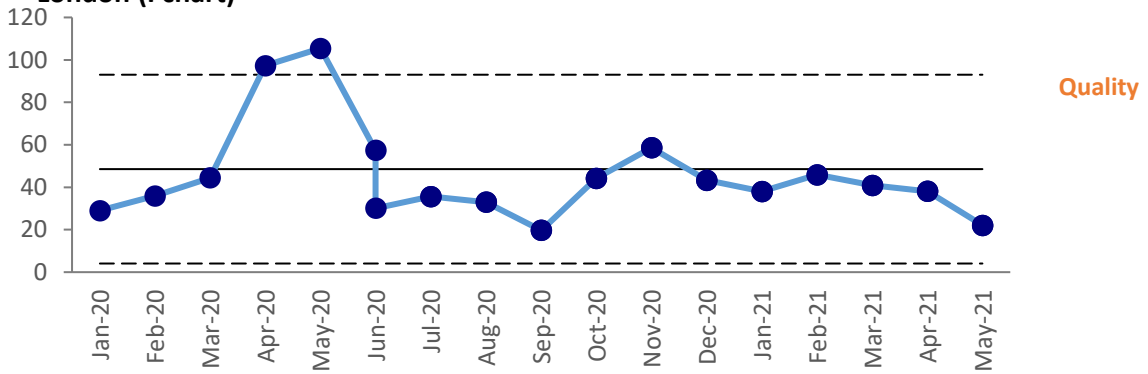
Women who are pregnant or new mothers - Projects

Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people.
A brief description of each project is provided along with a progress update.

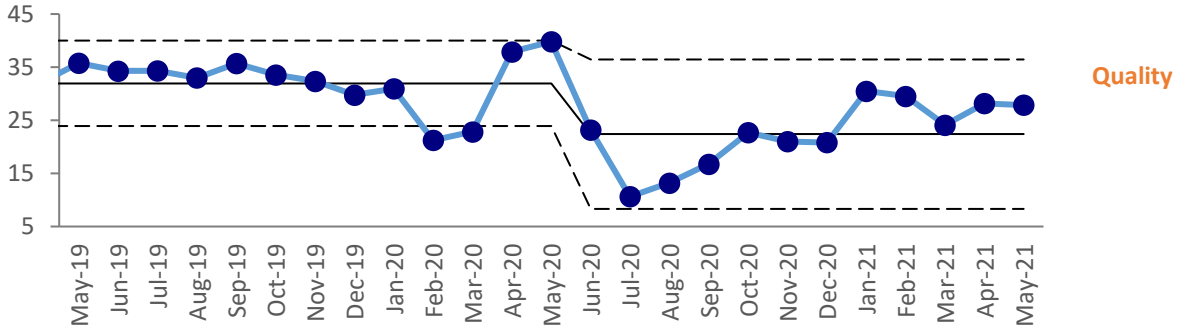
Project	How will this impact on outcomes, experience and/or value	Progress Update
City & Hackney – Preconception Increasing preconception referrals into the teams from community mental health teams.	New project so change ideas are in development. The aim is to improve mental health and obstetric outcomes for women with serious mental illness	Guidance was recently published "Delivering preconception care to women of childbearing age with serious mental illness" (Tommy's, 2021). The team know that referrals for preconception are very low so are collecting baseline data on this. This project is similar to the Newham project, but whilst Newham are focusing on the intervention offered, the City and Hackney project will focus on access.
Newham – An MDT approach to delivering preconception care	The aim is to improve mental health and obstetric outcomes for women with SMI	Preconception care was previously delivered as a one–off medical appointment. This project is focusing on expanding this offer to deliver individualised preconception care as a multidisciplinary offer, tailored to met the needs of the woman.
Trustwide – Increasing access to perinatal psychological therapies	One of the Long Term Plan objectives for perinatal mental health services states that access to psychological therapies should be expanded. This will improve outcomes for parents and infants.	This is a new project with a working group/project team currently being mobilised.
Trustwide – Reducing health inequalities	Recent research suggests that Black African, Asian and White Other women have significantly lower access to community mental health services and higher percentages of involuntary admissions than White British women.	This is a new project with a working group/project team currently being mobilised.

People with stable long term conditions

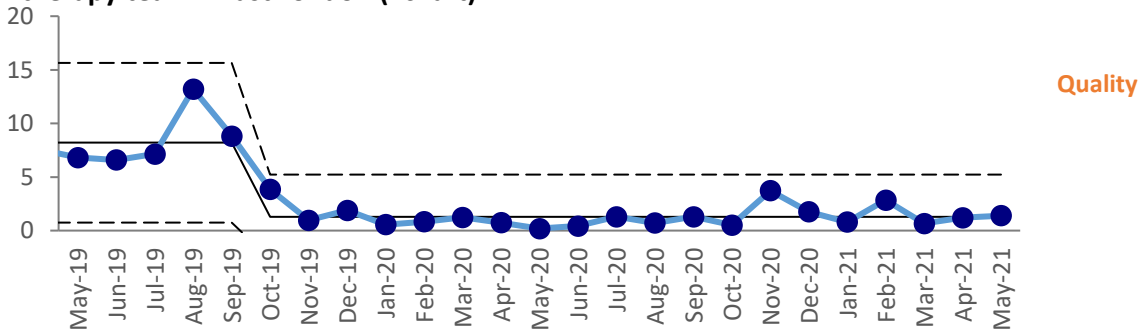
Average wait (in days) for initial appointment with the foot health team – East London (I chart)



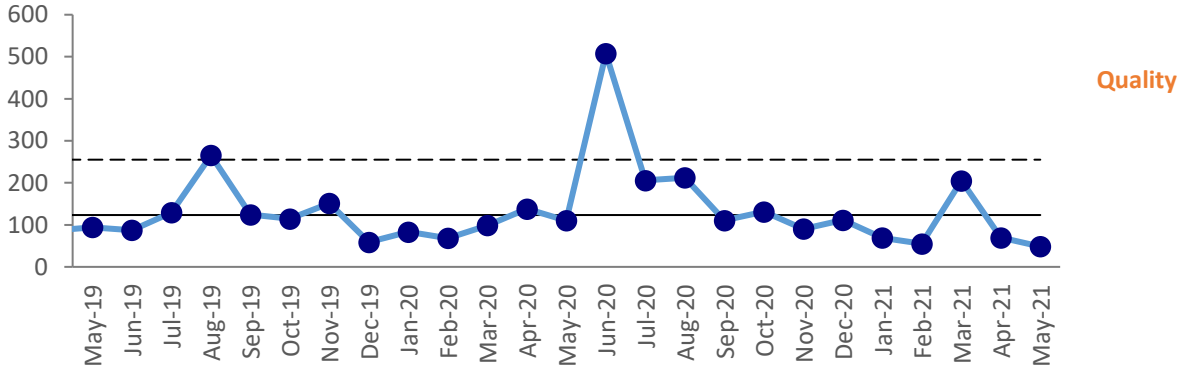
Average wait (in days) for initial appointment with the MSK and Physiotherapy teams – East London (I chart)



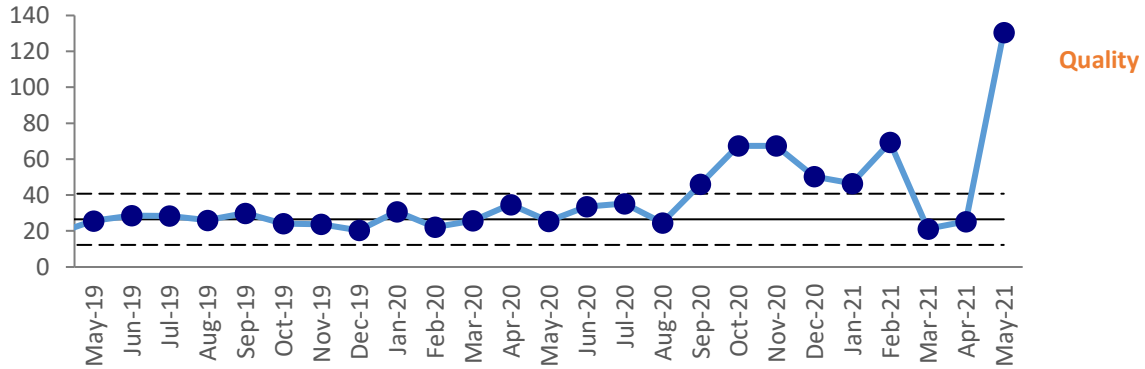
Average wait (in days) for initial face to face appointment with the Speech and language therapy team – East London (I chart)



Average days waited for initial appointment with the Continence Service – East London (I chart)

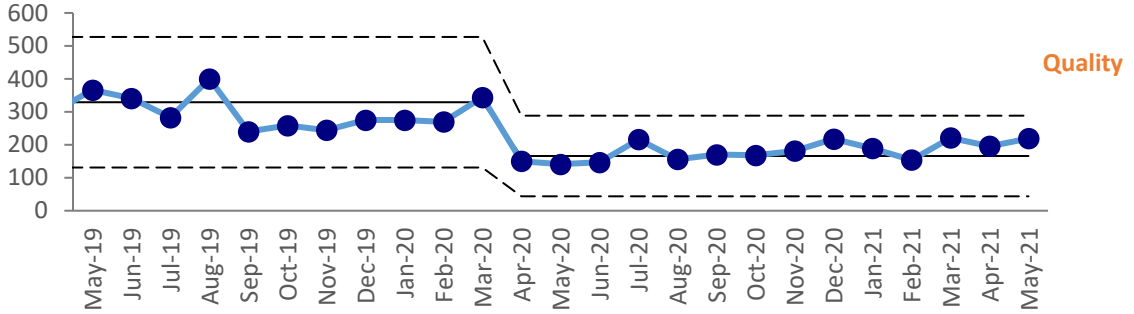


Average wait (in days) for initial face to face appointment with the Diabetes Service – East London (I chart)

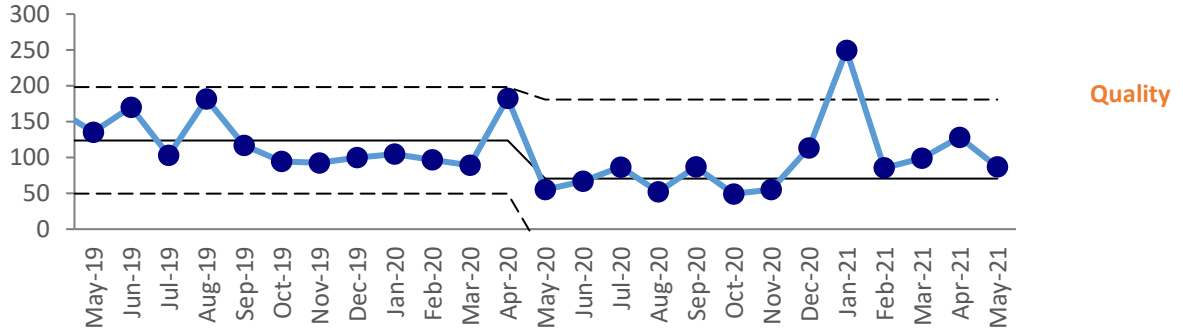


People with stable long term conditions

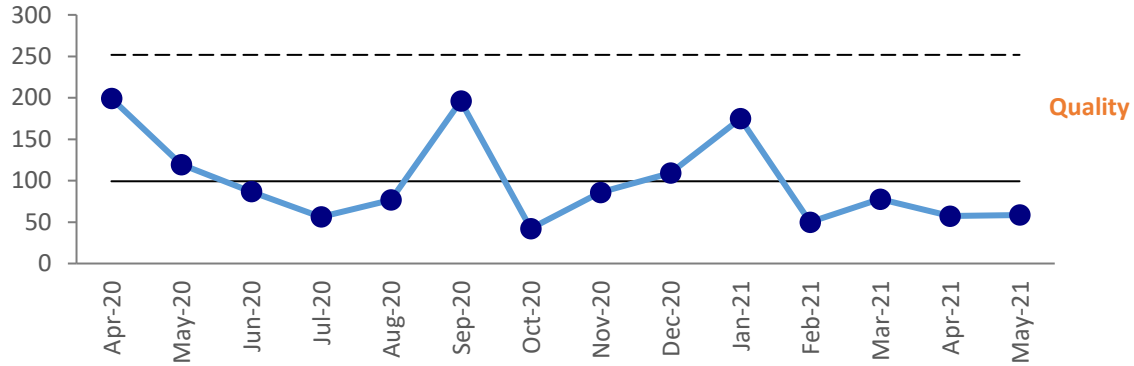
Average wait (in days) for initial appointment with the Continence Service – Bedfordshire (I chart)



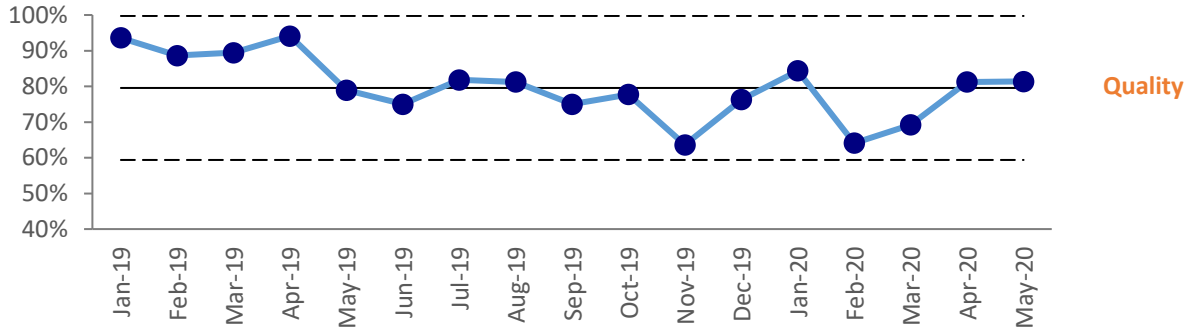
Average wait (in days) for initial appointment with podiatry team (I chart)



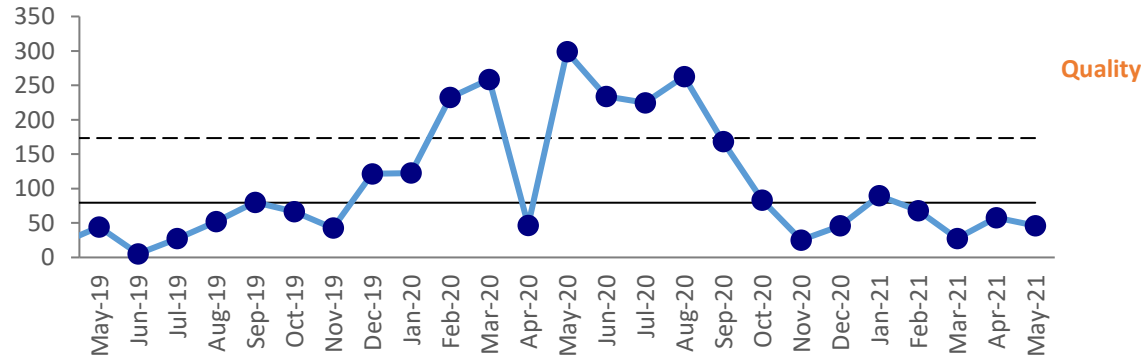
Average wait (in days) for initial face to face appointment with the Speech and language therapy team – Bedfordshire (I chart)



Percentage of patients treated within 18 weeks of referral to Wheelchair Service (p chart)



Average wait (in weeks) for initial appointment with Wheelchair Service (I chart)



What does the data tell us?

The indicators for this population focus on waiting times for service users with stable long-term physical conditions across East London and Bedfordshire. Waiting times are based on service users who have been seen each month (completed pathway) and do not include service users who have yet to be seen for assessment and treatment (incomplete pathway).

In East London, average waiting times to initial assessment remains consistently low for Foot Health, Speech and Language Therapy, Musculoskeletal (MSK), and Continence services. However, Foot Health services have a backlog of service users waiting to be seen. The service is in the process of developing a recovery plan to help manage waiting times for this cohort of service users. In addition, waiting times in the Diabetes Service have seen a big increase in May. The service was closed, except for urgent referrals, during the acute waves of the pandemic which led to a large backlog of service users waiting to be seen. The service has recently re-opened fully and has begun assessing and treating service users waiting the longest, which explains the much longer waits experienced by those seen in May 2021. The service is in the process of implementing a recovery plan and has adopted innovative practices to help increase capacity, such as offering group assessments and treatments, as well as offering treatment through a digital App (Desmond) that promotes self-care and self-management. Analysis of service user preferences suggests that between 20-30% of service users waiting to be treated will be seen through the Desmond App in the coming months, with the remaining offered face-to-face appointments.

In Bedfordshire, average waiting times for assessment and treatment remain low for Continence, speech and language therapy, Foot Health, and Wheelchair services. However, Podiatry and Wheelchair services have developed a backlog of service users waiting to be seen. This was partly due to COVID environmental precautions impacting clinical capacity by reducing the volume of clinics and appointment slots. In addition, the Podiatry service was paused to most new referrals during COVID, with the exception of acute high-risk foot complications requiring urgent intervention. However, the service is now starting to work through the backlog of less urgent new referrals. The service will see a temporary rise in waiting times as this backlog clears. To manage demand, the Wheelchair service implemented risk stratification, to prioritise contacts with service users with the greatest need. This has led to a gradual increase in lower risk cases that remain waiting to be seen. The service is receiving high numbers of referrals for service users that were shielding and want to be reviewed as their needs have changed. Both services are developing backlog recovery plans and are aiming to reconfigure services, in conjunction with our partners, to ensure placed-based care, and improve responsiveness in supporting individuals with stable long-term conditions, whilst preventing or managing deterioration in their health.

People with stable long term conditions - Projects

Below are the main projects under way to improve population health outcomes, quality of care and value for this population, aligned to what matters most to this group of people. A brief description of each project is provided along with a progress update.

Project	How will this impact on outcomes, experience and/or value	Progress Update
Diabetes Education recovery plan	Due to COVID, service users who required diabetes education classes have been unable to attend. This has meant a waiting list for this service. The service has developed a backlog recovery plan and has explored different ways to deliver education classes, either face-to-face, virtually or via an app.	A recovery plan has been created along with a trajectory which the service is working to deliver. This is being monitored every fortnight with the service lead and performance team. The service will be working closely with the People Participation Lead to explore how to best support service users on the waiting list and help collect valuable feedback to improve experience of care.
Increase Newham Telehealth Services	The Newham Telehealth Service has been in operation since 2012 and was seen as a crucial service at the time of pandemic when remote monitoring became a necessity. Patients are remotely monitored at home using different systems and devices, with support from experienced clinicians, nurses and support workers in coordination with GPs and hospital specialist teams. It has been widely successful and has reduced need for unnecessary A&E visits, GP visits, hospital admission and increased patient satisfaction. This QI project aims to sustain this momentum and increase use of telehealth across ELFT services in Newham. This can be done through increasing visibility and awareness of stakeholders, increasing patient participation and satisfaction and improving the referral process.	During COVID, the service enabled facilitation of patient discharges from the acute setting to the community, with escalation processes and the required interventions in place at the comfort of their own homes. The project will be presented at the next QI forum in July 2021 with the view to expanding the service across other community services
Backlog recovery plans for Speech and Language	Improved waiting times whilst supporting individuals with long term conditions, preventing or managing a deterioration in their health.	Backlog recovery plans and trajectory templates have been completed for Speech and Language therapies. Additional capacity has been recruited through temporary agency speech and language therapist employed to reduce the number of patients waiting to be seen.

People with stable long term conditions - Projects

Project	How will this impact on outcomes, experience and/or value	Progress Update
Backlog recovery plans for Wheelchair service	Improved waiting times whilst supporting individuals with long term conditions, preventing or managing a deterioration in their health.	The wheelchair service is in the process of finalising backlog recovery plans and trajectories using Trust templates, but work has started looking at those waiting longest. The initial review has indicated that the majority of the longest waiting service users have had an initial assessment or an appointment has been scheduled.
Backlog recovery plans for MSK podiatry	Improved waiting times whilst supporting individuals with long term conditions, preventing or managing a deterioration in their health.	Podiatry are in the process of finalising the recovery plan for routine referrals as part of a wider service plan. The service is also exploring different skill mix and staff configuration within the service to increase capacity and manage flow more effectively.
Triple aim QI project in Leighton Buzzard	Improving the health of the population of Leighton Buzzard who are over 65 with a diagnosis of dementia or cognitive impairment and two or more long term conditions, by ensuring seamless, accessible, continuity of care which is wrapped around the patient and their family.	This is a large triple aim population health project which includes several different initiatives aimed at improving care of those with stable long-term conditions. Project leads are meeting to discuss next steps and to agree a clear plan for the various workstreams.

What does the data tell us?

1. Purpose of Report

1.1 This section highlights financial performance for the financial year ended 31st May 2021.

2. Executive Summary

- Operating surplus (EBITDA*) to end of May 2021 of £1,787k compared to budget operating surplus of £2,935k.
- Net deficit of £1,148k (-1.3%) compared to planned net surplus of zero (0.0%).
- Year to date net surplus adverse against plan by £1,148k.
- NHS Improvement (NHSI) risk rating is not reported at Month 2.
- Cash balance at 31st May 2021 of £122.8m

3. Financial Framework

3.1 System wide plans for the first six months of the financial year ("H1") were submitted on 7th May. The Trust submitted a H1 financial and workforce plan to NHS Improvement (NHSI) on 26th May.

3.2 The Trust is assuming a H1 breakeven financial plan (i.e. net surplus of zero).

3.3 Opening expenditure budgets have been uploaded based on work completed by finance teams, including a review of non-pay budgets in clinical Directorates. The non-pay review resulted in Directorate non-pay budgets being increased by £6.9m in total.

3.4 A further list of cost pressures is being considered, and agreement has been made to provide additional funding to ICT and infection control budgets. Reserves budgets have been reviewed and devolved to local budgets as appropriate.

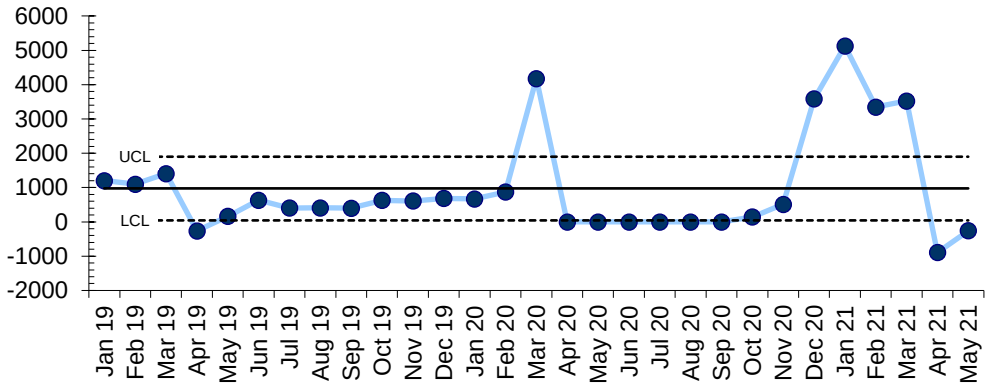
3.5 Income budgets have been revised since Month 1 to account for initial assumptions from draft system plans and expected new investments. Expenditure budgets have been allocated in reserves and will be allocated to Directorate budgets in line with costed proposals against each investment.

3.6 The Trust is assuming for financial reporting purposes that H1 plans continue for the second six months of the financial year ("H2"). Budgets will be amended accordingly as the financial framework for H2 is published and system assumptions are confirmed.

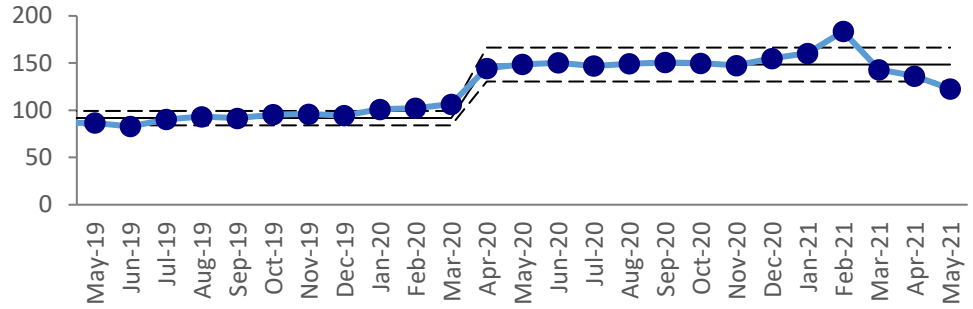
3.7 Directorate management teams will be asked to sign off their individual financial control totals following completion of the Month 2 accounts, on the basis of the assumptions set out above.

*EBITDA – Earnings before Interest, Depreciation and Amortisation

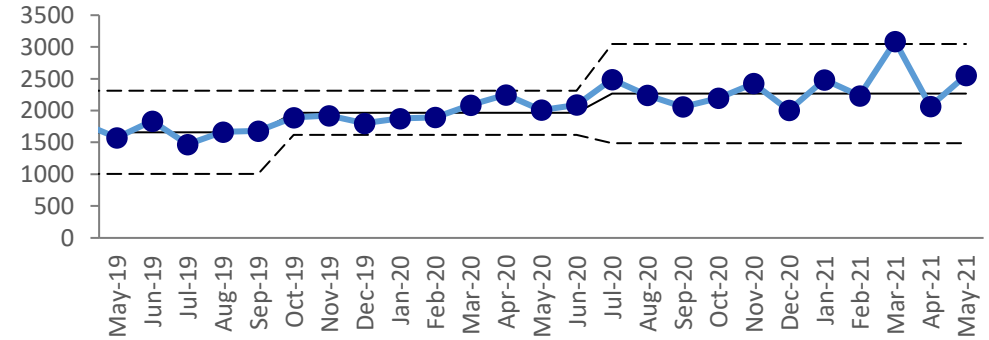
Surplus (£000) (Trustwide – I chart)



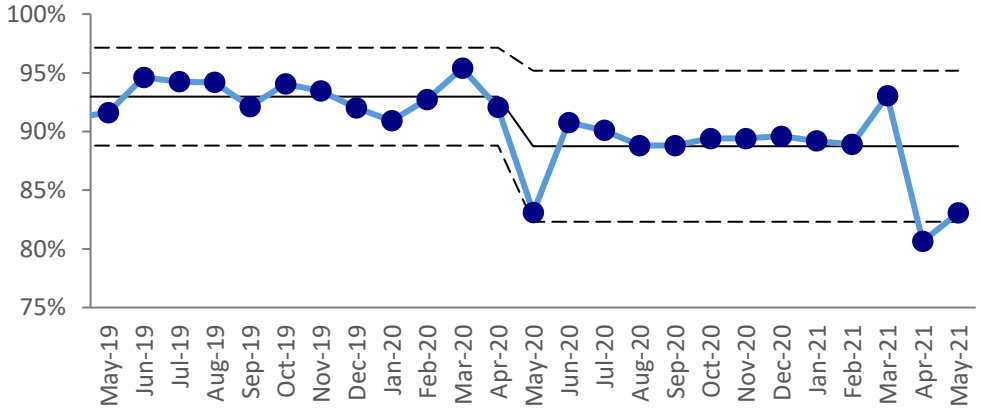
Cash Balance (£m) (Trustwide - I chart)



Agency vs ceiling (£000) (Trustwide – I chart)



The value of invoices paid within 30 days, as a percentage (I chart)



What does the data tell us?

4. Summary of Performance to 31st May 2021

4.1 The financial performance is summarised in the table below:

	YTD May-21			Annual	YTD Apr-21	Change
	Budget £000	Actual £000	Variance £000	Budget £000	Variance £000	+/- £000
Operating Income	90,544	90,319	(225)	528,409	(26)	(198)
Operating Spend	(87,609)	(88,532)	(923)	(510,799)	(872)	(51)
Operating Surplus (EBITDA)	**2,935**	**1,787**	**(1,148)**	**17,610**	**(898)**	**(249)**
Interest Receivable	0	0	0	0	0	0
Interest Payable	(329)	(329)	0	(1,972)	0	0
Depreciation	(1,757)	(1,757)	0	(10,544)	7	(7)
Public Dividend Capital	(849)	(849)	0	(5,094)	0	0
Net Surplus / (Deficit)	**0**	**(1,148)**	**(1,148)**	**0**	**(891)**	**(257)**

4.2 A six-month rolling income and expenditure run-rate is included as an appendix to this report.

4.3 Financial Viability Programme (FVP)
As a result of uploading the initial 2021/22 budgets and updating for H1 plan income assumptions, the Trust has an FVP requirement of £9.1m of which there is a £0.9m impact at Month 2 of which £0.1m has been achieved.

This is subject to change once funding for cost pressures is considered (see 3.4), final income assumptions are confirmed (3.5), and the H2 financial framework is known (3.6).

4.4 The opening balance includes £5.3m carried from previous years and £1.1m (0.28%) national efficiency assumption for H1.

4.5 A separate paper on financial viability is tabled and discussed at Finance Business and Investment Committee (FBIC) which includes relevant detail of the programme.

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.

No.	SOF Oversight Theme	Responsible Services	Measure	Risk Status	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 few areas that are development to support reporting 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.