East London NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
24 September 2020

Title	Integrated Performance report
Authors	Amrus Ali, Associate Director of Performance
Accountable executive directors	Dr Amar Shah, Chief Quality Officer Steven Course, Chief Finance Officer

Purpose of the Report: In light of the impact of Covid-19 pandemic the focus of this report has been adjusted to provide assurance to the Board on key performance indicators including safety, access and demand, experience and outcomes, people and finance.

Summary of key issues

When looking at our safety indicators, the number of unexpected deaths, safeguarding referrals, Information Technology (IT) related incidents, and rate of physical violence across our wards remain stable. There has been month on month improvement in terms of achieving follow-up contact within 72 hours and 7 days of inpatient discharge. There has been a decrease in reported incidents and incidents resulting in harm across the Trust during July, and pressure ulcers continue to be above normal levels.

Our access and demand indicators highlight decreasing demand across accident & emergency mental health liaison services, and increased demand across community and inpatient services. Access to our crisis mental health services remain responsive, with crisis presentations showing further increases in July. Waiting times for community mental health services and community health services remain stable. There has been an adverse impact on waiting times for Psychological Therapy Services (PTS). Overall, PTS services are starting to see a slight decrease in average waiting times from referral to assessment. This is still significantly above the waiting times of pre-COVID levels. The average waiting times for treatment continue to rise. However, in terms of the number of service users waiting for assessment, this has remained consistent in the last 3 months. The number of people waiting for treatment has decreased since February and continues to decrease with the use of virtual treatments. Our Improving Access to Psychological Therapy (IAPT) services have maintained performance, and referral activity has started to rise towards pre-COVID levels. Early Intervention Services (EIS) performance has declined but remains above the current national target of 65% of service users commencing treatment within two weeks of referral.

Overall, access to all services has been enhanced by the adoption of telephone and video contacts with service users. However, there remain challenges with reliable reporting on clinical systems and remote access that has led to under-reporting of monthly contacts and contributed to reduced reliability of annual care plan reviews for service users in mental health services. We are in the process of simplifying our RIO clinical system to make it clearer and simpler for staff to record activity more accurately.

Our staffing indicators highlight non-COVID related sickness and vacancy rates continue to remain low. Our experience and outcome indicators remain stable, showing that the number of complaints and Patient Advice and Liaison Service (PALS) enquires have not increased during the pandemic. Service user outcome measures continue to be captured, but there has been a noticeable shift towards concerns about employment issues during the pandemic.

Regarding financial performance, the operating surplus (EBITDA) to end of July 2020 is £5,634k compared to a planned operating surplus of £5,417k. The overall net surplus of zero (0.0%) compares to a planned net surplus of zero (0.0%) after adjusting for COVID related expenditure and reimbursement. This is in line with the interim breakeven plan. .

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 July 2020 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.

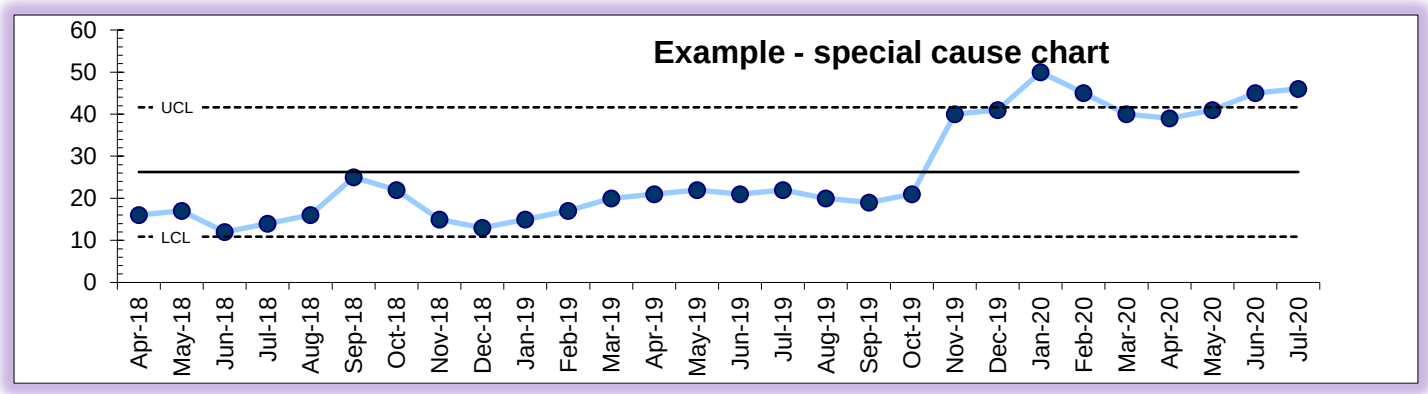
Explanation regarding the use of Statistical Process Control (SPC) charts: SPC charts are used to study how a system or process changes over time. It allows us to understand whether we are improving over time, and to pay attention in a more scientific way to 'signal' versus 'noise'. Signals in the data are based on standard rules used across industry and healthcare to identify 'special cause variation' – when the system is performing in a way that is unstable, requiring further investigation and potential mitigating action.

Introduction

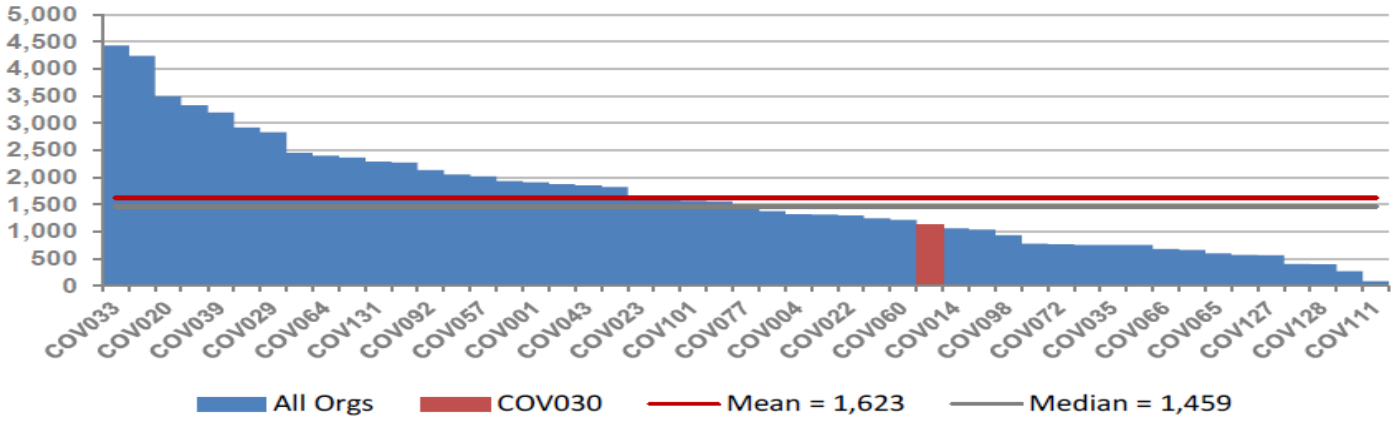
The Board integrated performance report has been adjusted during the Covid-19 pandemic to provide assurance to the Board on key performance indicators (safety, access and demand, experience and outcomes, people and finance) that have been agreed by the Board for monitoring during this period, as well as risks identified from the Board Assurance Framework (BAF). To provide additional sensitivity to change, we are presenting data weekly where possible, rather than our usual monthly frequency. It should be noted that as a result of the suspension of contract monitoring and reporting, some of the data presented in this report has not been subject to the usual local validation and checking processes.

The report includes control charts along with nationally available comparative data and a summary of ***how to interpret this information*** is provided below:

- Charts demonstrating instability (based on signals of special cause on the chart) are highlighted with a purple glow effect, as shown below.



- National comparative data presented in this report includes a series of bar charts which compares the performance of mental health providers across the country. This provides a summary of the distribution across the country and the Trust's position relative to other providers. This is indicated by the red coloured bar chart highlighted below for illustration purposes. The Trust benchmarking information has been separated by East London and Bedfordshire & Luton Mental Health services to better understand the variation across geographical locations.



1. Safety

The charts below demonstrate variation across a range of key safety measures. The number of unexpected deaths, safeguarding referrals, Information Technology (IT) related incidents, and rate

of physical violence across our wards remain stable. The number of reported incidents has been stable since April but we have seen a reduction during the last week of July, particularly related to care and treatment and violence and aggression incidents within Community Health Services and Mental Health services.

The percentage of incidents resulting in harm is also showing signs of reduction. The signs of reduction in incidents of harm in the past 2 months is reflected across all services. This is related to a decrease in care and treatment and violence and aggression incidents within Bedfordshire, Tower Hamlets, City & Hackney Mental Health services and Community Health services. It is believed this is partly the result of more accurate recording of incident harm categories, as well as the “Time to Think” quality improvement work which has been re-established across inpatient mental health services. This has supported teams to proactively monitor and deescalate potential harmful violence and aggression incidents.

Chart 1.1 Number of patient safety incidents reported (Trustwide - I chart)

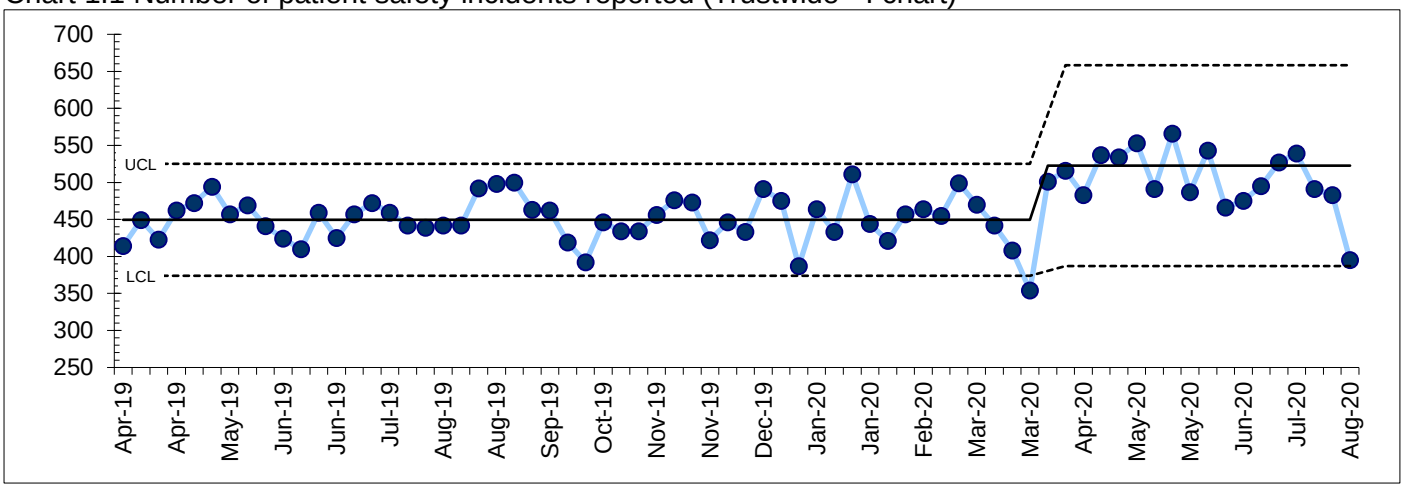


Chart 1.2 Percent of incidents resulting in harm (Trustwide – P chart)

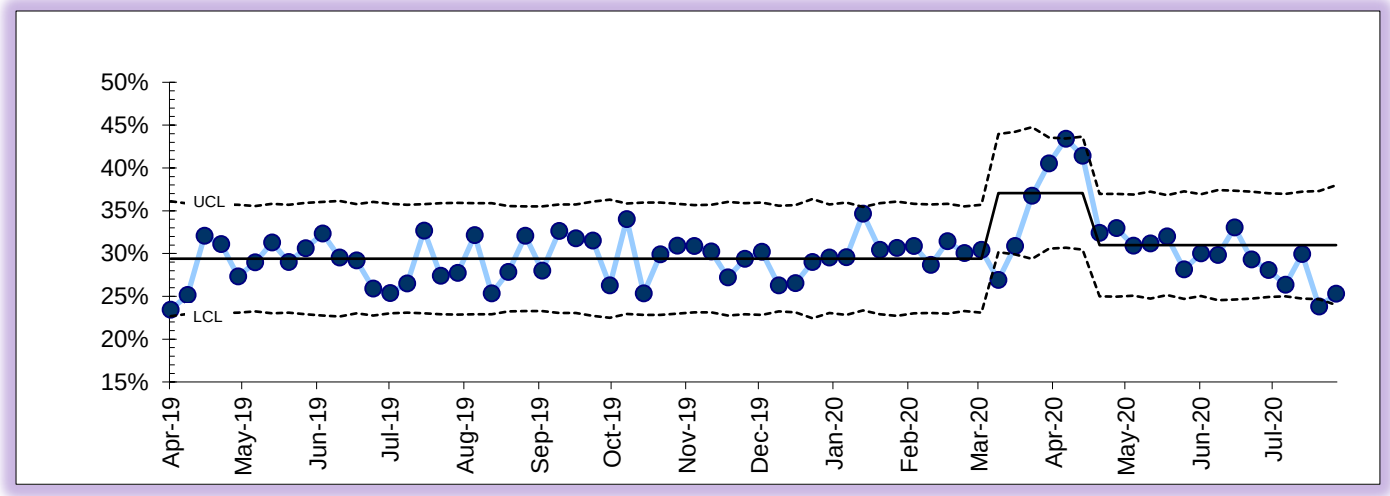


Chart 1.3 Rate of incidents of physical violence per 1000 occupied bed days (Trustwide – U chart)

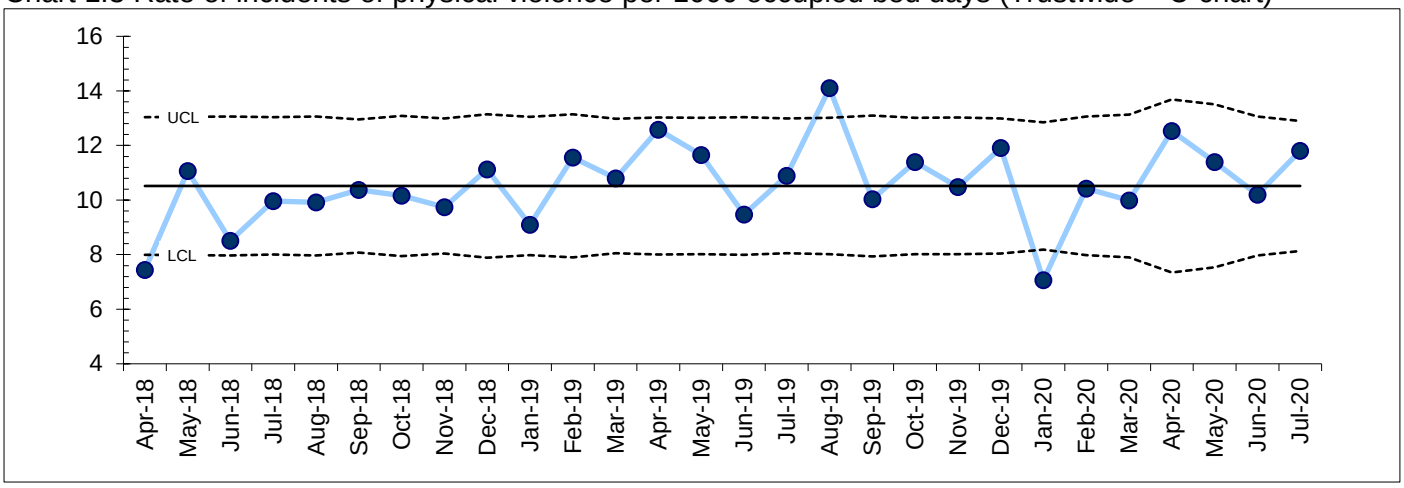
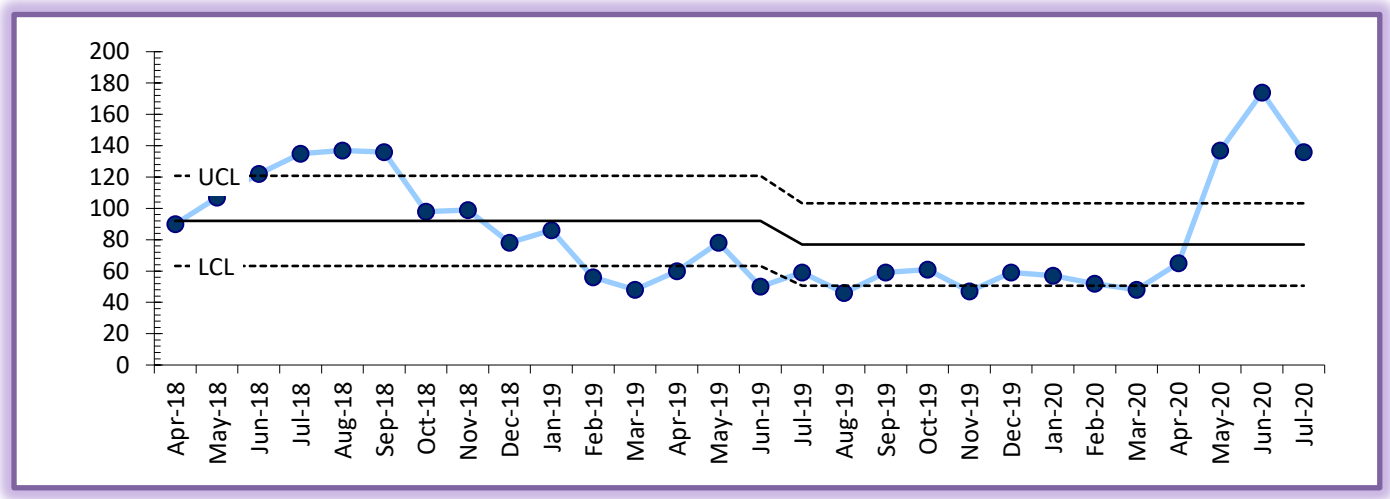


Chart 1.4 Number of Grade 2, 3 or 4 pressure ulcers (Trustwide - C chart)



The number of reported pressure ulcers continues to be above normal levels, increasing to a peak of 174 incidents during June and subsequently decreasing to 134 incidents in July. The main reason for this increase in June relates to the inclusion of Suspected Deep Tissue Injury (SDTI) cases. SDTI's have now been included due to changes in the way this cohort was reported, and national recommendations that were issued to eliminate variations in national reporting. The current guidance is that all SDTI's should be monitored until they are resolved (and incident updated on our reporting system) or they evolve and we re-report them and highlight the latest pressure ulcer category. Therefore, the numbers sometimes change in any given month as the SDTI evolves or resolves and as services are made aware of the exact condition of the pressure ulcer.

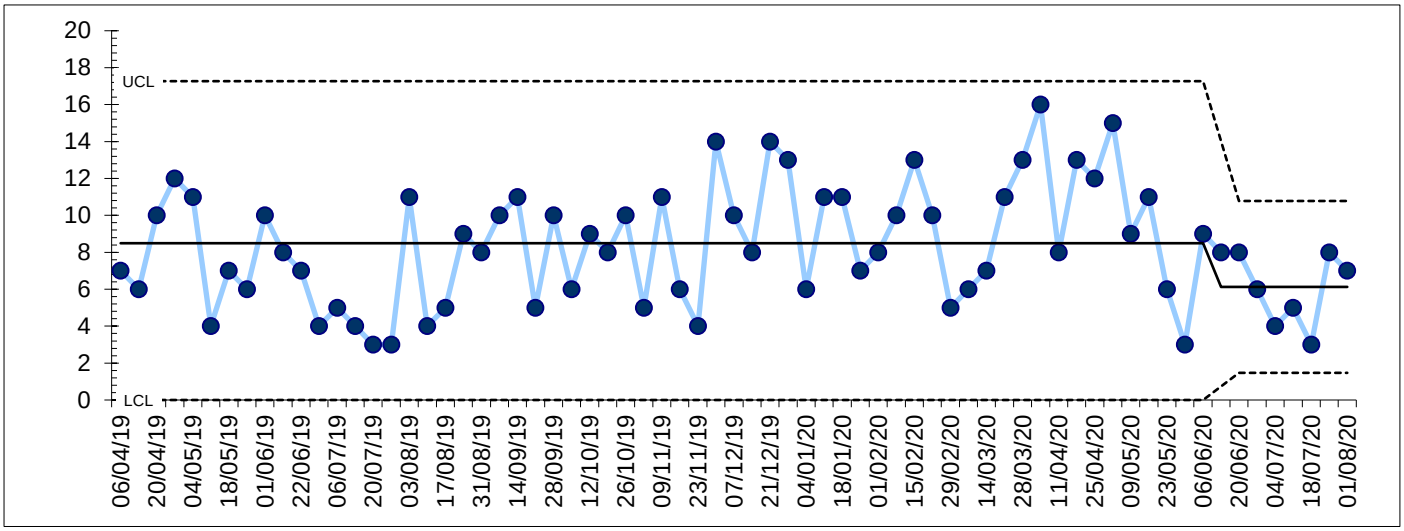
Tower Hamlets has historically been suspected of under reporting incidents and the Infection Control team have worked hard to improve this. The team continues to have pressure ulcer prevention and management training delivered monthly where reporting is positively encouraged. In addition, we have a new pressure ulcer team leader in post who has been working closely with service managers, promoting the importance of reporting and this has led to some early signs of increased reporting. The Tissue Viability Team who are continuing with weekly training via a virtual platform and attendance at these sessions remains high. The team have trained 212 staff since May in pressure ulcer prevention and management and wound assessment. This has promoted greater awareness and it is believed greater reporting of cases.

The other reason for the increase in June relates to a small rise in category 3 pressure ulcers, particularly in Newham where one service user was represented multiple times. This was the result of delays with accessing the correct pressure relieving mattress that led to the service user

developing further pressure ulcers under our care. Lessons from all incidents are shared with the team and plans put in place to mitigate and escalate potential delays with equipment.

During July pressure ulcer incident numbers have reduced, and the Tissue Viability Team are anticipating further improvements in the coming months as a result of a new initiative underway. The team is moving forward with a Trustwide quality improvement project which is testing a new change idea in one of the Extended Primary Care Teams (EPCT). This involves the use of telehealth to monitor service users on our EPCT caseload who have a urinary catheter in place and who are at risk of developing a pressure ulcer. Traditionally, this cohort of service users would only be reviewed once every 12 weeks unless there was a catheter problem. However, the aim of this telehealth intervention is to monitor these service users more frequently and to act quickly at the point of identifying red skin to proactively prevent a pressure ulcer developing. The team is hopeful that the test will be successful and can be scaled up to other teams.

Chart 1.5 Number of unexpected deaths (Trustwide – I chart)



Services are continuing to work towards the new 72-hour follow-up standard for post discharge care and support. The pandemic has momentarily paused the quality improvement project that had been initiated by our Medical Directors for mental health services to meet the new expectation. However, our newly appointed Suicide Prevention Lead for the Trust is now in post and has started taking this work forward again. Our medical directors have discussed the importance of maintaining focus on follow-up standards during Silver Command meetings and are continuing to monitor progress through local directorate management meetings.

Chart 1.6 Percent of service users followed up within 72 hours of discharge from ward (Trustwide - P chart)

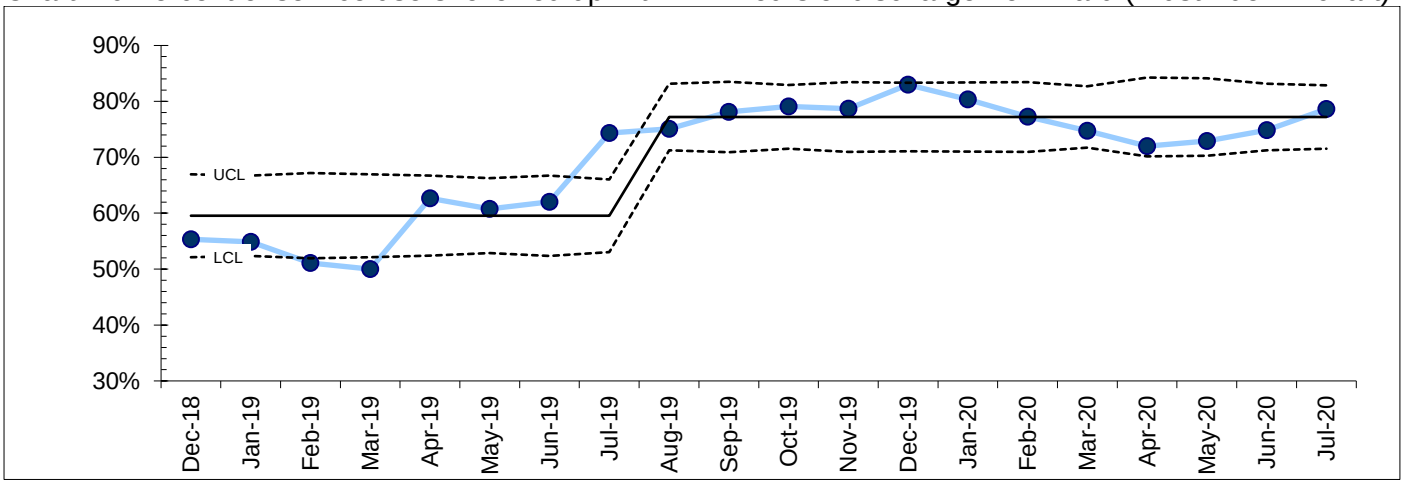
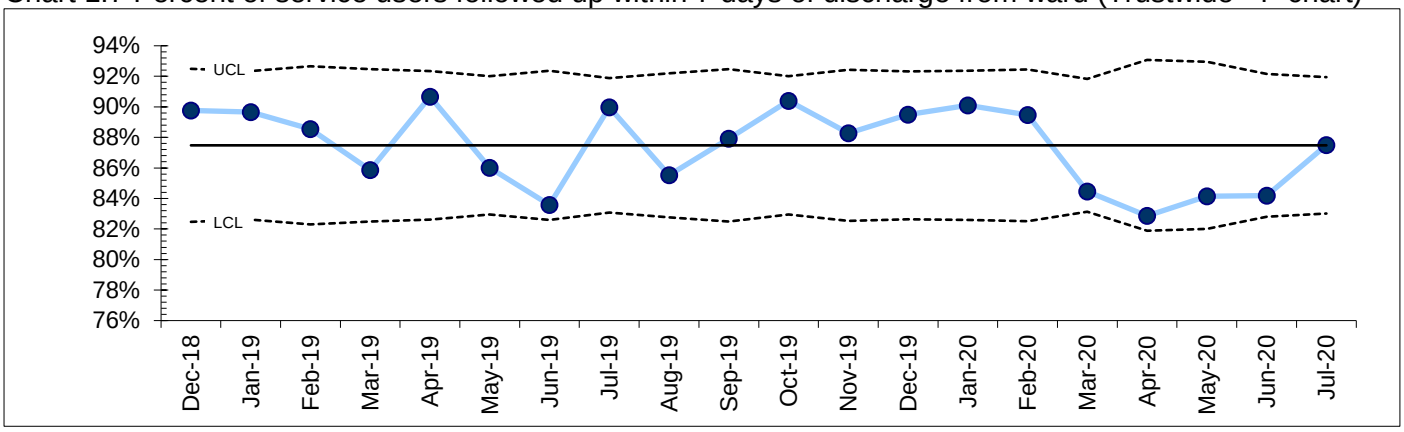


Chart 1.7 Percent of service users followed up within 7 days of discharge from ward (Trustwide - P chart)



The data above shows the Trust's compliance levels with post discharge follow-up care from inpatient mental health services. The data has been amended to include discharges from all adult and older adult wards including Perinatal and Forensic inpatient services to reflect recent changes to our national submissions. Chart 1.6 shows that since April there has been month on month improvement in service users being followed-up within 72 hours of discharge, and in July performance levels returned to pre-COVID levels with 78.7% compliance (with the target being 80%). This increase is largely attributable to consistent improvement in City and Hackney services moving from 55% compliance in April, to 78% in July.

Chart 1.7 shows that there has also been a similar improvement in 7-day follow-up compliance during the same period. It is expected that this standard will be replaced with the 72 hour standard next year. However, performance levels are currently below the national 95% target. The pandemic has impacted most of our services as a result of disruptions caused by rapid changes in community services and subsequent focus on crisis response. Local audit of delayed follow-up highlight that the main factors relate to service users not engaging with multiple follow up contacts offered within the designated timescale, some service users not having telephone or alternative contact mediums, and data entry errors by staff in recording positive contacts.

Chart 1.8 Number of reported IT or System access incidents (Trustwide – I chart)

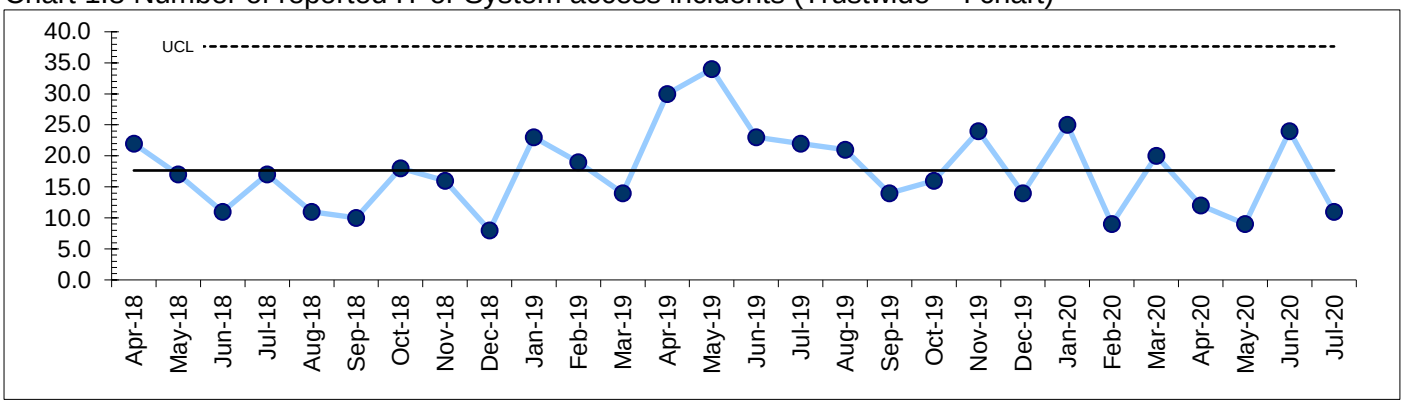
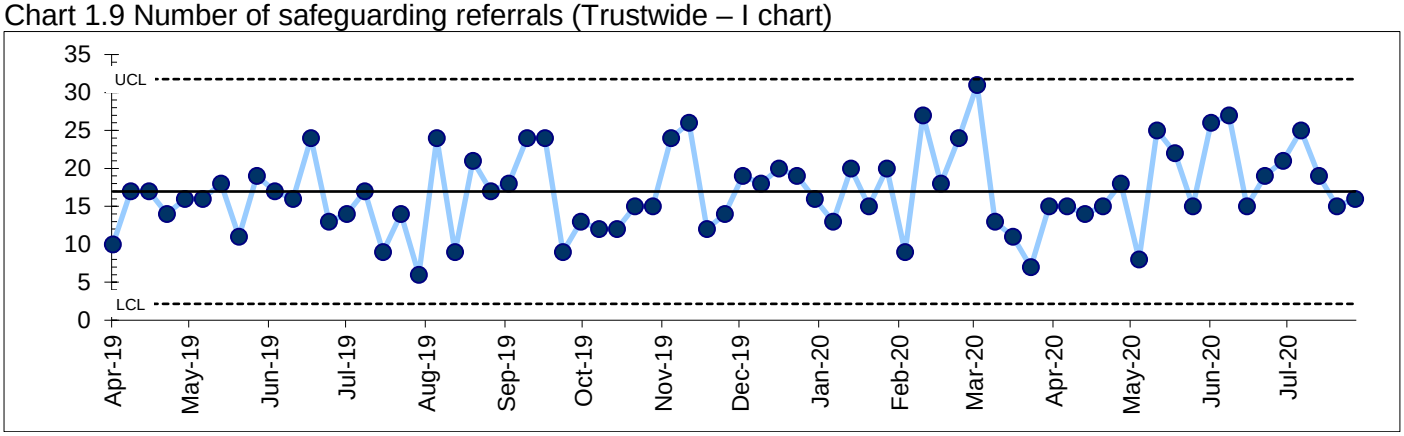


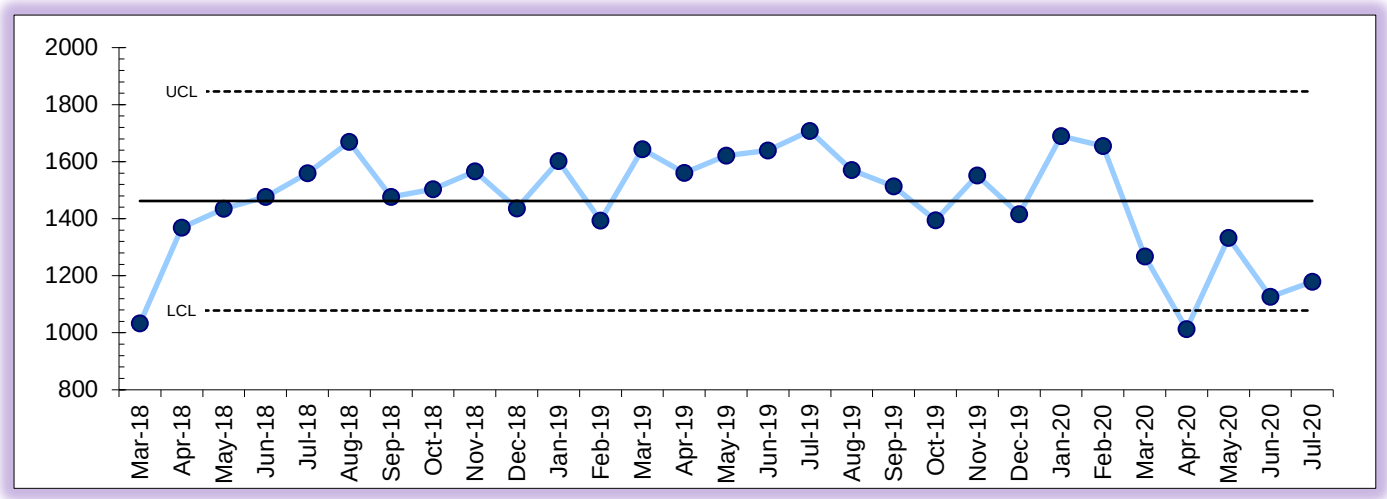
Chart 1.9 Number of safeguarding referrals (Trustwide – I chart)



2. Access and Demand

The charts and narrative below provide assurance across a range of demand and access indicators. As Government social distancing measures have started to ease, we have seen signs of rising demand across some services in the Trust. Referrals to Accident and Emergency (A&E) mental health liaison services increased during May, but have decreased during the months of June and July.

Chart 2.1 Number of referrals to A&E Mental Health Liaison services (Trustwide – I chart)



Inpatient bed occupancy is continuing to increase in July with the number of admissions also increasing from 397 in April to 582 in July. Chart 2.2b shows that this compares favourably to the national average of 90% bed occupancy for adult mental health services reported during July. Older adult mental health bed occupancy continues to be below national average in East London and similar to national average in Bedfordshire & Luton. However, bed pressures remain challenging, particularly in Bedfordshire & Luton where adult bed occupancy levels have been above national average with 100% occupancy. This has led to some Bedfordshire & Luton service users being admitted to beds on East London sites due to capacity issues. In City and Hackney, there have been similar challenges due to the closure of one of the wards on the 6th June as a result of staffing capacity issues but was subsequently reopened on the 22nd July after this was resolved.

Chart 2.2a Bed occupancy (Mental Health & Community Health – P' chart)

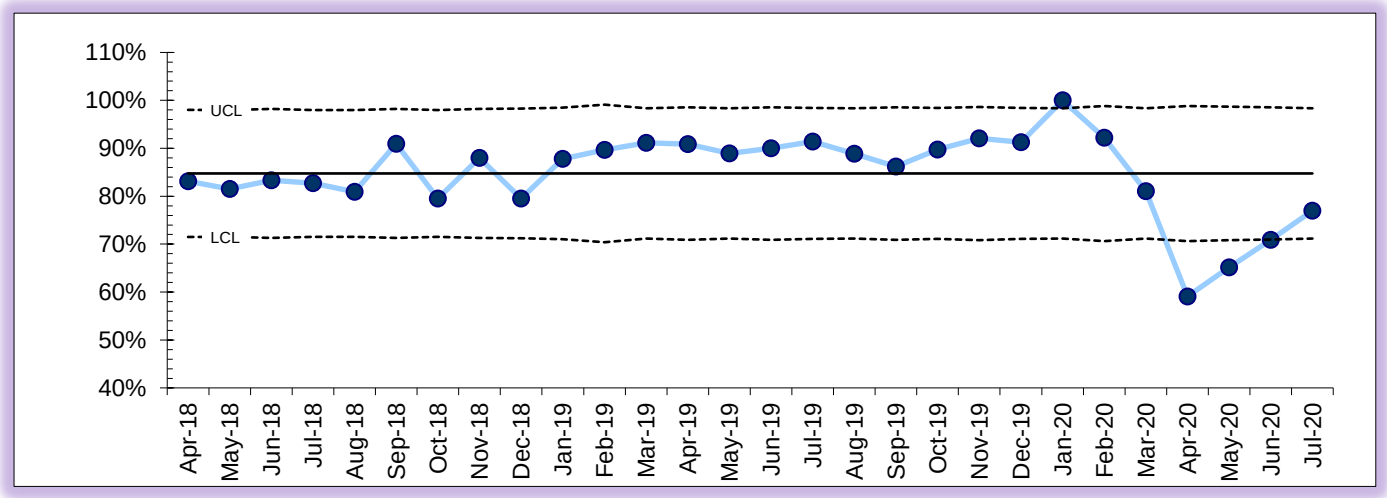
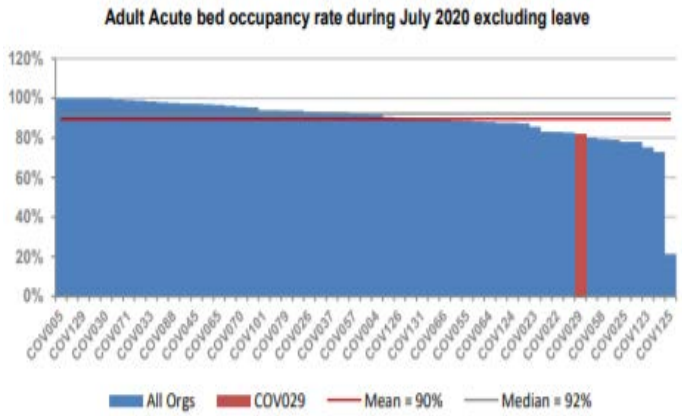
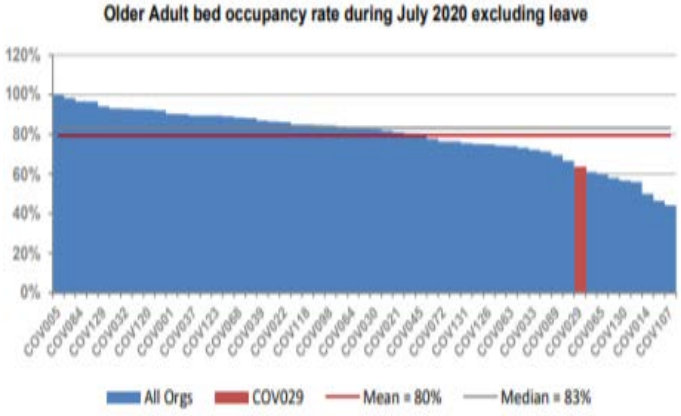


Chart 2.2b - National Mental Health Inpatient Occupancy (Source: *National Mental Health Benchmarking Network – July 2020*)

East London

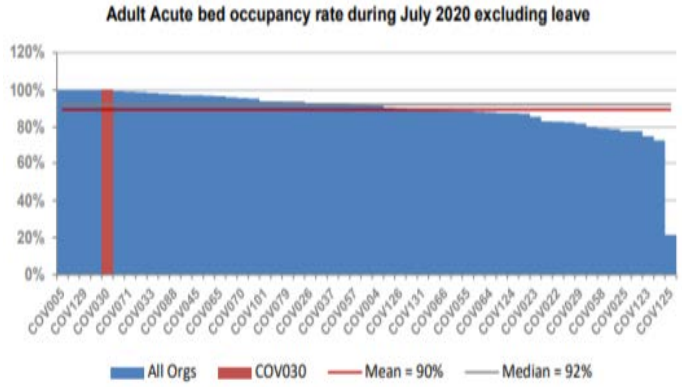


	2018/19	Jul-20	Change
National average	93%	90%	-3%
COV029	88%	82%	-7%

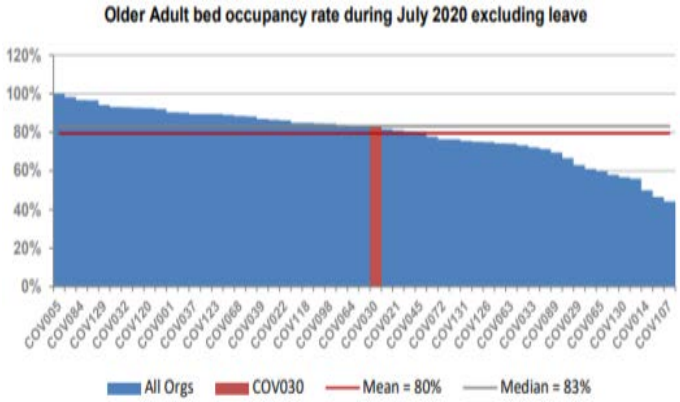


	2018/19	Jul-20	Change
National average	86%	80%	-7%
COV029	78%	63%	-20%

Bedfordshire and Luton



	2018/19	Jul-20	Change
National average	93%	90%	-3%
COV030	88%	100%	14%



	2018/19	Jul-20	Change
National average	86%	80%	-7%
COV030	95%	83%	-12%

Chart 2.3a and 2.3b highlight the number of mental health admissions is higher than the national average of 18.7 admissions per 100,000 population, with East London adult Mental Health inpatient services reaching 45.9 and 32.9 admissions in Bedfordshire and Luton. This reflects the increasing pressure mental health inpatient services are starting to experience, particularly from female and brand-new admissions during the month of July. This position is reviewed frequently in local bed management meetings and as part of the Mental Health Silver Command group, to ensure that robust plans are in place to mitigate pressures. All inpatient services are currently undertaking a review of recent admission activity to identity themes and wider factors that are contributing to the increase in demand, so that a coherent plan can be formulated in each locality to support admission avoidance, inpatient flow and system resilience. It is believed that one of the contributory factors leading to rising admission numbers is reduced face-to-face contact offered by community services and reduced engagement between service users and services since social distancing measures were put in place. As a result, guidance is being developed through the covid clinical workstream to support teams and staff to ensure that sufficient contact is being made, including timely and appropriate face-to-face contact with service users at risk of admission.

Chart 2.3a Number of admissions (Mental Health and Community Services – I chart)

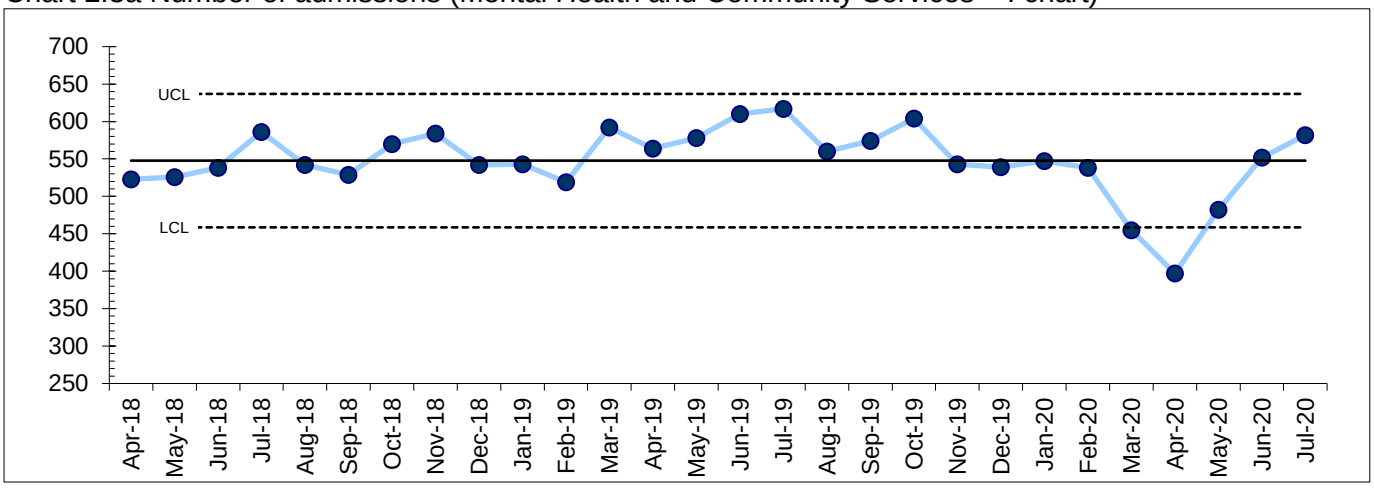
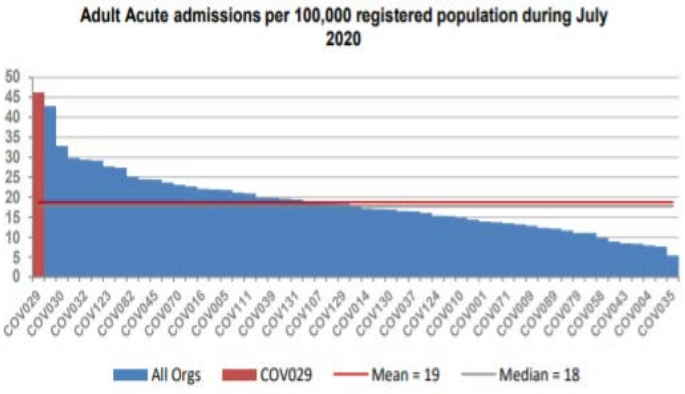
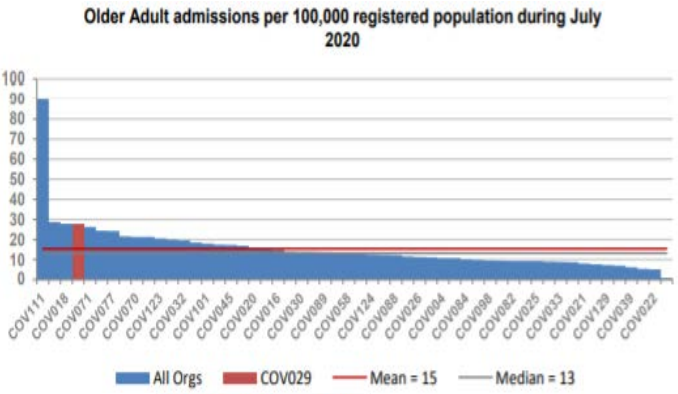


Chart 2.3b - National Mental Health Inpatient Admission Activity (Source: *National Mental Health Benchmarking Network – July 2020*)

East London

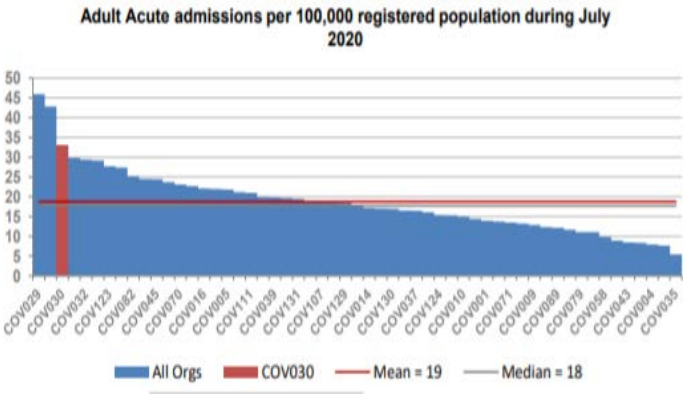


	2018/19	Jul-20	Change
National average	19.6	18.7	-4%
COV029	40.6	45.9	13%

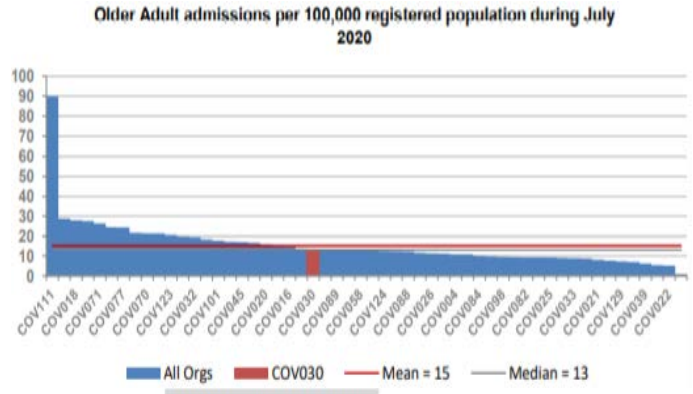


	2018/19	Jul-20	Change
National average	14.8	15.4	4%
COV029	25.9	27.4	6%

Bedfordshire and Luton



	2018/19	Jul-20	Change
National average	19.6	18.7	-4%
COV030	23.7	32.9	39%

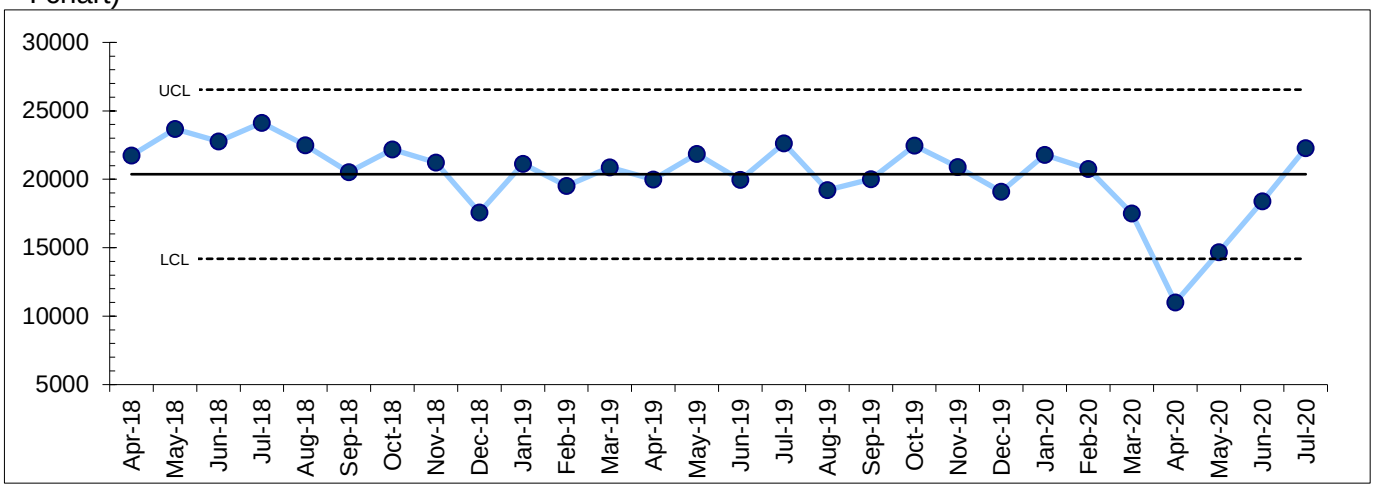


	2018/19	Jul-20	Change
National average	14.8	15.4	4%
COV030	12.6	13.8	10%

Referrals to Mental Health and Community Health Services has increased, from 11,005 in April to 22,288 in July. During this period, the number of referrals has increased by 42% in Bedfordshire Community Health Services, 47% in Mental Health Services and 61% in East London Community Health Services. Chart 2.4b highlights national referral data for Mental Health and CAMHS services,

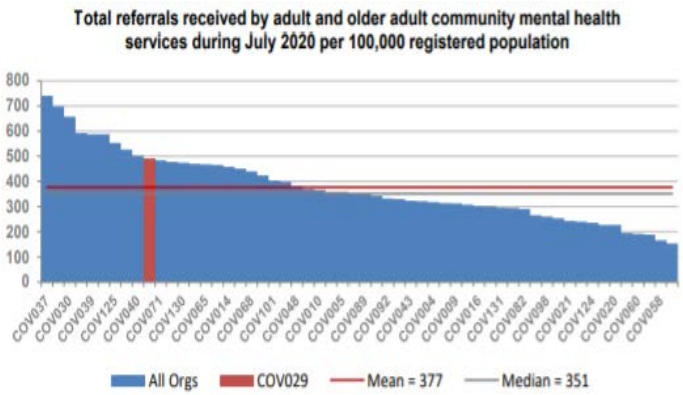
which suggests that the increase in adult referrals is higher in East London and Bedfordshire and Luton compared to the national average.

Chart 2.4a Total number of referrals to community teams (Mental Health, CAMHS & Community Services – I chart)

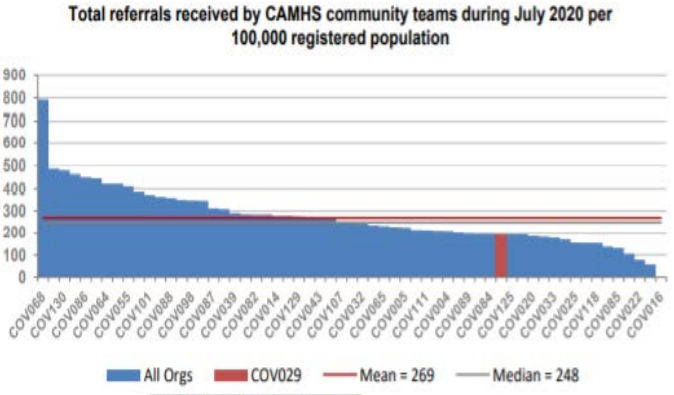


2.4b -Total referrals received by adult and older adult community mental health services and CAMHS (Source: *National Mental Health Benchmarking Network – July 2020*)

East London

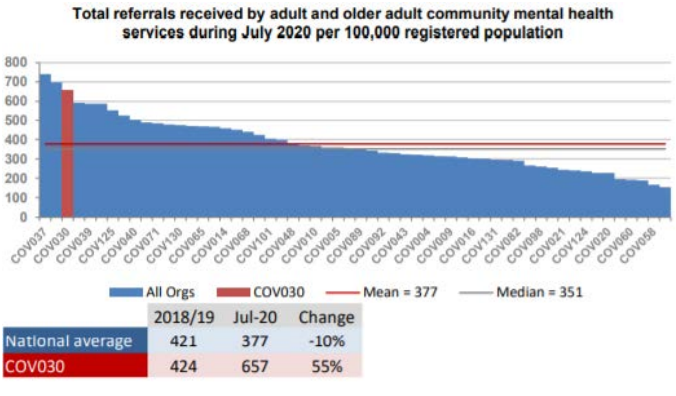


	2018/19	Jul-20	Change
National average	421	377	-10%
COV029	496	489	-2%

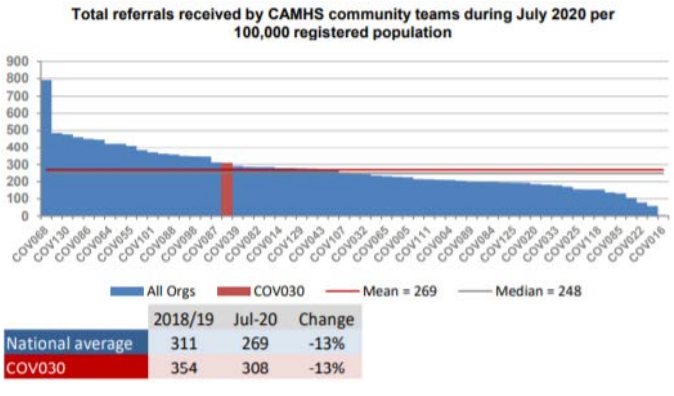


	2018/19	Jul-20	Change
National average	311	269	-13%
COV029	204	195	-4%

Bedfordshire and Luton



	2018/19	Jul-20	Change
National average	421	377	-10%
COV030	424	657	55%



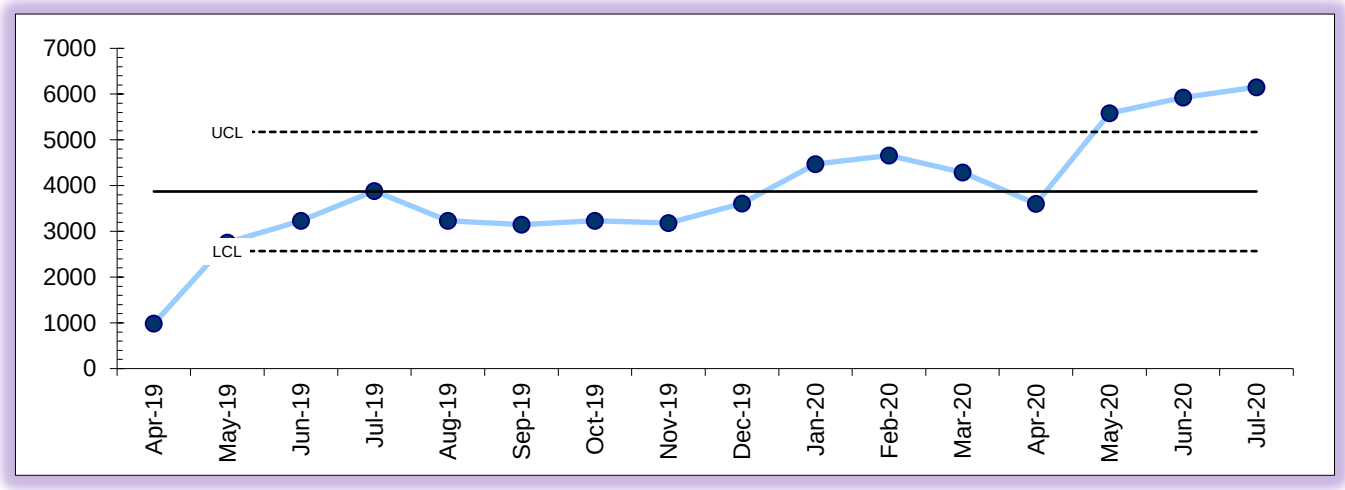
	2018/19	Jul-20	Change
National average	311	269	-13%
COV030	354	308	-13%

Mental Health Crisis pathway

Chart 2.5 below highlights activity across our mental health crisis lines. During June and July, there have been further increases in the number of crisis calls, largely across City and Hackney and Luton and Bedfordshire services. City & Hackney routinely has the highest activity with 2,856 calls in July followed by 1,722 calls in Newham, 998 calls in Tower Hamlets, and 577 calls in

Bedfordshire and Luton. More staff have been employed across all services to support this increase in activity. All services have reported an increase in the number of calls from service users not known to the Trust presenting for the first time to mental health services with psychotic symptoms. This appears to be related to service users whose condition has been exacerbated by the pandemic leading to deterioration in their mental well-being. Further work is underway by our public health team to better understand this cohort of service users and to explore the drivers behind these new presentations. However, some services have also reported an increase in the number of non-crisis calls, which could be potentially managed through other general helplines such as those offered by Mind or the Samaritans. It is believed that national publicity for mental health crisis services may be contributed to the increased number of calls. Some of the teams have started reviewing frequent callers to the crisis lines as well as service users who are known to the Trust, to review their care plans and identify better ways to support service users to access alternatives such as a local crisis café and the Primary Care Network Community Connector support. In addition, further work is underway to collaborate with local partners and commissioners to improve public communication strategies, and to explore additional investments in service provision to strengthen crisis pathways within each locality for the future.

Chart 2.5 Number of calls to crisis line (Trustwide – I chart)
*Luton & Bedfordshire commenced reporting in January



Access to Services and Future Demand Management

The average waiting time for assessment in CAMHS and adult & older adult community mental health remains stable with an average of 27.3 days. This data is based on waiting times for service users who have been seen. There are also service users who, for different reasons (cancellations, non-attendance, service user preference or other clinical reasons), have not yet been seen and are waiting for initial contact/assessment.

Chart 2.7 Average number of days from referral to assessment – attended cases (CAMHS, and adult Mental Health community teams – I chart)

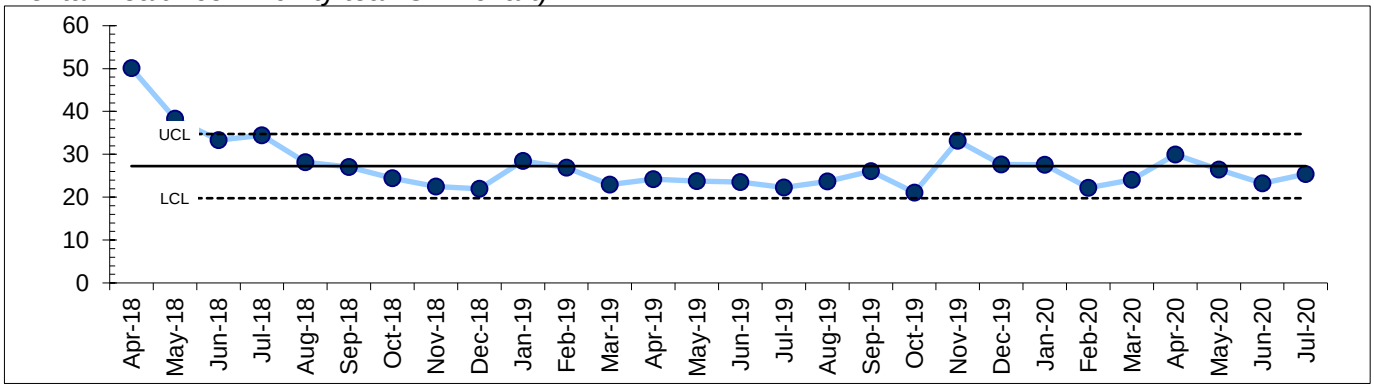


Chart 2.8a Average waiting times for referrals not yet seen for assessment – current snapshot (CAMHS, and adult Mental Health community teams – I chart)

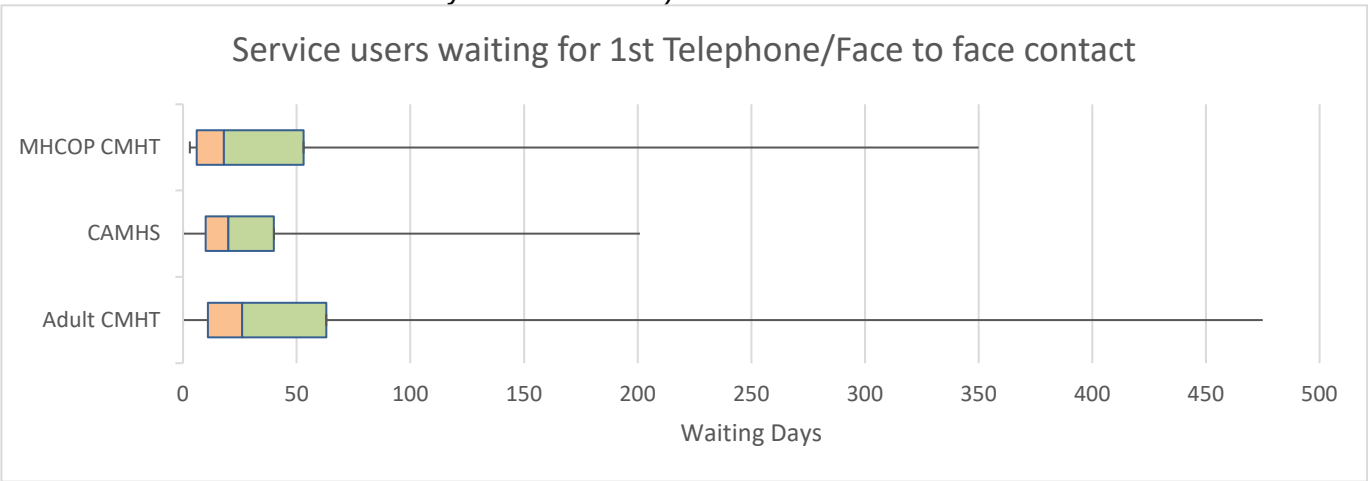


Chart 2.8a above shows that the median waiting time for service users still to be seen is currently 37 days in adult community mental health, 35 days in older adult community mental health, and 20 days in child and adolescent mental health services.

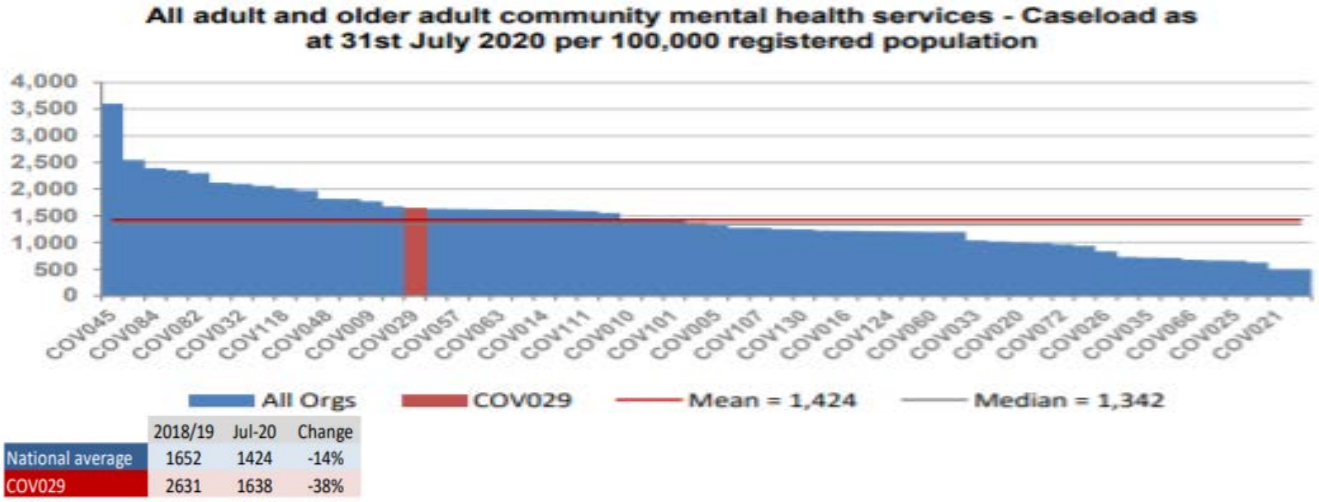
Service leads have conducted local audits of the longest waiters which has highlighted data quality issues caused by referral not being closed correctly on our clinical system which is being addressed through data cleansing exercises by administration and performance staff. In other instances, long waits have been due to service user choice or non-engagement, or repeat cancellations, or pending transfers to other internal teams. Teams have local reports in place to monitor all service users who are waiting for initial assessment, which local performance managers and administration leads are using to ensure appropriate action is taken to re-schedule appointments as necessary.

All community services have been impacted by recent increases in referral activity and have responded to this by putting in place a range of measures to ensure that they are able to effectively manage potential increase in demand or a second wave of the pandemic. In Mental Health services this has involved a thorough review of current caseloads across community teams, particularly focusing on long length of stay cases within care coordinated and outpatient settings. A number of service users have been actively stepped down into enhanced primary care teams, or new Primary Care Network (PCN) pathways that have started to be piloted in Mental Health Services in East London as part of NHS England's Long Term plan to improve mental health service provision in the community. This is supporting services to reduce current caseloads and increase capacity to manage new referrals, as well as supporting existing service users with their recovery journey by offering more tailored care closer to home.

Chart 2.8b highlights that national average caseload size is 1,424 service users per 100,000 population for community Mental Health services. Overall, East London and Bedfordshire and Luton Mental Health services have higher than average caseload sizes with 1628 and 1435 service users respectively per 100,000 population. This suggests that there may be further opportunities across all services to support service users to transition back to primary care and receive care closer to home.

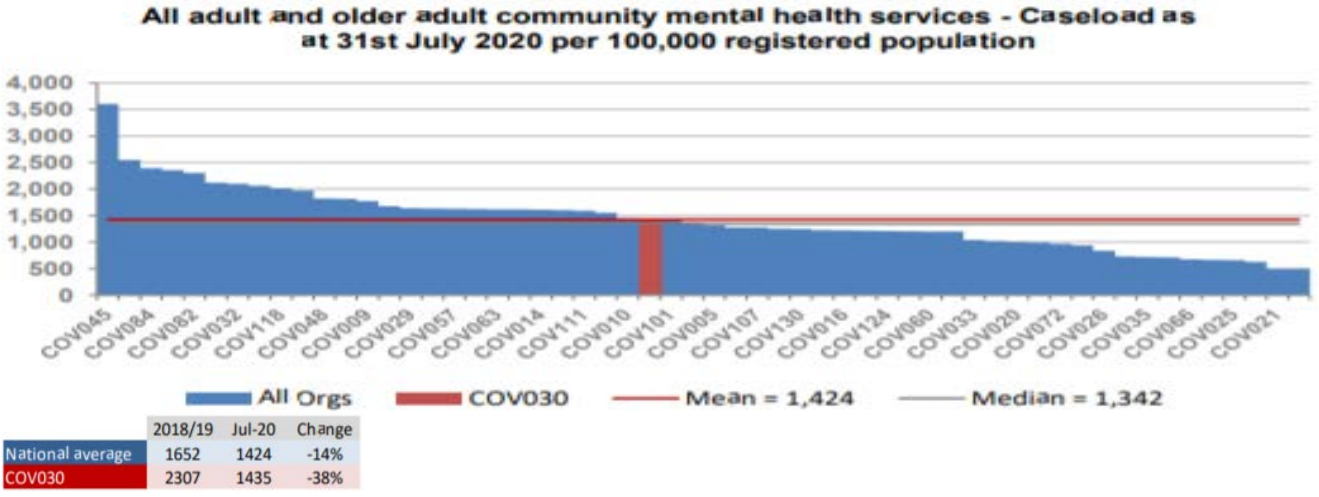
Chart 2.8b. National Mental Health Caseload sizes - adult and older adult community mental health and CAMHS services (Source: *National Mental Health Benchmarking Network – July 2020*)

East London



	2018/19	Jul-20	Change
National average	1652	1424	-14%
COV029	2631	1638	-38%

Bedfordshire and Luton



	2018/19	Jul-20	Change
National average	1652	1424	-14%
COV030	2307	1435	-38%

Much of the work around enhancing the primary care offer for mental services is currently underway. The pandemic has accelerated the shift towards integrated care and supported the development of new partnership models with local authorities, GP practices, third sector and voluntary sector organisations, commissioners and healthcare providers. As part of this transformation, new staffing resources including Community Connectors are now in place along with new forums such as blended multidisciplinary care team huddles to review the needs of service users and to organise resources for their care in new ways that were not available previously. This work is providing the Trust with a unified multi-agency framework to prioritise resources and develop local plans for each local PCN population and neighbourhood.

This work has also involved maximising the potential of digital consultations solutions across assessment and treatment pathways, offering face to face contact where clinically appropriate. This means that staff can work more flexibly from different locations, including home or different Trust sites to maintain workforce capacity. In addition, all staff across the Trust have now completed individual health and safety risks assessments as directed by NHS England and this has helped staff to safely and confidently return to the workplace. It has also supported the Trust to identify and manage risk more proactively and helped shape local service plans. There remain some staffing challenges where staff are continuing to shield due to underlying risk factors, or who need to self-isolate due to experiencing COVID-19 symptoms, but this is being closely monitored and supported by managers and our People and Culture department. In addition, several teams have now held “Shaping Our Future” workshops with service users, staff, partners and

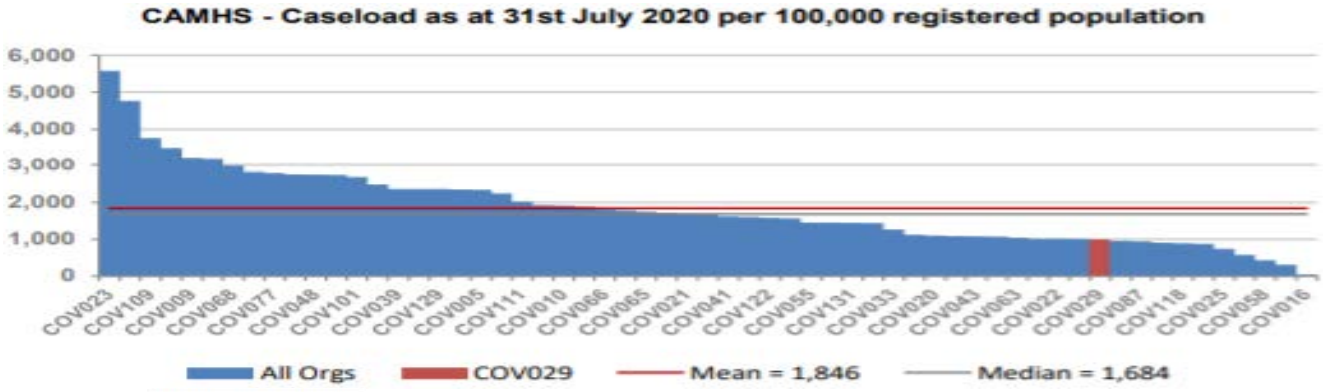
commissioners to help collaboratively design new service models and plan for future scenarios, such as an increased demand or a second pandemic wave. Teams are actively taking the necessary steps to ensure that we learn lessons from all the changes that have been implemented, and continue to improve the quality and resilience of services as we go forward.

There are still estate challenges experienced by the teams in terms of balancing social distancing measures and offering sufficient capacity to staff and service users to attend office sites in person. This is due to limitations on the number of staff or service users that can be on the premises at any one time. Services continue to stagger attendance times for clinics and are working with partners to maximise the use of all available estate facilities to help offer more face to face contact opportunities for contact closer to home.

CAMHS services have planned for an expected surge in referrals with schools reopening in September by focusing on maximising access during the lockdown period where demand on services has been lower than previous levels. This has provided the space to see service users on waiting lists and reduce caseload numbers. This is reflected in chart 2.8c below, which shows that CAMHS services caseload sizes are below the national average of 1,846 service users per 100,000 population. All CAMHS teams have been opened to self-referrals and crisis services have expanded to 7 days working as part of the all age 24/7 Crisis Services in each borough. Link workers to schools were set up and the reach of services was extended by publishing podcasts developed by service users and clinicians, for example, about COVID-19 anxiety. A letter will be circulated to all schools setting out the standard offer for schools in each area, including the offer available immediately from the beginning of September when schools reopen. The offer will be stepped up following discussions with schools, including how to access CAMHS support, training, webinars, videos and newsletters.

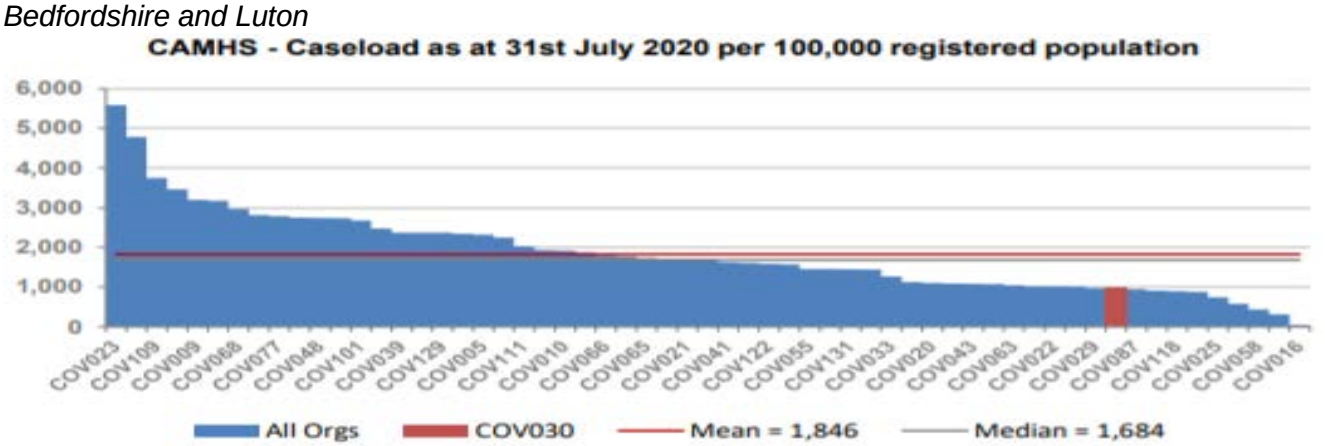
Chart 2.8c. CAMHS National Caseloads Sizes (Source: *National Mental Health Benchmarking Network – July 2020*)

East London



	2018/19	Jul-20	Change
National average	1890	1846	-2%
COV029	1429	975	-32%

Bedfordshire and Luton



	2018/19	Jul-20	Change
National average	1890	1846	-2%
COV030	1585	958	-40%

CAMHS services are developing a range of approaches to redevelop the core offer of services and maximise our capacity. This will involve developing a competency framework to support staff at all levels with virtual interventions. This will also include competencies required at different levels from basic consultations through to delivery of structured therapy and virtual groups. This framework will be used by leadership teams and line managers to support operating in this new way (irrespective of profession, seniority or grade). The training will be a stepped plan, first step will be access to existing films & webinars which all staff will complete. At higher levels there will be more bespoke training, underpinned by discipline-specific guidance. The CAMHS service has developed a short film made by service users and staff to highlight their own experiences of working digitally which has been shared with staff to promote new ways of working and to embed new practices. In addition, a protocol will be developed outlining how to decide when to offer face to face work, based on clinical and practical considerations. This is to be implemented across all services to reduce variation in the offer.

Community Health district nursing services in Bedfordshire and East London continue to maintain access targets for referrals despite staffing challenges caused by the pandemic and redeployment of capacity to support discharge from acute hospitals. In Community Health Services, several business cases have been put forward with commissioners to enhance the Integrated Discharge Hubs (IDH) that were established during the pandemic to help manage future demand across the wider health and social care system. The Integrated Discharge Team has regular multi-disciplinary sessions to track complex patients and their length of stay. The front door, Accident and Emergency, and the back door, Discharge Planning Team, work closely together. The integrated discharge team has escalation processes in place, supported by the Senior Managers and those from partner organisations to facilitate timely discharge and on-going care within a community setting.

Chart 2.9 Average waiting time in days for urgent referrals to district nursing / rapid response (East London – I chart)

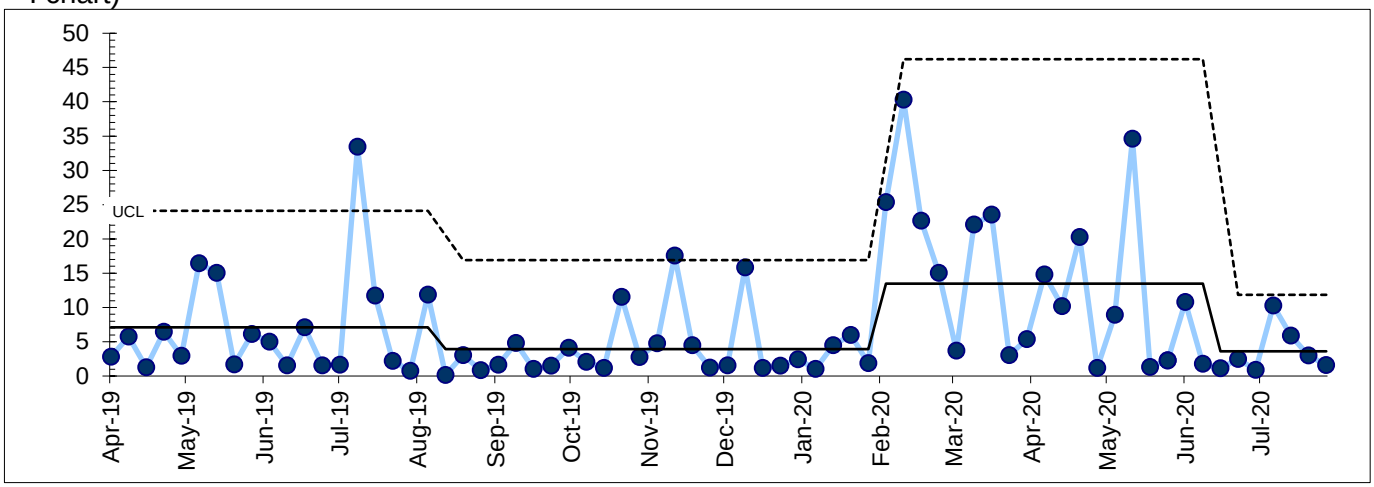
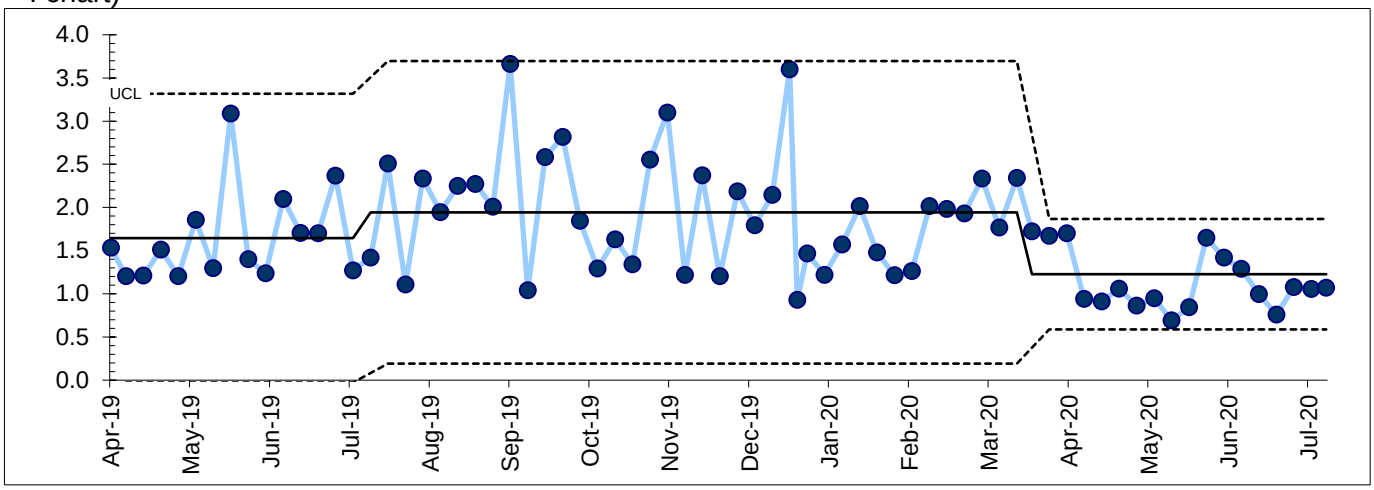
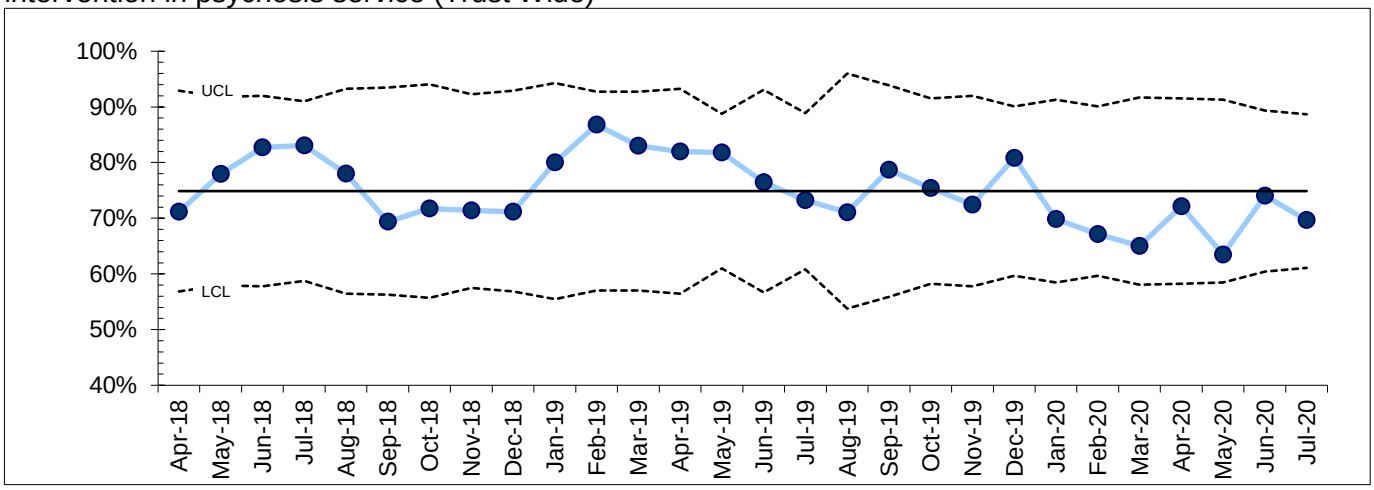


Chart 2.10 Average waiting times in days for referral to assessment to district nursing team (Bedfordshire – I chart)



Adult mental health Early Intervention Services (EIS) waiting time target for service users receiving NICE-compliant treatment within two weeks of referral has improved from 63.5% in May to 70.0% July. This national indicator is based solely on face to face contacts, with virtual/telephone contacts not included in figures. All services are offering telephone and video contacts as the primary method to engage with service users during the pandemic and therefore compliance levels are higher. There has also been some incorrect recording, difficulty engaging with service users and delays caused by inpatient services not making a referral to EIS services prior to discharge which has delayed timely access.

Chart 2.11 Percent of service users receiving NICE Standard treatment within two weeks of referral to early intervention in psychosis service (Trust Wide)



East London secondary care Psychological Therapy Services (PTS) since May are, overall, starting to see a slight decrease in average waiting times from referral to assessment. This is still significantly above the waiting times of pre-COVID levels. The average waiting times for treatment continue to rise across East London. The number of service users waiting for assessment has remained consistent in the last 3 months. The number of people waiting for treatment has decreased since February and continues to decrease with the use of virtual treatments.

Referrals decreased significantly from April because of temporary closure of services to new referrals, and redeployment of staff to respond to the pandemic. This reduced the capacity available to manage current waiting lists, resulting in increasing waiting times. The referrals in May, June and July have increased month on month but are still not at pre-COVID levels for East London as only Tower Hamlets PTS are open to all new referrals. City & Hackney is not currently open to new referrals and Newham PTS is only accepting referrals from Talking Therapies. Tower Hamlets PTS referrals are almost now at pre-COVID levels.

Chart 2.12 East London Psychological Therapy Services (PTS) – Number of referrals to services (I chart)

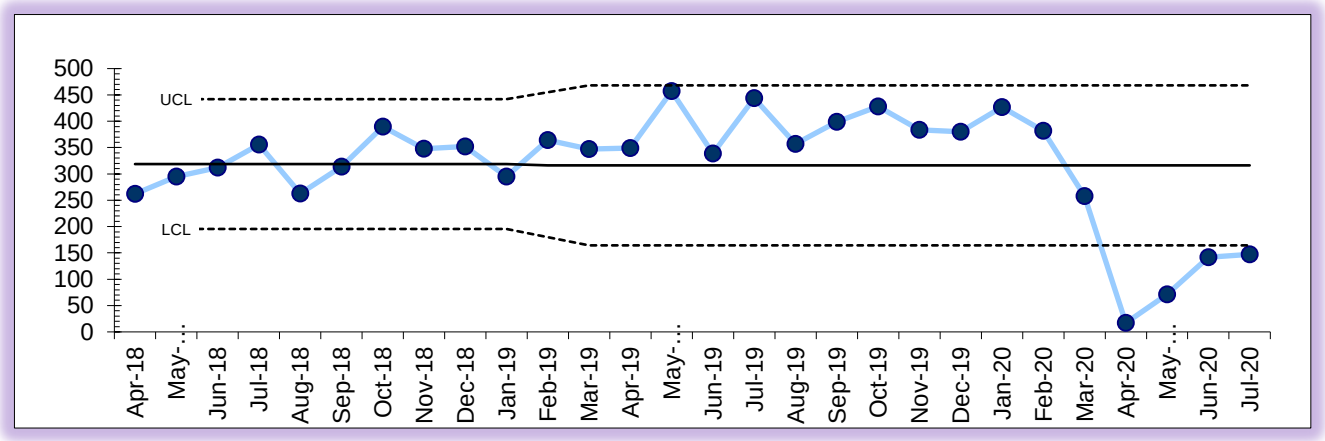


Chart 2.13 East London Psychological Therapy Services (PTS) - Average waiting (in days) from referral to assessment (telephone & face-to-face contacts – I chart)

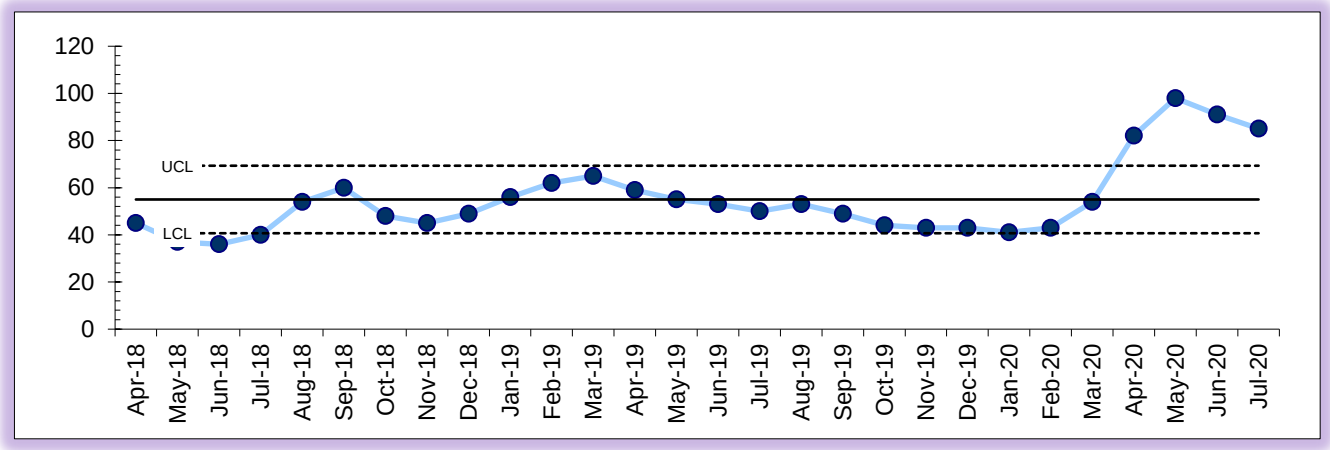


Chart 2.14 East London Psychological Therapy Services (PTS) - Average waiting time (in days) for treatment (telephone & face to face contacts – I chart)

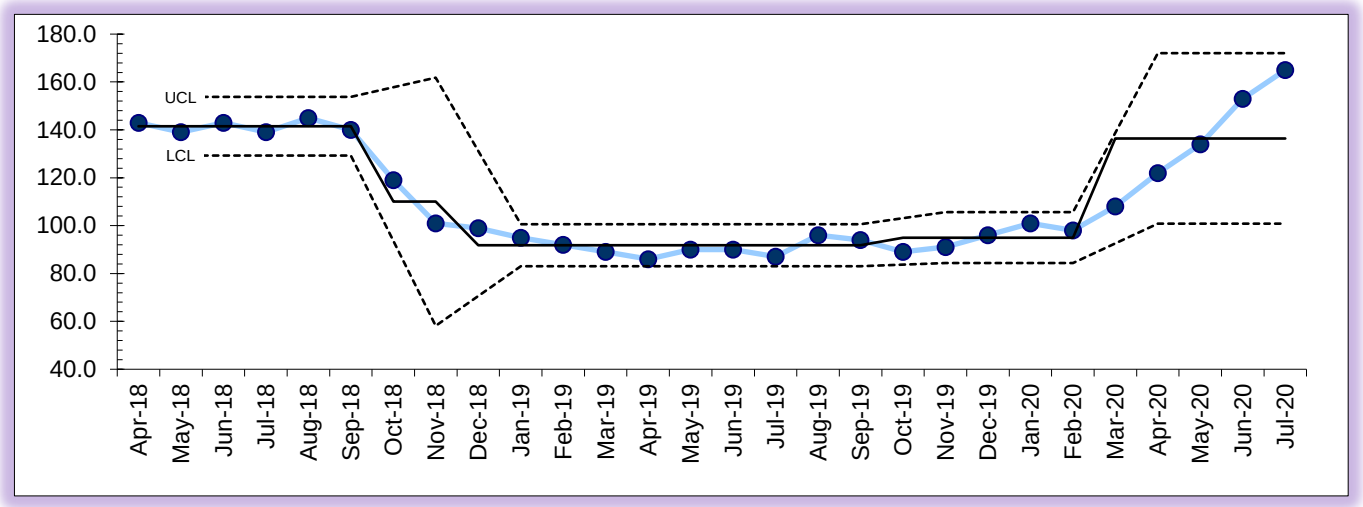


Chart 2.15 East London Psychological Therapy Services (PTS) - Number of service users waiting for assessment (telephone & face to face contacts – I charts)

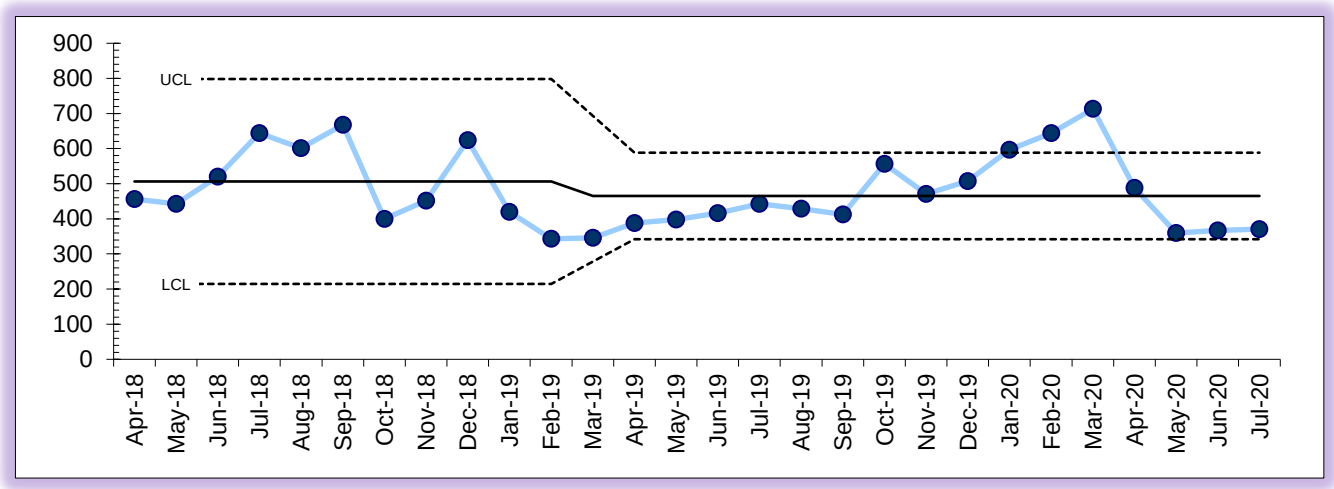
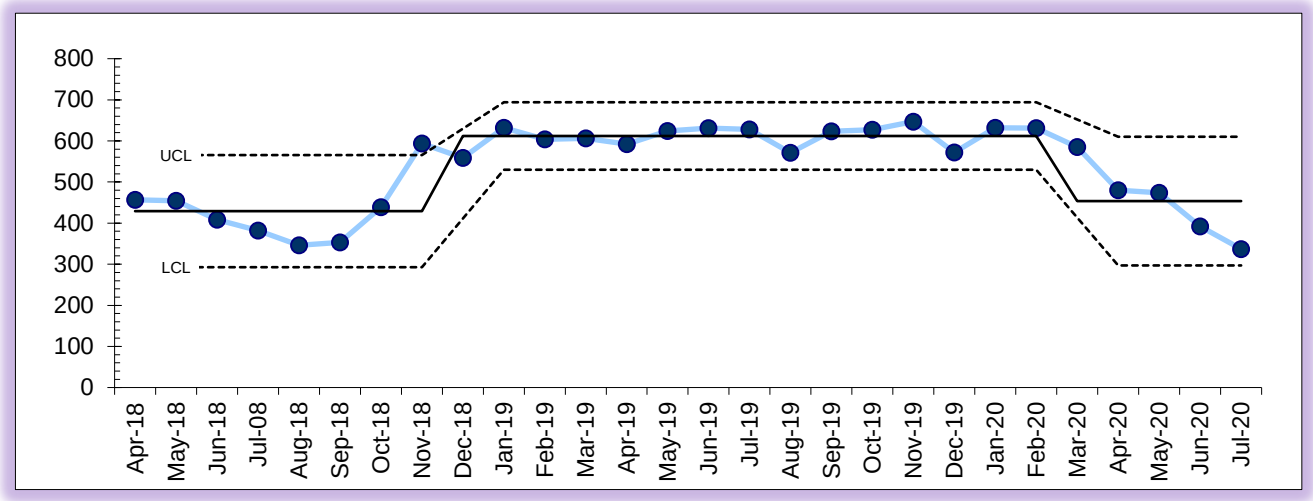


Chart 2.16 East London Psychological Therapy Services (PTS) - Number of service users waiting for treatment (telephone & face to face contacts – I chart)



All services have now moved to virtual delivery for pre-assessment, assessment and treatment. This change in how we provide assessment and treatment has been a challenge and most service users have welcomed the change. Challenges include service user reluctance to attend NHS sites as services restart limited face-to-face sessions, service users facing difficulty in accessing digital therapy, new digital offers taking up more resources from the team, poor internet connectivity, establishing safe and secure virtual delivery platforms, and difficulties in staff accessing clinical records remotely.

Initially our clinical systems were not able to capture virtual contacts and this lag has meant that at the outset of the change to remote working, some of this activity was not recorded correctly. The RiO system of documenting appointment outcomes is being reviewed to ensure that the changes in consultation type and outcomes are being consistently reflected. Most services are now able to provide assessment and treatment for those service users who are able and willing to engage remotely, but there are a significant number of service users who are not able to engage virtually. A backlog, especially for treatment, is continuing to build. All services are considering how to safely reintroduce face-to-face work, but there is likely to be continued impact on waiting times. It is likely that virtual delivery will continue as part of the future service model, but this will be dependent on further work with service users.

Due to increased pressure and anxiety caused by the pandemic, we predict that there will be a surge in referrals when all PTS services open to new referrals in the coming months, as there would likely be more need for these services. There have been preparatory discussions around

the plans to manage potential increased demand. All services are aware that demand is likely to rise, and their forward planning has taken this into consideration. Services will all be looking to working much more closely with the primary care networks and local IAPT services to manage demand more effectively together as a system. All services are continuing to develop robust demand and capacity modelling plans which will help them to identify any potential bottlenecks caused by the changes in service provision from face-to-face to mostly virtual contact, thereby reducing waiting times for service users and maximising our resources.

The City and Hackney service received increased referrals in the two months prior to the pandemic. As a result, a significant portion of its resources has been directed towards processing these referrals. They have now all received a telephone triage assessment and directed to online psychoeducational materials that have been developed by the team. Meanwhile existing treatments were paused temporarily, and supportive telephone contact offered instead, which has caused treatment waiting times to increase. Paused treatments have recommenced from the beginning of June. However, the service has accrued a very large list of several hundreds of service users who have received some form of psycho-educational intervention as a first treatment, and who will require some form of further treatment. The service has developed a recovery plan comprising of a range of short-term group and some individual treatments to support this cohort of service users. City and Hackney plans to re-open to new referrals from the beginning of October.

The Tower Hamlets service is currently meeting the 11-week assessment target and working towards treatment commencing within the 18-week goal. The service reviewed referrals where the service user had not engaged or where it was unclear what the service could offer. Since the service re-opened in May, it has experienced a rise in referrals and has moved to briefer, generic assessments (telephone and online) to increase flow. The process of delivering groups and individual treatment was put on hold while the team provided supportive interventions to people on the community mental health caseloads, which impacted treatment waiting times. The service is now returning to online delivery, with six groups offered online and a further seven planned for the coming months. Individual work has also resumed.

The Newham service normally achieves assessment within 11 weeks, but since the pandemic it has not been able to offer face-to-face group enrolment sessions, which has impacted on its performance. The service has successfully redeveloped its stepped care model and initially offered online psychoeducational group therapies in March and April. This has developed further and from 14th August, the therapeutic offer has progressed into a range of online group psychotherapies. Face to face appointments will also recommence in September to support completion of individual therapies for those referred prior to COVID.

Contacts with Service Users

The charts below highlight changes in our non-face to face contact with service users. Chart 2.17a shows the proportion of all contacts that have been made through telephone or video consultations, which has increased from 4% to 34.8% during the peak of the pandemic. However, during June and July there has been a week on week reduction in telephone and video contacts, reducing to a mean of 29.6%. National comparative data in chart 2.17b shows that during July, 59% of contacts nationally were provided by non-face to face consultations mediums in adult services and 75% in CAMHS services. Total clinical contacts per 100,000 population are also lower than the national average in East London. Factors that have contributed to this include reduced reliability of recording contacts and outcomes in the clinical record system, and confusion about how to record contact medium on our systems. We have conducted a review of the current clinical system outcome options for recording contact outcomes and simplified it so that it is clearer for staff to know which box they need to complete. The simplified set of outcome options will be launched in October and will be supported with training for staff to encourage accurate and timely recording of all activity.

2.17a Percentage of all contacts each week made via telephone or video-consultation (mental health & community health services – P chart)

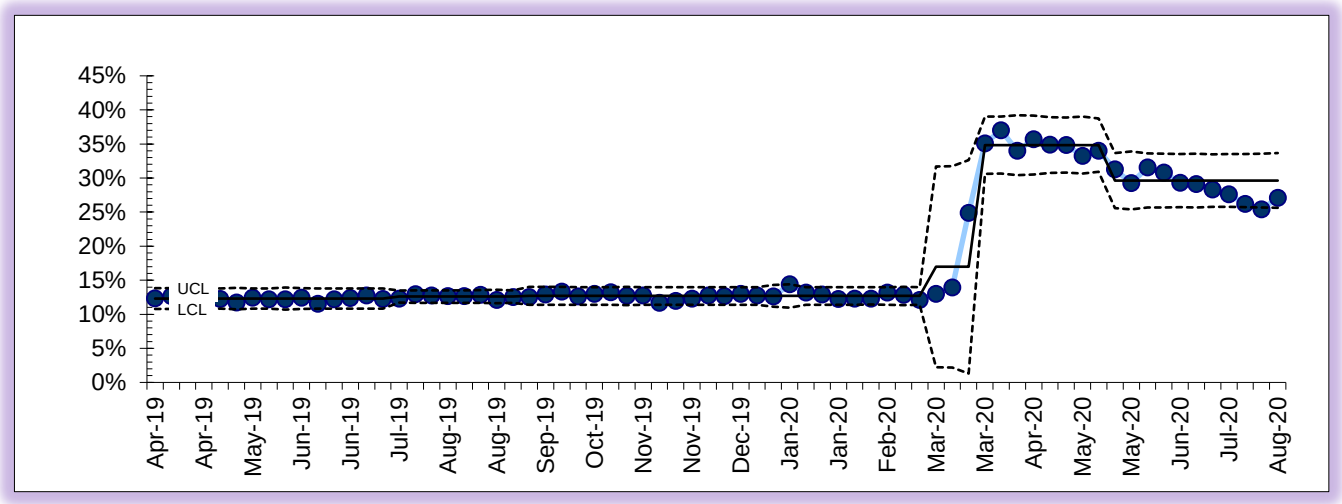


Chart 2.17b. National Mental Health Contact profile: face to face vs non- face to face (Source: *National Mental Health Benchmarking Network – July 2020*)

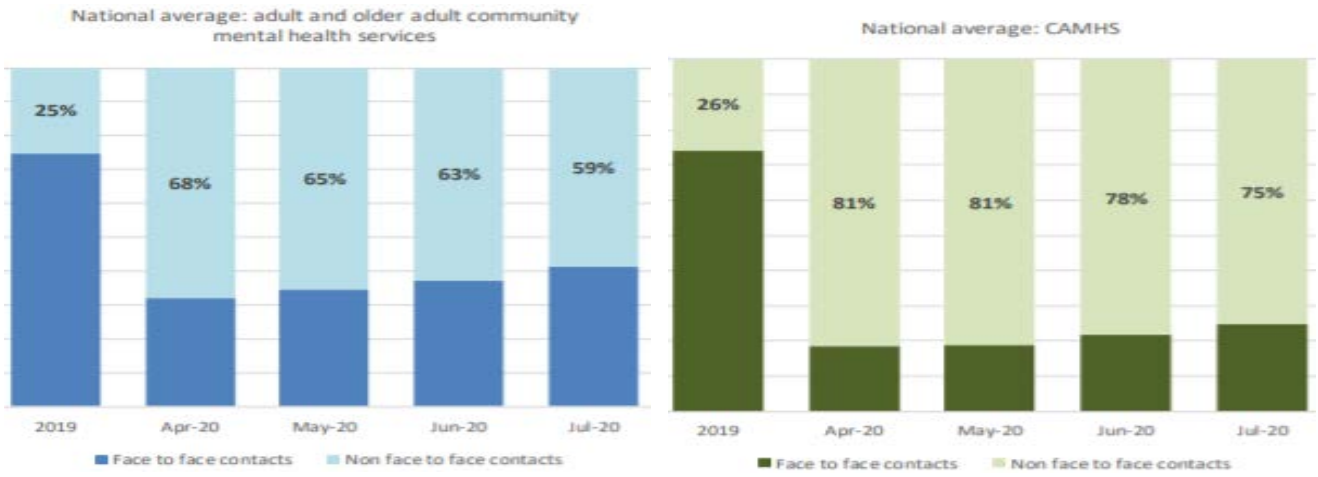
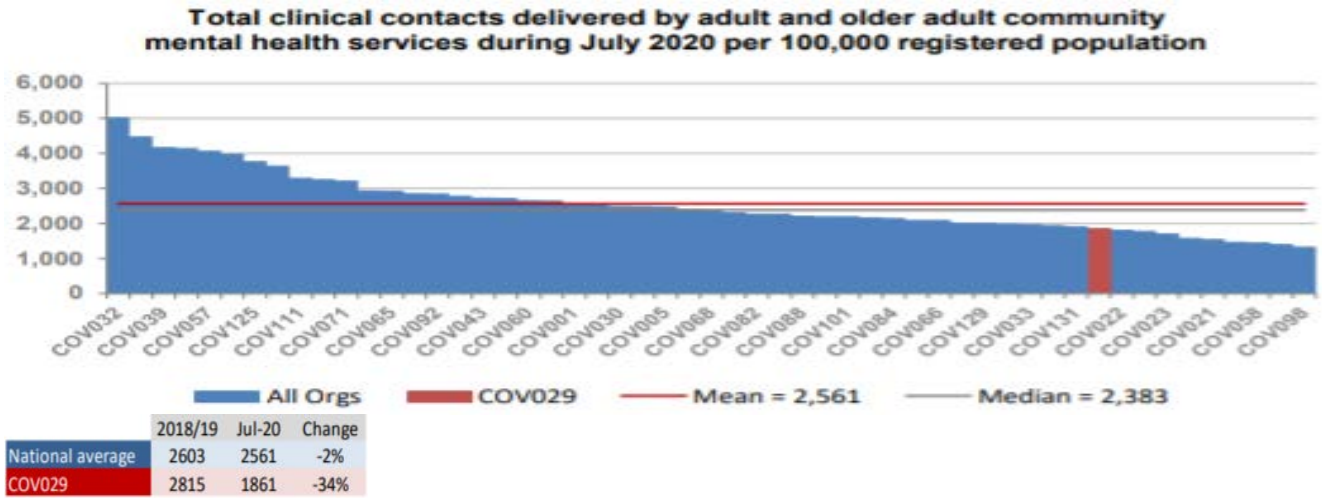


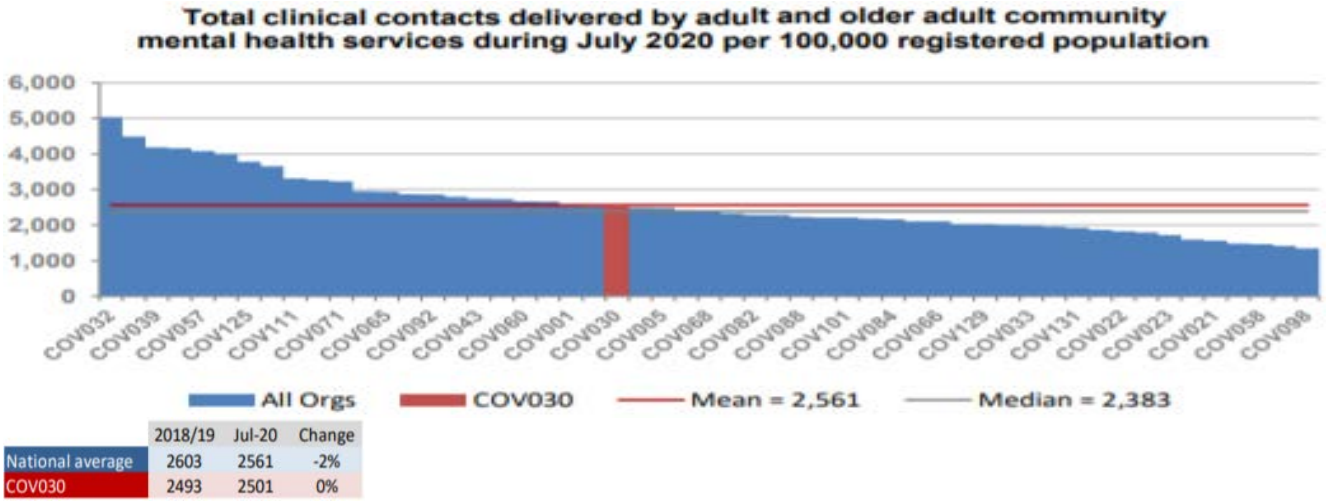
Chart 2.17c. Total contacts delivered by Community teams (Source: *National Mental Health Benchmarking Network – July 2020*)

East London



	2018/19	Jul-20	Change
National average	2603	2561	-2%
COV029	2815	1861	-34%

Bedfordshire and Luton



	2018/19	Jul-20	Change
National average	2603	2561	-2%
COV030	2493	2501	0%

Chart 2.18a shows that at the end of July, 80.4% of service users who were offered either telephone or video appointments attended successfully. Service users have been quickly able to adopt new digital solutions and, in many instances, have preferred to be contacted virtually because they feel more comfortable in their own home and avoids the need to travel. The proportion of service users contacted specifically via video contacts nationally is around 5% for adult mental health services and 22% for CAMHS services during the month of July as highlighted in chart 2.18b. This suggests that video contact in adult mental health services is still quite low nationally and further work may be required to maximise digital potential across mental health teams. It has also been recognised that some service users would prefer greater choice about how to connect with the team, as video-calls are not always preferred or possible.

Chart 2.18a Weekly attendance for routine appointments provided by telephone/video (CAMHS and adult mental health – P chart) Note: Community health excluded as they do not record non-attendance for telephone calls

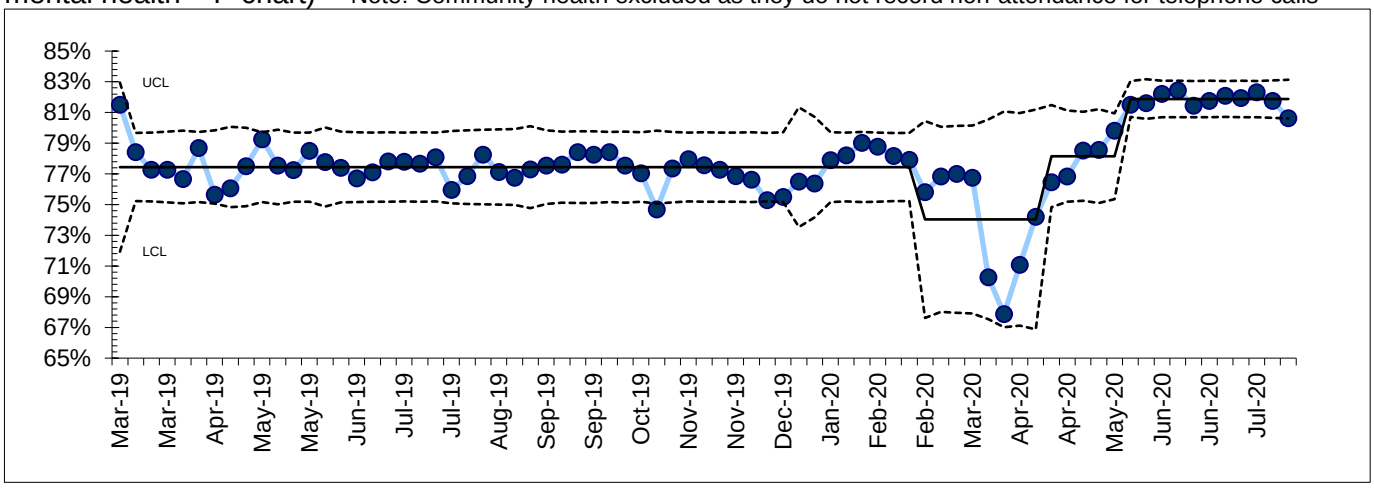


Chart 2.18b. National average: proportion of contacts delivered using digital technologies
Source: *National Mental Health Benchmarking Network – July 2020*)

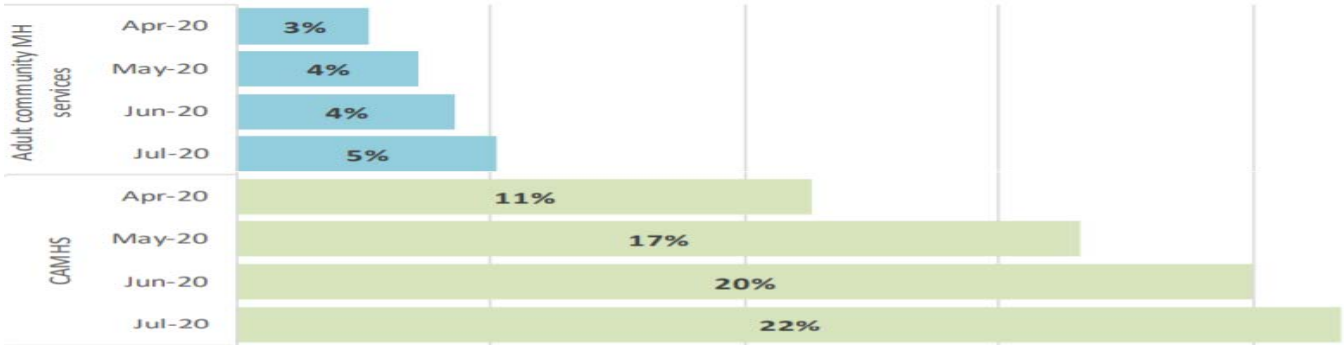


Chart 2.19 Percent of service users on CPA contacted each month (mental health – P chart)

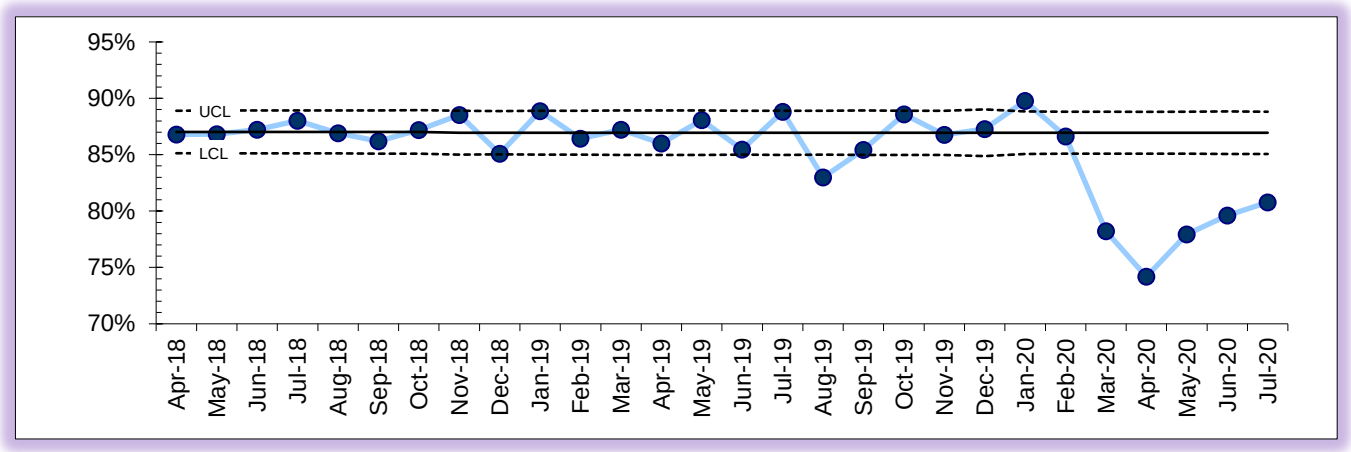
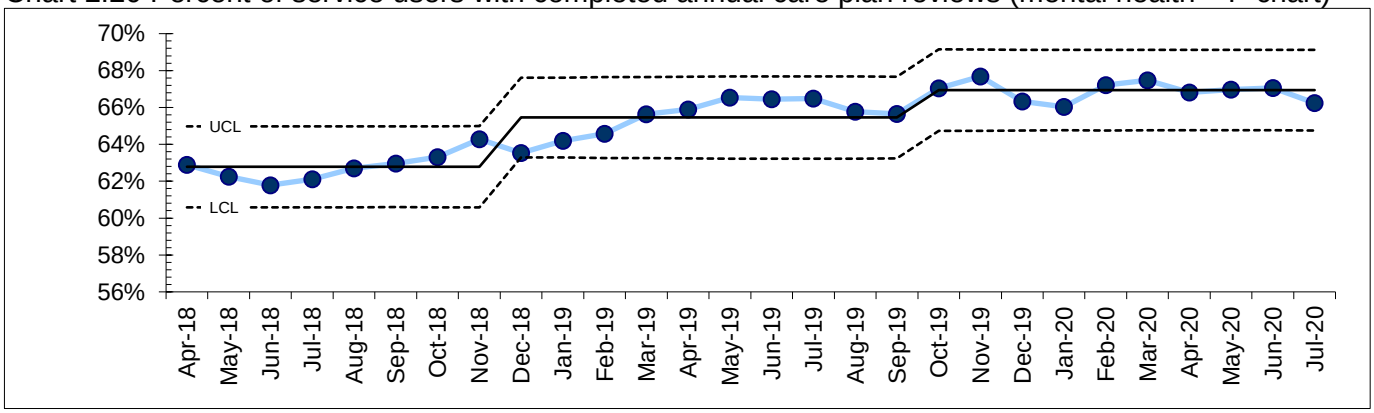


Chart 2.19 shows that monthly contact activity with service users who are care-coordinated by community mental health services has improved across all services from 74% in April to 80.8% in July. This reflects the positive impact of local reminders and training and awareness sessions led by local managers, and new contact performance reports that were released in June. This has provided teams more visibility of data on contacts by medium (telephone, face to face and virtual). All services are closely monitoring and reviewing the needs of service users through a risk rating scale, including those who are care coordinated, to ensure that they are contacted by telephone or video call each month, and sooner when needed. Where risks are identified, care coordinators have been offering face-to-face contact. All teams are continuing to remind staff of the need to record all clinical activity onto our clinical systems and we anticipate that this will improve once new contact outcome options are launched in October in our clinical system.

The percentage of care-coordinated service users with annual care plan reviews completed continues to hover around 66%. This is felt to accurately reflect operational practices and completion of the electronic DIALOG+ care plans, as well as on-going training and awareness needs for staff to embed new practices consistently across all services. There have also been challenges with remote access to clinical records for staff working from home, resulting in some staff using paper-based DIALOG+ forms rather than the online forms which feed the formal data reporting. Work is underway way in the Trust to focus on outcome measures and offering refresher training to staff to help them to complete DIALOG+ outcome forms correctly and in a timely manner.

Chart 2.20 Percent of service users with completed annual care plan reviews (mental health – P chart)



Improving Access to Psychological Therapies (IAPT) Services

The charts below demonstrate our performance against national IAPT performance and access indicators. Overall, the number of referrals and number of service users accessing IAPT services for their first contact significantly dropped during lockdown, which meant that none of the four services met their access targets in April or May. However, the number of referrals rose through a combination of communications via GP practices and natural increase resulting in all four

services meeting their local access targets in July. IAPT services in East London compare favourably to the national average referral activity, achieving 2700 referrals during the month of July against an average of 1,623 referrals nationally. However, Bedfordshire IAPT service fell below national average with 1050 referrals in the same period as highlighted in chart 2.21b.

The sharp reduction in referrals in the early weeks of lockdown allowed services to offer initial appointments quickly, typically within 1 week. This may reverse as the expected surge in demand takes place. In addition, the reduced need for triage slots during lockdown allowed services to reduce the size of their waiting lists, resulting in shorter average waits for second appointment. This has enhanced the trend towards shorter second appointment waiting times that had already been ongoing since autumn 2019. This progress would be put at risk if there is a sustained surge in demand as predicted nationally. Funding requirements to deal with a surge are being discussed with commissioners as part of the wider phase three system recovery plans. In the short term, additional capacity from subcontractors and agency staffing could be deployed to maintain acceptable waiting times in the face of a surge.

All services have maintained performance as a result of rapidly implementing and refining digital platforms to offer assessment and treatment remotely, which has been successfully utilised by service users. Services plan to resume some face-to-face contacts in October, but will continue to deliver a significant portion of therapy via digital channels as this has proven effective and flexible. This is consistent with a national mean average of 98% of all activity being provided by non-face to face contact methods, as highlighted in chart 2.21c. The current 6-week target is being maintained by all services and Tower Hamlets has now reached the same level of consistency as the other services. In addition, controls and checks are now in place which make 18-week breaches very rare, and 100% compliance is now normal for this indicator for all services.

Chart 2.21a Number of referrals to IAPT services (Trustwide – I chart)

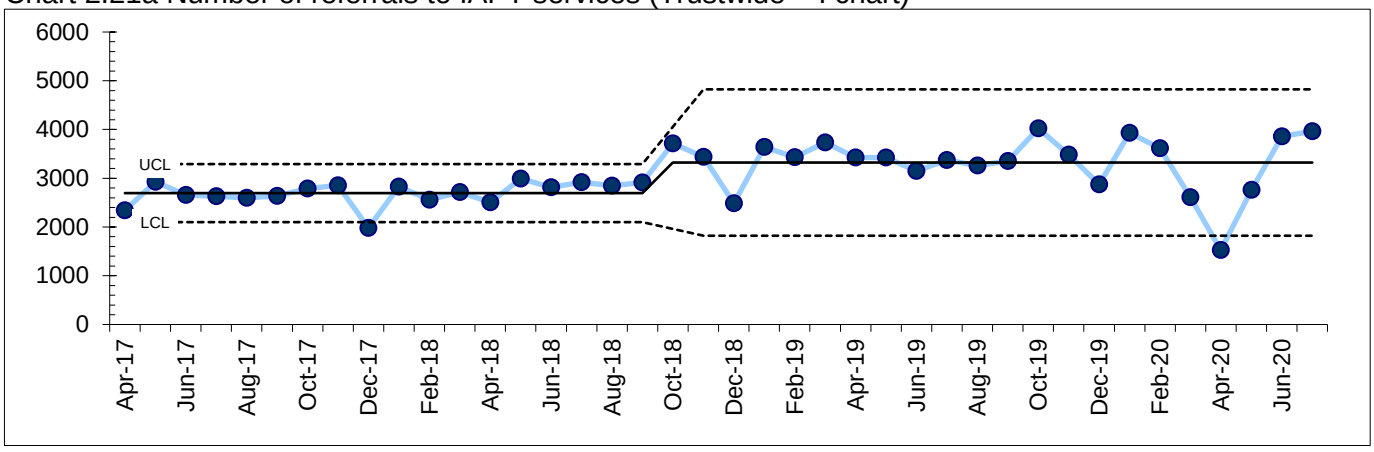
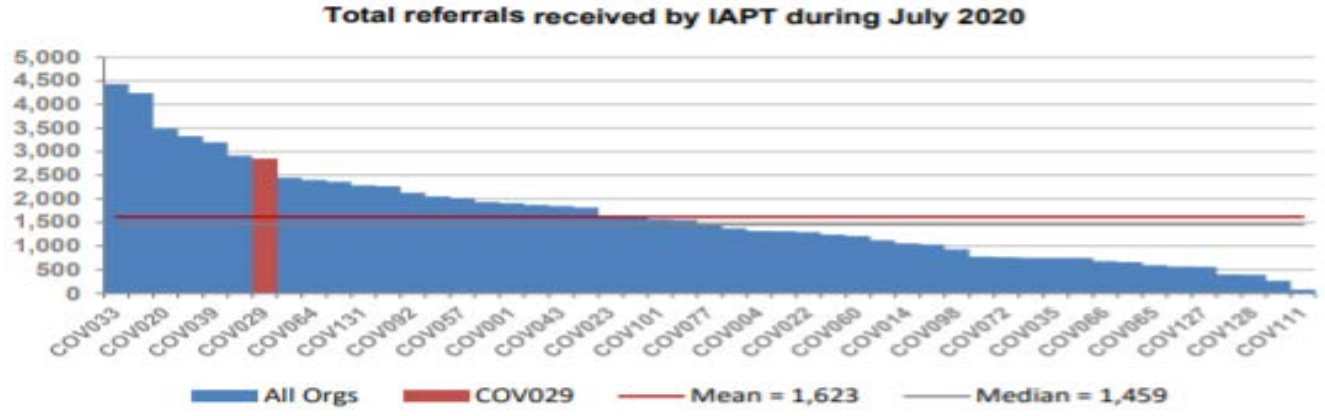


Chart 2.21b IAPT – Referrals received (Source: *National Mental Health Benchmarking Network – July 2020*)

East London



Bedfordshire and Luton

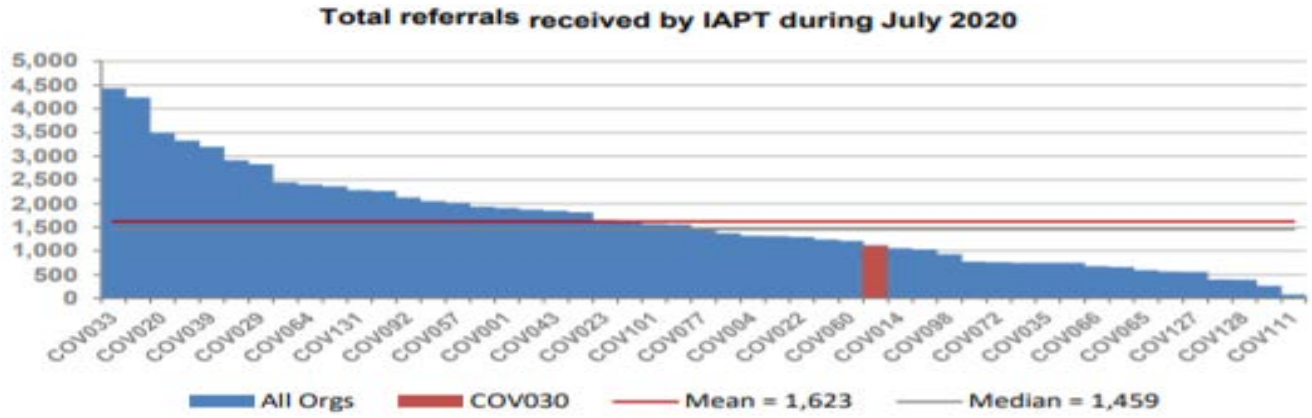


Chart 2.21c IAPT – National Contact Type and proportion of contacts delivered using digital technologies (Source: *National Mental Health Benchmarking Network – July 2020*)

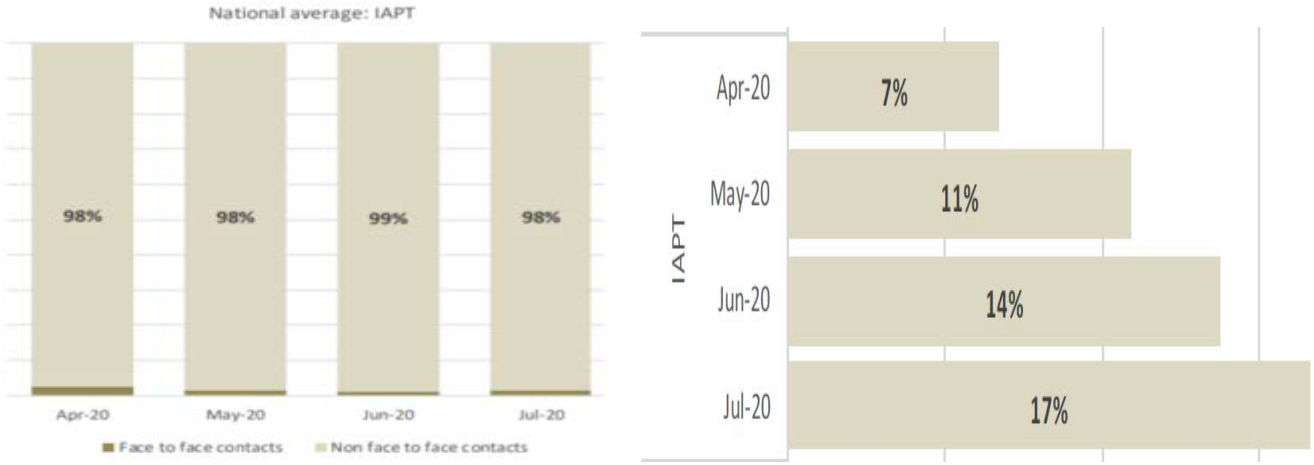


Chart 2.22 Number of service users starting treatment – first contact (Trustwide – I chart)

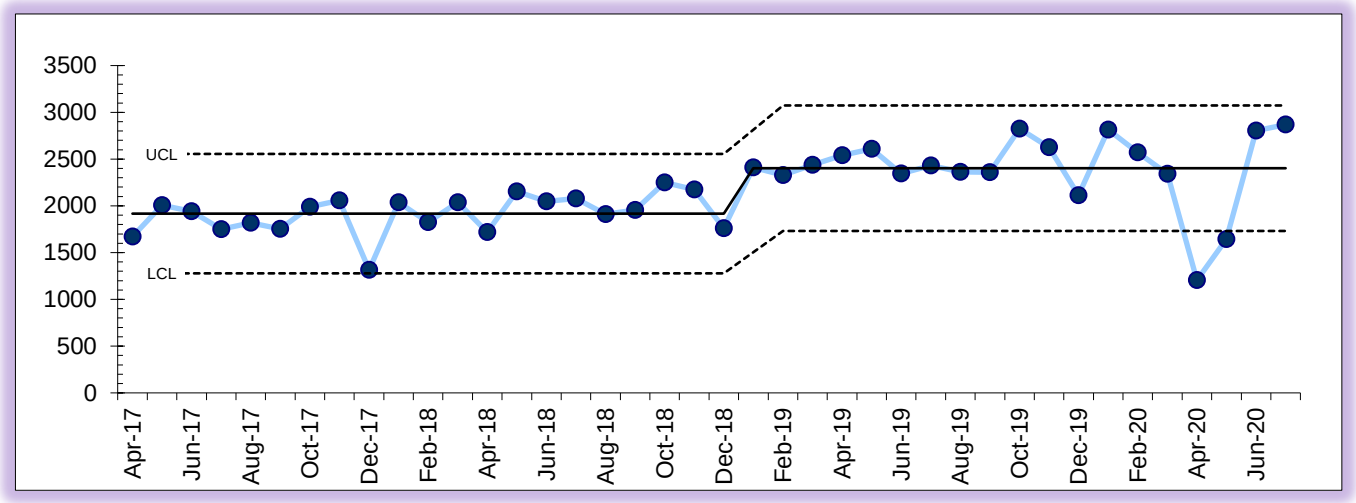


Chart 2.23 Percentage of service users starting treatment within six weeks of referral (Trustwide – P' chart)

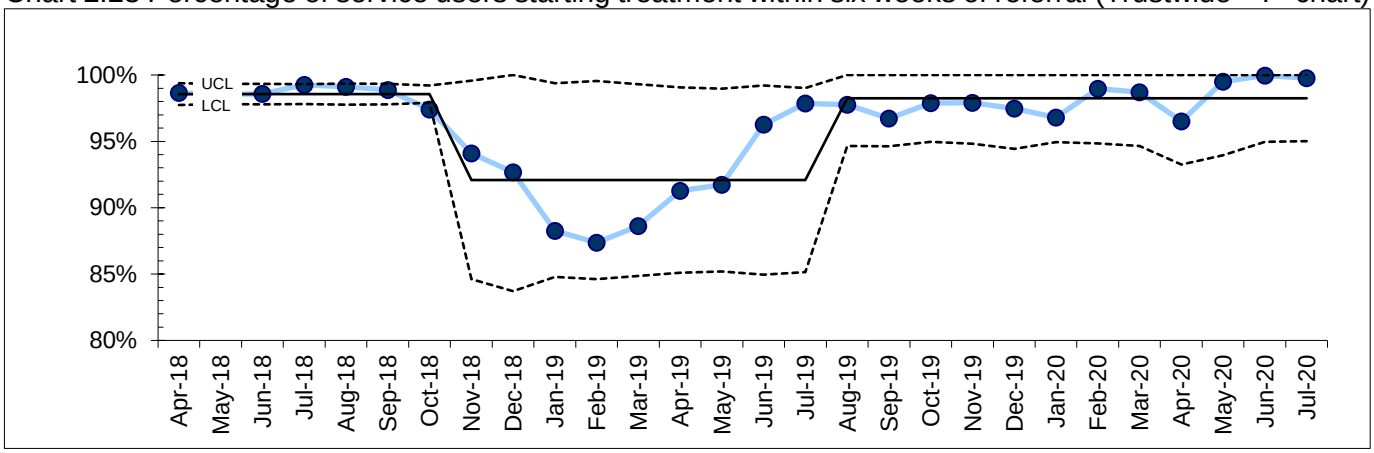


Chart 2.24 Percentage of service users started treatment within 18 weeks of referral (Trustwide – P chart)

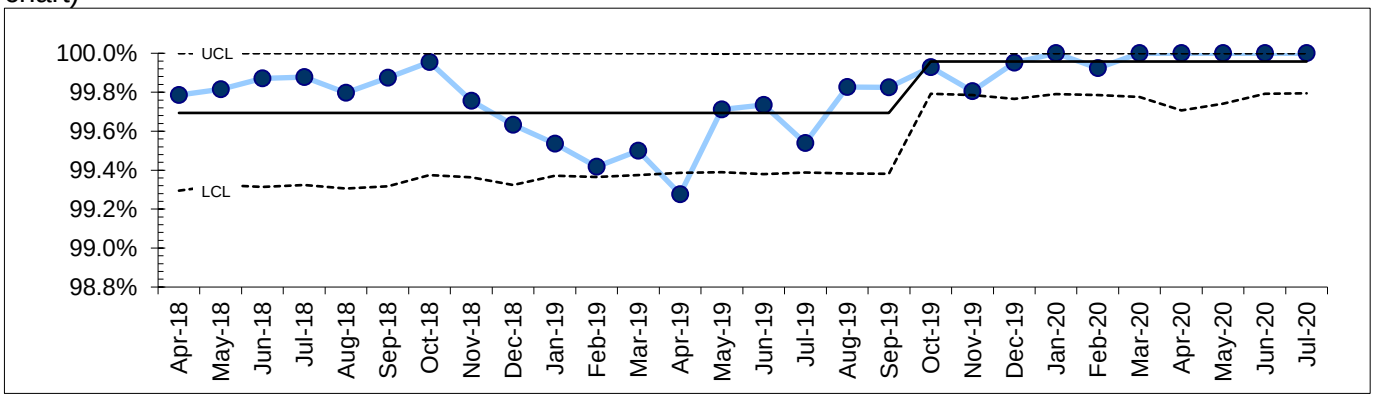


Chart 2.25 Average wait (days) to first appointment (Trustwide – I charts)

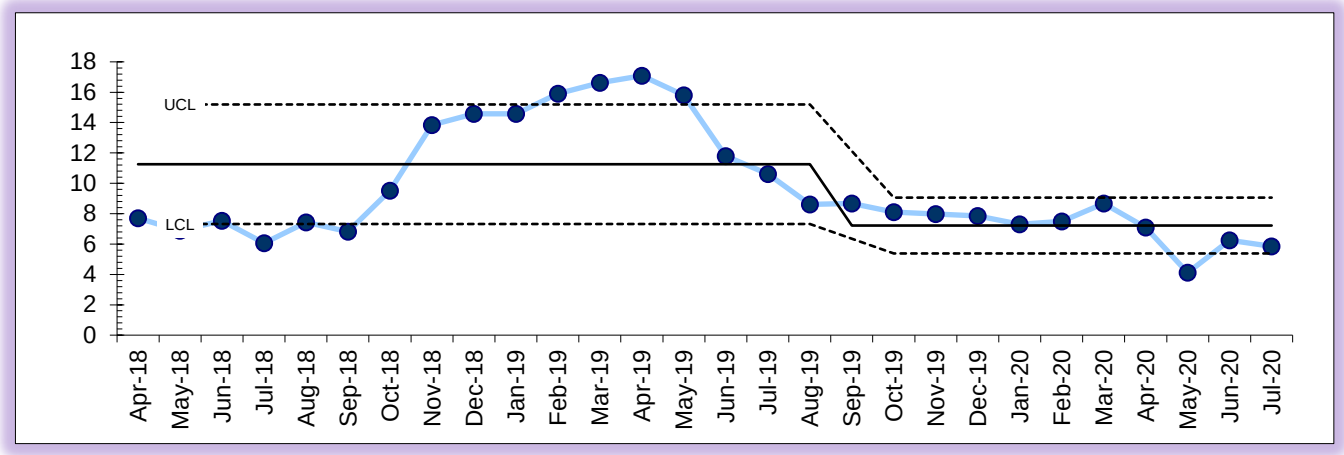
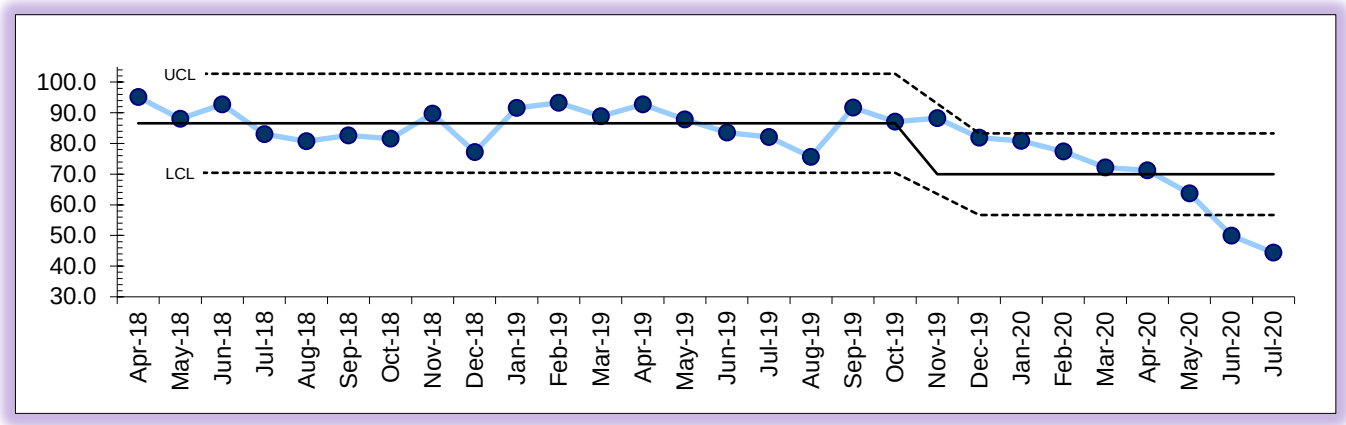


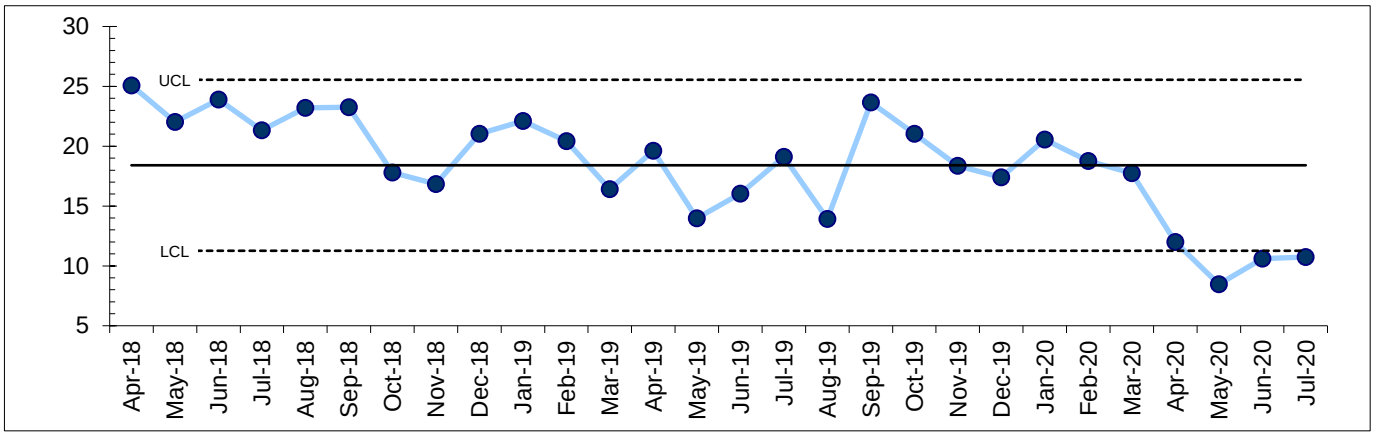
Chart 2.26 Average wait (days) to second appointment (Trustwide – I chart)



Perinatal Mental Health problems are those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 20% of new and expectant mums and covers a wide range of conditions. The NHS Long Term Plan builds on previous NHS commitments to invest and transforms perinatal services by increasing access to psychological therapies for women and their partners, and increasing the scope and availability of on-going support for service users with moderate and complex mental health needs. Under this plan, a total of 66,000 women nationally are expected to access specialist perinatal services by 2023/24. All Trust perinatal services have local service expansion plans in place as well as access targets to help deliver the expectations of the Long Term Plan.

The chart below shows that average waiting times for perinatal services has started to decrease since the start of the pandemic. This reflects reduced referrals to the service but also increased uptake of appointments offered virtually and by telephone. All services have had to adapt their service offer to include face to face and virtual contacts and this has been positively received by service users. All services have noticed an increase in anxiety and depression-related presentations which is largely related to the impact of the pandemic on health and well-being. Some services have also reported improved recovery scores which is believed to be linked to the positive impact of virtual and telephone contacts in enabling better engagement. This has led to better attendance and higher completion rates of treatment offered to service users. Some of our services have completed “shaping our future” workshops with service users, commissioners and partners to help develop future service models aimed at improving the quality of life for this population that we serve.

Chart 2.27 Average number of days from referral to assessment for Trustwide Perinatal Mental Health services – (I chart)



3. Staffing

The charts below describe a range of people indicators, to accompany the more detailed People report. Overall compliance remains stable against all indicators. The Trust continues to maintain a reduction in staff turnover levels (below the Trust target of 16%). Our vacancy rate has increased slightly in July. Recruitment is on-going using the streamlined processes devised during the Covid 19 pandemic. The number of staff compliant with Disclosure and Barring (DBS) checks has increased as result of changes in national Guidance to fast-track DBS checks and the Trust’s decision to extend DBS recheck periods from 3 years to 4 years. In addition, a number of staff are enrolled on the monthly DBS update service.

National guidance recommends that, for current NHS employees who have not changed roles and who have previously undertaken training in the core subjects of statutory and mandatory training, refresher training requirements should be suspended for the duration of the current crisis. Therefore, we will not be reporting on this indicator in this report until guidance changes. Whilst chart 3.1

illustrates a stable sickness absence figure, please note that following national guidance, any Covid-19 related staff absences is excluded from the sickness absence data and is recorded separately so therefore is not included in the chart below.

The Appraisal window has been extended until the end of September and we expect to see an increase.

Chart 3.1 Sickness (Trustwide – I chart)

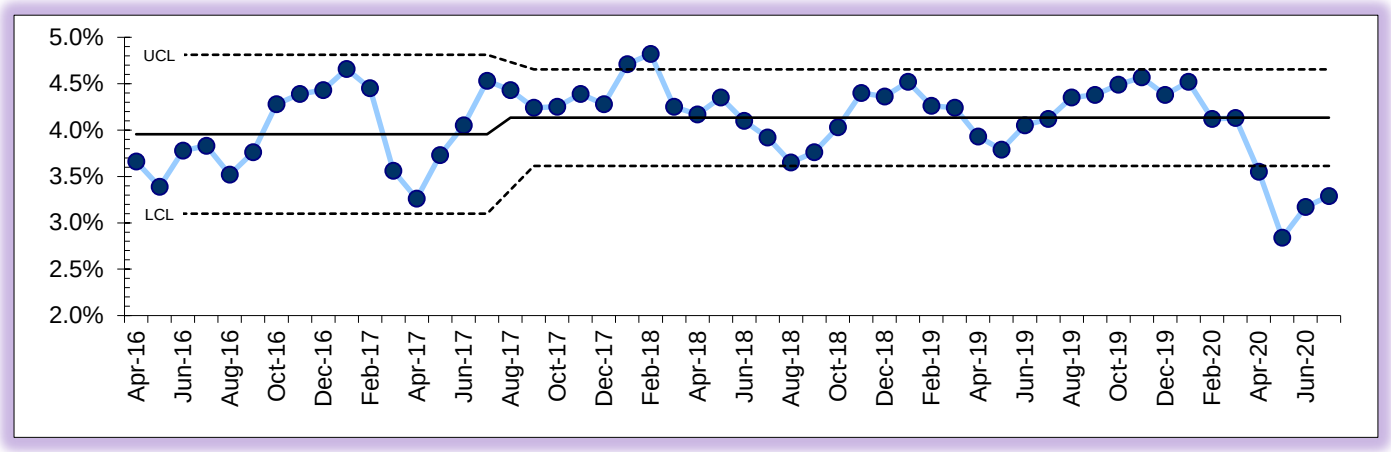


Chart 3.2 Percentage of posts vacant (Trustwide – I chart)

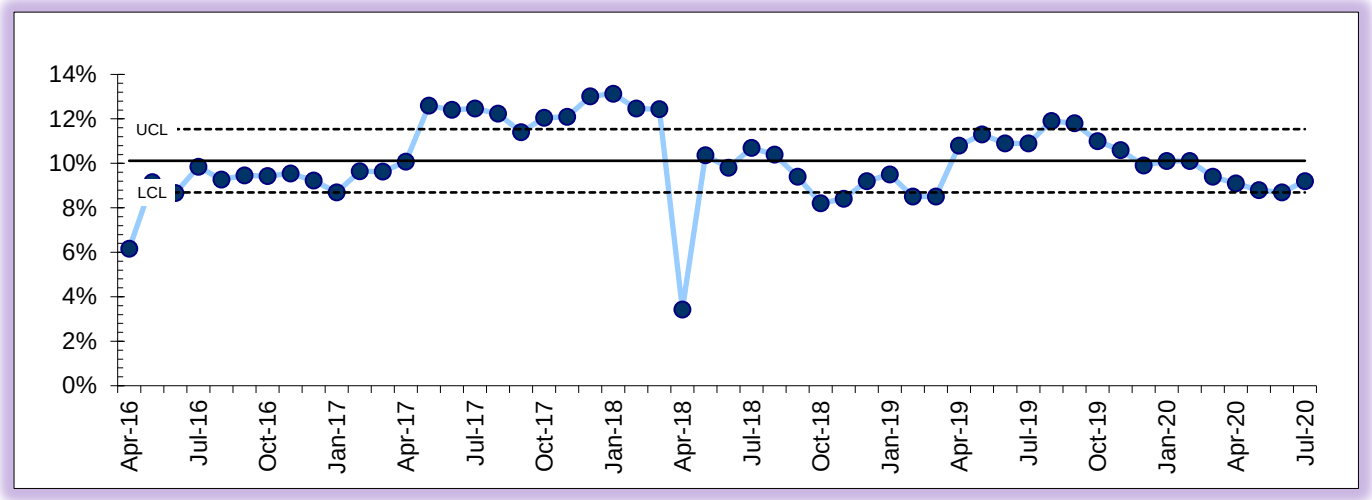


Chart 3.3 Turnover (Trustwide – I chart)

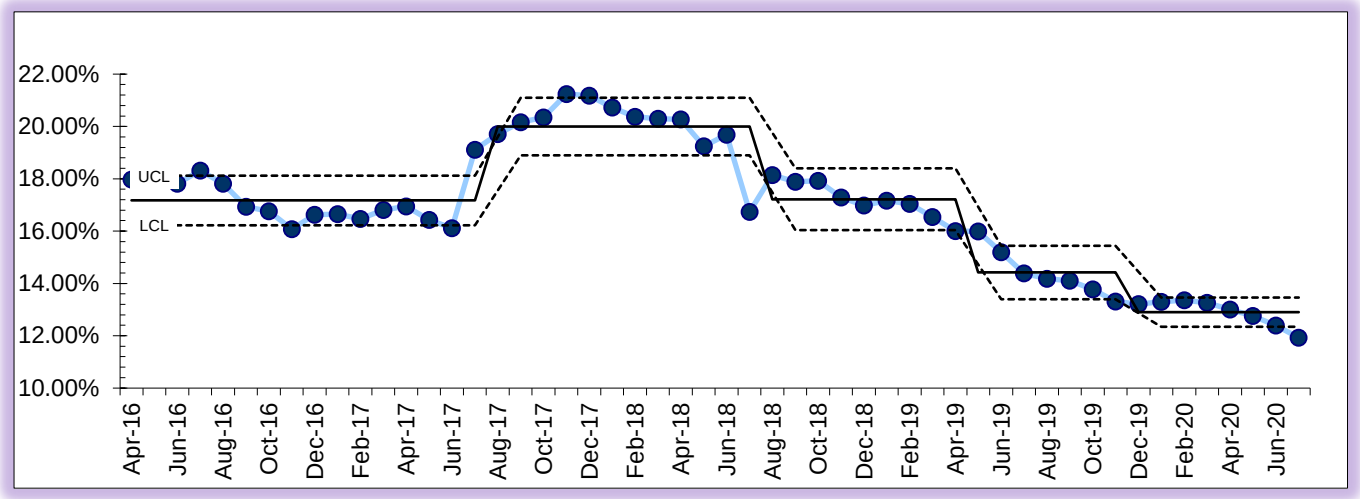


Chart 3.5 DBS clearance (Trustwide – P' chart)

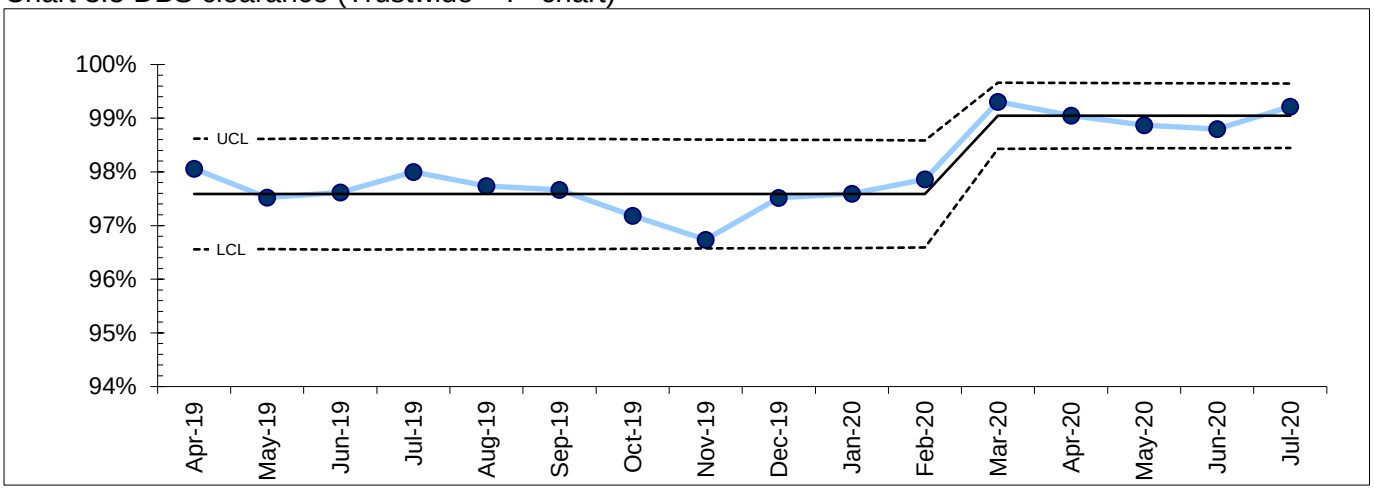
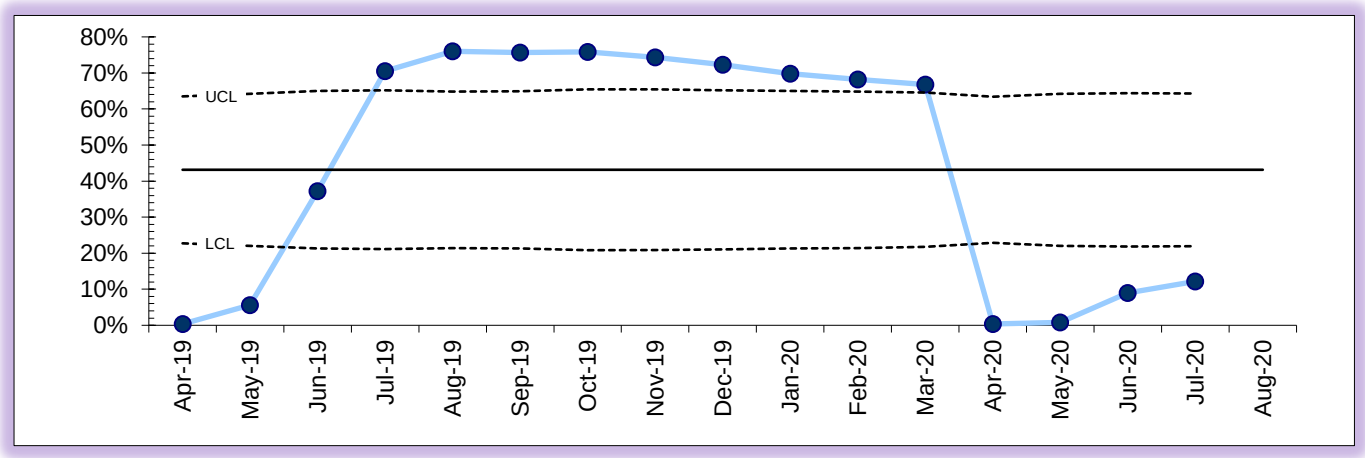


Chart 3.6 Percent of appraisals completed (P chart)



4. Experience and Outcomes

The charts below provide assurance across a range of service user experience and outcome indicators. The number of complaints continues to average six per week and PALs enquiries have decreased in the same period. IAPT recovery rates have started to increase in the past few months. Richmond has been undertaking some Quality Improvement work around recovery, particularly in the Step 2 team; there has also been a significant positive shift in Newham and more recently also in the other services. It is not yet clear what has caused this, but it may be related to the reduction in waiting times.

Friends and Family Test (FFT) has been suspended following national guidance. NHS England has replaced the original FFT question with new questions relating to whether service users will recommend the service they have used, with a range of new responses. The replacement question invites feedback on the overall experience of using the service. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. There has been a delay implementing the new guidance due to the pandemic and we are awaiting feedback from NHS England as to the new implementation date so that we can re-start national reporting. Chart 4.4 has been amended to show compliance levels with the new service user experience questions introduced locally since the start of April 2020. This shows that there has been a decrease in the number of service users responding positively about their experience of services during May and June before returning to normal levels during July. It is believed that this may be linked to the rapid changes that services have gone through as a result of the pandemic and the disruptions this caused. As the questions are new and as the figures only account for a third of usual levels of FFT responses, we anticipate that performance will improve as more teams restart using the new FFT survey in the coming months, and services become more settled.

Chart 4.1 Number of Complaints (Trustwide – I chart)

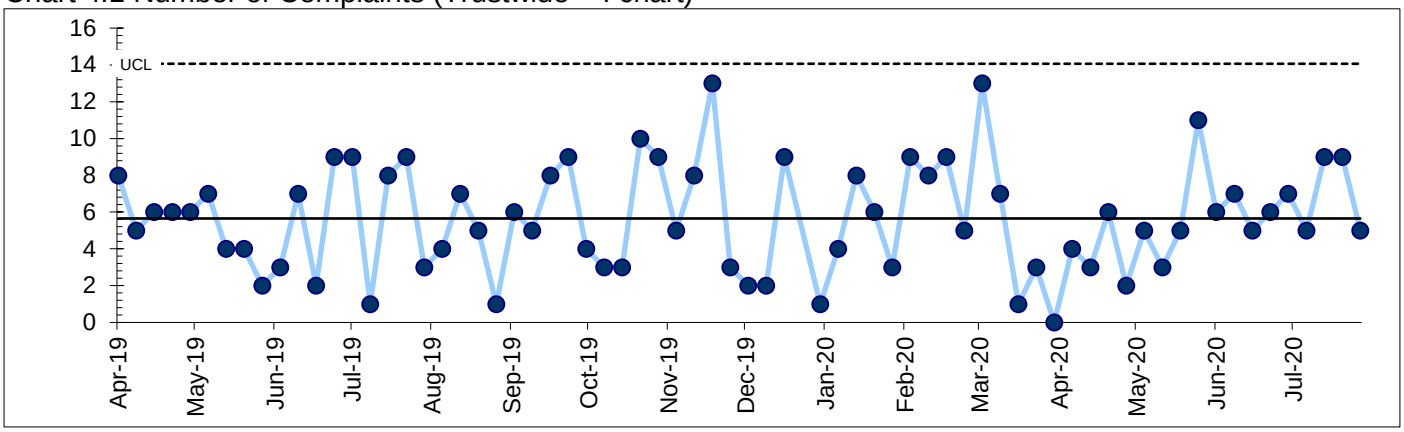


Chart 4.2 Number of PALs enquiries (Trustwide – I chart)

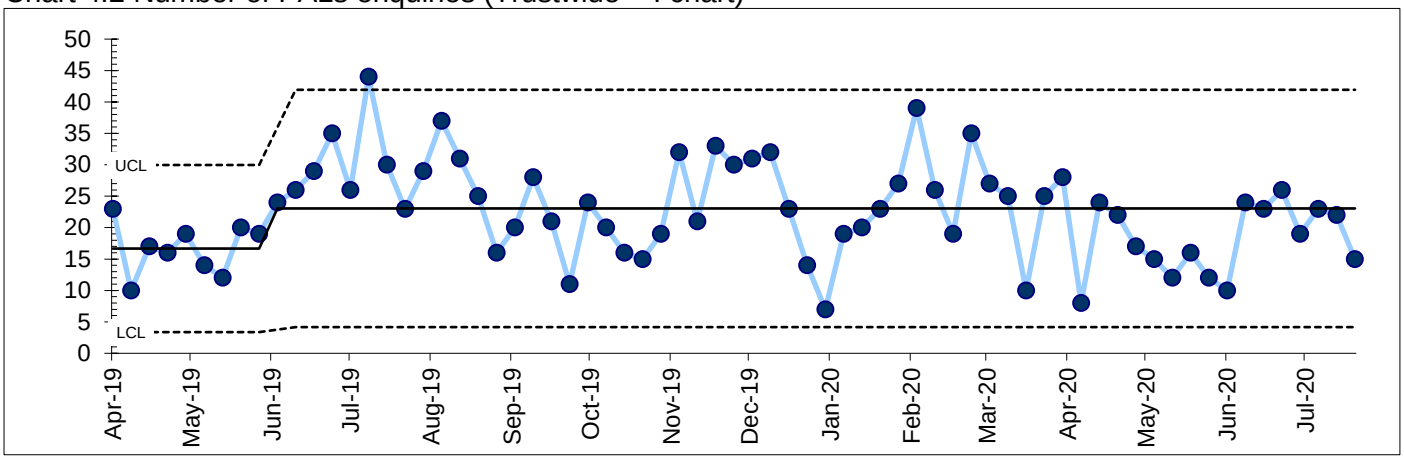


Chart 4.3 IAPT – percent demonstrating recovery at end of treatment (Trustwide – P chart)

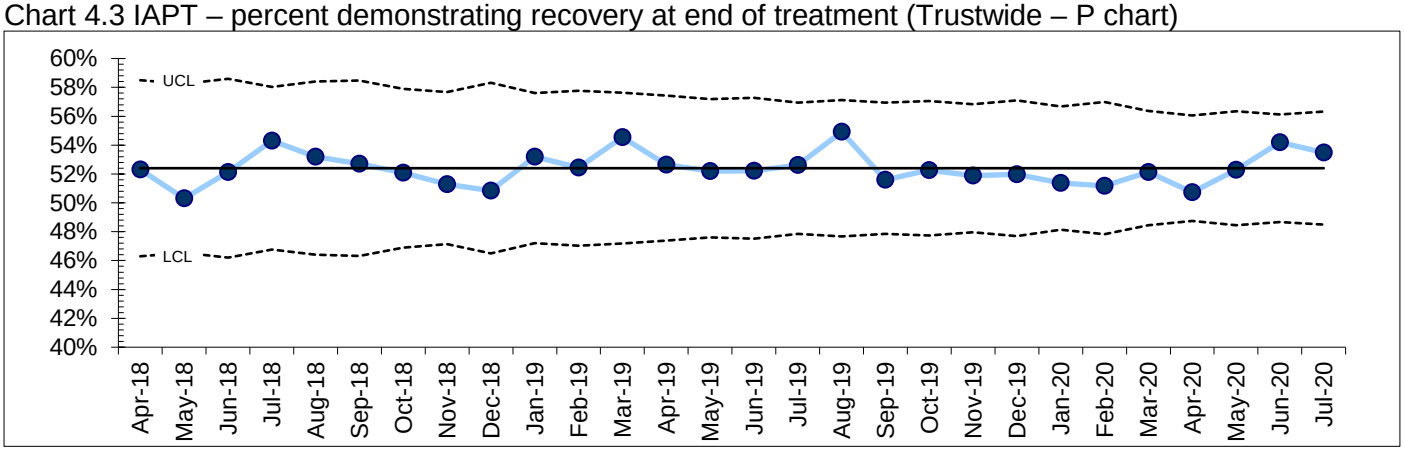
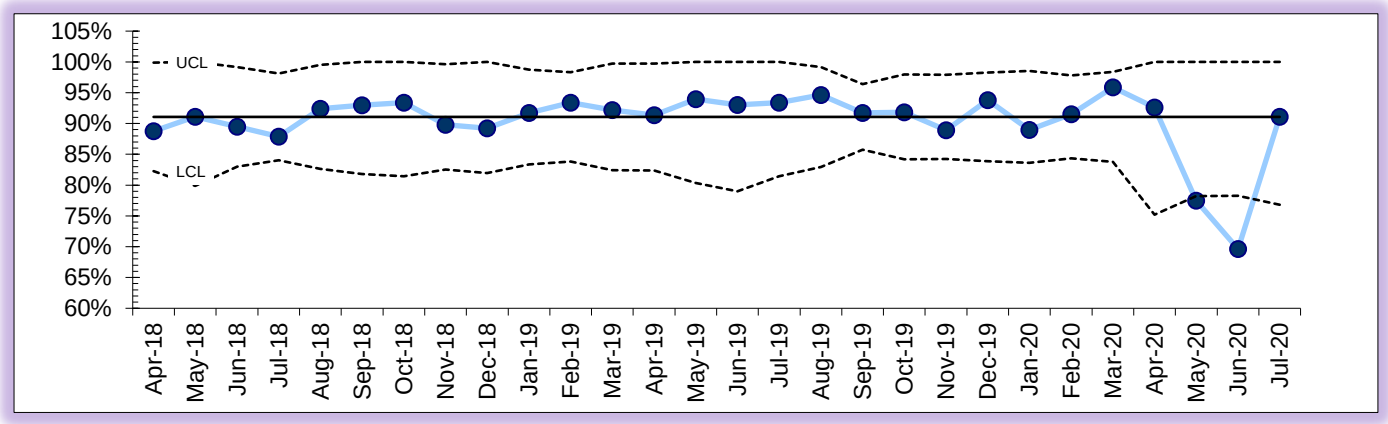


Chart 4.4 Percent recommending the service to friends and family (Trustwide – P' chart)



The charts below provide a summary of outcomes in mental health services based on DIALOG. The overall number of outcomes recorded decreased in April to its lowest level since 2017 but has increased. This reflects disruptions caused to services during the pandemic, as well as an effort by teams to maintain focus on outcomes during these challenging times. It has been recognised that further training is required to fully roll-out reliable and meaningful use of Dialog and Dialog+ across the organisation. To achieve this, the Trust is in the process of developing a bid to help provide training and hands-on support to teams across the organisation.

The data on service user dissatisfaction in charts 4.6 and 4.7 before and during the pandemic, shows that there has been a shift towards greater concerns about employment, followed by mental health and physical health issues. This reflects the current social and economic impact caused by the pandemic on our populations, particularly as a result of business closures, potential loss of the Government furlough scheme, and general uncertainty and anxieties about the future.

Chart 4.5 Number of DIALOG Forms completed (Trustwide – I chart)

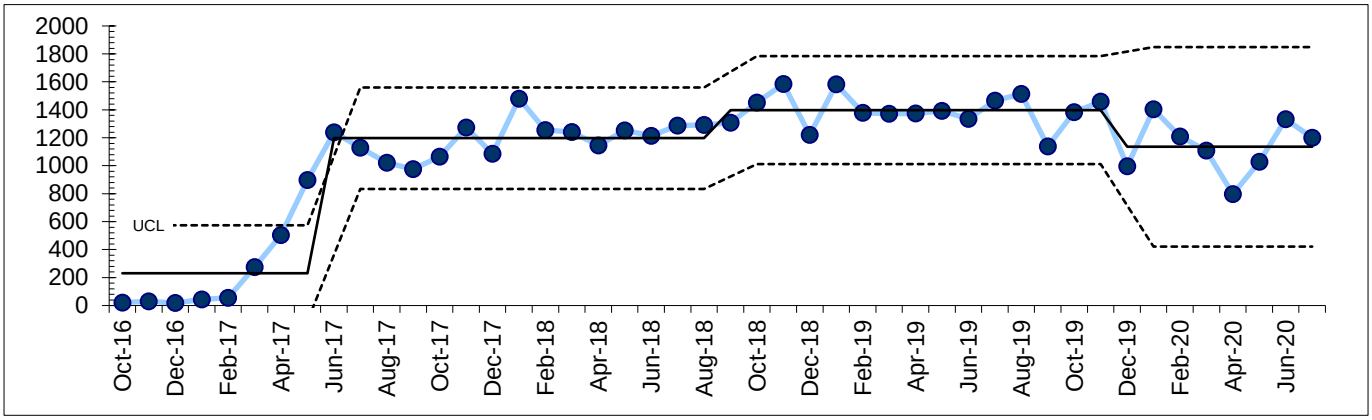


Chart 4.6 DIALOG Dissatisfaction scores by category prior to Covid (Trustwide – Pareto chart)

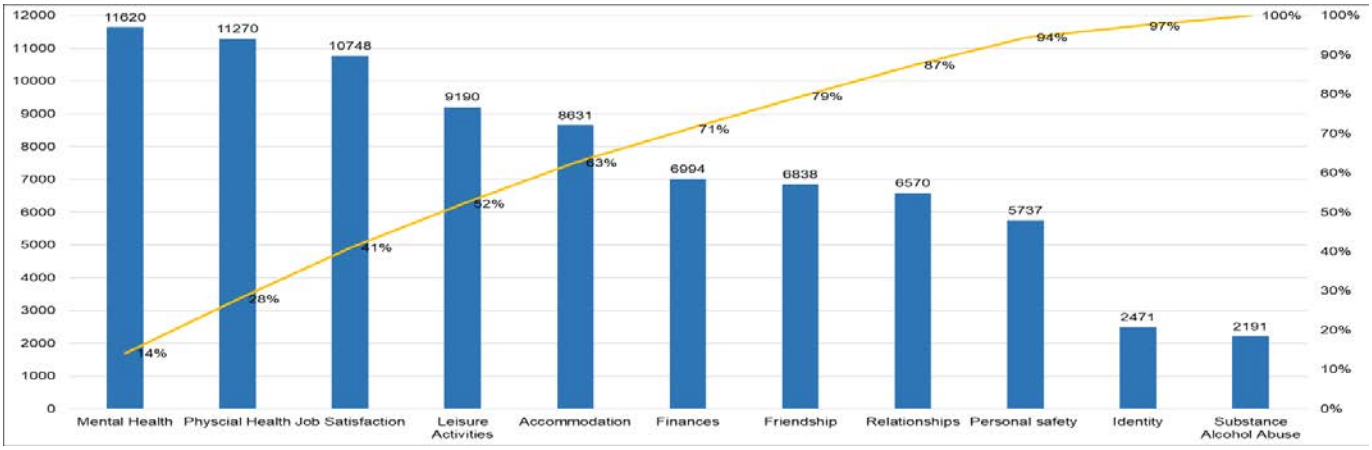
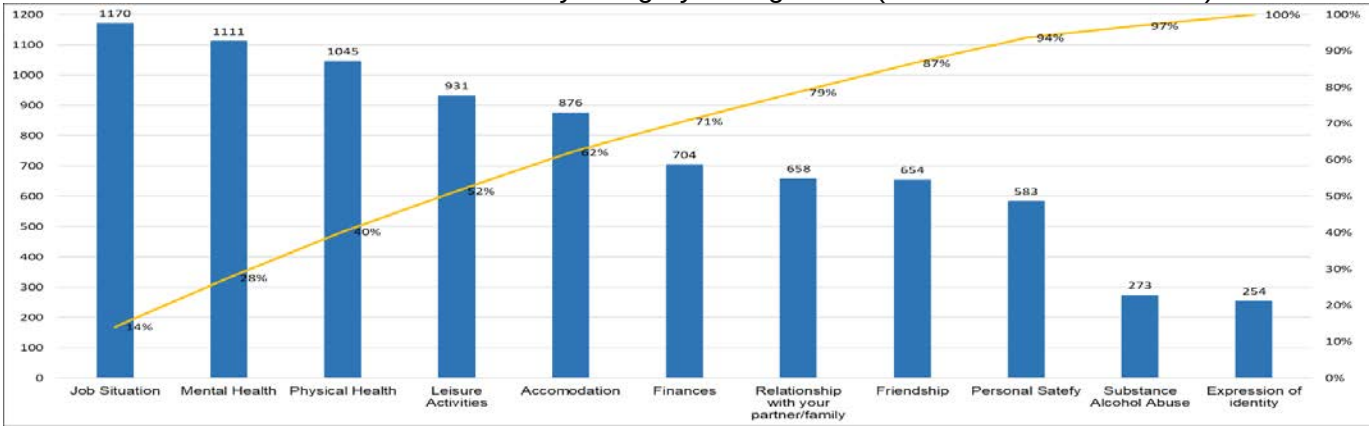
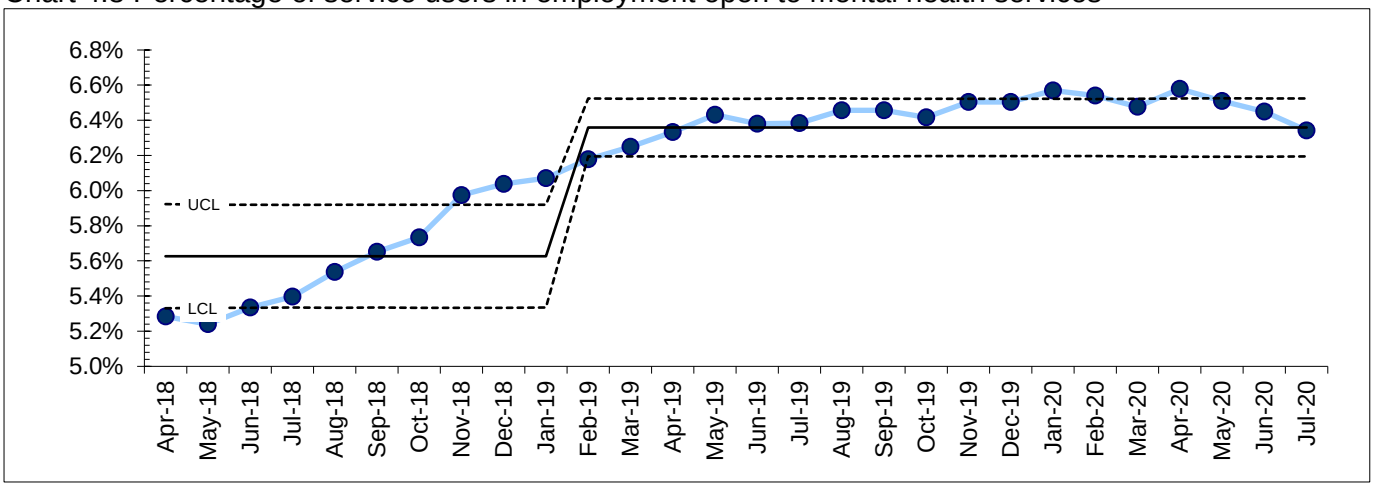


Chart 4.7 DIALOG Dissatisfaction scores by category during Covid (Trustwide – Pareto chart)



The charts below highlights the percentage of service users open to Mental Health services who are in employment. There has been a reduction from 6.6% in April to 6.4% in July which may have contributed to the feedback provided by service users around their dissatisfaction with job situation. A workstream has been setup with our People Participation lead, Public Health lead and Medical Directors to focus on this matter. Work is underway to conduct a mapping exercise of employment resources and services that are currently available as well as identifying any gaps in each locality. This information will then be used to develop local plans in each borough to improve the employment support offer across the Trust.

Chart 4.8 Percentage of service users in employment open to mental health services



5. Finance Performance

1 Executive Summary

1.1 Key conclusions are:

- Operating surplus (EBITDA) to end of July 2020 of £5,634k compared to planned operating surplus of £5,417k.
- Net surplus of zero (0.0%) compared to planned net surplus of zero (0.0%).
- Year to date net surplus variance on plan.
- NHS Improvement (NHSI) risk rating is not currently being reported.
- Cash balance of £146.9m as at the end of July 2020.

2 Financial Framework

2.1 Normal contracting arrangements are suspended under national COVID-19 arrangements. The Trust is receiving block payments from CCGs based on contract payments at Month 9 2019/20 (December 2019) plus a national top-up to reflect fluctuations caused by these temporary arrangements. The payments have been inflated to reflect national tariff inflator (2.3%) with no 2020/21 efficiency assumed. CCGs are not permitted to contract separately with Trusts under the current arrangements.

2.2 The Trust has assumed payments from other commissioners (e.g. local authority contracts) continues as per 2019/20. The Commercial Development Department (CDD) is writing to local authority commissioners to request uplifts to 2019/20 contracts. This to allow for;

(a) the 2019/20 pay award, the funding for which has been passed to local authorities in 2020/21, having been paid centrally to the Trust in 2019/20.

(b) an uplift for 2020/21 pay and prices inflation.

In order to be prudent, these uplifts have not been assumed in opening budgets. Income assumptions will be amended as revised contract values are agreed.

2.3 The Trust has had initial discussions with some CCGs in relation to funding of transformation programs that commenced in 2019/20, but for which the 2020/21 income needs to be received by CCGs and then devolved to the Trust. The Trust understands the transformation funding previously agreed for 2020/21 will be made available, although the mechanism for doing so is not yet clear.

2.4 The annual planning round has been suspended under national COVID-19 arrangements.

An opening budget has been uploaded to reflect a break-even position and to provide Directorates with a continuation of Month 12 2019/20 budgets, adjusted for known non-recurrent funding and major planned service changes not funded via draft 2020/21 contracts.

It is intended to replace this budget with an agreed 2020/21 budget once the temporary national arrangements come to an end.

2.5 The temporary block arrangements have been extended to the end of September with a move toward control totals and more formal contracting arrangements for the remainder of the financial year. The Trust is working with STP partners to produce a sector wide plan, assuming no second spike in COVID-19 cases.

3 Summary of Performance to 31st July 2020

3.1 The financial performance is summarised in the table below:

	YTD Jul-20			Temporary Annual	YTD Jun-20	Change
	Budget	Actual	Variance	Budget	Variance	+/-
	£000	£000	£000	£000	£000	£000
Operating Income	146,511	154,327	7,815	439,534	6,051	1,764
Operating Spend	141,095	148,693	(7,598)	423,283	(5,873)	(1,726)
Operating Surplus (EBITDA)	**5,417**	**5,634**	**217**	**16,250**	**179**	**39**
Interest Receivable	100	13	(87)	300	(62)	(25)
Interest Payable	(676)	(723)	(47)	(2,029)	0	(47)
Depreciation	(3,317)	(3,401)	(84)	(9,952)	(116)	33
Public Dividend Capital	(1,523)	(1,523)	0	(4,569)	0	0
Underlying Net Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**	**0**
Non-Recurrent Support Adjustment	0	0	0		0	0
Net Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**	**0**

The charts below provide assurance across a range of finance indicators.

Chart 5.1 Surplus (£000) (Trustwide – I chart)

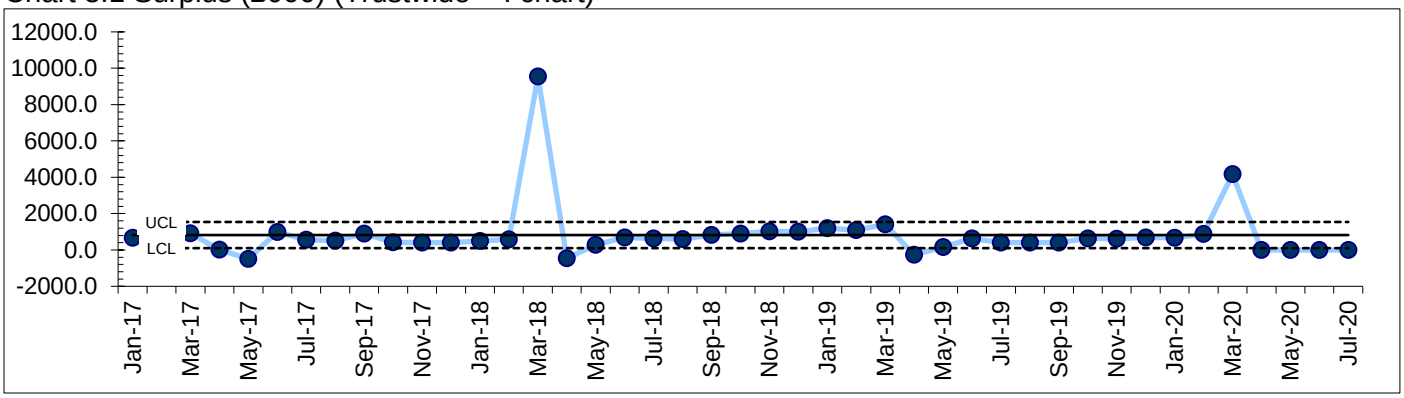


Chart 5.2 Cash Balance (Trustwide – I chart)

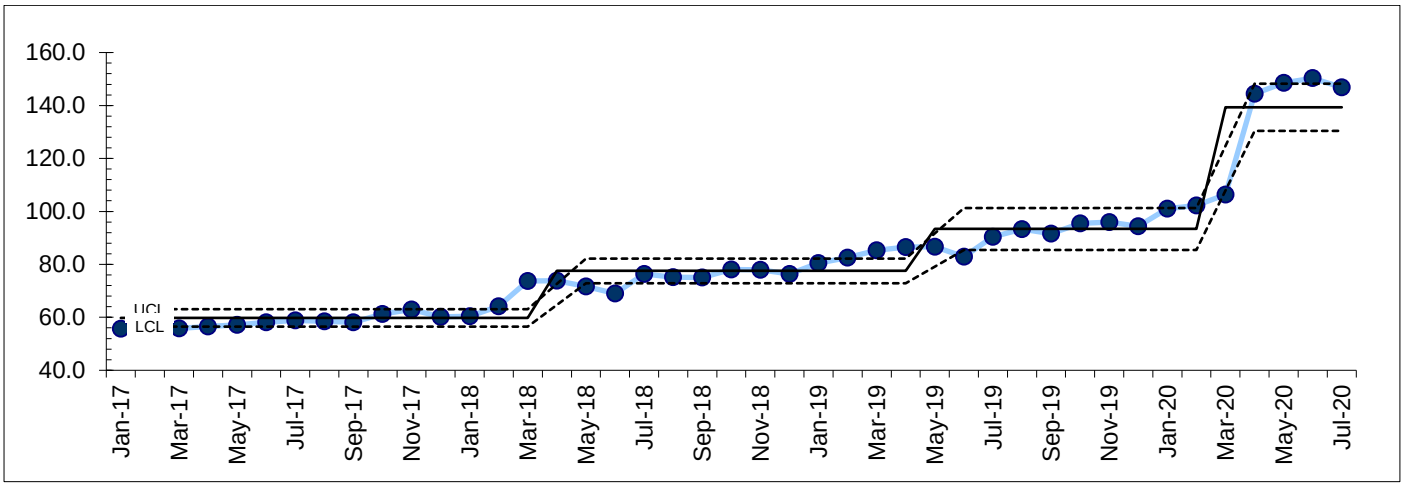


Chart 5.3 Agency vs ceiling (Trustwide – I chart)

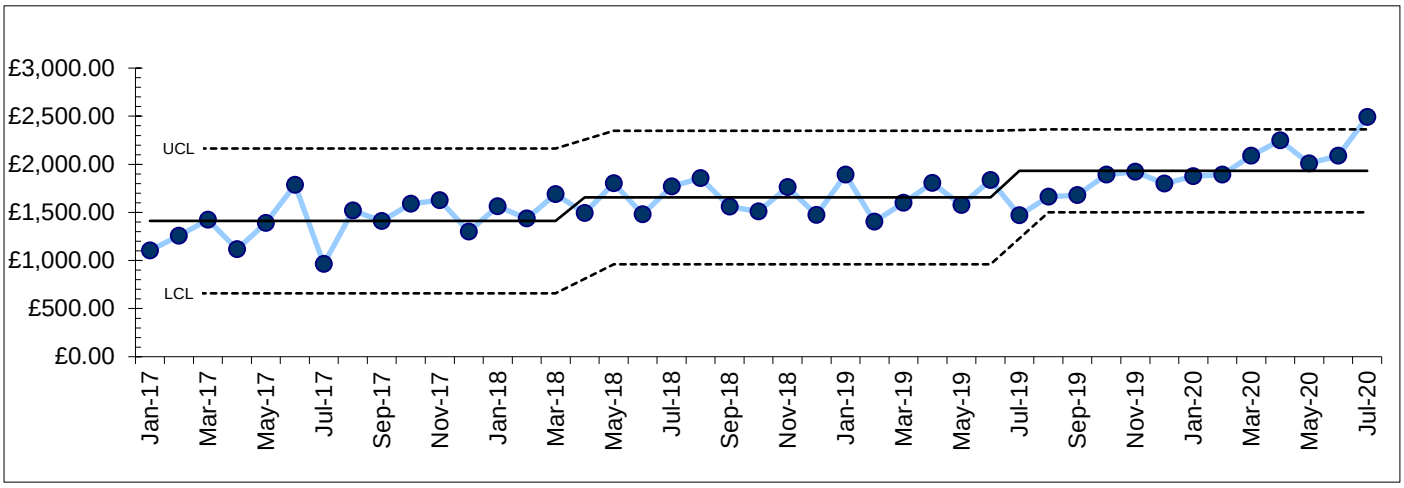
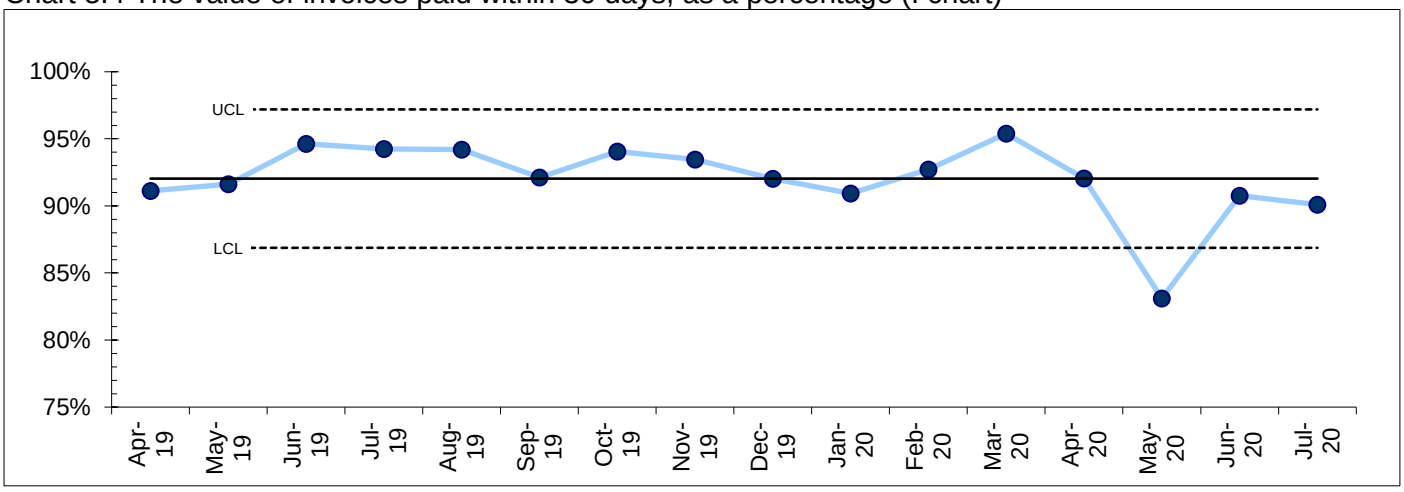


Chart 5.4 The value of invoices paid within 30 days, as a percentage (I chart)



7. Regulatory Compliance

NHS Improvement Single Oversight Framework

Trusts are segmented under the Single Oversight Framework (SOF) based on the level of support each provider needs which is designed to help NHS providers attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding'. NHS Trusts are placed on 1 of 4 "segments", with 1

being the lowest risk, and 4 being the highest risk. The Framework is divided into 5 themes. See table below for the Trust's current rating against each theme.

Theme	Current Rating	
Quality of Care		No Concerns
Finance and Use of Resources		NHS Improvement (NHSI) risk rating is not currently being reported.
SOF Operational Performance Indicators: • CQC rating • Complaints rate • Friend and Family Test scores • Patient safety alerts • Incidents of harm/Never events • % of service users followed-up on discharged from mental health ward • % of service users in settled accommodation • % of service users in employment • Admissions to adult facilities of services users under 16 years old • % of users with first episode of psychosis commencing treatment within two weeks of referral • IAPT services access times and recovery rates • Data Quality Maturity index • Staffing indicators – sickness, turnover, staff survey results • Finance sustainability indicators		No concerns relating to SOF indicators
Strategic Performance		No Concerns
Leadership and Improvement Capability		No Concerns

8. Recommendations and Action Being Requested

8.1 The Board is asked to **RECEIVE** and **DISCUSS** the report.