East London NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
23 July 2020

Title	Integrated Performance report
Authors & 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

Our safety indicators remain stable, however, there has been a notable increase in reported incidents across the Trust, pressure ulcers as well as reduced compliance with achieving follow-up contact within 72 hours and 7 days of inpatient discharge.

Our access indicators highlight increasing demand across accident & emergency mental health liaison services, and community and inpatient services. Access to Trust crisis mental health services remain responsive, with crisis presentations showing an increase in May. Access 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). However, 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.

Our staffing indicators highlight that there has been further reduction in non-covid-related sickness and vacancy rates.

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 May 2020 is £2,597k compared to a planned operating surplus of £2,482k. 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 equalities work stream.
Risk and Assurance	This report and supporting appendices cover performance for the period to the end of January 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, 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.

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, and the percentage of incidents resulting in harm, have both demonstrated an increase during May. There was an unusually high number of reported incidents during the third week of May, which primarily related to a rise in incidents across Community Health Services in Bedfordshire and Forensic services. The percent of incidents resulting in harm has risen from the previous average of 2.4% to 6-8% during May. This is related to care and treatment incidents and violence and aggression incidents in Forensic services, as well as care and treatment incidents in Community Health Services. The incidents in Forensic services related to issues concerning police custody and detention, transportation, self-harm as well as violence and aggression by four service users placed on long-term segregation. A review of these cases has since been conducted, and segregation has since been terminated for two of the service users in June. In addition, during this period there were several service users who tested positive for Covid-19 but refused to comply with social distancing measures, leading to incidents of violence. During the acute phase of the pandemic, service users were not able to go on leave as frequently and this may potentially have also contributed to the increase. Leave was restarted in June cautiously, and it is expected that this will have an impact on the overall levels of incidents on the forensic wards. Incidents causing harm in Community Health Services reflect the increased number of pressure ulcers reported, particularly in Bedfordshire. This is explored in more detail below.

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

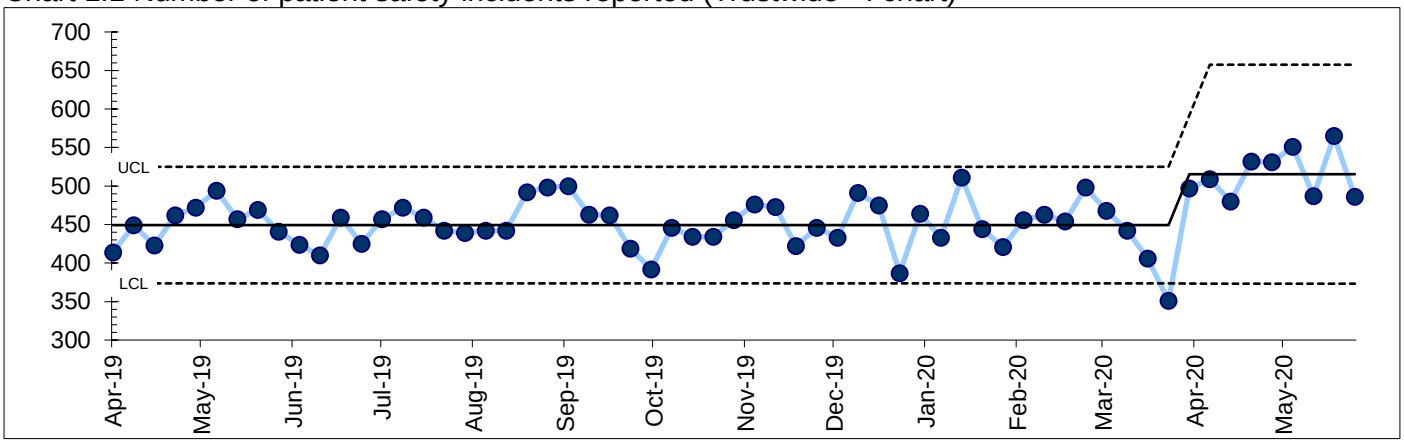


Chart 1.2 Percent of incidents resulting in harm (Trustwide – P chart)

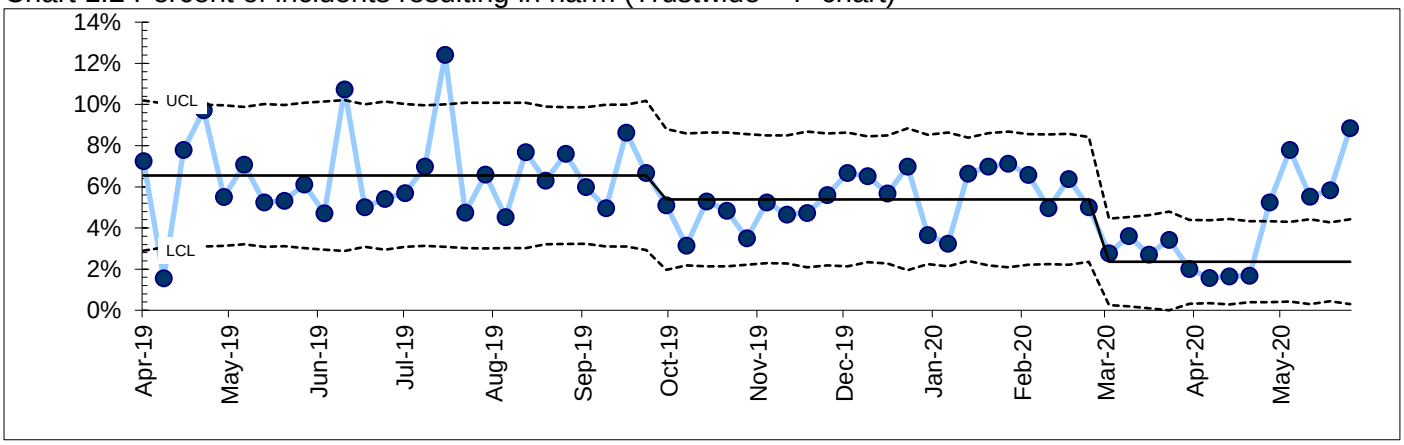


Chart 1.3 Rate of incidents of physical violence per 1000 occupied bed days (Trustwide – U chart)

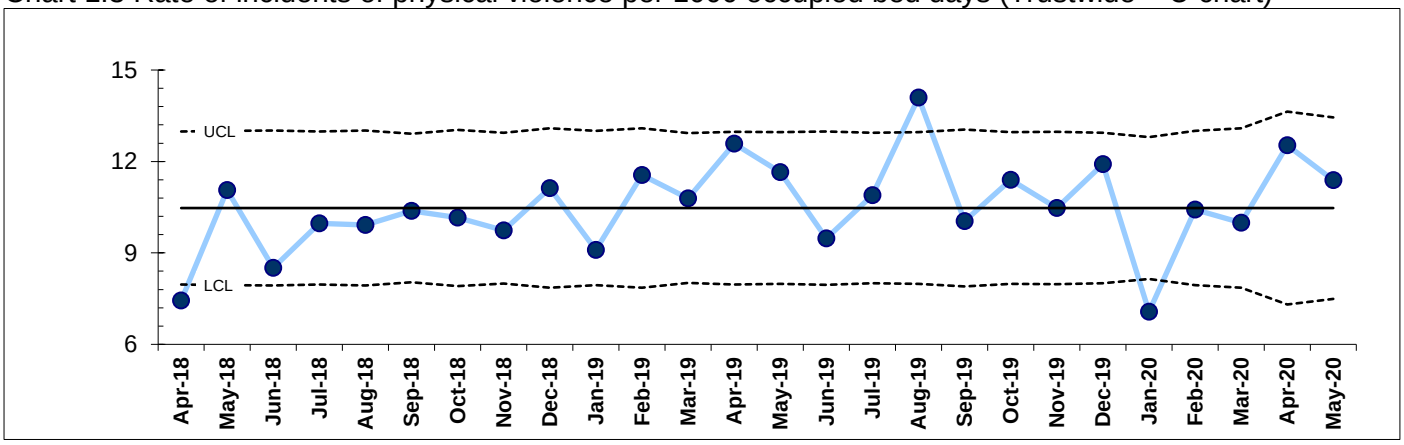
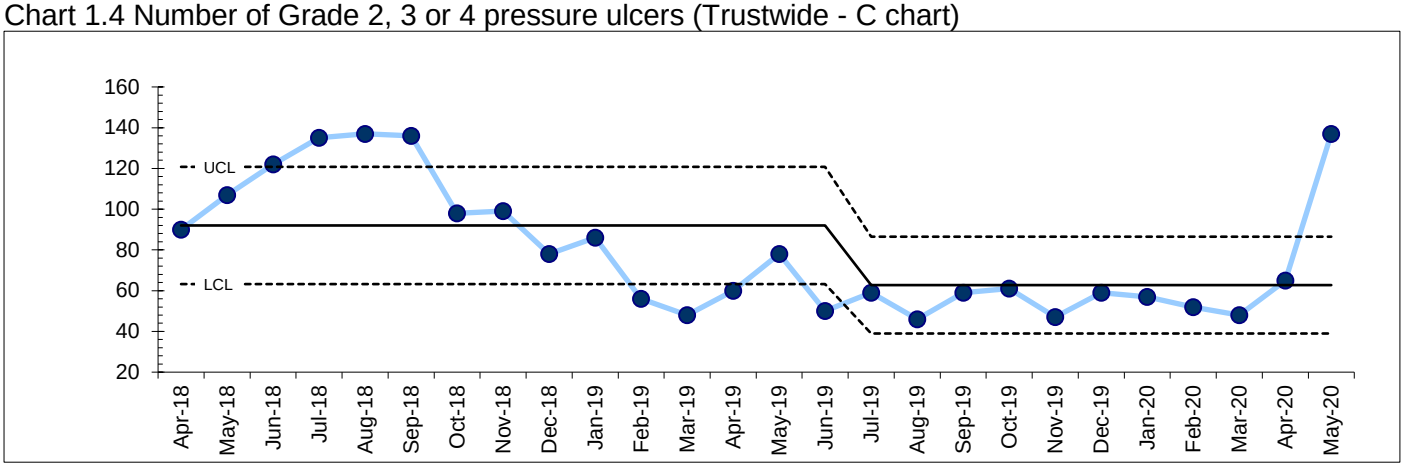


Chart 1.4 Number of Grade 2, 3 or 4 pressure ulcers (Trustwide - C chart)

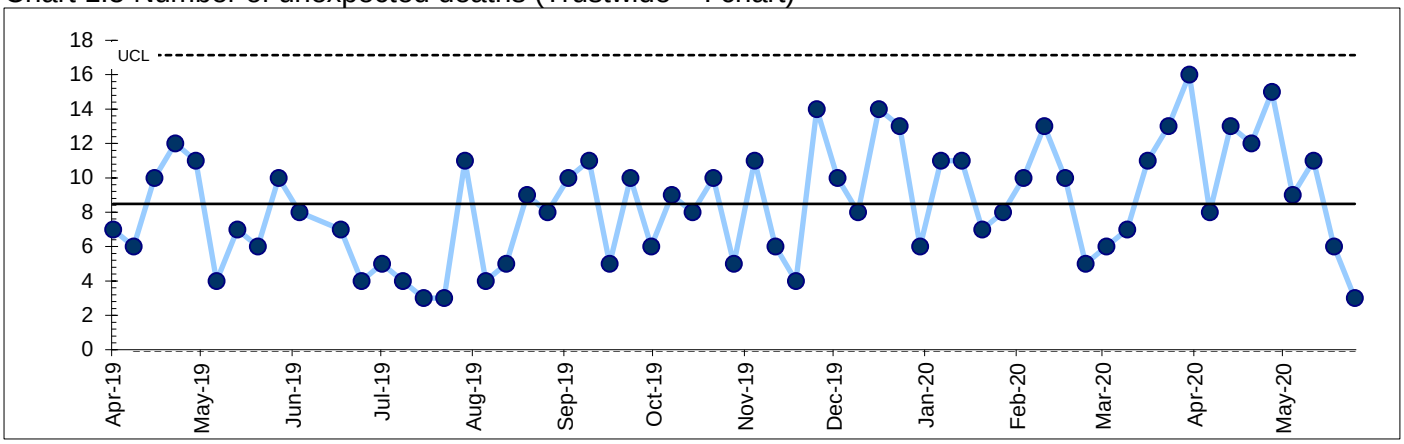


The number of reported pressure ulcers increased from 62 in April to 140 in May. The largest increases related to grade 2 and 3 pressure ulcers, particularly in Bedfordshire. The increase is believed to be related to the pandemic and also being reported by other community health services nationally. Some of the increase is also attributed to improvements in recording practices as a result of virtual training and awareness sessions on pressure ulcer prevention and management undertaken in May.

During March and April, a number of service users and families declined visits from community nurses at the start of the pandemic because they were shielding, or anxious about letting health care professionals into their homes. Additionally, more people socially distancing and shielding at home may have contributed to a decrease in usual levels of physical exercise, resulting in new pressure ulcer presentations, and for some, a deterioration of existing pressure ulcers. It is also possible that prevention advice has not been as robust as usual, because district nurses have

concentrated on prioritising essential and urgent duties during the pandemic. In Bedfordshire, seven service users accounted for 28% of grade 2 ulcers because the pressure ulcers were reported multiple times. This was due to deteriorating pressure ulcer conditions as a result of non-engagement, and refusal to accept nursing care or advice. Services are also seeing an increase in suspected deep tissue injuries during the pandemic which is an emerging picture of skin changes reported across Europe.

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



The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) have presented compelling evidence over the last few years that there is an increased risk of dying by suicide on days 2-3 following discharge from hospital. In response, NHS England and NHS Improvement introduced a national CQUIN indicator for 2019/20 to incentivise NHS providers to follow up all adults (not just those on the Care Programme Approach) within 72 hours of discharge from psychiatric inpatient care where they met specific criteria. It is expected that the 72 hour standard will replace the current national 7 day follow-up target. As a result of this compelling evidence base for intervention, the Trust has devoted a lot of time and resource to deliver improvement in this area through quality improvement projects led by our medical directors for mental health services. The project has engaged service users through conducting surveys to better understand service user experience and quality of follow-up care, as well as identifying ways to make improvements. This included introducing new follow-up pathways and developing guidance and standards for staff to follow and conducting training sessions across services. The pandemic has momentarily paused the project but it will be reconvened in due course. 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 the ward (Trustwide - P chart)

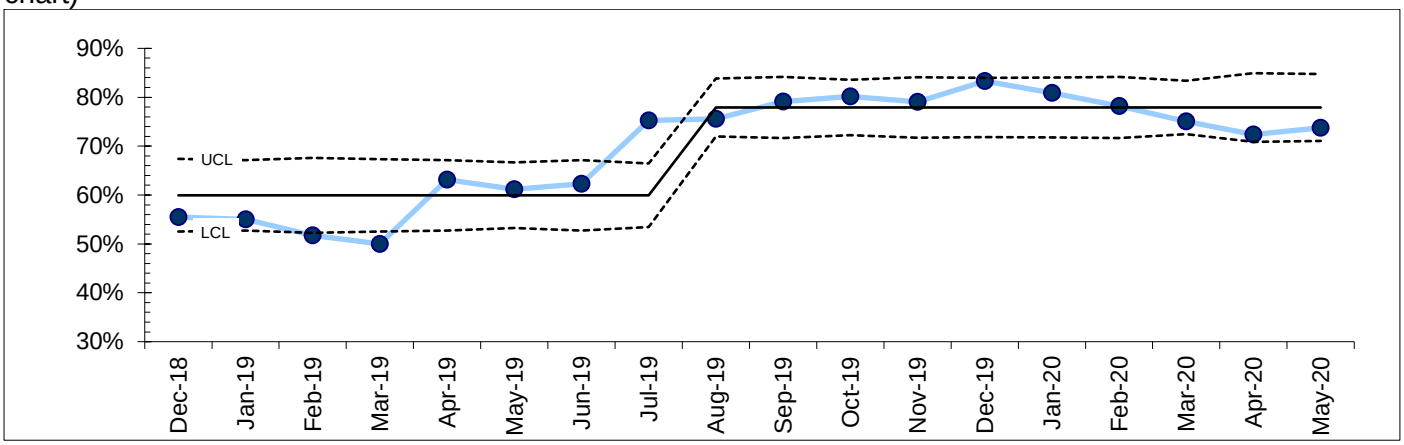
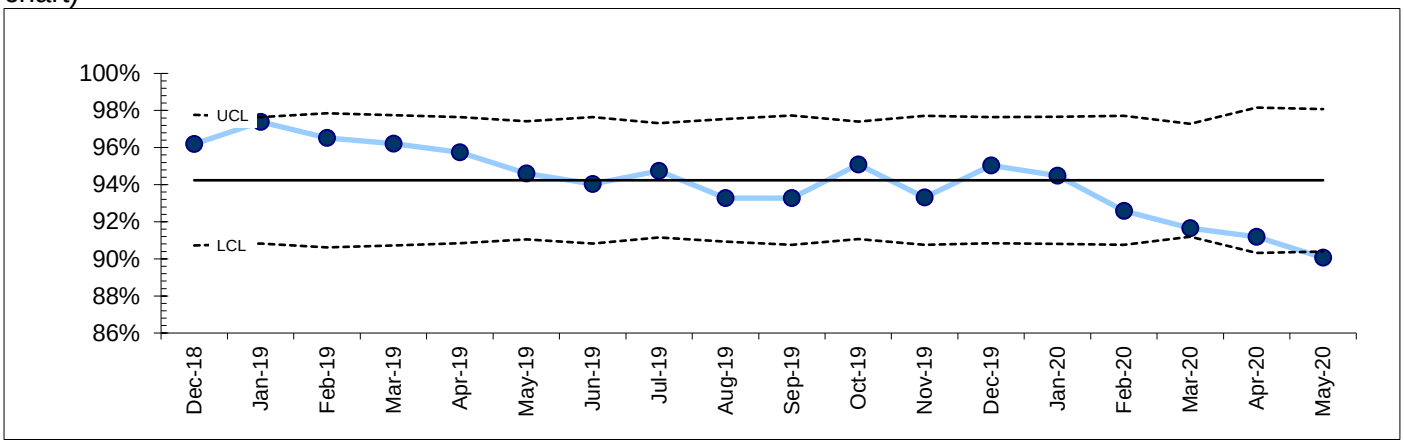


Chart 1.7 Percent of service users followed up within 7 days of discharge from the ward (Trustwide - P chart)



Over the past three months the percentage of service users currently receiving follow-up contact within 72 hours and 7 days of discharge from mental health inpatient services has been falling below national targets. In May, 72 hours compliance was 73.8% (target 80%) and 7 days compliance was 90.4% (target 95%). 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, particularly in City and Hackney and Tower Hamlets where compliance continues to be lower than the rest of the Trust. Local audits of cases of delayed follow-up highlight that the main factors relate to service users not engaging with multiple follow up contacts offered within designated timescales, some service users not having telephone or alternative contact mediums, and data entry errors by staff in recording positive contacts during the pandemic period.

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

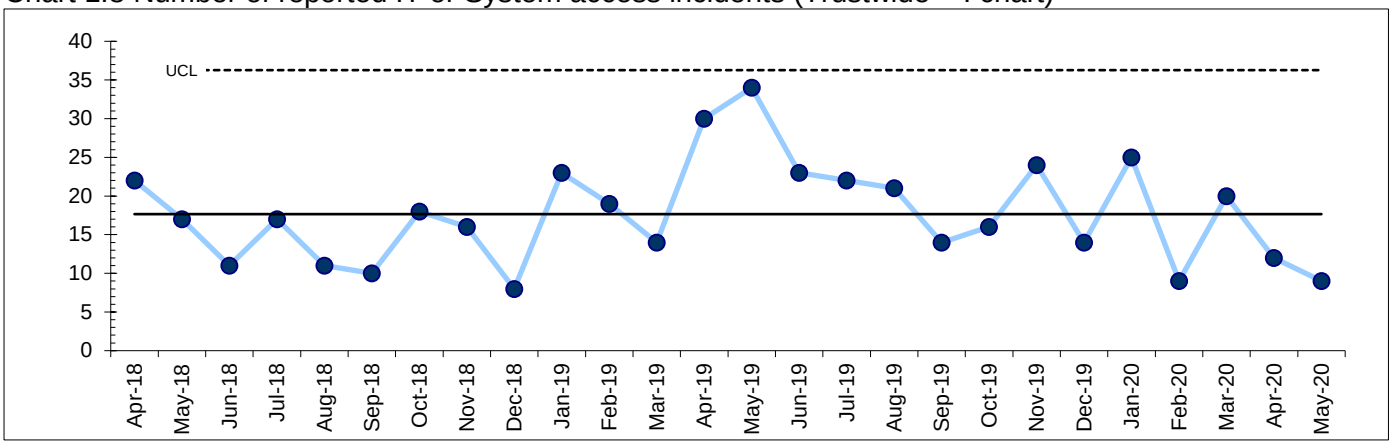
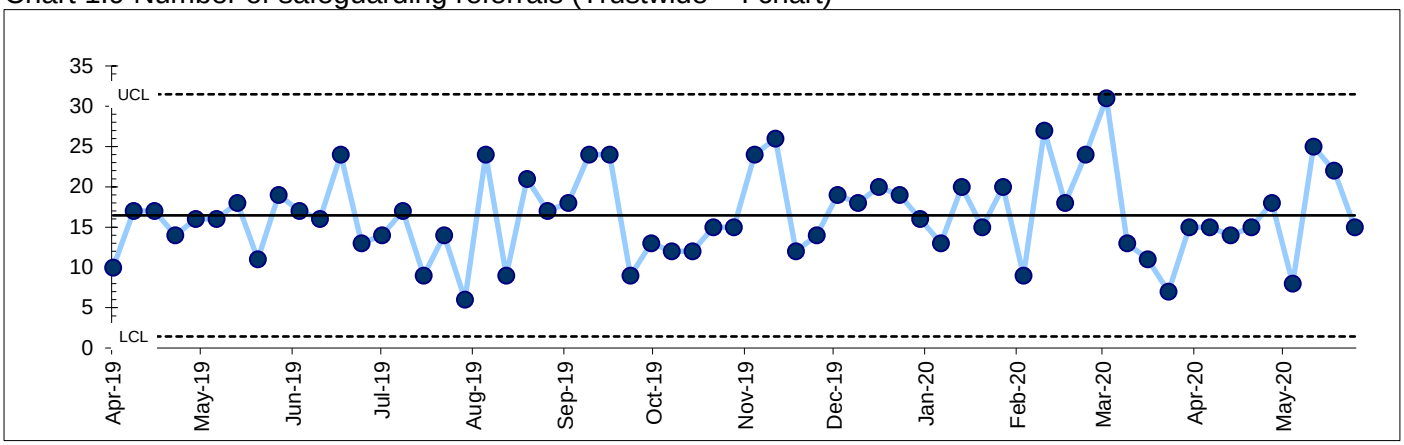


Chart 1.9 Number of safeguarding referrals (Trustwide – I chart)



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 various services in the Trust. Referrals to Accident and Emergency (A&E) mental health liaison services dropped in April, but returned back to usual levels in May. Mental Health and Community Health referrals also increased, from 11,005 in April to 13,285 in May. The largest increases took place in Tower Hamlets and Newham Community Health Services, with modest increases across Mental Health services. Inpatient bed occupancy remains below 65% with the number of admissions increasing from 397 in April to 461 in May.

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

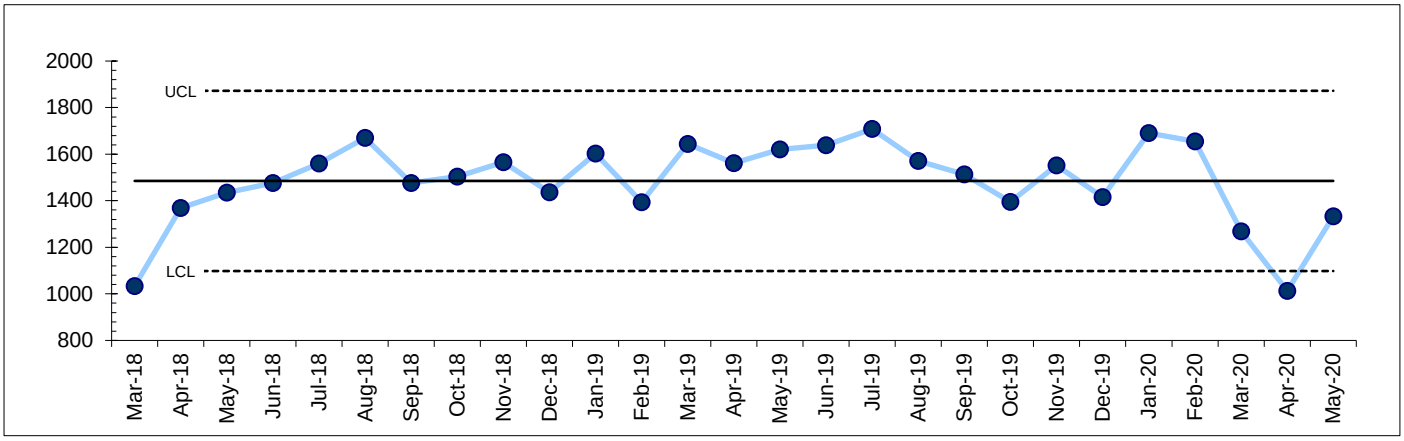


Chart 2.2 Bed occupancy (Mental Health & Community Health – P' chart)

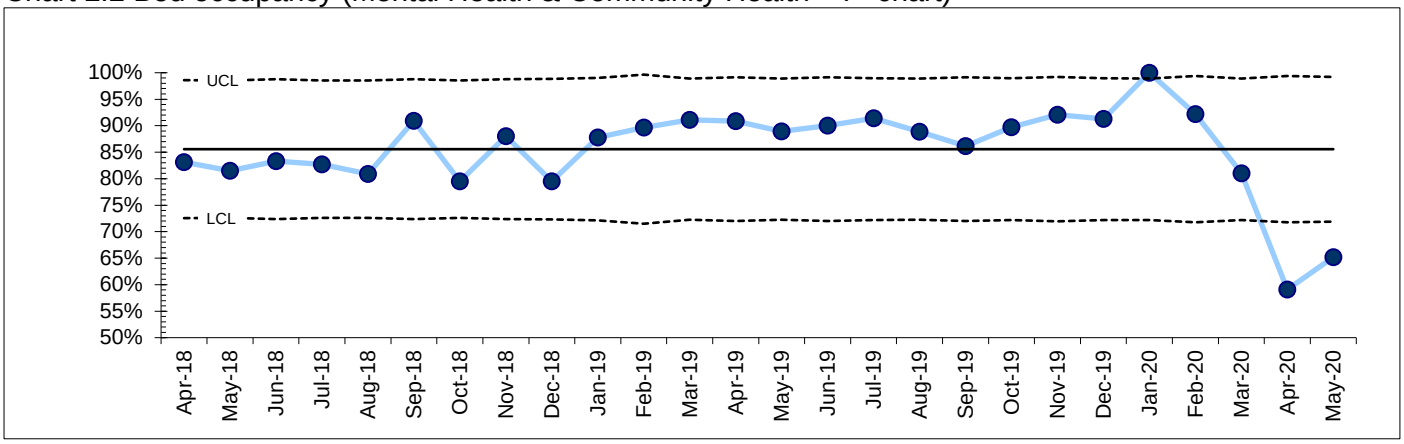


Chart 2.3 Number of admissions (Mental Health and Community Services – I chart)

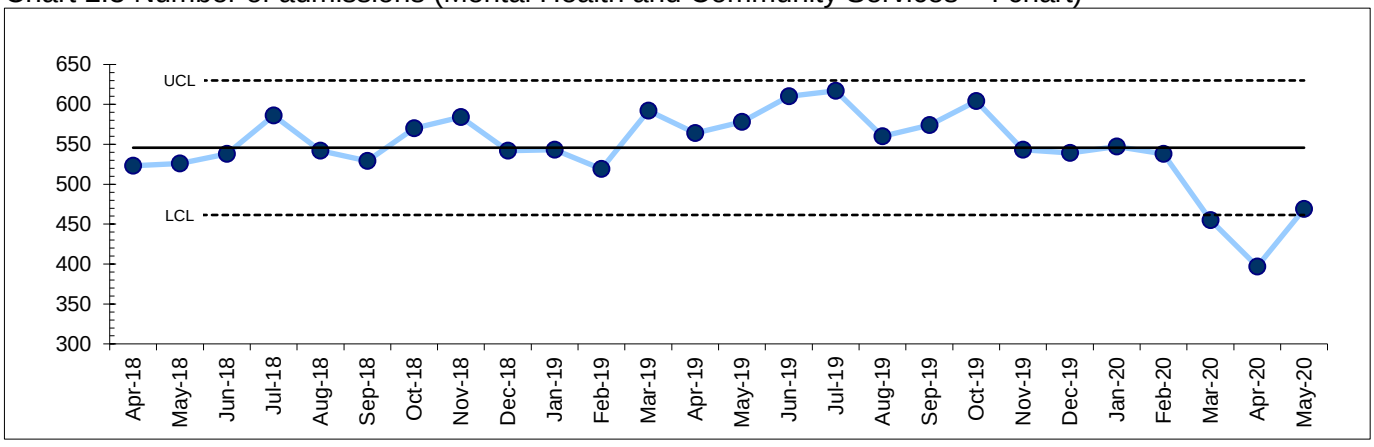
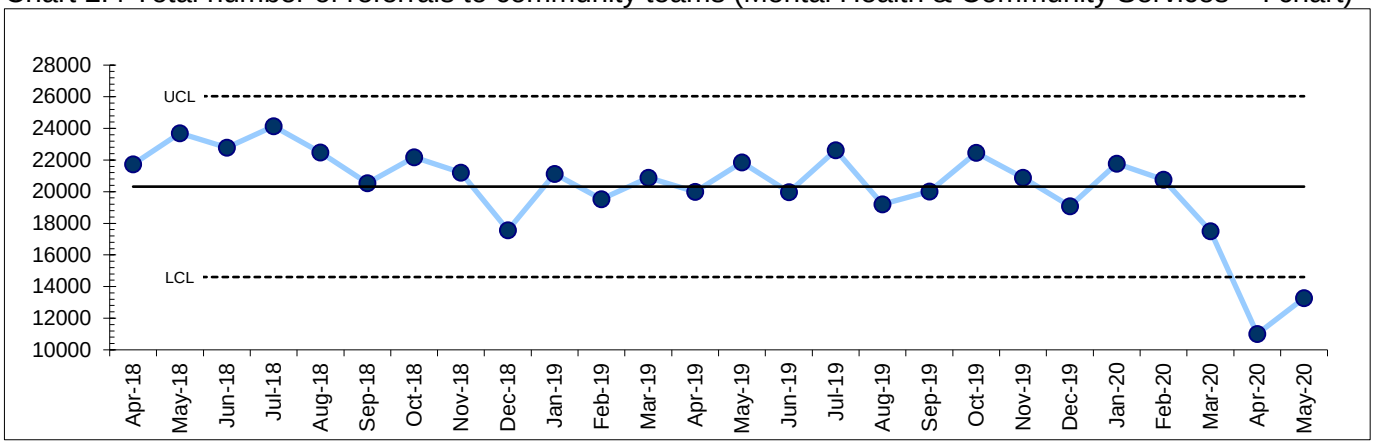


Chart 2.4 Total number of referrals to community teams (Mental Health & Community Services – I chart)

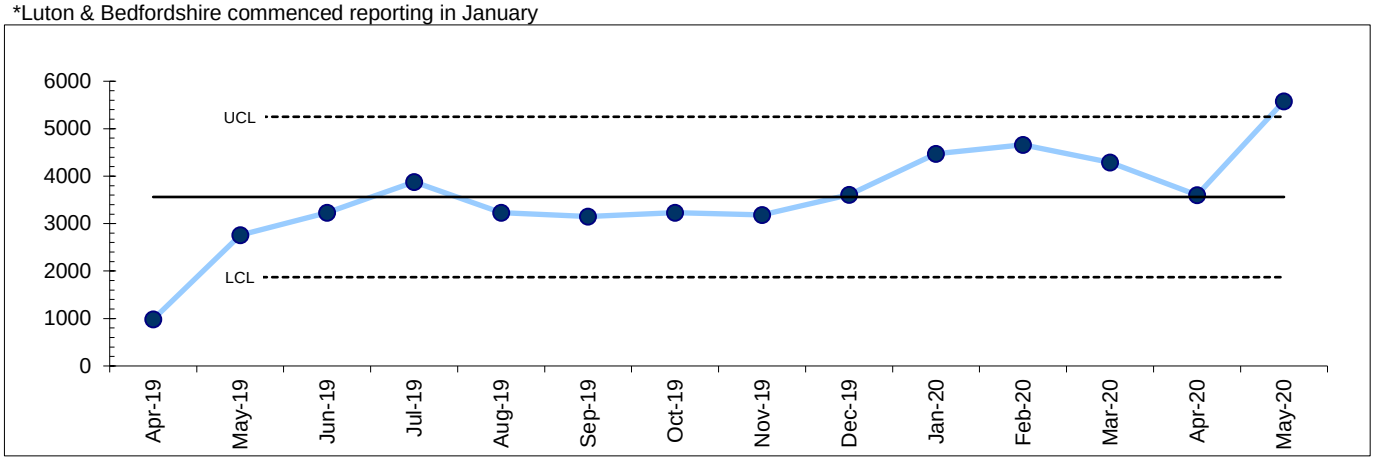


Mental Health Crisis pathway

The charts below highlight activity across our mental health crisis pathway in the Trust. During May, there has been an increase in the number of calls, particularly calls during routine hours from service users who are experiencing a mixture of anxiety and obsessive-compulsive behaviours as well as concerns about social isolation, employment, financial worries and fears about the future. Most services have also seen an increase in face to face contacts.

The increase in crisis activity has been challenging for all services, and most of our teams have had to employ extra bank staff to cover busy periods at additional costs to cope with the increasing pressure on staff and to answer calls in a timely manner. In City and Hackney new telephone lines have been set-up as a result of feedback from service users highlighting difficulties in getting through to the crisis line due to increased demand.

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



Access to Services

The charts below highlight access and waiting times for Child and Adolescent Mental Health services (CAMHS), adult & older adult Community Mental Health Teams (CMHTs) and community health district nursing services.

The average waiting time for assessment in CAMHS and Adult & Older Adult CMHTs remains stable with an average of 27.5 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)

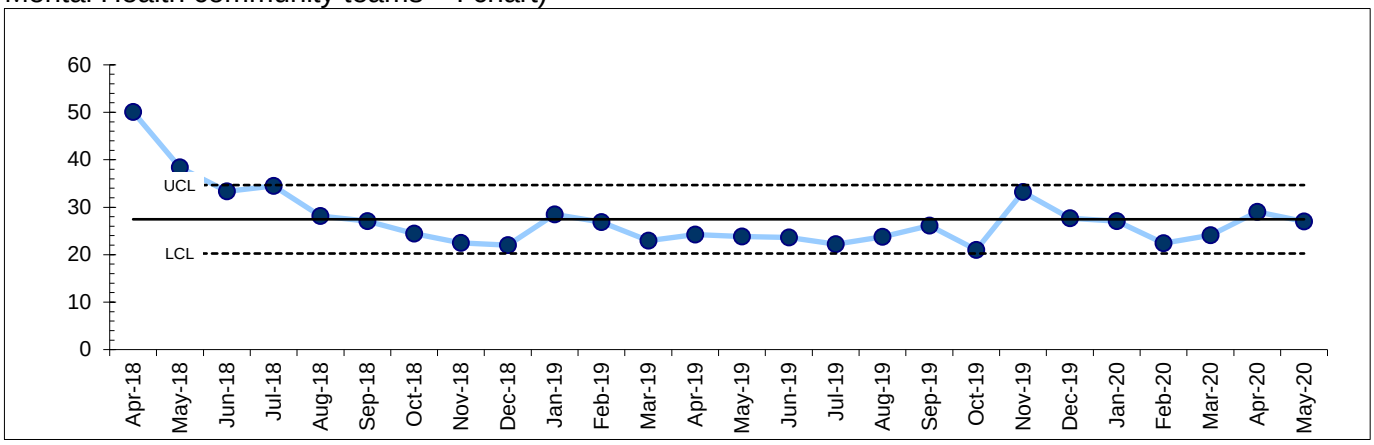
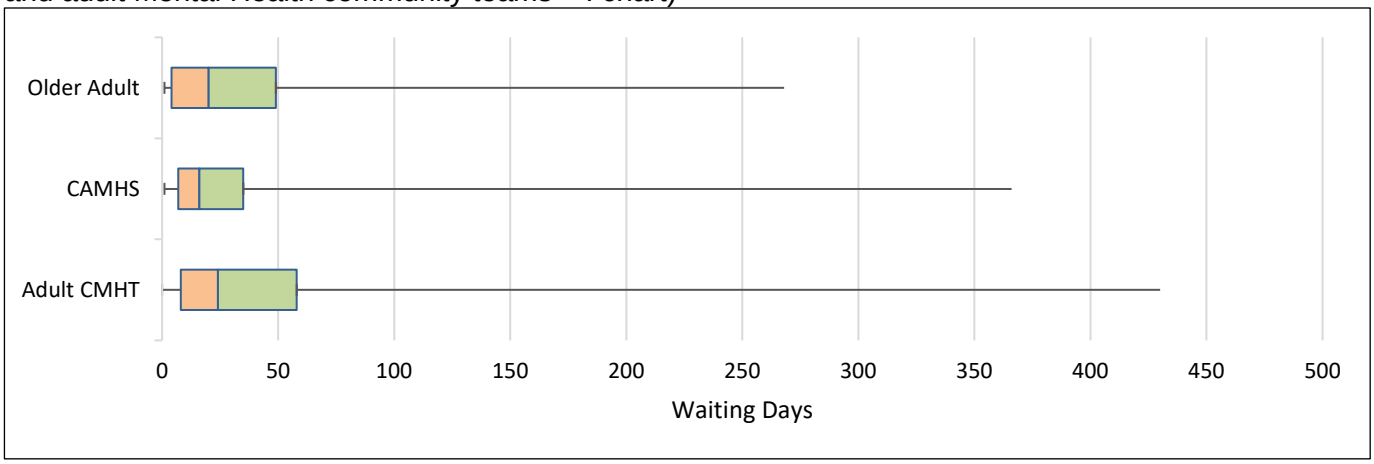


Chart 2.8 Average waiting times for referrals not yet seen for assessment – current snapshot (CAMHS, and adult Mental Health community teams – I chart)



The data for this cohort of service users is presented in chart 2.8 which shows that the median wait for service users still to be seen is 34 days in adult community mental health, 29 days in older adult community mental health, and 19 days in child and adolescent mental health services.

Local audits have highlighted that most of the longest waits related to referrals that have not been 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. In a small number of cases, it was found that some service users did experience genuine delays in accessing services due to appointments not being rescheduled promptly or capacity issues, for example, in CAMHS eating disorder and ADHD services. As part of our response to the pandemic, all teams have been undertaking risk assessments on their caseloads and referrals, and as part of this work they are continuing to proactively monitor the needs of all service users based on clinical urgency on daily basis. 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.

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

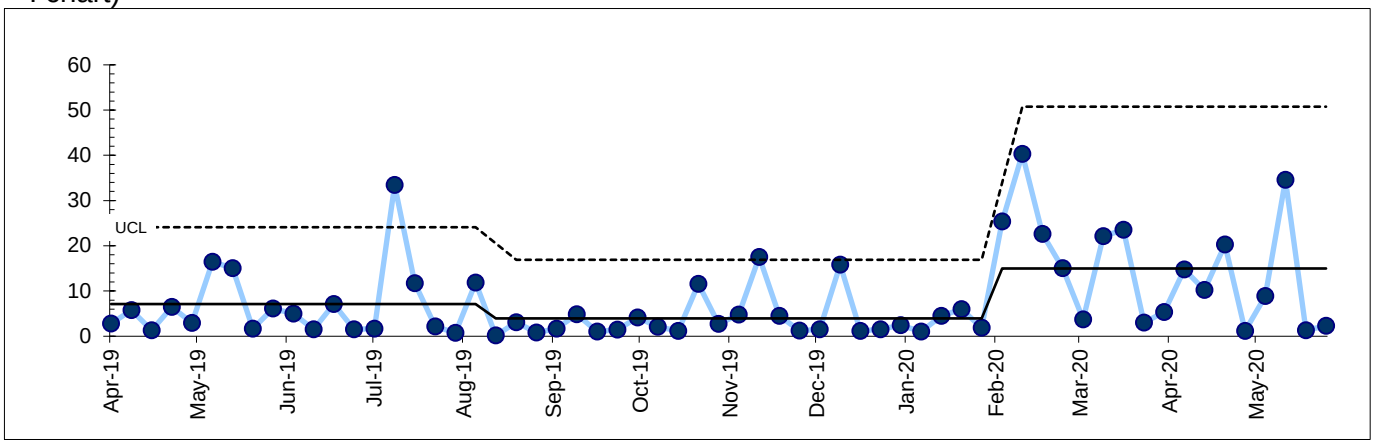
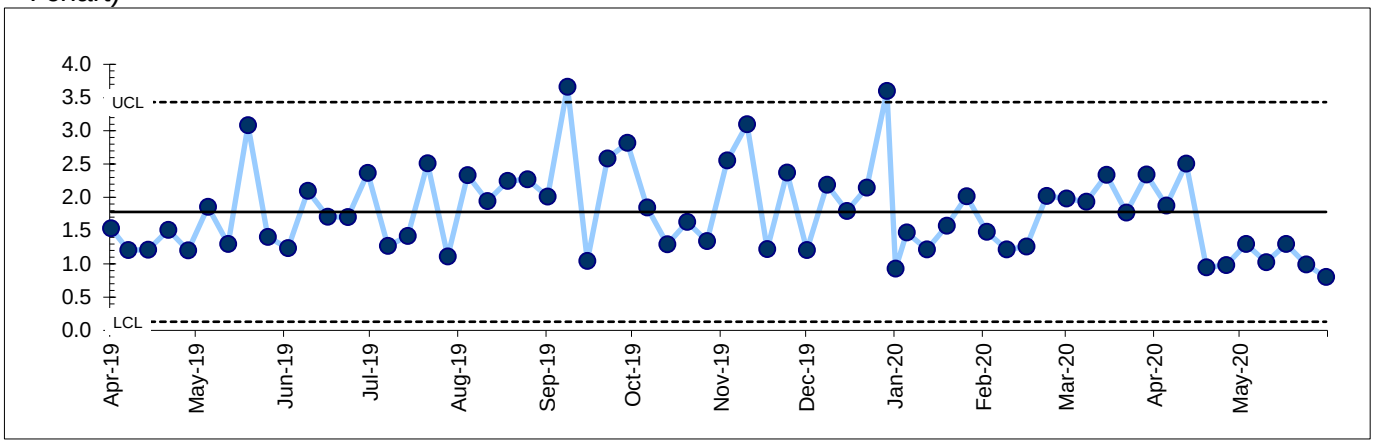
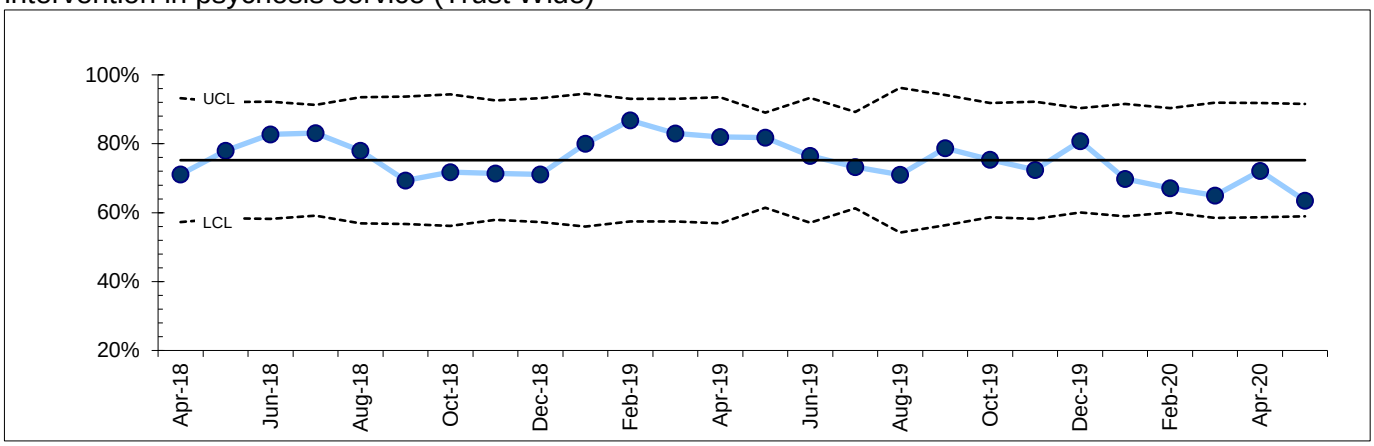


Chart 2.10 Average waiting times in days for referral to assessment to district nursing team (Bedfordshire – I chart)



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. The unusually high response time across East London during the second week of May was related to incorrect recording in teams where activity was linked to wrong referrals. Further training has been provided to staff resulting in improvements for the remainder of May. Unfortunately due to the configuration of the community health clinical record system (EMIS), we are unable to reverse incorrect recordings.

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



Adult mental health Early Intervention Services (EIS) waiting time target for referral to treatment is showing early signs of deterioration, moving from an average of 80.8% receiving NICE-compliant treatment within two weeks to 63.5% in May. This is largely due to reduced performance in Newham and Tower Hamlets services. The national indicator is based solely on face to face

contacts, with virtual/telephone contacts not included in figures above. All services are offering telephone and video contacts as the primary method to engage with service users during the pandemic. 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 to support timely access.

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

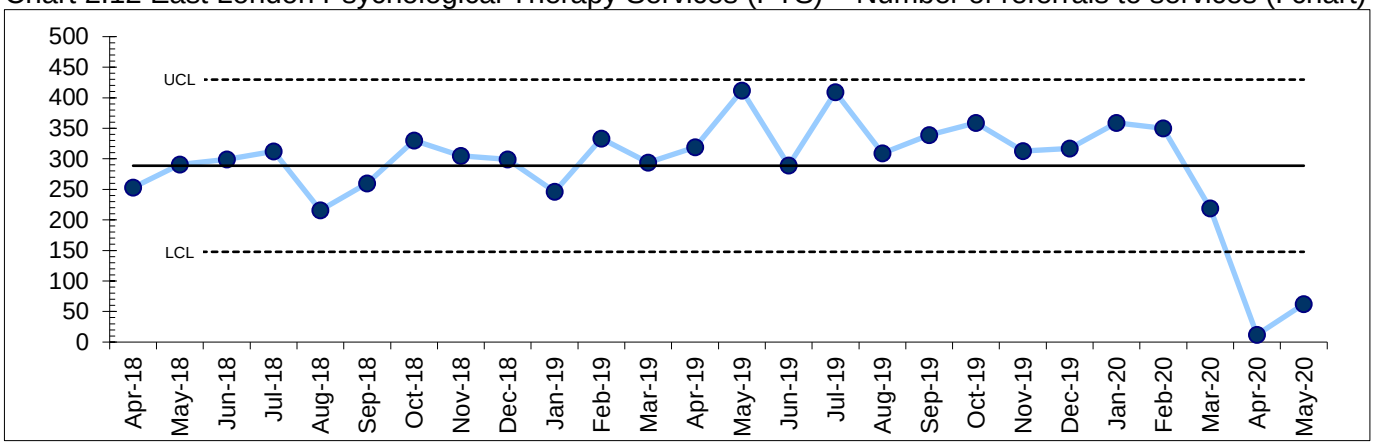


Chart 2.13 East London Psychological Therapy Services (PTS) - Average waiting (in days) from referral to assessment (telephone & face-to-face contacts – I chart)

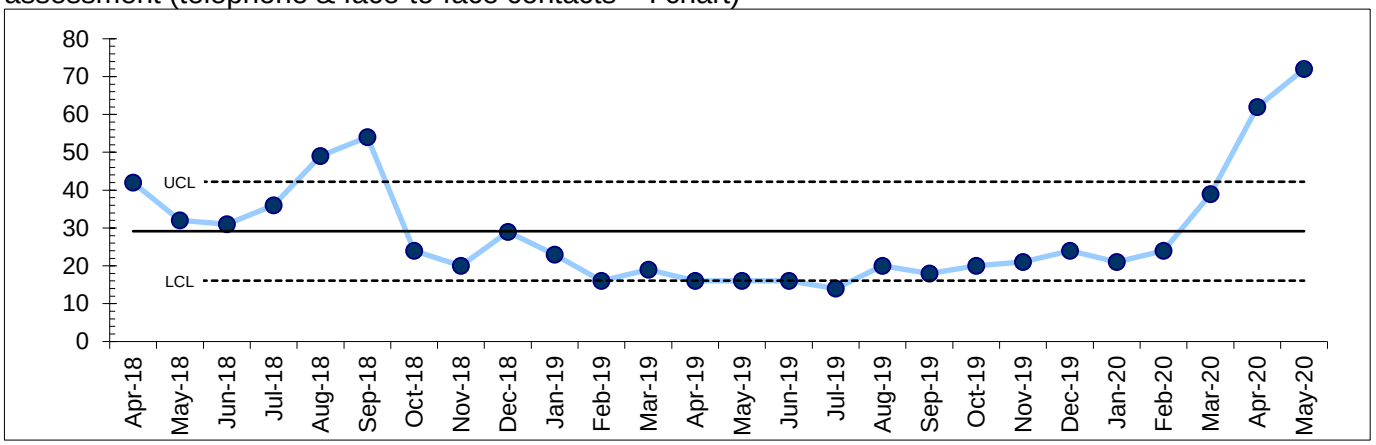


Chart 2.14 East London Psychological Therapy Services (PTS) - Average waiting time (in days) for treatment (telephone & face to face contacts – I chart)

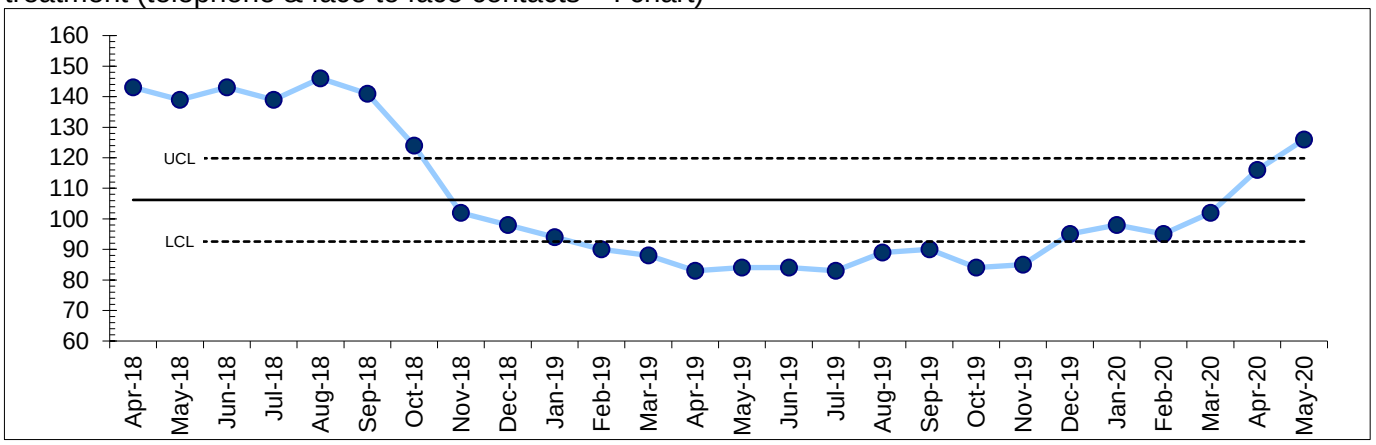


Chart 2.15 East London Psychological Therapy Services (PTS) - Number of service users waiting for assessment (telephone & face to face contacts – I charts)

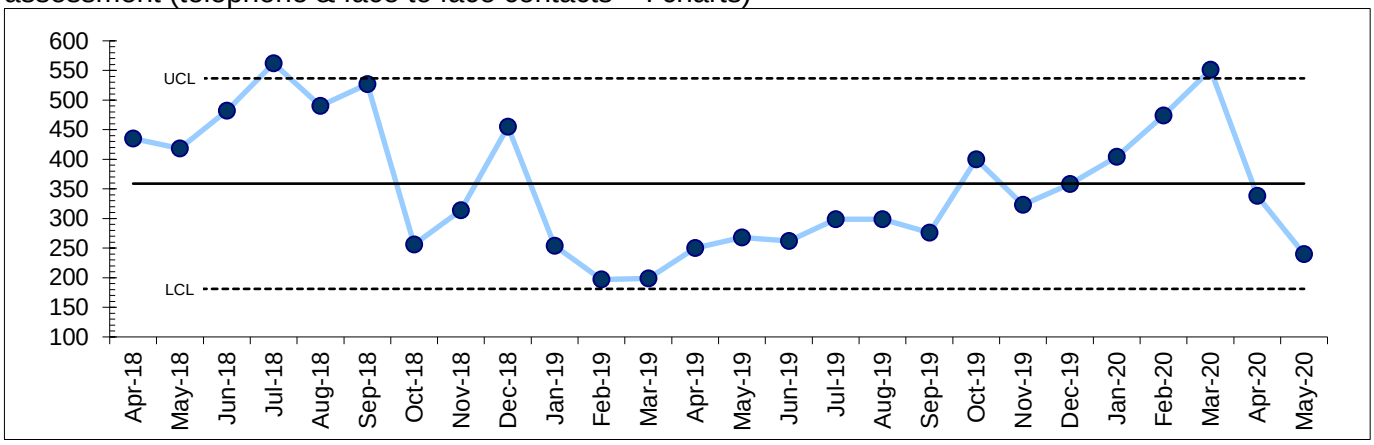
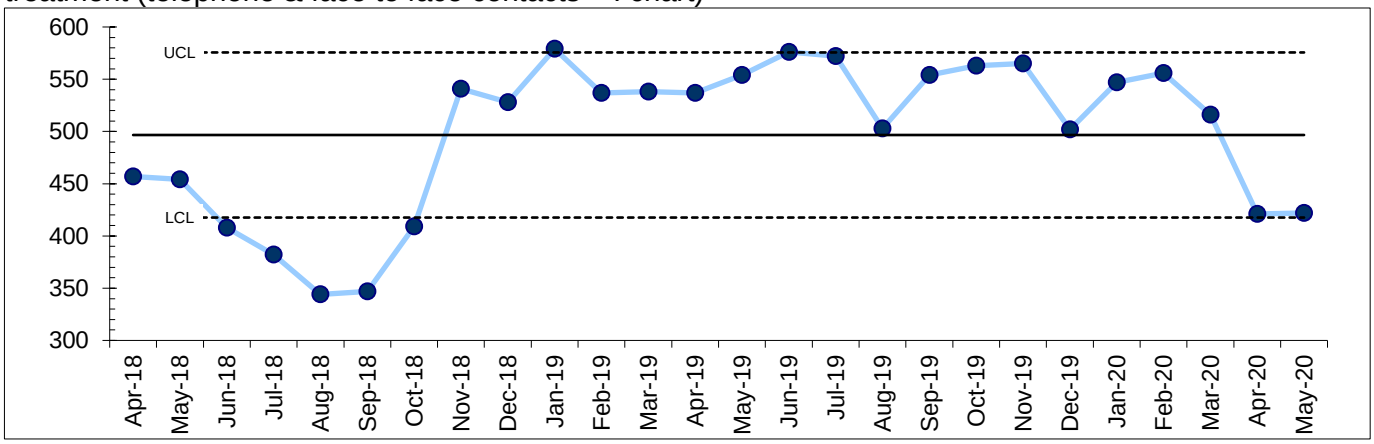


Chart 2.16 East London Psychological Therapy Services (PTS) - Number of service users waiting for treatment (telephone & face to face contacts – I chart)



East London secondary care Psychological Therapy Services (PTS) are continuing to show rising waiting times for assessment and treatment. Overall, the number of referrals has significantly dropped as a result 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. Services have now re-opened and have had to make major adjustments to the service offer. 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.

All services have now moved to virtual delivery for pre-assessment, assessment and treatments. 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. 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.

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.

The Tower Hamlets service is currently assessing people within the 11 week goal, 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 five groups offered online and a further seven planned for the coming months. Individual work has also resumed, but there have been on-going issues with technology and remote access and incorrect recording practices that have impacted on the team's performance.

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. However, the service has successfully redeveloped its Stepped Care Model and is working towards setting up the necessary IT infrastructure for staff and service users to fully realise the benefits of virtual assessments and interventions.

Contacts with Service Users

The charts illustrate change in our contact with service users over time. Overall there has been a big increase in the use of telephone and video consultations with service users, increasing from an average of 4% to 28%. In May, 79% of service users offered telephone and virtual appointments attended successfully, which is higher than face-to-face attendance. This reflects the pace at which the Trust has mobilised digital platforms such as Webex, Skype, Attend Anywhere and others to facilitate virtual contacts with service users to maintain delivery of care.

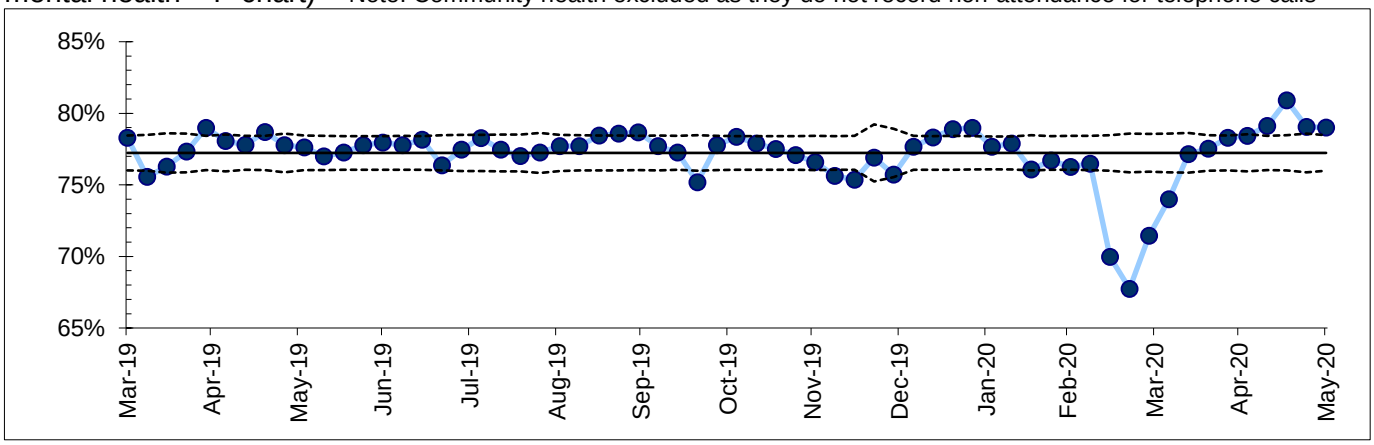
However, since the start of the pandemic there has been a reduction in monthly contacts for service users who are care-coordinated by our community mental health services. Whilst there has been an increase in the percentage of users contacted from 73% in April to 77% in May, the overall decline in performance is thought to be largely as a result of reduced compliance in updating clinical records with positive contacts made with service users. In addition, our clinical record system was only updated at the end of April to allow staff to capture virtual contacts, however not all staff are fully aware of this change and some have continued to face challenges with accessing clinical systems remotely from home. This is being addressed by our Digital Team through an upgrade of the Trust's remote access system, which is being piloted to make it easier for staff to access records from any device and any location.

In response to the pandemic, services developed local spreadsheets to monitor caseloads and make information more accessible to staff remotely to manage risks and take appropriate action quickly. However, this has created parallel recording practices and not all contacts have been uploaded onto our clinical system in a timely manner to accurately reflect performance. Staff have been reminded of the importance of updating clinical records and have developed processes with local administrative staff to update records where necessary. Further reminders, training and awareness sessions are taking place across services to embed and familiarise staff with new recording practices over the next few months. In June, a new contact monitoring report has been created to support staff to monitor activity levels by different communication methods (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. Where services do not have correct telephone numbers, teams have written to service users to ask them to provide correct information and to contact our services. Some services have also been looking at alternative ways to engage more frequently and flexibly with users based on their need, for example, by testing the use of WhatsApp Business groups and hosting virtual drop-in sessions on a regular basis. Other services have been utilising personal care budgets to purchase smartphones for service users to facilitate communication and support digital access.

The percentage of care-coordinated service users with annual care plan reviews completed has reduced to 65% in May. The decline is partly the result of updating performance reporting rules to more 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 legacy paper-based DIALOG+ forms rather than the online forms which feed the formal data reporting.

Chart 2.17 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



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

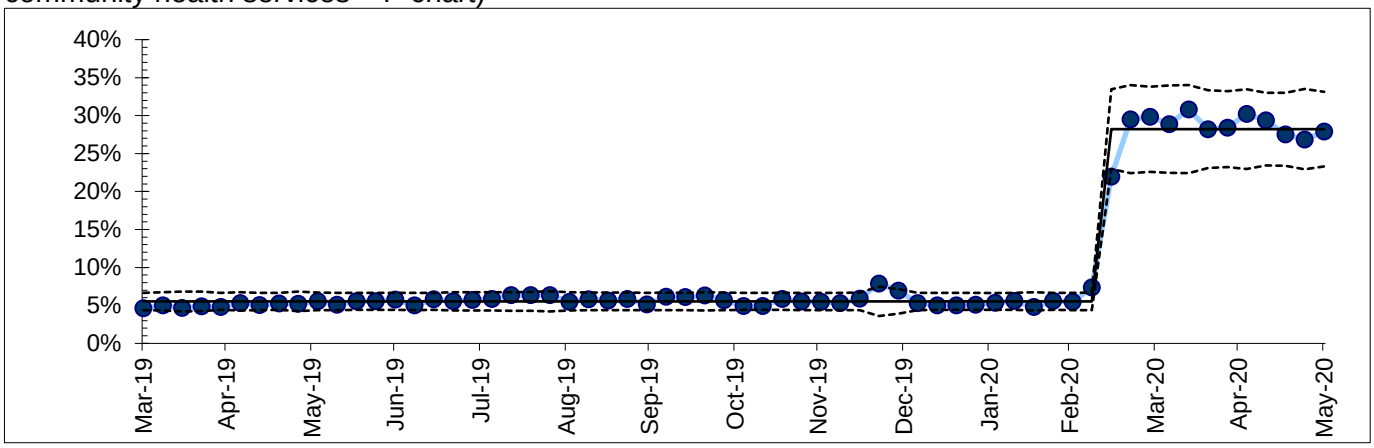


Chart 2.19 Percent of service users on CPA contacted each month (mental health – P chart)

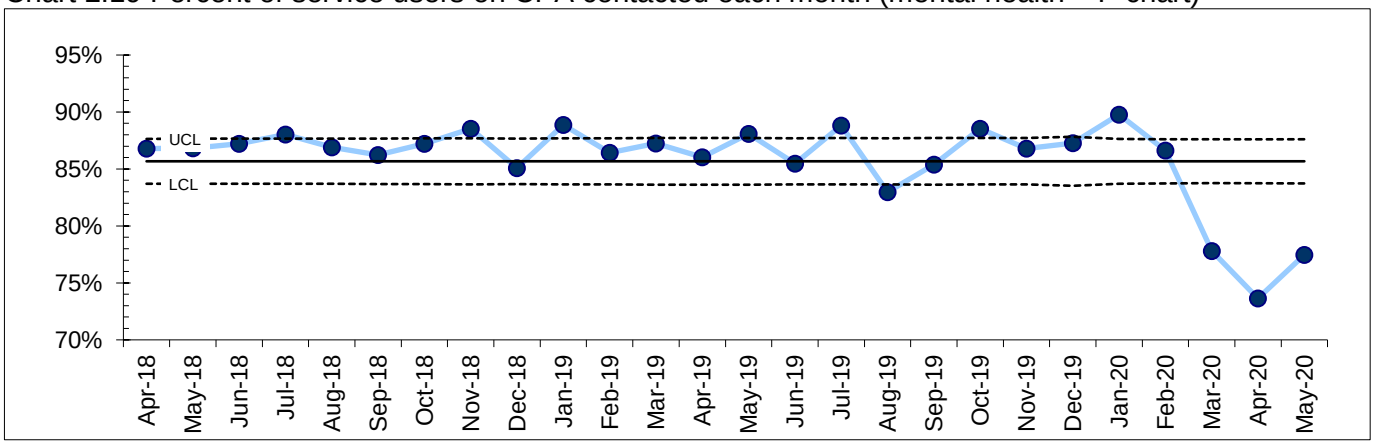
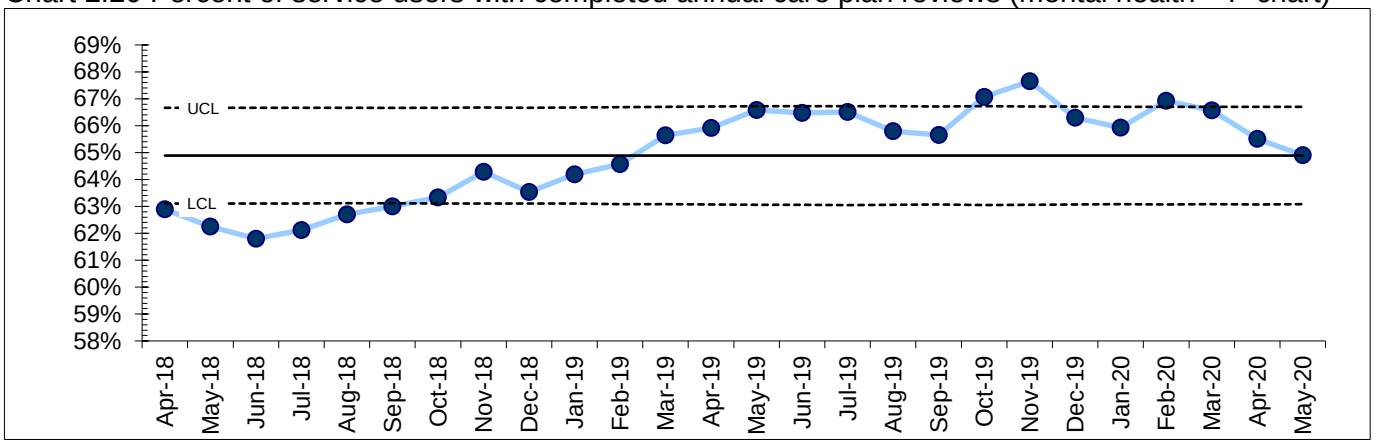


Chart 2.20 Percent of service users with completed annual care plan reviews (mental health – P chart)



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 the second half of March and remained low throughout April. However, the number of referrals has bounced back from a low of 1,527 in April to 2,830 in May. The number of service users attending first appointments is also increasing, but is not fully captured in chart 2.22 due to the delay between referrals being received and service users being seen for first contact.

The sharp reduction in referrals in the early weeks of lockdown allowed services to offer initial appointments even more quickly, bringing the average waiting times down below 1 week. This may reverse as the expected surge in demand takes place. In addition, the reduced need for triage slots has allowed more capacity to be directed towards clearing waiting lists. This has enhanced the trend towards shorter second appointment waiting times that had already been ongoing since autumn 2019. However, this may reverse if there is a sustained surge in demand, but it does place services in a good position to deal with a short-term surge.

All services have maintained performance as a result of rapidly testing and implementing digital platforms to offer assessment and treatment remotely, which has been successfully utilised by service users. The current 6-week target is being maintained by all services and Tower Hamlets has now reached the level of consistency on this target that the other services had already achieved, bringing the Trust average back to the position before Tower Hamlets Talking Therapies joined ELFT in October 2018. 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 2.21 number of referrals to IAPT services (Trustwide – P chart)

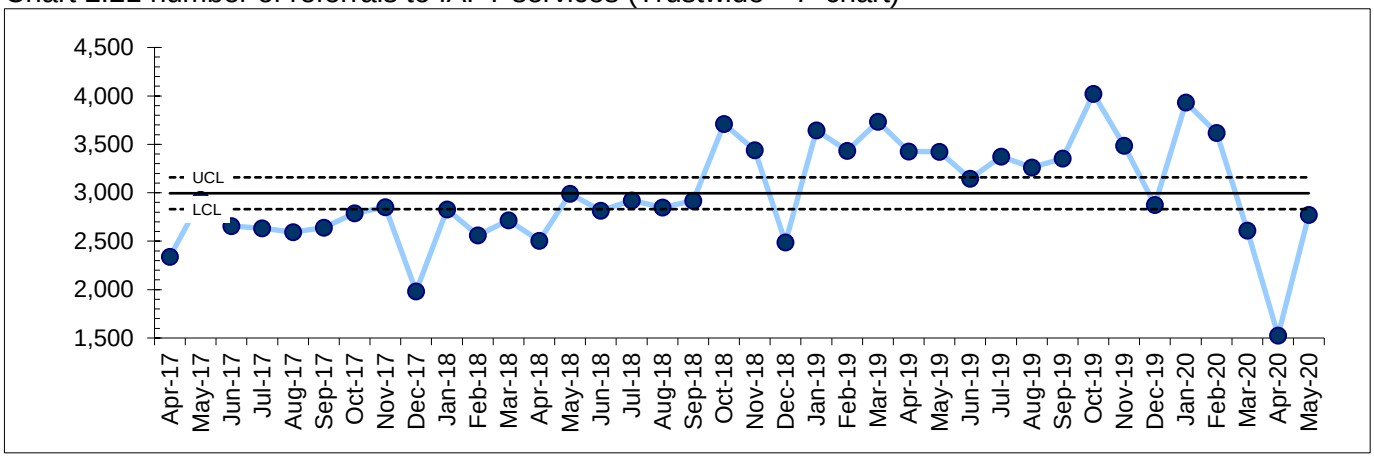


Chart 2.22 number of service users starting treatment – first contact (Trustwide – P chart)

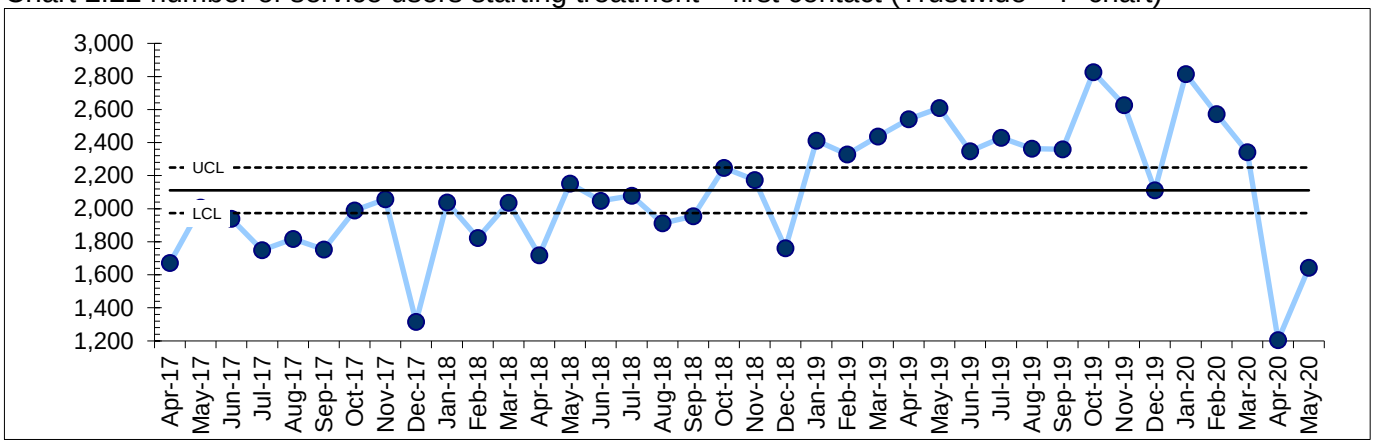


Chart 2.23 Percentage of service users starting treatment within six weeks of referral (Trustwide – P chart)

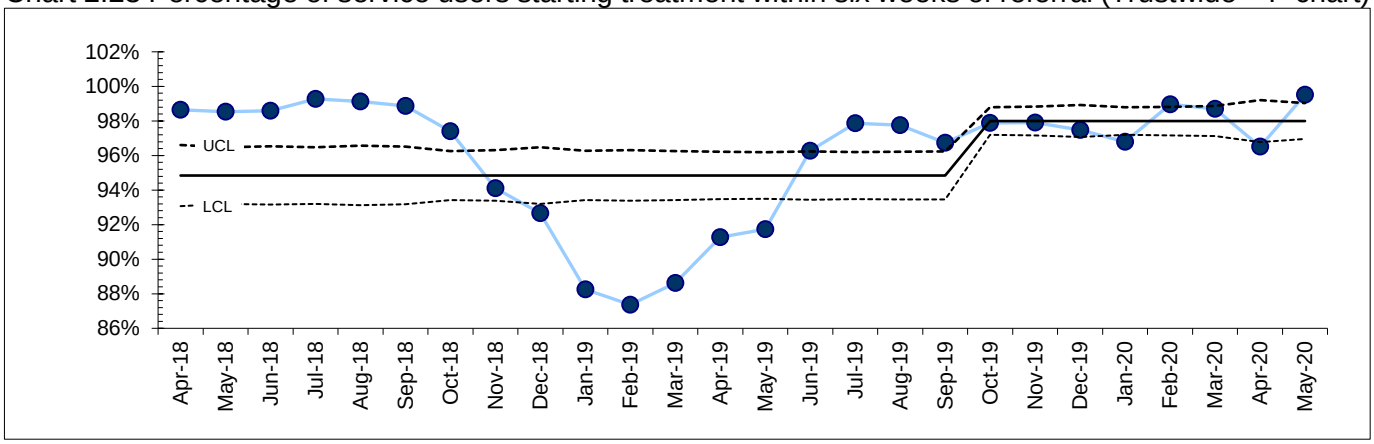


Chart 2.24 Percentage of service users started treatment within 18 weeks of referral (Trustwide – P chart)

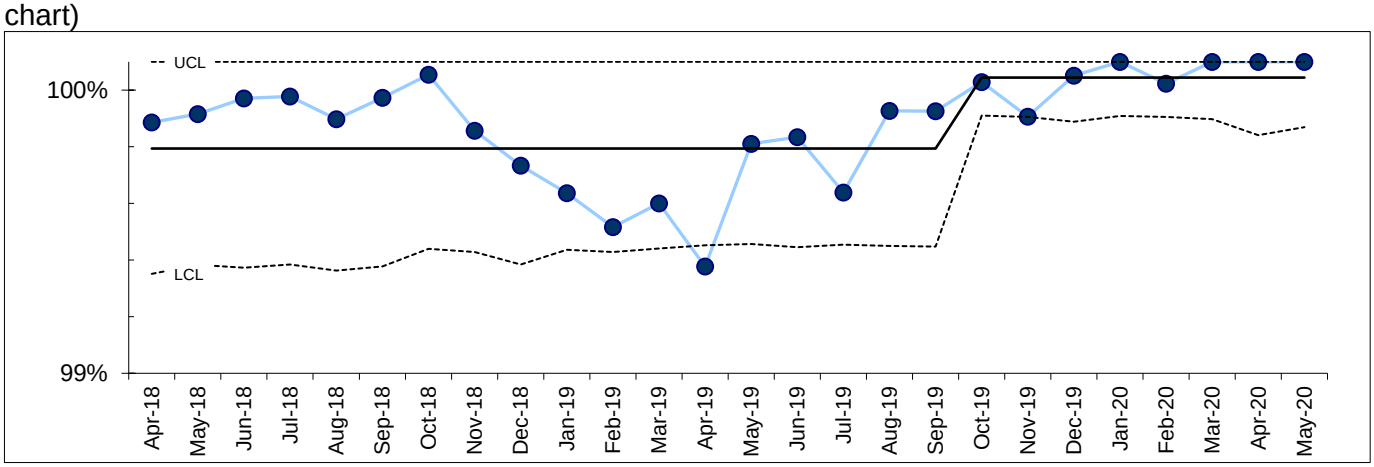


Chart 2.25 Average wait (days) to first appointment (Trustwide – I charts)

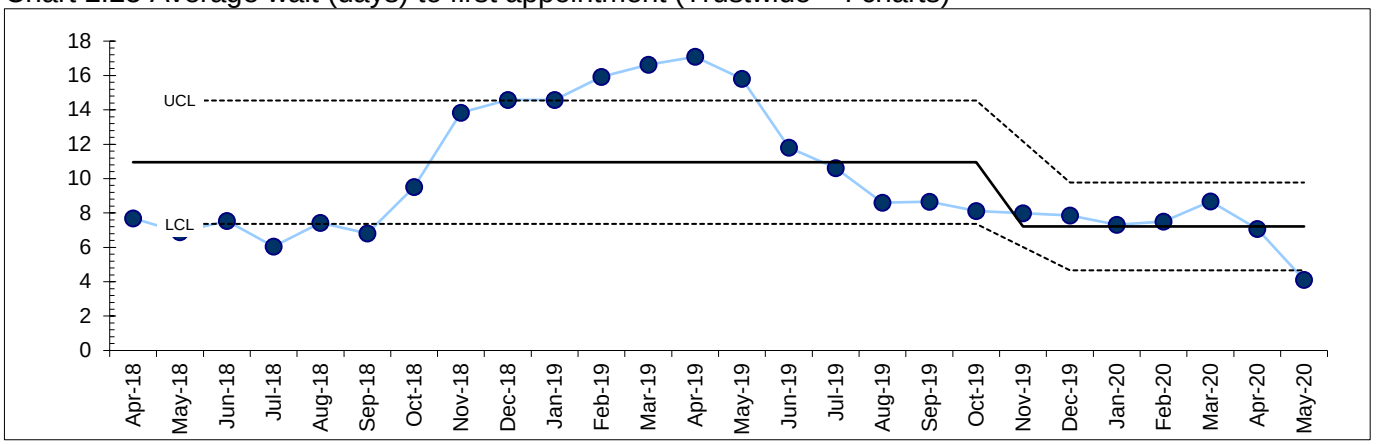
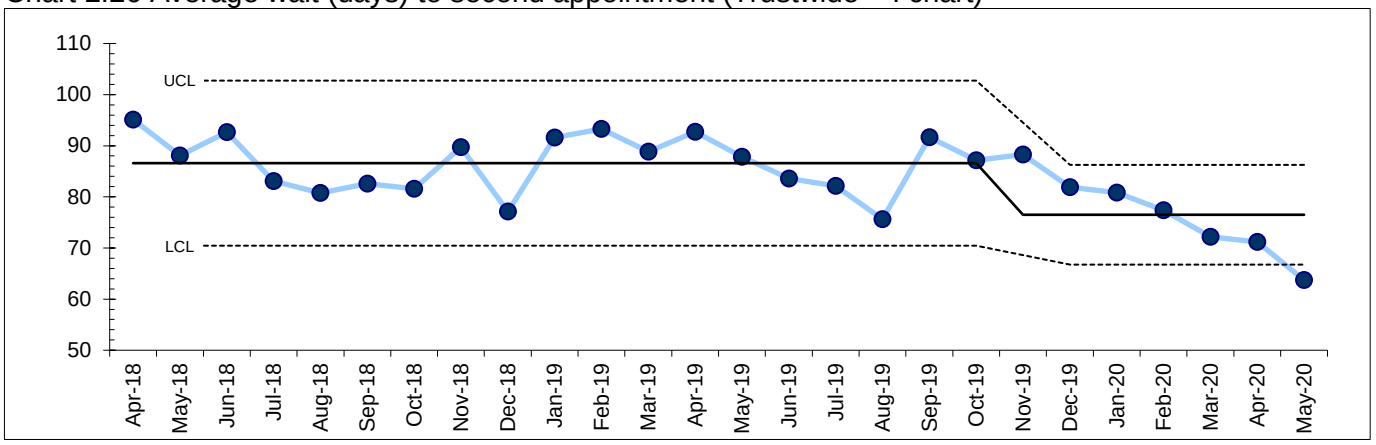


Chart 2.26 Average wait (days) to second appointment (Trustwide – I chart)



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 and vacancy rates continue to decrease. The number of staff compliant with Disclosure and Barring (DBS) checks has decreased slightly but still significantly higher than pre-Covid-19 as a 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.

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.

Chart 3.1 Sickness (Trustwide – I chart)

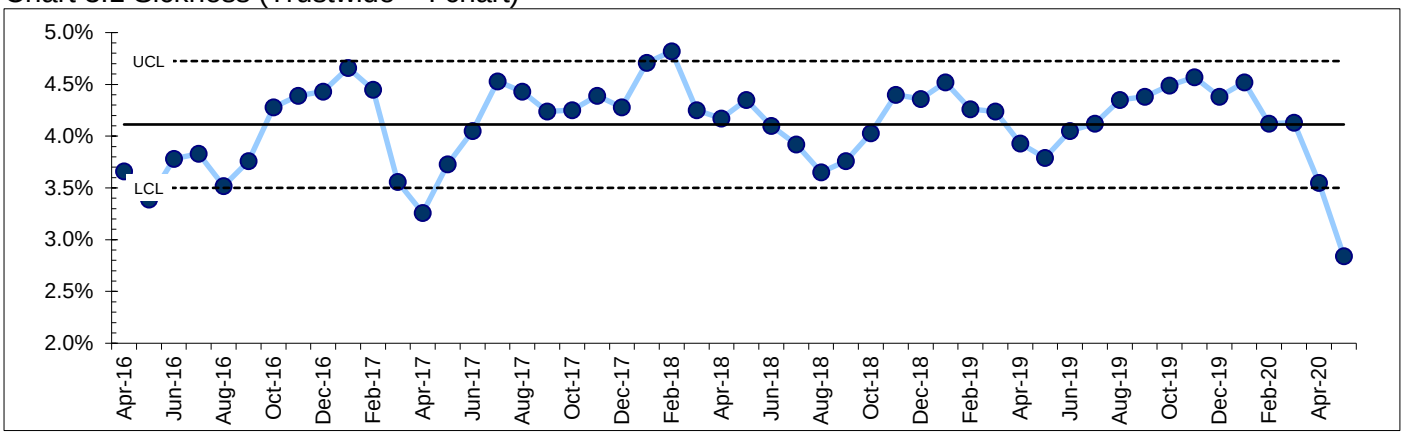


Chart 3.2 Percentage of posts vacant (Trustwide – I chart)

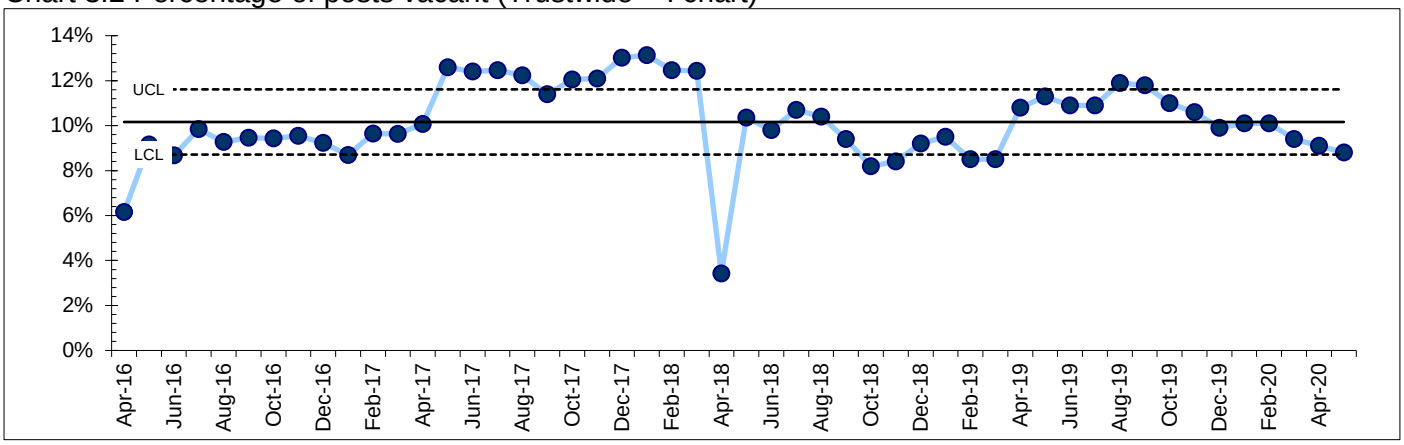


Chart 3.3 Turnover (Trustwide – I chart)

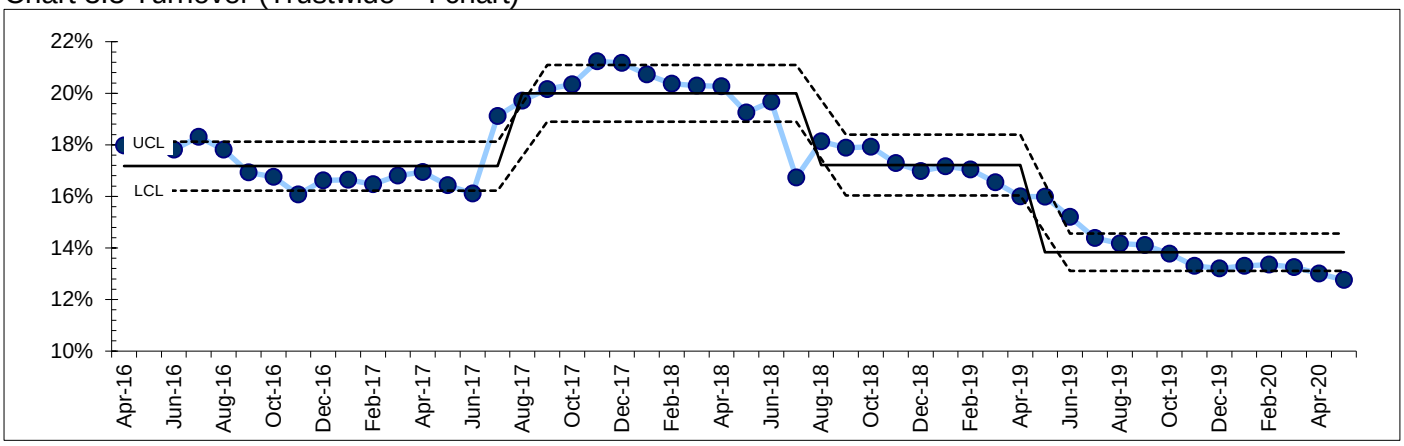


Chart 3.5 DBS clearance (Trustwide – P chart)

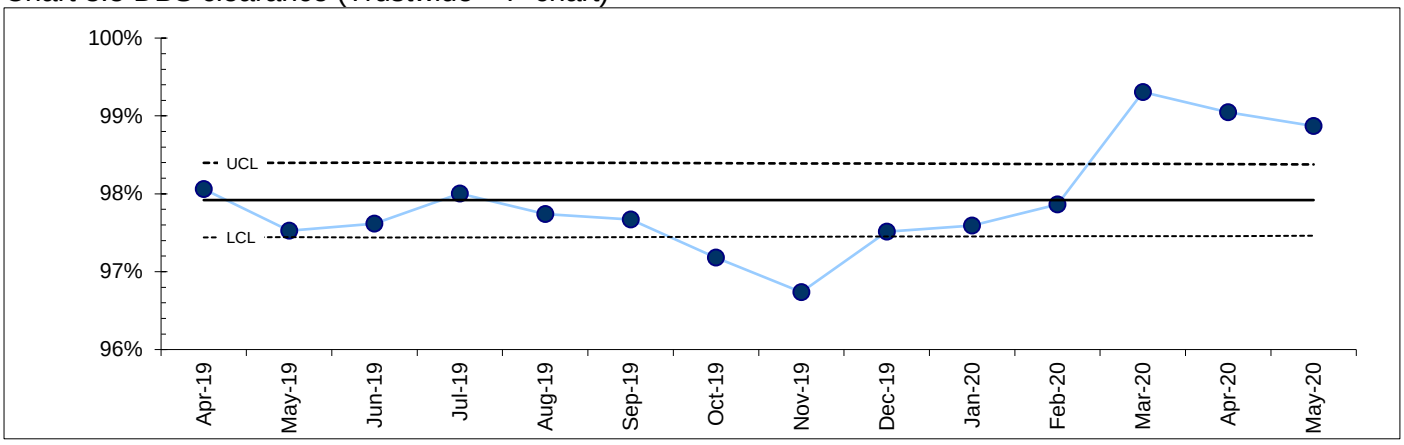
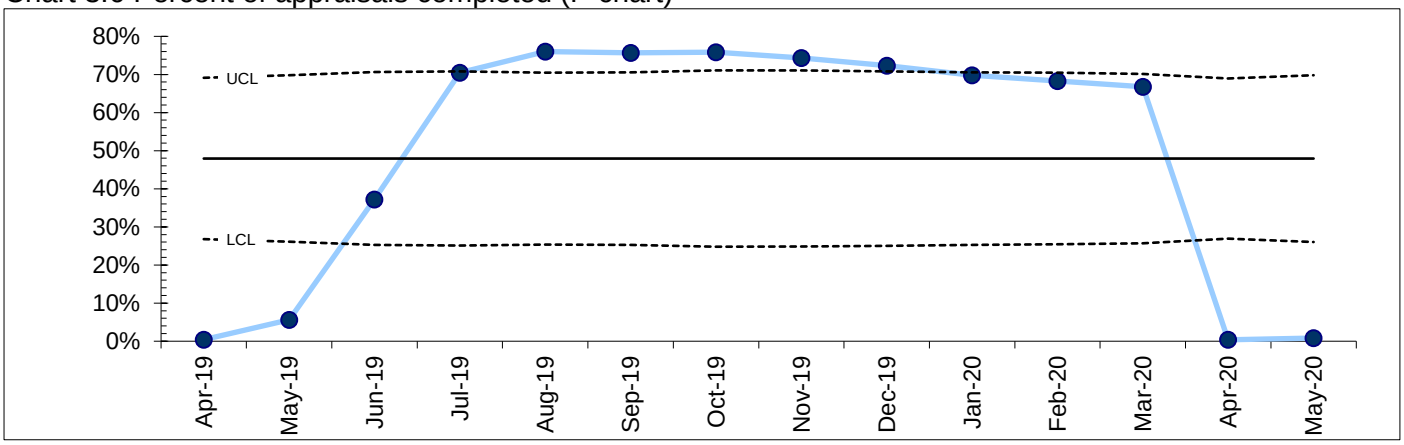


Chart 3.6 Percent of appraisals completed (P chart)



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 to an average of 16 in the same period. IAPT recovery rates are stable at 52% with Richmond service recording notably higher recovery rates than usual in May, and other services in the normal range. The percent of service users who would recommend our services to friends and family reached 100% in May, although with fewer responses than normal.

Chart 4.1 Number of Complaints (Trustwide – I chart)

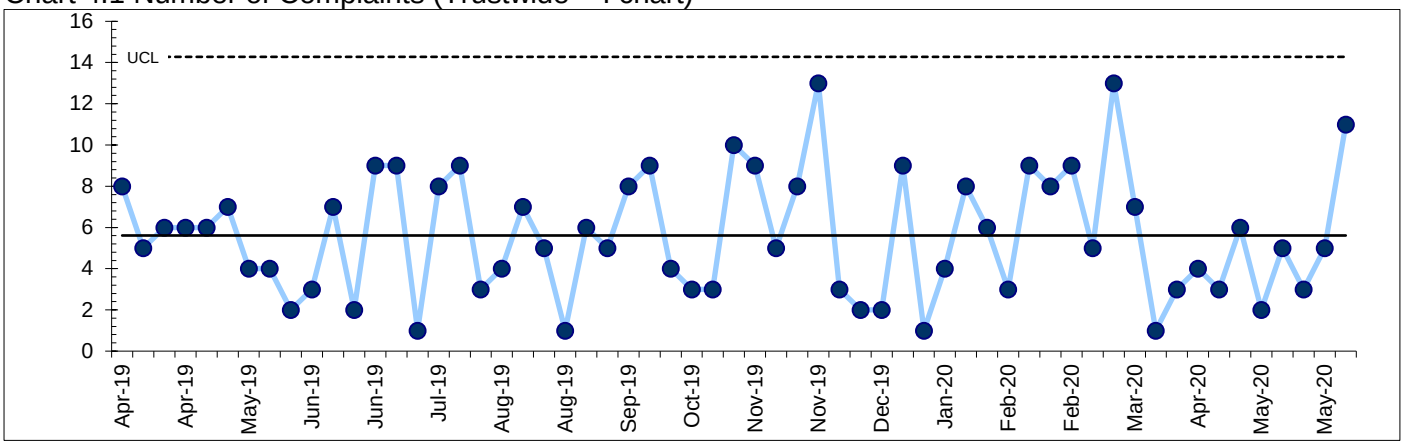


Chart 4.2 Number of PALs enquiries (Trustwide – I chart)

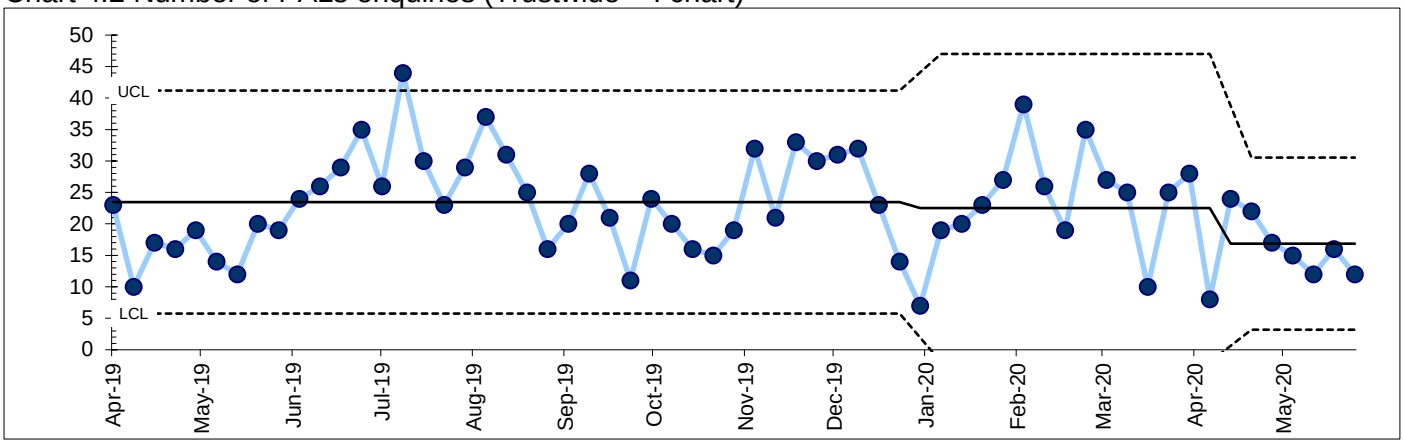


Chart 4.3 IAPT – percent demonstrating recovery at end of treatment (Trustwide – P chart)

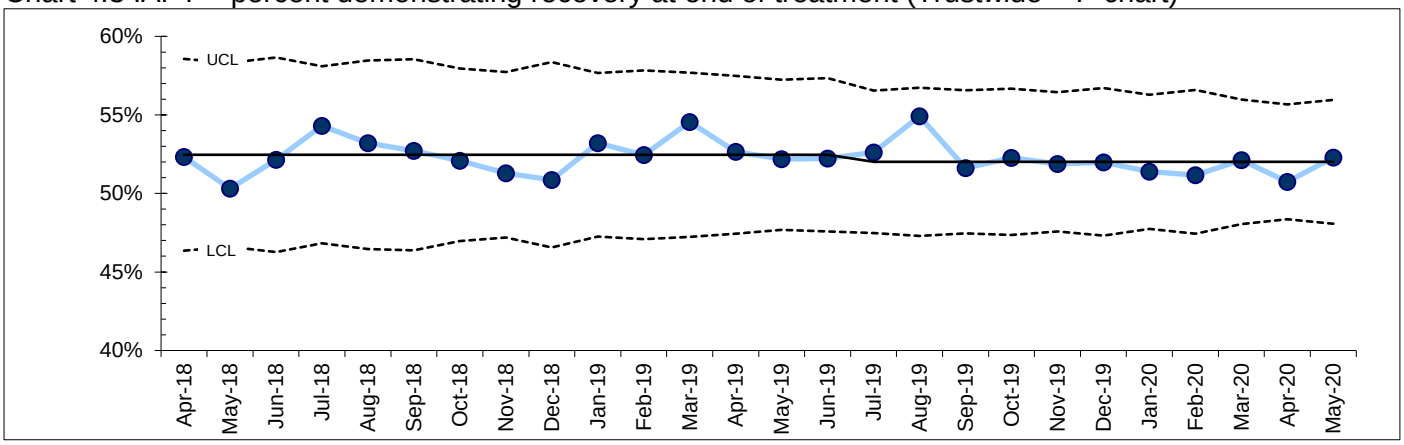
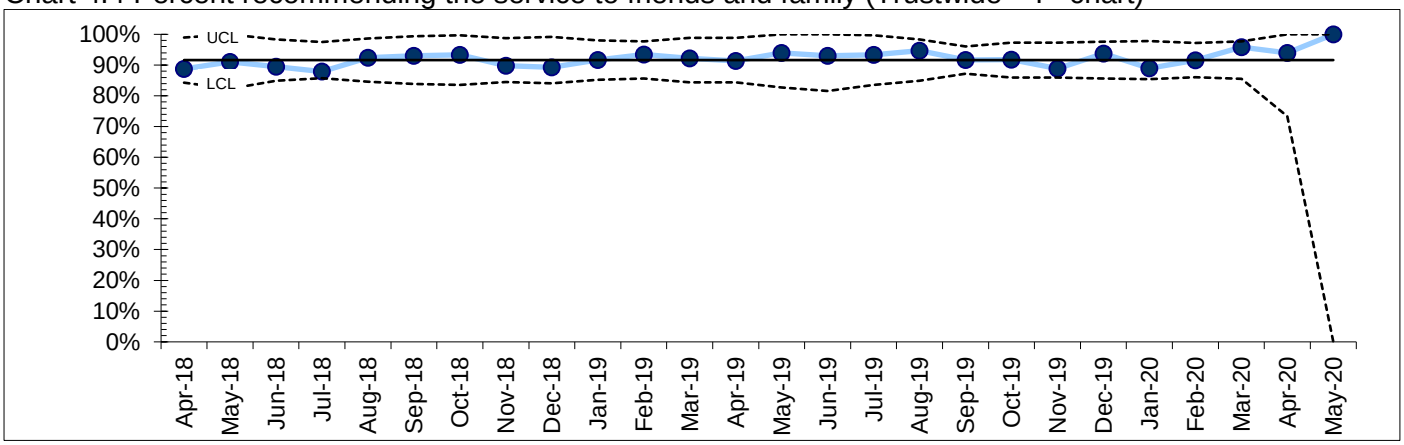


Chart 4.4 Percent recommending the service to friends and family (Trustwide – P' chart)



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 back to normal levels in May. 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 requited 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)

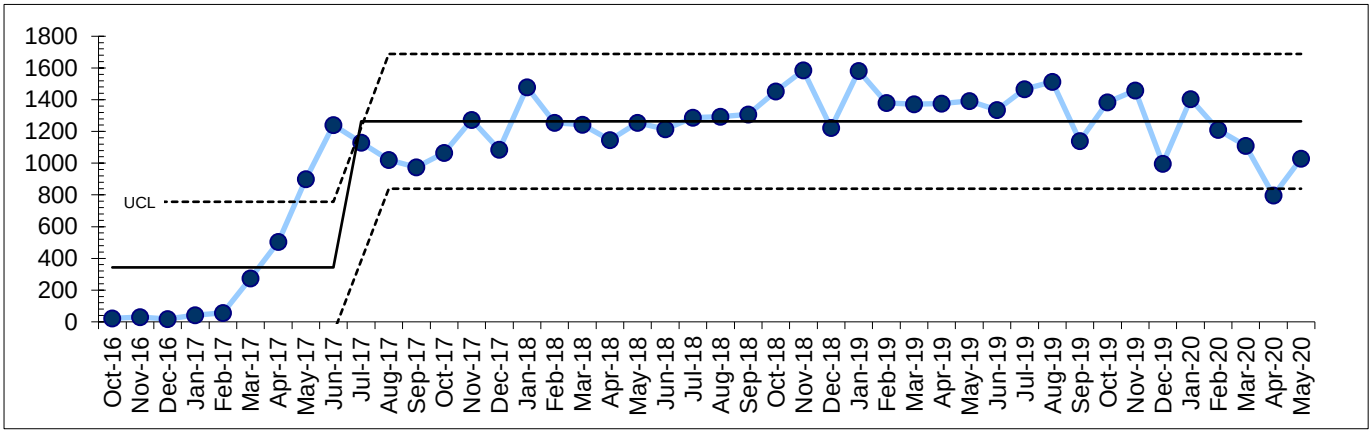


Chart 4.6 DIALOG Dissatisfaction scores by category Pre-Covid (Trustwide – Pareto chart)

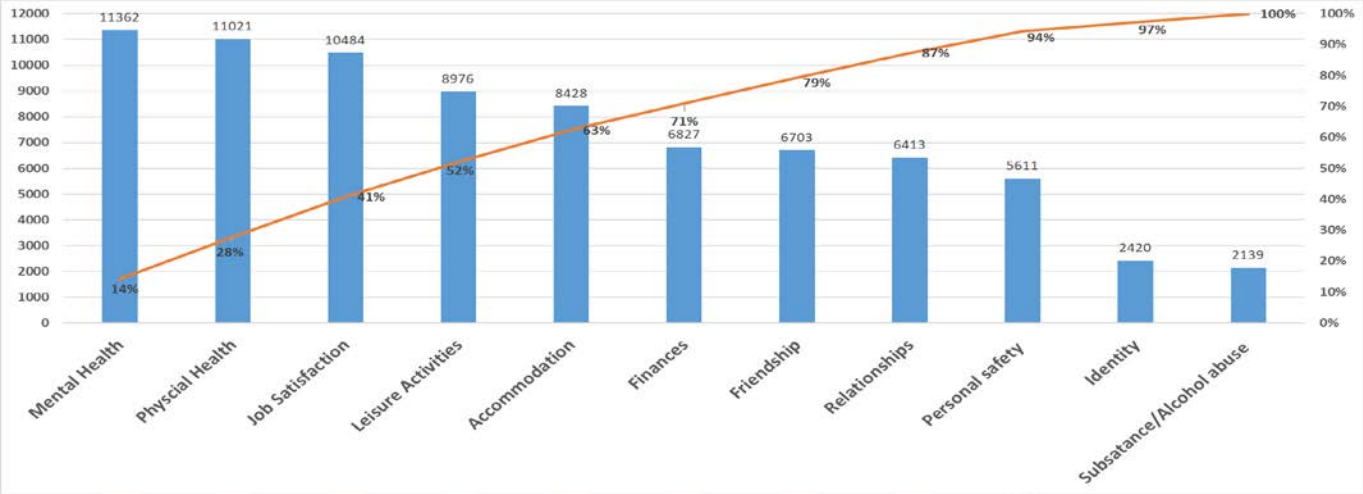
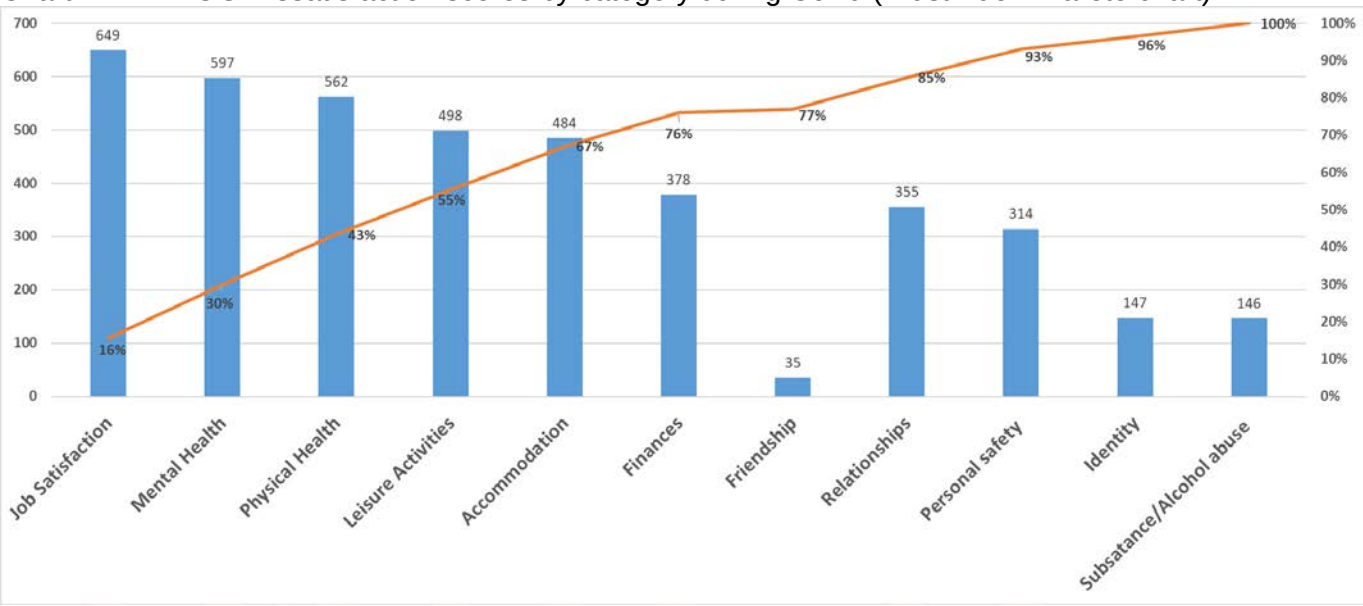


Chart 4.7 DIALOG Dissatisfaction scores by category during Covid (Trustwide – Pareto chart)



5. Finance Performance

Summary of Financial Performance

1.1 Key conclusions are:

- Operating surplus (EBITDA) to end of May 2020 of £2,597k compared to planned operating surplus of £2,482k.
- 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 £148.6m as at the end of May 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.

There is also some scope to take forward 2020/21 developments that aid recovery from COVID-19. East London CCGs are working to establish the contractual mechanisms for this given the temporary contracting arrangements.

2.4 The annual planning round has been suspended under national COVID-19 arrangements. The Trust has been asked to forecast and plan for a break-even position up to Month 4, after accounting for recovery of COVID-19 specific expenditure.

An opening budget has been uploaded to reflect this 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.

3 The financial performance is summarised in the table below:

	YTD May-20			Temporary Annual Budget	YTD Apr-20 Variance	Change +/-
	Budget £000	Actual £000	Variance £000	£000	£000	£000
Operating Income	73,234	76,354	3,120	439,404	1,685	1,436
Operating Spend	70,752	73,758	(3,006)	424,511	(1,634)	(1,372)
Operating Surplus (EBITDA)	**2,482**	**2,597**	**114**	**14,893**	**51**	**64**
Interest Receivable	50	13	(37)	300	(12)	(25)
Interest Payable	(363)	(363)	0	(2,175)	0	0
Depreciation	(1,168)	(1,246)	(78)	(7,008)	(39)	(39)
Public Dividend Capital	(1,002)	(1,002)	0	(6,010)	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**

4 Forecast to March 2021

4.1 The plan outlined above is consistent with achieving a break-even position under the COVID-19 block contracting arrangements.

4.2 This plan may be amended should normal planning and contracting arrangements resume.

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

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

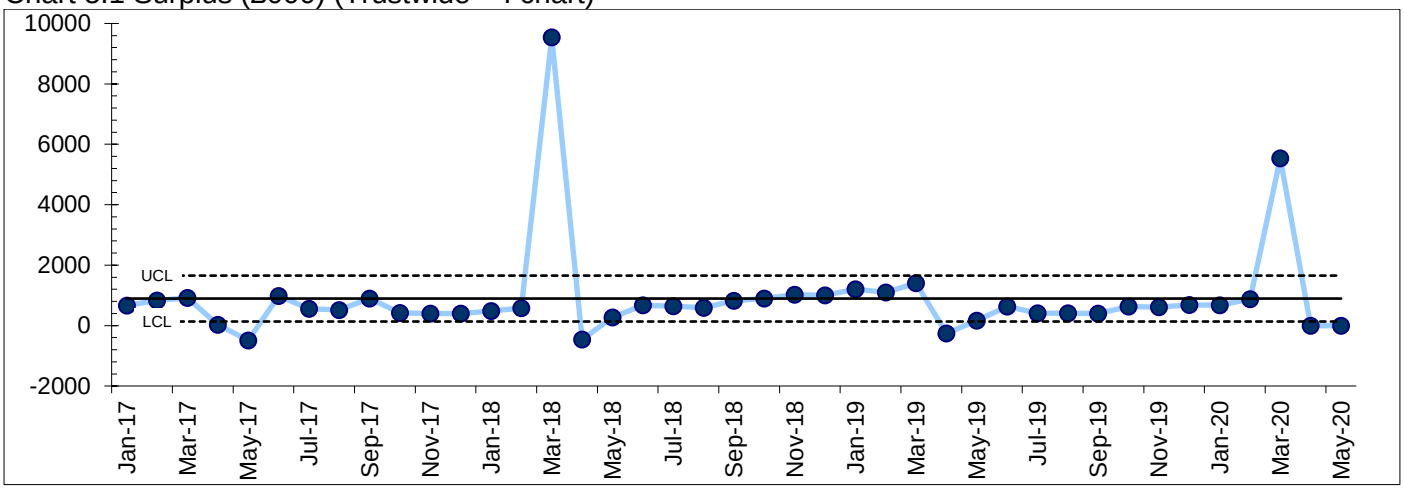


Chart 5.2 Cash Balance (Trustwide – I chart)

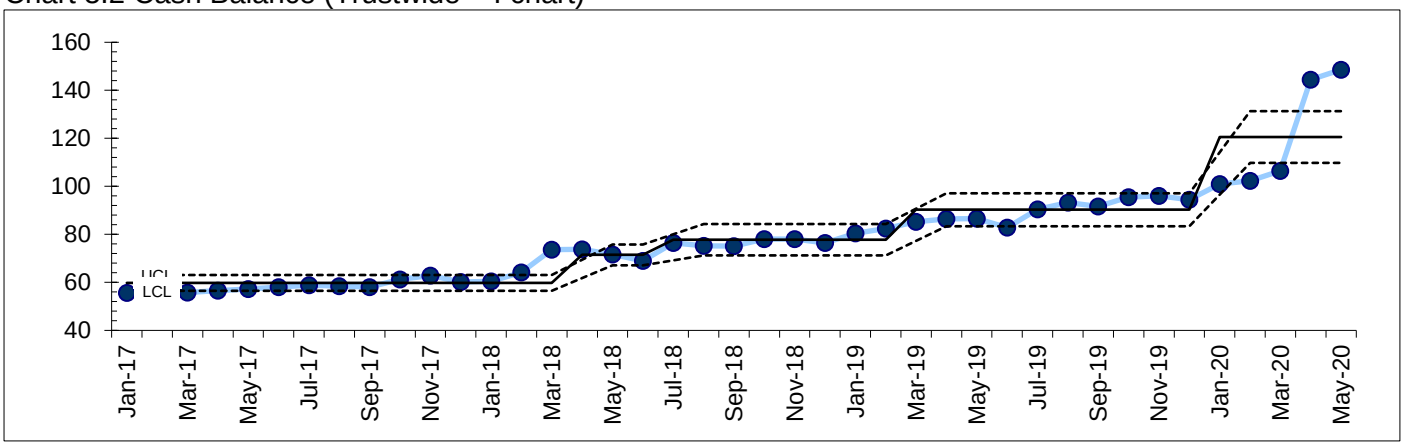


Chart 5.3 Agency vs ceiling (Trustwide – I chart)

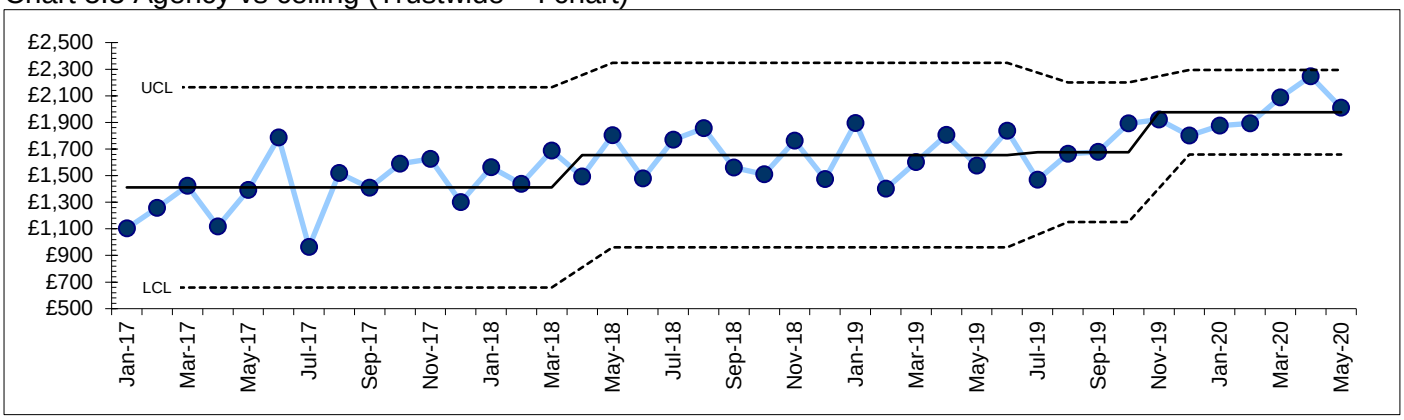
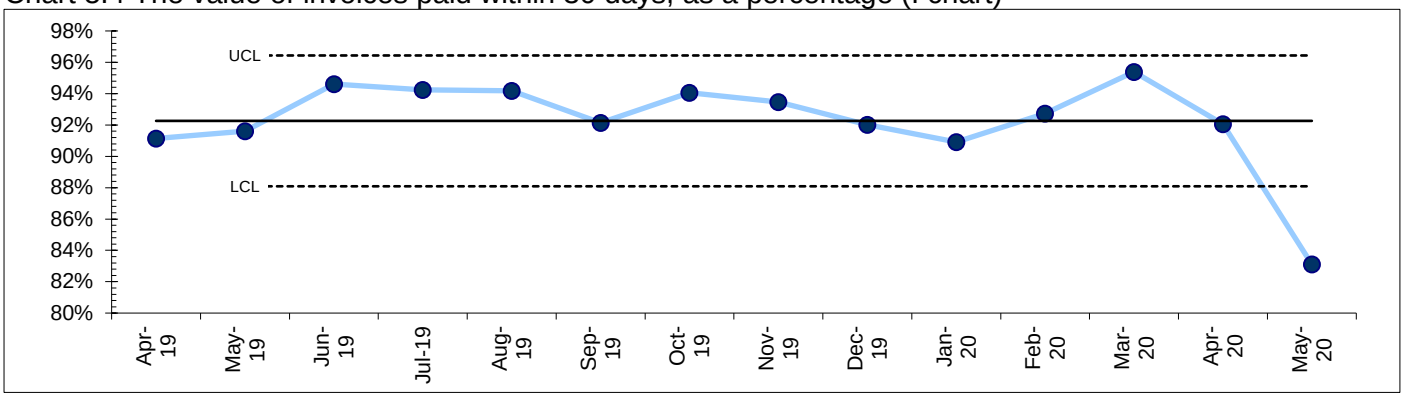


Chart 5.4 The value of invoices paid within 30 days, as a percentage (I chart)



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.