NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
20 May 2021

Title	Quality Report
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Accountable Executive Director	Dr Amar Shah, Chief Quality Officer

Purpose of the Report:

The Quality Report provides the board with an overview of quality across the Trust, incorporating the two domains of assurance and improvement. Quality control is now contained within the integrated performance report, which contains quality measures at organisational level.

Summary of Key Issues:

The Quality assurance section of the report focuses on the topic of contacts with service users during the pandemic, exploring the variation in face-to-face, telephone and video contacts across services. Although we see large variation across services, this is largely a factor of the different function of teams and their risk thresholds. The proportion of contacts conducted remotely is broadly in line with the variation seen nationally. The report shares the Trust guidance on choosing the most appropriate mode of contact, and the mechanisms in place to oversee this within services and directorates.

Quality Improvement (QI) has been utilised throughout the Trust to support our approach to complex quality issues and the challenges of the pandemic. Although there was disruption to quality improvement projects and supporting infrastructure around teams at the start of the pandemic, this has now largely returned back to normal. Plans for 2021-22 include strengthening the QI infrastructure including re-establishment of QI forums, improving the rigour of improvement work and ensuring authentic service user involvement.

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

Improved patient experience	☒	The information provided in the Quality Report supports the four strategic objectives of improving patient experience, improving population health outcomes, improving staff experience, and improving value for money. Information is presented to describe how we are understanding, assuring against, and improving aspects related to these four objectives across the Trust.
Improved health of the communities we serve	☒	
Improved staff experience	☒	
Improved value for money	☒	

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
	N/A

Implications:

Equality Analysis	Many of the areas that are tackled through quality assurance and quality improvement activities directly or indirectly identify or address inequity or disparity.

Risk and Assurance	There are no risks to the Trust based on the information presented in this report. The Trust is currently compliant with national minimum standards.
Service User / Carer / Staff	The Quality Report provides information related to experience and outcomes for service users, and experience of staff. As such, the information is pertinent to service users, carers, and staff throughout the Trust.
Financial	Much of our quality improvement activity helps support our financial position, through enabling more efficient, productive services or supporting cost avoidance. However, there is nothing presented in this report which directly affects our finances.
Quality	The information and data presented in this report help understand the quality of care being delivered, and our assurance and improvement activities to help provide high quality, continuously improving care.

1.0 Quality Assurance

1.1 Background

This report takes a deeper look at the use of in-person, telephone and video contacts with service users during the pandemic. The report aims to set out the systems in place to support decision making around the various modes of contact, and provide assurance that the modes of contact are meeting service user need, and maintaining quality and equity.

Figure 1 shows the current position across the trust in terms of modes of contacts employed within different services, and highlights the variation across services from IAPT where there is virtually no face to face contact, to Community Health Services where the vast majority of contacts are face to face.

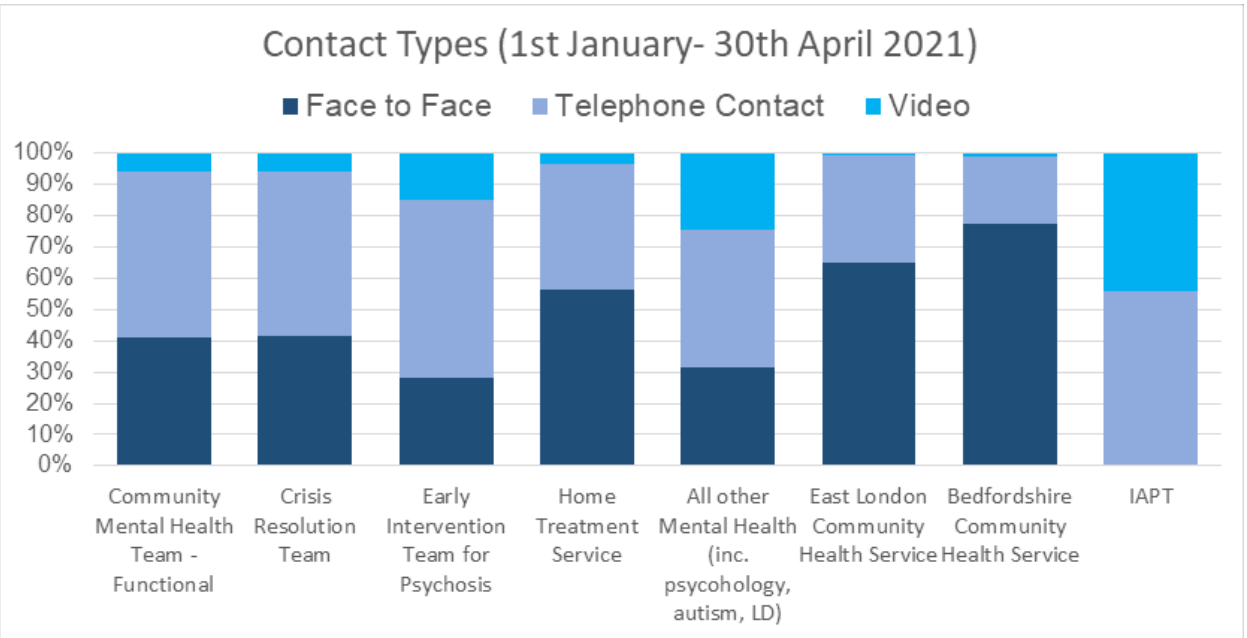


Figure 1. Variation in modes of contact across different types of ELFT services between January to April 2021

Figure 2 shows the comparative data from across England, from the NHS Benchmarking network. This shows that the use of digital consultation at ELFT is broadly in line with the variation seen nationally.

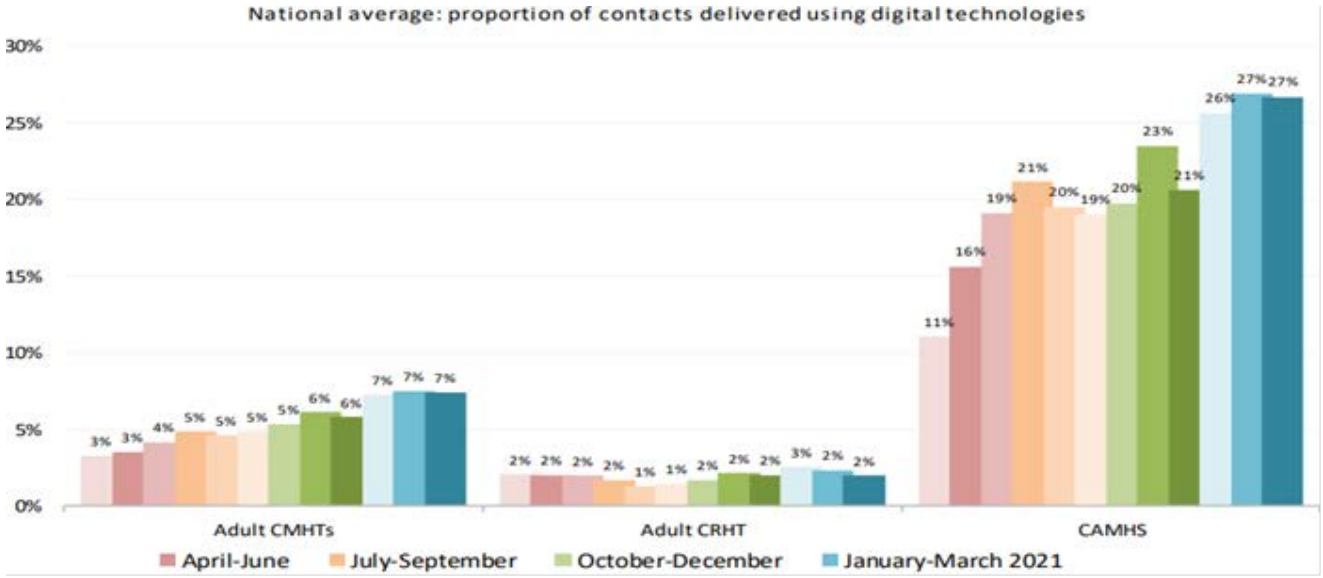


Figure 2. National average: proportion of contacts delivered using digital technologies. Source: National Mental Health Benchmarking Network – April 2021)

1.2 Guidance to support local decision-making

Since July 2020 the Trust has, via the COVID-19 Clinical Guidance workstream, had in place documented guidance for all clinical teams to support decision-making on virtual appointments/contacts versus face to face, and their implementation.

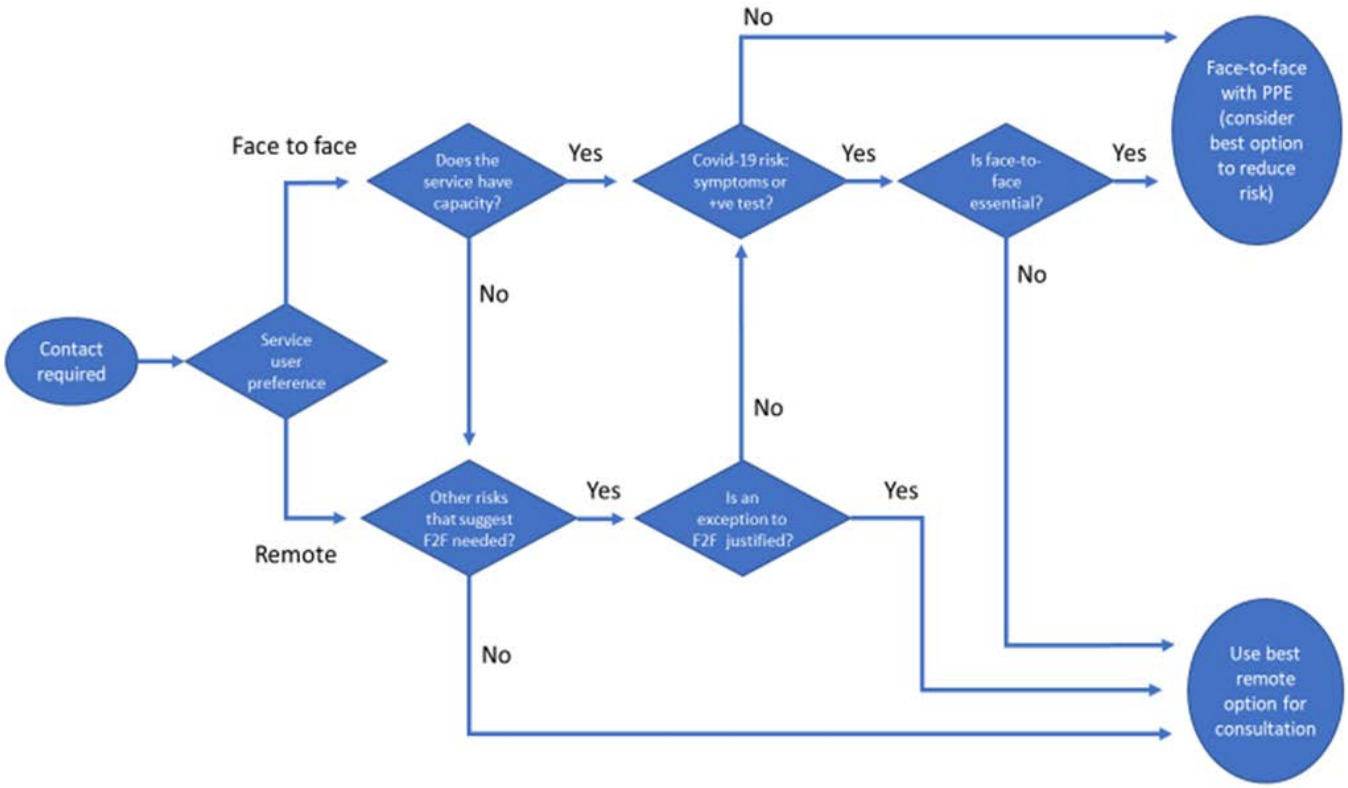


Figure 3. Decision-tree to support decision-making related to in-person or virtual consultation

This guidance is supplied alongside a ‘decision tree’ (figure 3) to provide a simple, practical tool for clinical services to support and enable implementation of the guidance.

The guidance makes clear that overall responsibility for deciding the method of contact lies with the clinician in consultation with service users, taking into consideration the following factors:

- Patient-centred care and co-production remaining at the core of ELFT ways of working
- Patient Safety
- Vulnerability and safeguarding concerns
- General risk factors and Covid-19 specific risk factors
- Mental state
- Nature of the task
- Access and ability to use remote communication methods
- Time since last face-to-face contact
- Disabilities
- Language

The guidance is also clear in supporting flexibility and the use of a combination of modes, according to the purpose and current situation. An approach exemplified in Memory Services, where information gathering and preparation may be conducted virtually, ahead of diagnostic assessment that takes place in person.

The guidance has been through a number of iterations, reflecting learning that has taken place as well as the incorporation of new national guidance and norms. The latest iteration was approved in November 2020.

Clinical services have thought deeply about this challenge, and how to make the right decisions with their service users. Memory services were some of the first to grapple with the difficulties presented in trying to protect older, more vulnerable, service users whilst providing meaningful assessment and diagnosis. Ultimately the services were unable to provide a full diagnostic service remotely, identifying the practical difficulty of observing signs and symptoms, diagnostic tools not being validated for remote use, and digital poverty as insurmountable barriers. The approach for these services is to work with carers by phone in advance, obtaining all information, so that the face-to-face assessment is shortened.

In contrast, IAPT services were quick to adopt a virtual approach at the start of the pandemic, reporting that it has created benefits for patients and clinicians, but have been balancing remote therapy and face to face appointments based on clinical need. Demand for face to face appointments in IAPT has been low so far.

For Perinatal Services, working with a vulnerable service user group, prior to the pandemic all contacts were offered face-to-face. Like most services, the perinatal teams had to adapt quickly to offering video appointments, but all the teams have offered face to face appointments throughout the pandemic to women who are high risk. Women are now asked for their preference of face-to-face appointment or video appointment at the

point of referral. The teams will risk assess how the appointment will take place based on the referral. and subsequent appointments will take into consideration the woman's current presentation, any safeguarding concerns and her preference. Going forward, the perinatal services are launching a new website that will allow women to self-refer which, it is hoped, will improve access to the services. Satisfaction around access and appointments is monitored via the service's Working Together Group and through feedback received through the patient experience feedback system.

In community mental health, teams reviewed their caseload at the start of the pandemic and used a risk rating to stratify the caseload. Decisions around nature and type of contact were discussed within the multidisciplinary team, in daily huddles and triage meetings and utilised the risk stratification. Creative practice was encouraged; for example the use of 3-way video consultation by the crisis pathway to obtain a perinatal opinion, or the introduction of outdoor therapeutic groups. Detailed guidance documents have supported teams to reinstate face-to-face appointments in a safe way. Video assessment for new referrals was often offered in the first instance, but if there were difficulties with accessing video assessment this would revert to an in-person assessment or as a last resort telephone assessment. Service users were offered a choice of digital platforms at the point of booking with the admin team. For service users who are known to the team, the care coordinator would discuss with the service user their preference and would facilitate this. Home visits have continued to be carried out where required.

In CAMHS, feedback from service users and clinicians helped determine the local decision-making about the use of in-person and digital consultations in 2020. This was supplemented through the shaping our future workshops held in the Summer. Within the 90 day plan developed by CAMHS for April to June 2021, this original guidance will be revisited to open up more opportunities for in-person contact whilst retaining video contact where this has resulted in improvements in care, improvements in value and where this is the preference of the young person and their family. This will be balanced with the flexible working needs of staff, availability of clinic room space, school spaces and homes. The use of digital versus in-person contact will continue to be monitored via supervision and multidisciplinary team meetings, and is agreed on a case-by-case basis taking into account each service user's preferences. People participation are currently supporting the collection of broad service user feedback about this balance. Information from Healthy London Partnership pre-pandemic suggests that 53% of children and young people wanted in-person sessions, with 35% preferring online sessions.

Our primary care services delivered over 280,000 appointments between April 2020 to March 2021, which is an increase from 2019-20. This has been achieved whilst delivering 6500 flu vaccinations, and 10,000 covid vaccinations (which has involved telephoning thousands of registered patients to book in). A key challenge has been overcoming patient fears; some patients have been very hesitant to bring themselves or children into services due to the risk of infection. At the start of the pandemic, there was an overnight switch to a first contact triage model where every patient is risk-assessed on the phone and via algorithms before being invited into the surgery. The practices have been regularly telephoning patients who are clinical extremely vulnerable during the pandemic. We have also opened up the homeless outreach service during the pandemic, which has

carried out over 860 consultations with people who are experiencing homelessness or are in vulnerable housing.

1.3 Monitoring

Data is available to clinical and management teams which shows information on type of contact and last contact by team. This is reviewed at both service-level and directorate-level meetings. The primary focus in reviewing the data is to ensure that no one was being left behind and to provide services with visibility on when a service user was last seen, called by telephone or had a video contact. Figure 4 shows that attendance at virtual contacts has been extremely high.

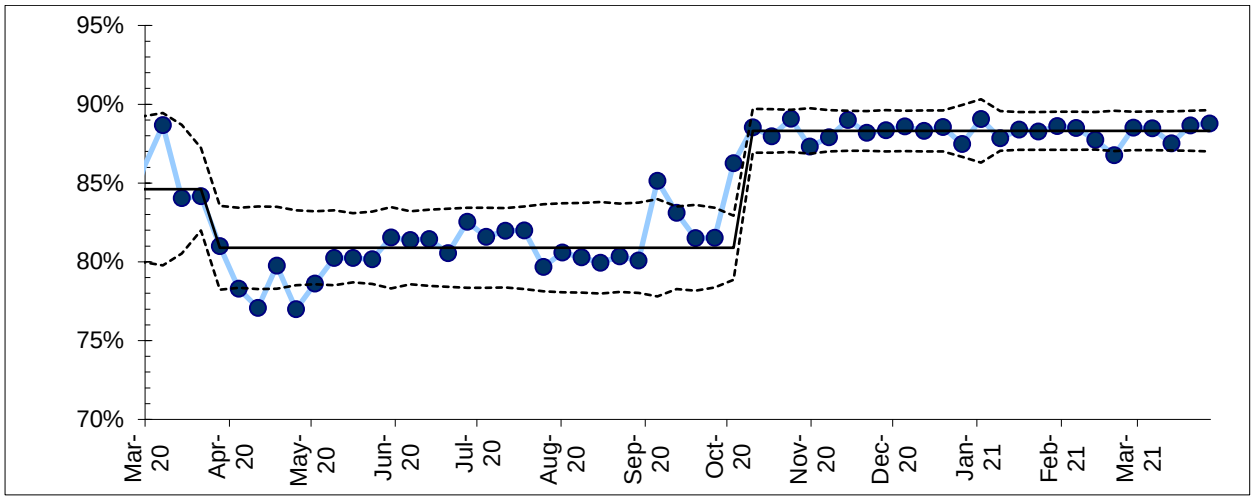


Figure 4. Weekly attendance for routine appointments provided by telephone/video (CAMHS and adult mental health – P chart)

From a quality assurance point of view, services also have access to waiting times data that includes virtual contacts, and ensures timely contact regardless of medium. Current data for the Board is included in the Integrated Performance Report, but the overview is a picture of reducing virtual contacts that reflect the increasing use of face-to-face contacts as societal restrictions ease (figure 5).

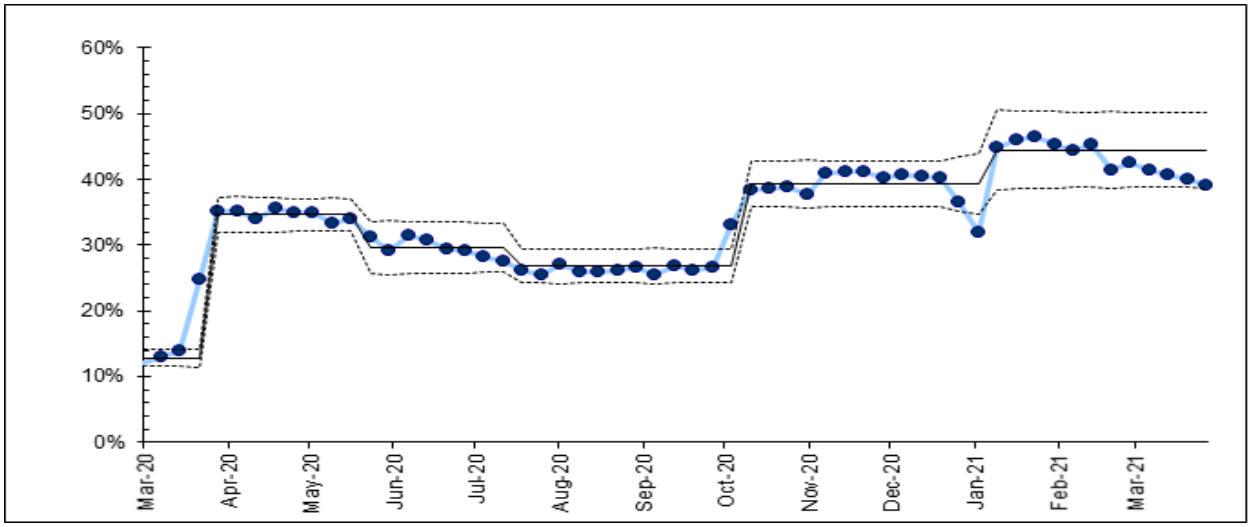


Figure 5. Percentage of all contacts each week made via telephone or video-consultation:

1.4 Other feedback and assurance

Patient Reported Experience Measures (PREM)

At the start of the pandemic, the Quality Assurance Team worked with a group of clinicians and service users to generate additional questions for inclusion in PREM surveys that aimed to understand the service user experience of changes introduced by services during the lockdown restrictions. The additional questions were put in place from May 2020 and continue to form a part of the survey. They are:

- While receiving care during COVID, what has worked well?
- Is there anything we could have done better during COVID?
- If you have experienced telephone/video sessions, were these helpful?

Collection of feedback at the start of the pandemic was patchy, the capacity of staff to collect the data and the risks inherent in the standard collection methods mitigated against high levels of feedback. However, over time, new approaches to collect feedback have emerged, infection control practices became tighter, and capacity improved, enabling increasing numbers of responses to be collected across increasing numbers of teams. As of March 2021, approximately 90 services are collecting around 1200 surveys each month. Whilst by no means providing the full picture, responses to the question – 'If you have experienced telephone/video sessions, were these helpful?' provide some insight as to how services are meeting need, and making decisions that suit service users.

Between October 2020 and April 2021, we have collected feedback from 2730 service users through this survey. With the caveat that some responses describe positive and negative aspects of experience, responses were the following:

- Not answered, not applicable or no opinion expressed – 56%
- Positive – 33%
- Negative – 11%

Of those patients who expressed an opinion, around 75% were broadly positive, and 25% were broadly negative about their experience of video or telephone consultation.

Complaints and compliments

Looking at complaints and complaints during the pandemic, searching the keywords 'video', 'virtual' and 'telephone' in the description of the complaint on the Datix system, we have found four compliments relating to telephone or video contacts, and one complaint regarding communication around a planned video consultation.

1.5 Summary and next steps

Many teams used the space afforded by the 'Shaping our Future' workstream to think further about how they support service users in the future, build upon innovations and new ways of working that service users like and meet their needs, whilst ensuring the greatest possible level of choice and flexibility. Consultation with service users and carers, reflection and discussion, and establishing sustainable systems and ways of

working feature in the forward plans of many services, particularly those such as IAPT, CAMHS and Perinatal services that have adopted virtual contacts at scale.

IAPT, for example are already well advanced with planning a blended model where remote therapy is offered alongside face-to-face delivery to ensure choice for every patient to guarantee equitable and high quality clinical provision – where appropriate based on local and national COVID guidelines. They have also offered access to confidential spaces and technology (IT suites) to ensure access where digital inequalities were identified. As set-out in the NHSE/I recovery plans, IAPT services are building a return to face-to-face appointments as dictated by patient choice (in line with local and national COVID guidelines) from the beginning of July, and formulating plans to ensure meaningful patient choice going forward.

One significant issue that has been a feature of service user feedback and workshop discussions through the shaping our future workstream is that of 'digital poverty', and the risk of increased inequalities arising from the provision of virtual consultation and contact.

In the general population, 4% of households do not have internet access at home. Digital exclusion is more likely to affect older adults: 6% of 55-64-year-olds and 18% of over 65 year-olds not having used the internet in the previous three months. People with any disability are more likely to be digitally excluded. To establish the severity of digital exclusion amongst service users, ELFT is working with City University to conduct a detailed survey of digital access, preferences and needs. This will inform how we support service users with digital engagement. There has been a digital steering group in place through the pandemic, with service users involved, to help lead our work in this area. The people participation team has increased the remuneration for service user involvement, to compensate for the increased costs of engaging virtually. We now have two people participation leads in post who are focusing specifically on digital inclusion.

Services are also focusing on equity of access, such as the quality improvement project in Tower Hamlets early intervention service, which is aiming to ensure equal access to psychology for service users. A survey of 2,152 service users presenting at the Richmond Wellbeing Service identified that 84% were able to satisfactorily access virtual care. However 12% depended on Smartphones which are insufficient for a quality video consultation, and 4% did not have a private space at home. Given that this is a primary care cohort from an affluent borough we anticipate that the planned survey will identify higher levels of digital exclusion.

The Richmond Wellbeing Service worked with Cisco, who donated two Webex boards and helped lock down the boards to create a digital pod so a service user could walk into a room, touch a screen to activate (if not already activated), have a consultation and leave. This requires no digital skill and enabled people to have a high-quality consultation. This approach also meant that spaces too small to accommodate social distancing could still function as a clinical space. Additional digital capacity consisted of repurposing PCs in Windows 10 kiosk mode to enable service users digitally safe web access.

As both BLMK & NEL Integrated Care Systems align the digital patient records more closely, the used of the patient or citizen held record will become more important as a communication method, being the repository for appointments, results, outcome data and

advice. The importance of inclusion for all citizens will then be even more critical, and we will work together at all levels of both ICSs to address the gap in provision & skills. The use of different modes of contact will continue to be monitored within services and directorate management teams. Our Trustwide clinical guidance will continue to be reviewed to ensure it adapts with the changing context.

2 Quality Improvement (QI)

QI status over the past year 2020-21:

Over the past year, 90-day plans were developed to support the application of QI across the Trust. Infrastructure around QI work was compromised at the peak of the first wave of the pandemic, seeing many QI projects postponed or cancelled. QI forums were suspended in some directorates. However, as the situation stabilised, QI work was re-invigorated and established again. During the last year, there has been a reduction in the total number of active QI projects (figure 6). This was partially due to the pandemic but also due to taking a more proactive approach to determine priorities and establish the viability of previous QI projects. This resulted in the closure of some inactive projects around September 2020.

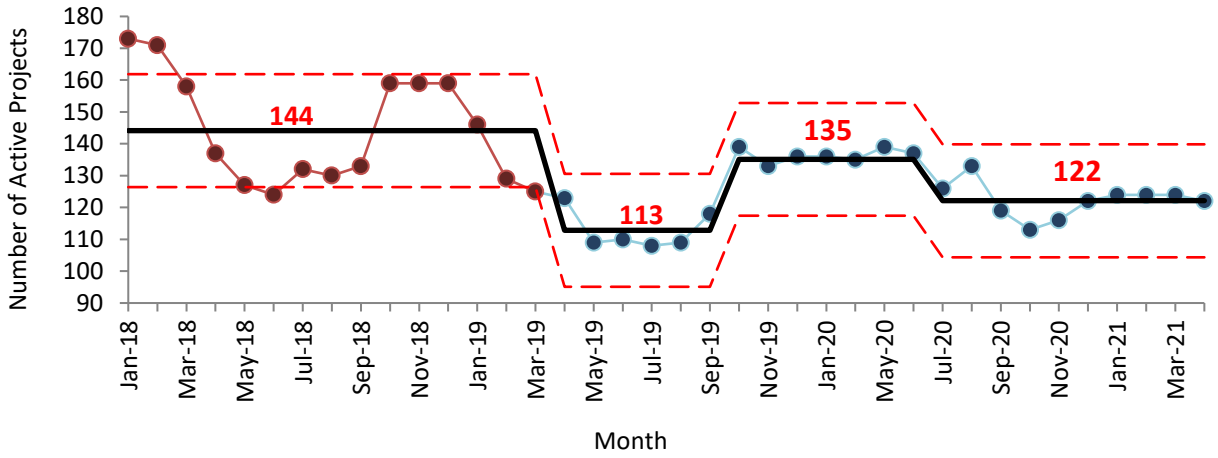


Figure 6: Total number of active QI projects

QI forums have continued in most directorates (figure 7). In the absence of a QI forum, some directorates have dedicated time to QI within directorate management meetings. A review of the functions of a QI forum will be conducted across all existing forums. Evidence so far shows that the function varies across directorates prompting a need for terms of reference to standardise the forums.

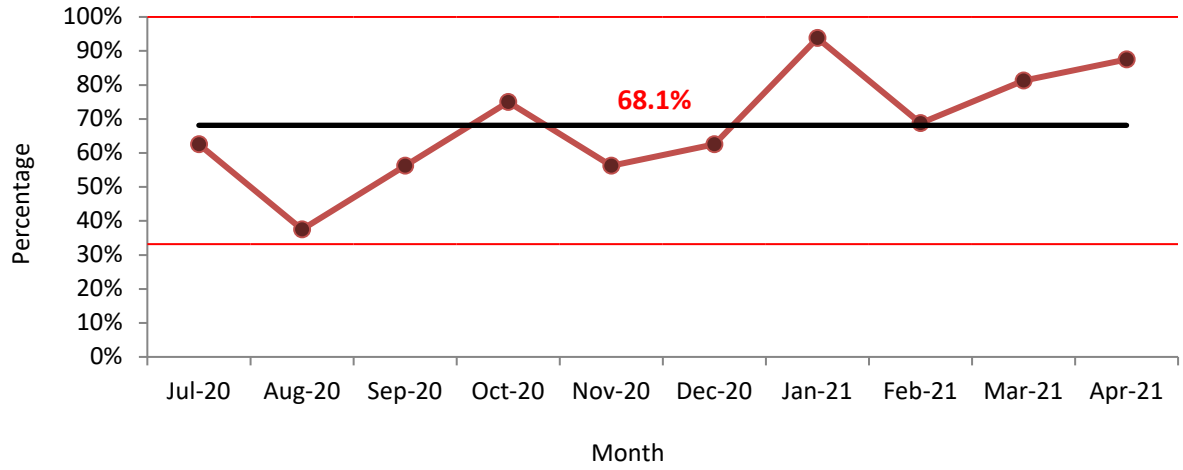


Figure 7: Percentage of active QI forums (including QI component in management meetings)

Staff and service user involvement in QI projects has deteriorated somewhat due to the pandemic (figure 8). This was partly due to inequity with access to technology and also due to projects being either suspended or cancelled. Re-engaging service users in QI work will be a focus through the next year by further strengthening the collaboration between the QI and people participation departments. Evidence from the QI mixed method evaluation reported that, service users suggested QI projects needed to feel meaningful to them to encourage involvement.

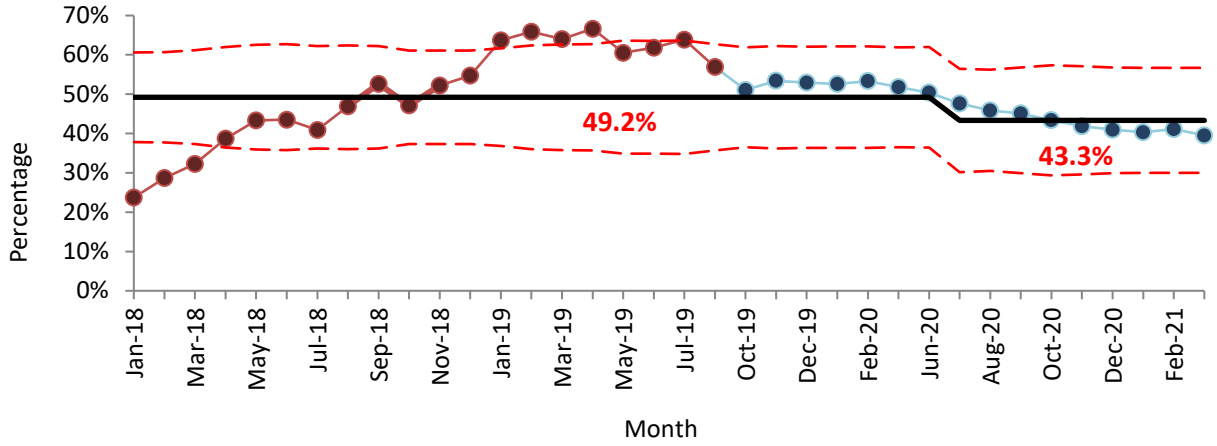


Figure 8. Percentage of Big I and Little I involvement in QI projects

The QI department conducted an exploration into what was viewed as meaningful quality improvement for service users. Current projects focused on this topic include one on 'improving authentic service user involvement' led and coached by service users. One change idea being tested is the development of a 'co-creators charter' which reminds project teams that service user involvement should be approached in a collaborative, respectful and empowering way. Another important project emerging is supporting service users back into the transition for employment after discharge from care.

Over 2020-21, QI has been utilised across the Trust as a helpful way to approach complex issues. Recent evidence of this is the request to directly support City and Hackney with their innovative project called 'covid secure'. The aim of this work was to support staff in the inpatient areas to raise concerns around the risks to their wellbeing

related to covid. This work has been scaled up throughout the Trust with Improvement Advisors supporting locally.

Between June and December 2020, the 'Shaping our Future' workshops, facilitated jointly by performance, quality improvement, people participation and population health, helped teams and directorates sense-make, develop plans for the future and consider where they could utilise quality improvement to support their priorities.

Plans for 2021-22:

The Trust's quality improvement plan (figure 9), demonstrates how QI work across the Trust will support delivery of the Trust's annual plan.

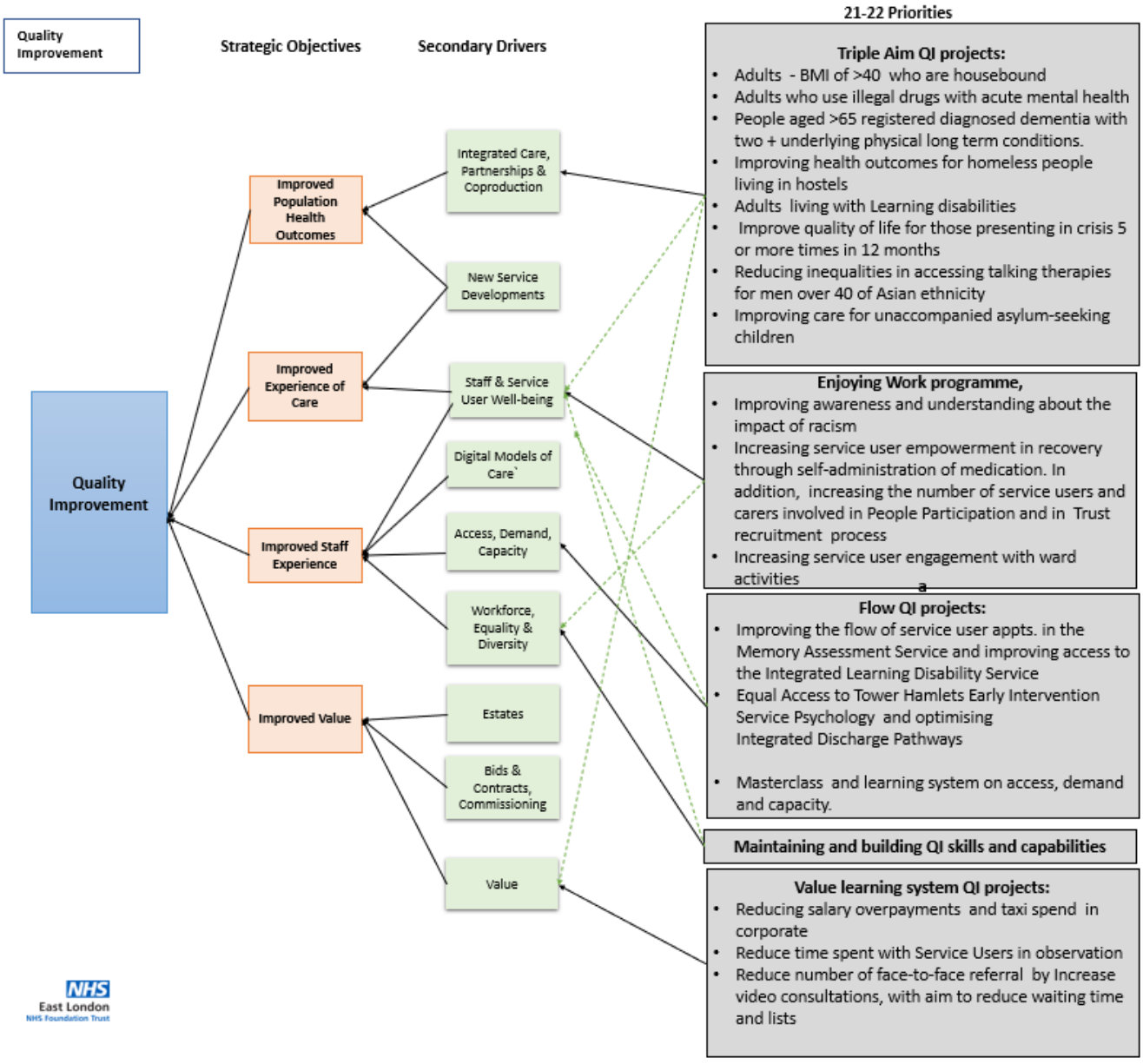


Figure 9. Trust annual quality improvement plan for 21-22

In support of this Trustwide quality improvement plan, the driver diagram below illustrates the priorities of the QI department in 2021-22 (figure 10).

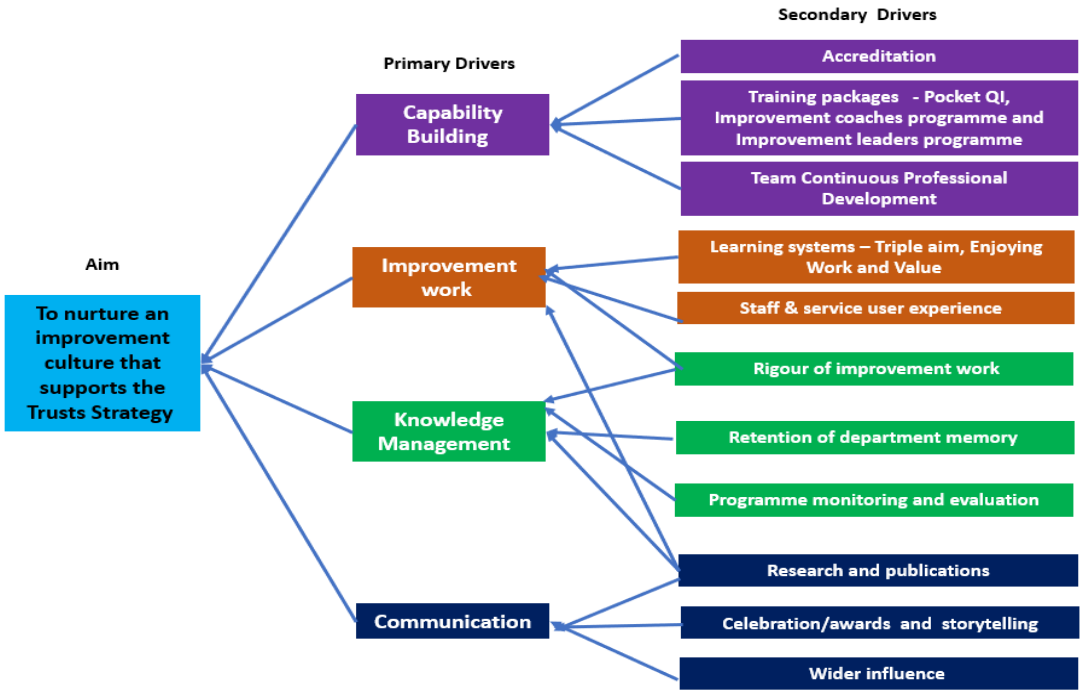


Figure 10. Quality Improvement department plan for 2021-22

Capability building:

The Trust has trained 688 people in QI in 2020 (figure 11) despite the challenges that the pandemic has presented. All of the QI training was redesigned to be delivered virtually in 2020-21, with hybrid options likely to be introduced in 2021-22. Building the QI knowledge and skills with our staff, service users and across partner organisations in our two integrated care systems is crucial to embedding a culture of quality improvement. In support of this, we have recently made Pocket QI available for external participants to join.

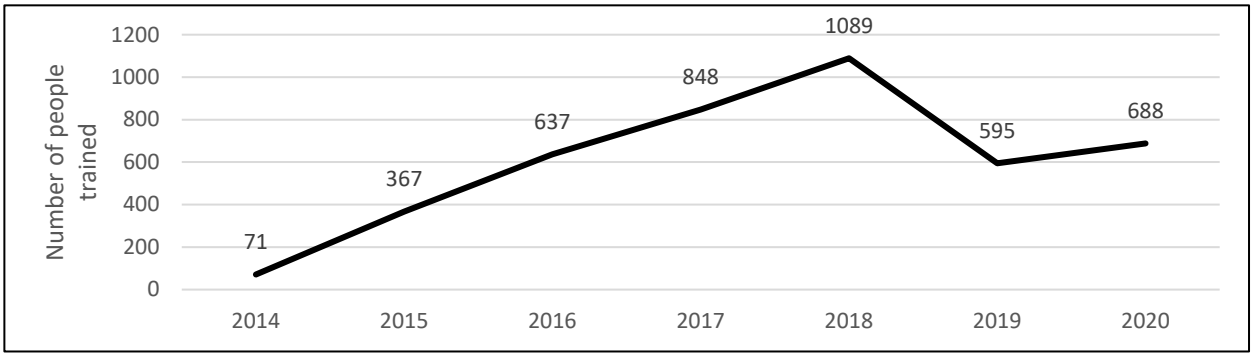


Figure 11. Number of people trained in QI methodology by calendar year

The main training programmes include Pocket QI, the Improvement Leaders Programme and the Improvement Coaches Programme. Pocket QI is a foundational one-day course aimed at engaging and inspiring people to adopt QI methods in their areas of work. The Improvement Leaders Programme is designed to support those leading a QI project or in

leadership roles to build a deeper knowledge of quality improvement. Wave 10 of our improvement leaders programme begins in May 2021. We have seen over 200 registrations for this programme, which is the most since 2016, and an indication of continuing engagement and interest in learning about and applying quality improvement across all areas of our services.

Improvement work:

The fourth cohort of our '*Enjoying Work*' learning system began in September 2020, in which teams are supported to apply quality improvement to redesign the work they work in order to enhance wellbeing and joy. From the twelve teams participating in cohort four, participants have the benefits of being able to test new ways of working and learning from other teams focused on the same topic.

The *'Value'* learning system has been relaunched in May 2021, to support the 14 QI projects where the primary aim is to remove cost, avoid cost or remove waste.

The *'Triple Aim'* learning system restarts in June 2021. The current nine triple aim projects are focused on achieving better population health, better quality of care and better value for specific populations:

- Leighton Buzzard residents over the age of 65 with dementia with two or more complex physical health conditions
- Adults who are diagnosed bariatric and are housebound
- Adults with learning disabilities
- Adults who are homeless
- Unaccompanied asylum-seeking children
- Care home residents
- Armed forces veterans

There are currently 21 teams using quality improvement to solve issues related to waiting times and demand. We are exploring the desire for a Trustwide learning system to provide additional support around this theme of work. In May and June 2021, two workshops are being offered in partnership with the performance team to support teams with demand and capacity modelling, and recovery planning.

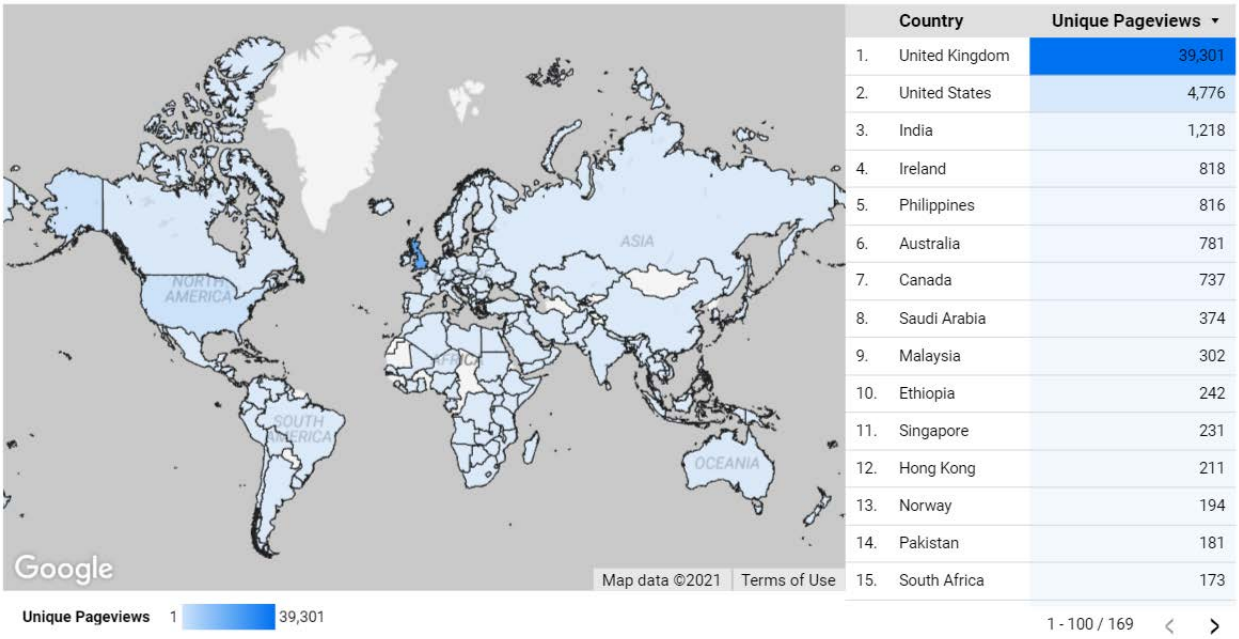
The annual visit from the Institute for Healthcare Improvement (IHI) is taking place virtually in 2020-21. The IHI team have spent time with each of our directorates. Areas of discussion have been wide ranging including the importance of partnership working across the system, tackling sexual safety, racism, inpatient violence and developing shared purpose for improvement work.

Knowledge management:

Supporting the rigour of improvement work across the Trust is a key objective for the year ahead. Improvement Advisors will review project work and guide QI coaches to ensure that projects are applying the method systematically in order to give our improvement work the best chance of success. Internal processes are being reviewed to guarantee that all knowledge gained around projects is accessible and comprehensive by strengthening the use of the 'Life QI' platform. The mixed method evaluation that commenced in January 2021 will continue at regular intervals, to ensure that we are listening, learning, and adapting the way we adopt quality improvement across the Trust.

Communication:

Regular storytelling about the impact and experience of our quality improvement work will remain a focus, in order to connect people with the purpose of QI and to celebrate the work and commitment of staff and service users. We will also be continuing to strengthen our position as a national and international thought-leader in the application of quality improvement within healthcare, through our quarterly open morning and our website which receives over 20,000 unique views a month from across the globe (figure 12).



	Country	Unique Pageviews
1.	United Kingdom	39,301
2.	United States	4,776
3.	India	1,218
4.	Ireland	818
5.	Philippines	816
6.	Australia	781
7.	Canada	737
8.	Saudi Arabia	374
9.	Malaysia	302
10.	Ethiopia	242
11.	Singapore	231
12.	Hong Kong	211
13.	Norway	194
14.	Pakistan	181
15.	South Africa	173

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Figure 12. Views of QI microsite by country during March and April 2021

3.0 **Recommendations and Action Being Requested**

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