NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
21 May 2020

Title	Integrated Performance report
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Purpose of the Report:

This report provides assurance to the Trust Board on delivery of the Trust strategy and Trust-wide performance, finance and compliance matters. The report is structured in line with the strategic outcomes in the Trust's strategy, along with information about regulatory compliance.

Summary of key issues

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, as well as describing our approach to learning and redesign in pursuit of our strategy.

Our safety indicators remain stable, however, there has been a notable reduction in reported incidents across the Trust as well as safeguarding referrals during the pandemic. There has also been an increase in unexpected deaths during the peak of the crisis with 10 cases related to the Covid-19 outbreak. Most of these deaths took place in our community mental health and physical health services.

Our access indicators highlight that since the start of the pandemic there has been a reduction in demand across primary care practices, accident & emergency mental health liaison services, community and inpatient services. This reflects the national trend across the NHS.

Access to Trust crisis mental health services remain responsive, with crisis presentations remaining stable. 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. However, primary care psychology services (IAPT) have maintained access performance. Early Intervention Services (EIS) access performance has decreased but remains above the 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.

Our staffing indicators highlight that sickness and statutory mandatory training levels remain stable with further reductions in vacancy rates. There has been positive improvement in Disclosure and Barring Service (DBS) checks as a result of extension to renewal dates.

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. Friends and Family Test scores have increased in March.

Regarding financial performance, the operating surplus (EBITDA) to end of March 2020 is £22,506k compared to a planned operating surplus of £20,446k. The net surplus performance against the NHSI Control Total is £8,294k (1.9%) after allocating non-recurrent support of £405k. This is an improvement against the previously forecast position largely due to receipt of additional unplanned non-recurrent income of £1,868k. There is a year to date favourable net surplus variance of £2,611k against the NHSI Control Total.

The overall net surplus of £9,391k (2.1%) compares to a planned net surplus of £5,683k (1.3%) after accounting adjustments. The Trust reports a year to date favourable net surplus variance of £3,708k against plan. The difference to the NHSI Control Total surplus is due largely to an impairment of assets accounting adjustment of £1,007k.

The Trust reported a cash balance of £106.4m to the end of March 2020. All March 2020 reported figures are subject to the annual audit of accounts.

The Trust remains in category "1" of the Single Oversight Framework overall, as it has met all national targets. The financial rating is "2", as high agency expenditure against the Trust agency cap has meant the Trust cannot achieve a financial risk rating of "1" for 2019/20.

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

Improved patient experience	☒	The report is structured around the four strategic priorities and the sections set out progress in each area.
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.

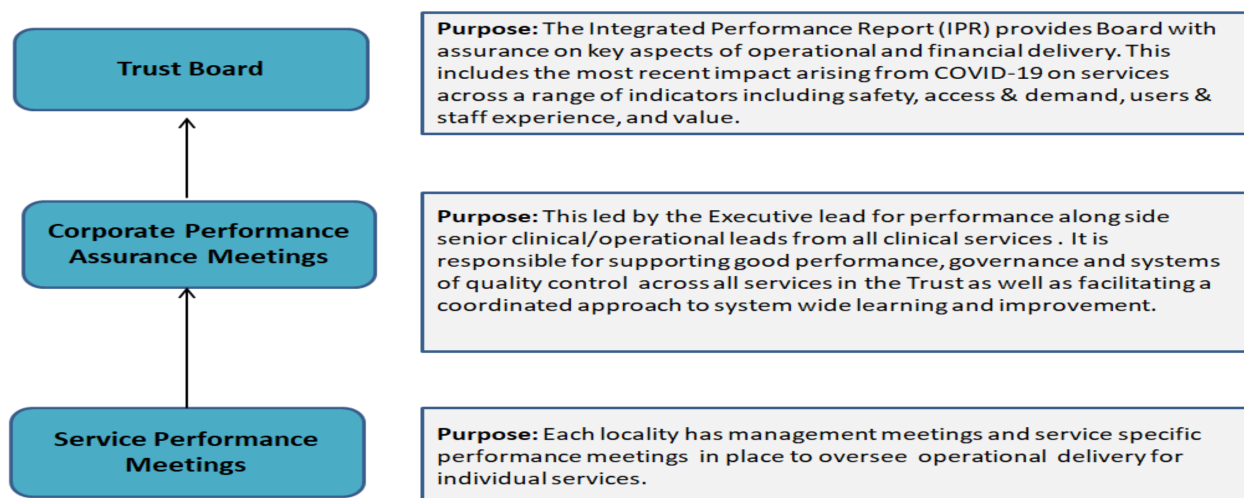
Explanation regarding the use of Statistical Process Control (SPC) charts: SPC charts are used to study how a system or process changes over time. It allows us to understand whether we are improving over time, and to pay attention in a more scientific way to 'signal' versus 'noise'. Signals in the data 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

In common with other NHS organisations and as a result of national guidance released on 17th March 2020, services and directorate management teams across the Trust have mobilised Business Continuity plans to respond to the COVID-19 (coronavirus) pandemic. This has impacted routine operational performance delivery. Service contract monitoring and negotiations with commissioners have been suspended. All reporting, except national and COVID-19 related reporting expectations, have been paused and block payment arrangements have been agreed for the first quarter of 2020-21. We are awaiting further national guidance on the plan beyond July 2020.

In light of these changes, the focus of this report has been adjusted to provide assurance to the Board on key performance indicators (safety, access and demand, experience and outcomes, people and finance) that have been agreed for monitoring during this pandemic, as well as risks identified from the Board Assurance Framework (BAF). This report will also provide the Board with an update on our approach to monitoring, understanding and learning from changes initiated during COVID-19 so that we can continue to work towards our Trust strategy and improve quality of life for the populations we serve.

Fig. 1 *Performance and assurance process*



1. Safety

The charts below demonstrate variation across a range of key safety measures. There has been a reduction in the number of reported safety incidents during March and April, together with a reduction in the percentage of incidents resulting in harm since the beginning of March. This may reflect the reduction in activity across community and inpatient services since the start of the COVID-19 pandemic. The number of unexpected deaths has shown unusually high numbers since the middle of March with two deaths related to the COVID-19 outbreak in March and eight deaths in April. The number of pressures ulcers has remained stable, and community health teams have been supporting staff to continue to monitor and report pressure ulcers over this period. The rate of physical violence is showing signs of reduction in March and April – as this is expressed as a rate, it would be unaffected by the reduction in bed occupancy during this period.

The number of safeguarding referrals demonstrates signs of potential reduction over the last eight weeks. One of the reasons for this dip is the reduction in face to face contact with service users across health and social care. In addition, service users may feel less able to contact services to highlight concerns whilst living at home with a potential perpetrator during the pandemic. However, this has been recognised as a national problem and we are working closely with our partners to

remain vigilant. There are early signs of increased activity in social care and particularly from the police, which we anticipate will lead to an increase in our reported activity next month.

We also recognise that staff often report safeguarding referrals on different systems, for example local authority databases and our Trust Datix system. During the pandemic, it is possible that recording of incidents on our system may have reduced as staff sought to minimise duplication of work and administrative burden on their teams. Our corporate Safeguarding teams have reminded all staff that safeguarding responsibility has not changed and that they are to continue reporting any concerns as normal on the Trust incident management system. They have also offered support to teams and circulated newsletters, leaflets and a checklist to remind staff about safeguarding responsibilities.

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

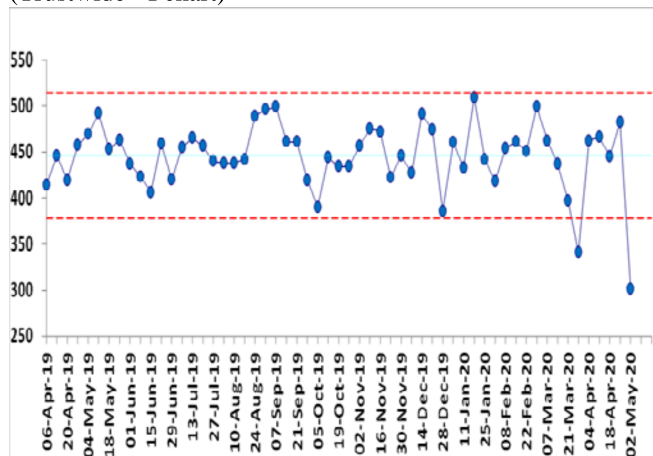


Chart 1.2 Percent of incidents resulting in harm (Trustwide – P chart)

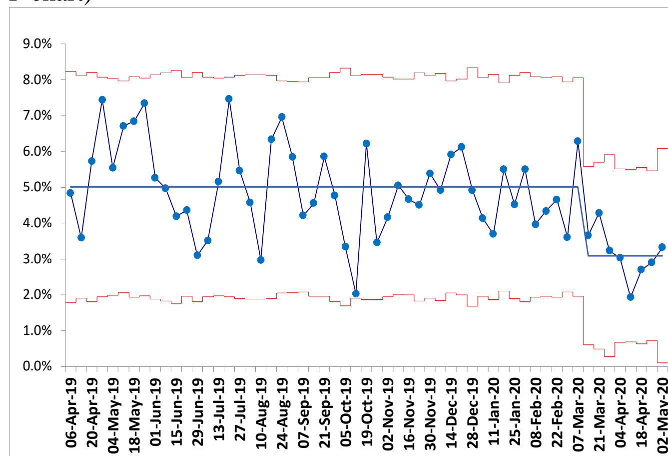


Chart 1.3 Rate of incidents of physical violence per 1000 occupied bed days (Trustwide – U chart)

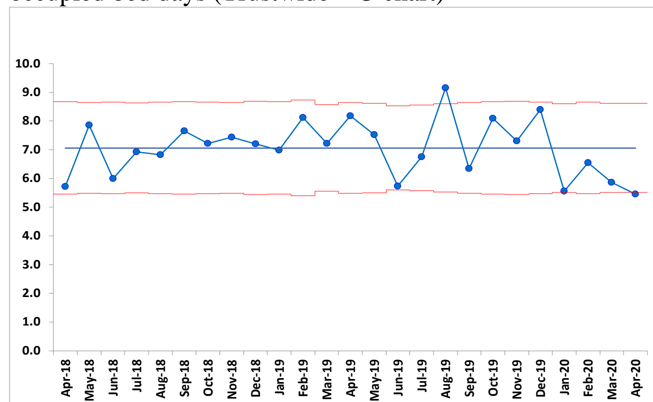


Chart 1.4 Number of Pressure ulcers resulting in harm (Trustwide - C chart)

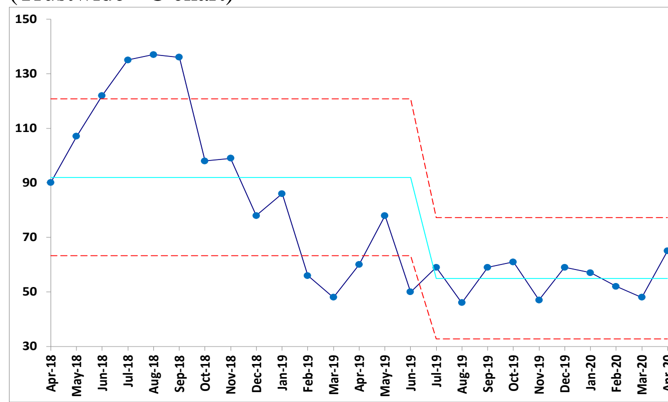


Chart 1.5 Number of unexpected deaths (Trustwide – I chart)

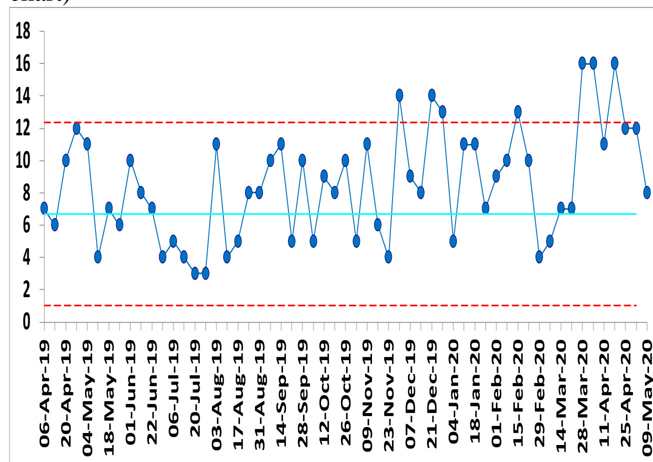


Chart 1.6 Percent of service users followed up within 72 hours of discharge from the ward (Trustwide - P chart)

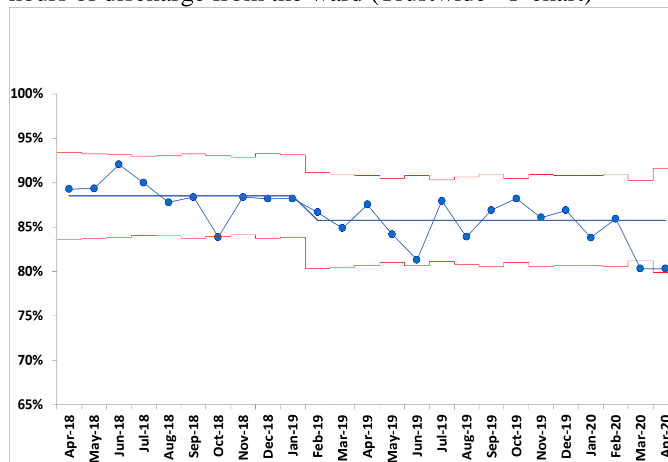


Chart 1.7 Number of reported IT or System access incidents (Trustwide – I chart)

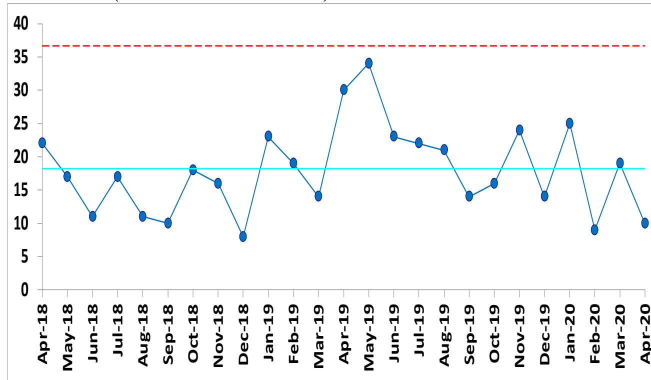
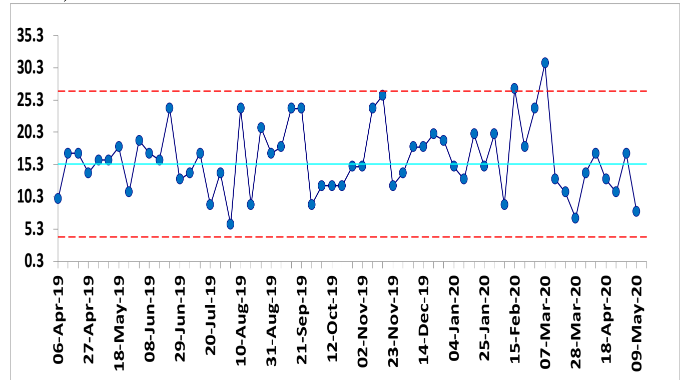


Chart 1.8 Number of safeguarding referrals (Trustwide – I chart)



2. Access and Demand

The charts and narrative below provide assurance across a range of demand and access indicators. We have seen a reduction in referrals to all A&E mental health liaison teams in March 2020; bed occupancy has reduced dramatically to around 60% due by a reduction in admissions; and the number of referrals to mental health & community health services across the Trust has reduced from an average of 12,4551 each month to 8,734 referrals in April. This is due to the impact of COVID-19 and reflects the national trend across the NHS. Most services in the Trust have experienced a reduction in demand as a result of the social distancing measures introduced by the Government. However, it is recognised that this does not reflect the true picture of need within our communities and therefore it is anticipated that there will likely to be an increase in activity in the near future once services return to normal. As described later in this report, our work on shaping the future will support services to prepare for several future scenarios, including an increase in demand.

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

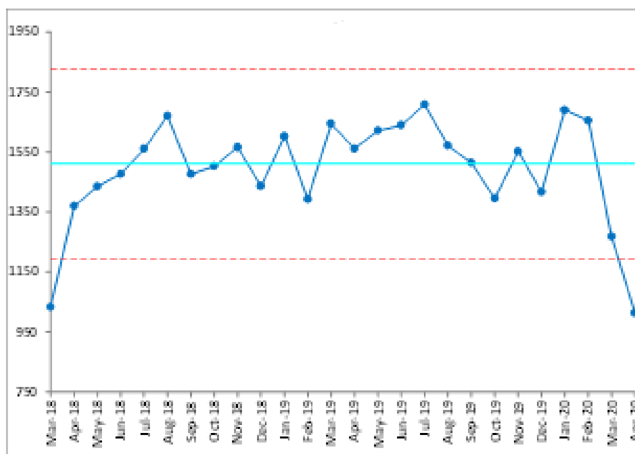


Chart 2.2 Bed occupancy (Mental Health & Community Health – Prime chart)

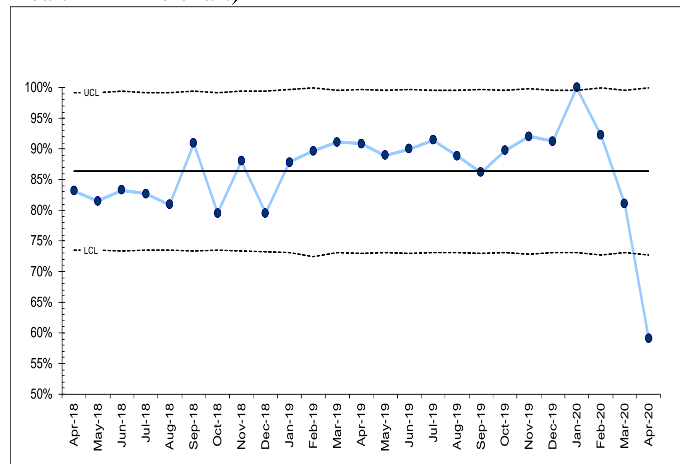


Chart 2.3 Number of admissions (Mental Health and Community Services – I chart)

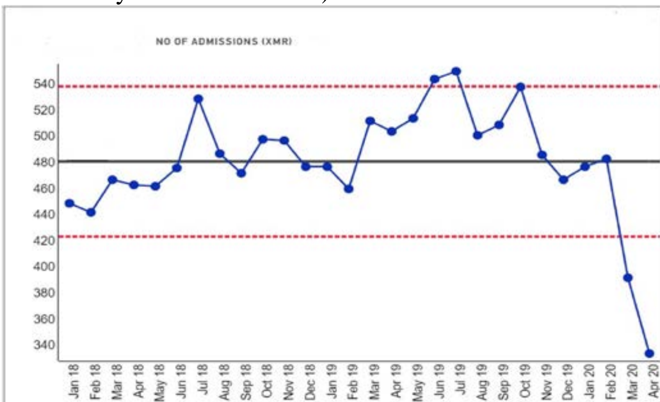
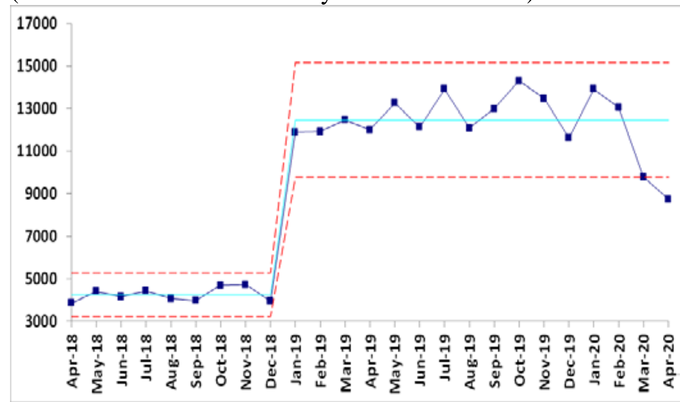


Chart 2.4 Total number of referrals to community teams (Mental Health & Community Services – I chart)



**Bedfordshire referral activity included from January 2019*

Mental Health Crisis pathway

The charts below highlight activity across our mental health crisis pathway across the Trust. Overall activity levels remain stable since the start of the pandemic. However, services have noticed an increase in the number of calls during routine hours, particularly a spike in calls from service users who have faced difficulty accessing their GPs. Most services have also seen an increase in face to face contacts. All crisis service capacity has been enhanced with redeployed staff to support anticipated increase in activity in the coming weeks and months. This is reviewed on a regular basis to ensure sufficient cover is in place at all times to respond rapidly to service users accessing the service.

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

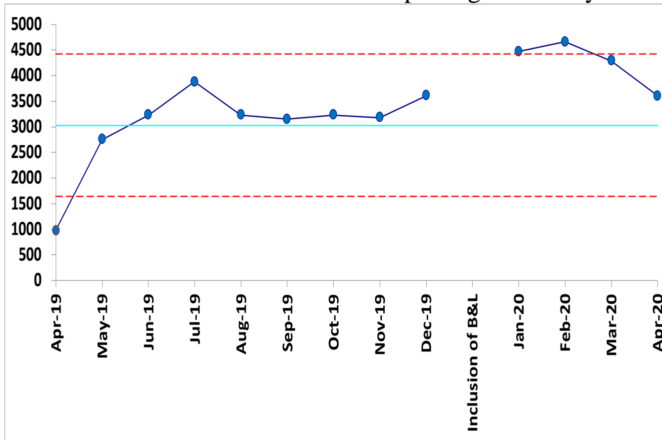
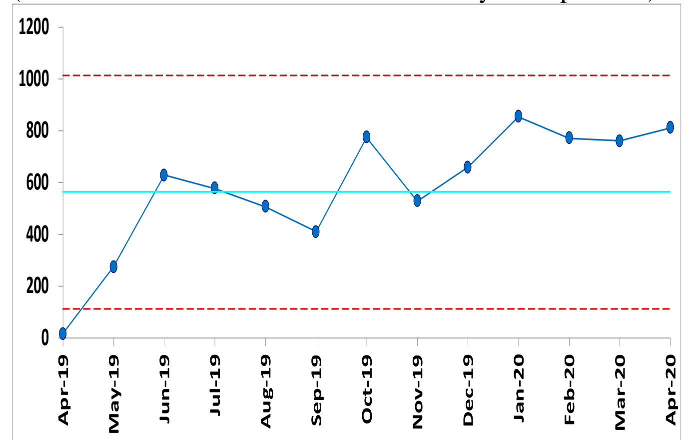


Chart 2.6 Number of repeat callers each month (I chart) (Luton & Bedfordshire excluded as currently not reportable)



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 wait of 24 days. However, this data is based on waiting time for service users who have been seen. There are 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. Waiting times for this cohort will be supplied in the July Board report once validation has been completed.

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 increased waiting times in East London during February to April was related to incorrect recording in teams where activity was linked to wrong referrals. Training has been provided to staff which improved the position in March, unfortunately due to the configuration of the community health clinical record system (EMIS), we are unable to reverse incorrect recordings.

Adult mental health Early Intervention Services (EIS) two week waiting time targets for referral to assessment is showing early signs of deterioration, moving from an average of 80.8% receiving NICE-compliant treatment within two weeks to 73.2% in April. This is partly due to the impact of reduced staffing and capacity due to COVID-19 but also because this national indicator is solely based on face to face contacts, with virtual/telephone contacts not included. All services are offering telephone and video contacts as a primary method to engage with service users during this pandemic and compliance levels remain above the national 65% target for all services.

Secondary care Psychological Therapy Services (PTS) are showing increased average waiting times for first assessment and treatment (face to face). During the acute phase of the crisis all PTS services initially closed to new referrals and face to face contacts, and some staff were redeployed to bolster frontline services such as crisis and home treatment teams. This meant that there was less capacity available to manage current waiting lists resulting in increasing waiting times. In addition, our services had to undertake significant redesign to support service users during the crisis and this resulted in delays to care but also new innovations such as psycho-educational podcasts, digital consultations and online psychotherapy to support delivery of care. Access to online digital resources has increased, as well as the use of video platforms for service user contact.

All PTS services have now fully reopened and have contacted service users to review current needs and co-produce their care plans. Service users have been given the option to receive care and treatment in a variety of new ways that work for them. This has led to some service users deciding to delay treatment due to concerns about COVID-19, thus increasing waiting times. In other instances, some service users have required more support to adopt alternative methods of assessment and treatment. Other service users have decided that their circumstances have changed and opted out of treatment, as demonstrated by the reduction in the number of service users waiting for second contact during this period (chart 2.14). Overall, there has been a reduction in referrals to these services, and teams are working closely with service users and people participation leads to co-design future service models and pathways that are sustainable, more accessible and responsive.

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

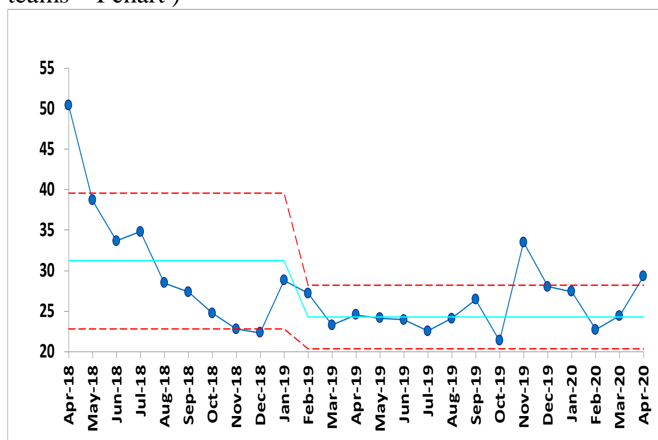


Chart 2.8 Average waiting time in days for urgent referrals to district nursing / rapid response (East London – I chart)

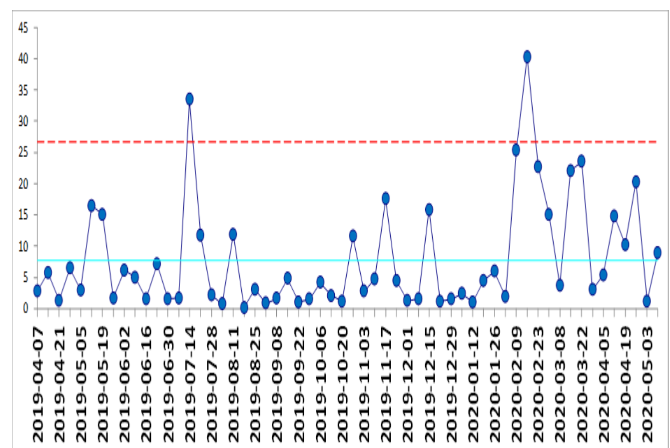


Chart 2.9 Average waiting times in days for referral to assessment to district nursing team (Bedfordshire – I chart)

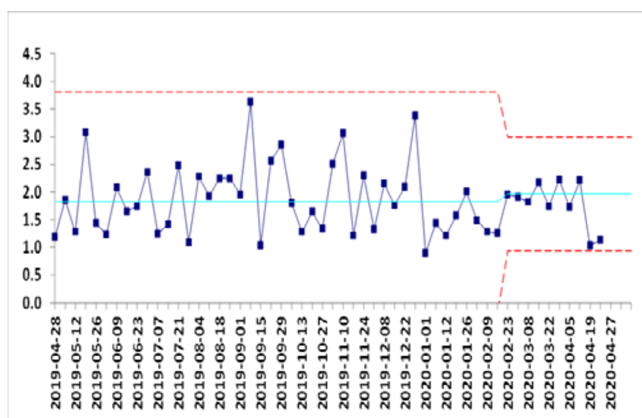


Chart 2.10 Percent of service users receiving NICE Standard treatment within two weeks of referral to early intervention in psychosis service (Trustwide – P chart)

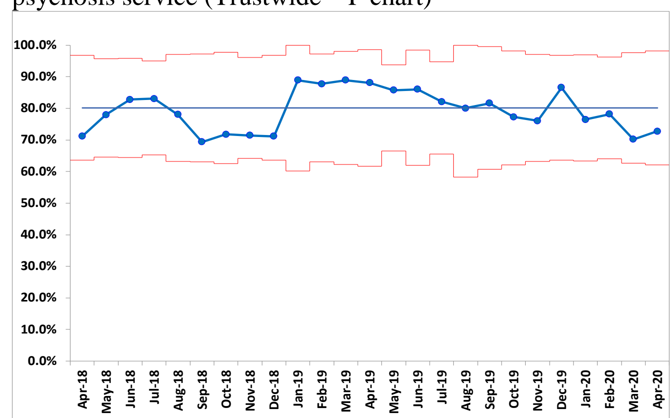


Chart 2.11 Trustwide PTS - Average waiting (in days) from referral to assessment (telephone & face-to-face contacts – I chart)

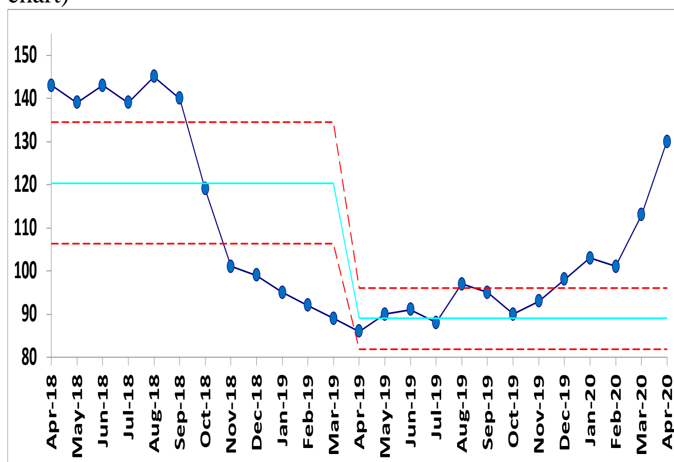


Chart 2.12 Trustwide PTS - Average waiting time (in days) for treatment (telephone & face to face contacts – I chart)

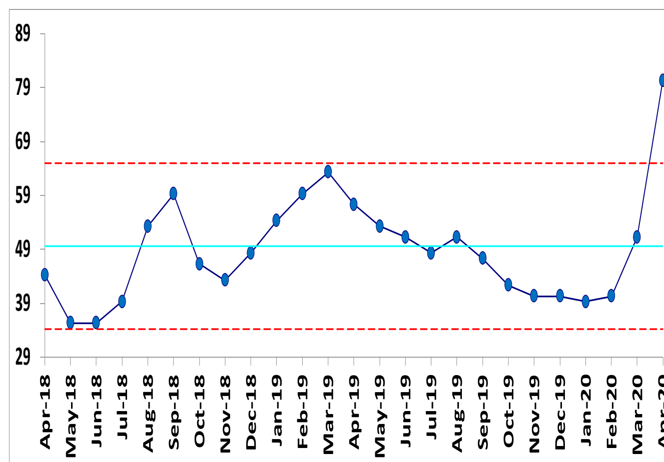


Chart 2.13 PTS - Number of service users waiting for assessment (telephone & face to face contacts – I charts)

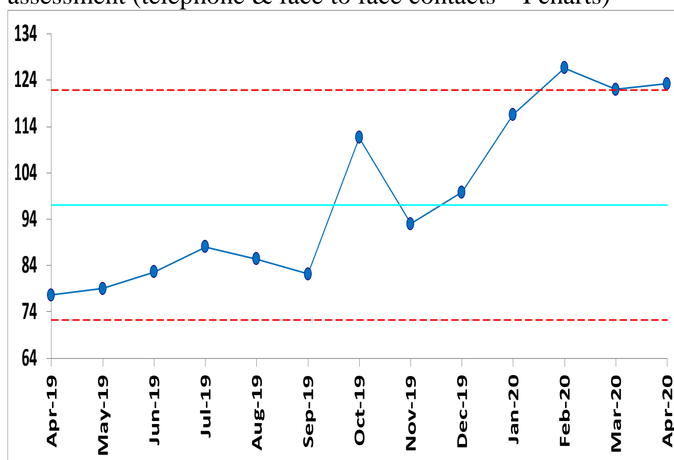
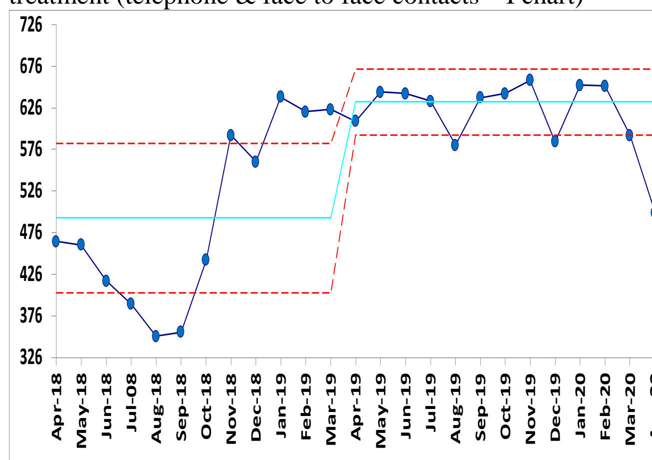


Chart 2.14 PTS- Number of service users waiting for treatment (telephone & face to face contacts – I chart)



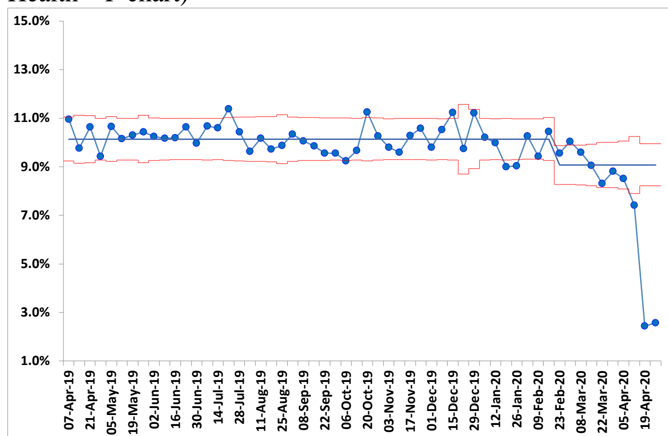
Contacts with Service Users

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 as well as a reduction in non-attendance for virtual/telephone contacts. 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, there has been a reduction in monthly contacts for service users who are care-coordinated by our community mental health services. This 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 during the acute phase of the pandemic. It is also the result of our clinical systems not being configured to capture virtual contacts which has since been launched at the end of April. This issue has been highlighted to services and team leads are working with their staff to make improvements to record keeping, and to follow the guidance issued to correctly log virtual activity. All services are closely monitoring and reviewing the needs of service users who are care coordinated and ensuring 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, as well as hands-on support such as delivering medication and food to service users in their homes. Where services do not have correct telephone numbers, they have written to service users to ask them to provide correct information and also to make contact with 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 setting up Whatsapp groups and hosting virtual drops in sessions on a regularly basis. Other

services have been utilising personal care budgets to buy service users smartphones to facilitate digital communication.

Chart 2.15 Non-attendance for routine appointments provided by telephone/video (CAMHS and adult Mental Health – P chart)



**Community health excluded as they do not record non-attendance for telephone calls*

Chart 2.16 Percentage of contacts each week made via telephone or video-consultation (Mental Health & Community Services – P chart)

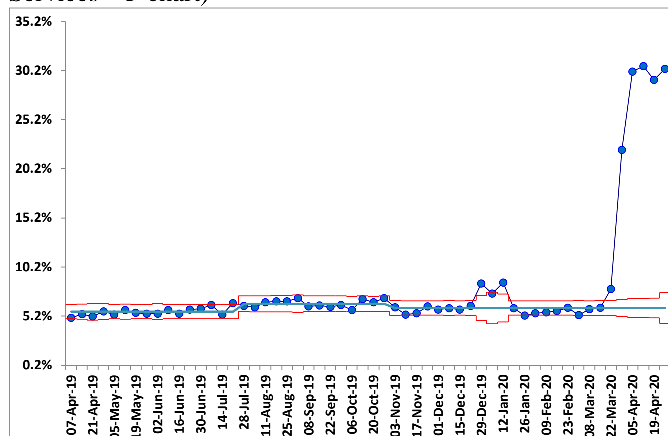
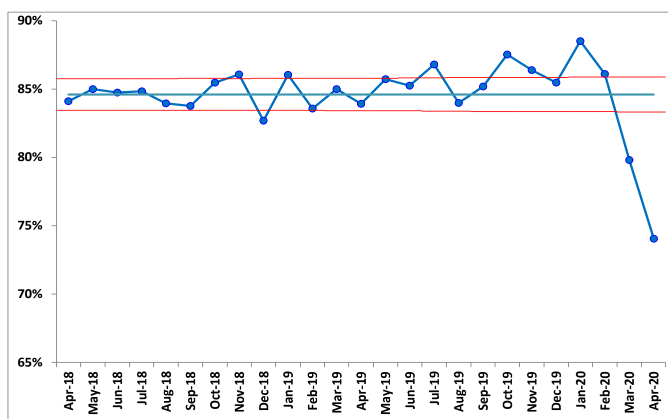


Chart 2.17 Percent of people on CPA contacted each month (Mental Health – P chart)



Improving Access to Psychological Therapies (IAPT) Services

The charts below demonstrate our performance against national IAPT performance and access indicators. Overall compliance remains stable. The 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.

However, like other services across the Trust, weekly referrals to IAPT since the social distancing started have been less than half of the numbers in January and February, despite the services all testing various ideas to encourage referrals (e.g. Facebook advertising, contacting GPs, local radio announcements, Covid-specific webinars). The sharpest reduction has been in self-referrals. GP and professional referrals have reduced but not so dramatically. This trend has been reported by IAPT services across London and elsewhere. The services will not be able to deliver the usual access levels until referral numbers rise. However, this has had a beneficial impact on waiting times as capacity is released from triage slots and the numbers joining waiting lists has reduced. The increase in average waiting times to first appointment from October 2018 (chart 2.20) relates to the impact of acquiring Tower Hamlets IAPT services, which has since improved.

Chart 2.18 Percentage of service users starting treatment within six weeks of referral (Trustwide – P' chart)

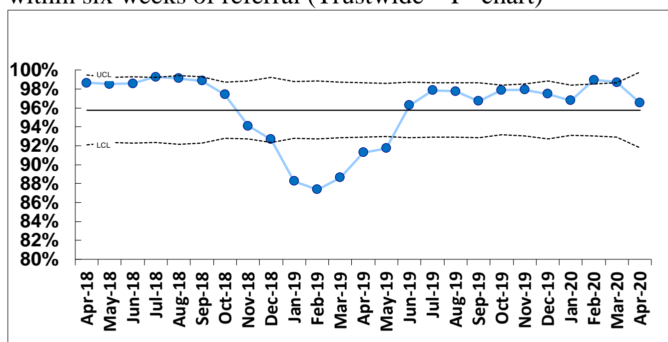


Chart 2.19 Percentage of service users started treatment within 18 weeks of referral (Trustwide – P' chart)

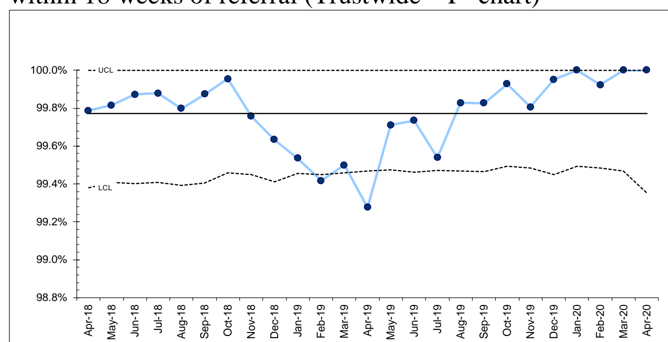


Chart 2.20 Average wait (days) to first appointment (Trustwide – I charts)

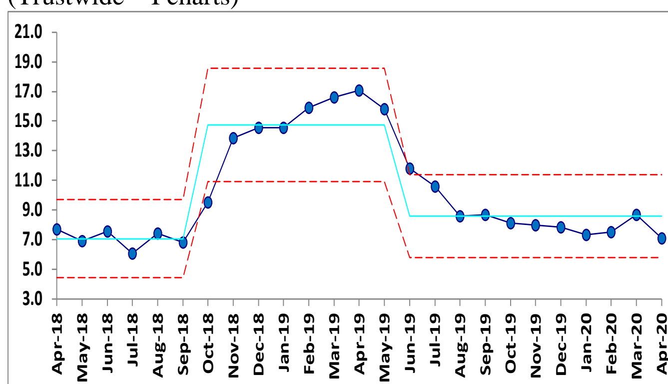
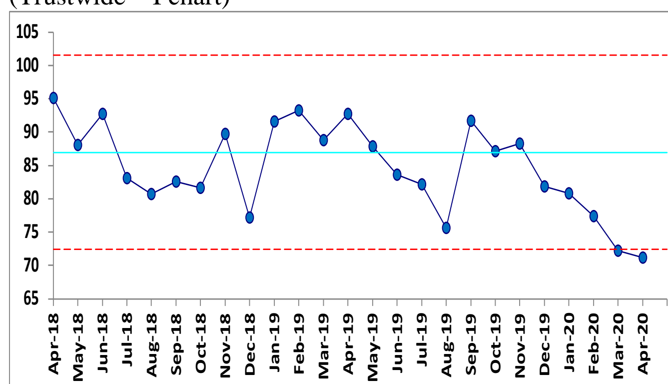


Chart 2.21 Average wait (days) to second appointment (Trustwide – I chart)



Primary Care Services

The charts below show the number of primary care contacts that are taking place in our East London GP Practices that support homeless service users in Newham, Tower Hamlets and City & Hackney. Luton and Bedfordshire GP practice activity was not available at the time of reporting, but we will hope to include over time. The charts highlight that there has been a decrease in the number of contacts across Newham and City & Hackney services, which reflects some of the impact caused by the pandemic. Newham has the largest service and operates two separate sites unlike the other services. It is also one of the most deprived boroughs in London with a significant homeless burden.

In Tower Hamlets, activity has remained stable. There has been a particular focus within the borough to repatriate previously homeless service users with tenancy agreements to accommodation out of the borough but currently registered to the practice. This has reduced its caseloads over time. Since the start of the pandemic all three services have had to respond to a growing number of service users living in temporary accommodation such as hostels and hotels. This outreach work has resulted in increases in temporary registrations and service user contacts. This work will likely increase activity in the coming months across all services. Tower Hamlets is in the process of recruiting staff to fully mobilise this scheme in the coming weeks.

Chart 2.22 Number of appointments per 1000 population (Tower Hamlets – U chart)

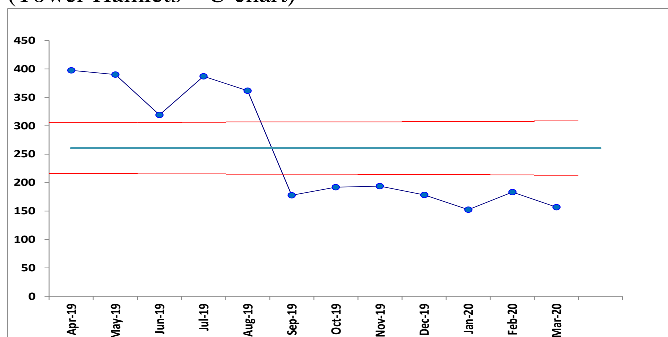


Chart 2.23 Number of appointments per 1000 population (Newham – U chart)

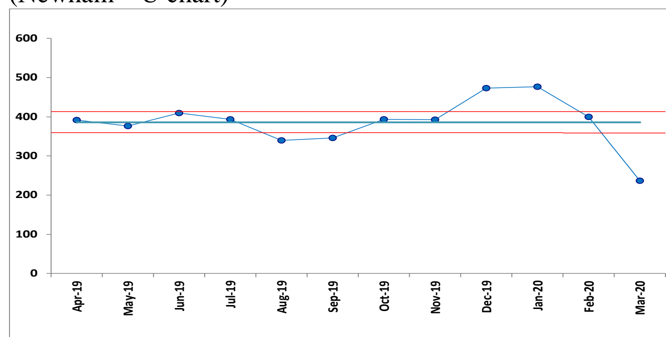
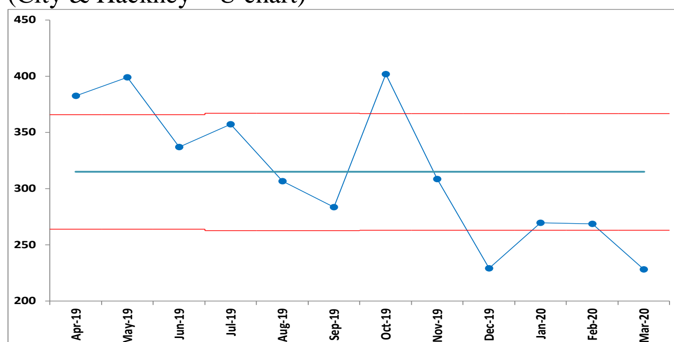


Chart 2.24 Number of appointments per 1000 population (City & Hackney – U chart)



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 increased 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.

The data also highlights that, on average, 72% of Agenda for Change (AfC) staff completed their appraisal in 2019-20. The new Appraisal window opened on 1 April 2020, however the completion deadline has been relaxed to October 2020, as there is an acknowledgement that the disruptions caused by the pandemic may impact some managers' ability to complete all appraisals by the end of June.

Chart 3.3 highlights that Statutory and Mandatory training compliance decreased from 89.13% in February to 87.99% at the end of March. Guidance from NHS Employers stipulates that statutory and mandatory training for supporting returning staff to the NHS has been reviewed and there are now four e-learning modules that are required as a minimum:

- Health, safety and welfare
- Fire safety
- Infection prevention and control – level 2
- Resuscitation – level 2.

It has also been recommended that, for current NHS employees who have not changed roles and who have previously undertaken training in the core subjects of statutory/mandatory training, refresher training requirements should be suspended for the duration of the current crisis. We have liaised with subject matter experts and the Directors of Nursing and have agreed that the minimum criteria are not enough for a mental health and community Trust and we have therefore revised this further. We are also developing online content and developing how learning and development is done in the Trust.

Whilst chart 3.1 illustrates a stable sickness absence figure we know through the reporting to NHS England, that in the peak of the pandemic there were approximately 1,000 staff who were absent due to Covid-19.

Chart 3.1 Sickness (Trustwide – I chart)

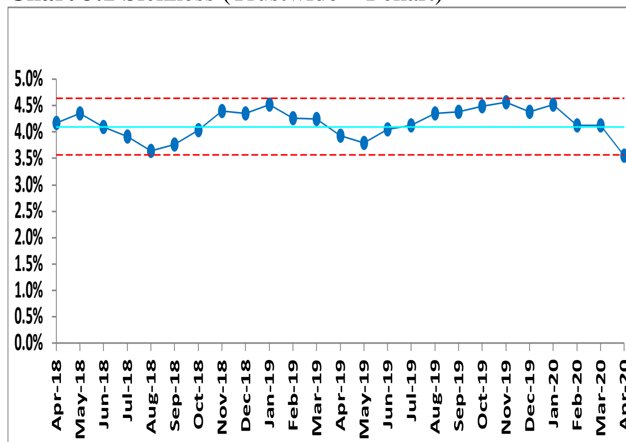


Chart 3.2 Percentage of posts vacant (Trustwide – I chart)

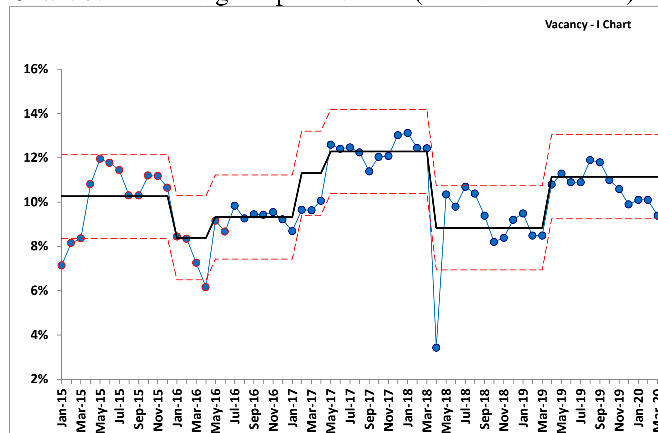


Chart 3.3 Mandatory training compliance (Trustwide – Prime chart)

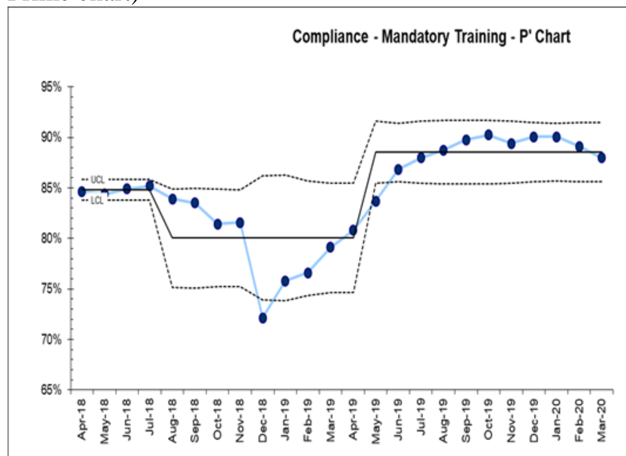


Chart 3.4 Turnover (Trustwide – I chart)

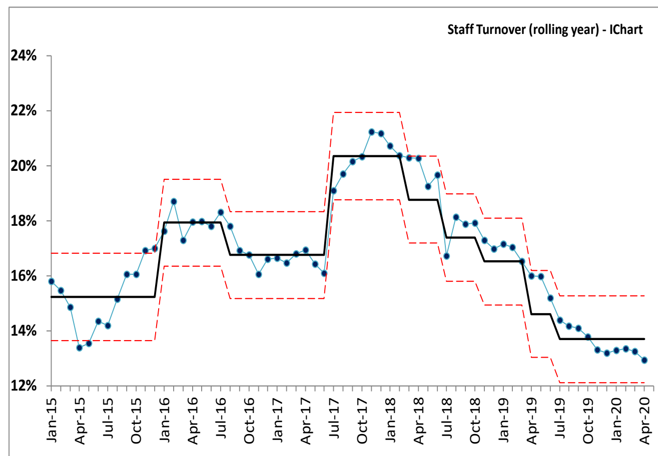


Chart 3.5 DBS clearance (Trustwide – P chart)

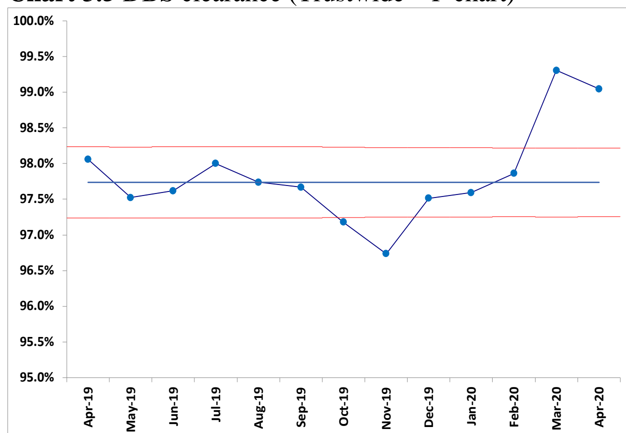
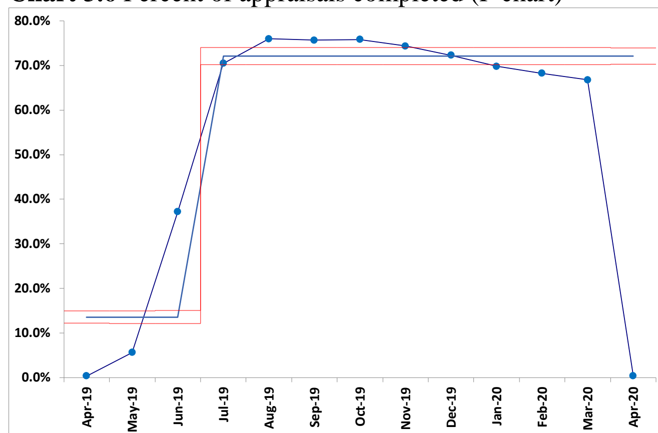


Chart 3.6 Percent of appraisals completed (P chart)



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 continue to average twenty in the same period. IAPT recovery rates are stable at 52% as is the percent of service users who would recommend our services to friends and family (95%).

Chart 4.1 Number of Complaints (Trustwide – I chart)

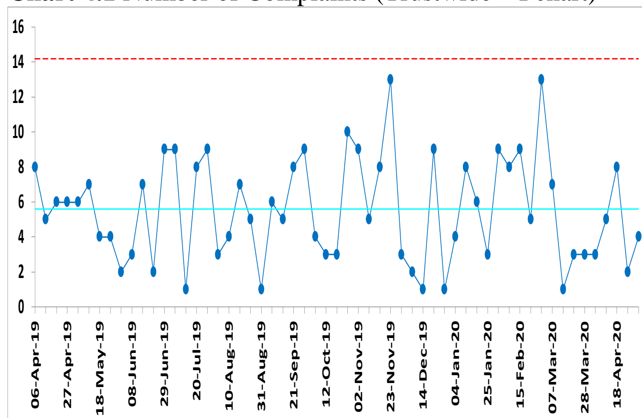


Chart 4.2 Number of PALs enquiries (Trustwide – I chart)

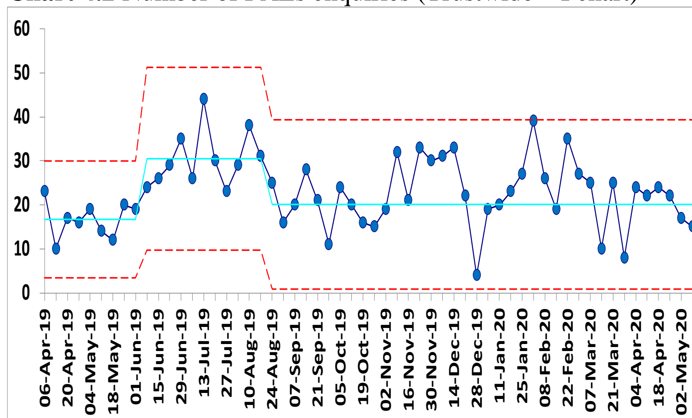


Chart 4.3 IAPT – percent demonstrating recovery at end of treatment (Trustwide – P chart)

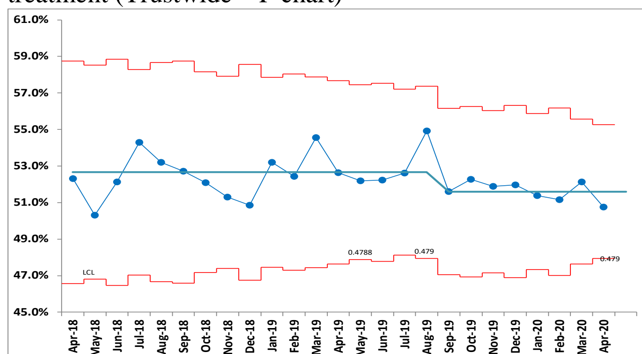
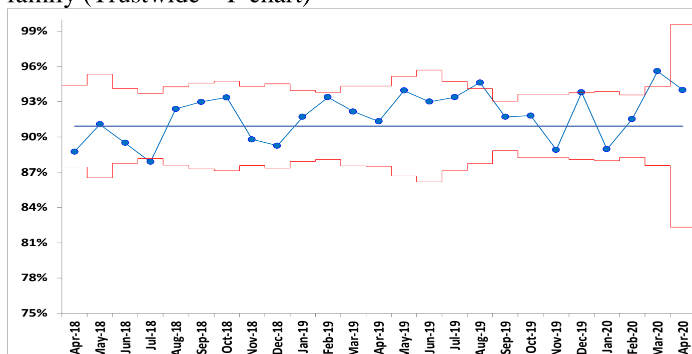


Chart 4.4 Percent recommending the service to friends and family (Trustwide – P chart)



5. Approach to understanding and learning from change during COVID 19 in order to shape our future

Following the initial urgent stage of rapid changes to service provision in order to prepare and manage the covid-19 outbreak, we introduced a short Quality Impact Assessment process in early April to systematically log all the changes introduced at service and directorate level, try to predict impact (both positive and negative), identify data that might help us spot the impact, and start extracting learning that would be useful in shaping future service provision. This was **phase one** of a four stage process outlined in the diagram below (Fig.2).

Fig 2 : *Approach to understanding and learning from change during covid-19 in order to shape our future*

	Steps	Aims	Support
1	Quality Impact Assessments (QIAs)	Service specific impact assessments conducted to understand immediate changes made by services and emerging issues/concerns/learning	Service management led
2	Facilitated Workshops (staff and service users)	**2 hour virtual workshop**: bringing service users and staff together with existing knowledge and data to draw out lessons from QIAs and changes that have taken place during covid-19 (what has worked, and what hasn't), in order to start identifying future service design. This will take a population health and equity lens from the outset, and integrate quality, performance, value and population health in the true meaning of the triple aim.	DMT led with facilitation organised and supported by local IA's, Working Together Groups, Performance & Corporate leads
3	Co–produced local plans to inform service improvements and priorities	Consolidate workshop findings into a local plan developed by senior DMT leads. This will be supported by local performance and improvement advisors, adopting improvement tools as necessary to help implement aspirations of services across DMTs and localities effectively and sustainably	DMTs will be supported by Performance, IAs, PPLs & Corporate colleagues as agreed with them
4	Oversight and review	On-going monitoring and support within existing structures. DMTs to oversee local coproduction and redesign. Corporate oversight through the directorate performance meetings.	On-going support will be primarily provided by IAs, and Performance (drawing in expertise from other corporate teams as needed)

Learning from *Phase one* – Quality Impact Assessments

The early learning from phase one has highlighted a number of themes emerging across the Trust, as highlighted below. We are in the process of exploring this further with services and service users, as part of phase two of shaping our future.

Theme	Key Learning
Digital	• Services have adopted digital technologies at a rapid pace which is positively impacting service user and staff satisfaction. Most services are offering virtual contacts together with options such as online materials, blogs, podcasts etc to support service users with their care and treatment. • Staff are working effectively from home using Microsoft Teams and Webex. Virtual conference calls have started to become the norm across the Trust and connectivity between staff across the organisation has increased in some ways during this pandemic, although without some of the human interaction and serendipitous conversation that requires face-to-face contact • Some staff members have experienced issues with access and usability of technology which team leaders continue to address. • Staff and services are on a journey in adopting the full extent of digital possibilities. For example, we have seen a large increase in telephone calls but less video calls. This is partly due to a need to upskill staff to adopt digital platforms and provide a stable infrastructure to support large-scale video-calling, but also due to some service users not having smartphones to engage with. In City and Hackney services have attempted to support through personal care budgets to acquire smartphones for service users where possible.
Changes in core service offer	• There have been a number of changes to services, many of which have enhanced the core service offer – such as mobile clozapine clinics, virtual inpatient multi-disciplinary meetings, empowering carers and family members to manage long-term conditions more independently, testing of flexible assertive community treatment (FACT) model rather than the traditional model of care in CMHTs. We may want to hold onto many of these changes, which is why we need to systematically work through a redesign process with a range of voices helping to co-design what our services need to look like in future to improve quality of life and focus on what matters most to those we serve.
Risk Management	• Services have had to take different approaches to managing risk during this pandemic which has primarily focused on clinical need and urgency. In some teams, the criteria for acceptance and discharge has changed to support more positive risk-taking. Some services have adopted risk ratings to identify high risk and low risk service users to help prioritise work across their caseloads. Further work during phase 2 will support services to understand what learning can be drawn from these approaches to manage caseloads more effectively and what adverse impact (if any) this might have had for non-urgent users and if they need to be supported differently in future.
Demand Assumption	• The anticipated increase in demand for many mental health services have not materialised as yet, and referrals are decreasing in most community teams. However, many teams are predicting an increase in near future and part of phase 2 of our learning and planning process will support services to plan for increased demand, among a number of future scenarios.
Inequalities	• It has been recognised that certain groups of staff and service users are disproportionally impacted by the pandemic such as BAME groups, and those with particular socio-economic risk factors. The executive team is actively exploring these issues with services and equality networks. The

	next phase of our response to covid-19 will include a specific Trustwide workstream focused on inequalities.
Integrated Working	• New partnerships, forums and true collaborative working with outside agencies (e.g. local authorities, primary care, voluntary sector) have emerged over the past two months which we would want to continue to nurture and build on. • Some examples of more integrated working across our internal directorates, to support staff and service users during covid-19

We are now in **phase two** of our approach to learning, which will involve virtual workshops with staff and service users to understand what matters most to the people and populations we serve, and to design our future service models around this. The workshops will enable services and service users to jointly determine what new practice to keep, what to adapt, what old practice they restart and what they no longer wish to go back to. There will also be support to plan proactively for several future scenarios, including increased demand as restrictions on movement ease, the impact of interruption of care for long-term conditions and increased prevalence of mental ill-health within the population.

5. Finance Performance

Summary of Financial Performance

- Operating surplus (EBITDA) to end of March 2020 of £22,506k compared to planned operating surplus of £20,446k before non-recurrent support.
- Net surplus of £9,391k (2.1%) compared to planned net surplus of £5,683k (1.3%) after allocating non-recurrent support and income received via STP.
- Year to date favourable net surplus variance of £3,708k.
- **Year to date favourable net surplus variance against control total of £2,611k.**
- NHS Improvement (NHSI) risk rating of “2” to end of March 2020 (TBC).
  Cash balance of £106.4m as at the end of March 2020.

1.1 The performance for the financial year 2019/20 is based on the M12 management accounts and post Month 12 accounting adjustments. The final position is subject to the external audit process. The risk ratings reported are subject to confirmation once the relevant returns have been submitted to NHSI.

1.2 Improvement against the previous control total forecast can be accounted for as a result of additional income received via the STP (£1,868k) in Month 12, and improvement in reserves assumptions relating to CQUIN payments resulting from national Covid-19 guidance to CCGs.

1.3 The overall net surplus is further improved as a result of an accounting adjustment relating to impairments (£1,007k).

2 Future income and contracting

2.1 The response to Covid has seen the usual contracting and performance reporting paused. In its place a temporary “block contract” arrangement has been put in place. Based on month 9 of 19/20 the Trust will receive a block payment equivalent to average income received at month 9 with a 2.8%. The Trust will still invoice other NHS providers for services provided.

2.2 These arrangements will be in place for the first 4 months of 20/21 at least. There is no efficiency element (financial viability/savings) required during these temporary arrangements.

2.3 The Trust will receive top up payments designed to ensure that the trust can meet a break even position during the period. This means that the Trust will still need to effectively manage income and expenditure to achieve this.

2.4 Covid-19 response and recovery cost are still to be claimed centrally on top of these block arrangements.

3 Summary of Performance to 31st March 2020

3.1 The financial performance is summarised in the table below:

	£m
Operating Income*	444.35
Operating Expenditure	(421.84)
EBITDA	**22.51**
Interest receivable	0.85
Interest payable	(2.31)
Depreciation	(7.24)
PDC	(6.00)
M12 Underlying Surplus/(Deficit)	**7.81**
Non-recurrent support	0.40
M12 adjustment	0.08
M12 Control Total Surplus/(Deficit)	**8.29**
2018/19 PSF	0.17
M12 reversal adjustment	(0.08)
M12 Surplus/(Deficit)	**8.38**
Impairment adjustment	1.01
2019/20 Surplus/(Deficit)	**9.39**

* Includes £1,868k additional income received via STP in Month 12. The Trust was required to show this as an improvement to the forecast outturn.

EBITDA – Earnings before Interest, Depreciation and Amortisation
PDC – Public Dividend Capital
PSF – Provider Sustainability Fund

3.2 The Trust has delivered a total surplus of £9.39m, including £3.32m PSF income (subject to audit).

4 Adoption of 2019/20 Accounts

4.1 The draft accounts will be submitted to NHS Improvement and our external auditors on 27th April 2020.

4.2 The draft accounts will be submitted by 11th May 2020.

4.3 The final audited accounts are expected to be presented to the Board for adoption on 25th June 2020.

5 Conclusions

5.1 The draft month 12 financial position, subject to audit, shows an overall surplus of £9.39m and a risk rating of “2”. The high agency expenditure against the Trust agency cap has meant the Trust cannot achieve a risk rating of “1” for 2019/20.

6 Risk

6.1 The Trust has an overall risk rating of “2”, based on the reported net surplus figures and other metrics.

6.1.1 The Financial Viability programme has a shortfall recognised in 19/20. Whilst there are plans in place to meet this shortfall in 20/21 this needs to be closely monitored to ensure this is met.

6.1.2 As part of the year end process the Trust Auditors assess the “going concern” basis of the Trust. In general this looks to satisfy the requirement that the Trust can predict with reasonable certainty that it has sufficient income and cash to undertake its business for the next 12 month period. Under usual conditions the Trust would have signed contracts with commissioners for at least the next year, guaranteeing income and cash in return for activity. Due to covid this process has been suspended and the NHS has resorted to a centrally determined block contract arrangement to the end of July 2020 with a view to extending this to the end of October 2020. NHSI are in the process of writing to Trusts and Auditors describing how Trusts are able to satisfy its going concern status under these conditions.

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

Chart 5.1 *Surplus(Trustwide – I chart)*

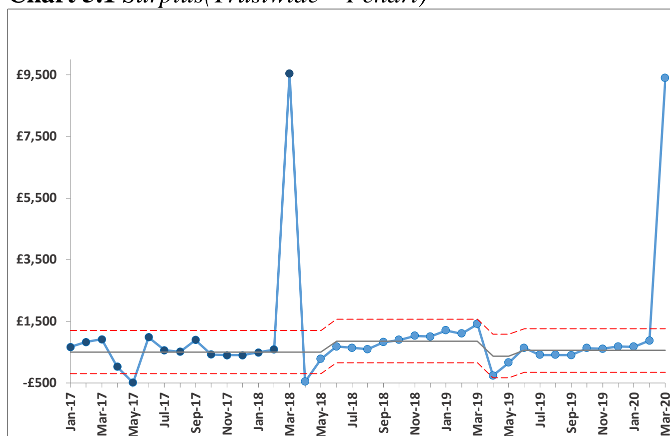


Chart 5.2 *Cash Balance(Trustwide – I chart)*

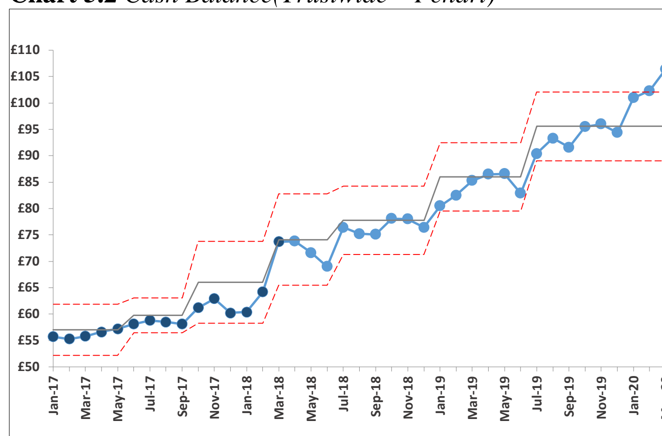


Chart 5.3 *Agency vs ceiling(Trustwide – I chart)*

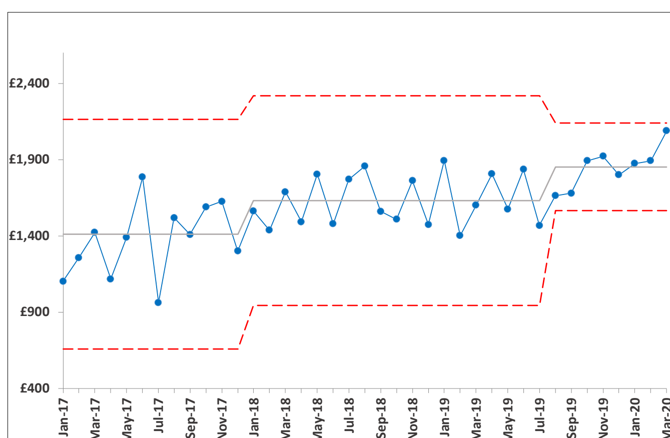
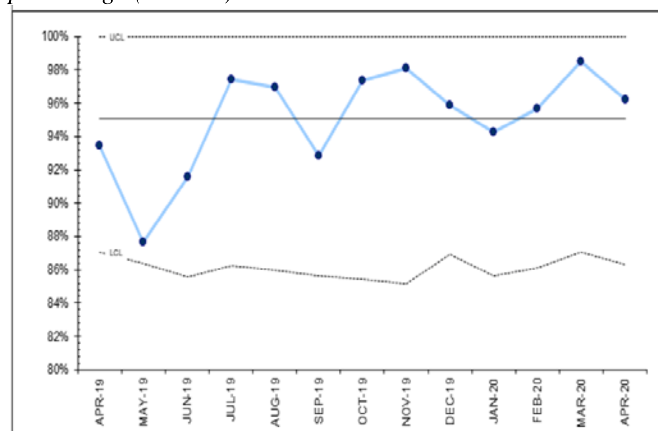


Chart 5.4 *The value of invoices paid within 30 days, as a percentage (P’chart)*



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		The Trust has an overall NHSI Risk Rating of "2".
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.