NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD: PUBLIC
3 December 2020

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

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

Summary of key issues

When looking at our safety indicators, the overall number of incidents, incidents resulting in harm, safeguarding referrals and Information Technology (IT) related incidents, remain stable. The rate of physical violence across our wards has shown signs of increase during August and September, before returning to normal levels in October. There has been improvement in terms of achieving follow-up contact within 7 days of inpatient discharge and follow-up within 72-hours remains stable. Pressure ulcers continue to be above normal levels and the number of unexpected deaths has shown signs of increase during September and October.

Our access and demand indicators highlight decreasing demand across accident & emergency mental health liaison and some inpatient services, and stable demand across community services. Access to our crisis mental health services remain responsive, with crisis presentations showing small increase in October. Waiting times for community mental health services and community health services are shorter now than prior to the pandemic. There has however been an adverse impact on waiting times for Psychological Therapy Services (PTS). PTS are starting to see a decrease in average waiting times from referral to assessment, but the waiting times for treatment continue to rise. The number of service users waiting for psychology assessment has started to increase in October due to the re-opening of City & Hackney PTS service. The number of people waiting for treatment has decreased since February and is currently stable. Our Improving Access to Psychological Therapy (IAPT) services have maintained performance, with referral activity back at 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.

Our staffing indicators highlight non-COVID related sickness and vacancy rates continue to remain low. Our experience and outcome indicators remain stable, showing that the number of complaints and Patient Advice and Liaison Service (PALS) enquires have remained 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 September 2020 is £9,786k compared to a planned operating surplus of £9,612k. The overall net surplus position amounts to 144k (0.1%) compared to a planned net surplus of target of 133k (0.0%). This is in line with the interim breakeven plan.

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

Improved patient experience	☒	
Improved health of the communities we serve	☒	
Improved staff experience	☒	

Improved value for money	☒	

Committees/meetings where this item has been considered

Date	Committee and assurance coverage
Various	Various sections of this report are submitted to the Service Delivery Board, Finance Business and Investment Committee and other Trust committees. Some of the performance information also submitted to commissioners and national systems.

Implications

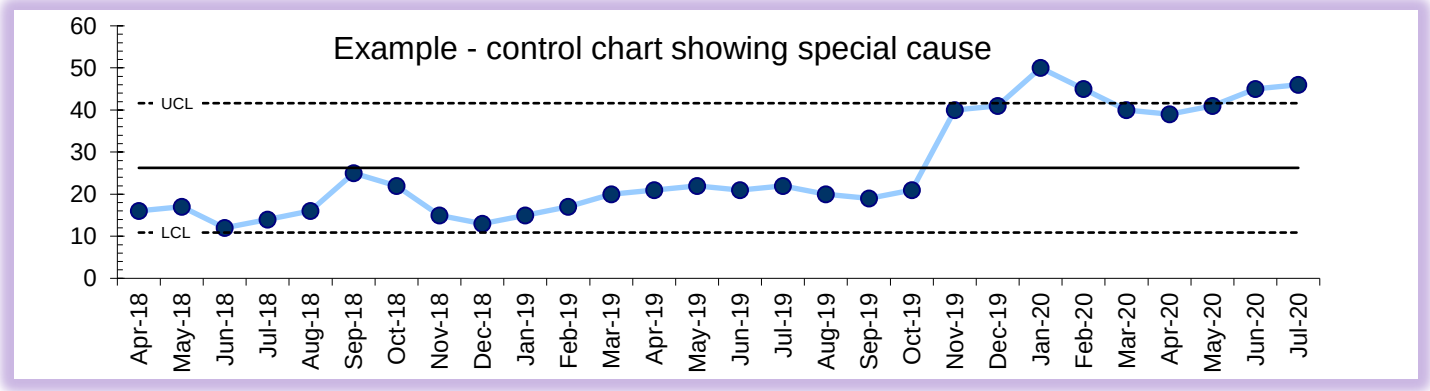
Impact	Update/detail
Equality Analysis	Some of the metrics in this report are designed to improve equalities by ensuring access to services and good outcomes. Analysis of the experience of different groups is undertaken as part of the Trust's inequalities work stream and population health task and finish group.
Risk and Assurance	This report and supporting appendices cover performance for the period to the end of October 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.

Introduction

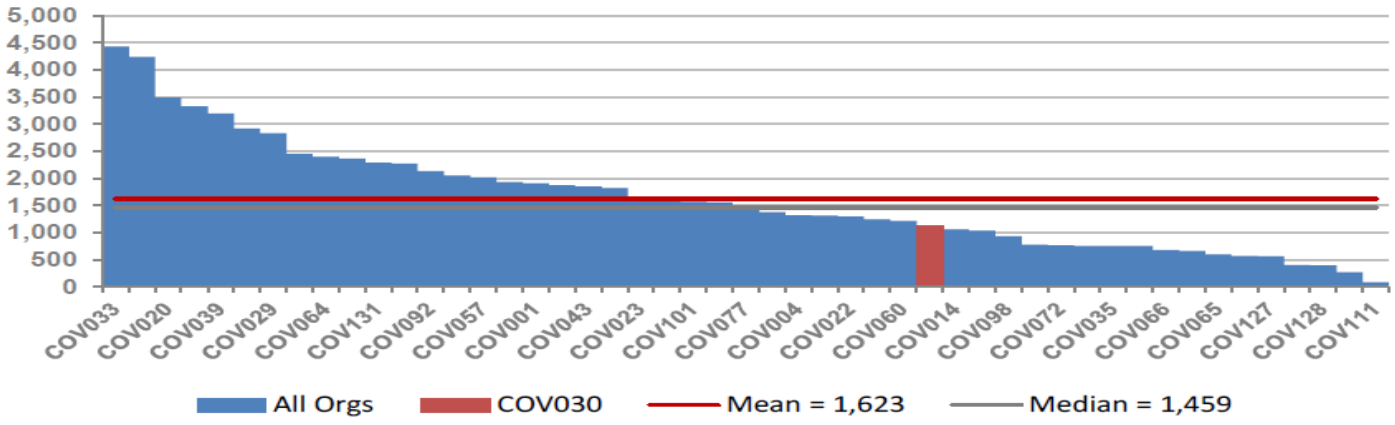
The Board integrated performance report has been adjusted during the Covid-19 pandemic to provide assurance to the Board on key performance indicators (safety, access and demand, experience and outcomes, people and finance) that have been agreed by the Board for monitoring during this period, as well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

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

- Charts demonstrating instability (based on signals of special cause on the chart) since the last Board report are highlighted with a purple glow effect, as shown below. Statistical process control charts, such as control 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.



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



1. Safety

The charts below demonstrate variation across a range of key safety measures. The overall number of incidents, incidents resulting in harm, IT related incidents remain stable.

The number of violence and aggression incidents across our inpatient services increased above normal levels during August and September, before returning back to the average in October. This increase was largely due to four young people on our adolescent inpatient ward (Coborn unit) in Newham and a few service users across our male adult intensive care (PICU) wards in East London, particularly in City and Hackney. The incidents at the Coborn unit related to several issues including non-compliance with medication, discharge issues caused by social care delays, and service users on the ward with complex mental health issues. The service manager for the inpatient service holds weekly incident reduction meetings where contributory factors are explored, and mitigation plans are developed and implemented. All plans are reviewed at monthly performance and quality meetings to monitor progress. The team are in the process of establishing a quality improvement project that will focus on staff value and respect, and this will include improving service user safety and care on the ward.

Violence and aggression incidents on adult PICU wards increased during August and September due to several acutely unwell service users, and those refusing to comply with enhanced measures to prevent COVID transmission. In City & Hackney, two service users accounted for most of the violence and aggression incidents. This was due to several factors including bed pressures, which meant that service users on the PICU could not move to general acute wards in a timely manner once they had stabilised. There were also some staffing gaps in nursing and ward psychology team which meant that some service users who could have benefited from psychological input were unable to receive support immediately. In addition, training sessions were organised for new starters on the ward to ensure they were fully aware of how to record and manage incidents, and this will have improved reporting practices during this period. However, in all incidents there was no harm reported to staff or service users, and all instances were deescalated promptly. Work is on-going to mange staffing pressures through daily safety huddles as part of the inpatient 'Time to Think' quality improvement programme.

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

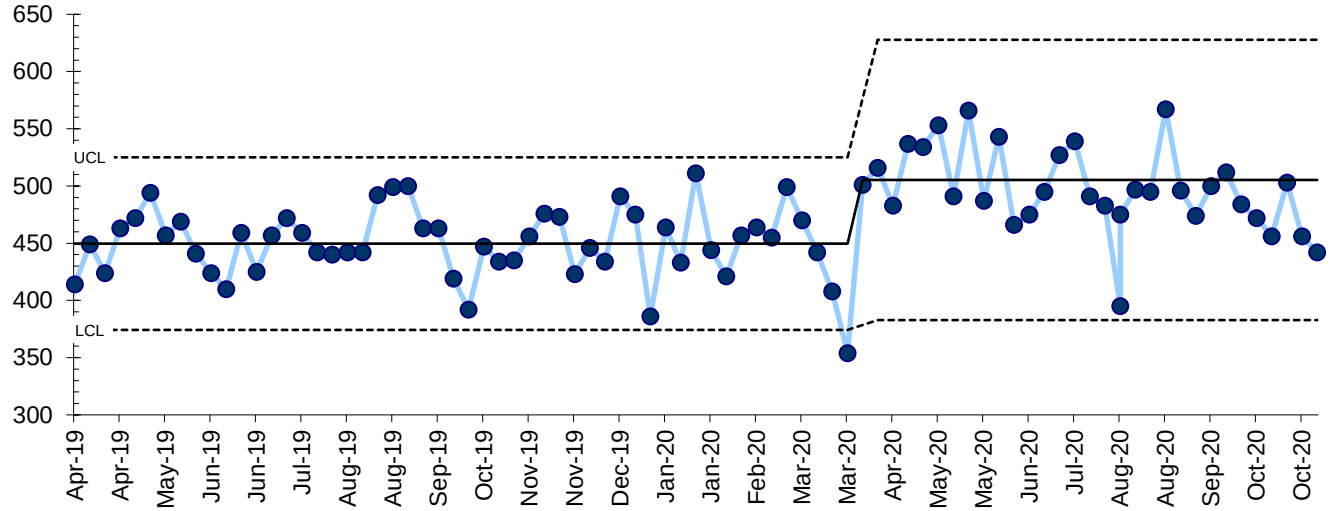


Chart 1.2 Percent of incidents resulting in harm (Trustwide – P chart)

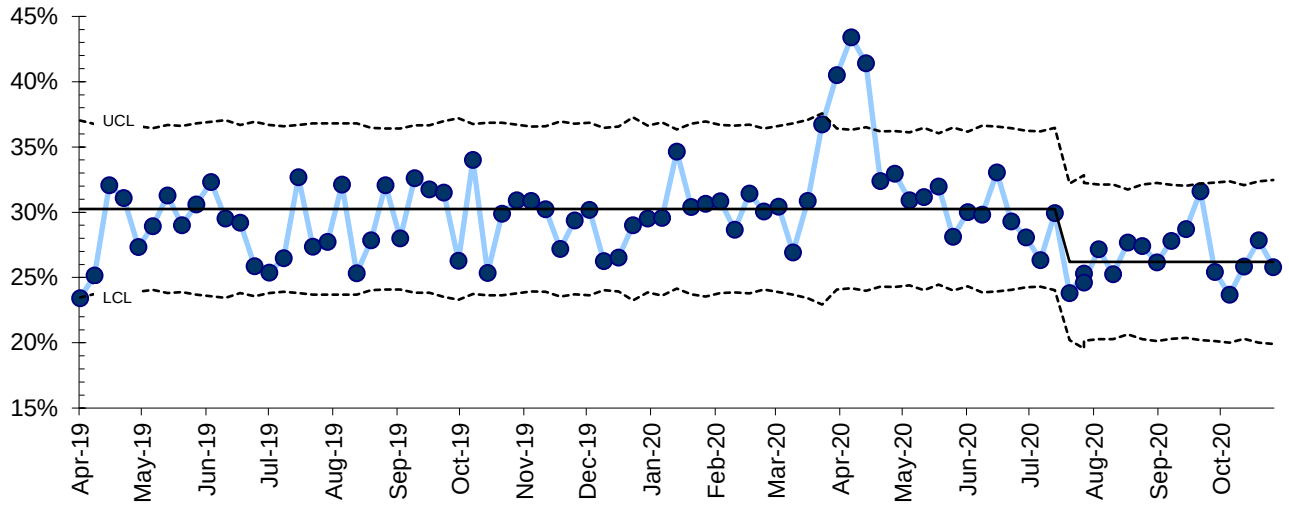


Chart 1.3 Rate of incidents of physical violence per 1000 occupied bed days (Trustwide – U chart)

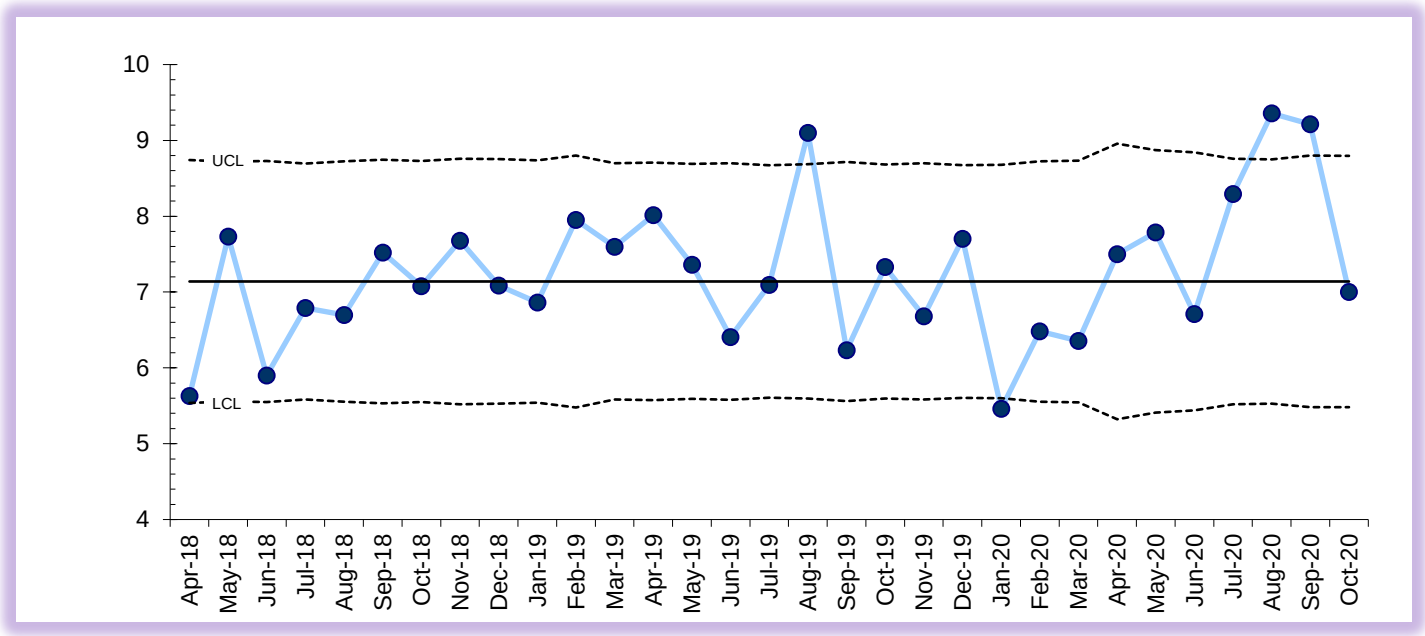
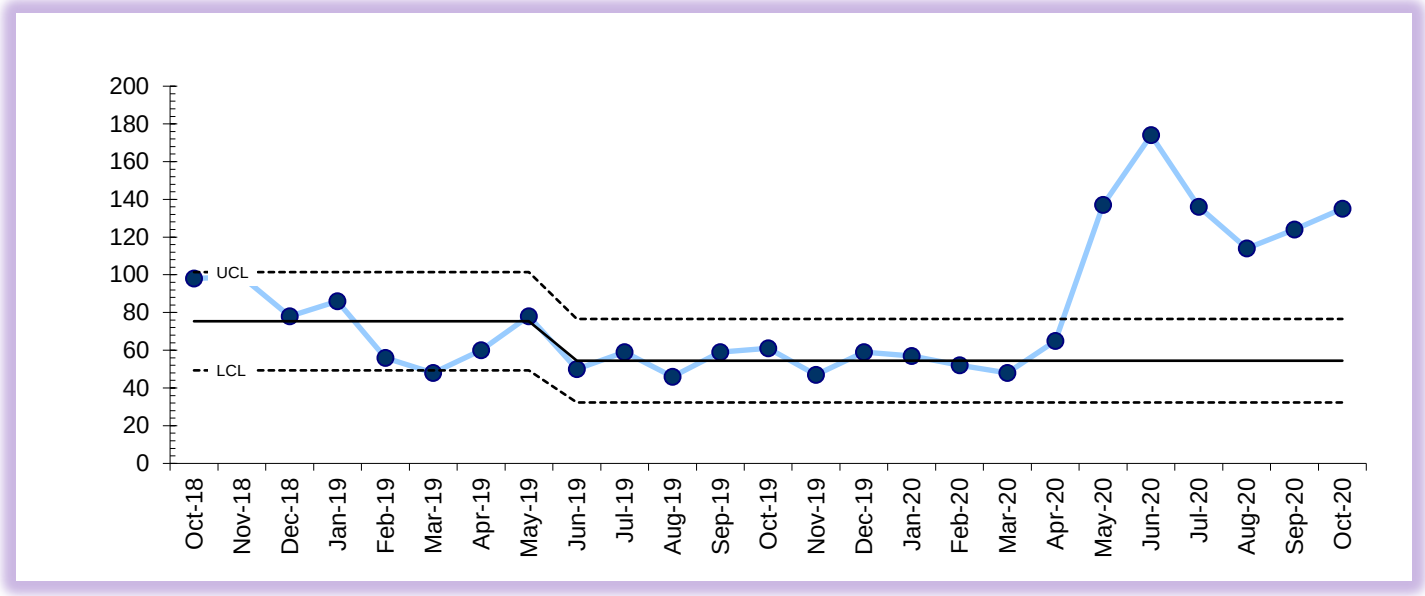


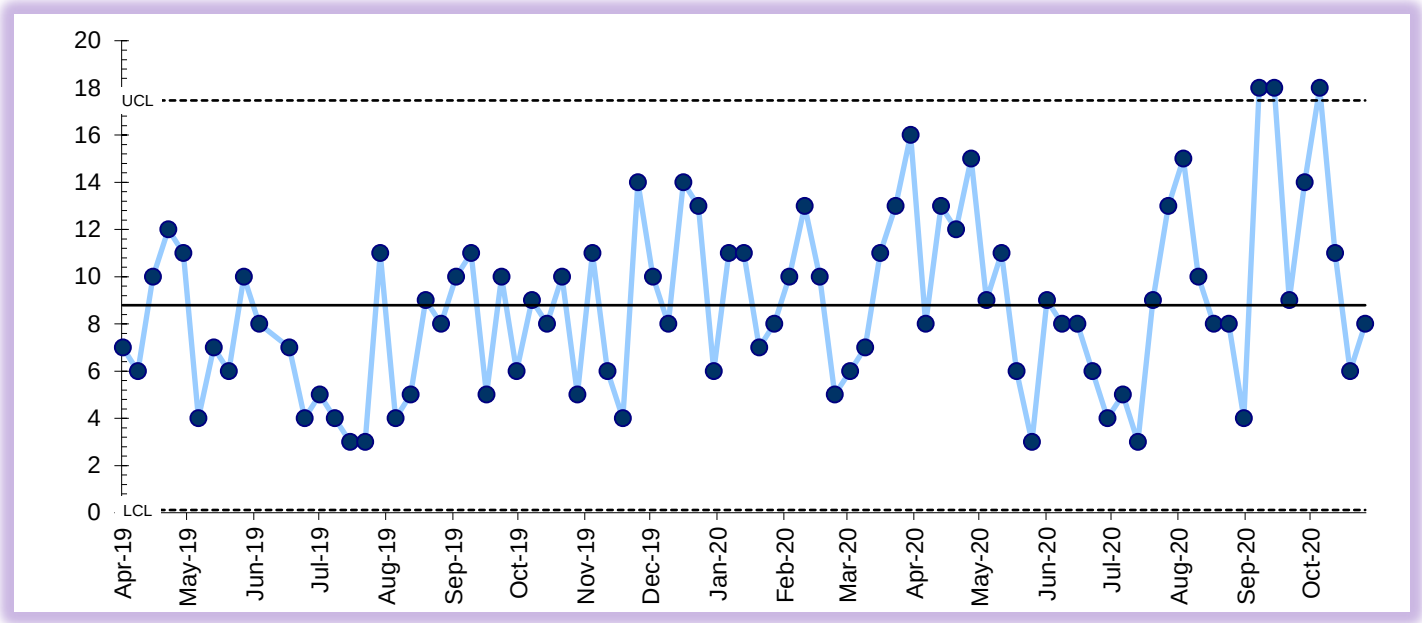
Chart 1.4 Number of Grade 2, 3 or 4 pressure ulcers (Trustwide - C chart)



The number of reported pressure ulcers continues to be above normal levels but has decreased from a peak of 174 cases in June to 135 cases in October. As highlighted in the previous report, figures have increased partly due to the inclusion of additional types of pressure ulcers (suspected deep tissue injuries) that have been included since June. Throughout phase one of the pandemic, it was difficult for staff to contact and engage with services users because of fears about the virus, and therefore there was less opportunity to conduct assessments to prevent the development of pressure ulcers. However, all teams across the Trust have worked hard to communicate to service users the importance of allowing nursing care to take place in the home, and we have slowly started to see a return to normal practices. This may have contributed to the reduction in cases.

District nursing teams are better placed for the second wave of the pandemic, through drawing on the learning and experiences over the past few months to create effective solutions. For example, during the acute phase of the pandemic when service users declined care it was just accepted by teams, whereas now teams have been trained to recognise that although service users have a right to decline care, staff also have a duty to positively encourage safe contact particular where potential risks are identified. They also realised that it was important to ensure that service users were aware of the consequences of declining care, such as the potential for pressure ulcers to deteriorate, which may lead to hospitalisation and further risks to well-being. In addition, teams learnt that some service users who were shielding were not mobilising as regularly, leading them to develop low grade pressure ulcers. In response to this, teams launched several preventative measures, such as establishing regular reminders and telephone contact with service users to ensure that they walked around in their home every 1-2 hours. Where service users remained at high risk, teams utilise a telehealth service and send out reminders via text message to monitor skin condition, exercise and activity levels, eating and drinking as well as keeping clean and dry.

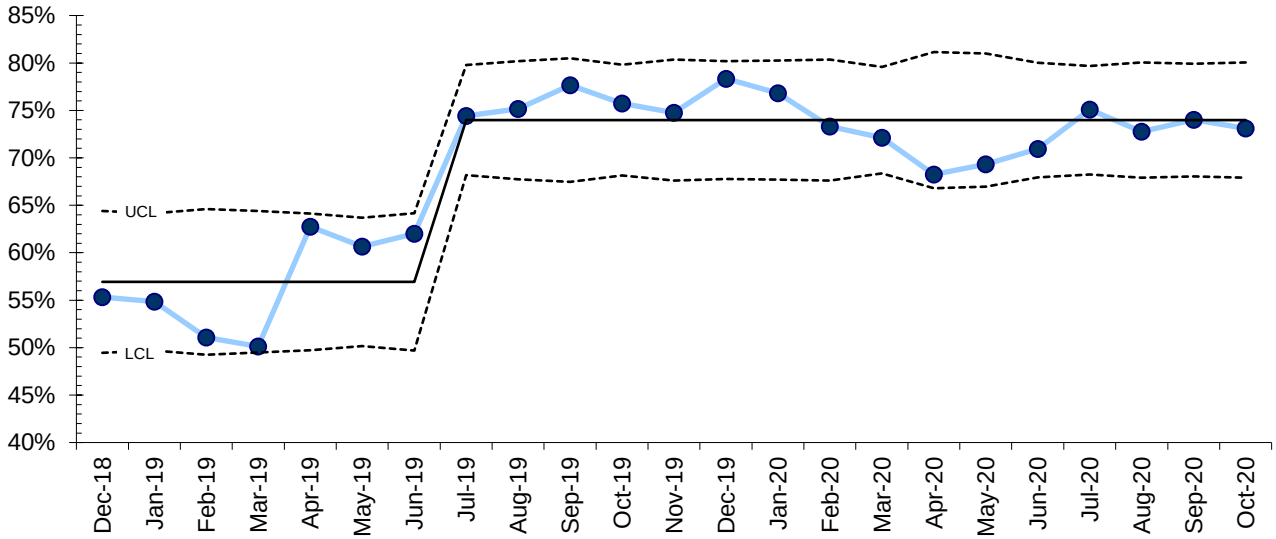
Chart 1.5 Number of unexpected deaths (Trustwide – I chart)



The number of unexpected deaths has shown signs of increase during September and early October. The outlying data points were community-related deaths, and on further review, they have been found to be expected and not relating to a patient safety incident. Only five deaths required further investigation under our Serious Investigation policy across Forensic, Bedfordshire and Luton, Newham and City Hackney mental health services during September and October. During this period there was an increase in foot health-related incidents, which are often due to a backlog of deaths that have been notified to the team. Foot health services in East London Community health services report incidents as unexpected, as at the time information about the death was received, it was not expected, and the deaths were linked to pre-existing illnesses with life-limiting prognosis or other medical conditions. There were also a few incidents that were duplicated and reported twice

by two different teams who received the same information at the same time. All unexpected deaths relating to mental health cases are escalated via the incident review pathway and overseen by a Medical Director with regard to any further investigations required. All deaths are monitored via the Trust's Learning from Deaths Committee which is chaired by a medical director.

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



The data above shows the Trust's compliance levels with post discharge follow-up care from inpatient mental health services. The data has been amended to include discharges from all adult and older adult wards, including Perinatal and Forensic inpatient services, to reflect recent changes to our national submissions. Chart 1.6 shows that service users being followed-up within 72 hours of discharge remains stable with 73.9% compliance.

Chart 1.7 shows that there has been an increase in 7-day follow-up compliance since June with performance reaching 85.9% in October. However, performance levels are currently below the national 95% target. Local audit of delayed follow-up highlight that the main factors relate to service users not engaging with multiple follow-up contacts offered within the designated timescale, some service users not having a telephone or alternative contact medium, and data entry errors by staff in recording positive contacts. As highlighted in previous reports, it is expected that this national standard will be replaced with the 72 hour standard next year.

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

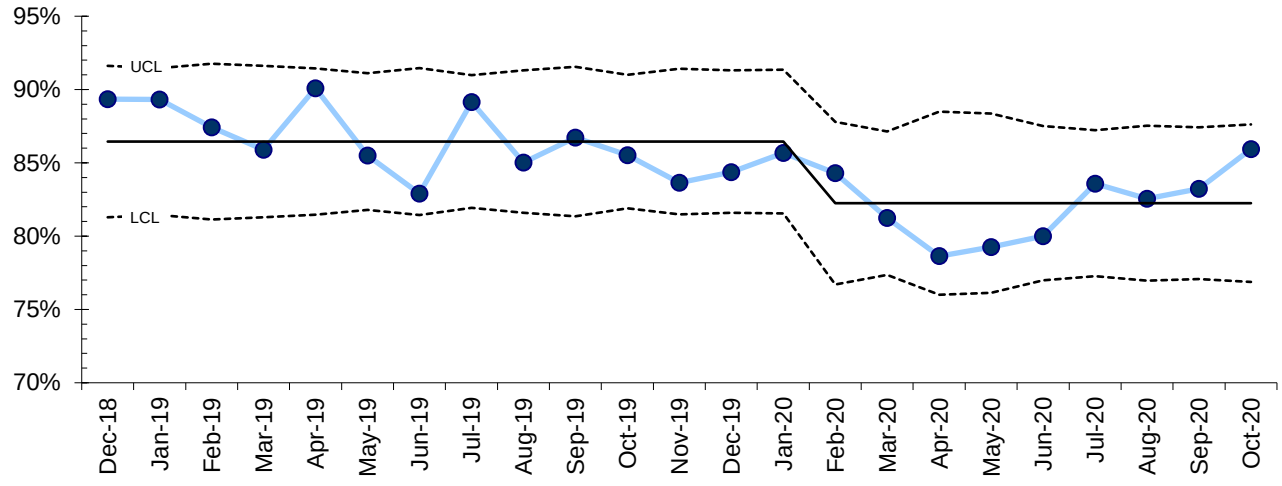
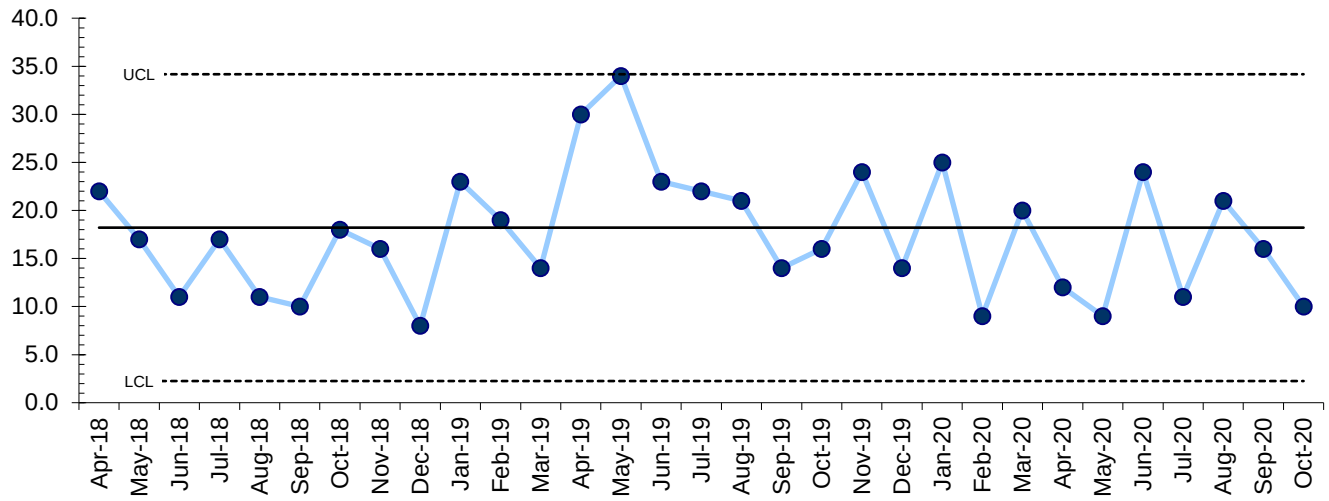
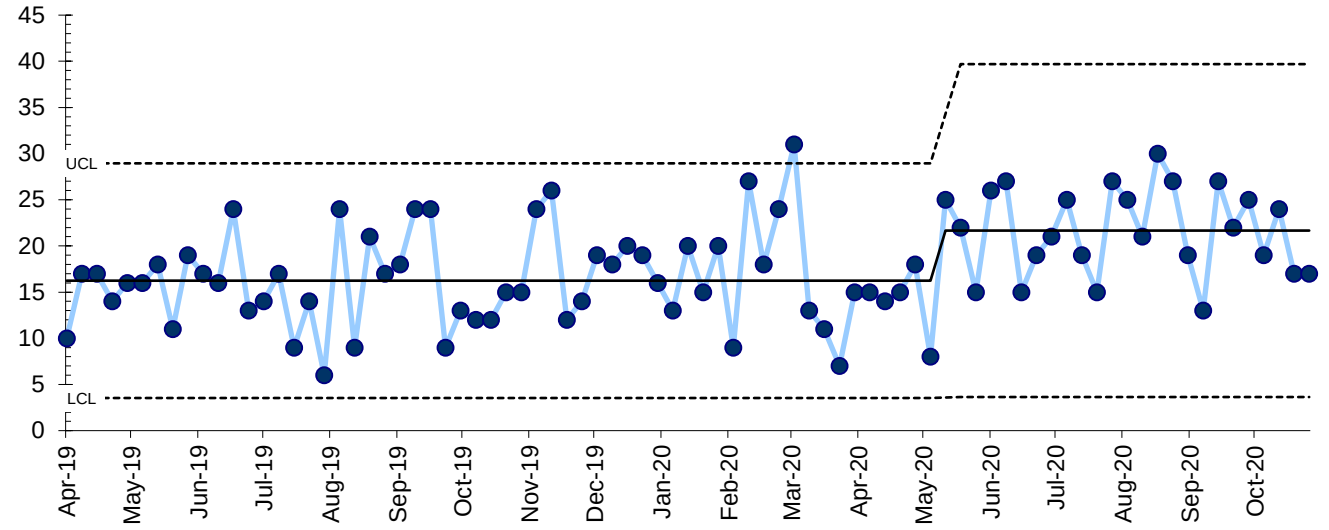


Chart 1.8 Number of reported IT or System access incidents (Trustwide –I chart)



The chart below highlights safeguarding concerns referral activity across the Trust. The data demonstrates that since May there has been an increase in the average number of concerns that were raised, from 16 referrals a week to 21. The number of safeguarding concerns is believed to have increased as more face to face contact took place with service users which resulted in more disclosures of abuse. Staff have reported seeing evidence of abuse during visits and consultations. The most frequently reported incidents of abuse relate to domestic abuse, self-neglect, and financial abuse. In terms of inpatient services, there has been increasing pressures on our wards and the use of health-based places of safety suites and increased involvement of Approved Mental Health Professionals (AMPH social workers) to carry out Mental Health Act assessments. Wards have reported having higher levels acuity on the ward, with more services users with complex needs resulting in more unsettled service users on the wards and concerns being raised.

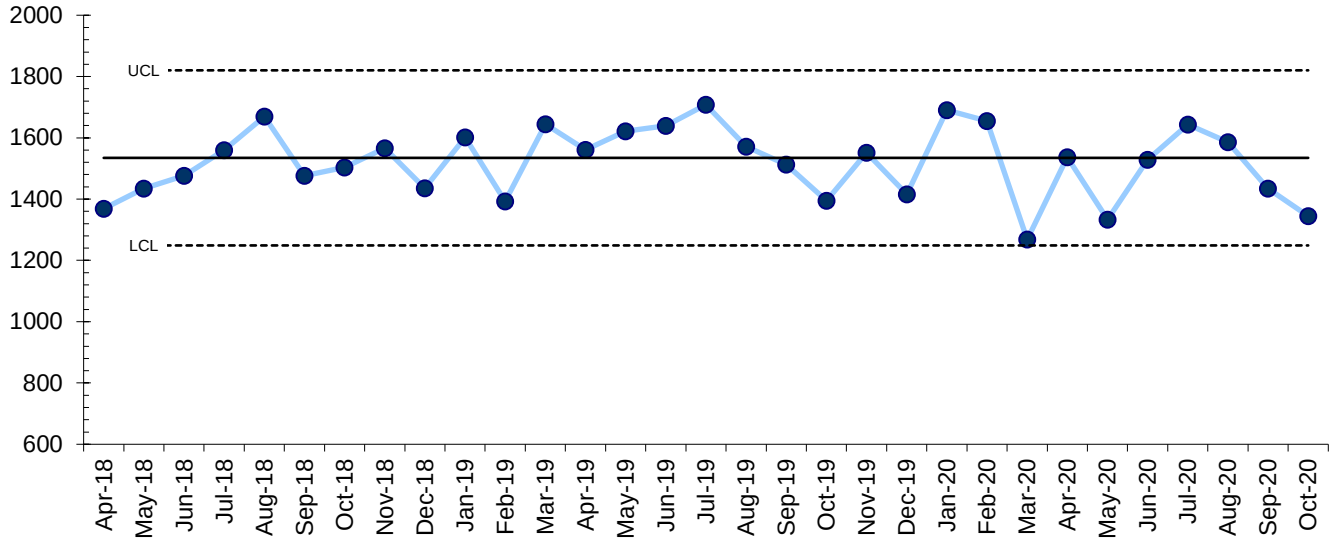
Chart 1.9 Number of safeguarding concerns referrals (Trustwide – I chart)



2. Access and Demand

The charts and narrative below provide assurance across a range of demand and access indicators. During August, September, and October there has been a slight reduction in admissions and inpatient occupancy levels across the Trust, and referrals to Accident and Emergency (A&E) mental health liaison services have remained stable.

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



Inpatient bed occupancy has decreased in October to 75.9% with the number of admissions also decreasing from 602 in July to 480 in October. Chart 2.2b shows that occupancy levels for adult mental health wards in East London continue to compare favourably to the national average with 78% occupancy compared to 91% nationally reported in September. In comparison, occupancy levels for adult wards across Bedfordshire and Luton remain consistently higher than the national average with 93% occupancy reported in the same period. The chart also shows that older adult mental health occupancy was below national average in East London and above the national average in Bedfordshire & Luton. However, bed pressures remain challenging, particularly in Bedfordshire & Luton where adult occupancy levels continue to move higher during October. This has meant that some Bedfordshire & Luton service users have been admitted to East London sites due to capacity issues. In addition, East London adult mental health bed capacity has been reduced over the past few months as a result of the agreement with our local Sustainability and Transformation Partnership (STP) to support North East London Foundation Trust (NELFT) with their bed capacity, particularly during a recent COVID outbreak on their wards. This resulted in additional NELFT service users being placed onto our wards in Newham during October.

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

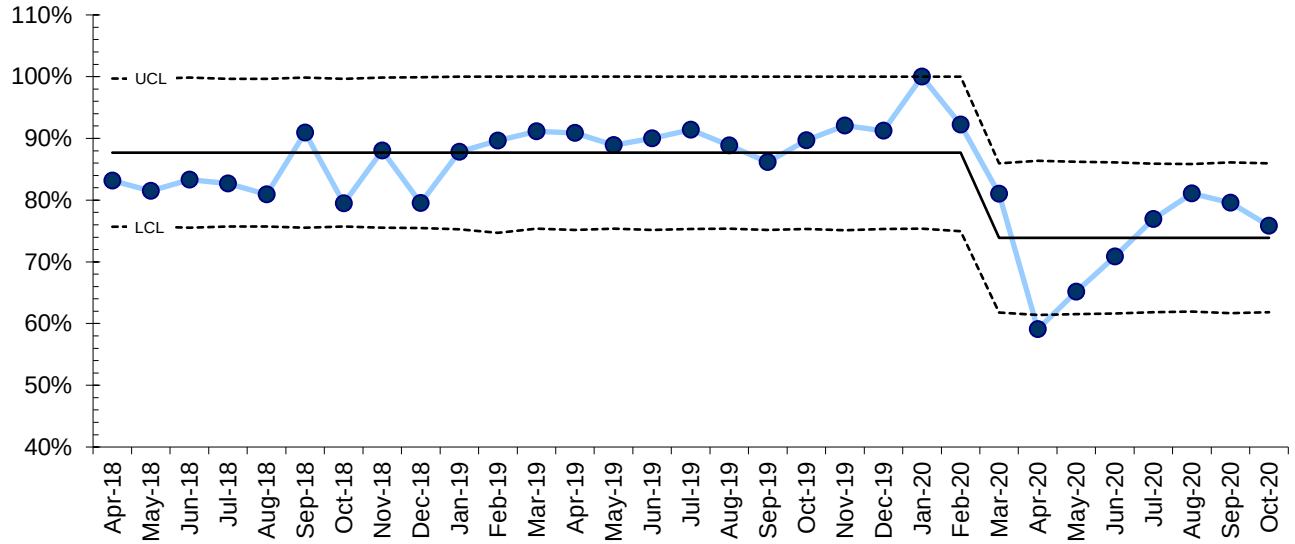
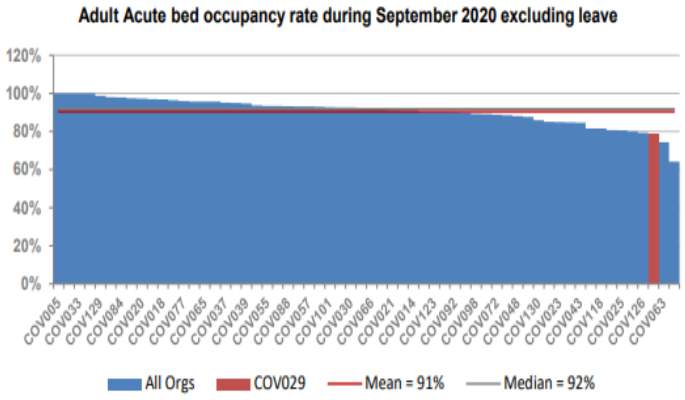
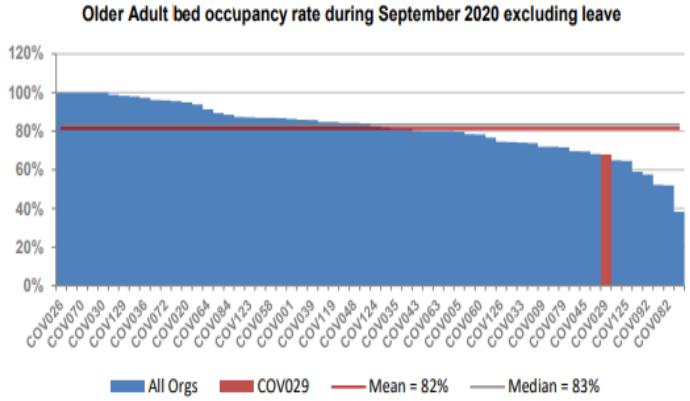


Chart 2.2b - National Mental Health Inpatient Occupancy (Source: *National Mental Health Benchmarking Network – September 2020*)

East London

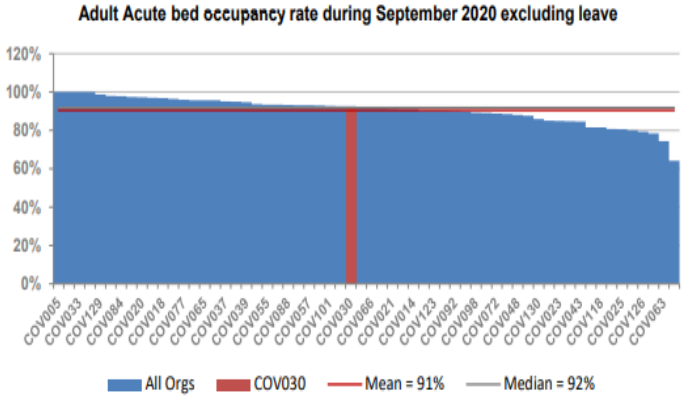


	2018/19	Sep-20	Change
National average	93%	91%	-2%
COV029	88%	78%	-11%

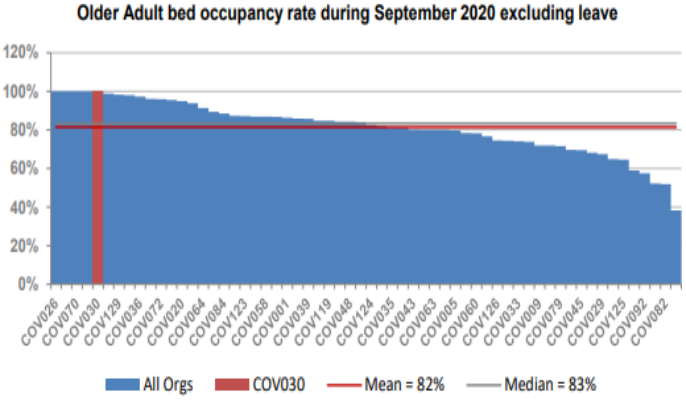


	2018/19	Sep-20	Change
National average	86%	82%	-5%
COV029	78%	68%	-14%

Bedfordshire and Luton



	2018/19	Sep-20	Change
National average	93%	91%	-2%
COV030	88%	93%	6%



	2018/19	Sep-20	Change
National average	86%	82%	-5%
COV030	95%	100%	6%

Chart 2.3 and 2.3b below, highlight the number of adult mental health admissions is higher than the national average of 16.5 admissions per 100,000 population as reported in September. This reflects the increasing pressure mental health inpatient services are starting to experience, particularly from female, brand-new admissions and increase in the level of acuity on our wards during past few months. There has also been an increase in formal admissions during August and September across most boroughs. This position is reviewed frequently in local bed management meetings and as part of the Mental Health Silver Command groups. All inpatient services are currently undertaking a review of recent admission activity to identity themes and wider factors that are contributing to the increase in demand, so that a plan can be formulated in each locality to support admission avoidance, inpatient flow and system resilience. It is believed that one of the contributory factors leading to rising admission numbers is reduced face-to-face contact offered by community services and reduced engagement between service users and services since social distancing measures were put in place. As a result, guidance has been issued through the Covid-19 clinical workstream to support teams and staff to ensure that the most appropriate method of contact is chosen.

To mitigate the risks of potential Covid-19 outbreaks on our inpatient wards during the coming months, services have drawn up local plans and identified key trigger points which will prompt the implementation of dedicated Covid-positive wards to contain spread of the virus. Trustwide guidance has been issued to support continued visits from carers and family members on our wards, with protocols such as pre-booking, temperature checks, wearing of PPE and maintaining social

distancing measures. Bedfordshire & Luton have created a triage ward for all admissions to adult acute wards allowing services to identify and promptly discharge service users who do not need a mental health intervention.

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

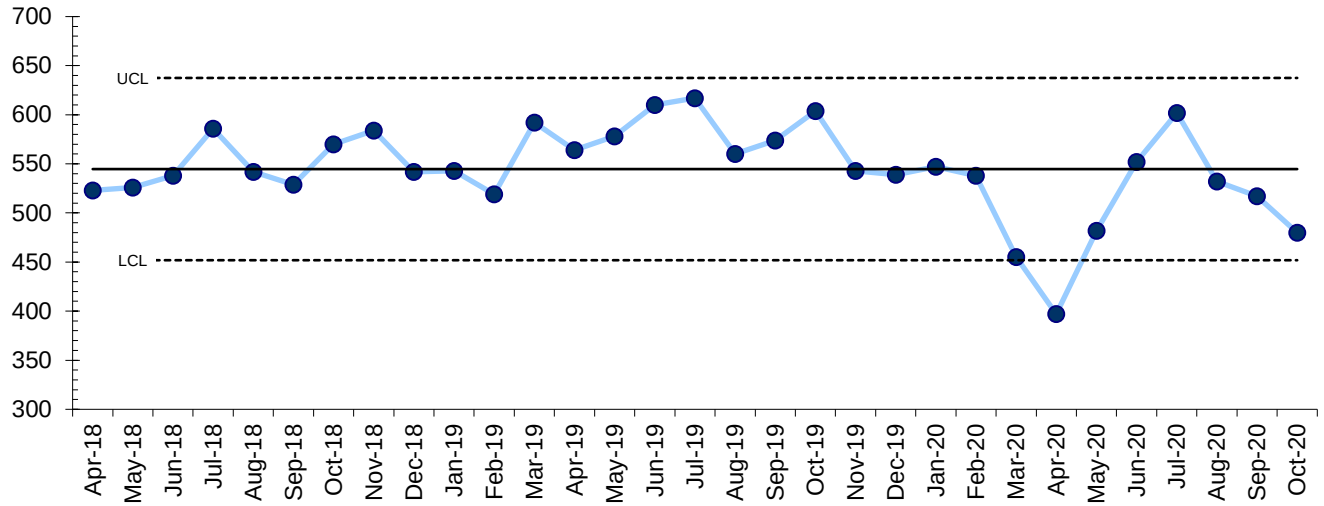
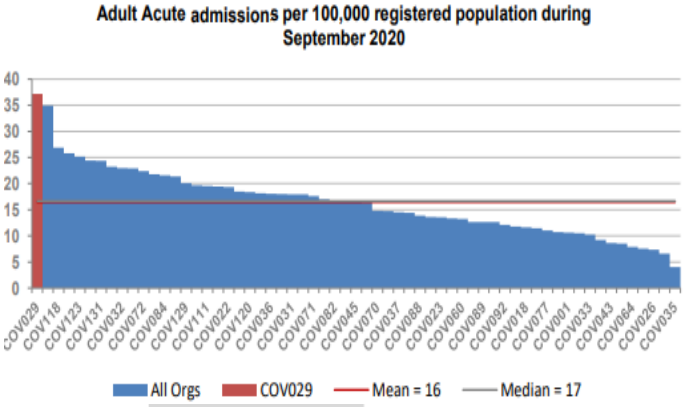
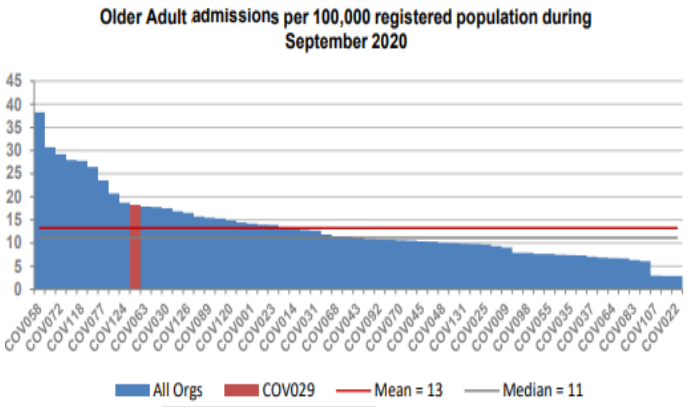


Chart 2.3b - National Mental Health Inpatient Admission Activity (Source: *National Mental Health Benchmarking Network – September 2020*)

East London

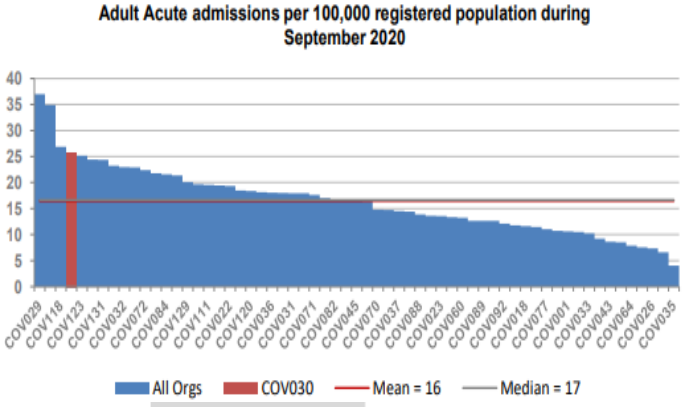


	2018/19	Sep-20	Change
National average	18.9	16.5	-13%
COV029	39.3	37.0	-6%

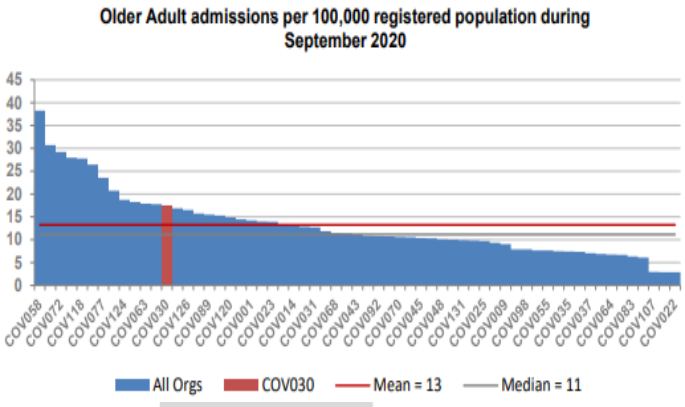


	2018/19	Sep-20	Change
National average	14.3	13.2	-7%
COV029	25.0	18.3	-27%

Bedfordshire and Luton



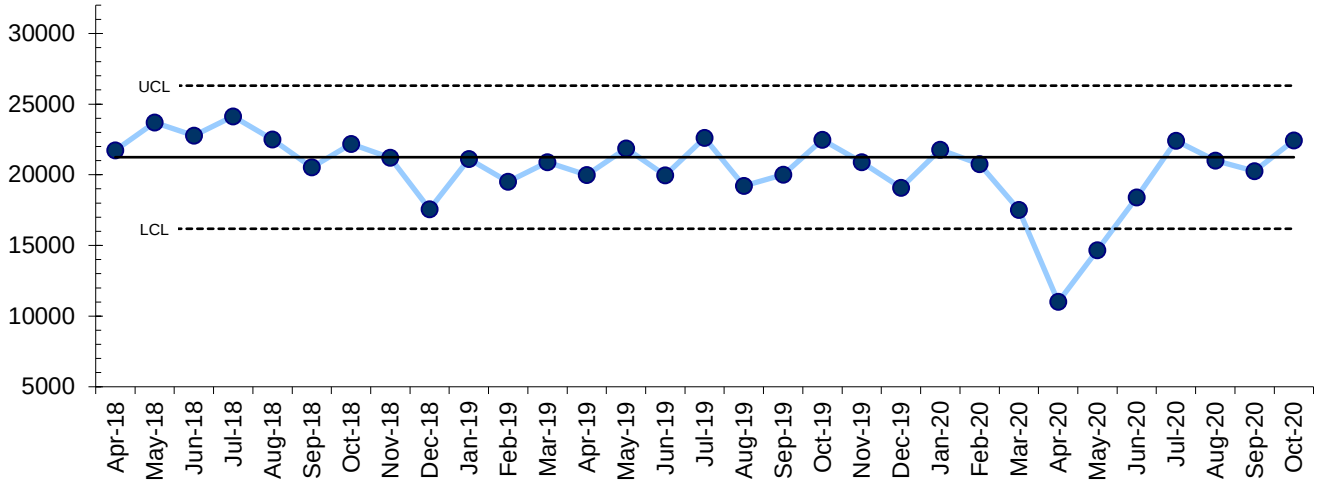
	2018/19	Sep-20	Change
National average	18.9	16.5	-13%
COV030	22.9	25.8	13%



	2018/19	Sep-20	Change
National average	14.3	13.2	-7%
COV030	12.2	17.5	44%

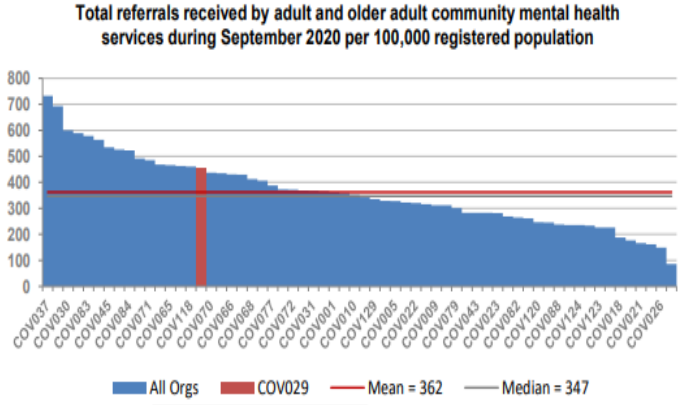
Referrals to Mental Health and Community Health Services have increased to pre-Covid levels and remain stable. Chart 2.4b highlights national referral data for Mental Health and CAMHS services, which suggests that the increase in adult referrals is higher in East London and Bedfordshire and Luton compared to the national average. CAMHS referrals are also higher than national average in Luton and Bedfordshire and lower in East London.

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

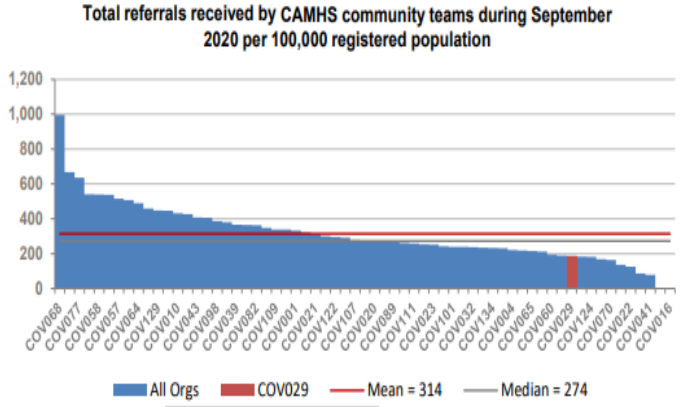


2.4b -Total referrals received by adult and older adult community mental health services and CAMHS (Source: *National Mental Health Benchmarking Network – September 2020*)

East London

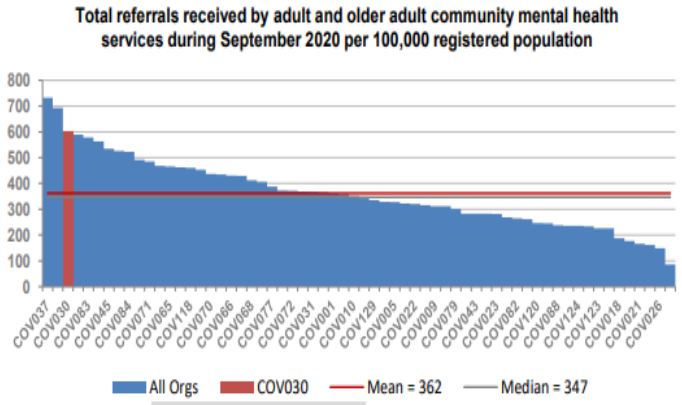


	2018/19	Sep-20	Change
National average	407	362	-11%
COV029	480	453	-6%

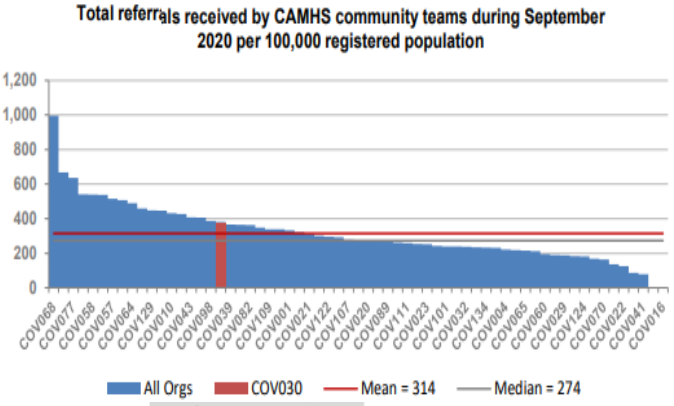


	2018/19	Sep-20	Change
National average	301	314	5%
COV029	198	187	-5%

Bedfordshire and Luton



	2018/19	Sep-20	Change
National average	407	362	-11%
COV030	411	600	46%

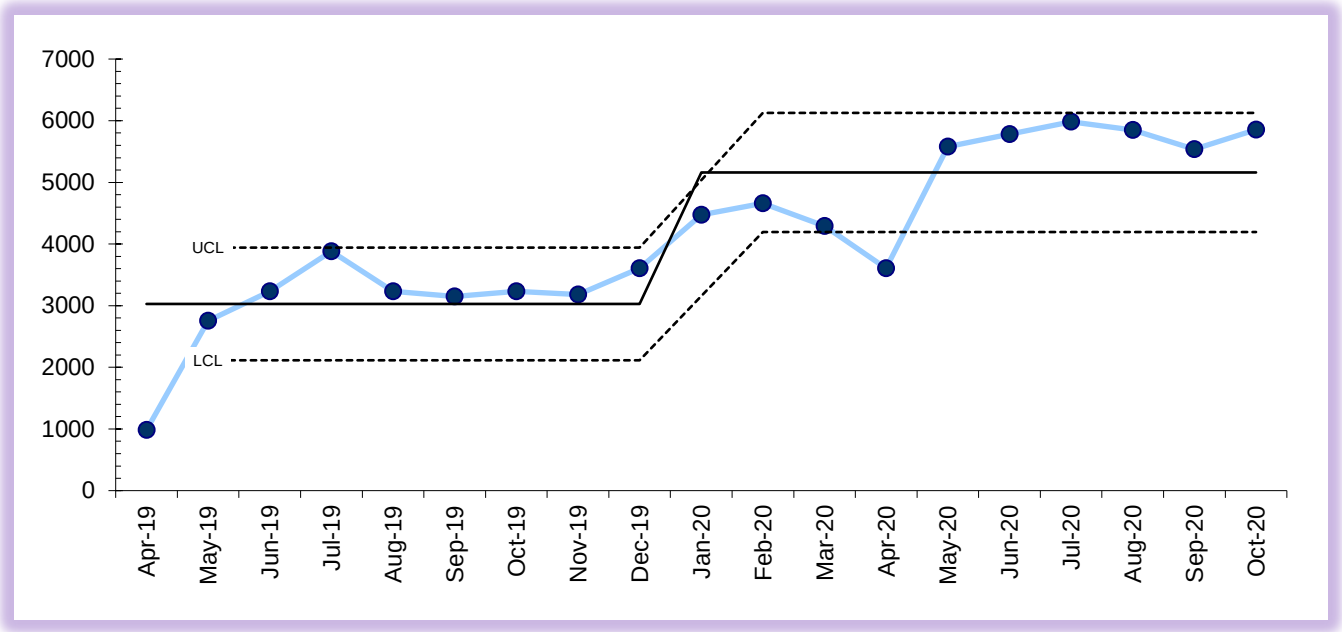


	2018/19	Sep-20	Change
National average	301	314	5%
COV030	342	380	11%

Mental Health Crisis pathway

Chart 2.5 below highlights activity across our mental health crisis lines. During the past few months, the number of calls has largely remained stable with most services are showing a small increase during October. City & Hackney routinely has the highest activity with 2,461 calls in October followed by 1,778 calls in Newham, 897 calls in Tower Hamlets, and 716 calls in Bedfordshire and Luton. As highlighted in previous reports, teams have put in place initiatives to manage this demand. All services continue to report an increase in the number of calls from service users not known to the Trust presenting for the first time to mental health services with psychotic symptoms. Some services have reported a reduction in calls from the NHS 111 service transferring calls to the crisis line. Other services have also started to receive a steady increase in calls from Police and London Ambulance Service (LAS), and calls from service users who cannot contact their community teams out of hours. The number of frequent callers to the crisis line accounts for at least 20% of total activity in each service. There has also been an increase in the number of crisis calls during working hours as well as out of hours, and most services have seen an increase in presentations related to Covid anxiety, bereavement and social isolation.

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



Access to Services and Future Demand Management

The average waiting time for assessment in CAMHS, Adult and Older Adult community mental health services has continued to decrease below normal levels, reaching an average of 18.1 days in October. This data is based on waiting times for service users who have been seen. There are also service users who, for different reasons (cancellations, non-attendance, service user preference or other clinical reasons), have not yet been seen and are waiting for initial contact/assessment.

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

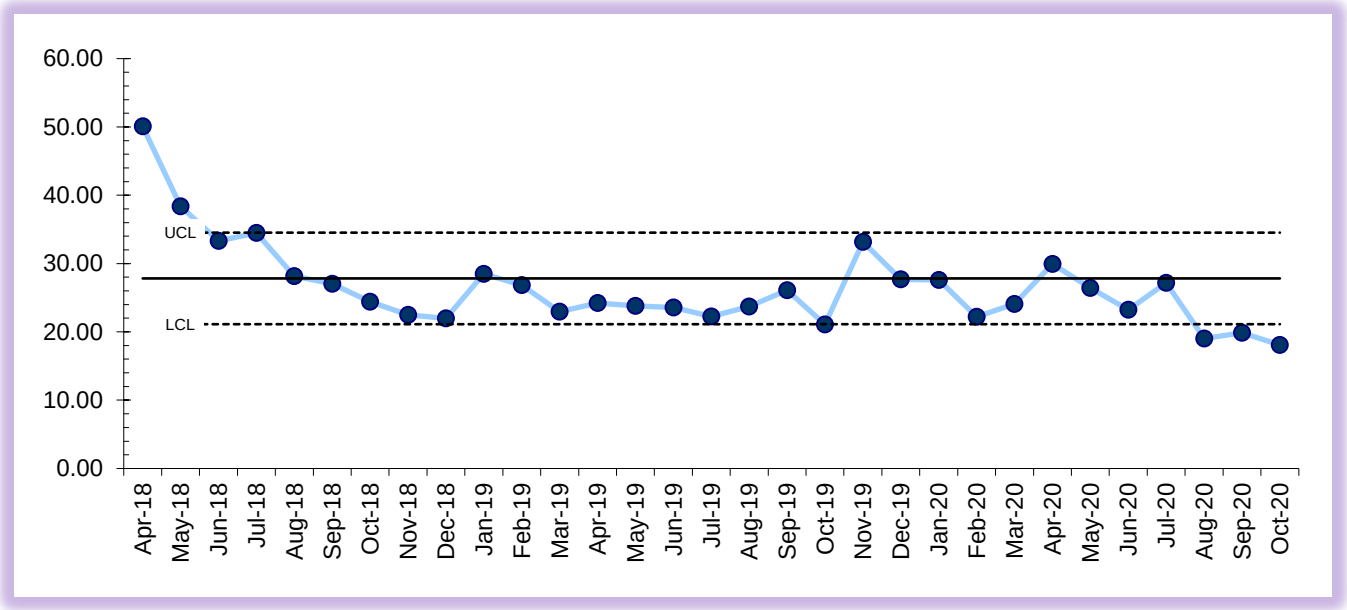


Chart 2.8a Average waiting times for patients referred who have not yet been seen for assessment – as at 31 October (CAMHS, and adult Mental Health community teams – I chart)

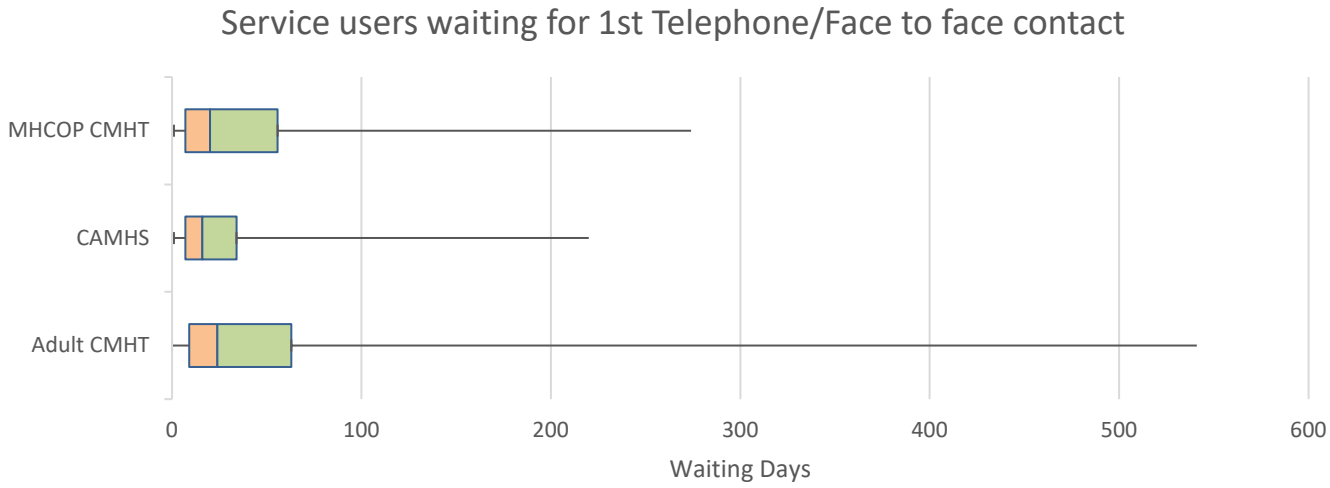


Chart 2.8a above shows that the median waiting time for service users still to be seen is currently 39 days in adult community mental health, 37.5 days in older adult community mental health, and 18 days in child and adolescent mental health services. Service leads have conducted local audits of the longest waiters which has highlighted data quality issues caused by referral not being closed correctly on our clinical system. This is being addressed through data cleansing exercises by administration and performance staff. In other instances, long waits have been due to service user choice or non-engagement, or repeat cancellations, or pending transfers to other internal teams, and some service users who are placed out of borough in adult community mental health teams and only require annual placement reviews. Teams have local reports in place to monitor all service users who are waiting for initial assessment, which local performance managers and administration leads are using to ensure appropriate action is taken to re-schedule appointments as necessary.

All community services are anticipating further increases in referral activity and have responded to this by putting in place a range of measures to ensure that they are able to effectively manage potential increase in demand or a second wave of the pandemic. In Mental Health services this has involved a thorough review of current caseloads across community teams, particularly

focusing on long length of stay cases within care coordinated and outpatient settings. All community teams have also continued to prioritise caseloads to identify service users who are most at risk during the next wave of the pandemic. This process has largely been a manual process, documented on local spreadsheets or electronically on separate shared team folders. However, performance colleagues are in the process of designing an electronic solution within our clinical system which will make information readily available for reporting and analysis and allow information to be shared and updated as part of routine clinical record keeping. This will help team mangers to identify trends and themes and allow them to act more effectively.

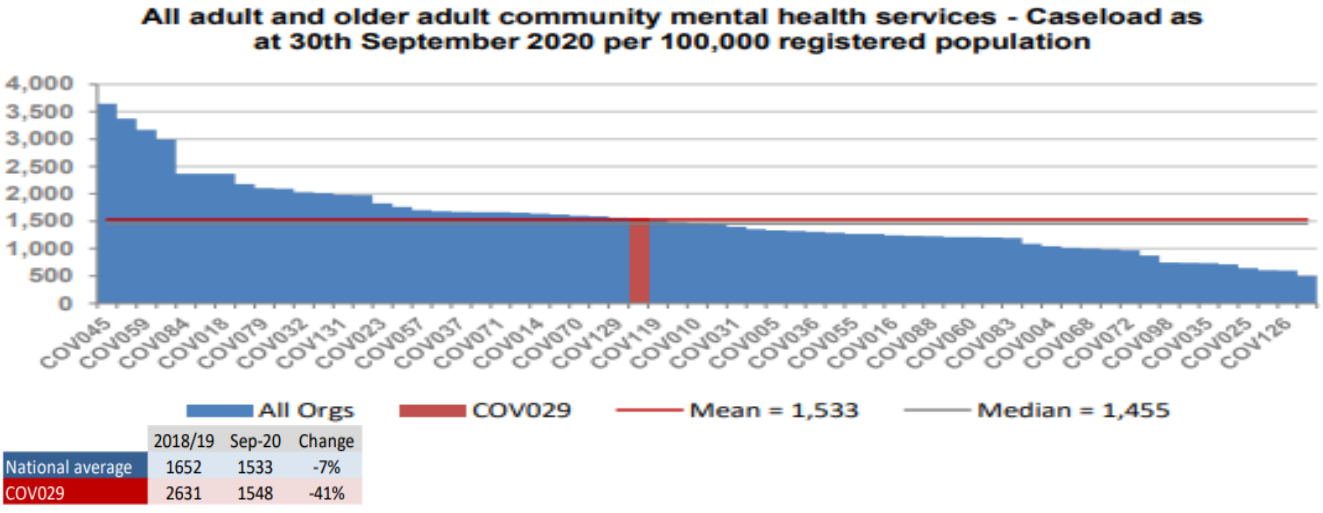
In Bedfordshire and Luton Mental health, each service pathway (Community, Learning Disabilities, Inpatients, Crisis) has set up a bronze command structure which meets regularly to review performance, discuss possible problems and act together to resolve issues so that the directorate can continue to deliver high quality care safely. These groups also review staff wellbeing and escalate concerns and issues to silver and gold command. Services have prioritised three key areas for staff: rest space/staff rooms, reflective practice and buddying across teams. Teams have established a Staff Wellbeing Group which is developing a staff survey to hear from staff what support they feel would be beneficial, as well as thinking about new ways to keep our staff well.

As highlighted in previous reports, Community teams have also been focusing on actively stepped down service users into enhanced primary care teams, or new Primary Care Network (PCN) pathways that have started to be piloted in Mental Health Services in East London as part of NHS England's Long Term plan to improve mental health service provision in the community. This is supporting services to reduce current caseloads and increase capacity to manage new referrals, as well as supporting existing service users with their recovery journey by offering more tailored care closer to home.

Chart 2.8b highlights that national average caseload size is 1,533 service users per 100,000 population for community Mental Health services. Overall, East London and Bedfordshire and Luton Mental Health services have similar average caseload sizes with 1548 and 1448 service users respectively per 100,000 population. This suggests that there may be further opportunities across all services to support service users to transition back to primary care and receive care closer to home.

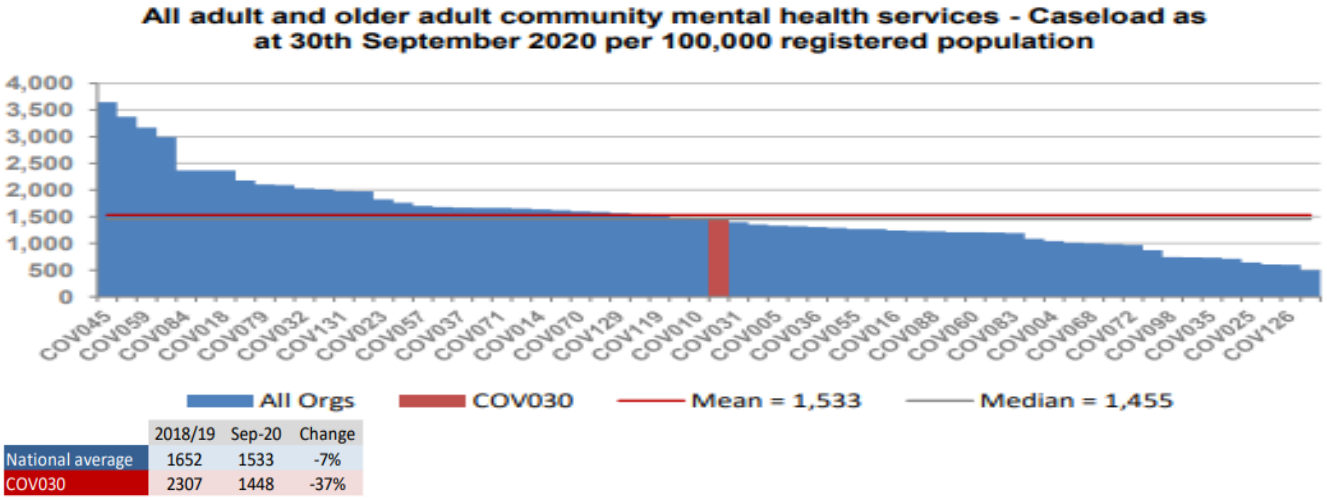
Chart 2.8b. National Mental Health Caseload sizes - adult and older adult community mental health and CAMHS services (Source: *National Mental Health Benchmarking Network – September 2020*)

East London



	2018/19	Sep-20	Change
National average	1652	1533	-7%
COV029	2631	1548	-41%

Bedfordshire and Luton



	2018/19	Sep-20	Change
National average	1652	1533	-7%
COV030	2307	1448	-37%

Much of the work around enhancing the primary care offer for mental services is currently underway. The pandemic has accelerated the shift towards integrated care and supported the development of new partnership models with local authorities, GP practices, third sector and voluntary sector organisations, commissioners and healthcare providers. As part of this transformation, new staffing resources including Community Connectors across East London are now in place, as part of community mental health transformation programme, along with new forums such as blended multidisciplinary care team huddles to review the needs of service users and to organise resources for their care in new ways that were not available previously.

This work has also involved maximising the potential of digital consultation solutions across assessment and treatment pathways, offering face to face contact where clinically appropriate. This means that staff can work more flexibly from different locations, including home or different Trust sites to maintain workforce capacity. There are still estate challenges experienced by the teams in terms of balancing social distancing measures and offering sufficient capacity to staff and service users to attend office sites in person. This is due to limitations on the number of staff or service users that can be on the premises at any one time. Services continue to stagger attendance times for clinics and are working with partners to maximise the use of all available estate facilities to help offer more face to face contact opportunities for contact closer to home.

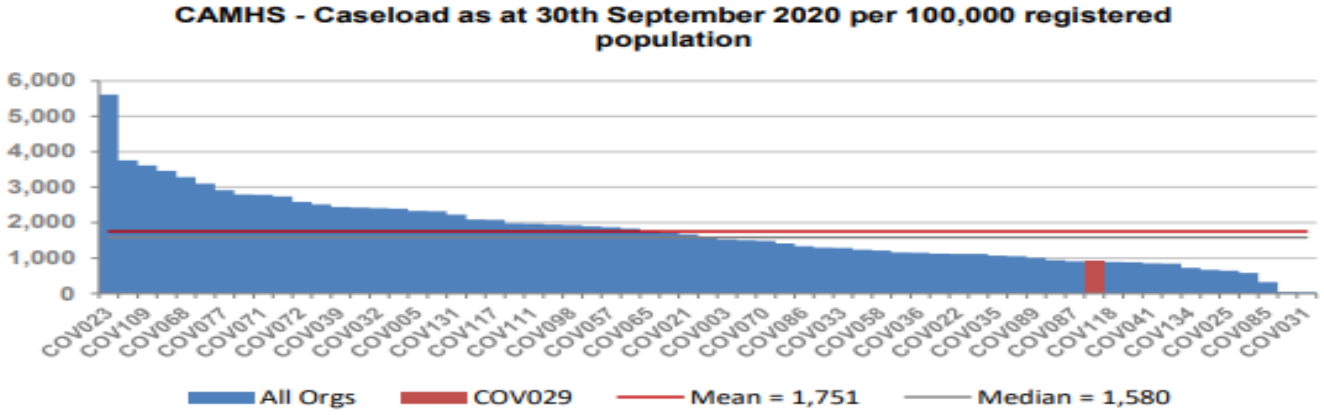
CAMHS services are seeing a surge in referrals since schools reopened in September, particularly referrals to Crisis teams and Eating Disorder services. During the lockdown period, teams focused on reducing waiting lists and caseload sizes. This is reflected in chart 2.8c below, which shows that CAMHS services caseload sizes are below the national average of 1,751 service users per 100,000 population.

Services are also seeing pressure on CAMHS Tier 4 (inpatient beds) nationally, which puts pressure on young people presenting in need of admission, pressure on A&E and paediatric teams in acute hospitals. Services have recently secured additional funding to support crisis teams in Bedfordshire and Luton and East London, which will help to mitigate some of the pressures experienced by teams.

All CAMHS teams have been opened to self-referrals and crisis services have expanded to 7 day working as part of the all-age 24/7 Crisis Services in each borough. Link workers to schools were set up and the reach of services was extended by publishing podcasts developed by service users and clinicians. Communication has gone to all schools setting out the standard offer for schools in each area. The offer will be stepped up following discussions with schools, including how to access CAMHS support, training, webinars, videos and newsletters.

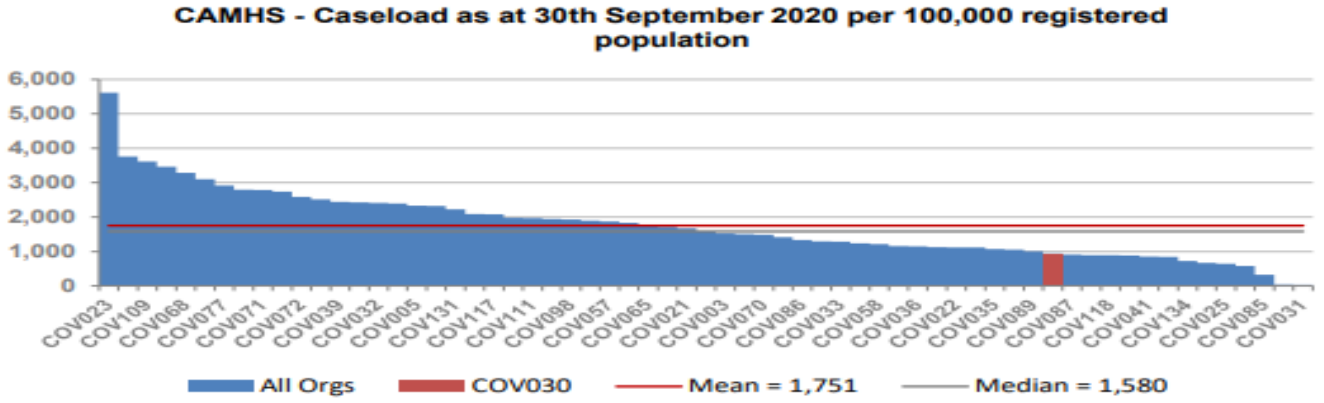
Chart 2.8c. CAMHS National Caseloads Sizes (Source: *National Mental Health Benchmarking Network – September 2020*)

East London



	2018/19	Sep-20	Change
National average	1890	1751	-7%
COV029	1429	893	-38%

Bedfordshire and Luton



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

Community Health district nursing services in Bedfordshire and East London continue to maintain rapid response to referrals despite staffing challenges caused by the pandemic and redeployment of capacity to support discharge from acute hospitals. The increase in waiting times during September across Bedfordshire related to staff sickness and self-isolation once children returned to school which reduced the capacity within the team to complete assessments in a timely manner. In East London, there was a similar increase in waiting times during October and this related to five service users and data quality issues. All five service users were seen within two days of the referral but had been incorrected linked to the wrong referral on the system.

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

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

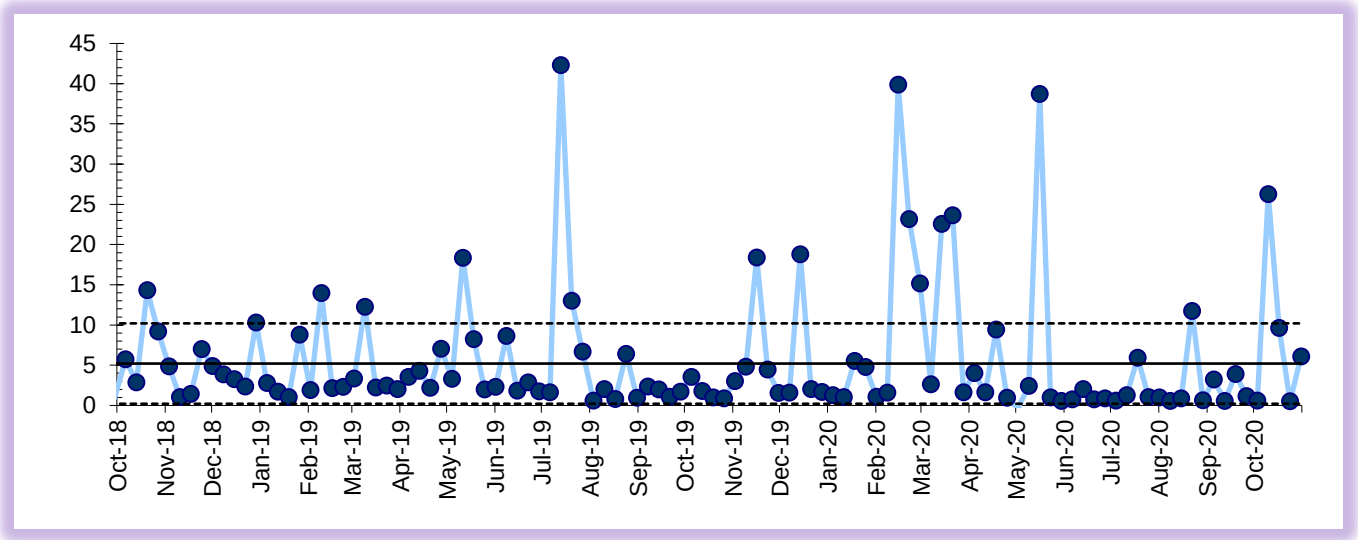
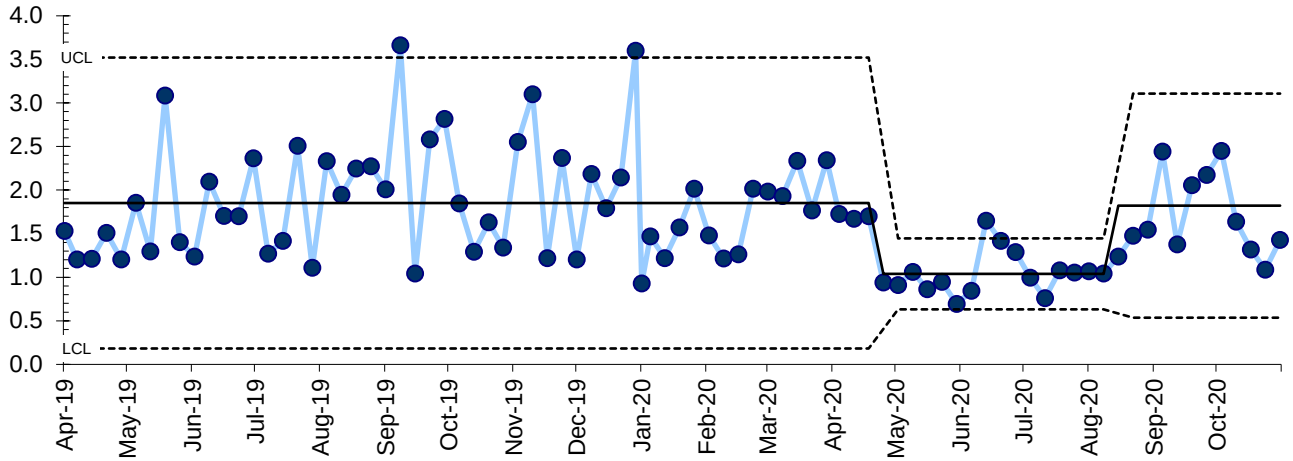
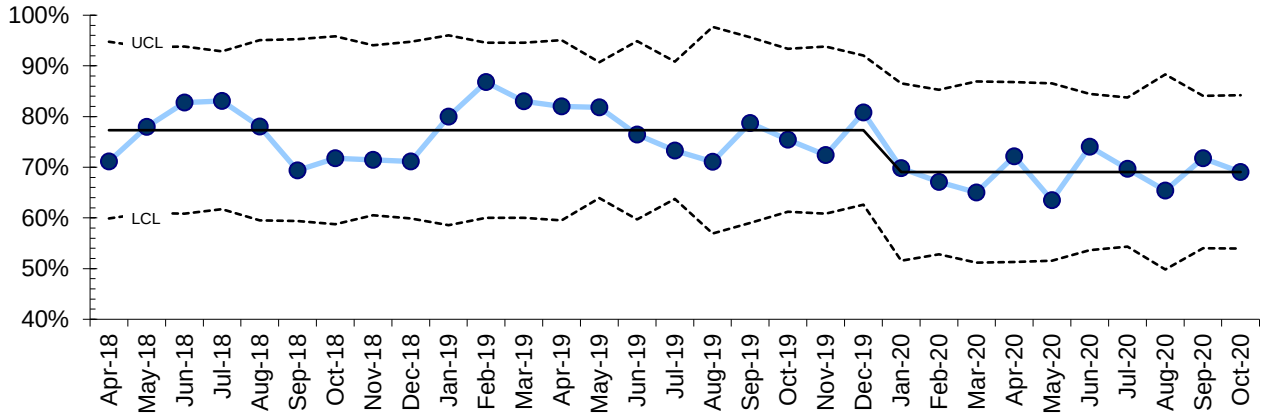


Chart 2.10 Average waiting times in days for referral to assessment to district nursing team (CHS Bedfordshire – I chart)



Adult mental health Early Intervention Services (EIS) waiting time target for service users receiving NICE-compliant treatment within two weeks of referral remains stable at 69.0% compliance in October, which is above the national target. As highlighted in previous report, this national indicator is based solely on face to face contacts, with virtual/telephone contacts not included in figures.

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



East London secondary care Psychological Therapy Services (PTS) since May are, overall, starting to see a decrease in average waiting times from referral to assessment, reaching pre-Covid levels in October. The average waiting times for treatment continue to rise across East London, but this is predicted to reduce as service users work their way through the treatment pathway. The number of referrals increased in October due to the re-opening of referrals to City and Hackney PTS service for the first time since the pandemic.

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

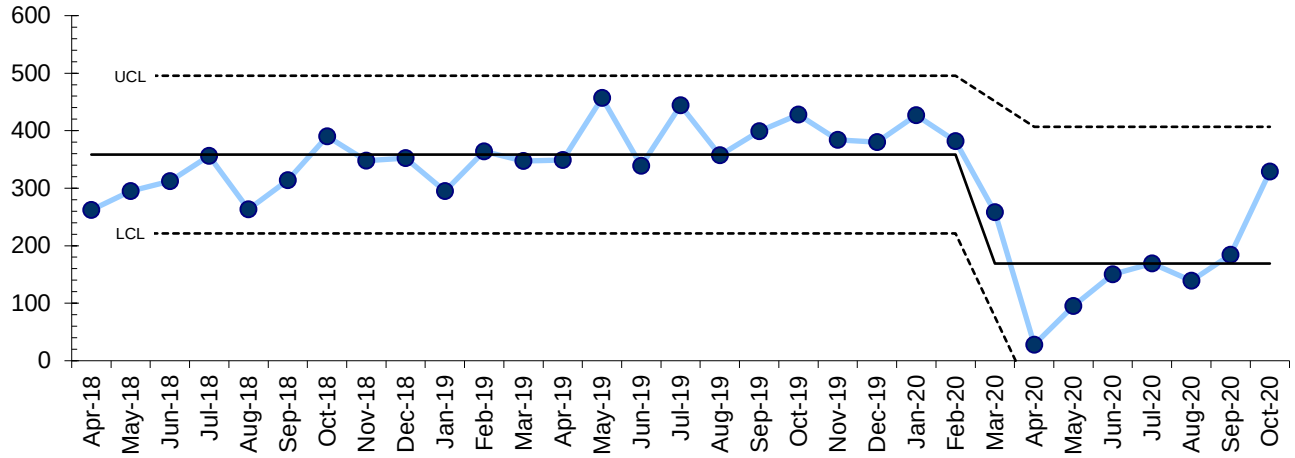


Chart 2.13 East London Psychological Therapy Services (PTS) - Average waiting (in days) from referral to assessment (telephone & face-to-face contacts – I chart)

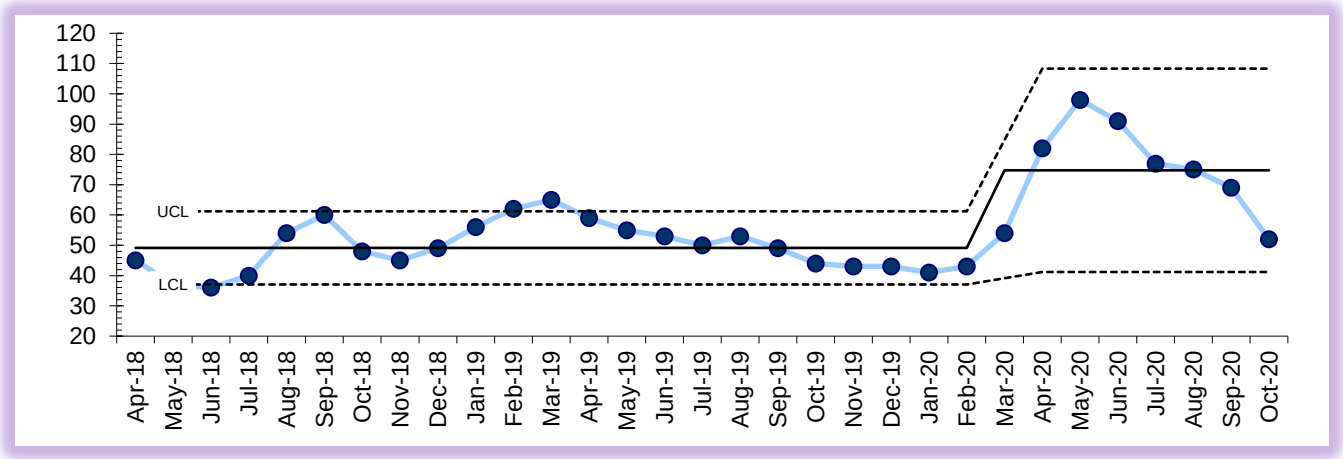


Chart 2.14 East London Psychological Therapy Services (PTS) - Average waiting time (in days) for treatment (telephone & face to face contacts – I chart)

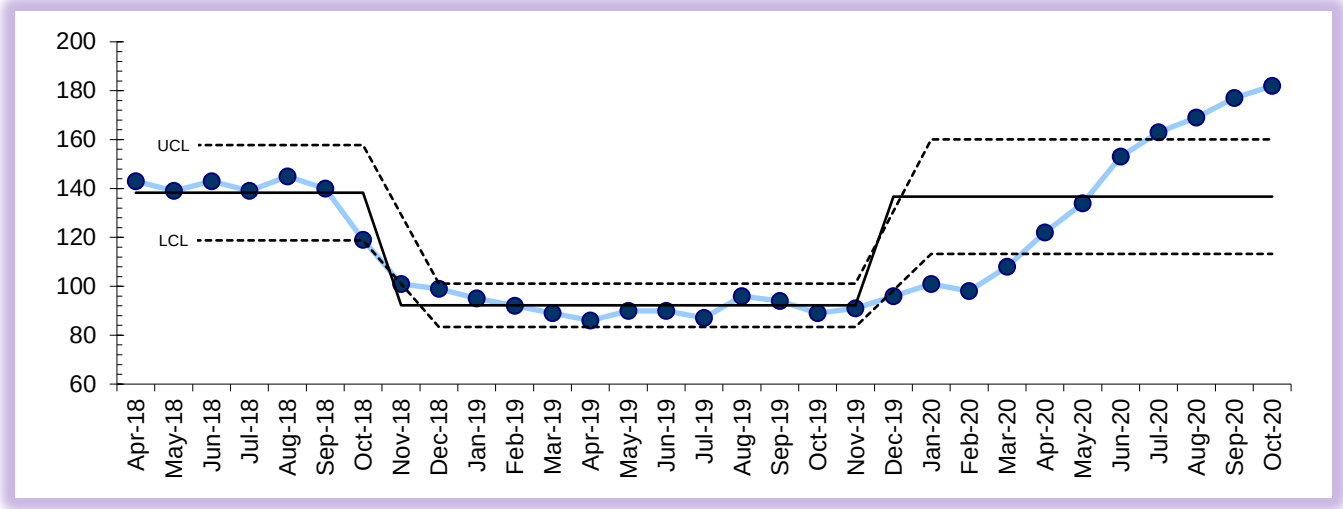


Chart 2.15 East London Psychological Therapy Services (PTS) - Number of service users waiting for assessment (telephone & face to face contacts – I charts)

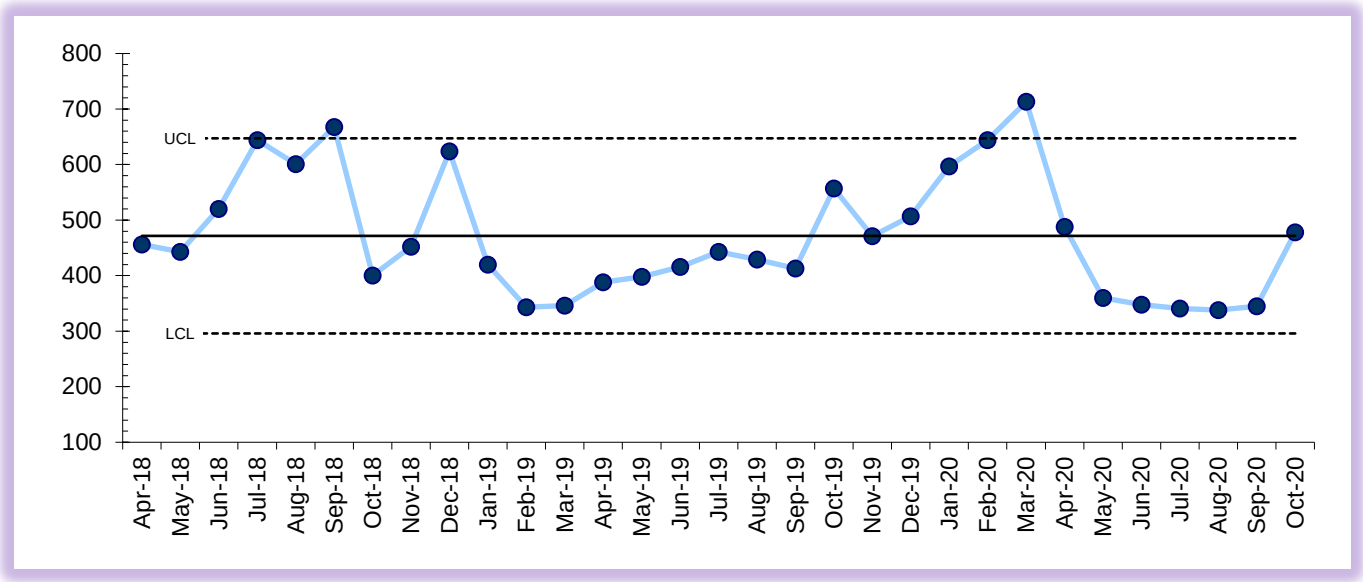
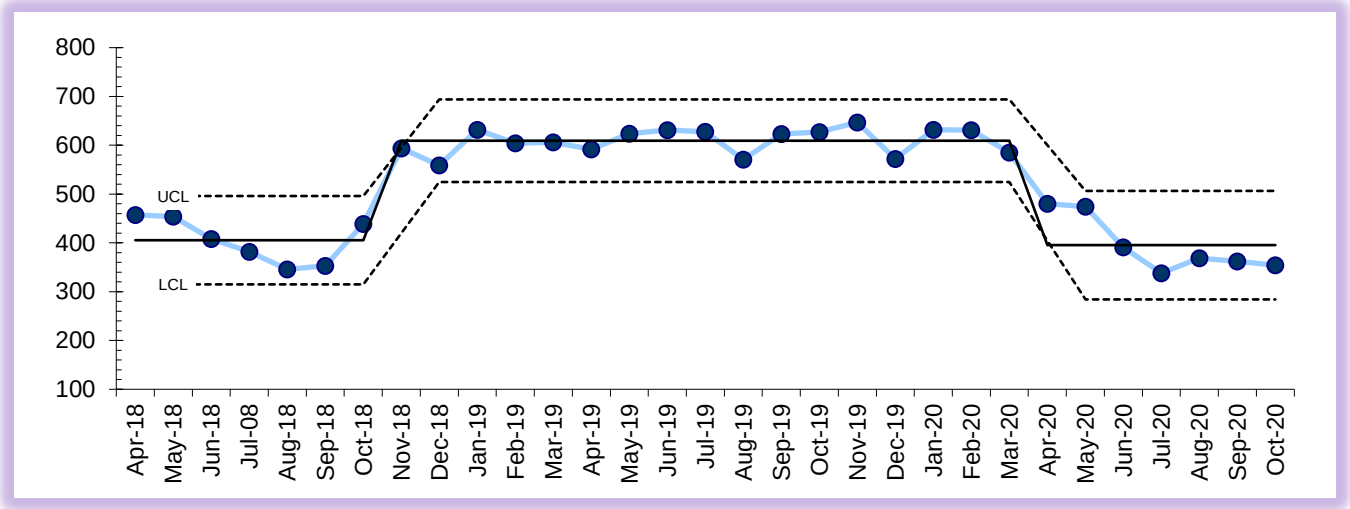


Chart 2.16 East London Psychological Therapy Services (PTS) - Number of service users waiting for treatment (telephone & face to face contacts – I chart)



As highlighted in previous reports, all services have now moved to virtual delivery for pre-assessment, assessment, and treatment. Services predict that there will be an increase in referrals over coming months. Services will all be looking to working much more closely with the primary care networks and local IAPT services to manage demand more effectively together as a system. All services are continuing to develop robust demand and capacity modelling plans which will help them to identify any potential bottlenecks caused by the changes in service provision from face-to-face to mostly virtual contact, thereby reducing waiting times for service users and maximising our resources.

In City & Hackney, waiting times for assessment and treatment have been affected by the suspension of the introductory enrolment sessions and the move to first treatment intervention being online podcast formats which are not captured on our clinical systems. The enrolment session has been re-reinstated through an online webinar in line with re-opening of the service to new referrals from 1 October. Since the service reopened, 160 new referrals were received, which has added to the assessment and treatment backlog. Paused treatments have recommenced from the beginning of June. 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.

Tower Hamlets was the first service to re-open to new referrals in May and referral levels increased to pre-Covid levels in June. This has led to a corresponding increase in first assessment waiting lists. The team continue to deliver group and individual treatments to a high standard, as well as engage in innovative practice. The service 'Information Session' has transferred online with a webinar available in both English and Sylheti. There are now eight groups running remotely and another three at the recruitment stage. Several clinicians were able to take advantage of increased diary flexibility during the redeployment phase to undertake a Patient-Led Booking QI project that has been a largely positive experience for service users and heath care professionals alike to help improve access, and which is now nearing completion. A group focused on the experience of racial trauma is also underway in the service. The team have an Away Day scheduled for December to come together as a team and think creatively about some of the ongoing challenges.

Referrals to the Newham service remain lower than other services, and assessment targets are broadly being achieved. However, there remains a backlog for treatment. The service has successfully redeveloped its stepped care model and offered online psychoeducational group therapies in March and April. This has developed further and from August, the therapeutic offer has progressed into a range of online group psychotherapies. As a result of these changes and new pathways getting established, the service is starting to see small improvements in waiting times and has been offering face to face appointments since September to support completion of individual therapies for those referred prior to Covid.

Contacts with Service Users

The charts below highlight changes in our virtual (non-face to face) contacts with service users. Chart 2.17a shows the proportion of all contacts (virtual & face to face) that have been successfully made through telephone or video consultations. This increased to 39.0% during October. National comparative data in chart 2.17b shows that during September, 59% of contacts nationally were provided by non-face to face consultations mediums in adult services and 67% in CAMHS services. Total clinical contacts per 100,000 population are also lower than the national average, particularly in East London as highlighted in chart 2.17c. Factors that have contributed to this include reduced reliability of recording contacts and outcomes in our clinical record system, and confusion about how to record the mode of contact on our systems. We have conducted a review of the current outcome options on our clinical system for recording contacts and simplified this from 1 October so that it is clearer for staff. The simplified set of outcome options has been introduced along with training material and guidance, and is likely to have contributed to the increase in non-face to face activity in October seen in chart 2.17a.

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

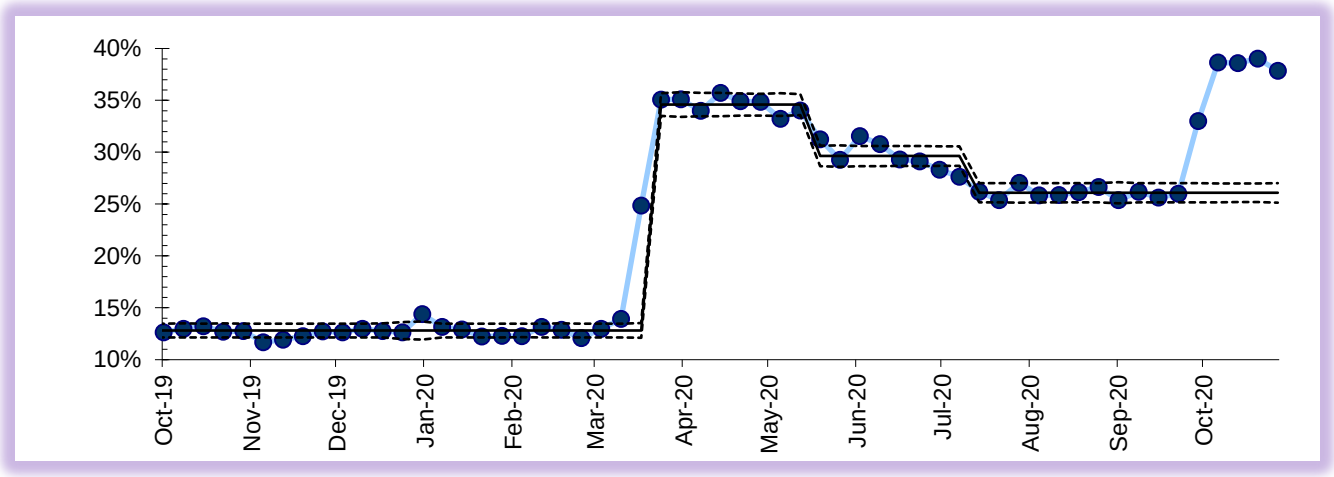


Chart 2.17b. National Mental Health Contact profile: face to face vs non- face to face (Source: *National Mental Health Benchmarking Network – September 2020*)

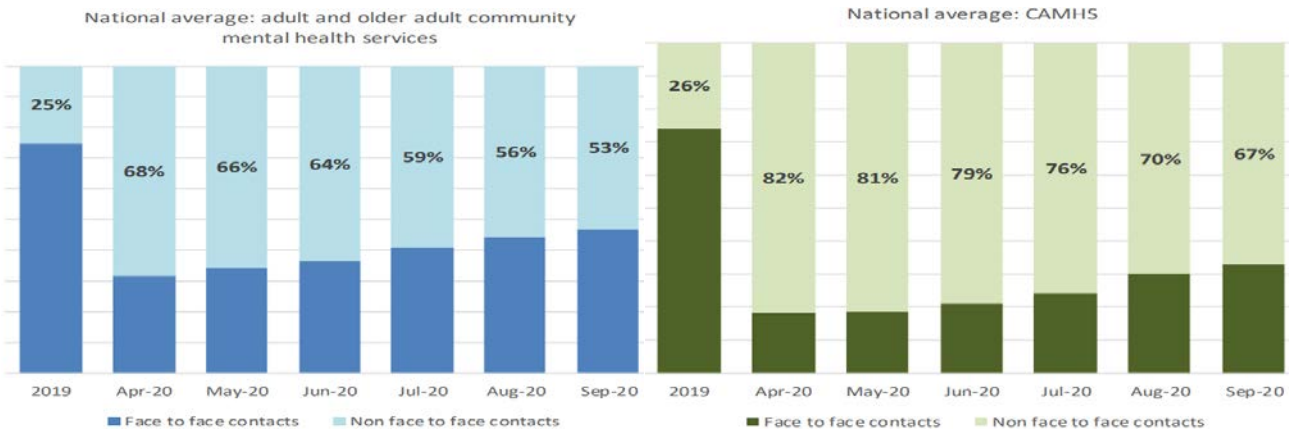
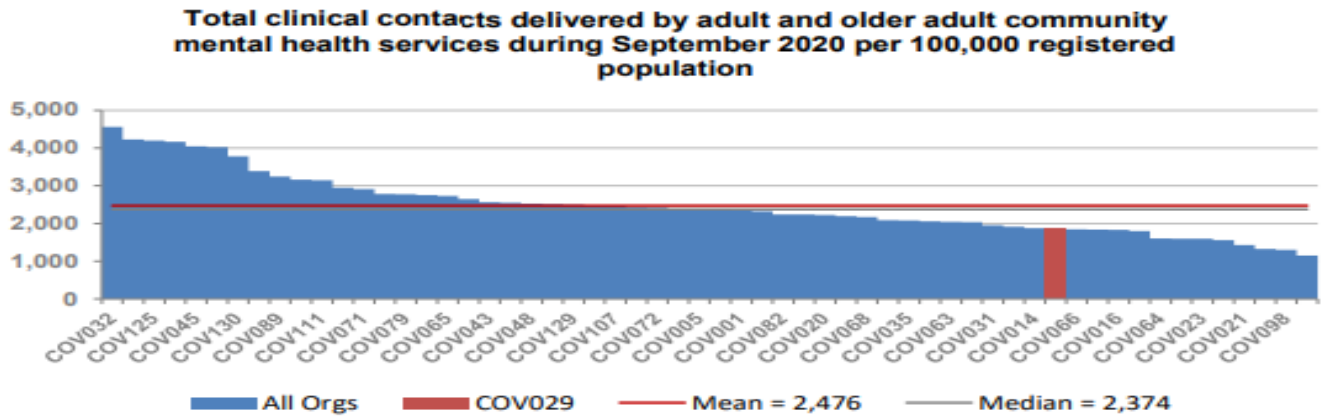


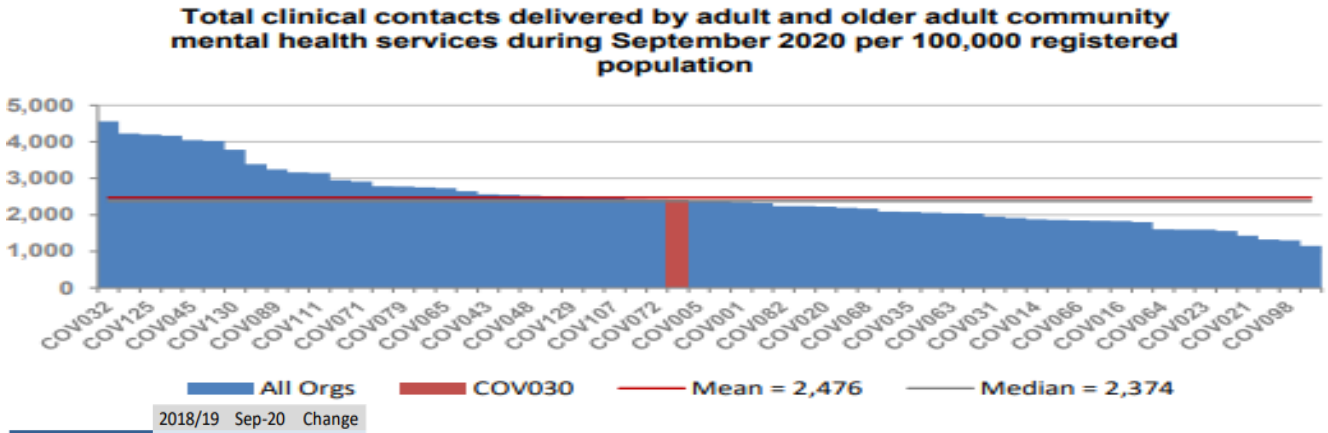
Chart 2.17c. Total contacts delivered by Community teams (Source: *National Mental Health Benchmarking Network – September 2020*)

East London



	2018/19	Sep-20	Change
National average	2519	2476	-2%
COV029	2724	1858	-32%

Bedfordshire and Luton



	2018/19	Sep-20	Change
National average	2519	2476	-2%
COV030	2413	2385	-1%

Chart 2.18a shows that there has been an improvement in virtual clinic attendance with an average of 86.8% of services users attending all telephone of video appointments. Service users

have been quickly able to adopt new digital solutions and, in many instances, have preferred to be contacted virtually because they feel more comfortable in their own home and avoids the need to travel. The proportion of service users contacted specifically via video contacts nationally is around 5% for adult mental health services and 20% for CAMHS services during the month of September as highlighted in chart 2.18b.

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

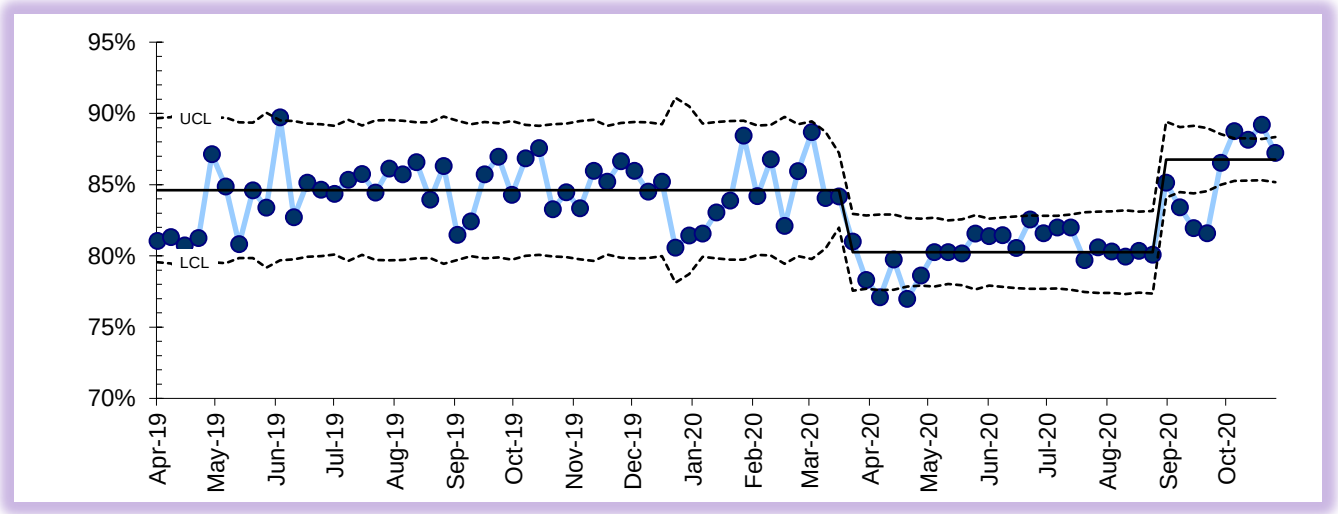


Chart 2.18b. National average: proportion of contacts delivered using digital technologies
Source: *National Mental Health Benchmarking Network – September 2020*)

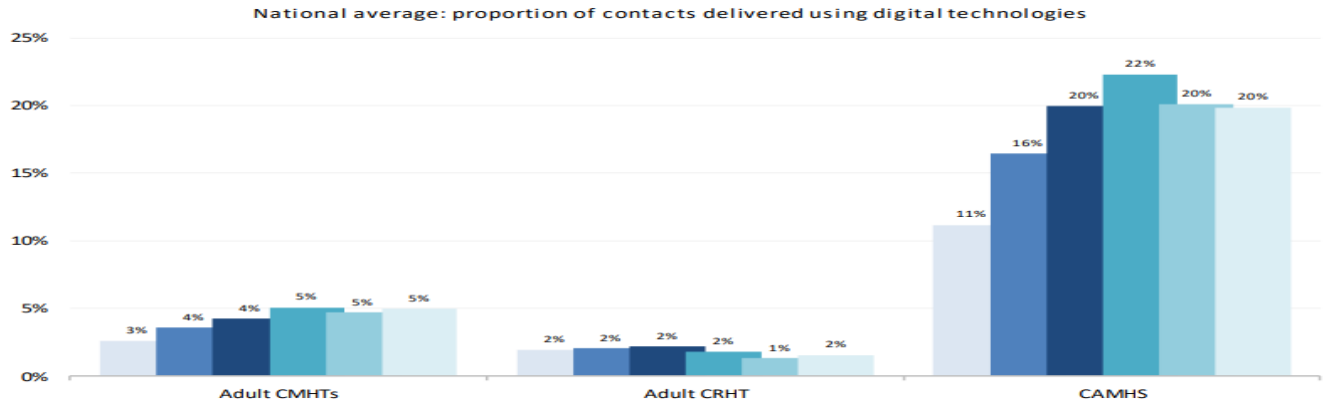


Chart 2.19 Percent of service users on CPA contacted each month – telephone/video and face to face (mental health – P chart)

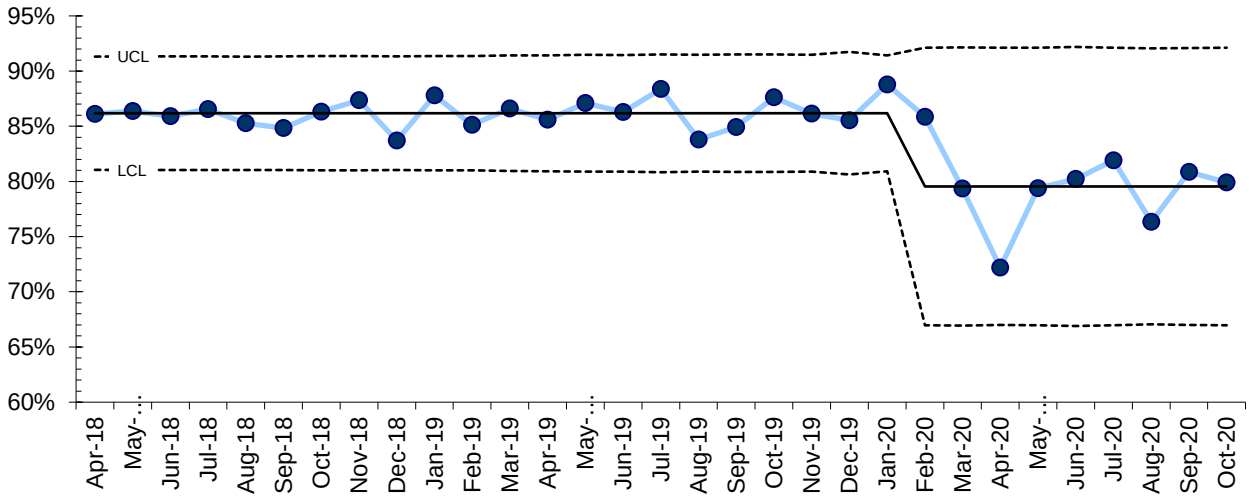
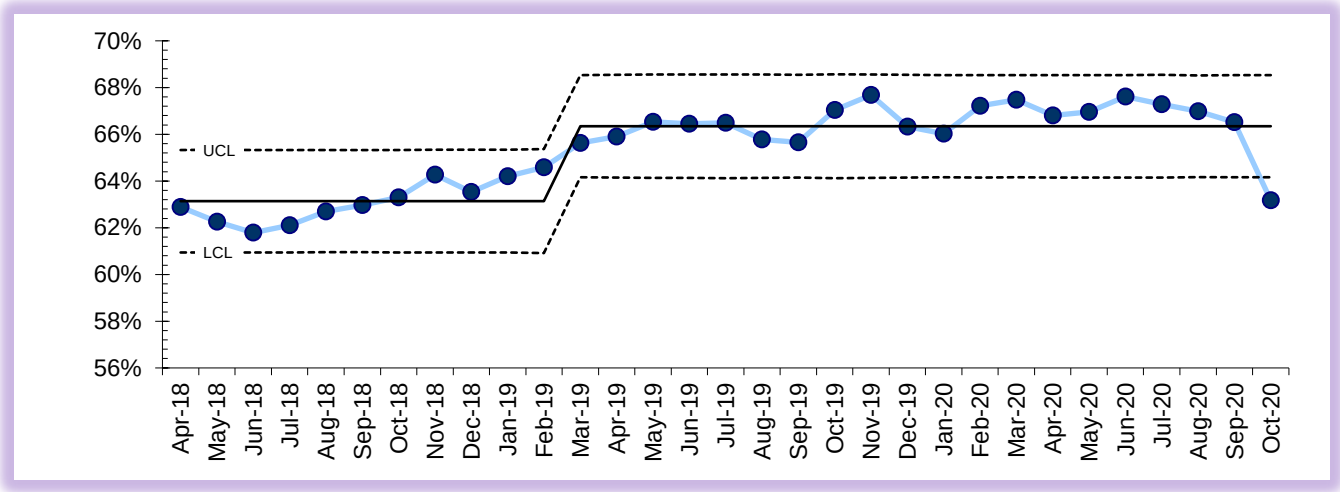


Chart 2.19 shows that monthly contact activity with service users who are care-coordinated by community mental health services remains stable with 79.5% service users contacted successfully, however, this still below pre-Covid compliance levels. A few older adult community teams experienced reduced contact compliance during the past few months mainly due to challenges with access to service users in their homes. For example, some care homes refused access and not all service users were contactable digitally or by telephone. Services have started to offer telephone and face to face contact where required or where risks have been identified. In some instances, service users did not engage with multiple contacts attempts and in other instances, positive contacts were not recorded correctly on our clinical system.

The percentage of care-coordinated service users with annual care plan reviews completed continues to hover around 66.3% and during October compliance reduced to 63.1%. This is felt to accurately reflect operational practice and completion of the electronic DIALOG+ care plans. Work is underway way to focus on outcome measures and offering refresher training to staff over the next few months to help them to complete DIALOG+ outcome forms correctly and in a timely manner.

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



Improving Access to Psychological Therapies (IAPT) Services

The charts below demonstrate our performance against national IAPT performance and access indicators. Overall, the number of referrals and number of service users entering treatment with IAPT services improved during Quarter 2 as lockdown measures were eased and new engagement techniques were introduced such as text messaging via GP practices. IAPT services in East London compare favourably to the national average referral activity, achieving 2500 referrals during the month of September against an average of 1,667 referrals nationally. However, Bedfordshire IAPT service fell below national average with 1200 referrals in the same period as highlighted in chart 2.21b.

The progress made in Quarter 1 towards reducing treatment waiting times has been maintained, with Newham, Richmond and Tower Hamlets now routinely meeting the standard of 90% within 90 days and Bedfordshire showing very significant improvement since the start of the year. This progress would be put at risk if there is a sustained increase in demand as predicted nationally, although as of October there is no sign of this in IAPT referral numbers. Funding for expansion to the national 25% access target has now been agreed with commissioners in Newham, Tower Hamlets and Bedfordshire, which will also help to reduce existing waiting lists, particularly in Bedfordshire.

All services have maintained performance as a result of rapidly implementing and refining digital platforms to offer assessment and treatment remotely, which has been successfully utilised by

service users. The announcement of a second national lockdown has postponed plans for a return to face-to-face delivery at scale. The services are now offering on-site digital access for people without the technology and/or privacy at home to take advantage of remote therapy options. The improved percentage of people achieving recovery suggests a relationship between shorter waits and better outcomes.

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

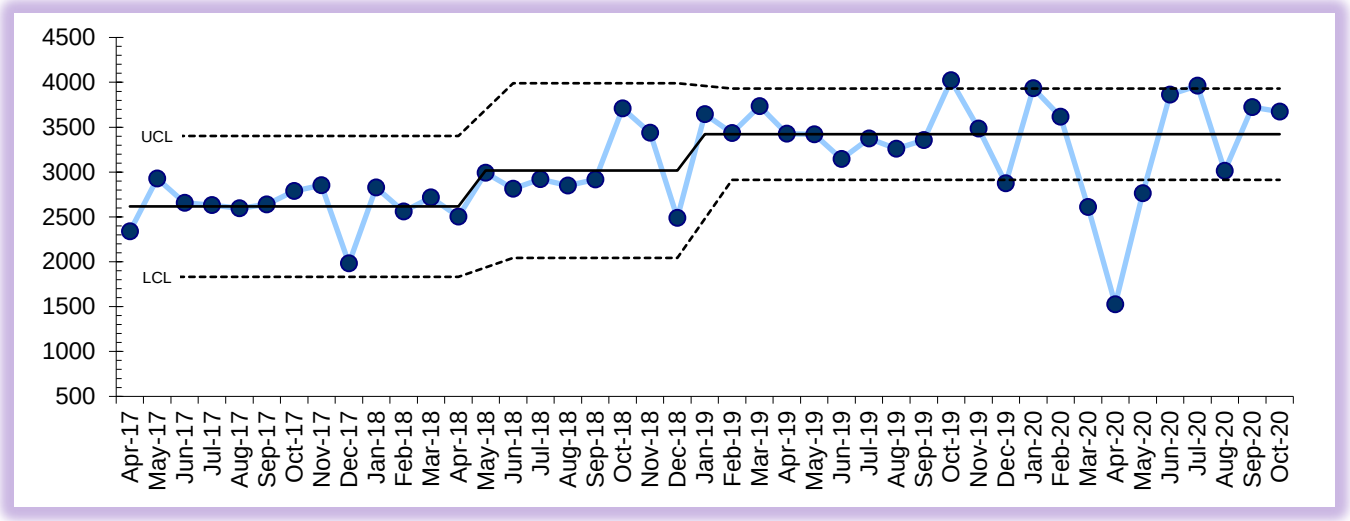
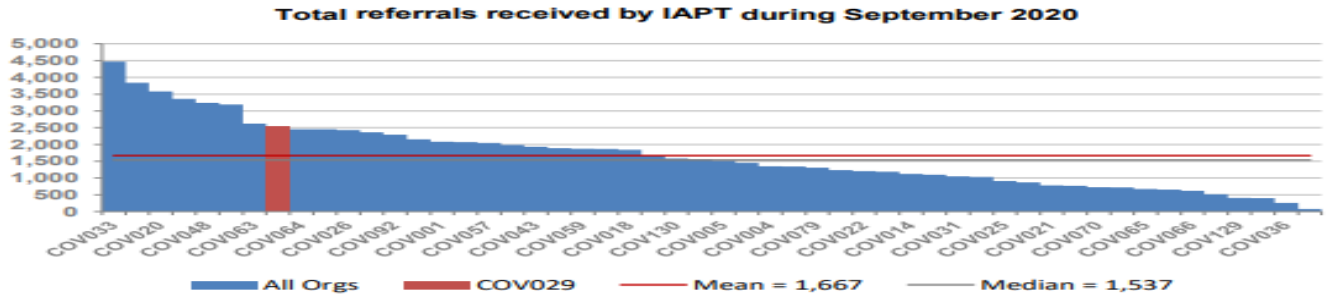


Chart 2.21b IAPT – Referrals received (Source: *National Mental Health Benchmarking Network – September 2020*)

East London



Bedfordshire and Luton

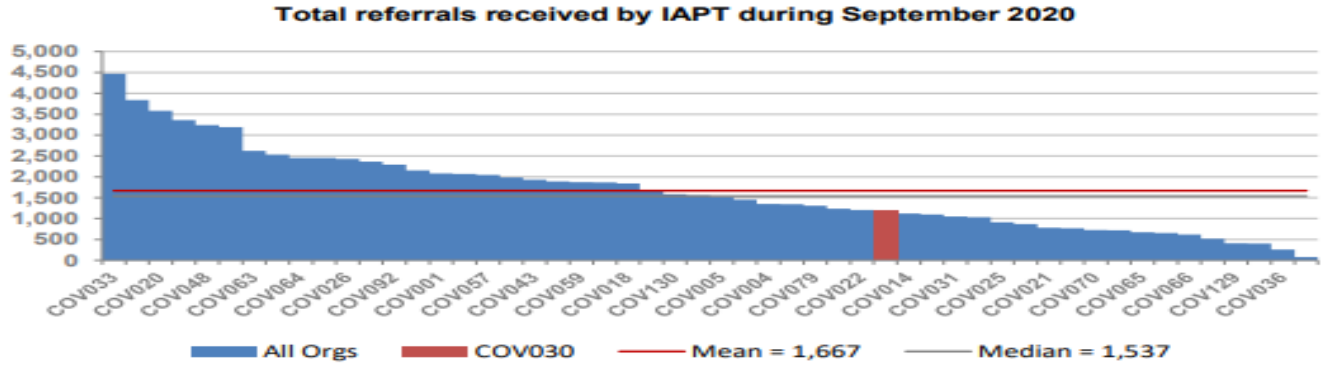


Chart 2.21c IAPT – National Contact Type and proportion of contacts delivered using digital technologies (Source: *National Mental Health Benchmarking Network – September 2020*)

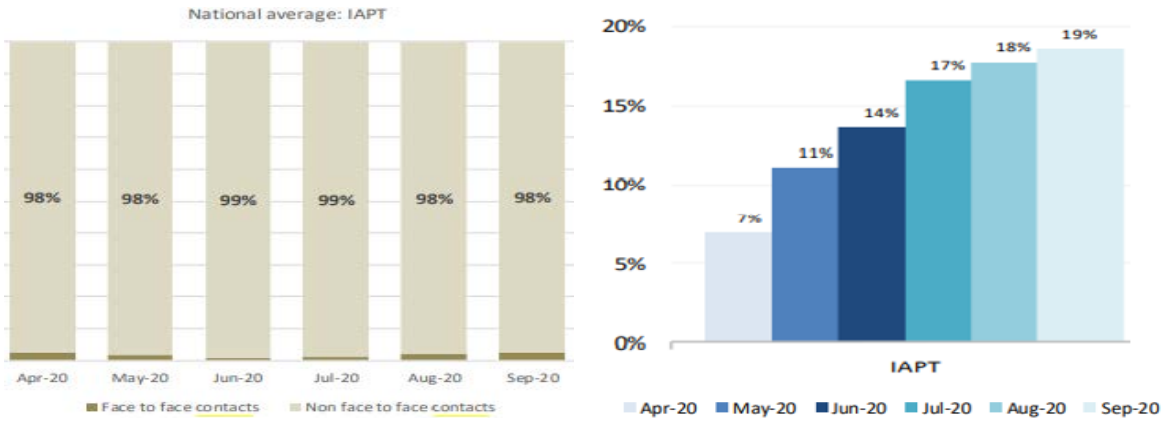


Chart 2.22 Number of service users starting treatment – first contact (Trustwide – I chart)

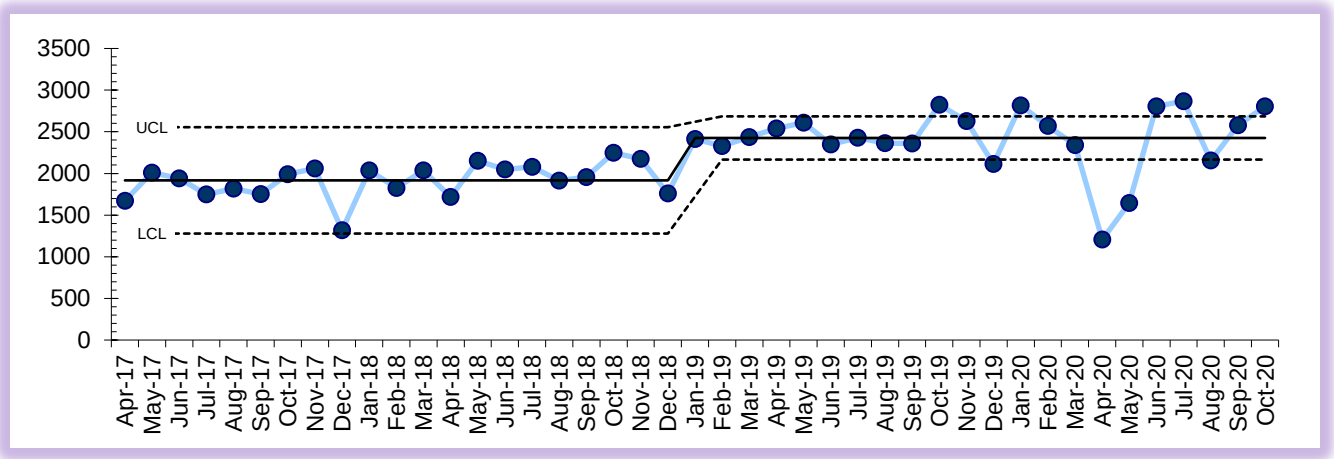


Chart 2.23 Percentage of service users starting treatment within six weeks of referral (Trustwide – P' chart)

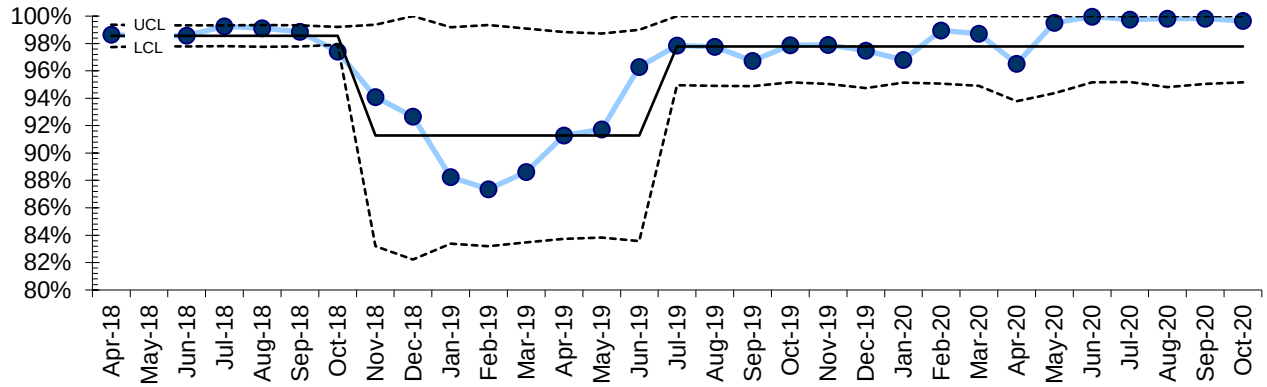


Chart 2.24 Percentage of service users starting treatment within 18 weeks of referral (Trustwide – P chart)

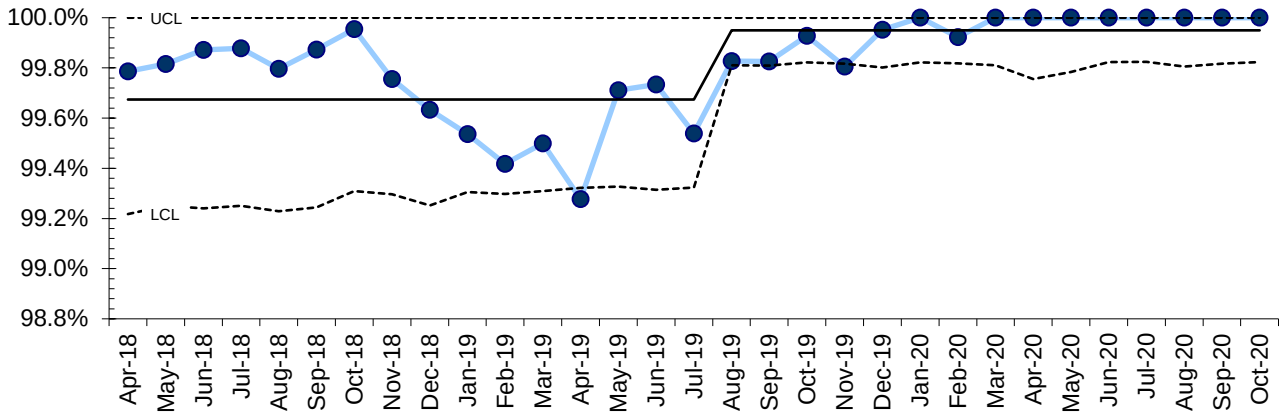


Chart 2.25 Average wait (days) to first appointment (Trustwide – I charts)

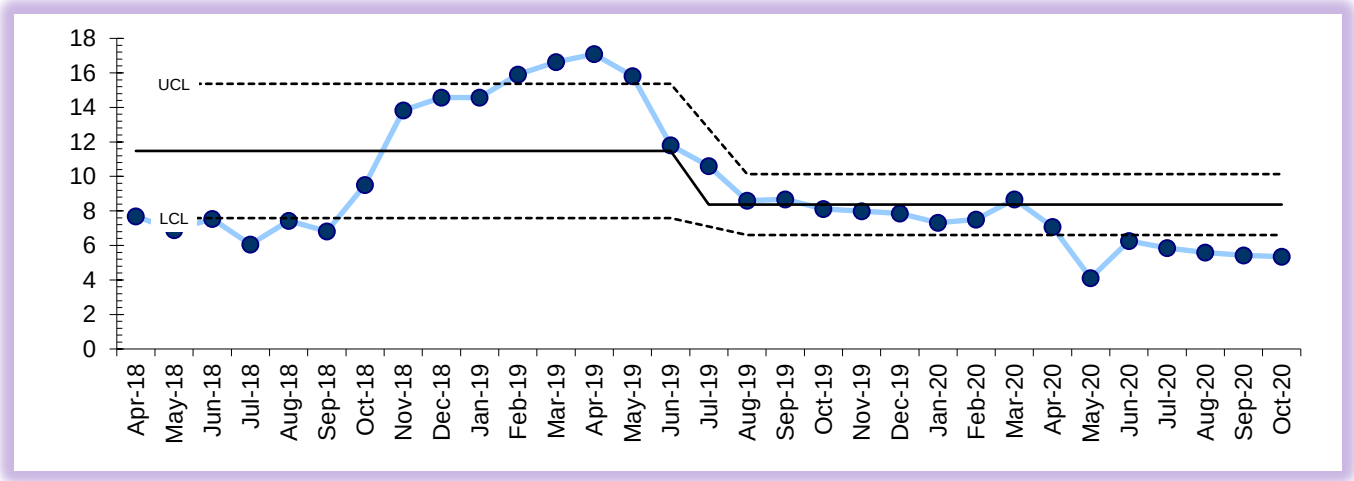


Chart 2.26 Average wait (days) to second appointment (Trustwide – I chart)

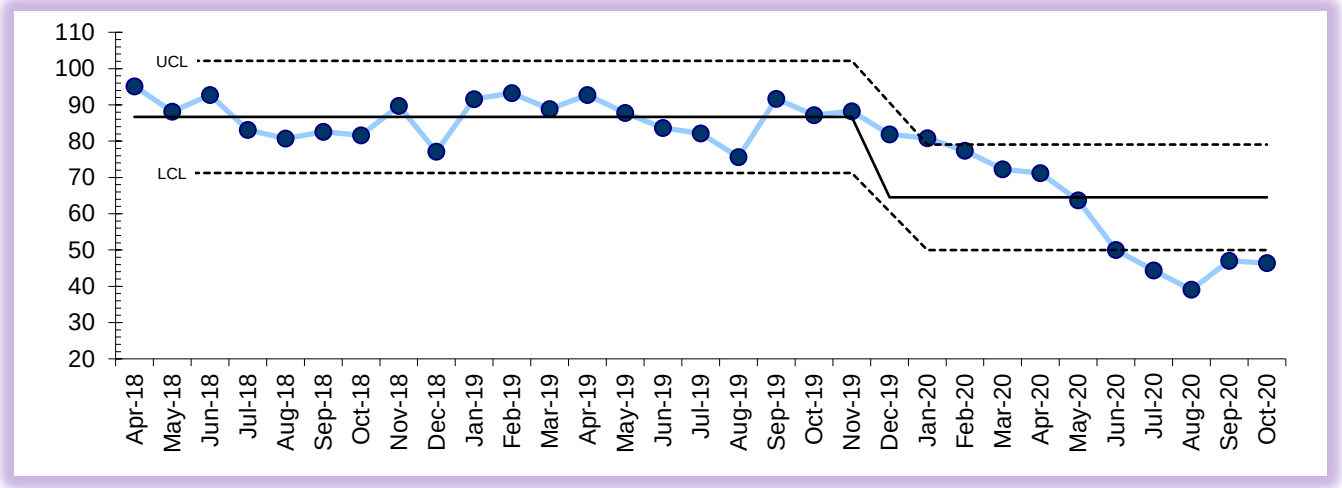
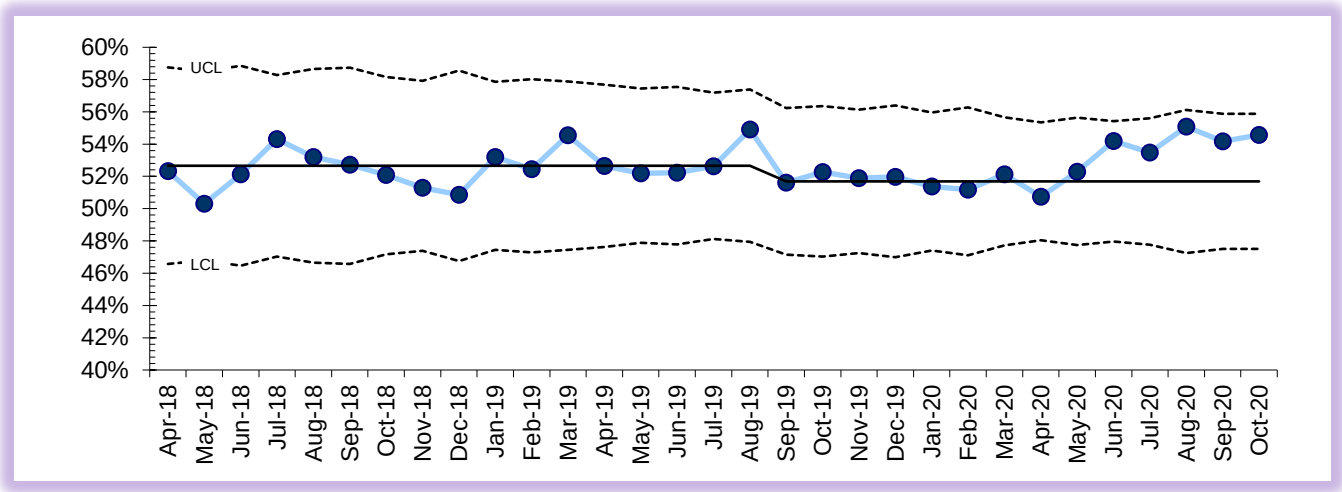


Chart 2.27 IAPT – percent demonstrating recovery at end of treatment (Trustwide – P chart)

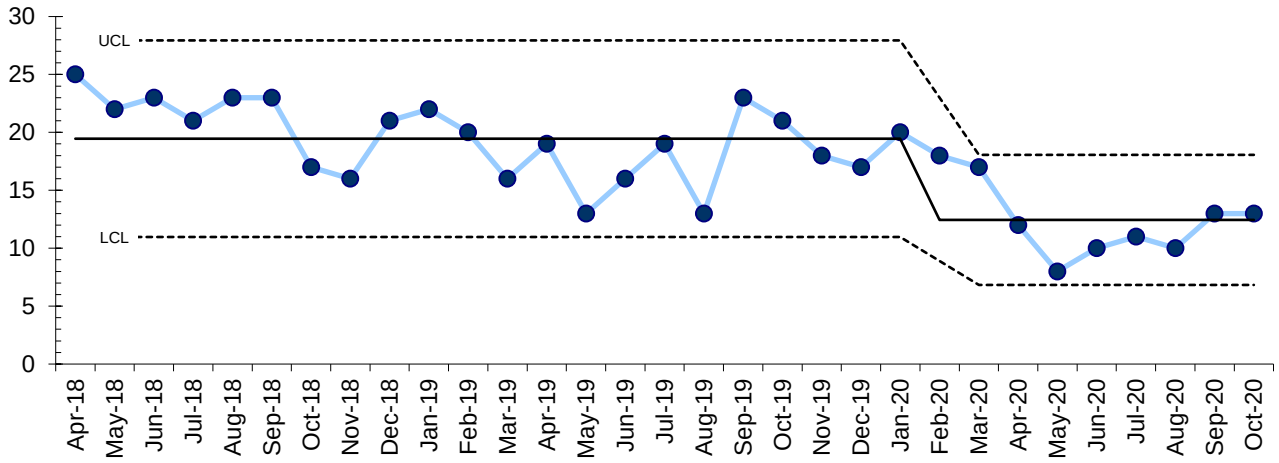


Perinatal Services

The chart 2.28 below shows that average waiting times for perinatal services has started to decrease since the start of the pandemic and remains stable. This reflects reduced referrals to the service but also increased uptake of appointments offered virtually and by telephone. All services have had to adapt their service offer to include face to face and virtual contacts and this has been positively received by service users. All services have noticed an increase in anxiety

and depression-related presentations which is largely related to the impact of the pandemic on health and well-being. Some services have also reported improved recovery scores which is believed to be linked to the positive impact of virtual and telephone contacts in enabling better engagement and shorter waiting times.

Chart 2.28 Average waiting times for referrals not yet seen for assessment to Trustwide Perinatal Mental Health services – (I chart)



Memory Services

The pandemic has led to significant changes in the way routine health care activity is organised across services. This has had, and continues to have, a significant impact on dementia diagnosis and assessment services (Memory Services). During the initial response to the pandemic, all our Memory Services were closed to new referrals between March and July and most services did not accept new referrals into the service, with some teams offering limited services such as advice and support to referrers. This meant that people with dementia or cognitive impairment were unable to access emotional, practical, legal and financial advice, as well as vital support services and pharmacological and non-pharmacological interventions. These factors are even more important at a time when symptoms may be worsened by social distancing and closure of community services and third sector organisations that would otherwise play a key role in supporting service users. Since July, all services have started re-opening services, however, the closure of services has created large backlogs of referrals that have yet to be assessed, which is causing significant pressures within the service to manage. All services have introduced a range of methods to assess and support service users such as home visits, virtual telephone or video contacts and onsite appointments. Most service users are not able to interact via virtual methods due to their health condition and therefore services are primarily offering home visits and onsite appointments. Appointments are therefore taking much more time to organise and to complete because staff must gather more information and ensure safe and effective conditions for staff to visit service users at their home. Services have also has faced delays receiving diagnostic imaging appointments and reports as a result of capacity challenges within acute providers.

3. Experience and Outcomes

The charts below provide assurance across a range of service user experience and outcome indicators. The number of complaints and PALs enquiries remain stable. The Friends and Family Test (FFT) have recently been restarted following a national review. NHS England has replaced the original FFT question and focusing more on the overall experience of using the service. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor service user experience. During November, our Quality Assurance team restarted capturing service user experience measures across the Trust by encouraged teams to collect

information using a range of methods. This included setting up online surveys and sharing these with service users through mobile devices, emails, sharing QR codes on leaflets, enlisting befriending service to call service users, text messages and telephone surveys. Chart 3.3 has been amended to show compliance levels with the new service user experience questions introduced. This shows that 94.3% of service users who responded to the survey in October reported a positive experience of services offered by the Trust.

Chart 3.1 Number of Complaints (Trustwide – I chart)

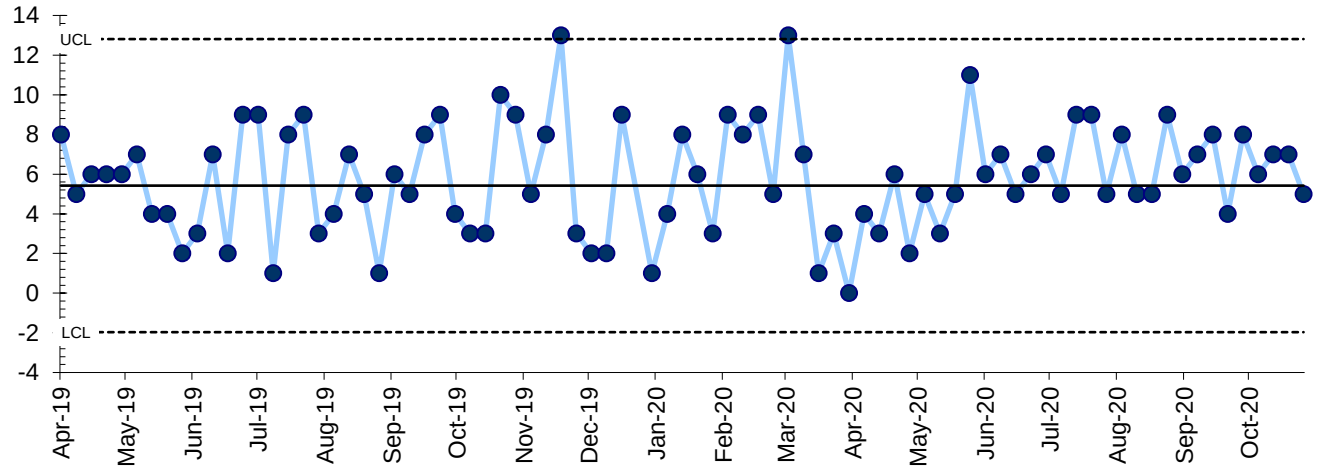


Chart 3.2 Number of PALs enquiries (Trustwide – I chart)

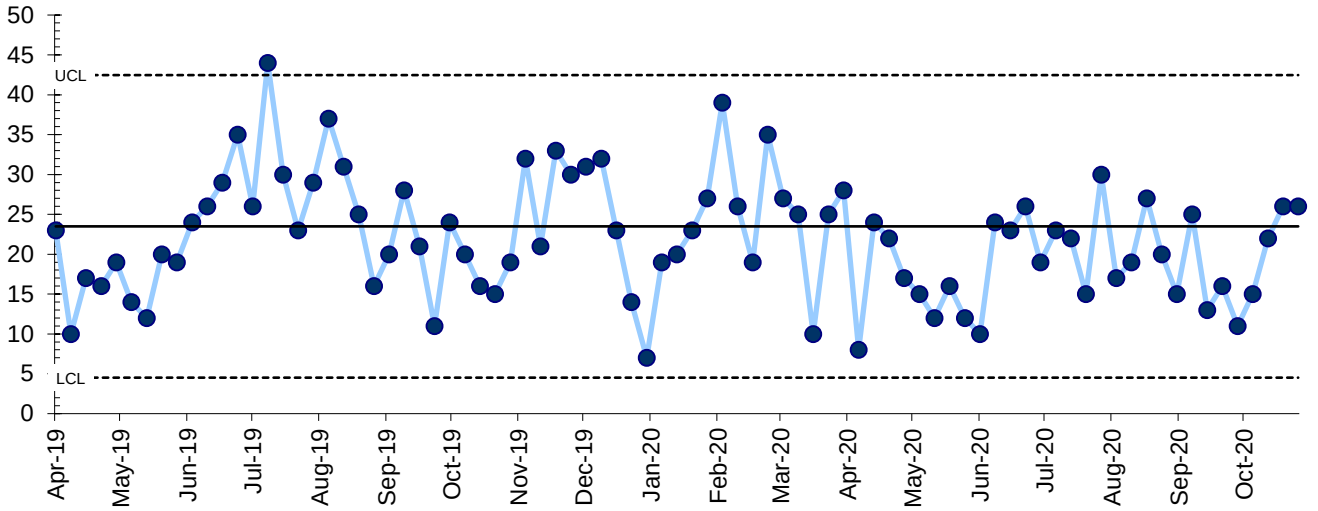
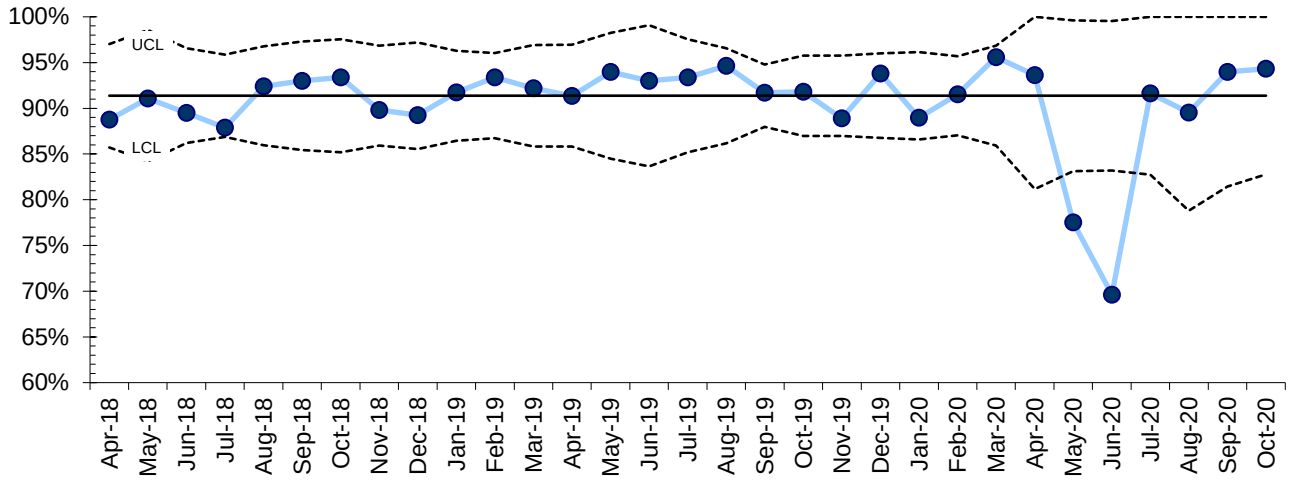


Chart 3.3 Percent of service users rating their experience positive – good or very good (Trustwide – P' chart)



The charts below provide a summary of outcomes in mental health services based on DIALOG. The data on service user dissatisfaction in charts 3.6 and 3.7 before and during the pandemic, continues to show 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 3.5 Number of DIALOG Forms completed (Trustwide – I chart)

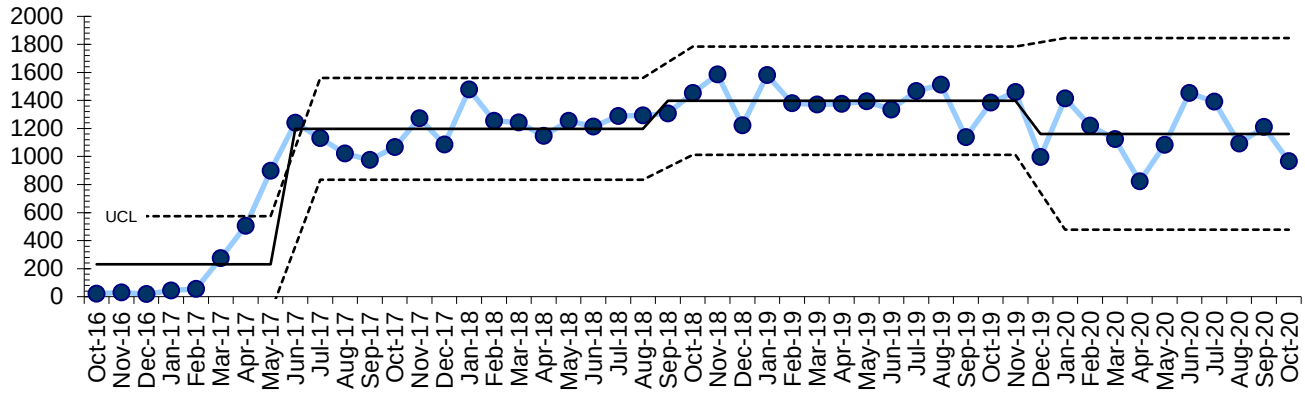


Chart 3.6 DIALOG Dissatisfaction scores by category prior to Covid (Trustwide – Pareto chart)

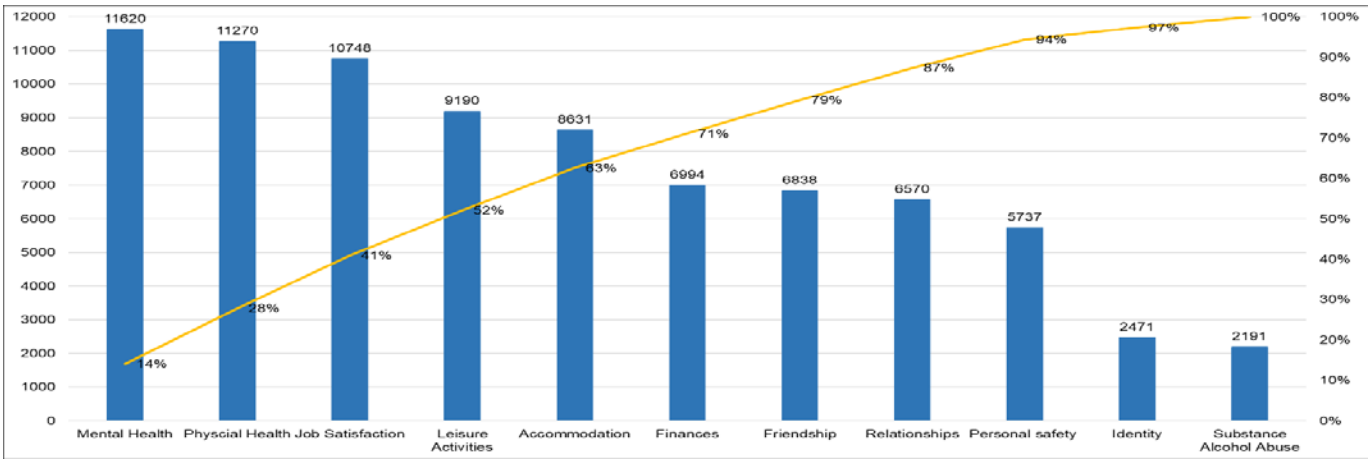


Chart 3.7 DIALOG Dissatisfaction scores by category during Covid (Trustwide – Pareto chart)

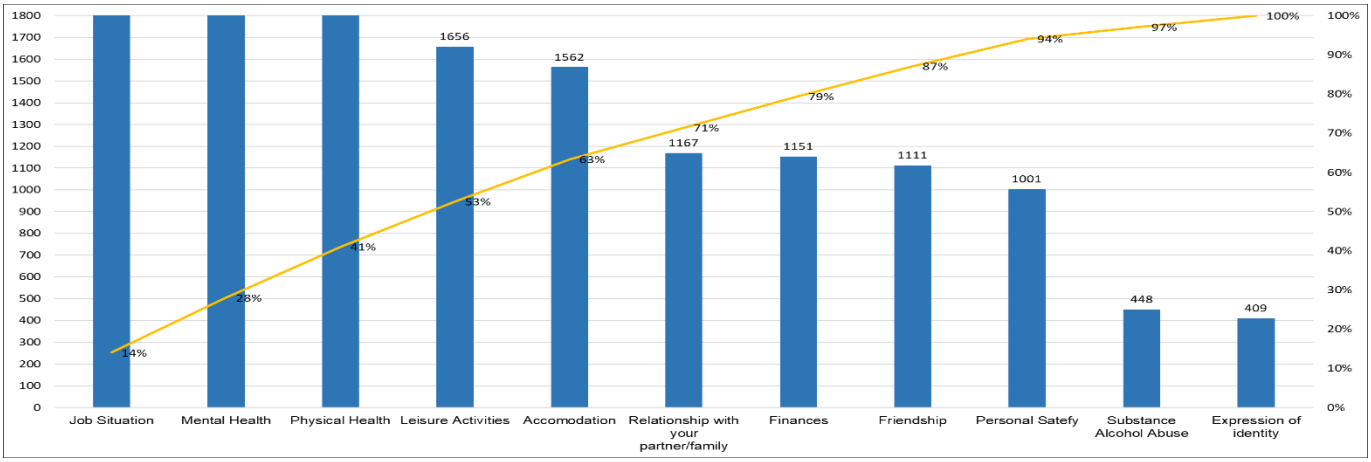
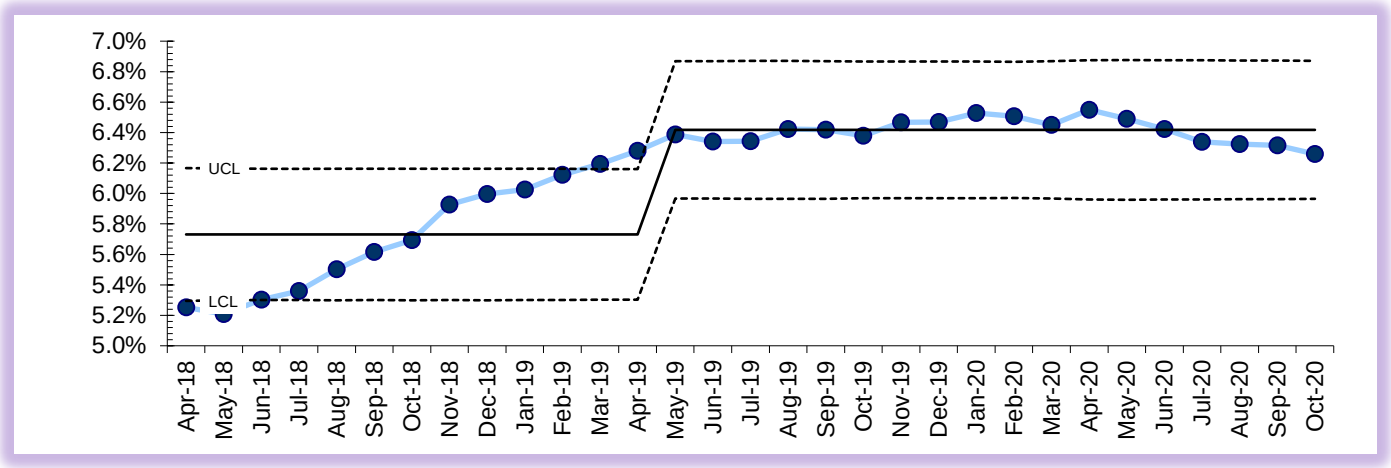


Chart 3.8 below highlights the percentage of service users open to Mental Health services who are in employment. There has been a reduction from 6.6% in April to 6.2% in October which may have contributed to the feedback provided by service users around their dissatisfaction with job situation.

Chart 3.8 Percentage of service users in employment open to mental health services (Trustwide – P chart)



4. Staffing

The charts below describe a range of people indicators, to accompany the more detailed People report. 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. Vacancies have decreased over the last two months with a significant increase in recruitment activity. The Trust continues to use streamlined recruitment processes devised during the Covid-19 pandemic and have also successfully taken part in new virtual recruitment and careers events. Staff turnover levels have increased slightly between September 2020 and October 2020 but still below the Trust target of 16%.

The number of staff compliant with Disclosure and Barring (DBS) checks has increased as result of changes in national Guidance to fast-track DBS checks and the Trust's decision to extend DBS recheck periods from 3 years to 4 years. In addition, a number of staff are enrolled on the monthly DBS update service.

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

Chart 4.1 Sickness (Trustwide – I chart)

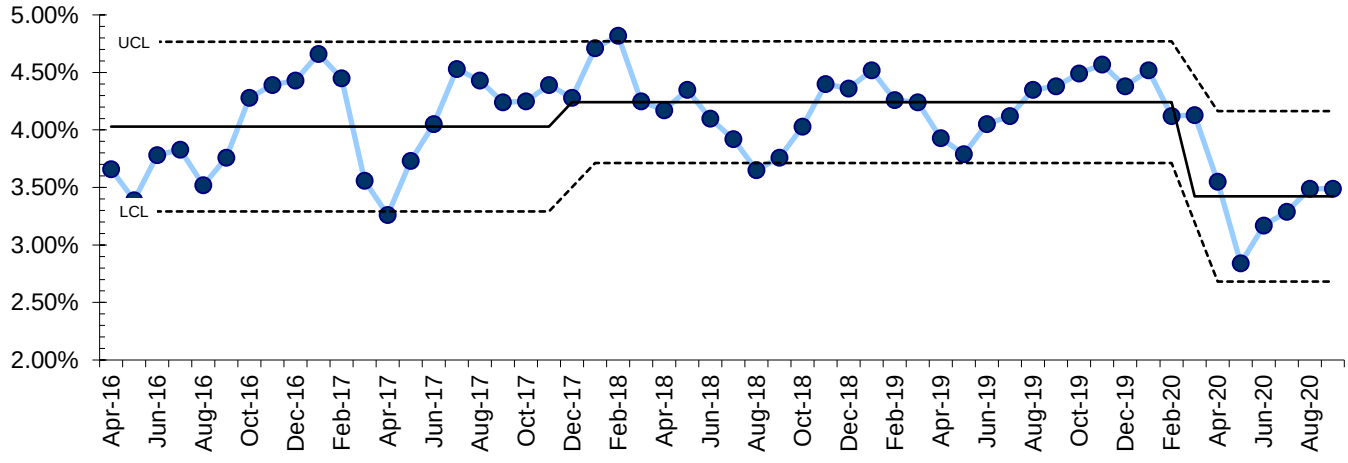


Chart 4.2 Percentage of posts vacant (Trustwide – I chart)

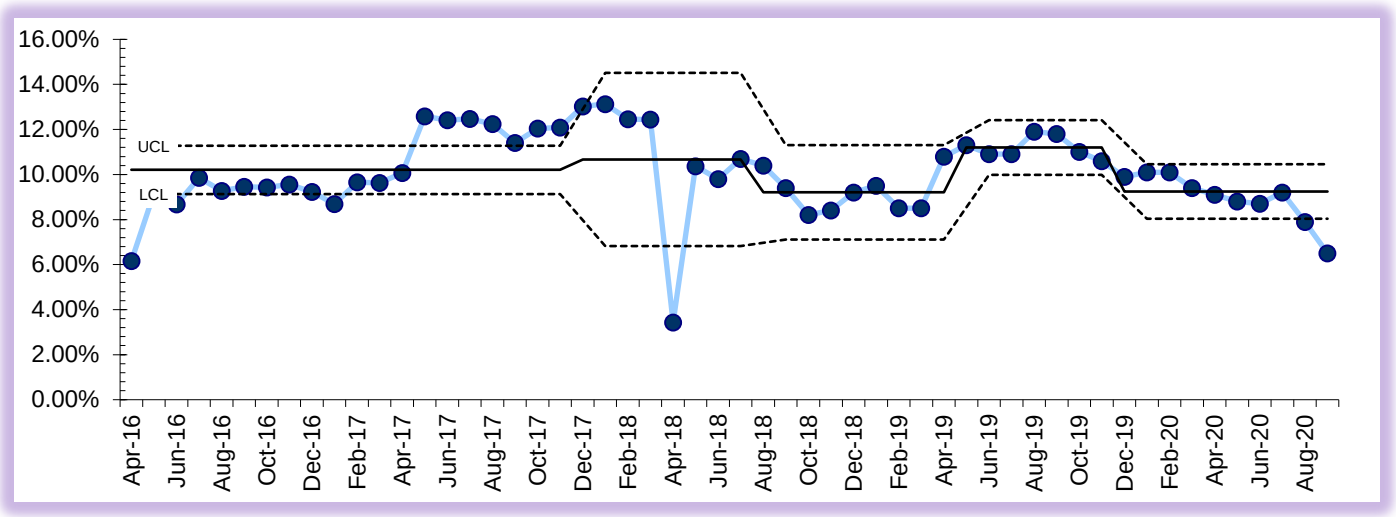


Chart 4.3 Turnover (Trustwide – I chart)

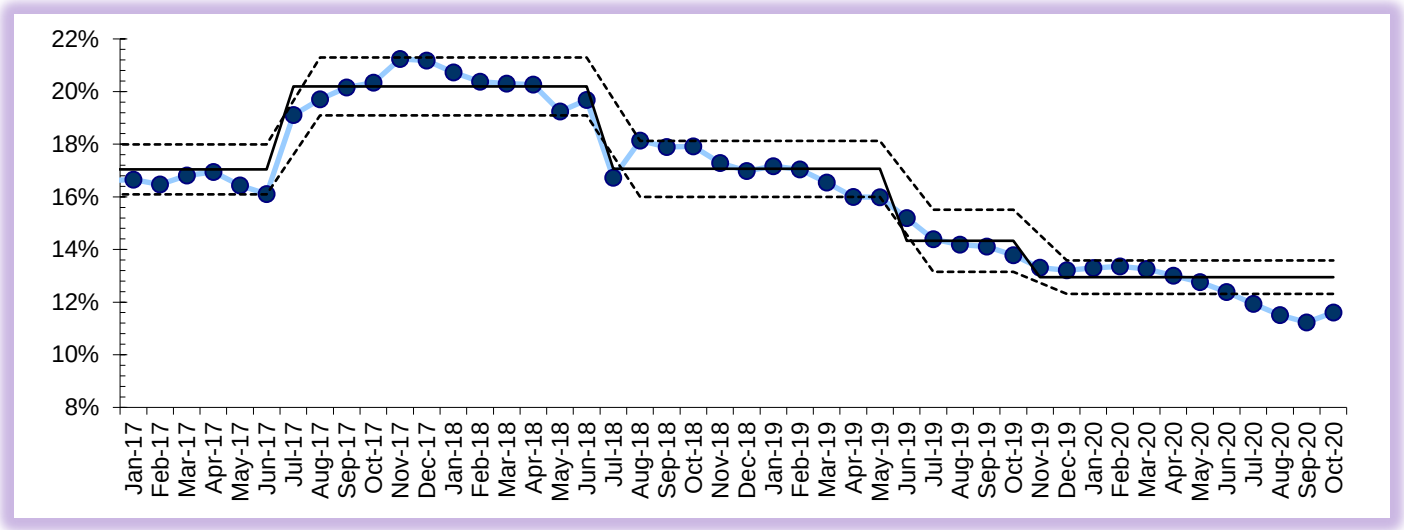
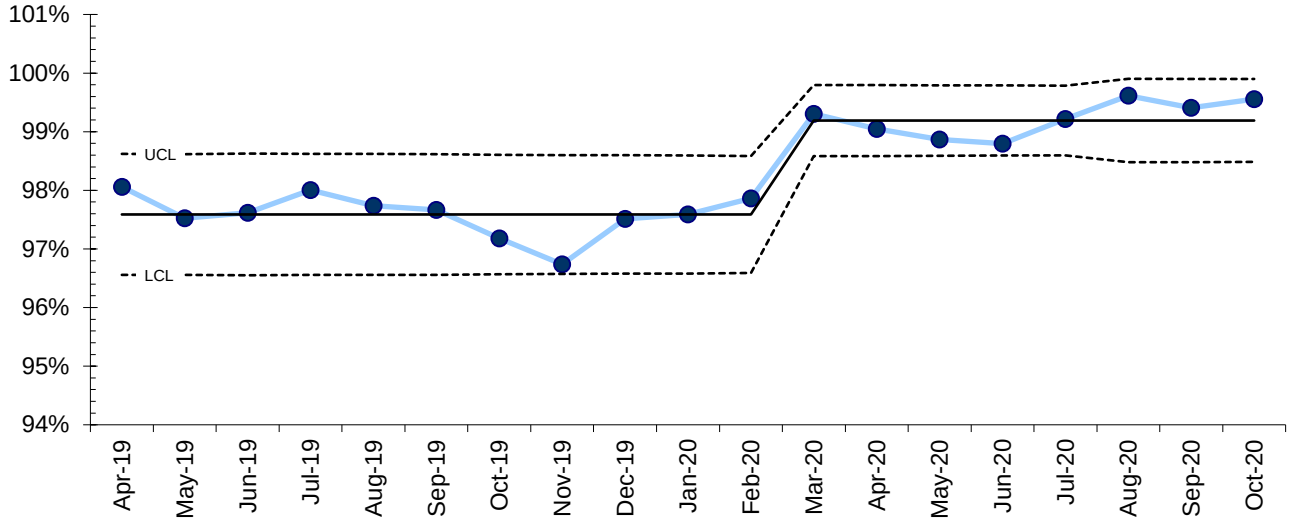


Chart 4.4 DBS clearance (Trustwide – P' chart)



5. Finance Performance

Executive Summary

1 Key conclusion are:

- Operating surplus (EBITDA) to end of October 2020 of £9,786k compared to planned operating surplus of £9,612k.
- Net surplus of £144k (0.1%) compared to planned net surplus of £133k (0.0%).
- Year to date net surplus variance on plan.
- NHS Improvement (NHSI) risk rating is not currently being reported.
- Cash balance of £149.8m as at the end of October 2020.

2 Financial Framework

2.1 Trust and STP Phase 3 plans were submitted to NHS Improvement (NHSI) during October 2020, setting out intended funding, investment, and expenditure for the remainder of financial year 2020/21.

The Trust now has a £5,311k deficit plan, and this has been reflected in the Month 7 financial position.

2.2 The key resulting budget changes are summarised below.

	£000
Month 6 Annual Budget Surplus / (Deficit)	**0**
Income	
Increase in block income	16,230
Development Funds	
Mental Health Investment (MHIS)	-9,441
Service Development Fund (SDF, Transformation)	-5,417
Wider service expansion	-2,235
Efficiency	
Phase 3 Financial Viability savings	3,729
Other Adjustments	
COVID-19 expenditure allocation	-4,848
Other offsetting adjustments	-3,329
Month 7 Annual Budget Surplus / (Deficit)	**-5,311**

2.3 Top-up funding for Month 1-6 of £12,817k has now been fully reflected in income and expenditure budgets, and the impact is apparent in the total income and expenditure variances this month.

2.4 From 1st October, elements of the NHS England (NHSE) Specialist Commissioning contract have been devolved to local Trusts. This Trust is the lead provider organisation for Child and Adolescent Mental Health services (CAMHS), and Barnet, Enfield, and Haringey Mental Health Trust (BEH) are the lead provider organisation for Forensic Services.

Income budgets have been adjusted to reflect full income for the CAMHS commissioning function being received, offset by expenditure budgets for planned payments to other Trusts

in the collaborative. There is a further adjustment to reflect Forensic income being received via BEH rather than NHSE.

2.5 The Trust has assumed payments from other commissioners (e.g. local authority contracts) continues as per 2019/20. The Commercial Development Department (CDD) has written 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.

The responses so far, where they have been received, suggest local authorities in general are not prepared to fund additional uplift. The national guidance issued does not indicate a clear responsibility in this regard.

In order to be prudent, these uplifts had not been assumed in opening budgets, and income assumptions will be amended if and when revised contract values are agreed.

3 Summary of Performance to 31st October 2020

The financial performance is summarised in the table below:

	YTD Oct-20			Temporary Annual Budget	YTD Sep-20 Variance	Change +/-
	Budget £000	Actual £000	Variance £000	£000	£000	£000
Operating Income	277,152	278,616	1,464	483,202	14,169	(12,704)
Operating Spend	267,539	268,830	(1,290)	472,262	(14,030)	12,740
Operating Surplus (EBITDA)	**9,612**	**9,786**	**174**	**10,939**	**138**	**36**
Interest Receivable	175	13	(162)	300	(137)	(25)
Interest Payable	(1,184)	(1,184)	0	(2,029)	0	0
Depreciation	(5,805)	(5,807)	(2)	(9,952)	(2)	0
Public Dividend Capital	(2,665)	(2,665)	0	(4,569)	0	0
Net Surplus / (Deficit)	**133**	**144**	**11**	**(5,311)**	**0**	**11**

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

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

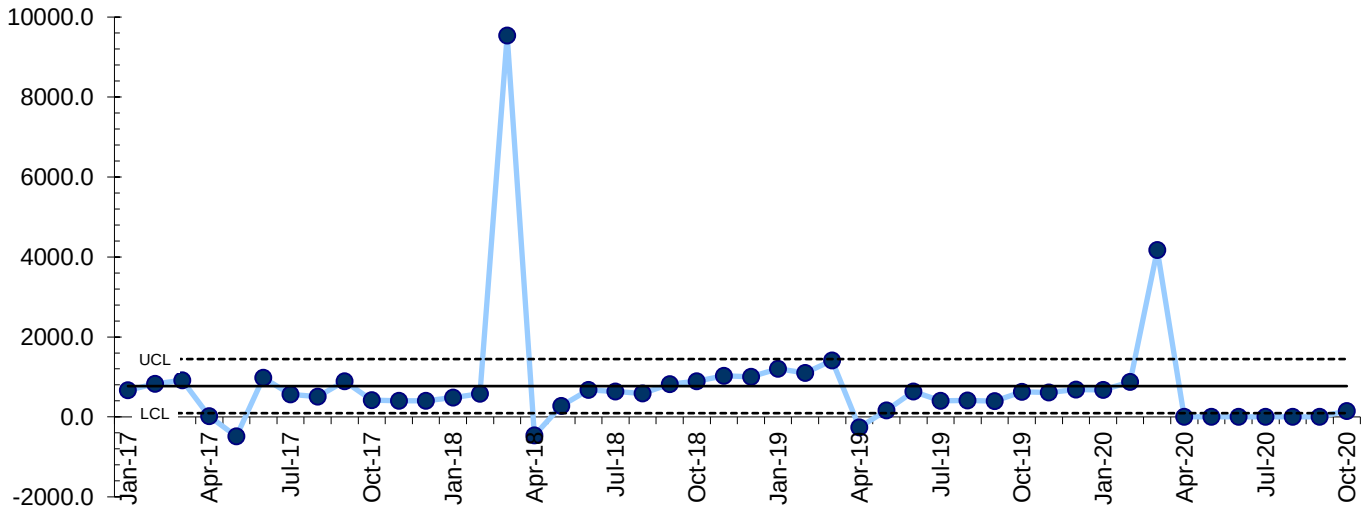


Chart 5.2 Cash Balance (Trustwide – I chart)

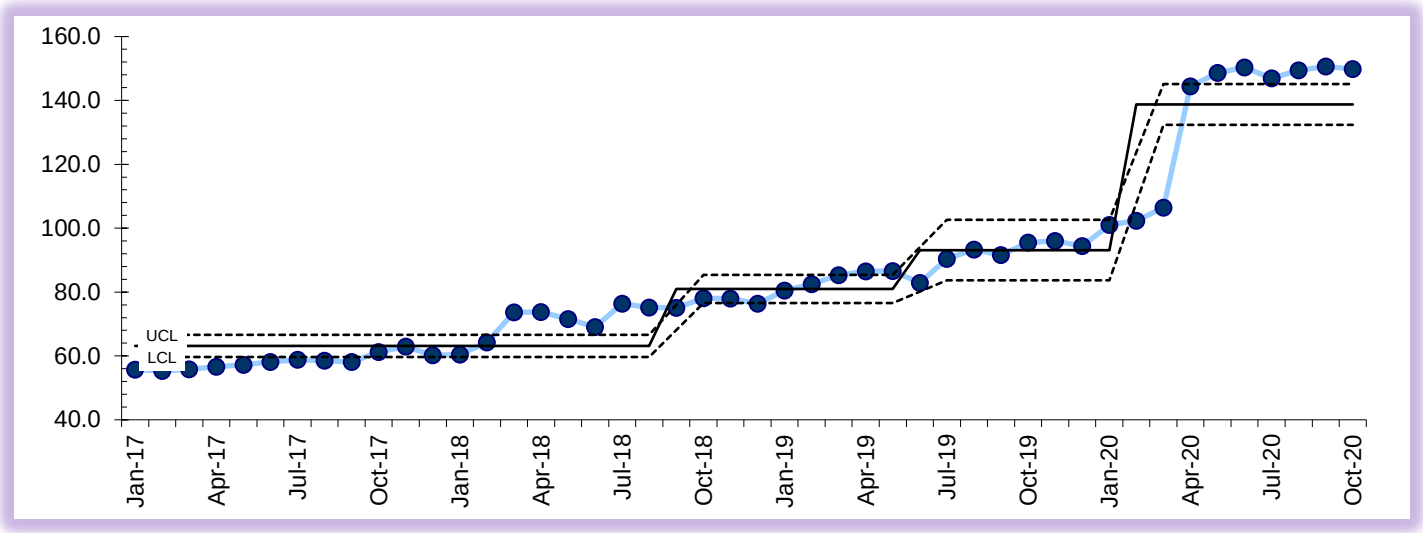


Chart 5.3 Agency vs ceiling (Trustwide – I chart)

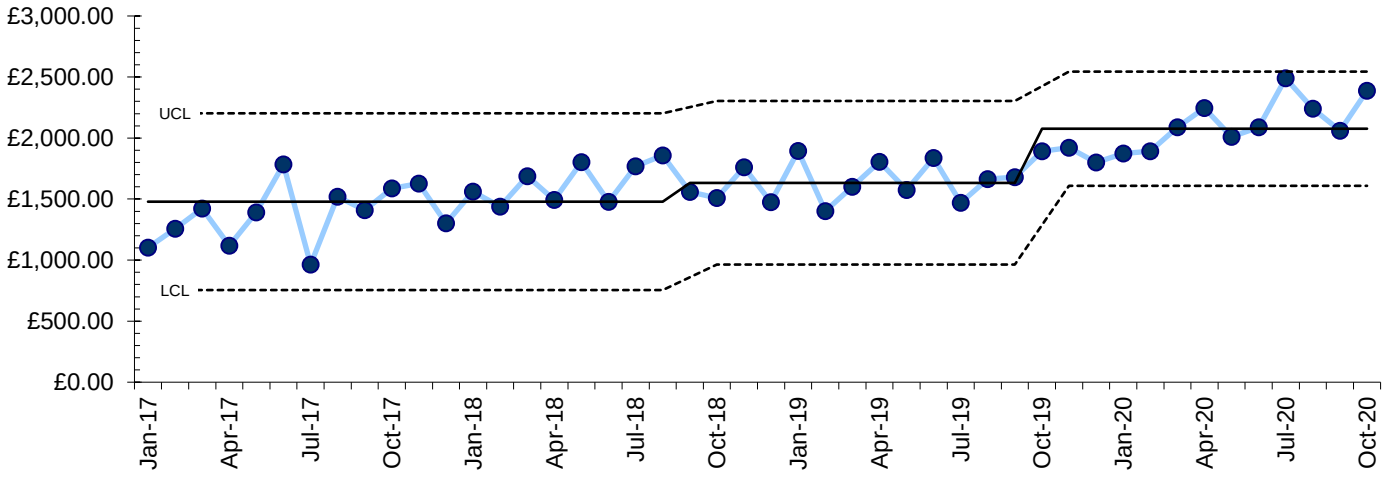
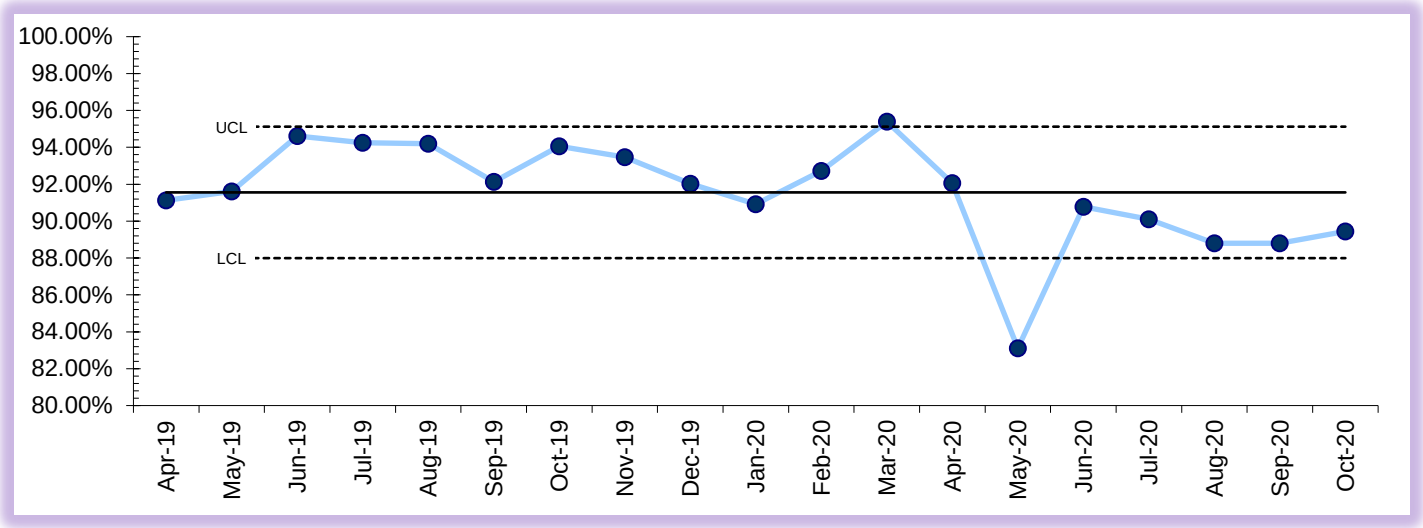


Chart 5.4 The value of invoices paid within 30 days, as a percentage (I chart)



7. Recommendations and Action Being Requested

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