Trust Board
29 June 2021

Board Performance Report
May 2021 (Month 2)

Highlighted Performance Movements - May 2021

Improved performance:

Metric	Performance - %	
Gatekeeping Target is >=95%	98.8%	Reported 93.2% last month
Care Programme Approach – 7-day follow up (reported 1 month in arrears) Target is 95%	94.3%	Reported 85.2% last month

Deteriorating Performance:

Metric	Performance	
Personality Disorder - over 52 weeks waiters (13 weeks)	214	Highest number of waiters reported
CAMHS Eating Disorder – one week (complete pathway) Target is 95%	33.3%	Unprecedented and sustained increased demand resulting in further deterioration in performance

Other areas to highlight:

Metric	Performance (No)	
No. of episodes of seclusions >2hrs *Target decreasing trend*	32	Increased from 30 reported last month
No. of episodes of supine restraint *Target decreasing trend*	4	No change to last month
No. of episodes of prone (unsupported) restraint *Target decreasing trend*	0	Decreased from 2 reported last month
No. of Category 2 pressure ulcers developed or deteriorated in LPT care *Target decreasing trend*	105	Decreased from 120 reported last month
No. of repeat falls *Target decreasing trend*	43	Decreased from 53 reported last month

2021/2022 New Performance Metric to be reported when data and target measurement agreed

KPI	Comments
DMH/Urgent Care Access	KPIs for the DMH Urgent Care/ Access services are currently being developed.
Mental Health Liaison Service 1hr/4hr/24hr response	Reporting of these KPIs requires new S1 templates - these are in draft form. The aim is to start completing these from 1st June.
Urgent Community Response Target is 80%	TPP have been developing a completely new 'UCR module' for SystmOne that includes something like a front end 'minute-by-minute countdown waiting list' for the 2 Hour responses that runs off on live data. The new module was released and IIT have been testing the RTT functionality within the new Community Therapy unit. Unfortunately initial testing has shown that the changes to the RTT functionality are very poor, and do not meet UCR standards and IIT are now working further with TPP to resolve the issues and specify the technical outputs.
Specialist Autism (Post Diagnostic) Wait for Assessment/ Wait for Treatment/ No. of Referrals	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.
Aspergers Wait for Assessment/ Wait for Treatment/ No. of Referrals	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.
LD Psychology Wait for Assessment/ Wait for Treatment/ No. of Referrals	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.
LD Community Wait for Assessment/ Wait for Treatment/ No. of Referrals	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.
CAMHS ED: Community Wait for Assessment/ Wait for Treatment	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.
CAMHS ED: Neurodevelopmental Wait for Assessment/ Wait for Treatment	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.
CAMHS Crisis	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.
All LD - No's waiting over 52 weeks	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.
CMHT's – No. patients with severe mental illness having 2+ contacts with Community Team	LPT is clarifying the KPI definition for this new indicator with NHSE/I.
Number of patients admitted with no previous contact with CMHT	Report is in development for this new indicator.
Learning Disabilities - Inpatients Target: CYP=3 Adult =36	This is a new KPI. Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.

1. Hospital Acquired COVID Infection Reporting

A nosocomial infection is an infection that is acquired in a hospital or other health care facility. How likely each patient Covid-19 case is to be a nosocomial case is based on the duration of time between admission to a healthcare facility and positive specimen date;.

- **Hospital-Onset Probable Healthcare-Associated** – positive specimen date 8 -14 days after hospital admission.
- **Hospital-Onset Definite Healthcare-Associated** – positive specimen date 15 or more days after hospital admission.

Indicator	Trust Position															
Total Admissions	**Month**	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Sparkline
	Total Admissions	404	353	389	330	374	366	368	381	377	347	396	377	406	398	437	
Covid Positive Prior to Admission	**Month**	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Sparkline
	Total Covid +ve Admissions	18	49	31	11	5	4	2	28	41	44	66	31	11	1	0	
	Covid +ve Admission Rate	4.5%	13.9%	8.0%	3.3%	1.3%	1.1%	0.5%	7.3%	10.9%	12.7%	16.7%	8.2%	2.7%	0.3%	0.0%	
Covid Positive Following Swab During Admission	**No of Days**	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Sparkline
	0-2	1	4	2	2	0	0	0	2	5	4	5	4	0	0	0	
	3-7	2	9	9	1	1	0	1	0	7	12	20	8	1	0	1	
	8-14	1	8	9	2	0	0	0	0	1	15	9	5	2	0	0	
	15 and over	11	14	5	2	0	0	0	7	5	29	18	35	9	1	0	
	Hospital Acquired Rate *	3.0%	6.2%	3.6%	1.2%	0.0%	0.0%	0.0%	1.8%	1.6%	12.7%	6.8%	10.6%	2.7%	0.3%	0.0%	
Overall Covid Positive Admissions Rate	**Month**	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Sparkline
	Total Covid +ve Admissions	33	84	56	18	6	4	3	37	59	104	118	83	23	2	1	
	Average Covid +ve Admissions	8.2%	23.8%	14.4%	5.5%	1.6%	1.1%	0.8%	9.7%	15.6%	30.0%	29.8%	22.0%	5.7%	0.5%	0.2%	

• Community-Onset (CO) positive specimen date - <=2 days after hospital admission or hospital attendance.
• Hospital-Onset Indeterminate Healthcare Associated (HO.IHA) – positive specimen date 3-7 days after hospital admission.
• Hospital-Onset Probable Healthcare-Associated (HO.pHA) – positive specimen date 8 -14 days after hospital admission.
• Hospital-Onset Definite Healthcare-Associated (HO.dHA) – positive specimen date 15 or more days after hospital admission.
** - Includes the Hospital-Onset Probable Healthcare-Associated and Hospital-Onset Definite Healthcare-Associated categories.*

Current LPT data sources for nosocomial Covid-19

Daily Directorate Covid-19 Sit-rep reports

The template includes; number of confirmed Covid-19 patients diagnosed with Covid-19 between midnight to 23.59:59 on the day before against the date of the positive specimen in line with the above definitions. This information is submitted directly to the ICC and copied to the Trust Infection Prevention and Control team.

IPC team local access database

The IPC team have a local access database for clinical patient reviews that captures all patients with long term infections and more recently Covid-19.The data source is taken from the daily Directorate sit-reps, or though IPC referrals. Data is validated using SystmOne records and ilab to confirm results. The system is backed up daily.
The objective is to move to a utilising System1 functionality when it is available, with reporting through Qliksense. The Information and IPC teams are currently working up this system and process.

Internal reporting

There was one definite case in April 21 which was identified on Maple ward within Mental Health Services, an RCA is currently underway. An initial cause being considered is the lack of compliance by the patient during a planned episode of leave. On return from leave the patient was managed in line with the Trust Testing Regime for Covid-19.

PHE has been updated and we are now supporting the revised pathways, admissions process update. We continue to test, screen and triage all contacts. An aggregated nosocomial/outbreak review of our cases from March 2020 until March 2021 has been undertaken and the report processed through the Quality Forum. This will be an appendix to the 6 monthly Trust Board report due on the 29th June 2021. Lessons have continued to be shared in real time to support and improve patient safety as identified.

A number of campaigns including Cleaning with Confidence and Every Action Counts have informed our processes to support the prevention of nosocomial infections. A further Spring Clean campaign is in progress to support the following:
- Dump the Junk
- How tidy is your cupboard
- Swap shop, can it be repurposed in another service if not needed (in line with mandatory requirements)
- Stock rotation, improving stock flow, expiry dates and stock levels.

Actions to minimise nosocomial Covid-19 infection

The weekly Trust wide outbreak meeting is attended by PHE and NHSE/I IPC leads. There have been no concerns to date escalated at the meeting in terms of our strategies and actions to minimise Covid-19 transmission. There is a Trust Outbreak quality improvement plan to ensure we are learning and sharing, one learning board has already been developed from lessons learnt and this will continue to be shared as an output from the meetings. We have also incorporated learning from NHFT and national webinars. Anne Scott as DIPC has instigated an aggregated review of all Trust outbreaks and a thematic review of the Trust nosocomial cases.

2. Quality Account

The following standards form the measures for the 2020/21 Quality Account

<table>
<tr><th rowspan="2">Standard</th><th rowspan="2">Trust Performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td rowspan="2">The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period</td><td rowspan="2"><table><tr><td>Dec-20</td><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td></tr><tr><td>73.2%</td><td>93.7%</td><td>81.0%</td><td>79.4%</td><td>93.2%</td><td>98.8%</td></tr></table></td><td rowspan="2"></td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="2">The percentage of patients on CPA (care programme approach) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period

(reported a month in arrears)</td><td rowspan="2"><table><tr><td>Nov-20</td><td>Dec-20</td><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td></tr><tr><td>91.3%</td><td>92.7%</td><td>83.5%</td><td>93.1%</td><td>85.2%</td><td>94.3%</td></tr></table></td><td rowspan="2">Improvement continues to be made following the migration to SystmOne and the introduction of revised guidance.</td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="2">The Trusts “Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period</td><td rowspan="2"><table><tr><td>2017/18</td><td>2018/19</td><td>2019/20</td><td>2020/21</td></tr><tr><td>7.4</td><td>6.4</td><td>7.1</td><td>6.9</td></tr></table></td><td rowspan="2">The majority of scores within Leicestershire Partnership NHS Trust’s results sit in the intermediate 60% of the Trusts surveyed by Quality Health, although there are also a number (over a third) that fall into the bottom 20% range, particularly with the Support and Wellbeing section. However, there is a trend of positive change in many of the scores.
Many scores continue to show improvement and there are more scores in the intermediate range than bottom now. The score for overall rating of care has moved from the bottom to intermediate range.
Older adults continue to report more positively.</td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2">Not applicable for SPC as reported infrequently</td></tr>
<tr><td rowspan="2">The percentage of patients aged:
(i) 0 to 15 and
(ii) 16 or over
readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period</td><td rowspan="2"><table><tr><td colspan="6">Age 0-15</td></tr><tr><td>Dec-20</td><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td></tr><tr><td>50.0%</td><td>0.0%</td><td>66.7%</td><td>0.0%</td><td>0.0%</td><td>66.7%</td></tr><tr><td colspan="6">Age 16 or over</td></tr><tr><td>33.3%</td><td>32.1%</td><td>32.5%</td><td>28.8%</td><td>31.7%</td><td>35.3%</td></tr></table></td><td rowspan="2"></td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2"></td></tr>
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2. Quality Account

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<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td rowspan="4">The number and, where available rate of patient safety incidents reported within the Trust during the reporting period</td><td>Dec-20</td><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td rowspan="4"></td><td rowspan="3">n/a</td><td rowspan="3">n/a</td></tr>
<tr><td>937</td><td>1086</td><td>986</td><td>964</td><td>1109</td><td>1090</td></tr>
<tr><td>56.7%</td><td>55.7%</td><td>57.0%</td><td>59.1%</td><td>62.9%</td><td>63.6%</td></tr>
<tr><td colspan="6"></td><td colspan="2"></td></tr>
<tr><td rowspan="4">The number and percentage of such patient safety incidents that resulted in severe harm or death</td><td>Dec-20</td><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td rowspan="4"></td><td rowspan="3">n/a</td><td rowspan="3">n/a</td></tr>
<tr><td>6</td><td>8</td><td>6</td><td>5</td><td>5</td><td>2</td></tr>
<tr><td>0.6%</td><td>0.7%</td><td>0.7%</td><td>0.5%</td><td>0.5%</td><td>0.2%</td></tr>
<tr><td colspan="6"></td><td colspan="2"></td></tr>
<tr><td rowspan="3">Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral
(reported a month in arrears)</td><td>Nov-20</td><td>Dec-20</td><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td rowspan="3">(Green)</td><td rowspan="2">?</td><td rowspan="2">UP</td></tr>
<tr><td>85.0%</td><td>91.7%</td><td>93.3%</td><td>84.6%</td><td>89.5%</td><td>89.5%</td></tr>
<tr><td colspan="6"></td><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="2">Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient Wards b) EIP Services c) Community Mental Health Services (people on care programme approach)</td><td colspan="6" rowspan="2">*Reported Bi-annually*

Inpatient Wards
Mar-20 / Sep-20 / Mar-21
60.0% / 58.0% / 96.0%

EIP Services
Mar-20 / Sep-20 / Mar-21
93.0% / - / 97.0%

Community Mental Health Services on CPA (arrears)
Mar-20 / Sep-20 / Mar-21
- / 34.0% / -

Comments on Sept 2020 results:
Results remain consistent for inpatient services compared to the last report (March). Results for CPA patients are of concern and need improving. The RED result for CPA patients can in large be accounted for by the impact of COVID19. Explicitly the impact has been as follows: suspension of blood test reminders sent out by the Leicestershire Physical Health Register (as agreed with the Head of Pharmacy) with the purpose of reducing pressure on CMHT staff and services, reduction in contact of CMHT with patients to abide by global social distancing requirements to reduce risk, limitations in staff and resource deployed elsewhere where acutely needed. The impact of COVID19 must be taken into account when reviewing these results. Going forward this is under constant review and adjusting in line with guidance provided.</td><td rowspan="2">Comments on March 2021 results

To continue the work as has been achieved thus far. Staff should be commended on their excellent work in this area particularly in light of the impacts and implications of COVID.</td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2">*Not applicable for SPC as reported infrequently*</td></tr>
<tr><td rowspan="3">Admissions to adult facilities of patients under 16 years old</td><td>Dec-20</td><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td rowspan="3"></td><td rowspan="2">n/a</td><td rowspan="2">n/a</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td colspan="6"></td><td colspan="2"></td></tr>
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3. NHS Oversight

The following targets form part of the new NHS Oversight Framework.

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60% *(reported a month in arrears)*	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21		?	UP
	85.0%	91.7%	93.3%	84.6%	89.5%	89.5%		Over the series of data points being measured, key standards are being delivered inconsistently	
Mental Health data submission to NHS Digital: % clients in employment No Target Set	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	Most recent published data is for February 2021. 2021/2021 Q4 data is due to be published next month.	NO	UP
	3%	4%	4%	3%	3%	4%		Key standards are not being delivered but are improving	
Mental Health data submission to NHS Digital: % clients in settled accommodation No Target Set	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	Most recent published data is for February 2021. 2021/2021 Q4 data is due to be published next month.	NO	UP
	37%	39%	39%	34%	32%	43%		Key standards are not being delivered but are improving	
6-week wait for diagnostic procedures (Incomplete) Target is >=99% *(reported a month in arrears)*	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	In line with national COVID-19 guidance, this service was suspended. It was re-established in October and due to COVID restrictions can only work at 60% previous activity. To support this additional audiologist capacity has been secured and a successful capital bid for an additional clinical room this financial year. The service is on track to deliver the recovery trajectory for the backlog of CYP, however new referrals are increasing.	YES	DOWN
	31.0%	28.4%	31.1%	42.4%	70.7%	72.0%		Key standards are being delivered but are deteriorating	

4(a). Access - Waiting Time Standards - DMH

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance							RAG/ Comments on recovery plan position	SPC Flag: Assurance of Meeting Target	SPC Flag: Trend
Adult CMHT Access Six weeks routine (incomplete pathway) Target is 95%		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Service has an improvement plan in place and additional capacity (weekend clinics and overtime) is supporting a reduction in waiting times. The incomplete compliance rate is improving consistently each month.	NO	NO CHANGE
		15.5%	6.1%	n/a	46.6%	59.2%	66.0%		Key standards are not being delivered and are deteriorating/ not improving	
Memory Clinic (18 week Local RTT) Target is 95%		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Service has a robust improvement plan and trajectory in place, based on a PDSA approach streamlining the patient pathway and maximising clinical capacity. The incomplete waiting times compliance is improving consistently and the number of people waiting is falling in line with this.		
	Complete	16.9%	17.0%	22.1%	13.5%	19.0%	25.9%		N/A	N/A
	Incomplete	44.1%	56.6%	62.2%	62.1%	63.0%	64.8%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Service has an improvement plan - some elements are dependent on increasing capacity to match the increase in demand. Recruitment to the specialist posts has been inconsistent. The service continues to work on a tender process, supporting by procurement to outsource the waiting list backlog.		
	Complete	13.3%	11.8%	23.5%	22.7%	18.2%	25.0%		N/A	N/A
	Incomplete	34.2%	35.3%	39.5%	38.0%	40.3%	37.3%		N/A	N/A

4(b). Access - Waiting Time Standards - CHS

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
CINSS - 20 Working Days (Complete Pathway) Target is 95%	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Urgent compliance is consistently 100%. Trajectory and action plan in place to meet 95% by March 2022.	N/A	N/A
	45.0%	61.3%	59.3%	31.3%	32.2%	27.6%			
Continence (Complete Pathway) Target is 95%	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	March 2020: Service suspended to support COVID system pressures & staff redeployed to community nursing hubs. Improvement plan in place with trajectory to reduce the number of patients waiting.	N/A	N/A
	6.3%	31.9%	37.8%	32.6%	23.3%	13.6%			

4(c). Access - Waiting Time Standards - FYPC

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	RAG/ Comments on recovery plan position	SPC Flag: Assurance of Meeting Target	SPC Flag: Trend
CAMHS Eating Disorder – one week (complete pathway) Target is 95%	83.3%	66.7%	100.0%	100.0%	66.7%	33.3%	Urgent - The Service has seen a sustained increase in urgent referrals, which is consistent with the National profile. Referrals are prioritised and additional capacity has been agreed through the MHIS. An improvement plan and trajectory are in place, which has Executive oversight. In addition, a number of young people are being supported in the community whilst waiting.	?	NO CHANGE
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%	66.7%	50.0%	0.0%	33.3%	50.0%	50.0%	Routine - routine referrals are being delayed due to the prioritisation of urgent cases. Additional capacity has been agreed through the MHIS and an improvement plan is in place, with Executive oversight.	?	DOWN
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Resources are being diverted to deal with the urgent referrals.	? Over the series of data points being measured, key standards are being delivered inconsistently	UP
Children and Young People's Access – 13 weeks (incomplete pathway) Target is 92%	100.0%	100.0%	100.0%	90.3%	78.2%	69.3%	The current KPI is breaching due to increasing demand and is forecast to deteriorate further over the next two months. Additional capacity has been agreed through the MHIS and an action plan to retrieve the KPI standard by end of Q2 is in place. This is dependent on workforce supply.	?	DOWN

5. 52 week waits

No patient should wait for more than 52 weeks from referral to the start of their treatment. From March 2020, the Trust will merge the existing Wait Times Group and the Harm Assurance Group to improve the governance and confidence of harm reviews for long waiting patients.

The following services have 52 week waits within their service:

Target	Trust Performance						Longest wait (latest month)	RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Cognitive Behavioural Therapy	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	117 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall. The improvement remains in line with the service's trajectory.	NO	NO CHANGE
	52	56	54	58	50	45			Key standards are not being delivered and are deteriorating/ not improving	
Dynamic Psychotherapy	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	140 weeks	The number of 52 week waiters continues to fall, and is now below the planned trajectory. Group offers continue to support the improvement plan, alongside a re-design of the future service offer under SUTG-MH.	NO	DOWN
	67	67	59	46	43	23			Key standards are not being delivered but are improving	
Personality Disorder	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	249 weeks	Plans to re-design the psychological treatment offer for patients with a personality disorders continue to be developed. Pilot psychological skills groups are taking place - planning is underway to scale up the delivery of these groups, within locality teams.	NO	UP
	105	107	204	205	210	214			Key standards are not being delivered and are deteriorating/ not improving	
CAMHS	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	79 weeks	This waiting list includes CYP waiting for treatment and those waiting for Neurodevelopmental assessment. The service is currently dealing with a spike in demand relating to the Access improvement plan 12- 18 months ago. Once this is clear there are significantly less children waiting per week and there will be a more rapid recovery.	NO	UP
	139	168	175	205	257	250			Key standards are not being delivered and are deteriorating/ not improving	

6. Patient Flow

The following measures are key indicators of patient flow:

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag: Assurance of Meeting Target	SPC Flag: Trend
Occupancy Rate - Mental Health Beds (excluding leave) Target is <=85%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Occupancy levels are closely monitored and actions taken in line with the covid surge plans to ensure adequate capacity is available on a day to day basis.	?	NO CHANGE
	67.2%	86.2%	80.5%	83.1%	83.8%	79.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	The Trust is below the local target rate of 93%, however there is engagement with commissioners to review the benefits of this target to support flow. Occupancy is one of a range of measures to support flow and 93% does not ordinarily work. The national level is 87% and this is still challenging due to the separation of red and green beds / IPC requirements.	?	DOWN
	71.5%	77.3%	75.3%	73.8%	76.0%	82.8%		Over the series of data points being measured, key standards are being delivered inconsistently	
Average Length of stay Community hospitals National benchmark is 25 days.	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Fluctuating LoS will be attributed to changes in discharge protocol as a result of the COVID-19 response	YES	DOWN
	17.6	16.0	16.9	17.6	17.1	16.6		Key standards are being consistently delivered and are improving/ maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	NHS Digital has advised this national metric is being paused to release resources to support the COVID-19 response. We will continue to monitor locally	?	NO CHANGE
	4.5%	4.5%	4.1%	3.1%	2.9%	2.7%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21		?	NO CHANGE
	73.2%	93.7%	81.0%	79.4%	93.2%	98.8%		Over the series of data points being measured, key standards are being delivered inconsistently	
Care Programme Approach – 7-day follow up Target is 95% *(reported a month in arrears)*	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Improvement continues to be made following the migration to SystmOne and the introduction of revised guidance.	?	NO CHANGE
	91.3%	92.7%	83.5%	93.1%	85.2%	94.3%		Over the series of data points being measured, key standards are being delivered inconsistently	
72 hour Follow Up after discharge Target is 80% *(reported a month in arrears)*	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21		N/A	N/A
	73.6%	76.4%	69.1%	78.8%	70.9%	80.4%			
Care Programme Approach 12-month standard Target is 95%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	A CPA review improvement plan is now in place. Performance deteriorated as reports were not available for a 5 month period during the SystmOne migration.	NO	DOWN
	66.2%	61.7%	52.2%	54.2%	64.9%	68.7%		Key standards are not being delivered and are deteriorating/ not improving	
Perinatal - Number and Percentage of women accessing service Target is 8.6%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Access for this indicator is defined as requiring a face to face or video consultation i.e. telephone contacts are excluded. Due to the pandemic, the service has been using telephone as a replacement for some face to face work. There are also some issues where the modality has not been recorded correctly. The service has an agreed trajectory for improvement in place.		
	650	622	593	547	504	502		N/A	N/A
	5.2%	5.0%	4.7%	4.4%	4.0%	4.0%		N/A	N/A

7. Quality and Safety

Target	Trust Performance	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	RAG/ Comments on recovery plan position	SPC Flag: Assurance of Meeting Target	SPC Flag: Trend
Serious incidents		11	10	5	10	10	2		N/A	NO CHANGE
									Over the series of data points being measured, key standards are being delivered inconsistently	
STEIS - SI action plans implemented within timescales (in arrears) Target = 100%		33.3%	35.6%	33.3%	31.0%	20.0%	14.3%	Awaiting validated data to assess achievement of measure	?	DOWN
									Over the series of data points being measured, key standards are being delivered inconsistently	
Safe staffing No. of wards not meeting >80% fill rate for RNs Target 0	Day	4	5	5	5	5	7	This measure has been temporarily suspended during COVID-19 as staffing capacity is changing rapidly and continually to respond to the pandemic	NO	NO CHANGE
	Night	0	0	0	0	0	0		Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day						12.4	12.3		N/A	N/A
									Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend		16	21	40	23	30	32		N/A	NO CHANGE
									Key standard has no target; however performance is consistent	
No. of episodes of supine restraint Target decreasing trend		15	25	25	8	4	4		N/A	NO CHANGE
									Key standard has no target; however performance is consistent	
No. of episodes of side-line restraint Target decreasing trend		2	33	15	14	27	29		N/A	NO CHANGE
									Key standard has no target; however performance is consistent	
No. of episodes of prone (unsupported) restraint Target decreasing trend		1	0	2	0	2	0		N/A	NO CHANGE
									Key standard has no target; however performance is consistent	
No. of episodes of prone (supported) restraint Target decreasing trend		2	7	2	2	5	5		N/A	NO CHANGE
									Key standard has no target; however performance is consistent	

Measure								Commentary		
No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory)		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Oversight of the pressure ulcer data occurs at the LPT Pressure Ulcer Quality Improvement Group. This group is responsible for the Pressure Ulcer Quality Improvement project and LifeQI is the tool being used to capture this work.		
	Category 2	76	87	79	100	120	105		N/A	NO CHANGE
	Category 4	3	2	6	5	3	5		N/A	NO CHANGE
									Key standard has no target; however performance is consistent for category 2 and consistent for category 4	
No. of repeat falls Target decreasing trend		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	General reduction in patient numbers over the Covid period will result in greater variance than has been seen historically. This is monitored via the Falls Steering Group including the impact on Harm.		
		61	43	54	65	53	43		N/A	NO CHANGE
									Key standard has no target; however performance is consistent	
LD Annual Health Checks completed Target is 75%		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	To date from 1 April 2021, 255 completed, 10% up on last year at the same time 10 DNA, 3 declined in the same period		
						106	255		N/A	N/A
LeDeR Reviews completed within timeframe		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	20/21 YTD - 76.3% Currently no change in stats for LeDeR as the new review system will be launched on 15 June		
									N/A	N/A

8. Data Quality

The following measures are key indicators of the quality of data completeness. These should be read alongside the Mental Health Services Data Standards (MHSDS) set out in section one of this report.

Target	Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
MH Data quality Maturity Index Target >=95%	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Latest data published is for February 2021	NO	UP
	93.5%	93.6%	90.6%	91.2%	91.2%	91.5%		Key standards are not being delivered but are improving	

9. Workforce/HR

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag: Assurance of Meeting Target	SPC Flag: Trend
Normalised Workforce Turnover rate (Rolling previous 12 months) Target is <=10%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	The Trust is below the ceiling set for turnover.	YES	DOWN
	8.7%	8.4%	8.7%	8.4%	8.5%	8.8%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	The vacancy rate is higher than the Trust target.	NO	UP
	10.0%	10.1%	9.1%	9.5%	10.8%	12.4%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Sickness absence is currently lower than the Trust target, absences are being managed with support from HR.	NO	DOWN
	5.4%	5.0%	5.1%	4.1%	3.5%	4.4%		Key standards are not being delivered but are improving	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Sickness absence is currently lower than the Trust target, absences are being managed with support from HR.	n/a	n/a
	£711,902	£679,838	£675,994	£486,469	£477,073	£580,557		SPC to be included once 13 data points have been provided	
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21		n/a	n/a
	4.9%	4.9%	4.9%	4.9%	4.7%	4.4%		Not applicable for SPC as measuring cumulative data	
Agency Costs Target is <=£641,666 (NHSI national target)	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Agency costs as at M2 2021/22 were £1,556k.	?	UP
	£1,193,443	£1,593,262	£1,976,000	£2,635,595	£1,531,718	£1,556,256		Over the series of data points being measured, key standards are being delivered inconsistently	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	The Trust is meeting the target set for Core Mandatory Training.	YES	NO CHANGE
	93.2%	93.3%	93.3%	93.4%	94.0%	94.6%		Key standards are being consistently delivered and are improving/ maintaining performance	
Staff with a Completed Annual Appraisal Target is >=80%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	The Trust is meeting the target set for Annual Appraisal	YES	DOWN
	86.2%	86.5%	86.4%	86.7%	88.2%	89.5%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	The Trust is meeting the target set.	NO	UP
	23.2%	23.4%	23.6%	23.7%	23.8%	23.7%		Key standards are not being delivered but are improving	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21		n/a	n/a
	59.7%	60.0%							
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	The Trust is meeting the target set for clinical supervision	NO	UP
	82.1%	81.5%	80.4%	82.1%	85.6%	88.1%		Key standards are not being delivered but are improving	
Health and Wellbeing Activity - Number of LLR staff contacting the hub in the reporting period (1 month in arrears)	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21		N/A	N/A
						135			

RAG rating against improvement plans

A simple RAG rating is used to assess compliance to the recovery plan:

- Red – a target that is not being delivered
- Amber – a target that is not being delivered but has an approved recovery plan with trajectory that is being met or there is a query about delivery
- Green – a target that is being delivered

Statistical process control (SPC) ratings against performance

The Trust has introduced SPC icons to indicate assurance of whether the process is expected to consistently meet or fail the target; and if a process is in special cause or common cause variation.

Icon	Performance Description
NO	The system is expected to consistently fail the target
YES	The system is expected to consistently pass the target
?	The system may achieve or fail the target subject to random variation

Icon	Trend Description
UP	Special cause variation – cause for concern (indicator where high is a concern)
DOWN	Special cause variation – cause for concern (indicator where low is a concern)
NO CHANGE	Common cause variation
UP	Special cause variation – improvement (indicator where high is good)
DOWN	Special cause variation – improvement (indicator where low is good)

Useful icon combinations to understand performance:

Performance	Trend	Description
YES	UP/ DOWN or NO CHANGE	Key standards are being consistently delivered and are improving/ maintaining performance
YES	UP/ DOWN	Key standards are being delivered but are deteriorating
?	Any trend icon	Over the series of data points being measured, key standards are being delivered inconsistently
NO	UP/ DOWN	Key standards are not being delivered but are improving
NO	UP/ DOWN or NO CHANGE	Key standards are not being delivered and are deteriorating/ not improving

Performance headlines – May 2021

The SPC measure includes data up to the current reporting month for the indicator

Key:			
(green)	The SPC measure has improved from previous month	NEW	The first assessment of a metric using SPC
	The SPC has not changed from previous month	R	Metric will be removed from future reports
(red)	The SPC measure has deteriorated from previous month	C	Change in performance can be attributed to COVID-19

Key standards being consistently delivered and improving or maintaining performance

- **C** Length of stay - Community Services
- Normalised Workforce Turnover rate
- Core Mandatory Training Compliance for Substantive Staff

Key standards being delivered but deteriorating

- **C** 6-week wait for diagnostic procedures
- Staff with a Completed Annual Appraisal

Key standards being delivered inconsistently

- CAMHS ED one week (complete)
- Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral
- CAMHS Eating Disorder – four weeks - (complete pathway)
- Children and Young People's Access – four weeks (incomplete pathway)
- Children and Young People's Access – 13 weeks (incomplete pathway)
- **C** Occupancy rate – mental health beds (excluding leave)
- **C** Average Length of stay (excluding leave) from Bradgate acute wards
- Delayed transfer of care (DToC)
- Gatekeeping
- CPA 7 day
- C Diff
- STEIS action plans completed within timescales
- Agency Cost
- Admissions to adult facilities of patients under 16 years old
- **C** Occupancy rate – community beds (excluding leave)

Key standards not being delivered but improving

- Mental Health data submission - % clients in employment (target updated to: no target set)
- Mental Health data submission - % clients in settled accommodation (target updated to: no target set)
- MH Data Quality Maturity Index
- % of staff from a BME background
- % of staff who have undertaken clinical supervision within the last 3 months
- Sickness Absence
- (green) Dynamic Psychotherapy over 52 weeks

Key standards not being delivered but deteriorating/ not improving

- **C** Adult CMHT Access six week routine (incomplete)
- CPA 12 month
- Safe Staffing
- Cognitive Behavioural Therapy over 52 weeks
- Personality Disorder over 52 weeks
- CAMHS over 52 weeks
- (red) Vacancy rate

Key standard we are unable to assess using SPC

- Patient experience of mental health services
- Readmissions with 28 days
- Patient safety incidents
- Patient safety incidents resulting in severe harm or death
- Serious incidents (no target)
- Quality indicators (no targets)
- Cardio-metabolic assessment and treatment for people with psychosis