# Trust Board
# 26 October 2021

# Board Performance Report
# September 2021 (Month 6)

**Highlighted Performance Movements - September 2021**

**Improved performance:**

| Metric | Performance | |
|---|---|---|
| CAMHS Eating Disorder – one week (complete pathway)<br>Target is 95% | 100.0% | Highest performance reported in the last 6 month period |
| Cognitive Behavioural Therapy | 27 | Lowest number reported |

**Deteriorating Performance:**

| Metric | Performance | |
|---|---|---|
| 6-week wait for diagnostic procedures (Incomplete)<br>Target is >=99%<br>(reported a month in arrears) | 49.9% | Lowest performance in the last 6 month period |

**Other areas to highlight:**

| Metric | Performance (No) | |
|---|---|---|
| Serious Incidents | 1 | Decreased from 5 reported last month |
| No. of episodes of seclusions >2hrs<br>*Target decreasing trend* | 24 | Increased from 7 reported last month |
| No. of episodes of sideline restraint<br>*Target decreasing trend* | 22 | Increased from 13 reported last month |
| No. of Category 2 pressure ulcers developed or deteriorated in LPT care<br>*Target decreasing trend* | 93 | Decreased from 105 reported last month |

**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 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Sparkline |
| | **Total Admissions** | 404 | 353 | 389 | 330 | 374 | 366 | 368 | 381 | 377 | 347 | 396 | 377 | 406 | 398 | 437 | 418 | 404 | 412 | 391 | |
| 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 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Sparkline |
| | **Total Covid +ve Admissions** | 18 | 49 | 31 | 11 | 5 | 4 | 2 | 28 | 41 | 44 | 66 | 31 | 11 | 1 | 0 | 3 | 6 | 20 | 12 | |
| | **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% | 0.7% | 1.5% | 4.9% | 3.1% | |
| 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 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Sparkline |
| | **0-2** | 1 | 4 | 2 | 2 | 0 | 0 | 0 | 2 | 5 | 4 | 5 | 4 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | |
| | **3-7** | 2 | 9 | 9 | 1 | 1 | 0 | 1 | 0 | 7 | 12 | 20 | 8 | 1 | 0 | 1 | 0 | 0 | 2 | 1 | |
| | **8-14** | 1 | 8 | 9 | 2 | 0 | 0 | 0 | 0 | 1 | 15 | 9 | 5 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | |
| | **15 and over** | 11 | 14 | 5 | 2 | 0 | 0 | 0 | 7 | 5 | 29 | 18 | 35 | 9 | 1 | 0 | 0 | 0 | 2 | 2 | |
| | **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% | 0.0% | 0.0% | 0.7% | 0.5% | |
| 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 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Sparkline |
| | **Total Covid +ve Admissions** | 33 | 84 | 56 | 18 | 6 | 4 | 3 | 37 | 59 | 104 | 118 | 83 | 23 | 2 | 1 | 3 | 6 | 26 | 16 | |
| | **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% | 0.7% | 1.5% | 6.3% | 4.1% | |

*• 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 through 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 were two definite nosocomial cases reported on Cedar Ward in September 2021, this is being managed as a patient and staff Covid-19 outbreak. The patient cases were identified through the routine testing, patients were immediately isolated and transferred to Gwendolen Ward, both patients were asymptomatic and remained well during isolation.

We continue to test, screen and triage all patients and use a risk assessment process. The pathways for patient admission have been updated to reflect the changes to a number of recent recommendations i.e. PPE useage. There are no red wards currently in use in the Trust, however a number of beds/areas have been identified in the directorates that meet the covid isolation requirements if patients test positive. Gwendolen Ward can be opened as a red/high risk ward and was opened for two positive patient cases in August 2021 and reopened in September 2021.

The campaign Hands, Face, Clean your space launched on the 15 July 2021, to support the Trusts recovery plans and continue to promote the Infection prevention and control messages, these include:
- 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 has been reinstated due to an increase in Covid-19 outbreaks to ensure lessons learnt and actions are widely shared.

**2. Quality Account**

The following standards form the measures for the 2020/21 Quality Account that being reported against in 2021/22 until the new metrics have been agreed.

| Standard | Trust Performance | RAG/ Comments on recovery plan position | SPC Flag: Assurance of Meeting Target | SPC Flag: Trend |
|---|---|---|---|---|
| The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period | Apr-21: 93.2%<br>May-21: 98.8%<br>Jun-21: 100.0%<br>Jul-21: 100.0%<br>Aug-21: 100.0%<br>Sep-21: 100.0% | | ? | NO CHANGE |
| | | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| 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 | 2017/18: 7.4<br>2018/19: 6.4<br>2019/20: 7.1<br>2020/21: 6.9 | 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.<br>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.<br>Older adults continue to report more positively. | n/a | n/a |
| | | | *Not applicable for SPC as reported infrequently* | |
| The percentage of patients aged:<br>(i) 0 to 15 and<br>(ii) 16 or over<br>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 | **Age 0-15**<br>Apr-21: 0.0%<br>May-21: 66.7%<br>Jun-21: 0.0%<br>Jul-21: 0.0%<br>Aug-21: 0.0%<br>Sep-21: 0.0%<br>**Age 16 or over**<br>Apr-21: 31.7%<br>May-21: 35.3%<br>Jun-21: 32.8%<br>Jul-21: 40.8%<br>Aug-21: 47.9%<br>Sep-21: 45.2% | | n/a | n/a |

**2. Quality Account**

The following standards form the measures for the 2020/21 Quality Account that being reported against in 2021/22 until the new metrics have been agreed.

| Standard | Trust Performance | | | | | | RAG/ Comments on recovery plan position | SPC Flag: Assurance of Meeting Target | SPC Flag: Trend |
|---|---|---|---|---|---|---|---|---|---|
| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | | |
| The number and, where available rate of patient safety incidents reported within the Trust during the reporting period | 1087 | 1079 | 1153 | 1048 | 955 | 972 | | n/a | n/a |
| | 62.5% | 62.1% | 65.0% | 61.5% | 59.0% | 61.2% | | | |
| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | | |
| The number and percentage of such patient safety incidents that resulted in severe harm or death | 3 | 1 | 10 | 4 | 9 | 8 | | n/a | n/a |
| | 0.3% | 0.1% | 0.9% | 0.4% | 0.9% | 0.8% | | | |
| | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | | |
| 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)* | 84.0% | 89.5% | 79.2% | 87.5% | 78.3% | 72.4% | (green) | ? | UP |
| | | | | | | | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | | |
| Admissions to adult facilities of patients under 16 years old | 0 | 0 | 0 | 0 | 0 | 0 | | n/a | n/a |

**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)**

*Reported Bi-annually*

| Service area | Mar-20 | Sep-20 | Mar-21 | Sep-21 |
|---|---|---|---|---|
| **Inpatient Wards** | 60.0% | 58.0% | 96.0% | 94.0% |
| **EIP Services** | 93.0% | - | 97.0% | - |
| **Community Mental Health Services on CPA (arrears)** | - | 34.0% | - | 54.0% |

RAG/ Comments on recovery plan position: Comments on September 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.

SPC Flag – Assurance of Meeting Target: n/a; Trend: n/a

*Not applicable for SPC as reported infrequently*

**3. NHS Oversight**

The following targets form part of the 2020/21 NHS Oversight Framework.

| Target | Trust Performance | | | | | | RAG/ Comments on recovery plan position | SPC Flag: Assurance of Meeting Target | SPC Flag: Trend |
|---|---|---|---|---|---|---|---|---|---|
| Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral<br><br>Target is >=60%<br>*(reported a month in arrears)* | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | ? | UP |
| | 84.0% | 89.5% | 79.2% | 87.5% | 78.3% | 72.4% | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| 6-week wait for diagnostic procedures (Incomplete)<br><br>Target is >=99%<br><br>*(reported a month in arrears)* | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | In line with national COVID-19 guidance, this service was suspended. It was re-established in October 2020 but due to COVID restrictions can only work at 60% previous activity. We are continuing to support the additional audiologists with the COVID backlog finance until March 2022. The original recovery trajectory was to report a positive KPI in July/August 2021. There has however been a surge in referrals over the last few months and this is now expected March 2022. The position will then be sustainable if the COVID restrictions are lifted | YES | DOWN |
| | 70.7% | 72.0% | 75.2% | 68.6% | 58.7% | 49.9% | | 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 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | RAG/ Comments on recovery plan position | SPC Flag: Assurance of Meeting Target | SPC Flag: Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| Adult CMHT Access<br>Six weeks routine<br><br>Target is 95% | Complete | 58.6% | 59.8% | 69.6% | 60.3% | 57.2% | 66.7% | Service has an improvement plan in place and additional capacity (weekend clinics and overtime) is supporting a reduction in waiting times. Significant improvement has been made over the last few months. | N/A | N/A |
| | Incomplete | 59.2% | 66.0% | 63.8% | 58.1% | 47.8% | 45.3% | | NO | NO CHANGE |
| | | | | | | | | | Key standards are not being delivered and are deteriorating/ not improving | |
| Memory Clinic<br>(18 week Local RTT)<br><br>Target is 95% | Complete | 19.0% | 25.9% | 43.8% | 25.5% | 48.5% | 51.6% | 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. The service has had 2 WTEs on long term sick leave from May to September which has impacted on progress. Both members of staff have returned during September. | N/A | N/A |
| | Incomplete | 63.0% | 64.8% | 68.1% | 68.5% | 68.7% | 69.7% | | N/A | N/A |
| ADHD<br>(18 week local RTT)<br><br>Target is:<br>Complete - 95%<br>Incomplete - 92% | Complete | 18.2% | 25.0% | 5.6% | 18.2% | 20.0% | 12.5% | The tender process for outsourcing part of the waiting list backlog closed on 1st October - evaluations are underway.<br>Other elements of the ADHD improvement plan continue to be progressed, although rcruitment remains challenging. | N/A | N/A |
| | Incomplete | 40.3% | 37.3% | 37.6% | 39.9% | 36.9% | 34.3% | | 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)<br><br>Target is 95% | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Urgent compliance is consistently 100%. Trajectory and action plan in place to meet 95% by March 2022. | N/A | N/A |
| | 32.2% | 27.6% | 36.6% | 30.8% | 31.9% | 26.2% | | | |
| Continence (Complete Pathway)<br><br>Target is 95% | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Improvement plan in place with trajectory to reduce the number of patients waiting and increase productivity. | N/A | N/A |
| | 23.3% | 13.6% | 40.6% | 33.7% | 44.0% | 50.1% | | | |

**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 | Performance | | | | | | | RAG/ Comments on recovery plan position | SPC Flag: Assurance of Meeting Target | SPC Flag: Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | | |
| CAMHS Eating Disorder – one week (complete pathway)<br><br>Target is 95% | | 66.7% | 33.3% | 0.0% | 30.0% | 50.0% | 100.0% | 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 |
| | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | | |
| CAMHS Eating Disorder – four weeks (complete pathway)<br><br>Target is 95% | | 50.0% | 50.0% | 33.3% | 42.9% | 22.2% | 30.0% | 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 |
| | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | | |
| Children and Young People's Access – four weeks (incomplete pathway)<br><br>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. | ? | UP |
| | | | | | | | | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | | |
| Children and Young People's Access – 13 weeks (incomplete pathway)<br><br>Target is 92% | | 78.2% | 69.3% | 71.5% | 74.8% | 89.2% | 100.0% | The KPI is now being met following a sustained effort by the team to get the waiting list into the ideal number range. The service has increased the available slots in the third quarter to meet the expected surge of referrals when schools go back | ? | NO CHANGE |
| | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | | |
| Aspergers - 18 weeks (complete pathway) | Wait for Treatment | 93.9% | 93.1% | 97.9% | 100.0% | 92.9% | 93.8% | The service is receiving an increase in referrals and this may start to impact on the target. This is being monitored at DMT and Silver meetings. | N/A | N/A |
| | No. of Referrals | 56 | 42 | 68 | 30 | 63 | 45 | | | |
| | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | | |
| LD Community - 8 weeks (complete pathway) | Wait for Assessment | 93.6% | 91.4% | 87.5% | 89.2% | 89.1% | 88.3% | | N/A | N/A |
| | No. of Referrals | 135 | 97 | 112 | 126 | 118 | 97 | | | |

**5. 52 week waits**

No patient should wait for more than 52 weeks from referral to the start of their treatment.

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 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | 87 weeks | The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall. | NO | DOWN |
| | 50 | 45 | 38 | 47 | 36 | 27 | | | Key standards are not being delivered but are improving | |
| Dynamic Psychotherapy | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | 112 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 |
| | 43 | 23 | 20 | 19 | 13 | 13 | | | Key standards are not being delivered but are improving | |
| Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | 215 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 from December. The number of patients waiting for treatment is rising, as the service works through the assessment waiting list of over 52 week waits. | NO | UP |
| | 210 | 214 | 241 | 325 | 364 | 380 | | | Key standards are not being delivered and are deteriorating/ not improving | |
| Therapy Service for People with Personality Disorder - assessment waits over 52 weeks (a month in arrears) | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | 132 weeks | The service has been working through the historical backlog of long waiters for assessment using focussed 'assessment weeks'. These have been effective in reducing the number of waiters over 52 weeks. | N/A | N/A |
| | 632 | 628 | 660 | 523 | 502 | 486 | | | | |
| CAMHS | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | 91 weeks | As at 4th October there were 140 waiting over a year, 41 for treatment and 97 for neuro-developmental diagnosis. This is a sustained improvement position. Both lists are performing against the expected trajectory. We are currently working through a spike of referrals 12-18 months ago and once this is cleared the numbers waiting at each week are considerably less and the trajectory recovers quicker. | NO | UP |
| | 257 | 250 | 219 | 218 | 233 | 192 | | | 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 | Trend |
| Occupancy Rate - Mental Health Beds (excluding leave)<br><br>Target is <=85% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-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. | ? | DOWN |
| | 83.8% | 79.0% | 82.0% | 77.7% | 79.4% | 78.4% | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| Occupancy Rate - Community Beds (excluding leave)<br><br>Target is >=93% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-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 |
| | 76.0% | 82.8% | 81.1% | 84.1% | 80.0% | 86.3% | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| Average Length of stay<br><br>Community hospitals<br><br>National benchmark is 25 days. | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | The Trust consistently is below the national benchmark of 25 days. | YES | NO CHANGE |
| | 17.1 | 16.6 | 17.7 | 18.2 | 15.7 | 19.7 | | Key standards are being consistently delivered and are improving/ maintaining performance | |
| Delayed Transfers of Care<br><br>Target is <=3.5% across LLR | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-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. | ? | DOWN |
| | 2.9% | 2.7% | 2.9% | 1.9% | 3.1% | 2.5% | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| Gatekeeping<br><br>Target is >=95% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | ? | NO CHANGE |
| | 93.2% | 98.8% | 100.0% | 100.0% | 100.0% | 100.0% | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| 72 hour Follow Up after discharge<br><br>Target is 80%<br><br>*(reported a month in arrears)* | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | N/A | N/A |
| | 70.9% | 80.4% | 88.1% | 87.6% | 79.1% | 78.0% | | | |
| Perinatal - Number and Percentage of women accessing service<br><br>Target is 8.6% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Access for this indicator is defined as requiring a face to face or video consultation i.e. telephone contacts are excluded.<br>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. | N/A | N/A |
| | 504 | 502 | 480 | 481 | 488 | 484 | | | |
| | 4.0% | 4.0% | 3.8% | 3.8% | 3.9% | 3.9% | | N/A | N/A |

**7. Quality and Safety**

| Target | Trust Performance | | | | | | | RAG/ Comments on recovery plan position | SPC Flag: Assurance of Meeting Target | SPC Flag: Trend |
|---|---|---|---|---|---|---|---|---|---|---|
| Serious incidents | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | N/A | NO CHANGE |
| | | 10 | 2 | 18 | 8 | 5 | 1 | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| STEIS - SI action plans implemented within timescales (in arrears)<br><br>Target = 100% | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Awaiting validated data to assess achievement of measure | ? | DOWN |
| | | 20.0% | 14.3% | 50.0% | 66.5% | 22.2% | 25.0% | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| Safe staffing<br>No. of wards not meeting >80% fill rate for RNs<br><br>Target 0 | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | This measure has been temporarily suspended during COVID-19 as staffing capacity is changing rapidly and continually to respond to the pandemic | NO | UP |
| | Day | 5 | 7 | 7 | 5 | 5 | 6 | | Key standards are not being delivered and are not improving<br>*SPC based on day shift* | |
| | Night | 0 | 0 | 1 | 1 | 1 | 1 | | | |
| Care Hours per patient day | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | N/A | N/A |
| | | 12.4 | 12.3 | 12.3 | 12.5 | 12.4 | 12.2 | | Key standard has no target; however performance is consistent | |
| No. of episodes of seclusions >2hrs<br><br>Target decreasing trend | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | N/A | NO CHANGE |
| | | 30 | 32 | 28 | 16 | 7 | 24 | | Key standard has no target; however performance is consistent | |
| No. of episodes of supine restraint<br><br>Target decreasing trend | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | N/A | NO CHANGE |
| | | 4 | 4 | 9 | 6 | 17 | 14 | | Key standard has no target; however performance is consistent | |
| No. of episodes of side-line restraint<br><br>Target decreasing trend | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | N/A | NO CHANGE |
| | | 5 | 29 | 29 | 16 | 13 | 22 | | Key standard has no target; however performance is consistent | |
| No. of episodes of prone (unsupported) restraint<br><br>Target decreasing trend | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | N/A | NO CHANGE |
| | | 2 | 0 | 1 | 0 | 0 | 0 | | Key standard has no target; however performance is consistent | |
| No. of episodes of prone (supported) restraint<br><br>Target decreasing trend | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | N/A | DOWN |
| | | 5 | 5 | 5 | 3 | 2 | 5 | | Key standard has no target; however performance is consistent | |

| Measure | | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Commentary | | |
|---|---|---|---|---|---|---|---|---|---|---|
| No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care<br><br>Target decreasing trend (RAG based on commissioner trajectory) | Category 2 | 120 | 105 | 103 | 98 | 105 | 93 | The Directorate has some improvement targets set by CCGs and an improvement plan. | N/A | UP |
| | Category 4 | 3 | 5 | 7 | 3 | 4 | 5 | | N/A | NO CHANGE |
| | | | | | | | | | *Key standard has no target; however performance is consistent for category 2 and consistent for category 4* | |

| Measure | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Commentary | | |
|---|---|---|---|---|---|---|---|---|---|
| No. of repeat falls<br><br>Target decreasing trend | 53 | 43 | 46 | 64 | 47 | 45 | 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. | N/A | NO CHANGE |
| | | | | | | | | *Key standard has no target; however performance is consistent* | |

| Measure | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Commentary | | |
|---|---|---|---|---|---|---|---|---|---|
| LD Annual Health Checks completed - YTD<br><br>Target is 75% | 106 | 255 | 430 | 583 | 702 | 968 | Year To date from 1 April 2021, 968 competed. In Q2 more checks completed than previous year | N/A | N/A |

| Measure | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Commentary | | |
|---|---|---|---|---|---|---|---|---|---|
| LeDeR Reviews completed within timeframe | | | | | | | New LeDeR system is in place – need to redefine. | N/A | N/A |
| | *15 awaiting alloation, 15 on hold and 16 in progress* | | | | | | | | |

**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<br><br>Target >=95% | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | | ? | UP |
| | 91.2% | 91.5% | 91.3% | 91.0% | 91.4% | 92.6% | | Over the series of data points being measured, key standards are being delivered inconsistently | |

**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)<br><br>Target is <=10% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | The Trust is below the ceiling set for turnover. | YES | DOWN |
| | 8.5% | 8.8% | 9.1% | 9.1% | 9.1% | 9.3% | | Key standards are being consistently delivered and are improving performance | |
| Vacancy rate<br><br>Target is <=7% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | NO | UP |
| | 10.8% | 12.4% | 12.2% | 11.6% | 11.5% | 11.3% | | Key standards are not being delivered and are deteriorating/ not improving | |
| Health and Well-being Sickness Absence (1 month in arrears)<br><br>Target is <=4.5% | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | NO | NO CHANGE |
| | 3.5% | 4.4% | 4.6% | 5.1% | 5.3% | 5.2% | | Key standards are not being delivered but are improving | |
| Health and Well-being Sickness Absence Costs (1 month in arrears)<br><br>Target is TBC | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | n/a | n/a |
| | £477,073 | £580,557 | £639,392 | £668,739 | £717,582 | £748,440 | | | |
| Health and Well-being Sickness Absence YTD (1 month in arrears)<br><br>Target is <=4.5% | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | n/a | n/a |
| | 4.7% | 4.4% | 4.5% | 4.7% | 4.9% | 5.0% | | Not applicable for SPC as measuring cumulative data | |
| Agency Costs<br><br>Target is <=£641,666 (NHSI national target) | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | NO | UP |
| | £1,531,718 | £1,556,256 | £1,919,728 | £1,775,099 | £1,852,385 | £2,040,719 | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| Core Mandatory Training Compliance for substantive staff<br><br>Target is >=85% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | The Trust is meeting the target set for Core Mandatory Training. | YES | UP |
| | 94.0% | 94.6% | 94.2% | 92.5% | 92.0% | 92.6% | | Key standards are being consistently delivered and are improving/ maintaining performance | |
| Staff with a Completed Annual Appraisal<br><br>Target is >=80% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | The Trust is meeting the target set for Annual Appraisal | YES | DOWN |
| | 88.2% | 89.5% | 89.9% | 85.2% | 84.8% | 83.2% | | Key standards are being delivered but are deteriorating | |
| % of staff from a BME background<br><br>Target is >= 22.5% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | The Trust is meeting the target set. | ? | UP |
| | 23.8% | 23.7% | 23.7% | 23.9% | 24.1% | 24.0% | | Over the series of data points being measured, key standards are being delivered inconsistently | |
| Staff flu vaccination rate (frontline healthcare workers)<br><br>Target is >= 80% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | n/a | n/a |
| | | | | | | | | | |
| % of staff who have undertaken clinical supervision within the last 3 months<br><br>Target is >=85% | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | NO | DOWN |
| | 85.6% | 88.1% | 85.4% | 75.9% | 69.1% | 75.7% | | Key standards are not being delivered and are deteriorating | |
| Health and Wellbeing Activity - Number of LLR staff contacting the hub in the reporting period (1 month in arrears) | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | | N/A | N/A |
| | | 135 | 148 | 240 | 1080 | 130 | | | |

**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 – September 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
- C Diff
- STEIS action plans completed within timescales
- Agency Cost
- **C** Occupancy rate – community beds (excluding leave)
- % of staff from a BME background
- MH Data Quality Maturity Index

**Key standards not being delivered but improving**

- Sickness Absence
- Dynamic Psychotherapy over 52 weeks
- (green) Cognitive Behavioural Therapy over 52 weeks

**Key standards not being delivered but deteriorating/ not improving**

- **C** Adult CMHT Access six week routine (incomplete)
- Safe Staffing
- Personality Disorder over 52 weeks
- CAMHS over 52 weeks
- Vacancy rate
- (white) % of staff who have undertaken clinical supervision within the last 3 months

**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
- Admissions to adult facilities of patients under 16 years old

## Governance table

| For Board and Board Committees: | Trust Board | |
|---|---|---|
| Paper sponsored by: | Sharon Murphy - Interim Director of Finance and Performance | |
| Paper authored by: | Information Team | |
| Date submitted: | 18/10/2021 | |
| State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s): | | |
| If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured: | | |
| State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning | Monthly report | |
| STEP up to GREAT strategic alignment*: | High **S**tandards | |
| | **T**ransformation | |
| | **E**nvironments | |
| | **P**atient Involvement | |
| | Well **G**overned | x |
| | Single Patient **R**ecord | |
| | **E**quality, Leadership, Culture | |
| | **A**ccess to Services | |
| | **T**rustwide Quality Improvement | |
| Organisational Risk Register considerations: | List risk number and title of risk | 35 - Provides assurance of the improving quality and availability of data reporting to inform quality decision making |
| Is the decision required consistent with LPT's risk appetite: | | |
| False and misleading information (FOMI) considerations: | | |
| Positive confirmation that the content does not risk the safety of patients or the public | | |
| Equality considerations: | | |