Leicestershire Partnership NHS
NHS Trust

Trust Board
21 December 2021

Board Performance Report
October 2021 (Month 7)

Highlighted Performance Movements - October 2021

Improved performance:

Metric	Performance	
Aspergers - 18 weeks (complete pathway)	100.0%	
72 hour Follow Up after discharge Target is 80% (reported a month in arrears)	82.6%	Target met after 2 months below target

Deteriorating Performance:

Metric	Performance	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	395	Highest number reported

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	5	Increased from 1 reported last month
No. of episodes of seclusions >2hrs *Target decreasing trend*	8	Decreased from 24 reported last month
No. of episodes of sideline restraint *Target decreasing trend*	9	Decreased from 22 reported last month
No. of repeat falls *Target decreasing trend*	39	Decreased from 45 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	Oct-21	Sparkline
	Total Admissions	404	353	389	330	374	366	368	381	377	347	396	377	406	398	437	418	404	412	391	436	
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	Oct-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	13	
	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%	3.0%	
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	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Sparkline
	0-2	1	4	2	2	0	0	0	2	5	4	5	4	0	0	0	0	0	1	1	2	
	3-7	2	9	9	1	1	0	1	0	7	12	20	8	1	0	1	0	0	2	1	1	
	8-14	1	8	9	2	0	0	0	0	1	15	9	5	2	0	0	0	0	1	0	3	
	15 and over	11	14	5	2	0	0	0	7	5	29	18	35	9	1	0	0	0	2	2	11	
	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%	3.2%	
	• 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.*																					
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	Oct-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	30	
	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%	6.9%	

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 eleven definite and three probable nosocomial cases reported in October 2021. This is broken down into three probable and two definite cases on Coalville Ward 4 and eight definite cases at Mill Lodge. These have been managed as patient and staff Covid-19 outbreaks. A further patient was identified on Wakerley Ward. There is no linkage between either outbreak or the isolated Wakerley Ward patient. All of the patients affected have made a full recovery.

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.

<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="3">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><table><tr><td>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr><tr><td>98.8%</td><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>100.0%</td></tr></table></td><td rowspan="3"></td><td>  </td><td>  </td></tr>
<tr><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td></td></tr>
<tr><td rowspan="3">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="3"><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="3">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></td></tr>
<tr><td rowspan="3">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><table><tr><td colspan="6">Age 0-15</td></tr><tr><td>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr><tr><td>0.0%</td><td>0.0%</td><td>0.0%</td><td>0.0%</td><td>0.0%</td><td>0.0%</td></tr><tr><td colspan="6">Age 16 or over</td></tr><tr><td>10.1%</td><td>9.5%</td><td>5.1%</td><td>9.7%</td><td>9.0%</td><td>6.0%</td></tr></table></td><td rowspan="3">This indicator is currently on hold and being reworked to reflect the correct methodology as agreed at FPC.</td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td></td></tr>
</table>

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<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>The number and, where available rate of patient safety incidents reported within the Trust during the reporting period</td><td>
<table>
<tr><td>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr>
<tr><td>1082</td><td>1146</td><td>1051</td><td>960</td><td>1001</td><td>967</td></tr>
<tr><td>62.3%</td><td>65.0%</td><td>61.7%</td><td>59.0%</td><td>60.6%</td><td>60.2%</td></tr>
</table>
</td><td></td><td>n/a</td><td>n/a</td></tr>
<tr><td>The number and percentage of such patient safety incidents that resulted in severe harm or death</td><td>
<table>
<tr><td>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr>
<tr><td>1</td><td>10</td><td>4</td><td>8</td><td>7</td><td>13</td></tr>
<tr><td>0.1%</td><td>0.9%</td><td>0.4%</td><td>0.8%</td><td>0.7%</td><td>1.3%</td></tr>
</table>
</td><td></td><td>n/a</td><td>n/a</td></tr>
<tr><td>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>
<table>
<tr><td>Apr-21</td><td>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td></tr>
<tr><td>89.5%</td><td>79.2%</td><td>87.5%</td><td>78.3%</td><td>72.4%</td><td>75.0%</td></tr>
</table>
</td><td></td><td>?</td><td>UP</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td>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>Reported Bi-annually
Inpatient Wards
<table>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td></tr>
<tr><td>60.0%</td><td>58.0%</td><td>96.0%</td><td>94.0%</td></tr>
</table>
EIP Services
<table>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td></tr>
<tr><td>93.0%</td><td>-</td><td>97.0%</td><td>-</td></tr>
</table>
Community Mental Health Services on CPA (arrears)
<table>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td></tr>
<tr><td>-</td><td>34.0%</td><td>-</td><td>54.0%</td></tr>
</table>
</td><td>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.</td><td>n/a</td><td>n/a</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">Not applicable for SPC as reported infrequently</td></tr>
<tr><td>Admissions to adult facilities of patients under 16 years old</td><td>
<table>
<tr><td>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table>
</td><td></td><td>n/a</td><td>n/a</td></tr>
</table>

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	Trend
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60% *(reported a month in arrears)*	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		?	UP
	89.5%	79.2%	87.5%	78.3%	72.4%	75.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
6-week wait for diagnostic procedures (Incomplete) Target is >=99% *(reported a month in arrears)*	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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
	72.0%	75.2%	68.6%	58.7%	49.9%	58.2%		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	Trend
Adult CMHT Access Six weeks routine Target is 95%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Although significant improvement has been made over the last few months the service has deviated from the planned trajectory. There are several work packages through SUTG MH which will support a review of the trajectory and this work is currently being brought together to inform a revised action plan / trajectory.	N/A	N/A
	Complete	59.8%	69.6%	60.3%	57.2%	66.7%	60.9%			
	Incomplete	66.0%	63.8%	58.1%	47.8%	45.3%	56.6%		NO	NO CHANGE
									Key standards are not being delivered and are deteriorating/ not improving	
Memory Clinic (18 week Local RTT) Target is 95%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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 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. Memory clinic performance deep dive taking place at DMT in November 2021.	N/A	N/A
	Complete	25.9%	43.8%	25.5%	48.5%	51.6%	49.1%			
	Incomplete	64.8%	68.1%	68.5%	68.7%	69.7%	70.6%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	The tender process for outsourcing part of the waiting list backlog is currently being reassessed and plans are in development to take this forward. Other elements of the ADHD improvement plan continue to be progressed, although rcruitment remains challenging.	N/A	N/A
	Complete	25.0%	5.6%	18.2%	20.0%	12.5%	15.4%			
	Incomplete	37.3%	37.6%	39.9%	36.9%	34.3%	33.9%		N/A	N/A

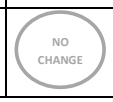
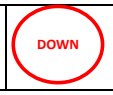
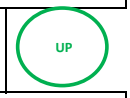
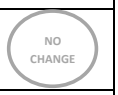
4(b). Access - Waiting Time Standards - CHS

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%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Urgent compliance is consistently 100%. Trajectory and action plan in place to meet 95% by March 2022. It is expected that compliance will reduce before it consistently increases, due to the increased ratio of patients seen who have already breached. End of Oct position - predicted 23 off the net list position, however have exceeded this with 52 and thus exceeded the trajectory	N/A	N/A
	27.6%	36.6%	30.8%	31.9%	26.2%	20.7%			
Continence (Complete Pathway) Target is 95%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Improvement plan in place with trajectory to increase productivity and reduce the number of patients waiting. It is expected that compliance will reduce before it consistently increases, due to the increased ratio of patients seen who have already breached. In September, the WL reduced by 261 pts (compared to the month before) The WL is at its lowest since December 2020 We have seen a month on month increase in assessments completed since January 2020	N/A	N/A
	13.6%	40.6%	33.7%	44.0%	50.1%	46.0%			

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	Trend
CAMHS Eating Disorder – one week (complete pathway) Target is 95%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	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.		
		33.3%	0.0%	30.0%	50.0%	100.0%	85.7%		Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	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.		
		50.0%	33.3%	42.9%	22.2%	30.0%	42.9%		Over the series of data points being measured, key standards are being delivered inconsistently	
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	The service are now consistently meeting this target		
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Children and Young People's Access – 13 weeks (incomplete pathway) Target is 92%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	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		
		69.3%	71.5%	74.8%	89.2%	100.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Aspergers - 18 weeks (complete pathway)	Wait for Treatment	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	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
		93.1%	97.9%	100.0%	92.9%	93.8%	100.0%			
	No. of Referrals	42	68	30	63	45	57			
LD Community - 8 weeks (complete pathway)	Wait for Assessment	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		N/A	N/A
		91.4%	87.5%	89.2%	89.1%	88.3%	81.0%			
	No. of Referrals	97	112	126	118	97	143			

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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	92 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall.	NO	DOWN
	45	38	47	36	27	23			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	116 weeks	The number of 52 week waiters are 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
	23	20	19	13	13	14			Key standards are not being delivered but are improving	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	218 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
	214	241	325	364	380	395			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)	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	135 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
	628	660	523	502	486	403				
CAMHS	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	94 weeks	As at 4th November there were 82 waiting over a year, 28 for treatment and 54 for neuro-developmental diagnosis. This is a sustained improvement position. Both lists are performing against the expected trajectory.	NO	NO CHANGE
	250	219	218	233	192	125			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) Target is <=85%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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
	79.0%	82.0%	77.7%	79.4%	78.4%	81.6%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust is below the local target rate of 93%. In October work has been done to identify the reasons for delayed discharges to LPT and now working collaboratively to ensure patients are not delayed going forwards. Extended criteria to admit patients awaiting packages of care with a start date (this may contribute to increased length of stay going forwards).	?	DOWN
	82.8%	81.1%	84.1%	80.0%	86.3%	82.2%		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.	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust consistently is below the national benchmark of 25 days.	YES	NO CHANGE
	16.6	17.7	18.2	15.7	19.7	17.8		Key standards are being consistently delivered and are improving/ maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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
	2.7%	2.9%	1.9%	3.1%	2.5%	3.1%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		?	NO CHANGE
	98.8%	100.0%	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 Target is 80% *(reported a month in arrears)*	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		N/A	N/A
	80.4%	88.1%	87.6%	79.1%	78.0%	82.6%			
Perinatal - Number and Percentage of women accessing service Target is 8.6%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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.	N/A	N/A
	502	480	481	488	484	466		N/A	N/A
	4.0%	3.8%	3.8%	3.9%	3.9%	3.7%			

7. Quality and Safety

Target	Trust Performance	RAG/ Comments on recovery plan position	SPC Flag	
			Assurance of Meeting Target	Trend
Serious incidents	May-21: 2; Jun-21: 18; Jul-21: 8; Aug-21: 5; Sep-21: 1; Oct-21: 5		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%	May-21: 14.3%; Jun-21: 50.0%; Jul-21: 66.5%; Aug-21: 22.2%; Sep-21: 25.0%; Oct-21: 9.0%		?	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: May-21: 7; Jun-21: 7; Jul-21: 5; Aug-21: 5; Sep-21: 6; Oct-21: 4 Night: May-21: 0; Jun-21: 1; Jul-21: 1; Aug-21: 1; Sep-21: 1; Oct-21: 2	Kirby & Welford Ward adjust skill mix to include Medicines Administration technicians and Mental Health Practitioners. Gillivers adjusted the RN levels due to reduced occupancy. A review of Thornton and Beechwood to be included in the monthly safe staffing analysis.	NO	NO CHANGE
			Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day	May-21: 12.3; Jun-21: 12.3; Jul-21: 12.5; Aug-21: 12.4; Sep-21: 12.2; Oct-21: 12.2		N/A	N/A
			Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend	May-21: 32; Jun-21: 28; Jul-21: 16; Aug-21: 7; Sep-21: 24; Oct-21: 8	Apositive shift over the past 3 months in the reduction of times being spent in seclusion. There are some outliers that are prolonged episodes, due to patients being nursed in our PICUs that are waiting for medium secure beds. Seclusion was not used in FYPC/LD in October.	N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of supine restraint Target decreasing trend	May-21: 4; Jun-21: 9; Jul-21: 6; Aug-21: 17; Sep-21: 14; Oct-21: 17	Side lay often gives the number of patients being given Rapid Tranquilisation under restraint and the patient needs to be put into supine before they can be moved into side lay.	N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of side-line restraint Target decreasing trend	May-21: 5; Jun-21: 29; Jul-21: 16; Aug-21: 13; Sep-21: 22; Oct-21: 9		N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of prone (unsupported) restraint Target decreasing trend	May-21: 0; Jun-21: 1; Jul-21: 0; Aug-21: 0; Sep-21: 0; Oct-21: 2	Since October 2021 all incidents of prone (both supported and unsupported) are reviewed post incident to understand the rational for use. Analysis has shown; one incident used in error by an agency nurse, another was to manage a patient who needed to be searched prior to seclusion being started. The team are working with the ward to ensure use of the safety pod to reduce this type of incident. Two incidents were to manage patients who required rapid tranquilisation and staff could not put them into side lay.	N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of prone (supported) restraint Target decreasing trend	May-21: 5; Jun-21: 5; Jul-21: 3; Aug-21: 2; Sep-21: 5; Oct-21: 2		N/A	DOWN
			Key standard has no target; however performance is consistent	

No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory)		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	The Pressure Ulcer Quality Improvement (QI) Group, established in September 2020, continues to identify and deliver interventions in order to reduce the number of pressure ulcers (of any category) that develop and deteriorate in our care and importantly, to improve patient outcomes and reduce patient harm. associated with poor health.	N/A	UP
	Category 2	105	103	98	105	93	98		N/A	NO CHANGE
	Category 4	5	7	3	4	5	6		*Key standard has no target; however performance is consistent for category 2 and consistent for category 4*	
No. of repeat falls Target decreasing trend		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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.	N/A	NO CHANGE
		43	46	64	47	45	39		*Key standard has no target; however performance is consistent*	
LD Annual Health Checks completed - YTD Target is 75%		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year To date from 1 April 2021, 1316 AHC's completed.	N/A	N/A
		255	430	583	702	968	1316			
LeDeR Reviews completed within timeframe		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	New LeDeR system is in place – need to redefine.	N/A	N/A
	Allocated				10	16	13		N/A	N/A
	Awaiting Allocation				16	15	11		N/A	N/A
	On Hold				16	15	6		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
	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		?	UP
MH Data quality Maturity Index Target >=95%	91.5%	91.3%	91.0%	91.4%	92.6%	92.9%		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	Trend
Normalised Workforce Turnover rate (Rolling previous 12 months) Target is <=10%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust is below the ceiling set for turnover.	YES	DOWN
	8.8%	9.1%	9.1%	9.1%	9.3%	9.5%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		NO	UP
	12.4%	12.2%	11.6%	11.5%	11.3%	11.1%		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%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		NO	NO CHANGE
	4.4%	4.6%	5.1%	5.3%	5.2%	5.1%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		n/a	n/a
	£580,557	£639,392	£668,739	£717,582	£748,440	£709,372			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		n/a	n/a
	4.4%	4.5%	4.7%	4.9%	5.0%	5.0%		Not applicable for SPC as measuring cumulative data	
Agency Costs Target is <=£641,666 (NHSI national target)	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		NO	UP
	£1,556,256	£1,919,728	£1,775,099	£1,852,385	£2,040,719	£2,639,144		Over the series of data points being measured, key standards are being delivered inconsistently	
Core Mandatory Training Compliance for substantive staff Target is >=85%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust is meeting the target set for Core Mandatory Training.	YES	UP
	94.6%	94.2%	92.5%	92.0%	92.6%	92.9%		Key standards are being consistently delivered and are improving/ maintaining performance	
Staff with a Completed Annual Appraisal Target is >=80%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		YES	DOWN
	89.5%	89.9%	85.2%	84.8%	83.2%	78.2%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust is meeting the target set.	?	UP
	23.7%	23.7%	23.9%	24.1%	24.0%	24.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		n/a	n/a
						31.9%			
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		NO	NO CHANGE
	88.1%	85.4%	75.9%	69.1%	75.7%	77.3%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Wellbeing Activity - Number of LLR staff contacting the hub in the reporting period (1 month in arrears)	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		N/A	N/A
	135	148	240	1080	130	139			

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 – October 2021

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

Key:			
	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
	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

Dynamic Psychotherapy over 52 weeks
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
% of staff who have undertaken clinical supervision within the last 3 months
Sickness Absence

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:	10/12/2021	
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	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide 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:		