Trust Board
25 January 2021

Board Performance Report
December 2021 (Month 9)

Highlighted Performance Movements - December 2021

Improved performance:

Metric	Performance	
Gatekeeping Target is >=95%	100.0%	
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60% (reported a month in arrears)	89.5%	

Deteriorating Performance:

Metric	Performance	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	473	Lowest performance reported
Delayed Transfers of Care Target is <=3.5% across LLR	3.8%	Last reported over target in Feb 2021

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	5	Decreased from 8 reported last month
No. of episodes of seclusions >2hrs *Target decreasing trend*	9	Increased from 7 reported last month
No. of episodes of prone (Unsupported) restraint	0	Decreased from 1 reported last month
No. of repeat falls *Target decreasing trend*	25	Decreased from 32 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	Nov-21	Dec-21	Sparkline
	Total Admissions	404	353	389	330	374	366	368	381	377	347	396	377	406	398	437	418	404	412	391	436	403	379	
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	Nov-21	Dec-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	12	17	
	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%	3.0%	4.5%	
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	Nov-21	Dec-21	Sparkline
	0-2	1	4	2	2	0	0	0	2	5	4	5	4	0	0	0	0	0	1	1	2	1	3	
	3-7	2	9	9	1	1	0	1	0	7	12	20	8	1	0	1	0	0	2	1	1	1	8	
	8-14	1	8	9	2	0	0	0	0	1	15	9	5	2	0	0	0	0	1	0	3	1	7	
	15 and over	11	14	5	2	0	0	0	7	5	29	18	35	9	1	0	0	0	2	2	11	0	38	
	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%	0.2%	11.9%	
	• 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	Nov-21	Dec-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	15	73	
	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%	3.7%	19.3%	

<u>Current LPT data sources for nosocomial Covid-19</u>
<u>Daily Directorate Covid-19 Sit-rep reports</u>
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.

<u>IPC team local access database</u>
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.

<u>Internal reporting</u>
The increase in definite nosocomial cases is linked to increased community transmission of the new variant of concern; Omicron. Tthis has resulted in an increased number of Covid-19 outbreaks with the Trust currently reporting and managing 14 outbreaks, 13 of which are in in-patient settings affecting both staff and patients. All outbreaks are reported and managed in line with national guidance. Early learning has identified some key themes for learning that have been shared at Trust wide clinical and professional forms and included in our communication briefings to staff. Key themes include; adherence to being BBE, good hand washing tecniques, increased numbers of visitors who have subsequently tested positive following contact, car sharing, uniform and work wear adherence, PPE fatigue.

<u>Actions to minimise nosocomial Covid-19 infection</u>
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. Visiting limited to exceptional circumstances only, continued in-patient testing and patient placement according to risk, staff lateral flow testing, increased touch point cleaning.

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" colspan="6">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>Jul-21
100.0%</td><td>Aug-21
100.0%</td><td>Sep-21
100.0%</td><td>Oct-21
100.0%</td><td>Nov-21
97.2%</td><td>Dec-21
100.0%</td><td rowspan="2"></td><td>?</td><td>UP</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">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></td><td>2017/18
7.4</td><td>2018/19
6.4</td><td>2019/20
7.1</td><td>2020/21
6.9</td><td></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="6"></td><td colspan="2">Not applicable for SPC as reported infrequently</td></tr>
<tr><td rowspan="4">The percentage of inpatients discharged with a subsequent inpatient admission within 30 days</td><td colspan="6">Age 0-15</td><td rowspan="4"></td><td rowspan="3">n/a</td><td rowspan="3">n/a</td></tr>
<tr><td>Jul-21
0.0%</td><td>Aug-21
0.0%</td><td>Sep-21
0.0%</td><td>Oct-21
0.0%</td><td>Nov-21
0.0%</td><td>Dec-21
0.0%</td></tr>
<tr><td colspan="6">Age 16 or over</td></tr>
<tr><td>7.9%</td><td>9.2%</td><td>6.9%</td><td>6.2%</td><td>8.0%</td><td>4.5%</td><td colspan="2"></td></tr>
</table>

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<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td rowspan="3">The number and, where available rate of patient safety incidents reported within the Trust during the reporting period</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td rowspan="3"></td><td rowspan="3">n/a</td><td rowspan="3">n/a</td></tr>
<tr><td>1008</td><td>903</td><td>937</td><td>928</td><td>1054</td><td>1138</td></tr>
<tr><td>60.9%</td><td>57.6%</td><td>58.5%</td><td>57.4%</td><td>58.9%</td><td>56.8%</td></tr>
<tr><td rowspan="3">The number and percentage of such patient safety incidents that resulted in severe harm or death</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td rowspan="3"></td><td rowspan="3">n/a</td><td rowspan="3">n/a</td></tr>
<tr><td>4</td><td>8</td><td>7</td><td>7</td><td>11</td><td>8</td></tr>
<tr><td>0.4%</td><td>0.9%</td><td>0.7%</td><td>0.8%</td><td>1.0%</td><td>0.7%</td></tr>
<tr><td rowspan="2">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>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td rowspan="2"></td><td>?</td><td>NO CHANGE</td></tr>
<tr><td>87.5%</td><td>78.3%</td><td>72.4%</td><td>75.0%</td><td>66.7%</td><td>89.5%</td><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="10">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">*Reported Bi-annually*</td><td rowspan="10">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 rowspan="3">n/a</td><td rowspan="3">n/a</td></tr>
<tr><td colspan="6">**Inpatient Wards**</td></tr>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td><td></td><td></td></tr>
<tr><td>60.0%</td><td>58.0%</td><td>96.0%</td><td>94.0%</td><td></td><td></td><td colspan="2" rowspan="7">*Not applicable for SPC as reported infrequently*</td></tr>
<tr><td colspan="6">**EIP Services**</td></tr>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td><td></td><td></td></tr>
<tr><td>93.0%</td><td>-</td><td>97.0%</td><td>-</td><td></td><td></td></tr>
<tr><td colspan="6">**Community Mental Health Services on CPA (arrears)**</td></tr>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td><td></td><td></td></tr>
<tr><td>-</td><td>34.0%</td><td>-</td><td>54.0%</td><td></td><td></td></tr>
<tr><td rowspan="2">Admissions to adult facilities of patients under 16 years old</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td rowspan="2"></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>
</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	SPC Flag: Trend
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60% *(reported a month in arrears)*	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21		?	NO CHANGE
	87.5%	78.3%	72.4%	75.0%	66.7%	89.5%		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)*	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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. If COVID restrictions remain we will need to maintain the current over staffed position to maintain KPI	YES	DOWN
	68.6%	58.7%	49.9%	58.2%	64.9%	72.9%		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							RAG/ Comments on recovery plan position	SPC Flag: Assurance of Meeting Target	SPC Flag: Trend
Adult CMHT Access Six weeks routine Target is 95%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	The total numbers of waiters for an assessment in November 2021 was 402. Although significant progress has been made, this is indicative of an underperformance against the planned trajectory of 350. Actions to address the shortfall against trajectory have been put in place including: - Additional staff recruited and staff offered overtime hours. - new assessment approach is being implemented across the CMHTs. - Consultant desk top paper caseload review commenced in December 2021. - Task and Finish Group which will explore supporting transition into primary care to be established. Practice Development Nurse to support with this. - 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. - Quality summit taking place which will support a deep dive into CMHTs.	Key standards are not being delivered but are improving	
	Complete	60.3%	57.2%	66.7%	60.9%	68.4%	66.6%		N/A	N/A
	Incomplete	58.1%	47.8%	45.3%	56.6%	68.8%	73.5%		NO	UP
Memory Clinic (18 week Local RTT) Target is 95%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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. Substantive recruitment to 2.0WTE posts agreed.		
	Complete	25.5%	48.5%	51.6%	49.1%	39.5%	51.4%		N/A	N/A
	Incomplete	68.5%	68.7%	69.7%	70.6%	77.1%	79.5%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	A tender to outsource part of the waiting list went out to market and closed on 1st October, however, this was unsuccessful. A revised procurement exercise is currently in development. Other elements of the ADHD improvement plan continue to be progressed, although recruitment remains challenging, therefore, alternative roles are being explored.		
	Complete	18.2%	20.0%	12.5%	15.4%	21.4%	18.5%		N/A	N/A
	Incomplete	39.9%	36.9%	34.3%	33.9%	31.4%	29.7%		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%	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Urgent compliance is consistently 100%. Trajectory and action plan in place to meet 95% by March 2022, however service is currently off trajectory and therefore improvement plan is being reviewed with further actions to bring compliance back in line with trajectory.	N/A	N/A
	30.8%	31.9%	26.2%	20.7%	21.3%	20.9%			
Continence (Complete Pathway) Target is 95%	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Improvement plan in place to increase productivity and reduce the number of patients waiting. It is expected that compliance will decrease before it consistently increases, due to the increased ratio of patients seen who have already breached. Numbers on waiting list are reducing and number of 1st assessments are increasing.	N/A	N/A
	33.7%	44.0%	50.1%	46.0%	39.7%	46.1%			

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	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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%		30.0%	50.0%	100.0%	85.7%	77.8%	83.3%	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 In Nov. 5 out of 6 children passed and one was seen at 10 days due to difficulty contacting family and not lack of available appointments.	?	NO CHANGE
									Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		42.9%	22.2%	30.0%	42.9%	20.0%	30.8%	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. Current progress is ahead of trajectory.	?	DOWN
									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%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	The service are now consistently meeting this target	?	UP
									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%		74.8%	89.2%	100.0%	100.0%	100.0%	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.	?	NO CHANGE
									Over the series of data points being measured, key standards are being delivered inconsistently	
Aspergers - 18 weeks (complete pathway)	Wait for Treatment	100.0%	92.9%	93.8%	100.0%	95.8%	97.1%	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	30	63	45	57	47	88			
LD Community - 8 weeks (complete pathway)	Wait for Assessment	89.2%	89.1%	88.3%	81.0%	79.2%	84.2%		N/A	N/A
	No. of Referrals	126	118	97	143	104	93			

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	SPC Flag: Trend
Cognitive Behavioural Therapy	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	103 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall.	NO	DOWN
	47	36	27	23	17	24			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	125 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
	19	13	13	14	21	21			Key standards are not being delivered but are improving	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	227 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
	325	364	380	395	460	473			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)	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	143 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
	523	502	486	403	360	341				
CAMHS	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	105 weeks	As at 31st December 100 waiting over a year, 49 for treatment and 51 for neuro-developmental diagnosis. This is a sustained improvement position. Both lists are performing against the expected trajectory. Average wait for an ND assessment is 28 weeks down from a peak of 38 weeks	NO	NO CHANGE
	218	233	192	125	141	169			Key standards are not being delivered and are deteriorating/ not improving	
All LD - No's waiting over 52 weeks	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	157 weeks		N/A	N/A
	18	21	25	24	21	14				

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%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-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
	77.7%	79.4%	78.4%	81.6%	81.3%	85.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	The Trust is below the local target rate of 93%. Work continues 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
	84.1%	80.0%	86.3%	82.2%	85.1%	84.3%		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.	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	The Trust consistently is below the national benchmark of 25 days.	YES	NO CHANGE
	18.2	15.7	19.7	17.8	18.3	18.2		Key standards are being consistently delivered and are improving/ maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-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
	1.9%	3.1%	2.5%	3.1%	3.3%	3.8%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21		?	UP
	100.0%	100.0%	100.0%	100.0%	97.2%	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)*	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21		N/A	N/A
	87.6%	79.1%	78.0%	82.6%	89.9%	86.1%			
Perinatal - Number and Percentage of women accessing service Target is 8.6%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Access for this indicator is defined as requiring a face to face or video consultation i.e. telephone contacts are excluded. The service has an agreed trajectory for improvement in place and are working through an action plan which is monitored at DMT.	N/A	N/A
	481	488	484	466	495	522			
	3.8%	3.9%	3.9%	3.7%	4.0%	4.2%		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
		Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21			
Serious incidents		8	5	1	5	8	5	There is a robust process for escalating to serious incident and we are aiming to investigate only were there is a clear requirement or opportunity for learning. The investigation methodology is also developed to obtain learning in the most efficient way and reduce the burden on clinical staff time.	?	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%		66.5%	22.2%	25.0%	9.0%	0.0%	TBC	The three directorates are all bringing the oversight of SI action plans into their formal governance process to provide the oversight required to ensure timely closure of actions.	?	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	5	5	6	4	3	7	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
	Night	1	1	1	2	1	1		Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day		12.5	12.4	12.2	12.2	12.4	11.6		N/A	N/A
									Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend		16	7	24	8	7	9	A positive 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 prone (Supported) restraint Target decreasing trend		3	2	5	2	2	1	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	DOWN
									Key standard has no target; however performance is consistent	
No. of episodes of prone (Unsupported) restraint Target decreasing trend		0	0	0	2	1	0		N/A	NO CHANGE
									Key standard has no target; however performance is consistent	
Total number of Restrictive Practices		164	174	226	194	272	204		N/A	N/A

Indicator		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Commentary		
No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory)	Category 2	98	105	93	98	90	97	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	NO CHANGE
	Category 4	3	4	5	6	11	6		N/A	NO CHANGE
									Key standard has no target; however performance is consistent for category 2 and consistent for category 4	

Indicator		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Commentary		
No. of repeat falls Target decreasing trend		64	47	45	39	32	25	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	DOWN
									Key standard has no target; however performance is consistent	

Indicator		Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Commentary		
LD Annual Health Checks completed - YTD Target is 75%		9.2%	14.7%	17.9%	27.5%	30.8%	39.4%	Year To date from 1 April 2021	N/A	N/A

Indicator		Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Commentary		
LeDeR Reviews completed within timeframe	Allocated		10	16	13	12	12	New LeDeR system is in place – need to redefine.	N/A	N/A
	Awaiting Allocation		16	15	11	19	29		N/A	N/A
	On Hold		16	15	6	3	1		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%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		?	UP
	91.0%	91.4%	92.6%	92.9%	93.0%	93.2%		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	SPC Flag: Description
Normalised Workforce Turnover rate (Rolling previous 12 months) Target is <=10%	Jul-21: 9.1% Aug-21: 9.1% Sep-21: 9.3% Oct-21: 9.5% Nov-21: 9.6% Dec-21: 9.4%	The Trust is below the ceiling set for turnover.	YES	NO CHANGE	Key standards are being consistently delivered and are improving performance
Vacancy rate Target is <=7%	Jul-21: 11.6% Aug-21: 11.5% Sep-21: 11.3% Oct-21: 11.1% Nov-21: 10.5% Dec-21: 11.4%	The vacancy rate has been below average for most of the last 12 months. The rates increased significantly from April 2021 onwards. This is due to the creation of new posts from additional investment that have not yet been recruited to.	NO	UP	Key standards are not being delivered and are deteriorating
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Jun-21: 5.1% Jul-21: 5.3% Aug-21: 5.2% Sep-21: 5.1% Oct-21: 5.4% Nov-21: 5.8%	Sickness absence is currently higher than the Trust target, all absence is being appropriately managed within the services with support from HR.	NO	UP	Key standards are not being delivered and are deteriorating
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Jun-21: £668,739 Jul-21: £717,582 Aug-21: £748,440 Sep-21: £709,372 Oct-21: £790,515 Nov-21: £848,444		n/a	n/a	
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Jun-21: 4.7% Jul-21: 4.9% Aug-21: 5.0% Sep-21: 5.0% Oct-21: 5.1% Nov-21: 5.2%	Sickness absence is currently higher than the Trust target, all absence is being appropriately managed within the services with support from HR.	n/a	n/a	Not applicable for SPC as measuring cumulative data
Agency Costs Target is <=£641,666 (NHSI national target)	Jul-21: £1,775,099 Aug-21: £1,852,385 Sep-21: £2,040,719 Oct-21: £2,639,144 Nov-21: £2,086,944 Dec-21: £2,752,153	There is high use of agency staff throughout 2021, this has enabled us to ensure there is adequate supply of staff to services	NO	UP	Key standards are not being delivered and are deteriorating/ not improving
Core Mandatory Training Compliance for substantive staff Target is >=85%	Jul-21: 92.5% Aug-21: 92.0% Sep-21: 92.6% Oct-21: 92.9% Nov-21: 93.4% Dec-21: 93.9%	The Trust is meeting the target set for Core Mandatory Training.	YES	UP	Key standards are being consistently delivered and are improving/ maintaining performance
Staff with a Completed Annual Appraisal Target is >=80%	Jul-21: 85.2% Aug-21: 84.8% Sep-21: 83.2% Oct-21: 78.2% Nov-21: 76.0% Dec-21: 75.0%	There has been a decrease in rates over the last few months which could be a result of moving to a new system for recording appraisals and staff needing to get used to the new functionality. It could also be a result of increased annual leave, sickness absence and self-isolation.	YES	DOWN	Key standards are being delivered but are deteriorating
% of staff from a BME background Target is >= 22.5%	Jul-21: 23.9% Aug-21: 24.1% Sep-21: 24.0% Oct-21: 24.0% Nov-21: 24.4% Dec-21: 24.7%	The Trust is meeting the target set.	?	UP	Over the series of data points being measured, key standards are being delivered inconsistently
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	Jul-21: Aug-21: Sep-21: Oct-21: 31.9% Nov-21: 46.3% Dec-21: 57.9%		n/a	n/a	
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Jul-21: 75.9% Aug-21: 69.1% Sep-21: 75.7% Oct-21: 77.3% Nov-21: 78.6% Dec-21: 72.7%	There has been a decrease in rates over the last few months which could be a result of moving to a new system for recording appraisals and staff needing to get used to the new functionality. It could also be a result of increased annual leave, sickness absence and self-isolation.	NO	DOWN	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)	Jun-21: 240 Jul-21: 1080 Aug-21: 102 Sep-21: 130 Oct-21: 139 Nov-21: 210		N/A	N/A	

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 – December 2021

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

Key:			
The SPC measure has improved from previous month (green)		NEW	The first assessment of a metric using SPC
The SPC has not changed from previous month (white)		R	Metric will be removed from future reports
The SPC measure has deteriorated from previous month (red)		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
- **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
- Adult CMHT Access six week routine (incomplete)

Key standards not being delivered but deteriorating/ not improving

- Safe Staffing
- Personality Disorder over 52 weeks
- CAMHS over 52 weeks
- % of staff who have undertaken clinical supervision within the last 3 months
- Sickness Absence (red)
- Agency Cost
- Vacancy rate (red)

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:	18/01/2021	
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
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	20 - Performance management framework is not fit for purpose
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:		