Leicestershire Partnership NHS
NHS Trust

Trust Board
31 January 2023

Board Performance Report
December 2022 (Month 9)

The metrics in this report relate to the following bricks in the Step Up to Great Strategy

Highlighted Performance Movements - December 2022

Improved performance:

Metric	Performance	
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%	100.0%	This is a sustained performance as priority is given to the urgent referrals, any compliance issues is usually due to patient choice or late cancellation
Cognitive Behavioural Therapy 52 Weeks	0	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall. Trajectories have been reset with a view to reducing longest waiters for treatment to a maximum of 35 weeks. Long term reduction in wait times to be delivered via the transformation plan, integrating assessment and intervention within the locality Treatment and Recovery Teams.

Deteriorating Performance:

Metric	Performance	
ADHD (18 week local RTT) Target is: Complete - 95%	0.0%	Long waits to access and obtain treatment continue to be an ongoing challenge for the service with referral rates continuing to increase and recurrent commissioned capacity remaining at the capacity agreed in 2016/17. Non-recurrent funding has been made available to support a reduction in waiting times and investment plans are currently in development. Proposing to undertake a workshop to review our mode and ways of working.
Continence (Complete Pathway) Target is 95%	25.2%	This is expected until the backlog is cleared as the patients are seen in chronological order (unless clinical appropriate to see sooner via the traige matrix). Therefore compliance was expected to decrease as the proportion of patients seen outside of the 20 working day target is much higher than those seen within 20 working days. Compliance will start to increase over the coming months when this ratio starts to change.

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	3	Increased from 2 reported last month
Total number of Category 2 pressure ulcers developed or deteriorated in LPT care	88	Decreased from 91 reported last month
No. of episodes of prone (Supported) restraint	2	Increased from 1 reported last month
No. of repeat falls *Target decreasing trend*	36	Increased from 33 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		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Admissions	398	437	418	404	412	391	436	403	379	400	359	397	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Admissions	360	383	380	398	422	395	445	437	458				
Covid Positive Prior to Admission		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Covid +ve Admissions	1	0	3	6	20	12	13	12	17	30	4	25	
	Covid +ve Admission Rate	0.3%	0.0%	0.7%	1.5%	4.9%	3.1%	3.0%	3.0%	4.5%	7.5%	1.1%	6.3%	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Covid +ve Admissions	13	3	7	15	4	8	22	6	33				
	Covid +ve Admission Rate	3.6%	0.8%	1.8%	3.8%	0.9%	2.0%	4.9%	1.4%	7.2%				
Covid Positive Following Swab During Admission	**No of Days**	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	0-2	0	0	0	0	1	1	2	1	3	4	6	5	
	3-7	0	1	0	0	2	1	1	1	8	6	7	9	
	8-14	0	0	0	0	1	0	3	1	7	6	2	7	
	15 and over	1	0	0	0	2	2	11	0	38	43	11	22	
	Hospital Acquired Rate *	0.3%	0.0%	0.0%	0.0%	0.7%	0.5%	3.2%	0.2%	11.9%	12.3%	3.6%	7.3%	
	No of Days	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	0-2	3	0	4	15	5	2	7	4	5				
	3-7	17	2	9	13	4	5	21	2	15				
	8-14	15	2	5	10	2	4	9	5	11				
	15 and over	34	5	33	28	12	16	37	10	19				
	Hospital Acquired Rate *	13.6%	1.8%	10.0%	9.5%	3.3%	5.1%	10.3%	3.4%	6.6%				
	• 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		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Covid +ve Admissions	2	1	3	6	26	16	30	15	73	89	30	68	
	Average Covid +ve Admissions	0.5%	0.2%	0.7%	1.5%	6.3%	4.1%	6.9%	3.7%	19.3%	22.3%	8.4%	17.1%	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Covid +ve Admissions	82	12	58	81	27	35	96	27	83				
	Average Covid +ve Admissions	22.8%	3.1%	15.3%	20.4%	6.4%	8.9%	21.6%	6.2%	18.1%				

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

Covid cases have increased in the last two months (November/December) prior to the end of the year. This is in line with the regional and national picture. To support patient and staff safety, covid requirements were reviewed. Wearing face masks in all areas where patients are seen (including outpatients and outreach clinics) has been reintroduced. Lateral Flow Testing (LFT) has been introduced into community hospital admissions to support safe patient placement and reduce any associated risk as is possible. This process has identified patients who are positive for covid-19 but are asymptomatic, testing therefore would not normally have been undertaken for these patients. Mask wearing for visitors in all areas has also been re-introduced.

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 are being reported against in 2022/23 until the new metrics have been agreed.

Standard	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	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 Target is >=95%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		?	UP
	100.0%	100.0%	100.0%	100.0%	100.0%	98.2%		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 No Target		2017/18	2018/19	2019/20	2020/21	2021/22	The majority of scores within Leicestershire Partnership NHS Trust sit in the bottom 20% of the Trusts surveyed by Quality Health. There are 7 scores in the intermediate 60% range and no scores in the top 20% range. Despite this, the Trust does perform fairly well on the score for service users knowing how to contact the person in charge of organising their care if they have a concern.	n/a	n/a
		7.4	6.4	7.1	6.9	6.4		*Not applicable for SPC as reported infrequently*	
The percentage of inpatients discharged with a subsequent inpatient admission within 30 days No Target	**Age 0-15**							n/a	n/a
	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
	Age 16 or over								
	5.2%	4.4%	4.4%	3.4%	5.4%	7.3%			
The number and, where available rate of patient safety incidents reported within the Trust during the reporting period No Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		n/a	n/a
	1130	1248	990	1110	1238	1148			
	54.4%	64.6%	61.7%	61.2%	63.6%	63.9%			
The number and percentage of such patient safety incidents that resulted in severe harm or death No Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		n/a	n/a
	6	20	11	8	7	8			
	0.5%	1.6%	1.1%	0.7%	0.6%	0.7%			
72 hour Follow Up after discharge Target is >=80% *Aligned with national published data* *(reported a quarter in arrears)*	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	•Task and finish group has been set up to review process inline with national guidance. •A review of discharges is taking place to establish capacity across Community and Urgent Care services to complete the 72 hour follow up contact. •A Quality Improvement project has been established to review and refine processes and ensure there is a robust criteria in place.	N/A	N/A
	78.0%	75.0%	69.0%	76.0%	82.0%	85.0%			

3. CQUINs

The following indicators form part of the 2022/2023 National CQUIN scheme. These will be reported in line with the national submission requirements. The submission deadlines are as follows. Performance will be reported into the BPR thereafter.

Quarter 1 - 25 August 2022
Quarter 2 - 27 November 2022
Quarter 3 - 27 February 2023
Quarter 4 - 28 May 2023

CQUIN No	CQUIN	Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CCG1	Staff flu vaccinations	Min- 70% Max- 90%				
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	Min- 20% Max- 35%	25.0%	50.0%		
CCG 10a	Routine Outcome monitoring in CYP and Perinatal MH services	Min- 10% Max- 40%	4.5%	10.0%		
CCG 10b	Routine Outcome monitoring in CMHT (inc MHSOP)	Min- 10% Max- 40%	0.0%	0.0%		
CCG 12	Biopsychosocial assessments in MH Liaison services	Min- 60% Max- 80%	95.0%	98.0%		
CCG 13	Malnutrition Screening Achieving 70% screening in inpatient hospitals	Min=50% Max=70%	0.0%	0.0%		
CCG 14	Assessment, diagnosis, and treatment of lower leg wounds Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment	Min=25% Max= 50%	0.0%	5.1%		
CCG 15	Assessment and documentation of pressure ulcer risk Achieving 60% assessment in inpatient hospitals	Min=40% Max= 60%	70.0%	69.1%		
PSS6	Delivery of formulation or review within six weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings	Min: 50% Max: 80%	N/A	100.0%		
PSS7	Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings	Min: 65% Max: 80%	93.1%	N/A		

Commentary:

CCG1 - Reporting begins in Quarter 3
CCG10a/b - Awaiting official MHSDS figures - % given indicative
CCG13 - Data tracing underway. Will be able to report first figures in December 2022
CCG14 - Improvement seen during Quarter 3 with 23.4% reported at the end of October 2022 – on target to achieve minimum for Quarter 3
PSS7 - Quarter 2 - Data not available nationally as yet

4. Mental Health Core Data Pack

The following indicators are LPT's performance as per the Mental Health Core Data Pack. The source for this data is nationally submitted data. Performance is published a quarter in arrears.

Target	Trust Performance							RAG/ Comments on recovery plan position (LPT)
(B1) Discharges followed up within 72hrs Target is >=80%		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	•Task and finish group has been set up to review process inline with national guidance. •A review of discharges is taking place to establish capacity across Community and Urgent Care services to complete the 72 hour follow up contact. •A Quality Improvement project has been established to review and refine a processes and ensure there is a robust criteria in place.
	LLR	75.0%	74.0%	71.0%				
	LPT	78.0%	75.0%	69.0%	76.0%	82.0%	85.0%	
(D1) Community Mental Health Access (2+ contacts) LLR Target is 3351		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	
	LLR	10904	10973	11018				
	LPT	10875	10920	10940	11015	11010	11010	
(E1) CYP access (1+ contact) LLR Target is 10014		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	This target has moved from 2 contacts over the financial year to 1 contact over a rolling year. The system is reporting above target level, LPT is underperforming and there is discussion with ICS to change target due to partner providers more likely to get first contact under new methodology. We are continuing to work as a system to improve the health inequalities in specific population groups that have lower uptake of service provision. Due to national issue there is only local data available
	LLR	11133	11454	11534				
	LPT	5925	5935	5975	5990	6000	6055	
(E4) CYP eating disorders waiting time - Routine Target is >=95% Rolling 12 months (quarterly)		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	The service has received significant additional MHIS investment and have successfully recruited key staff. This is starting to have an impact and they are currently over performing to the recovery trajectory. In November 2022 they were at 93.75%
	LLR			29.0%			29.0%	
	LPT			29.0%			39.4%	
(E5) CYP eating disorders waiting time - Urgent Target is >=95% Rolling 12 months (quarterly)		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	The service continue to prioritise the urgent referrals. Failure of the target is normally due to patient choice rather than a limitation of capacity. The service have been at 100% the last 3 months
	LLR			85.0%			85.0%	
	LPT			84.5%			87.5%	
(G3) EIP waiting times - MHSDS Target is >=60%		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	The service continue to maintain compliance against target.
	LLR	83.3%	81.8%	81.0%				
	LPT	83.0%	83.9%	79.3%	71.7%	71.4%	70.8%	
(I1) Individual Placement Support LLR Target is 191		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Targeted work with teams that have high number of patients registered as unemployed. Event taking place on 30th November, open to all staff, to raise awareness of the service. Robust recovery plan in place that is regularly monitored.
	LLR	125	176	206				
	LPT	125	170	205	235	265	295	

(K2) OOA bed days - inappropriate only No Target		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	
	LLR	2	6	61	60	55	0	
	LPT	0	5	30	30	30	0	
(L1) Perinatal access - rolling 12 months No Target		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Due to a functionality change on the MH Core Data Pack, the chart previously reported can no longer be shown as a benchmark against more than one provider.
	LLR	682	707	747				
	LPT	675	700	735	770	805	820	
(L2) Perinatal access - year to date LLR Target is 315		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	•Current priority remains to reduce DNA rates, exploring some targeted work. •Meeting regularly with the national team and local commissioners to provide assurance around actions to improve performance. •Continued drive to recruit to the service. •Active campaign in progress to increase awareness of the service and, therefore, referrals into the service.
	LLR	181	276	356				
	LPT	180	280	360	415	490	550	
(N1) Data Quality - Consistency No Target		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	
	LLR	100.0%	80.0%	100.0%	100.0%			
	LPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
(N2) Data Quality - Coverage Target is >=95%		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	
	LLR	83.3%	80.0%	83.3%	83.3%			
	LPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
(N3) Data Quality - Outcomes Target is >=40%		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	
	LLR	21.9%	24.0%	24.3%	22.9%			
	LPT	22.3%	24.3%	24.5%	23.1%	22.5%	22.3%	
(N4) Data Quality - DQMI score Target is >=90		Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	
	LLR	59.8	60.3	60	56.5	61.8		
	LPT	94.0	94.0	95.0	91.0	94.0	94.0	
(N5) Data Quality - SNOMED CT Target is 100%		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	
	LLR	82.8%	94.2%	94.8%	97.3%			
	LPT	90.6%	99.0%	99.1%	98.8%	98.6%	98.7%	

5. NHS Oversight

The following targets form part of the 2021/22 NHS Oversight Framework that are being reported against in 2022/23. We continue working with Commissioners to understand the metrics to be reported at system/organisational level.

Target	Trust Performance						RAG/ Comments on recovery plan position
2-hour urgent response activity Early Implementer Target is 70% *(Local data)*	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	77.0%	80.8%	84.6%	75.7%	73.2%	81.3%	
Daily discharges as % of patients who no longer meet the criteria to reside in hospital No Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	18.9%	15.9%	20.4%	20.1%	19.9%	22.2%	
Reliance on specialist inpatient care for adults with a learning disability and/or autism *(CCG data)* No Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	29	29	28	29	29	32	
Reliance on specialist inpatient care for children with a learning disability and/or autism *(CCG data)* No Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	5	5	8	9	10	9	
Regulator Ratings No Target			*Fin Year*	*Score*	*Comments*		
	Overall CQC rating (provision of high quality care)		2021/2022	2	2 = requires improvement		
	CQC Well Led Rating		2021/2022	2	2 = requires improvement		
	NHS SOF Segmentation Score		2022/2023	2	*Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues*		
Potential under-reporting of patient safety incidents - Number of months in which patient safety incidents or events were reported to the NRLS No Target	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	October 2022 is the most recent data published						
National Patient Safety Alerts not completed by deadline No Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	0	0	0	0	0	1	
	Reporting is at point in time and cannot be backdated.						
MRSA Infection Rate No Target *(local data)*	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	0	0	0	0	0	0	

Clostridium difficile infection rate No Target *(local data)*	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	0	0	4	2	1	0	
E.coli bloodstream infections No Target *(local data - reported in arrears)*	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
	1	1	1	0	2	2	
VTE Risk Assessment No Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	Indicator is a placeholder as is not yet defined in the SOF Technical Guidance						
Percentage of people aged 65 and over who received a flu vaccination No Target *(LLR data - reported a month in arrears)*	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
				23.2%	67.3%	77.1%	
Proportions of patient activities with an ethnicity code No Target	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	
	Indicator is a placeholder as is not yet defined in the SOF Technical Guidance						

6(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%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	• The focus of the service is the wider transformation programme. • A flagship component of the Long Term Plan ambition to integrate mental health services around primary care. This will be in both 'fully' integrated (geographically organised teams) and 'virtual' (e.g. systemwide teams operating and tailoring offers in neighbourhoods) • It will move to delivering an ambitious 4 week access target for people with SMI and delivery of three priority pathways (Personality disorder, eating disorder and Community rehab); • There are also multiple delivery expectations on access and recovery for the different targeted populations; • Delivering acceptable waiting times and meeting performance expectations is expected to be a significant component of the transformation of services. These are built into the transformation schemes deliverables. This includes focusing on maximising the performance potential of services as they transition and transform.	N/A	N/A
	Complete	57.5%	53.2%	56.3%	57.1%	66.4%	69.7%		NO	UP
	Incomplete	55.3%	50.6%	54.1%	61.3%	65.5%	62.4%		Key standards are not being delivered but are improving	
Memory Clinic (18 week Local RTT) Target is 95%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	• A trajectory to improve waiting times compliance has been developed. • The service is completing a month of follow up activity to move patients through the pathway. The effect on waiting times will be monitored. • Weekend clinics have been agreed and commenced on Saturday 14th January to increase capacity.	N/A	N/A
	Complete	31.6%	27.7%	17.0%	18.8%	9.6%	22.1%		N/A	N/A
	Incomplete	62.9%	63.2%	64.8%	63.6%	65.9%	61.4%			
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	• Long waits to access and obtain treatment continue to be an ongoing challenge for the service with referral rates continuing to increase. • Work has started with ADHD Solutions to support patients pre-diagnosis, whilst on the waiting list and post-diagnosis. • Agreed to recruit to NMP (Non-Medical Prescriber) and Specialist Pharmacist roles.	N/A	N/A
	Complete	6.3%	11.1%	5.9%	8.7%	0.0%	0.0%		N/A	N/A
	Incomplete	1.6%	0.5%	0.3%	0.2%	0.4%	0.6%			
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	The service continues to maintain compliance against target.	?	UP
		85.0%	78.6%	87.5%	81.3%	92.9%	88.2%		Over the series of data points being measured, key standards are being delivered inconsistently	

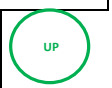
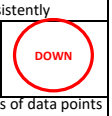
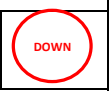
6(b). Access - Waiting Time Standards - CHS

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-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Number of new patients seen continued to increase in November. The waiting list decreased by 84 and the waiting list is signifcantly lower than the predicted trajectory. As of 28/12/22 - the longest waiter without an appt booked is 7 weeks. The longest waiter with an appt booked is 9 weeks. At the end of December (28/12/22) out of the 229 patients waiting there were 22 patients waiting over 4 weeks and 7 that did not have an appointment booked, Discharges are continuing to increase month on month which helps with patient flow.The service now has more patients waiting within the 20 working day target than outside the target and therefire, it is expected that compliance will continue to increase.	N/A	N/A
	29.3%	28.5%	13.4%	17.9%	25.6%	41.1%			
Continence (Complete Pathway) Target is 95%	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Number of patients waiting continues to decrease due to transformation actions and effective waiting times management. Referrals increased by 157, however the waiting list reduced by 237. Trajectory with best, likely and worse case scenarios in place and monitored monthly; service is currently over-achieving on the likely case scenario. Longest waiter is currently 16 weeks (1 patient) and the next longest is 10 weeks. Compliance is based on a 20 working day target and will not be achieved until the backlog of patients are seen, as patients are seen in chronological order unless deemed priority via traige matrix. Compliance reduced this month due to the proportion of longest waiters seen, compared to those in target. We expect to see compliance start to increase again over the coming months.	N/A	N/A
	50.1%	46.7%	45.9%	33.0%	44.3%	25.2%			

6(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%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	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. CYP are supported in the community whilst waiting through First Steps		
		n/a	100.0%	66.7%	100.0%	100.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	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. The current recovery trajectory is showing an increase in recovery over projection due to new posts being filled and the use of 'First Steps' to provide early preventative intervention.		
		62.5%	70.0%	88.9%	60.0%	87.5%	93.8%		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%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	The service are now consistently meeting this target		
		100.0%	100.0%	94.4%	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%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	A recent spike in referrals is being addressed through additional clinics. A recovery trajectory is in place with expected recovery May 2023. This is heavily reliant on appropriate referrals from the Triage and Navigation Hub		
		90.9%	92.1%	79.9%	62.3%	54.9%	55.5%		Over the series of data points being measured, key standards are being delivered inconsistently	
Aspergers - 18 weeks (complete pathway) Target is 95%	Wait for Treatment	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	The service has received record referrals with 866 referrals by the end of 21/22. This would be an increase of 127% from the 20/21 referral rate of 20/21 or 57% from the previous record of 549 referrals in 2019/20. The current referral rates suggest 800+ referrals for 22/23. (RTT). The service were given non-recurrent additional funding this year which have been risk-managed with recurrent staffing who are coming into post now and will have some overall impact. The service has implemented stricter referral in criteria from October which has significantly reduced the number of referrals	N/A	N/A
		0.0%	0.0%	6.3%	3.4%	0.0%	0.0%			
	No. of Referrals	71	66	58	48	5	1			
LD Community - 8 weeks (complete pathway) Target is 95%	Wait for Assessment	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Currently 57 out of 116 incomplete pathways are referrals from within LD. The service is reviewing this pathway and is working to update the KPI to remove this. For new external referrals, the service has been able to reduce to the total number of patients on the core new assessment waiting list from 108 in July to 49 in November.	N/A	N/A
		64.5%	66.1%	59.7%	41.1%	57.6%	60.7%			
	No. of Referrals	77	55	53	75	49	48			
6-week wait for diagnostic procedures (Incomplete) Target is >=99%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	In line with national COVID-19 guidance, this service was suspended. It was re-established in October 2020. We were able to address a significant amount of the backlog in 2021/22 with additional Headroom Investment. The service has reviewed their COVID IPC arrangements and are now offering close to pre-covid numbers per clinic.		
		70.4%	62.0%	71.8%	71.8%	75.6%	78.7%		Key standards are being delivered but are deteriorating	

7. 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	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	52 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall. Trajectories have been reset with a view to reducing longest waiters for treatment to a maximum of 35 weeks. Long term reduction in wait times to be delivered via the transformation plan, integrating assessment and intervention within the locality Treatment and Recovery Teams.	NO	DOWN
	22	13	2	0	1	0			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	93 weeks	The number of 52 week waiters are below the planned trajectory. Trajectories have been reset with a view to reducing longest waiters for treatment to a maximum of 35 weeks. Long term, sustainable reduction in wait times to be delivered via the transformation plan, integrating assessment and intervention within the locality Treatment and Recovery Teams. Trajectories are being reset.	NO	DOWN
	14	13	11	8	7	8			Key standards are not being delivered but are improving	
Therapy Service for People with Personality Disorder - assessment waits over 52 weeks (a month in arrears)	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	194 weeks	Currently exploring options around recording/reporting of referrals to strengthen reporting processes and illustrate flow through the TSPPD pathway. The treatment waiting times for TSPPD refer to period waiting for the current treatment offer. The longest patient waiting has previously been seen for treatment and is waiting for a specific treatment. Following recruitment of new staff and the development of treatment programmes, a significant number of service users are being offered and completing treatment within locality teams.	N/A	N/A
	317	300	288	287	278	276				
CAMHS	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	97 weeks	These are split between treatment waits and Neurodevelopmental diagnosis.	NO	UP
	127	134	146	183	197	218			Key standards are not being delivered and are deteriorating/ not improving	
All LD - No's waiting over 52 weeks	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	175 weeks	The majority of these are with the Adult Autism Service. There are still a few not wishing to be seen due to increased vulnerabilities.	N/A	N/A
	105	104	103	119	118	123				

8. 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%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	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.	?	UP
	85.4%	88.2%	89.8%	90.9%	92.9%	90.9%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	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).	?	UP
	92.3%	92.2%	90.5%	86.8%	88.5%	91.3%		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-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	The Trust consistently is below the national benchmark of 25 days.	YES	UP
	20.7	21.6	21.4	20.8	18.5	20.3		Key standards are being delivered but are deteriorating	
Delayed Transfers of Care Target is <=3.5% across LLR	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	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.	?	UP
	5.8%	4.8%	4.4%	5.0%	5.9%	4.3%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		?	UP
	100.0%	100.0%	100.0%	100.0%	100.0%	98.2%		Over the series of data points being measured, key standards are being delivered inconsistently	
Inpatient Admissions to LD and MH Wards with a Learning Disability *(Rolling 12 Month)* Target: Adult =36 CYP=3	**Adult**						The service are working through issues with the data.	N/A	N/A
	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22			
	CYP								
	Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.								
Admissions to adult facilities of patients under 18 years old Target = 0	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		n/a	n/a
	0	0	0	0	0	0			

9. Quality and Safety

Target	Trust Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Serious incidents		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		?	NO CHANGE
		5	8	6	5	2	3			
	Indicator under review								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		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		NO	NO CHANGE
	Day	8	5	4	4	4	3			
	Night	2	2	2	1	1	1			
									Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day No Target		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		N/A	N/A
		11.1	11.2	11.4	11.3	11.3	10.8			
									Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		N/A	NO CHANGE
		7	8	7	13	19	4			
									Key standard has no target; however performance is consistent	
No. of episodes of prone (Supported) restraint Target decreasing trend		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		N/A	DOWN
		0	2	0	2	1	2			
									Key standard has no target; however performance is consistent	
No. of episodes of prone (Unsupported) restraint Target decreasing trend		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		N/A	DOWN
		0	0	0	0	0	0			
									Key standard has no target; however performance is consistent	
Total number of Restrictive Practices (No target)		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		N/A	N/A
		180	166	108	109	221	88			

No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory) *(Reported a months in arrears)*		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22		N/A	NO CHANGE
	Category 2	81	66	121	87	91	88			
	Category 4	6	3	3	6	4	3		N/A	NO CHANGE
									Key standard has no target; however performance is consistent for category 2 and consistent for category 4	
No. of repeat falls Target decreasing trend *(Reported a months in arrears)*		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22		N/A	DOWN
		31	36	32	27	33	36			
									Key standard has no target; however performance is consistent	
LD Annual Health Checks completed - YTD Target is 70%		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Year To date from 1 April 2022	N/A	N/A
		14.6%	20.9%	27.6%	32.9%	38.9%	45.0%			
LeDeR Reviews completed within timeframe (No Target)		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	New LeDeR system is in place – need to redefine.	N/A	N/A
	Allocated	25	17	16	84	20	21			
	Awaiting Allocation	2	11	12	12	5	8		N/A	N/A
	On Hold	0	2	2	1	0	1		N/A	N/A

10. 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%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		YES	DOWN
	9.7%	9.3%	9.2%	9.1%	8.8%	8.8%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		NO	UP
	14.3%	15.5%	14.3%	13.6%	12.9%	12.7%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22		NO	NO CHANGE
	5.1%	5.0%	4.8%	5.1%	5.8%	5.4%		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	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22		n/a	n/a
	£745,752	£805,372	£755,961	£811,202	£968,224	£897,101			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22		n/a	n/a
	4.9%	5.1%	4.9%	4.9%	5.1%	5.1%		Not applicable for SPC as measuring cumulative data	
Agency Costs	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		NO	UP
	£2,893,923	£2,523,943	£2,661,362	£2,677,028	£2,653,661	£2,723,956		Key standards are not being delivered and are not improving	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		YES	UP
	93.2%	93.8%	93.8%	94.4%	94.8%	94.2%		Key standards are being consistently delivered and are improving	
Staff with a Completed Annual Appraisal Target is >=80%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		YES	DOWN
	81.3%	82.2%	82.2%	82.7%	83.3%	82.8%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		?	UP
	25.0%	25.1%	25.2%	25.2%	25.4%	25.9%		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-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		n/a	n/a
	n/a	n/a	n/a	n/a	47.4%	51.9%			
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22		NO	NO CHANGE
	83.9%	77.9%	77.9%	78.9%	80.8%	79.4%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Wellbeing Activity - No of LLR staff contacting the hub in the reporting period	2022-23 Q1	2022-23 Q2	2022-23 Q3	2022-23 Q4			The data has been cleansed, the numbers are now specific to the Hub.	N/A	N/A
	275	242							

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 2022

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

Normalised Workforce Turnover rate
Core Mandatory Training Compliance for Substantive Staff

Key standards being delivered but deteriorating

C 6-week wait for diagnostic procedures
C Length of stay - Community Services
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 – 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
C Occupancy rate – community beds (excluding leave)
% of staff from a BME background
MH Data Quality Maturity Index
Children and Young People's Access – four weeks (incomplete pathway)

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
Agency Cost
Vacancy rate
Sickness Absence
% of staff who have undertaken clinical supervision within the last 3 months
CAMHS over 52 weeks

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)
Admissions to adult facilities of patients under 18 years old

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	Sharon Murphy - Director of Finance and Performance	
Paper authored by:	Information Team	
Date submitted:	23/01/2023	
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	69 - If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience.
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:		