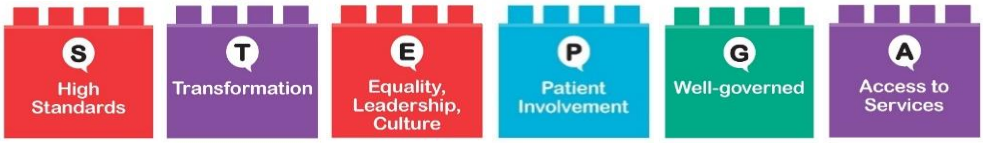
Leicestershire Partnership NHS
NHS Trust

Trust Board
28 March 2023

Board Performance Report
February 2023 (Month 11)

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



Highlighted Performance Movements - February 2023

Improved performance:

Metric	Performance	
Cognitive Behavioural Therapy - 52 weeks	0	
2-hour urgent response activity Early Implementer Target is 70%	85.1%	

Deteriorating Performance:

Metric	Performance	
Memory Clinic (18 week Local RTT) Target is 95%	5.0%	
ADHD (18 week local RTT) Target is: Complete - 95%	11.0%	

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	3	Increased from 2 reported last month
Total number of Category 4 pressure ulcers developed or deteriorated in LPT care	5	No change from last month
No. of episodes of prone (Supported) restraint	3	Increased from 0 reported last month
No. of repeat falls *Target decreasing trend*	30	Decreased from 30 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		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	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	477	380		
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	22	15		
	Covid +ve Admission Rate	3.6%	0.8%	1.8%	3.8%	0.9%	2.0%	4.9%	1.4%	7.2%	4.6%	3.9%		
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	16	10		
	3-7	17	2	9	13	4	5	21	2	15	10	11		
	8-14	15	2	5	10	2	4	9	5	11	14	7		
	15 and over	34	5	33	28	12	16	37	10	19	14	21		
	Hospital Acquired Rate *	13.6%	1.8%	10.0%	9.5%	3.3%	5.1%	10.3%	3.4%	6.6%	5.9%	7.4%		
	• 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	76	64		
	Average Covid +ve Admissions	22.8%	3.1%	15.3%	20.4%	6.4%	8.9%	21.6%	6.2%	18.1%	15.9%	16.8%		

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

Cases of covid within LPT have continued to reduce in line with the national picture. LPT have stood down admission testing for Covid-19 and removed the need to wear face masks in non inpatient areas, outpatients, corridors, lifts and social spaces. In areas with increased incidences or outbreaks of covid, visitors will also still be requested to wear masks.

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%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		YES	NO CHANGE
	100.0%	100.0%	100.0%	98.2%	97.3%	98.4%		Over the series of data points being measured, key standards are being consistently delivered and are improving/ maintaining performance	
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
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
	Age 16 or over								
	4.4%	3.4%	5.4%	7.3%	5.1%	4.5%			
The number and, where available rate of patient safety incidents reported within the Trust during the reporting period No Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		n/a	n/a
	979	1074	1206	1091	1384	1265			
	61.0%	59.1%	61.8%	60.8%	61.6%	62.1%			
The number and percentage of such patient safety incidents that resulted in severe harm or death No Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		n/a	n/a
	11	8	5	7	11	12			
	1.1%	0.7%	0.4%	0.6%	0.8%	0.9%			
72 hour Follow Up after discharge Target is >=80% *Aligned with national published data* *(reported a quarter in arrears)*	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Performance has been consistently above the 80% target since August 2022. Task and finish group has been set up to review processes. A Quality Improvement project has been established to review and refine a meaningful contact and ensure there is a robust criteria in place.	N/A	N/A
	69.0%	76.0%	82.0%	85.0%	91.0%	86.0%			

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%			52.3%	
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	Min- 20% Max- 35%	25.0%	50.0%	100.0%	
CCG 10a	Routine Outcome monitoring in CYP and Perinatal MH services	Min- 10% Max- 40%	4.5%	10.0%	12.5%	
CCG 10b	Routine Outcome monitoring in CMHT (inc MHSOP)	Min- 10% Max- 40%	0.0%	0.0%	6.0%	
CCG 12	Biopsychosocial assessments in MH Liaison services	Min- 60% Max- 80%	95.0%	98.0%	99.0%	
CCG 13	Malnutrition Screening Achieving 70% screening in inpatient hospitals	Min=50% Max=70%	0.0%	0.0%	73.5%	
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%	26.3%	
CCG 15	Assessment and documentation of pressure ulcer risk Achieving 60% assessment in inpatient hospitals	Min=40% Max= 60%	70.0%	69.1%	72.9%	
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%	100.0%	
PSS7	Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings	Min: 65% Max: 80%	93.1%	100.0%	100.0%	

Commentary:

CCG1 - compared to 50.3% for the Midlands
CCG10a/b - Awaiting official MHSDS figures figures (national difficulties with the data) - % given indicative
PSS6/7 - Quarter 3 Data not available nationally as yet - % given indicative

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%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Performance has been consistently above the 80% target since August 2022. Task and finish group has been set up to review processes. A Quality Improvement project has been established to review and refine a meaningful contact and ensure there is a robust criteria in place.
	LLR	71.0%				88.0%	84.0%	
	LPT	69.0%	76.0%	82.0%	85.0%	91.0%	86.0%	
(D1) Community Mental Health Access (2+ contacts) LLR Target is 3446		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
	LLR	11018				11165	11270	
	LPT	10940	11015	11010	11010	11140	11245	
(E1) CYP access (1+ contact) LLR Target is 10853		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-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.
	LLR	11534				12785	12535	
	LPT	5975	5990	6000	6055	6100	6135	
(E4) CYP eating disorders waiting time - Routine Target is >=95% Rolling 12 months (quarterly)		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-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						56.5%	
	LPT			39.4%			57.3%	
(E5) CYP eating disorders waiting time - Urgent Target is >=95% Rolling 12 months (quarterly)		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-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						57.3%	
	LPT			87.5%			88.1%	
(G3) EIP waiting times - MHSDS Target is >=60%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	The service continue to maintain compliance against target.
	LLR	81.0%				75.6%	77.8%	
	LPT	79.3%	71.7%	71.4%	70.8%	78.0%	80.0%	
(I1) Individual Placement Support LLR Target is 509		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Work continues to raise awareness of the service. A dedicated employment specialist is assigned to each team. Additional posts have been identified to meet next years target and included in the planning documents for 2023/24. Awaiting confirmation of funding to start recruitment as early as possible.
	LLR	206	240	270	295	335	370	
	LPT	205	235	265	295	330	365	

(K2) OOA bed days - inappropriate only No Target		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
	LLR	61	60	55	0	0	0	
	LPT	30	30	30	0	0	0	
(L1) Perinatal access - rolling 12 months LLR Target 1202		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
	LLR	747				905	940	
	LPT	735	770	805	820	900	935	
(L2) Perinatal access - year to date LLR Target is 840		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Continued drive to recruit to the service. Active campaign in progress to increase awareness of the service and, therefore, referrals into the service. Investment funding for 2023/24 is currently being agreed and workforce plans finalised.
	LLR	356	410	490	550	645	700	
	LPT	360	415	490	550	645	700	
(N1) Data Quality - Consistency No Target		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
	LLR	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	LPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
(N2) Data Quality - Coverage Target is >=95%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
	LLR	83.3%	83.3%	83.3%	83.3%	87.5%	83.3%	
	LPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
(N3) Data Quality - Outcomes Target is >=40%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
	LLR	24.3%	22.9%	22.3%	22.1%	21.6%	21.2%	
	LPT	24.5%	23.1%	22.5%	22.3%	21.8%	21.4%	
(N4) Data Quality - DQMI score Target is >=90		May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	
	LLR	60.5	60.7	62.5	60.8	59.8	60.1	
	LPT	95.2	94.9	94.8	94.7	94.9	95.2	
(N5) Data Quality - SNOMED CT Target is 100%		Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	
	LLR	94.8%	97.3%	92.9%	93.8%	95.0%	95.6%	
	LPT	99.1%	98.8%	98.6%	98.7%	98.7%	98.8%	

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)*	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	84.6%	75.7%	73.2%	81.3%	89.5%	85.1%	
Daily discharges as % of patients who no longer meet the criteria to reside in hospital No Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	20.4%	20.1%	19.9%	22.2%	20.9%	20.4%	
Reliance on specialist inpatient care for adults with a learning disability and/or autism *(CCG data)* No Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	28	29	29	32	33	32	
Reliance on specialist inpatient care for children with a learning disability and/or autism *(CCG data)* No Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	8	9	10	9	9	7	
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	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-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	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	0	0	0	1	1	1	
	Reporting is at point in time and cannot be backdated.						
MRSA Infection Rate No Target *(local data)*	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	0	0	0	0	0	0	

Clostridium difficile infection rate No Target *(local data)*	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	4	3	1	0	3	1	
E.coli bloodstream infections No Target *(local data - reported in arrears)*	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
	1	0	2	0	2	0	
VTE Risk Assessment No Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	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)*	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	
		23.2%	67.3%	77.1%	79.2%	80.4%	
Proportions of patient activities with an ethnicity code No Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
	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	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	RAG/ Comments on recovery plan position	SPC Flag: Assurance of Meeting Target	SPC Flag: Trend
Adult CMHT Access Six weeks routine Target is 95%	Complete	56.3%	57.1%	66.4%	69.7%	65.1%	63.2%	Caseload reviews are continuing , the outcomes of which are to be actioned. Additional capacity has developed through weekend discharge clinics to action the outcomes of the consultant caseload reviews. This should result in an increased number of discharges now that there is capacity to action the outcomes from the caseload review. The first workshop in relation to the transformation programme recently took place to launch the new 'implementing Planned Treatment and Recovery Teams' project has taken place which worked through key features of new teams, key process steps to implementing new teams.	N/A	N/A
	Incomplete	54.1%	61.3%	65.5%	62.4%	59.6%	54.4%		NO	NO CHANGE
									Key standards are not being delivered and are deteriorating/ not improving	
Memory Clinic (18 week Local RTT) Target is 95%	Complete	17.0%	18.8%	9.6%	22.1%	17.6%	5.0%	The service continues maximise all clinic slots to increase capacity. Weekend clinics have been agreed and commenced on Saturday 14th January, increasing capacity and reducing waits. A trajectory to improve waiting times compliance has been developed and is being regulary monitored.	N/A	N/A
	Incomplete	64.8%	63.6%	65.9%	61.4%	61.1%	58.6%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%	Complete	5.9%	8.7%	0.0%	0.0%	20.0%	11.8%	Long waits to access and obtain treatment continue to be an ongoing challenge for the service with referral rates continuing to increase. Non-recurrent funding agreed to recruit to NMP (Non-Medical Prescriber) and Specialist Pharmacist roles. Work has started with ADHD Solutions to support patients pre-diagnosis, whilst waiting and post-diagnosis.	N/A	N/A
	Incomplete	0.3%	0.2%	0.4%	0.6%	0.6%	0.5%		N/A	N/A
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60%		87.5%	81.3%	92.9%	88.2%	80.0%	88.2%	The service continues to maintain compliance against target.	?	NO CHANGE
									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%	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	42% increase in complete compliance since Aug 22 to Jan 23. The waiting list is signifcantly lower than the predicted trajectory. As of 27/2/22 - the longest waiter without an appt booked is 7 weeks. The longest waiter with an appt booked is 10 weeks. At the end of February (27/2/22) out of the 222 patients waiting there were 24 patients waiting over 4 weeks and 2 of those that did not have an appointment booked. The service continues to have more patients waiting within the 20 working day target than outside the target and therefore, it is expected that compliance will continue to increase.	N/A	N/A
	13.4%	17.9%	25.6%	41.1%	49.7%	55.0%			
Continence (Complete Pathway) Target is 95%	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Number of patients waiting continues to decrease slightly. N.B. the number has reduced by 800 since Jan 22. Referrals increased in January by circa. 250 on previous month, which had an inevitable negative impact on the numbers waiting. However, the service is currently over-achieving on the likely case scenario. Longest waiter is was 11 weeks (3 patients). 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. However, complete compliance continues to steadily increase as predicted, as more patients are now waiting within target than out of target.	N/A	N/A
	45.9%	33.0%	44.3%	25.2%	34.6%	48.9%			

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%		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	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	?	NO CHANGE
		66.7%	100.0%	100.0%	100.0%	100.0%	83.3%		Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Routine - routine referrals are now being seen within the 4 week timeframe after a sustained period of recovery using the additional capacity provided through MHIS and the use of 'First Steps' to provide early preventative intervention.	NO	UP
		88.9%	60.0%	87.5%	93.8%	100.0%	83.3%		Over the series of data points being measured, Key standards are not being delivered but are improving	
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	The service are now consistently meeting this target	YES	NO CHANGE
		94.4%	100.0%	100.0%	100.0%	100.0%	100.0%		Over the series of data points being measured, key standards are being consistently delivered and are improving/ maintaining performance	
Children and Young People's Access – 13 weeks (incomplete pathway) Target is 92%		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	A recent spike in referrals is being addressed through additional clinics. A recovery trajectory is in place with expected recovery Q2 2023/24. This is heavily reliant on MHIS investment and recruitment	?	DOWN
		79.9%	62.3%	54.9%	55.5%	58.6%	58.3%		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	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	The service currently has increasing demand not matched by capacity. There is a business case for further investment that will begin to address the issue. If there is no investment we would expect this to remain at low non-compliance. The service are looking at alternative mitigation if there is no increased investment	N/A	N/A
		6.3%	3.4%	0.0%	0.0%	27.3%	14.8%			
	No. of Referrals	58	48	5	1	6	33			
LD Community - 8 weeks (complete pathway) Target is 95%	Wait for Assessment	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	The service are demonstrating a slow recovery in line with the trajectory	N/A	N/A
		59.7%	41.1%	57.6%	60.7%	71.4%	88.2%			
	No. of Referrals	53	75	49	48	50	49			
6-week wait for diagnostic procedures (Incomplete) Target is >=99%		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	The service are currently plateaued with no significant recovery predicted. The directorate has approved non-recurrent temporary recruitment to compensate for staff maternity leave and long term sickness to mitigate	NO	NO CHANGE
		71.8%	71.8%	75.6%	78.7%	66.8%	76.9%		Key standards are not being delivered and are deteriorating/ not improving	

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	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	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
	2	0	1	0	3	0			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	100 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
	11	8	7	8	8	11			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)	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	200 weeks	Currently finalising new recording/reporting processes to strengthen reporting processes and illustrate flow through the TSPPD pathway. As part of step-up-to-great and planned care work stream the service continues to work to a position whereby all first assessments for planned treatment, which includes those going onto the TSPPD pathway, will be provided through the planned treatment and recovery teams as part of a pathfinder/consulter assessment process. This will serve as the initial assessment as part of an integrated planned community offer	N/A	N/A
	288	287	278	276	274	40				
CAMHS	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	105 weeks	These are split between treatment waits and Neurodevelopmental diagnosis.	NO	NO CHANGE
	146	183	197	218	221	200			Key standards are not being delivered and are deteriorating/ not improving	
All LD - No's waiting over 52 weeks	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	122 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
	103	119	118	123	125	117				

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%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	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
	89.8%	90.9%	92.9%	90.9%	94.9%	94.3%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	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).	?	NO CHANGE
	90.5%	86.8%	88.5%	91.3%	91.9%	89.3%		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.	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	The Trust consistently is below the national benchmark of 25 days.	YES	NO CHANGE
	21.4	20.8	18.5	20.3	21.6	20.6		Key standards are being consistently delivered and are improving/ maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	NHS Digital has advised this national metric is being paused to release resources to support the COVID-19 response. We will continue to monitor locally.	?	NO CHANGE
	4.4%	5.0%	5.9%	4.3%	3.8%	3.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		YES	NO CHANGE
	100.0%	100.0%	100.0%	98.2%	97.3%	98.4%		Over the series of data points being measured, key standards are being consistently delivered and are improving/ maintaining performance	
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
	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23			
	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	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		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	Sep-22: 6; Oct-22: 5; Nov-22: 2; Dec-22: 3; Jan-23: 2; Feb-23: 3 *Indicator under review*		?	NO CHANGE
			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: Sep-22: 4; Oct-22: 4; Nov-22: 4; Dec-22: 3; Jan-23: 4; Feb-23: 4 Night: Sep-22: 2; Oct-22: 1; Nov-22: 1; Dec-22: 1; Jan-23: 2; Feb-23: 2		NO	NO CHANGE
			Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day No Target	Sep-22: 11.4; Oct-22: 11.3; Nov-22: 11.3; Dec-22: 10.8; Jan-23: 10.9; Feb-23: 11.2		N/A	N/A
			Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend	Sep-22: 7; Oct-22: 13; Nov-22: 19; Dec-22: 4; Jan-23: 19; Feb-23: 11		N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of prone (Supported) restraint Target decreasing trend	Sep-22: 0; Oct-22: 2; Nov-22: 1; Dec-22: 2; Jan-23: 0; Feb-23: 3		N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of prone (Unsupported) restraint Target decreasing trend	Sep-22: 0; Oct-22: 0; Nov-22: 0; Dec-22: 0; Jan-23: 0; Feb-23: 1		N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
Total number of Restrictive Practices (No target)	Sep-22: 108; Oct-22: 109; Nov-22: 221; Dec-22: 88; Jan-23: 106; Feb-23: 162		N/A	N/A

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)*		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23		N/A	NO CHANGE
	Category 2	121	87	91	88	88	94			
	Category 4	3	6	4	3	5	5		N/A	NO CHANGE
									Key standard has no target; however performance is consistent for category 2 and consistent for category 4	
No. of repeat falls Target decreasing trend *(Reported a months in arrears)*		Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23		N/A	NO CHANGE
		32	27	33	36	35	30			
									Key standard has no target; however performance is consistent	
LD Annual Health Checks completed - YTD Target is 70%		Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Year To date from 1 April 2022	N/A	N/A
		27.6%	32.9%	38.9%	45.0%	53.0%	63.9%			
LeDeR Reviews completed within timeframe (No Target)		Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	New LeDeR system is in place – need to redefine.	N/A	N/A
	Allocated	16	84	20	21	25	23			
	Awaiting Allocation	12	12	5	8	5	7		N/A	N/A
	On Hold	2	1	0	1	2	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%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		YES	DOWN
	9.2%	9.1%	8.8%	8.8%	9.0%	8.6%		Key standards are being consistently delivered and are maintaining performance	
Vacancy rate Target is <=7%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		NO	UP
	14.3%	13.6%	12.9%	12.7%	13.4%	13.2%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23		?	NO CHANGE
	4.8%	5.1%	5.8%	5.4%	6.1%	5.7%		Over the series of data points being measured, key standards are being delivered inconsistently	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23		n/a	UP
	£755,961	£811,202	£968,224	£897,101	£1,008,541	£962,669			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23		n/a	n/a
	4.9%	4.9%	5.1%	5.1%	5.2%	5.3%		Not applicable for SPC as measuring cumulative data	
Agency Costs	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		NO	NO CHANGE
	£2,661,362	£2,677,028	£2,653,661	£2,723,956	£2,507,308	£2,640,025		Key standards are not being delivered and are not improving	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		YES	UP
	93.8%	94.4%	94.8%	94.2%	95.4%	95.7%		Key standards are being consistently delivered and are improving	
Staff with a Completed Annual Appraisal Target is >=80%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		?	UP
	82.2%	82.7%	83.3%	82.8%	82.6%	83.9%		Key standards are being delivered inconsistently	
% of staff from a BME background Target is >= 22.5%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		YES	UP
	25.2%	25.2%	25.4%	25.9%	25.7%	25.8%		Over the series of data points being measured, key standards are being consistently delivered and are improving	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		n/a	n/a
	n/a	n/a	47.4%	51.9%	53.7%	53.8%			
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23		NO	UP
	77.9%	78.9%	80.8%	79.4%	81.1%	81.0%		Key standards are not being delivered but are 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				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 – February 2023

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
Children and Young People's Access – four weeks (incomplete pathway)
C Length of stay - Community Services
Gatekeeping
% of staff from a BME background

Key standards being delivered but deteriorating

Key standards being delivered inconsistently

CAMHS ED one week (complete)
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral
Sickness Absence
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)
Staff with a Completed Annual Appraisal
C Diff
C Occupancy rate – community beds (excluding leave)

Key standards not being delivered but improving

Dynamic Psychotherapy over 52 weeks
Cognitive Behavioural Therapy over 52 weeks
% of staff who have undertaken clinical supervision within the last 3 months

Key standards not being delivered but deteriorating/ not improving

Safe Staffing
Personality Disorder over 52 weeks
Agency Cost
Vacancy rate
CAMHS over 52 weeks
Adult CMHT Access six week routine (incomplete)
CAMHS Eating Disorder – four weeks - (complete pathway)
C 6-week wait for diagnostic procedures

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:	28/03/2023	
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:		